MAMSS

OPPE, FPPE, & PEER REVIEW

How, When, and Why

October 17, 2025

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MDReview

Sharon Beckwith, President
Peer Review & Clinical Quality Consulting
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External Peer Review Powered by MDReview – A Hardenbergh Company

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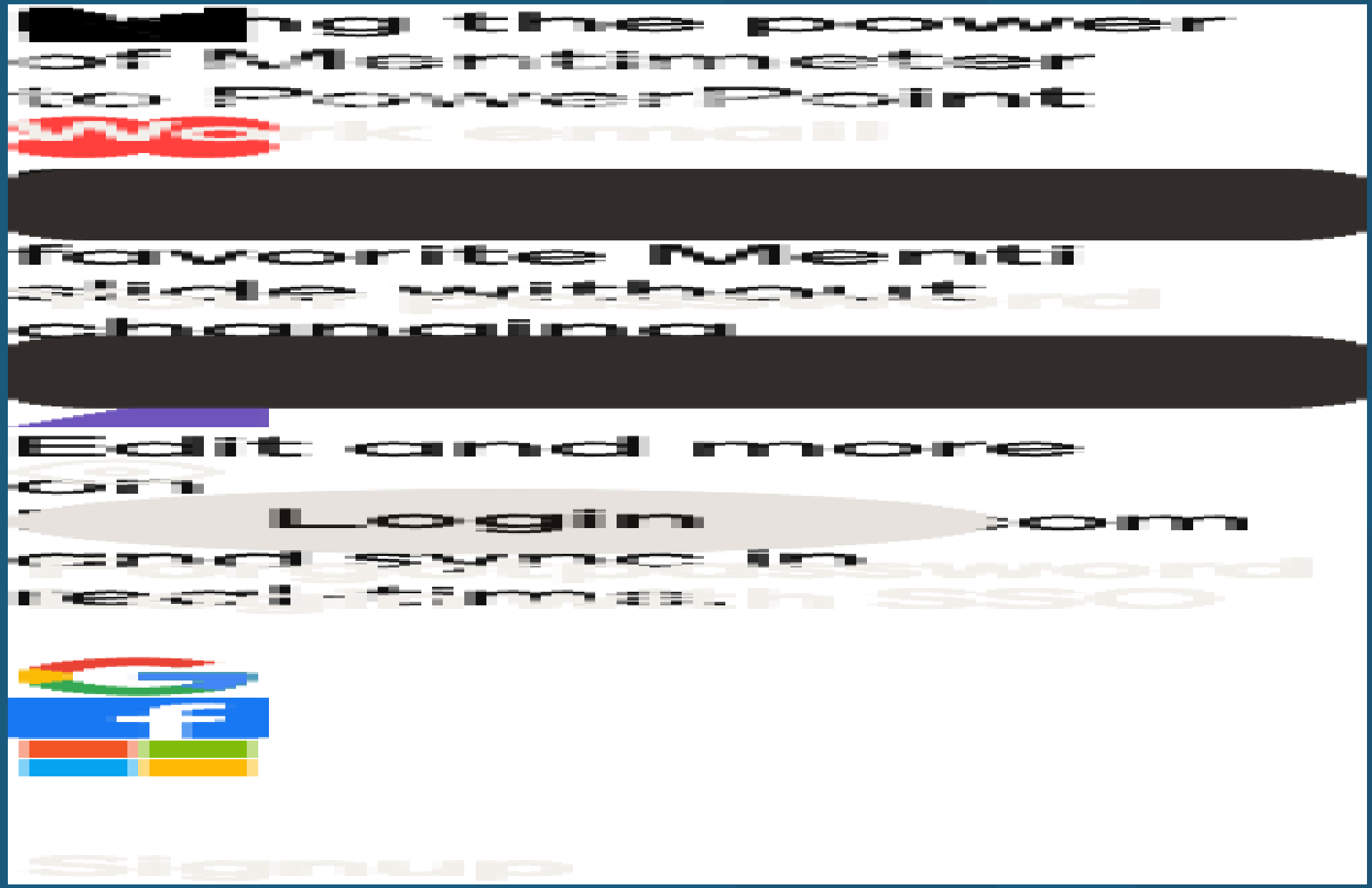
WORKFORCE SOLUTIONS | EXTERNAL PEER REVIEW Powered by MDReview | CONSULTING SOLUTIONS | PHYSICIAN LEADERSHIP

Medical Staff Services • Credentialing • Provider Enrollment • Peer Review • Quality • Risk Management



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Why Do We Credential, Appropriately Privilege, and Monitor the Performance of Physicians & APPs?

It's all about *competency*

Responsibility of the *m* [illegible] sure that the physicians and APPs on staff are d[illegible] form the privileges they have been granted

Medical Staff Professionals
&
Hospital Administration

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Who Owns It?

Governance
Quality
Peer Review
Credentialing
Bylaws

Repository of Institutional Memory/Knowledge

↓

<u>Medical Staff</u>

Quality Team & Med Staff Professionals

…<u>not</u> the CEO, CMO, CNO, or "Administration"

The Organized Medical Staff

Medical Staff Bylaws

Credentialing and Privileging

- Assure competency of practitioners to provide high quality, safe patient care
- Implement process to support objective, evidence-based decisions about medical staff appointments and recommendations to grant or deny privileges

Organized Medical Staff
- Develop approved procedure list
- Implement a process to evaluate applicants
  - Licensure
  - Education
  - Training
  - Current competence
  - Physical ability to care for patients
- Submit applicants to the governing body for approval
- Notify the applicant and other required entities about privileging decisions
- Monitor use of privileges and quality of care

Governing Body
Quality and Regulatory Committee
GMH Board of Directors
- Approve appointments and reappointments
- Approve criteria for expedited process
- Applicants not eligible for expedited process
  - MEC recommendation is adverse or has limitations
  - Challenges to licensure
  - Involuntary termination at another hospital
  - Involuntary limitation, reduction, denial or loss of clinical privileges
  - Unusual pattern of or excessive professional liability actions with judgments against the applicant

The Joint Commission
MS.06.01.01

rticipation)

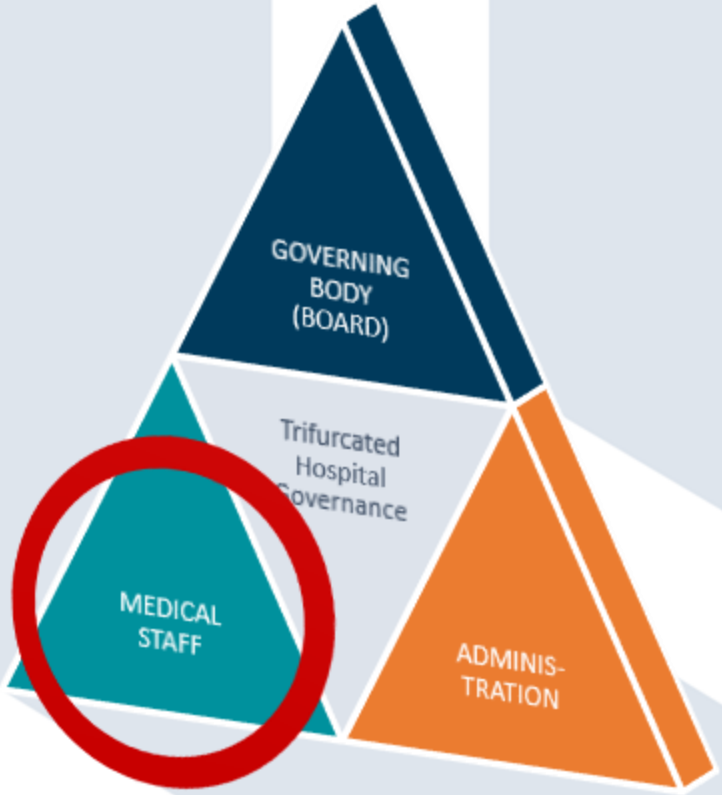
mission, DNV, etc.)

DNV

WHEN TRUST MATTERS

NATIONAL INTEGRATED ACCREDITATION FOR HEALTHCARE ORGANIZATIONS (NIAHO®)

REVISION 25-0



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.***

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The Organized Medical Staff

Medical Staff

- The medical staff is responsible for the quality of medical care provided to patients, and all of the component parts that go into that.
- Subject to oversight by the governing body, but largely a self–governing entity.
- Practitioners appointed to the medical staff must comply with the bylaws, rules and regulations, and policies that are adopted by the medical staff, as well as applicable hospital administrative policies.
- ***Medical Staff Office Professionals are crucial to this effort***

~~CEO~~

~~CNO~~

~~"Admin"~~

Progressive Approach to Quality

"Life Cycle of Credentialing"

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Progressive Approach to Quality

"Life Cycle of Credentialing"

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F/OPPE Fundamentals

Practicalities of focused and ongoing practice quality evaluation

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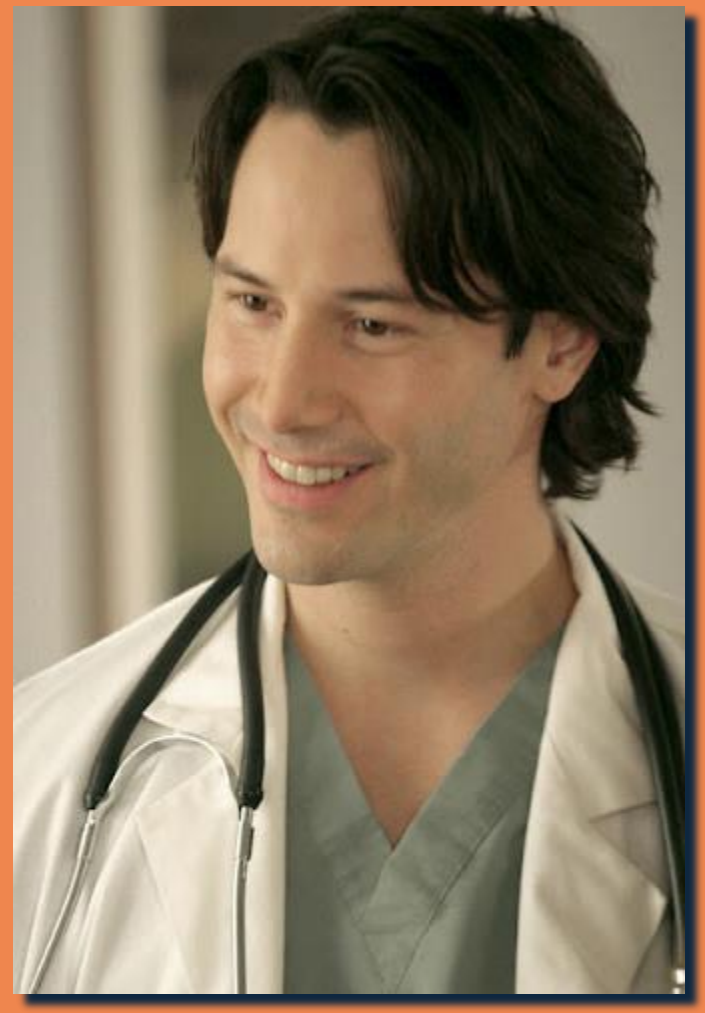
Meet Dr. Neo

- Dr. Neo is a recent residency and fellowship trained surgical specialist and has applied for privileges at your hospital.
- Dr. Neo's application was submitted, the medical staff services team has performed primary source verification and completed all necessary steps to present this applicant to the credentials committee.
- ***Now what?***



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Credentialing & Privileging

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Granting Privileges Should Be

- A documented, objective, and evidence-based process.
- Based on defined criteria including training, experience and demonstrated current competence.
- Based on services provided at the facility or location.
- Consistently and uniformly applied for all applicants.
- Reviewed Regularly – a periodic review of each specialty's Delineation of Privileges (DOP), with input from medical staff members *(focus for Department Chair)*

* FPPE

When there are questions or concerns raised about an applicant, the application should be considered incomplete and not processed until those concerns are resolved.

