**Provider Competency Evaluation and Documentation**

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**BIOGRAPHICAL SKETCH, KATHY MATZKA, CPMSM, CPCS**

Kathy Matzka, CPMSM, CPCS, FMSP, is a speaker, consultant, and writer with over 30 years of experience in credentialing, privileging, and medical staff services. Ms. Matzka worked for 13 years as a hospital medical staff coordinator before venturing out on her own as a consultant, writer, and speaker. She holds certification by the National Association Medical Staff Services (NAMSS) in both Medical Staff Management and Provider Credentialing. She is one of the first recipients of the NAMSS Fellow Designation. The Fellow Designation is the pinnacle of achievement and acknowledgment for the Medical Services Professional (MSP), recognizing a career MSP who has made outstanding contributions to the profession through service as a leader, mentor, and educator.

Ms. Matzka has authored a number of books related to medical staff services including *Medical Staff Standards Crosswalk: A Quick Reference Guide to The Joint Commission, CMS, HFAP, and DVN Standards, Chapter Leader’s Guide to Medical Staff: Practical Insight on Joint Commission Standards*, *Compliance Guide to Joint Commission Medical Staff Standards,* and *The Medical Staff Meeting Companion Tools and Techniques for Effective Presentations*. For eight years, she was the contributing editor for *The Credentials Verification Desk Reference* and its companion website *The Credentialing and Privileging Desktop Reference.* She is co-author of the 6th and 7th Editions of HcPro’s publication *Verify and Comply*: *Credentialing and Medical Staff Standards Crosswalk.* Her latest book is *The Clinician’s Quick Guide to Credentialing and Privileging* which is a resource for physicians and other practitioners.

She has performed extensive work with NAMSS’ Education Committee developing and editing educational materials related to the field including *CPCS and CPMSM Certification Exam Preparatory Courses* and *Study Guides, CPMSM and CPCS Professional Development Workshops, Standards Comparison Grid,* and *NAMSS Core Curriculum*. These programs are essential educational tools for both new and seasoned medical services professionals. She also served as a speaker for NAMSS.

Ms. Matzka shares her expertise by serving on the Credentialing Resource Center’s News, Analysis, and Education Board.

Ms. Matzka is a highly-regarded industry speaker, and in this role has developed and presented numerous programs for professional associations, hospitals, and hospital associations on a wide range of topics including provider credentialing and privileging, medical staff meeting management, peer review, negligent credentialing, provider competency, and accreditation standards.

In her spare time, Ms. Matzka takes pleasure in spending time with her family, listening to music, traveling, hiking, fishing, and other outdoor activities.

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# Sample Letter for Verification of Training

|  |
| --- |
| **Background and Instructions**In an effort to improve and streamline the credentialing process, the Accreditation Council for Graduate Medical Education (ACGME), American Hospital Association (AHA), National Association of Medical Staff Services (NAMSS), and Organization of Program Directors Associations (OPDA) have collaborated to create a standardized “Verification of Graduate Medical Education Training” (VGMET). This group has also been working with the Federation of State Medical Boards (FSMB) to address the needs for licensure within the form and will continue that work.The VGMET form has three sections:1. **Section One**: Verification of graduate medical education training. Completed for all.
2. **Section Two:** Additional comments as needed.
3. **Section Three:** Attestation.

**For 2016 and future graduates**:The form would be completed **once** by the program director at the time of completion of the internship, residency or fellowship (separate form for each training program completed). The signed form would be placed in the trainee’s file. The form would be photocopied and sent with Cover Letter 2 (see below) to hospitals or other organizations requesting verification of training. **For pre-2016 graduates**:The form would be completed **once** – if and when a program receives a request for verification of training.The current program director (often not the PD at the time of graduation) would review the file and complete the form based on information contained therein. He/she would sign and date the form and send to the requesting hospital with Cover Letter 2 (see below).Thereafter, that form would be used in response to all requests for training verification – a photocopy of the form, and a signed dated cover letter attesting that the form accurately reflects information about the trainee in the file.  |

***Cover Letter 1***

**CONFIDENTIAL AND PRIVILEGED**

**PEER REVIEW DOCUMENT**

[Date]

[Residency Program Director]

[Organization]

[Address 1]

[Address 2]

[City, State, Zip]

**Re: [Name of Trainee]**

**[DOB or NPI]**

Dear Dr. [Residency Program Director Name]:

The above-referenced individual has applied for medical staff appointment and/or clinical privileges at [name of requesting entity]. This individual has indicated that he/she received training at your institution.

Your assistance in completing the enclosed form is greatly appreciated. Please fax or e-mail the completed form to [name of requesting department] at [facsimile #] and [e-mail address of requesting entity]. The individual named above has signed the enclosed authorization and release form that authorizes you to provide this information.

Should you have any questions, please contact this department at [requesting department phone number]. Thank you in advance for your immediate attention to this request.

Sincerely,

[Name]

[Title]

Enclosures: (i) Verification of Graduate Medical Education Training Form

 (ii) Authorization and Release Form

***Cover Letter 2***

**VERIFICATION OF GRADUATE MEDICAL EDUCATION & TRAINING**

**CONFIDENTIAL AND PRIVILEGED**

**PEER REVIEW DOCUMENT**

[Date]

**Re:**

**[Name of Trainee]**

**[DOB or NPI]**

**[Residency or fellowship program]**

**[Training Dates 1]**

**[Training Dates 2 (if applicable)]**

[Hospital or credentialing organization]

[Department/Program]

[Organization]

[Address 1]

[Address 2]

[City, State, Zip]

Dear [Hospital or credentialing organization]:

The above-referenced physician trained at this institution in this program and during the dates referenced above. The enclosed Verification of Graduate Medical Education Training Form summarizes this individual’s performance during that period of training.

