Focused Professional Practice Evaluation (FPPE)

**Medical and Dental Staff Policy**

**DEFINITION:** Focused Professional Practice Evaluation (FPPE) is a process whereby the Medical and Dental Staff evaluates the competency and professional performance of its staff members. FPPE is not considered an investigation and is not subject to regulations afforded in the investigation process. If FPPE results in an action plan to perform an investigation, the process identified in the Meridian Hospital Medical and Dental Staff Bylaws would be followed.

**PURPOSE:** When a staff member has the credentials to suggest competence, but additional information or a period of evaluation is needed to confirm the competence or if a question arises regarding an individual’s professional practice during the course of the Ongoing Professional Practice Evaluation (OPPE).

**SCOPE:** Medical and Dental Staff and Health Professional Affiliates of Meridian Hospitals.

**POLICY:** Upon appointment to the Medical and Dental Staff or Health Professional Affiliate Staff of Meridian Health each staff member shall have his/her performance monitored and evaluated. FPPE shall be performed and documented for each staff member who is granted new clinical privileges by the Board of Trustees or for anyone referred from the OPPE process. (EP1)

**THE EVALUATION:**

**Factors to be considered**
Criteria used for evaluation include, but are not limited to:

- a) concurrent review of the staff member’s assessment and treatment of patients;
- b) review of invasive and non-invasive clinical procedures performed and their outcomes;
- c) blood utilization, medication management, and morbidity and mortality data;
- d) requests for test procedures, use of consultants, and medical record compliance.

**The Evaluation process**
Information used for evaluation may be obtained through any of the following:

- a) concurrent and/or targeted medical record review;
- b) direct observation;
- c) monitoring/proctoring;
- d) discussion with other staff members involved in the care of specific patients;
- e) data collected QI&O;
- f) sentinel event data;
- g) applicable peer review data.
THE PROCESS

Initial and New Privileges:
The Section Chief or Department Chair shall decide what type and what duration of proctoring is most appropriate for each staff member taking into consideration the clinical experience and training and the clinical privileges requested. (EP3) During the new applicant interview process, the Department Chair/or designee shall discuss with the applicant the FPPE process and outline the criteria and evaluation process that will be used during his/her FPPE period using the attached grid (EP 3). The evaluation may be performed by the Department Chair, the Section Chief, or a member of the Medical/Dental Staff (non-Associate). If a monitor/proctor cannot be chosen from the Medical Staff due to an obvious or perceived potential conflict of interest, the Department Chair in conjunction with the Chair of the Credentials Committee shall decide if an outside monitor/proctor is required (EP3). If a current member of the medical staff is granted a new privilege by the Board of Trustees, the same process shall take place during the review of the applicant’s credentials. Evaluation forms shall be submitted to the Medical Staff Office upon completion but no later than the time frames established by the Department Chair or designee. Concerns regarding an individual’s clinical competence and/or practice shall be acted upon immediately. At the conclusion of the assigned FPPE period, the Department Chair shall recommend to either conclude FPPE or extend FPPE based on evaluation of the staff member’s current clinical competence, practice behavior and ability to perform the requested privileges (EP6). If the recommendation is to extend FPPE, a report shall be sent to the Credentials Committee.

Referral from OPPE:
Staff members may be referred for FPPE as a result of the Ongoing Professional Practice Evaluation (OPPE) process by the Section Chief, Department Chair, QI&O Committee, Credentials Committee or the Medical Executive Committee.

Quality of Care Issues:
Quality of care issues should be addressed as they arise in order to provide continuous quality patient care and safety, and to assure favorable clinical outcomes. A quality concern may be raised by the Medical and Dental Staff, Health Professional Affiliate Staff, Nursing Staff, or through the QI&O process. If a collegial approach to the concern is not effective, the concerned party will file a written report with the Senior VP of Medical and Academic Affairs, the President of the Medical Staff, the Department Chair or the Section Chief. A monitoring plan shall be developed whenever there is question of demonstrated clinical competence and shall be provided to the Medical Executive Committee and the Senior VP of Medical and Academic Affairs.

