

Medical Staff Evaluation Policy Example

The example provided here is based on the *Policy Template*. It is only an example; your organization should have medical staff policies appropriate for its own processes.

Haven Hospital	Title Medical Staff Evaluation Policy		Identification Number MGT.MSE.01.05.RQD
Organization(s) <input checked="" type="checkbox"/> Haven Hospital <input checked="" type="checkbox"/> Haven Heart Clinic	Level <input checked="" type="checkbox"/> System <input type="checkbox"/> Division <input type="checkbox"/> Department	Category <input type="checkbox"/> Clinical <input checked="" type="checkbox"/> Management <input type="checkbox"/> Regulatory	Posting Date 10 Apr 2018 Effective Date 07 May 2018
Review Cycle <input checked="" type="checkbox"/> 1 year <input type="checkbox"/> 3 years Last Review Date: 28 Mar 2018		REPLACES Title: Medical Staff Evaluation Policy Effective Date(s): 21 Jun 2015	

POLICY

Medical staff must be monitored and evaluated on an ongoing basis to assess competence for all granted privileges.

PURPOSE

To provide guidance and procedures for the ongoing monitoring and evaluation process used to assess competence for privileges granted to medical staff. This process allows for timely identification and addressing of any potential problems with a staff member’s performance, including trends that may impact quality of care and patient safety. It supports compliance with Joint Commission International (JCI) Standard GLD.6.2 (see REFERENCES).

SCOPE

This policy applies to medical staff members who hold privileges in the organization and all of its facilities, as designated above.

DEFINITIONS

- **Medical staff:** Physicians, oral and maxillofacial surgeons, dentists, podiatrists, and independent practitioners or independent allied health professionals who are privileged through the organization and subject to medical staff bylaws [may be referred to in this document as *practitioners*]

RESPONSIBILITIES

- The **Credentials Committee** has primary responsibility to monitor compliance with this policy.
- The **Peer Review Committee**, represented by **medical staff quality reviewers**, is responsible for providing the Credentials Committee with data for current practitioners collected through the evaluation process described in this policy.
- The **department chairs** have primary oversight of the evaluation process for practitioners in ... [Text Removed for Example] ...

PROCEDURES

A. Frequency of Evaluation

1. **Predefined frequency:** Ongoing monitoring and evaluation is performed on all designated medical staff members at predefined intervals, consistent with regulations and accreditation requirements (see REFERENCES).
2. **Minimum frequency**
... [Text Removed for Example] ...

B. Data Monitored and Evaluated

1. **Development:** Departments determine the type of data monitored and the process for evaluating that data, with approval from the Credentialing Committee and the MEC.
2. **Data types**
 - a. **Evaluation report:** Three areas of performance data are included in a performance evaluation report for each medical staff member (see C. Step 2.):
 1. Behaviors
 2. Professional Growth – including the following:
 - i. Patient care
 - ii. Medical/clinical knowledge
 - iii. Practice-based learning
 - iv. Interpersonal and communication skills
 - v. Professionalism
 - vi. System-based practices
 - vii. Stewardship of resources
 3. Clinical Results
3. **Data sources:** The evaluation report is based on examination of data, which may include but is not limited to the following:
 - a. **Data reports:** These reports contain hospital-wide or department-specific inpatient data, such as the following:
 1. Overall risk adjusted and complication data
 2. Utilization summary
 3. Patient safety indicators
 4. Medical staff quality indicators
 5. Specialty-specific medical staff Indicators
 6. Patient satisfaction data
 - b. **Benchmark data:** The individual practitioner data is compared to internal and external benchmarks when available.
4. **Zero data:** Zero data is data and can be evidence of good performance (e.g., no returns to the OR, no complaints, etc.). Review of privileges are evaluated at reappointment and consideration of the reason for zero or low volumes is taken into consideration (e.g., staff member is no longer performing the procedure, is taking patients elsewhere for the procedure, the privilege is typically a low-volume procedure, etc.).

C. Evaluation Process

Step 1. A medical staff quality reviewer from the Peer Review Committee completes an administrative review of the available data on a medical staff member and prepares a summary noting pertinent findings and comparisons across time periods. A supervising staff member evaluates assigned independent allied health professionals.

Step 2. ... [Text Removed for Example] ...

D. Identified Issues or Concerns

1. **Request for additional information:** For any identified issue or concern in the evaluation report, the vice president of medical affairs or the department chair or designee may request additional information for further review of the medical staff member.
2. **Process options:** The evaluation process continues until the vice president of medical affairs or the department chair or designee does one of the following:
 - a. OPTION A: States satisfaction with the information received and reviewed
 - b. . . . [Text Removed for Example] . . .

E. Other Use of Evaluation Information:

1. **Privileging:** Ongoing monitoring and evaluation is one factor in the decision to maintain, revise, or revoke existing privileges(s), prior to or at the time of renewal. Information from this process is incorporated into the reappointment process.
2. **System Performance Improvement:** Relevant information obtained from the ongoing monitoring and evaluation reviews is forwarded for inclusion into department and/ or hospital system performance improvement activities, maintaining confidentiality.

F. Confidentiality and Security of Information: All peer review information, including individual and aggregate staff member data, is confidential in accordance with Medical Staff Bylaws and laws pertaining to confidentiality and nondiscoverability. Peer review information is not to be used within the organization for purposes other than performance improvement or corrective action as described in this policy.

REFERENCES

1. Joint Commission International Hospital Accreditation Standards, 6th Edition
2. Medical Staff Policy
3. Medical Staff Bylaws
4. Medical Staff Code of Conduct Policy

ATTACHMENTS

[none]

APPROVAL

<p>Name and Credentials Moira Finn-Abbas, MD, PhD</p> <p>Title Medical Director</p>	<p>Name and Credentials Edwin Goddard</p> <p>Title President of the Board of Directors</p>
<p>Signature <i>Moira Finn-Abbas</i></p>	<p>Date 05 Apr 2018</p>
<p>Signature <i>Edwin Goddard</i></p>	<p>Date 06 Apr 2018</p>