

What REALLY Happens Inside The Principal's Office: Examples Of The 'What', 'How' And 'Who' Of FPPE From Multiple Institutions

Warren S. Sandberg, M.D., Ph.D.
Professor & Chair,
Department of Anesthesiology,
Vanderbilt University School of Medicine



New from the JC- OPPE:

As of Jan 2008, all clinicians must have-

- Ongoing
 - Professional
 - Practice
 - Evaluation
-
- On more than one axis
 - 'More frequently than annually'

Question of Competence

You learn that the Hospital Medical Staff Committee is considering suspending the privileges of one of your clinicians (Bob).

- You are asked to advise the committee whether Bob is 'competent'.
- Now what?
- How do we **know** that Bob is competent?
- How do we **prove** that Bob is incompetent?
- Put yourself in Bob's position...

JC Expectations:

Performance measurement (*and documentation*) for various aspects of medical staff practice competencies as outlined in MS.4.00.

- General competencies for medical staff include:
 - Patient Care
 - Medical/Clinical Knowledge
 - Practice-based Learning and Improvement
 - Interpersonal and Communication Skills
 - Professionalism
 - Systems-based Practice

Definition (JC):

Ongoing Professional Practice Evaluation:

- “a document summary of **ongoing** DATA collected for the purpose of assessing a practitioner’s clinical competence and professional behavior.
- The information gathered during this process factored into decisions to:
 - maintain,
 - revise,
 - revoke

existing privilege(s) **prior to** or at the end of the two-year license and privilege renewal cycle”

Definition (JC):

Ongoing Professional Practice Evaluation:

- **...ongoing...**
 - Has to be more frequently than annual review
 - Annually is periodic; the data review must be ongoing
 - Ideally continuous; at least every 6 months
- ...DATA...
 - Getting the data: This is the hard part!
- ...decisions regarding existing privilege(s)
 - Who reviews the data?

First Pass Solution:

- AIMS-based data collection grounded in ASA standards for monitoring-
- ***'Qualified personnel present'***
 - Attestations of 'presence' & 'medical direction' signed within 2 hours of end of anesthesia care
- ***'Monitor of ventilation'***
 - Measurement of end-tidal CO₂ for all general anesthetics
- ***'Monitor of circulation'***
 - Blood pressure documented *before presence of 0.1 MAC volatile anesthetic in breathing circuit

4/3/08	9:50 AM	9:51 AM	9:52 AM	9:53 AM	9:54 AM	9:55 AM	9:56 AM	9:57 AM	9:58 AM	9:59 AM	10:00 AM	10:01 AM
--------	---------	---------	---------	---------	---------	---------	---------	---------	---------	---------	----------	----------

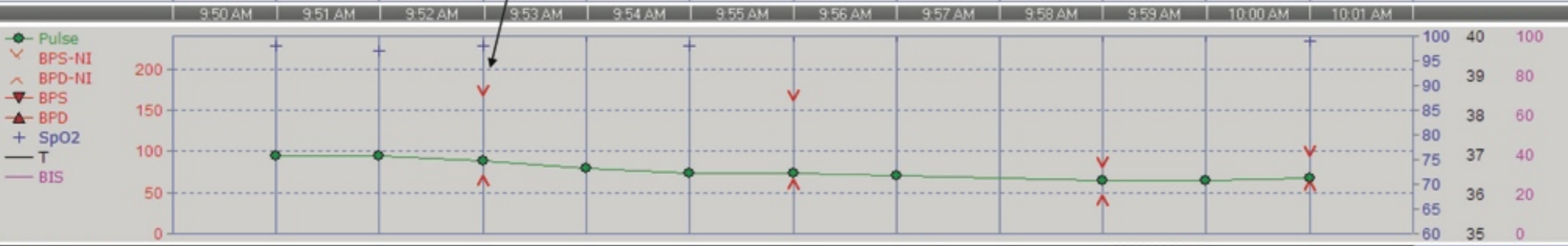
Automatic Gas	9:50 AM	9:51 AM	9:52 AM	9:53 AM	9:54 AM	9:55 AM	9:56 AM	9:57 AM	9:58 AM	9:59 AM	10:00 AM	10:01 AM	Units
O2 fi				96	95	97	98	98	98	96	97	97	%
N2O fi				0	0	0	0	0	0	2	0	0	%
Sevoflurane fi										0.9	1	1	%
CO2 et				31	5	29	32	31	21	7	24	8	mmHg

