


Utilizing FPPE and OPPE Effectively

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OPPE & FPPE

- For the sake of this presentation, OPPE and FPPE will be discussed as it pertains to physicians.
- However, all information applies to all other practitioners that are credentialed and privileged through the medical staff

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Joint Commission FAQs

- There are Joint Commission FAQs for OPPE and FPPE
 - FPPE - new as of December 15, 2008
 - OPPE – updated as of May 27, 2009

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FPPE & OPPE Common Points

- In both FPPE and OPPE standards there are several common points:
 - The sources of the information regarding the physicians can be the same sources for each
 - There is no indication as to who must collect, aggregate, and distribute this information

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Sources of Information

- ✓ Periodic chart review
- ✓ Direct observation
- ✓ Monitoring of diagnostic and treatment techniques
- ✓ Discussion with other individuals involved in the care of each patient including consulting physicians, assistants at surgery, nursing, and administrative personnel

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FPPE Definition

- a) New Physicians to the Organization / New privileges for an individual
 - EVERY new physician to an organization and new privileges given to physicians who are already members of the medical staff
 - MUST have FPPE conducted to assure that the physician is competent regarding the privileges that are granted to that physician

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FPPE Definition

- b) Focused review for practitioners who have identified issues with the provision of safe, quality patient care
 - This was previously called “Peer Review”
 - EP 1 does not apply to this type of Focused Review

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FPPE

- What is to be collected must be determined by the medical staff
- There are no standardized time frames for when this must be accomplished. It is up to each organization
- Time frames may vary based on high and low volume privileges; or on high or low risk privileges

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New Physicians and/or Privileges

- There is no exemption for board certification, documented experience, or reputation
- All applicants for new privileges must have a period of focused review
 - Not necessarily a probation period
 - Does not require Bylaws or Rules & Regulation changes.

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New Physicians and/or Privileges

- Medical Staff must develop:
 - Criteria for conducting performance evaluations
 - Method for establishing the monitoring plan specific to the requested privilege

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New Physicians and/or Privileges

- Medical Staff must develop:
 - Method to determining the duration of performance monitoring
 - Circumstances under which monitoring by an external source is required

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Grouping of Privileges for FPPE

- Similar privileges may be grouped together
- Can evaluate a set number of practice with a mix of these similar privileges
- But can not look at one privilege from the group

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Medical Staff Office & Quality Management

- A system should be established where the QM office informs the MSO when a physician is nearing the end of their focus period so that the MSO personnel can begin the process of having the material reviewed.

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Medical Staff Office & Quality Management

- If the medical staff determine that more monitoring is required, then the process repeats until the medical staff are satisfied that they have enough information to act appropriately.

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OPPE Definition

- Every physician on staff, regardless of the amount of activity that physician has at the organization, must receive feedback on their performance more often than once a year.

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OPPE

- Designed to act like an update on performance for physicians in between times of reappointment
- Relevant information from OPPE is integrated into performance improvement activities

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OPPE

- In essence, a profile or report card is to be generated for each physician on staff
- This is designed to allow physicians to take steps to improve performance on a more timely basis

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OPPE Implementation Survey

- The Searcy Exchange conducted a survey of its readers;
- Results were published September 4, 2009 in The Searcy Exchange – a newsletter from Morrisey’s Consulting Services
 - Total number organizations responding – not disclosed
 - 23% of organizations responding have not yet implemented OPPE

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OPPE Implementation Survey

- Of the 77% who have implemented OPPE:
 - 50% were able to produce specialty-specific reports;
 - Approximately 75% are able to provide some comparative data;
 - Approximately 40% have established targets or thresholds;
 - Over 50% produce reports at six month intervals

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OPPE Implementation Survey

- Of the 77% who have implemented OPPE:
 - Approximately 40% of the respondents indicated that the Medical Staff Office is responsible for producing OPPE reports, with 45% indicating that Quality Management produces the reports

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OPPE

- Generating these reports on an annual basis is not often enough
 - TJC feels that once a year is really periodic review and not an ongoing review
 - The medical staff determines the frequency with which the reports will be generated

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OPPE – Clearly Defined Process

1. Who is responsible for reviewing performance data
 - ✓ Department Chair
 - ✓ Department as a whole reviews all members
 - ✓ Credentials Committee
 - ✓ MEC
 - ✓ Special committee of the Medical Staff

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OPPE – Clearly Defined Process

2. How often the data will be reviewed
 - ✓ Defined by the medical staff (e.g. 3 mo, 6 mo, 9 mo, etc)
 - ✓ Must be more often than once per year
 - ✓ Once a year is considered “Periodic” rather than “Ongoing”

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OPPE – Clearly Defined Process

3. The process to be implemented to use the data to make decision as to whether to continue, limit or revoke privileges
 - ✓ Could include defining who can make and approve a recommendation for action (e.g. dept. chair, credentials committee, MEC, etc)
 - ✓ The decision from the review must be documented whether to continue with privileges or not, along with the supporting documentation

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OPPE – Clearly Defined Process

- 4. How data will be incorporated into the credentials files
 - ✓ Need a defined process for the data to be in the credentials file and for review to occur

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OPPE - What to Include?

