Focused Professional Practice Evaluation (FPPE) & Ongoing Professional Practice Evaluation (OPPE) Criteria

DEPARTMENT	*FPPE Initially Granted "Core" Privileges*	*FPPE (Focused Review)Triggers*	*OPPE Indicators*
Anesthesia **Med. Staff→** **QR PIC-Cristina Refec→**	Anesthesiologist, CRNA, Anesthesia PA • Early direct observation 5 Cases, establish IV access, and establish arterial pressure line Nurse Practitioner • Supervising physician feedback	• Circumstances that include (but are not limited to) identified trends as deemed by review of designated indicators, the provider's significant deviation from the standards of performance as determined by the Department Chief or by a standing peer review committee of the medical staff, the determination that the performance of the provider consistently has deviated from established hospital policies and procedures. This may include "never" or sentinel events (example: wrong nerve site surgery).	<u>Review:</u> • Referral/Variance • Validated provider behavior incident • Validated patient complaints • Acute MI, Arrest, Death or re-intubation w/in 24 hrs anesthesia • New neurological impairment • Injury to pt / major (requires treatment and follow-up • Complication due to post-op nerve block <u>Informational (Rule) Letter</u> • Non-participation timeout • Compliments • Blood Appropriateness • Blood consents • Documentation – Inaccurate, Do not Use abbreviations, anesthesia eval, Post-procedure note,-Illegible med orders <u>Supervising Physician Feedback</u> – NP/PA

Emergency Medicine **QR- PIC Jennifer Lopez (All)**	Physician (Adult Medicine) • Review of 5 early cases that include one or more of the following procedures: Central line placement, chest tube insertion, rapid sequence intubation, joint reduction, trauma management, procedural sedation, lumbar puncture, laceration repair Physician (Pediatric Medicine) • Review of 5 early cases that include one or more of the following procedures - Procedural sedation, lumbar puncture, laceration repair Nurse Practitioner or Physician Assistant • Observation of Laceration repair (3) and incision and drainage (2) • Supervising Physician Feedback	• Circumstances that include (but are not limited to) identified trends as deemed by review of designated indicators, the provider's significant deviation from the standards of performance as determined by the Department Chief or by a standing peer review committee of the medical staff, the determination that the performance of the provider consistently has deviated from established hospital policies and procedures. This may include "never" or sentinel events (example: wrong site surgery).	Review • Referral/Variance • Intervention after Moderate Sedation • Validated provider behavior incident • Validated patient complaint • Discrepancy between discharge summary and autopsy report Informational (Rule) Letter • C-Spine Clearance orders • Non-participation timeout • Compliments (physician liaison) • Blood Appropriateness • Blood consents • Documentation – Inaccurate, Do not Use abbreviations, H&P, Post-procedure note, Illegible med orders Supervising Physician Feedback – NP/PA Nurse Screen - Injury to Organ (pneumothorax, post procedure bleeding), ED mortality, Cardiac Arrest PTA

.Family Medicine **QR- PIC Janis Murray→**	Physician • Review of 5 early cases	• Circumstances that include (but are not limited to) identified trends as deemed by review of designated indicators, the provider's significant deviation from the standards of performance as determined by the Department Chief or by a standing peer review committee of the medical staff, the determination that the performance of the provider consistently has deviated from established hospital policies and procedures. This may include "never" or sentinel events (example: wrong site surgery).	<u>Review</u> • Referral/Variance • Discrepancy discharge summary and autopsy report • Validated provider behavior incident • Validated patient complaint • Suicide/homicide during hospital stay or within 30 days of discharge <u>Informational (Rule) Letter</u> • Compliments • Blood Appropriateness • Blood consents • Documentation – Inaccurate, H&P, Post-procedure note, Illegible med orders • Stroke, VTE Measures – info letter, rates • Telemetry Orders (Medical-Surgical) that do not meet ACC Criteria <u>Rate</u> • GECC attending physician visit w/in 72 hrs of admission and documentation of progress notes every 30 days for the first 3 months, then every 60 days • Complication & readmission rates • ALOS <u>Nurse Screen</u> - Non-surgical mortality, hospital acquired DVT/PE

