Manual: Hospital and Hospital Clinics
Chapter: Medical Staff MS
Topic: Focused Professional Practice Evaluation (FPPE) - Understanding The Requirements

What are the key elements organizations need to understand regarding the Focused Professional Practice Evaluation requirements ?

Any examples are for illustrative purposes only.

Intent
The Focused Professional Practice Evaluation (FPPE) is a process whereby the medical staff evaluates the privilege-specific competence of the practitioner that lacks documented evidence of competently performing the requested privilege(s) at the organization. This process may also be used when a question arises of a currently-privileged practitioner's ability to provide safe, high quality patient care.

A period of FPPE is required for all new privileges. This includes privileges requested by new applicants and all newly-requested privileges for existing practitioners. There is no exemption based on board certification, documented experience, or reputation.

Design - The FPPE process must be pre-defined and consistently implemented for all newly requested privileges. The performance monitoring process must also be clearly defined and include, at a minimum, the following:

- criteria for conducting performance evaluations,
- method for establishing the monitoring plan specific to the requested privilege,
- method to determining the duration of performance monitoring, and
- circumstances under which monitoring by an external source is required.

The period of FPPE begins at the time privileges are granted, regardless of which process was followed (e.g., temporary, expedited, full privileges, etc). For example, if temporary privileges are granted on July 1, 2021, however, the governing body does not meet until September 15, 2021, the period of FPPE starts July 1, 2021. The FPPE requirements also apply when temporary privileges are granted for a limited period of time to meet an important patient care need.

Data - Both qualitative and quantitative criteria (data) should be considered when designing the process. For example, limiting criteria to quantitative data may only represent the presence or absence of information but may not reflect the quality of the information reviewed. Consider the following:

Qualitative Data - Qualitative or 'categorical' data, may be described as data that 'approximates and characterizes' and is often non-numerical in nature. This type of data may be collected through methods of observations, discussion with other individuals, chart review, monitoring of diagnostic and treatment techniques, etc.

Examples(^) may include, but are not limited to:

- Description of procedures performed
- Periodic Chart Review

    o quality/accuracy of documentation
    o appropriateness of tests ordered / procedures performed
    o patient outcomes

- Types of patient complaints
- Code of conduct breaches
- Peer recommendations

- Discussion with other individuals involved in the care of patient(s), IE: consultants, surgical assistants, nursing, administration, etc.

Quantitative Data - Quantitative data often reflects a certain quantity, amount or range and are generally expressed as a unit of measure. Contrasted with qualitative data, quantitative data generally relates to data in the form of numerical quantities such as measurements, counts, percentage compliant, ratios, thresholds, intervals, time frames, etc.
Examples(^) may include, but are not limited to:

- Length of stay trends
- Post-procedure infection rates
- Periodic Chart Review
    - Dating/timing/signing entries
    - T.O./V.O. authenticated within defined time frame
    - Presence/absence of required information (H & P elements, etc)
- Number of H & P / updates completed within 24 hours after inpatient admission/registration
- Compliance with medical staff rules, regulations, policies, etc.
- Documenting the minimum required elements of an H & P / update.
- Compliance with core measures

^Note: The manner in which such data is captured could represent either – or both – qualitative and quantitative information.

Data Sources - The data source used for the FPPE process must include practitioner activities performed at the organization where privileges have been requested. This may include activities performed at any location that falls under the organization's single CMS Certification Number (CCN). For example, if an organization operates two hospitals that fall under the same CCN number, data from both hospital locations may be used.

Multi-hospital Systems - In multi-hospital systems where each hospital operates independently under separate CCN numbers, data from those entities may be used to supplement local data.

Low-volume Practitioners - When practitioner activity at the 'local' level is low or limited, supplemental data may be used from another CMS-certified organization where the practitioner holds the same privileges. The use of supplemental data may NOT be used in lieu of a process to capture local data. Organizations choosing to use supplemental data should assess and determine the supplemental data's relevance, timeliness, and accuracy.

Examples where supplemental data could be used may include, but are not limited to:

- activity is limited to periodic on-call coverage for other physicians or groups
- occasional consultations for a clinical specialty

Consistent with the "Medical Staff" chapter, the medical staff must develop policies and procedures which ensure oversight of local data and the use of supplemental data.

FPPE for non-inpatient areas - Privileges are required for any practitioner providing a medical level of care/decision-making, therefore, FPPE applies to all settings/locations included in the scope of the hospital survey. Examples of settings may include, but are not limited to: On and off-campus outpatient services, clinics, hospital owned physician office practices, free-standing emergency/urgent care centers, etc.

Additional Resources
The Joint Commission Perspectives: The official newsletter of The Joint Commission August 2019 / Volume 39 / Number 8

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