


HCPro, Inc., presents

Performance Monitoring, Poliner, and P4P: Address quality and utilization while avoiding peer review litigation

A 90-minute interactive audioconference

Wednesday, September 19, 2007

1:00 p.m.–2:30 p.m. (Eastern)
12:00 p.m.–1:30 p.m. (Central)
11:00 a.m.–12:30 p.m. (Mountain)
10:00 a.m.–11:30 a.m. (Pacific)

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The **"Performance Monitoring, Poliner, and P4P: Address quality and utilization while avoiding peer review litigation"** audioconference materials package is published by HCPro, Inc., 200 Hoods Lane, P.O. Box 1168, Marblehead, MA 01945.

In our materials, we strive to provide our audience with useful and timely information. The live audioconference will follow the enclosed agenda. Occasionally, our speakers will refer to the enclosed materials. We have noticed that non-HCPro audioconference materials often follow the speakers' presentations bullet-by-bullet and page-by-page. However, because our presentations are less rigid and rely more on speaker interaction, we do not include each speaker's entire presentation. The enclosed materials contain helpful resources, forms, crosswalks, policies, charts, and graphs. We hope that you will find this information useful in the future.

For more information, please contact:

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Dear Program Participant,

Thank you for participating in our "**Performance Monitoring, Poliner, and P4P: Address quality and utilization while avoiding peer review litigation"** audioconference, featuring speakers **Carol S. Cairns, CPMSM, CPCS,** and **Michael R. Callahan, JD,** and moderated by **Todd Morrison.**

Our team is excited about the opportunity to interact with you directly. We encourage you to ask our experts your questions during the program. If you would like to submit a question before the audioconference, please send it to the producer, Abigail Gresla, at *agresla@hcpro.com* and provide the program date in the subject line. We cannot guarantee that your question will be answered during the program, but we will do our best to include a good cross section of questions.

Following the program, we would like your feedback in order to help us ensure a positive experience for our customers and deliver the best possible products and services. Because your time is valuable, we have limited the evaluation to a few brief questions found at the link below. Please forward the link to others at your facility who attended the program, so they can provide their input as well:

http://www.zoomerang.com/survey.zgi?p=WEB226TXCGQ46S

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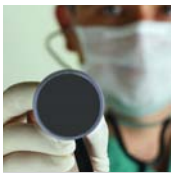
At HCPro, we appreciate hearing from our customers. So if you have comments, suggestions, or ideas about how we can improve our programs, or if you have any questions about today's show, please do not hesitate to contact me. And if you would like any additional information about our other products and services, please contact our customer service department at 800/650-6787.

Thank you, again, for attending the HCPro program today. We hope you found it to be informative and helpful and that you will continue to rely on HCPro programs as an important resource for pertinent and timely information.

Sincerely,

L. Marchwinski

Leokadia Marchwinski
Director of Multimedia Production
HCPro, Inc.



CONTENTS

AGENDA

I. Industry developments

A. Expected quality outcome standards driving public and private payers in using pay for performance criteria in reimbursement decisions
B. Joint Commission Medical Staff standards/ongoing performance monitoring
C. Practice of profiling physicians regarding various factors (length of stay, cost per patient visit, outcomes, number of tests ordered, etc.)

II. The Golden Rules of Peer Review

III. Power of the Pyramid

IV. Identification of remedial measures to improve quality and utilization without triggering hearings and Data Bank reports

V. Management of practitioners at the top of the pyramid

VI. How to deal with over-utilizers: Can a hospital impose disciplinary action when other remedial efforts have failed?

VII. Poliner v. Texas Health Systems case

A. Cardiologist obtained a $366 million verdict (later reduced) as a result of a wrongful summary suspension
B. When, if ever, should summary suspensions be used?
C. What conditions would trigger a summary suspension?

IIX. Taking steps to ensure the data your organization are collecting are treated as confidential

IX. Live Q&A

SPEAKER PROFILES

Carol S. Cairns, CPMSM, CPCS

Carol S. Cairns is a senior consultant at The Greeley Company. She brings more than 30 years of experience in healthcare management to her work with hospitals and medical staffs nationwide.

