The Complete Guide to OPPE and FPPE

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Juli Maxworthy, DNP, MSN, MBA, RN, CNL, CPHQ, CPPS, CHSE

The Complete Guide to OPPE and FPPE would not have been possible without the contributions of other experts in professional practice evaluation. We have assumed the mantle of these pioneers in the hopes of providing information that will aid individuals and their organizations in their never-ending journey toward improving patient care.

The work of ongoing professional practice evaluation (OPPE) and focused professional practice evaluation (FPPE) is often taken on by well-intentioned individuals. As in any change management initiative, these individuals often encounter disappointments along the way, but also many successes. The purpose of this body of work is to provide the foundational knowledge, practical guidance, and tools necessary for future (and sustainable) successes in professional practice evaluation.

This project wouldn't have been possible without the unending support of my better half, Dr. Gary Witherell. His love gives me the support to continue growing, becoming a better person, and, in this particular case, becoming a better writer. Many thanks to my family and friends, especially my children.

I would like to thank HCPro for providing the necessary support and encouragement to get this project completed. In particular, I would like to thank Delaney Rebernik, who has been a great writing partner and who has gently made this book a much better one through her efforts.

About the Authors

Juli Maxworthy, DNP, MSN, MBA, RN, CNL, CPHQ, CPPS, CHSE

Juli Maxworthy, DNP, MSN, MBA, RN, CNL, CPHQ, CPPS, CHSE, brings 30 years of nursing experience to her roles. Her last clinical position was Vice President of Quality and Risk, in which, along with other responsibilities, she oversaw many activities of the medical staff. She has implemented OPPE and FPPE at the institutions where she oversaw the process. Through her work, she has learned how challenging and rewarding the implementation of these processes can be for both the organization that is mandated to execute OPPE/FPPE to maintain accreditation and for the medical staffs that are trying to understand exactly what the mandates mean and how they are going to successfully meet them.

Dr. Maxworthy is the CEO of WithMax Consulting Inc., a healthcare consulting and medical writing company located in the San Francisco Bay area. In that capacity, she utilizes her extensive experience to help healthcare organizations navigate these changing and challenging times. Dr. Maxworthy recently authored *The OPPE Toolbox* and *The FPPE Toolbox,* co-authored *The Healthcare Simulation Program Builder* for HCPro, and co-edited a 60-chapter textbook titled *Defining Excellence in Simulation Programs*. She has spoken at the local, national, and international level on various healthcare topics. Dr. Maxworthy recently obtained Certified Healthcare Simulation Educator (CHSE) certification from the Society for Simulation in Healthcare. She is the chair for the Accreditation Committee for the Society for Simulation, as well as Region One Coordinator for Sigma Theta Tau International.

Dr. Maxworthy holds a doctorate in nursing practice and two master's degrees (nursing and business administration). She is a certified professional in healthcare quality with the National Association of Healthcare Quality as well as in patient safety with the National Patient Safety Foundation. She is currently an assistant professor at the University of San Francisco, where she is the chair of the Healthcare Leadership and Innovation Department, as well as director of the BSN to DNP program.

Evalynn Buczkowski, RN, BSN, MS

Evalynn Buczkowski, RN, BSN, MS, is senior director at MedAssets/Vizient Advisory Solutions. She has more than 30 years of healthcare experience in consulting and in leadership roles in the delivery of healthcare services. Her background and experience provide strong knowledge and proven leadership skills for accreditation and regulatory compliance, clinical quality, case management, and medical staff affairs.

Prior to joining MedAssets/Vizient Advisory Solutions, Buczkowski was a regional leader in a large multihospital system. In that role, she provided leadership for the clinical and operational aspects of clinical quality; clinical informatics; accreditation; medical staff administration, including credentialing and peer review; case management, utilization review, and social work; and infection prevention. Core competencies include innovative healthcare delivery models, case management/care coordination, value-based care strategies, clinical quality processes and structures, physician-hospital alignment, accreditation/regulatory compliance, medical staff affairs, and physician performance (OPPE/FPPE).

Buczkowski is a former member of the Michigan Health and Hospital Association's Quality and Accountability Committee. In addition, she has recently published two books on the topics of OPPE and FPPE and has had national speaking engagements as a result of those publications.

