to, not only for regulatory compliance but for 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.

With so many procedures and so many physicians at City of Hope, have there ever been any issues with maintaining communication?

“I 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.

MS standards

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, data bank dates, identity verification—all the terms of privileges,” says Luchsinger.
The surveyors were impressed with the physicians’ ability to articulate every step of the fair hearing processes, she says. The physicians were able to talk about why the process was so lengthy and able to discuss the time frames put forth.

Stroger Hospital used the same tactic of highlighting its toughest cases when choosing an example of a physician requesting additional privileges. In this case, it chose a family physician who had requested OB-GYN privileges.

“This was one of the additional privilege cases we were able to demonstrate from start to finish, showing how we coordinated with the physician and OB-GYN,” says Luchsinger. Specifically, the family physician had requested delivery privileges at Stroger Hospital—which was of particular interest to the OB-GYN surveyor in training.

“The OB surveyor couldn’t believe there was a happy ending” for that case, says Luchsinger. The surveyor relayed that in her experience a family physician is not always allowed to deliver.

For one of the FPPE examples, the hospital chose a case where a provider had a pattern of behavioral issues, prompting the credentialing committee to request an FPPE plan be outlined and agreed to by the department and physician.

“There was the ability for the credentials committee chair and members to not just tell stories, but really relate the important aspects of the case without the Joint Commission manual in front of him,” says Luchsinger. “They approached it from a commonsense angle as to why they undertook these actions.”

This ability to demonstrate the fundamentals without having to refer back to chapter and verse of the standards showed a core understanding of the “why” behind the process, not just rote memorization.

“They discussed safety, consistency, and best practices,” says Luchsinger. “I’d have to say the surveyors were impressed.”

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For the participating physicians, there was an opportunity
to see the value of many internal programs. “It was an
affirmation of their processes,” says Luchsinger. “And it
was a positive experience—they had great feedback from
the surveyors about what they see by comparison across
the country. Being told that they did a textbook job and
should be applauded for it.”

There were examples that came up during the survey
where recommendations that were not the popular
suggestion proved to be the right one—processes that
would cause more headaches or controversy, but were
done for the right reasons. This was communicated up to
leadership as well.

Among the takeaways from this particular survey: the
obvious note that continual survey readiness is still
incredibly important. “Don’t ever fall behind,” says
Luchsinger. She also recommends staying on top of
OPPE and FPPE schedules and processes, paying close
attention to your bylaws, and looking closely at the EPs
of MS.01.01.01. Regarding the latter, “even though you
might think you meet the intent of the standard, use
another eye, whether it’s legal counsel or the medical
staff,” to review, she says.

Having the medical staff take more ownership of the
processes it was directly involved with made a big impact
on this survey as well. “They understand how important
it is to own the processes—they are the gatekeepers of the
organization for providers,” says Luchsinger.

Overall, it was not a confrontational survey by any stretch.
“For the credentialing part, it was conversational and
educational, but when reviewing the bylaws, it was firm,”
says Luchsinger. “With the medical staff leadership it was
a very pleasant experience and an opportunity to share
our practices and challenges.”

The survey also provided a wakeup call for providers
and staff. “Because it was unannounced and you’re on
the ground running, the medical staff recognizes their
responsibility,” says Luchsinger. “It got everyone's attention.”

On pulling challenging files to show surveyors, she says
“[it] was a decision I might have not wanted to do early
on, but they truly were the ones that would show the most
substance. You put the medical staff out there to explain
it, and they talk about the quality and patient care impact,
and it comes from the heart.”

are a public health system, so a lot of the requirements for
consideration for employment come into play. They said
we put the F in fair hearing.”

A room full of physicians who had clearly participated in
the process and could speak to it was invaluable. “It was
their time to shine,” says Luchsinger.

Having had the chance to be introduced to the type
of health system that Cook County is, and what its
population is like, the surveyors understood the
complexities of the organization and why the actions
being taken—such as allowing a family physician delivery
privileges—was not unusual.

**Done but not finished**

Even once the credentialing and medical staff session was
officially over, their role in the Joint Commission visit was
not finished.

“You sigh with relief, but it’s not over yet. The surveyors
wanted to see certain files and documents before our
leadership session,” says Luchsinger. “They wanted to be
sure of how we were doing what we said we did.”

Of course, as with any survey, there were some follow-up
recommendations from the surveyor for process upgrades
or improvements.

“We did get a couple of recommendations for ways to
improve those MS.01.01.01 elements,” says Luchsinger.

It should be noted that MS.01.01.01 has been a high-focus
area for Joint Commission surveys in recent years. In
fact, it’s the first standard from the Medical Staff chapter
to appear on The Joint Commission’s annual top 20 most
challenging standards lists in recent memory, a testament
to just how much attention it’s receiving from surveyors.

The overall survey seemed to be very intent on the bylaws,
even more so than previous surveys. “I’ve been here
for past surveys, and this was a very robust review—it
seemed to be something new,” says Luchsinger.

**Recap and review**

The survey proved to be an opportunity to see where the
organization was succeeding. The physician surveyors felt
that the organization's credentialing process was one of
its best practices, and relayed this information up to the
leadership at Cook County.