

**SANTA ROSA
MEMORIAL HOSPITAL
AND AFFILIATED ENTITIES**

**ONGOING PROFESSIONAL
PRACTICE EVALUATION
POLICY
(OPPE)**

ONGOING PROFESSIONAL PRACTICE EVALUATION POLICY (OPPE)

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ONGOING PROFESSIONAL PRACTICE EVALUATION POLICY (OPPE)

1. ***Scope of Policy.*** All Practitioners who provide patient care services at Santa Rosa Memorial Hospital (the “Hospital”) are subject to ongoing professional practice evaluation (“OPPE”).
2. ***Definitions.***
 - (a) “Medical Staff Leader” means any Medical Staff officer, service chair, or committee chair.
 - (b) “OPPE” means the ongoing review and analysis of data that helps to identify any issues or trends in Practitioners’ performance that may impact on quality of care and patient safety. OPPE is a significant Medical Staff responsibility. It fosters an efficient and effective evidenced-based reappointment process. It is also part of the effort to provide educational opportunities that help all Practitioners consistently provide quality, safe, and effective patient care. A flow chart of the OPPE process is attached as **Appendix A**.
 - (c) “Practitioner” means any individual who has been granted clinical privileges and/or membership by the Board, including, but not limited to, members of the Medical Staff and Allied Health Professionals.
 - (d) “PPE Support Staff” means the clinical and non-clinical staff who support the professional practice evaluation (“PPE”) process generally and the OPPE process described in this Policy. This may include, but is not limited to, staff from the Performance Improvement and/or Medical Staff Administration departments.
3. ***OPPE Data to Be Collected.***
 - 3.A ***Service Data Elements.*** Each Service, in consultation with the PPE Support Staff and Chief Medical Officer, shall determine the OPPE data to be collected for each Practitioner in the Service and, where appropriate and relevant, the expected parameters of performance for each data element. Depending on the size of the Service, data elements may be identified for Specialties within the Service. All Service data elements and parameters shall be approved by the Professional Practice Evaluation Committee (“PPEC”). **Appendix B** includes a list of data elements that are currently in effect for each Service.
 - 3.B ***Data Elements for All Practitioners.*** The PPEC shall establish OPPE data elements that are relevant to all Practitioners on the Medical Staff (regardless of Service) and, where appropriate and relevant, the PPEC shall also establish the expected parameters of performance for each data element. **Appendix C** includes a list of data elements that are currently in effect for all Practitioners.

3.C **Guidelines.** The following guidelines will be used in determining the OPPE data elements to be collected:

- (1) quality and performance improvement department representatives shall be consulted to inform and support the assessment process;
- (2) medical informatics/information technology department representatives shall be consulted to determine the available information system capabilities;
- (3) for Service OPPE elements, the type of data that would reasonably be expected to reflect clinically significant issues for the specialties within the Service shall be considered; and
- (4) when possible, the expected parameters of performance shall be based on relevant clinical literature and nationally recognized benchmarks.

4. **OPPE Reports.**

4.A **Reports.** An OPPE report for each Practitioner shall be prepared at least every eight months. A copy shall be placed in the Practitioner's file and considered in the reappointment process and in the assessment of the Practitioner's competence to exercise the clinical privileges granted. A Practitioner's OPPE report may include:

- (1) the Practitioner's activity during the OPPE period (i.e., numbers of procedures, admissions, and consults);
- (2) clinical performance as measured by the approved Service and Medical Staff OPPE data elements listed in Appendices B and C;
- (3) the number of Informational Letters sent pursuant to the Professional Practice Evaluation Policy (Peer Review) (Informational Letters are a non-punitive, educational tool to help improve Practitioner performance through the use of feedback);
- (4) the number of cases reviewed pursuant to the Professional Practice Evaluation Policy (Peer Review) and the dispositions of those cases; and
- (5) the number of complaints addressed pursuant to the Medical Staff Professionalism Policy and the disposition of those matters.

4.B **Review by PPE Support Staff, Medical Staff Leader, and Service Chair.**

- (1) **Initial Review.** The PPE Support Staff will review each OPPE report. As needed, the PPE Support Staff will consult with the Chief Medical Officer

and/or a Medical Staff Leader (e.g., the PPEC Chair, a Medical Staff Officer, or the Service Chair).

