



LEE MEMORIAL HEALTH SYSTEM

BOARD OF DIRECTORS

QUALITY & EDUCATION Committee of the Whole MEETING

January 14, 2010, 2:00pm
Lee Memorial Hospital Boardroom
2776 Cleveland Ave, Ft. Myers, FL 33901

ELECTRONIC BOARD PACKET

ALL MEETINGS ARE OPEN TO THE PUBLIC AND THE PUBLIC IS INVITED TO ATTEND

Any Public Input pertaining to an agenda item is limited to three minutes and a
"Request to Address the Board of Directors" card must be completed
and submitted to the Board Assistant prior to the meeting.

LEE MEMORIAL HEALTH SYSTEM BOARD OF DIRECTORS

**QUALITY & EDUCATION
COMMITTEE OF THE WHOLE MEETING**

**Thursday, January 14, 2010
2:00 p.m.**

Lee Memorial Hospital Boardroom

AGENDA

1. CALL TO ORDER (Steve Brown, MD, Quality & Education Chairman)

The meeting of the Quality & Education Committee of the Whole of the Lee Memorial Health System Board of Directors will be called to order. Matters concerning the business of Lee Memorial Health System consisting of Gulf Coast Medical Center & Lee Memorial Hospital/ HealthPark Medical Center and its subsidiaries (HealthPark Care Center Inc., Lee Memorial Home Health, Inc., Cape Memorial Hospital, Inc. doing business as Cape Coral Hospital, and Lee Memorial Medical Management, Inc.) may be reported, discussed and recommended by the Committee of the Whole, then referred to the Full Board of Directors for final action.

2. PUBLIC INPUT: Any public input pertaining to items on the Agenda is limited to three minutes and a "Request to Address the Board of Directors" card must be completed and submitted to the Board Administrator prior to meeting.

3. Nov 12, 2010 Quality & Education Committee Meeting Minutes (*Approval*)
(Linda Brown, ARNP, MSN Board Secretary)

4. Hospitalist Task Force (*Update*)
(Drs. Burdzy, Dr. Keys & Dr. Krivenko, Chief Medical Officer – 10 min)

5. Medical Staff Credentialing (*Update – 35 min*)

- a. Credentialing Introduction/Process
(Sandy Wharton, CPMSM, CPCS, System Director Medical Staff Svcs)
- b. Focused Professional Practice Evaluation & Ongoing Professional Practice Evaluation
(Mark Greenberg, MD, System Medical Director)
- c. Credentialing Legal Overview
(Cathy Kahle, System Legal Counsel)

6. HPI Safety Program (*Verbal Update*)
(Chuck Krivenko, M.D., Chief Medical Officer/Clinical & Quality Services – 10 min)

7. Other Items

8. Date of the next REGULAR Quality/Education Committee of the Whole Meeting:

February 11, 2010 - 1:00pm

Lee Memorial Hospital Boardroom, 2776 Cleveland Avenue, Ft. Myers, FL 33901

9. ADJOURNMENT of QUALITY & EDUCATION COMMITTEE

P.O. BOX 2218
FORT MYERS, FLORIDA
33902

239-332-1111

CAPE CORAL HOSPITAL

GULF COAST MEDICAL CENTER

HEALTHPARK MEDICAL CENTER

LEE MEMORIAL HOSPITAL

THE CHILDREN'S HOSPITAL

THE REHABILITATION HOSPITAL

LEE PHYSICIAN GROUP

LEE CONVENIENT CARE

BOARD OF DIRECTORS

DISTRICT ONE

Stephen R. Brown, M.D.
Marilyn Stout

DISTRICT TWO

Richard B. Akin
Nancy M. McGovern, RN, MSM

DISTRICT THREE

Lois C. Barrett, MBA
Linda L. Brown, MSN, ARNP

DISTRICT FOUR

Frank T. La Rosa
Dawson C. McDaniel

DISTRICT FIVE

James Green
Jason Moon



**LEE MEMORIAL HEALTH SYSTEM
BOARD OF DIRECTORS**

**PUBLIC INPUT –
AGENDA ITEMS:**

**Any public input
pertaining to items on the
Agenda is limited to three
minutes and a
“Request to Address the Board of Directors”
card must be completed and
submitted to the Board Assistant
prior to meeting.**

Refer to Board Policy: 10:15E: Public Addressing the Board

Non-Agenda Item:

Individuals wishing to address the Board on an item NOT on the Agenda, the Board office must be notified of subject matter at least seven (7) days prior to the meeting to allow staff time to prepare and to insure the matter is within the jurisdiction of the Board.