Cairns applies her management and clinical experiences to help healthcare providers develop solutions to their unique needs and objectives. She has particular expertise in credentialing and privileging.

Ms. Cairns has authored several HCPro books on credentialing and privileging including *Solving the AHP Conundrum: How to comply with HR Standards Related to Non-Privileged Practitioners*; *Verify and Comply: A Quick Reference Guide to the JCAHO and NCQA Standards for Credentialing, Fourth Edition*; and *A Guide to AHP Credentialing; Core Privileges: A Practical Approach to Development and Implementation- Third Edition*. As a clinical faculty member for JCAHO, she wrote *The Medical Staff Handbook: A Guide to Joint Commission Standards*; and The *LIP's Guide to Credentials Review and Privileging*. Ms. Cairns coauthored, as a faculty member for the National Association Medical Staff Services, the agency's educational program on credentialing.

Prior to joining The Greeley Company, Cairns held positions as a clinical faculty member for the Joint Commission on Accreditation of Healthcare Organizations, faculty member for NAMSS, faculty member at NCQA, surveyor in the certification program at CVO, medical staff director and coordinator of services for Provena Saint Joseph Medical Center and Silver Cross Hospital. She also served as president of PRO-CON.

Michael R. Callahan, JD

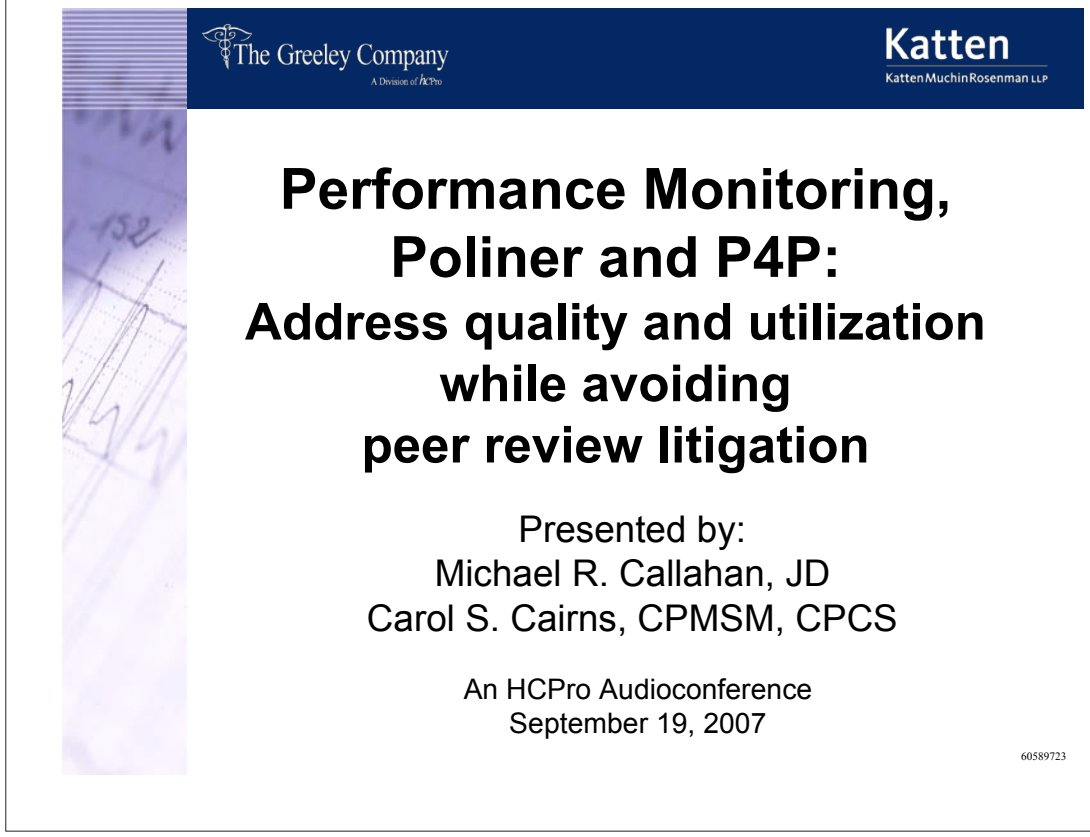
Michael R. Callahan concentrates his practice in healthcare, assisting clients on a variety of healthcare legal issues including healthcare antitrust, healthcare and HIPAA regulatory compliance, medical staff credentialing, hospital–medical staff relations, and mergers and acquisitions. He leads the firm's HIPAA compliance group.