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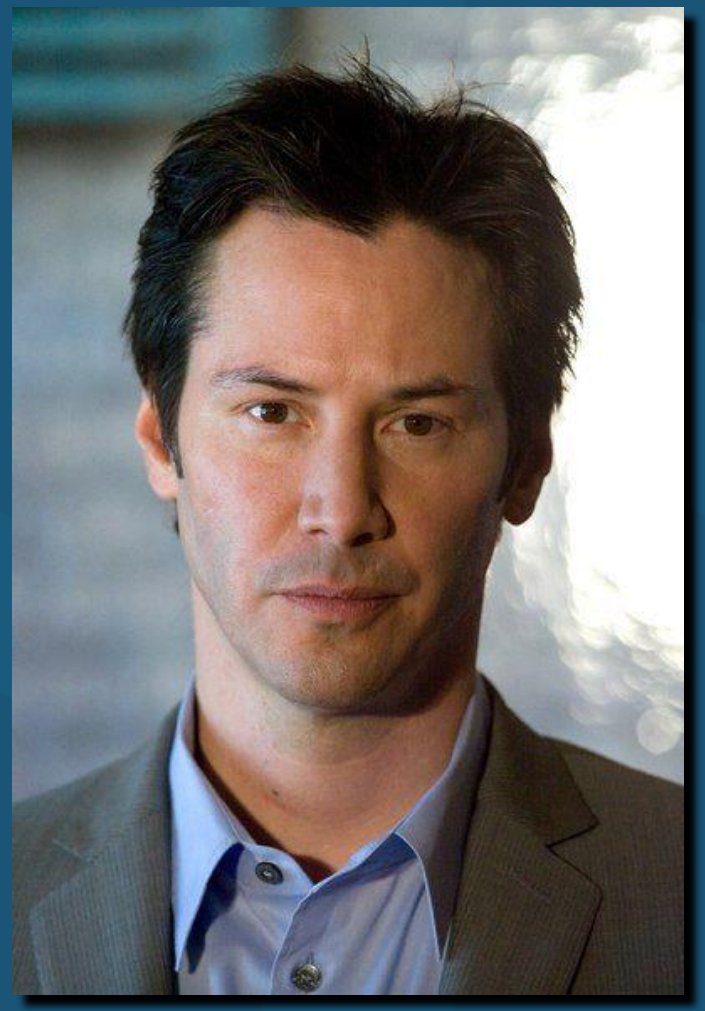
Dr. Neo was granted clinical privileges.
All physicians and APPs with newly granted privileges **should *(must)*** be reviewed for a volume or time limited period.
This is done via a focused period of practice quality evaluation *(FPPE or equivalent)*



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MS.08.01.01 Focused Professional Practice Evaluation

The Organized Medical Staff defines the circumstances requiring focused monitoring and evaluation of a practitioner's professional performance.

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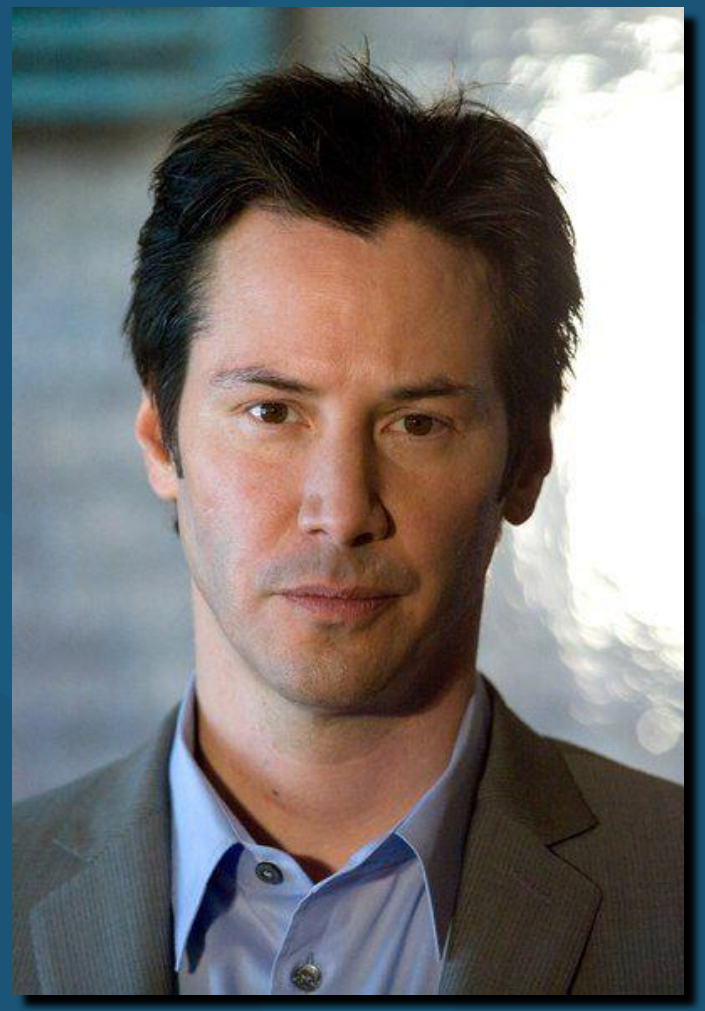

*DNV does not require an FPPE process for newly granted privileges, but **does require** collection and evaluation of practitioner-specific performance data.*

DNV

MS.8 PERFORMANCE DATA

Practitioner specific performance data for physicians and other practitioners who have been granted clinical privileges is required to be evaluated, analyzed and appropriate action taken as necessary when variation is present and/or standard of care has not been met as defined by medical staff policy/procedure.

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Focused Professional Practice Evaluation

Initial Granting of Privileges

FPPE allows evalu…oner who does not have do…

1) Newly appoi…

2) New privileg…

3) For establish… competence are raised (*"Triggered FPPE"*)

Data may be colle…t or retrospective cha…tion, proctoring, exter…

FPPE is time-limi…

FPPE

FPPE is implemented (1) for all newly requested privileges, and (2) whenever a question arises regarding a practitioner's ability to provide safe, high quality patient care, or a "trigger" event occurs. A Department Chairperson, any peer review committee, the MEC or the Board may recommend FPPE.

Periods of FPPE implemented for reasons other than for a newly requested privilege must be time-limited (for a specific period of time OR a specific volume/number of procedures, admissions, encounters, etc.). The terms of the FPPE must be communicated to the affected practitioner or AHP in writing, which shall include the reasons for the FPPE; the specific period of time or specific volume/number of procedures, admissions, encounters, etc.; and the method for monitoring specific to the privileges giving rise to the review.

Information gathered for review may include, but not be limited to:

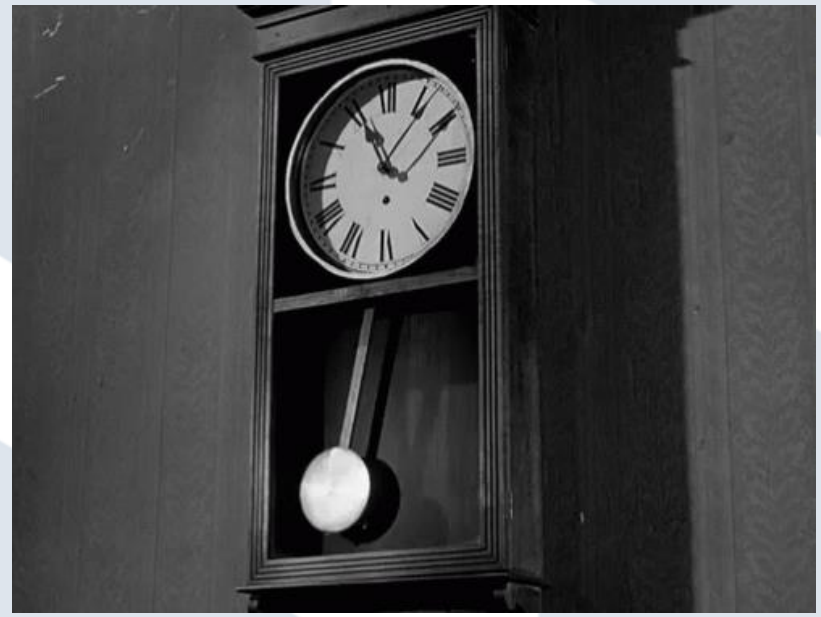
a. Periodic chart review
b. Direct observation
c. Monitoring of diagnostic and treatment techniques
d. Discussion with other individuals involved in the care of each patient including consulting physicians, assistants at surgery, nursing, and administrative personnel.
e. Method for determining the duration of performance monitoring:

Focused Professional Practice Evaluation

✱ *6-12 months*

- Time frame is defined by your polices
- Use timelines to keep everyone informed of time frame and progress
- What if not enough of the clinical activity has taken place during the allotted time?
  - *Can be extended, as long as the rationale is documented*
  - *But……this can't be an unlimited time frame*

FPPE is time-limited



Focused Professional Practice Evaluation

Initial Granting of Privileges

Credentials Committee in collaboration with the department chair develops criteria for evaluation

Department Chair

DOP Forms

Outcome Data is gathered

Initial FPPE Criteria – *based upon clinical privileges*

Analyze Data

Dept Chair reviews data and makes an informed decision re: continuing or concluding FPPE

Dr. Neo passes through his 6 month initial focused evaluation period / FPPE with no concerns being raised

Every member of the medical staff who is granted clinical privileges should *(must)* participate in continuous / ongoing quality of care monitoring *(OPPE or equivalent)*

Dr. Neo is no different…

MS.08.01.03

OPPE allows the organization to identify practice trends that impact quality of care

