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I. Purpose

The purpose of this policy is to provide guidance to the Medical Staff in overseeing professional practice evaluation activities aimed at measuring, assessing, and enhancing the quality of healthcare at Stanford Health Care Tri-Valley. This is done in accordance with the Medical Staff Bylaws, Rules and Regulations, and relevant policies.

The following core competencies, as identified by the Joint Commission, serve as the standards for evaluating the competency of privileged practitioners:

- A. Patient Care: Delivering compassionate, appropriate, and effective care that promotes health, prevents illness, treats disease, and provides end-of-life care.
- B. Medical and Clinical Knowledge: Possessing knowledge of established and emerging biomedical, clinical, and social sciences, and applying this knowledge to patient care and the education of others.
- C. Practice-Based Learning and Improvement: Utilizing scientific evidence and methods to investigate, evaluate, and enhance patient care practices.
- D. Interpersonal and Communication Skills: Demonstrating interpersonal and communication skills that foster the establishment and maintenance of professional relationships with patients and families and effectively collaborating as a member or leader of a healthcare team.
- E. Professionalism: Exhibiting behaviors that reflect a commitment to continuous professional development, ethical practice, sensitivity to diversity, and a responsible attitude toward patients, the profession, and society.
- F. System-Based Practice: Understanding the contexts and systems in which healthcare is delivered and applying this knowledge to improve and optimize healthcare outcomes.

II. Policy Statement

This policy establishes the framework for achieving the following goals:

- A. Ongoing monitoring and evaluation of the professional competence of all privileged practitioners, including their understanding of how human, team, and system factors influence their practice.
- B. A constructive approach to Professional Practice Evaluation that identifies opportunities for improvement in both technical skills and behaviors that enhance teamwork and systems, while reducing the potential for human error.

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C. Ensuring that the processes for professional practice evaluation are consistent, fair, and timely.

The findings from the Medical Staff Quality Committee (MSQC), as outlined in this policy, will be incorporated into the assessment of each practitioner's quality of care during their reappointment to the Medical Staff and on an ongoing basis as appropriate.

The MSQC will oversee the activities of all specialty-specific subcommittees and will provide quarterly reports to the Medical Executive Committee (MEC).

This policy also applies to Advanced Practice Providers (APPs), including nurse practitioners, physician assistants, certified registered nurse anesthetists, and clinical nurse specialists.

The findings of the committee will be shared, with appropriate safeguards to maintain the confidentiality of individual practitioners, with relevant channels for potential system improvements.

III. Definitions

- A. **Medical Staff Quality Committee (MSQC):** serves as the primary peer review body and is ultimately accountable to the Medical Executive Committee for overseeing the Professional Practice Evaluation processes across all clinical services.
- B. **Focused Professional Practice Evaluation (FPPE):** a time-limited process designed to assess the privilege-specific competency of individual practitioners in the following situations:
 - 1. Upon initial appointment to the medical staff or the granting of privileges.
 - 2. When privileged practitioners request new privileges.
 - 3. When a concern regarding a practitioner's professional competency arises.
Note: Refer to the Initial Focused Professional Practice Evaluation (IFPPE) Policy for details on items 1 and 2 above.
- C. **Ongoing Professional Practice Evaluation (OPPE):** the routine monitoring of data metrics and core competencies for current medical staff members. Note: Refer to the Ongoing Professional Practice Evaluation (OPPE) Policy for more information.
- D. **Peer:** a practitioner whose competencies are equal to or greater than those of the practitioner being reviewed. The MSQC will determine the level of subject matter

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expertise required for a provider to be considered a peer in all peer reviews conducted by or on behalf of the hospital.

- E. **Care Review:** conducted by the medical staff, utilizing its own members to review the professional competence of privileged practitioners, with the aim of improving performance and ensuring safe, high-quality patient care.
- F. **Specialty-Specific Quality Committee:** any subcommittees of the MSQC tasked with conducting specialty-specific care reviews; for example, the OB Quality Committee (OBQ).
- G. **Physician:** a Doctor of Medicine or osteopathy, dental surgery or dental medicine, or podiatric medicine who is licensed to practice in California.
- H. **Practitioner:** an individual whose credentials are evaluated by the Medical Staff for the recommendation of clinical privileges.
- I. **Professional Behavior:** as outlined in the Medical Staff Code of Professional Behavior Policy, each member of the Medical Staff at SHC Tri-Valley is expected to uphold a high standard of professional behavior, ethics, and integrity to foster an environment that promotes the highest quality of care.

