
Jonathan B. Kruskal, MD, PhD
Ronald L. Eisenberg, MD, JD
Muneeb Ahmed, MD
Bettina Siewert, MD

Abbreviations: ACGME = Accreditation Council for Graduate Medical Education, FPPE = focused professional practice evaluation, OPPE = ongoing professional practice evaluation

RadioGraphics 2018; 38:1593–1608
https://doi.org/10.1148/rg.2018180163

Content Code: SO

From the Department of Radiology, Beth Israel Deaconess Medical Center, One Deaconess Rd, Boston, MA 02215. Received April 26, 2018; revision requested May 24 and received May 25; accepted May 31. All authors have disclosed no relevant relationships. Address correspondence to J.B.K. (e-mail: jkruskal@bidmc.harvard.edu).

©RSNA, 2018

Introduction

In 2000, the publication of the Institute of Medicine’s landmark report, To Err is Human: Building a Safer Health System (1), raised disturbing questions about the quality of health care in the United States; this report estimated that up to 98,000 people die each year as a result of preventable medical error. More recently, the Institute of Medicine released Improving Diagnosis in Health Care (2), which states that “most people will experience at least one diagnostic error in their lifetimes, sometimes with devastating consequences” and concludes that “urgent change is warranted to address this challenge.”

In an effort to improve oversight of physician performance, presumably to drive improved performance, different evaluation processes and requirements have been introduced at the institutional, state, and federal levels. One mandatory approach to evaluating physician performance is through an ongoing professional practice
evaluation (OPPE), a vaguely defined screening tool that is defined by The Joint Commission as “continuing data collected for the purpose of assessing a practitioner’s clinical competence and professional behavior” (3). The information gathered during this OPPE process is used as a factor in deciding whether to maintain, revise, or revoke existing practitioner privileges before or at the end of the required 2-year license and privilege renewal cycle. According to the Joint Commission, “FPPE is the follow-up process to determine the validity of any positive findings or triggers (whether true or false) that are identified through the OPPE process.” The first requirement for implementing an effective OPPE system is that a policy must exist within your practice that clearly describes the OPPE process.

Basic Requirements for Implementing an Effective OPPE System

The first requirement for implementing an effective OPPE system is that a policy must exist within your practice that clearly describes the OPPE process. This policy should define exactly how the professional practice of each radiologist will be evaluated, as well as what data are collected and where the data are stored. As more and more data are available or stored in a digital manner, including on dashboards, this information is not typically retrieved and placed in the record (a) unless there are specific reasons for a further review or (b) when an FPPE is being triggered.

Who Should Undergo an OPPE?

Data should be collected for all radiologists who have privileges to practice in an institution, not just those with perceived performance issues. The OPPE process must therefore be implemented for all members of the department, even if they are known to be providing excellent patient care. Information is used to identify performance issues so that early intervention can occur. Many of the data may already be collected, such as those used to track compliance.
approach this process on the basis of the Accreditation Council for Graduate Medical Education (ACGME) Core Competencies (7) (Table 2).

Before implementing an OPPE system that is based on the core competencies as defined by the ACGME, a series of questions must be answered relating to all steps of the process, to ensure consistency, to eliminate bias, and to be uniform and fair to all members of the department (Table 2). Table 3 shows examples of different performance improvement activities that can be undertaken.

What Data Should Be Collected That Are Reflective of Professional Practice Competency?
The Joint Commission standard suggests that organizations may choose to collect whatever data they believe are representative and appropriate and also suggests broad categories of data to consider (Table 1) (3). The OPPE process is a screening one intended to identify outliers. Outliers may occur at both ends of the spectrum, and we believe strongly that good performance should be recognized and acknowledged. If not, such evaluation processes will continue to be seen as punitive, onerous, and unhelpful.

For Radiologists, What Performance Categories Should Be Evaluated?
The easiest way to meet the Joint Commission requirements for effective physician evaluation is to approach this process on the basis of the Accreditation Council for Graduate Medical Education (ACGME) Core Competencies (7) (Table 2).

