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Health Care Update

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Katten Muchin Rosenman LLP is pleased to present this newsletter from the Health Care Practice, to keep our clients informed on developments in health care law and the implications for your business.

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Focus on: Credentialing

Poliner Decision Reversed: Strategies for Effective Peer Review Processes Amid Legal Uncertainty

The Poliner appellate court decision reversed a $366 million verdict against a hospital and physicians who imposed a summary suspension against a cardiologist for quality of care issues. To view materials from a webinar on Poliner presented by Katten partner Michael Callahan, click here. Topics include recommendations on how to maximize immunity protections under federal law as well as best practices for implementing an effective peer review program.

Kadlec Reversed: How to Collect and Share Credentialing Data While Avoiding Legal Risk

On May 8, 2008, the Kadlec decision was reversed. The Fifth Circuit Court of Appeals reversed the district court's opinion, which included a holding that Lakeview Medical Center ("Lakeview") and Lakeview Anesthesia Associates ("LAA") had a duty to disclose to Kadlec Medical Center that Dr. Berry, a former partner with LAA, had a drug problem when it made inquiry after Berry applied to Kadlec for medical staff membership. To view materials from a webinar on credentialing following the reversal of the Kadlec decision presented by Katten partner Michael Callahan, click here. This presentation reviews the Kadlec decision and the implications of its reversal. It also discusses best practices for gathering and disclosing information regarding physicians for purposes of appointment and reappointment.

Kadlec Reversed: Navigating Exclusive Contracts and Employment Agreements to Ensure Physician Competency

Traditionally, independent physicians made up the majority of medical staff members at most community hospitals. But more and more hospitals are moving to new medical staff models, including employment of physicians and increased use of exclusive contracting for services, and more and more physicians are seeking such arrangements. Changes in medical staff models have presented problems and caused confusion for both physicians and hospitals. Katten partner Michael Callahan, along with William Cors, an experienced physician executive and vice president of medical staff services for health care consultancy The Greeley Company, recently presented a webinar on the topic of exclusive contracts—their benefits for both hospitals and physicians, the new medical staff models they create and where these models break down. To view the presentation, which offers suggestions for alternative contract provisions and best practices for hospitals for requesting and gathering information, click here.

Duty to Disclose in Illinois After Kadlec?

In the wake of the Fifth Circuit Court of Appeals' recent reversal of the Kadlec decision, many hospitals are left questioning whether laws in their state create a duty to disclose information when responding to third-party inquiries about current and former medical staff physicians who have documented quality of care or impairment problems. As you may recall, because the Fifth Circuit's interpretation of this issue turned on state law in Louisiana, the analysis of whether a duty to disclose exists will vary from state to state. In light of this state-specific analysis, if a situation like Kadlec occurred in Illinois, what obligations would Illinois hospitals have in terms of disclosing information to other hospitals and medical centers about former medical staff physicians?

Summary of Kadlec II

In the Kadlec I decision, the District Court for the Eastern District of Louisiana held that Lakeview Medical Center ("Lakeview") and Lakeview Anesthesia Associates ("LAA") both had a duty to disclose to Kadlec Medical Center that Dr. Berry, a former partner with LAA, had a drug problem when Kadlec inquired after Berry applied there for medical staff membership. In Kadlec II, the Fifth Circuit reversed part of this decision, holding that under Louisiana law, there is no affirmative duty to disclose this information absent a fiduciary or confidential relationship between the hospitals. However, the court emphasized that parties have an obligation to avoid affirmative misrepresentations in referral letters or responses of any kind to another hospital. Accordingly, the court upheld liability against LAA because it stated that Dr. Berry was "excellent" and a very good clinician even though they had fired him two months earlier because of his Demerol addiction and his potential threat to patients. Further, the Fifth Circuit held that once a hospital does disclose information about a physician which creates a "misapprehension" about qualifications, or if the disclosures are misleading, it has an obligation to clarify the information provided.

No legal duty to disclose in Illinois

Illinois law appears to track Louisiana law in the sense that there is no affirmative duty to disclose information between unaffiliated hospitals unless some special circumstances exist, such as fiduciary or confidential relationships. Some examples of situations where these relationships may exist include hospital members within a multi-hospital physician hospital organization or between sister hospitals in a health care system. However, even in the absence of fiduciary or confidential relationships, parties will still face potential liability for fraudulent and negligent misrepresentation claims in certain situations, just as LAA was held liable for intentional misrepresentation as a consequence of its misleading statements about Dr. Berry.

