

New York State Association Medical Staff Services Annual Conference

Negligent Credentialing

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Michael R. Callahan assists hospital, health system and medical staff clients on a variety of health care legal issues related to accountable care organizations (ACOs), patient safety organizations (PSOs), health care antitrust issues, Health Insurance Portability and Accountability Act (HIPAA) and regulatory compliance, accreditation matters, general corporate transactions, medical staff credentialing and hospital/medical staff relations.

Michael's peers regard him as "one of the top guys [...] for credentialing—he's got a wealth of experience" (*Chambers USA*). Additionally, his clients describe him as "always responsive and timely with assistance," and say he is "informed, professional and extremely helpful" and "would recommend him without reservation" (*Chambers USA*). Michael's clients also commend his versatility, and say "He is willing to put on the hat of an executive or entrepreneur while still giving legal advice," according to *Chambers USA*.

He is a frequent speaker on topics including ACOs, health care reform, PSOs, health care liability and peer review matters. He has presented around the country before organizations such as the American Health Lawyers Association, the American Medical Association, the American Hospital Association, the American Bar Association, the American College of Healthcare Executives, the National Association Medical Staff Services, the National Association for Healthcare Quality and the American Society for Healthcare Risk Management.

Michael was recently appointed as chair of the Medical Staff Credentialing and Peer Review Practice Group of the American Health Lawyers Association. He also was appointed as the public member representative on the board of directors of the National Association Medical Staff Services.

He was an adjunct professor in DePaul University's Master of Laws in Health Law Program, where he taught a course on managed care. After law school, he served as a law clerk to Justice Daniel P. Ward of the Illinois Supreme Court.

Goals of Program

- What must a plaintiff establish in order to succeed in a negligent credentialing case
- Review of recent cases and their impact on a hospital's duty to protect patients
- How to successfully defend against these actions
- The importance of establishing and uniformly applying credentialing criteria as well as documenting grounds for exceptions to minimize negligent credentialing claims
- What impact does your New York's peer review confidentiality statute have on the hospital's ability to defend against these lawsuits
- How to maximize your peer review protections as applied to physician profiling

Negligent Credentialing - Environmental Overview

- Plaintiffs are looking for as many deep pockets as possible in a malpractice action
 - Hospital has the deepest pockets
- Tort reform efforts to place limitations or “caps” on compensatory and punitive damages have increased efforts to add hospitals as a defendant
- Different Theories of Liability are utilized
 - Respondent Superior
 - Find an employee who was negligent
 - Apparent Agency
 - Hospital-based physician, i.e., anesthesiologist, was thought to be a hospital employee by the patient and therefore hospital is responsible for physician’s negligence

Negligent Credentialing - Environmental Overview (cont'd)

- Doctrine of Corporate Negligence
 - Hospital issued clinical privileges to a practitioner who provided negligent care who they knew or should have known was not competent
- Industry shift from reimbursing providers based on the volume of services provided to the value of services obtained
- Greater transparency to general public via hospital rankings, published costs and outcomes, accreditation status, state profiling of physicians, etc.

Negligent Credentialing - Environmental Overview (cont'd)

- Required focus on evidenced-based guidelines and standards and the six Joint Commission competencies (patient care, medical knowledge, practice based learning and improvement, interpersonal and communication skills, professionalism and systems based practice) and ongoing and focused professional practice evaluation (“OPPE” and “FPPE”) as a basis of determining who is currently competent to exercise requested clinical privileges
- The result of all of these evolving developments is an unprecedented focus on how we credential and privilege physicians as well as the volume of information we are requesting and generating as part of this ongoing analysis

The Tort of Negligence

- Plaintiff must be able to establish:
 - Existence of duty owed to the patient
 - That the duty was breached
 - That the breach caused the patient's injury
 - The injury resulted in compensable damages

Duty - Doctrine of Corporate Negligence

- Hospital, along with its medical staff, is required to exercise reasonable care to make sure that physicians applying to the medical staff or seeking reappointment are competent and qualified to exercise the requested clinical privileges. If the hospital knew or should have known that a physician is not qualified and the physician injures a patient through an act of negligence, the hospital can be found separately liable for the negligent credentialing of this physician
- Doctrine also applies to managed care organizations such as PHOs and IPAs and also will apply to ACOs, CINs, etc.

