WakeMed Health & Hospitals
Medical Staff Policy

Ongoing Professional Practice Evaluation (OPPE) and Focused Professional Practice Evaluation (FPPE) Policy for Current Practitioners

**Why:** At WakeMed, our ultimate responsibility is to the safety and well-being of our patients. FPPE and OPPE have been developed to achieve this goal.

**Goal:**
To establish an ongoing, systematic, data driven process for the medical staff to evaluate practitioner performance and maintain accountabilities for addressing opportunities for performance improvement.

**Definition:** Ongoing Professional Practice Evaluation (OPPE) is defined as measurement of physician performance data by the organization to assess competency and approve privileges on an ongoing basis and to allow it to take steps to improve performance in a timely manner.

**Definition:** Focused Professional Practice Evaluation (FPPE) for performance issues require that organized medical staff develops criteria to be used for evaluating the performance of practitioners when issues affecting the provision of safe, high quality patient care are identified. The establishment of an FPPE process for performance issues is required by The Joint Commission and adequate compliance of the organization’s process is surveyed by The Joint Commission.

**Scope:**

1. This policy addresses the ongoing evaluation (OPPE) of practitioners who are currently exercising privileges as either a member of the medical staff or as a Licensed Independent Practitioner (LIP) under the evaluation of the medical staff. It also addresses the focused evaluation (FPPE) of these practitioners that arise from concerns identified by OPPE.
2. During the OPPE and FPPE process under this policy, the practitioner is not considered to be “under investigation” for the purpose of reporting requirements under the Healthcare Quality Improvement Act.
3. This policy does not address FPPE 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.

**Policy:**

1. **Selection of Practitioner Performance Measures for OPPE**
   Practitioner performance measures will be selected that:
   A. Provide data to evaluate the six Core Competencies
      - Patient Care
      - Medical Knowledge
      - Practice Based Learning and Improvement
      - Interpersonal & Communications Skills
      - Professionalism
      - Systems Based Practice
   B. Are appropriate to the practitioner’s specialty
   C. Reflect practitioner performance
   D. Can be attributed to individual practitioners.
   E. Are publicly reported data as related to the practitioner’s specialty
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These measures will utilize multiple sources of data described in the Medical Staff Performance Measurement Indicator list. Whenever applicable, the indicators should be linked to specific privileges or privilege groups.

2. **OPPE Report and Practitioner Performance Feedback**
   A. The best approach to improve practitioner performance is to provide practitioners with their own data on the general competencies on a regular basis through a Practitioner Feedback Report (PFR). These reports are available to individual practitioners upon request. Even outstanding physicians who have never been found to have potential concerns/problems with their patient care may benefit greatly and improve their performance by being provided a copy of their own data on the general competencies on a regular basis through a Practitioner Feedback Report (PFR). The same report will be used by the medical staff leaders as the OPPE report for systematic evaluation and follow-up.
   B. The OPPE report will be a starting point for identifying improvement opportunities and is not considered definitive until further evaluation, including FPPE if appropriate, is used to understand the variation in performance relative to expectations and discussed with the practitioner involved.
   C. The data is considered confidential to the individual practitioner and appropriate medical staff leaders (i.e. Department Chairs, Departmental QI Chairs, Medical Staff Quality Improvement Committee (MSQI), Medical Staff Officers, Peer Review Advisory Committee (PRAC), and Credentials Committee).
   D. Evaluation of practitioner lacking sufficient clinical activity will be addressed in the Low Volume/No Volume Policy.
   E. The report may contain indicators for feedback. The Committee will determine which indicators are most useful for reappointment decisions.
   F. Over time as indicators are added to the report, the medical staff should receive sufficient notice prior to the use of any new indicators in credentialing and privileging decisions.

3. **Responsibility for Indicator Data Evaluation for OPPE**
   The evaluation of OPPE data will be conducted on an ongoing basis by the appropriate department chair or designee, with oversight provided by the PRAC. This evaluation will be either based on rate and rule indicators exceeding defined thresholds or from the results of case review.

4. **Thresholds for Focused Professional Practice Evaluation**
   In most instances, routine OPPE reports will NOT identify areas of concern. However, if the results of OPPE indicate a potential concern with practitioner performance, based on the data exceeding a predetermined medical staff indicator acceptable level, FPPE may be indicated. In addition, a single serious or egregious event may also initiate FPPE. FPPE may be initiated through the procedure described below. (Attachment 1: Focused and Ongoing Professional Practice Evaluation Circumstances requiring Monitoring and Evaluation)

**Procedure:**

1. **FPPE for Case Reviews:**
   If the findings of the departmental QI Committees or the MSQI on an individual case review, or a series of case reviews, identify the potential for individual practitioner improvement, the following procedure will be used for conducting FPPE:
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A. The departmental QI/MSQI Chair will communicate the potential practitioner improvement opportunities to the appropriate Department Chair.
B. The Department Chair will communicate the improvement opportunities with the practitioner to determine the best approach.
C. Following the communication, the Department Chair will document the conclusions and whether there is either a need to obtain additional data or if a performance improvement plan is required.

2. FPPE for Routine OPPE Report Review:
   A. The Department Chair will review the semi-annual OPPE reports of the department members within 30 days of distribution and communicate with the practitioner those indicators rated “Exceeds Threshold” if any indicators have two sequential reporting periods in the Exceeds threshold Category.
   B. After follow-up, the Department Chair will document conclusions for each indicator that was communicated to the practitioner and whether there is either a need for further obtaining additional data or if an improvement plan is required
   C. The MSQI Chair will follow-up with the department chair if no communication is received within 30 days of the report being distributed regarding areas that Exceeds Threshold.