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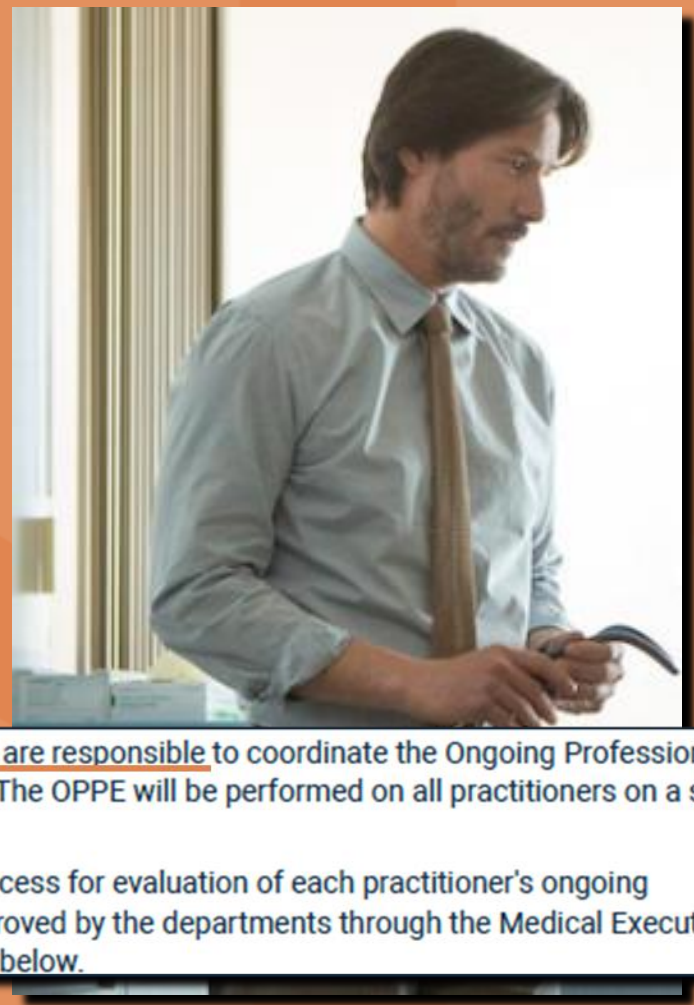

OPPE

OPPE is used to assess the competence of those practitioners privileged through the medical staff process. All OPPE data will be reviewed by the applicable Department Chairperson or Section Medical Director or his/her designee/reported for review/action at least every nine (9) months for overall performance and comparison purposes or to determine whether there are any performance improvement initiatives that need to be addressed further, which are related to organizational processes or clinical practices.

All reviews shall be considered a part of the confidential peer review activity of the medical staff, and the written results of OPPE shall become part of the practitioner or AHP's quality file and will be included in the decision to maintain existing privileges, revise existing privileges or to revoke existing privileges prior to or at the time of renewal. Results of OPPE shall be communicated in writing to the practitioner or AHP at least every nine (9) months.

granted clinical privileges is required to be evaluated, analyzed and appropriate action taken as necessary when variation is present and/or standard of care has not been met as defined by medical staff policy/procedure.

1. The respective department chair(s) are responsible to coordinate the Ongoing Professional Practice Evaluation (OPPE) review. The OPPE will be performed on all practitioners on a semi-annual basis.
2. The type of information and the process for evaluation of each practitioner's ongoing professional practice has been approved by the departments through the Medical Executive Committee. The defined process is below.

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Ongoing Professional Practice Evaluation

Competency is a Combination of Two Principles

[1] Have you do

Numbers – How M

[2] When you did it,

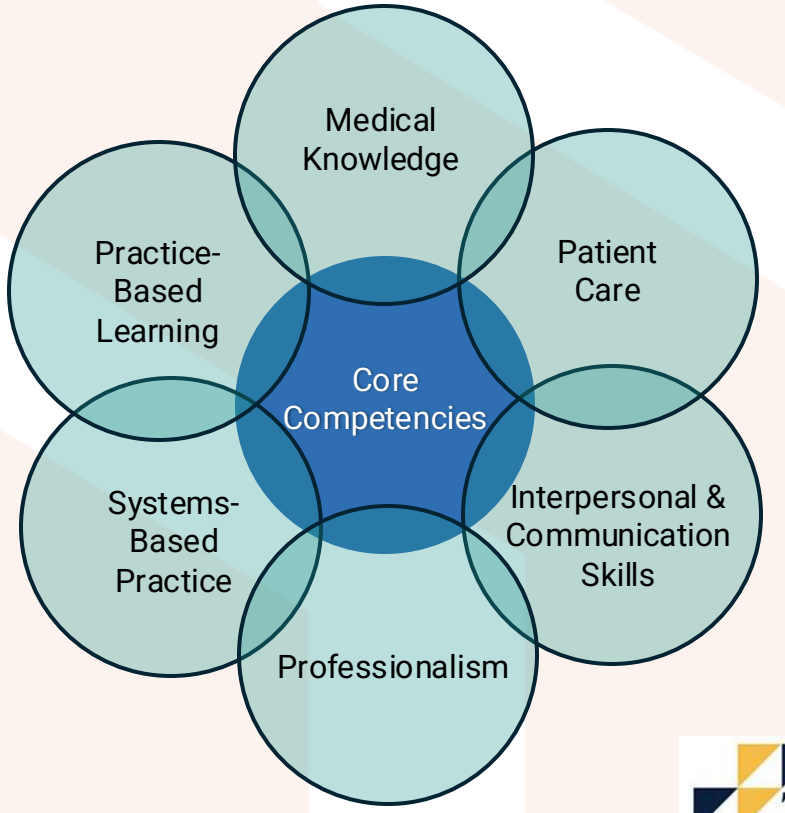
Quality M

Ongoing Professional Practice Evaluation / Monitoring
(OPPE)

The process by which the Organized Medical Staff evaluates the current clinical competency of every licensed individual practitioner exercising privileges using appropriate *quantitative* and *qualitative* data.

OPPE Requirements

General "Core" Competencies Assessment
~ *Everyone* ~



Quality Indicators

- Measures should be clearly defined
  - *Different service lines require different indicators*
- Who reviews the data should be clearly defined
- The process must be clearly defined
- ***Results should be*** **(must be)** ***used in credentialing and Peer Review***
- Focused & Continuous / Ongoing practice quality monitoring should be **(must be)** applied to all privileged practitioners

Indicators are defined by the Medical Staff Departments
Correlating with core competencies and clinical privileges

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OPPE Requirements

Indicators by Department / Service Line

"Triggers" are unacceptable levels of performance within established defined criteria

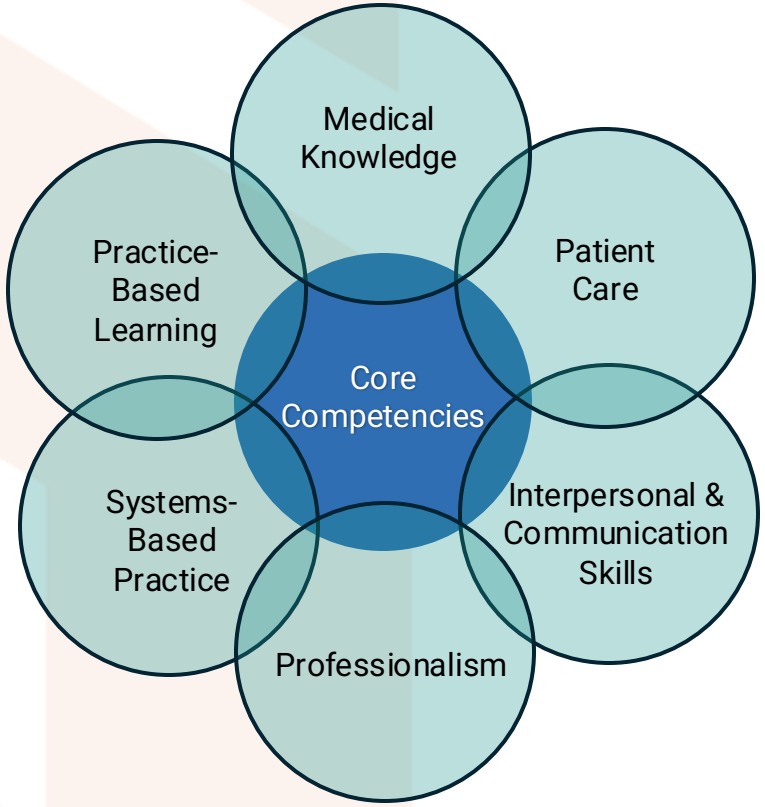
- Prolonged Length of Stay compared to peers
- Defined # of individual peer reviews w/ adverse determinations
- Elevated infection rates
- Blood loss greater than specified amount in the OR
- Unscheduled return the ED within 24 hours of discharge
- Unexpected returns to OR
- Failure to meet core measure guidelines – stroke, sepsis and cardiac alerts
- Outliers in patient satisfaction data/high level of complaints
- Utilization of tests, procedures, and consultants
- Blood and pharmaceutical usage

Ongoing Professional Practice Evaluation

OPPE or Equivalent – Continuous / Ongoing Quality of Care Monitoring

Outcome Data is gathered

Departments define data for areas of competency



Analyze Data

Dept Chair reviews data for outliers and opportunities for improvement

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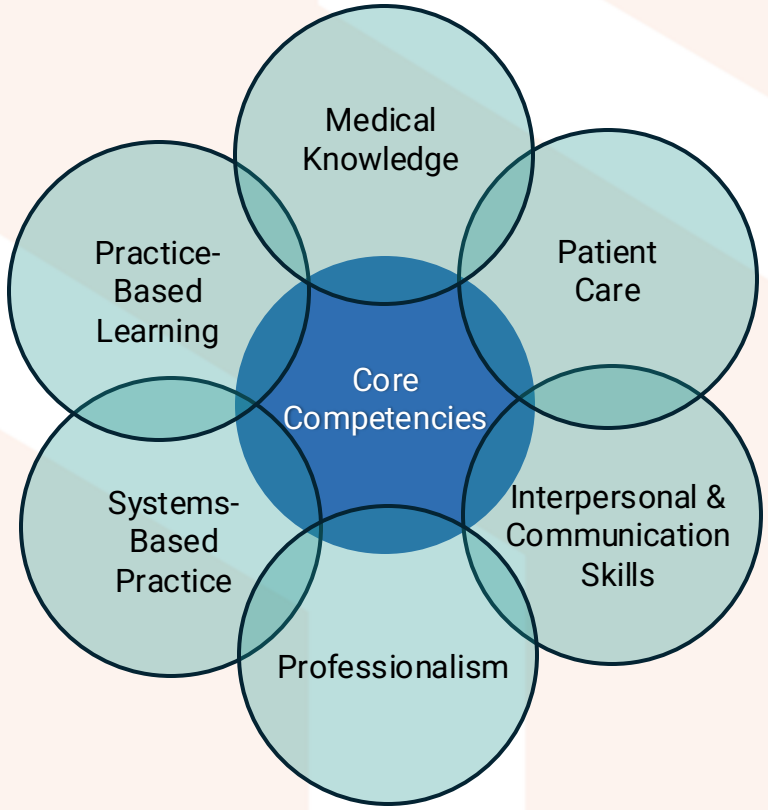
OPPE Requirements – *Quality Indicators*