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Medicine **Med. Staff →**	Cardiologist • Direct observation of 2 cardiac catheterizations, 2 electrophysiological studies, 2 pacers, 2 ICD implants, 2 biventricular pacers, Peripheral diagnostic and peripheral vascular PTAs per delineation of privileges	• Circumstances that include (but are not limited to) identified trends as deemed by review of designated indicators, the provider's significant deviation from the standards of performance as determined by the Department Chief or by a standing peer review committee of the medical staff, the determination that the performance of the provider consistently has deviated from established hospital policies and procedures. This may include "never" or sentinel events (example: wrong site surgery).	<u>Review</u> • Referral/Variance • Intervention after Moderate Sedation • Discrepancy discharge summary and autopsy report • Validated provider behavior incident • Validated patient complaint • Suicide/homicide during hospital stay or within 30 days of discharge • Cardiac Cath/PCI – Mortality, intubation in cath lab, bleeding complication (hematoma > 10 cm, retroperitoneal hemorrhage, hematoma requiring transfusion or vascular repair, emergency surgical intervention, stroke after procedure, contrast induced nephropathy, device embolization, Acute or Subacute stent thrombosis • EP –Mortality, unplanned intubation, perforation with tamponade, perforation, lead dislodgement, pocket infection with explantation, stroke, pneumothorax • TAVR – major vascular access site complication requiring surgical intervention, perforation, neurologic deficit after procedure, aortic valve re-intervention after TAVR during initial hospitalization <u>Informational (Rule) Letter</u> • Non-participation timeout • Compliments • Blood Appropriateness • Blood consents • Documentation – Inaccurate, Do not Use abbreviations, H&P, Post-procedure note, Illegible med orders • Stroke, VTE Measures – info letter, rate • Telemetry Orders (Medical-Surgical) that do not meet ACC Criteria <u>Rate</u> • GECC attending physician visit w/in 72 hrs of admission and documentation of progress notes every 30 days for the first 3 months, then every 60 days • Complication & readmission rates • ALOS <u>Track/trend</u> • Cath Lab Hematoma with
Med. Staff →	Gastroenterologist • Direct early observation of 3 EGDs , 3 colonoscopies, 1 PEG, and 3 ERCPs with sphincterotomy		
Med. Staff →	Pulmonologist • Direct early observation of 3 bronchoscopies		
QR- PIC- Janis Murray→	All other Physicians • Review of 5 early cases		
Rita Michael→	Nurse Practitioner or Physician Assistant • Procedures • Supervising Physician Feedback		
QR-PIC- Janis Murray→	Psychologist, Social Worker, Psychiatric CNS, Licensed Professional Counselor, Marriage & Family Therapist • Review of 5 early cases		
QR-PIC- Janis Murray→	Low/ No volume providers- office-based or consultative & Nocturnist • 3 peer recommendations of provider's choice outside of proctored provider's practice		

			pseudoaneurysm Supervising Physician Feedback – NP/PA Nurse Screen - Non-surgical mortality, Injury to organ (e.g., pneumothorax, bleeding post-procedure), hospital acquired DVT/PE