IV. Care Review

Care Review is a structured activity aimed at evaluating actual or potential harm to patients arising from various circumstances, including but not limited to:

1. Non-compliance with hospital or medical staff policies.
2. Behaviors that hinder optimal functioning of the clinical team.
3. Failure to adhere to processes designed to reduce human errors, enhance clinical teamwork, or strengthen care delivery systems.
4. Instances where care deviated from established clinical guidelines and best practices, or care is deemed inappropriate.
5. Unexpected patient deaths or disabilities.
6. Referrals from hospitals, clinics, or committees.
7. Referrals from staff or requests from patients and/or their families.

Care Review Findings:

1. May recommend improvements in technical skills and/or provide training or coaching in areas such as communication, teamwork, professionalism, and the

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importance of systems that protect patients and reduce the risk of human error by practitioners.

2. May result in a Focused Professional Practice Evaluation (FPPE) aimed at individual performance improvement.
3. Are included in the metrics reported during ongoing professional practice evaluations (OPPE).

Care Review activities are conducted in a confidential and collegial manner.

V. Care Ratings

Care review determinations include:

- A. **Exemplary Care:** The provider's care exceeded the standards of even the most experienced and competent clinicians, showcasing a commitment to the highest levels of clinical practice and adherence to established guidelines.
- B. **No Opportunity for Improvement:** The provider's care was consistent with the practices of most experienced and competent clinicians and aligned with established clinical guidelines and best practices.
- C. **Minor Opportunity for Improvement:** The provider's care included certain elements that were not fully aligned with how most experienced and competent clinicians would have managed the case, and/or did not completely adhere to established clinical guidelines and best practices.¹
- D. **Significant Opportunity for Improvement:** The provider's care contained significant elements that were not aligned with how most experienced and competent clinicians would have managed the case, and/or did not conform to established clinical guidelines and best practices.²

When applicable, if a review identifies areas for improvement, the committee will provide evidence-based practice guidelines to support its findings and feedback.

¹ Some examples include, but are not limited to, an error others may have made, incomplete/inaccurate documentation, a minor variance from rule or policy, an error made due to an unrecognized risk, a human error, or an error resulting from a minor lack of knowledge.

² Some examples include but are not limited to: an error others with the same training would not have made under the same circumstances, substantially or intentionally inaccurate or absent documentation, a major variance from policy, an error resulting from a major lack of knowledge, carelessness, recklessness, and/or knowingly accepting an unjustifiable risk, or conscious disregard of a rule or policy without any mitigating social benefit.

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Opportunities for improvement will be categorized as follows:

1. Clinical judgement
 - a) Choice and/or timeliness in ordering diagnostic tests
 - b) Timeliness and/or appropriateness of diagnosis
 - c) Addressing abnormal results of diagnostic tests
 - d) Timeliness of treatment initiation and/or appropriate treatment choice
 - e) Timely initiation of appropriate actions during periods of clinical deterioration
 - f) Clinical judgment, not otherwise specified
2. Documentation
 - a) Communication not timely with other caregivers
 - b) Does not substantiate clinical course and treatment
 - c) Illegible
 - d) Other
3. Performance of a procedure or treatment
4. Communication of critical, clinical patient information to appropriate provider/care team
5. Policy Compliance
6. Supervision of APP/trainees

VI. Care Review Process/Procedure

A. The Care Review process is outlined in Appendix A.

B. Individual Case Reviews:

1. Cases for individual case review may be identified by:
 - a) Review indicators (Triggers), as defined by the Medical Staff Quality Committee and other Quality Committees. The Medical Staff shall review and approve the review indicators annually. Cases will be pre-screened by a Quality Management Clinical Specialist.
 - b) Case referrals are identified through:
 - (1) Incident reports
 - (2) Patient/family complaints
 - (3) Sentinel/adverse events
 - (4) Regulatory agencies
 - (5) Practitioners
 - (6) Risk Management