General "Core" Competencies Assessment
~ *Everyone* ~



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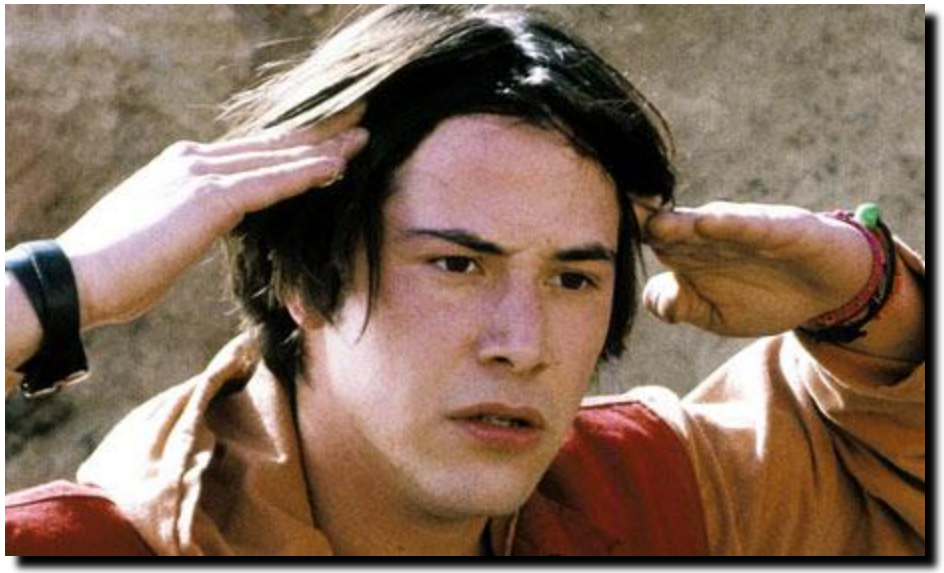
A Universal Starting Point

ACGME Core Competencies



What do those even mean?

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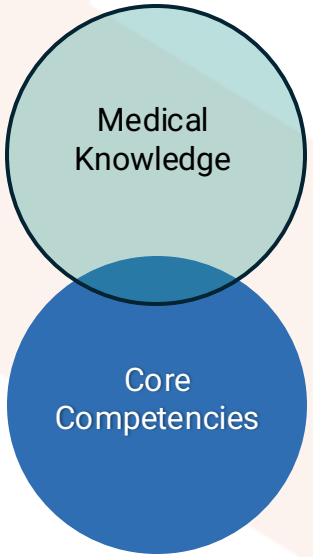
F / OPPE Requirements

General "Core" Competencies Assessment
~ *Everyone* ~



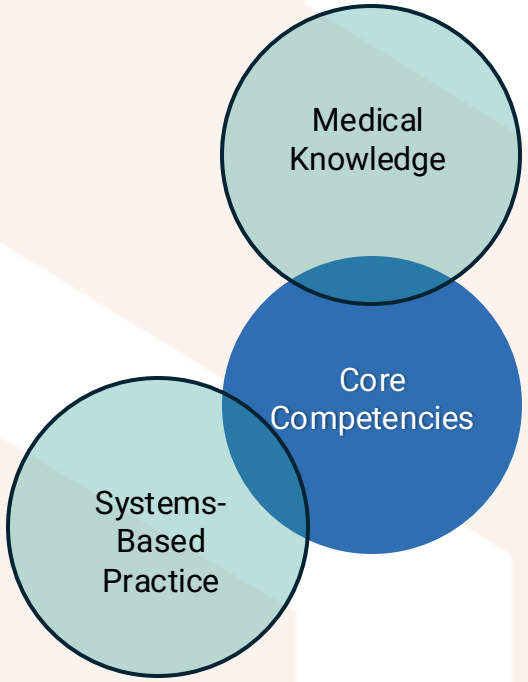
Quality Indicators – Medical Knowledge

Demonstrates knowledge about established and evolving biomedical, clinical, epidemiological and social behavioral sciences as well as the application to patient care

- Peer review findings – case reviews
- FPPE reports / findings
- Clinical complaints / compliments
- Crimson data
- Level of clinical activity
- Mortality
- Complications of condition or care
- 30-day readmissions for same MS-DRG
- H&P Audits – documentation of minimum required elements
- Current board certification
- CME attestation
- Most current peer references
- Appropriate test orders
- Appropriate utilization of consultants
- Trends in length of stay
- Rate of procedure infections
- Review of charting with consideration to quality, appropriateness, & accuracy of documentation
- Compliance with core measures
- Staff complaints / compliments
- Patient complaints / compliments

F / OPPE Requirements

General "Core" Competencies Assessment
~ *Everyone* ~



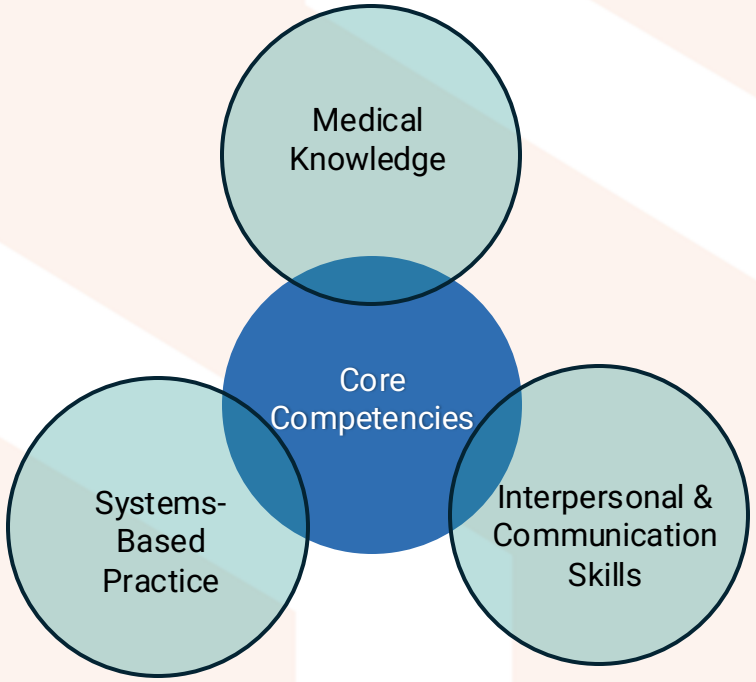
Quality Indicators – Systems-Based Practice

Demonstrates awareness of and responsiveness to the larger context and system of health care and the ability to effectively call on other resources in the system to provide optimal health care

- Length of Stay
- Committee involvement
- CME attestation
- Most current peer references
- 30-day readmissions for same MS-DRG
- Peer review findings – case reviews
- Relevance of tests ordered and procedures performed
- Appropriate utilization of consultants
- Compliance with core measures
- Participates in interdisciplinary team meetings

F / OPPE Requirements

General "Core" Competencies Assessment
~ *Everyone* ~



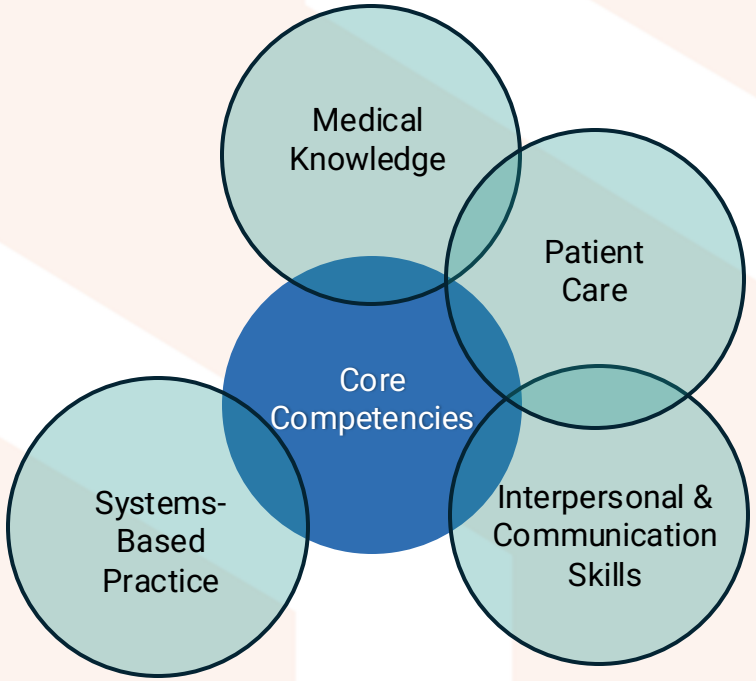
Quality Indicators – Interpersonal & Communication Skills

Demonstrates interpersonal and communication skills that result in effective information exchange and collaboration with patients, their families, and the healthcare team

- Professionalism complaints / compliments
- Compliance with applicable Medical Staff and organization policies and procedures
- Timely and adequate completion of patient records
- Patient complaints / compliments
- Staff complaints / compliments
- Frequency of missing information in charts
- Dating, timing, and signing / authenticating of entries
- Telephone / verbal orders authenticated within the defined timeframe
- Medical Record Delinquency
- Non-participation in surgical time-out
- ED call response greater than 30 minutes
- Consult delays
- Participates in interdisciplinary team meetings

F / OPPE Requirements

General "Core" Competencies Assessment
~ *Everyone* ~



Quality Indicators – Patient Care

Provides appropriate and effective patient care for the treatment of health problems

- F / OPPE & Peer Review reports / findings
- Clinical complaints / compliments
- Crimson data
- Level of clinical activity -- Low volume Physician / APP?
- Mortality & complications
- 30-day readmissions for same MS-DRG
- Current board certification
- CME attestation
- Most current peer references
- Appropriate test orders
- Appropriate utilization of consultants
- Trends in length of stay
- Compliance with core measures
- Non-participation in surgical time-out
- ED call response greater than 30 minutes
- Consult delays

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F / OPPE Requirements

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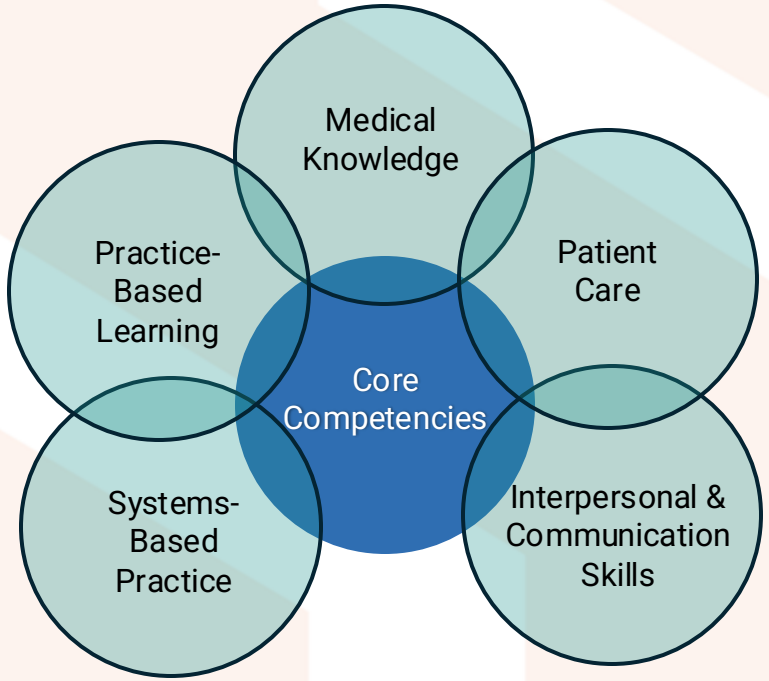

