



## OPPE, FPPE, & PEER REVIEW

How, When, and Why

*Part 2 – F/OPPE, Credentialing, and Peer Review:  
Getting in Sync*

New Jersey State Association Medical Staff Services

May 1 -2, 2025

## Sara Cameron, CPMSM, CPCS Senior Director Professional Services & Senior Consultant



Sara Cameron serves as the Senior Director of Professional Services and a Senior Consultant at The Hardenbergh Group, bringing over 20 years of rich experience in healthcare administration, Medical Staff Services, and Graduate Medical Education. Throughout her career, she has partnered with large health systems to implement best practices in credentialing, privileging, peer review, professional development, and performance improvement.

Sara has made a significant impact by designing and implementing comprehensive professional practice evaluations and clinical peer review systems that enhance healthcare quality. Her efforts in establishing a central verification office enabled the standardization of credentialing practices across nine hospitals, leading to improved governance and efficiency. Through her innovative approach, she has fostered a culture focused on opportunities for improvement, effectively reducing complication rates, lengths of stay, and emergency department readmissions.

Additionally, Sara has been instrumental in transitioning organizations to electronic medical records and paperless credentialing processes. She has developed robust onboarding and orientation programs for physicians and medical staff leaders, ensuring they are well-equipped to tackle the challenges in healthcare.

A graduate of the NAMSS Leadership Certificate Program, Sara is an engaged leader within the National Association of Medical Staff Services (NAMSS), where she has held various volunteer and elected roles, including committee positions and board membership. Passionate about education, she has delivered extensive training sessions and authored several publications on medical staff leadership, making a lasting impact in the healthcare community.

## DISCLOSURES

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## Dr. Neo has been on staff for two years and is now due for *reappointment*

- ✓ “Current competence” for privileges requested
- ✓ Provider profile – OPPE/FPPE\*
- ✓ Peer Reviews
- ✓ License & DEA Certificates
- ✓ CME
- ✓ Liability Insurance
- ✓ NPDB “sweep” & Criminal Background Check

# F/OPPE Information Flow



Peer Review/Performance Committee  
The Department of Education's Office of the  
Chair is responsible for the peer review of staff, which  
may include initially being appointed to different roles or an  
Official Staff Review Committee for further review.  
Review meetings shall be conducted in a professional  
manner with the staff member being fully informed of the  
**This recommendation is then forwarded to  
the Board of Directors.**

## Credentials Committee

## Medical Executive Committee

# Medical Staff Reappointments

The Credentials Committee is responsible for reviewing and verifying the credentials of each medical staff member before they are eligible for reappointment.

This will include:

- Reviewing application materials: The credentials committee typically reviews each medical staff member's reappointment application materials, which can include information such as their medical education, training, licensure, and any malpractice or disciplinary history.
- Conducting background checks: The committee may also conduct background checks to verify the accuracy of the information provided by the medical staff member and to ensure that they meet all of the hospital's qualifications for staff membership.
- Applying standards and criteria: The credentials committee applies specific standards and criteria to evaluate the qualifications of each medical staff member, such as required CME hours or number of patient encounters.

# Medical Staff Reappointments

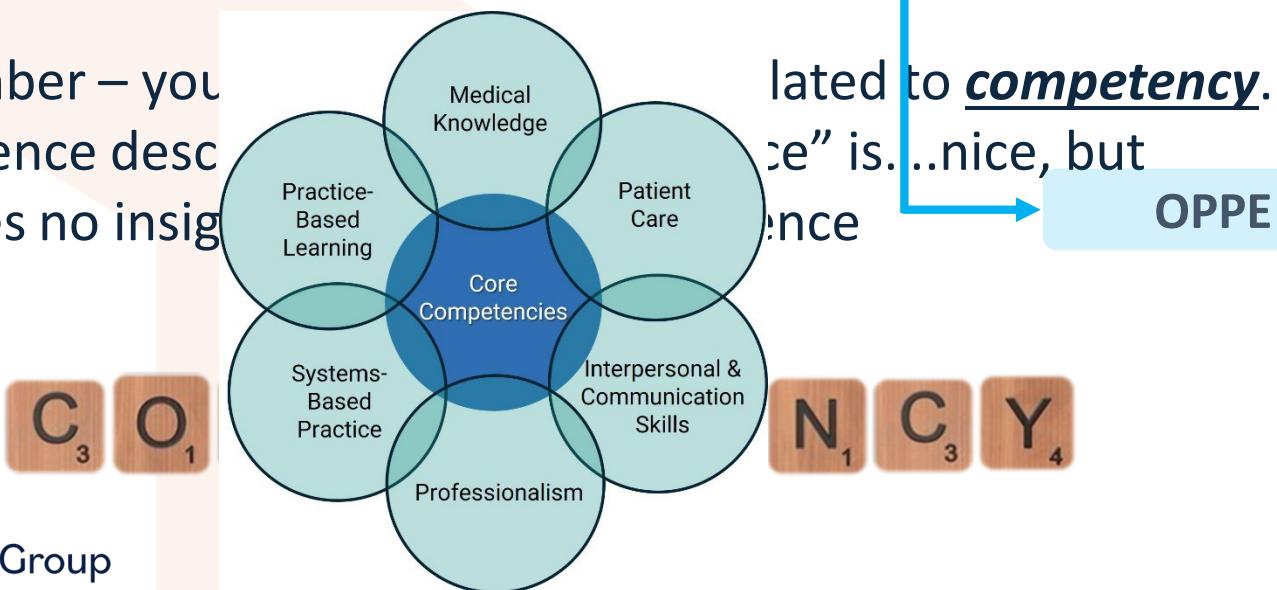
The Credentials Committee is responsible for reviewing and verifying the credentials of each medical staff member before they are eligible for reappointment.

*Overall, the credentials committee plays a critical role in ensuring that medical staff members meet the hospital's standards for reappointment and maintaining the hospital's compliance with accreditation and regulatory requirements. The committee's thorough evaluation process can help protect patient safety and ensure the highest quality of care –*

*It cannot function without a robust Peer Review process, including focused and ongoing / continuous practice evaluation data.*

# Medical Staff Reappointments

- All references are not equal – be sure they are appropriate peer references (i.e., hold the same privileges) \*
- Ensure reference forms include ACGME area of competency
  - Ask specific questions
  - Ask for review of currently granted privileges
- Remember – you A reference desc provides no insig



## Peer Evaluations / References

# F/OPPE & Credentialing / Reappointments

## *Negligent Credentialing*

If the organization knew or should have known that a practitioner is not qualified and the practitioner injures a patient through an act of negligence, the organization can be found separately liable for the ***negligent credentialing*** of this practitioner.



The image is a screenshot of a news article from NBC News. The header reads "U.S. NEWS" and the main title is "Florida hospital ignored years of complaints about surgeon, patients and families allege". Below the title, a sub-headline states: "The orthopedic surgeon caused 'hundreds of devastating injuries' while displaying signs of having a neurological condition, according to court documents." At the bottom of the screenshot, there is a photograph of the exterior of Ascension St. Vincent's hospital, showing its name in blue letters above a white cross on a building with many windows.

# F/OPPE & Credentialing / Reappointments

## *Negligent Credentialing*

### **522 lawsuits filed against retired orthopedic surgeon, Ascension St. Vincent's**

Dr. David Heekin is accused of operating on patients while impaired by a progressive neurological condition

2022

Between 2016 and 2020, patients noticed Dr. Richard David Heekin slurring his words and having “difficulty with balance, inability to concentrate, angry outbursts, erratic behavior, gait disturbances and impaired judgment and mood,” according to court documents.

License surrendered 2021

The suits claim the hospital allowed Dr. David Heekin to operate on patients for years even as he was allegedly suffering a progressive neurological condition that caused him to lose his balance and slur his speech. The suits allege he caused devastating injuries and even the death of one patient.

### **I-TEAM: Appeals court rules more than 2,700 texts and images regarding doctor at the center of malpractice lawsuits be released in discovery**

St. Vincent's employees whose communications are at issue planning to ask for a rehearing, court filing shows

The text messages and images in question are from 2014 to 2021.

litigated has been disclosed by the plaintiffs in public legal filings. It says, we “are going to both report him to the state I think. He is out of his mind today. He's so confused... “not making any sense,” and “can't form a full sentence.”

### **I-TEAM: Former Ascension CEO compelled to testify at deposition in negligence lawsuits**

A former orthopedic surgeon at Ascension St. Vincent's accused of operating while impaired in hundreds of lawsuits

# Low/No Volume Providers

## *F / OPPE Data Challenges*

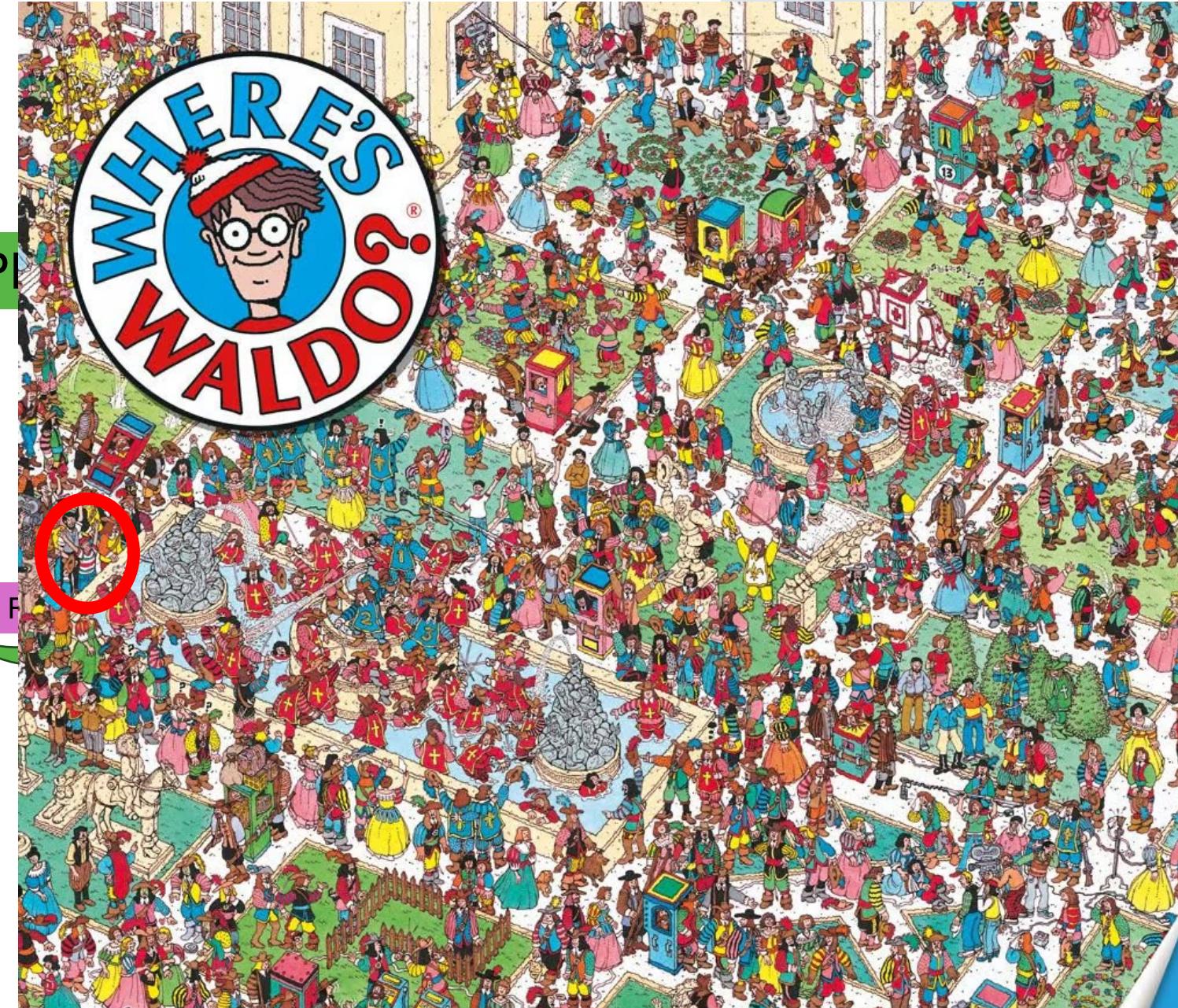


OPPE  
Low / No Volume  
Providers  
Peer  
OPPE

FPPE

OPPE

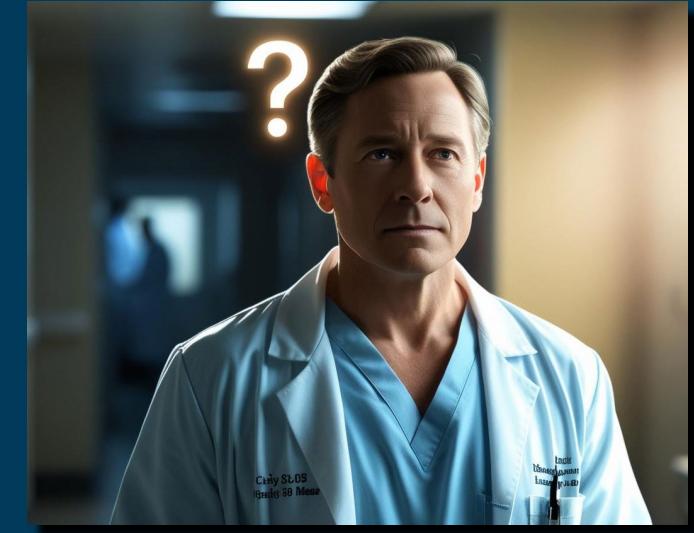
...etc



# Low / No Volume Providers

Low & No Volume providers create significant quality monitoring and credentialing challenges for most medical staffs

