Proctoring, FPPE, and the notification process

Since The Joint Commission launched the focused professional practice evaluation (FPPE) concept and the related ongoing professional practice evaluation (OPPE), hospitals have struggled to find an ideal method for performing and tracking these processes.

For certain states, however, FPPE was more of a name change than a new concept—California, for example, has required proctoring since the 1980s. So how does FPPE look and work in an organization with several decades of proctoring experience under its belt?

“This method of observation is not new in California,” says Graciela Lopez, CPMSM, director of the medical staff services department (MSSD) at City of Hope in Duarte, Calif. “Despite the years, proctoring is still one of the methods the medical staff uses to determine and validate competence.”

Proctoring remains a requirement for new and existing practitioners requesting clinical privileges, as well as a condition for privilege renewal and for privileges performed so infrequently that current competency is not feasible, she says.

“It’s a process that complements and enhances safe patient care,” says Lopez.

But let’s flash forward to the notification process and the complexities it can include.

“We’ve tried various methods over the years, but the most efficient process to complete proctoring is through effective communication with all involved—if the method of proctoring is clear, then tracking it’s not a problem,” says Lopez.

We have had the advantage to be familiar with the proctoring process prior to the advent of The Joint Commission’s FPPE, so compliance with the overall process has gone fairly well.

“Having support from medical staff leadership and administration is very helpful, too,” says Lopez. “It’s a team effort.”

In fact, it was an administrator who helped inspire the idea of looping leadership into the proctoring process pre-FPPE.

“One former administrator had made a comment that it would be helpful if we provided a copy of our tracking tool to the various clinical departments and peer review committees,” says Lopez. “Sometimes peer pressure and friendly competition between departments do wonders.”

Notification and FPPE

It falls on the medical staff office to make sure the proctoring/FPPE process is firing on all cylinders.

“It can be a very intense process,” says Lopez. “We do a lot of work behind the scenes. Again, having a clear, fair, and transparent proctoring process makes the follow-up and notification process seamless. Prior to the granting of clinical privileges by the board, the department chair would have identified the method of proctoring, confirmed the number of cases to be proctored, and who the assigned proctor will be. We then prepare an appropriate board letter to the practitioner with emphasis on the proctoring requirements and time frame for completion.”

Specifics are provided ahead of time and in writing. Whenever possible, the first cases must be proctored; overall, proctoring requirements must be met within the first 12 months of the date the privileges were granted. If a practitioner does not complete proctoring requirements within the expected time frame solely because of lack of volume, then the clinical privileges being proctored are deemed voluntarily withdrawn, unless an extension is granted by the medical executive committee (MEC) at its sole discretion.

The MSSD tracks each practitioner’s name, staff status, assigned department, and proctoring requirements on a tracking tool (an Excel sheet works well for this purpose).

“An aggregated proctoring list is routinely presented to the credentialing committee and MEC,” says Lopez.
These peer review committees are kept abreast of who is on the list and who has partially completed proctoring. The committees normally delegate a department representative to follow up with practitioners as necessary and emphasize the importance of completing the proctoring requirements.

To augment notification, a department-specific proctoring list is presented as part of each department quality assurance meeting for tracking purposes. Follow-up letters are sent to practitioners who remain on the pending proctoring list on a monthly basis, with a copy sent to the department chair/division chief.

A termination or release of proctoring requirements is processed through the medical staff mechanism, subject to confirmation by the board. A separate board letter is prepared informing the practitioner that no further proctoring is required—or that additional proctoring is necessary.

All about communication
Voluntary withdrawal of clinical privileges due to volume-based failure to complete proctoring is not considered an adverse or punitive action, Lopez notes. As stated above, if a specific clinical privilege is not exercised within 12 months and the practitioner does not request a formal extension, the affected privileges are considered to have been voluntarily withdrawn per medical staff policy. The MSSD provides advance written notifications to the practitioner and respective department chair/division chief should this occur.

“A final letter is sent from the MSSD to the practitioner stating that lack of proctoring completion will result in voluntary withdrawal of specific privilege(s) and that a notification will be sent to the credentials committee for action,” says Lopez.

The final board letter confirms acceptance of a voluntary withdrawal of specific privileges due to lack of volume; excerpts from the medical staff bylaws supporting the action are included in the letter.

“In this circumstance, we inform practitioners that loss of clinical privileges is not considered an adverse action based on medical disciplinary cause or reason and that the action is not reportable to any regulatory agency,” says Lopez. The practitioner's clinical privileges are then updated in the medical staff privileging system.