Quality Indicators – Practice-Based Learning

Demonstrates the ability to investigate and evaluate patient care practices, appraises and assimilates scientific evidence to continuously improve patient care based on constant self-evaluation and life-long learning

- F / OPPE & Peer Review reports / findings
- Clinical complaints / compliments
- Crimson data
- Complications of condition or care
- 30-day readmissions for same MS-DRG
- H&P Audits
- Current board certification
- CME attestation
- Most current peer references
- Appropriate test orders
- Appropriate utilization of consultants
- Trends in length of stay
- Compliance with core measures
- Committee participation

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F / OPPE Requirements

General "Core" Competencies Assessment
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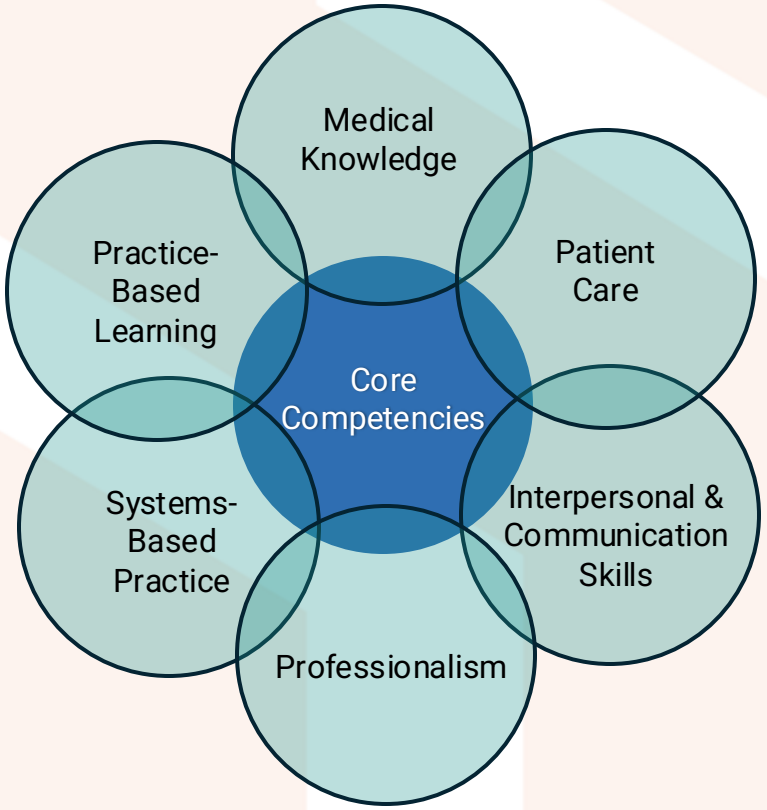

Quality Indicators – Professionalism

Demonstrates a commitment to carrying out professional responsibilities, and adherence to ethical principles

- Professionalism complaints / compliments *
- Compliance with applicable Medical Staff and organization policies and procedures
- Timely and adequate completion of patient records
- Clinical complaints / compliments
- Most current peer references
- Committee participation
- Non-participation in surgical time-out
- ED call response greater than 30 minutes
- Consult delays
- Participates in interdisciplinary team meetings

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OPPE Use in Assessing Competency

Fundamentally, organizations must collect all performance data covering all elements of performance

- Each practitioner's OPPE should ***(must)*** be evaluated by a Medical Leader for current competency *(Chief of Department)*
- Comparative Reports
  - Physician profiles should ***(must)*** be compared to external benchmark data & compared to others in the same department
- OPPE must be done more often than annually – *practically, every 6 or 8 months*
- Specific Practitioner Feedback
  - **Provide performance data on a routine basis to each physician**
- Low volume physicians & APPs can be challenging to assess
- Time intensive – *automate data collection & report generation as much as is feasible to ease the burden on the Quality Team and Medical Staff leaders*

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OPPE Use in Assessing Competency

"Ongoing" = At Least Annually

Data Benchmarks & Thresholds

- **Benchmarks** - Based on recognized standards when available, the expected results of a Physician / APP practicing at the Hospital.
- **Thresholds** - The minimum results of a Physician / APP practicing at the Hospital recognizing that low volumes can result in a short term sub-threshold result in a given indicator. When sub-threshold results persist, consideration must be given to identify opportunities for improvement.
- **Comparative Data** - De-identified comparative Department data may be presented in aggregate to influence performance.

OPPE – refer to data that exists, monitoring common practice areas

Compare to department data

Compare to national benchmark data

Specific Practitioner Feedback

Provide performance data on a routine basis to each physician & APP

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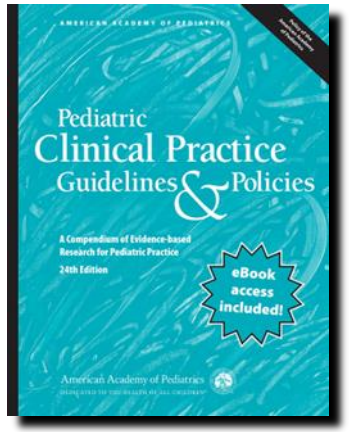
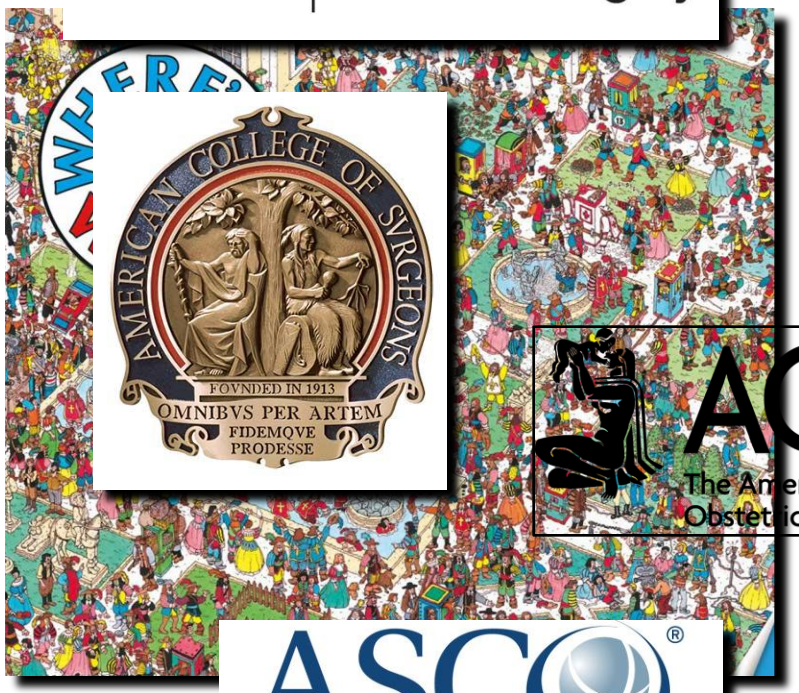
OPPE Use in Assessing Competency



SVS | Society for Vascular Surgery



Clinical Guidelines
ACP
American College of Physicians
Leading Internal Medicine, Improving Lives

THE SOCIETY OF THORACIC SURGEONS
Established 1964

ASCRS
American Society of Colon & Rectal Surgeons

ACOG
The American College of Obstetricians and Gynecologists

Compare to national benchmark data

American College of Radiology™

ASCO®
American Society of Clinical Oncology

AMERICAN COLLEGE of CARDIOLOGY®

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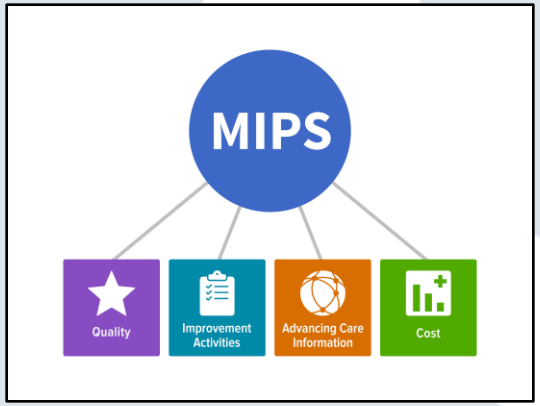
OPPE Use in Assessing Competency

STS National Database™
Trusted. Transformed. Real-Time.

ACS tqip TRAUMA QUALITY IMPROVEMENT PROGRAM



ACS NSQIP
National Surgical Quality Improvement Program
American College of Surgeons

Stretch your dollars…

Commission on Cancer® ACCREDITED PROGRAM
A QUALITY PROGRAM of the AMERICAN COLLEGE OF SURGEONS

MBSAQIP
METABOLIC AND BARIATRIC SURGERY ACCREDITATION AND QUALITY IMPROVEMENT PROGRAM

Quality Incentive Programs
Anthem
aetna
Cigna
Humana
UnitedHealthcare

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OPPE Use in Assessing Competency

PATIENT CARE
provides appropriate and effective patient care for the treatment of health problems.

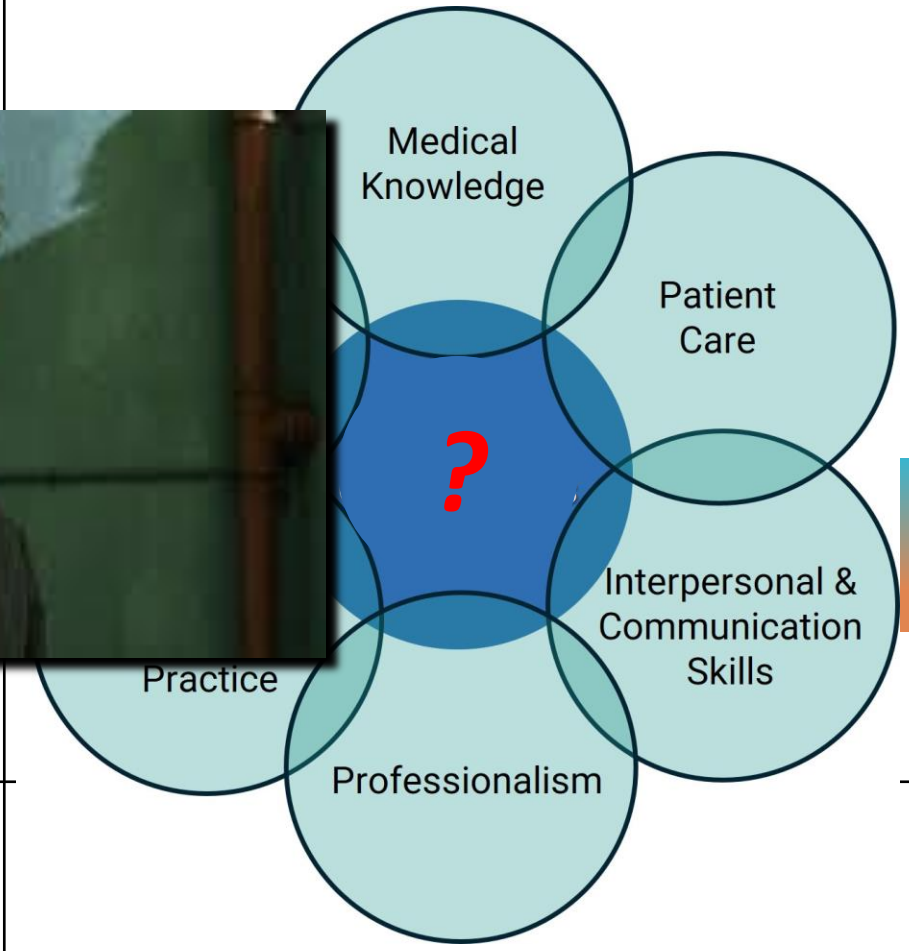
MEDICAL KNOWLEDGE
Demonstrates knowledge about established and evolvi
social behavioral sciences as well as the application to

PRACTICE-BASED LEARNING AND IMPROVEMENT
Demonstrates the ability to investigate and evaluate pat
scientific evidence to continuously improve patient care
learning.