- TJC now requires that the physicians utilize the General Competencies from AGME in the credentialing and privileging processes.
- OPPE Profiles is the perfect spot to implement these
- Volume and acuity are also important

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OPPE – Type of Data to be Collected

- Need to be defined by individual medical staff departments and approved by the organized medical staff
- Standards require an evaluation for all practitioners not just those with performance issues

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OPPE – Type of Data to be Collected

- Must have pertinent data for all specialties within a department, but does not have to be the same for all specialties in the department
- Departments will know best what type of data will reflect both good and problem performance for the various practitioners in the department

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Criteria May Include:

- Review of operative and other clinical procedure(s) performed and their outcomes
- Pattern of blood and pharmaceutical usage
- Requests for tests and procedures
- Length of stay patterns
- Morbidity and mortality patterns
- Practitioner's use of consultants
- Other relevant criteria as determined by the organized medical staff

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OPPE – Information Identified & Analyzed

- Most practitioners perform well and that data must be included as well as the performance issues
- The fact that a practitioner does not fall out on pre-defined screening criteria is not sufficient to meet the requirements for performance data on every practitioner

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OPPE – Information Identified & Analyzed

- Remember: Zero data is in fact data
- Zero data may be evidence of good performance, e.g. no returns to surgery, no complications, no complaints, no infections, etc.

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OPPE – Information Identified & Analyzed

- TJC feels that it is important to know when someone is not performing certain privileges over a given period of time
- TJC states that it would not be acceptable to find at the 2-year reappointment that someone has not performed a privilege in 2-years
- Zero performance of a privilege should be evaluated to determine possible reasons

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OPPE – Information Identified & Analyzed

- Zero performance of a privilege should be evaluated to determine possible reasons:
 - Is the practitioner no longer performing the privilege, e.g. no open cholecystectomies because they are now all done laproscopically
 - Is the practitioner taking patients needing the privilege to other organizations
 - Is the privilege typically a low volume procedure that has yet to be done

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OPPE – Information Identified & Analyzed

- The information resulting from the evaluation needs to be used to determine whether to continue, limit, or revoke any existing privilege(s) at the time the information is analyzed.

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OPPE – Information Identified & Analyzed

- Based on the analysis, several possible actions could occur, including but not limited to:
 - Revoking the privilege because it is no longer required
 - Suspending the privilege, which suspends the data collection, and notifying the physician that if they wish to reactivate it they must request a reactivation

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OPPE – Information Identified & Analyzed

- Based on the analysis, several possible actions could occur, including but not limited to:
 - Determining that the zero performance should trigger a focused review (MS. 4.30 EP5) whenever the practitioner actually performs the privilege
 - Determining that the privilege should be continued because the organization's mission is to be able to provide the privilege to its patients

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ACPE/ACGME Core Competencies

- Patient Care
- Medical/Clinical knowledge
- Professionalism
- Interpersonal & Communication
- Systems-Based Practice
- Practice-Based Learning & Improvement

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Six Competencies

(as defined by Dr. Christopher Heller, MD, FACS, 2009)

- Patient Care:
 - Deliver quality patient care which is safe. Effective, efficient, timely, patient-centered, and equitable.
- Medical/Clinical Knowledge:
 - Use sound clinical judgment based on evidence-based medicine and best clinical practice

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Six Competencies

- Interpersonal and Communication Skills:
 - Establish a respectful relationship thru open communications with peers, patients, and other members of the healthcare team
- Professionalism:
 - Acts as a mentor to other members of the healthcare team with exemplary behavior and observance of the Rules and Regulations of the medical staff

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Six Competencies

- Systems-based Practice:
 - Understands and uses the resources of the local healthcare delivery system
- Practice-based Learning and Improvement:
 - Incorporates into one's daily practice new evidence-based medicine and lessons learned from experience
 - Other 5 competencies should drive this one

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Physician Profile per Dr. C. Heller

- Volume/Acuity
 - Attending vs Principle Procedure Provider
- Patient Care
 - Outcomes Data
- Medical/Clinical Knowledge
 - Peer Review Data
- Professionalism
 - Rule Infractions (medical staff & medical records)

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Physician Profile per Dr. C. Heller

- Interpersonal & Communication
 - Relationship Data
- Systems-Based Practice
 - Utilization Data
- Practice-Based Learning & Improvement
 - Process Data and Outcomes (Core Measures)

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Other Required Elements

- Targets/Thresholds - (want to reach this level)
- Alarms – (don't want to fall below this level)
- Timeframes
- Comparative Data
- Measure Over Time
- Ability to Drill Down on data