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- (7) Pharmacy and Therapeutics/Infection Control Committee
 - (8) Utilization Management
2. Individual case reviews may also be performed when a threshold for an indicator is exceeded.
- C. Indications for Focused Professional Practice Evaluation (FPPE)
1. Any single egregious or sentinel event, as determined by a Medical Staff Quality Committee, may be reviewed for consideration of a FPPE.
 2. When the results of individual case reviews for a physician exceed a threshold for concern, the Quality Committee will review the findings to determine if FPPE is recommended.
 - a) Thresholds are determined by the Medical Staff.
 - b) Thresholds for concern:
 - (1) Within any 12-month period, any of the following criteria have been met:
 - (a) 2 cases rated significant opportunity for improvement in physician care
 - (b) 1 case rated significant opportunity for improvement in physician care AND 2 cases rated minor opportunity for improvement in physician care
 - (c) 4 cases rated minor opportunity for improvement in physician care
 - (2) An unusual individual case or clinical pattern of care identified during a quality review.
 3. Upon referral, the Medical Executive Committee will determine whether FPPE is warranted.
- D. Care Review Process
1. Case identification occurs through Medical-Staff approved triggers or through referrals.
 2. Quality Management Clinical Specialists screen the cases for indicator criteria and assign the case to a physician reviewer. Cases will be assigned on a rotating basis. If initial reviewer indicates there is a potential conflict of interest, QM Clinical Specialists will reassign the case to another member of the committee.
 3. The physician reviewer examines the case and completes the reviewer section of the Peer Review Form, including the recommended preliminary

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determination and submits the review to the QM department. If the preliminary determination indicates a potential minor/significant opportunity for improvement, the physician reviewer completes the bases for findings and proposes key questions for the practitioner whose care is being reviewed.

- a. If additional expertise is required for the internal review, the initial physician reviewer will contact the Committee Chair and/or QM Clinical Specialist to facilitate a second reviewer.
 - b. Those cases with a preliminary disposition of “No opportunity for improvement” will be compiled along with the brief reason for referral and presented to the MQSC/specialty-specific quality committee. A committee member may propose review of a case which, upon approval by a simple majority vote, will necessitate review at the next meeting.
4. Reviews indicating a potential minor/significant opportunity for improvement will be presented to MSQC/ Specialty-Specific Subcommittees by the initial physician reviewer.
 - a. If the committee agrees that there is a potential minor/significant opportunity for improvement, the committee will send a request for information (RFI) to the practitioner whose care is under review.
 5. The initial physician reviewer will present the case a second time to the MQSC/specialty-specific quality committee, inclusive of the practitioner under review’s response to the RFI.
 6. The MQSC/specialty-specific quality committee will make the case determination by simple majority vote.
 7. The practitioner will be notified in writing of the outcome.
 - a. In cases that are determined to have a minor/significant opportunity for improvement, the applicable Department Chief will also receive notification. The Department Chief is expected to submit an action plan to MSQC/specialty-specific quality committee.
 - i. As needed, the Physician Well Being Committee will be offered as a resource, to the practitioner whose care is being reviewed.
 8. If a practitioner disagrees with any finding of the MQSC/specialty-specific quality committee he/she may submit a written appeal regarding the determination. Once the appeal is reviewed by MEC, the final determination will be sent to the practitioner under review and applicable Department Chief.

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9. All MQSC/specialty-specific quality committee determinations are subject to change by the Medical Executive Committee.
 10. Final reviews indicating a minor/significant opportunity for improvement are tracked by the Quality Management Clinical Specialist supporting the committees. A copy of the action plan will be placed in the QM file.
 11. Care review determinations are also tracked in OPPE.
 12. For those cases determined to have potential opportunities for improving system performance or potential issues with nursing/other department care, the Committee Chair or designee will communicate the issue to the appropriate Committee/Department.
- E. Participants in the Review Process
1. The Chief of Staff appoints new members to MSQC and Specialty-Specific Subcommittees, with input from the respective committee chairs.
 2. The MSQC will be comprised of active Medical Staff members in good standing, representing the following specialties: Anesthesiology, Cardiology, Cardiothoracic Surgery, Critical Care/Intensivist, Emergency Medicine, Family Medicine, Gastroenterology, General Surgery, Internal Medicine, OB/GYN, Orthopedics, Pediatrics Hospitalist, Radiology, and Urology.
 - a. Additional members shall be appointed ad hoc, as needed.
 - b. The Chief of Staff and Vice Chief of Staff are non-voting members of the MSQC.
 3. A quorum consists of (5) voting members for MSQC; of (3) voting members for specialty-specific subcommittees.
 4. MSQC members are appointed to two-year terms and may serve up to two consecutive terms, rotating off for at least a year before reappointment. Specialty-Specific Subcommittees of MSQC may have varying term limits, with annual review of membership.
 5. The MSQC Chair will serve a three-year term.
- F. Case Review Time Frames
1. Case reviews will be conducted by the Medical Staff in a timely manner. The goal is for routine cases to be completed as quickly as possible and with 120 days from the date the chart is reviewed by the Quality Management Clinical Specialist.
 2. Complex cases may require additional review time beyond 120 days. The status of complex cases will be monitored by Quality Management and the