- Where do you find data?
- What data should be tracked?
- How can we grant privileges without adequate PPE and Quality Data?
- *Does this increase exposure for negligent credentialing?*



# Meet Low / No Volume Dr. Neo

- Dr. Neo is a residency and fellowship trained surgical specialist who has been in practice elsewhere for 5 years and has now applied for privileges at your hospital
- *Dr. Neo's practice is almost exclusively outpatient, and your CEO is salivating at the prospect that he will be bringing cases to the hospital-owned outpatient surgery center*
- Dr. Neo's application was approved by Credentials Committee, the MEC, and the Hospital Board
- *Great! Now what metrics will be used for his initial FPPE, and how do you monitor them?*



# Recognize Low/No Volume Drivers

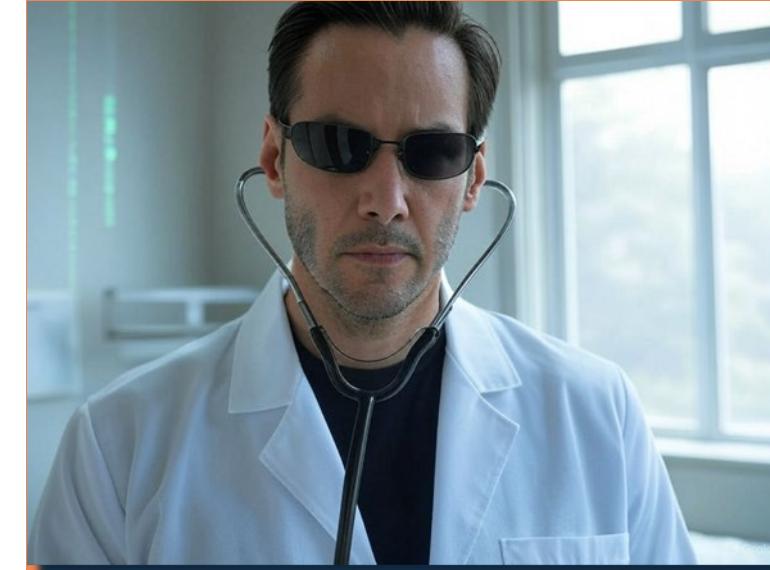
- Increase in hospitalist programs
- *Ambulatory surgery centers expanding services*
- Increased utilization of Endoscopy Suites
- *Expansion of minimally invasive procedures being performed in outpatient settings*
- Financial incentives – Specialist ownership stakes in outpatient settings, ASCs, endoscopy suites, cardiac cath labs....
- *Increasing number of providers (often women) pursuing work/life balance and time for family*
- Many providers hold on to privileges because of previous reimbursement requirements – which may no longer be relevant
  - *There still are 3<sup>rd</sup> party payers that still require physicians maintain hospital medical staff membership to participate in their network*



# Understanding the “need”

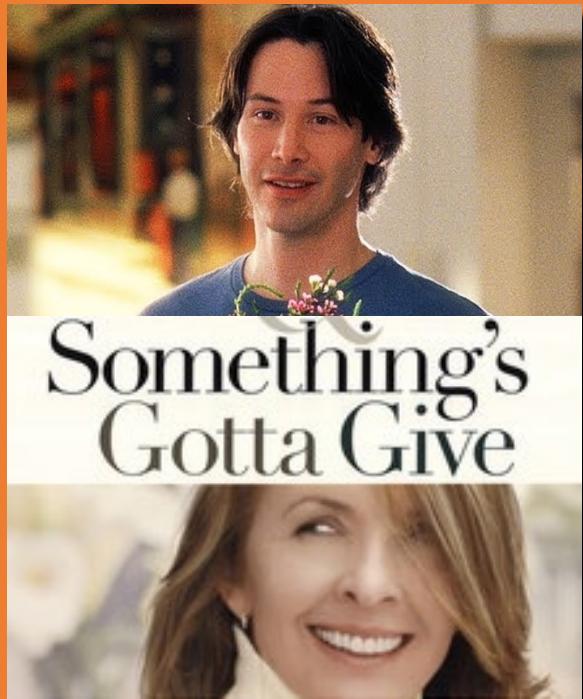
*Why does a provider need hospital privileges?*

- Staff membership / privileges may be a requirement from third party payer(s)
  - Membership alone, without privileges, may meet this requirement
- Perception
  - They have always had privileges; removing “active privileges” may be seen as a punishment or viewed negatively
- Having a conversation is important --- provide understanding regarding the differences between hospital staff membership & hospital privileges



# Understanding your “need”

*What's the big deal, and why is it my problem?*



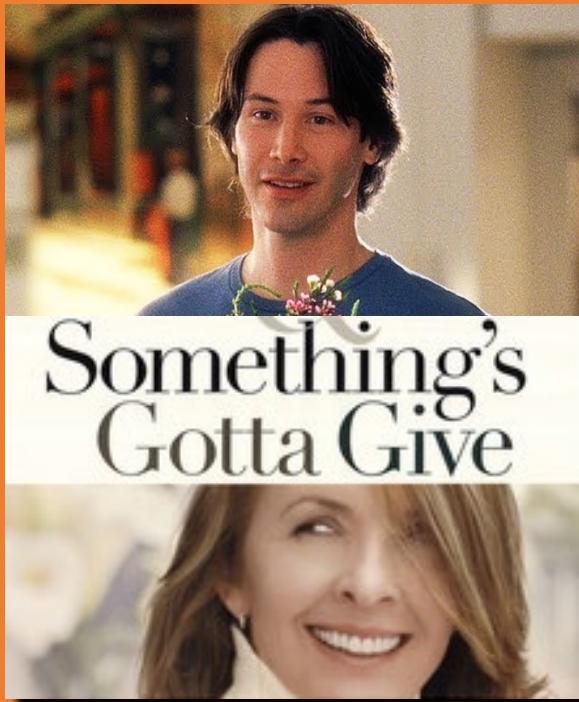
- Accreditation bodies have raised the bar regarding the need to link privileges with demonstrated current competence
- A threadbare “credentials file” is not sufficient
- PPE and Quality Data are required to demonstrate competency.....
  - ....***and must be used in the recredentialing process***

**FPPE is time-limited**  
***& cannot go on indefinitely***

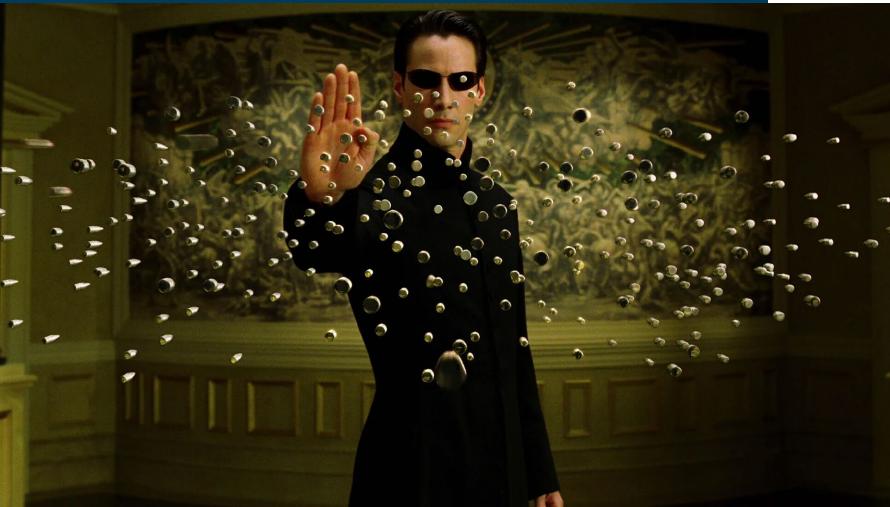


# Understanding your “need”

*What's the big deal, and why is it my problem?*



- Low & No Volume providers by definition do not provide enough hospital-based care to demonstrate evidence of competence
- Medical staff leaders and MSPs responsible for credentialing / recredentialing need a little creativity and flexibility to identify data sources for these providers
- Creativity and flexibility can also help solve this issue for providers who don't truly require full hospital privileges



Meet Their Needs  
&  
Satisfy Your Needs

# Expand Medical Staff Membership Definitions

## *Distinguish between medical staff membership and medical staff privileges*

- Separate privileges from medical staff membership
- Most commonly, active medical staff members are eligible to vote, sit on committees, and hold an office
  - An important point of discussion with this option
- Privileges delineate what care a provider can deliver to patients in the hospital. Providers must demonstrate their clinical competence to perform granted privileges
- Many hospitals have a “Refer & Follow” privilege category
  - Allows a provider to visit or see a patient in the hospital, but not to provide care

# “Refer & Follow” Privileges Example

## *Distinguish between medical staff membership and medical staff privileges*

Primary care physician in the community has a good relationship with the hospital. She refers patients from her practice to hospital for inpatient care, surgery, etc.

- The primary care provider is an active member of the medical staff but does not care for patients in the hospital.
- If a patient from her practice is admitted, they are cared for by the hospitalist service.
- The PCP may visit the patient in the hospital, view the chart and talk with the hospitalist or other providers about patient's course of care.

# “Refer & Follow” Privileges Example

## *Distinguish between medical staff membership and medical staff privileges*

This structure has built a good relationship between the PCP and the hospital, with the providers practicing within the hospital, and elevates the level of care provided to the patient as the PCP is well informed about the continuum of care and prepared to continue care after discharge.

**if you are  
happy,  
I am  
happy...**

## *Distinguish between medical staff membership and medical staff privileges*

Podiatrist with hospital privileges for 25 years is due for reappointment. Has maintained privileges despite rarely setting foot in the hospital.....Why?

- What is his perspective?
- What might require him to provide care in the hospital?
- Wanted the option to see his patients if they were admitted...but agreed he would not be providing care.
- *Had always had privileges, and never considered another option....*

“Meeting  
the Need”  
Example

# *Distinguish between medical staff membership and medical staff privileges*

Solution : Affiliate Staff Membership / “refer & follow”

- Winding down his practice
- No need or desire for political rights & responsibilities of full staff privileges



*"You can't always get what you want but if you try sometimes well you just might find you get what you need."*

*– The Rolling Stones*

**“Meeting the Need” Example**

# Low / No Volume Providers

## *Maintain good relationships*

- It's important to maintain good relationships with providers in the community – they are a crucial referral source
- Provide them with opportunities to “stay involved” with the hospital
- Establish & maintain good lines of communication with hospitalists and hospital based specialists
- Provide education / CME opportunities
- Consider varying levels of hospital staff membership & privileges
- Maintaining engagement is a critical part of medical staff planning and development

~~DIS vs. Them~~  
We

# Remember: PPE must be performed on all *privileged* providers



- Understanding Low / No Volume Providers' needs can permit removing them from PPE requirements...*and simplify your life*
- Requires appropriate bylaws to define these categories
- Are all of your privileged providers currently in the correct category?