**LEE MEMORIAL HEALTH SYSTEM BOARD OF DIRECTORS
QUALITY & EDUCATION COMMITTEE OF THE WHOLE MEETING MINUTES
Thursday, November 12, 2009**

LOCATION: Lee Memorial Hospital Boardroom, 2776 Cleveland Avenue, Fort Myers, FL 33901

MEMBERS PRESENT: Steve Brown, M.D., Quality & Education Chairman; Richard Akin, Board Chairman; Nancy McGovern, RN, MSM, Vice Chairman; Marilyn Stout, Board Treasurer; Linda Brown, MSN, ARNP, Board Secretary; Lois Barrett, MBA, Director; Dawson McDaniel, Director; Frank La Rosa, Director; Jason Moon, Director; David Berger, M.D., Community Representative/Quality & Education Committee; Margaret Byrnes, Community Representative/Quality & Education Committee

MEMBERS ABSENT: James Green, Director; Denise Heinemann, DrPH, Community Representative/Quality & Education Committee; Tuck Wilson, M.D., Physician Leadership Council Consultant/Quality & Education Committee

OTHERS PRESENT: James Nathan, CEO/President; Cathy Stephens, Board of Directors' Liaison; Mary McGillicuddy, Chief Legal Officer; John Wiest, Chief Financial and Institutional Services Officer; Doug Luckett, Chief Administrative Officer/GCMC/CCH; Larry Antonucci, M.D., Chief Operating Officer/Hospital Services; Gaile Anthony, Chief Administrative Officer/LMH; Jon Cecil, Chief Human Resources Officer; Charles Swain, Chief Compliance and Internal Audit Officer; Sharon MacDonald, Chief Foundation Officer and Vice Present/Oncology Services; Angela D'Anna, System Director/Internal Audit; John Iacuone, M.D., Executive Director/The Children's Hospital; Marilyn Kole, M.D., System Medical Director/Clinical Services; Becky Watt, System Director/Clinical Decision Support; Sally Jackson, System Director/Community Projects; Jack Eikenberg, Community Representative/Planning Committee; Marliese Mooney, Physician Leadership Council Consultant/ Planning Committee; Craig Clapper, Senior Partner & Chief Operating Officer/Healthcare Performance Improvement; Mike Ellis, Guest; Patrick Comer, Reporter; Isabel Firth, Administrative Secretary/Board of Directors; Beth Kilgore, Executive Secretary/Board of Directors

NOTE: Documents referred to in these minutes are on file by reference to this meeting date in the Office of the Board of Directors and on the Board of Directors website at www.leememorial.org/boardofdirectors, for public inspection.

SUBJECT	DISCUSSION	ACTION	FOLLOW-UP
MEETING CALLED TO ORDER		<p>The Quality & Education Committee of the Whole meeting was CALLED TO ORDER at 1:00p.m. by Steve Brown, M.D. Quality & Education Committee Chairman</p> <p>The Board sits as the Lee Memorial Health System Board of Directors of Gulf Coast Medical Center, Lee Memorial Hospital, HealthPark Medical Center and the Board of Directors of its subsidiary corporations: Cape Memorial Hospital, Inc. doing business as Cape Coral Hospital; Lee Memorial Medical Management, Inc.; Lee Memorial Home Health, Inc.; and HealthPark Care Center, Inc.</p>	
PUBLIC INPUT	There was NO "Public Input".		
CONSENT AGENDA	<p>Steve Brown asked if anyone wished to pull any items listed on the Consent Agenda consisting of the following:</p> <p>A. October 8, 2009 Quality & Education Committee Meeting Minutes</p> <p>B. FY 2009, 4th Quarter Risk Management Report (Exhibit 1)</p>	<p>A motion was made by Dawson McDaniel to approve the Consent Agenda consisting of the following items.</p> <p>A. October 8, 2009 Quality & Education Committee Meeting Minutes</p> <p>B. FY 2009, 4th Quarter Risk Management Report (Exhibit 1)</p> <p>The motion was seconded by Richard Akin and it carried with no opposition.</p>	
HEALTHCARE PERFORMANCE IMPROVEMENT (HPI)	<p>Jim Nathan said during the earlier Board Lunch workshop, Craig Clapper with Healthcare Performance Improvement (HPI) presented four draft recommendations to the Board for endorsement regarding patient safety priorities. Jim reviewed the following HPI Recommendations (Exhibit 2):</p> <ol style="list-style-type: none"> 1. Make patient safety a top priority for the System. 2. Adopt the work plan (proposed milestones). 3. Charge Administration, HPI, Physician Safety Group and Legal with presenting a solution at the January meeting for making harm visible. 4. Charge the Physicians Safety Group with presenting a plan at the February meeting for safer processes and physician Red Rules. <p>Discussion ensued with regard to making harm visible and appropriately addressing the specific issues for positive change. Dawson McDaniel said the community should be aware of</p>	<p>(Linda Brown entered the meeting at 1:15pm)</p> <p>(Jason Moon entered the meeting at 1:20pm)</p>	