Where Should All These Data Be Kept?
Many organizations keep these data separate from the credentials file, and only outcomes from the evaluation need to be documented in the credentials file. For example, the credentials file may show data verifying participation in a peer review process but should not include the actual

| Table 1: The Joint Commission’s Suggestions for Data That Should Be Collected for an OPPE |
|---------------------------------|-------------------------------------------------------------------------------------|
| Category of Data                | Examples Suggested by The Joint Commission                                         |
| Data that are typically collected by the institution’s office of professional staff affairs | Specialty and subspecialty board certification status  
Maintenance of training (MOC, CME) to support approved privileges  
Current state licensure status  
Compliance with the institution’s mandatory training and screening programs  
Adverse patient event and outcomes data  
Compliments and complaints from stakeholders |
| Radiologist compliance data    | Compliance with mandatory institutional safety and education requirements  
Communication and documentation of critical findings  
Compliance with The Joint Commission’s Universal Protocol (for interventional radiologists) |
| Periodic chart review          | Audit of the content of the individual’s reports and report recommendations, compared with those of section members  
Timeliness of reports (report turnaround time), compared with peers and defined departmental practice guidelines |
| Clinical privilege review      | Privilege-specific results from the division peer review program  
Participation in the peer review process (number of cases submitted, compared with defined requirements)  
Peer review data review (comparison with peers in the division and with national benchmarks) |
| Direct observations            | Best suited for radiologists performing procedures or interacting with patients |
| Multisource feedback from stakeholders | Interpersonal and communications skills, including interactions with patients and/or their family members, referring physicians, and other colleagues  
Leadership skills (best suited for section chiefs and modality directors in academic programs)  
Surveys of peers and other clinical staff members working with the radiologist in specific cases |
| Outcomes review                | Patient satisfaction data  
Procedure outcomes data |

Source.—Reference 3.
Note.—CME = continuing medical education, MOC = maintenance of certification, Universal Protocol = Universal Protocol for Preventing Wrong Site, Wrong Procedure, and Wrong Person Surgery.
Table 2: Examples of Criteria That Can Be Used to Evaluate the Professional Practice of Radiologists, According to the Six Core Competencies Defined by the ACGME

<table>
<thead>
<tr>
<th>ACGME Core Competency*</th>
<th>Examples of Radiology Performance Metrics</th>
</tr>
</thead>
<tbody>
<tr>
<td>Patient care and procedural skills</td>
<td>Productivity (case volumes and work relative value units ([RVUs]) Report turnaround time, compared with departmental benchmarks Report edits, addenda, or errors Compliance with policies for critical results notification Compliance with policies for The Joint Commission’s Universal Protocol Volume of cases relative to specific privileges Procedure outcomes (for interventional radiologists) Radiologist’s availability to patients and referring physicians Incident reports and/or sentinel events</td>
</tr>
<tr>
<td>Medical knowledge</td>
<td>Maintenance of certification status Fellowship training (subspecialty board certification) Continuing medical education requirements met Multisource feedback from colleagues and referring physicians Academic rank Academic productivity, invited lectures, scholarship Report from the faculty development committee</td>
</tr>
<tr>
<td>Practice-based learning and improvement</td>
<td>Participation in practice quality improvement projects Teaching profile Trainee teaching scores and feedback Educational media</td>
</tr>
<tr>
<td>Interpersonal and communication skills</td>
<td>Data from multisource feedback surveys from colleagues Relationship with the medical staff Relationship with the hospital staff Compliments and complaints from stakeholders Reports are complete and follow national reporting standards Personal report turnaround time within the departmental goals</td>
</tr>
<tr>
<td>Professionalism</td>
<td>Conduct with colleagues, staff, and patients and their families Data from multisource feedback surveys of stakeholders Punctuality Medical staff, committee, and department meeting attendance and participation Accountable for personal behavior Compliance with required training programs Timely response to administrative requests and surveys Staff complaints (department, peers, or referring physicians) Complaints from trainees Letters or notes of commendation</td>
</tr>
<tr>
<td>Systems-based practice</td>
<td>Peer review submissions and data Participation in practice quality improvement efforts Compliance with the initiatives of The Joint Commission’s National Patient Safety Goals Participation in multidisciplinary conferences Compliance with required education tests (eg, infection control) Feedback from mentor Feedback from the section or division chief</td>
</tr>
</tbody>
</table>

*Source.—Reference 7.
Note.—Data from this process are then evaluated in determining whether to continue, limit, or revoke a radiologist’s privileges.
performance data generated by peer review. That information is for internal management.