This form:

\_\_\_\_ was completed at the time the trainee left the program,
or

\_\_\_\_ was completed by the current program director, based on a review of the trainee’s file, after the trainee had left the program, and is sent to you upon receipt of a signed authorization and release form by the former trainee.

This cover letter attests that the enclosed information contains a complete and accurate summary of the trainee’s performance in thisprogram. We are unable to provide information about training or practice after completion of this program, and trust that you will obtain that information from the appropriate programs/institutions.

Sincerely,

[Program Director or Institutional Official]

[Title]

[Organization]

[Address 1]

[Address 2]

[City, State, Zip]

Enclosures: (i) Verification of Graduate Medical Education & Training Form

**VERIFICATION OF GRADUATE MEDICAL EDUCATION & TRAINING**

|  |
| --- |
| **Section I: Verification of training and performance during training**  **(*To be completed for EACH trainee)*** |
| Trainee’s Full Name:Click here to enter text. | DOB:Click here to enter text. | NPI:Click here to enter text. |
| Program Specialty or Subspecialty:[ ] Preliminary Program: Click here to enter text. Date From/To: Click here to enter text.[ ] Core Residency Program: Click here to enter text. Date From/To: Click here to enter text.[ ] Fellowship Program: Click here to enter text. Date From/To: Click here to enter text. |
| Training Program Accreditation: [ ]  ACGME [ ]  AOA [ ] OtherIf marked “other,” please indicate accreditation type or list “none:” Click here to enter text.Program ID #: Click here to enter text. |
| Did the above-named trainee successfully complete the training program which she/he entered? [ ]  Yes [ ]  NoIn addition to completion of full specialty training, completion of a transitional year or a planned preliminary year(s) would constitute completion of a program.*(If NO, please provide an explanation in the “Additional Comments” section below or enclose a separate document.)* |

|  |
| --- |
| Was the trainee subject to any of the following during training?1. Conditions or restrictions beyond those generally

associated with the training regimen at your facility; [ ] Yes [ ]  No1. Involuntary leave of absence; [ ]  Yes [ ]  No
2. Suspension; [ ]  Yes [ ]  No
3. Non-promotion/non-renewal; or [ ]  Yes [ ]  No
4. Dismissal. [ ]  Yes [ ]  No
 |
| Upon completion of the training program, the individual was deemed to have demonstrated sufficient competence in the specialty/subspecialty to enter practice without direct supervision. [ ]  Yes [ ]  No [ ]  N/A*(If NO, please provide an explanation in the “Additional Comments” section below or enclose a separate document.)* |
| Did the program endorse this trainee as meeting the qualifications necessary for admission to the specialty’s board certification examination? [ ]  Yes [x]  No [ ]  N/AIf NO, indicate the reason(s):[ ]  This trainee was a preliminary resident.[ ]  Trainee was not eligible for certification.[ ]  Trainee involuntarily or voluntarily left this program before completion.\*[ ]  No certification is available for this subspecialty.[ ]  Other.\*\**Please provide an explanation in the “Additional Comments” section below or enclose a separate document.* |

|  |
| --- |
| **Section II: Additional Comments** |
| Please utilize this comment area to provide additional information in response to any of the questions noted above on this form. *(If additional space is needed, please enclose a separate document.)*Click here to enter text. |
| **Section III: Attestation** |
| The information provided on this form is based on review of available training records and evaluations.Signature: Click here to enter text.Printed Name: Click here to enter text.GME Title: Click here to enter text.Phone Number: Click here to enter text.Email: Click here to enter text.Date Form Completed: Click here to enter text. |

In an effort to improve and streamline the credentialing process, the Accreditation Council for Graduate Medical Education (ACGME), American Hospital Association (AHA), National Association Medical Staff Services (NAMSS), and Organization of Program Directors Associations (OPDA) have collaborated to create a standardized “Verification of Graduate Medical Education Training (VGMET)” form designed to be completed once at the completion of training (or at the first opportunity thereafter when the program is asked to complete a verification/credentialing form). This group has also been working with the Federation of State Medical Boards (FSMB) to address the needs for licensure within the form and will continue that work. This VGMET is then time-stamped and inserted in the trainee’s file. This time-stamped form, along with a cover letter from the current program director or institutional official, serves as the program’s verification of training. The form will not include detailed lists of current procedural or technical competencies.

# Sample Letter: Facility Privileges and Competency Validation

Date

Facility Name

Facility Address

Regarding applicant: John Doe, M.D.

Specialty: General Surgery

Dear Medical Services Professional:

We have received an application from the above-named provider for medical staff appointment and privileges. A copy of the privileges requested is attached. The applicant noted that s/he currently, or has in the past, held privileges at your facility. In order to process the application we require documentation experience, ability, and current competence on the six areas of “General Competencies” adopted from the Accreditation Council for Graduate Medical Education (ACGME) and the American Board of Medical Specialties (ABMS) joint initiative. These competencies include assessment of patient care, interpersonal and communication skills, professionalism, medical knowledge, practice-based learning and improvement, and systems-based practice.

***Our policies require completion of the enclosed form. Failure to receive this form will delay consideration of the applicant’s request for privileges. Also, our policies require the physician to document competency in performing specific procedures by allowing our organization to obtain a copy of his/her privilege form from your hospital as well as a list of the actual procedures performed in the past 12 months and the outcomes for those procedures. The applicant has authorized you to provide this information to our organization via signature on the attached Authorization and Release Form.***

Sincerely,

Medical Staff Coordinator

# CONFIDENTIAL Evaluation of Privileges and Competency Validation

Name of Facility Providing Information:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Name of Practitioner for which Information is Provided:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Dates on Staff: From \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ To \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Has the practitioner been subject to any disciplinary action, restrictions, modifications, or loss of [ ]  Yes [ ]  No

privileges or medical staff appointment either voluntary or involuntary at your facility?