Duty - Doctrine of Corporate Negligence (cont'd)

- Restatement of this Doctrine and duty is found in:
 - Case law, i.e., Darling v. Charleston Community Hospital, (33 Ill. 2d 326 (1965)); Frigo v. Silver Cross Hospital (377 Ill. App. 3d 43 (1st Dist. 2007)); Spradley v. Pergament Home Ctrs., 689 N.Y.S. 2d-516 (1999); Palmer v. City of Rome, 466 N.Y.S. 2d 238 (1983)
 - State hospital licensing standards
 - Accreditation standards, i.e., The Joint Commission and Healthcare Facilities Accreditation Programs
 - Medical staff bylaws, rules and regulations, department and hospital policies, corporate bylaws and policies

Duty - Doctrine of Corporate Negligence (cont'd)

- Some questions associated with this duty:
 - How are core privileges determined?
 - Based on what criteria does hospital grant more specialized privileges?
 - Are hospital practices and standards consistent with those of peer hospitals?
 - Were any exceptions to criteria made and, if so, on what basis?

Duty - Doctrine of Corporate Negligence (cont'd)

- Were physicians to whom the exemption applied “grandfathered” and, if so, why?
- Did you really scrutinize the privilege card of Dr. Callahan who is up for reappointment but has not actively practiced at the Hospital for the last two or more years?
- Has each of your department’s adopted criteria which they are measuring as part of The Joint Commission FPPE or OPPE obligations such as length of stay patterns or morbidity and mortality data?
- Has the hospital developed policies to identify, implement, monitor and enforce provider compliance with required quality metrics?

Breach of Duty

- The hospital breached its duty because:
 - It failed to adopt or follow state licensing requirements
 - It failed to adopt or follow accreditation standards, i.e., FPPE and OPPE
 - It failed to adopt or follow its medical staff bylaws, rules and regulations, policies, core privileging criteria, etc.
 - It reappointed physicians without taking into account their accumulated quality or performance improvement files

Breach of Duty (cont'd)

- It reappointed physicians even though they have not performed any procedures at hospital over the past two years and/or never produced adequate documentation that the procedures were performed successfully elsewhere
- It failed to require physicians to establish that they obtained additional or continuing medical education consistent with requirement to exercise specialized procedures
- It appointed/reappointed physician without any restrictions even though they had a history of malpractice settlements/judgments, disciplinary actions, insurance gaps, licensure problems, pattern of substandard care which has not improved despite medical staff intervention, current history or evidence of impairment, non-compliance with quality metrics, etc.

Breach of Duty (cont'd)

- It failed to grandfather or provide written explanation as to why physician, who did not meet or satisfy credentialing criteria, was otherwise given certain clinical privileges
- It required physician to take ED call even though physician clearly was not qualified to exercise certain privileges
- It gave privileges to a physician who did not meet their eligibility criteria
- It did not collect and/or review all of the information required as part of its appointment/reappointment procedures

Causation

- The hospital's breach of its duty caused the patient's injury because:
 - If the hospital had uniformly monitored and applied its credentialing/privileging criteria, physician would not have received the privileges which he negligently exercised and which directly caused the patient's injury
 - History of malpractice suits since last reappointment should have forced hospital to further investigate and to consider or impose some form of remedial or corrective action, including reduction or termination of privileges, and such failure led to patient's injury

Causation (cont'd)

- Causation is probably the most difficult element for a plaintiff to prove because plaintiff eventually has to establish that if hospital had met its duty, physician would not have been given the privileges that led to the patient's injury
- Plaintiff also must prove that the physician was negligent. If physician was not negligent, then hospital cannot be found to have breached the Doctrine of Corporate Negligence