**Who Determines the Outcomes of the Review—One Individual or a Committee?**

It must be clearly defined which person or committee reviews the data to make the recommendation whether to continue, limit, or revoke a radiologist’s privileges. As an example, in a large multispecialty practice, the decision maker might be the section or division chief, along with the department chair. Other organizations defer decisions such as limiting or revoking privileges to higher bodies, such as a credentials committee or a medical executive committee, or even a hospital board. Depending on the size of a practice, review might be even be undertaken by the entire practice. Whenever an action is taken that affects privileges, these data need to be documented, along with supporting information. Table 4 lists options for the determination of outcomes after an OPPE process has been completed.

### Table 3: Performance Improvement Activities

<table>
<thead>
<tr>
<th>Activity</th>
</tr>
</thead>
<tbody>
<tr>
<td>Peer review case submissions</td>
</tr>
<tr>
<td>Peer review case audits</td>
</tr>
<tr>
<td>Near-miss project submissions</td>
</tr>
<tr>
<td>Peer learning cases submitted</td>
</tr>
<tr>
<td>Procedure outcomes and learning rounds</td>
</tr>
<tr>
<td>Learning cases from multidisciplinary meetings</td>
</tr>
<tr>
<td>Critical results notification audits</td>
</tr>
<tr>
<td>Audits of national patient safety goals (Universal Protocol, hand washing, closeouts)</td>
</tr>
<tr>
<td>QAPI adverse event incident reports</td>
</tr>
<tr>
<td>Practice quality improvement project participation</td>
</tr>
<tr>
<td>Patient and staff safety callouts</td>
</tr>
<tr>
<td>Participation on section or modality quality assurance rounds</td>
</tr>
<tr>
<td>Departmental quality assurance or quality improvement committee member</td>
</tr>
<tr>
<td>Quality assurance or quality improvement lectures to trainees</td>
</tr>
<tr>
<td>QAPI grand rounds attendance</td>
</tr>
<tr>
<td>Submission and presentation of an abstract for an RSNA quality improvement report (formerly known as an RSNA storyboard)</td>
</tr>
<tr>
<td>Oral presentation on a quality topic at a regional or national meeting</td>
</tr>
<tr>
<td>Peer-reviewed manuscript on a quality or practice improvement topic</td>
</tr>
</tbody>
</table>

Note.—Radiologists participate in practice quality, safety, and improvement activities in many ways, and each way should be considered and recognized. This table shows the different types of activities that we recognize, and indeed encourage, for effective participation. QAPI = quality assurance and performance improvement, RSNA = Radiological Society of North America.

### Table 4: Options for the Determination of Outcomes after Completion of an OPPE

<table>
<thead>
<tr>
<th>Outcome Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>The radiologist is performing well or within desired and defined expectations, and no further action is warranted at this time. All current privileges should be maintained.</td>
</tr>
<tr>
<td>One or more specific issues are identified during the screening process that now require a more detailed FPPE process.</td>
</tr>
<tr>
<td>A specific privilege is revoked because it is no longer needed or is no longer applicable to the radiologist. Examples in this category include a particular procedure that the radiologist no longer performs or a type of study (eg, brain MRI) that the radiologist no longer interprets.</td>
</tr>
<tr>
<td>A privilege is suspended, which suspends further data collection; and the practitioner must request reactivation should the radiologist desire to continue performing that specific procedure or study. Suspension of a privilege may occur for cause.</td>
</tr>
<tr>
<td>A zero performance (ie, no data available) should trigger an FPPE whenever a practitioner actually performs the specific privilege. As an example, a radiologist performs lung biopsies, but no performance data are collected or are available that allow procedure outcomes to be evaluated.</td>
</tr>
<tr>
<td>A privilege should be continued because it matches the organization’s mission to provide the privilege to patients. An example is a new mission-relevant procedure that an organization has recently introduced for which data collection is scant owing to the low numbers at the onset of introducing this new procedure.</td>
</tr>
</tbody>
</table>

How Often Should Performance Data Be Collected and Reviewed?