Callahan is recognized for his experience in and knowledge of the healthcare industry. He is a frequent speaker on topics including integrated delivery systems, hospital-physician joint ventures, physician recruitment and retention, medical staff matters, Medicare fraud and abuse, and HIPAA. He has presented around the country before organizations such as the American Health Lawyers Association, the American Academy of Hospital Attorneys, the American Medical Association, the American Hospital Association, the American Bar Association, the American College of Healthcare Executives, and the National Association of Medical Staff Services. Callahan has been recognized by his peers for his legal acumen as an Illinois Leading Lawyer in Antitrust, as an Illinois Super Lawyer for Health Care, in *Best Lawyers in America* (since 1991), in *Corporate Counsel,* in *Marquis Who's Who in American Law,* and in the 2005 and 2006 editions of *Chambers USA: America's Leading Lawyers for Business.* He is also the recipient of the 1995 Illinois Association Medical Staff Services Leadership Award.

Callahan has served in positions as chair of the Health and Hospital Committee of the Chicago Bar Association, the Board of the Illinois Association of Health Care Attorneys, and as coeditor of the *Antitrust Health Care Chronicle,* an antitrust healthcare publication for the Section of Antitrust Law of the American Bar Association. Callahan has been a past member of the Steering Committee of the Hospital and Physicians Relations Committee of the American Academy of Hospital Attorneys (AAHA) and chair of its Joint Venture Task Force, as well as two separate task forces of the AAHA and the Section of Antitrust Law of the American Bar Association examining the Health Care Quality Improvement Act. He served on the DePaul College of Law Alumni Board and is also an adjunct professor in DePaul's Masters in Health Law Program, where he teaches a course on managed care.


EXHIBIT A

Presentation by **Carol S. Cairns, CPMSM, CPCS,** and **Michael R. Callahan, JD**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Performance Monitoring, Poliner and P4P:
Address quality and utilization while avoiding peer review litigation
Presented by:
Michael R. Callahan, JD
Carol S. Cairns, CPMSM, CPCS
An HCPro Audioconference
September 19, 2007
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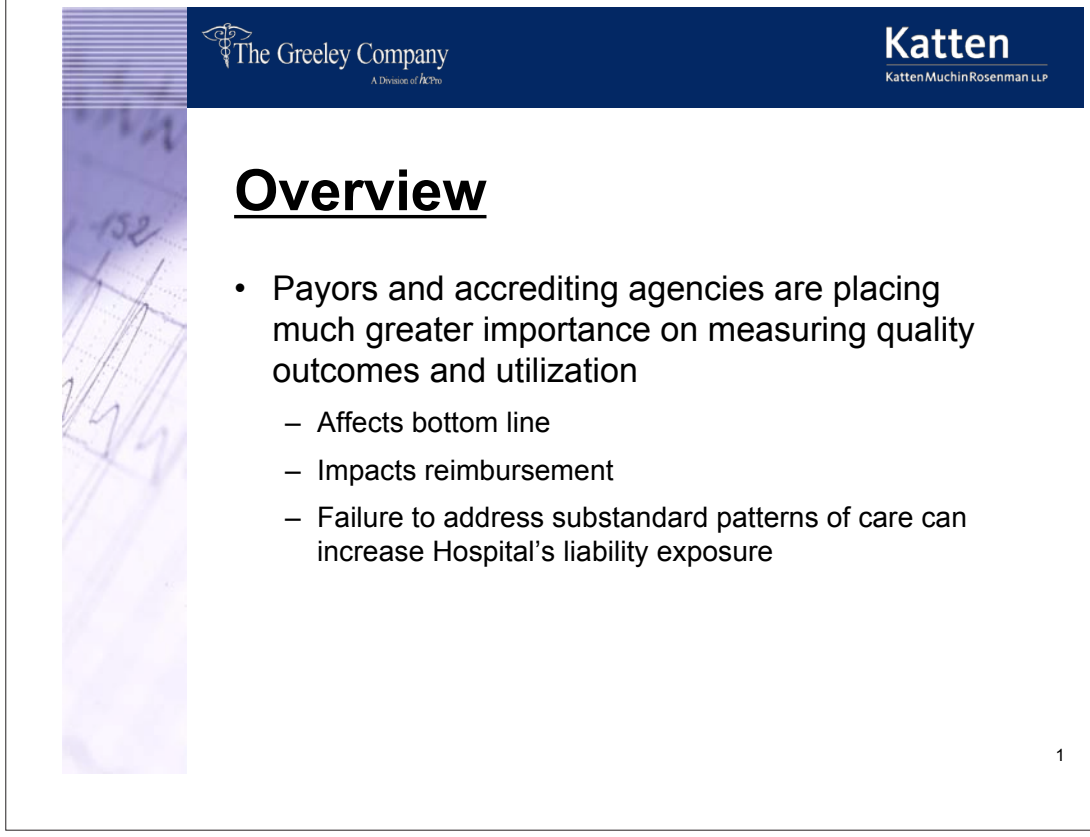
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Overview
• Payors and accrediting agencies are placing much greater importance on measuring quality outcomes and utilization
– Affects bottom line
– Impacts reimbursement
– Failure to address substandard patterns of care can increase Hospital's liability exposure
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Overview (cont'd)

