UPMC
POLICY AND PROCEDURE MANUAL

POLICY: HS-MS0004 *
INDEX TITLE: Medical Staff

SUBJECT: FPPE Policy To Confirm Practitioner Competence And Professionalism OF UPMC (New Members/New Privileges)
DATE: April 1, 2024

This Policy applies to the following United States based UPMC facilities, including any providers who practice therein:

[Check all that apply]

☒ UPMC Children's Hospital of Pittsburgh	☒ UPMC Pinnacle Hospitals
☒ UPMC Magee-Womens Hospital	☒ Harrisburg Campus
☒ UPMC Altoona	☒ West Shore Campus
☒ UPMC Bedford	☒ Community Osteopathic Campus
☒ UPMC Chautauqua	☒ UPMC Carlisle
☒ UPMC East	☒ UPMC Memorial
☒ UPMC Hamot	☒ UPMC Lititz
☒ UPMC Horizon	☒ UPMC Hanover
☒ Shenango Campus	☒ UPMC Muncy
☒ Greenville Campus	☒ UPMC Wellsboro
☒ UPMC Jameson	☒ UPMC Williamsport
☒ UPMC Kane	☒ Williamsport Campus
☒ UPMC McKeesport	☒ Divine Providence Campus
☒ UPMC Mercy	☒ UPMC Cole
☒ UPMC Northwest	☒ UPMC Somerset
☒ UPMC Passavant	☒ UPMC Western Maryland
☒ Main Campus	
☒ Cranberry	
☒ UPMC Presbyterian Shadyside	
☒ Presbyterian Campus	
☒ Shadyside Campus	
☒ UPMC Western Psychiatric Hospital	
☒ UPMC St. Margaret	

Provider-based Ambulatory Surgery Centers

☒ UPMC Altoona Surgery Center
☒ UPMC Children's Hospital of Pittsburgh North
☒ UPMC St. Margaret Harmar Surgery Center
☒ UPMC South Surgery Center
☒ UPMC Center for Reproductive Endocrinology and Infertility
☒ UPMC Digestive Health and Endoscopy Center
☒ UPMC Surgery Center – Carlisle
☒ UPMC Surgery Center Lewisburg
☒ UPMC Pinnacle Procedure Center
☒ UPMC West Mifflin Ambulatory Surgery Center
☒ UPMC Community Surgery Center
☒ UPMC Leader Surgery Center

Free-Standing Ambulatory Surgery Facilities:

☐ UPMC Hamot Surgery Center **(JV)**
☐ Hanover SurgiCenter
☐ UPMC Specialty Care York Endoscopy
☐ Susquehanna Valley Surgery Center
☐ West Shore Surgery Center **(JV)**

FPPE POLICY TO CONFIRM PRACTITIONER COMPETENCE AND PROFESSIONALISM

(NEW MEMBERS/NEW PRIVILEGES)

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FPPE POLICY TO CONFIRM
PRACTITIONER COMPETENCE AND PROFESSIONALISM

(NEW MEMBERS/NEW PRIVILEGES)

1. ***Scope of Policy*.** All Practitioners who are granted new clinical privileges at a Participating UPMC Hospital (the "Hospital") are subject to focused professional practice evaluation ("FPPE") to confirm their:

   (a) clinical competence to exercise the clinical privileges that have been granted to them; and

   (b) professionalism, which includes (i) the ability to work with others in a professional manner that promotes quality and safety; and (ii) the ability to satisfy all other responsibilities of Practitioners who are granted clinical privileges at the Hospital (i.e., "citizenship" responsibilities).

   Practitioners are required to cooperate with the FPPE process as outlined in this Policy. A flowchart that depicts the FPPE process to confirm competence and professionalism is attached as Appendix A.

2. ***FPPE Clinical Activity Requirements.***

   2.A ***Development of Clinical Activity Requirements.***

   (1) Each Department will recommend the following FPPE clinical activity requirements:

   (a) ***For New Practitioners:***

   (i) the number and types of procedures or cases that will be reviewed to confirm a new Practitioner's competence to exercise the core and special privileges in his or her specialty;

   (ii) how those reviews are to be documented; and

   (iii) the expected time frame in which the evaluation will be completed (generally six months); and

   (b) ***For Practitioners with Existing Clinical Privileges Who Are Requesting New Privileges:***

   (i) the number and types of procedures or cases that must be reviewed to confirm a Practitioner's competence to exercise

a new privilege that is granted during a term of appointment or at reappointment;

(ii) how those reviews are to be documented; and

(iii) the expected time frame in which the review will be completed (generally six months).

