Stanford HEALTH CARE / Stanford MEDICINE Health Care Tri-Valley	**Last Approved Date: March 2023**
Policy Title: Ongoing Professional Practice Evaluation (OPPE)	
Departments Affected: Medical Staff Office and Credentialed SHC Medical Staff and SHC Tri-Valley Medical Staff: Licensed Independent Practitioners and Advanced Practice Providers (LIP/APPs)	

I. PURPOSE:

The purpose of Ongoing Professional Practice Evaluation (OPPE) is to ensure that the hospital, through the activities of its medical staff, assesses each Licensed Independent Practitioner/Advanced Practice Provider (LIP/APP)'s clinical competence and professional behavior on an ongoing basis. OPPE information is factored into the decision to maintain, modify, or revoke existing clinical privilege(s). It is also used when appropriate to recommend further evaluation such as a Focused Professional Practice Evaluation (FPPE).

II. POLICY:

It is the policy of Stanford Health Care (SHC) and Stanford Health Care Tri-Valley (SHCTV) to review relevant and meaningful OPPE data for each LIP/APP every eight months as a part of a robust program to ensure that safe and effective care is being delivered at SHC. To maintain meaningful review, it is the policy of SHC and SHCTV that each service-line specific OPPE metrics, performance targets and thresholds are determined by individual departments, and regularly reviewed and approved by Service/Department Chiefs and the Medical Executive Committee (MEC).

III. DEFINITIONS:

A. Ongoing Professional Practice Evaluation (OPPE) is a regular assessment of a LIP/APP's clinical competence and professional behavior based on service-specific metrics monitored for this purpose. Through this process, LIP/APPs receive feedback for potential improvement or confirmation of achievement related to the effectiveness of their professional practice in all service-specific LIP/APP competencies.

B. Focused Professional Practice Evaluation (FPPE) is the focused evaluation of an LIP/APP's competence in performing a specific privilege or privileges. This process is implemented through Medical Staff policy and process when a question arises regarding an LIP/APP's ability to provide safe, high-quality patient care as identified through OPPE or other processes. (See Medical Staff and APP Professional Practice Evaluation policy)

C. LIP/APP Competencies: The medical staff has determined that for purposes of defining its expectations of performance, measuring performance, and providing performance feedback it will use Joint Commission (TJC) standards outlined below, whenever possible:

1. Patient Care: LIP/APPs are expected to provide patient care that is compassionate, appropriate, and effective for the promotion of health, prevention of illness, treatment of disease, and care at the end of life.
2. Medical/Clinical Knowledge: LIP/APPs 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. Practice-Based Learning and Improvement
3. LIP/APPs are expected to be able to use scientific evidence and methods to investigate and improve patient care practices.
4. Interpersonal and Communication Skills: LIP/APPs are expected to demonstrate interpersonal and communication skills that enable them to establish and maintain professional relationships with patients, families, and other members of health care team.
5. Professionalism: LIP/APPs are expected to demonstrate behaviors that reflect a commitment to continuous professional development, ethical practice, an understanding and sensitivity, and a responsible attitude toward their patients, their profession, and society.
6. Systems-Based Practice: LIP/APPs are expected to demonstrate both an understanding of the contexts and systems in which health care is provided, and the ability to apply this knowledge to apply their knowledge to improve and optimize health care.

D. Conflict of Interest: A conflict of interest (COI) arises when there is a divergence between an individual's private interests and their professional obligations to the Medical Staff, Hospital, patients, and employees such that an independent observer might reasonably question whether the individual's professional actions or decisions are determined by considerations of personal gain, financial or otherwise. A conflict of interest depends on the situation and not the character of the individual. Service/Department Chiefs will determine whether or not a disqualifying conflict is present.

E. Reviewer: Service/Department Chief or designee responsible for the OPPE review. Designee is identified by the Service/Department Chief.

F. Licensed Independent Practitioner (LIP): Any practitioner permitted by law and the organization to provide care and services, without direction or supervision, within the scope of the practitioner license and consistent with individually assigned clinical responsibilities and can perform within their scope of practice.

G. Advanced Practice Providers (APP): Advanced practice providers include but not limited to physician assistants (PA), certified registered nurse anesthetists (CRNAs), certified nurse-midwife (CRM), nurse practitioner (NP), and clinical nurse specialist (CNS) who can provide care and services under the supervision of a LIP.

