I. PURPOSE

To assure that the hospital, through the activities of its medical staff, assesses the ongoing professional practice and competence of its medical staff, conducts professional practice evaluations, and uses the results of such assessments and evaluations to improve professional competency, practice, and care. This policy covers all medical staff members as identified in the Medical Staff Bylaws. The term "physician" will be used in this document to represent all Medical Staff Members. Efforts are made to both evaluate individual physician performance as well as to improve the system of care.

Throughout this Policy, the phrase "Professional Practice Evaluation" replaces the traditional phrase "Peer Review." This policy refers to the records and proceedings of the Medical Staff, which has the responsibility of evaluation and improvement of the quality of care rendered in the Hospital. The records and proceedings of the Medical Staff that relate to this Policy in any way are protected from discovery pursuant to California Evidence Code, Section 1157.

Goals:

A. Identify opportunities for practice and performance improvement of individual physicians who have privileges in the Hospital and teams.
B. Monitor clinical performance of Medical Staff physicians.
C. Monitor for significant trends in performance by analyzing aggregate data and case findings.
D. Assure that the process for professional practice evaluation is clearly defined, objective, equitable, defensible, timely, and useful.
E. Improve the quality of care provided by individual physicians.
F. Identify and help execute system-wide improvement, addressable by focused project teams and enterprise-wide performance improvement efforts.

II. POLICY STATEMENT

It is the policy of Lucile Packard Children's Hospital Stanford (LPCHS) to comply with statutory and regulatory requirements regarding ongoing professional practice evaluation and focused professional practice evaluation. Ongoing data review and findings of physician practice and performance are evaluated by professional practice evaluation committees with a focus on improvement. The findings of those committees are used to assess the quality of care of individual physicians.

III. OVERVIEW

A. Professional Practice Evaluation
   1. Ongoing Professional Practice Evaluation (OPPE) is a program that allows the Medical Staff to identify professional practice trends that have an impact on quality of care and patient safety on an ongoing basis.

The program includes:

a. Evaluation of an individual physician's professional performance and includes opportunities to improve care based on recognized standards. It differs from other quality improvement processes in that it evaluates the strengths and opportunities of an individual physician's performance and competence related to their privileges rather than appraising the quality of care rendered by a group of professionals or by a system.
b. Multiple sources of information including, but not limited to, the review of individual cases, the review of aggregate data, compliance with hospital policies, the Rules and Regulations of the Bylaws of the Medical Staff, clinical standards, and the use of rates compared against established benchmarks or norms.
c. Individual evaluation is based on generally recognized clinically appropriate care. This process provides physicians with feedback for personal improvement and/or confirmation of personal achievement related to the effectiveness of their professional, technical, and interpersonal skills in providing patient care.
d. Service chiefs are responsible for determining practice specific OPPE metrics and ensuring physician adherence to metrics. Service chiefs incorporate this information as part of privileging decisions.

2. Focused Professional Practice Evaluation (FPPE) is a process whereby the Medical Staff evaluates to a greater extent the competency and professional performance of a specific physician. Two circumstances trigger FPPE initiation: New Privileges and Professional Competency Concerns. FPPE for new privileges is not considered an investigation as defined in the Medical Staff Bylaws and is not subject to regulations afforded in the investigation process. If a FPPE results in an action plan to perform an investigation, the process identified in the Medical Staff Bylaws would be followed. FPPE related to professional competency concerns is considered an investigation under National Practitioner Data Bank requirements.
   a. Initial Proctoring: The initial proctoring program is a component of FPPE (see Proctoring policy). Proctoring for newly appointed medical staff members is managed by the Medical Staff Services Department.
   b. Focused Review based on a Professional Competence Concern: A specific physician focused review is a second component of FPPE. Focused review is considered an investigation and is used when questions arise regarding a currently privileged physician's ability to provide safe, high-quality patient care based on a pattern of reviews of individual cases, a pattern of not meeting targets on OPPE indicators, or in unusual situations, one case of significant clinical concern, as determined by the Care Improvement Committee, the Chief Medical Officer (CMO) the Associate Chief Medical Officers (ACMOs), The Medical and Surgical CIC Co-Chairs, the President of the Medical Staff, and/or Department Chair. The process outlined in the Medical Staff Bylaws must be followed. Insofar as National Practitioner Data Bank reporting requirements are concerned, it is not a restriction of privileges but is an investigation under National Practitioner Data Bank rules requiring a report if the practitioner resigns or takes a leave of absence during the FPPE.

(See sections V.D. Thresholds for focused review and V.B.1 for Performance Review Committee).

B. Peer
1. A "peer" is an individual who is practicing in the same profession and who has expertise in the appropriate subject matter.
2. The level of subject matter expertise required to provide meaningful evaluation of a physician's performance will determine what "practicing in the same profession" means on a case-by-case basis.

C. Professional Practice Evaluation Committees (PPEC)
1. The "Professional Practice Evaluation Committee(s)" are designated by the Medical Executive Committee or its designee to perform professional practice evaluation on an ongoing basis. The Service Chief, or his/her designee will determine the degree of subject matter expertise required for a provider to be considered a peer for all professional practice evaluations performed by or on behalf of the hospital. See Appendix A for procedure.
2. See Appendix B for list of professional practice evaluation committees.

