Stony Brook
University Hospital

IMPORTANT INFORMATION REGARDING YOUR CLINICAL PRIVILEGES

Dear Practitioner:

In our efforts to provide our patients with the highest quality medical staff to assure the highest standards of care and in compliance with Joint Commission standards, Stony Brook University Hospital (SBUH) has implemented a Focused Professional Practice Evaluation (FPPE) process. As a newly appointed member of the staff with privileges or a current member of the staff who has been granted an additional privilege(s), your department will conduct a review to confirm current competence with respect to the privileges you have been granted.

Attached is the SBUH policy (and required forms) that delineates the process as well as the responsibilities of the practitioner, the evaluator, the departmental credentials committee and the chief of service.

Please contact your Chief of Service immediately to determine who has been assigned to perform your FPPE. Contact your assigned evaluator to establish a plan for the FPPE. You must notify the evaluator of each case which is to be evaluated. The department will determine the type of evaluation to be done as defined in the policy.

If completed FPPEs are not submitted to the Medical Staff Office within six (6) months of the beginning your clinical activity, your privileges will be administratively suspended and you will not be able to treat patients at SBUH, SBUH/Southampton or SBUH/Eastern Long Island, including Article 28 facilities.

Please refer to Responsibilities of the Evaluated Practitioner and Procedural Rights: Failure to Meet FPPE Requirements which is enclosed.

Please sign and return the attached confirmation that you have received this policy and understand that noncompliance may result in voluntary relinquishment of your privileges.

Please review the attached policy to assure that the requirements for this process are fulfilled in the specified period. Note: If you have been granted a privilege (s)which require proctoring or supervision, a Proctor Form has also been included in this communication.

Thank you for your cooperation with this focused review.

Sincerely yours,
Joyce Klein, CPMSM
Director

CC: Chief of Service
Department Credentials Committee Chair
Division Chief

I attest that I have received the FPPE policy and understand that noncompliance may result in voluntary relinquishment of my privileges.

_____

Printed Name

_____ _____

Signature Date

FPPE Policy – Overview of Requirements

5 FPPEs are required for Core privileges. The FPPEs must be representative of general clinical practice

3 FPPEs for EACH non-Core privilege (Category 1 or Supplemental, etc)

FPPEs must be completed and submitted within 6 months of beginning clinical activity.

FPPE for Core not completed in 6 months from beginning of clinical activity: Practitioner will receive a letter advising them they have ONE more month to have the FPPEs submitted or their privileges will be voluntarily relinquished within one month.

FPPE for NON-CORE not been completed within 6 months from beginning of clinical activity: An explanation may be submitted to the Chief of Service (e.g., a procedure which is rarely performed). Any explanations endorsed by the Chief of Service must be submitted to the Medical Staff Office. If the Medical Staff Office does not receive any information, the practitioner will receive a letter from the Medical Staff Office stating that the privilege will be voluntarily relinquished within one (1) month

Focused Professional Practice Evaluation Policy

Focused professional practice evaluation (FPPE) is a process whereby the organization evaluates the privilege-specific competence of a practitioner who does not have documented evidence of competently performing the requested privilege at the organization. FPPE is for a time-limited period during which the organization evaluates and determines the practitioner's professional performance. {JC MS4.30 Intro)

Initial competency of practitioners new to the medical staff shall have privilege-specific competency evaluated by review of competency information obtained from current and former institutions, where privileged, followed by a focused review when appointed at SBUH.

FPPE will occur under the following circumstances:

- All new appointments
- Current staff requesting new/additional privilege(s) not previously performed at SBUH
- When a question arises regarding a currently privileged practitioner's ability to provide safe, high quality patient care

Purpose: To establish a systematic evaluation process to ensure that there is sufficient information available to confirm the current competence of practitioners who initially request privileges at SBUH, practitioners who request additional privileges, and those practitioners whose competency has been questioned.