Introduction Evolving Challenges and Opportunities in OPPE and FPPE

Juli Maxworthy, DNP, MSN, MBA, RN, CNL, CPHQ, CPPS, CHSE

Ever since The Joint Commission introduced ongoing professional practice evaluation (OPPE) and focused professional practice evaluation (FPPE) in a 2007 revision to its medical staff standards, medical staff leaders, medical staff professionals (MSP), and quality directors have strived (and often struggled) to find the best paths toward compliance.

OPPE and FPPE contain significant gray areas that, given today's variable healthcare climate, are unlikely to clear anytime soon. In fact, as healthcare marches toward value-based outcomes, new peer review circumstances and expectations will surface. But in addition to the challenges inherent in the coming change, there's opportunity. With the proper approach and widespread buy-in, OPPE and FPPE have the potential to highlight and improve practitioners' great work in the most transparent of ways.

Healthcare veterans must pave the way for newcomers to continue and advance this important work. Given the nation's graying workforce (particularly in healthcare), it's more critical than ever to develop and implement relevant performance indicators that provide proper (and respectful) avenues for validating, remediating, or, at times, revoking clinical privileges.

As an example, consider the story of Dr. James, a fictional surgeon who's beloved for his warm bedside manner and well respected for his important contributions to the field. Early in his career, Dr. James developed a modification to a procedure that reduced complication rates, and his colleagues and other surgeons adopted his process with similar results.

In recent years, Dr. James' OPPE data has not reflected his established reputation. However, the administrative staff knows him well, so they glance over his performance lapses during recredentialing and grant him privileges even though he fails to meet certain minimum requirements. Often, his cases undergo peer review, but his colleagues believe that he is a great surgeon, and, as a result, the peer review committee merely skims his poor outcomes and pities him for his bad luck.

This goes on until a surgical patient suffers significant harm at Dr. James' hand and sues him for malpractice. The patient also sues the hospital for negligent recredentialing, and the resulting settlement ultimately loses the organization millions of dollars.

This story isn't true, but it isn't far-fetched, either. Hospitals frequently encounter similar situations. In fact, Dr. Atul Gawande's book *Complications* (2003) discusses the prevalence of failing physician peer review. He shares a similar story of an orthopedic surgeon, Dr. Hank Goodman (pseudonym), who was a star medical student and resident and one of the most sought-after surgeons in his field. However, the pressures of career, family, and finances eventually caught up with him. His care quality deteriorated, and malpractice suits streamed in. Dr. Goodman's poor practice continued for several years under the watchful eyes of his peers, who, for many reasons, didn't confront him.

The most troubling aspect of Gawande's story is its resonance. To err is human, and practitioners, after all, are human. So are the people who look the other way when clinical mistakes accumulate. However, human nature doesn't negate the shared responsibility of medical staff, MSPs, and quality professionals to do their due diligence in approving qualified and competent healthcare practitioners to care for patients.

As members of the healthcare industry, we tend to get bogged down in the minutiae of the daily workflow and sometimes forget about the underlying purpose—and consequences—of seemingly mundane and routine tasks. For example, The Joint Commission developed OPPE and FPPE standards when it became clear that two-year evaluation cycles weren't frequent enough for monitoring patient care.

This book is a companion to *The OPPE Toolbox* and *The FPPE Toolbox,* which provide a variety of peer review tools, forms, policies, and other resources that have been tested in the trenches and vetted by experts (including this author). *The Complete Guide* draws on the spirit of those texts and complements their contents with practical guidance and strategies to steer readers on the road toward excellence in healthcare. I hope you find this body of work helpful on your journey—one that doesn't have a final destination.

Section 1

The Nuts and Bolts

1 Laying the Foundation: The Fundamentals of Peer Review

Peer review, as it applies in today's healthcare landscape, involves the evaluation of an individual practitioner's professional performance for all relevant competency categories. It draws from multiple sources of data and identifies opportunities to improve care. Given these important aims, all practitioners granted privileges are subject to the peer review process.

The Scope of Peer Review

What sets peer review apart from other quality improvement processes is its narrow focus on the strengths and weaknesses of an individual practitioner's performance rather than on the overall quality of care provided by a system or group of professionals.

Throughout the peer review process, practitioners receive feedback for the purpose of personal improvement or confirmation of personal achievement related to the effectiveness of their professional, technical, and interpersonal skills in providing patient care. Individualized quality reports, which practitioners receive at regular intervals at least once per year (and hopefully more often), are one form of this feedback. In addition, the institution integrates provider-specific peer review results into its credentialing and privileging process and, as appropriate, into its other performance improvement activities (e.g., patient satisfaction projects).