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Barriers to Implementation

- Physician Barriers
- Organization Barriers
- Profile Barriers

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Physician Barriers

- Why do we have to do this?
- No involvement in developing the process
- Too much information
- That is not my data or the data is wrong
- You are measuring the wrong thing

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Overcoming Physician Barriers

- Educate the medical staff that these programs will :
 - Provide physician feedback to identify opportunities for improvement and to drive performance improvement efforts
 - To use the information to assist in reappointment process
 - To use the information to assure that quality evidence-based patient care is being delivered to the patients

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Overcoming Physician Barriers

- Involve the medical staff in the development and implementation of the programs, policies and procedures
- Prepare a list of FAQ's before implementing the profiles;
 - How to read the report
 - How report was created
 - How data will be interpreted
 - How organization will utilize the data

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Overcoming Physician Barriers

- When educating the medical staff, include information concerning:
 - No perfect data
 - No perfect measures
 - FPPE and OPPE are works in progress
 - Must have comparative data
 - Must be able to drill down

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Organization Barriers

- Culture of blame; not just culture where mistakes happen
- Lack of understanding IT resources for information
- Coding issues (Who, what, right codes, etc)
- Data from multiple sources & systems
- Unconstructive criticism without suggested solutions

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Overcoming Organization Barriers

- Organization needs to be working on a culture of patient safety and quality
- Identify IT sources of information to be utilized
- Coding processes must be reviewed and revised as necessary
- Medical staff and the organization must determine how to attribute data to whom & what to do about low volume practitioners

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Overcoming Organization Barriers

- Organization needs to define each measure in terms of;
 - It's description of what is and is not included
 - Where it is obtained from
 - Who the owner is (ultimately responsible for the measure)
 - Rationale for measure
 - Cautions required (difficult to assign to specific practitioners so review on case by case basis)
 - Disclaimers (ie: sample size may be small)

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Overcoming Organization Barriers

- Organization must determine how to identify data that can be utilized for Pas, AHP, CRNAs, Psychologists, and other such personnel
- When criticism is voiced, listen carefully, respond appropriately, and encourage ideas for improvement; Involve those individuals in the improvement process;

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Profile Barriers

- Volume / acuity
- Who to attribute data to
- Sample size per physician
- Data collection
- Case / Peer review
- Distribution of profile

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Overcoming Profile Barriers

- Start small with a limited number of measures you are already collecting
- Use a single profile per specialty and try to keep it to 1 or 2 pages
- Start with high volume specialties
- Involve the physicians in the specialties in the selection of the measures, their comparison data, etc.

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No Volume Practitioners

- XXX Hospital is required to perform ongoing professional practice evaluation (OPPE) for existing medical staff members. What this means for existing medical staff members, is if you do not have any cases at XXX Hospital, you will be required to submit an OPPE report or proof of clinical competency from your primary facility...

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No Volume Practitioners

- ... every 6 months, in order to maintain your existing privileges. Failure to submit the requested documentation will result in automatic status change of your current Medical Staff Membership Status to active Community Based.

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EXAMPLE of a 8-month distribution of the data

	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec
Med	X								X			
Surg		X								X		
OB			X								X	
FP				X								X
Psyc					X							
Pedi						X						

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Medical Staff Office vs Quality Management

- OPPE:
- Once the frequency of the OPPE reporting has been determined, the MSO and QM must determine how the reporting and communication regarding the reporting will be handled by both departments

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Medical Staff Office vs Quality Management

- For example, the MSO may send a list at the beginning of the month of the physicians who are due to have their OPPE report generated in the next 3 months
- This will give the QM department time to capture any additional data they need for the OPPE report

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Medical Staff Office & Quality Management

- The QM department or the MSO department may be the ones responsible for delivering the data to the physician and to the reviewer(s) so continued communication will be essential

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Bi-Annual Profile

- The items that are on the OPPE form are not necessarily the information found on the bi-annual profile utilized at time of reappointment
- The OPPE documents however should be utilized in addition to the profile at the time of reappointment so that the medical staff can determine progress that has been made by the physician

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Summary

- In order to meet these standards for FPPE & OPPE, processes must be established by the medical staff with assistance from the MSO and the QM departments.
- These processes should already be in place according to TJC standards, so there is no time to waste.

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Summary

- When you go back to your organizations, make an assessment of what you currently have working, what is in progress, and what needs to be initiated.
- Work with the Chief of the Medical Staff and other appropriate physicians to get the monitors identified for OPPE and to establish the required processes.

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Summary

- As soon as the medical staff, the QM department and the MSO can pull it together, implement the program, or at least parts of it when possible
- May want to go back to the past quarter or start fresh with the next month in terms of the implementation.

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Summary

- If you, your staff, the QM department or medical staff have any questions, I will try to answer them, but you always have the resources (SIG) from TJC that you can utilize.

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