Are you aware of any restrictions, modifications, or loss of privileges or medical staff appointment, [ ]  Yes [ ]  No

either voluntary or involuntary, at any another facility?

Are you aware of any physical or mental condition that could affect this practitioner’s [ ]  Yes [ ]  No

ability to exercise clinical privileges as requested, or would require accommodation to perform

privileges safely and competently?

*If the answer to any of the above questions is “YES”, please explain:* \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Evaluation:** Please rate the practitioner in the following areas.

* **Patient Care** is compassionate, appropriate, and effective for the treatment of health problems and promotion of health. Procedural skills are adequate and reflect those of a graduate of an accredited training program.
* **Medical Knowledge** about established and evolving biomedical, clinical, and cognate (e.g. epidemiological and social-behavioral) sciences and the application of this knowledge to patient care
* **Practice-Based Learning and Improvement** that involves investigation and evaluation of their own patient care, appraisal and assimilation of scientific evidence, and improvements in patient care
* **Interpersonal and Communication Skills** that result in effective information exchange and teaming with patients, their families, and other health professionals
* **Professionalism**, as manifested through a commitment to carrying out professional responsibilities, adherence to ethical principles, and sensitivity to a diverse patient population
* **Systems-Based Practice**, as manifested by actions that demonstrate an awareness of and responsiveness to the larger context and system of health care and the ability to effectively call on system resources to provide care that is of optimal value.

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
|  | **Excellent** | **Good** | **Fair** | **Poor** | **Unable to****evaluate** |
| Patient care/Procedural skills |  |  |  |  |  |
| Medical knowledge  |  |  |  |  |  |
| Practice-based learning and improvement  |  |  |  |  |  |
| Interpersonal and communication skills |  |  |  |  |  |
| Professionalism |  |  |  |  |  |
| Systems-based practice |  |  |  |  |  |

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Signature Date

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Name, Position/Title (Please Print) Phone Number

***Please return this form within 2 weeks along with a copy of the applicant’s privilege list for your hospital and a list of the actual procedures performed in the past 12 months and the outcomes for those procedures.***

# Sample Peer Recommendation Letter

Date

Facility Name

Facility Address

Regarding applicant: John Doe, M.D.

Specialty: General Surgery

Dear \_\_\_\_\_\_\_\_\_\_\_\_\_\_:

We have received an application from the above-named provider for medical staff appointment and privileges. A copy of the privileges requested is attached. The applicant has listed you as a peer who will be willing to provide a recommendation. In order to process the application we require your evaluation of the applicant’s experience, ability, and current competence in the areas of medical/clinical knowledge, technical and clinical skills, clinical judgment, interpersonal skills, communication skills, and professionalism.

***Our policies require completion of the enclosed form. Failure to receive this form will delay consideration of the applicant’s request for privileges. You may supplement the form with additional information, if you so desire. The applicant has authorized you to provide this information to our organization via signature on the attached Authorization and Release Form.***

Sincerely,

Medical Staff Coordinator

# Sample Peer Recommendation Form

CONFIDENTIAL Professional Peer Reference & Competency Validation

Page 1 of 2

Name of Applicant:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Name of Evaluator:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Relationship to Applicant:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

How well do you know the applicant? [ ]  not well [ ]  casual personal acquaintance [ ]  professional acquaintance [ ]  very well

Do you refer your patients to the applicant? [ ]  yes [ ]  no. If no, list reason(s) why not \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

 \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**PLEASE RATE THE PRACTITIONER IN THE FOLLOWING AREAS**

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
|  | **Excellent** | **Good** | **Fair** | **Poor** | **Unable to****evaluate** |
| **Medical knowledge -** Practitioner should have a good knowledge of established and evolving biomedical, clinical, and cognate sciences, and how to apply this knowledge to patient care. This is evidenced by completion of educational and training requirements as well as on-the-job experience, inservice training, and continuing education. |  |  |  |  |  |
| **Technical and clinical skills** - Skill involves the capacity to perform specific privileges/procedures. It is based on both knowledge and the ability to apply the knowledge.  |  |  |  |  |  |
| **Clinical judgment** - Clinical judgment refers to the observations, perceptions, impressions, recollections, intuitions, beliefs, feelings, inferences of providers. These clinical judgments are used to reach decisions, individually and/or collectively with other providers, about a patient’s diagnosis and treatment.  |  |  |  |  |  |
| **Communication skills** - The provider should create and sustain a therapeutic and ethically sound relationship with other care givers, patients, and their families. He/she should be able to communicate effectively and demonstrates caring, compassionate, and respectful behavior. This also includes effective listening skills, effective nonverbal communication, eliciting/providing information, and good writing skills |  |  |  |  |  |
| **Interpersonal skills** - Areas of evaluation include how the provider works effectively with other professional associates, including those from other disciplines, to provide patient-focused care as a member of a healthcare team. |  |  |  |  |  |
| **Professionalism** - Professionalism is demonstrated by respect, compassion, and integrity. It means being responsive and accountable to the needs of the patient, society, and the profession. It means being committed to providing high-quality patient care and continuous professional development as well as being ethical in issues related to clinical care, patient confidentiality, informed consent, and business practices. |  |  |  |  |  |

CONFIDENTIAL Professional Peer Reference & Competency Validation

Page 2 of 2

Name of Applicant:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Name of Evaluator:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Relevant training and experience –** In reviewing the attached request for privileges, do you feel that the applicant’s training and experience are adequate to carry out these procedures?

