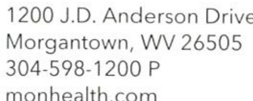


Welcome to the Mon Health System Medical Staff! Attached you will find information regarding Mon Health's Focused and Ongoing Professional Practice Evaluation process (FPPE/OPPE) process. These processes of review are required by Joint Commission standards. Attached you will find the following:

- Explanation of Physician Focus Profile – *We utilize Premier's Physician Focus as a tool to evaluate physicians that practice within the Mon Health Medical Center.*
- Example of Physician Focus Profile – *Indicators on the Profile are in accordance with our FPPE and OPPE Policies and Procedures.*
- Example of Manual OPPE/FPPE Profile utilized for when a Physician Focus Profile is unavailable, or if there is low or no activity at Mon Health.
- Mon Health System Focused Professional Practice Evaluation Policy and Procedure
- Mon Health System Ongoing Professional Practice Evaluation Policy and Procedure
- Mon Health System Acceptable Abbreviations Policy and Procedure and attachment of official "Do Not Use" list.

In accordance with the Joint Commission Standards, the Medical Staff By-Laws, and the FPPE Policy and Procedure, the Focused Professional Practice (FPPE) is utilized for the initial appointment period evaluation, when requesting additional privileges, when a concern is evident through the Ongoing Professional Practice Evaluation reviews, and there may be additional instances where a Focused Review may be utilized. Please review the FPPE Policy and Procedure for more details.

In accordance with the Joint Commission Standards and the OPPE Policy and Procedure, the Ongoing Professional Practice Evaluation (OPPE) reviews are completed every 6 months once a physician has completed the initial FPPE review. Please review the OPPE Policy and Procedure for additional details.

Abbreviations continue to be an area of focus at Mon Health for all practitioners. The Abbreviation Policy and Procedure is attached for your reference. The Official "Do Not Use" List is attached for example of abbreviations not to use and suggestions for alternatives. Please review these items for more details.

Once a FPPE/OPPE profile is completed, the profile is reviewed with your Department Chief. Upon signed approval by the Department Chief, your FPPE/OPPE profile will be retained on file in the Medical Staff Office and will be utilized for your 2 year re-appointment process. You will receive a copy of your completed review via secure email to the email address you have provided to the Medical Staff Office.

If you have any questions, or concerns regarding this process, please feel free to contact the Med. Staff Performance Improvement Analysts:

Therese Wilson, RN
Medical Staff Performance Improvement Specialist
304.598.1392
wilsont@monhealthsys.org

Mark Wotring, RN
Medical Staff Performance Improvement Specialist
304.598.1238
wotringm@monhealthsys.org

Mon Health Medical Center

Explanation of Premier Physician Focus Profile

Information Regarding Ongoing Professional Practice Evaluation (OPPE)

Attached, you will find your "**OPPE Profile**" for the time period stated. The Joint Commission now *mandates* regular review of practitioner performance. You will receive this profile every six months. This profile will also become part of your credentials file and will be reviewed by your department chairperson and considered at the time of re-credentialing. This process requires no follow-up on your part unless you are contacted to review your profile or unless you have questions/concerns and would like to discuss.

The following summary is included to assist you with interpretation of the profile:

Header

Role(s): Options include Attending, Admitting, Consulting, Principal Procedure Surgeon, and/or Procedure All. If more than one role is listed, the profile includes cases where you played at least one of the listed roles. Cases are only counted once in each profile.

Risk Method: We use 3M for risk adjustment, which is the same methodology as our coding system.

Internal Peer: Includes practitioners within your specialty, or as similar as possible based on availability.

External Peer: Includes practitioners who work in similar settings from at least 5 peer facilities in the database, with the same timeframe and same risk method.

Timeframe: The date range of the data included in the profile. The only exception is the trended chart, which goes back two years from the last month of the timeframe.

Outcomes (Inpatient Data Only)

Includes the number of cases that qualified for the outcomes risk adjustment. Some cases may not qualify if values required are missing, or may be excluded by the risk method. Outcome cases are used to calculate Observed, and Expected values. Examples include:

- Mortality excludes patients who were transferred to another acute care facility.
- Length of stay excludes patients with an expected LOS greater than the 99th percentile.

Observed: The actual value for outcome cases.

Expected: The expected value based on risk method, which adjusts for patient severity, and other factors such as age, gender, diagnosis, and procedures.

Observed/Expected (O/E): The observed value divided by the expected value produces a ratio. A ratio of less than 1.0 indicates you are performing better than expected. Greater than 1.0 indicates there is an opportunity for improvement.

Complications: Includes a list of conditions based on the presence of secondary diagnosis codes. The condition is considered a complication if it is not documented to be present on admission (POA).

