Credentialing & Peer Review
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Evaluate tools for assessing MD communication skills

The JCAHO's 2007 standards have sent many hospitals scrambling to figure out how they will comply with the new, more stringent requirements for practitioner monitoring. According to the standards, hospitals must monitor the following six areas of general competency on an ongoing basis:

- Patient care
- Medical/clinical knowledge
- Practice-based learning and improvement
- Interpersonal and communication skills
- Professionalism
- Systems-based practice

The JCAHO will require hospitals to collect data to support their analysis of practitioners in each of these general competency areas.

Clinical-based competencies such as patient care, clinical knowledge, and continuous learning are familiar, and data on them are readily available. But data that purport to measure more ambiguous skills (e.g., communication and professionalism) represent new ground for many practitioners and administrators. Further, because measuring practitioners' adeptness in carrying out these competencies is considered more of a social science measure than hard science, it may be more difficult for the hospital community to embrace and accept, says **Robert A. Marder, MD**, vice president of The Greeley Company, a division of HCPro, Inc., in Marblehead, MA.

Because the JCAHO has decided that physicians' interpersonal skills and professionalism are among the hallmarks of excellent patient care, it is important for hospitals to adopt fair and neutral methods of evaluating these traits, notes **Jay Silverman,** an attorney with Ruskin Moscou Faltichek, PC, in Uniondale, NY. Hospitals must attempt to gather reliable data that compare physicians with a norm, because the JCAHO will require it, and because medical staff take a somewhat distrustful stance towards the exercise. Hospitals must also strive to ensure that the medical staff sees the measurements as objective and not politically or economically motivated, Silverman says.

Consider perception data

Various methods of measuring these intangible qualities have arrived on the scene, and hospitals must decide which tools they will use to measure

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group can to lead to an unfair result. The patient's opinion of the physician's willingness to listen, educate, and display empathy is more important than that of a physician colleague. The opinion of the nursing staff regarding the physician's ability to explain medication orders clearly is important, but a patient's assessment of the same criteria may be skewed by the patient's anxiety about side effects or distrust of pharmaceuticals.

Provide a learning opportunity. If a hospital gathers data about a physician's communication and interpersonal skills, the information should be useful to both the physician under scrutiny and the hospital, says Silverman. Resistance among medical staff is likely to erode if the physicians are presented with information that will help them practice medicine more efficiently and effectively.

In most cases, communication or interpersonal problems identified by the perception survey can be remedied once the physician is made aware of the issue, Marder says. Presenting the findings in a neutral way that compares the physician with others within the same specialty can make the data more convincing to the physician and serve as a catalyst for improvement. ■

Keep legal implications in mind when constructing a proctoring program

New JCAHO standards emphasize facilities' need to continuously evaluate the clinical competence of physicians who hold privileges on their medical staff. To comply with the JCAHO's new requirement to monitor practitioners using sound data, many hospitals are exploring the use of proctoring.

Specifically, the 2007 standards require a level of organization-specific data regarding privileged physician performance that has not been required in the past, says **Robert Marder, MD,** vice president of The Greeley Company, a division of HCPro, Inc., in Marblehead, MA. When a practitioner initially applies for privileges at an institution, it is no longer sufficient for the prospective employer to simply contact other institutions for information on which to base privileging decisions, he says. Instead, the new standards require institutions to generate their own data regarding a physician's competency.

The 2007 JCAHO standard calls for Focused Professional Practice Evaluation (FPPE) for practitioners who are new to an institution and for practitioners about whom questions of competence or fitness have been raised. In the case of new practitioners, says attorney **Michael Callahan** of Katten Muchin Rosenman, LLP, in Chicago, the standard has been interpreted to mean that organizations must

- conduct continuous observation and evaluation of the practitioner
- gather data regarding the practitioner's practice patterns
- gather data about the practitioner's past clinical training and competence
- assess the practitioner's judgment and decision-making skills
- assess his or her general fitness to practice

These requirements differ from the traditional method, whereby organizations granted practitioners provisional privileges, which allowed physicians to perform certain procedures and have their performance reviewed after a set period of time. The new standards impose a duty on the hospital to closely monitor physicians who are new to the staff and to address any issues right away, Callahan explains.