[ ]  No - If no, please provide an explanation\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

[ ]  Yes

[ ]  Unable to evaluate

**Current competence –** In reviewing the attached request for privileges, do you feel that the applicant is currently competent to carry out these procedures?

[ ]  No - If no, please provide an explanation\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

[ ]  Yes

[ ]  Unable to evaluate

**Health Status -** Are you aware of any physical or mental condition that could affect this practitioner’s ability to exercise clinical privileges in his/her specialty area, or would require an accommodation to exercise those privileges safely and competently?

[ ]  No

[ ]  Yes - If yes, please provide an explanation\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

[ ]  Unable to evaluate

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Overall Recommendation (check ONE):**

[ ]  I recommend privileges as requested without reservation.

[ ]  I recommend privileges as requested with the following reservation(s) (use back of form, if necessary

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

[ ]  I do not recommend this applicant for the following reason(s) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Signature Date

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Name, Position/Title (Please Print) Phone Number

***Please return this form within 2 weeks. Failure to receive the form will delay consideration of the applicant’s request for privileges.***

# Focused Professional Practice Evaluation Plan

Practitioner Name:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Medical Staff Department: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Practitioner Specialty:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Reason(s) for Review**

* Initially requested privilege(s) for current medical/professional staff (list privilege(s)) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

* Newly-credentialed practitioner new to staff
* Referred to peer review due to incident
* Low volume of clinical activity
* Trigger (list) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
* Other:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Duration (Complete for recommended timeframe and/or volume)**

* Time Specific: Start Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ End Date:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
* Volume Specific: Designated # of Cases: \_\_\_\_\_\_\_\_\_\_
* Other (specify):\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Method for Monitoring** *(Check all that apply)*

* Chart review
	+ Retrospective (name of reviewer)\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
	+ Concurrent (name of reviewer)\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
* Direct observation by (name of observer)\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
* Monitoring of diagnostic and treatment techniques and clinical practice patterns via QAPI program
* Proctoring by (name of proctor) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
* External Review (list criteria met)\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
* Discussions with other individuals, involved in the care of the patient, including consulting physicians,

assistants at surgery, nursing and administrative personnel

* Other (list) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Additional Individual(s) Assigned for Review/Observation/Monitoring/Proctoring**

*\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_*

*\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_*

*\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_*

**Additional Details/Specifics of Plan**

*\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_*

*\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_*

*\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_*

Signature:

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Departmental Chair

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Printed Name of Department Chair

# Proctoring Resources

## Sample Policy Regarding Proctoring

PURPOSE:

The purpose of this policy is to define the \_\_\_\_\_\_\_\_\_\_ (“Hospital”) process and standards for evaluating the performance of Medical Staff members through direct observation.

Definition of Proctoring: The personal presence of an assigned physician (hereafter referred to as “Proctor”) who does not have a treatment relationship with the patient, who is designated to provide clinical teaching or to monitor the clinical performance of another physician to facilitate quality of care to patients, as required for purposes of credentialing, reappointment, quality improvement, or corrective action.

POLICY:

A. Candidates for Proctoring

1. Physicians who may require proctoring include new applicants seeking privileges, current Medical Staff members seeking new or additional clinical privileges, or sanctioned physicians in need of additional evaluation and/or training to have certain clinical privileges maintained or restored.

2. To be reportable to the National Practitioner Data Bank, the decision to assign a Proctor must be based on an assessment of a physician’s professional competence or professional conduct and constitute a restriction on the physician’s privileges lasting more than thirty (30) days. Such a decision to assign a Proctor based on an assessment of the physician’s competence or conduct must follow the process in Article \_\_ of the bylaws. All other proctoring is not reportable to the National Practitioner Data Bank. For example, if the Proctor is not required to grant approval before medical care is provided, if the Proctor is assigned to a physician recently granted new or additional clinical privileges, or if the Proctor is providing training or evaluation as part of a quality improvement or peer review process, the assignment of the Proctor is not reportable.

3. Nothing set forth in this policy shall: (i) operate to prevent the Hospital or Medical Staff Committees from taking action as provided for in Article \_\_\_ bylaws or (ii) supersede the rights of the physician as provided for in the bylaws.

B. Assignment of a Proctor

The Proctor must be a member of the Medical Staff with appropriate unrestricted clinical privileges in good standing to perform the procedures that he/she will proctor. If no Medical Staff members who have the necessary qualifications are available to proctor, special arrangements may be made for selection of a Proctor who is not a current member of the Medical Staff or for the Medical Staff member to receive proctoring at another hospital. A prospective Proctor who is not a member of the Medical Staff must apply for appointment to the Medical Staff and for clinical privileges. In addition, he/she must have documented training, skill, and current competence in the service or procedure that is the subject of the proctoring. With regard to Medical Staff members applying for new or additional privileges, the physician is responsible for contacting potential Proctors and choosing his/her Proctor, but the Department Chairperson must approve the choice of Proctor.

1. If an assigned Proctor is unable to fulfill proctoring responsibilities, he or she shall notify the Vice President of Medical Affairs (“VPMA”), Department Chairperson, or appropriate Medical Staff Committee Chairperson who shall assign another Proctor.

2. The proctored physician shall have the option of requesting more than one Proctor who will monitor a sequence of cases.

3. The Department Chairperson or the appropriate Medical Staff Committee will determine the appropriate number of procedures or observations the Proctor will evaluate.

1. Routine New or Additional Clinical Privilege Request. The Department Chairperson may at any time determine that the physician has received sufficient proctoring and demonstrates competence in the clinical privileges under review and therefore may terminate the required proctoring program before the proctor has observed or reviewed the designated number of procedures. In such a case, the Department Chairperson will notify the physician of this determination and will make a report to the credentials committee for the physician’s file to be incorporated in the Board’s decision to grant the clinical privileges under review.
2. Other Proctoring. The proctored physician must complete the designated number of procedures.