Similar to Louisiana law, the relevant causes of action under Illinois law are negligent misrepresentation and fraudulent misrepresentation. The major difference between the two claims is the state of mind of the person making the statement. A hospital could be liable for negligent misrepresentation if it makes a representation it believes to be true, but is, in fact, false and the hospital reasonably should have known it was false.

For example, if a hospital states that a physician with a contracted group was not impaired but it had suspicions that the physician had a drinking problem, it could be alleged that the hospital was negligent in not further investigating this concern given its contractual relationship with the group. Fraudulent misrepresentation can be established in two scenarios. First, a hospital could face liability if it makes an affirmative representation which it knows to be false, or the representation is made with reckless disregard as to whether the statement is true or false. Second, the omission of certain information can constitute a fraudulent misrepresentation if the parties have a fiduciary or confidential relationship, as discussed earlier, and a hospital makes the statement with an intent to deceive the other party.

Recommendations

- Remember—bad facts make bad law. Although there is no affirmative duty to disclose in Illinois, a hospital that withholds information regarding documented and substantiated impairment, quality of care, behavioral or other problems that are clearly relevant to a hospital's appointment decision and/or could adversely affect patient care, does so at its own risk. If there is a fiduciary or confidential relationship between the hospitals,i.e., they are sister hospitals in a health care system, there is an affirmative duty to disclose.
- Responses to third-party inquiries should be truthful, objective and based on documented events. Responses which simply provide dates during which a physician was on the medical staff and is in good standing should only be used for physicians who have not had any quality of care, professional conduct or similar issues. These response letters should not be used if any remedial action has been imposed within the previous two years.
- Responses that are misleading or create misapprehensions may give rise to liability claims either from the inquiring hospital or the physician.

- If a response may be likely to result in an adverse decision regarding a physician's membership or privileges, consider requiring the physician to sign an absolute waiver of liability form before providing the information.
- Disclosure of adverse information should be reviewed and carefully coordinated through appropriate management personnel and, when necessary, legal counsel.

Please Note: The laws from state to state will vary. Although the issue of whether there is a duty to disclose in your state is probably very similar to the laws and court decisions in Louisiana and Illinois, you should consult with your legal counsel to determine what standards apply to your facility. ■

10 Steps to Protect Sensitive Practitioner Data

Changes to health care landscape create potential pitfalls for hospitals and medical staff offices

Published in *Credentialing & Peer Review Legal Insider*
By Michael R. Callahan

In the never-ending quest to improve health care quality and safety and decrease costs, public and private payers and accreditation bodies have raised the bar for health care organizations and practitioners by expecting them to comply with specific practice standards and patient outcomes in order to receive enhanced reimbursement and continued accreditation.

Pay-for-performance (P4P) programs and The Joint Commission's standards for focused and ongoing performance monitoring of practitioners are examples of initiatives generating large amounts of sensitive data that, in the wrong hands or if subject to discovery in a malpractice or similar action, could provide a plaintiff's attorney with significant documentation and evidence to prove a negligent credentialing claim.

More data generation, more risk

P4P programs established by Medicare and commercial insurance companies develop standardized measurements for practitioners' performance regarding specific patient conditions such as asthma, diabetes, coronary heart disease, and myriad others. Providers who show evidence of compliance with established protocols and patient outcomes are eligible to receive additional reimbursement.

The Joint Commission (formerly JCAHO) now requires that accredited hospitals develop ongoing professional practice evaluation (OPPE) and focused professional practice evaluation (FPPE) programs that rely on the use of evidence-based measurements for all medical staff members. The goal of OPPE is to continuously monitor whether practitioners already on the medical staff are currently qualified to exercise the clinical privileges granted to them, whereas FPPE aims to use criteria-based measures when assessing a practitioner's competence before initially granting a privilege or when a red flag has been raised regarding competence.

Joint Commission-suggested criteria include but are not limited to:

- Patterns of blood and pharmaceutical use
- Length of stay (LOS) patterns
- Morbidity and mortality data
- Use of consultants
- Requests for tests and procedures
- Clinical outcomes

The Joint Commission requires hospitals to adopt and apply one or more criteria and then monitor and measure the results. The accreditor's expectation is that hospitals will implement remedial measures as soon as they identify any substandard patterns rather than wait to review and remedy practitioner outcomes every two years at reappointment.

Enhanced efforts to track practitioner data

P4P programs and OPPE/FPPE standards are only select examples of enhanced efforts, spurred in part by public demand for more transparent results, to identify outcomes and results so that payers and consumers can make better-informed decisions about providers. To monitor compliance efforts and to educate practitioners about how their practices measure up to identified standards, hospitals have designed computerized and other tracking methods that generate individualized and aggregate physician profiling data. For example, some programs look at major diagnoses (e.g., heart failure, cardiac arrhythmia, angina, and percutaneous cardiovascular without acute myocardial infarction) and then

evaluate a practitioner's performance by examining factors such as average LOS, average cost, mortality, complicating factors, outcomes, readmission, number of consultants utilized, and drugs used.