Definitions: Evaluation may be performed using prospective, concurrent or retrospective approaches. Practitioners who most often provide cognitive care, as opposed to procedural care, will be evaluated prospectively and/or retrospectively. Prospective, concurrent and retrospective approaches may be used for evaluating practitioners who request privileges to perform various procedures.

Evaluation (FPPE) includes one or more of the following:

(1) Prospective review: presentation of cases with planned treatment outlined for treatment concurrence or review of case documentation for treatment concurrence

(2) Concurrent review: real-time observation of a procedure

(3) Retrospective: review of a case after care has been completed, which may include interviews with personnel involved in the care of the patient

Scope: This Policy applies to all practitioners who request initial privileges, including initial applicants for Medical or Allied Staff appointment and current members of the Medical or Allied Staff who request additional clinical privileges, and active practitioners whose competency has been questioned.

Practitioners requesting membership but not exercising privileges do NOT require an FPPE.

The scope of the FPPE plan shall be as indicated above. However, each department shall define the appropriate evaluation method to determine what constitutes a practitioner's current competency.

Oversight/Responsibilities:

Each Department Credentials Committee (DCC) is charged with the responsibility of monitoring departmental compliance with this policy. It accomplishes this oversight by submitting regular reports related to the progress of each practitioner, who is required to be evaluated, as well as any issues or problems involved in implementing this policy to the Medical Staff Office.

The Chief of Service, or his/her designee, will determine changes to improve performance based on results of FPPEs, including proctoring, and implementation of practitioner-specific performance improvement plans, if

appropriate. Practitioner specific improvement plans will be submitted to the DCC for review and approval.

The Chief of Service will provide the DCC with data that is systematically collected through the OPPE processes for those practitioners, as appropriate, to confirm current competence and potential referral for FPPE.

Evaluation Method: Evaluation may be performed using prospective, concurrent, or retrospective approaches, as defined above. The appropriate methods for evaluation of each individual practitioner will be determined by the DCC based on recommendations from the Division Chief, if applicable, or Chief of Service.

The institutional FPPE forms must be utilized. Departments may submit revisions of the FPPE forms to the Chief Medical Officer (CMO) for approval.

Selection of Evaluator(s): The Chief of Service shall be responsible for selecting and assigning the evaluator(s). Once the evaluator is assigned, it is the practitioner's responsibility to contact the evaluator and organize the FPPE review.

Duration of Evaluation Period: At a minimum, a retrospective review of the ***FIRST** five (5) cases which are representative of the practitioner's principle practice for newly appointed practitioners. These privileges are designated CORE.

Any privilege that is not designated CORE, as determined by each clinical service, will require at a minimum three (3) FPPEs for EACH privilege (i.e., Category 1, Supplemental privileges, etc.) It is anticipated that the FPPE review shall be completed within six months of the start of clinical activity. The DCC may define additional evaluations based on specific cases.

Responsibilities of Evaluators:

1. The evaluator's role to review and observe cases, not of a supervisor or consultant. The practitioner who is serving solely as an evaluator is an agent of the hospital. The evaluator receives no compensation directly or indirectly from any patient for this service. Evaluators must be must be members in good standing of the medical/allied staff of SBUH and must have unrestricted privileges to perform any procedure(s) to be concurrently evaluated.

2. Evaluators will monitor those portions of the medical care rendered by the practitioner that are sufficient to be able to judge the quality of care provided in relationship to the privilege(s) requested. The performance of a specific procedure shall be reviewed, or in the situation that the privilege encompasses cognitive care, then the relative components of the patient's chart must also be reviewed for that aspect of care.

3. Evaluators will ensure the confidentiality of the evaluation results and forms. The evaluator will deliver the completed proctoring form(s) to the DCC.