Drugs_Fluids

Clindamycin [mg]													600 mg
Fentanyl [mcg]				150									225 mcg
Morphine [mg]													10 mg
Midazolam [mg]													2 mg
Propofol [mg]							150					50	230 mg
Cisatracurium [mg]								10					23 mg
Glycopyrrolate [mg]													0.6 mg
Metoprolol [mg]													5 mg
Phenylephrine										2 Minute(s)			0 d/0 h/42 m
Neostigmine [mg]													3 mg
Haloperidol [mg]													1 mg
Ondansetron [mg]													4 mg
Lactated Ringers [ml]													1,250 ml

Sevoflurane inspiration begins at 9:59 AM

Blood Pressure monitoring begins at 9:53 AM



ECG Rhythm	NSR
BloodLoss	
TOF	

9:42 AM	9:43 AM	9:44 AM	9:45 AM	9:46 AM	9:47 AM	9:48 AM	9:49 AM	9:50 AM	9:51 AM	9:52 AM	9:53 AM
---------	---------	---------	---------	---------	---------	---------	---------	---------	---------	---------	---------

Automatic Gas	9:42 AM	9:43 AM	9:44 AM	9:45 AM	9:46 AM	9:47 AM	9:48 AM	9:49 AM	9:50 AM	9:51 AM	9:52 AM	9:53 AM	Units
O2 fi				30	96	30	26	24	26	23	23		%
N2O fi				0	0	61	68	71	67	73	74		%
Sevoflurane fi						0.5	3.6	3	2.6	2.5	2.5		%
CO2 et				0	0	22	33	31	13	25	26		mmHg

Drugs_Fluids	9:42 AM	9:43 AM	9:44 AM	9:45 AM	9:46 AM	9:47 AM	9:48 AM	9:49 AM	9:50 AM	9:51 AM	9:52 AM	9:53 AM	Units
Clindamycin [mg]													450 mg
Fentanyl [mcg]										25			100 mcg
Propofol [mg]								100					100 mg
Ondansetron [mg]													4 mg
Lactated Ringers [ml]													500 ml

Sevoflurane inspiration begins at 9:48 AM

Blood Pressure monitoring begins at 9:51 AM



ECG Rhythm													NSR
BloodLoss													
TOF													

Sample Clinician Report

91/95 Total

Physician Name: Dr. X
 Peoplesoft ID: 9999999
 Re-Credentialing Period: January 2009 to March 2009
 Reporting Time Period: May 2008 to October 2008
 Report Issued On: January 16th, 2009

COMPLIANCE SIGN OFF METRIC		
	Physician	Group
Compliant Cases	176	21,991
Non-Compliant Cases	14	205
Total	190	22,196
Compliant Cases	92.63%	99.08%
Non-Compliant Cases	7.37%	0.92%
Total	100.00%	100.00%

Conclusion
 Your performance on this metric for this period was below the group representing 95% of all DACC members with sufficient data for evaluation.

Non-Compliant Cases
 DATE OF SERVICE AND MRN FOR NON-COMPLIANT CASES SHOWN HERE

BP MONITORING METRIC		
	Physician	Group
Compliant Cases	157	12,130
Non-Compliant Cases	3	356
Total	160	12,486
Compliant Cases	98.13%	97.15%
Non-Compliant Cases	1.88%	2.85%
Total	100.00%	100.00%

Conclusion
 Your performance on this metric for this period was within the group representing 95% of all DACC members with sufficient data for evaluation.

Non-Compliant Cases

END TIDAL CO2 METRIC		
	Physician	Group
Compliant Cases	N/A	16,190
Non-Compliant Cases	N/A	161
Total	0	16,351
Compliant Cases	N/A	99.02%
Non-Compliant Cases	N/A	0.98%
Total	0.00%	100.00%

Conclusion
 Insufficient Data Available for Metric

Non-Compliant Cases



Other AIMS Options: UNC

- Abstract #A731, ASA 2011 (Dave is here)
- 43 physicians and 49 CRNAs
- AIMS-generated peer-to-peer (within role group) and care-team 360° evaluations.
- Random day selection, each clinician, 3x/month
 - 2 care team, 1 peer-to-peer
- Structured response questions (10 p2p, 7 care team)
- Scored 1 (strongly disagree) to 4 (strongly agree)



