

Credentialing Resource Center Symposium

Privileging Challenges and Solutions

Greeley
+HCPRO

Current Issues in Negligent Credentialing

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Goals of Program

- What a plaintiff must 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
- The impact your state's peer review confidentiality statute has on the hospital's ability to defend against these lawsuits
- How to maximize your peer review protections as applied to physician profiling and pay-for-performance information

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 has 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 and therefore hospital is responsible for physician’s negligence

Environmental Overview (cont.)

– Doctrine of Corporate Negligence

- Hospital issued clinical privileges to an unqualified practitioner who provided negligent care
- Emphasis on Pay for Performance (“P4P”) and expected or required quality outcomes as determined by public and private payors
- Greater transparency to general public via hospital rankings, published costs and outcomes, accreditation status, state profiling of physicians, etc.

Environmental Overview (cont.)

- 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 system-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
 - That 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.

Duty—Doctrine of Corporate Negligence (cont.)

- Restatement of this Doctrine and duty is found in:
 - Case law, i.e., *Darling v. Charleston Community Hospital*
 - State hospital licensing standards
 - Accreditation standards, i.e., The Joint Commission and Healthcare Facilities Accreditation Program
 - Medical staff bylaws, rules and regulations, department and hospital policies, corporate bylaws and policies

Duty—Doctrine of Corporate Negligence (cont.)

- Some questions associated with this duty:
 - How are core privileges determined?
 - Based on what criteria does the 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.)

- 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 six years?
- Has each of your department’s adopted criteria that they are measuring as part of FPPE or OPPE obligations such as length-of-stay patterns or morbidity and mortality data?

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.)

- 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, etc.

Breach of Duty (cont.)

- 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 he or she clearly was not qualified to exercise certain privileges
- Violated critical pathways, ACOG, ACR standards

Causation

- The hospital's breach of its duty caused the patient's injury because:
 - If the hospital had uniformly applied its credentialing criteria, physician would not have received the privileges which he or she negligently exercised and which directly caused the patient's injury
 - History of malpractice suits since last reappointment should have forced the 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 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 negligent

Examples of Negligent Credentialing Cases

- Darling v. Charleston Community Memorial Hospital (1965)
- Frigo v. Silver Cross Hospital (2007)
- Larson v. Wasemiller (Minn. Sup. Ct. 2007)
- Smithey v. Brauweiler (2008)

- See materials pack for more information on these cases

Examples of Negligent Credentialing Cases (cont.)

- 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

Examples of Negligent Credentialing Cases (cont.)

- 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.)

- 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.)

- 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.

Examples of Negligent Credentialing Cases (cont.)

- Jury reached a verdict of \$7,775,668.02 against Silver Cross
- Podiatrist had previously settled for \$900,000.00
- Hospital had argued that its criteria did not establish nor was there an industrywide 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

Examples of Negligent Credentialing Cases (cont.)

- 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
- 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

Examples of Negligent Credentialing Cases (cont.)

- Jury verdict was affirmed. Petition for leave to appeal to Illinois Supreme Court was denied.
- See also Larson v. Wasemiller (Minn. Sup. Ct. 2007)
 - For the first time, the Supreme Court of Minnesota recognized that the tort of negligent credentialing “is inherent in and the natural extension of well established common law rights.”

Examples of Negligent Credentialing Cases (cont.)

- Court noted that at least 30 states recognize this tort theory and only two states, Pennsylvania and Maine, have rejected the claim. Other related theories are direct or corporate negligence, duty of care for patient safety, negligent hiring and negligent selection of independent contractors.
- Court further held that the tort of negligent credentialing was not preempted by the peer review statute.

Defending Against a Corporate Negligence Claim

- Existence of duty and breach of duty and causation is usually established through expert testimony
- Expert must establish that duty was not met, i.e., that hospital adopted and followed all standards as reflected in its bylaws and procedures, and/or no breach occurred and/or if there was a breach, it did not cause patient's injuries

Defending Against a Corporate Negligence Claim (cont.)

- 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

Defending Against a Corporate Negligence Claim (cont.)

- 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 physicians to get them back on track by implementing other remedial measures such as monitoring, proctoring, additional training, etc. (See Golden Rules of Peer Review on p. 48.)
- Attempt to introduce physician's peer review record to establish that hospital met its duty.

Defending Against a Corporate Negligence Claim (cont.)

- 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.)

- 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, and policies and procedures.
 - Remember: Bylaws, policies and procedures, and guidelines are all discoverable. They also create the hospital's 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.)

- Confer with your peers. Standard of care can be viewed as national, i.e., Joint Commission, internal, or areawide 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.)

- 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 your state 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?
- 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.)

- 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.

The Era of Pay for Performance

- Payors and accrediting agencies are placing much greater importance on measuring quality outcomes and utilization
 - Affects bottom line
 - Impacts reimbursement
 - Failure to address substandard patterns of care can increase hospital's liability exposure

The Era of Pay for Performance (cont.)

- Average length of stay of patients at many hospitals exceeds the Medicare mean rather substantially
- Significant dollars are lost due to length of stay and inefficient case management

The Era of Pay for Performance (cont.)

- Payors, including Medicare and Blue Cross/Blue Shield, are adopting Pay for Performance standards as a way to incentivize providers to meet identified goals and measures so as to increase reimbursement
- Costs and outcomes are becoming subject to public reporting and being used by private parties:
 - CMS
 - Leapfrog
 - The Joint Commission
 - Unions

The Era of Pay for Performance (cont.)