4. If at any time during the evaluation period, the evaluator has concerns about the practitioner's competency to perform specific clinical privileges or care related to a specific patient(s), the evaluator should promptly notify the respective Chief of Service. One of the following may be recommended:

   (a) The Chief of Service will intervene and adjudicate the conflict if the evaluator and the practitioner disagree as to what constitutes appropriate care for the patient.
   (b) The QA liaison will review the case for possible peer review at the next department meeting.
   (c) Additional or revised evaluation requirements may be imposed upon the practitioner until the evaluator can make an informed judgment and recommendation regarding the clinical performance of the individual being evaluated.

5. If during the initial period of evaluation, the evaluator feels there may be imminent danger to the health

and safety of any individual, the continuation of the privilege(s) requested and evaluations are subject to being discontinued by the Chief of Service or CMO.

6. All members of the medical/allied staff with relevant privileges, within each department, must serve as evaluators when asked to do so.

7. In addition to specialty and privilege-specific issues, evaluations also will address the general competencies.

Responsibilities of the Practitioner Being Evaluated

1. The practitioner must provide the necessary cases to the evaluator for review in a timely manner; if applicable, must obtain agreement from the evaluator to attend and observe the procedure and/or the practitioner must provide the evaluator with access to all information regarding the patient's clinical history and care, pertinent physical findings, lab and x-ray results; the course of treatment or management including a copy of the H&P, operative reports, consultations, and discharge summaries.

2. The practitioner shall notify the evaluator of each case in which care is to be evaluated and, when concurrent evaluation is required, do so in sufficient time to enable the evaluator to conduct the review. For surgical or invasive procedures where concurrent evaluation is required, the practitioner must secure agreement from the evaluator to attend and observe the procedure.

3. The practitioner has the option of requesting a change of evaluator, if disagreements with the current evaluator may adversely affect his/her ability to complete the FPPE timely and satisfactorily. This request is made to the Chief of Service.

4. Inform the evaluator of any unusual incidents associated with his/her patients.

5. It is the responsibility of the practitioner to ensure documentation of the satisfactory completion of their FPPE, which includes the completion and delivery of all FPPE forms to the DCC. If the completed FPPE forms have not be received by the Medical Staff Office within six (6) months, a letter will be sent to the practitioner advising them that their clinical privileges will be voluntarily relinquished in one (1) month if the completed FPPE forms are not submitted to the MSO. If the forms are not received after this one-month extension period, the practitioner will receive a letter from the MSO stating that the privilege has been voluntarily relinquished and they must immediately stop performing the privilege(s).

6. If the FPPE has not been completed within 6 months for a non-CORE privilege, an explanation may be submitted to the Chief of Service (e.g., a procedure which is rarely performed). Any explanations endorsed by the Chief of Service must be submitted to the Medical Staff Office.

If the Medical Staff Office does not receive any information, the practitioner will receive a letter from the MSO stating that the privilege will be voluntarily relinquished within one (1) month. If the MSO does not receive an FPPE or an explanation after this one-month extension period, the practitioner will receive a letter from the MSO stating that the privilege(s) is voluntarily relinquished and they must immediately stop performing the privilege(s).

Procedural Rights: Failure to Meet FPPE Requirements:

1. Failure to meet FPPE requirements will automatically result in a review, conducted by the departmental QA committee, of clinical cases performed. If failure to satisfy FPPE requirements is simply numerical, the privilege(s) is deemed to be withdrawn for administrative reasons, which is not reportable

2. If a practitioner's appointment or clinical privileges are deemed to be voluntarily relinquished for failure to

complete FPPE requirements for reasons other than not meeting the timeframe for FPPE completion, the practitioner shall be notified in writing before a report of that voluntary relinquishment is made to the MEC.

3. As part of the notice of acknowledging the voluntary relinquishment and the reason(s) for it, the practitioner shall be given an opportunity to request, within 10 days, a meeting with the DCC, at which time the practitioner shall have an opportunity to explain or discuss extenuating circumstances involving his or her failure to provide sufficient clinical experience for a satisfactory evaluation. At that meeting none of the parties shall be represented by counsel; minutes shall be kept; the practitioner may present evidence of extenuating circumstances and why the evaluation period should be extended; any party may ask questions of any party relative to the practitioner's appointment or clinical privileges.