D. Conflict of Interest
1. A member of the Medical Staff asked to perform professional practice evaluation may have a conflict of interest if he or she is not able to render an unbiased opinion due to some substantive and quantifiable reason such as involvement in the patient's care or direct competition with the physician under review.
2. It is the individual reviewer's obligation to disclose the potential conflict to the professional practice evaluation committee.
3. The professional practice evaluation committee's responsibility is to determine whether the conflict would prevent the individual from participating and the extent of that participation if allowed.
4. Individuals determined to have a conflict may be present during the group discussion and professional practice evaluation. They will, however, be required to recuse themselves from the review and/or causal analysis.

IV. PRINCIPLES

A. The PPE Process should be viewed as an engine for learning and systems improvement rather than judgment or punishment. Individual attribution of suboptimal care will be performed only when system errors are excluded, educational opportunities have been fully exploited, or trend of concerning issues is noted.
1. Member driven, with a significant increase in self-reporting
2. Transparent
3. Constructive
4. Dynamic
5. Focused on both team function, individual and team accountability
6. Intimately linked with Quality Improvement

B. Human Factors
1. To err is human. Therefore, humans delivering health care will occasionally make errors, and simple human error does not necessarily indicate substandard care or a substandard caregiver. However, we are all responsible to continually identify and implement means of minimizing the effects of human fallibility on the care of patients.
2. Except in rare cases of clearly unacceptable care, the medical staff organization's primary goal is to support fellow medical staff members in their ongoing efforts to improve their own quality of care; equally importantly we aim to assist in identifying and encouraging systematic improvements in our care processes, always with the goal of improving the overall quality of care at LPCHS.

C. Confidentiality
1. Professional Practice Evaluation information is privileged and confidential in accordance with medical staff and hospital bylaws, state, and federal laws (including California Evidence Code Section 1157), and regulations pertaining to confidentiality and non-discoverability.
   a. Committee members will sign a statement of confidentiality at initial participation and annually thereafter.
   b. Attendance will be kept for each professional practice evaluation meeting and committee members unable to maintain at least 50% attendance over a year may be replaced.
   c. The hospital will keep provider-specific professional practice evaluation and other quality information concerning a physician in a secure location. Provider specific professional practice evaluation information includes information related to:
      (1) Performance data for all dimensions of performance measured for that individual physician.
      (2) The individual physician's role in sentinel events, significant incidents, or near misses.
      (3) Correspondence to the physician regarding commendations, comments regarding practice performance, or corrective action.
   d. Professional practice evaluation information is available only to authorized individuals who have a legitimate need to know this information, based upon their responsibilities as a medical staff leader or hospital employee. They shall have access to the information only to the extent necessary to carry out their assigned responsibilities. Only the following individuals shall have access to provider-specific professional practice evaluation information, and only for purposes of quality improvement and as part of their official duties. The components of the quality file which are available are limited to the Performance Report (unless otherwise stated).
      (1) CMO, Associate CMOs, Medical and Surgical Co-chairs of CIC, President and Vice President of the Medical Staff (complete file is available)
      (2) Medical staff service chiefs for members of their division only (complete file is available)
      (3) Care Improvement Committee
      (4) The involved physician (as provided in the Medical Staff Bylaws)
      (5) Hospital Risk Management

(6) Hospital quality staff who support PPECs
(7) Medical staff services professionals to the extent that access to this information is necessary for the reappointment or re-credentialing process or formal corrective action
(8) Individuals surveying for accrediting bodies with appropriate jurisdiction (e.g., The Joint Commission or state/federal regulatory bodies)
(9) Credentials Committee at the time of re-appointment or upon request of the Chair
(10) Department Chair
(11) Chief Quality Officer

e. No copies of professional practice evaluation documents will be created and distributed unless authorized by CMO, Associate CMOs, or President of the Medical Staff or policy.

D. Reliability of Review Process

1. Professional practice evaluation is conducted in a manner that is objective, equitable, timely and consistent.
   a. Case selection is done by use of pre-determined indicators and referrals. See Appendix A, B.
   b. Objective screening per pre-determined criteria is part of the screening process for case identification.
   c. Review of cases is performed by the PPECs or CIC members in accordance with procedures listed in Appendix C.
   d. Follow-up is conducted as identified in Appendix A and will be reported to the Medical Executive Committee as needed.

2. The Care Improvement Committee (CIC) will evaluate reliability of Professional Practice Evaluation committees based on reports submitted to CIC.

V. OVERSIGHT AND REPORTING

A. Direct oversight of the professional practice evaluation process is delegated by the Medical Executive Committee to the Care Improvement Committee and Professional Practice Evaluation Oversight Committee (PPEOC) (see Appendix D for infrastructure).

1. The Care Improvement Committee will meet at least quarterly. Additional meetings will be held if warranted. The CIC will follow the process outlined in Appendix A of this document except that the attending physician is not required to attend the meeting unless he/she requests to participate or unless requested by the PPEC chair.

2. At the discretion of the CIC co-chairs, the Care Improvement Committee will review cases that were identified at the Service PPEC level as having significant system/process and team function improvement opportunities. These cases may involve any of the following:
   a. 3 or more services involved or reviewed
   b. 4 or more categories chosen on the taxonomy tool

c. Discretion of PPE Program Manager

3. Causal Analysis
   a. Each case reviewed at the PPEC will be rated with causal analysis. Care at LPCHS is provided by inter-professional teams, and one individual is seldom responsible for outcomes independent of others. As such, the PPE process identifies whether the rating should be attributed to "teams" or to individual physicians.
   b. If individual physician performance concerns are raised, the PPEC co-chairs will refer the case to the Performance Review Committee (Section V. B)

4. The CIC physician leadership and PPE Program Managers meet at least quarterly to review:
   a. PPEC case reviews to determine appropriate action plan, including referral to CIC, Service Chiefs, Administrative Committees, or Medical Executive Committee
   b. Professional Practice Evaluation Policy review
   c. Recommendation of case review indicators
   d. Educational needs of the Medical Staff identified through professional practice evaluation, i.e. informed consent