SUBJECT	DISCUSSION	ACTION	FOLLOW-UP
	<p>efforts being made throughout the System to make a positive cultural change for patient safety. Jim Nathan said making harm visible applies to many different areas in System and this will be a cultural change lead by the Board and Administration. Steve Brown said the Board should have key oversight in this System-wide initiative and requested adding this as number one of the HPI recommendations to the Board.</p>	<p>A motion was made by Marilyn Stout to endorse the following Healthcare Performance Improvement (HPI) recommendations:</p> <ol style="list-style-type: none"> 1. LMHS Board of Directors to have key oversight of this program. 2. Make patient safety a top priority for the System. 3. Adopt the work plan consisting of the following Proposed Milestones: <ol style="list-style-type: none"> a) Complete culture design by 18 Jan 2010 b) Begin Red Rule implementation by 10 Dec 2009 c) Begin leader education by 16 Feb 2010 d) Begin physician & staff education by 24 Mar 2010 (to complete by 24 Sep 2010) 4. Charge Administration, HPI, Physician Safety Group and Legal with presenting a solution at the *January meeting for making harm visible. 5. Charge the Physician Safety Group with presenting a plan at the *February meeting for safer processes and physician Red Rules. <p><i>*(dates dependent on new proposed Board meeting schedule- see Governance item #6)</i></p> <p>The motion was seconded by Lois Barrett and it carried with no opposition.</p> <p><i>*(dates dependent on new proposed Board meeting schedule- see Governance item #6)</i></p>	
<p>H1N1 VIRUS (SWINE FLU)</p>	<p>Marilyn Kole provided an update on the current status of the H1N1 (Swine Flu) in our community (Exhibit 3). Nancy McGovern asked Marilyn what the policy and guidelines are for employees who are experiencing flu symptoms. Marilyn said policy states for employees to stay home from work until they are symptom free for twenty-four hours.</p>		
<p>HOSPITALIST TASK FORCE</p>	<p>Larry Antonucci provided a historical background on the hospitalist program and the creation of hospitalist task force. He said the task force convened to review the recommendations presented by Dr. Krivenko. The task force has also been examining the Emergency Department coverage issue.</p>		<p><i>Update to the Board in the future</i></p>
<p>GENERAL SURGICAL CALL</p>	<p>Richard Akin provided a verbal update on the General Surgical Call situation. He said there has been a lot of activity around this problem and the primary topics of consideration are creating access of coverage at hospitals, by pairing hospitals together and therefore sharing call coverage or have hospitals independent with their own separate call coverage system. Richard said these issues have gone back to the Physician Leadership Council (PLC) for further discussion however, if it can not be resolved the Board will become involved in making the final decision. Linda Brown said, if necessary, the Board will need a full report on this issue to include the history surrounding this topic in order to make the final decision. Discussion ensued with regard to call coverage and unassigned patients.</p>		
<p>FY 2009 3RD QTR ORGANIZATIONAL PERFORMANCE MEASURES SCORECARD</p>	<p>Becky Watt reviewed the FY 2009, 3rd Quarter Organizational Performance Measure Scorecard.</p>	<p>A motion was made by Nancy McGovern to accept the FY 2009, 3rd Quarter Organizational Performance Measure Scorecard. The motion was seconded by Dawson McDaniel and it carried with no opposition.</p>	