C. Function and Responsibility of the Proctor

1. Competence is assessed by evaluation of a physician’s performance under clinical conditions. The proctor will complete a form for each procedure he or she monitors. The form will include documentation of the appropriateness of patient selection, appropriate education and discussion with patient and family, knowledge of equipment, skill in use of equipment, monitoring, technical expertise in performance, and management and knowledge of possible adverse outcomes.

2. If medical care is provided, the Proctor will evaluate the proctored physician’s performance from the time of admission until discharge including the indications for admission, discharge, diagnostic work-up, and therapy management. The Proctor reviews the care of the patient utilizing the patient’s record, discussions with the physician, and actual observation as the basis for the review. Invasive medical procedures will be proctored by direct observation.

3. If a surgery or an invasive procedure is performed, the Proctor will evaluate the indication for the procedure, the technique for the procedure, how it is performed, and the preoperative, operative, and postoperative care of the patient. The Proctor may utilize the patient’s record, discussion with the physician, and actual observation as the basis for the review.

4. The Proctor’s primary responsibility is to evaluate the proctored physician’s performance. However, if the Proctor believes that immediate intervention is warranted in order to avert harm to a patient, the Proctor may take any action he/she finds reasonably necessary to protect the patient.

5. Proctors shall not receive compensation directly or indirectly from any patient for this service.

6. Proctors shall complete the Verification of Proctored Procedure/Treatment Form for each proctored case and a Proctoring Summary Report at the conclusion of the proctoring. The forms shall be provided to the Department Chairperson or appropriate Medical Staff Committee. The proctoring reports shall remain confidential in accord with other Medical Staff peer review information.

7. The Department Chairperson or appropriate Medical Staff Committee will review, acknowledge, and document the Proctor’s reports in its recommendation and report and place such report in the applicant’s file. If the purpose of the proctoring is for new or additional clinical privileges, the report will be provided to the Credentials Committee for recommendations concerning the requested clinical privileges.

D. Responsibility of the Proctored Physician

1. The proctored physician shall be responsible for notifying the assigned Proctor(s) of each patient whose care is to be evaluated. For surgical or invasive medical procedures to be observed, the proctored physician shall be responsible for arranging the time of the procedure with the Proctor.

2. The proctored physician shall provide the information that is requested by the Proctor regarding the patient and the planned course of treatment.

3. The proctored physician shall inform the patient that another physician may observe and assist in the procedure. Both the Proctor and the proctored physician’s name shall be included on the informed consent form.

E. Proctoring Duration

1. A Medical Staff member may request an extension of time to complete the proctoring if he or she has not had a sufficient number of cases to satisfy the proctoring requirements in whole or in part.

2. If a proctored physician completes the necessary number of proctored cases, but has not achieved satisfactory proficiency during proctoring, as concluded by the Proctor, Department Chairperson, VPMA, or the appropriate Medical Staff Committee, he or she may be proctored on additional cases.

3. Failure to satisfactorily complete the proctoring shall be reviewed and acted upon in accordance with the procedures set forth in the bylaws. This provision does not preclude the initiation of corrective action pursuant to Article \_\_ of the bylaws.

## Verification of Proctored Procedure/Treatment

If a surgery or an invasive procedure is performed, the Proctor should evaluate the indication for the procedure, the technique for the procedure, how it is performed, and the preoperative, operative, and postoperative care of the patient. The Proctor may utilize the patient’s record, discussion with the physician, and actual observation as the basis for the review.

Proctored Physician: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Proctor: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Procedure/Treatment:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Comments: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_­­­­\_\_\_\_\_\_\_\_\_\_

Areas of in need of Improvement: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Procedure Completed Successfully: \_\_\_\_\_ Yes \_\_\_\_\_ No

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Signature, Proctoring Physician Date

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Signature, Proctored Physician Date

## CONCURRENT PROCTORING: Procedural / Surgical Evaluation Form

TO: Department Chair \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Confidential File for: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ By Assigned Proctor: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Patient Medical Record # \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Diagnosis: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Procedure(s):\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Complications as applicable: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

***Please answer all the following: If the answer to any of the following is “no”, attach an explanation sheet***

***Mark a √ in the appropriate box***

|  |  |  |  |
| --- | --- | --- | --- |
| **Yes** | **No** | **NA** |  |
|  |  |  | **Was there pre-operative justification for the surgery documented?** |
|  |  |  | **Were patient rounds made daily?** |
|  |  |  | **Were calls answered promptly by the practitioner?** |
|  |  |  | **Did the practitioner cooperate with you (the proctor) concerning this review?** |
|  |  |  | **Was all necessary information (history, physical, progress notes, op note, etc.) recorded by the practitioner in a timely manner in the patient’s medical record?** |
|  |  |  | **Was the above information legible?** |
|  |  |  | **Were the entries made in the record informative?** |
|  |  |  | **Were the entries by the practitioner appropriate/** |
|  |  |  | **Was the practitioner’s use of diagnostic services (lab, imaging, etc.) appropriate?** |
|  |  |  | **Was the practitioner’s surgical technique appropriate?** |
|  |  |  | **Did the pre-operative diagnosis coincide with postoperative findings?** |
|  |  |  | **Was postoperative care adequate and within industry standards?** |
|  |  |  | **Was the operative report complete, accurate and timely?** |
|  |  |  | **Were complications, if any, recognized and managed appropriately?** |
|  |  |  | **Was there any evidence that the practitioner exhibited any disruptive or inappropriate behavior?** |
|  |  |  | **Was there any evidence of patient dissatisfaction?** |

|  |  |  |
| --- | --- | --- |
| **BASIC ASSESSMENT** | **Satisfactory** | **Unsatisfactory** |
| 1. Basic medical knowledge |  |  |
| 2. Clinical judgment |  |  |
| 3. Communication skills |  |  |
| 4. Use of consultants if indicated |  |  |
| 5. Professional attitude |  |  |
| 6. Recordkeeping |  |  |
| 7. Relationship to patient |  |  |