5. The CIC Co-Chairs are members of the Professional Practice Evaluation Oversight Committee (PPEOC). This committee will consist of the Medical and Surgical CIC Co-Chairs, the CQO, CMO and designated ACMO, Medical Staff President and Vice President, and PPE program managers. The PPEOC will report to the MEC annually. The committee will be led by the CMO and Medical Staff President and will oversee the following:
   a. CIC actions taken as a result of PPEC
   b. Ad-hoc Performance Review Committees and action plans
   c. OPPE infrastructure and reporting
   d. Behavioral Review and action plans
   e. FPPE

6. The CIC reviews the actions taken by the service PPEC to identify whether further action is required. If further action is required, the CIC will identify the appropriate committee, service, hospital administrator or physician leadership for required follow-up.

7. The Care Improvement Committee and PPEOC will report to the Medical Executive Committee at least once each year.

B Performance Review Committee

1. This is an ad hoc committee and viewed as an extension of professional practice evaluation when there is a case in which concerns are raised regarding significant physician performance issues. The committee is accountable to the MEC. The committee will be composed medical staff leadership including CMO, ACMOs, President of the Medical Staff, CQO, Service Chief of the involved physician(s), and may include other subject matter experts. The PRC will determine if any of the following actions are needed: 1) no action, 2) referral to the MEC for an official medical staff action and/or request an FPPE, or 3) counseling, education or performance improvement plan. All data will be maintained in a confidential database that will be available for continuous reporting and trending of physicians.

C. Reporting of OPPE Data

1. OPPE uses a ACGME core competency-based measurement framework: patient care, medical knowledge, professionalism, interpersonal and communication skills, and systems-based practice. This structure aims to provide a holistic evaluation of a physician's professional practice. The PPEOC has responsibility for approval of generic metrics and targets for OPPE. The following are the generic metrics:
   a. Timely Completion of H&P Note
   b. HIMS Suspensions
   c. Behavioral Events
   d. Patient/Family Grievances
   e. Exemplary Care
   f. Annual Education: Attestation

   The OPPE reporting includes specialty-specific metrics for each specialty to better represent the specialized care that each specialty provides. Specialty-specific metrics are developed with the Service Chief for each specialty.

2. OPPE profiles will be distributed to the Service Chiefs and the Medical Staff Office. Service chiefs should incorporate this information into privileging decisions.

3. OPPE profiles from Stanford Health Care (SHC) will be used for physicians in the SHC Staff Category to supplement the decision for granting privileges based on the information sharing agreement between both hospitals.

4. Requests for physician performance data, see "Confidentiality of Medical Staff/Advance Practice Professional Staff Records".
   a. Requests for physician performance data will be made by the individual physician in writing.
   b. The most recent Physician Performance Report in total will be shared as designated in the request. No partial reports will be provided.

D. Targets for focused review:

1. The following are examples when a focused review as part of the FPPE process may be requested by the PPEC Co-Chair, Service Chief, CMO, ACMO, or CQO.

a. Any single egregious case or sentinel event as judged by the CMO, ACMO, the CIC, or President of the Medical Staff or designee may result in a focused review.
b. If requested by a service chief when a physician's individual performance does not meet the predetermined target for generic and/or specialty OPPE metrics indicator (see Appendix E).

2. Upon completion of the FPPE, the results will be shared with the physician under review, who will have the opportunity to submit a response, on such terms as the PRC Ad-Hoc committee shall establish. This will occur prior to the report to the Medical Executive Committee.

3. The results of this review will be presented to the Medical Executive Committee, and in summary to the Board of Directors.

E. Circumstances which may require external professional practice evaluation:

1. External professional practice evaluation will take place under the following circumstances if deemed appropriate by the Care Improvement Committee, CMO, ACMO, President and VP of the Medical Staff, and/or designee:
   a. Cases involving litigation, or the potential for a lawsuit as determined by Risk Management.
   b. Ambiguity – when dealing with vague or conflicting recommendations from internal reviewers or PPEC and conclusions from this review will directly affect a physician's membership or privileges.
   c. Lack of internal expertise or conflict of interest – when no one on the medical staff has adequate expertise in the specialty under review or when the only physicians on the Medical Staff with that expertise are determined to have a conflict of interest regarding the physician under review as described above.
   d. New technology – when a medical staff member requests permission to use new technology or perform a procedure new to the hospital and the medical staff does not have the necessary subject matter expertise to adequately evaluate the quality of care involved.
   e. Miscellaneous issues –the Medical Executive Committee or governing board may require external professional practice evaluation in any circumstances deemed appropriate by either of these bodies.