Examples of Negligent Credentialing Cases

- Darling v. Charleston Community Memorial Hospital (1965)
 - First case in the country to apply the Doctrine of Corporate Negligence
 - Case involved a teenage athlete who had a broken leg with complications and was treated by a family practitioner
 - Leg was not set properly and patient suffered permanent injury
 - Hospital claimed no responsibility over the patient care provided by its staff physician

Examples of Negligent Credentialing Cases (cont'd)

- Court rejected this position as well as the charitable immunity protections previously provided to hospitals
- Part of the basis for the decision was the fact that hospital was accredited by the Joint Commission and had incorporated the Commission's credentialing standards into its corporate and medical staff bylaws

Examples of Negligent Credentialing Cases (cont'd)

- These standards reflected an obligation by the medical staff and hospital to make sure physicians were qualified to exercise the privileges granted to them
- Physician was found to be negligent
- The medical staff and hospital's decision to give privileges to treat patients with complicated injuries to an unqualified practitioner directly caused the patient's permanent injuries. Therefore, the hospital was held liable for the damages

Examples of Negligent Credentialing Cases (cont'd)

- Frigo v. Silver Cross Hospital (2007)
 - Frigo involved a lawsuit against a podiatrist and Silver Cross
 - Patient alleged that podiatrist's negligence in performing a bunionectomy on an ulcerated foot resulted in osteomyelitis and the subsequent amputation of the foot in 1998
 - The podiatrist was granted Level II surgical privileges to perform these procedures even though he did not have the required additional post-graduate surgical training required in the Bylaws as evidenced by completion of an approved surgical residency program or board eligibility or certification by the American Board of Podiatric Surgery at the time of his initial appointment in 1992

Examples of Negligent Credentialing Cases (cont'd)

- At the time of his reappointment, the standard was changed to require a completed 12 month podiatric surgical residency training program, successful completion of the written eligibility exam and documentation of having completed 30 Level II operative procedures
- Podiatrist never met these standards and was never grandfathered. In 1998, when the alleged negligence occurred, he had only performed six Level II procedures and none of them at Silver Cross

Examples of Negligent Credentialing Cases (cont'd)

- Frigo argued that because the podiatrist did not meet the required standard, he should have never been given the privileges to perform the surgery
- She further maintained that the granting of privileges to an unqualified practitioner who was never grandfathered was a violation of the hospital's duty to make sure that only qualified physicians are to be given surgical privileges. The hospital's breach of this duty caused her amputation because of podiatrist's negligence
- Jury reached a verdict of \$7,775,668.02 against Silver Cross
- Podiatrist had previously settled for \$900,000.00

Examples of Negligent Credentialing Cases (cont'd)

- Hospital had argued that its criteria did not establish nor was there an industry-wide standard governing the issuance of surgical privileges to podiatrists
- Hospital also maintained that there were no adverse outcomes or complaints that otherwise would have justified non-reappointment in 1998
- Court disagreed and held that the jury acted properly because the hospital's bylaws and the 1992 and 1993 credentialing requirements created an internal standard of care against which the hospital's decision to grant privileges could be measured

Examples of Negligent Credentialing Cases (cont'd)

- Court noted that Dr. Kirchner had not been grandfathered and that there was sufficient evidence to support a finding that the hospital had breached its own standard, and hence, its duty to the patient
- This finding, coupled with the jury's determination that Dr. Kirchner's negligence in treatment and follow up care of Frigo caused the amputation, supported jury's finding that her injury would not have been caused had the hospital not issued privileges to Dr. Kirchner in violation of its standards
- Jury verdict was affirmed. Petition for leave to appeal to Illinois Supreme Court was denied

Defending Against a Corporate Negligence Claim

- Existence of duty and breach of duty and causation is usually established through expert testimony
- Plaintiff's expert must establish that Doctrine of Corporate Negligence was breached, i.e., that hospital failed to:
 - Comply with Medicare CoPs, accreditation standards
 - Comply with its own bylaws, credentialing/privileging standards
 - Did not effectively monitor compliance with quality requirements
 - Did not respond quickly or appropriately when problems were identified
- In some jurisdictions it is an affirmative defense if hospital can establish, through expert and other testimony, that it fully complied with all required standards

