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How to Avoid or Limit the Need for Peer Review Fair Hearings and Data Bank Reports

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Program Objectives

- Provide recommendations regarding best practices, bylaw provisions and other strategies to address and resolve quality and peer review issues without resorting to “investigations” and hearings.
- Discussion on what constitutes an “investigation” for Data Bank purposes.
- Use of collegial intervention.
- What actions are and are not reportable to the Data Bank – when can a physician resign without a report?
- When pursuing a code of conduct/disruptive behavior pathway is more appropriate than peer review/investigation procedures.
- How to manage the peer review process and investigation stages to avoid hearings and litigation.

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The Changing Healthcare Landscape

- Consolidation of health care market
  - Hospital and physician group mergers
  - Practice acquisitions
  - Physician employment
- Provider margins are under attack
  - Reductions in Medicare/Medicaid reimbursement – new federal legislation?
  - Higher costs
  - Private payer reductions
- New models of provider integration are emerging
  - Co-management arrangements
  - Patient centered medical home
  - ACOs
  - Insurance company/provider networks
  - Clinically integrated networks
  - Joint operating companies

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The Changing Healthcare Landscape (cont'd)

- Shift from "Volume to Value" as a basis of reimbursement
  - Pay for performance
  - ACO quality metrics
  - Value Based Purchasing
  - MACRA
  - Reduced or denied reimbursement for:
    - Hospital acquired conditions
    - Never events – (Billing Medicare for a never event is considered a false claim)
    - Readmissions within 30 days

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The Changing Healthcare Landscape (cont'd)

- Never Events
  - Surgery on wrong body part
  - Surgery on wrong patient
  - Wrong surgery on a patient
  - Death/disability associated with use of contaminated drugs
  - Patient suicide or attempted suicide resulting in disability
  - Death/disability associated with medication error

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The Changing Healthcare Landscape (cont'd)

- Hospital Acquired Conditions
  - Foreign object left in patient after surgery
  - Death/disability associated with intravascular air embolism
  - Death/disability associated with incompatible blood
  - Stage 3 or 4 pressure ulcers after admission

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Impact of Changing Landscape

- Existing and future quality metrics and outcome measures need to be incorporated into appointment/reappointment procedures, including privileging and credentialing, quality improvement and utilization standards and studies and OPPE/FPPE monitoring programs.
- Failure to meet standards will result in lower reimbursement, and will increase potential liability under theories of respondeat superior, apparent agency and corporate negligence.

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Impact of Changing Landscape (cont'd)

- Failure to meet standards could result in:
  - Exclusion from ACO membership
  - Loss of accreditation
  - Loss of managed care contracts
  - Increased insurance premiums
  - Loss of clinical privileges/medical staff/ACO membership
  - Increased governmental investigations/enforcement actions tied to billing for substandard care ("worthless services")
- These changes will likely increase the volume of peer review quality improvement activity and therefore the possibility of more investigations, hearings and litigation.

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Managing the Peer Review Process – Fundamental Principles

- Follow your bylaws and all applicable rules, regs and policies
- Follow applicable state and federal laws
- Address issues immediately – the longer you wait the more difficult it is to act
- Document, document, document
- Always try to resolve issues and adopt solutions at the lowest possible level – concept of “collegial intervention”
- Be transparent and adopt fair procedures – peer review is not a shell game
- Involve physicians early on in the process

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Managing the Peer Review Process – Fundamental Principles (cont'd)

- Distinguish your "peer review/quality improvement process" from the investigation/remedial action phase.
- Know what actions are and are not reportable to the state and to the Data Bank and what actions trigger hearings under the Bylaws.
- Avoid conflicts of interest.
- Make sure that your documentation trail is protected under state/federal confidentiality statutes and amend your bylaws and policies accordingly.
- Need to create and promote a "just culture" environment where physicians and other practitioners can acknowledge errors and accept responsibility without fear of reprisal or loss of privileges.