Contemporary Forms of Peer Review

Healthcare organizations cannot assume that a practitioner is competent simply because he or she has completed medical school and residency training, holds a valid state medical license, and obtains some ongoing medical education hours. In recognition of the additional assessment necessary beyond these minimal markers of clinical ability, regulatory and accreditation bodies have imposed extensive credentialing and privileging standards on hospitals and other healthcare entities they review. Such requirements

typically include the historic proxies for competence: adequate education and training, licensure, and board certification. However, they also demand additional evidence of sufficient clinical ability.

In general, hospital accreditation organizations carry out their work on behalf of the Centers for Medicare & Medicaid Services (CMS) to ensure that facilities meet Medicare's *Conditions of Participation* (*CoP*). CMS has demanded that practitioners caring for hospitalized Medicare patients demonstrate their current competency in relevant clinical activities. In addition, hospitals (generally through their medical staffs) must continuously monitor the clinical performance of privileged providers to ensure that they do not deviate from competent practice.

The beginning of OPPE and FPPE

Early in the 21st century, increasing revelations of poor quality care in American hospitals put great pressure on The Joint Commission to strengthen its requirements related to practitioner competence. In response, the accreditor introduced the concepts of ongoing professional practice evaluation (OPPE) and focused professional practice evaluation (FPPE) in a 2007 update to its medical staff standards.

Whereas the standard for OPPE meant that medical staffs would monitor clinical competence on a routine basis, the standard for FPPE required medical staffs to create a process to evaluate, in a timely manner, clinical competency under several specific circumstances, such as when the organization has no direct data confirming a physician's competency or when OPPE findings suggest that a clinical competency or professional behavior problem may exist.

The Healthcare Facilities Accreditation Program (HFAP) adopted the language and standards of OPPE and FPPE and put them into effect in 2015. Other accrediting agencies use different terminology for their requirements to monitor competence; however, their expectations are increasingly in the vein of OPPE and FPPE.

OPPE and FPPE, which complement and build on the work of one another, are often referred to collectively as professional practice evaluation.

OPPE

OPPE is the routine monitoring and evaluation of current competency and professional behavior in practitioners with granted privileges. It is accomplished through the peer review process, and the gathered information factors into decisions to maintain, revise, or revoke existing privileges.

Assessed competencies

Typically, areas of OPPE evaluation align with the Accreditation Council for Graduate Medical Education's (ACGME) six core competencies. Originally developed to assess medical residents in ACGME-accredited training programs, these competencies have since become the industry standard for determining quality performance throughout the careers of physicians and, when relevant, other practitioners. They are as follows:

1. **Patient care:** Practitioners provide care that is compassionate, appropriate, and effective for the treatment of health problems and promotion of overall health.
2. **Medical knowledge:** Practitioners demonstrate knowledge about established and evolving biomedical, clinical, and cognitive sciences and apply this knowledge to patient care.
3. **Practice-based learning improvement:** Practitioners evaluate, incorporate scientific evidence into, and improve their patient care practices.
4. **Interpersonal and communication skills:** Practitioners demonstrate interpersonal and communication skills that result in effective information exchange and collaboration between patients, their families, and peers.
5. **Professionalism:** Practitioners commit to carrying out professional responsibilities, adhere to ethical principles, and show sensitivity to a diverse patient population.
6. **Systems-based practice:** Practitioners are aware of and responsive to the larger context and system of healthcare. Using this insight, they effectively call on system resources to provide optimal care.

Performance indicators

OPPE relies on performance indicators, also known as performance measures, to assess how a practitioner is performing in key competency areas. Typically, the ACGME's core competencies serve as the basis for developing indicators. However, individual measures are hospital-specific and derive from a number of sources, including regulatory and accreditation requirements, national and industry standards, evidence-based best practices, and internal initiatives. A strong set of indicators measures multiple dimensions of a practitioner's performance, including his or her clinical ability and impression on others.

✓ TIP

All indicators should be reviewed regularly and revised based on new regulatory requirements, scientific discoveries, advances in practice based on those discoveries, and changes within the organization. If two years of review doesn't identify any issues in a particular area, it makes sense to drop that indicator for the time being and move on to something else.