Fine Tun

PROFESSIONALISM
Demonstrates a commitment to carrying out professional responsibilities, and adherence to ethical principles.

SYSTEMS-BASED PRACTICE
Demonstrates awareness of and responsiveness to the larger context and system of health care and the ability to effectively call on other resources in the system to provide optimal health care.



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F / OPPE

A word about TJC & DNV

Determination of Competency

Joint Commission surveyors will be looking for documentation of the hospital's FPPE/OPPE processes and how they are applied to the credentialing and privileging process for its practitioners.

- Facilities can be cited for lack of robust OPPE/FPPE processes
- Initial FPPE can be cited for lack of timeliness and lack of documentation
- "For cause/Triggered" FPPE frequently gets cited for lack of action and on-going measurement
- Does OPPE and FPPE data feed back to the credentialing body?
- **Bottom Line : OPPE/FPPE must be more than just a paper process**

F / OPPE

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Reporting Requirements

OPPE and FPPE information is reported to the MEC and the Board

OPPE and FPPE are parts of the peer review process – protected

- They are not adverse actions
- They are not “investigations”
- They are not reportable to the National Practitioner Data Bank or State Medical Board
- They are part of feedback and, if needed, managing poor performance

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F/OPPE Information Flow

Medical Executive Committee

This recommendation is then forwarded to the Board of Directors.

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

- ✓ “Current competence” for privileges requested
- ✓ Physician / APP profile – OPPE/FPPE/equivalent* Data
- ✓ Peer Review Data
- ✓ License & DEA Certificates
- ✓ CME
- ✓ Liability Insurance
- ✓ NPDB “sweep” & Criminal Background Check

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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.

This will include:

- Making recommendations: Based on their review, the credentials committee makes recommendations to the medical executive committee & the hospital board on whether to approve or deny each medical staff member's reappointment application.

- Monitoring compliance: The credentials committee may also be responsible for monitoring compliance with ongoing professional practice evaluation *(OPPE)* and focused professional practice evaluation *(FPPE)* requirements, which can impact the member's eligibility for reappointment.

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.

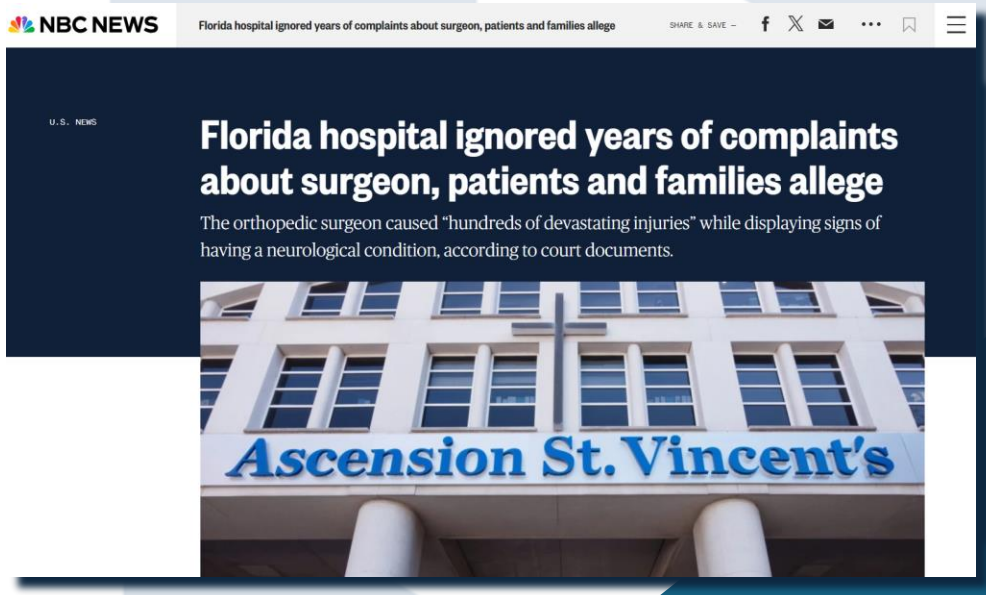
*Overall, the credentials committee plays a critical role in ensuring that medical staff members meet the hospital's standards for reappointment and maintaining the hospital's compliance with accreditation and regulatory requirements. The committee's thorough evaluation process can help **protect patient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

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.



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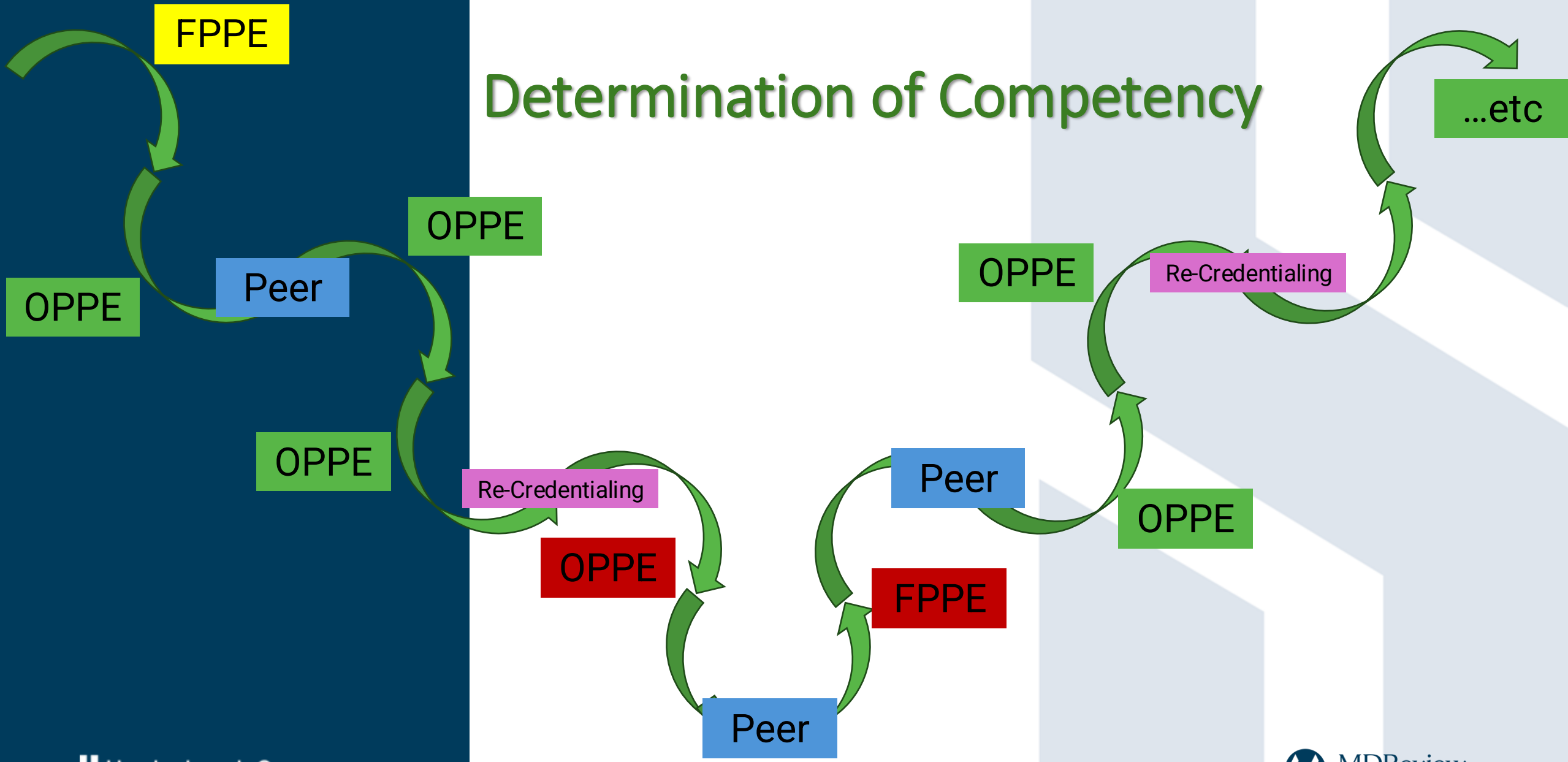
Determination of Competency