- 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

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Overview (cont'd)

- 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 use by private parties
  - CMS
  - Leapfrog
  - The Joint Commission
  - Unions

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Overview (cont'd)

- Provider Performance – creating standardization among payors
  - Health plans are providing standardized measurements with potential for bonuses in following areas:
    - Asthma
    - Breast Cancer Screening
    - Diabetes
    - Childhood Obesity
    - IT investment/use
    - Adverse Drug Reaction

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Overview (cont'd)

- 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

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Overview (cont'd)

- 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 critical of how many hospitals grant privileges without determining current competency
  - CMS wants to see criteria developed for clinical privileges and an evaluation as to whether the physician is qualified to perform requested privileges

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Overview (cont'd)

- 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

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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 WCC	129	6.6	4.7	1.9
182	ESOPHAGITIS, GASTROENT & MISC DIGEST DISORDERS AGE>17 WCC	117	4.7	3.4	1.3
143	CHEST PAIN	106	2.8	1.7	1.1
521	ALCOHOL/DRUG ABUSE OR DEPENDENCE WCC	104	3.9	4.2	-0.3
296	NUTRITIONAL & MISC METABOLIC DISORDERS AGE>17 WCC	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 WCC	76	6.5	3.8	2.7
132	ARTHEROSCLEROSIS WCC	73	3.9	2.2	1.7
320	KIDNEY & URINARY TRACT INFECTIONS AGE >17 WCC	73	6.0	4.2	1.8
138	CARDIAC ARRHYTHMIA & CONDUCTION DISORDERS WCC	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 WCC	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 WCC	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

Source: Michael R. Callahan, JD

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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