When issues are identified that affect the provision of safe high quality care, a monitoring plan is warranted whenever there is cause to: (EP2)

a) question the demonstrated clinical competence of any staff member; or
b) question the care or treatment of a patient or management of a case by any staff member; or
c) have reason to suspect violation by any staff member of applicable ethical standards of the Medical and Dental Staff Bylaws, Rules and Regulations, Policies, Meridian Corporate Bylaws, or Professional Code of Conduct.

Attachments: Department Chair- FPPE Interview Checklist
Meridian Health
Jersey Shore University Medical Center

FOCUSED PROFESSIONAL PRACTICE EVALUATION

Staff Member: ___________________________ Specialty: ___________________________

Is this staff member currently practicing “unsupervised” at another Meridian Health or local area facility? _____ If yes, which facility __________________________________________

FPPE Trigger: ☐ New Member ☐ New Privilege ☐ Finding from OPPE

Focused Professional Practice Evaluation will occur on this individual in the following manner:
(Check all boxes that will apply)

<table>
<thead>
<tr>
<th>EVALUATION PROCESS</th>
<th>TERMS</th>
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</thead>
<tbody>
<tr>
<td>Concurrent medical record review</td>
<td>Minimum # of records ________</td>
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<tr>
<td>Targeted medical record review</td>
<td>Minimum # of records ________</td>
</tr>
<tr>
<td>Retrospective chart review</td>
<td>Minimum # of records ________</td>
</tr>
<tr>
<td>Direct observation of procedures</td>
<td>Minimum # of procedures ___</td>
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<tr>
<td></td>
<td>Types of Cases: ____________</td>
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<tr>
<td>Discussion with other practitioners</td>
<td>Minimum # ______</td>
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<td></td>
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<tr>
<td>External peer review</td>
<td></td>
</tr>
<tr>
<td>Data collected through Q I&amp; O</td>
<td>As applicable</td>
</tr>
<tr>
<td>Sentinel event data</td>
<td>As applicable</td>
</tr>
<tr>
<td>Peer review data</td>
<td>As applicable</td>
</tr>
</tbody>
</table>

Assigned Supervising/Collaborating Physician(s) ___________________________ or  ☐ N/A
FOCUSED PROFESSIONAL PRACTICE EVALUATION REVIEW  
(To be completed by the Department Chair or Section Chief)

Practitioner: _______________________________ Specialty: _________________________________  
Date Appointed to the Staff: _________________  

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**DEPARTMENT CHAIR REVIEW**

1. Has this staff member completed all aspects of his/her FPPE?  
   - Yes  
   - No

2. Does this staff member demonstrate current clinical competence?  
   - Yes  
   - No

3. Was this staff member cooperative with colleagues, nurses and other hospital staff?  
   - Yes  
   - No

4. Has this staff member demonstrated any signs of unacceptable behavior?  
   - Yes  
   - No

5. Has this staff member abided by the Rules and Regulations of the Department, Medical/Dental Staff and the hospital?  
   - Yes  
   - No

6. Have there been any problems with availability or responsiveness?  
   - Yes  
   - No

7. Has this staff member demonstrated any signs of physical or mental health limitations that may prevent him/her from exercising the privileges granted?  
   - Yes  
   - No

If you answered NO to any of the above, please explain: ______________________________________
_______________________________________________________________________________________
_______________________________________________________________________________________

COMMENTS:  
_____________________________________________________________________________________
_____________________________________________________________________________________
_____________________________________________________________________________________

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**RECOMMENDATION:**

- CONCLUDE FPPE and BEGIN OPPE
- GRANT NEW PRIVILEGE IN _____________________________________
- TO PRESIDENT OF THE MEDICAL/DENTAL STAFF – IMMEDIATE THREAT TO PATIENT SAFETY
- TO PHYSICIAN HEALTH COMMITTEE-IMPAIRMENT SUSPECTED
- IMPROVEMENT PLAN RECOMMENDED