Defending Against a Corporate Negligence Claim (cont'd)

- Courts and juries may be less likely to hold in favor of the plaintiff even if, for example, a physician's lack of qualifications or history of malpractice actions raises the issue of whether privileges should have been granted, as long as some action was taken, i.e., physician was being monitored or proctored or was under a mandatory consultation
- A judge and jury will be more likely to find in favor of the plaintiff if the hospital did absolutely nothing with respect to the physician's privileges
- Although the peer review record may not be discoverable, the actions taken or not taken are not privileged

Defending Against a Corporate Negligence Claim (cont'd)

- It will be important for hospital to establish that there is not necessarily a black and white standard on what qualifications are absolutely required before issuing clinical privileges although such a position, at least for certain privileges, may have been established, i.e., PTCAs
- Also, the hospital should argue that even if a physician was identified as having issues or problems, a reduction or termination of privileges is not always the appropriate response. Instead, the preferred path is for the hospital to work with the physician to get them back on track by implementing other remedial measures such as monitoring, proctoring, additional training, etc.
- Attempt to introduce physician's peer review record to establish that Hospital met it's duty

Defending Against a Corporate Negligence Claim (cont'd)

- You must evaluate whether your peer review statute does or does not allow introduction of peer review record into evidence for this purpose
- Denying a plaintiff access to this information usually makes it more difficult to prove up a negligent credentialing claim
- Most statutes do not permit the discovery or admissibility of this information because to do so would have a chilling effect on necessary open and frank peer review discussion. There is no statutory exception that allows a hospital to pick and choose when I can or cannot introduce information into evidence

Defending Against a Corporate Negligence Claim (cont'd)

- In Frigo, hospital's attempt to establish that duty was met by showing, through the peer review record, that podiatrist had no patient complaints or bad outcomes was denied because prohibition on admissibility into evidence was absolute
- Court stated, however, that this information was somewhat irrelevant because the Hospital clearly did not follow its own standards

Other Preventative Steps to Consider

- Conduct audit to determine whether hospital and medical staff bylaws, rules and regulations and policies comply with all legal accreditation standards and requirements
- If there are compliance gaps, fix them
- Determine whether you are actually following your own bylaws, policies and procedures

Remember: Bylaws, policies and procedures and guidelines are all discoverable. They also create the hospitals internal standard. If you do not follow your bylaws and standards, you arguably are in breach of your patient care duties

- If you are not following your bylaws and policies, either come into compliance or change the policies
- Update bylaws and policies to stay compliant

Other Preventative Steps to Consider (cont'd)

- Confer with your peers. Standard of care can be viewed as national, i.e., Joint Commission, internal or area-wide so as to include the peer hospitals in your market. If your practices deviate from your peers, this will be held against you as a breach of the standard of care
- It is very important to understand from your insurance defense counsel how plaintiff's attempt to prove a corporate negligence violation as well as how these actions are defended
 - These standards have a direct impact on hospital prophylactic efforts to minimize liability exposure

Other Preventative Steps to Consider (cont'd)

- What testimony must plaintiff's expert assert to establish a claim and what must defense expert establish to rebut?
- Every state has its own nuances and you must understand them in order to defend accordingly
- Does the New York peer review statute allow for the introduction of confidential peer review information under any circumstances either to support a plaintiff's claim or to defend against it? - Yes
- If the file information would help the hospital, can the privilege be waived in order to defend the case? Realize that plaintiff also would have access. Will this help or hurt you?

Other Preventative Steps to Consider (cont'd)

- The answers to these questions are important because the hospital may want to create a record of compliance with its duty that is not part of an inadmissible peer review file. This effort must be coordinated with internal and/or external legal counsel
- Otherwise, take steps for maximizing protections under peer review confidentiality statute