Improvement Plan Development:

Whether based on case reviews or OPPE monitoring, the following procedure will be used for developing improvement plans:

1. The Department Chair, with the assistance of the MSQI/PRAC chair or designee, will determine if additional data is needed or if the current data indicates an improvement plan should be developed.
2. If additional data is needed, the Department Chair, with the assistance of QI support, will define the data study.
3. Following review of the additional data, the department chair will communicate to MSQI/PRAC regarding whether an improvement plan is required.
4. If it is agreed an improvement plan is indicated, the Department Chair with the assistance of the MSQI Chair or designee, will develop the improvement plan utilizing the following elements:
   A. Clearly state the opportunity for improvement;
   B. Specific aim of goal to be attained and timeframe;
   C. Proposed action;
   D. Follow-up measurement; and
   E. End game- release from FPPE or curtailment of privileges.

Improvement Plan Accountability

1. The Department/QI Chair will monitor adherence to the improvement plan for compliance and report his/her findings to the MSQI.
2. The MSQI Chair will report to the MEC regarding practitioner improvement plans developed and any instance where a plan is not developed when requested or is perceived to be inadequate.
3. The support staff will track results and report regularly on the status to the MSQI Committee
4. If the results of the improvement plan monitoring indicate concerns regarding competency for specific privileges or maintaining membership, the MSQI Chair will inform the MEC of the need for formal investigation or corrective action as determined in the Medical Staff Bylaws.
Use of OPPE and FPPE at reappointment

1. At the time of reappointment, the Department Chair will review the past two years of OPPE and FPPE data and document the interpretation and any improvement activities for each indicator that required follow up during that period of time.

2. The Department Chair will also be provided an interim report of rule indicator events and case review results since the last OPPE report.
Attachment 1: Circumstances Requiring Monitoring and Evaluation

**Purpose:** To define the process under which focused professional practice evaluation (FPPE) is performed as defined by Elements of Performance for MS.08.01.01.

**Criteria for Review:**

1. To evaluate a practitioner granted initial privileges or an established practitioner requesting additional privileges not part of the common core for his/her specialty.
2. When practitioner performance does not meet expected standard of practice.
3. When a practitioner’s initial FPPE is extended.

**Process:** The Medical Staff has defined the following steps to implement focused practice evaluation:

1. Identify new appointments and grant associate status for one year.
   a) Under the supervision of the Department Chair or designee.
   b) Evaluation of performance is carried out by any of the following:
      i. Chart review, monitoring clinical practice patterns, simulation, proctoring, external review (see note when indicated*) and discussion with other individuals involved in the care of the patient
      ii. The Department Chair determines the length of monitoring based on practitioner performance.
   c) The Department Chair, upon recommendation of the Vice Chair, determines if performance meets standard of practice.
   d) If performance meets standards of practice, at the end of the Initial FPPE period (6 months), the practitioner will be monitored through the OPPE process.
   e) If performance expectations are not met, the Vice Chairman can recommend an extension of the FPPE status, change in privileges, or reduction in privileges to the Department Chairman.

2. Practitioners with full privileges fall under the ongoing professional practice evaluation (OPPE) for performance monitoring:
   a) OPPE includes ongoing review of data sources such as:
      i. Peer Review results
      ii. Documentation audits
      iii. Medical records
      iv. Core Measures
      v. Department specific indicators
      vi. Other sources of available and reliable data

3. Performance monitoring is used to identify acceptable performance and circumstances for focused review such as:
   a) Variant data, patterns or negative trends
   b) Trigger events, such as significant departure from the standard of care or quality issue.

4. When potential performance concerns are identified, focused professional practice evaluation may be recommended and an action plan is developed.
   a) By the Department Chair or designee with the practitioner
   b) Is documented in the practitioner’s QI file
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c) Will contain performance expectations and measures to assure compliance
d) The duration of focused performance will be determined by the Department Chair in collaboration with the Vice Chair.
e) Monitoring of the practitioner performance plan is the responsibility of the Department Chair. Types of monitoring may include but are not limited to:
   i. Case review
   ii. Proctoring
   iii. Peer Review
f) Actions employed to resolve performance issues:
   i. Continuing education
   ii. Additional training
   iii. Referrals to NC PHP
   iv. Change in privileges
   v. Others

5. Actions to directly address performance issues may include:
   a) Immediate plans to correct performance
   b) Request a Focused Peer Review Process as defined in the Medical Staff Policy Ongoing Professional Practice Evaluation (OPPE) and Focused Professional Practice Evaluation (FPPE) Policy for Current Practitioners

6. Relevant patterns and trends identified by the Department Chair are reported to the MEC to take appropriate action as needed.

External Peer Review (EPR):

Circumstances for EPR may include but are not limited to the following:

- Lack of internal expertise: when no one on the medical staff has adequate expertise in the specialty under review; including new procedures or technology or the only practitioners on the medical staff with that expertise are determined to have a significant conflict of interest
- Ambiguity: when dealing with vague or conflicting recommendations from internal reviewers or medical staff committees.
- Legal concerns: when the medical staff needs confirmation of internal findings or an expert witness for potential litigation or fair hearing
- Credibility: when or if the medical staff or board needs to verify the overall credibility of the IPR process typically as an audit of IPR findings.
- Benchmarking: when an organization is concerned about the care provided by its physicians relative to best practices and wishes to better define its expectations and as future quality monitoring to determine whether improvement has been achieved.
- Lack of internal resources: when the medical staff has the expertise but lacks sufficient time to perform EPR.
- In addition, the MEC or governing board may require external peer review in any circumstances deemed appropriate by either of these bodies.

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