2. The Care Improvement Committee will inform the Medical Executive Committee when there is a request for external professional practice evaluation

VI. RELATED DOCUMENTS

A. Medical Staff Bylaws and Rules and Regulations of the Medical Staff
B. Joint Commission Hospital Accreditation Standards: Medical Staff
C. Confidentiality of Medical Staff/Advance Practice Professional Staff Records

VII. APPENDICES

A. Professional Practice Evaluation Process/Procedure
B. Diagram for PPE Committee Structure and Reporting Relationship
C. Indicator List by Division/Department
D. New Causal Analysis Taxonomy Tool

VIII. DOCUMENT INFORMATION

A. Legal Authority/References
   1. Medical Staff Standards located in the Joint Commission Hospital Accreditation Standards
   2. California Evidence Code 1157
B. Author/Original Date
   December 11, 2006
C. Distribution and Training Requirements
   1. This policy resides in the Medical Staff Office Policy Manual for LPCHS.
   2. New documents or any revised documents will be distributed to physicians through the Medical Staff Office.
D. Review and Renewal Requirements
   This policy will be reviewed and/or revised every three years or as required by change of law or practice.
E. Review and Revision History
   1. Medical Staff Quality Assurance and Improvement Activities October 2002
   2. Medical Staff Professional Practice Evaluation Policy December 2006; September 2009; October 2012; October 2016; March 2018
F. Approvals
   1. Medical Executive Committee LPCHS: April 12, 2007, September 19, 2009; November 8, 2012; October 14, 2016; March 3, 2018, 1/21, 7/22, 4/25
   2. LPCHS Hospital Board: April 20, 2007, October 16, 2009, November 16, 2012; October 18, 2016, 1/21, 7/22, 4/25

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Appendix A

Professional Practice Evaluation Process/Procedure

A. Professional Practice Evaluation Committees (PPEC)
   1. A quorum is required for all committee actions, including case analysis, closure of summary cases, and performance improvement activities.
   2. A quorum is defined as a minimum of three members, excluding any members who have cases under review.
   3. PPECs (see Appendix B) meet on a regular basis (at least 4 times per year).

   3. In addition to cases identified by case review indicators, cases may be reviewed based on specific referral criteria (see B2).
   4. Individual PPECs identify follow-up actions needed based on individual case review and/or identified trends.
   5. Follow-up actions identified by the PPECs are assigned to the appropriate committee, service, and hospital administrator or physician leadership. Communication of action plan taken is reported back to that PPEC.

B. Indicators for review (see Appendix B for listing by committee)
   1. Rule and rate based indicators identify individual instances of non-compliance with administrative or clinical processes.
      a. The PPEOC approves generic OPPE indicators for the medical staff. Service specific metrics for Practice Based Indicators are selected by the Service Chiefs of individual divisions/departments in collaboration with the analytics department.
      b. Predetermined targets for each indicator are identified (see Appendix E).
      c. When a target is exceeded, the Service Chief determines if a focused review is indicated.
      d. Rule and rate based indicators are evaluated periodically to determine if the indicator(s) and target(s) should be modified.
   2. Individual case review
      a. Cases for individual case review will be based on "significant clinical events" identified by:
         (1) Pre-determined review indicators including, but not limited to, return to ICU within 24 hours, expiration, unplanned return to surgery, and complications of a procedure
         (2) Incident reports
         (3) Patient/family grievances
         (4) Sentinel events and events required by regulatory agencies to be reported
         (5) Referral from physicians or other clinicians
         (6) Referral from Mortality and Morbidity Committees
         (7) Referral from Risk Management
         (8) Referrals from Patient Safety/iCare reports

b. Patterns/trends for a rule or rate based indicator exceeding a target may result in individual case review.

c. Once a case is identified for review, a determination is made on whether a full review or a summary review is needed. This decision is made with input from the committee chairpersons.

(1) All cases which are identified to be summary cases are summarized by the Professional Practice Evaluation Program Manager (PPEPM) from review of the medical record. When summary cases are presented to the committee, any committee member may request a full review, which will be conducted at the next PPEC meeting.

(2) As with all cases, a quorum is needed to determine that no full review is needed. A quorum is at least 3 committee members.

(3) A case summary is written by the PPEPM for all cases which are identified for full review. These cases are then assigned to a physician reviewer as described below.

d. The physician involved in the care of the patient will be invited to attend the PPEC meeting and/or provide a written input for all cases identified for full review.

e. Each case for full review will be assigned to the attending physician of record, PPEC member and/or content expert for presentation to the committee.

(1) The primary focus is on whether there were improvement and learning opportunities related to medical decision-making and systems independent of the outcome of care.

(2) The case analysis may be deferred if it is determined that more information is required.

f. Committee members perform an analysis of each case (See Appendix C). A consensus must be reached for case analysis.

g. The attending of record is informed in writing of the case analysis findings, improvement opportunities and follow-up actions.

h. If the attending of record does not agree with the causal analysis, he/she may submit his/her written objection to the Medical and Surgical Co-Chairs of the CIC for preliminary review and further action.

(1) The objection to the causal analysis may be reviewed by the CMO/ Medical and Surgical Co-Chairs of the CIC. They determine whether the case would benefit from an external review (see Section V.D.) or review by the CIC.

(2) If the case does not meet criteria for external review, the written objection to the causal analysis is included with the PPEC case analysis.