<table>
<tr>
<td rowspan="6">Obstetrics/ Gynecololgy

Med. Staff→

Med. Staff→

Med. Staff→

QR-PIC- Janis Murray→

Med. Staff→

QR-PIC- Janis Murray→

QR-PIC- Janis Murray→</td>
<td>Physician – OB
▪ Direct observation of Cesarean Section, Operative Vaginal Delivery, Vaginal Delivery, Circumcision,
(1of the 2 following Must Be Monitored)
▪ Tubal Ligation, Cerclage</td>
<td rowspan="6">• Circumstances that include (but are not limited to) identified trends as deemed by review of designated indicators, the provider's significant deviation from the standards of performance as determined by the Department Chief or by a standing peer review committee of the medical staff, the determination that the performance of the provider consistently has deviated from established hospital policies and procedures. This may include "never" or sentinel events (example: wrong site surgery).</td>
<td rowspan="6"><u>Review</u>
• Referral/Variance
• Discrepancy discharge summary and autopsy report
• Validated provider behavior incident
• Validated patient complaint
• Suicide/homicide during hospital stay or within 30 days of discharge
• Unplanned return to surgery
• Birth Injury (cerebral hemorrhage, subgaleal hemorrhage (exclude pre-term)
• Injury to patient (operative laceration not recognized and repaired, uterine rupture, repair of vaginal laceration in OR
<u>Informational (Rule) Letter</u>
• Non-participation timeout
• Compliments
• Blood Appropriateness
• Blood consent
• Documentation – Inaccurate, Do not Use abbreviations, H&P, Post-procedure note, Illegible med orders
• Wound infection (deep SSI)(targeted procedures)
• VTE measures
• Telemetry Orders (Medical-Surgical) that do not meet ACC Criteria
<u>Rate</u>
• Complication & readmission rates
• ALOS
• Robotic complications (hemorrhage/injury organ), readmits after OP procedure
<u>Supervising Physician Feedback</u> – NP/PA, RNFA
<u>Nurse Screen</u> – transfer to ICU or another facility, APGAR <u>≤</u> 5 at 5 min, other attended delivery or unattended delivery (avoidable), surg mortality < or > 3 days post-op, non-surgical mortality, eclamptic seizure, birth injury (clavicle fracture, brachial plexus), elective delivery < 39 completed weeks, hospital acquired DVT/PE, injury to patient and/or organ (accidental operative laceration, fourth degree perineal laceration)</td>
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<td>Physician - Gyn
▪ Direct observation of Gynecologic Procedures -
○ Total Abdominal Hysterectomy
○ Vaginal Hysterectomy
○ Operative Laparoscopy
(3 of the following 5 must be monitored)
○ Operative Hysteroscopy
○ Suction D&C
○ Laparoscopic Assisted Vaginal Hysterectomy (LAVH)
○ Pelvic Relaxation Procedure
○ Urinary Incontinence Procedure</td>
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<td>Robotics
• Direct observation of 2 cases, followed by
• Retrospective review of 5 early charts</td>
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<tr>
<td>CNMW
• Direct observation of 3 cases Vaginal Delivery, Circumcision (1)</td>
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<tr>
<td>NP
• Supervising Physician Feedback</td>
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<td>RNFA
• Supervising Physician Feedback</td>
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Oral & Maxillofacial Surgery **Med. Staff→**	• Direct observation of 10 cases	• Circumstances that include (but are not limited to) identified trends as deemed by review of designated indicators, the provider's significant deviation from the standards of performance as determined by the Department Chief or by a standing peer review committee of the medical staff, the determination that the performance of the provider consistently has deviated from established hospital policies and procedures. This may include "never" or sentinel events (example: wrong site surgery).	<u>Review</u> • Referral/Variance • Validated provider behavior incident • Validated patient complaints • Mortality <u>Informational (Rule) Letter</u> • Non-participation timeout • Compliments • Blood Appropriateness • Blood consent • Documentation – Inaccurate, Do not Use abbreviations, H&P, Post-procedure note, Illegible med orders <u>Rate</u> • Complications

Orthopedic Surgery **Med. Staff→** **QR-PIC- →** **Cristina Refec** **QR-PIC- →** **Cristina Refec** **QR-PIC- →** **Cristina Refec**	Physician or Podiatrist • Direct observation of 2 cases, followed by • Retrospective review of 5 cases (effective 1/2009) NP or PA • Supervising Physician Feedback RN First Assist • Supervising Physician Feedback	• Circumstances that include (but are not limited to) identified trends as deemed by review of designated indicators, the provider's significant deviation from the standards of performance as determined by the Department Chief or by a standing peer review committee of the medical staff, the determination that the performance of the provider consistently has deviated from established hospital policies and procedures. This may include "never" or sentinel events (example: wrong site surgery).	<u>Review</u> • Referral/Variance • Validated provider behavior incident • Validated patient complaints • New neurological impairment • Injury to an organ, major nerve or blood vessel • Surgical mortality • Unplanned return to surgery <u>Informational (Rule) Letter</u> • Non-participation timeout • Compliments (physician liaison) • Blood Appropriateness • Blood consent • Documentation – Inaccurate, Do not Use abbreviations, H&P, Post-procedure note, Illegible med orders • Telemetry Orders (Medical-Surgical) that do not meet ACC Criteria • Deep or organ/ space wound infection <u>Rate</u> • Complication rate • Readmission rate, ALOS <u>Supervising Physician Feedback</u> – NP/PA, RNFA • <u>Nurse Screen</u> - intraoperative EBL > expected, hospital acquired DVT/PE, dural tear not discovered at time of injury and requires treatment