- (2) ***Data Within Expected Parameters of Performance/No Concerns.*** If the OPPE report reveals that the Practitioner's data is within, or better than, expected performance parameters and no other issues or concerns are noted, the PPE Support Staff shall provide a copy of the report to the Practitioner or notify the Practitioner how to access the report. The PPE Support Staff shall also indicate that the report is being provided solely for the Practitioner's information and use in his or her patient care activities and that no response and no further review are necessary at that time. The PPE Support Staff shall notify the applicable Service Chair of these determinations.

- (3) ***Data Not Within Expected Parameters of Performance, Raises Questions, and/or Based on Low Volume.*** If performance is not within expected parameters or raises any questions or concerns, or if the Practitioner has had insufficient volume at the Hospital to generate meaningful data, the PPE Support Staff shall:
 - (a) provide a copy of the report to the Service Chair; and
 - (b) provide a copy of the report to the Practitioner or notify the Practitioner how to access it and indicate that it has been forwarded to the Service Chair for review. The Practitioner will also be informed that the Service Chair will contact the Practitioner if he or she determines that any response or further review is required.

- (4) ***Review by Service Chair.***
 - (a) When an OPPE report is forwarded to the Service Chair, he or she shall make one of the following determinations:
 - (i) The data do not reflect a pattern or issue regarding the Practitioner's performance that requires further review. In such case, the Service Chair shall document his or her findings and include them in the Practitioner's file along with the OPPE report.
 - (ii) The data reflect a pattern or issue regarding the Practitioner's performance that requires further review. In such case, the Service Chair shall notify the PPE Support Staff and proceed in accordance with the Professional Practice Evaluation Policy (Peer Review) or the Medical Staff Professionalism Policy, as applicable.

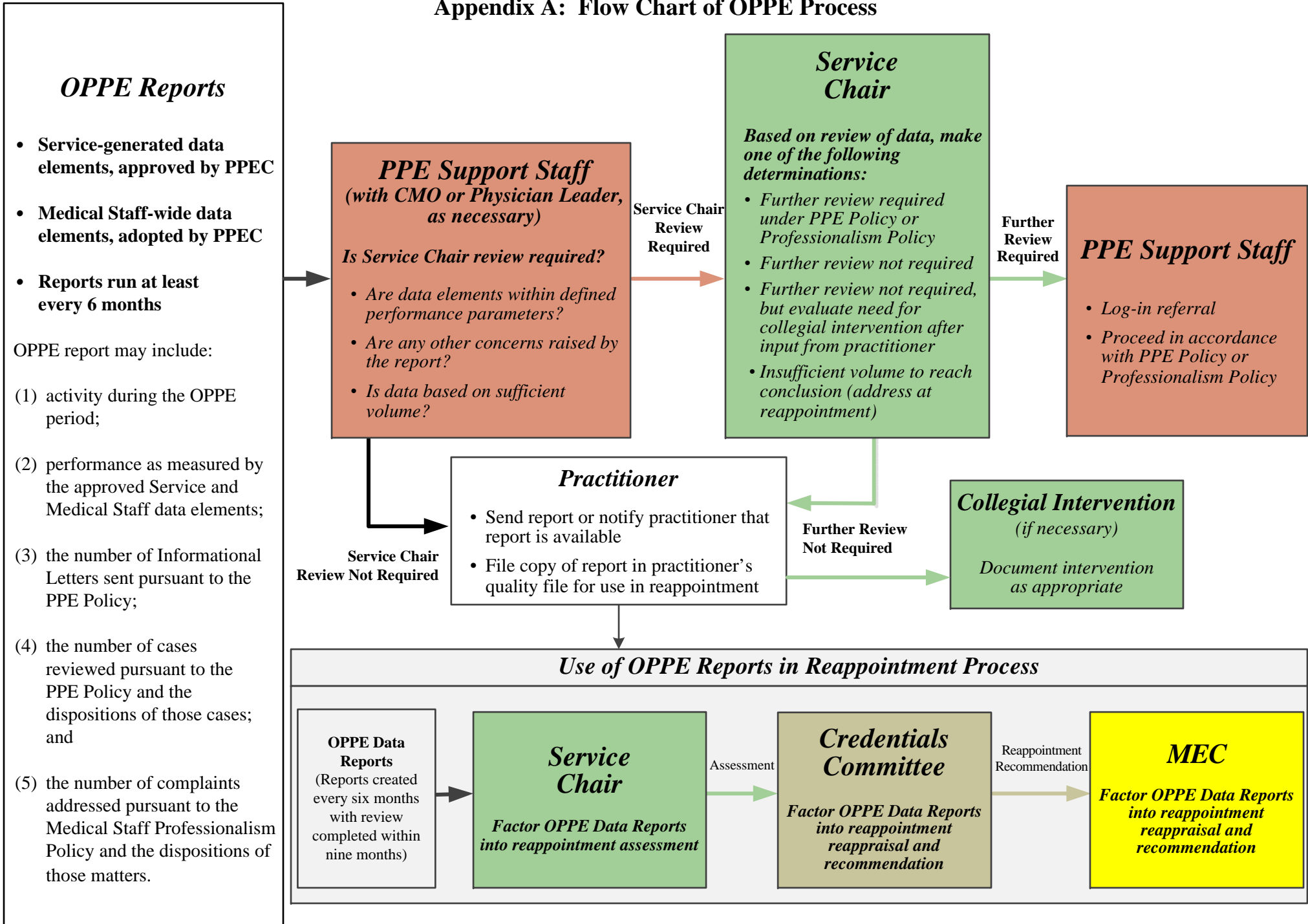
- (iii) The data reflect a potential issue with the Practitioner's performance, but the issue is not so significant that further review is necessary under the Professional Practice Evaluation Policy (Peer Review) or the Medical Staff Professionalism Policy. In such case, the Service Chair shall obtain the Practitioner's input and then, if warranted, conduct a collegial intervention (as defined in Section 4.C of the Professional Practice Evaluation Policy) with the Practitioner. Any such collegial meeting should be documented via a follow-up letter to the Practitioner, with such documentation being included in the Practitioner's file along with the OPPE report.
 - (iv) The data reflect insufficient activity at the Hospital to evaluate the Practitioner's practice, in which case the Service Chair shall document this conclusion so that the OPPE report is properly evaluated as part of any application for reappointment submitted by the Practitioner. (At reappointment, procedures set forth at §5.B.1 of the Credentialing Policy for obtaining information from Medical Staff members with minimal activity shall be followed.)
- (b) In making determinations pursuant to this section, the Service Chair may review the underlying cases that make up the data or other relevant information.