Source: Michael R. Callahan, JD

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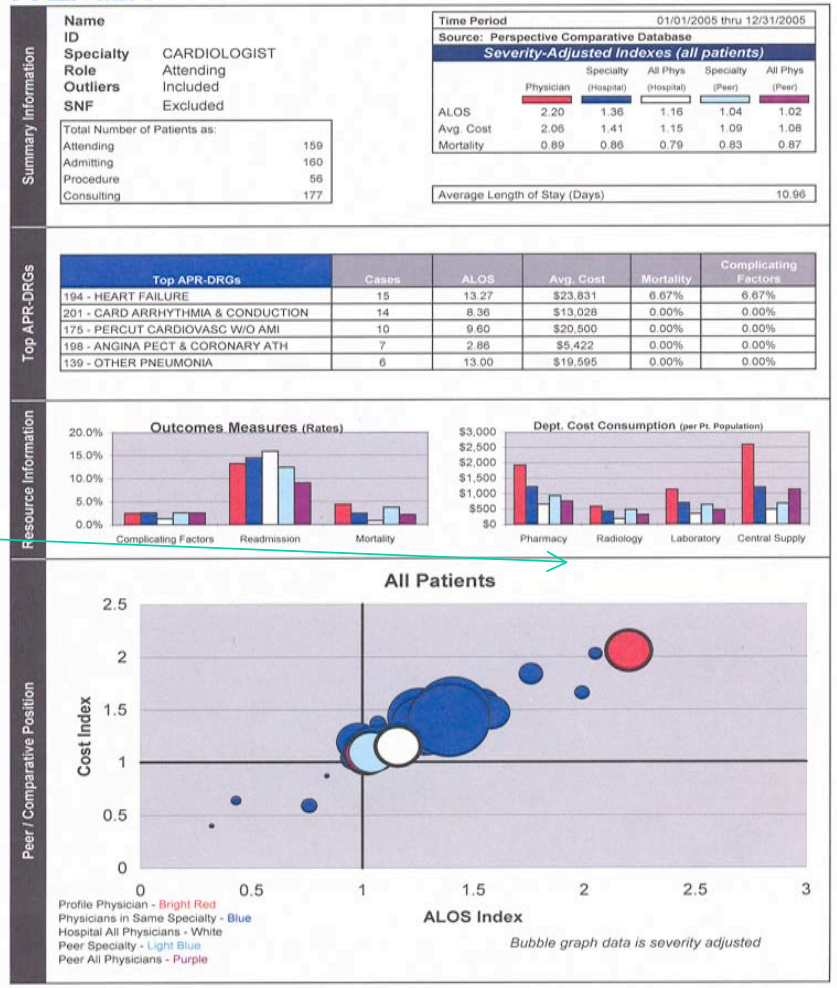
Example by Major Dx

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

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



Source: Michael R. Callahan, JD

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Sample Physician Profile Report

Physician Profile Report

Provider: John Smith, MD **Dept:** Medicine **Period:** Jan. 2005-Dec. 2005

Activity Data	
Admissions	200
Consults	12
Procedures	80
Total encounters	250
Transfusions (episodes)	100

Performance Data	Indicator Type	Phys Volume	Phys Data	Excellence Performance Target	Acceptable Performance Target	Target Source	Current Rating	Previous Rating
Clinical Quality:								
Risk Adj. Mortality Index: All DRGs	Rate	200	0.95	0.85	1.25	IS		
Risk Adj. Complication Index	Rate	200	1	0.85	1.25	IS		
Peer Review Results: Cases rated 3	Review	10	2	0	2	PRC		
Blood Use Not Meeting Criteria	Rule	N/A	0	1	4	PRC		
Pharm. Recommendations Accepted	Rate	20	90%	90	75%	P&T		
Risk Adj. Mortality Index: DRG 89	Rate	20	1.3	0.85	1.25	IS		
Risk Adj. Complication Index: DRG89	Rate	20	1.1	0.85	1.25	IS		
CHF Patients on ACEI at D/C	Rate	25	85%	95%	85%	P&T		
AMI Patients on ACEI at D/C	Rate	15	90%	95%	85%	P&T		
Service Quality								
ED page response w/in 30 minutes	Rule	N/A	0	1	4	PRC		
Incidents of delayed consultation	Rule	N/A	1	0	2	PRC		
Patient satisfaction with physician	Rate	50	65%	75%	50%	PRC		
Validated patient complaints on MD communication/responsiveness	Rule	N/A	0	0	3	PRC		
Patient Safety								
Compliance with Med abbreviations	Rate	20	80%	95%	85%	P&T		
Incidents of illegible medication orders	Rule	N/A	1	2	4	P&T		
Incidents of non-participation in pre-procedure timeouts	Rule	N/A	0	0	1	OR		
H&P report not dictated w/in 24 hrs	Rule	N/A	0	0	2	MEC		
H&P/OP report elements	Rate	20	100%	95%	85%	MEC		
Resource Utilization: General								
Severity Adj. LOS Index: All DRGS	Rate	200	0.9	0.85	1.25	UM		
Severity Adj.Cost Index:All DRGS	Rate	200	1.1	0.85	1.25	UM		
Delayed Starts in OR/Procedure Area	Rule	N/A	1	1	4	OR		
Sev. Adj. LOS Index:DRG 89	Rate	20	0.85	1.0	1.25	UM		
Sev. Adj.Pharm Cost Index:DRG 89	Rate	20	0.85	1.0	1.25	UM		
Peer and Coworker Relationships								
Validated physician behavior incidents	Rule	N/A	2	0	3	MEC		
Citizenship								
Medical Records Suspensions	Rule	280	0	0	3	MEC		
Meeting Attendance	Rate	8	75%	>70%	>50	MEC		