UNC AIMS-mediated 360

Peer to Peer OPPE
ITEM
1. This clinician arrives on time to accept clinical responsibilities (professionalism)
2. This clinician is organized and well-prepared for his/her clinical assignment (pt care)
3. When requested, this clinician relies on colleagues (interpersonal and communication skills)
4. This clinician exemplifies professional behavior
5. This clinician adapts well to the changing needs of the patient
6. This clinician demonstrates respect for the patient and colleagues
7. This clinician exemplifies the best of the profession
8. I am comfortable "handing off" my patient to this clinician
9. This clinician practices evidence-based medicine
10. Additional comments

Care Team OPPE
ITEM
1. Provides patient care that is compassionate, appropriate and effective (patient care)
2. Demonstrates knowledge about established and evolving science related to the practice of anesthesiology (medical knowledge)
3. Investigates and evaluates evidence and improves patient care practices (Practiced based learning)
4. Demonstrates interpersonal and communication skills that result in effective information exchange and optimal patient care (interpersonal and communication skills)
5. Demonstrates a commitment to carrying out professional responsibilities (professionalism)
6. Demonstrates ability to use hospital based resources to provide optimal care (system-based practice)
7. Additional comments

- Results: 761 evaluations in 6 months
- Everyone above average on all axes
- Few (21) ratings less than 3



So What Does Vandy Do?

- Outcomes collected routinely for all patients:
 - Initial post-op pain in PACU
 - PACU PONV
 - Initial PACU Temp (normothermia)
 - Antibiotic prophylaxis
 - CVL protocol documentation
 - Overall satisfaction with anesthesia care (call at home)
- Created linkage to OPPE mechanism
- Added AIMS-mediated 360° modeled after UNC



FPPE

- Under certain circumstances, a focused professional practice evaluation is indicated.
- New members of the medical staff.
- Individuals whose practice performance is outside the norm of the group.
- “Could be as simple as the Chair walking into the OR, looking around and declaring everything is OK”
- How to apply to new staff?

FPPE for New Staff

- Good old days: paper work / references -- Done.
- New: Privileging combined with FPPE and OPPE becomes a three step process:
 - Privileges are approved based on medical staff criteria.
 - Physician completes medical staff's Focused Professional Practice Evaluation process to assure initial performance of privileges and organization expectations
 - Physician meets ongoing performance expectations through OPPE.

Monthly Cycle for New Staff

New MGH faculty get the OPPE process run monthly: feed

Physician Name: Dr. X
Peoplesoft ID: 9999999

Re-Credentia Reporting Time Period: January 2009 to March 2009
Report Issued On: May 2008 to October 2008
January 16th, 2009

COMPLIANCE SIGN OFF METRIC		
	Physician	Group
Compliant Cases	176	21,991
Non-Compliant Cases	14	205
Total	190	22,196
Compliant Cases	92.63%	99.08%
Non-Compliant Cases	7.37%	0.92%
Total	100.00%	100.00%

Conclusion
Your performance on this metric for this period was below the group representing 95% of all DACC members with sufficient data for evaluation.

Non-Compliant Cases
DATE OF SERVICE AND MRN FOR NON-COMPLIANT CASES SHOWN HERE

BP MONITORING METRIC		
	Physician	Group
Compliant Cases	157	12,130
Non-Compliant Cases	3	356
Total	160	12,486
Compliant Cases	98.13%	97.15%
Non-Compliant Cases	1.88%	2.85%
Total	100.00%	100.00%

Conclusion
Your performance on this metric for this period was within the group representing 95% of all DACC members with sufficient data for evaluation.