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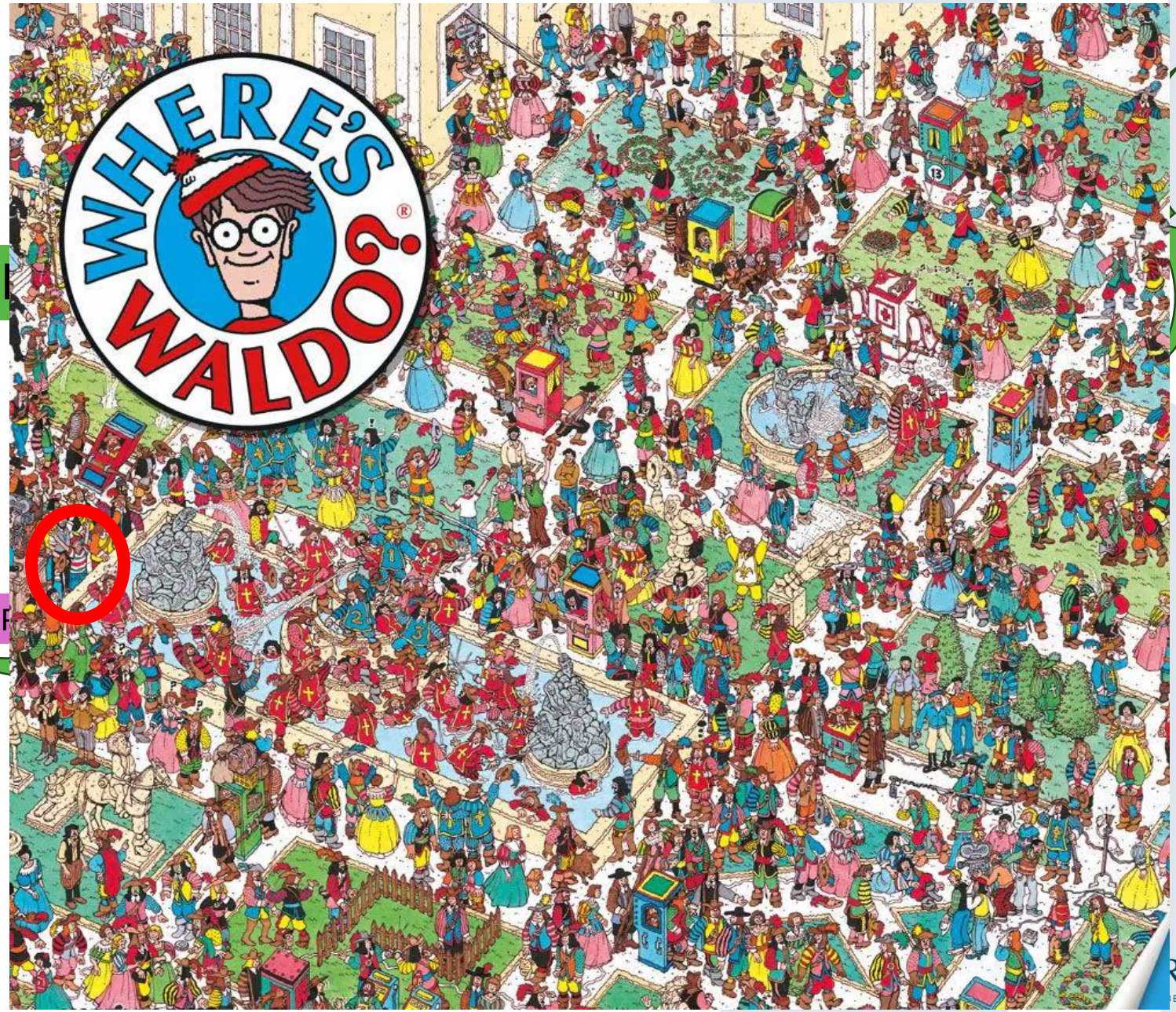
FPPE

OPPE

Peer

OPPE

Low / No Volume Physicians & APPs



...etc

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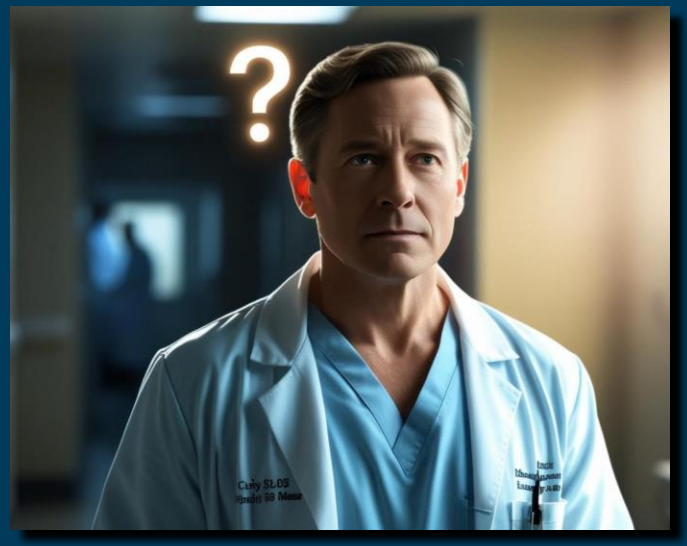
Review

Low / No Volume Physicians & APPs

Low & No Volume physicians & APPs 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?*



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Considerations

"Triggered" FPPE Design

- Tailored to meet the issue of concern
  - Purpose
  - Focus
  - Time or volume requirements
  - Monitoring process – well defined
  - Data collection and review – well defined
  - Appropriate approval prior to institution
- ***Follow up, or fail***

Peer Review Should Be:

Responsive

Non-Punitive

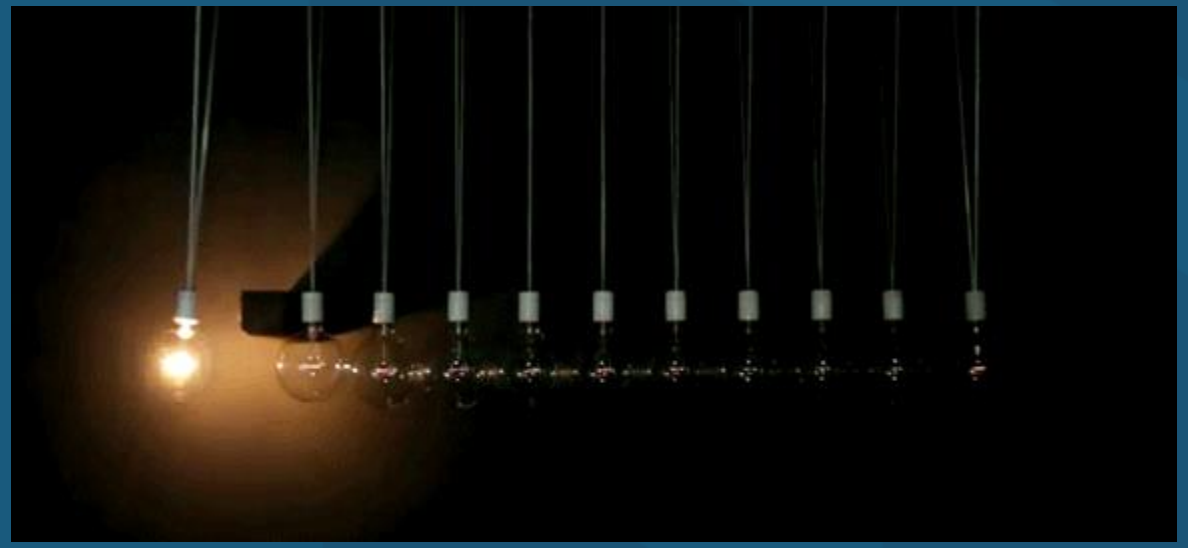
Peer Review

Educational

Collegial

Complimentary of Care When Appropriate

Putting the pieces into motion



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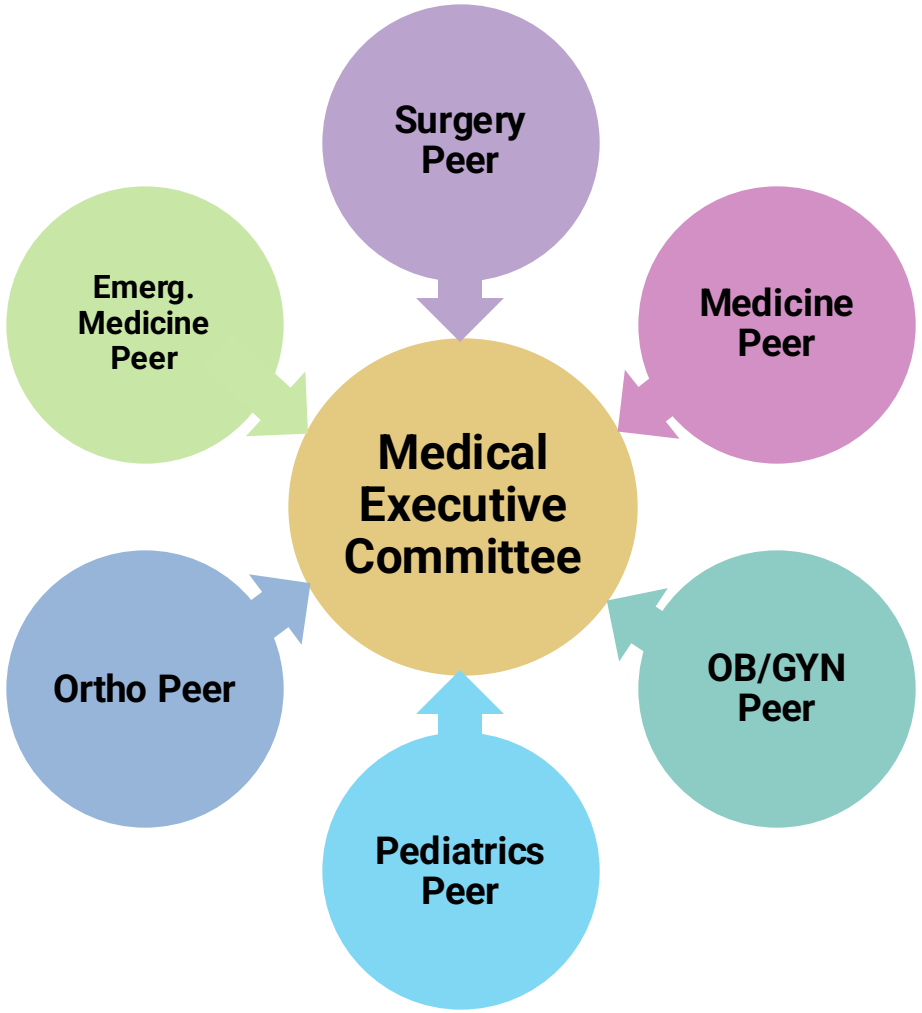
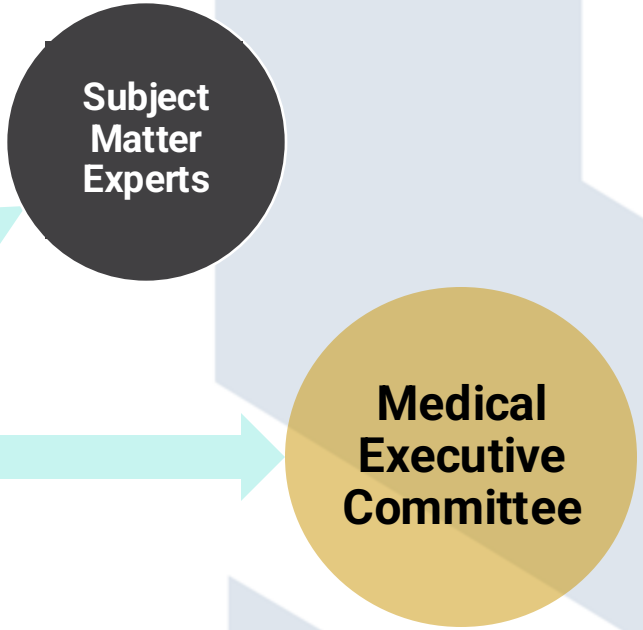
Historical Peer Review



- 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



Addresses concerns of efficiency, consistency, and fairness

Encourages utilization of aggregate data **(OPPE, indicators)**

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Contemporary Peer Review Stages