The relinquishment of privileges is not necessarily a permanent action. In fact, the board letter notifying that the privileges will be voluntarily relinquished includes language informing the practitioner that if he or she anticipates performing a related procedure in the near future, a formal request must be made and submitted to the MSSD and proctoring must be performed and completed in a timely fashion.

We must consider the tone of the notification letters regarding proctoring.

“We try to keep a balance in the tone of our letters,” says Lopez. “We simply state the facts and follow the medical staff bylaws and related policies and procedures; we have not had anyone state that they were never notified” about the status of the proctoring process.

And while voluntary relinquishment of clinical privileges is based on administrative reasons rather than disciplinary ones, it is always addressed with the utmost scrutiny and respect.

“We do not take the proctoring process lightly; we always check and verify,” says Lopez.

Instances in which there is a low window of opportunity to practice a specific procedure (through no fault of the practitioner) are not rare in the organization. For example, the focus of a practitioner who seeks privileges may have been research-oriented rather than specific to clinical practice. Some procedures are fairly uncommon and do not provide practitioners the opportunity to perform the required number of cases within the 12-month time frame.

“If a certain procedure is done infrequently, it is not the fault of the physician not to be able to complete proctoring. In this case, the practitioner, through her/his department chair/division chief, may submit a timely request to the credentials committee for additional time to complete proctoring before the 12 months expire,” says Lopez. “The request must be in writing, describe the good cause reasons for the extension, and specify the additional time desired.”

Troubleshooting
FPPE and proctoring might not always be an easy task, but it's something every organization must be committed
With so many procedures and so many physicians at City of Hope, have there ever been any issues with maintaining communication?

“It have not experienced many issues at this institution,” says Lopez. “We are fortunate to have excellent practitioners who understand and support the proctoring process. We also have the support from administration and medical staff leadership. We have institutional policies and procedures in place that guide the proctoring process.”

It is important to remember that proctoring isn’t just a means of evaluating technical and cognitive skills, she says. In the process, the medical staff can determine a practitioner’s ability to collaborate with others, communication skills, and professional behaviors. Proctoring and the notification process do not need to be laborious and difficult to accomplish; otherwise, we could miss the most important focus of this activity—validation of current competence to sustain high quality of care and patient safety.

It is one additional measure to demonstrate that we are doing everything possible to confirm a practitioner’s competence,” says Lopez. “We’ve already verified a practitioner’s clinical expertise through the comprehensive credentialing and privileging functions; proctoring is one additional element to fulfill.”

The method of proctoring will likely be different for each practitioner, which can provide an additional level of complexity for the medical staff office.

“The chair has the prerogative to implement additional proctoring requirements. It is always useful to depict the minimum proctoring requirements within each respective privilege delineation form—this allows the practitioner and the MSSD to efficiently identify the proctoring requirements for each privilege ahead of time,” Lopez says.

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**Joint Commission survey looks at MS.01.01.01, OPPE, and FPPE**

*Early arrival allows hospital to test continual readiness*

The Joint Commission was scheduled, on paper, to arrive in first quarter 2013—which was why, in October 2012, John H. Stroger, Jr. Hospital of Chicago’s Cook County was a little surprised to see Joint Commission surveyors at their door one Tuesday morning. Although the arrival was a little startling, the organization was able to jump right into its survey, says Charlene Luchsinger, CPMSM, CPCS, director of credentialing for the Cook County Health and Hospitals System.

Medical staff standards were one of the first areas the surveyors looked to, she says. “Right off the bat they requested certain elements of the bylaws to be identified,” says Luchsinger. “They sent a checklist for MS.01.01.01, elements of performance [EP] 12 through 36.” The surveyors specifically asked to complete the checklist and note exactly where each element was addressed in the medical staff bylaws.

Credentialing, also, was an early target. “The credentialing review was an examination of files by both type and tracer,” says Luchsinger.

The lead surveyor was a keen-eyed vascular surgeon, she says. The team also included an OB-GYN physician who was shadowing the vascular surgeon as a surveyor in training. The combination made for interesting discussions during the visit, as the surveyors’ mutual expertise allowed for very astute questions.

Their review of the privileging processes was fairly familiar, says Luchsinger. “They wanted to see privilege identification, expiration dates on licenses and DEAs, database dates, identity verification—all the terms of privileges,” says Luchsinger.