Adopted by the Medical Executive Committee on March 13, 2018.

Approved by the Board on March 27, 2018.

SANTA ROSA MEMORIAL HOSPITAL

Appendix A: Flow Chart of OPPE Process



APPENDIX B

OPPE DATA ELEMENTS BY SERVICE

This Appendix lists OPPE data to be collected for Practitioners in each Service and, where applicable, the expected parameters of performance for each data element. This Appendix may be modified by the PPEC at any time and approved by the Medical Executive Committee. Notice of any revisions shall be provided by the PPEC to the Medical Staff.

	Core Measure Focus Group / Population – Measure -	Patient Safety Indicators (AHRQ)+C2:D4	Department Specific
Anesthesiology		PSI 6 Iatrogenic Pneumothorax Rate associated with central line placement by Anesthesia provider	Death within 48 hours of anesthesia
			Post op MI/Stroke within 48 hours of procedure
CVMS (CARDIOVASCULAR Surgery)	Mort 30 CABG - 30 Day Mortality rate	PSI 4 Death Rate among Surgical Inpatients with Serious Treatable Complications	Post op Renal Failure
	MORT 30- Acute Myocardial Infarction (AMI) 30 days post discharge	PSI 6 Iatrogenic Pneumothorax Rate	Medication Management (i.e. Beta blockers/ARBs) (STS)
	Mort 30 - Heart Failure (HF) 30 day mortality	PSI 11 Postoperative respiratory failure rate	Surgical Site Infection
	Readm 30 CABG - 30 Day readmission rate	PSI 9 Perioperative hemorrhage or hematoma rate	Procedure volume
		PSI 12 Post op pulmonary embolism or deep vein thrombosis rate	HCAHPS - Cath lab (Physician Communication)
		PSI 13 Postoperative sepsis rate	
		PSI 14 Postoperative wound rate dehiscence rate	
		PSI 15 Accidental puncture or laceration rate	
Interventional Cardiology	AMI 1 Aspirin on Arrival	PSI 6 Iatrogenic Pneumothorax Rate	Median time to immediate PCI for STEMI patients (in minutes)
	AMI 7 a Fibrinolytic Therapy (co mins)	PSI 11 Postoperative respiratory failure rate	Proportion of STEMI patients receiving immediate PCI w/in 90'
	Time to PCI	PSI 9 Perioperative hemorrhage or hematoma rate	
	MORT 30 Acute Myocardial Infarction (AMI) 30 days post discharge	PSI 12 Post op pulmonary embolism or deep vein thrombosis rate	
	Mort 30 - Heart Failure (HF) 30 day mortality	PSI 13 Postoperative sepsis rate	
		PSI 14 Wound Dehiscence	
Medicine/ Family Medicine	MORT 30- Acute Myocardial Infarction (AMI) 30 days post discharge	PSI 4 Death rate among Surgical inpatients with serious treatable complications	Surgical Site Infections for the practitioners with OB Privileges.
	Mort 30- Chronic Obstructive Pulmonary disease (COPD) 30 day mortality	PSI 11 Post op respiratory failure	Sepsis Mortality
	Mort 30-Pneumonia (PN) 30 day mortality	PSI 12 Post op PE/VTE	