Excellent Performance
Acceptable Performance
Needs follow up

Source: The Greeley Company

Please see Exhibit C for full size version

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Joint Commission Standards

- Standard 3.10
  - Performance improvement. Medical staff is **actively** involved in measurement, assessment and improvement of the various TJC PI standards

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Joint Commission Standards

(Cont'd)

- Standards MS.4.10 through MS.4.45
  - MS. 4.10 through 4.45 have been significantly rewritten
  - The purpose of these Standards is to establish additional evidence-based processes to determine a practitioner's competency.
  - With regard to privileging, the new Standard imposes a higher burden in determining whether the applicant or current med staff physician has the degree of training education and experience required to perform each of the requested privileges and procedures.

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Joint Commission Standards

(Cont'd)

- Emphasis is on three new concepts
  - General Competencies
    - Patient care
    - Medical/clinical knowledge
    - Practice-based learning and improvement
    - Interpersonal and communications skills
    - Professionalism
    - Systems-based practice
  - Focused Professional Practice Evaluation
  - Ongoing Professional Practice Evaluation

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Joint Commission Standards

(Cont'd)

- MS.4.30 – Focused Professional Practice Evaluation
  - Standard expects the medical staff to identify and implement a method of evaluating practitioners without current performance documentation at the hospital, whether the physician is new or is an existing physician seeking new privileges, including processes where quality of care concerns arise, criteria for extending the evaluation period, and for communicating and acting on the results of the evaluation.

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Joint Commission Standards

(Cont'd)

- Would require "performance monitoring" particularly for those new physicians who have yet to establish a track record with the hospital or when questions about competency or ability are raised.
- Methods of focused professional practice evaluation can include, but are not limited to chart review, monitoring, clinical practice patterns, simulation, proctoring, external peer review, and discussion with other individuals involved in patient's care. (Rationale for MS.4.30)
- All accumulated information from focus evaluation process must be integrated into performance improvement activities. (Id.)
- Effective January 1, 2008, a period of focused professional evaluation is implemented for all initially requested privileges.

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Joint Commission Standards

(Cont'd)

- MS.4.40 – Ongoing Professional Practice Evaluation
  - Under the ongoing professional practice evaluation, here is a heightened emphasis on evaluating a physician's practice so as to identify trends that impact on quality of care and patient safety. Such criteria can include but are not limited to, the following:
    - Review of operative and other clinical procedures performed and their outcomes;
    - Pattern of blood and pharmaceutical usage;
    - Request for test and procedures;
    - Length of stay patterns;
    - Morbidity and mortality data;

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Joint Commission Standards

(Cont'd)

- Practitioners usage of consultants;
- Other relevant criteria.

– Ongoing evaluation must be factored into any decisions to maintain, revise or revoke privileges.

– Problems identified during ongoing review should trigger a focused review.

– "Ongoing" does not mean once a year.

– Medical Staff Bylaws must evidence how the staff will evaluate and act upon a report of concerns relating to a practitioner's clinical practice and/or competence and further, that the concerns are uniformly investigated and addressed.