The OPPE standard, as defined by The Joint Commission, requires that organizations look at performance data on practitioner privileges on an ongoing basis (rather than at 2-year reappointments), to allow steps to be taken to improve performance on a timely basis. The Joint Commission specifies “ongoing,” rather than specific intervals. The frequency of OPPEs should therefore be defined by the medical staff of the institution, with most selecting reviews at 8-month intervals to meet the ongoing requirement.

What if a Radiologist Is Not Performing Sufficient Numbers of the Studies or Procedures for Which She or He Is Privileged?

The Joint Commission considers it important to know when a practitioner is not performing certain
procedures over time. The Joint Commission recommends evaluating why the practitioner is no longer performing the procedure, or if the procedure is typically low volume or has yet to be done. The Joint Commission does not consider it acceptable that a practitioner has not performed a procedure for which he or she is privileged for 2 years or more.

**How Should We Approach No or Zero Data?**
The Joint Commission considers zero data to be data. What exactly is “zero data”? For example, no complications, no complaints, or no infections are considered positive zero data, whereas not performing a specific procedure may indicate negative data if there is a reason why this non-performance is occurring.

**Do the Performance Data Have to Be Shared with the Radiologist?**
To some extent, the answer to this question depends on the culture of a practice or institution. Although sharing is not mandatory, always consider sharing the data with the radiologist. In addition to offering positive feedback in areas in which the radiologist is doing well, the shared data may encourage practitioners to seek to self-modify behavior, knowing what types and examples of data are being collected. Presentation of comparative data aggregated from peers (such as data from scorecards and dashboards) can serve as a strong influence. We also find it helpful for our radiologists to know the extent of administrative tasks that are being performed for them to allow them to meet regulatory requirements and thus to practice.

**Measuring Outcomes for Interventional Radiologists**
Outcomes for interventional radiologists should be analyzed irrespective of whether this analysis falls within the scope of the OPPE process, and outcomes analysis is commonly performed at many institutions by means of morbidity and mortality reviews of procedural complications. However, an interventional radiology–specific OPPE process should include several additional components. Basic metrics, such as minor or major complication rates for the interventional radiology service and for individual operators, can be easily determined (\((\text{number of cases submitted for quality assurance review divided by number of cases performed by the interventional radiology service or individual}) \times 100\)).

A procedure-specific review committee should be designated, and it should include a division quality assurance officer (and there may be more than one if procedures are performed in several different divisions), as well as members from departmental leadership (eg, the chief of interventional radiology, vice chairs for quality and/or interventional services). The committee should identify metrics to observe for all proceduralists within the department. At a minimum, these metrics should include compliance with basic certification (eg, moderate sedation and advanced cardiac life support training), defining procedures to evaluate (either all or select key procedures), and defining “triggers” for additional review, such as complication rate thresholds (general or procedure-specific rates) and sentinel events flagged from morbidity and mortality reviews. The Society of Interventional Radiology has published quality guidelines for many different types of procedures, with suggested threshold numbers for procedure-specific complication rates that can be used as benchmarks for practice outcomes.

Several additional challenges remain in developing a more comprehensive interventional radiology–specific OPPE. Use of data from cases discussed at morbidity and mortality meetings (cases that may include only patients who experienced major complications) alone may not provide sufficient material for regular practice review and may overlook early signs of operator performance requiring further investigation in patients who do not experience a complication (ie, technical or clinical variance that has not yet reached a threshold for poor patient outcome). At our institution, a web-based application (app) has been developed for easy procedure-specific peer review, where several interventional radiology faculty review cases on a regular basis and submit their consensus evaluations directly into the app. Separately, at institutions in which multidisciplinary teams have been established for specific systems or diseases (eg, liver tumor care teams), such teams may also offer an additional forum for clinical case review. In addition, given the wide range and number of procedures performed in interventional radiology by any given practice, acquiring procedure-specific data for individual operators and developing thresholds that might trigger additional review can be cumbersome. This problem may be overcome by identification of key procedures and/or procedures considered equivalent (eg, including all vascular angiography and venography together or all image-guided biopsies together) because they use similar core skill sets, which may simplify the review process.