Individual results are compared with those of peers to determine whether the practitioner is performing on par with the peer group or is an outlier in one or more categories. The goal of this profiling exercise, especially as applied to outlier results, is to improve outcomes and modify practices where warranted.

Balancing sensitive data protection with duty to protect patients

Lost in the above-described efforts to improve health care quality and safety and decrease costs is the fact that hospitals and practitioners are generating increasing amounts of sensitive information about practitioners that a plaintiff could use against the hospital and/or its medical staff practitioners in a negligent credentialing claim.

How? It is a fairly established law that hospitals have a duty to patients to ensure that practitioners are currently competent to exercise the clinical privileges the hospital grants to them. If a hospital grants privileges to an unqualified practitioner—or if the hospital knew (or should have known) that the practitioner was not qualified based on internal or external studies, reports, or peer review analyses but took no action to limit or remove the privileges in question—the hospital may be found independently negligent if the practitioner is found negligent.

In order for a plaintiff to establish a breach of this duty, he or she will request that the hospital provide copies of any and all information obtainable, including but not limited to:

- Bylaws
- OPPE and FPPE procedures
- Physician profiling results
- Use of P4P standards and outcomes
- Peer review studies

For example, if the plaintiff can use this information to establish that the hospital negligently granted privileges to an outlier physician who consistently had high mortality results over the years as evidenced in his or her physician profiling reports, the hospital could be at risk.

What materials are discoverable? Which are not protected by courts?

It is common knowledge that bylaws and policies and procedures documents are discoverable. On the other hand, most states have adopted statutes that protect certain privileged and confidential reports, studies, minutes, and other documentation that fall under the statutory definition of peer review materials. Each state has a different statute and therefore a different standard, in addition to interpretive case law, that sets forth what is and is not discoverable. The problem is that most hospitals must rush to generate profiling and other data to fulfill P4P and accreditation requirements and have not taken into account whether their peer review statutes protect these reports or certain aspects of them.

Moreover, hospitals often create these profiles through the use of software created by third-party vendors that do not distinguish between data that might be privileged and those that are not. Although courts generally recognize the need to protect pure peer review information because of the accepted public policy need to encourage open and frank internal discussions about physician quality and performance, they tend to interpret the statutes strictly. For example, business, financial, risk management, and similar reports prepared for non-peer review purposes are not usually protected if simply run through a peer review committee. On the other hand, reports that are specifically designed for or requested by a designated committee for a statutory peer review purpose stand a much greater chance of being treated as a protected and nondiscoverable document in the courts.

10 steps to legally protect sensitive information

So, what is a physician profiling report? It usually contains cumulative and individual results as well as sensitive and generic information. Would a plaintiff love to get his or her hands on this information? Absolutely. Will it be protected? That depends on what steps a hospital has taken to maximize protection under its peer review statutes. The following are some important and practical steps a hospital and medical staff should consider to protect against the discovery of sensitive information that could be used against both parties in a malpractice suit or other action (hospitals can and should use these steps in all instances in which they gather practitioner data—not just in regard to P4P or OPPE/FPPE):

1. List all relevant reports, studies, forms, analyses, profiling data, etc., that a hospital uses in carrying out its P4P, quality assurance, peer review, risk management, credentialing, and similar functions.
2. Identify those reports and information or portions thereof that, if accessible to a patient or plaintiff's attorney, could be used to support a malpractice or corporate negligent claim.
3. Identify all applicable state and federal confidentiality statutes, such as peer review, physician-patient, medical

record, HIPAA, attorney-client, business record, and others that arguably apply to this data set.

4. Determine the scope of protections afforded under the statutes and applicable case law, and/or the steps needed to at least assert a confidentiality argument, to the list referenced in step 1 in order to make an objective assessment about what data are likely to be protected and what may or will be discoverable.
5. Identify documents, or portions of documents, that remain after completing steps 1-4, and determine the level of sensitivity of the remaining information.
6. If sensitive information remains, consider whether it can be moved to, consolidated with, or reauthorized by a peer review committee (or determine what other steps can be taken) to maximize protection under the applicable statutes.
7. Determine whether the remaining sensitive information can be deidentified or aggregated without minimizing its effectiveness.
8. Adopt bylaws, policies, and procedures that use statutory buzzwords (e.g., "This report is privileged and confidential under the ________ Act because it has been authorized for development and use by the _________ Committee for the purpose of reducing morbidity and mortality and to improve patient care"). This action may be self-serving, but courts have held that not making this internal designation suggests that the hospital did not consider the document confidential.
9. Consult with legal counsel in developing a plan—or at minimum meet with counsel regarding the final review of the plan.
10. Update the plan as forms and the law change.