Targets for Outcomes

In addition to comparing your performance to an Internal Peer and an External Peer, the Outcomes section (except for volume) also compares your performance to specific target levels for performance. A symbol indicates if the values for the outcome exceeded (✔), met, or failed to meet (✖) the target for the Timeframe.

For risk-adjusted outcomes, the target levels are based on the confidence levels (75%, 95%, or 99%) of statistical significance. Statistical significance indicates if the variation between the Observed and Expected values is significant and not due to random chance. Targets are defined as follows:

- **Exceeds the benchmark** (✔). The group's Observed value is better than the expected, and the difference between the Observed value and the Expected value is statistically significant at 95% or above confidence level.
- **Matches the benchmark** (no symbol). The group's Observed value is statistically equal to the Expected value. There could be a difference between the Observed and the Expected value, but the difference is statistically insignificant.
- **Fails to meet the benchmark** (✖). The group's Observed value is worse than expected, and the difference between the Observed value and the Expected value is statistically significant at 95% or above confidence level.

Procedures: Top six, by volume, that you performed. Includes principal and secondary procedures.

Evidence Based Care (EBC): This section displays your top six measures sorted by the greatest opportunity. The section will not appear if you were not responsible for any EBC measures

Complication distribution: Displays your top five complications by rate. This includes all CMS hospital acquired conditions. This section is code based, and not risk adjusted.

Patient Safety Indicators (PSI): displays top five with highest rate. The Agency for Healthcare Research and Quality (AHRQ) publishes incidents, determined by ICD code, that are potentially preventable complications or adverse events.

Resources: Displays a bar graph of the top 10 resources with greatest use variation between you and the internal peer.

Outpatient: You will only see this tab if outpatient data is available, and applicable to you.

Profile generation requires data consolidation from many different systems. Any change, in any one of those systems, can create issues with data integrity. We are making every effort to validate, and reconcile this data before it is reported to you. If you have concerns, or questions, please contact the Physician Focus Administrator at 304-598-1238.

Example of Premier Profile for Physicians

PREMIER CONNECT | PHYSICIANFOCUS™

Physician Name
(Speciality)
Monongalia Health System Inc.
Role(s) Admitting, Attending, Consulting, Principal Procedure Surgeon, Procedure (All) Surgeon

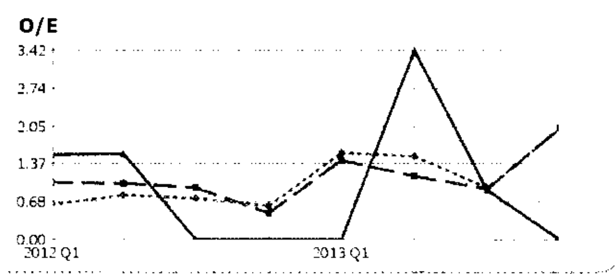
Risk Method: 3M™ APR DRG
Internal Peer: Specialty
External Peer: Standard
Total IP Cases: 190 of 190
Total OP Cases: 11 of 11

Profile Status: Current
Timeframe: Sep 2017 - Feb 2018

Outcomes

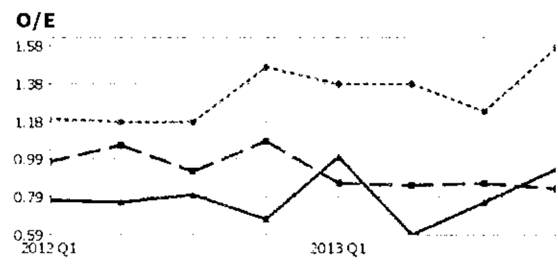
MORTALITY

	Cases	Observed	Observed/ Expected
My Performance	**190**	**2.1%**	**1.3**
Internal Peer	550	3.8%	1.3
External Peer	1,548	3.6%	1.4



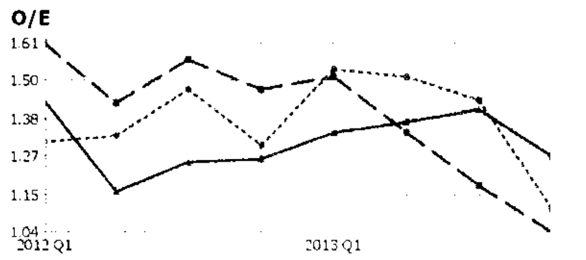
COMPLICATIONS

	Cases	Observed	Observed/ Expected
My Performance	**192**	**28.1%**	**0.8**
Internal Peer	553	27.8%	0.9
External Peer	1,563	39.6%	1.4