The 2007 JCAHO standards also call for Ongoing Professional Practice Evaluation (OPPE), which applies to physicians who already hold privileges at the institution. OPPE requires the hospital to conduct a continuous program of monitoring and evaluation of the physician's competence, rather than the cyclical review that is currently in place.

Data required for other purposes

In addition to the JCAHO standards, other interests are driving hospitals' need to acquire and frequently analyze data on physician performance, Callahan says. The Centers for Medicare & Medicaid Services, third-party payers, liability insurers, and others continually seek data to support their participation, coverage, and reimbursement decisions. Further, hospitals require much of these data to maintain and expand operations in a fiscally sound manner.

Hospitals also increasingly need objective documentation to support their privileging decisions. Two recent cases have underscored the need for hospitals to have tangible support for their privileging decision-making:

- **Poliner vs. Presbyterian Hospital of Dallas (2006).** The physician at the center of this suit won a verdict

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against a hospital in which the physician alleged bad faith peer-review activities. Although a substantial monetary award was thrown out by an appeals court, the court supported the lower court's finding that the peer-review activities that the hospital conducted were motivated by economic and competitive considerations, rather than patient care interests.

- Ka**dlec Medical Center (2006).** A jury found a hospital liable for failing to inform another institution that a physician who had previously been granted privileges at the first institution had been fired by the anesthesia group that employed him for reasons relating to patient care. The original hospital, having no duty to report the physician's firing because the physician was not a hospital employee, merely confirmed the dates of the physician's privileges when queried by the subsequent hospital. This case demonstrates that juries expect hospitals to take an active role in protecting patients from problematic physicians—even when the physician is no longer practicing at the institution.

Both cases demonstrate that the discretion previously given by courts, juries, and even licensing bodies to hospitals regarding privileging decisions is eroding, explains Callahan. If a peer-review activity or privileging decision is called into question, Callahan says, the hospital benefits by having its own data, generated from within its own institution, to support its activities and decisions. Close observation of one physician by another, with periodic review of the proctor's reports, is one method that hospitals can use to acquire the data they need and compile support for their credentialing decisions.

JCAHO allows flexibility

The JCAHO standards are not "prescriptive," says Marder. In other words, they permit the institution to create a program that is adapted to fit the circumstances and makes sense given the institution's needs and resources.

Example: A hospital may decide that when it grants privileges to a physician new to the institution, the hospital may review a given number of that physician's cases quarterly over the first year in which he or she practices at the institution. The actual number of cases may vary depending on whether the physician is experienced or new to practice. The review may consist of merely reviewing charts after the fact, or may involve mentoring or consultation with a more experienced physician prior to allowing the new practitioner to provide treatment at the facility.

For more complicated procedures or decision-making, the program may require the presence of another physician in the room. The type of proctoring that an institution requires can change the longer the physician works with the facility. The point is that any proctoring program should enable the hospital to gain objective information about the physician's clinical competence and medical decision-making skills with the intent of providing the best care to the patient, Marder says.

Acquisition of information triggers an obligation to act on it

Callahan cautions that any proctoring program must include frequent reviews of the information that it generates. Once a proctor has filed a report indicating a potential problem, the hospital is legally "on notice" and must investigate and seek solutions to any problem that it confirms, he says. Failure to do so not only goes against the JCAHO standards but also can lead to liability in malpractice suits or negligent credentialing actions, Callahan adds.

Marder suggests that proctoring reports be reviewed quarterly as a matter of course. If a proctor identifies a problem with a physician's practice, more frequent reviews/closer supervision may be in order.

Ensure that proctoring is not reportable. Callahan points out that some forms of "proctoring" can amount to limitations that are reportable to the National Practitioner Data Bank. If a hospital imposes a condition that a physician must get prior permission to perform a treatment or procedure, that condition amounts to a reportable limitation of privileges—and it also may trigger the fair hearing process. Callahan suggests working closely with the hospital attorney to ensure that the proctoring program doesn't inadvertently create a reportable event.

Proctoring and the clinical quality office. Although recent court decisions in many states have eroded the confidentiality of peer-review material, most states still offer good faith peer review some protection from disclosure, Callahan says.

Again, it is wise to consult the hospital attorney to construct your proctoring program in a manner that takes full advantage of whatever confidentiality provisions are available.

This will encourage thorough proctoring and candid reports that can be used not only to support credentialing decisions, but also to help the physician become a more effective practitioner. ■

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