By following these steps, a hospital and medical staff can better appreciate the manner in which it develops internally P4P and quality assurance information (e.g., information gathered through OPPE/FPPE) and whether there are additional ways to retain the confidentiality of the data to the extent possible. Following the preceding 10 steps likely will result in changes to the way your hospital generates and memorializes sensitive data, as well as modify the way it shares this information. Remember that not all information is protected under the statutes. However, too many hospitals are unnecessarily making a plaintiff's job easier by failing to understand where the confidentiality lines are being drawn. ■

Negligent Credentialing Developments: Impact of Recent Cases and New Joint Commission Medical Staff Standards

Plaintiffs are looking for as many deep pockets as possible in a malpractice action, and hospitals have the deepest. Tort reform efforts to place limitations or "caps" on compensatory and punitive damages have increased efforts to add hospitals as a defendant. Recent developments in credentialing include a new emphasis on pay for performance ("P4P") and expected or required quality outcomes as determined by public and private payors; greater transparency to the general public via hospital rankings, published costs and outcomes, accreditation status and state profiling of physicians; and a 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) as well as ongoing and focused professional practice evaluation ("OPPE" and "FPPE") as a basis of determining who is currently competent to exercise requested clinical privileges. These developments have resulted in an unprecedented focus on how hospitals credential and privilege physicians as well as the volume of information requested and generated as part of this ongoing analysis. Partner Michael Callahan's presentation on negligent credentialing developments explores the following topics:

- 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
- Overview and impact of the Joint Commission Medical Staff Standards on negligent credentialing arguments
- 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 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 P4P information

Click here to view the presentation materials. If you would like to receive a free DVD of this webinar presentation, please email Michael Callahan at michael.callahan@kattenlaw.com.■

Industry Events

September 10

IAHA 26th Annual Health Law Symposium
Presented by the Illinois Association of Healthcare Attorneys
Chicago, Illinois

W. Kenneth Davis, Jr. spoke on "The 'Stark' Truth: The Impact of Recent and Proposed Changes on Physician Practice and Ventures"

For the presentation materials, click here.

September 12

24th Annual Risk Managers Meeting
Presented by Illinois Risk Management Services
Springfield, Illinois

Michael Callahan spoke on "Negligent Credentialing Issues"

September 11

IHA's Leadership Summit
Presented by the Illinois Hospital Association
Galena, Illinois

Michael Callahan, W. Kenneth Davis, Jr. and Brian Annulis spoke on "Hot Legal Topics for Hospital Leaders"

For the presentation materials, click here.

September 16

RBMA Fall Educational Conference
Presented by the Radiology Business Management Association
San Antonio, Texas

W. Kenneth Davis, Jr. spoke on "Leasing and Infrastructure Deals Under Attack – What to Avoid?"

For the presentation materials, click here.

September 26

MAMSS 2008 Fall Education Conference
Presented by Maryland Association Medical Staff Services
Baltimore, Maryland

Michael Callahan spoke on "Negligent Credentialing Developments," "Protection of Documents" and "Updates: Kadlec & Poliner"

October 11-15

NAMSS 32nd Annual Conference
Presented by National Association Medical Staff Services
Milwaukee, Wisconsin

Michael Callahan spoke on "Negligent Credentialing Cases on the Rise: Are Hospitals at Greater Risk?"

October 15-17

Managing Legal Exposure in Radiology
Presented by the Radiology Business Management Association
Philadelphia, Pennsylvania

W. Kenneth Davis, Jr. spoke on "The Laws Keep Changing: Ask the Speaker How to Market in a Compliant Fashion" and on "Tax-Exempt Laws and Radiology Groups: Myth versus Reality"

October 20-22

Diagnostic Imaging Institute:
Taking Care of Business
Presented by the Washington G-2 Report
Arlington, Virginia

W. Kenneth Davis, Jr., will speak on "Critical Developments on the Regulatory and Legal Fronts" and "How to Build Your Business Through a Competitive Sales & Marketing Program"

For more information, click here.

Accolades

Katten's Health Care Practice received a top ranking in the 2008 edition of *Chambers USA: America's Leading Lawyers for Business*. Practice members Michael Callahan (Chicago) and Peter Nadel (New York) received the highest rankings in their individual states. Other leading attorneys were W. Kenneth Davis, Jr., Laura Keidan Martin and Steven Olson.

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