Non-Compliant Cases

END TIDAL CO2 METRIC		
	Physician	Group
Compliant Cases	N/A	16,190
Non-Compliant Cases	N/A	161
Total	0	16,351
Compliant Cases	N/A	99.02%
Non-Compliant Cases	N/A	0.98%
Total	0.00%	100.00%

Conclusion
Insufficient Data Available for Metric

Non-Compliant Cases

- Zero additional effort to create reports
- Reviewed by Credentialing Committee Chair

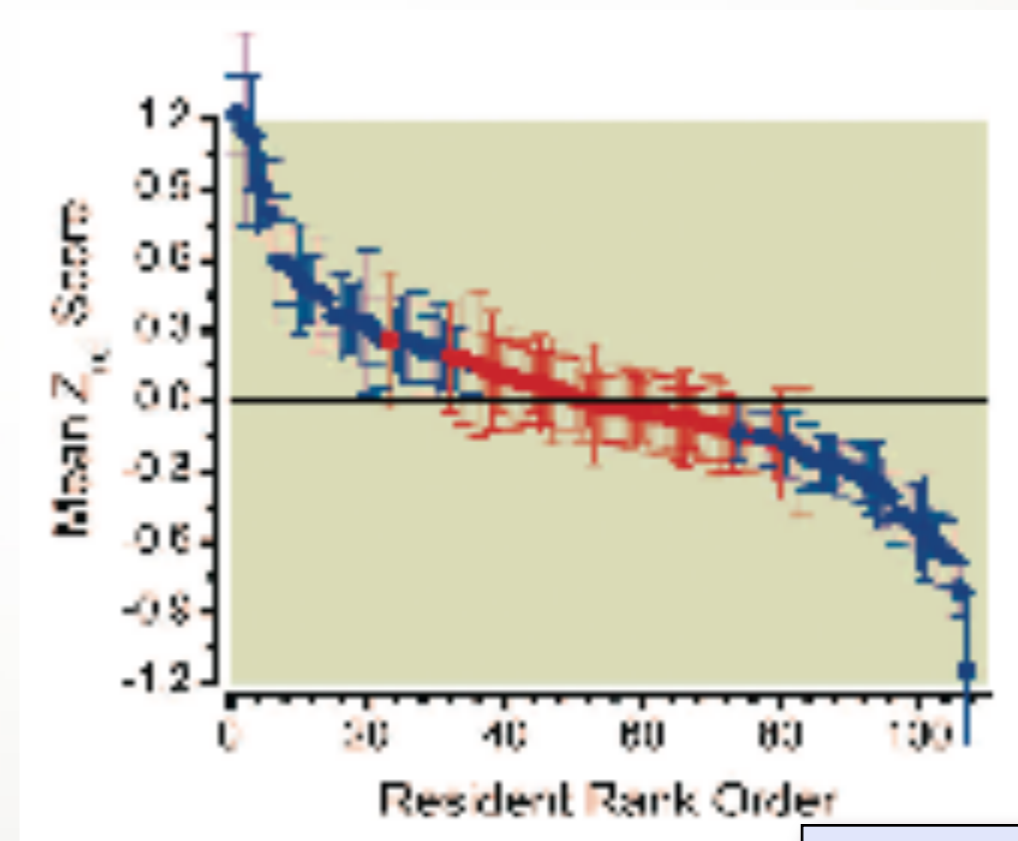
FPPE from OPPE Process

- Expectation for OPPE to generate FPPE
- Temptation is to write OPPE as surveillance for non-routine or 'never' events.
- Potential jeopardy for high risk services
- If OPPE is designed to establish group *inclusion*:
 - Look for outliers (works for machine data and 360°)
 - There might not be outliers!
 - Colleagues might be reluctant to score each other as unacceptable but might consistently use the lower end of acceptable to send a subtle