SUBJECT	DISCUSSION	ACTION	FOLLOW-UP
OTHER ITEMS Proposed 2010 Board Meeting Schedule (informational)	Cathy Stephens announced the proposed change to the FY 2010 Board Committee meeting schedule, which includes alternating the Planning and Quality & Education Committee meetings every other month and changing the start time to 3:00pm rather than 1:00pm. The Board of Directors will vote on this change at their Dec 3, 2009 Full Board Meeting. David Berger said based on his work schedule he is not in favor of the time change. Margaret Byrnes said she would like to have a schedule which is consistent every month for the sake of planning her schedule.		
NEXT REGULAR MEETING	The next REGULAR Quality & Education Committee of the Whole meeting, to be determined.		
ADJOURNMENT		The Quality & Education Committee of the Whole meeting was ADJOURNED at 2:00p.m. by Steve Brown, M.D., Quality & Education Committee Chairman.	

Minutes were recorded by Beth Kilgore, Executive Secretary/Board of Directors Office

 Linda Brown, MSN, ARNP
 Board Secretary

UNAPPROVED

RESPONSIBILITIES OF PHYSICIANS PROVIDING INPATIENT CARE

Basic Responsibilities

To provide inpatient general medical care to patients a physician must meet the following requirements:

- 1) Be credentialed by the LMHS credentials committee.
- 2) Maintain board certification in Internal Medicine or Family Practice or be eligible to be admitted to the certification process and achieve board certification within the time frame set forth in the Medical Staff Bylaws.
- 3) Maintain all customary narcotics and controlled substance numbers and licenses.
- 4) Dress in appropriate attire and maintain appropriate hygienic standards.
- 5) Wear a LMHS identification badge in a conspicuous location at all times.
- 6) Adhere to all sections of the LMHS bylaws and Department of Medicine Rules and Regulations.
- 7) If *locum tenens* status, physician must meet the credentialing requirements of the LMHS Medical Staff Bylaws for the specialty of Internal Medicine or Family Practice prior to any patient contact.

Responsibilities Regarding Admission of Patients

- 1) Admit all patients requiring admission with whom an established doctor patient relationship exists.
- 2) If accepting unassigned patients, adhere to the policy regarding such admissions
- 3) Admit pregnant women with a primarily medical diagnosis who's fetus has a gestational age of less than or equal to 20 weeks by ultrasound. Obtain any needed obstetrical consult.

Responsibilities Regarding Communication

- 1) Properly identify yourself to the patient and provide contact information through which the patient and/or family members are able to contact you.
- 2) Keep legible notes.
- 3) Use LMHS standardized order sets when possible.
- 4) Provide an adequate sign out to other physicians when they take over care of your patients, including coverage for weekends and nights.
- 5) Employ methods to insure continuity of care in both the inpatient and outpatient settings.

Standards Regarding Consultations

- 1) Limit the number of consultations to those necessary to achieve appropriate medical care for the patient.
- 2) Work with consultant physicians to create clinical protocols that allow appropriate care and negate the necessity for consultations for commonly occurring conditions generally encountered.
- 3) Comply with the required telephonic communication physician to physician for all urgent or emergent consultation requests.
- 4) The attending physician is to make every attempt to evaluate the patient and generate a History and Physical before consulting another physician.
- 5) Admitting physicians are encouraged to communicate personally with consultants regarding all consults to ensure that the reason for consultation and level of urgency are clearly communicated. Consultants are encouraged to communicate personally with the attending physician regarding significant events or decisions regarding patient care.
- 6) If the patient already has a relationship with a consultant whose services are required, this physician is to be consulted.

Responsibilities Regarding Patient Discharge

- 1) Work directly with the consulting physicians to determine the appropriate date for discharge.
- 2) Begin discharge planning at the time of admission. Whenever possible arrange in advance any transfers to nursing facilities, home health or Hospice referrals, and the like.
- 3) Avoid 'discharge if ok with' orders. The attending physician is to contact the consultant(s) and clarify any clinical care or follow up issues.
- 4) Make every effort to dictate a discharge summary at the time of discharge.

