<table>
<tr><td>The Miriam Hospital:
Administrative Manual</td><td>Subject:
Ongoing Professional Practice Evaluation (OPPE) Policy</td><td>File Under:
MS-01
Medical Staff</td></tr>
<tr><td>Issuing Department:
Quality Management</td><td></td><td>Latest Revision Date:
March 31, 2008</td></tr>
<tr><td>Original Procedure Date:
March 10, 2008</td><td>Page 1 of 3</td><td>Approved By:

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(Director)

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(Executive)</td></tr>
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ONGOING PROFESSIONAL PRACTICE EVALUATION (OPPE) POLICY

I. **PURPOSE**: It is the policy of The Miriam Hospital to use the information produced through execution of the Hospital Quality Improvement Plan to enable providers and their supervisors to assess and improve, as indicated, individual performance. This is accomplished through the provision of individual feedback performance data presented, whenever possible, with relevant comparative performance.

This ensures that there is a standard and objective process with sufficient information available to confirm the current expectations for performance of the Active medical staff and credentialed Allied Health Professionals (nurse practitioners, physician's assistants and Certified Registered Nurse Anesthetists) - collectively Licensed Independent Practitioners (LIP's). Ongoing professional practice evaluation (OPPE) information is used to assess practitioner performance. It is factored into the decision to maintain or change existing privileges and is incorporated into the reappointment process. This information is part of the peer review process and is subject to the protection of Health Care Quality Improvement Act of 1986 and State law.

II. **DEFINITIONS:** LIP's will receive ongoing department/specialty specific feedback in the following areas on a regular basis. The Hospital wide Quality Management Data Base will be the primary repository of all data available. Each department will be responsible for determining which metrics will be evaluated as well as appropriate thresholds for satisfactory competency.

1. **Patient care**: A measure of the medical quality of care provided to patients. Examples include the quality core measures being tracked by the Departments
2. **Interpersonal/Communication**: A measure of the interpersonal skills and use of appropriate written and oral methods of communication by the provider. Examples include complaints and/or staffs disciplinary issues normalized to patient care volume or teaching evaluations.
3. **Practice based learning**: A measure of how well new information and/or feedback on practice experience are translated into changes in practice. Examples include M&M reviews and quality indicator performance.

4. **Medical knowledge**: A measure of how well the provider keeps current with recent trends and changes in literature that form the basis of practice. Examples include CME earned.
5. **Systems based practice**: A measure of how the systems in use at The Miriam Hospital are used to provide care to patients. Examples include POM use, medication errors, and compliance with he universal protocol and other safety policies.
6. **Professionalism:** A measure of the provider's maintenance of the standards of conduct expected of members of the active staff. Examples include medical records delinquencies and/or suspensions.

III. **SCOPE**: This Policy applies to all LIP's who have been granted clinical privileges or patient care services at The Miriam Hospital. Performance parameters are reviewed semi-annually by the Chief/Director of the department/division, and feedback is provided to the LIP on a regular basis.

IV. PROCESS

Responsible Person	Task
Department Chief/Div. Director	Determine quality indicators and establish thresholds and targets for satisfactory performance for all competencies. If hospital-wide information is not being utilized, the department/division will provide electronic information into the Hospital wide Quality database through the department indicator reporting process.
Medical Staff Office	Provide to Quality Management the list of department members subject to Ongoing Professional Practice Evaluation review.
Quality Management	Provide reports from Performance Insight with the names of the department members and related quality indicator data. These reports highlight physicians whose performance is below the established performance threshold. Send form electronically to department Chief. The Chief will provide the LIP's in the department with their individual performance reports.
Department Chief/Div. Director	Action plans will be implemented for LIP's whose performance *is below threshold*. Reports of action plans will be entered into the Hospital wide Quality database and forwarded to the Credentials Committee for monitoring. Feedback to the LIP will be provided and action plan enforced.

V. GUIDELINES

Procedural or cognitive skills that cross-departmental boundaries will require the development of common indicators and minimum thresholds for acceptable practice (as described in the cross-specialty credentialing process). Coordination and development of the cross-departmental indicators and thresholds will be the responsibility of Clinical Quality Council (CQC) in conjunction with the MEC.

Competency assessment will be done in a standardized manner for each department, with patient care, interpersonal and systems based practice elements being reported semi-annually, and the remainder reported on a yearly basis.

Analysis of performance will occur at the individual department level, and will be discussed at the CQC as part of the department/divisional routine reports. For those indicators that are hospital-wide the analysis will also be reported to the Profession and Academic Affairs (PAA) committee of the Board of Trustees on a semi-annual basis where applicable.

VI. Consequences of Poor Performance:

LIP's whose performance is found to be below the department's established threshold for competence will be required to comply with the plan for improvement established in conjunction with his/her department's Chief. If the LIP repeatedly performs below threshold expectations the Chief will require and implement a Focused Professional Practice Evaluation (see FPPE policy).

VII. Responsibilities of the Medical Staff Office and Quality Management Department:

1. The Medical Staff Office will receive a copy of each LIP's report and will place that in the quality section of his/her credentials file. This will be available to the Credentials Committee at the time of re-credentialing.
2. The Quality Management Department will be responsible for working with each department on an annual basis to review the continued relevance of the indicators chosen as well as the thresholds and targets, and will assist with updating them as appropriate.

References:

Joint Commission Standards Medical Staff 4.10, 4.20, 4.30, 4.40, 4.45
The Miriam Hospital Focused Professional Practice Evaluation Policy
The Miriam Hospital Quality Improvement Plan Admin Policy 11b