LENGTH OF STAY

	Cases	Observed	Observed/ Expected
My Performance	**186**	**9.6**	**1.4**
Internal Peer	544	8.6	1.3
External Peer	1,542	8.2	1.4

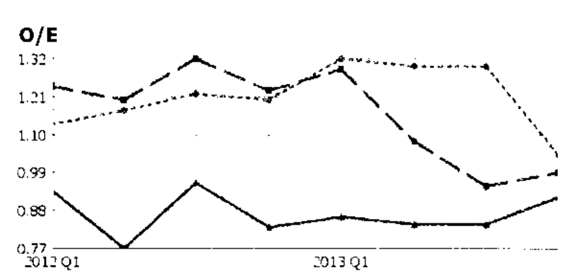


30-DAY READMISSIONS

	Cases	Observed	Observed/ Expected
My Performance	**186**	**11.3%**	**0.8**
Internal Peer	529	14.9%	1.1
External Peer	1,489	13.9%	1.1

COST PER CASE

	Cases	Observed	Observed/ Expected
My Performance	**190**	**$29,718**	**0.9**
Internal Peer	547	$34,547	1.1
External Peer	1,538	$35,178	1.3



Exceeds target   Fails to meet target

My Performance   Internal Peer   External Peer

Procedures Top 6 by Cases

	Cases	% Cases	Internal Peer % Cases	External Peer % Cases	Internal Peer Variation	External Peer Variation
39.61 Aux extracorp circ open heart surg	128	67%	46%	42%	21%	25%
36.15 Single Mammary-coronary art bypass	109	57%	36%	31%	21%	26%
36.12 Aortocoronary bypass, two arteries	50	26%	18%	13%	8%	13%
36.11 Aortocoronary bypass, one artery	32	17%	10%	7%	7%	10%
99.04 Transfusion of packed cells	29	15%	14%	10%	1%	5%
39.63 Cardioplegia	28	15%	5%	7%	9%	8%

Evidence Based Care Top 6 by Opportunity

	Missed Opportunities	Rate	Internal Peer Rate	External Peer Rate
Rcvd Appropriate VTE Prophylaxis w/n 24 Hrs Prior to t...(SCIP-VTE-2)	1	50%	100%	100%
Influenza Immunization (IMM-2)	1	67%	100%	100%
Pneumococcal Immunization - Overall Rate (IMM-1a)	2	71%	75%	81%
Prophylactic antibiotic within 1 hr prior to surg incision-Overall Rate (SCIP-Inf-1a)	1	97%	99%	99%
ACEI or ARB for LVSD (AMI-3)	0	100%	100%	
Aspirin Prescribed at discharge (AMI-2)	0	100%	100%	

Complications Distribution Top 5 by Rate

	Rate	Internal Peer	External Peer
Hypotension	13%	7%	8%
Acute Renal Failure	8%	9%	14%
Respiratory Failure	6%	5%	8%
Sepsis/Bacteremia	3%	2%	3%
Cellulitis/Skin Infection	2%	0%	1%

Patient Safety Indicators Top 5 by Rate

	Rate	Internal Peer	External Peer
Accidental Puncture or Laceration	1%	1%	0%
Postop Hemorrhage or Hematoma	1%	1%	0%
Postop PE or DVT	1%	1%	1%

Resources Top 10 by Internal Peer % Use Variation

	% Use	Internal Peer % Use Variation	External Peer % Use Variation	Quantity per Resource Case	Internal Peer Quantity Variation	External Peer Quantity Variation
Sutures, Synthetic, Nonabsorbable	83%	54%		17.4	5.1	
Sutures, Metallic, Stainless Steel	78%	51%		1.1	0.0	
Rehabilitation therapy (regime/therapy)	91%	49%	64%	6.7	0.7	1.0
Clips, Implantable	70%	47%		1.2	-0.7	
Leads	78%	45%	52%	2.2	0.1	0.2
insulin aspart-insulin aspart protamine [generic name]	73%	44%		1.7	-0.1	
Sutures, Synthetic, Absorbable	92%	44%		7.4	1.8	
Sutures, Natural, Nonabsorbable	85%	43%		5.6	1.0	
Catheters, Urinary	77%	43%	30%	1.1	0.0	-0.1
Adhesives, Liquid*	1%	-52%	-8%	1.5	-0.3	0.0

Outpatient Procedures (ICD) Top 6 by Cases

	Cases	Total Procedures	% Cases	Internal Peer % Cases	External Peer % Cases	Internal Peer Variation	External Peer Variation
86.07 Insert vascular access device	4	4	36%	0%		36%	
40.11 Lymphatic structure biopsy	4	4	36%	20%		16%	
34.22 Mediastinoscopy	4	4	36%	27%		10%	
33.23 Bronchoscopy NEC	2	2	18%	0%		18%	
87.39 X-ray chest wall soft tissue NEC	2	2	18%	0%		18%	
36.11 Aortocoronary bypass, one artery	1	1	9%	0%		9%	