*“Yeah, not really”*



## Low Volume Providers

Potential datapoints for low volume providers (*FPPE & OPPE*)

- Patient complaints
- Adverse outcomes / near misses reported by staff
- Outlier performance on core measures
- Data from a sister facility
- Billing data from physician's office
- Appropriate peer references at time of recredentialing
- Random chart sample reviews

# F / OPPE

## Low Volume Providers

Potential datapoints for low volume providers (*FPPE & OPPE*)

- If available, gather OPPE from Group or Sister facility
- Request “Letter of Good Standing” from non-affiliated facility where the provider has privileges

***Ensure your OPPE policy is clear***

- Provider must supply current competency and quality data to renew privileges
- It is the provider’s responsibility to ensure this data is available

# Low Volume Providers

## 4.5 APPLICANT'S RESPONSIBILITY

Any individual who is requesting appointment, reappointment, a change in Medical Staff category, and/or the granting, renewal or revision of Clinical Privileges shall have the burden of producing accurate and adequate information in a timely matter for a thorough evaluation of the qualifications and suitability for the requested status or Privileges, resolving any reasonable doubts about these matters, and satisfying requests for information. This burden may include submission to a medical or psychological examination at the applicant's sole cost, as provided in the Medical Staff Bylaws or these Rules. An applicant's failure to meet the burden of proving his/her qualifications and suitability for the requested status or Privileges shall be grounds for administrative withdrawal of an application or request, as applicable, in accordance with these Credentialing and Privileging Rules.

## Low Volume Providers

- a. For practitioners granted privileges lacking sufficient clinical activity (Low Volume/No Volume practitioners), to evaluate competency through OPPE reports, the following procedure will be used:
  - 1) An OPPE report will be run by the Quality and Patient Safety (QPS) Department and evaluated to determine if there is sufficient data for OPPE based on the Medical Staff defined activity thresholds.
  - 2) If sufficient data is not present for the biennial credentialing review, the Medical Staff Office will be informed of the need to obtain the appropriate information as follows:
    - i. Practitioners with activity at other acute care or procedural facilities relevant to privileges requested: Request peer references and OPPE results from other facilities.
    - ii. Practitioners with mainly ambulatory care activity: Request peer references and peer review results (if available) from ambulatory care facilities.

- 7.3.4 In circumstances where there is insufficient peer review data available, current competency to perform the requested Privilege may be verified from a peer, defined as an appropriate practitioner in the same professional discipline who has personal knowledge of the applicant's professional performance and competence.

# Low Volume Providers – *Telemedicine & Locums*

If you don't have a policy, ***develop one***

- Gather OPPE data from a sampling of the facilities where the physician has provided care in the recent past
- This is the applicant's responsibility
  - The contract with the telemedicine or locums provider should include language to ensure this is as easy and seamless as possible

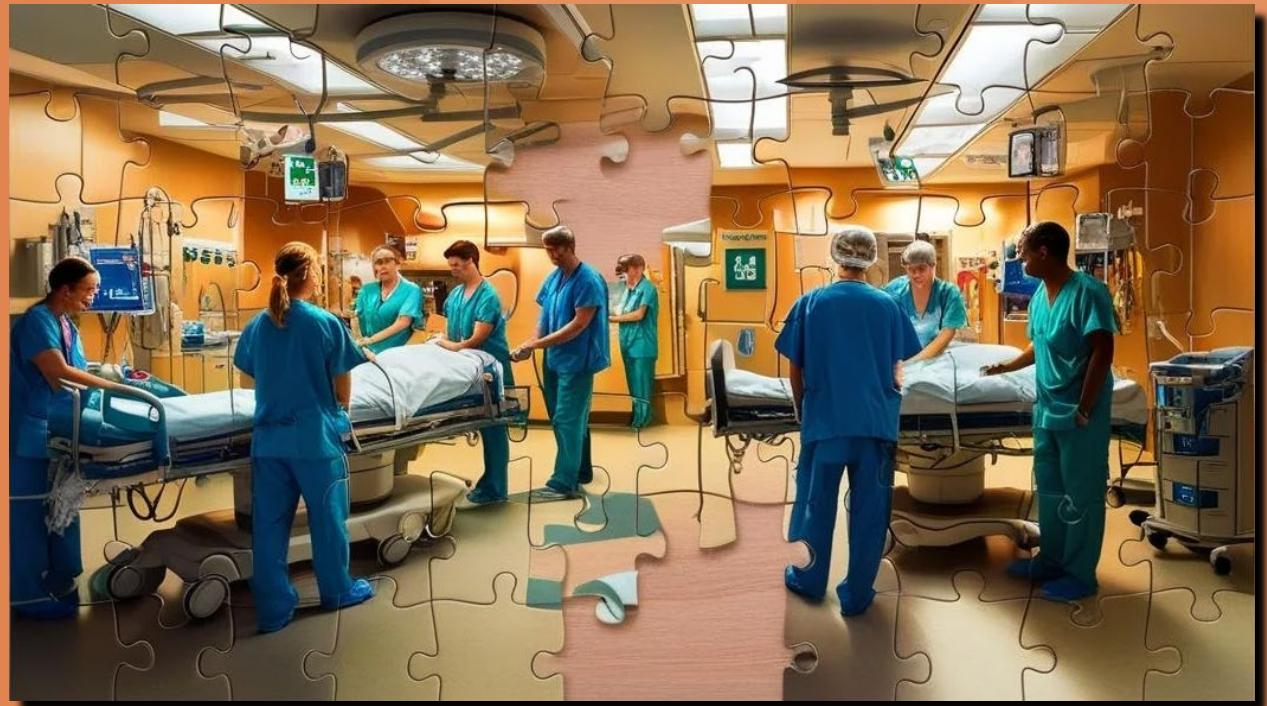
<sup>5</sup> For a telemedicine applicant or an applicant who has primarily worked in a locum tenens capacity and is requesting application to the Medical Staff, verification of other hospital staff memberships may be limited to the most recent 5 years and to the hospital at which the applicant primarily practiced. If the applicant has more than 10 hospital staff memberships during the past 5 years, verification of a sample of 5 will be obtained, to include those hospitals at which the applicant had the higher volumes.

# Low Volume Provider OPPE Use

TABLE 2

Practice Setting	Information Requested	Impact on Eligibility for Privileges
Active inpatient practice with sufficient quality data at one or more other inpatient institutions	Peer review results at other inpatient institutions and professional references	Independent inpatient privileges within the scope of recent practice
Active ambulatory facility-based practice (e.g., ASC, endoscope suite), but with little or no inpatient activity	Peer review results at ambulatory facilities and professional references	Independent inpatient privileges within the scope of recent ambulatory practice/co-management for other requested privileges pending additional data
Active outpatient practice (e.g., physician office or clinic) but with little or no inpatient activity	Professional references	Independent inpatient privileges within the scope of ambulatory practice/co-management or dependent privileges for other requested privileges pending additional data
Active practice not primarily based in the local community, but which provides necessary clinical services (e.g., locum tenens or telemedicine)	Peer review results at other inpatient institutions and /or professional references	Independent inpatient privileges within the scope of recent practice/co-management or dependent privileges for other requested privileges pending additional data
Restricted inpatient practice at all institutions (e.g., orthopedist requesting only hand privileges or physicians reducing their workload and intensity of practice)	Peer review results at CRH and other inpatient institutions and/or professional references	Independent inpatient privileges with the scope of recent practice/co-management or dependent privileges for other requested privileges pending additional data
Little or no recent clinical practice due to time off and who wish to return to practice (e.g., and OB/GYN returning to practice after taking several years to raise children)	Professional references from previous practice settings	Co-management or dependent privileges for all privileges pending additional data
Clinically inactive practitioners who only seek to continue their affiliation as a member of the medical staff	N/A	Ineligible for privileges

# F / OPPE Data for Low Volume APPs



# Low Volume Providers

## *OPPE assessment for Low Volume APPs*

- Attribution of care can be tricky
- Input from supervising physicians is crucial
- How to document assessment and monitoring data?



# Low Volume Providers

## *OPPE assessment for Low Volume APPs*

FACILITY: _____	SPECIALTY: _____	DEPARTMENT: _____
FACILITY: _____	SPECIALTY: _____	DEPARTMENT: _____
FACILITY: _____	SPECIALTY: _____	DEPARTMENT: _____
FACILITY: _____	SPECIALTY: _____	DEPARTMENT: _____

A process of the Ongoing Professional Practice Evaluation (OPPE) has been implemented for all practitioners who are granted clinical privileges for an HSHS - CID Hospital. The OPPE process is an evaluation by which HSHS - CID hospitals determine the practitioner's professional performance per the established OPPE process.

**Allied Health Professional:** YES I have 4 cases. NO I do not have 4 cases (reviewer will be prompted to complete attestation of competency below).

**KEY:** 1= Possible compromise of care \*(Comment required) 2= Needs improvement \*(Comment required) 3=Good 4= Outstanding 5=N/A (Per Privileges granted)

	Patient Medical Record #	Date of Service	Patient Management-Triage and stabilization	Diagnostic tests ordered appropriate for the history and exam	Plan of care appropriate for diagnosis	Appropriate use of consults	Appropriate ER Notes or procedures documented	Discharge Planning/Summary-initiated appropriately, complete	Repair of simple lacerations, application & removal of traction/casts
1	123456	2/5/2021	4	4	3	3	4	2	3
2	234567	4/6/2021	4	4	3	3	4	3	3
3	345678	5/5/2021	4	4	3	3	3	3	3
4	456789	5/31/2021	4	4	3	3	3	3	3

Comments:

**Reviewer:** (Supervising Physician): The AHP has listed 4 cases for my review: YES Proceed to review cases. NO Proceed to Attestation below.

**Attestation of Clinical Competency:**

According to your knowledge of this individual available to you, do you feel they are currently competent to provide services as defined by their privileges?

Yes, competent  
NO, needs improvement. Please comment: \_\_\_\_\_  
Unable to evaluate

**NOTE:** Do not place this form on the patient's medical record. Please do not photocopy or share this confidential report with anyone except the supervising physician or chairperson of the appropriate department. This document is considered privileged and confidential peer review information in accordance with Illinois Statues and federal laws and regulations covering peer review protection.

# Low Volume Providers

## *OPPE assessment for Low Volume APPs*

**Assessment of Competence**  
Time Frame: November 1, 2019 to June 30, 2020

NAME: \_\_\_\_\_ TITLE: \_\_\_\_\_ DATE: \_\_\_\_\_ CLINIC: \_\_\_\_\_

Evaluation: To your knowledge, please base your evaluation upon demonstrated performance compared to that reasonably expected of an individual with similar level of training, experience and background as the one referred to above.

Note: A comment is required for any rating of - "needs improvement"

Demonstrates knowledge and competence in assessment, planning, implementation and teaching of patients and healthcare team.	
Interpersonal & Communication Skills (relationship with patients, families and healthcare team)	
Technical & clinical competence as delineated on the scope of practice or privilege card	
Medical and Clinical Knowledge and Judgement (Ability to apply knowledge to clinical problems & ability to work with conflict in a respectful manner)	
Professionalism: Responsive and Accountable	
Adequacy and timeliness of documentation	
Adherence to Ethical Principles	
Assesses and customizes care/service accordingly for customer's specific cultural/racial/spiritual/religious/language/special needs and beliefs.	

Additional Comments: \_\_\_\_\_  
Based on your observation and supervision, does this Allied Health Professional competently perform the duties of his/her position and the duties for the privileges/scope of practice requested?  Yes  No

If No - please indicate details of any known performance that needs improvement and an action plan including completion dates to address any deficiencies:  
\_\_\_\_\_  
\_\_\_\_\_

Sponsoring Physician or Administrative Representative Signature (if applicable) \_\_\_\_\_ Date \_\_\_\_\_

NOTE: Do not place this form on the patient's medical record. Please do not photocopy or share this confidential report with anyone except the supervising physician or chairperson of the appropriate department. This document is considered privileged and confidential peer review information in accordance with Illinois Statutes and federal laws and regulations covering peer review protection.