	Mort 30 - Heart Failure (HF) 30 day mortality		
	PC01 Elective delivery for those FMP who provide OB services		
	VTE6 Potentially Preventable VTE/PE (this measure is outcome based but includes prophylaxis requirement too.		
Internal Medicine/Hospitalist Service	MORT 30- Acute Myocardial Infarction (AMI) 30 days post discharge	PSI 4 Death rate among Surgical inpatients with serious treatable complications	Sepsis Mortality against Peer group
	Mort 30- Chronic Obstructive Pulmonary disease (COPD) 30 day mortality	PSI 6 Iatrogenic Pneumothorax associated with insertion by IM/Hospitalist provider	All Cause 30 Day Readmission
	Mort 30-Pneumonia (PN) 30 day mortality	PSI 12 Post op PE/DVT	
	Mort 30 - Heart Failure (HF) 30 day mortality	PSI 13 Post op Sepsis	
Nephrology	Serum phosphorus (NQF endorsed)	PSI-7 Central Venous Catheter-Related Blood Stream Infection rate as pertains to DRG 585.6 (end stage renal disease)	30 Readmission for chronic hemodialysis patients
	Patients on Erythropoiesis Stimulating Agent (ESA) Hgb > 12.0 (NQF, AMA endorsed)		Overall Mortality against external peer group Dialysis risk adjusted
Neurology	STK 1 VTE Prophlaxis	PSI 6 Iatrogenic Pneumothorax associated with insertion by Neurologist	Stroke Readmission
	STK 2 Discharge on Antithrombotic Therapy		Stroke Mortality
	STK 3 Antithrombotic Therapy for Atrial Fibrillation/Flutter		
	STK4 Thrombolytic Therapy		
	STK 5 Antithrombotic Therapy By End of Hospital Day 2		
	STK 6 Discharged on Statin Medication		
	STK 8 Stroke Education		
	STK 10 Assessed for Rehabilitation		

Neurosurgery	VTE 6 Potentially Preventable VTE/PE (this measure is outcome based but includes prophylaxis requirement too.	PSI 4 Death rate among Surgical inpatients with serious treatable complications	Postoperative Mortality
	STK 8 Stroke Education	PSI 6 Iatrogenic Pneumothorax	Surgical Site infection
		PSI 9 Postoperative Hemorrhage or Hematoma	
		PSI 11 Postoperative Respiratory Failure- ? Aspiration Pneumonia	
		PSI 12 Perioperative Pulmonary Embolism or Deep Vein Thrombosis	
		PSI 13 Postoperative Sepsis	
		PSI 15 Accidental Puncture or Laceration	
Orthopedic Surgery	READM 30- Hips and Knees: 30 Day All Cause Readmission following elective Total Hip and Total Knee Arthroplasty	PSI 6 Iatrogenic Pneumothorax	30 day all Cause Readmission w/in 30 days
	VTE 6 Potentially Preventable VTE/PE (this measure is outcome based but includes prophylaxis requirement too.	PSI 9 Postoperative Hemorrhage or Hematoma	Surgical Site Infections
	Mortality	PSI 11 Postoperative Respiratory failure	
		PSI 12 Perioperative Pulmonary Embolism or Deep Vein Thrombosis	
		PSI 13 Postoperative Sepsis	
Lab/ Pathology			% of consultations diagnosed < 20 mins
			% of specimens signed out < 1 day
Perinatal	PC – 01 Elective Delivery - < 39 weeks	PSI 4 Death rate among surgical patients with serious treatable complications	Pediatric readmission within 30 days
	PC – 02 Cesarean Section	PSI 9 Post op Hemorrhage or hematoma	Maternal Mortality
	PC – 04 Health Care Associated Bloodstream Infections in Newborns	Birth Trauma Rate – Injury to Neonate	
	PC 05 Exclusive Breast Milk Feeding	PSI 18 Obstetric Trauma Rate (3-4 th degree laceration) – Vaginal Delivery With Instrument	
		PSI 19 Obstetric Trauma Rate (3-4 th degree laceration) – Vaginal Delivery Without Instrument	
Pediatrics	CAC 2 Patients with Asthma Discharged on Steroid Inhaler		CAC 2 Patients with Asthma Discharged on Steroid Inhaler
	CAC 3 Home Management Plan of Care Given to Patient/ Caregiver		CAC 3 Home Management Plan of Care Given to Patient/ Caregiver
Radiology	OP 8 MRI Lumbar Spine for Low back pain	PSI 9 Postoperative Hemorrhage or Hematoma	Mammography reviews
	OP-10 Abdomen CT use of Contrast Material	PSI 13 Postoperative Sepsis	Imaging: Double reads completed
	OP 13 Cardiac Imaging for Preoperative risk assessment for Non Cardiac low risk surgery	PSI 15 Accidental Puncture or Laceration	