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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 that do not trigger hearings and use them — medical staff leaders need to be willing to implement
- Comply with bylaws, rules and regulations and quality improvement policies

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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

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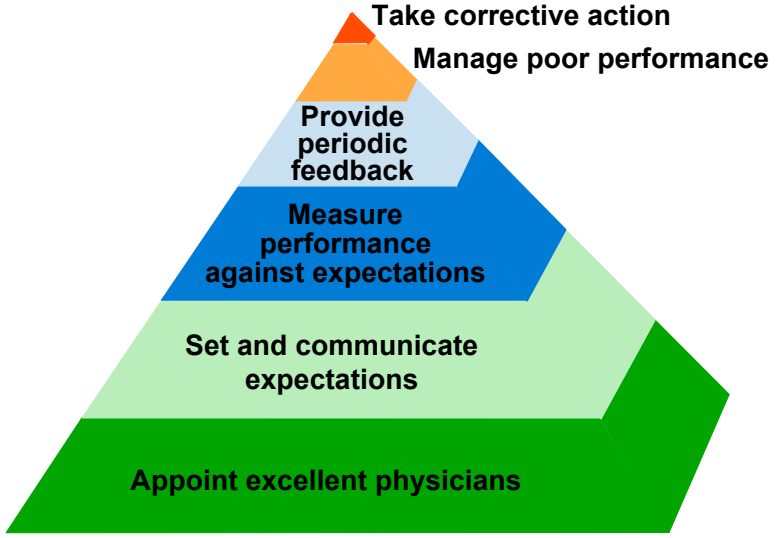
The Performance Pyramid



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Other Forms of Remedial Action

- Retraining/Re-education as revealed by performance monitoring and physician data surveys
- Retrospective or concurrent audits
- Monitoring
- Proctoring
- Probations
- Reprimand

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Other Forms of Remedial Action (cont'd)

- Voluntary relinquishment of clinical privileges at the time of reappointment
- Removal from ER call duty
- Mandatory consultations which do not require prior approval
- Conditional Reappointments
- Reduction in staff category
- Administrative suspensions, i.e., medical records

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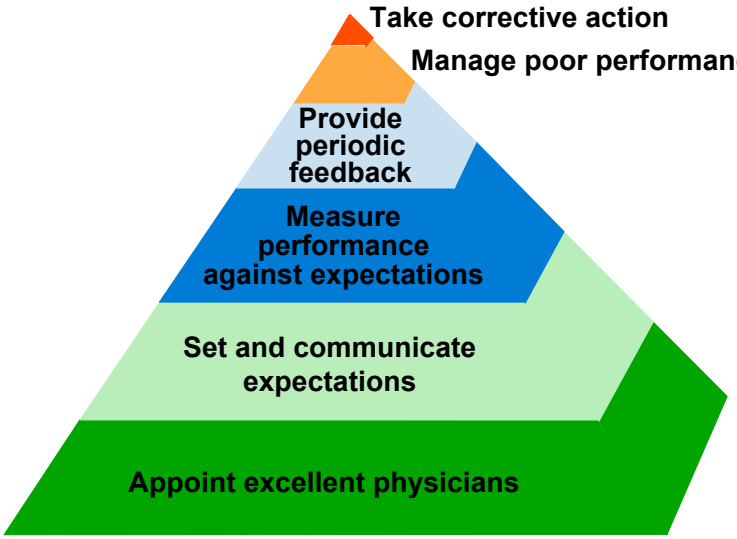
The Performance Pyramid



Source: The Greeley Company

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What Can You Do With Over-Utilizers and Poor Performers When Non-reportable Remedial Actions Fail?

- Must first ask question of whether patients are being placed at risk, or if problem is simply lost hospital revenue, or both
  - What supportive documentation on quality and costs have been generated?
  - Has information been shared with physician and has he/she been given comparative data as well as a reasonable opportunity to respond and improve?

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What Can You Do With Over-Utilizers and Poor Performers When Non-reportable Remedial Actions Fail? (cont'd)

- Has the hospital and medical staff implemented progressive, non-reportable remedial actions?
- Has such action resulted in measurable improvement?
- Have remedial efforts and decisions been uniformly applied?