(2) In developing such recommendations, Departments should attempt to identify "index" procedures or cases that will demonstrate a Practitioner's competence to perform a bundle of privileges (i.e., the skills required to perform the index procedure or case are the same skills required to perform privileges in the bundle).

(3) Departments may consult with the PPE Specialists Committee, the Chair of the Professional Practice Evaluation Committee ("PPEC"), and Vice President of Medical Affairs.

(4) The FPPE clinical activity requirements shall be reviewed by the Credentials Committee and approved by the Medical Executive Committee. They shall be reviewed periodically by the Departments to ensure their continued effectiveness.

(5) The Credentials Committee and Medical Executive Committee may modify the FPPE requirements for a particular applicant if the applicant's credentials indicate that additional or different FPPE may be required.

2.B ***Gathering FPPE Data.***

(1) ***Mechanism for FPPE Review.***

(a) ***Data to Be Reviewed.*** The FPPE clinical activity requirements will utilize at least one of the following review mechanisms to confirm competence:

(i) retrospective chart review by internal or external reviewers (a Retrospective Chart Review Form that may be used to document these reviews is included as FPPE-1 in the FPPE Policy to Confirm Practitioner Competence and Professionalism Manual ("FPPE Manual"));

(ii) concurrent proctoring (i.e., direct observation) of procedures or patient care practices (if proctoring is used as a mechanism to gather data pursuant to this Policy, the Department Committee will send written guidance to the Practitioner under review and the Proctor outlining their

responsibilities. A Memo Regarding Proctoring for FPPE to Confirm Competence and a Proctoring Review Form to be completed by the Proctor are included in the FPPE Manual); and/or

(iii) discussion with other individuals also involved in the care of the Practitioner's patients or who have observed the Practitioner during patient care activities (a 360° Review Form that may be used to document such discussions is included in the FPPE Manual).

Review of available Ongoing Professional Practice Evaluation ("OPPE") data, other quality data, and concerns about professionalism may also be used to confirm competence.

(b) ***Selection of Cases.*** The PPE Specialists Committee, the Vice President of Medical Affairs, and/or the Department Committee will select the specific cases to be evaluated and the individuals who will be asked to provide information about the Practitioner, with the goal being an effective and fair review process. To that end, cases should be selected either randomly or in a deliberate manner that ensures a representative sample is reviewed. Generally, FPPE should not be conducted on the first "x" cases because of the possible selection bias that may result.

(c) ***Cooperation of Practitioner.*** As a condition of Medical Staff appointment and clinical privileges, Practitioners are required to cooperate with the data gathering outlined in this Policy. For example, if cases are to be proctored the Practitioner must promptly notify the Proctor when cases are scheduled.

(2) ***FPPE Reviewers.*** Practitioners who have completed the FPPE process described in this Policy and who hold applicable clinical privileges are obliged to provide a reasonable amount of service as a FPPE Reviewer through chart review, proctoring, direct observations, and/or discussions with others involved in the patient's care. Reviewers will be assigned by the Department Committee. If no qualified Practitioners are available, the Department Committee shall consult with the Leadership Council regarding the need for an external review. FPPE Reviewers act on behalf of, and their work product is a record of, the Credentials Committee and Medical Executive Committee.

(3) ***Partners as FPPE Reviewers.*** Consistent with the conflict of interest guidelines set forth in the Credentials Policy, partners and other individuals who are affiliated in practice with a Practitioner may serve as FPPE Reviewers and conduct chart review, proctoring, direct observations, and/or

discussions with others involved in the patient's care. Such individuals shall comply with the standard procedures that apply to all other individuals who serve as FPPE Reviewers, such as the use of Hospital forms and the requirements related to confidentiality.