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Hypothetical Scenario

Dr. Callahan is a 68 year old orthopedic surgeon at a stand alone suburban community hospital. He leads a large practice group which is loyal to the hospital but it is struggling financially and currently is considering a number of merger/affiliation/acquisition options. Dr. Callahan was a former Department Chair and Chief of Staff and is one of the hospital's biggest admitters.

The quality, risk management and medical staff offices and personnel are hard working professionals but are overworked, underpaid and understaffed due to cutbacks. The tendency is to "silo" information and protect turf rather than share and collaborate.

Hypothetical Scenario (cont'd)

Medical Staff leaders and Department Chairs/Section Chiefs are unpaid volunteers all with busy schedules. Recruitment of new leaders is becoming increasingly more difficult.

Recently, a number of Dr. Callahan's cases have been "falling out" based on hospital-wide and Department specific quality indicators including a higher incidence of post-op infections, questionable surgical procedures and complications associated with misplaced instrumentation. In addition, his behavior has been described as "odd" including temperamental outbursts and verbally abusive behavior towards nurses and even patients.

Peer Review Phase – Preliminary Assessment

- Hypothetical presents both a quality of care issue as well as a possible impairment problem – how does one proceed?
- Department Chair, Medical Staff President, VPMA/CMO should meet to review available information (although case reviews already should have commenced in accordance with peer review policies).
- Should probably proceed down a dual path rather than just the quality review because "causation" has not been determined. Has Callahan's possible impairment caused the adverse patient outcomes?
- Also need to decide if you are dealing with a behavioral issue to be addressed under your existing Code of Conduct policy or an impairment problem under your Physician Wellness Committee process.

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Quality of Care Review

- Peer review/quality management procedures should be designed to capture adverse outcomes and related information from multiple resources and methods:
  - HAC
  - Never events
  - Medical Staff/Department quality indicators
    - Post-op infections
    - Lawsuits
    - Return to surgery within identified number of days

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Quality of Care Review (cont'd)

- Patient complaints
- Over-utilization reports
- Physician periodic quality reports
- Incident reports
- Non-compliance with quality metrics/outcomes
- OPPE/FPPE criteria

- Committee review of randomly selected cases or cases in which issues have been identified.
- Cases assigned for review should avoid actual conflicts of interest and be based on medical record and any accompanying documentation – if more information is needed, ask for it.
- Consult with Risk and Quality Departments

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Quality of Care Review (cont'd)

- Where nurses or other non-physicians make the initial judgment on whether cases are forwarded to a committee for review you should occasionally audit their work.
- Cases reviewed by physicians on a committee are compared to indicators or standards. If they "fall out", they are given a preliminary rating or ranking on escalating scale of severity.
  - Best Practice: Depending on the preliminary ranking, physician should be provided an opportunity to meet with Committee and/or provide written comments to respond to assessments/concerns.

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Quality of Care Review (cont'd)

- Best Practice: Physician should be given records and relevant material and the preliminary assessment in advance of the meeting or submission of comments.
- Best Practice: Bylaws should include a provision that the failure to appear/timely respond can result in a recommendation for remedial action.

- Once the physician's comments and information are received, Committee should give final rankings to be included in its minutes and report. Document should reflect physician's responses and the Committee's response to these comments.

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Quality of Care Review (cont'd)

- Report also should evaluate concerns, if any, about judgment, acceptance of responsibility, impairment, etc.
- Report, and any recommendations, should be forwarded to Department Chair, VPMA/CMO, and any Medical Staff and/or hospital-wide Quality or Performance Improvement Committee.
- Department Chair should keep track of all related quality reports and other information in physician's quality file to determine existence of any patterns of substandard care or related issues – ongoing monitoring is a requirement.
- Information needs to be assessed in order to determine whether an FPPE plan or other remedial measure, which does not trigger a hearing or an investigation, is warranted.