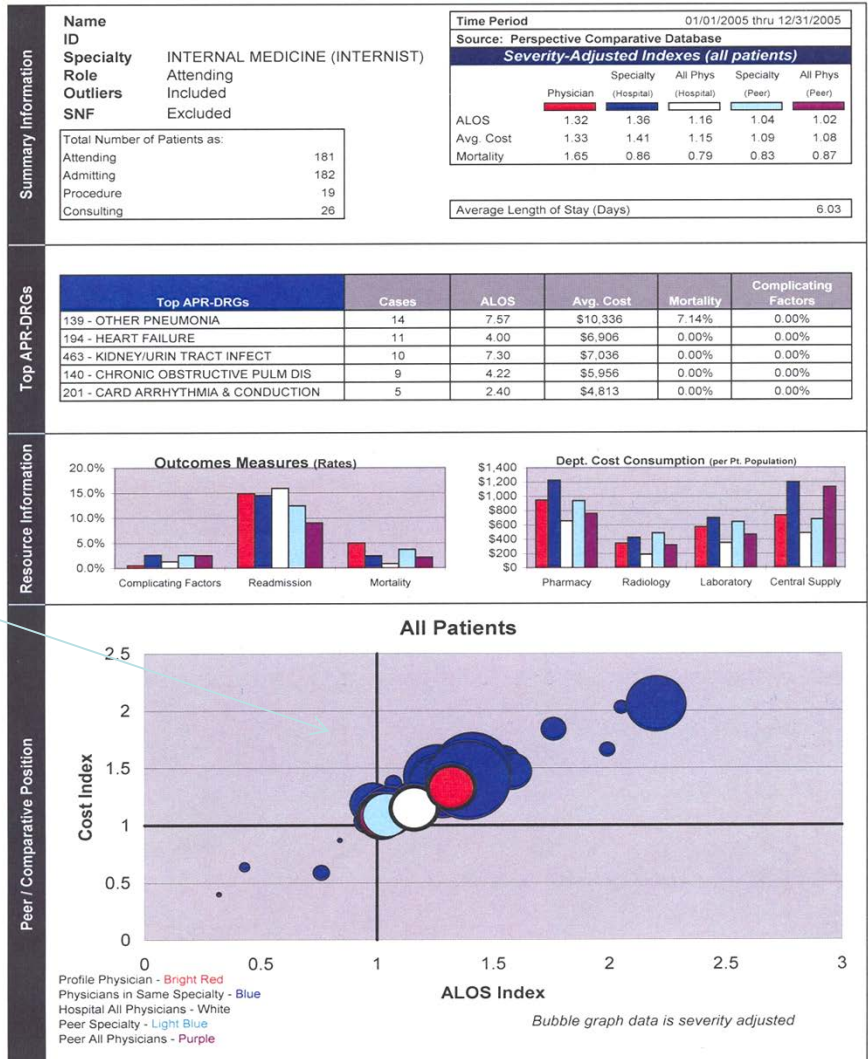
Variance Between Medicare Geo. Mean and Actual ALOS by Top 20 DRG's at Example Hospital

MEDICARE ONLY					
DRG #	DRG DESCRIPTION	ADMITS	ALOS	MEDICARE GEO. MEAN	VARIANCE
127	HEART FAILURE & SHOCK	294	6.6	4.1	2.5
88	CHRONIC OBSTRUCTIVE PULMONARY DISEASE	152	5.9	4.0	1.9
89	SIMPLE PNEUMONIA & PLEURISY AGE>17 W CC	129	6.6	4.7	1.9
182	ESOPHAGITIS, GASTROENT & MISC DIGEST DISORDERS AGE>17 W CC	117	4.7	3.4	1.3
143	CHEST PAIN	106	2.8	1.7	1.1
521	ALCOHOL/DRUG ABUSE OR DEPENDENCE W CC	104	3.9	4.2	-0.3
296	NUTRITIONAL & MISC METABOLIC DISORDERS AGE>17 W CC	85	5.5	3.7	1.8
416	SEPTICEMIA AGE>17	78	10.4	5.6	4.8
124	CIRCULATORY DISORDERS EXCEPT AMI, W CARD CATH & COMPLEX DIAG	77	4.9	3.3	1.6
174	G.I. HEMORRHAGE W CC	76	6.5	3.8	2.7
132	ARTHEROSCLEROSIS W CC	73	3.9	2.2	1.7
320	KIDNEY & URINARY TRACT INFECTIONS AGE >17 W CC	73	6.0	4.2	1.8
138	CARDIAC ARRHYTHMIA & CONDUCTION DISORDERS W CC	71	5.2	3.0	2.2
14	INTRACRANIAL HEMORRHAGE OR CEREBRAL INFARCTION	68	7.6	4.5	3.1
188	OTHER DIGESTIVE SYSTEM DIAGNOSES AGE>17 W CC	68	5.7	4.2	1.5
125	CIRCULATORY DISORDERS EXCEPT AMI, W CARD CATH W/O COMPLEX DIAG	64	3.7	2.1	1.6
395	RED BLOOD CELL DISORDERS AGE>17	60	4.4	3.2	1.2
130	PERIPHERAL VASCULAR DISORDERS W CC	59	7.2	4.4	2.8
204	DISORDERS OF PANCREAS EXCEPT MALIGNANCY	58	5.5	4.2	1.3
294	DIABETES AGE >35	52	5.2	3.3	1.9