Department Chair-Signature or Section Chief  Date
individual proctored: ____________________________________________

Diagnosis: ____________________________ Date of Admission: ________________

MR#: __________________ Procedure name (if applicable) ___________________________

Direct/Concurrent Review ☐ Retrospective Review ☐

<table>
<thead>
<tr>
<th>PATIENT CARE/MEDICAL KNOWLEDGE</th>
<th>Yes</th>
<th>No</th>
<th>N/A</th>
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</thead>
<tbody>
<tr>
<td>H&amp;P/consultation is complete, accurate and on the chart</td>
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<tr>
<td>The diagnosis is consistent with the data</td>
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<tr>
<td>The orders are appropriate</td>
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<tr>
<td>Daily progress evaluations appropriate to clinical findings</td>
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<tr>
<td>Consultants are used appropriately</td>
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<tr>
<td>Ancillary services are used appropriately</td>
<td></td>
<td></td>
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<tr>
<td>Abnormal lab results recognized/followed-up</td>
<td></td>
<td></td>
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<tr>
<td>Complications managed appropriately</td>
<td></td>
<td></td>
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<tr>
<td>Drug and therapeutic regimens meet acceptable standards</td>
<td></td>
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<table>
<thead>
<tr>
<th>SYSTEMS-BASED PRACTICE</th>
<th></th>
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<tbody>
<tr>
<td>Case management is consistent with clinical presentation</td>
<td></td>
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<tr>
<td>Plans for follow-up care documented</td>
<td></td>
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<tr>
<td>Discharge summary is complete</td>
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<thead>
<tr>
<th>INTERPERSONAL/COMMUNICATION SKILLS</th>
<th></th>
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<tbody>
<tr>
<td>Evidence of appropriate interaction with colleagues and staff</td>
<td></td>
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</tr>
<tr>
<td>Evidence of appropriate interaction with patient and/or family</td>
<td></td>
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<thead>
<tr>
<th>PROFESSIONALISM:</th>
<th></th>
<th></th>
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</thead>
<tbody>
<tr>
<td>Entries are legible</td>
<td></td>
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<tr>
<td>No evidence of unacceptable abbreviations</td>
<td></td>
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</table>

If you answered NO to any of the above, please explain: ________________________________________

_____________________________________________________________________________________

Comments __________________________________________________________________________

_____________________________________________________________________________________

Overall Assessment

<table>
<thead>
<tr>
<th>MEDICAL KNOWLEDGE</th>
<th>SATISFACTORY</th>
<th>NON-SATISFACTORY</th>
<th>N/A</th>
</tr>
</thead>
<tbody>
<tr>
<td>PATIENT CARE</td>
<td>SATISFACTORY</td>
<td>NON-SATISFACTORY</td>
<td>N/A</td>
</tr>
<tr>
<td>SYSTEMS-BASED PRACTICE</td>
<td>SATISFACTORY</td>
<td>NON-SATISFACTORY</td>
<td>N/A</td>
</tr>
<tr>
<td>INTERPERSONAL/COMMUNICATION</td>
<td>SATISFACTORY</td>
<td>NON-SATISFACTORY</td>
<td>N/A</td>
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<tr>
<td>PROFESSIONALISM</td>
<td>SATISFACTORY</td>
<td>NON-SATISFACTORY</td>
<td>N/A</td>
</tr>
<tr>
<td>PRACTICE-BASED LEARNING</td>
<td>SATISFACTORY</td>
<td>NON-SATISFACTORY</td>
<td>N/A</td>
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</tbody>
</table>

Signature of Reviewer: ____________________________ Date ____________________

Print Name: ______________________________________________________________________
Meridian Health  
Jersey Shore University Medical Center  

PROCEDURES  
Focused Professional Practice Evaluation

Individual Proctored: ______________ Date of Procedure: ___________ MR # __________

Name of Procedure: _______________________ Diagnosis ______________________________