W<sub>4</sub> A<sub>1</sub> R<sub>1</sub> N<sub>1</sub> I<sub>1</sub> N<sub>1</sub> G<sub>2</sub> S<sub>1</sub>

E<sub>1</sub>

C<sub>3</sub>

C<sub>3</sub> A<sub>1</sub> V<sub>4</sub> E<sub>1</sub> A<sub>1</sub> T<sub>1</sub> S<sub>1</sub>

U<sub>1</sub>

T<sub>1</sub>

I<sub>1</sub>

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N<sub>1</sub>

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E<sub>1</sub>



## Low Volume Providers - *Caution*

If the organization knew or *should have known* (due to training, quality, or cognitive deficits) and the practitioner can be found separately liable.

*The difficulties associated with low volume providers can be overcome by taking the following steps into consideration:*



Due to training, quality, or cognitive deficits, the organization can be found separately liable for the practitioner.

*be taken*

# The Late Career, Low Volume Physician

***Do any of these scenarios sound familiar?***

- A late-career primary care physician still wants to manage ICU patients but fails to utilize the resources of critical care physicians and underestimates the severity of his patient's illness — and an avoidable poor outcome follows.
- An older urologist with waning dexterity perforates a patient's bladder during a routine cystoscopy — maybe more than once!
- A general surgeon with a pristine 40-year track record nicks a patient's common bile duct in 50% of his most recent laparoscopic cholecystectomies.
- ***Knowledge, Skill, or Cognitive Deficit?***



**EEOC Sues Yale New Haven Hospital for Age and Disability Discrimination**

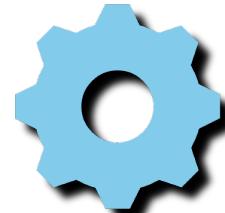
Hospital Unlawfully Subjected Only Physicians Over 70 to Neuropsychological and Eye Exams, Federal Agency Charges

# The Late Career, Low Volume Physician

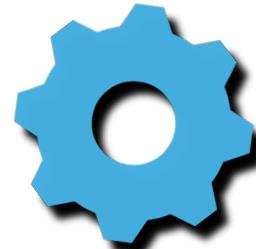
*Practice Performance Data Ensures Context, Perspective, Fairness, & Patient Safety*



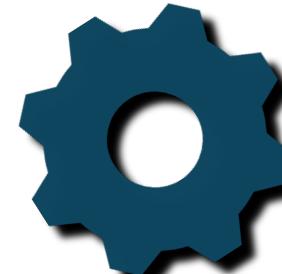
Patient Complaints or Staff Concerns?



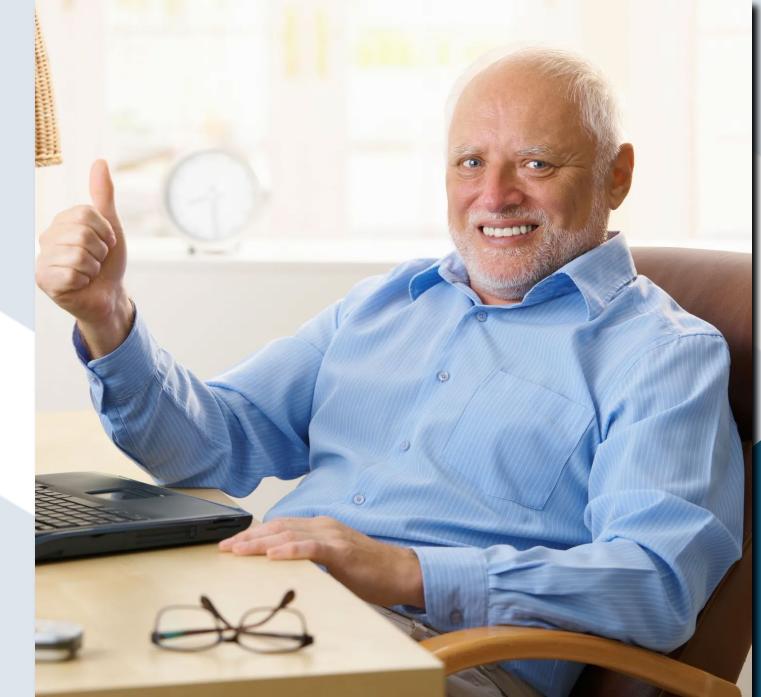
Outlier on Core Measures?



Medication errors?



Peer References?



Are there other concerns?

**Peer Review Should Be:**

Responsive

Peer Review

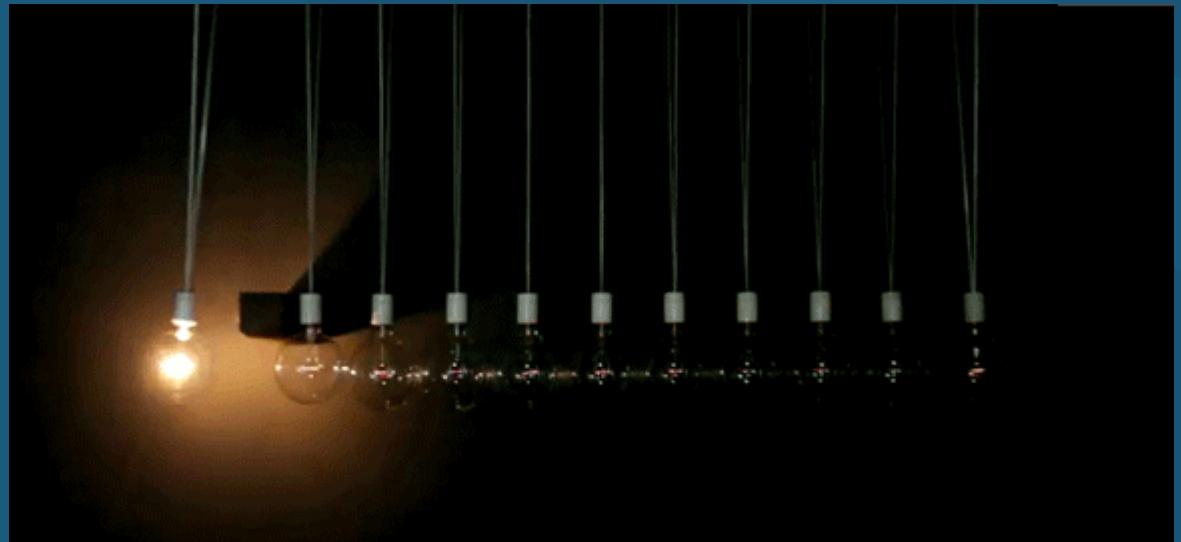
Educational

Collegial

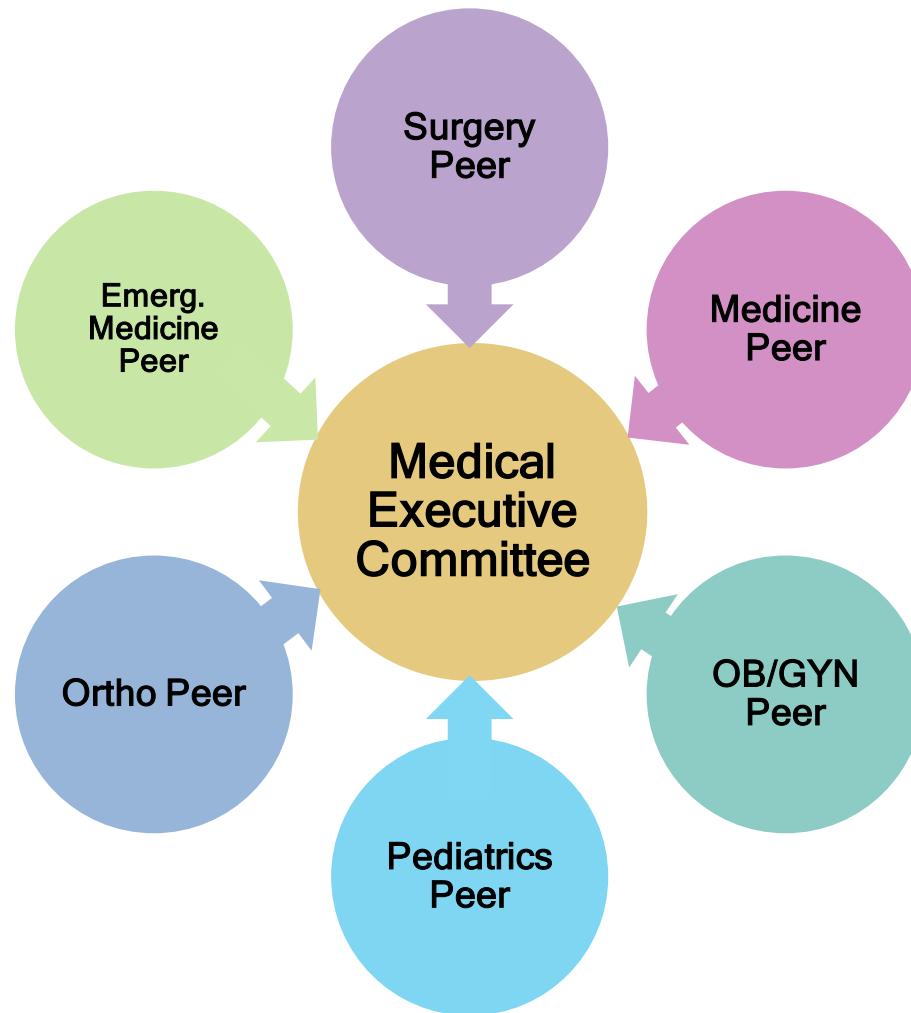
**Putting the pieces into motion**

Complimentary of Care When

Appropriate

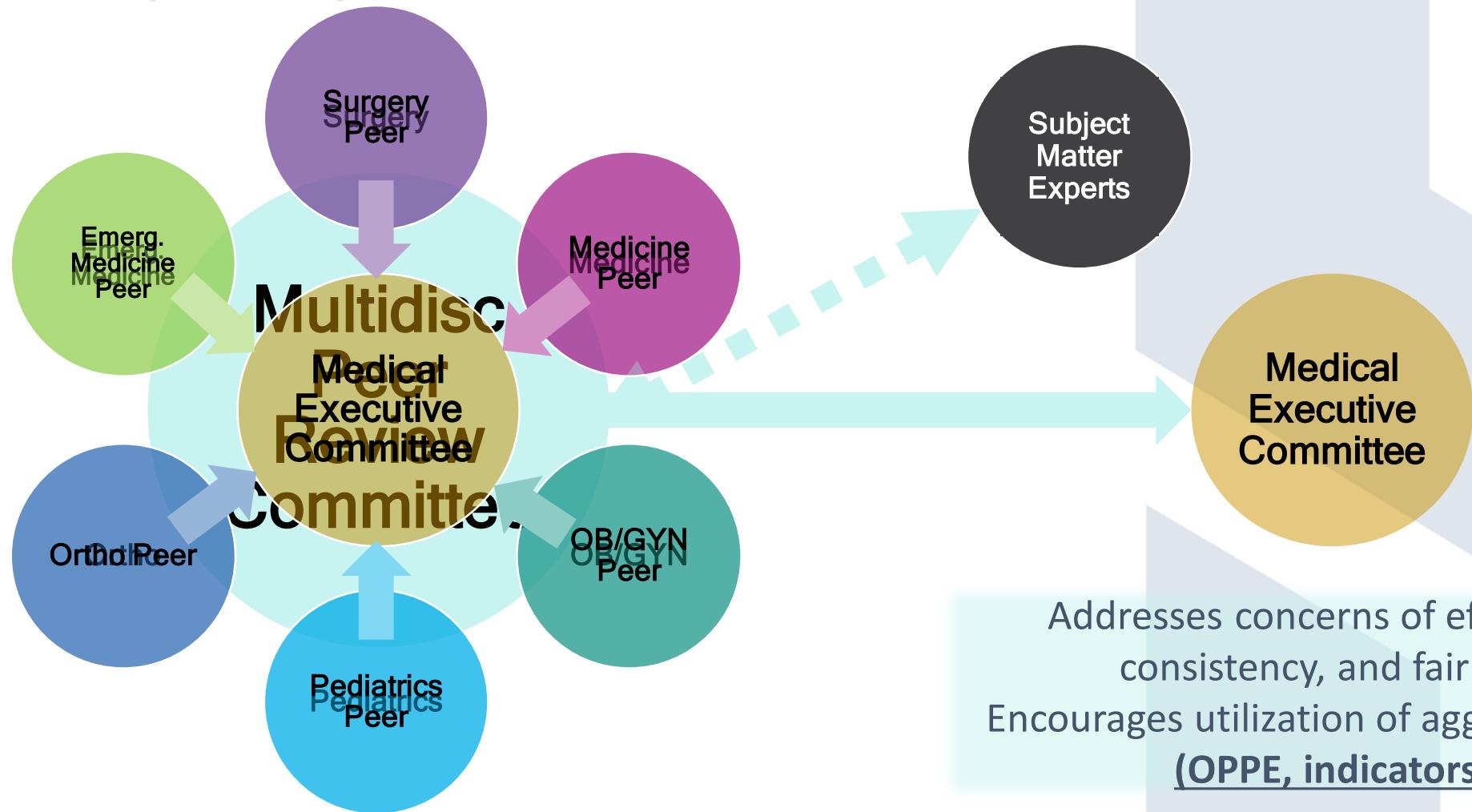


# Historical Peer Review



- Independent Peer Reviews reporting to MEC
- Heavily case review-driven process
- Lack of coordination of process improvement opportunities
- Heavy use of limited Medical Staff resources
- Perception of unfairness / conflict of interest
- Not terribly efficient
- Viewed as punitive, rather than helpful & educational