IV. SCOPE:

A. This policy addresses the OPPE of LIP/APPs who are currently exercising clinical privileges at SHC. Concerns identified by OPPE may be referred to the CIC/Medical Staff Quality Committee for appropriate action or may be considered through the reappointment process.

B. During OPPE under this policy, the LIP/APP is NOT considered to be "under investigation" for the purposes of reporting requirements.

C. This policy does NOT address the Initial Focused Professional Practice Evaluation (IFPPE) required to establish current competency of newly appointed LIP/APPs, LIP/APPs applying for new privileges or LIP/APPs returning to active practice after a prolonged period of inactivity (refer to SHC Policy 'Initial Focused Professional Practice Evaluation (IFPPE) for New Providers, New Privileges).

V. RESPONSIBILITY:

A. Primary Responsibility: Service/Department Chief

1. Annual review, approval, and appropriate updates of service specific OPPE metrics; Periodic review of all assigned staff's OPPE metrics as part of Ongoing Professional Practice Review, with emphasis on facilitating medical staff member's understanding of the OPPE process in relation to their own continual improvement and performance opportunities.

B. Medical Staff:

1. The primary responsibility of the medical staff during the OPPE process is to understand their data relative to their peers, to recognize OPPE as a starting point for identifying improvement opportunities and that it is used to understand differences in performance relative to expectations.

C. Oversight Responsibility: Medical Executive Committee (MEC)

1. Ensure each LIP/APP's clinical competence and professional behavior are reviewed on an ongoing basis.

D. Facilitator Responsibility: Medical Staff Services Department

1. Facilitate periodic review of OPPE and documentation of completion by Service/Department Chiefs; ensure complete and accurate recredentialing files are maintained for all Medical Staff.
2. Escalate reviewer non-compliance to Chief of Staff (or designee) as appropriate.

E. Data Support: Quality Patient, Safety and Effectiveness Department (QPSED)/Medical Staff Quality Committee.
1. Lead annual review, approval of OPPE metrics and complete updates to OPPE Metrics reporting platform.

VI. PROCEDURE:

A. Periodic review and approval of OPPE metrics
1. The Quality, Patient Safety and Effectiveness Department staff facilitates periodic review of all service specific OPPE metrics as directed by the medical staff for these reviews, and ensures updates are made to the OPPE data platform available to Reviewers for their assigned staff, and to each LIP/APP for their own awareness and review.
   a. Compile current metrics, benchmarks, and targets for each service
   b. Meet with each Service/Department Chief to review and consider changes based on their service specific needs and goals
   c. Ensure new metrics are reviewed and approved by MEC
   d. Ensure all requested updates are correctly reflected in OPPE reports available to Medical Staff

B. OPPE Reports
1. Each LIP/APP can access their own OPPE report at any time through the Statit/Quality department database platform to assess their own performance and progress towards service specific goals.
2. Reviewers (Service/Department Chief or designee can access all OPPE reports they are responsible for in the Statit/Quality department database platform for the purposes of periodic review as well as recredentialing reviews.

C. Periodic LIP/APP Performance Feedback
1. Evaluation of OPPE reports will be conducted by the Reviewer every 8 months (SHC) 9 months (SHCTV). A designee may be appointed if a conflict of interest is present or if additional support is needed (link to Conflict of Interest Policy).

2. Reviewer will review the OPPE database, which includes all LIP/APPs, for their corresponding service and communicate any opportunities for improvement to the LIP/APP. This process may trigger a FPPE.
3. Reviewer will answer the attestation/questionnaire and email response to the Medical Staff Services Department. The email response, which includes the attestation/questionnaire responses, will be considered as a completed review, and saved in a secure electronic location. The Reviewer may document conclusions based on this review. Reviewer conclusion options include but are not limited to:
   a. Acceptable Performance
   b. Recommend FPPE
4. The Medical Staff Services Department will track the attestation/questionnaire submissions. Reviewers who do not respond within 1-2 weeks of due date will be contacted a second time via email, and the Chief of Staff (or designee) will receive an alert and/or escalation of non-compliance as described above.
5. Notifications will be sent to all Reviewers within the 8-month cycle (SHC) 9-month cycle (SHCTV). OPPE review is also done at recredentialing.