1st Stage – Initiation of PR Process

2nd Stage – Screening

3rd Stage – Multidisciplinary Committee

Starts with Triggers:

- *Referrals*
- *Indicators*

***OPPE**

Quality Department prescreens with the Chair

"Predictable outcome within accepted standards of care"
"There was Opportunity for Improvement"
"Significant Variance from accepted standards of care rendered to this patient"

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Contemporary Peer Review Stages

4th 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*

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Potential Sanctions

"Triggered" Focused Practice Review (FPPE)

Restriction of Certain Privileges

Temporary Suspension of Privileges

Revocation of Privileges

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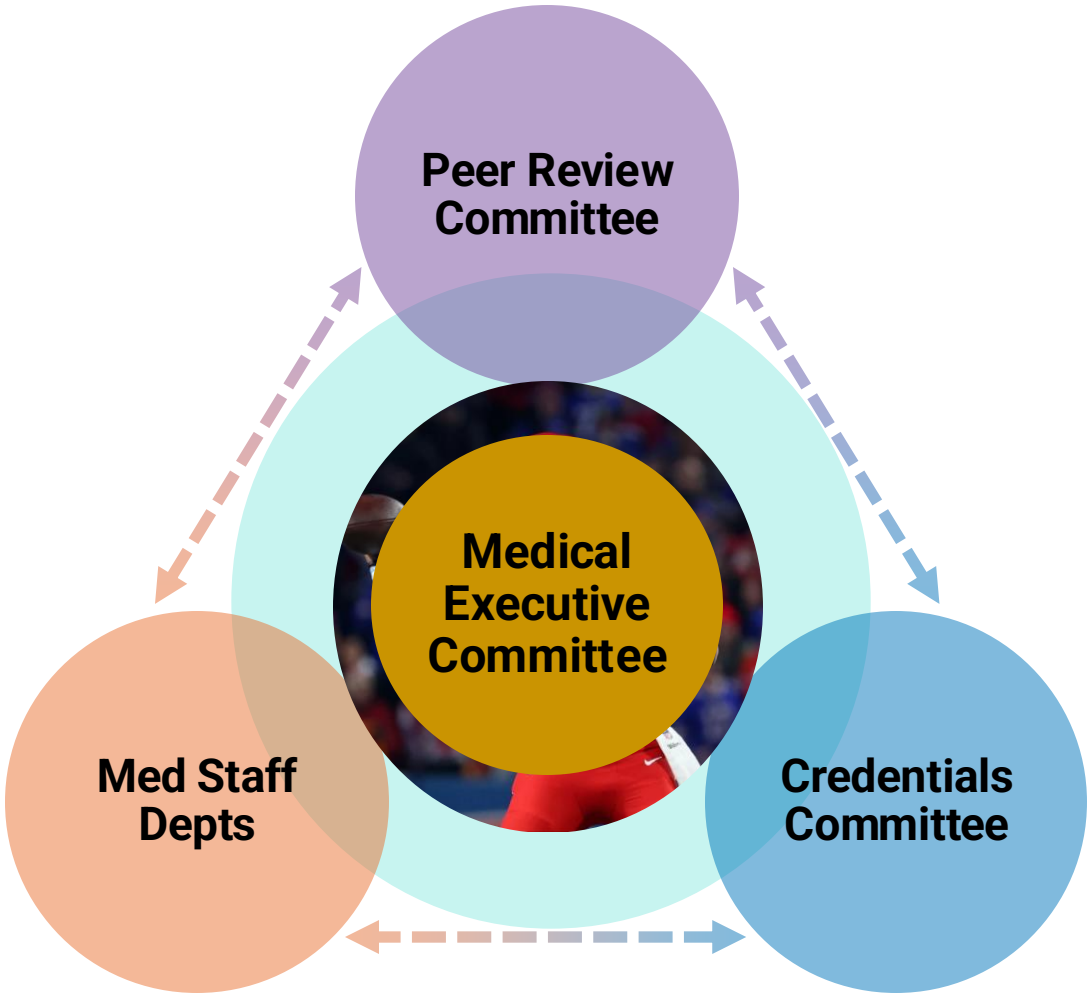
Complementary, Hand-in-Glove Roles



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

Credentialing & Peer Review Scenarios

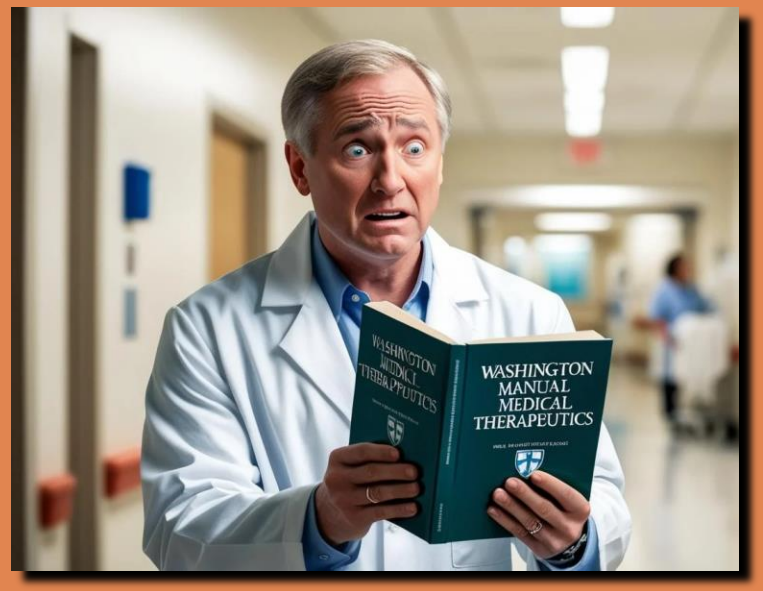
Scenario 1

"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**

Credentialing & Peer Review Scenarios



Scenario 2

OPPE review reveals that one hospitalist has a higher than average LOS for certain common hospitalizations. A deeper dive also demonstrates:

- **Nursing complaints about prescribing errors**
- **Two recent unanticipated returns to the ED for patients with community acquired pneumonia, with a concern for a lack of following antibiotic regimen guidelines**

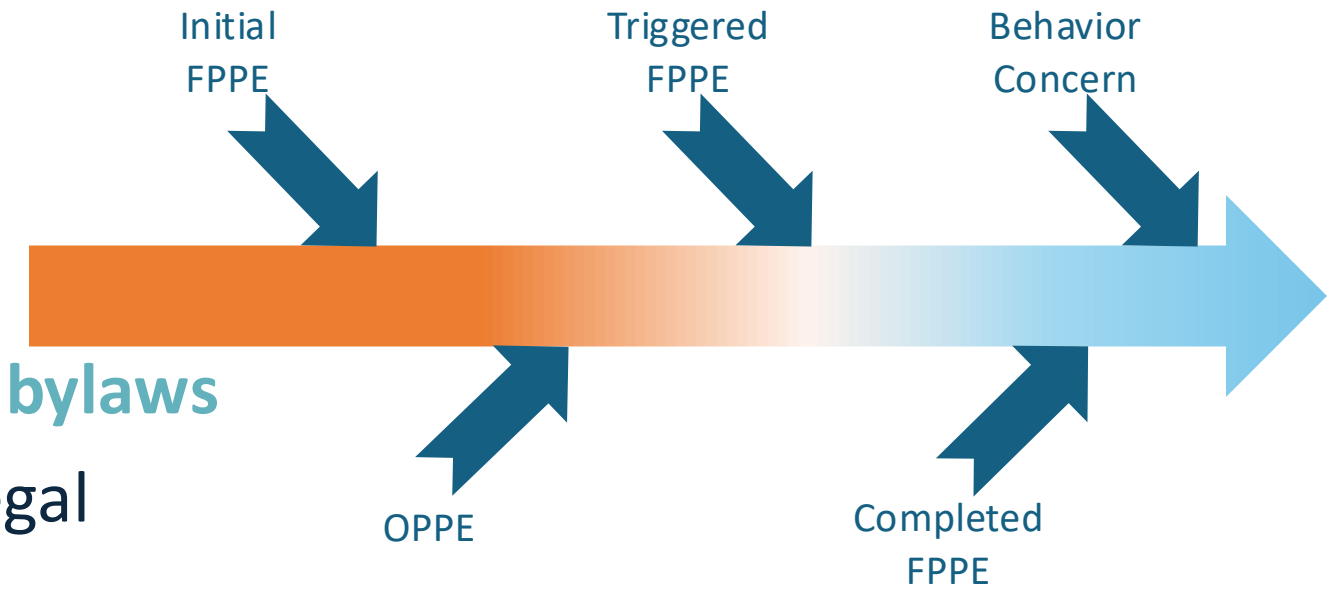
What should the Peer Review Committee do next?

- **Any additional data available?**
- **Track & Trend?**
- ***Triggered FPPE?***

Medical Staff Professional's Role

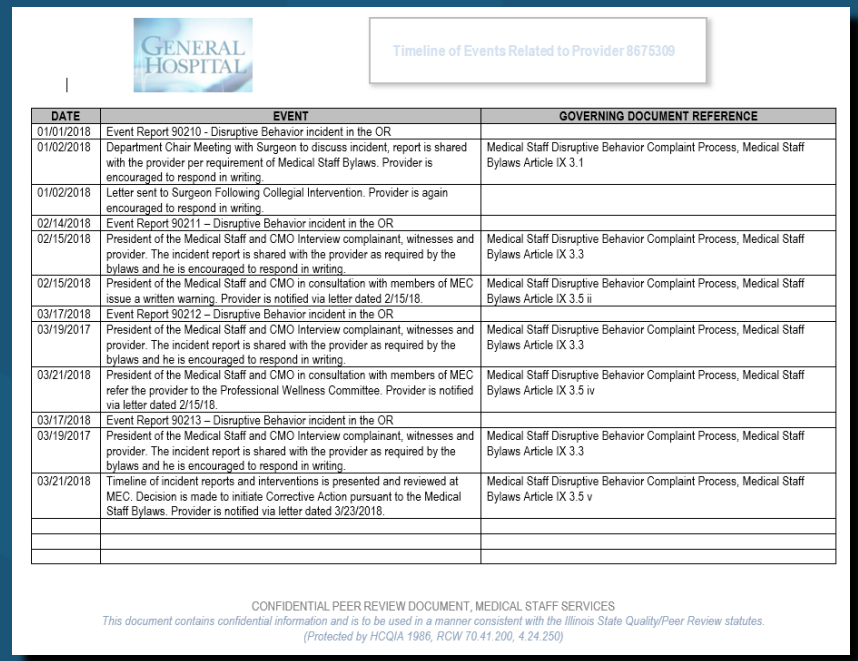
Supporting Medical Staff Leaders

- Provide dedicated time for Medical Staff Leaders
- Complete documentation
  - **"The whole (hi)story"**
  - **Demonstrate timeline & interventions as outlined by bylaws**
- Arrange availability of HR and Legal teams as required
- Ensure accountability



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

It's a WHY *ency*

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Thank you!

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Want to chat?

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