Focused Professional Practice Evaluation (FPPE) & Ongoing Professional Practice Evaluation (OPPE) Criteria

Pathology **Med Staff→**	Physician • Review of first 100 cases PA • Direct observation of first 20 cases, work is supervised & reviewed daily by pathologist • Supervising Physician Feedback	• Circumstances that include (but are not limited to) identified trends as deemed by review of designated indicators, the provider's significant deviation from the standards of performance as determined by the Department Chief or by a standing peer review committee of the medical staff, the determination that the performance of the provider consistently has deviated from established hospital policies and procedures.	Review • Referral/Variance • Validated provider behavior incident • Frozen section findings agreement with final pathology report (Code 1, 2 or 3) • Retrospective internal or external peer review (Code 1, 2, or 3) Informational Discussion • failure to conduct pre-autopsy MR review, preliminary autopsy report not completed timely manner per R&R, final autopsy report incomplete or not done per current R&R Supervising Physician Feedback – PA

Pediatrics **QR-PIC-Janis Murray All →**	Neonatologist • Direct observation of Umbilical vein catheter (2), umbilical artery catheter (2), peripheral central line (2), ventricular access device tap (1), thoracentesis/chest tube placement (1), peripheral arterial puncture/line (2), lumbar puncture (2), percutaneous central venous line (2), endo-tracheal intubation (2), circumcision (1) • Review of 3 cases full/near term infants, 2 cases 28 or less week or less than 1000 gram neonate	• Circumstances that include (but are not limited to) identified trends as deemed by review of designated indicators, the provider's significant deviation from the standards of performance as determined by the Department Chief or by a standing peer review committee of the medical staff, the determination that the performance of the provider consistently has deviated from established hospital policies and procedures. This may include "never" or sentinel events (example: wrong site surgery).	<u>Review</u> • Referral/Variance • Intervention after Moderate Sedation • Validated provider behavior incident or patient complaint • Validated patient complaints <u>Informational (Rule) Letter</u> • Non-participation timeout • Compliments • Blood Appropriateness • Blood consents • Documentation – Inaccurate, Do not Use abbreviations, H&P, Post-procedure note, Illegible med orders <u>Rate</u> • Complication & readmission rates • ALOS <u>Supervising Physician Feedback</u> – NP/PA <u>Nurse Screen</u> – mortality (NICU)
QR-PIC-Janis Murray All →	Neonatal NP or PA • Direct observation of Umbilical vein catheter (2), umbilical artery catheter (2), peripheral central line (2), ventricular access device tap (1), thoracentesis/chest tube placement (1), peripheral arterial puncture/line (2), lumbar puncture (1), percutaneous central venous line (2), endo-tracheal intubation (2) • Review of 3 cases full/near term infants, 2 cases 28 or less week or less than 1000 gram neonate		
QR-PIC-Janis Murray All →	Pediatrician – • Review of 5 cases minimum requirements to be (3 healthy term newborns, 2 infants with clinical issues of either jaundice, at- risk for sepsis, hypoglycemia, or late preterm infant)		
QR-PIC-Janis Murray All →	Pediatric Cardiologist – • Review of 5 cases of infants with potential underlying cardiac disease in the NICU or newborn nursery to include transthoracic echocardiogram and 12 lead EKG rhythm strip interpretation		
QR-PIC-Janis Murray All →	Other NP or PA • Supervising Physician Feedback Low/ No volume providers- office-based or consultative : • 3 peer recommendations of provider's choice outside of proctored provider's practice		