Example by Major Dx

- Heart Failure
- Card. Arrhythmia
- Percut Cardiovasc w/o AMI
- Angina

This physician's overall performance is In line w/the peer group



This report is confidential. It has been prepared for professional review and performance improvement purposes pursuant to applicable laws. The contents of this report may be disclosed only in accordance with applicable laws.

LLP

Example by Major Dx

- Heart Failure
- Card. Arrhythmia
- Percut Cardiovasc w/o AMI
- Angina

This physician's overall performance is significantly worse the peer group



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Steps to Maximize Confidentiality Protection Under Peer Review Statute

- The relevant provisions of New York Education – Article 131 - §6527
 - Neither the proceedings nor the records relating to performance of a medical or a quality assurance review function or participation in a medical and dental malpractice prevention program nor any report required by the department of health pursuant to section twenty-eight hundred five-1 of the public health law described herein, including the investigation of an incident reported pursuant to section 29.29 of the mental hygiene law, shall be subject to disclosure under article thirty-one of the civil practice law and rules except as hereinafter provided or as provided by any other provision of law. No person in attendance at a meeting when a medical or a quality assurance review or a medical and dental malpractice prevention program or an incident reporting function described herein was performed, including the investigation of an incident reported pursuant to section 29.29 of the mental hygiene law, shall be required to testify as to what transpired thereat. The prohibition relating to discovery of testimony shall not apply to the statements made by any person in attendance at such a meeting who is a party to an action or proceeding the subject matter of which was reviewed at such meeting. (Emphasis added)

Steps to Maximize Confidentiality Protection Under Peer Review Statute (cont'd)

- It is important for all medical staff leaders and the hospital to know the language and interpretation of your peer review statute
- As a general rule, courts do not like confidentiality statutes which effectively deny access to information
- Although appellate courts uphold this privilege, trial courts especially look for ways to potentially limit its application and will strictly interpret the statute
- The courts have criticized attorneys for simply asserting the confidentiality protections under the Act without attempting to educate the court about what confidentiality and peer review is or explaining why the information in question should be treated as confidential under the act
- One effective means of improving the hospital and medical staffs odds is to adopt a medical staff bylaw provision or policy which defines “peer review” and “peer review committee” in an expansive manner while still consistent with the language of the Act. Examples are set forth below:

Peer Review:

- “Peer Review” refers to any and all activities and conduct which involve efforts to reduce morbidity and mortality, improve patient care or engage in professional discipline. These activities and conduct include, but are not limited to: the evaluation of medical care, the making of recommendations in credentiality and delineation of privileges for Physicians, LIPs or AHPs seeking or holding such Clinical Privileges at a Medical Center facility, addressing the quality of care provided to patients, the evaluation of appointment and reappointment provided to patients, the evaluation of appointment and reappointment applications and qualifications of Physicians, LIPs or AHPs, the evaluations of complaints, incidents and other similar communications filed against members of the Medical Staff and others granted clinical Privileges. They also include the receipt, review, analysis, acting on and issuance of incident reports, quality and utilization review functions, and other functions and activities related thereto or referenced or described in any Peer Review policy, as may be performed by the Medical Staff or the Governing Board directly or on their behalf and by those assisting the Medical Staff and Board in its Peer Review activities and conduct including, without limitation, employees, designees, representatives, agents, attorneys, consultants, investigators, experts, assistants, clerks, staff and any other person or organization who assist in performing Peer review functions, conduct or activities