**Generally, how would you rate this practitioner’s skill and competence in performing this examination?**

**[ ]  Outstanding** **[ ]  Acceptable**

**[ ]  Unacceptable** **[ ]  Unable to evaluate because: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

COMMENTS: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_­­­\_\_\_\_\_\_\_\_\_\_\_\_\_\_

## Proctoring Summary Report

Proctored Physician: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Proctor: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Number of Procedures/Treatment Episodes Proctored: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Comments: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Areas in need of Improvement: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Proctoring Completed Successfully: \_\_\_\_\_ Yes \_\_\_\_\_ No

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Signature, Proctoring Physician Date

**Department Chair Recommendation**

* The applicant appears to meet all of the qualifications for unsupervised practice in that department, has discharged all of the responsibilities of staff membership, and has not exceeded or abused the prerogative of the category to which the appointment was made, and that the member has satisfactorily demonstrated the ability to exercise the clinical privileges initially granted in those departments. It is recommended that proctoring cease.
* It is recommended that proctoring continue for \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

(list number of procedures and/or time frame)

Comments\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Signature, Department Chairperson Date

## Medical Proctor’s Report Sample 1

Patient Name or M.R.#\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Admission/Start Date\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Discharge/End Date\_\_\_\_\_\_\_\_\_\_\_\_\_

Attending Physician\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Proctoring Physician\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

|  |  |  |
| --- | --- | --- |
|  | **appears Appropriate**  |  |
| **Area of review** | **Yes** | **No** | **N/A** | **Comments** |
| **Diagnostic workup:** |  |  |  |  |
| Necessity of admission(s) |  |  |  |  |
| Initial level of care/placement |  |  |  |  |
| History and physical examination (promptness, thoroughness, significant negative, problem-oriented, etc) |  |  |  |  |
| Problem formulation (initial impression(s), rule-outs, assessment, thoroughness, justification, etc) |  |  |  |  |
| Use of diagnostic tests, labs, x-rays, etc. |  |  |  |  |
| Initial orders (activity, diet, vital signs, parenteral, fluids, clarity, legibility, etc |  |  |  |  |
| Diagnostic procedures (especially invasive, such as endoscopy, arthroscopy, imaging, biopsies, catheterizations, etc |  |  |  |  |
| **Patient Management:** |  |  |  |  |
| Antibiotic drug use (prophylactic, therapeutic choice of drug, dosage, route, duration, combinations, toxicity monitoring, serum levels, etc.) |  |  |  |  |
| Use of other drugs (digitalis, glycosides, diuretics, psychotropics, corticosteroids, anticoagulants, etc.) |  |  |  |  |
| Use of blood and blood products |  |  |  |  |
| Use of ancillary services (P.T., Respiratory Therapy, Social Service, Dietary, etc.)  |  |  |  |  |
| Monitoring patient’s condition (vital signs, weights, intake/output, follow-up lab tests, and x-rays, etc.) |  |  |  |  |
| Diet including parenteral alimentation |  |  |  |  |
| Level of care (include placement, such as ICU, Step Down, etc.), activity level, use of isolation, etc. |  |  |  |  |
| Length of stay |  |  |  |  |
| Progress notes |  |  |  |  |
| Complications (anticipated, recognized promptly, dealt with appropriately, etc) |  |  |  |  |
| Placement (transfer, home , ECF, home health, etc.) |  |  |  |  |
| Patient education/instruction (regarding diet, mediations, follow-up, level of activity, etc.) |  |  |  |  |

**Proctoring physician’s signature**

## Medical Proctor’s Report Sample 2

Patient Name or M.R.#\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Admission/Start Date\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Discharge/End Date\_\_\_\_\_\_\_\_\_\_\_\_\_

Attending Physician\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Proctoring Physician\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Generic Competencies - Rate on scale of 1 (poor) to 5 (excellent)**

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
|  | **1** | **2** | **3** | **4** | **5** |
| Basic medical knowledge |  | ⁪  |  |  |  |
| Clinical judgment |  |  | ⁪  |  |  |
| Procedural skills |  |  |  |  |  |
| Communication skills |  |  |  |  |  |
| Use of consultants |  |  | ⁪  |  |  |
| Professional attitude |  |  |  |  |  |
| Record-keeping |  |  | ⁪  |  |  |
| Relationship to patient |  | ⁪  |  |  |  |
| Cost-effectiveness |  |  |  |  |  |

 ⁪

**General comments on the handling of this case:**

**Proctoring physician’s signature**

# Sample Indicators for LIP APRNs and PAs

|  |  |  |
| --- | --- | --- |
| **Specialty** | **FPPE** | **OPPE** |
| Nurse Midwife | * Proctor for first 2 cases vaginal delivery
* Review of charts for first 5 cases
* Discussion with nurse manager of OB and NB nursery
 | * 3rd and 4th degree lacerations following vaginal delivery
* Delivery unattended by provider
* Significant birth trauma
* Medical records legibility
 |
| CRNA | * Anesthesiologist present in OR room to proctor first 2 major surgical procedures
* Discussion with OR nurse manager/OR staff
 | * ICU admission due to anesthesia management
* Medical records legibility
 |
| Emergency Department PA | * ED physician closely monitor/proctor for (X) shifts
* Visual monitoring of (X) procedures performed (i.e. suture of laceration, removal of foreign body, nasogastric intubation etc.)
 | * Death in ED
* Unplanned returns within 48 hours for same complaint
* Patients admitted to Med/Surg and moved to ICU within 4 hours of admission
 |
| APRN | Need to customize pertaining to area of practice. | * Refer to/consult with other health care professionals, as appropriate
* Order appropriate diagnostic tests
* Medication usage
* Medical records documentation
* Any department-specific indicators relevant to all LIPs
 |