3. ***FPPE for Professionalism.*** In addition to assessing clinical competence, the FPPE process for new Practitioners will also assess the Practitioner's professionalism based on the following criteria:

(a) cooperation with the FPPE clinical activity requirements for the Practitioner's specialty and the monitoring process described in this Policy;

(b) compliance with the Medical Staff Professionalism Policy, including appropriate interactions with nursing, other Hospital personnel, the Practitioner's colleagues, and patients and their families;

(c) compliance with medical record documentation requirements, including those related to use of CPOE and the EHR;

(d) timeliness and quality of response to consultation and ED call requests;

(e) completion of any orientation program requirements (e.g., patient safety modules; EHR training); and

(f) compliance with protocols that have been adopted by the Medical Staff or the Practitioner's department.

The Leadership Council may recommend that these criteria for professionalism be modified or expanded, with such modifications or expansions being reviewed and approved by the Credentials Committee and Medical Executive Committee.

4. ***Notice of FPPE Requirements.*** When notified that a request for privileges has been granted, Practitioners shall be informed of the relevant FPPE clinical activity requirements and of their responsibility to cooperate in satisfying those requirements. New applicants will also be informed that the FPPE process will be used to assess their professionalism, as described above. An Initial Appointment Letter and a Reappointment Letter which inform Practitioners of their FPPE requirements are included in the FPPE Manual.

5. ***Review of FPPE Results.***

5.A ***Review by PPE Specialists Committee.***

(1) Information gathered for purposes of FPPE shall be reported to the PPE Specialists Committee, who shall compile the information and prepare it for subsequent review as set forth in this Policy. An FPPE to Confirm

Competence and Professionalism Review Form is included in the FPPE Manual.

(2) If any information gathered for FPPE suggests that a concern may exist that requires expedited review, the FPPE Reviewer and/or the PPE Specialists Committee will notify the Chairs of the Credentials Committee or the Leadership Council, and the applicable Department Committee, who shall determine whether the concern should be referred for processing under the Professional Practice Evaluation Policy (Peer Review), the Professionalism Policy, or the Credentials Policy.

(3) The PPE Specialists Committee shall determine whether any of a Practitioner's cases or activities have been reviewed pursuant to the Professional Practice Evaluation Policy (Peer Review) or the Medical Staff Professionalism Policy. If so, a summary of these matters shall be included with the Practitioner's FPPE results.

5.B ***Review by the Department Committee.***

(1) At the conclusion of the expected time frame for completion of the FPPE, the relevant Department Committee shall review the results of a Practitioner's FPPE and provide a report to the Credentials Committee. The report shall address whether:

(a) the Practitioner fulfilled all the clinical activity requirements;

(b) the results of the FPPE confirmed the Practitioner's clinical competence;

(c) the results of the FPPE confirmed the Practitioner's professionalism; and/or

(d) additional FPPE is required to make an appropriate determination regarding clinical competence and/or professionalism.

The FPPE to Confirm Competence and Professionalism Review Form which is included in the FPPE Manual can be used to document the Department Committee's review.

(2) In addition, the Department Committee may engage in Initial Mentoring Efforts (e.g., discussions, mentoring, coaching, and sharing of comparative data) with a Practitioner where the FPPE results indicate that competence and professionalism are confirmed, but where there is nonetheless an opportunity for the Practitioner to improve upon an aspect of his/her clinical care or citizenship responsibilities.

5.C ***Review by Credentials Committee.***[1] Based on the Department Committee's assessment and report, and its own review of the FPPE results and all other relevant information, the Credentials Committee will make one of the following determinations and notify the Practitioner.

(1) ***Competence and Professionalism Are Confirmed.*** The FPPE process has confirmed clinical competence and professionalism for all clinical privileges and no further FPPE is necessary.

(2) ***Questions or Concerns Exist*** *(three options).*

(a) ***Extend FPPE Due to Questions.*** Some questions exist and additional FPPE is needed to confirm clinical competence and/or professionalism with respect to some or all clinical privileges. In such case, the Credentials Committee will identify what additional FPPE is needed and the time frame for it.

(b) ***Conclude FPPE, but use Collegial Counseling or Performance Improvement Plan.*** Concerns exist about the Practitioner's competence to exercise some or all of the clinical privileges granted or the Practitioner's professionalism. In such case, the Credentials Committee will identify the details of the Collegial Counseling or the Performance Improvement Plan that should be pursued with the Practitioner in order to adequately address the concerns. Prior to making such a determination, the Credentials Committee will obtain the input of the Practitioner as set forth in Section 5.E of this Policy. In developing a proposed Performance Improvement Plan or other intervention, the Credentials Committee may also request input or assistance from the PPEC (for clinical issues) or the Leadership Council (for behavioral issues).