# Contemporary Peer Review



## **PEER REVIEW COMMITTEE**

The Peer Review Committee is responsible for:

- Identification of data to be measured
- Assuring appropriate collection of data

*Bottom line –  
Peer Review involves a lot more than reviewing cases*

*Reporting findings and conclusions to the Medical Executive*

Committee. The Medical Executive Committee is responsible for action or recommendations for action based upon the findings and conclusions of the medical staff Peer Review Committee initiatives

# Contemporary Peer Review Stages

## *1<sup>st</sup> Stage - Initiation of PR Process*

Starts with Triggers:

- Referrals
- Indicators
  - Rule-based
  - Rate-based

Attribution of care can be challenging

- Straightforward for procedural care
- Aggregate data and complex care can be more problematic

*Be wary of complaints that cannot be validated but observe their frequency.*



# Contemporary Peer Review Stages

## 2<sup>nd</sup> Stage - Screening

Quality Department prescreens with the Chair

- A Minor Rule Violation (simple), or
- A Significant Quality Event (complex)
- Keep track of those that don't get referred to Peer Review Committee ("Track & Trend")



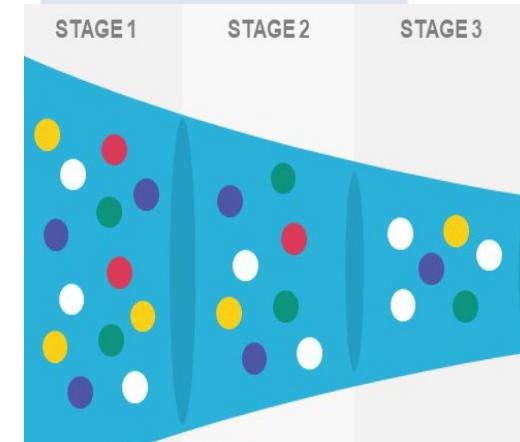
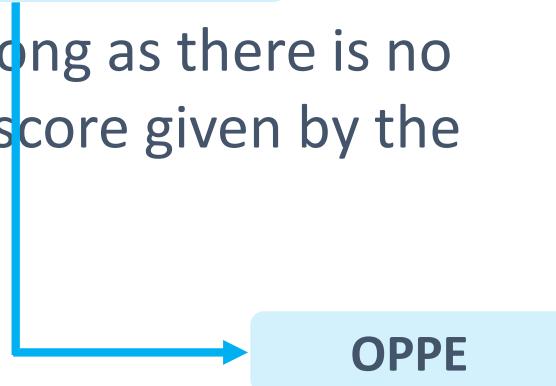
Note: Be diligent at determining whether an event is a minor violation of the medical staff rule or a complex quality event.

OPPE

# Contemporary Peer Review Stages

## 3<sup>rd</sup> Stage - Multidisciplinary Committee

- All significant quality concerns /complex events will be referred to the MD Peer Review Committee
- The MD PRC will categorize the event
- If no changes in privileges are recommended and no sanctions – the event is “Tracked and Trended”
- Note: Once a score is rendered, (as long as there is no recommendation for sanctions) the score given by the MD committee will be final

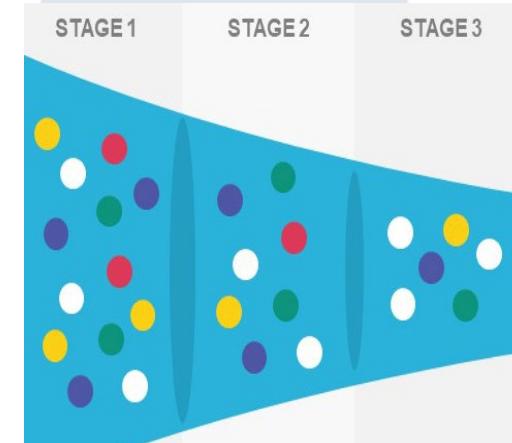


- “Predictable outcome within accepted standards of care”
- “There was **Opportunity for Improvement**”
- “**Significant Variance** from accepted standards of care rendered to this patient”

# Contemporary Peer Review Stages

## 3<sup>rd</sup> Stage - MD PRC Considerations

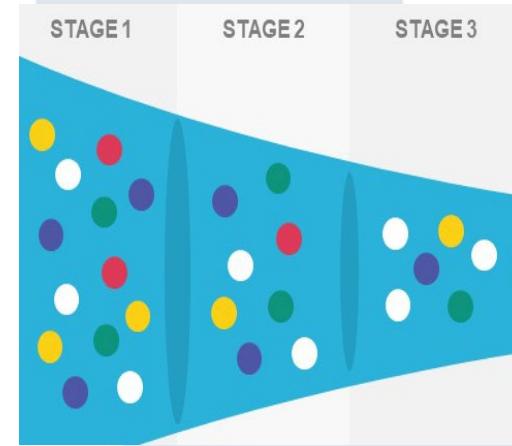
- Should a summary report to the MD Peer Review Committee regarding the cases that were scored as be minor be presented?
- Should the physician who reviews the chart contact the physician under review to get all of the facts, prior to scoring the chart?
- When should a letter be sent to a physician if a response is anticipated to be required?
  - Best Practice – request a response in writing from the physician under review if there are questions or concerns before a final rating, but do not let this delay the process
  - Appearance in person....



# Contemporary Peer Review Stages

## *3<sup>rd</sup> Stage - MD PRC Decision Options*

- No further action or review
- Educational/Informational letter
- Collegial intervention
- **FPPE plan**
  - CME/additional education
  - Monitoring/review of set number of cases
  - Proctoring
  - Referral to formal evaluation & assessment program
  - Additional training
- Referral to Medical Executive Committee



# Contemporary Peer Review Stages

## *4<sup>th</sup> Stage - Management of Sanctions*

- If any sanctions or changes in privileges are recommended, the issue will be forwarded to the MEC
- MEC will either support recommendation, ask for further review or disagree with the recommendation
- If MEC supports a significant sanction, the Appeals Process & Fair Hearing Plans are initiated
- *Ultimately the Board (Governing Body) makes the final determination on sanctions*

### Potential Sanctions

“Triggered” Focused Practice Review (*FPPE*)  
-----

Restriction of Certain Privileges  
-----

Proctoring  
-----

Chart Review / Monitoring Clinical Practice Patterns  
-----

Temporary Suspension of Privileges  
-----

Revocation of Privileges  
  
MD Review  
A HARDENBERGH COMPANY

# Contemporary Peer Review Stages

## *4<sup>th</sup> Stage - Additional Actions*

Exemplary care, regardless of the patient's outcome, should be formally recognized

Separate documentation concerns from care concerns

Systems / process issues identified should generate communication with administration

The appropriate Department Chair should be informed of any care / documentation concerns

### Educational (Redirection)

Who should participate in Peer Review? Information Sharing?

# F/OPPE Information Flow



Peer Review / Professional Practice Committee



Department Chair



Provider



Credentials Committee

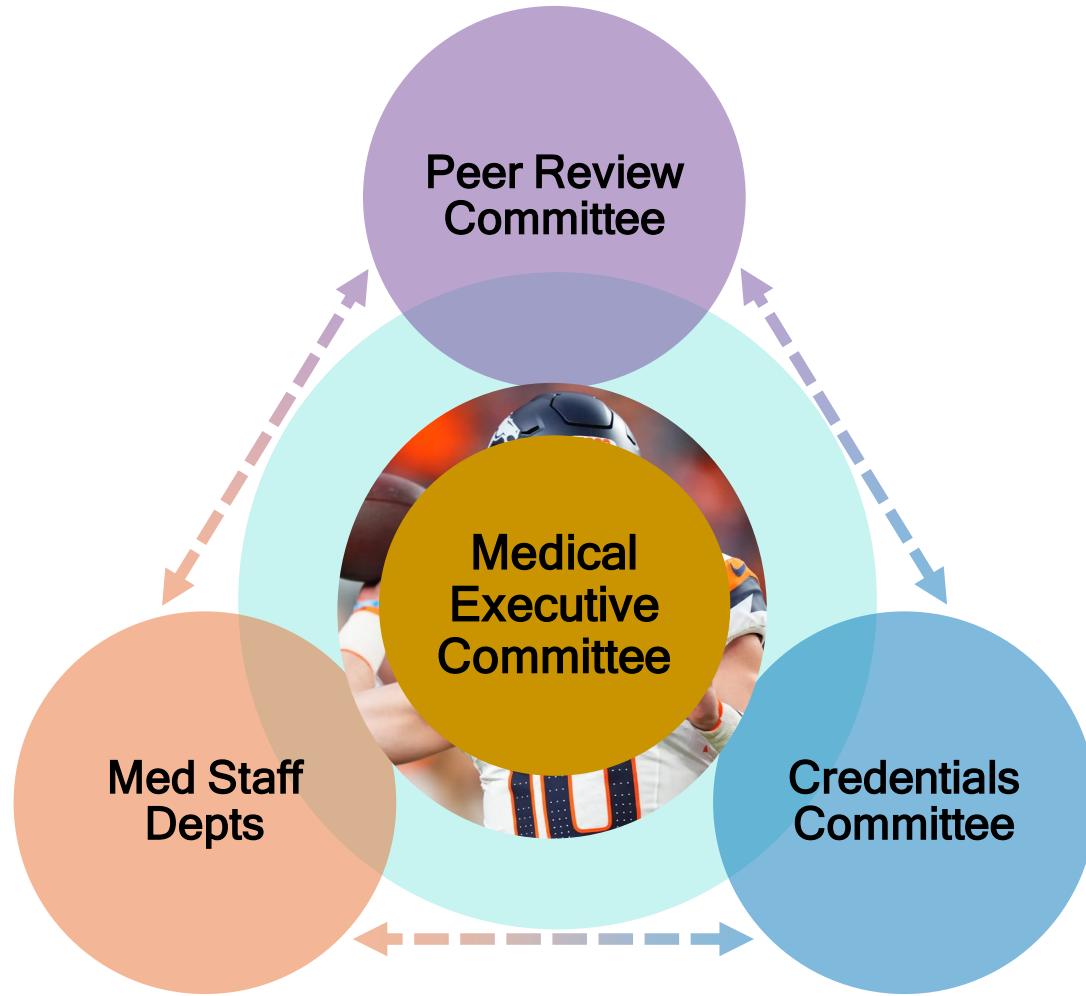


Medical Executive Committee

FPPE and OPPE require effective communication & collaboration between:

- Medical Staff
- Quality Department
- Medical Staff leaders/Department Chairs/CMO
- Risk management
- MSPs - Credentialing/Privileging
- Nursing Leadership

# Complementary, Hand-in-Glove Roles



Credentials Committee ensures that prospective and current medical staff members meet the hospital's standards for appointment and reappointment

- Initial FPPE
- OPPE
- Incorporation of Peer Review data

Medical Staff Departments are crucial in developing

- Specialty-specific indicators
- Appropriate OPPE and initial FPPE criteria

Peer Review Committee provides input to

- MEC
- Credentials Committee
- Feedback to Departments

Peer review, FPPE, and OPPE data must be utilized in staff recredentialing --- it cannot just be a paper process

# F / OPPE & Peer Review

*write it down*

 Hardenbergh Group

## Consistent Method of Communicating Findings

- How are results shared with providers?