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practitioners involved will be kept apprised of the process. A complex case may be one in which multiple services are involved, or one that prompts external review.

3. Cases identified as high risk or requiring a response to an external agency (e.g. Joint Commission (JC), Centers for Medicare and Medicaid (CMS), insurance agencies, etc.) may require an expedited review process. Immediate review by a MSQC or Specialty-Specific Quality Committee member will be performed.

G. Oversight and Reporting

1. Direct oversight of the peer review process is delegated by the MEC to the MSQC.
 - a) Specialty-Specific Quality subcommittees will report findings to MSQC monthly.
2. The MSQC will meet regularly to review cases and review the findings of Specialty-Specific Quality Committee(s).
3. The MSQC will report to the MEC quarterly.
4. The MSQC activities will be reported to the Board Quality and Services Subcommittee quarterly.

VII. External Review

- A. The Medical Staff Quality Committee may request the services of a peer who is not a member of the medical staff. If deemed appropriate by the Chief of Staff, the MEC or the Board of Directors, external peer review may take place for any reason, including, but not limited to:
 1. when no peer on the medical staff has sufficient expertise to evaluate a practitioner's competence;
 2. peers on the medical staff have conflicts of interest that could be reasonably perceived as affecting the objectivity of their review; or
 3. internal review has produced ambiguous, inconclusive, or conflicting results.
- B. If the practitioner under review is affiliated within the Stanford Medicine Enterprise, the Medical Staff Quality Committee may request input from the specialty surgery Division Chief in Stanford University School of Medicine, as allowable by the Practitioner Information Sharing Agreement. The final case determination will be made by MSQC.

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- C. The body/committee authorizing the external review will determine the process for, and communication of, that review.
- D. The Chief of Staff will inform the MEC when there is a request for external review. Input from the relevant Department Chief, as well as the practitioner being reviewed, should be solicited and considered prior to engaging external evaluation, when appropriate.

VIII. Focused Professional Practice Evaluation (FPPE)

- A. The FPPE process is outlined in Appendix B.
- B. An FPPE is a systematic, time-limited process for evaluating an individual practitioner’s competence to perform the clinical privileges granted to them. FPPEs is initiated under the oversight of MEC when the following occurs:
 - 1. Initial (See IFPPE policy) or expanded privileges are granted.
 - 2. A question arises regarding a currently privileged practitioner’s ability to provide safe, high-quality patient care.
 - 3. Data indicating an incident or pattern in a practitioner’s practice raises a question as to the practitioner’s ability to competently exercise the privileges granted to them.
 - 4. Results of any Professional Practice Evaluation activity indicate the need for performance improvement.
- C. FPPE is not considered an investigation as defined by the Medical Staff bylaws and is not subject to regulations afforded in the investigation process. If a FPPE results in an action plan to perform an investigation, the process identified in the Medical Staff Bylaws would be followed.
- D. A practitioner specific focused professional practice evaluation may be requested by the Chief Medical Officer (CMO), Chief of Staff (COS), Department Chief, Credentials Committee, or MSQC.
- E. The Chief of Staff, or designee, with the assistance of the Department Chief in which the practitioner practices and with the assistance of the Credentials Committee is responsible for overseeing the practitioner for the FPPE period and making recommendations on their competency to exercise privileges granted. Focused evaluations will specify the competency being evaluated and identify the performance indicators to measure improvement. The following methods of evaluation may be used:
 - 1. Personal observation