# Department of Emergency Medicine - Focused Professional Practice Evaluation for PA/APRN

**INFORMATION**

PRACTITIONER’S NAME: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

EVALUATOR’S NAME: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

MEDICAL RECORD NUMBER:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

VISIT DATE: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**OBSERVATION:**

 **SATISFACTORY UNSATISFACTORY**

**ACCURACY OF DIAGNOSIS & MEDICAL**

 **JUDGEMENT [ ]  [ ]**

**QUALITY OF MEDICAL RECORDS [ ]  [ ]**

**COOPERATION WITH HOSPITAL STAFF [ ]  [ ]**

**RELATIONSHIP WITH PATIENT [ ]  [ ]**

**EVALUATION OF CLINCAL CARE PROVIDED**:

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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**EVALUATORS SIGNATURE:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**DATE:** \_\_\_\_\_\_\_\_\_\_\_\_

# Provisional Performance Evaluation Nurse Practitioner or Physician Assistant

**CONFIDENTIAL FOR FILE OF:**

|  |  |
| --- | --- |
| Practitioner Name: |  |
| Evaluator(s): |  |
| Patient Medical Record #: |  |
| Diagnosis or Procedure: |  |
|  |  |
| Complications: |  |
|  |  |

***PLEASE ANSWER ALL OF THE FOLLOWING***

***(If the answer to any of the following questions is no, please attach an explanation)***

|  |  |  |  |
| --- | --- | --- | --- |
|  |  | **YES** | **NO** |
| 1. | Was there adequate evidence to support diagnosis or procedure? |  |  |
| 2. | Was the initial level of care appropriate? |  |  |
| 3. | Was the practitioner’s problem-formulation (initial impressions, rule-outs, assessment, etc.) appropriate? |  |  |
| 4. | Did the practitioner cooperate with you concerning this review? |  |  |
| 5. | Was all necessary information (i.e., history, physical, progress notes, operative notes and summary) recorded by the practitioner in a timely manner in the patient’s medical record? |  |  |
| 6. | Were entries in the patient’s medical record countersigned by the supervising/collaborating physician within the appropriate timeframe? |  |  |
| 7. | Was the above information recorded in a legible manner? |  |  |
| 8. | Were the entries made in the patient’s record by the practitioner informative? |  |  |
| 9. | Were the entries made in the patient’s record by the practitioner appropriate? |  |  |

***(OVER)***

**Provisional Performance Evaluation**

**Nurse Practitioner/Physician Assistant - Page Two**

|  |  |  |  |
| --- | --- | --- | --- |
|  |  | **YES** | **NO** |
| 11. | Was the practitioner’s use of the following services appropriate? |  |  |
|  | a. X-Ray |  |  |
|  | b. Lab |  |  |
|  | c. Invasive Diagnostic Procedures |  |  |
| 12. | Was the practitioner’s technique for procedures appropriate?(if applicable) |  |  |
| 13. | Did pre-admission diagnosis coincide with discharge findings? |  |  |
| 14. | Were complications (if any) recognized and managed appropriately? |  |  |

***(If the answer to any of the following questions is yes, please attach an explanation)***

|  |  |  |  |
| --- | --- | --- | --- |
|  |  | **YES** | **NO** |
| 1. | Was there evidence of any patient dissatisfaction with the practitioner? |  |  |
| 2. | Was there any evidence of unethical behavior on the part of the practitioner? |  |  |
| 3. | Did the practitioner exhibit any disruptive or inappropriate behavior? |  |  |
| 4. | Was there any evidence that the practitioner did not adhere to Medical Center or Medical Staff policies, bylaws or rules and regulations? |  |  |

|  |  |
| --- | --- |
| Comments/Additional Information |  |
|  |  |
|  |  |
|  |  |
|  |  |
|  |  |

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Practitioner Evaluator’s Signature Date

# Anesthesia Proctor's Report for CRNA

Patient medical record number\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Proctoring Anesthetist

Primary Anesthetist\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date & Time

Procedure\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Emergency case  Yes  No

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Evaluate in Terms of Completeness and Accuracy:**

**1. ANESTHESIA PLAN** Acceptable Unacceptable

a. Preop Assessment  

 b. Special Monitoring  

c. Technique  

Comments

**2. ANESTHETIC MANAGEMENT** Acceptable Unacceptable

a. Use of Appropriate Agents  

b. Control of Hemodynamic Stability  

c. Response to Changes  

d. Fluid and Blood Replacement  

Comments

**3. IMMEDIATE POSTOP CARE** Acceptable Unacceptable

a. Emergence from Anesthesia  

b. Recovery  

c. Analgesia  

d. Appropriate Orders  

Comments

 Acceptable Unacceptable

**4. CONDUCT OF PROCEDURES (if indicated)**  

Comments\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**5. OVERALL PERFORMANCE**

Acceptable Unacceptable

a. Cooperation with Colleagues and Staff  

b. Overall impression of care provided  

c. Is there any aspect of this patient's care

 with which you are uneasy or uncomfortable? Yes No 

Comments

Date Proctoring Anesthesiologist Signature

# Focused Professional Practice Evaluation (FPPE) Report

**(To be included in Credentials File)**

**Practitioner Name:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Department:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Time Period for Review: From:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ To:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

The information from Focused Professional Practice Evaluation has been reviewed and based on this review:

[ ]  The practitioner is performing well or within desired expectations and it is recommended that current privileges continue and FPPE cease.