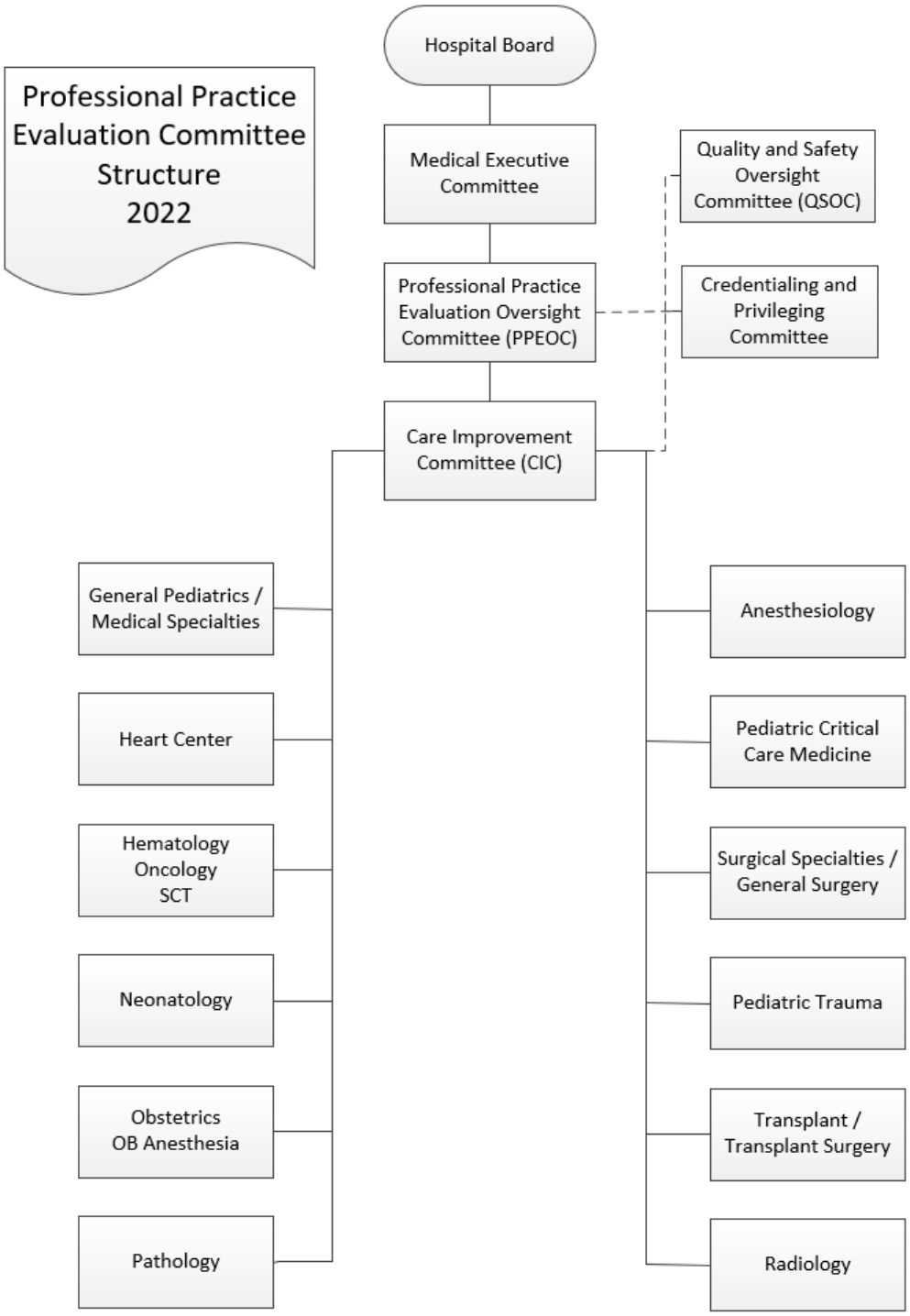
C. Participants in the review process:

1. The Service Chief will designate members for individual PPECs. Each PPEC will have a defined membership and will not be composed of the whole division/service. The membership will be subject to approval of the Medical and Surgical Co-Chairs of the CIC.
2. Divisions which have a substantial population of patients who have community attending physicians should have a community attending physician(s) identified as a committee member in addition to faculty physicians.
3. The Service Chief(s) will consider rotation of members at least once every three years.

