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Utilizing Proctors for Competency Evaluations

WHITE PAPER

*Editor's note: In this white paper, **Michael Callahan, Esq.,** partner at Katten Muchin Rosenman, LLP, in Chicago; and **Christine Mobley, CPMSM, CPCS,** president of C Mobley & Associates, LLC, and owner of Edge-U-Cate, LLC, in Colorado Springs, Colorado, answer questions regarding the use of proctors to assess physician competency.*

Q Why has there been interest in the use of proctoring in recent years?

Mobley: Proctoring has been around for a long time, even before the Joint Commission standards listed it as one of the options for evaluating competence, but because accreditors are now utilizing that term I think more people are considering the use of a proctor.

Callahan: Over the years, there's been a much greater emphasis by hospitals and medical staffs to implement various "remedial measures" as a way of getting physicians back on track. Aside from official FPPE that physicians are placed on when they join a medical staff, there's ongoing monitoring that takes place under OPPE standards. In addition, the healthcare industry is focused on achieving identified quality metrics and outcomes, pay for performance standards, etc., as a condition of reimbursement. That has been reflected in the metrics that have been incorporated into the Medicare Shared Savings Program and certified ACOs [accountable care organizations] that are approved by CMS. There's also value-based purchasing metrics that all Medicare providers have to meet. In addition, we have "never events," such as wrong-site surgeries and hospital-acquired infections and conditions, which affect not just reimbursement, but liability issues, licensure, and accreditation. Consequently, there is a lot more analysis, review, and monitoring that needs to take place than ever before.

And in the spirit of 'just culture,' we're moving away from the blame game and looking more into processes that led up to these outcomes, as well as individual actions and responsibility. I think more and more facilities are implementing different devices and different measures to work with physicians. Proctoring is one of those tools. It tends to be implemented when there's perhaps a greater concern about a physician's quality of practice.

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Other measures that may have been implemented beforehand could have been reeducation, concurrent and retroactive review of cases, and some degree of monitoring. Proctoring is considered one step up from these measures but below what we would consider to be an "investigation" with respect to Data Bank reporting implications.

Q When is it appropriate to use proctors?

Mobley: There are the two times when a proctor would be considered, but it's one of several options. There's no accreditation requirement that I know of that practitioners have to be proctored. It's an option.

The first instance being when someone is first granted privileges and the organization wants someone to observe them to see that they do have the skill set that was indicated on all the paperwork they received.

Also, according to many of the accreditation standards, the other time proctoring would be used is once a physician is on staff or a practitioner with privileges (as this could apply to nurse practitioners, physician assistants, and anyone else who is privileged). If during his or her ongoing review, there are concerns by a peer review committee or a department chair, then one of the options is to say, "We're now going to look at your work over the next couple of months" or, "We want to have the next two procedures observed." It can be for however long the committee determines, based on its review of the care up to that point.

Callahan: There's proctoring that a lot of times is being implemented when a person gets on a medical staff as part of an FPPE policy which does not raise Data Bank reporting issues. It's just part of a uniform standard that's applied to all new physicians and also does not trigger hearing rights.

Now consider if there's someone who has been on the staff for a while and the normal peer review process has been picking up some cases that have dropped out—maybe postop infections, blood loss, or some other questionable outcomes and judgements. These cases are typically reviewed through the quality and/or peer review process. At some point, if there are repeat issues, such as a pattern of substandard care, questions about judgment or technique, or interactions with personnel, someone may be called in as part of a developed proctoring plan. This is still viewed as part of normal peer review and not in the investigation stages, which is a critical term as it relates to potential Data Bank reports.

Proctoring can be combined with a consultation requirement. For example, let's say an orthopedic surgeon has a tendency to operate on patients who are poor surgical candidates—they're obese or have bad heart conditions. If the surgeon thinks he or she can help patients to improve their quality of life but there is a high risk of death, this surgeon could be required to meet with the department chair whenever a patient's morbidity-mortality index exceeds a certain amount to make a convincing argument why a patient could benefit

from a procedure. As long as the department chair cannot veto the physician's decision, it is not a reportable event.

Q What considerations regarding the National Practitioner Data Bank have to be considered when setting up a proctoring plan?

Callahan: In proctoring, you generally are not taking away anyone's privileges or reducing them. You have somebody there watching a practitioner, but they still get to exercise all of their privileges. But let's say a surgeon is placed on a 45-day or 60-day proctoring regiment and he or she cannot exercise or do any surgery unless the proctor is present. The Data Bank views that as a restriction on privileges, and since that plan lasts for more than 30 days, they take the position that that is a reportable event.

This seems to be analogous to the mandatory consultation situation where a department chair can veto a request to operate and that restriction lasts more than 30 days. This is reportable. So by analogy, the Data Bank is saying that if a surgeon can't do anything unless someone else is there and available to proctor and that's more than 30 days, their action is reportable.

Where it gets a little gray is if a physician has to proctor 10 of Dr. Callahan's cases, and based on Callahan's volume, he'd normally be able to do that in less than 30 days, but for whatever reason it goes past 30 days (Callahan was on vacation, had a death in the family, or his volumes were down). Does it suddenly become a reportable action under these circumstances? I think not. I'm sure the Data Bank understands that there are these kinds of variations, and I think, to their credit, they're trying to get some feedback from the industry to which might vary their interpretation.