Responsibilities Regarding Care Management

- 1) Work directly with the care management department to identify patient care options that facilitate the clinical and social recovery of the patient.
- 2) When a patient needs to be transferred to another facility, the attending physician is to collaborate with the physician(s) at the accepting facility in order to insure that appropriate communication and transfer arrangements occur prior to the actual transfer of the patient.

Responsibilities Regarding Response Times

- 1) All telephone calls from patient departments and floors should be answered within 20 minutes.
- 2) Urgent calls should be answered within 10 minutes.
- 3) Each admitting physician must provide a written protocol on how the physician is to be contacted. The physician must provide a back-up plan should attempts at contact fail.
- 4) If immediate physician assistance is needed for medical emergencies, every attempt should be made to render it.
- 5) Patients admitted for general medical care must be seen within 12 hours of admission orders being given.
- 6) Stable patients requiring admission to Intensive Care Units who are not admitted to the ICU team must be seen within 6 hours of admission orders being given.

Responsibilities Regarding Documentation

- 1) An original note must be written upon evaluating a patient.
- 2) Notes from other physicians should not be 'cut and pasted' to generate a progress note.

Responsibilities Regarding Patient Census

- 1) Maintain a patient census that does not exceed 25 patients on a given day.
- 2) Adjust and reduce the census to meet the demands of critically ill patients.
- 3) Variances due to unusually high admission or discharge activity are acceptable as long as patient load limitations are adhered to in a good faith manner.

Responsibilities Regarding Physician Assistants and Nurse Practitioners

- 1) Physicians Assistants and Nurse Practitioners are to identify themselves as such at all times and give contact information for their supervising physician.
- 2) Business casual attire, at a minimum is to be worn.
- 3) A LMHS identification badge is to be worn in a conspicuous location at all times.
- 4) The supervising physician must personally examine and evaluate all patients daily even if already seen by an allied health practitioner.
- 5) All PAs and ARNPs are to maintain all required certifications.
- 6) All PAs and ARNPs are to adhere to LMHS bylaws.

Quality and Standards

- 1) Quality measures promulgated by the Department of Medicine and Physician Quality and Standards committee are to be followed.
- 2) Any identified deficiencies are to be addressed and every effort be made to improve performance
- 3) Report any quality or behavioral issues to the appropriate body of the medical staff such as the Quality and Standards Committee, the medical Executive Committee, and/or the Department of Medicine.

HOSPITALISTS

Definition of a Hospitalist

A hospitalist is defined as a physician who has completed a residency in, and is board certified or board eligible in the specialties of internal medicine or family medicine who practices exclusively in the hospital setting.

Additional Responsibilities Pertaining to Hospitalists

The following responsibilities are to be applied to hospitalists in addition to those stated above.

Responsibilities of Hospitalist Groups

- 1) Insure each of their members meets the definition of a hospitalist.
- 2) Aid in the credentialing process for group members and follow all appropriate policies and procedures.
- 3) Orient their physicians to their duties in LMHS.
- 4) Meet all volume, acuity, and patient satisfaction needs of the facility.
- 5) Monitor quality measures such as HCAPS scores, length of stay, and other clinical indicators approved by the institution, Department of Medicine, and Medical Executive Committee.
- 6) Provide proper staffing to fulfill these obligations.
- 7) Report any quality or behavioral issues to the appropriate body of the medical staff such as the Quality and Standards Committee, the medical Executive Committee, and/or the Department of Medicine.
- 8) Encourage participation of group members in appropriate committees and task forces.

Basic Responsibilities of Each Hospitalist

- 1) Maintain ACLS and BLS.
- 2) Actively participate in committees and work groups applicable to direct patient care.

Responsibilities Regarding Communication

- 1) Provide a brochure to all admitted patients introducing and describing the functions of a hospitalist.
- 2) Communicate with the primary care physician on admission, discharge, and when any significant changes in clinical condition occur.
- 3) Arrange to have the dictated discharge summary faxed to the PCP upon discharge. This discharge summary is to include at a minimum: admitting and discharge diagnosis, relevant history and physical findings, description of any procedures, all relevant labs and studies, discharge medications, discharge diet and activity, follow up plans, and discharge condition.
- 4) Any issues requiring prompt follow up must be communicated verbally to the physician(s) with whom the patient will follow after discharge.