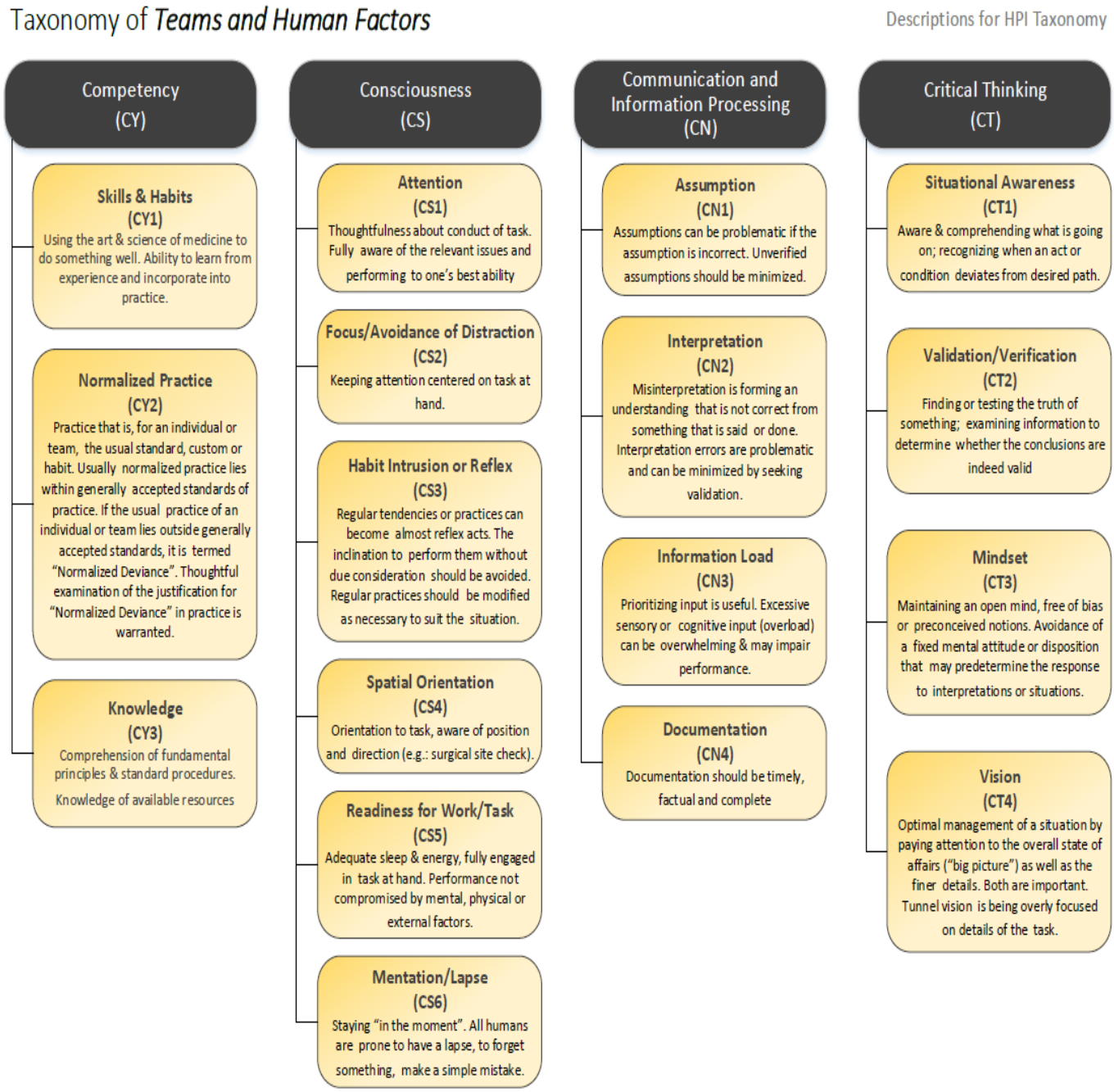
4. The Service Chief shall appoint two Co-chairpersons for each PPEC with the approval of CIC Co-Chairs. An evaluation of the term of appointment should occur every three to six years. A chair may be reappointed by the service chief for additional terms.
5. The work of all physicians granted privileges will be reviewed through the professional practice evaluation process.
6. In the process of the Causal Analysis, all members are voting members. Fellow and resident physicians may participate on the professional practice evaluation committees as part of their medical education. RNs and APPs may be invited to become PPEC members.
7. Care provided by fellow and resident physicians will be attributed to the attending/supervising physician during the evaluation and causal analysis.
8. In the event of a conflict of interest or circumstances that would suggest a biased review, the Professional Practice Evaluation Committee (PPEC) or the CIC will replace, appoint, or determine who will participate in the process, so that bias does not interfere in the decision-making process.
9. Allied health professionals may participate in the review process if deemed appropriate based on their job responsibilities.
10. Center for Pediatric and Maternal Value will provide the following support to the committee:
    a. Provide PPEC with data for defined indicators
    b. Provide PPEC with cases for review
    c. Advise Medical Staff as to what data is available
    d. Provide staffing and/or consultation for each PPEC
    e. Provide Medical Staff Office with OPPE data for physician performance reports and Physician Performance Improvement Plans and progress updates as appropriate

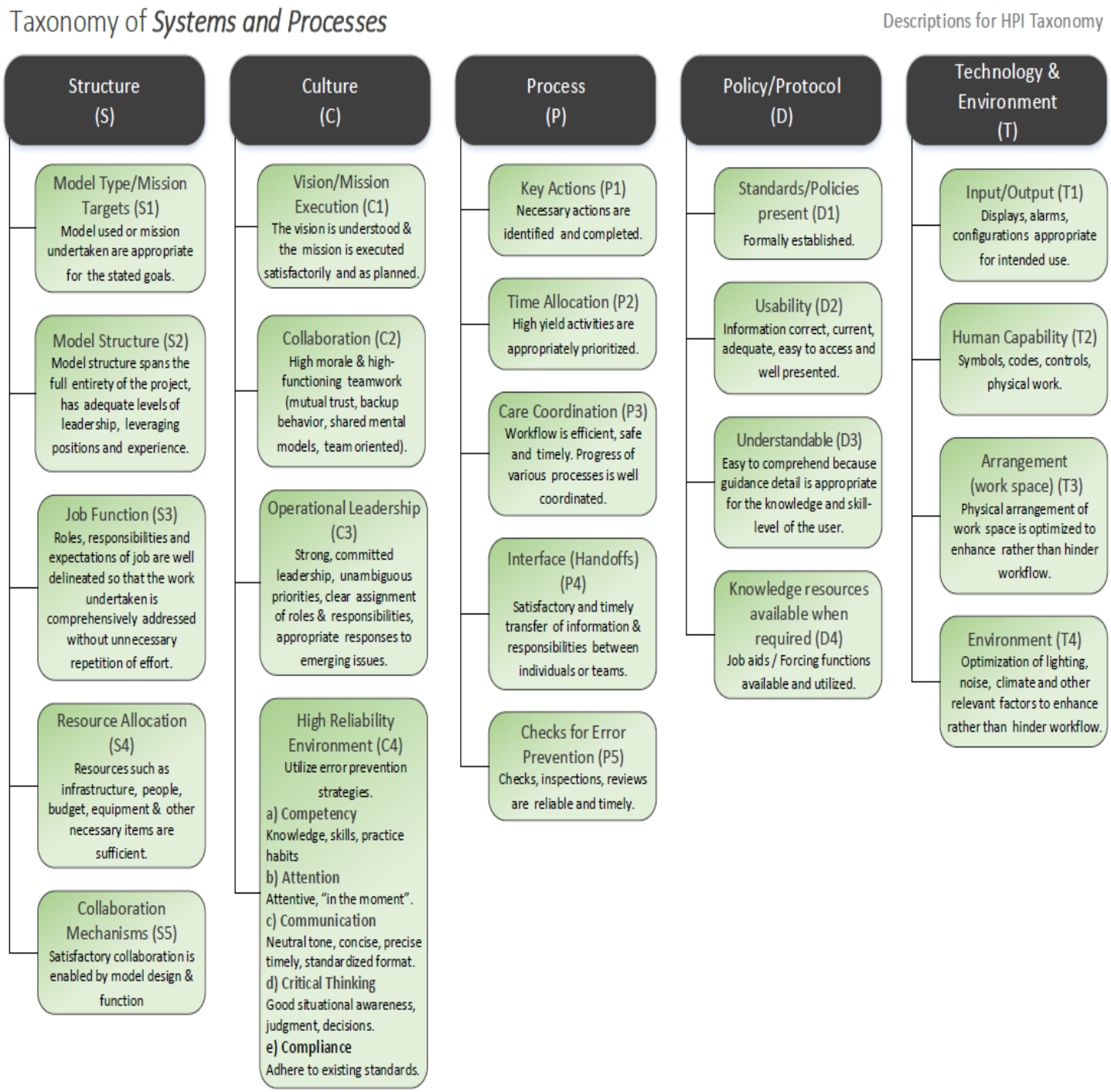
D. Professional practice evaluation time frames:
1. Professional practice evaluation will be conducted by the Medical Staff in a timely manner. The goal is for routine cases to be completed within 90 days from the date the case is identified for review.
    a. Once a case is identified for review by the PPEC Co-Chairs, it will be prioritized for review at the PPEC meeting.
    b. If the physician invited to the PPEC meeting has a conflict with the timing of the PPEC meeting, the physician may submit written input of his/her care provided in the case, or may request a postponement of the review for one month. After a one-month postponement, the case will be reviewed with or without the presence of the physician(s) involved at the next meeting.
    c. For cases involving physicians on sabbatical, or for urgent cases which cannot be postponed, the timing of the review will be at the discretion of the CIC Medical and Surgical Co-Chairs.
2. Complex cases may require additional review time beyond 90 days. The complex cases are monitored by the Center for Pediatric and Maternal Value. A complex case may be one where multiple services are involved, or one which requires external review for reasons identified in section V.D.