[ ]  Issue(s) exist or trigger(s) met requiring continuation of Focused Evaluation. The specific issue(s) is (are)\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

 \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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[ ]  Practitioner has not had sufficient patient volume or has not met assigned FPPE requirements. Continue FPPE for \_\_\_\_\_\_ months.

[ ]  Other\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

 Signature, Department Chair Date

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

 Name Department Chair

# Ongoing Professional Practice Evaluation (OPPE) Report

**(To be included in Credentials File)**

**Practitioner Name:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Department:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Time Period for Review: From:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ To:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

The information from Ongoing Professional Practice Evaluation has been reviewed and based on this review:

[ ]  The practitioner is performing well or within desired expectations and no further action is warranted. It is recommended that current privileges continue.

[ ]  Issue(s) exist or trigger(s) met requiring a focused evaluation. The specific issue(s) is (are)\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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[ ]  Practitioner has had no patient contact for \_\_\_\_\_ months, notify practitioner and initiate focused review.

[ ]  Other\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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 Signature, Department Chair Date

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

 Name Department Chair

# Recommendation and Approval Form for Medical Staff Appointment and Clinical Privileges

Practitioner Name:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Staff Status:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Department:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Specialty:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

***Departmental Recommendation***

Based on the evaluation of the education, training, current competence, health status, skill, character, and judgment of the applicant the following recommendations are made:

❑ Privileges be granted/renewed

❑ Medical staff membership be granted/renewed

❑ Additional privileges requested be granted

❑ Privileges be modified as follows: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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❑ Privileges not be granted/renewed

❑ Medical staff membership not be granted/renewed (comment below)

❑ Additional privileges requested be denied (comment below)

Comments:

 Department Chairman Date

***Credentials Committee Recommendation***

Based on the evaluation of the education, training, current competence, health status, skill, character, and judgment of the applicant and on the evaluations and recommendations of the Department Chairman the following recommendations are made:

❑ Concur with recommendation(s) of the Department Chairman and forward these recommendations to the Medical

 Executive Committee

❑ Do not concur with the recommendations of the Department Chairman, and instead make the following recommendations:

 \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

 Credentials Committee Representative Date

***Medical Staff Executive Committee Recommendation***

Based on the evaluation of the education, training, current competence, health status, skill, character, and judgment of the applicant, and on the evaluations and recommendations of the Department Chairman and Credentials Committee, the following recommendations are made:

❑ Concur with recommendation(s) of the Department Chairman and Credentials Committee and forward these

 recommendations to the governing body for consideration.

❑ Do not agree with the recommendations of the Department Chairman, and Credentials Committee and instead make the

 following recommendations: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

 Medical Staff Executive Committee Representative Date

***Governing Body Approvals/Action Taken***

Based on the evaluation of the education, training, current competence, health status, skill, character, and judgment data and information, and on the recommendations of the Medical Staff, the following action is taken:

❑ Concur with and approve the recommendation(s) of the Medical Staff.

❑ Do not concur with the recommendations of the Medical Staff. Action taken is documented in Board minutes of \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_.

 (date)

 Board of Trustees Representative Date

# Documenting Recommendations

## Sample language for medical staff minutes:

“Committee members reviewed the applications, the supporting documentation, the Department Chairmen’s recommendations, and information received during the credentialing and privileging processes [or insert OPPE/FPPE etc., as appropriate]. Based on this review, it is the committee’s opinion that the following applicants meet the requirements for Medical Staff appointment and have documented appropriate education, training, experience, current competency, clinical judgment, professionalism, and health status to perform the privileges requested. It was moved, seconded, and carried to recommend to the *[fill in Credentials Committee or MEC as appropriate]* approval of the following appointments and clinical privileges [or insert cessation of FPPE, etc]:”

## Sample language for Board minutes:

“Board members reviewed the applications, the supporting documentation, the Department Chairmen’s recommendations, Medical Executive Committee’s recommendations, and information received during the credentialing and privileging processes [insert OPPE/FPPE etc., as appropriate]. Based on this review, it is the Board’s opinion that the following applicants meet the requirements for Medical Staff appointment and clinical privileges [insert cessation of FPPE etc., as appropriate] as recommended and it was moved, seconded, and carried to approve of the following appointments and clinical privileges [insert cessation of FPPE, etc]:”

# Sample Peer Review Form

***WARNING - The information contained in this report is CONFIDENTIAL. Improper disclosure of the information contained herein may result in disciplinary action, as well as civil or criminal penalties.***

ASSIGNED TO DOCTOR(S):\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

COMMITTEE/DEPARTMENT REFERRED TO:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

EVENT DATE:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

PATIENT RECORD #:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

ADMISSION DATE:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_DISCHARGE DATE:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

PHYSICIAN(S) INVOLVED IN REVIEW \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**REASON FOR REFERRAL:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**SUMMARY:**

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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**RESULTS OF PHYSICIAN REVIEW**

[ ]  **CARE APPROPRIATE - NO FURTHER ACTION NECESSARY -** Please provide documentation to reflect the bases for decision regarding the appropriateness of review of care/service. (Use back of page, if necessary.)

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**[ ]  FURTHER ACTION NECESSARY AS STATED BELOW (Use back of page if necessary)**

 [ ]  Documentation Only **[ ]** Counseling [ ]  Disciplinary Action [ ]  Refer to \_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**PHYSICIAN REVIEWER SIGNATURE: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_DATE\_\_\_\_\_\_\_\_\_\_\_\_\_\_**