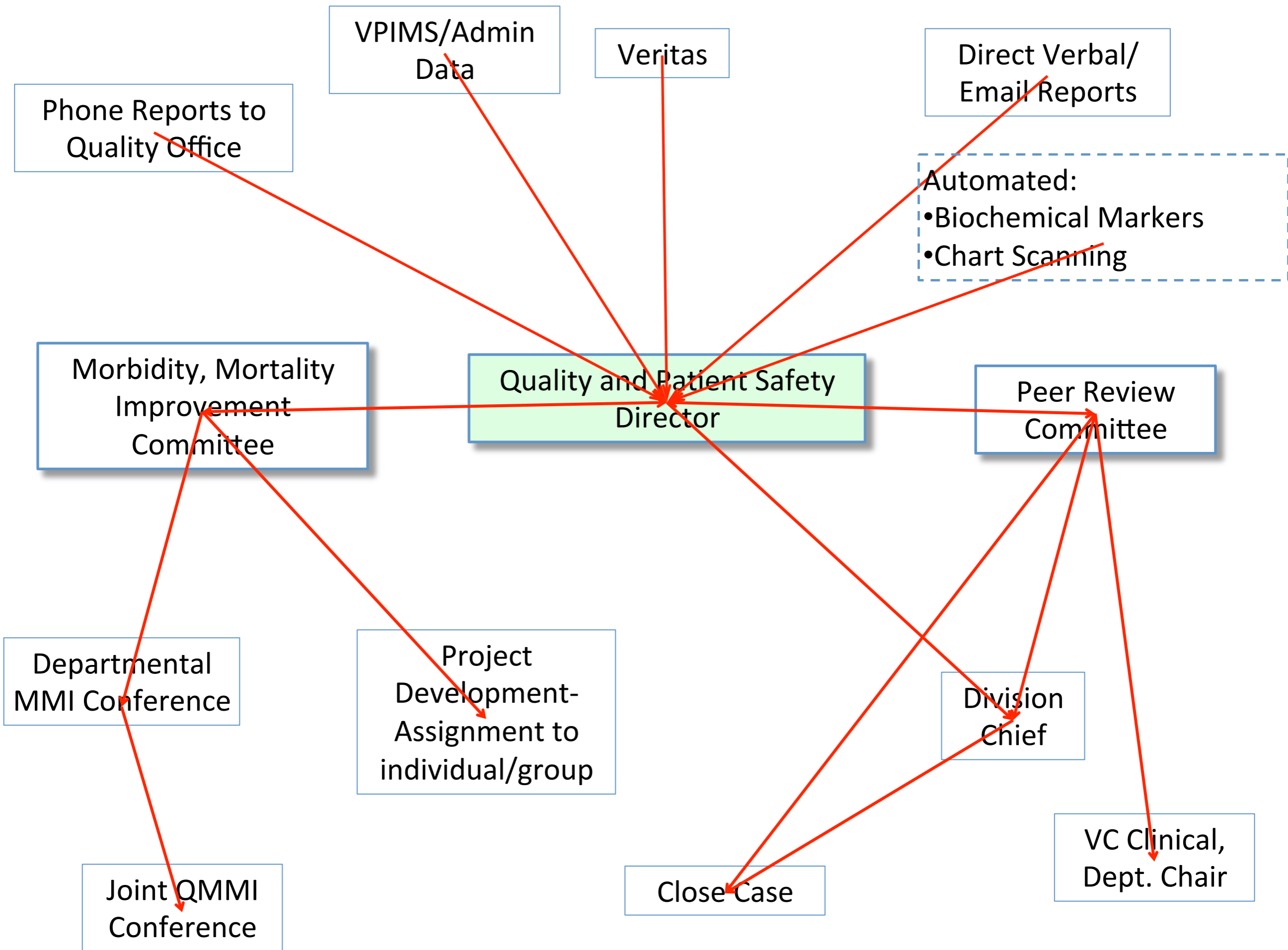


Info From Compressed Scales

- Compute Z score:
$$Z = (\text{Rater score}_{\text{individual}} - \text{Rater mean}_{\text{all}}) / \text{Rater SD}_{\text{all}}$$
- Expresses a rater's score for an individual subject in context of that rater's average score for all the subjects they rate.
- Example: evals of residents by faculty - high and low performers are clearly visible.



Baker, Anes115, (2011)