D. Improvement Plan Development
1. The Reviewer will determine if additional data are needed, if performance is acceptable, or if a FPPE is needed.
2. If additional data are needed, the Service/Department Chief, with the assistance of QPSED/Medical Staff Quality Committee, will define the additional evaluation.
3. Following data review, if an improvement plan is required, the Reviewer will develop the improvement plan.
4. If the results of the improvement plan monitoring indicate concerns regarding competency for specific privileges or maintaining medical staff membership, the Reviewer will inform the CIC/Medical Staff Quality Committee of the need for consideration for FPPE.

VII. CONFIDENTIALITY:

A. The following statutory language will be added to all OPPE documentation, i.e., minutes, agendas, and attachments.
1. "All OPPE documents are confidential and protected under California Evidence Code 1156, 1157."

B. E-mail communication of confidential OPPE proceedings or documentation must be encrypted and include statutory language.

C. OPPE electronic or paper documentation will be kept in confidential, protected areas. (QPSED, Medical Staff Quality Committee, or Medical Staff Services Department)
D. OPPE information will be stored in Statit/Quality department database, and/or a LIP/APP's credentials file that is available only to authorized individuals who have a legitimate need to know this information based on their responsibilities. Files may be reviewed only under the supervision of the manager of the Medical Staff Services Department or designee.
E. OPPE data will be retained permanently in the application and/or credentialing database.

VIII. COMPLIANCE:

A. All workforce members including employees, contracted staff, students, volunteers, credentialed medical staff, and individuals representing or engaging in the practice at Stanford Health Care (SHC) are responsible for ensuring that individuals comply with this policy.
B. Violations of this policy will be reported to the Department Manager and any other appropriate Department as determined by the Department Manager or in accordance with SHC policy. Violations will be investigated to determine the nature, extent, and potential risk to SHC. Workforce members who violate this policy will be subject to the appropriate disciplinary action up to and including termination.

IX. RELATED DOCUMENTS/PROCEDURES:

A. Medical Staff Bylaws, 2021
B. Medical Staff Policy: Peer Review and Focused Professional Practice Evaluation (FPPE) Policy for Medical Staff and Advanced Practice Providers (APPs)
C. Medical Staff Policy: Conflict of Interest
D. Medical Staff Policy: Medical Staff and Advanced Practice Professionals (APP) Credential File Maintenance
E. Medical Staff Policy: Credentialing and Privileging of Medical Staff and AHP/APP
F. Medical Staff Policy: SHC Policy Initial Focused Professional Practice Evaluation (IFPPE) for New Providers, New Privileges
G. California Business and Professions Code Section 805

X. APPENDICES:

A. OPPE Data – Detailed Description

XI. DOCUMENT INFORMATION:

A. Legal References/Regulatory Requirements:
   1. Code of Federal Regulations §482.22(a)(1) (Medicare Conditions of Participation)
   2. The Joint Commission Hospital Accreditation Manual 2020, Medical Staff Chapter MS.08.01.03.SHC Medical Staff Bylaws and Rules and Regulations
   3. California Evidence Code: §1156. Records of medical or dental study of in-hospital staff committee, and §1157. Proceedings and records of organized committees having responsibility of evaluation and improvement of quality of care
   4. Medical Staff Bylaws, 2021

B. Original Document
   1. Author/Date: Shelagh Nolan RN, Director, Quality Management/03/2019

C. Stored in: Manual Name

D. Review and Renewal Requirements:
   1. This policy/procedure will be reviewed and/or revised every three years or as required by change of law or practice.

E. Review and Revision History:
   1. 01/2022: Megan Mahoney MD, Chief of Staff; Ross Campbell JD (Medical Staff Council); Sharon Hartley JD, (SHC Council); Eric Bernier RN, Executive Director, Quality and Patient Safety; Eric Hadhazy, Administrative Director Quality Consulting, Analytics and Reporting; Debra Green-Oliphant PhD, Administrative Director, Medical Staff Services; Shelagh Nolan RN, Director, Quality Management

F. Approvals:
   1. 04/2016 Care Improvement Committee; Medical Executive Committee; SHC Board of Directors
   2. 10/2017 Care Improvement Committee; Medical Executive Committee; Board of Directors
   3. 07/2022 Medical Executive Committee; SHC Board Credentials, Policy & Procedure Committee, SHC TV MEC 03/2023, SHC TV Board 03/2023

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APPENDIX A: OPPE – Detailed Data Description

Appendix
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