☐ Direct observation  ☐ Retrospective Review

### PRE-OPERATIVE WORK-UP

<table>
<thead>
<tr>
<th>Item</th>
<th>Yes</th>
<th>No</th>
<th>N/A</th>
</tr>
</thead>
<tbody>
<tr>
<td>H&amp;P is complete and accurate</td>
<td></td>
<td></td>
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<tr>
<td>Appropriate consents signed</td>
<td></td>
<td></td>
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<tr>
<td>Appropriate lab and radiology</td>
<td></td>
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<td></td>
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<tr>
<td>Indications for procedure appropriate</td>
<td></td>
<td></td>
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<tr>
<td>Site marked if indicated</td>
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### INTRA-OPERATIVE

<table>
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<tr>
<th>Item</th>
<th>Good</th>
<th>Fair</th>
<th>Poor</th>
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</thead>
<tbody>
<tr>
<td>Timeliness of practitioner</td>
<td></td>
<td></td>
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<tr>
<td>“Time Out” documented</td>
<td></td>
<td></td>
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<tr>
<td>Management of complication(s), if any</td>
<td></td>
<td></td>
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<tr>
<td>Pre-op diagnosis compares with post-op diagnosis</td>
<td></td>
<td></td>
<td></td>
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<tr>
<td>Clinical and technical skills</td>
<td></td>
<td></td>
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<tr>
<td>Professional interaction with colleagues and staff</td>
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<td></td>
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</table>

### CHART REVIEW

<table>
<thead>
<tr>
<th>Item</th>
<th>Yes</th>
<th>No</th>
<th>N/A</th>
</tr>
</thead>
<tbody>
<tr>
<td>Operative report complete, accurate and timely</td>
<td></td>
<td></td>
<td></td>
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<tr>
<td>Disposition of patient appropriate</td>
<td></td>
<td></td>
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<tr>
<td>Complications, if any, recognized and managed appropriately</td>
<td></td>
<td></td>
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<tr>
<td>Care provided meets recognized standards</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Entries were legible</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

If you answered NO or POOR, please explain:

________________________________________________________________________________________
________________________________________________________________________________________

Comments:

________________________________________________________________________________________
________________________________________________________________________________________

Overall Assessment

MEDICAL KNOWLEDGE  ☐ SATISFACTORY  ☐ NON-SATISFACTORY  ☐ NI
PATIENT CARE  ☐ SATISFACTORY  ☐ NON-SATISFACTORY  ☐ NI
SYSTEMS-BASED PRACTICE  ☐ SATISFACTORY  ☐ NON-SATISFACTORY  ☐ NI
INTERPERSONAL/COMMUNICATION  ☐ SATISFACTORY  ☐ NON-SATISFACTORY  ☐ NI
PROFESSIONALISM  ☐ SATISFACTORY  ☐ NON-SATISFACTORY  ☐ N/A
PRACTICE-BASED LEARNING  ☐ SATISFACTORY  ☐ NON-SATISFACTORY  ☐ N/A

Signature of Reviewer: _____________________________ Date _____________

Print Name: ________________________________________________
PLEASE COMPLETE AT THE CONCLUSION OF EACH PROCEDURE AND RETURN THE COMPLETED FORM TO THE MEDICAL STAFF OFFICE

 Individual Proctored: _____________________________ Date of Procedure: _____________

 Name of Procedure: _____________________________ Emergency Case:  □ Yes  □ No

 Medical Record Number: __________________

 □ Direct observation  □ Retrospective Review
 Setting:  □ Inpatient  □ Outpatient - SDS  □ Emergency Room  □ ICU

 Length of Procedure: ________________ Type of Anesthesia: ______________________

 Pre-op:
 Anesthesia note completed with time and date:  □ Yes  □ No
 Pertinent labs and physical findings noted:  □ Yes  □ No
 Anesthesia risk noted:  □ Yes  □ No
 Anesthesia plan noted:  □ Yes  □ No
 Signature present:  □ Yes  □ No
 General conduct and timeliness:  Adequate____ Inadequate____