FPPE Examples

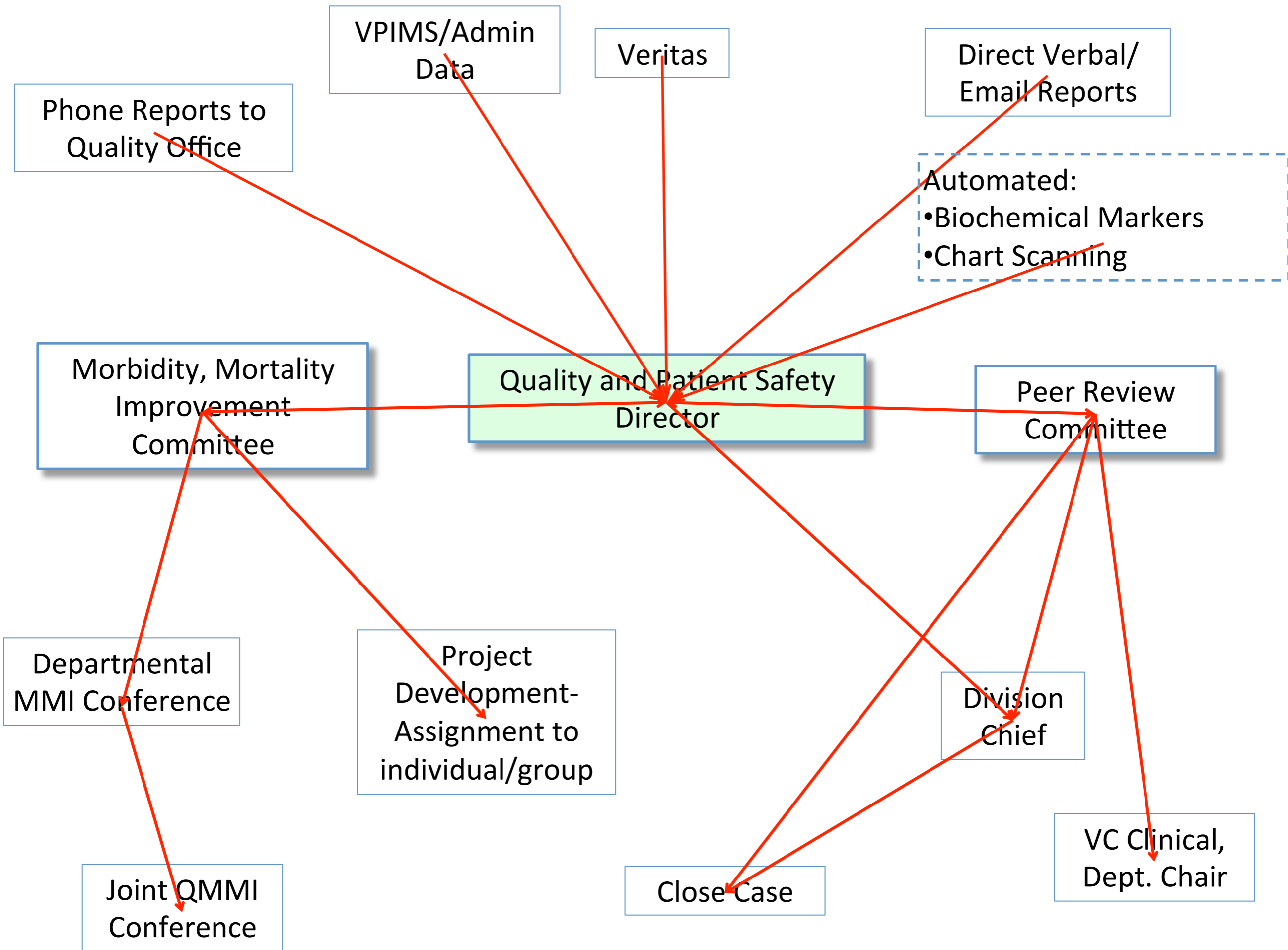
- A member of the faculty consistently neglected to complete anesthesia documentation (documentation completion rates and lag times are reported monthly).
 - Since there was no specific educational component required, we withheld the individual's clinical productivity bonuses until performance improved and monitored monthly for 6 months.
- Inadequate technical skills
 - FPPE consisted of faculty proctored technical training and sim-center education.
- Inadequate team communication in the OR, implicated in adverse outcomes
 - FPPE consisted of sponsoring the individual (attendance required) for three rounds of Anesthesia Crisis Resource Management Training at a simulation center separate from Vanderbilt.



What Does OPPE/FPPE Provide?

- Objective measures described seek to:
 - Establish group membership by seeking to demonstrate that everyone follows the same norms of practice.
 - Identify group members who may not be following the norms of practice as established.
 - Provide a framework to create new norms when practice that appears to be out of norm is in fact appropriate.
 - Raise flags when physicians are truly out of the group.
- Start from the assumption that we all well trained, well intentioned and competent.
- Everyone should be able to be in or get there.





Conclusions:

- OPPE and FPPE are here to stay
- Don't have to be odious
- Technology & practice inhomogeneity will dictate institution-by-institution implementation.