Peer Review (Cont'd)

- “Peer Review Committee” means a Committee, Section, Division, Department of the Medical Staff or the Governing Board as well as the Medical Staff and the Governing Board as a whole that participates in any Peer Review function, conduct or activity as defined in these Bylaws. Included are those serving as members of the Peer Review committee or their employees, designees, representatives, agents, attorneys, consultants, investigators, experts, assistants, clerks, staff and any other person or organization, whether internal or external, who assist the Peer Review Committee in performing its Peer Review functions, conduct or activities. All reports, studies, analyses, recommendations, and other similar communications which are authorized, requested or reviewed by a Peer Review Committee or persons acting on behalf of a Peer Review Committee shall be treated as strictly confidential and not subject to discovery nor admissible as evidence consistent with those protections afforded under the Medical Studies Act. If a Peer Review Committee deems appropriate, it may seek assistance from other Peer Review Committees or other committees or individuals inside or outside the Medical Center. As an example, a Peer review Committee shall include, without limitation: the MEC, all clinical Departments and Divisions, the Credentials Committee, the Performance Improvement/Risk Management Committee, Infection Control Committee, the Physician’s Assistance Committee, the Governing Board and all other Committees when performing Peer Review functions, conduct or activities

Peer Review (Cont'd)

- Another concept to keep in mind is that Appellate Courts have held that information which is normally generated within the hospital or medical staff which is not clearly treated as a “peer review document” cannot be kept confidential by simply submitting it to a Peer Review Committee for review and action. Therefore, the hospital and medical staff should consider identifying those kinds of reports, such as incident reports, quality assurance reports, etc., as being requested by or authorized by a qualified Peer Review Committee
- Unilateral vs. committee action should be avoided
- Self-serving language such as “privileged and confidential under the Act: document cannot be admissible or subject to discovery” should be placed at the top or bottom of Peer Review materials
- If there is a challenge as to whether the Act applies to Peer Review documents, hospital and medical staff should prepare appropriate affidavits, or other testimonials which effectively educate the court as to why these materials should be considered confidential and therefore, protected under the Act
- If a physician or plaintiff cannot admit Peer Review Information into evidence, it can effectively foreclose one or more causes of action because the physician will not be able to introduce proof to substantiate the claim, i.e., an alleged defamatory statement made during a Peer Review proceeding

How do state confidentiality/privilege protections compare to those offered under the Patient Safety Act? – New York

- New York
 - New York Education – Article 131-§6527
 - The proceedings and records relating to the performance of a medical or quality assurance function or participation in a medical and dental malpractice prevention program shall not be subject to disclosure
 - No person in attendance at a meeting when a medical or quality assurance review or a medical or dental malpractice prevention program or an incident reporting function was performed shall be required to testify as to what transpired

How do state confidentiality/privilege protections compare to those offered under the Patient Safety Act? – New York (cont'd)

- The prohibition relating to the discovery of testimony shall not apply to the statements made by any person in attendance at such a meeting who is a party to an action or proceeding the subject matter of which was reviewed at such meeting
- The protections and limitations apply to the records, documentation or committee actions and incident reporting relating to a mandated adverse event reporting (N.Y. Pub. L. §2801-l and investigation prior to granting and renewing of clinical privileges (§2801-k)

How do state confidentiality/privilege protections compare to those offered under the Patient Safety Act? – Patient Safety Act

- Patient Safety Act
 - The confidentiality and privilege protections afforded under the PSA generally apply to reports, minutes, analyses, data, discussions, recommendations, etc., that relate to patient safety and quality if generated or managed, or analyzed within the PSES and collected for reporting to a PSO

