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I. PURPOSE

The purpose of Ongoing Professional Practice Evaluation (OPPE) is to ensure that the hospital, through the activities of its medical staff, assesses a practitioner’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 STATEMENT

OPPE is conducted for each practitioner every nine months. The review is performed by the Service Chief or designee. Each service evaluates and recommends their service-specific performance targets and thresholds. The Service Chief or designee also evaluates and recommends service-based OPPE indicators ..

III. DEFINITIONS

A. Ongoing Professional Practice Evaluation (OPPE) is data collected for the purpose of assessing a practitioner’s clinical competence and professional behavior. Through this process, practitioners receive feedback for potential improvement or confirmation of achievement related to the effectiveness of their professional practice in all practitioner competencies.

B. Focused Professional Practice Evaluation (FPPE) is the focused evaluation of practitioner competence in performing a specific privilege or privileges. This process is implemented whenever a question arises regarding a practitioner’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. Practitioner Competencies

The medical staff has determined that for purposes of defining its expectations of performance, measuring performance, and providing performance feedback it will use the American College of Graduate Medical Education Framework outlined below, whenever possible.

D. Patient Care

Practitioners 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.

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E. Medical/Clinical Knowledge

Practitioners 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.

F. Practice-Based Learning and Improvement

Practitioners are expected to be able to use scientific evidence and methods to investigate, evaluate, and improve patient care practices.

G. Interpersonal and Communication Skills

Practitioners 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 teams.

H. Professionalism

Practitioners 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.

I. Systems-Based Practice

Practitioners 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 improve and optimize health care.

J. Conflict of Interest A member of the medical staff requested to perform OPPE evaluation may have a conflict of interest if he or she may not be able to render a fair and constructive opinion. Potential conflicts of interest are outlined in the Conflict of Interest for Medical Staff policy. It is the obligation of the reviewer to disclose to the Care Improvement Committee (CIC) Chair or Chief of Staff, in advance, the potential conflict. It is the responsibility of the CIC Chair or Chief of Staff to determine, on a case-by-case basis, if a potential conflict is substantial enough to prevent the individual from completing the review. The determination of the CIC Chair or Chief of Staff will prevail in any disagreement regarding the existence of a conflict.

K. Reviewer

Service Chief or designee responsible for the OPPE review. Designee is identified by the Service Chief.

IV. SCOPE

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

B. During OPPE under this policy, the practitioner 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 practitioners, practitioners applying for new privileges or practitioners 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 Chief

B. Oversight Responsibility: Medical Executive Committee (MEC)

C. Facilitator Responsibility: Medical Staff Services Department

D. Data Support: Quality Patient, Safety and Effectiveness Department (QPSED)

VI. DUTIES AND RESPONSIBILITIES

A. Chief of Staff:

1. Assures that Reviewer evaluates OPPE data at least every nine months and perform the subsequent follow-up per the process outlined in this policy

2. Assist Reviewers with improvement plans when required

B. Reviewer:

1. Evaluates OPPE reports and the subsequent follow-up per the process outlined in this policy

2. Develops improvement plans when required

3. At the time of reappointment, reviews the past two years of OPPE and FPPE data (if applicable) for individual providers and considers findings in the re-credentialing process. OPPE reports will be maintained with the corresponding reappointment.

C. Medical Staff:

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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.

D. Medical Staff Services Department:

1. Coordinates use of OPPE information into the credentialing and FPPE processes
2. Coordinates notification of the OPPE review to the Reviewer (i.e., Service Chief or designee).
3. Escalate Reviewer non-compliance and/or other concerns to the Chief of Staff or designee.

E. Quality Improvement:

1. Assembles indicator data from data systems for inclusion into OPPE reports
2. Coordinates all types of indicator data into the OPPE reports based on the current department OPPE metrics

VII. PROCESS/PROCEDURE

A. OPPE Report

1. The Quality Department staff coordinates all types of indicator data, including volume data for the OPPE report based on the current OPPE metrics.
2. The OPPE metrics will continue to be refined over time to allow a thorough evaluation of practitioner performance. The report will encompass hospital-wide indicators and specialty specific indicators.
3. At the time of reappointment, the Reviewer will review the most current 24 months of OPPE and FPPE data and document the interpretation and any improvement activities for each practitioner.

B. Practitioner Performance Feedback

1. Evaluation of OPPE reports will be conducted by the Reviewer every 9 months. A designee may be appointed if a conflict of interest is present or if additional support is needed. The Medical Staff Services Department will notify the evaluator/reviewer via email and include an attestation/questionnaire within the body of the email in support of the

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review process. The OPPE reports are available for review at any time in the Statit database.

2. Reviewer will review the OPPE database, which includes all practitioners, for their corresponding service and communicate any opportunities for improvement to the practitioner. This process may trigger a FPPE.
3. Reviewer will answer the attestation/questionnaire and email response to the SHC MSSD. 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 SHC MSSD will alert and/or escalate non-compliance as described above.
5. Notifications will be sent to all Reviewers within the 9-month cycle.

C. 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 Chief, with the assistance of QPSED, 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 of the need for consideration for FPPE.

VIII. CONFIDENTIALITY

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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. (QPSSED or Medical Staff Services department)

D. OPPE information will be stored in Statit and/or a practitioner’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.

IX. OVERSIGHT AND REPORTING OF OPPE ACTIVITY:

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A written annual report to the MEC will include a summary of all OPPE actions and compliance with this policy. The Director of the Medical Staff Services Department will produce and present this report.

A. REFERENCES:

1. The Joint Commission Hospital Accreditation Manual 2016, Medical Staff Chapter MS.08.01.03.SHC Medical Staff Bylaws and Rules and Regulations
2. SHC Policy Initial Focused Professional Practice Evaluation (IFPPE) for New Providers, New Privileges

B. APPROVALS

- Care Improvement Committee – 4/16
- Medical Executive Committee – 4/16, 10/17
- Board of Directors – 4/16, 10/17

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