SAINT JOSEPH
Regional Medical Center

Version #: 12

Title: ONGOING PROFESSIONAL PRACTICE EVALUATION (OPPE)

Document Owner: Chris Stefaniak	PI Team: N/A	Date Created: 10/01/2007
Approver(s): Denise Duschek, Karyn Delgado	Date Approved with no Changes: 06/09/2020	Date Approved: 3/18/2020 12/01/2007
Location: Saint Joseph Regional Medical Center (SJRMC) – Mishawaka and Plymouth		Department: Medical Staff Services (14001_80012)

Printed copies are for reference only. Please refer to the electronic copy for the latest version.

POLICY:

1. The OPPE requires that the medical staff conduct an ongoing evaluation of each practitioner's professional performance. This process allows any potential problems with a practitioner's performance or trends that impact quality of care and patient safety to be identified and resolved in a timely manner. The OPPE also fosters an efficient, evidence-based privilege renewal process. The information resulting from the ongoing professional practice evaluation is used to determine whether to continue, limit, or revoke any existing privileges(s).

PROCEDURE:

A. The respective department chair(s) or designated physician representative(s) are responsible to coordinate the Ongoing Professional Practice Evaluation (OPPE) review. The OPPE will be performed on all practitioners every six months allowing an additional 60 day review period if necessary.

B. The type of information and the process for evaluation of each practitioner's ongoing professional practice has been approved by the departments and through the Medical Executive Committee. The defined process is below.

C. At each six month review, every practitioner will be reviewed by the department/specialty Chair or designated physician representative. This review will be factored into the decision to maintain existing privileges(s), to revise existing privilege(s) or to revoke an existing privilege prior to or at the time of renewal. The fact that a practitioner doesn't fall out on screening criteria does not meet the requirement for performance data review although zero data is in fact data and can be evidence of good performance, e.g. no returns to the OR, no complaints, etc. Review of privileges are evaluated at reappointment and consideration of the reason for zero or low volumes is taken into consideration, e.g. no longer performing the procedure, taking patients elsewhere for the procedure or privilege is typically a low volume procedure, etc.

D. Data reports and information that are included in the OPPE include, as applicable:

   1) Midas Statit Specialty Profiles – These reports include inpatient and outpatient data for both the individual physician and comparison with the aggregate of the physicians in that specialty÷

   2) Midas Occurrence Report – Midas is a tool for collecting clinical practice concerns as well as patient and family concerns and compliments. The Occurrence Monitoring and Peer Review policy defines the process for collecting, investigating and addressing these concerns. This report includes individual and aggregated physician information on:

      a) Risk related occurrences

      b) Quality Indicators & Quality Indicator related occurrences

3) No/Low Volume Practitioner –
   a) Attestation of Clinical Competence
   b) Peer Reference, as needed
   c) OPPE data may be obtained from a CMS-certified organization. However, any information received can be used only as supplemental information, not in lieu of collecting organization-specific data.

E. The department chair or designated physician representative will document pertinent findings and recommendations in the Midas Statit database to include:
   1) Confirmation that the practitioner has been reviewed and there are no potential problems with performance or trends that would impact the quality of care and patient safety. The individual practitioner will then be reviewed again at their next sixth month OPPE.
   2) Request for additional review for an individual practitioner based on an identified issue. Information gathered for review may include, but not be limited to:
      a) Drill down reports
      b) Additional performance of a specific procedure
      c) Additional Monthly Review
      d) Direct Observation
      e) Concurrent Monitoring
      f) Retrospective Chart Review
      g) Discussion with other individuals involved in the care of the practitioner's patients including consulting physicians, assistants at surgery, nursing and administrative personnel
   3) This review process will continue until the Department Chair or designated physician representative is either:
      a) Satisfied with the information received and reviewed, or
      b) Recommendations are made to the Credentials Committee or Physician Well Being Committee, as applicable, for review and recommendation to the Medical Executive Committee for action including, but not limited to the initiation of the Collegial Investigation per the Medical Staff Bylaws Credentials Policy Manual.
   4) Request for immediate action according to the Medical Staff Bylaws can be taken at any time during the OPPE process, which may include, but not limited to, forwarding concerns to the following committees:
      a) Credentials Committee for review
      b) Physician Well Being Committee for review (SJRMC-Mishawaka)
      c) Medical Executive Committee

F. The information gained by the review of the above information will be filed and incorporated into the two-year reappointment process. A summary report will also be forwarded to medial staff leaders. Single incidents or trending of quality and safety issues that impact the safety of patients will require immediate action by the medical staff.

G. "Trigger" -There may be circumstances where a single incident or evidence of a clinical practice trend may be identified through the OPPE process. If so, this will trigger a Focused Professional Practice Evaluation, which will be conducted according to Medical Staff Policy.

1) Triggers may include, but are not limited to, data obtained from quality indicators, risk indicators, utilization indicators, unexpected deaths, medical leave of absence, Hospital and Medical Staff Bylaws, Rules & Regulations or policy violations.

H. If behavior is identified as a possible issue, the Medical Staff Code of Conduct Policy will be followed as a component of the OPPE.

I. Relevant information obtained from the OPPE will be forwarded for inclusion into the performance improvement activities maintaining confidentiality.

References/Standards:

- Joint Commission Hospital Accreditation Standards (HAS) 2010
- Joint Commission Perspectives, August 2019, Volume 39, Issue 8
- Reappointment Cycle with OPPE Table
- Policy Origin Date: October 2007 (M), October 2007 (P)
- Review Date: December 2009 (M), December 2012 (M), December 2009 (P), August 2010 (P), December 2012 (P), December 2015 (M), February 2016 (P), December 2018 (M), February 2020 (M & P)
- Revised Date: August 2008 (M), September 2010 (M), December 2013 (M), August 2008 (P), September 2010 (P), September 2013 (P), September 2017 (M), March 2020 (M & P)
- Effective Date: December 2007(M), December 2007(P)
- Reviewed/Recommended By: Medical Executive Committee
- Policy 157