Celebrate great  
performance in public.

Remediate deficient  
performance in private.

- Communication /documentation deficiencies
- Behavioral/Professional concerns

 MDReview  
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# Peer Review Considerations

## Disruptive Providers

- Disruptive behavior and its potential for causing patient harm are closely linked
- When there appears to have been a significant behavioral component in a case under review, it is the Peer Review Committee's responsibility to break that link to allow care evaluation to be undertaken independently
- Create a separate pathway for evaluating and adjudicating possible behavioral problems



**Maintains Peer Review Protections**

**“Triggered” FPPE is an excellent tool in this scenario**

# Credentialing & Peer Review Scenarios

- Scenario 1
  - “Later career” general surgeon requests Robotic Surgery privileges
  - What are the next steps for the Credentials Committee?
  - Review of education, training, etc.
  - FPPE for new credentials
  - Proctoring
- Scenario 2
  - Busy ophthalmologist
  - OPPE “catches” apparent higher rate of cataract surgery complications
    - *But volumes are low – majority of procedures are done at an outpatient center*
  - What should the Peer Review Committee recommend?
  - Any additional data available?
  - Track/trend vs “Triggered” FPPE?



# Takeaways

- Follow your processes
  - *F/OPPE cannot just be paper processes*
  - *Robust PPE supports robust Peer Review & Credentialing*
- If it isn't documented....it didn't happen
- Help yourself! Use a standardized documentation timeline



GENERAL HOSPITAL

Timeline of Events Related to Provider 8675309

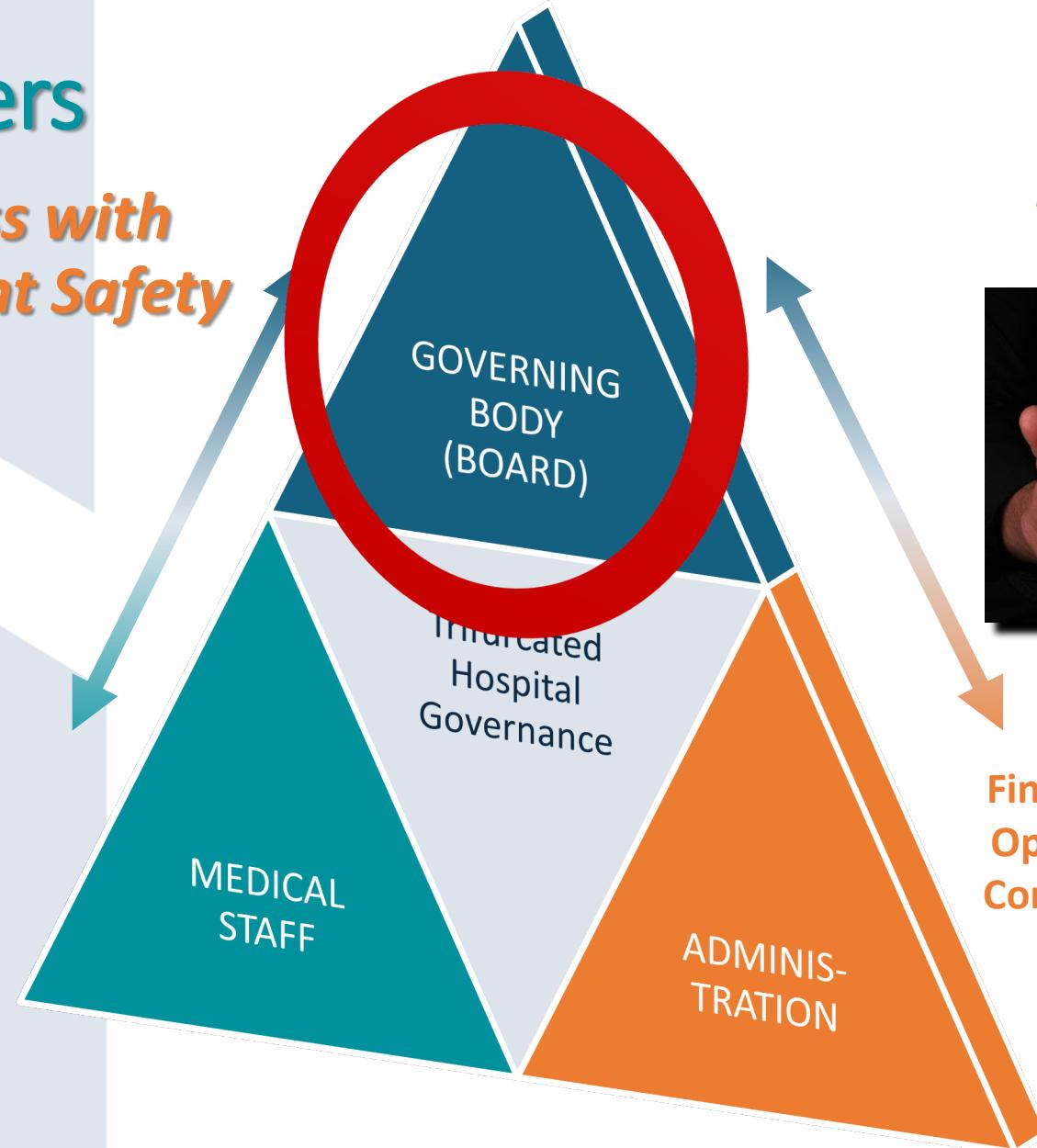
DATE	EVENT	GOVERNING DOCUMENT REFERENCE
01/01/2018	Event Report 90210 - Disruptive Behavior incident in the OR	
01/02/2018	Department Chair Meeting with Surgeon to discuss incident report is shared with the provider per requirement of Medical Staff Bylaws. Provider is encouraged to respond in writing.	Medical Staff Disruptive Behavior Complaint Process, Medical Staff Bylaws Article IX 3.1
01/02/2018	Letter sent to Surgeon Following Collegial Intervention. Provider is again encouraged to respond in writing.	
02/14/2018	Event Report 90211 - Disruptive Behavior incident in the OR	
02/15/2018	President of the Medical Staff and CMO Interview complainant, witnesses and provider. The incident report is shared with the provider as required by the bylaws and he is encouraged to respond in writing.	Medical Staff Disruptive Behavior Complaint Process, Medical Staff Bylaws Article IX 3.3
02/15/2018	President of the Medical Staff and CMO in consultation with members of MEC issue a written warning. Provider is notified via letter dated 2/15/18.	Medical Staff Disruptive Behavior Complaint Process, Medical Staff Bylaws Article IX 3.5 ii
03/17/2018	Event Report 90212 - Disruptive Behavior incident in the OR	
03/19/2017	President of the Medical Staff and CMO Interview complainant, witnesses and provider. The incident report is shared with the provider as required by the bylaws and he is encouraged to respond in writing.	Medical Staff Disruptive Behavior Complaint Process, Medical Staff Bylaws Article IX 3.3
03/21/2018	President of the Medical Staff and CMO in consultation with members of MEC refer the provider to the Professional Wellness Committee. Provider is notified via letter dated 2/15/18.	Medical Staff Disruptive Behavior Complaint Process, Medical Staff Bylaws Article IX 3.5 iv
03/17/2018	Event Report 90213 - Disruptive Behavior incident in the OR	
03/19/2017	President of the Medical Staff and CMO Interview complainant, witnesses and provider. The incident report is shared with the provider as required by the bylaws and he is encouraged to respond in writing.	Medical Staff Disruptive Behavior Complaint Process, Medical Staff Bylaws Article IX 3.3
03/21/2018	Timeline of incident reports and interventions is presented and reviewed at MEC. Decision is made to initiate Corrective Action pursuant to the Medical Staff Bylaws. Provider is notified via letter dated 3/23/2018.	Medical Staff Disruptive Behavior Complaint Process, Medical Staff Bylaws Article IX 3.5 v

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# Physician Leaders

*Partners for Success with  
Quality & Patient Safety*

CMS Condition of  
Participation §482.22 - The  
hospital must have an  
organized medical staff ...  
***which is responsible for  
the quality of medical care  
provided to patients by  
the hospital.***



*With competing priorities,  
patient safety can get lost  
in the shuffle*



**Financial Viability,  
Operations, Meet  
Community Needs**

# Why Do We Credential, Appropriately Privilege, and Monitor Performance of Physicians & APPs with Peer Review?

It's a W H Y e n c y





Thank  
You



[SCameron@HardenberghGroup.com](mailto:SCameron@HardenberghGroup.com)

*Let's Chat!*



# What About Non-Hospital Settings?

## *Single & Multispecialty Clinics, FQHCs*

### FQHCs

- The health center must have an ongoing quality improvement/assurance (QI/QA) system that includes clinical services and [clinical] management and maintains the confidentiality of patient records.
- The health center has a board-approved policy(ies) that establishes a QI/QA program.<sup>1</sup> This QI/QA program addresses the following:
  - The quality and utilization of health center services;
  - Patient satisfaction and patient grievance processes; and
  - Patient safety, including adverse events.

### Clinic Settings?

- More difficult, but not impossible
- More flexibility with larger / multispecialty practices
- Best practices



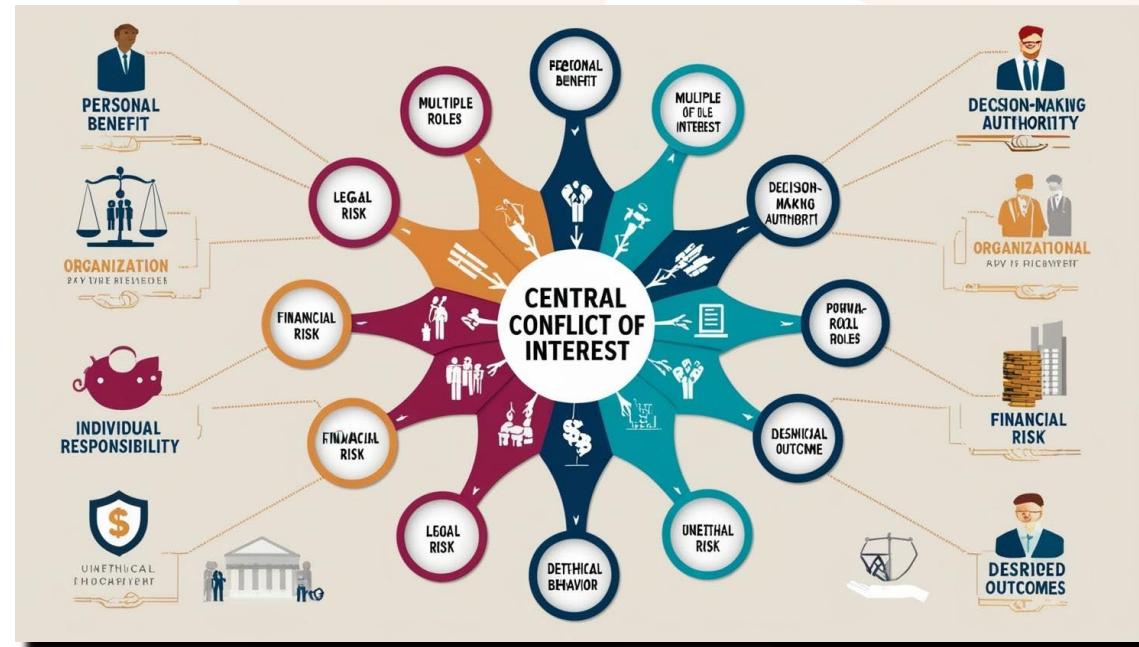
**THERE ARE TWO TYPES OF PEOPLE IN THIS WORLD:**

1) those who can extrapolate from incomplete data

# Peer Review in the Outpatient Arena

## *Challenges*

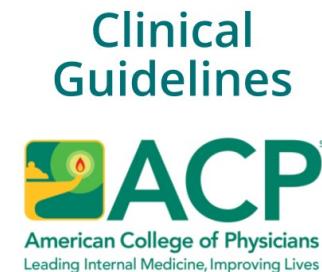
- Identifying viable, unbiased reviewers
- Developing robust assessment programs
- Influence of collegial and business ties which can hamper meaningful evaluations
  - Shared clinic ownership
  - Be acutely aware of conflicts of interest