We must also acknowledge that interventional radiology is evolving rapidly in many institutions (in part because of changing requirements from the new interventional radiology/diagnostic radiology residency training pathway) to include clinical practice elements such as outpatient clin-
ics, inpatient consulting services, and the development of interventional radiology as its own distinct admitting service. Methods of OPPE review of this part of an interventional radiology practice may ultimately need to more closely approximate practices developed in other procedural specialties, such as surgery or gastroenterology.

**Tools That We Use in an OPPE**

We have developed numerous dashboards and reports for use during the OPPE process. Many of the necessary data are collected in an overall OPPE dashboard that is used to populate a competency-based evaluation form (Fig 1). The six major core competencies have been defined by the ACGME (7,8).

**Medical Record Review: Radiology Report Content**

A comprehensive medical record review provides critical information for assessing and improving radiologist performance, adding value, and improving the delivery of patient care. As an example, our system has developed a report recommendation dashboard that analyzes the number of reports containing recommendations per section (per selected time interval), as well as by individual radiologists within a section (Fig 2). The same dashboard displays each individual recommendation, which can be further categorized as to whether it was value adding, appropriate, compliant or not compliant with approved departmental algorithms for managing...
incidental findings, or likely not necessary. This dashboard serves as a technique for constructive feedback–based learning, in which the submitting radiologist can focus on the specific area that needs improvement (Fig 3). The dashboard also offers an opportunity for positive reinforcement of especially excellent reports.

**Credentialing and Peer Review Dashboards**

One dashboard provides, at a single glance, current data on the status of a radiologist’s professional licensure, Drug Enforcement Administration and controlled substance license status, hospital credentials, and continuing medical education. The report recommendation dashboard depicts the percentage of reports containing recommendations grouped by clinical section and the individual reporting radiologist. The data can be further broken down to actual recommendations, and the loop can be closed by providing anonymous electronic feedback to the individual reporting radiologist (Fig 3). In this example, the lower section shows the numbers of reports with recommendations for six different radiologists, including one individual who is an outlier (when compared with section colleagues), with 18.8% of the radiologist’s reports containing recommendations, compared with the section average of 8.8%. 

**OB/Gyn** = obstetric-gynecologic.
education credits, as well as peer learning participation (Fig 4). A dashboard displays individual peer review data, ensuring that all radiologists are participating in the peer review process, that a representative spectrum of cases is being reviewed, and that there are no outliers in terms of scoring and opinions. There also is a dashboard listing discrepancies revealed by the peer review process. Another dashboard categorizes discrepancies according to type, organ system, and possible effects.

Compliance with Mandatory Testing: The Universal Protocol Compliance Monitoring Process
The requirements and content of mandatory testing are typically defined at the institutional level and are defined in response to The Joint Commission’s National Patient Safety Goals and current Joint Commission requirements (Fig 5). One major area of concern for interventional procedures in our hospital is compliance with The Joint Commission’s Universal Protocol for Preventing Wrong Site, Wrong Procedure, and Wrong Person Surgery, which includes proper informed consent by the patient and physician; the availability of all necessary equipment; immediate assessment of patient vital signs if medication is given; proper labeling of syringes with medication, dosage, and concentration; and documentation of all elements of the “time-out.” This time-out process refers to the requirement, in every interventional procedure, that all activity be stopped so that all team members are free to focus on such factors as documenting at least two patient identifiers; confirming the name, medical record number, and date of birth on the consent and requisition; confirming any allergies; verifying the procedure and the proper side for the procedure; having any prerequisite laboratory tests ordered and checking the results; arranging for specimen collection; discontinuing medications if applicable; and administering any necessary medications before the procedure. A compliance dashboard (Fig 6) is used to manage and ensure compliance with mandatory education and safety tests that are required and defined by an institution or even a practice.

Critical Results Communication Compliance and Audit Process
Periodic evaluation is necessary to document compliance with the communication of critical results, both emergent and nonemergent, to appropriate health care providers. In our system, the hospital policy for notification of critical results is readily visible on our web portal, and an audit tool is used to ensure compliance with the required elements of results notification (Fig 7).