Appendix B

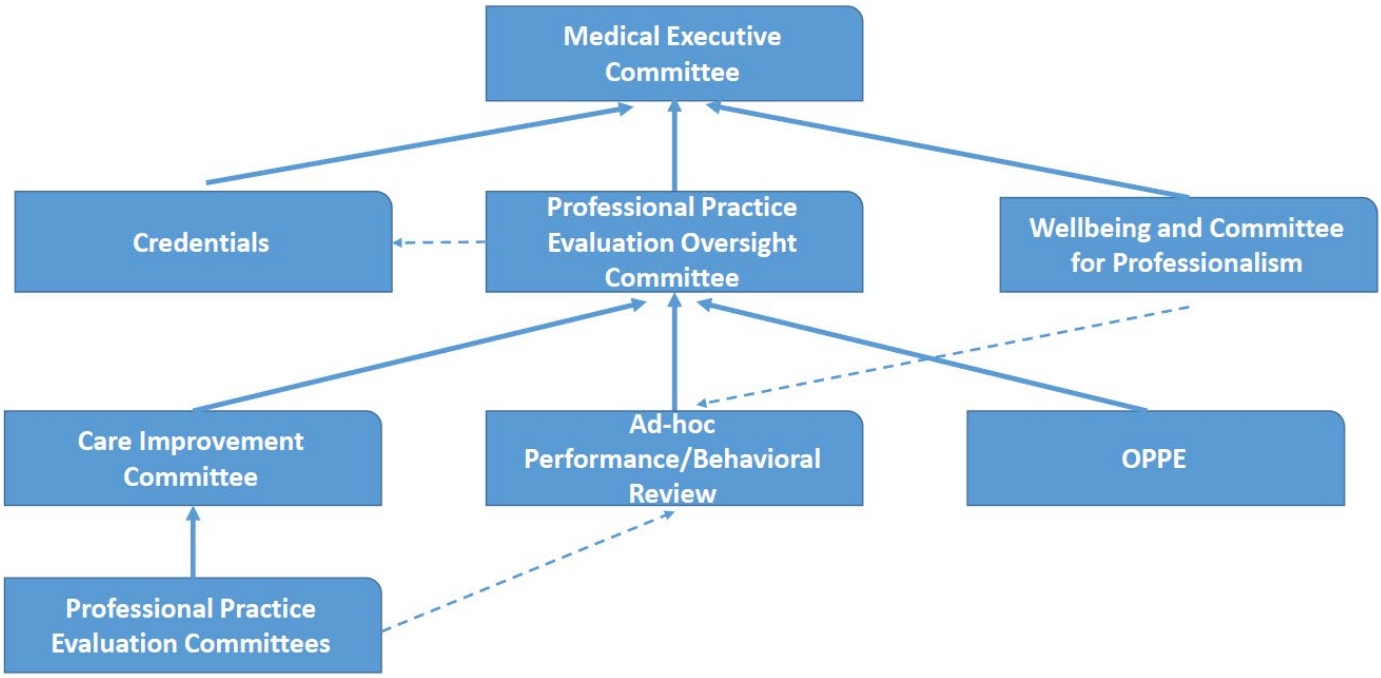

Professional Practice Evaluation Committee Structure 2022
Hospital Board
Medical Executive Committee
Quality and Safety Oversight Committee (QSOC)
Professional Practice Evaluation Oversight Committee (PPEOC)
Credentialing and Privileging Committee
Care Improvement Committee (CIC)
General Pediatrics / Medical Specialties
Heart Center
Hematology Oncology SCT
Neonatology
Obstetrics OB Anesthesia
Pathology
Anesthesiology
Pediatric Critical Care Medicine
Surgical Specialties / General Surgery
Pediatric Trauma
Transplant / Transplant Surgery
Radiology

