MEDICAL STAFF ONGOING PROFESSIONAL PERFORMANCE EVALUATION POLICY (OPPE)

I. PURPOSE

A. To establish a process that defines the mechanism that will be employed to monitor the professional performance of the individual members of the Medical Staff and Allied Health Staff. Monitoring criteria will be designed to measure quality and safety of patient care provided based upon the scope of practice of each member and/or Allied Health Professional inclusive of specialty skills delineated within the granted privileges.

II. POLICY

A. This policy, in conjunction with the Bylaws of _____ and all regulatory and accreditation requirements, shall guide the division/departmental OPPE review in their monitoring and reporting activities. OPPE will be an on-going process that is reviewed and documented every _____ months for each member of the Medical Staff and Allied Health Professional Staff.

III. DEFINITIONS:

Ongoing Professional Practice Evaluation (OPPE)	A process through which the organized medical staff conducts ongoing evaluation of each practitioner's clinical competence and professional behavior in order to determine whether the practitioner's privileges should be continued, limited, or revoked prior to or at the time of reappointment. OPPE is a peer review activity that requires a collection of positive data on each practitioner rather than relying on the absence of negative data
Delineation of (Clinical) Privileges (DOP)	A specific patient care activity, treatment or service, or a group of closely related patient care activities, treatments or services that may be granted to a member of the medical or allied health staff by the Board of Trustees. A member of the medical staff may only perform activity/procedures for which the DOP has been granted, except in emergency situations as defined in the Medical Staff Bylaws.
Rate-based indicator	A ratio, having the number of a specific event as the numerator and the specific opportunities for the event to occur as the denominator, such as "observed deaths/expected deaths". The indicator shall have a threshold value which triggers
Rule-based Indicator	A count of the occurrence of a specific event, such as "unsigned progress notes". The indicator shall have a threshold value which triggers practice review

Quality of Care Committee	Multi-departmental committee focused on reviewing clinical care throughout organization. QOC reports to the Medical Executive Committee and Governing Body.
Insert your local committee	

IV. RESPONSIBILITY

A. Medical Staff Office (MSO)/Quality Department
   1. MSO Duties
      a. Orchestrates the schedule for departmental OPPE. Ensures the frequency for OPPE is determined by the Medical Staff.
      b. Distributes OPPE documents to individual and division chair
      c. Maintains and cohorts' feedback from the division chairs concerning the review of OPPE reports and potential performance improvement plans.
      d. Provides OPPE documents to Committee responsible for reappointment process.
   2. Quality Department
      a. Assists the Medical Staff in developing quality indicators that are measurable and representative of quality and patient outcomes
      b. Maintains systems to aggregate, analyze and trend practitioner–specific data
      c. Builds OPPE report and Division summary every ____ months

B. Division/Department Chairs
   1. Participates in the selection and development of the indicators that will be utilized for their specific department and/or division.
   2. Reviews entire Division's individual performance summary reports at prescribed frequency. (Indicate frequency here.)
   3. Identifies any metric below established thresholds or concern on the OPPE report and discusses with individual practitioner; develops a written individual performance improvement plan with the practitioner.
   4. Returns signed report to MSO within 4 weeks including any performance improvement plans.

C. Credentials Committee
   1. Review the OPPE reports for each practitioner at each reappointment.
   2. Immediately reviews the recommendations from the division chairs concerning recommendations and/or performance improvement plans including considerations for continuation or modification of individual practitioner's privileges in response to OPPE data.

D. Medical Executive Committee

1. Review and approves the OPPE Policy
2. Reviews and approves the selected indicators for each department/division
3. Reviews and approves Credentials committee reports on the performance of OPPE

V. PROCESS

A. Development of OPPE Metrics

1. OPPE metrics are developed by Division Chairs in conjunction with the Quality Department and Risk Management.
2. There must be a clear definition of the data to be collected and, in the case of a rate–based indicator, a clearly defined denominator. Each indicator, whether rate-based or rule-based, shall have a data collection period and a threshold which shall trigger further review.
3. OPPE data may include both division specific data based upon DOP for a division and data that are applicable across multiple divisions. The OPPE data must be pertinent to the individual's privileges. This could be a subset of the DOP for a division.
4. In selecting data to be used for OPPE, consideration shall be given to the 6 ACGME Core Competencies that comprise clinical competence and professional behavior. These are:
   a. Practice Based Improvement
   b. Patient Care/Procedural Skills
   c. Professionalism
   d. Interpersonal/Communication Skills
   e. System Based Practice
   f. Medical/Clinical Knowledge
5. In addition, consideration should be given to selecting data that could be indicative of quality of care or patient safety issues, obtainable, relevant, and meaningful to practitioner competency

B. The OPPE Procedure

1. The _____ department will obtain data and populate an OPPE report for each practitioner every ____ months based upon a predetermined schedule approved by the Department Chairs.
2. Reports will be sent to the individual practitioner and their corresponding division chair for review.
3. If the division chair identifies any practitioner falling below pre-established thresholds or has other concerns with the OPPE report, the division chair will attempt to determine the reason for the deviation, by drilling down into the data, facilitating chart review through the Peer Review Process, referring case(s) for Quality Reviews and /or Root Cause Analysis, discussion with others involved in the cases or whatever further investigation could help clarify the deviation including discussion with the individual practitioner. Based on this review, the division chair will make a recommendation and document the steps taken to reach this recommendation. When recommendations result in the development of an individual performance improvement plan, a copy of the plan and the plan for monitoring performance will be submitted with the summary report. Recommendations that support the suspension, modification or termination of privileges will be sent to Credentials Committee. The division chair will sign the summary report and forward to the MSO within 4 weeks of receipt of the OPPE reports.

4. Any individual performance improvement plans recommending modification, suspension or termination of privileges will be communicated directly to the Credentials Chairperson for immediate facilitation. All other individual performance improvement plans generated from the OPPE reports, will be forwarded to the Committee at the next regularly scheduled meeting. It will be the responsibility of the _____ to supply aggregate data by practitioner and make it available for their review. The Performance Improvement Plan must address the expected level of improvement in measurable terms, frequency at which monitoring will occur and anticipated time frame for acceptable performance.
5. Once a practitioner has satisfactorily completed a performance improvement plan, the division chair will forward the results of the performance improvement plan to the MSO for Credentials Committee review.

6. If a practitioner has not satisfactorily completed a performance improvement plan prior to the next OPPE report, the practitioner will be referred to the Credentials Committee for further action. A focused Practitioner Performance Evaluation (FPPE) will be initiated by the Committee unless they recommend modification, or termination of privileges.

7. Policy to be reviewed every 3 years.

VI. References:

See Also:

- FPPE Policy; Medical Staff Bylaws, Rules & Regulations
- The Joint Commission Hospital Accreditation Program Medical Staff Chapter January 2021