4. At the conclusion of the meeting, the DCC shall make a written report and recommendation. The report shall include the minutes of the meeting held with the practitioner. After reviewing the *DCCs* recommendation and report, the Chief of Service shall make a recommendation to the MEC. The MEC shall adopt the Chief of Service's recommendation as its own, send the matter back to the Chief of Service with specific concerns or questions, or make a recommendation different from the Chief of Service outlining specific reasons for disagreement.

5. The Practitioner shall not be entitled to a hearing or other procedural rights as set forth in the Medical Staff Bylaws (Article III) for any privilege that is voluntarily relinquished.

Procedural Rights: Recommendations for Termination of Appointment or Reduction in Clinical Privileges:

If there is a recommendation by the MEC to terminate the practitioner's appointment, privileges being evaluated, or other clinical privileges due to questions about qualifications, behavior or clinical competence, the practitioner *shall* be entitled to the hearing and appeal process outlined in the Medical Staff Bylaws {Article **III).**

FPPE shall be conducted when a question arises, as a result of peer review, regarding a currently privileged practitioner's professional performance that may affect the provision of safe and high quality patient care, ongoing monitoring or when there appears to be a trend of any of the following circumstances.

Sentinel Events - as defined by the Joint Commission {JC).
Near Misses - Any process variation which did not offset the outcome, but for which a recurrence carries a significant chance of a serious adverse outcome.
Serious Events - An event, occurrence or situation involving the clinical care of a patient that results in death or compromises patient safety and results in an unanticipated injury requiring the delivery of additional health care services.
Unusual pattern of behavior or pattern of care
Professional practice that impacts on the quality of care and patient safety
Other complaints/issues that may arise that are referred by the President Medical Board, Chief of Service, CMO, or Chief Quality Officer.

The decision to assign a period of performance monitoring to further assess current competence will be based on the evaluation of a practitioner's current clinical competence, practice behavior and ability to perform the requested privileges that are at issue. Other existing privileges in good standing should not be affected by this decision. The terms, methods and duration of the evaluation period shall be determined by the Chief of Service and/or CMO or designee and may include:

Chart review
Monitoring Clinical Practice Patterns
Proctoring
Continuing Medical Education Retraining
Medical evaluation and treatment
External peer review

Participants in the FPPE Process: The FPPE shall be conducted by the respective **DCC.** In the event that the review requires specific expertise in a clinical area, the credentials committee may supplement their review by obtaining the assistance of a practitioner with expertise in the specific area.

It is essential that the FPPE be conducted in a way that avoids conflict of interest or circumstances that suggest a conflict of interest.

External Peer Review: If external peer review is necessary, the external peer review process delineated in the Rules and Regulations shall be followed. External peer review may be obtained when:

a. There is a lack of internal expertise or when the only practitioners on the medical/allied staff with expertise are partners, associates or direct competitors of the practitioner under review
b. The potential for conflict of interest cannot be appropriately resolved by the MEC or Medical Board
c. The MEC or Medical Board requires external peer review in any circumstances deemed appropriate by either of these bodies.

Procedures Initially Granted with Supervision or Proctoring.

For privileges requiring proctoring or supervision, the FPPE requirement will be fulfilled with the submission of Proctoring Forms. If the respective department credentials committee determines the practitioner may now perform the privilege independently, there will be no further requirement for FPPE.

Changing the condition of a privilege from "with supervision or with proctoring" will be determined by the respective credentials Committee and will not be presented to the Medical Board. This is retroactive for any privilege that required proctoring or supervision regardless of when the privilege was granted, provided we have received documentation of proctoring and the privilege may be performed independently.

No practitioner can require the hospital to obtain external peer review. Reference: JC

9/15/08 revision; 4/09 revision; 8/18/12 revision;10/21/14 revision; 8/17/15; revision; 10/20/20 reviewed; June 2022 revision; 11/2023 revision