How do state confidentiality/privilege protections compare to those offered under the Patient Safety Act? – Patient Safety Act (cont'd)

- Any licensed provider, i.e., physician, physician group, surgicenters, clinic, hospital, nursing home, home health facility, etc., can be covered under the PSA whereas in many states the kinds of providers that can be protected is more limited
- The confidentiality and privilege protections afforded under the PSA generally apply to reports, minutes, analyses, data, discussions, recommendations, etc., that relate to patient safety and quality if generated or managed, or analyzed and collected within the PSES for reporting to a PSO

How do state confidentiality/privilege protections compare to those offered under the Patient Safety Act? – Patient Safety Act (cont'd)

- The scope of what can be protected under the PSA, generally speaking, is broader than New York
- Any licensed provider, i.e., physician, physician group, surgicenters, clinic, hospital, nursing home, home health facility, etc., can be covered under the PSA
- The protections apply in both state and, for the first time, federal proceedings
- The protections can never be waived
- If the protections are greater than those offered under state law the PSA pre-empts state law

How do state confidentiality/privilege protections compare to those offered under the Patient Safety Act? – Patient Safety Act (cont'd)

- PSWP is not admissible into evidence nor is it subject to discovery
- Key to these protections is the design of the provider's and PSO's patient safety evaluation system ("PSES")

Additional Steps to Ensure that Data Collected and Reports Prepared are Treated as Confidential

- Goal is to maximize efforts to keep performance monitoring, quality and utilization data and reports and peer review records as privileged and confidential from discovery in litigation proceedings
- List all relevant reports, studies, forms, reports, analyses, etc., which are utilized by the hospital and medical staff
 - Profiling data and reports
 - Comparative data
 - Utilization studies
 - Outcomes standards and comparisons by physicians
 - Incident reports
 - Quality assurance reports

Additional Steps to Ensure that Data Collected and Reports Prepared are Treated as Confidential (cont'd)

- Patient complaints
- Cost per patient visit, ALOS, number of refunds and consultants used, etc.
- Identify which reports and info, if discoverable, could lead to hospital/physician liability for professional malpractice/corporate negligence
- Identify all applicable state and federal confidentiality statutes and relevant case law
 - Peer review confidentiality statute – Medical Studies Act
 - Patient Safety and Quality Improvement Act of 2005
 - Physician-patient confidentiality
 - Medical Records

Additional Steps to Ensure that Data Collected and Reports Prepared are Treated as Confidential (cont'd)

- Attorney-client communications
 - Business records
 - Records, reports prepared in anticipation of litigation
 - HIPAA
 - Drug, alcohol, mental health statutes
- Identify scope of protections afforded by these statutes, and steps needed to maintain confidentiality, to list of reports to determine what are and are not practiced
 - Can steps be taken to improve or maximize protection?

Additional Steps to Ensure that Data Collected and Reports Prepared are Treated as Confidential (cont'd)

- What documents are left and how sensitive is the information in the reports?
- If sensitive information remains, can it be moved to or consolidated with a confidential report?
- Can information be de-identified or aggregated while not minimizing its effectiveness?
- Adopt self-serving policies, bylaws, etc., which identify these materials as confidential documents – need to be realistic. A document is not confidential because you say it is. See attached definitions of “Peer Review” and “Peer Review Committee”
 - Need to consult with your legal counsel before finalizing your plan
 - Plan needs to be updated as forms and law changes

Golden Rules of Peer Review

- Physicians need to be able to say “I made a mistake” without fear of retribution or disciplinary action
- Everyone deserves a second or third chance
- Medical staffs and hospitals should strive to create an intra- professional versus adversarial environment
- Steps should be taken to de-legalize process
- Develop alternative remedial options and use them
- Comply with bylaws, rules and regulations and quality improvement policies

Golden Rules of Peer Review (cont'd)

- Apply standards uniformly
- Take steps to maximize confidentiality and immunity protections
- Know what actions do and do not trigger a Data Bank report and use this knowledge effectively
- Be fair and reasonable while keeping in mind the requirement to protect patient care
- Determine whether physician may be impaired