Outpatient Procedures (CPT) Top 6 by Cases

	Cases	% Cases	Internal Peer % Cases	External Peer % Cases	Internal Peer Variation	External Peer Variation
A9270 Non-covered item or service	8	73%	47%		26%	
85027 complete cbc automated	8	73%	47%	13%	26%	60%
80048 metabolic panel total ca	8	73%	47%		26%	
85610 prothrombin time	8	73%	60%	13%	13%	60%
36415 routine venipuncture	8	73%	60%		13%	
71010 chest x-ray 1 view frontal	7	64%	60%	10%	4%	53%

MON HEALTH MEDICAL CENTER
PROFESSIONAL PRACTICE EVALUATION
PHYSICIAN

PEER REVIEW PROTECTED
WV Code, Chap. 30, Art. 3C, Sec 1 et seq.
WV Health Care Review Orig. Act

NAME	
STAFF STATUS	
ID NUMBER	
PERIOD COVERED	
DEPARTMENT/SECTION	

[illegible]	[illegible]
Total Attending-Inpatient	
Total Attending-Outpatient	
Total Attending-ED	
Total Consulting	

[illegible]	[illegible]
Total Patient Visits/Total Procedures/Screenings/Orders Performed (see attached list)	

Patient Care

[illegible]	[illegible]
Total Cases to Committee	0
Education Letters/Letters requesting further information	0
Collegial Interventions	0
Performance Improvement Plans	0

Practice-based Learning

[illegible]	[illegible]
Total Units Transfused	
Total Appropriate	

[illegible]	[illegible]	[illegible]
Total Unacceptable Abbreviations		>6
Total Suspensions		>2

Interpersonal and Communication Skills

[illegible]	[illegible]
TotalReferrals to Practitioner Conduct Committee	

Origination:	8/6/2013
Effective:	7/31/2018
Last Approved:	7/31/2018
Last Revised:	5/21/2018
Next Review:	7/30/2021
Owner:	Mary Edwards: Vice President Medical Affairs
Area:	Medical Staff Office
Standards & Regulations:	
Applicability:	Mon Health Medical Center

Mon Health Medical Center
"Mon Health"

Focused Professional Practice Evaluation, MS-003

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POLICY:

Purpose

1. To clearly define the process utilized for facilitating the evaluation of each practitioner's professional practice;
2. To define the type of data (criteria/indicators) to be collected for the focused professional practice evaluation. *(Note: The criteria defined for Ongoing Professional Practice Evaluation will be utilized as screening triggers for a possible Focused Professional Practice Evaluation);*
3. To ensure the information resulting from the focused professional practice evaluation is used to determine whether to continue, limit, or revoke any existing privileges;
4. To define the process for collecting, investigating, and addressing clinical practice concerns, including the process utilized to identify trends that impact quality of care and patient safety;
5. To ensure reported concerns regarding a privileged practitioner's professional practice are uniformly investigated and addressed as defined by hospital policy and applicable law;
6. To define those circumstances in which an external review or focused review may be necessary; and,
7. To define the medical staff's leadership role in the organization's performance improvement activities related to practitioner performance and ensure that when the findings are relevant to an individual's performance, the findings in the evaluations of competence are in accordance with recognized standards.

Scope

This policy applies to all Medical Staff and Allied Health Professionals who provide a "medical level of care" (making medical diagnosis and/or medical treatment decisions) and who are credentialed and privileged by the Credentials Committee in accordance with the Bylaws, Rules and Regulations.

Definitions

1. **Focused Professional Practice Evaluations (FPPE)**- A time-limited evaluation of practitioner

competence in performing a specific privilege. This process is implemented for:

a. All initially requested (provisional) privileges granted after January 1,2008, including practitioners new to the organization and practitioners already on staff requesting new privileges; and
b. Whenever a question arises regarding a practitioner's ability to provide safe, high quality patient care as identified by, but not limited to Ongoing Professional Practice Evaluations, trends observed, Peer Review activity, or feedback from other medical professionals.

2. ***Practitioner*** - For purposes of this policy, practitioner is defined as individuals with Medical Staff or Allied Health Professional Staff privileges.