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Quality of Care Review (cont'd)

- Best Practice: Bylaws should contain a provision which encourages, if not requires, "collegial intervention" as a first step in the process where issues are identified so as to attempt to address issues in a pro-active, supportive manner. Goal is to remediate at lowest level possible. (See example Bylaw provision)
- Best Practice: Department/Section Chairs should be given some latitude in implementing low level remediation measures, i.e., monitoring, proctoring, retrospective/concurrent case reviews, without a formal investigation and without having to recommend remedial/corrective action – can seek MEC support if needed.

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Quality of Care Review (cont'd)

- Any recommendations, whether by a Department or Medical Staff/Hospital-wide Committee, during this Peer Review phase should follow these guidelines:
  - All recommendations should avoid the need for a hearing or Data Bank report.
  - Emphasis should be on progressive remedial measures.
  - All recommendations and support for the decision needs to be documented.
  - Consider allowing the physician to appear before the Committee before a recommendation is made.

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Quality of Care Review (cont'd)

- Once a recommendation is made and implemented, physician compliance with recommendation must be carefully tracked, and reports made and submitted to Department Chair and other appropriate personnel.
- Specific time frames should be identified.
- Compliance and non-compliance need to be documented and shared with physician.
- If Physician is non-compliant there should be a face-to-face meeting where he needs to be told that repeated violations or any adverse events may require escalation of review and imposition of additional remedial measures.
- Don't wait to provide feedback if an urgent problem arises which requires immediate action.

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Quality of Care Review (cont'd)

- Keep in mind that if physician resigns at any point during this Peer Review Phase, it is not reportable to the Data Bank because he is not under investigation nor is he resigning in lieu of corrective/remedial action.
  - "Investigation" is not a defined term under the statute or Data Bank Guidebook.
  - The Data Bank Guidebook, issued in April, 2015, adopts a broad interpretation of what constitutes an investigation. (E-34)
  - If a formal targeted process is used and relates to a specific practitioner's professional competence or conduct, such a review which could include an FPPE is considered an investigation by the Data Bank.
  - Investigations are not reportable – "only the surrender or restriction of clinical privileges while under investigation or to avoid investigation is reportable." (E-19)
  - " A routine review of a particular practitioner is not an investigation." (E-19)

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Quality of Care Review (cont'd)

- An investigation, once triggered, remains in effect until final decision is made. (E 45 at Q&A No. 19)
- "Investigations" should only be triggered at the time of a formal written request for remedial/corrective action where the result could be a reportable action.
- Data Bank is on record in stating that they will defer to the Medical Staff Bylaws as to when an investigation commences.
- "Investigation" should be a defined term in your Bylaws which cites to the provision which references a formal request for corrective/remedial action. All other reviews taking place before such a request should be characterized as routine peer review.

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Behavioral Assessment Phase

- Need to determine whether aberrant behavior should be addressed under the Code of Conduct process or the Physician Wellness Committee process.
  - Decision will be based largely on how behavior compares with past conduct, the details contained in incident/occurrence reports and any follow up interviews which may be necessary.
- Once a path is chosen, you generally will be expected to follow the process until the end but either option should allow for ability to trigger remedial action if necessary to protect patients.

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Behavioral Assessment Phase (cont'd)

- Best Practice: Bylaws should require all credentialed practitioners to report to a Department Chair or Medical Staff officer any behavior where there is any "reasonable suspicion" of impairment. If documentation supports this assessment, physician should be required to consent to an internal evaluation by the Physician Wellness Committee to determine whether a formal assessment should be conducted. Failure to meet with the Committee or abide by its recommendation can be grounds for remedial action.

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Behavioral Assessment Phase (cont'd)

- If a physician is placed in a rehab or similar program while on a leave of absence and returns with full privileges, no report to the Data Bank is required.
  - Check state law because you may be required to advise the state if physician is found to be impaired – also need to review the definition of "impairment" under state law.
- If privileges are reduced, action may be reportable and could trigger hearing rights.
- Physicians who were in a rehab program and return to the hospital with privileges should be placed on an action plan which must be monitored for compliance.