 Intra-op:
 Adequate setup of anesthesia machine:  □ Yes  □ No
 Knowledge of anesthesia machine, ventilator, and monitors:  □ Yes  □ No
 Technical skills:  □ Yes  □ No
 Fluid management:  Adequate____ Inadequate____
 Knowledge of anesthesia agents and drugs:  □ Yes  □ No
 Knowledge of surgical procedure:  □ Yes  □ No
 General conduct and timeliness:  Adequate____ Inadequate____

 Post-op:
 General conduct and timeliness:  Adequate____ Inadequate____
 Pertinent information relayed to PACU staff:  □ Yes  □ No
 Post–op anesthesia note:  □ Yes  □ No
 Narcotic verification log completed:  □ Yes  □ No

 General Comments:
 __________________________________________________________________________
 __________________________________________________________________________

 Department Chair Recommendation:

 □ Conclude FPPE and begin OPPE □ Extend FPPE □
 If recommending an extension, please explain: __________________________________________________________________________
 __________________________________________________________________________
 __________________________________________________________________________

 ___________________________    ______________________
 Department Chair-Signature     Date
Meridian Health
Jersey Shore University Medical Center

DEPARTMENT OF PATHOLOGY
FOCUSED PROFESSIONAL PRACTICE EVALUATION REVIEW
(To be completed by Department Chair or Section Chief)

Practitioner:__________________ Specialty: _______________ Date Appointed to Staff: _________

Assigned supervising/collaborating physician: __________________________

Focused Professional Practice Evaluation will occur on this staff member in the following manner:
Direct observation of procedures ________ All cases signed out for 30 days ________
60% of cases signed out for the next 30 days _____ 30% of cases signed out for the next 30 days _____

Turn-around time (TAT):
 Surgical Pathology _____
 Non-Gyn Cytopathology _____
 Gyn Cytopathology _____
 Autopsy Preliminary Report _____
 Autopsy Final Report _____

External peer review from outside consultation:
 Surgical Pathology _____
 Cytopathology _____

DEPARTMENT CHAIR REVIEW

1. Has this staff member completed all aspects of his/her FPPE? YES NO
2. Does this staff member demonstrate current clinical competence? YES NO
3. Was this staff member cooperative with colleagues, laboratory staff and other hospital staff? YES NO
4. Has this staff member exhibited any signs of unacceptable behavior? YES NO
5. Has this staff member abided by the rules and regulations of the Department, Medical and Dental Staff and the Hospital? YES NO
6. Have there been any problems with availability or responsiveness? YES NO
7. Has this staff member demonstrated any signs of physical or mental health limitations that may prevent him/her from exercising the privileges granted? YES NO

COMMENTS:_________________________________________________________________

RECOMMENDATION:

☐ Conclude FPPE and begin OPPE  ☐ Extend FPPE

If recommending an extension, please explain: ________________________________________________
_____________________________________________________________________________________
_____________________________________________________________________________________  
________________________     ______________    __________________________
Department Chair-Signature              Date      Practitioner Signature
PLEASE RETURN THE COMPLETED FORM TO THE MEDICAL STAFF OFFICE

Individual Proctored: ______________________________
Medical Record Number: ___________________________

☐ Direct observation ☐ Retrospective Review

FILM READING

Routine Interventional and Diagnostic Radiology Procedures
(Abdomen, GU, GI, Skeletal, Thoracic imaging, etc.)

Special Interventional Procedures:
(Angiography, Venography, Myelography
Endovascular Therapy etc.)

Other: ____________________________

CT

Ultrasound

Nuclear Medicine

TOTAL NUMBER OF CASES REVIEWED:

Performance Comments:
________________________________________________________________________________________
________________________________________________________________________________________

Interpretation Comments:
________________________________________________________________________________________
________________________________________________________________________________________

Signature of Reviewer: ____________________________ Date: ___________________________

Department Chair Recommendation:

☐ Conclude FPPE and begin OPPE ☐ Extend FPPE

If recommending an extension, please explain: _________________________________________________
________________________________________________________________________________________
________________________________________________________________________________________

_________________________    ______________
Department Chair-Signature    Date