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2. Chart review
3. Interviews with colleagues and peers
4. Simulation
5. Other approaches determined by the applicable professional practice evaluation committee

F. Following the completion of the FPPE, a summary of the review findings will be reported back to MEC.

G. Conflict of Interest

1. A member of the Medical Staff asked to perform a professional practice evaluation has a conflict of interest if, for example, he or she might not be able to render an unbiased opinion due to either involvement in the patient's care or holds a relationship with the practitioner as a direct competitor or partner.
2. It is the individual reviewer's obligation to disclose any potential conflict. The peer review committee chair's determination will prevail in any disagreement regarding the existence of conflict.
3. Procedures for addressing potential conflicts of interest are outlined in the "Conflict of Interest" policy.
4. Individuals determined to have a conflict may not be present during care review discussions or decisions other than to provide information if requested.

IX. Advanced Practice Providers

Professional practice evaluation of non-physician practitioners granted Advanced Practice Provider (APP) status by the medical staff and hospital board is conducted in the same manner as the professional practice evaluation of physicians as applicable to the licensing/certification of the APP. The input of the Director of Advanced Practice Providers will be sought if needed.

X. Confidentiality of Review Activities and Materials

- A. All activities carried out under this policy are authorized by the Health Care Quality Improvement Act of 1986, codified at 42 U.S.C. § 11111, et seq., or California Evidence Code, § 1157, or both, and are subject to the provisions of the medical staff bylaws and applicable policies of the medical staff (Appendix C).

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- B. E-mail communication of confidential peer review proceedings or documentation should generally be encrypted and any communication containing Protected Health Information (PHI) must be encrypted. Communications should be labeled as protected information using the following designation or similar language: CONFIDENTIAL Information: This information is protected by California Evidence Code Section 1157.
- C. Practitioners and committees participating in the peer review/FPPE processes must not disclose what transpired in their meetings except to the extent necessary to carry out one or more purposes of the process.
- D. All minutes, documents, and information received or produced under this policy are confidential Medical Staff materials protected by California Evidence Code Section 1157 and other applicable law. Documents should be labeled as confidential, but such labeling is not required for the confidentiality protections to apply.
- E. Access to confidential material: Those authorized to have access to peer review materials include the following:
 - 1. Members of the administrative staff who need access to the information to perform their functions.
 - 2. Consultants, attorneys, or other professionals engaged by the Hospital to the extent necessary for them to assist in performing their functions.
 - 3. Representatives of regulatory or accreditation agencies who are entitled by law to have access to the information.

A practitioner does not have a right to access materials, including materials related to the practitioner's own practice, except as authorized by law or as provided for in the Medical Staff Bylaws.

XI. Related Documents

- 1. Medical Staff Bylaws, Rules and Regulations, and Policies of the Medical Staff
- 2. Ongoing Professional Practice (OPPE) policy
- 3. Initial Focused Professional Practice (IFPPE) policy

XII. Document Information

- 1. Legal Authority/References
 - a) The Joint Commission Accreditation Standards
 - b) California Evidence Code Section 1157

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- c) Greeley [A Chartis Company] Peer Review Boot Camp for Stanford Health Care, May 2024
- 2. Author/Original Date: October 2003
- 3. Distribution and Training Requirements
 - a) This policy resides in the Medical Staff Office Policy Manual for Stanford Health Care Tri-Valley.
 - b) New documents or any revised documents will be distributed to physicians through the Medical Staff Office.
- 4. Review and Renewal Requirements
 - a) This policy will be reviewed and/or revised every three years or as required by change of law or practice.
- 5. Review and Revision History
 - a) Quality Management Department (as Hospital policy): October 2003, April 2005, June 2007, amended July 2009, April 2015, July 2017, June 2020, June 2023, amended May 2024, November 2025
- 6. Approvals
 - a) Medical Staff Quality Committee, November 2025
 - b) SHC Tri-Valley Medical Executive Committee, January 2026
 - c) SHC Tri-Valley Board of Directors, January 2026

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Appendix A: Care Review Process

