UPMC
POLICY AND PROCEDURE MANUAL

POLICY: HS-MS0005 *
INDEX TITLE: Medical Staff

SUBJECT: Ongoing Professional Practice Evaluation Policy (Oppe) of UPMC
DATE: April 1, 2024

This Policy applies to the following United States based UPMC facilities, including any providers who practice therein:

[Check all that apply]

☒ UPMC Children's Hospital of Pittsburgh	☒ UPMC Pinnacle Hospitals
☒ UPMC Magee-Womens Hospital	☒ Harrisburg Campus
☒ UPMC Altoona	☒ West Shore Campus
☒ UPMC Bedford	☒ Community Osteopathic Campus
☒ UPMC Chautauqua	☒ UPMC Carlisle
☒ UPMC East	☒ UPMC Memorial
☒ UPMC Hamot	☒ UPMC Lititz
☒ UPMC Horizon	☒ UPMC Hanover
☒ Shenango Campus	☒ UPMC Muncy
☒ Greenville Campus	☒ UPMC Wellsboro
☒ UPMC Jameson	☒ UPMC Williamsport
☒ UPMC Kane	☒ Williamsport Campus
☒ UPMC McKeesport	☒ Divine Providence Campus
☒ UPMC Mercy	☒ UPMC Cole
☒ UPMC Northwest	☒ UPMC Somerset
☒ UPMC Passavant	☒ UPMC Western Maryland
☒ Main Campus	
☒ Cranberry	
☒ UPMC Presbyterian Shadyside	
☒ Presbyterian Campus	
☒ Shadyside Campus	
☒ UPMC Western Psychiatric Hospital	
☒ UPMC St. Margaret	

Provider-based Ambulatory Surgery Centers

☒ UPMC Altoona Surgery Center
☒ UPMC Children's Hospital of Pittsburgh North
☒ UPMC St. Margaret Harmar Surgery Center
☒ UPMC South Surgery Center
☒ UPMC Center for Reproductive Endocrinology and Infertility
☒ UPMC Digestive Health and Endoscopy Center
☒ UPMC Surgery Center – Carlisle
☒ UPMC Surgery Center Lewisburg
☒ UPMC Pinnacle Procedure Center
☒ UPMC West Mifflin Ambulatory Surgery Center
☒ UPMC Community Surgery Center
☒ UPMC Leader Surgery Center

Free-Standing Ambulatory Surgery Facilities:

☐ UPMC Hamot Surgery Center **(JV)**
☐ Hanover SurgiCenter
☐ UPMC Specialty Care York Endoscopy
☐ Susquehanna Valley Surgery Center
☐ West Shore Surgery Center **(JV)**

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 a Participating UPMC Hospital (the "Hospital") are subject to ongoing professional practice evaluation ("OPPE"). A flow chart of the OPPE process is attached as Appendix A.

2. ***OPPE Data to Be Collected.*** OPPE data elements will be developed and collected for each specialty. Data elements that are relevant to all Practitioners irrespective of specialty may also be developed and collected. Where appropriate, the expected parameters of performance for each data element will also be identified.

3. ***OPPE Reports.***

3.A ***Frequency and Content.*** An OPPE report for each Practitioner should be prepared at a minimum of every 12 months. A copy will 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 specialty data elements;

(3) the number of Information Letters sent pursuant to the Professional Practice Evaluation Policy (Peer Review) ("PPE Policy");

(4) the number of cases reviewed pursuant to the PPE Policy and the dispositions of those cases;

(5) the number of complaints addressed pursuant to the Medical Staff Professionalism Policy and the disposition of those matters; and

(6) other data added by the PPE Specialists Committee.

3.B ***Review by the PPE Specialists Committee.***

(1) ***Initial Review.*** The PPE Specialists Committee will review each OPPE report. As needed, the PPE Specialists Committee may consult with the Vice President of Medical Affairs and/or a Medical Staff Leader before classifying the report as follows:

(a) data within expected parameters of performance/no concerns;

(b) data reflects exceptional performance or significant improvement;

(c) no activity/insufficient volume; or

(d) data not within expected parameters of performance or raises questions.