Radiology **QR-PIC-** **Janis Murray** **All →**	Mammographic Procedures – • Direct observation of stereotactic biopsies (2), ultrasound guided biopsy (2)	• Circumstances that include (but are not limited to) identified trends as deemed by review of designated indicators, the provider's significant deviation from the standards of performance as determined by the Department Chief or by a standing peer review committee of the medical staff, the determination that the performance of the provider consistently has deviated from established hospital policies and procedures. This may include "never" or sentinel events (example: wrong site surgery).	Review • Referral/Variance • Intervention after Moderate Sedation • Validated provider behavior incident or patient complaint • Validated patient complaints • PeerVue score of 3b or 4b • Pneumothorax requiring Chest Tube after procedure Informational (Rule) Letter • Non-participation timeout • Compliments • Blood Appropriateness • Blood consents • Documentation – Inaccurate, Do not Use abbreviations, H&P, Post-procedure note, Illegible med orders • Wound infection Supervising Physician Feedback – PA and NP Nurse Screen – injury to organ/patient, biopsy procedure complications (bleeding, hematoma, infection, peritonitis, hemoptysis), mortality
	Interventional Radiologist • Direct observation of tunneled central venous catheter (3), image guided biopsy (3), non-tunneled central venous catheter placement (3)		
	Diagnostic Radiologist • Review of 10 plain radiograph films and 10 cross sectional films via PeerVue		
	Other – (NightHawk) • Review of 10 Diagnostic Imaging Cases via PeerVue		
	PA or NP • Direct observation of 2 Thoracentesis, 2 PICC, 2 Paracentesis		
QR-PIC- **Janis Murray** **All →**	Rad Onc • Direct observation of 2 cases		
	Radiation Physicist • Direct observation of 2 cases by Supervising Physician		

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Surgery **Med. Staff – All direct observation** **QR Staff- Cristina Refec retrospective reviews** **QR staff- Cristina Refec →** **QR staff- Cristina Refec →**	Surgeon • Direct observation of 5 cases, then • Retrospective review of 5 cases Bariatrics • Direct observation of 3 open cases, 3 closed cases, then • Retrospective review of 10 early cases Robotics • Direct observation of 2 cases (if lap experience) or 5 cases (if no lap experience, then • Retrospective review of 5 early cases NP or PA • Procedures (CVOR only) • Supervising Physician Feedback RN First Assist • Supervising Physician Feedback	• Circumstances that include (but are not limited to) identified trends as deemed by review of designated indicators, the provider's significant deviation from the standards of performance as determined by the Department Chief or by a standing peer review committee of the medical staff, the determination that the performance of the provider consistently has deviated from established hospital policies and procedures. This may include "never" or sentinel events (example: wrong site surgery).	<u>Review</u> • Referral/Variance • Discrepancy discharge summary and autopsy report • Validated provider behavior incident • Validated patient complaints • Dural tear not discovered at time of injury and requires treatment • Stroke after endarterectomy • Accidental enterotomy not recognized & repaired at time of injury • Anastomotic leak • Injury to organ, major nerve or blood vessel • Wound hematoma after plastic surgery (excludes s/p radiation pts) • TAVR – major vascular access site complication requiring surgical intervention, perforation, neurologic deficit after procedure, aortic valve re-intervention after TAVR during initial hospitalization. <u>Informational (Rule) Letter</u> • Non-participation timeout • Compliments (physician liaison) • Blood Appropriateness • Blood consents • Documentation – Inaccurate, Do not Use abbreviations, H&P, Post-procedure note, Illegible med orders • Deep or organ/ space wound infection (SSI) for targeted procedures only • VTE measures • Telemetry Orders (Medical-Surgical) that do not meet ACC Criteria <u>Rate</u> • GECC attending physician visit w/in 72 hrs of admission and documentation of progress notes every 30 days for the first 3 months, then every 60 days • Complication rate • Robotic complications (hemorrhage/injury organ), readmits after OP procedure • Readmission rate, ALOS <u>Supervising Physician Feedback</u> – NP/PA/RNFA <u>Nurse Screen</u> - mortality, hospital acquired DVT/PE, unscheduled returns to surgery

Note – does not include Surgical Assistants.

Revisions Approved by:

CV Surgery Quality Committee	05/18/2016
EP Quality Committee	05/23/2016
Cath/PCI Quality Committee	03/11/2016
Department of Anesthesia (Dept. Vice Chief)	05/18/2016, 07/25/2016
Department of Emergency Medicine PI Committee	05/18/2016
Department of Family Practice (Dept. Chief)	05/23/2016
Department of Medicine PI Committee	05/11/2016
Department of Ob/Gyn PI Committee	04/20/2016
Department of Orthopedics PI Committee	05/26/2016
Department of Pediatrics PI Committee (Dept. Chief)	04/27/2016
Department of Radiology PI Committee (Dept. Chief)	05/12/2016
Department of Surgery PI Committee (Dept. Chief)	05/11/2016

Reviewed and Approved by:

Medical Performance Improvement Committee	07/19/2016
Credentials Committee	07/07/2016
Multispecialty Peer Review Committee	07/11/2016
Medical Executive Committee	08/09/2016