Policy

1. The information used in the Focused Professional Practice Evaluation may be acquired through the following:
   a. Periodic chart review;
   b. Direct observation;
   c. Monitoring of diagnostic and treatment techniques;
   d. Feedback from other individuals involved in the care of the patient, including but not limited to consulting physicians, assistants at surgery, nursing and administrative personnel; and,
   e. Output from practitioner-specific data analysis software.
2. Criteria/indicators will include triggers and fall generally into the following six areas of general competence:
   a. Patient care;
   b. Medical/clinical knowledge;
   c. Practice-based learning and improvement;
   d. Interpersonal and communication skills;
   e. Professionalism; and
   f. System-based practice.
3. Triggers can be single incidents or evidence of a clinical practice trend
4. Monitoring criteria should include measures that are specialty-specific and evidence-based.
5. The applicable Medical Staff Department and the Medical Executive Committee (MEC) will approve indicator criteria and trigger (threshold) parameters.
6. Criteria/indicators may be added or deleted at the recommendation of the Medical Executive Committee, Department Chairperson, Peer Review Committee, and/or Credentials Committee.
7. The list of criteria/indicators will be reviewed on an ongoing basis and in conjunction with this policy.
8. Reported concerns regarding privileged practitioner's professional performance will be uniformly investigated and addressed as defined by the organization and applicable law.
9. Any individual (including patient/family, Medical Staff, Allied Health Professional, or hospital staff) may report any concerns regarding the professional performance of a practitioner.
10. Relevant information from the practitioner practice review process will be integrated into performance improvement initiatives and will be utilized to determine whether to continue, limit, or revoke existing

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privileges.

11. If there is uncertainty regarding the practitioner's professional performance, the course of action defined in the Medical Staff Bylaws for further evaluation will be followed. If the performance of the practitioner is sufficiently egregious, the Chief of Staff, VPMA, or CEO shall determine, within his/her sole discretion, whether the provisions of this policy need not be followed, whereupon the provisions of the Bylaws, and not this policy, shall govern.
12. The activities of the focused professional practice evaluation are considered privileged, confidential, and peer review protected.

RESPONSIBILITY:

Medical Staff, Allied Health Professional Staff, Medical Staff Office

PROCEDURE:

I. ***FPPE Review Process***

1. The Medical Staff Performance Improvement Analyst, or designee, will analyze retrospective chart review data using the Premier Physician Focus reporting system or create a manual FPPE profile if a Premier Physician Focus report is unavailable;
2. The period of FPPE can be either of the following:
    i. Time (volume may be excessive or insufficient); and,
    ii. Procedure/admission/activity oriented (allows for flexibility and dealing with infrequently performed privileges).
3. Privileges may need to be extended if minimum activity does not occur;
4. There will be no exemption for board certification, documented experience, or reputation;
5. Similar procedures/activities may be grouped together, with evaluation of a set number of any mixes of the privileges;
6. The outcome of FPPE will be documented and decisions made as to the following:
    i. Further need for FPPE;
    ii. Continuation or limiting of privilege(s); and,
    iii. Need for Performance Improvement Plan.
7. At the time of appointment of new privileges, the Credentials Committee will determine the following:
    i. Criteria for conducting performance monitoring;
    ii. A monitoring plan specific to the requested privilege;
    iii. The duration of performance monitoring; and,
    iv. Circumstances under which monitoring by an external source is required.

II. ***Interventions***

Depending upon the findings of the focused professional practice review, interventions may be implemented. The criteria utilized to determine the type of intervention includes severity, frequency of occurrence and trigger (thresholds) level exceeded. Interventions may include, but are not limited to,

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proctoring, individual action plan, and performance improvement plan. All practitioner requests for intervention will be in the form of a letter or collegial intervention. All correspondence will be confidential and will be kept on file in the Medical Staff Office.

Definitions and Responsibilities of Roles During Intervention Process:

1. **Medical Staff Performance Improvement Analvst/Desiqnee**
   a. *Definition* - Individual responsible for coordinating and facilitating review activities.
   b. *Responsibility* -
      i. Forwards to the designated Department Chairperson or Peer Review Committee, as appropriate, all cases that exceed the designated triggers.
2. **Department Chairperson**
   a. *Definition*-As defined in the Medical Staff Bylaws.
   b. *Responsibility* -
      i. Retains responsibility for practitioner performance within the Department;
      ii. Sends any questionable determinations for further review to the Peer Review Committee; and,
      iii. Facilitates and provides oversight of any recommended actions/interventions.
3. **Peer Review Committee**
   a. *Definition* - As defined in the Medical Staff Bylaws.
   b. *Responsibility* -
      i. Reviews all referred cases;
      ii. Documents a final decision on reviewed cases that includes conclusions, recommendations, and actions taken (if necessary); and,
      iii. Possesses the authority to recommended interventions as necessary (Refer to Peer Review Policy #MS-004).
4. **Credentials Committee**
   a. *Definition* - As defined in Medical Staff Bylaws.
   b. *Responsibility* -
      i. Considers all recommendations from the Department Chair and Peer Review Committee at the time of practitioner recredentialing; and,
      ii. Makes a recommendation to the Medical Executive Committee regarding practitioner classification of privileges based on the above findings.
5. **Medical Executive Committee**
   a. *Definition- As defined in the Medical Staff Bylaws*
   b. *Responsibility* -
      i. Serves as oversight committee for medical staff performance improvement activities; and,
      ii. Considers all recommendations from the Credentials Committee and gives recommendations to the Board of Directors.