For more on performance indicators, see Chapters 4 and 5.

FPPE

FPPE is a process through which a practitioner's professional performance is evaluated to confirm current competence. It is typically used for practitioners who are new to the medical staff, have been granted new or expanded privileges, or have potential performance concerns that have been identified through OPPE. This evaluation is privilege specific, evidence based, and time limited. The term "time limited" is commonly interpreted as meaning within three months or a suitable period based on practice volume and specialty-specific privileges.

FPPE evaluates cognitive or procedural skills as well as conduct and may be done prospectively, concurrently, or retrospectively through chart review, performance monitoring, internal or external peer review, and morbidity/mortality reviews or discussion.

Events that warrant FPPE

Accreditors currently require the performance of FPPE in the following cases.

Practitioners are new or reentering the healthcare facility

Medical staffs must conduct FPPE when practitioners come to the organization directly from their training programs, are otherwise new to the organization, or are returning to the organization. FPPE must occur even if there are documented records of performance outcomes and privileges internally or from another facility. These evaluations should be at the individual level. Although aggregate evaluations may call attention to practitioners with outlier performance levels, organizations must review all practitioners in this category, not only those who fall outside the acceptable ranges. Aggregate reviews will not meet the requirements for this type of FPPE.

Practitioners are seeking new or expanded privileges

Medical staffs must verify the appropriateness of the specific privileges requested, regardless of whether the applicant is new to the organization or already practices there.

Practitioners fall outside acceptable ranges on thresholds for OPPE indicators

A threshold is a specific numerical value (e.g., rate or volume of instances) that reflects acceptable, and in some cases excellent, performance on a given clinical indicator. Organizations determine appropriate thresholds for their specific practitioner population based on the relevant indicator, national and industry benchmarks, academic research, and internal data. When a provider falls below an established threshold for a given indicator, the performance lapse triggers FPPE. For more on performance indicators, benchmarks, and thresholds, see Section 2.

Sample triggers

Following is a non-exhaustive list of specific events that could trigger FPPE:

- **A sentinel event** or near miss with potential for significant patient harm. FPPE of a particular practitioner involved in such an event is in addition to (or part of) any root-cause analysis performed.
- **Results from chart review** indicating that a practitioner delivered problematic care or significantly deviated from the standard of practice.
- **Specific complaints or incident reports** suggesting a quality concern about a specific practitioner. Such complaints or concerns can be raised by hospital staff, professional colleagues, patients, or their families.
- **A pattern of malpractice suits** atypical for someone in the same specialty. Or, alternatively, a single malpractice suit in which an adverse judgment is rendered and the patient care negligence alleged was significant or suggests a pattern of problematic care in the eyes of a medical staff peer review committee.
- **The limitation or termination of privileges** at another institution for reasons relating to quality of care or unprofessional conduct.
- **Violations of the medical staff code** or expectations of professional conduct.
- **Failure to comply with stated performance expectations** established by the medical staff/hospital board (e.g., an expectation that approved clinical protocols will be followed unless a justification for deviation is documented).

- **An unusual, adverse patient care event** or pattern of care as established by the practitioner's department chair, a medical staff peer review committee, a medical staff officer, a hospital director of quality, or a hospital physician executive.
- **OPPE results** suggesting that a particular practitioner is a performance outlier or does not perform in accordance with benchmarks or indicators adopted by the medical staff executive committee (e.g., patterns of unnecessary diagnostic tests or treatments, excessive lengths of stay, frequent readmissions, or an unusual number of returns to the emergency department or the operating room).
- **Low volume of procedures** or admissions over an extended time period that raise concern about maintenance of expertise and competence.

Conducting FPPE

The following are the three primary methods for conducting FPPE:

1. **Prospective review:** A proctor discusses with a practitioner his or her intended approach to that clinician's actual cases
2. **Concurrent review:** A designated expert or peer provides direct observation
3. **Retrospective review:** A designated practitioner performs a chart review

For more on FPPE performance methods, see Section 4.

Determining sufficient review

To ensure that FPPE activities provide sufficient insight into a practitioner's competency, organizations may employ any of the following approaches:

- **Establish a time period over which FPPE will occur.** Consider altering this duration according to the given practitioner's level of documented training or experience. For example, new applicants from an outside residency program and even tenured practitioners coming from other organizations may not have data to share. The duration of their FPPE may be longer than that performed for practitioners who come from a residency program within the organization or who have documented outcomes from another facility.
- **Set a specific number of procedures or admissions to review.** This decision should be based on key competency variables, including expectations established for previous applicants with similar backgrounds and the performance data provided by the current applicant.

