P. O. Box 1110
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Policy: On-Going Professional Practice Evaluation

I. Scope:

This policy applies to all practitioners credentialed and privileged through the Medical Staff process

II. Purpose:

The Ongoing Professional Practice Evaluation (OPPE) allows the organization to identify practice trends that have an impact on quality of care and patient safety. Identification of trends may require intervention by the organized medical staff. OPPE information is factored into the decision to maintain existing privilege(s), to revise existing privilege(s), or to revoke an existing privilege prior to or at the time of referral.

III. Definitions:

Ongoing Professional Practice Evaluation (OPPE): A documented summary of ongoing data collected for the purpose of assessing a practitioner's clinical competence and professional behavior.

Peer: An individual practicing in the same profession and who has expertise in the appropriate subject matter. The level of subject matter expertise required to provide meaningful evaluation of a practitioner's performance determines what "practicing in the same profession" means on a case-by-case basis. For example, for quality issues related to general medical care, a physician (MD or DO) may review the case of another physician. For specialty-specific clinical issues such as evaluating the technique of a specialized surgical procedure, a peer is an individual who is well-trained and competent in that surgical specialty.

Practitioner: For purposes of this policy, practitioner is defined as individuals with Medical Staff or Allied Healthcare privileges.

IV. Policy:

1. OPPE will begin immediately after satisfactory completion of the Focused Professional Practice Evaluation (FPPE) for initial privileges.
2. All peer review documents are handled with strictest confidence and are protected under federal and state laws addressing peer review. The documents are the sole property of the hospital and may not be released without court order.
3. Relevant information resulting from the OPPE will be integrated into performance improvement activities consistent with the organization's policies and procedures that are intended to preserve confidentiality and privilege of information.
4. Individual evaluations are based on recognized standards of care.
5. The evaluations of practitioner performance will be reviewed every six months.
6. If there is uncertainty regarding the practitioner's clinical competence, practice behavior, or ability to perform the requested privilege, the organized Medical

Staff may complete a FPPE as outlined by Medical Staff Policies and Procedures.

7. Data will be collected on all practitioners, not just those with performance issues.

V. Procedure:

1. The criteria to be used for OPPE will be determined by the individual departments and approved by the organized medical staff. The data should be specialty-specific.
2. Existing data may be used as pertinent to individual evaluations:
    1. Surgical Care Improvement Project (SCIP)
    2. Core measures
    3. Medical record delinquency
    4. Infection control surveillance data
    5. Medical staff performance improvement data
        1. Medical assessment and treatment of patients
        2. Use of medications
        3. Use of blood and blood components
        4. Operative and other procedural data
        5. Appropriateness of clinical practice patterns
        6. Significant departures from established patterns of clinical practice
        7. Return to surgery data
        8. Procedural complication data
    6. Other data as defined by the medical staff
    7. The Quality Department will coordinate the collection of data. Data may be acquired by patient record review, direct observations, and discussions with other healthcare providers.
    8. The data will be reviewed by the Medical Staff Performance Improvement: Credentials Committee
    9. When variations to acceptable practice is noted, a referral will be made to the Medical Executive Committee (MEC) for feedback to the provider. If practitioner continues with deviations from standard practice, the Credentials Committee will recommend to MEC a consideration for FPPE For Cause.
    10. Other criteria that could trigger the need for FPPE:
        1. A sentinel event directly or indirectly attributed to the practitioner,
        2. Morbidity and mortality exceeding internal benchmarks or nationally recognized rates,
        3. A trend of patient, family, staff or peer complaints,
        4. Increasing lengths of stay compared to service/other providers without known or documented explanation,
        5. Unplanned returns to surgery
        6. Frequent or repeat readmissions suggesting possibly poor or inadequate initial management or treatment, or
        7. Patterns of unnecessary diagnostic testing/treatments.
    11. When indicated, an individualized performance improvement plan will be developed by the Medical Staff and documented with stipulations of what is required, who is accountable, how improvement will be measured or documented and the time period for completion of the plan. The plan may include:
        1. Necessary education
        2. Proctoring/assisting for defined privilege
        3. Counseling
        4. Physician/practitioner assistance programs
        5. Suspension of specific privilege

6. Revocation of specific privilege

12. External peer review may be used in the following circumstances:
    1. Cases involving litigation, or the potential for a lawsuit as determined by Risk Management
    2. Ambiguity—when dealing with vague or conflicting recommendations from internal reviewers or medical staff committee and conclusions from this review will directly affect a practitioner's membership or privileges
    3. Lack of internal expertise or peer—when no one on the medical staff has adequate expertise in the specialty under review or when the only practitioners on the medical staff with that expertise are determined to have a conflict of interest regarding the practitioner under review.
    4. The Medical Executive Committee or Governing Board may require external professional evaluation in any circumstances deemed appropriate.

VI. References:

The Joint Commission, (2012) Hospital Standards Manual, MS.08.01.03

VII. Related NWTHS Policies:

Focused Professional Practice Evaluation

VIII. Attachment(s):

OPPE Flowchart

Effective date: 12/2012
Review date:05/2013

Medical Staff Ongoing Professional Practice Evaluation (OPPE)

6 Month Cycle:
OPPE Schedule

Meeting Month	Review Period	Department
January	July-December	Internal Med (Group 1)
February	August-January	Internal Med (Group 2)
March	September-February	Surgery (Group 1)
April	October – March	Surgery (Group 2)
May	November –April	Pedi/OB
June	December – May	ED, Fam Pr, Psych, & Allied Health
July	January – June	Internal Med (Group 1)
August	February – July	Internal Med (Group 2)
September	March – August	Surgery (Group 1)
October	April – September	Surgery (Group 2)
November	May – October	Pedi/OB
December	June – November	ED, Fam Pr, Psych & Allied Health

LIP's: MIDAS Profile is printed for each physician in the designated department

Quality Management reviews the profile for any significant variance:
- 3 or more occurrences
- Any Core Measure OFI
- Any QOC outside the standard of care

Allied Healthcare Provider (AHP): Charts reviewed from patient contact list that is provided by practitioner. Patient contact list is requested from each Allied Health practitioner at initial privileging request and every 6 month OPPE cycle for review of charts.

Provision of patient contact information is considered in OPPE assessment. Quality Management reviews chart documentation and feedback from staff working directly with practitioner for any significant findings – including documentation, process deviation and behavior concerns.

QM generates a "No Findings" list for practitioners who have no significant findings

Findings chart developed for practitioners with a trend or have met criteria for review by Medical Staff. The chart will provide comparison with previous 6 month period(s)

Both Findings charts and No Findings list are presented monthly to the Medical Staff QI Committee / Credentials for review and recommendations
*Note: practitioners who have not had activity during the 6 month review period will be identified on the No Activity list

Each list is reviewed and recommendations as applicable are made based on practice trends that warrant intervention. These recommendations are referred to MEC each month.

Physicians and/or AHP's who show significant trends in quality performance can be referred to FPPE For Cause investigation