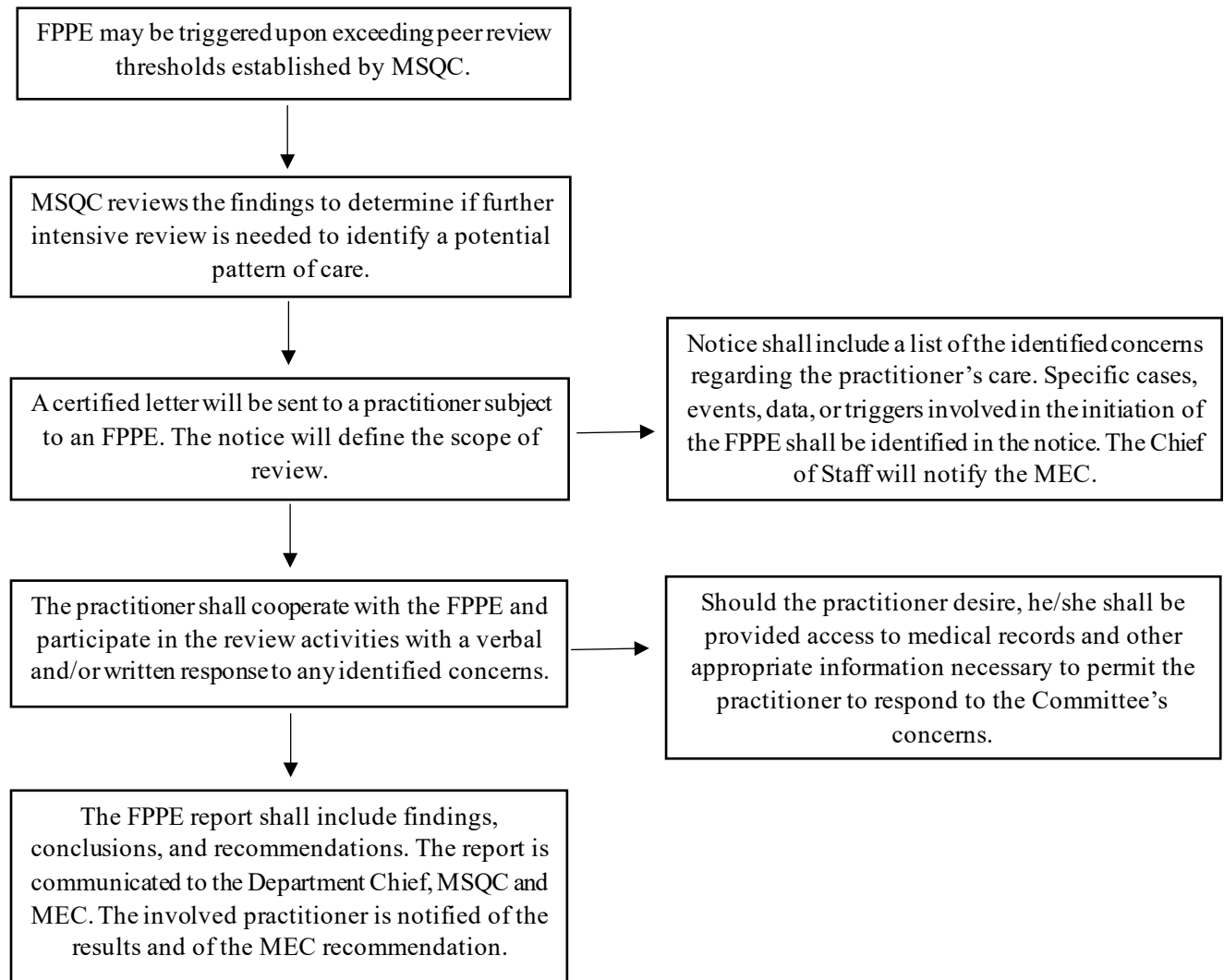


*Physician pre-screen option may be employed

**Preliminary Request for Information may be sent prior to initial presentation to MD Quality Committee, at Physician Reviewer's discretion

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Appendix B: Focused Professional Practice Evaluation (FPPE)



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Appendix C: Evidence Code 1157

Evidence Code 1157 Protection from Discovery of Peer Review Records & Proceedings

Neither the proceedings nor the records of organized committees of medical [...] staffs in hospitals, or of a peer review body, as defined in Section 805 of the Business and Professions Code, having the responsibility of evaluation and improvement of the quality of care rendered in the hospital, or for that peer review body, [...] shall be subject to discovery.