Q What are some issues with using proctors?

Mobley: Years ago when organizations used proctoring, I don't think it was as much of an issue as it is today. Today with fee-for-service, physicians don't have a lot of time to say, 'I'm going to take a couple of hours out of my billing practices to observe somebody.' It's more difficult today to get physicians to agree to proctor, which is why it's just one of several evaluation options.

The California Medical Association (CMA) has always had proctoring guidelines, so in California it's been an industry practice for many, many years to assign or have the practitioner choose proctors. That's why I'm saying proctoring been done for a long time, but now a lot more places are considering it because it's now written in the accreditation standards.

The issue is finding people who are willing to give up their time to do it, which brings up the question of whether anyone pays for their proctors.

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Q How can you find proctors?

Callahan: Proctoring is an important tool, though it's not always easy to implement. If you're at an academic medical center, you have employed physicians, and this may be part of their job. If you're in a community hospital and you're looking for somebody to be a proctor, then it's not an easy thing to do. Sometimes you have to bring in somebody from the outside and give them temporary privileges. Obviously the worst thing you can do is give a proctoring obligation to somebody who is unqualified. Ideally, you try to find somebody internal, who you know by reputation, by competency, and you know is going to be objective. That's always first and foremost.

You're always trying to find somebody who has already been through the process, and it's only when you have no other options that you're forced to go outside.

Q Do you think proctors should be compensated?

Mobley: In today's world, I think that we might see that, but I don't know if many organizations do. What I have seen is if an organization is recruiting a specialist because they don't have anyone in that specialty, the organization may offer to pay for a proctor's time to come in and observe once that new practitioner has been granted initial privileges. That's where I would see someone paying for the proctoring. Or if a practitioner who had a subspecialty and really wanted to practice it at the organization, that practitioner may be willing to compensate someone to come in and observe and evaluate them. This might be more prevalent in an organization where this specialist or subspecialist is the only one around. They could have someone come in for half a day or a couple hours or a couple of procedures and observe, and then write up an evaluation.

Callahan: Just as you would pay for outside reviews, I think a proctor should get paid. But if it's a hospital employee, then he or she is already getting paid. Whether it's the hospital that pays or whether the physician being proctored contributes, those are details that need to be worked out.

Q What should be addressed in an organization's proctoring policy?

Mobley: I think it can be a small policy or it can be an expanded policy, depending upon how many different types of proctoring the organization might want to address. Is it going to allow an assistant to be the proctor? If there's going to be compensation, who is going to pay? What are the obligations of the proctor? What are the obligations of the privileged practitioner? If they are allowed to choose the proctor, can they be an associate, or must it be someone else outside the practice? If you pay someone to come in, what happens if they believe there should be intervention? How should that be handled? Are they privileged or are they not privileged?

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This is where you will want to get some legal advice from your medical staff attorneys when you're writing up these policies, or at least when you're going to enter into any kind of agreement with an external proctor. You might want some legal advice on how to set up the parameters for that so everybody involved knows what the rules are.

Part of the policy should address, if applicable, any consent issues with the patient. Let's say you're going to bring somebody in to observe. Is there an obligation to tell the patient that there will be an observing surgeon in the operating room? If there's going to be an assistant surgeon, does that patient have to be knowledgeable about that? The policy should address any consent issues or concerns.

I've done quite a few talks about privileging where proctoring has come up, and I think it is more difficult today to find people willing to give up their time to do this. But then again, part of medical staff members' responsibilities, especially the active medical staff, should be—as an obligation of their medical staff membership—they are willing to assist in the evaluation in the new practitioners coming on staff. A lot of bylaws may address that in general, but it's part of your obligation to participate in the evaluation process. You just don't want to overburden any particular practitioner by having to give up billed time to do the evaluation.

Proctoring is big business, and it's important. A lot of people like to use that methodology, but I think you need to have policies and procedures so that you have a standardized process.

Q As a consultant, what questions are you getting about the use of proctoring?

Mobley: It's interesting because I think that when the standards were published, there was so much talk about proctoring that many people thought they had to use the proctoring methodology, so there's been education going on to let people know it's only one option.

California has been utilizing proctoring for a long time (per their CMA proctoring guidelines), but even for California it's been a guideline, not a requirement. I think a lot of organizations have to understand that this is one of many options. They don't have to utilize a proctoring methodology if they're using other methodologies.

Call to action

If you still have questions about credentialing and competency assessment, attend the 2016 Credentialing Resource Center Symposium, to be held April 7–8 in Orlando, Florida. At this conference, experts Hugh Greeley; Carol S. Cairns, CPMSM, CPCS; Todd Sagin, MD, JD; and Sally Pelletier, CPMSM, CPCS, will provide tips and tools to help you overcome your credentialing competency assessment challenges.

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- Reengineering FPPE to Make It Effective and Rational
- OPPE and FPPE: Doing It Right and Making It Meaningful
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