Additional Hospitalist Standards

The above standards are the minimum to be maintained by all hospitalist physicians and groups. Stricter standards may be applied as requirements of any contractual agreement between the hospitalist or group and LMHS or other entities. Any stricter requirements must be clearly delineated in a contract between the hospitalist or group and other entity. LMHS or any other contracting entity, and not the Department of Medicine are responsible for monitoring adherence to any standard stricter than those above. Any contracts, such as those involving subsidies for patient care, are beyond the authority of the Department of Medicine providing the above minimum standards are met.

QUALITY COMPLIANCE

The administration will collect and provide data regarding the above measures and any other quality measures as decided upon by the System Quality Committee to the System Quality Committee on a quarterly basis. The System Quality Committee will review this data and if concerns arise will address them with the appropriate facility Physician Quality and Standards Committee.

Medical Staff Credentialing

Credentialing Introduction/Process

Sandra L. Wharton, CPMSM, CPCS

Focused Professional Practice Evaluation

And

Ongoing Professional Practice Evaluation

Mark Greenberg, M.D.

Credentialing Legal Overview

Cathy Kahle

Credentialing

exists to protect patients

Credentialing

is the foundation for
patient safety and quality
of care

Medical Staff Bylaws

PART III – Credentials Procedures

outlines governance for
credentialing and
privileging

Credentialing Policies

- Confidentiality Policy
- Competency Policy (for practitioners returning to provide acute inpatient care)
- Expedited Credentialing Policy
- Focused Professional Practice Evaluation Policy
- Medical Staff Privilege Dispute Resolution Policy
- Practitioners-in-Training Policy
- Preceptorship Policy
- Telemedicine Policy
- Temporary Privileges – Urgent Patient Care, Treatment and/or Service Need

System Credentialing/Privileging Committee

Began January, 2010

Composition – 15 members
(3 from each Medical Staff)

Co-Chairmen

Emad Salman, M.D.

Doug Savage, M.D.

Members

Charles Boggs, M.D.

Jon Burdzy, D.O.

Alan Claunch, M.D.

Gary Correnti, M.D.

Diana DeVall, M.D.

Timothy Dougherty, M.D.

William Hearn, D.O.

Timothy Keys, M.D.

Emad Mansour, M.D.

Murali Muppala, M.D.

Fletcher Reynolds, M.D.

Thomas Seitz, M.D.

Brett Shannon, D.O.

Medical Staff Credentialing

Pre-application Process

The purpose of the pre-application screening process shall be to avoid the costly and time-consuming application process in those circumstances where an applicant fails to meet the minimum eligibility criteria. Practitioners who do not meet the minimum eligibility criteria for appointment are not entitled to fair hearing rights.

The Board Liaison for credentialing reviews each pre-application for compliance with institutional needs.

Initial Application Process

- Completed, signed and dated Medical Staff application form
- Privilege delineation form
- Copies of all documents/information (medical school, internship, residency, fellowship, ECFMG, etc.) to confirm applicant meets criteria for membership and/or privileges in order to verify current competency
- Board certification or statement of admissibility/acceptance to sit for Board exam
- Malpractice insurance
- Florida medical license
- DEA registration
- Certificates – ACLS, PALS, ATLS (if applicable)
- Photo
- Application fee

Primary Source Verification Process

- License to practice in Florida – Florida Board of Medicine website
- Licenses to practice in other states – Federation of State Medical Boards
- DEA registration – DEA Diversion website
- Medical school, internship, residency and fellowship – AMA or AOA profile or in writing from primary source
- ECFMG – ECFMB website
- Board certification – CertiFacts
- Healthcare organization affiliations – primary source
- Professional liability insurance – copy of certificate or proof of financial responsibility from State of Florida
- Settlements and judgments – National Practitioner Data Bank (NPDB)
- Medicare/Medicaid sanctions – OIG and GSA website
- Background check – outside vendor (American Background)
- Peer references – primary source
- Identity of applicant – view government-issued identification (driver's license, passport, etc.)