(2) All OPPE reports will be made available to the applicable Department Committee for its review. However, reports categorized as (b), (c), or (d) above may be flagged for further review.

(3) All OPPE reports will also be made available to the applicable Practitioner, upon request, with a copy going to the Practitioner's quality file for use at reappointment.

3.C ***Review by Department Committee.***

(1) Based on review of data, the Department Committee will make an appropriate determination, which could include, but is not limited to:

- report involves a new hire/appointee;
- report raised no concerns;
- no volume/no clinical privileges;
- Practitioner may need follow-up;
- review completed and no concerns exist or continued monitoring is needed; and
- review completed and collegial counseling and/or education/support is needed.

(2) The Department Committee will document its findings, which will be included in the Practitioner's file along with the OPPE report.

(3) OPPE reports involving a Department Committee member may be reviewed by another Committee member or the Medical Staff President (or designee).

4. ***Delegation of Functions.***

(a) The Medical Executive Committee is responsible for the OPPE/quality assurance process described in this Policy, subject to the oversight of the Board. To promote a prompt and effective review process, the Medical Executive Committee hereby expressly delegates to the PPE Specialists Committee, Medical Staff Leaders and the Vice President of Medical Affairs the authority to perform the functions

described in this Policy on behalf of the Medical Executive Committee. Actions taken by these individuals will be reported to and reviewed by the Medical Executive Committee as set forth in this Policy.

(b) When a function under this Policy is to be carried out by one of the individuals identified in the prior subsection, by a member of Hospital management, by a Medical Staff member, or by a Medical Staff committee, the individual, or the committee through its chair, may delegate performance of the function to a qualified designee who is a Practitioner or Hospital employee (or a committee of such individuals). Any such designee must treat and maintain all information in a strictly confidential manner and is bound by all other terms, conditions, and requirements of this Policy. In addition, the delegating individual or committee is responsible for ensuring that the designee appropriately performs the function in question. Any documentation created by the designee are records of the committee that is ultimately responsible for the review in a particular matter.

(c) When an individual assigned a function under this Policy is unavailable or unable to perform that function, one or more Medical Staff Leaders may perform the function personally or delegate it to another appropriate individual as set forth above.

5. ***Definitions.*** Unless otherwise indicated below, the terms used in this Policy are defined in the Medical Staff Credentials Policy.

(a) ***"Ongoing Professional Practice Evaluation"*** or ***"OPPE"*** means the ongoing review and analysis of data that helps to identify any issues or trends in Practitioners' performance that may impact quality of care and patient safety.

(b) ***"PPE Specialists Committee"*** means a member of the PPE Specialists Committee at a Participating UPMC Hospital. This may include, but is not limited to, a Quality Department RN Reviewer, VPMA, applicable Department Chair, representatives from Medical Staff Services, and/or representatives of the Wolff Center who work on behalf of the Participating UPMC Hospital.

6. ***Amendments.***

(a) The Medical Staffs and Board at each Participating UPMC Hospital have independently adopted this Policy as their own by voting to approve it for use at each of their respective facilities. In doing so, the Participating UPMC Hospitals have delegated to the Medical Review Council the authority to develop and adopt amendments to this Policy.

(b) Notice of any amendments will be provided to the Medical Executive Committees at each Participating UPMC Hospital for their information. Any amendments to this Policy will take effect immediately upon receiving notice of the changes from the Medical Review Council.

(c) If any Medical Executive Committee has concerns about an amendment, they may bring the concern to the attention of the Medical Review Council. The Medical Executive Committee may also recommend to its Board that the Hospital opt out of this Policy and reestablish its own.

SIGNED: Donald M. Yealy, MD
Senior Vice President, UPMC and Chief Medical Officer, UPMC Health Services
ORIGINAL: April 1, 2024
APPROVALS:
Policy Review Subcommittee: March 13, 2024
Executive Staff: March 29, 2024 (effective April 1, 2024)
PRECEDE:
SPONSOR: UPMC Medical Staff Services

*** With respect to UPMC business units described in the Scope section, this policy is intended to replace individual business unit policies covering the same subject matter. In-Scope business unit policies covering the same subject matter should be pulled from all manuals.**

UPMC HOSPITALS

Appendix A: Flowchart of OPPE Process