(c) ***Refer to Medical Executive Committee.*** If more significant concerns exist about a Practitioner, the Credentials Committee will refer the matter to the Medical Executive Committee for its independent review under the Medical Staff Credentials Policy. In making such a referral, the Credentials Committee may provide findings and recommendations for review by the Medical Executive Committee.

(3) ***Low-Volume Practitioners*** *(three options).*

(a) ***Extend FPPE Due to Inactivity.*** The time period for FPPE will be extended for up to six months because the individual did not fulfill the FPPE clinical activity requirements for some or all clinical

[1] For Critical Access Hospitals without a Credentials Committee, these determinations will be made by the VPMA in conjunction with the President of the Medical Staff, on behalf of the MEC.

privileges, thus preventing an adequate assessment of the individual's clinical competence or professionalism. The time frame for initial FPPE will generally not extend beyond 12 total months after the initial granting of privileges.

(b) ***Transfer to Membership-Only Staff Category or the Automatic Relinquishment of Certain Privileges Due to Inactivity.*** The individual shall either: (i) be transferred to a membership-only staff category for failure to meet FPPE clinical activity requirements for all privileges, or (ii) automatically relinquish specific clinical privileges for which the individual failed to meet the applicable requirements.

(c) ***Grant Exception to Certain Low Volume Practitioners.*** The Credentials Committee may determine that a low volume Practitioner will be permitted to maintain appointment and clinical privileges beyond the initial FPPE period based on the limited availability of needed services in a specialty area, coverage requirements, the rare nature of a given procedure or treatment, or other relevant factors. In these circumstances, the Practitioner's competence and professionalism will be confirmed as follows:

(i) Completion of the initial FPPE requirements over the duration of the Practitioner's two-year appointment term and/or reliance on the ongoing clinical and professionalism review processes that are conducted for all Practitioners; and

(ii) Review of any supplemental performance data regarding the Practitioner that may be obtained from other entities where the Practitioner maintains a more active practice.

The Credentials Committee may decide that FPPE has been completed with respect to certain clinical privileges while additional action will be taken with respect to other clinical privileges. The FPPE to Confirm Competence and Professionalism Review Form which is included in the FPPE Manual can be used to document the Credentials Committee's review.

Letters that can be used to inform the Practitioner of the decision of the Credentials Committee are included in the FPPE Manual.

5.D ***Review by Medical Executive Committee.*** The Medical Executive Committee will review matters that are referred to it by the Credentials Committee using the process set forth in the Credentials Policy.

5.E ***Input by Practitioner.***

(1) ***General.***

(a) When concerns have been raised about the Practitioner or other information is required, the Practitioner shall be provided notice of the issue and shall respond in writing. Upon the request of either the Practitioner or the committee conducting the review, the Practitioner may also provide input by meeting with appropriate individuals to discuss the issues.

(b) The committee requesting input may also ask the Practitioner to provide a copy of, or access to, medical records from the Practitioner's office that are relevant to a review being conducted under this Policy. Failure to provide such copies or access will be viewed as a failure to provide requested input. Any records obtained from the Practitioner's office pursuant to this section will be maintained as part of the confidential PPE/peer review file, but will not be included in the Hospital's medical record.

(2) ***Failure to Provide Written Input or Attend Meeting.*** A Practitioner's failure to provide written input or attend a meeting when requested to do so pursuant to this Policy will result in the automatic relinquishment of the Practitioner's clinical privileges, provided the following conditions are satisfied:

(a) the Practitioner is asked in writing to provide written input to, or attend a meeting with, a committee as set forth in this Policy;

(b) the written request gives the Practitioner a reasonable amount of time (generally 5 days) to provide the written input or to prepare for the meeting; and

(c) the written request notifies the Practitioner that failure to provide the written input or attend the meeting will result in the automatic relinquishment of clinical privileges pursuant to this Policy.