- **Vary the approach depending on key circumstances,** such as volume or risk. For example, when conducting FPPE for low-volume procedures, consider defining a specific number of procedures rather than a time period for monitoring.

Time Frames

Regulators, accreditors, and bylaws require medical staffs to conduct peer review in a timely manner, though their definitions of "timely" vary. Each hospital must define its own turnaround times within the compliance parameters established by relevant regulators and accreditors, keeping in mind the importance of obtaining and applying results as quickly as possible. For example, the goal may be for routine cases to be completed within 90 days and for complex cases to be completed within 120 days, with the starting point as the date on which the chart is referred to the committee providing oversight to the process, such as the medical staff quality committee, quality management coordinator, or other designee. Medical staff policy should also specify when exceptions are allowed based on factors such as case complexity, reviewer availability, or urgency.

The medical executive committee (MEC) delegates oversight of the peer review process to an appropriate committee, which reports back to the MEC and the board regularly. Hospital staff members are assigned to support the designated peer review committee and to provide volume and outcome data to the medical staff services department in the form of practitioner profiles as requested.

The Roles of Various Stakeholders

A robust peer review process often hinges on collaboration among a variety of disciplines. Specific participants are selected according to medical staff policies and procedures. In addition to the practitioner and the designated reviewer, additional support staff, including medical staff professionals (MSP) and quality professionals, may participate as specified in their job descriptions and/or by invitation (e.g., by a vote of the MEC or peer review committee members).

Medical staff leaders

Typically, a peer review committee, or in some cases the MEC, determines the degree of subject matter expertise required for a provider to be considered a peer for all peer reviews performed by or on behalf of the hospital.

In the event of a conflict of interest or circumstances that would suggest a biased review, the peer review committee or the MEC determines the specific party that will participate in the review process.

Conflicts of interest

A conflict of interest may exist if a member of the medical staff is not able to render an unbiased opinion. Automatic conflict of interest would result if the practitioner is the one under review—he or she can't sign off on his or her own review. Other conflicts of interest might arise if the designated peer is involved in the patient's care or if the peer has a relationship with the practitioner involved, either as a direct competitor or as a partner.

The individual reviewer is obligated to disclose any potential conflict to the peer review committee, which in turn must determine whether the conflict would prevent the individual from participating at all or would affect the extent of that participation. Individuals determined to have a conflict may not be present during peer review body discussions or decisions other than to provide information if requested.

For more on conflicts of interest, see Chapter 18.

Peers

In this context, a peer is an individual practicing in the same profession who has expertise in the appropriate subject matter. The level of subject matter expertise required to provide meaningful evaluation of a practitioner's performance will determine what "practicing in the same profession" means on a case-by-case basis. For example, in quality issues related to general medical care, a physician (MD or DO) may review the care of another physician. For specialty-specific clinical issues, such as evaluating the technique of a specialized surgical procedure, a peer is an individual who is well trained and competent in that surgical specialty.

Proctors

A proctor provides direct evaluation in real time by observing performance in an actual situation. This means the proctor must be present during service delivery and, depending on hospital policy, may be expected to intervene if necessary. Any intervention must be immediately reported to the appropriate group chair.

The proctor's role is that of an evaluator of technical and cognitive skills. The proctor is not a teacher, consultant, or mentor, nor does the proctor necessarily have a formal physician-patient relationship with the patient.

For more on proctoring, see Chapter 11.

MSPs

Although MSPs don't assess practitioners' competence, they can ensure that the organized medical staff has the bylaws, policies, and procedures in place to conduct a consistent, fair, effective, and well-documented peer review process. In addition, the medical staff services department can be instrumental in ensuring that medical staff leaders follow through with established processes for peer review and in diminishing conflicts of interest.

MSPs' peer review activities include the following:

- Data collection and organization
- Reporting
- Process oversight
- Meeting management
- Administrative tasks

In addition, new applicants must be oriented and mentored to ensure that they don't perceive the high level of initial oversight as unique to them or punitive in any way. Acceptance packets typically include the peer review policy and all the forms necessary to ensure that newcomers understand both the process and the expectations of the organization. See Tool 1.1 in the Appendix for a sample peer review policy.