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Behavioral Assessment Phase (cont'd)

- Plan should describe consequences for non-compliance.
- Need to determine how to respond to third party inquiries.

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How to Manage an Investigation

- Investigation triggered by a formal written request from designated Medical Staff Officer, Department/Section/Committee Chair or member of senior management.
- Should only be made if collegial intervention or other non-reportable measures have failed or if clearly inadequate to address identified problem.
- Written request should contain sufficient detail so that MEC can determine whether an investigation should be triggered.
- Request should contain accompanying documentation.
  - Best Practice: Request should not specify action sought, i.e., reduction or termination of privileges. Investigation and recommendation should be left to ad hoc committee.

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How to Manage an Investigation (cont'd)

- Better to use an independent or ad hoc investigating committee when remedial/corrective action is requested, instead of full MEC, that can be appointed by either the Department Chair or the MEC.
  - Best Practice:
    - Need at least one or more members on the Committee who are of the same specialty and ideally are not a direct competitor.
    - Use physicians who are knowledgeable, respected and who will "do the job".

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How to Manage an Investigation (cont'd)

- Prior to Committee's recommendation, all relevant information should be shared with physician in advance and physician should have the right to an informal meeting with Committee to discuss identified problems.
- Meetings are informal – attorneys not allowed.
- Committee should prepare a report with findings to support recommendation to the MEC which are linked to existing standards/requirements under applicable Bylaws, Rules, Regs and policies – physician's comments should be reflected in report.
- If some kind of remedial action is recommended, try to find a balance between protecting patients while avoiding decisions that will trigger hearing rights – <u>hearings should be limited to what is reportable</u>.

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How to Manage an Investigation (cont'd)

- If using outside reviewers, make sure you develop paper trail to maximize confidentiality protections under state/federal peer review statutes. Also, reviewers should not make any recommendations on what remedial action, if any, to take.
  - Reviewers should agree in advance to serve as a witness in case a hearing is required in the future, otherwise report may be useless.
  - Outside review should be used on a limited basis and only when actual conflicts of interest exist, or the physician is already claiming bias or where an expertise not otherwise available on the medical staff is needed.

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How to Manage an Investigation (cont'd)

- Outside reports are double-edge swords because they really cannot be ignored.
- Physician should be given a copy of the report as well as the opportunity to respond before the ad hoc committee makes its recommendation.

- Should attempt to perfectly comply with Bylaw procedures although only "substantial compliance" is required.

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How to Manage an Investigation (cont'd)

- Investigation and recommendations need to be fair, reasonable and consistent. Questions to ask include "how did we handle these issues or problems in the past?" and "do we have enough information on which to base an informed decision?"
- Some hospitals and medical staffs attempt to get the adversely affected physician to come up with an acceptable action plan which they must follow.
- Remember you are creating an administrative record that will be very important in case there is a hearing and subsequent litigation.

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Collegial Intervention

It is the policy of the Medical Staff leadership of the Medical Center to work collegially with Medical Staff members to assist them in delivering high quality and safe medical care, to continually improve their clinical skills, to comply with Medical Staff and Medical Center policies, and to meet all performance expectations as established from time to time by the Medical Staff. Medical Staff policies, including those on Peer Review, performance improvement, conduct, and Physician health and impairment describe some of the collegial interventions available to Medical Staff leaders in working with colleagues whose clinical performance or professional conduct is problematic. Collegial intervention may include letters of warning/concern, a reprimand, a notice that the Physician's conduct will be monitored for a period of time and/or that similar conduct in the future will result in remedial action, including but not limited to, termination from the Medical Staff, a voluntary agreement to attend meetings, CME courses, obtain consultations, or other appropriate action. Collegial intervention shall not entitle a member to a hearing or appeal under the fair hearing rights outlined in Article VIII.

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