Cal. Evid. Code, § 1157, subd. (a)

What Is Evidence Code Section 1157?

- Section 1157 prevents “discovery” in litigation and most formal and informal administrative proceedings and preserves the confidentiality of the **proceedings and records of peer review bodies** and **their organized committees** charged with **evaluating and improving the quality of care** rendered by certain health care professionals.¹
- The purpose of Section 1157 is to improve the quality of medical care in hospitals by encouraging candor among medical staff members evaluating patient care (note that it applies to all quality improvement activities, not just peer review), without the worry that participants may be compelled to testify or provide information in most legal proceedings.
- Section 1157 generally provides broader protection than the attorney-client privilege as information can be shared for a valid purpose without waiving its protections. Its application and limitations are summarized in this document.

§ 1157 Checklist

- Information regarding records or proceedings
- Organized Committee or Peer Review Body
- Concerning evaluation and improvement of quality of care

What Does Section 1157 Protect?

- “Proceedings” and “Records” protected by Section 1157 include:
 - Records and minutes of peer review bodies (such as Medical Staff Committees, many foundations, health plans, group practices of a certain size).
 - Credentials/quality and/or peer review files concerning individual practitioners.
 - Applications for privileges.
 - Records of all performance improvement activities.
 - Discussions and deliberations within the confines or direction of Medical Staff Committees.
 - The identity of Medical Staff Committee members.
- “Proceedings” and “Records” **do not** include:
 - Hospital files (but clearly marked Medical Staff documents in hospital files remain protected).
 - The fact that peer review occurred.
 - Information not derived from an investigation into and review of quality of care.
 - Patient charts.

¹ “Organized committees of medical staffs” include all committees focused on evaluation or improvement of quality of care, e.g., not just the Medical Executive Committee or Credentialing Committee, but would include Well-being committee, Departmental committees and Quality Assurance committees.

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Appendix C: Evidence Code 1157 (continued)

Limitations On The Protection Provided by Section 1157

- Section 1157 is a bar to discovery in state civil actions but California case law is split as to its applicability in criminal proceedings.
- Section 1157 does not automatically apply to civil actions in Federal Court, though a court may choose to apply Section 1157 depending on the circumstances of the case at hand.
- Section 1157 protection does not apply to a physician subject to discipline involving hearing rights.
- Section 1157 does not apply to disclosures required by law. For example, requests from other peers review bodies under Bus. & Prof. Code section 809.08 or in response to requests from the California Medical Board, CDPH, CMS, NPDB, or Joint Commission.
 - While there is no Section 1157 protection when responding to requests from authorities like the Medical Board, access to information generally protected by Section 1157 does not extend to otherwise privileged information. For example, attorney-client privilege, where applicable, must still be asserted.
- This discovery bar is not absolute and can be waived by voluntary disclosure or carelessness in identifying or asserting the protection.
 - While protected under Section 1157, voluntary testimony by peer review participants about proceedings and records² is generally permissible, though most Medical Staff and Peer Review Bylaws prohibit such disclosure.

Section 1157: Practice Pointers

- Always assert protection under Section 1157.
- Maintain documents under "custody and control" of Medical Staff Offices.
- Limit access to necessary persons (that is, individuals with a legitimate reason for having access to the information such as legal counsel to the medical staff or hospital, members of the Board of Directors when reviewing the recommendations of a fair hearing committee, or administration to the extent necessary to conduct or be aware of peer review).
- Require requests for access to be made through designated person within Medical Staff Office.
- If copies are necessary, only release uneditable PDF copies.
- Password protect electronic access.
- Utilize/institute training programs.
- Mark or stamp any committee or peer review documents as "CONFIDENTIAL".
- Avoid over-designating information as specifically protected by Section 1157 when the same information is otherwise required to be disclosed.
- Avoid summarizing or mischaracterizing information: where possible quote actual language or produce redacted documents.

Please contact Stanford University's Office of the General Counsel Alice Ho at 650-723-0457 or Andrea Fish at 650-721-1953 with any questions about Section 1157 and its application.

² Voluntary disclosure can occur, for example, when the peer review body or a member provides information (e.g. a committee member tells protected information to those not involved, a response is given to an inquiring entity which is not a peer review body, or disclosure is made to a physician under review which is outside the review process) or fails to properly assert the protection.