	OP 14 Simultaneous use of Brain CT and Sinus CT		
Surgery	VTE 6 Potentially Preventable VTE/PE (this measure is outcome based but includes prophylaxis requirement too).	PSI 4 Death Rate among Surgical Inpatients with Serious Treatable Complications	Postoperative Mortality
Medicine-GI	OP 29 Endoscopy/Polyp surveillance: Appropriate follow up for average risk patients	PSI 9 Perioperative Hemorrhage or Hematoma	Patient Volume for *endoscopy
	OP30 Endoscopy/Polyp surveillance: Colonoscopy interval for patients with a history of Adenomatous Polyps- Avoidance of inappropriate use.	PSI 15 Accidental Puncture or Laceration	<i>Gastrointestinal Hemorrhage Mortality Rate (Can be tracked through Premier)</i>
Emergency Medicine	ED Throughput - Median Time from ED Arrival to ED Departure for ED patients / Admitted patients	PSI 6 Iatrogenic Pneumothorax Rate	ED Return within 72 hours followed by admission
	AMI - Aspirin at arrival	PSI 15 Accidental Puncture or Laceration Rate	**Sepsis Bundle Compliance - 3 hour
	STK - Thrombolytic Therapy		
	Outpatient AMI / Chest Pain - Aspirin at Arrival		
	Outpatient AMI-Median Time to Xfer to Another Facility for Acute Coronary Intervention		
	Outpatient AMI/Chest Pain - Median Time to ECG		
	Outpatient Stroke - Head CT/MRI Results for Stroke patients w/ Scan Interp w/in 45 min of Arrival		
	Outpatient Pain Management - Median Time to Pain Management for Long Bone Fracture		
Critical Care	Sepsis 3 hour bundle (ABX, Lactate, IV, Blood Culture)	PSI 6 Iatrogenic Pneumothorax	Return to ICU within 48 hours
	VTE6 Potentially Preventable VTE/PE (this measure is outcome based but includes prophylaxis requirement too).		Catheter Associated Urinary tract infections (CAUTI)
	MORT 30- Acute Myocardial Infarction (AMI) 30 days post discharge		
	Mort 30- Chronic Obstructive Pulmonary disease (COPD) 30 day mortality		
	Mort 30-Pneumonia (PN) 30 day mortality		
	Mort 30 - Heart Failure (HF) 30 day mortality		

Examples of Service-specific OPPE data elements to be considered include:

- *complication rate;*
- *infection rate;*
- *unplanned return to surgery rate;*
- *nulliparous term singleton vertex (“NTSV”) C-section rate;*

- *data reported to relevant registries (for example, those operated by the Society of Thoracic Surgeons (“STS”) and the American College of Cardiology (“ACC”));*
- *compliance with evidence-based practice protocols; and*
- *compliance with core measures as defined by the Centers for Medicare & Medicaid Services and/or the Joint Commission.*

APPENDIX C

**OPPE DATA ELEMENTS
FOR ALL PRACTITIONERS**

This Appendix lists OPPE data to be collected for all Practitioners, regardless of specialty. Where applicable, it also lists the expected parameters of performance for each data element. This Appendix may be modified by the PPEC at any time and approved by the Medical Executive Committee. Notice of any revisions shall be provided to the Medical Staff.

<i>Data Elements</i>	<i>Expected Performance Parameters</i>

Examples of Medical Staff-wide OPPE data elements to be considered include:

- *risk-adjusted mortality;*
- *ALOS;*
- *use of approved abbreviations;*
- *compliance with other medical record requirements (timeliness of H&Ps, dating, timing, and signing orders);*
- *patient satisfaction scores; and*
- *pharmacy cost per case.*