# Peer Review in the Outpatient Arena

## *Challenges Solutions*

- Identify practice-specific, meaningful, and measurable metrics
  - Patient satisfaction surveys
  - Staff interactions / complaints / compliments
  - Adherence to best practice guidelines
  - Documentation adequacy
  - Survey of referring / referral physicians
- Random chart reviews
- Identify “triggers” for in-depth focused reviews



# ACOG

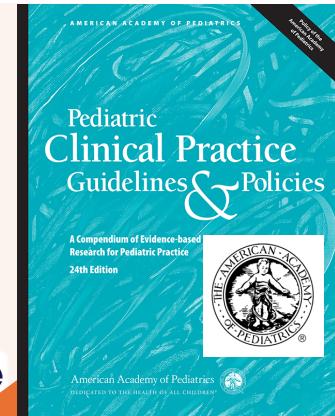
The American College of  
Obstetricians and Gynecologists



# AMERICAN COLLEGE of CARDIOLOGY®



American Society of  
Clinical Oncology



American College  
of Radiology™



# Peer Review in the Outpatient Arena

## *“Trigger” Samples*

- Unexpected mortality within 48 hours of clinic visit
- Unplanned return to clinic within 72 hours with original symptoms
- Iatrogenic injury
- Moderate to severe adverse medication reactions
- Improper consent
- Nosocomial infection from procedure performed in clinic
- Delay in referral to ED, higher level of care, or specialist consultant
- Behavioral concerns

- Patient complaints
- Documentation concerns
- Medication error
- Delay in responding to test or ordered procedure results
- Critical lab or diagnostic studies not addressed
- Excess controlled substance prescribing
- Adverse outcome / serious reportable event
- Improper / inadequate midlevel provider supervision
- Quality of care concern letter from hospital, regulatory agency, or insurance company
- Litigation claims

# Peer Review in the Outpatient Arena

## *Challenges Solutions*

- Develop a standardized process & apply it consistently
- Schedule periodic (every 2 years or so) review of the QI and Peer Review processes
- Compare individual and organization-wide performance with published guidelines and benchmarks
  - Develop improvement plans as indicated
- **Don't forget to**
  - Make it legal
  - Ensure confidentiality
  - Consider external review when appropriate



# Peer Review Scenarios





## Peer Review Scenario #1

*Quality of Care  
Concern*

# Possible Excess Complication Rate

A general surgeon who has been on staff for one year has had two patient mortalities in the past month following bowel resection with anastomosis.

A review of this physician's OPPE reveals that this physician is an outlier with anastomotic leaks in comparison to his surgical peers.



Peer Review  
Scenario #1

*Quality of Care  
Concern*

# Possible Excess Complication Rate

*What Steps?*

Department Chair ~~Reviews the OPPE data with the~~  
~~Peer Review Committee~~

*Is the Department free of conflict of interest?*

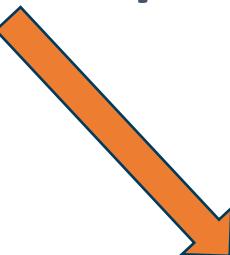


## Peer Review Scenario #1

*Quality of Care  
Concern*

# Possible Excess Complication Rate

***Next Steps?***



The Peer Review Committee must now develop a plan to validate or invalidate the concern.



## Peer Review Scenario #1

### Quality of Care Concern

 Hardenbergh Group

*Routine utilization of standardized timeline forms assists both Medical Staff Professionals and Peer Review Committee members in remaining organized and aware of the investigation's progress*



DATE	Event	Comments	Reference
01/01/2018			
01/02/2018	Letter sent to Surgeon following Collegial review. Provider is encouraged to respond in writing.		Medical Staff Disruptive Behavior Complaint Process, Medical Staff Bylaws Article IX 3.3
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Do Yourself A Favor!

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## Peer Review Scenario #1

### *Quality of Care Concern*

# Possible Excess Complication Rate

**Pull data!**

## *The Review Design*

- All Adult patients undergoing a bowel resection with anastomosis for a 24 month period
- Patients with a postoperative leak based on standardized criteria were identified
- Patient characteristics, surgical procedures, and operating surgeon were noted
- Overall complication and leak rates by surgeon were compared using national morbidity and mortality data



## Peer Review Case Study #1

### *Quality of Care Concern*

# Possible Excess Complication Rate

## *The Initial Review Process*

- Once the data was compiled, the Peer Review Committee assigned a small sub-committee to review the data
- Individual case reviews by a group of peers was performed for *all* patients with a leak who died, to determine any potential relationship between the complication and mortality



## Peer Review Case Study #1

### *Quality of Care Concern*

# Possible Excess Complication Rate

## *Initial Sub-Group Findings*

- Sixty-four patients underwent resection with anastomosis during the review period.
- Twelve patients experienced leaks (5.3%), four of whom died (most studies put the national leak rate at ~3%)
- Leak rate for the highest volume surgeons ranged from 0.6% to 9.1%
- Overall complication rates varied from 30.5% to 44%
- Of the four mortalities, two occurred in highly morbid patients undergoing emergent procedures with resultant high risks for morbidity and mortality.



## Peer Review Case Study #1

### *Quality of Care Concern*

# Possible Excess Complication Rate

## *Initial Suspicions*

- The vast majority of deaths were attributed to co-morbidities
- Critical analysis found that two deaths were not attributed to co-morbidities
- Critical analysis found that two deaths were not attributed to co-morbidities

The two deaths not attributed to co-morbidities were patients of the provider under review --validating this provider as an outlier in his specialty.

***Now what?***

The committee now has the option to develop a remediation plan. But what will that look like?



## Peer Review Scenario #1

### *Quality of Care Concern*

# Possible Excess Complication Rate

## *Initial S*

- The review found no information about the provider's outcomes.
- This provider preferred performing an end-to-end (E-E) vs. side-to-end (S-E) anastomosis technique in all his cases.
- At times, antibiotic prophylaxis was appropriate.
- Antibiotic prophylaxis and discontinuation of corticosteroids
- The review found no information about the provider's use of intraoperative air leak test.

Three key opportunities in this provider's cases were identified.

information  
ood and poor

complications

surgical  
the surgeon



## Peer Review Scenario #1

*Quality of Care  
Concern*

# Possible Excess Complication Rate

## *Options Moving Forward*

- More extensive review with other privileged providers
- External Peer Review
- Creation of a Remediation Plan



## Peer Review Scenario #1

### *Quality of Care Concern*

# Possible Excess Complication Rate

To address these identified opportunities the Peer Review Committee developed a “*Triggered FPPE*” / Voluntary Improvement Plan:

- Proctoring by a colorectal surgeon on the Side-to-End anastomosis technique (shown in some studies to ***Creation of a Remediation Plan*** lower risk of anastomotic leak)
- Incorporation of antibiotic prophylaxis and temporary discontinuation of corticosteroids (when in use) into cases
- Addition of intraoperative air leak test into colorectal anastomoses.



## Peer Review Scenario #1

### *Quality of Care Concern*

# Possible Excess Complication Rate

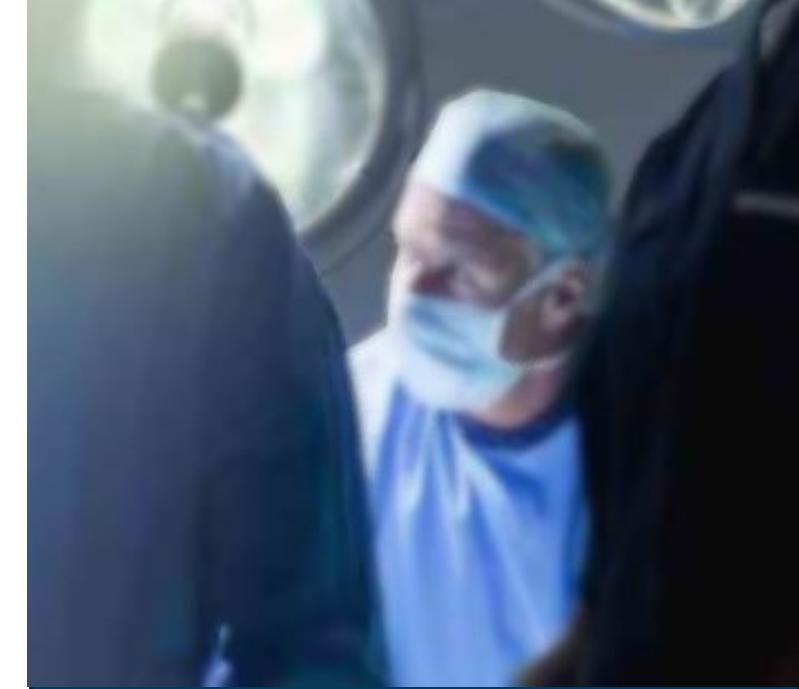
*To assure provider competency and patient safety the Peer Review Committee kept this provider on a focused review plan for one year.*

*This included review of all bowel resections with anastomosis performed by this provider during those 12 months.*

# Impaired Provider

## *Background*

- Young Vascular Surgeon
- Joined practice immediately following completion of fellowship
- Recruited with the understanding that he would join an established vascular surgery program led by experienced & respected surgeons
- Practice setting:
  - Acute care hospital
  - Level 2 Trauma facility
  - 250 beds



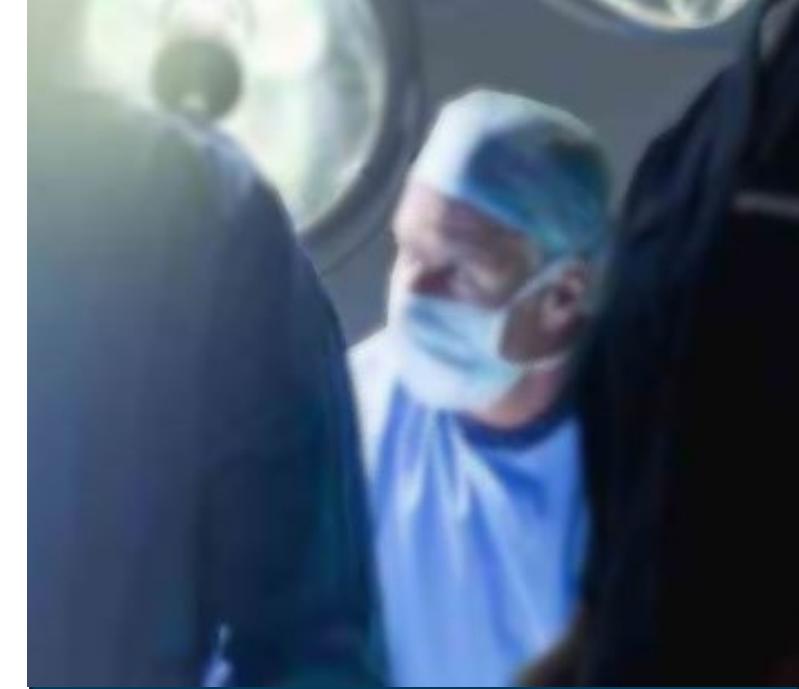
## Peer Review Scenario #2

### *Impaired Provider*

# Impaired Provider

## *Background – Joining Clinical Practice*

- New surgeon came from a respected training program
- Satisfactory reviews from residency coordinator & references
- Joined a well-respected group with two senior physicians who were able & interested in mentoring new partner
- All three physicians would share the call burden