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6. **Practitioner Under Review**
    a. *Definition* - The practitioner whose performance is being reviewed.
    b. *Responsibility* -
        i. Reviews Focused Professional Practice Evaluations when received and provides written or electronic authentication; and,
        ii. Participates in interventions when requested.

Supporting Policies/Procedures:

1. Code of Conduct Policy;
2. Patient and Family Complaints Policy;
3. Practitioner Health Policy;
4. Medical Staff Bylaws/Rules and Regulations;
5. Fair Hearing Plan; and,
6. Medical Staff Peer Review Policy.

References:

1. The Joint Commission CAMH - MS.08.01.01; and,
2. Standards BoosterPak for Focused Professional Practice Evaluation/Ongoing Professional Practice Evaluation (FPPE/OPPE)—published by The Joint Commission.

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Attachments

No Attachments

Applicability

Mon Health Medical Center

Mon Health Medical Center "Mon Health"

Origination:	7/31/2018
Effective:	6/18/2019
Last Approved:	6/18/2019
Last Revised:	7/31/2018
Next Review:	6/17/2022
Owner:	Mary Edwards: Vice President Medical Affairs
Area:	Medical Staff Office
Standards & Regulations:	
Applicability:	Mon Health Medical Center

Ongoing Professional Practice Evaluation, MS-007

POLICY:

Purpose

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1. To clearly define the process utilized for facilitating the continuous evaluation of each practitioner's professional practice;
2. To define the type of data (criteria/indicators) to be collected for the ongoing professional practice evaluation. *(Note: The criteria defined for Ongoing Professional Practice Evaluation will be utilized as screening triggers for a possible Focused Professional Practice Evaluation);*
3. To ensure the information resulting from the ongoing professional practice evaluation is used to determine whether to continue, limit or revoke any existing privileges;
4. To define the process for collecting, investigating, and addressing clinical practice concerns, including the process utilized to identify trends that impact quality of care and patient safety;
5. To ensure reported concerns regarding a privileged practitioner's professional practice are uniformly investigated and addressed as defined by hospital policy and applicable law;
6. To define those circumstances in which an external review or focused review may be necessary; and,
7. To define the Medical Staff's leadership role in the organization's performance improvement activities related to practitioner performance and ensure that when the findings are relevant to an individual's performance, the findings in the ongoing evaluations of competence are in accordance with recognized standards.

Scope

This policy applies to all Medical Staff and Allied Health Professional Staff who provide a "medical level of care" (making medical diagnosis and/or medical treatment decisions) and who are credentialed and privileged by the Credentials Committee in accordance with the Bylaws, Rules and Regulations.

Definitions

- ***Ongoing Professional Practice Evaluation (OPPE)*** - A documented summary of ongoing data collected for the purpose of assessing a practitioner's clinical competence and professional behavior. The information gathered during this process factors into decisions to maintain, revise, or revoke existing privilege(s).
- ***Practitioner*** - For purposes of this policy, practitioner is defined as individuals with Medical Staff or Allied Health Professional Staff privileges.

Policy

1. The information used in the Ongoing Professional Practice Evaluation may be acquired through the following:
   a. Periodic chart review;
   b. Direct observation;
   c. Monitoring of diagnostic and treatment techniques;
   d. Feedback from patients as well as other individuals involved in the care of the patient, including but not limited to consulting physicians, assistants at surgery, nursing and administrative personnel; and,
   e. Output from practitioner-specific data analysis software.
2. Criteria/indicators will include triggers and fall generally into the following six areas of general competence:
   a. Patient care;
   b. Medical/clinical knowledge;
   c. Practice-based learning and improvement;
   d. Interpersonal and communication skills;
   e. Professionalism; and
   f. System-based practice.
3. Triggers can be single incidents or evidence of a clinical practice trend;
4. Monitoring criteria should include measures that are specialty-specific and evidence-based;
5. The applicable Medical Staff Department and the Medical Executive Committee (MEC) will approve indicator criteria and trigger (threshold) parameters;
6. Criteria/indicators may be added or deleted at the recommendation of the Medical Executive Committee;
7. The list of criteria/indicators will be reviewed on an ongoing basis, every three years per hospital policy;
8. Reported concerns regarding privileged practitioner's professional performance will be uniformly investigated and addressed as defined by the organization and applicable law;
9. Any individual (including patient/family, Medical Staff, Allied Health Professional, or hospital staff) may report any concerns regarding the professional performance of a practitioner;
10. Relevant information from the practitioner practice review process will be integrated into performance improvement initiatives and will be utilized to determine whether to continue, limit, or revoke existing privileges;