Credentialing Interviews

Minimum of two (2) by Dept. Chairman or Section Chief of primary facility and members of System Cred./Priv. Committee

Application Processing Timeframe

180 days

from receipt of completed application to date of Board approval

Medical Staff Reappointment Process

- All reappointments and renewals of clinical privileges are for a period not to exceed 24 months.
- All practitioners submit reappointment application at least 60 days prior to expiration of membership.
- Verification of information performed by Medical Staff Services
- Evaluation for reappointment reviewed by Section Chief and Dept. Chairman and report submitted to System Credentialing/Privileging Committee
- Approval by Facility Medical Executive Committee for Board consideration of reappointment to the Medical Staff

Ongoing Professional Performance Evaluation (OPPE)

OPPE: Regulatory Background

- The Joint Commission (TJC) and Medicare (as a “condition of participation”) require an ongoing assessment of a provider’s clinical competence.
- TJC named it’s process “ongoing professional performance evaluation.”

OPPE: Goals

- Create a medical staff culture that accepts performance feedback in the spirit of continuous improvement.
- Provide physicians with systematic, timely, and periodic feedback, not just at reappointment.
- Highlight areas of excellence as well as areas of improvement opportunities.
- Allow physicians the opportunity to self-improve based on the data provided.

OPPE: Design Principles

- Routine feedback to be provided to each physician.
- Indicators (rules, rates, or reviews) will be organized by the competence category being measured.
- Use a summary score card with color indicators.
- Depending on volumes, may need to use up to a rolling 2 year data collection period.
- Physician activity (volume) data will be separated from the performance data.

OPPE: Target and Selection Principles

- Selection supervised by the medical staff.
- For each indicator, 2 targets will be selected to define 3 levels of performance: “exceeds”, “meets”, and “needs improvement.”
- Whenever possible, targets will be based on external benchmarks.
- Distribution of reports will occur semi-annually.

OPPE: Report Interpretation

- Data to be viewed only as a broad comparison of physician competence and only as a starting point for identifying improvement opportunities.
- Department Chairs will review and address areas in need of improvement.
- Department Chairs will report their activity to the Physician Quality Committees.
- The first 6 to 12 months of feedback reports will be viewed as a “pilot test.”

OPPE: Draft Indicators

- Technical Quality: case reviews with “aspirational goals”
- Patient Safety: rules violations to include unsafe abbreviations, legibility, informed consent, H&P completed within 24 hours of admission, post-procedure notes
- Citizenship: rules violation for medical record delinquencies
- Service: patient complaints
- Relationships: medical and system staff complaints
- Resource Utilization: use of physician blood transfusion orders
- Future steps: rate and specialty specific data

Physician Performance Feedback Report

Legend	
■ Excellent	
■ Acceptable	
■ Needs Follow-up	

Provider:

ID:

Specialty:

DRAFT

Activity

Time Period	Volume
	Admissions
	Procedures
	Consultations

		SCORE		
Focused Professional Practice Triggers	Target	Excellent	Acceptable	Needs Follow-up
Technical Quality Case reviews with "Aspirational goals".	0 and 2			
Patient Safety Documentation rules violations: <ul style="list-style-type: none"> <input type="checkbox"/> Unsafe Abbreviations. <input type="checkbox"/> H&P not completed within 24 hours of admission. <input type="checkbox"/> Handwritten Immediate post-procedure note. <input type="checkbox"/> Informed Consent <input type="checkbox"/> Legibility (Signature illegible by two reviewers and no physician number provided). 	2 and 6			
Citizenship Medical record delinquencies – Non compliance resulting in any form of suspension as per Medical Staff Rules and Regulations.	0 and 1			
Service Validated by Department Chair Patient complaints regarding non-clinical issues	0 and 2			
Relationships Validated by Department Chair Medical and hospital staff complaints regarding non-clinical issues	0 and 2			
Resource Utilization Noncompliance with the use of physician Blood Transfusion orders.	0 and 1			

LEE MEMORIAL HEALTH SYSTEM
BOARD OF DIRECTORS

OTHER ITEMS

**LEE MEMORIAL HEALTH SYSTEM
BOARD OF DIRECTORS**

**DATE OF THE NEXT
REGULARLY SCHEDULED
MEETING**

**QUALITY
Committee of the Whole
MEETING**

***Thursday,
Feb 11, 2010
1:00pm***

Lee Memorial Hospital Boardroom
2776 Cleveland Ave, Ft. Myers, FL 33901