Quality professionals

The quality department (or equivalent group) gathers, monitors, and trends peer review data, often in collaboration with the medical staff services department. In addition, quality professionals may refer potential performance issues identified through root-cause analysis to the peer review committee.

Based on research of national standards and professional association materials, the quality department may recommend specific clinical indicators for evaluating practitioner performance. The medical staff must review these recommendations prior to board approval.

Challenges and Risk Areas

The credentials committee and MEC, as part of the credentials process, regularly review the capability, competence, and health status of each practitioner who has been granted clinical privileges in accordance with the medical staff bylaws, and all credentialed practitioners attest to their health as part of

the application process. The MEC may consider more in-depth evaluation when a practitioner self-refers with certain concerns, including the following:

- Potential health issues
- Questions regarding his or her ability to safely provide quality patient care
- A return to work after a leave of absence for health-related issues

External peer review

When no practitioner on a medical staff can be considered a peer, the organization must have a policy in place regarding external peer reviewers. Because external review can be costly as well as time-consuming, most organizations try to avoid using it when at all possible. However, it is nonetheless important to have a policy in place should the need for external review arise.

In many hospitals, the service line or department chair, peer review committee, or another designated group will make recommendations on the need for external peer review to the MEC. The policy must also define the circumstances in which external review will occur and state that no practitioner may require the hospital to obtain external peer review if it is not deemed appropriate by the MEC or the board.

Circumstances requiring external peer review may include the following:

- **Litigation:** When dealing with the potential for a lawsuit.
- **Ambiguity:** When dealing with vague or conflicting recommendations from internal reviewers or medical staff committees. Conclusions from this review will directly impact a practitioner's membership or privileges.
- **Lack of internal expertise:** When no one on the medical staff has adequate expertise in the specialty under review, when the only practitioners on the medical staff with that expertise are determined to have a conflict of interest regarding the practitioner under review as described above, or when the potential for conflict of interest cannot be appropriately resolved by the MEC or board.
- **Miscellaneous issues:** When the medical staff needs an expert witness for a fair hearing, for evaluation of a credentials file, or for assistance in developing a benchmark for quality monitoring.
- **Any other circumstances deemed appropriate** by the governing board or the MEC.

For more on external peer review, see Chapter 11.

APP peer review

When a facility issues privileges for advanced practice providers (APP), collecting performance data can be a challenge because APP data typically aren't specified in patient care records.

When chart-based, automated data collection methods aren't available, the organization must have other ways to gather and report on APPs' performance. The practitioner's supervising physician may be required to review a set number of charts per year, as specified in the medical staff peer review policy—for example, at least five charts per year for each APP under his or her supervision. Results of the chart review would then be documented and submitted to the quality department.

For more on professional practice evaluation for APPs, see Chapter 15.

Low-volume providers

Low-volume providers may have difficulty completing initial FPPE according to the established time frame. The credentials committee may be asked to grant an extension, and if they are, they must be provided with a report of cases completed to date and the reasons for the delay. An applicant who doesn't utilize the facility for a sufficient period up front may not qualify for continued privileges. Always talk to the practitioner. Explain the situation, ask for information, and offer alternatives, such as community status.

For more on professional practice evaluation for low- and no-volume practitioners, see Chapter 16.

Late-practice evaluation

Increasingly, organizations are implementing policies for evaluating older members of the medical staff—often for practitioners at age 70, or earlier if peer or self-referral occurs. The policy may contain steps such as the following:

- An anonymous assessment of the practitioner's performance as compared with the ACGME's core competencies. This review is often performed by selected references, such as peers and staff who work closely with the practitioner.
- Decreased time between ongoing review periods.
- Periodic focused review.
- Health evaluation. The practitioner may use his or her own annual or employment physical. However, regardless of the chosen evaluation, the practitioner must attest that he or she has had an annual physical, and that no health conditions that would prevent safe practice were found.
- Annual, rather than biennial, reappointment.

In the case of ongoing illness, a comprehensive fitness-to-work evaluation may be requested. If the practitioner can safely practice hospital medicine, reasonable accommodations will be made whenever possible in accordance with the Americans With Disabilities Act. For more on professional practice evaluation for aging practitioners, see Chapter 2.