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11. If there is uncertainty regarding the practitioner's professional performance, the course of action defined in the medical staff bylaws for further evaluation will be followed. If the performance of the practitioner is sufficiently egregious, the Chief of Staff, VPMA, or CEO shall determine, within his/her sole discretion, whether the provisions of this policy need not be followed, whereupon the provisions of the Bylaws, and not this policy, shall govern; and,
12. The activities of the ongoing professional practice evaluation are considered privileged and confidential.

RESPONSIBILITY:

Medical Staff, Allied Health Professional Staff, Medical Staff Office

PROCEDURE:

I. ***OPPE Review Process:***

   1. The Medical Staff Performance Improvement Analyst, or designee, will analyze retrospective chart review data using the Physician Focus OPPE reporting system or create a manual profile from data obtained through other data collection software or data provided by physicians;
   2. Practitioner's OPPE profiles will be compiled and reviewed every six months;
   3. After compilation, the practitioner's OPPE profile will be reviewed and signed by the Department Chief. The Department Chief will review at-large members, and Section Chiefs. The Department Chiefs' OPPE profiles will be reviewed by the Chief of Staff. The Chief of Staff may also review and sign all other practitioner OPPE profiles as necessary.
   4. Following review by the practitioner and the Department Chief, if no action is required, the practitioner's OPPE profile will be maintained in the Medical Staff Office in a secure location and/or electronically on the Hospital's secure network under password protection. After review if action is required, please refer to the Interventions section of this policy.
   5. For low volume/no volume practitioners who do not utilize the hospital with sufficient frequency to allow for an adequate evaluation of current clinical competence, the practitioner will be responsible for providing alternative information for review that will allow an informed decision regarding the Ongoing Professional Practice Evaluation. This may include:
      i. OPPE data from their primary hospital where they have significant volume relating to the privileges being requested at Mon Health Medical Center;
      ii. Data from ambulatory clinics;
      iii. Office data, which may include, but is not limited to a report of the types (diagnosis) and numbers of patients seen;
      iv. Ancillary testing ordered; and/or,
      v. Collegial interventions with members of the Medical Staff or Allied Health Professional Staff.

II. ***Interventions***

The criteria utilized to analyze the OPPE profile includes severity, frequency of occurrence and trigger(thresholds) level exceeded. Observed outliers, or trends, will be referred for FPPE. Need for physician practice intervention will be determined at the discretion of the Peer Review Committee and/or Credentials Committee. Interventions may include, but are not limited to proctoring, individual action plan, and performance improvement plan. All intervention activity will be maintained in the Medical Staff Office

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in a secure location and/or electronically on the Hospital's secure network under password protection.

Definitions and Responsibilities of Roles During Intervention Process:

1. **Medical Staff Performance Improvement Analyst/Desiqnee**
   a. *Definition* - Individual responsible for coordinating and facilitating review activities.
   b. *Responsibility*-
      i. Forwards all cases that exceed the designated triggers to the Peer Review Committee and/ or Credentials Committee upon the request of the Department Chief.
      ii. Provides periodic summary reports (OPPE) on an ongoing basis to the Department Chief, Peer Review Committee, and Credentials Committee if necessary. Individual practitioners will receive a copy when action is required or upon request.
2. **Department Chief**
   a. *Definition* - As defined in the Medical Staff Bylaws.
   b. *Responsibility* -
      i. Reviews the Ongoing Professional Practice Reports and meets, when necessary, with individual practitioners when trends or suboptimal performance is identified.
      ii. Retains responsibility for practitioner performance within the Department;
      iii. Provides summary reports on practitioner performance activities to the Credentials Committee and if necessary, the Peer Review Committee;
      iv. Sends any questionable determinations for further review to the Peer Review Committee;
      v. Facilitates and provides oversight of any recommended actions/interventions; and,
      vi. Implements a Focused Professional Practice Evaluation when indicated.
3. **Peer Review Committee**
   a. *Definition* - As defined in the Medical Staff Bylaws
   b. *Responsibility* -
      i. Reviews all referred cases;
      ii. Documents a final decision on reviewed cases that includes conclusions, recommendations, and actions taken (if necessary); and,
      iii. Possesses the authority to recommended interventions as necessary (Refer to Peer Review Policy #MS-004).
4. **Credentials Committee**
   a. *Definition* - As defined in Medical Staff Bylaws.
   b. *Responsibility*-
      i. Considers all recommendations from the Department Chief and Peer Review Committee at the time of practitioner recredentialing; and,
      ii. Makes a recommendation to the Medical Executive Committee regarding practitioner classification of privileges based on the above findings.
5. **Medical Executive Committee**

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a. *Definition- As defined in the Medical Staff Bylaws.*

b. *Responsibility -*

i. Serves as oversight committee for medical staff performance improvement activities; and,

ii. Considers all recommendations from the Credentials Committee and gives recommendations to the Board of Directors.

