SOUTHERN NEVADA COMMUNITY HEALTH CENTER
POLICY AND PROCEDURE

DIVISION:	FQHC	**NUMBER(s):**	CHCA-017
PROGRAM:	Division Wide	**VERSION:**	1.04
TITLE:	Ongoing Professional Practice Evaluation – Peer Review Policy	**PAGE:**	1 of 6
		EFFECTIVE DATE:	
DESCRIPTION:	Professional Practice Evaluation Process	**ORIGINATION DATE:** February 11, 2020	
APPROVED BY: **CHIEF EXECUTIVE OFFICER - FQHC:**		**REPLACES:** Version 1.03	
Randy Smith, MPA	Date		

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I. PURPOSE

To establish an ongoing professional practice evaluation (OPPE) program to measure the performance of licensed independent practitioners (LIPs) to support decision making for the granting, renewal, modification, and removal of privileges.

II. SCOPE

This policy applies to all employed, contracted, and volunteer LIPs providing clinical care services at Southern Nevada Community Health Center (SNCHC).

III. POLICY

SNCHC is committed to ensuring patient safety and delivering high quality clinical care services. To achieve these objectives, the health center engages in an ongoing professional practice evaluation using standardized tools and metrics to assess clinical proficiency, professional behavior, and patient satisfaction.

IV. PROCEDURE

A. The evaluation process uses standardized tools to support the professional practice evaluation through:

1. The use of clearly defined criteria approved by the Chief Medical Officer (CMO)/Medical Director.
2. A clearly defined process for collecting, assessing, and addressing clinical practice performance, concerns and for identifying best practices.

3. Utilization of trend analysis to capture clinical quality and patient safety performance over time.
4. A process that ensures that identified concerns regarding a LIP's professional practice are uniformly investigated and addressed as defined by policies and applicable law.
5. A process that gives individual LIPs access to their performance reports and relevant internal and external benchmarks.
6. Requires LIP participation in peer review activities.
7. Utilizes clinical performance measures, patient satisfaction, access, and employee evaluation data.

B. The health center will conduct assessment activities through the Quality Improvement (QI) Work Group using information acquired through the following:

1. Targeted and Program Specific Chart Audits
2. Peer Review Chart Audits (Internal and/or External)
    a. CMO/medical director or designee will select charts. A calendar of what charts will be audited will be published.
        i. Random Selection
        ii. Selection based on Quality Measure or General Area
    b. Chart audits will be performed quarterly.
    c. Five (5) charts per quarter
3. Direct Observations
    a. Clinical Practice Techniques/Patterns
    b. Diagnostic and Treatment Techniques
    c. Workflows and Access
4. Proctoring
5. Patient Complaints/Grievances
6. Patient Satisfaction Survey

C. The professional practice evaluation provides a mechanism to validate that patient care is based on current clinical standards of care utilizing six areas of general competencies:

1. Clinical/Medical Knowledge
2. Interpersonal and Communication Skills
3. Patient Care

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4. Practice Based Learning and Improvements
5. Professionalism
6. System-based Practice.

D. On a quarterly basis the Quality Improvement Work Group will review summary reports of LIP performance for the purpose of conducting and evaluating process improvement activities.

E. Ongoing professional practice evaluation and any corrective actions shall be conducted pursuant to the criteria established in this policy.

F. Relevant information from LIP performance reviews will be integrated into performance improvement activities and will be utilized to determine whether to continue, modify or remove existing privileges. Based on the findings of the ongoing professional practice review, interventions may be implemented. The criteria utilized to determine the type of intervention includes an assessment of severity/risk and/or frequency of occurrence. Interventions include, but may not be limited to, proctoring, education, focused review, and corrective actions. Types of interventions include:

1. Benchmarking, identifying indicators to use for comparative analysis for LIP performance.
2. Collecting and comparing aggregate data for these indicators.
3. Developing thresholds to identify standard performance for focused review.
    a. For peer reviews below threshold, the CMO/medical director, or designee, will reassess to confirm scoring accuracy.
4. An action plan for LIP's that score below the threshold will be implemented. All LIPs who score below the threshold at the second occurrence will have peer reviews presented to the Professional Practice Evaluation Committee.
    a. First Occurrence: LIPs will meet with the CMO/medical director for an information discussion, review of clinical standards, and training as needed. A follow-up peer review in the same focus areas will occur at (90) days. If the practitioner successfully meets the threshold of the peer review, no additional action is taken. Those practitioners who score below the threshold are required to advance to the second occurrence phase.
    b. Second Occurrence: LIPs will meet with the CMO/medical director for a formal discussion. Additional support, review of clinical standards, direct observations, and training will be implemented via a formal (60) performance improvement plan. A second follow-up peer review in the same focus areas will occur at (60) days. If the practitioner successfully meets the threshold of the peer review, no

additional action is taken. Those practitioners who score below the threshold are required to advance to the third occurrence phase.

c. Third Occurrence: LIPs will meet the CMO/medical director for a formal discussion clinical performance. Additional support, review of clinical standards, direct observations, and training will be implemented via a formal (30) performance improvement plan. A third follow-up peer review in the same focus areas will occur at (30) days. If the practitioner successfully meets the threshold of the peer review, no additional action is taken. Those practitioners who score below will be subject to formal disciplinary action, up to and including modification or removal of privileges and/or termination from the practice.

G. The purpose of the Professional Practice Evaluation Committee is to support the CMO/medical director in assessing clinical competencies and any determinations with respect to modifications or removal of privileges.

H. The Professional Practice Evaluation Committee will be comprised of the following positions:

1. Chief Medical Officer/Medical Director
2. FQHC Chief Executive Officer
3. Human Resources Business Partner
4. Licensed Independent Practitioner (LIP) or representation by a peer who shares the same discipline

I. The committee will meet as necessary to support activities of the Ongoing Professional Practice Evaluation.

J. The committee will engage Human Resources as needed to discuss and receive guidance around employee performance related issues that may arise through the evaluation process.

K. Practitioners who had their privileges modified or removed may appeal the decision in writing to the District Health Officer (DHO). The DHO will review the findings and supporting documentation. The DHO will speak with the relevant parties as needed. The DHO will have the final decision-making authority. The DHO's decision will be communicated in writing to the appealing practitioner.

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Acronyms/Definitions

Acronym	Definition
Licensed Independent Practitioners (LIPs)	Medical Doctor (MD) Doctor of Osteopathic Medicine (DO) Physician Assistants (PA) Advance Practice Registered Nurse (APRN) Psychiatric/Mental Health APRN Licensed Mental Health Therapist (LMHT) Licensed Clinical Social Worker (LCSW) Pharmacist (PharmD)
External Review	A review conducted by an unbiased physician or other practitioner in an appropriate specialty or subspecialty who is actively in practice or has recently retired, but who is not a member of the Medical Staff.
On-going Professional Practice Evaluation (OPPE)	A process to identify professional practice trends and provide on-going evaluation of performance impacting clinical care and patient safety.
Peer Review	The objective measurement, assessment, and evaluation by Peer Reviewers or Peer Review Committees, of the quality of care provided by individual LIPs and OLCPs as well as the identification of opportunities to improve care.

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V. REFERENCES

Quality Management Plan

Quality Management Program Policy

VI. DIRECT RELATED INQUIRIES TO

CMO/Medical Director

HISTORY TABLE

Table 1: History

Version/Section	Effective Date	Change Made
Version 4		1. Updated CMO title throughout the policy 2. Updated meeting name in section B 3. Updated section F4 4. Moved section G to section K 5. Added purpose of committee in new section G 6. Updated section H 7. Updated meeting frequency in section I 8. Removed Dentists (DDS) and Psychologist (PhD/PsyD) from acronyms section. 9. Added Psychiatric/Mental Health APRN and Licensed Mental Health Therapist (LMHT) to acronyms section
Version 3	05/20/2025	1. Added Licensed Independent Practitioner (LIP) under IV. Procedures, section H 2. Removed OLCP throughout the policy. 3. Removed Other Licensed and Certified (OLCP) Professional from Acronyms/Definitions section
Version 2	01/21/2025	1. Corrected acronym in section D 2. Updated section F 3. Updated position titles in section H
Version 1	5/25/2023	1. Reformatted 2. Added history table
Version 0	2/11/2020	Origination Date 2/11/2020

VII. ATTACHMENTS

Not Applicable

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