Of course, audit dashboards for measuring and managing compliance are only effective if they are actively managed and if the data are used for teaching to facilitate learning and improvement. Simply collecting data will never result in any improvement! For members of the quality assurance

Figure 4. Dashboard output for a radiologist’s participation in the peer review process. One dashboard for a radiologist’s credentialing, compliance, and participation provides, at a single glance, current data on the status of a radiologist’s professional licensure and participation in practice improvement, as well as quality and performance improvement participation efforts. In this example, note the many activities that are considered as effectively participating in performance improvement efforts, beyond peer review. ABR = American Board of Radiology, BIDMC = Beth Israel Deaconess Medical Center, DEA = Drug Enforcement Administration, MOC = maintenance of certification.
committee and other departmental leaders, a radiology safety scorecard has been developed to provide a top-level depiction of the current status of a broad spectrum of metrics, including the topics listed previously, as well as appropriate dosage of medication in moderate sedation; serious adverse events; extravasations; contrast material reactions; staff injury; and proper hand hygiene. If required, the data can be drilled down to individual staff members during their performance review.

**Referring Provider Survey Tool**

Feedback on skills and professionalism are also gleaned from referring physicians, who evaluate the radiologist’s consultative ability; communication of results; suggestion of additional studies, when needed, and facilitation of having the studies performed; and provision of accurate interpretations in which the reviewer has confidence (Fig 8). In our hospital, we have learned the value of soliciting feedback from referring physicians suggested by the radiologist (positive feedback is much encouraged and welcomed) and also from data-driven referrers (ie, top referrers). Our experience has taught that referring physician data are only as good as the thought that goes into developing the questions, selecting appropriate physicians to provide feedback, analyzing the data, identifying and implementing effective change, and resurveying the right stakeholders.

Multidisciplinary conferences are an excellent source of material for peer review. Consequently, we have developed a data entry app for providing “point of service” peer feedback from cases reviewed at these venues (Fig 9). We have found such conferences to be extremely useful for identifying opportunities for constructive feedback relating to radiologist reports and recommendations, with referring physicians offering practical and specific feedback at these meetings.

Figure 5. Checklist for auditing compliance with The Joint Commission’s Universal Protocol. This checklist is used as part of the dashboard for compliance with mandatory testing, specifically the Universal Protocol compliance audit tool. 

DOB = date of birth, MRN = medical record number.
Figure 6. Dashboard output of the hospital educational requirements compliance dashboard. Compliance with the many regulatory tests is easily documented and managed with a database that includes automatic reminders of upcoming courses and tests that an institution requires.

Figure 7. Example of output from the critical results notification audit tool. This tool has been designed to extract every report containing so-called critical findings and to evaluate compliance with mandatory reporting and documentation requirements. IVC = inferior vena cava.
Multisource feedback programs provide an opportunity to obtain constructive information about the many roles and tasks that we perform as radiologists. These roles include diagnostic skills obtained through direct observation during the performance of procedures (Fig 10), as well as interpersonal and communication skills displayed during interactions with patients and their family members (Fig 11). Reviews are also sought from other stakeholders, such as colleagues, technologists, nurses, administrative personnel, and patients.

For section chiefs, modality directors, and all staff in leadership positions, there is an assessment of leadership skills (9) (Fig 12), which includes creating a cooperative working environment among section members, facilitating research and educational initiatives in the section, delegating responsibility when appropriate, encouraging implementation of new technologies, promoting quality assurance, and holding regular section meetings, among other items. When broadened to include a coaching component, this assessment becomes a 360° tool.

The assessment of interpersonal and communication skills (Fig 11) addresses a broad spectrum of topics, including “customer” focus (meeting the expectations of patients and physicians); adherence to an appropriate set of core values; integrity and trust; patience with other people and processes; teamwork; treating patients, technologists, support staff, and colleagues with respect; and utilizing analysis and creativity in solving difficult problems. Another important
criterion is accepting constructive feedback and demonstrating a willingness to make changes when appropriate. Indeed, the survey on interpersonal and communication skills often allows the radiologist to become aware of otherwise unanticipated improvement opportunities.