6. **Practitioner Under Review**

a. *Definition* - The practitioner whose performance is being reviewed.

b. *Responsibility -*

i. Reviews Ongoing Professional Practice Evaluations when received; and,

ii. Participates in interventions when requested.

Supporting Policies/Procedures

1. Code of Conduct Policy; MS-001
2. Patient and Family Complaints and Grievances Policy; RI-005
3. Practitioner Health; MS-002
4. Medical Staff Bylaws/Rules and Regulations
5. Medical Staff Peer Review Policy; MS-004

References

1. The Joint Commission CAMH - MS.08.01.01 and MS.08.01.03; and,
2. Standards BoosterPak for Focused Professional Practice Evaluation/Ongoing Professional Practice Evaluation (FPPE/OPPE)—published by The Joint Commission.

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Attachments

No Attachments

Applicability

Mon Health Medical Center

Mon Health Medical Center
"Mon Health"

Origination:	7/17/2012
Effective:	5/6/2021
Last Approved:	5/6/2021
Last Revised:	5/6/2021
Next Review:	5/5/2024
Owner:	Beverly Ellis: Coding Supervisor
Area:	HIM
Standards & Regulations:	
Applicability:	Mon Health Medical Center

Acceptable Abbreviations

POLICY:

It is the policy of Mon Health that to avoid misinterpretation, only those symbols and abbreviations listed in **Stedman's Medical Abbreviations, Acronyms & Symbols** are to be used in the medical record by those authorized to make entries in the medical record.

RESPONSIBILITY:

Health Information Management (HIM) Director, Medical Record Committee, Medical Executive Committee

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PROCEDURE:

1. The HIM Department will monitor the use of abbreviations in the medical record.
2. The Performance Improvement Analysts, and designated HIM Clerk will review medical records for use of unacceptable abbreviations and report their findings to the Medical Record Committee, who will then take any necessary action.
3. Current copies of **Stedman's Medical Abbreviations, Acronyms & Symbols will be available** for reference as Mon Health Medical Center's approved abbreviation guide in the HIM Department, as well as the House Supervisor's Office.
4. There are abbreviations, acronyms, and symbols that have been shown to be prone to cause confusion and subsequent medication errors. The list of abbreviations, acronyms, and symbols approved by the medical staff that should not be used is attached.

REFERENCES:

Joint Commission E-dition. July 1,2015. Information Management Chapter. Standard IM.02.02.01.

Stedman's Medical Abbreviations, Acronyms & Symbols

Attachments

Official "Do Not Use" List

Approval Signatures

Step Description	Approver	Date
Administrative Approval	Mary Edwards: Vice President Medical Affairs	5/6/2021
	Stephanie Carnes: HIM Director	5/6/2021

Applicability

Mon Health Medical Center

IM-079 Acceptable Abbreviations, Attachment to Policy

Official "Do Not Use" List

Do Not Use	Potential Problem	Use Instead
U or u (unit)	Mistaken for "0" (zero), the Number "4" (four) or cc	Write "unit"
IU (International Unit)	Mistaken for IV (intravenous) or the number 10 (ten)	Write "International Unit"
Q.D., QD, q.d., qd (daily) Q.O.D., QOD, q.o.d. qod (every other day)	Mistaken for each other Period after the Q mistaken for "I" and "O" mistaken for "I"	Write "daily" Write "every other day"
Trailing zero (X.0 mg)* Lack of leading zero (.X mg)	Decimal point is missed	Write X mg Write 0.X mg
MS	Can mean morphine sulfate Or magnesium sulfate	Write "morphine sulfate" Write "magnesium sulfate"
$MgSO_4$ and MSO_4	Confused for one another	

* **EXCEPTION:** A trailing zero may be used only where required to demonstrate the level of precision of the value being reported, such as for laboratory results, imaging studies that report size of lesions, or catheter/tube sizes. It may not be used in medication orders or other medication-related documentation.

Original Approval Date: 07-17-12
Last Review Date (no changes) 5/15/2018