(3) ***Automatic Resignation.*** If the Practitioner fails to provide written input or meet within thirty (30) days of an automatic relinquishment, the Practitioner's Medical Staff membership and clinical privileges will be automatically resigned.

5.F ***Decision Not an Adverse Action.*** A decision that a Practitioner will be transferred to a membership-only staff category or will automatically relinquish his or her clinical privileges for failure to satisfy clinical activity requirements is not an

adverse action that must be reported to the National Practitioner Data Bank or any state licensing board.

5.G ***Future Application for Privileges.*** A Practitioner who is transferred to a membership-only staff category or who automatically relinquishes certain privileges will be ineligible to apply for the clinical privileges in question for two years from the date of the transfer or automatic relinquishment, unless an exception is approved by the Medical Executive Committee for good cause.

6. ***Delegation of Functions.***

(a) The Credentials Committee is responsible for the FPPE/quality assurance process described in this Policy, subject to the oversight of the Medical Executive Committee and Board. To promote a prompt and effective review process, the Credentials Committee hereby expressly delegates to the PPE Specialists Committee, FPPE Reviewers, Department Committee, Medical Staff Leaders and the Vice President of Medical Affairs the authority to perform the functions described in this Policy on behalf of the Credentials Committee. Actions taken by these individuals will be reported to and reviewed by the Credentials Committee as set forth in this Policy.

(b) When a function under this Policy is to be carried out by one of the individuals identified in the prior subsection, by a member of Hospital management, by a Medical Staff member, or by a Medical Staff committee, the individual, or the committee through its chair, may delegate performance of the function to a qualified designee who is a Practitioner or Hospital employee (or a committee of such individuals). Any such designee must treat and maintain all information in a strictly confidential manner and is bound by all other terms, conditions, and requirements of this Policy. In addition, the delegating individual or committee is responsible for ensuring that the designee appropriately performs the function in question. Any documentation created by the designee are records of the committee that is ultimately responsible for the review in a particular matter.

(c) When an individual assigned a function under this Policy is unavailable or unable to perform that function, one or more Medical Staff Leaders may perform the function personally or delegate it to another appropriate individual as set forth above.

7. ***Definitions.*** Unless otherwise indicated below, the terms used in this Policy are defined in the Medical Staff Credentials Policy.

(a) ***"Focused Practice Professional Evaluation"*** or ***"FPPE"*** means a time-limited period during which a Practitioner's professional performance is evaluated. All initially-granted clinical privileges, whether at the time of initial appointment, reappointment, or during the term of appointment, shall be subject to FPPE.

(b) ***"PPE Specialists Committee"*** means a member of the PPE Specialists Committee at a Participating UPMC Hospital. This may include, but is not limited to, a Quality Department RN Reviewer, VPMA, applicable Department Chair, representatives from Medical Staff Services, and/or representatives of the Wolff Center who work on behalf of the Participating UPMC Hospital.

8. ***Amendments.***

(a) The Medical Staffs and Board at each Participating UPMC Hospital have independently adopted this Policy as their own by voting to approve it for use at each of their respective facilities. In doing so, the Participating UPMC Hospitals have delegated to the Medical Review Council the authority to develop and adopt amendments to this Policy.

(b) Notice of any amendments will be provided to the Medical Executive Committees at each Participating UPMC Hospital for their information. Any amendments to this Policy will take effect immediately upon receiving notice of the changes from the Medical Review Council.

(c) If any Medical Executive Committee has concerns about an amendment, they may bring the concern to the attention of the Medical Review Council. The Medical Executive Committee may also recommend to its Board that the Hospital opt out of this Policy and reestablish its own.

SIGNED: Donald M. Yealy, MD
Senior Vice President, UPMC and Chief Medical Officer, UPMC Health Services
ORIGINAL: April 1, 2024
APPROVALS:
Policy Review Subcommittee: March 13, 2024
Executive Staff: March 29, 2024 (effective April 1, 2024)
PRECEDE:
SPONSOR: UPMC Medical Staff Services

*** With respect to UPMC business units described in the Scope section, this policy is intended to replace individual business unit policies covering the same subject matter. In-Scope business unit policies covering the same subject matter should be pulled from all manuals.**

UPMC HOSPITALS

Appendix A: FPPE Process to Confirm Practitioner Competence and Professionalism