## Peer Review Scenario #2

### *Impaired Provider*

## Impaired Provider



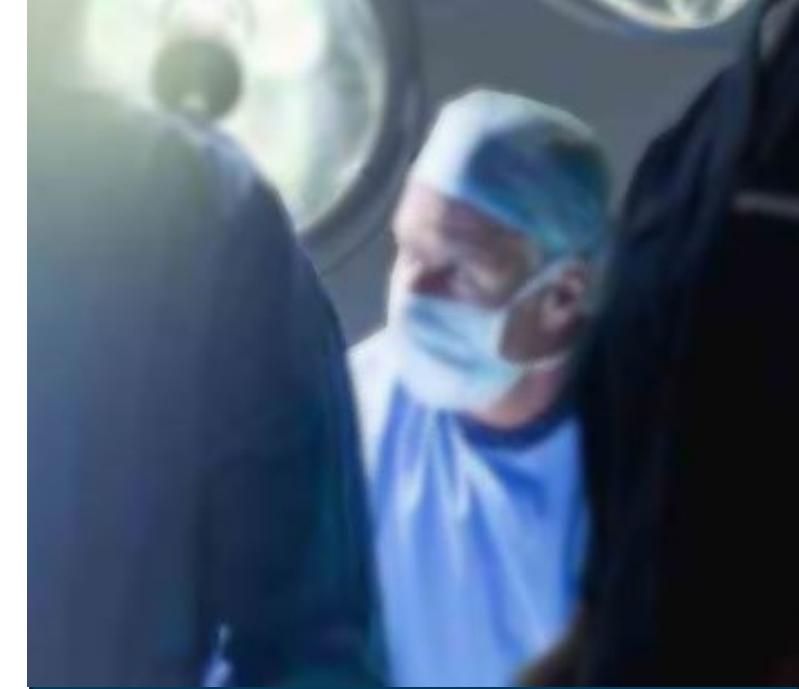
Peer Review  
Scenario #2

*Impaired  
Provider*

# Impaired Provider

## *Concerns*

- New findings from intraoperative
- The surgeon in the OR was late
- A smell
- Senior staff stopped by
- And



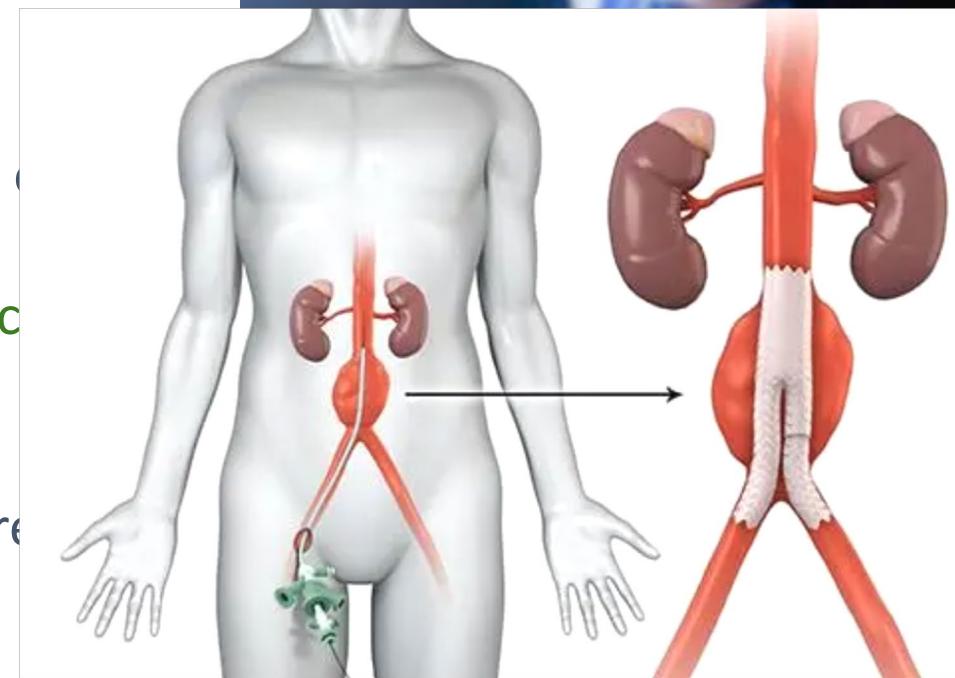
## Peer Review Scenario #2

### *Impaired Provider*

# Impaired Provider

## *Catastrophic Event*

- 60 yo male with a 6.1cm AAA incidentally discovered on CT scan for trauma
- Patient taken to the OR for EVAR (endovascular aortic aneurysm repair with endograft)
- Expired from exsanguination six hours postop due to inappropriately placed percutaneous arterial puncture closure device
- Concern is raised by surgical PA, nursing, and anesthesiologist involved in the operation
- *Provider is suspended pending investigation*

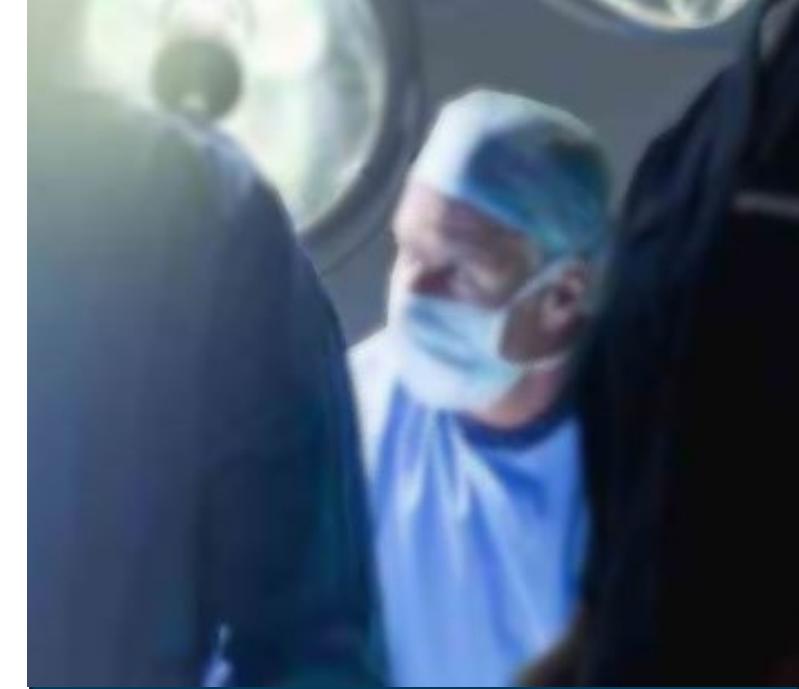


*Provider*

# Impaired Provider

## *Medical Staff Impact & Implications*

- Lack of documentation and a lack of any action taken in prior years, combined with poor clinical outcomes had a dramatic impact on the medical staff
  - Colleagues have lost / lack trust in the physician
  - Cardiology & General surgery are hesitant to refer patients
  - Anesthesiologists are reluctant to provide coverage for his cases
  - Surgical PAs and nursing staff are concerned about patient outcomes and are reluctant to assist in the OR

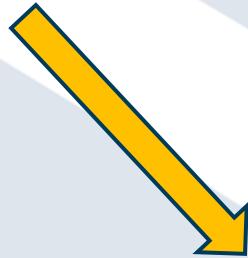


Peer Review  
Scenario #2

*Impaired  
Provider*

# Impaired Provider

## *Next Steps?*



Medical Staff leadership initiates a review of the index case as well as 5 additional cases that were identified as “concerning”



Peer Review  
Scenario #2

*Impaired  
Provider*

# Impaired Provider

## *Initial Review Findings*

- Internal case reviews identified significant clinical concerns
  - Medical / clinical knowledge deficits
  - Clinical judgement concerns
  - Surgical technique issues
  - Observed to “panic” in the OR when complications arose
  - Tremor observed by others in the OR
- “Burnout” concerns raised
  - Physician stressed, over-worked
  - On call 24/7, sole vascular surgeon by this time



Peer Review  
Scenario #2

*Impaired  
Provider*

# Impaired Provider

## *Confounding Factors*

- No well-documented history of concerns that were previously raised and (at least partially) addressed
- The hospital does not have a Physician Wellness Committee



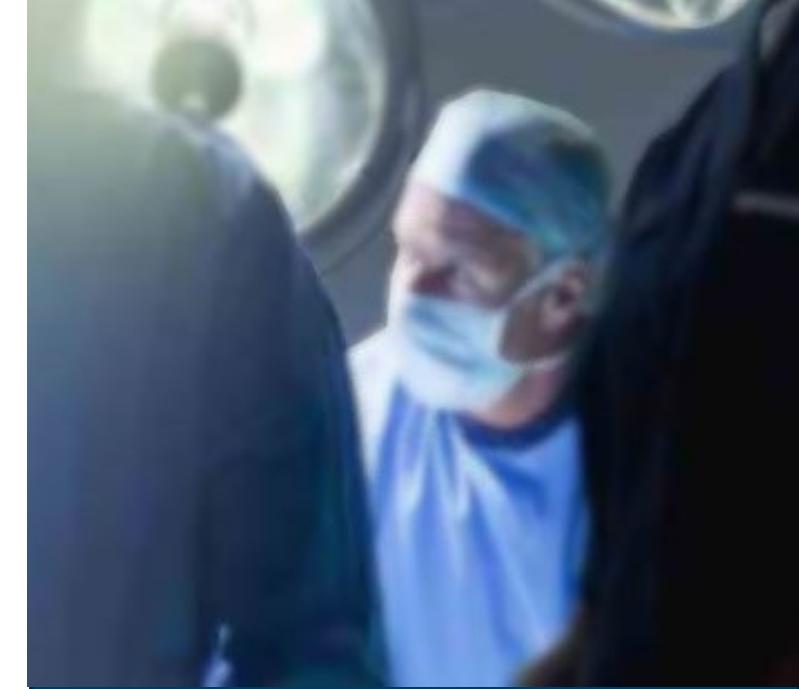
## Peer Review Scenario #2

### *Impaired Provider*

# Impaired Provider

## *Cases Sent for External Review*

- Appropriate reviewer selected
  - Vascular surgeon, similarly trained
  - Unbiased with no conflict of interest
- Case selection for review – index case plus 10 additional randomly selected cases
- Findings – external review identified similar, significant concerns
  - Medical / clinical knowledge deficits
  - Clinical judgement concerns
  - Surgical technique issues



## Peer Review Scenario #2

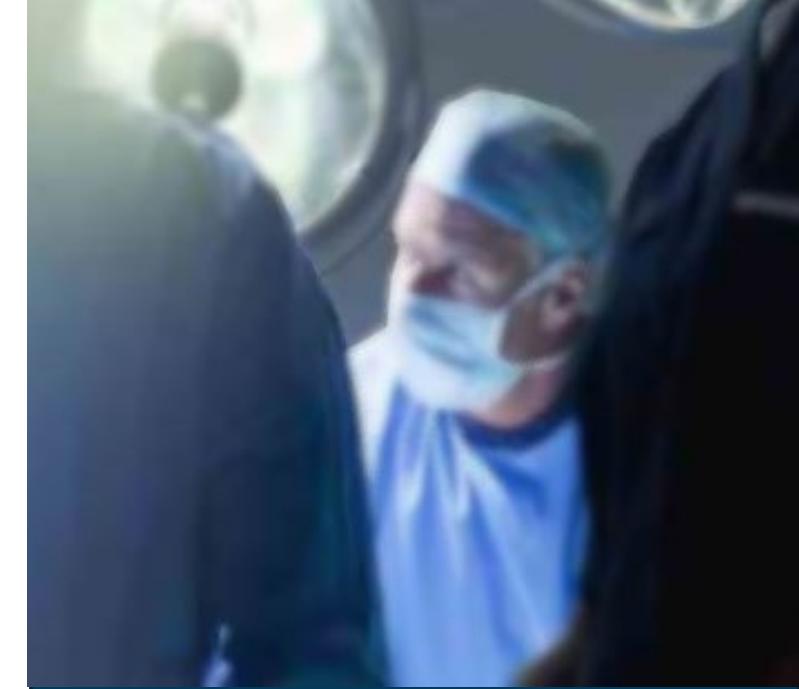
### *Impaired Provider*

# Impaired Provider

## *Next Steps?*

Medical Staff leadership mandates a full mental & physical evaluation of the physician through the state Physician Health Program

- A physical condition is identified – tremor
- Tremor is noted to be “worsened under stressful conditions”



## Peer Review Scenario #2

### *Impaired Provider*

# Impaired Provider

## *Conclusion*

- Physician's surgical privileges were revoked \*
- Hospital pursues development of a physician wellness committee
  - Burnout & stress issues may have been better addressed by a wellness committee, separately from peer review concerns
- Opportunity for improvement identified in medical staff processes and documentation of those processes



## Peer Review Scenario #2

### *Impaired Provider*



Thank  
You



*Let's Chat!*



[SCameron@HardenberghGroup.com](mailto:SCameron@HardenberghGroup.com)