Employed practitioners

The same peer review process applies to employed and contracted practitioners; however, administration must be notified and involved when any action is considered on employed practitioners' medical staff membership and/or clinical privileges, because the disciplinary process may differ. Follow the appropriate medical staff bylaws when findings lead to a recommendation for action on a practitioner's medical staff membership and/or clinical privileges.

Confidentiality

When peer review information is clearly identified as such, it is considered privileged and confidential information in accordance with medical staff and hospital bylaws, state and federal laws, and regulations pertaining to confidentiality and nondiscoverability.

Obligations to protect peer review information

Organizations are required to protect provider-specific peer review and other quality information concerning a practitioner in a secure, locked format in the medical staff services department, quality department, or other location as specified in hospital policy. Documents stored electronically are subject to all requirements dictated by the applicable state, the Health Insurance Portability and Accountability Act of 1996, and other privacy regulations. Access to electronic information should be limited with the same diligence as access to paper files.

Provider-specific peer review information should include the following:

- Performance data for all dimensions of performance measured for that individual practitioner
- The individual practitioner's role in sentinel events, significant incidents, or near misses
- Correspondence to the practitioner regarding commendations, practice performance, or corrective action

Terms for accessing confidential information

Peer review information should be made available only to authorized individuals with a legitimate need based on their responsibilities as medical staff leaders or hospital employees. Authorized individuals may access the information, but only to the extent necessary to carry out their assigned duties. Medical staff bylaws or policies must clearly indicate the individuals who are authorized to access provider-specific peer review information and for what purposes. Authorized personnel may include the following:

- Medical staff officers
- Department, group, or service line chiefs (but only members of a practitioner's department, group, or clinical service)
- Members of the MEC, credentials committee, and/or peer review committee
- Hospital risk manager
- Hospital director of quality improvement
- MSPs (when access to confidential peer review information is necessary for recredentialing or formal corrective action)
- Individuals surveying for accrediting bodies with appropriate jurisdiction or for state/federal regulatory bodies
- Individuals with a legitimate purpose for access as determined by the hospital board of directors
- The hospital CEO, when information is needed to take immediate formal corrective action

The organization should also clearly indicate that copies of peer review documents may not be created and distributed unless authorized by hospital policy or the CEO.

Terms for accessing the credentials file

Medical staff bylaws or policies must outline the process for accessing a practitioner's credentials file. The credentials file is the property of the hospital and must be maintained with the strictest confidence and security. All such files must be maintained by the designated agent of the organization in locked storage or secure electronic format. Medical staff and administrative leaders may access the files for peer

review and institutional reasons. In general, files may be shown to accreditation and licensure agency representatives, but only with the permission of the CEO or designee.

Medical staff bylaws and policies should also indicate when practitioners may review their credentials file. This might be allowed in the following circumstances:

- On written request approved by the current medical staff president, CEO, or credentials committee chair.
- In the presence of the MSP, a designee of administration, or a medical staff leader.
- When confidential letters of reference have been removed. Confidential letters should be sequestered in a separate file and removed from the formal credentials file prior to review by the practitioner.

✓ TIP

A medical staff might consider including a provision in bylaws and policies that allows the medical staff services department to copy for a requesting practitioner any material provided by that practitioner, such as licenses, board certification, and résumé/CV. Other documents, such as primary source verifications completed by the medical staff services department, may not be removed from the file or copied.

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The Complete Guide to OPPE and FPPE is your comprehensive guide to navigating today's OPPE and FPPE landscape, and a handy companion to ***The OPPE Toolbox*** and ***The FPPE Toolbox.*** Authors Juli Maxworthy, DNP, MSN, MBA, RN, CNL, CPHQ, CPPS, CHSE, and Evalynn Buczkowski, RN, BSN, MS, shed light on the industry's most pressing questions about hard-to-evaluate practitioners, data aggregation, effective reporting strategies, and more. Plus, customizable forms make for a seamless transition from education to application.

With a healthy blend of practical guidance on core OPPE and FPPE concepts and targeted strategy on specific pain points, ***The Complete Guide*** is a must-have for medical staff veterans and newcomers alike.

This book will help you:

- Evaluate and strengthen existing OPPE/FPPE approaches
- Integrate, evaluate, and share meaningful performance data
- Understand confusing OPPE/FPPE scenarios
- Prepare for the future of OPPE/FPPE

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