Appendix C: Causal Analysis Taxonomy




Taxonomy of Systems and Processes
Descriptions for HPI Taxonomy
Structure (S)
Model Type/Mission Targets (S1)
Model used or mission undertaken are appropriate for the stated goals.
Model Structure (S2)
Model structure spans the full entirety of the project, has adequate levels of leadership, leveraging positions and experience.
Job Function (S3)
Roles, responsibilities and expectations of job are well delineated so that the work undertaken is comprehensively addressed without unnecessary repetition of effort.
Resource Allocation (S4)
Resources such as infrastructure, people, budget, equipment & other necessary items are sufficient.
Collaboration Mechanisms (S5)
Satisfactory collaboration is enabled by model design & function
Culture (C)
Vision/Mission Execution (C1)
The vision is understood & the mission is executed satisfactorily and as planned.
Collaboration (C2)
High morale & high-functioning teamwork (mutual trust, backup behavior, shared mental models, team oriented).
Operational Leadership (C3)
Strong, committed leadership, unambiguous priorities, clear assignment of roles & responsibilities, appropriate responses to emerging issues.
High Reliability Environment (C4)
Utilize error prevention strategies.
a) Competency
Knowledge, skills, practice habits
b) Attention
Attentive, "in the moment".
c) Communication
Neutral tone, concise, precise timely, standardized format.
d) Critical Thinking
Good situational awareness, judgment, decisions.
e) Compliance
Adhere to existing standards.
Process (P)
Key Actions (P1)
Necessary actions are identified and completed.
Time Allocation (P2)
High yield activities are appropriately prioritized.
Care Coordination (P3)
Workflow is efficient, safe and timely. Progress of various processes is well coordinated.
Interface (Handoffs) (P4)
Satisfactory and timely transfer of information & responsibilities between individuals or teams.
Checks for Error Prevention (P5)
Checks, inspections, reviews are reliable and timely.
Policy/Protocol (D)
Standards/Policies present (D1)
Formally established.
Usability (D2)
Information correct, current, adequate, easy to access and well presented.
Understandable (D3)
Easy to comprehend because guidance detail is appropriate for the knowledge and skill-level of the user.
Knowledge resources available when required (D4)
Job aids / Forcing functions available and utilized.
Technology & Environment (T)
Input/Output (T1)
Displays, alarms, configurations appropriate for intended use.
Human Capability (T2)
Symbols, codes, controls, physical work.
Arrangement (work space) (T3)
Physical arrangement of work space is optimized to enhance rather than hinder workflow.
Environment (T4)
Optimization of lighting, noise, climate and other relevant factors to enhance rather than hinder workflow.

Appendix D


Medical Executive Committee
Credentials
Professional Practice Evaluation Oversight Committee
Wellbeing and Committee for Professionalism
Care Improvement Committee
Ad-hoc Performance/Behavioral Review
OPPE
Professional Practice Evaluation Committees

Appendix E

Indicator List by Division/Department

The Medical Staff at Lucile Packard Children's Hospital Stanford have selected the General Competencies and Expectations from the Accreditation Council for Graduate Medical Education (ACGME) as a framework for assessing the competency of each member of the medical staff. These competencies are also used for Board Certification. The following indicators have been selected for each competency and will be used for all physicians. Each service may select additional indicators when appropriate.

Patient Care

Definition – Physicians are expected to provide patient care that is compassionate, appropriate, and effective for the promotion of health, prevention of illness, treatment of disease, and at the end of life.	**Target**
Indicator –Service specific metrics are selected by individual divisions/ departments.	**Per service specifications**

Medical Knowledge

Definition – Physicians are expected to demonstrate knowledge of established and evolving biomedical, clinical, and social sciences and the application of their knowledge to patient care and the education of others.	**Target**
Indicator – Most recent completion date of the annual education attestation. "Not available" indicates there is no completion date on file.	**N/A**

Practice Based Learning

Definition – Physicians are expected to be able to use scientific evidence and methods to investigate, evaluate, and improve care.	**Target**
Indicator –Service specific metrics are selected by individual divisions/ departments.	**Per service specifications**

Interpersonal Communication

Definition – Physicians are expected to demonstrate interpersonal and communication skills that enable them to establish and maintain professional relationships with patients, families, and other members of the healthcare team.	**Target**
Indicator –Percentage of H&P notes in EPIC dictated ≤ 24 hours of admission	**≥ 90%**
Indicator – Total number of HIMS suspensions due to medical record incompletion	**≤ 3**

Professionalism

Definition – Physicians are expected to demonstrate behaviors that reflect a commitment to continuous professional development, ethical practice, an understanding and sensitivity to diversity, and a responsible attitude toward their patients, their profession, and society.	**Target**
Indicator – Exemplary Care	**None**
Indicator – Patient Family Grievances	**≤ 1**
Indicator – Behavioral Events	**≤ 1**

System-based Learning

Definition – Physicians are expected to demonstrate an understanding of the contexts and systems in which health care is provided and the ability to apply this knowledge to improve and optimize healthcare.	**Target**
Indicator –Service specific metrics are selected by the Service Chief of individual divisions/ departments.	**Per service specifications**