- Provider Performance—Creating Standardization among Payors
 - Health plans are providing standardized measurements with potential for bonuses in the following areas:
 - Asthma
 - Breast cancer screening
 - Diabetes
 - Childhood obesity
 - IT investment/use
 - Adverse drug reaction

The Era of Pay for Performance (cont.)

- Hospital and medical staff leaders must prepare to address the significant increase in utilization, cost, and quality data which will be generated through external and internal sources
 - Need to find a way that enhances efficiencies and deals with “outliers” in a constructive manner so as to increase quality

The Era of Pay for Performance (cont.)

- CMS and certain accrediting bodies are also concerned about whether medical staff physicians are truly qualified and competent to exercise all of the clinical privileges granted to them
 - CMS quite critical of how many hospitals grant “core privileges” without determining current competency
 - CMS wants to see criteria developed for each clinical privilege and an evaluation as to whether the physician is qualified to perform each

The Era of Pay for Performance (cont.)

- How can hospital and medical staff determine a physician's competency when they do nothing or very little at the hospital
 - Physicians tend to accumulate privileges
 - Reappointment tends to be a rubber stamp process

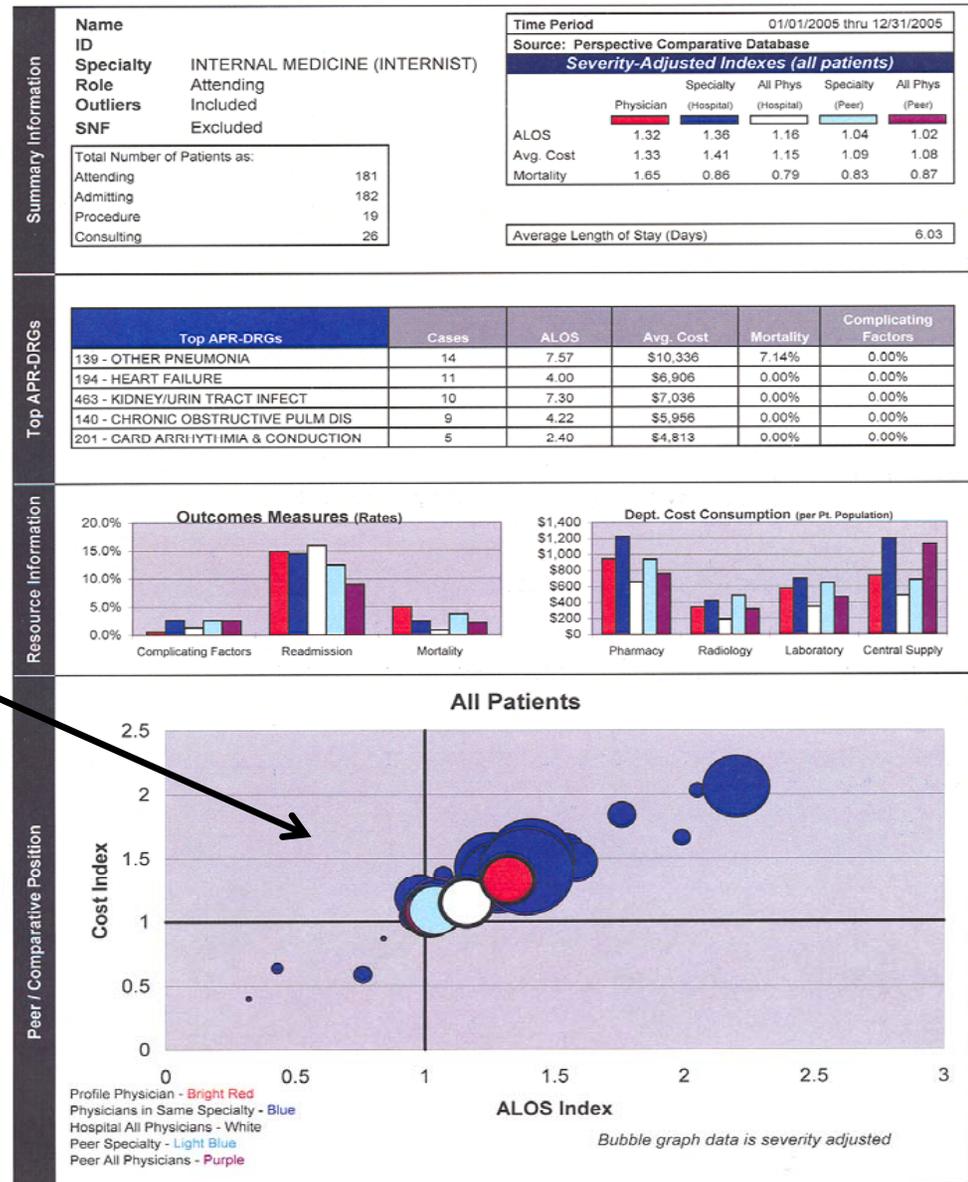
Variance Between Medicare Geo. Mean and Actual ALOS by Top 20 DRGs at Example Hospital

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



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Steps to Maximize Confidentiality Protection Under Peer Review Statute

- 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 staff's 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. (See materials pack for more information.)

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
- Need to identify the following:
 - 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.)

- 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
- Physician-patient confidentiality
- Medical records

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

- 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.)

- 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.”)

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

- 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.)

- 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

Other Forms of Remedial Action

- Mandatory consultations which do not require prior approval
- Proctoring
- Monitoring
- Retraining/reeducation
- Voluntary relinquishment of clinical privileges at the time of reappointment
- Administrative suspensions, i.e., medical records
- Retrospective or concurrent audits

Other Forms of Remedial Action (cont.)

- Reduction in staff category
- Removal from ER call duty
- Probations
- Reprimand
- Conditional reappointments
- Physician's Assistance Committee



Questions?

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