**Procedure Outcome Tool**

Traditional peer review processes are not effective for radiologists performing image-guided procedures. Instead, the focus should be on a review of actual outcomes and lessons learned, compared with desired outcomes and lessons learned. Our department has developed an interventional radiology outcome app (Fig 13), which serves as the management tool for a procedure peer-learning program. This tool allows data from clinical review sessions and patient rounds to be uploaded, collected, and analyzed. The app can be used to identify individual and group improvement opportunities, as well as to provide teaching materials.

**What Are Examples of Triggers for an FPPE?**

Although debatable, controversial, and even contentious, examples of radiologist performance triggers have been defined (5). It is simpler to define thresholds for radiologists performing procedures, such as three or more adverse outcomes or complaints by patients or other stakeholders during a defined period of time (such as 6 months). For diagnostic radiologists, the challenge comes in the practice culture and the willingness to participate in effective peer review and learning processes. If major misses with important consequences are not
Figure 12. Leadership feedback form from the leadership skills and effectiveness evaluation tool. Multisource feedback programs provide an opportunity to obtain constructive feedback about the many roles and tasks that radiologists perform. This form is based in part on questions used in the Mayo leadership evaluation process (9), and we have developed a tool to solicit feedback from radiologists as a component of evaluating the skills and effectiveness of clinical and modality leaders working in an academic environment. Information gleaned from such a survey should be used to provide constructive feedback and to guide coaching and improvement efforts when necessary. QA = quality assurance.
reported, a performance-based trigger is unlikely to occur. It is well recognized that current peer review practices grossly underestimate and under-report many interpretive and perceptual errors, in large part to minimize the chances of a trigger review taking place. Until we see a true culture shift toward peer learning practices, as well as the removal of any punitive consequences for reporting errors, this climate is unlikely to change (10).

With the emergence of ad hoc and anecdotal peer learning programs, the challenge will be to design these programs in a manner that will allow the data to be used for OPPE and FPPE purposes. Peer learning is not a traditional score-based process, a fact that we believe fosters participation and reporting. In reality, for purposes of regulatory performance evaluation, we strongly believe that participation in the peer review or learning process is sufficient and that internal learning cultures and processes should be allowed to manage actual case errors.

**What Happens during a Survey by The Joint Commission?**
The site surveyor will explore how the organization monitors the performance of practitioners on a continuous basis and is most likely to discuss the credentialing and privileging process. In our own experience, surveyors are interested in how prior training and experience are linked to the initial credentialing process. In other words, how do we verify that a new hire can do those many things for which he or she is requesting privileges, including procedures? Most often, case logs, training certification, and supportive letters of verification from former program directors are more than adequate to meet this requirement.

Site surveyors are usually most interested in how the FPPE and the OPPE processes are implemented and managed on an ongoing basis. Policies should exist and be readily available that clearly describe the OPPE and FPPE processes. Surveyors are also interested in how privileges are communicated back to physicians and their supervisors to ensure that practitioners practice within the scope of their defined privileges.

Surveyors also are likely to ask how practice-specific privileges are evaluated and monitored. Random peer review of cases has some value, but unless these random reviews include representative cases from each practitioner’s profile of cases, no practice-specific evaluation of privileges has been obtained. Thus, if a radiologist is privileged to perform fluoroscopic studies of the small bowel, cases of this type should be included in the performance evaluation process.

**Challenges and Controversies in Developing an Effective OPPE Process**
Although the requirements are somewhat vague, it is important to work to keep the OPPE process as simple as possible. Indeed, in the current environment of increasing and onerous regulatory demands, any efforts at minimizing complex administrative tasks should be supported and encouraged. We should shift the focus from measuring and collecting data to a focus on learning and improvement instead (9).
For example, whenever possible, use data that you almost certainly collect already for radiologists as a component of your quality improvement, clinical operations, and hospital compliance programs. Remember that the focus of an effective screening OPPE system should be on collecting relevant data that can lead to improved performance; it is not intended to be punitive in any way.

In summary, the OPPE process is required to meet The Joint Commission’s physician performance standards; and to the uninitiated, the process might appear as an especially onerous requirement. When the OPPE process is built into the current set of commonly used performance metrics and is managed according to the suggestions we have provided, the task can be simplified considerably.

References