- If sufficient quality issues exist such that patients are or may be placed at risk, formal corrective actions proceedings under the bylaws should be triggered if steps outlined above have been followed

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What Can You Do With Over-Utilizers and Poor Performers When Non-reportable Remedial Actions Fail? (cont'd)

- First offer physician opportunity to resign in lieu of formal corrective action
- This is a reportable event

- If only cost issues are involved but there is no measurable adverse impact on quality, taking corrective action will be more difficult
  - Physician will argue that this is "economic credentialing"
  - Hospital/medical staff will need to adopt medical staff bylaws or policy or corporate bylaw or policy to support the imposition of corrective action

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What Can You Do With Over-Utilizers and Poor Performers When Non-reportable Remedial Actions Fail? (cont'd)

- Decision is not reportable
- Could propose a different form of administrative hearing versus traditional medical staff hearing process
- These decisions are likely to be opposed by the Medical Staff on principle, at least, because of how their decision might be implemented in the future.
- If hospital can propose a carefully designed procedure that incorporates reasonable standards, the Golden Rules, and progressive discipline and can demonstrate concrete adverse input resulting from over-utilization, Medical Staff might support establishment of disciplinary procedures

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Poliner – An Overview of the Case

- Key Facts
  - Dr. Lawrence Poliner is a board certified cardiologist who sought membership and clinical privileges at Presbyterian Hospital of Dallas in 1997.
  - Several questions arose regarding three incidents in the cath lab, one resulting in a patient's death, that led to a review by two Medical Staff Committees and later by the Department of Internal Medicine.
  - During the pendency of this review, a fourth case was identified in which it was alleged that an angioplasty was performed on the wrong artery leaving the blocked artery untouched. Director of Lab reviewed this error as potentially life threatening.

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Poliner – An Overview of the Case (cont'd)

- Shortly thereafter, Department Chair met with Poliner after meeting with hospital management, including the CEO and VPMA, and requested that he voluntarily agree not to exercise any cath lab procedures until an ad hoc committee could be appointed to review these cases.
  - Poliner claimed that he was not told about the fourth case, did not have an opportunity to defend himself against the accusations, was not told which cases were to be reviewed, that he could not consult with legal counsel before signing the "abeyance letter", and unless he signed within three hours of receiving the letter, he would be summarily suspended.

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Poliner – An Overview of the Case (cont'd)

- Committee reviewed 44 cases and found that substandard care had been rendered in 29 cases.
- Cases and findings referred back to the Department which sought an outside review. The review was not conducted prior to scheduled Department meeting.
- Poliner sent a letter one day before the scheduled meeting seeking a one or two day extension in order to prepare. Request was denied.

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Poliner – An Overview of the Case (cont'd)

- Poliner was given one hour to discuss the cases. Department Committees unanimously recommended suspension based on:
  - Poor clinical judgment
  - Inadequate skills, including angiocardiology and echocardiography
  - Unsatisfactory medical record documentation
  - Substandard patient care

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Poliner – An Overview of the Case (cont'd)

- Upon receipt of report, Department Chair summarily suspended Poliner's cath lab and echocardiography privileges. Admitting, consultation, non-cath lab privileges and echos were unaffected.
- Hearing was held almost three months later based on Poliner's request.
- Hearing Committee recommended unanimously that Poliner's privileges be restored, with conditions, and determined that the summary suspension, when imposed, was appropriate.

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Poliner – An Overview of the Case (cont'd)

- Poliner sought to appeal the earlier decision which imposed the summary suspension because he wanted his record cleared.
- Poliner was informed that the sole basis for any appeal is whether he had been provided procedural due process.
- Appeals Committee held that Poliner received due process and that it did not have the authority to overturn the suspension. This decision was upheld by the Board.

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Poliner – Court Decision

- Poliner filed a multi-count complaint in federal court against the hospital and several physicians based on:
  - Antitrust, both state and federal
  - Breach of contract by failure to follow due process procedures under the bylaws
  - Business disparagement, slander and libel
  - Tortious interference with business and with prospective advantage
  - Texas Deceptive Trade Practices Act
  - Intentional inflection of emotional distress and mental anguish

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Poliner – Court Decision (cont'd)

- A declaration that defendants were not entitled to immunity under HCQIA or the Texas Medical Practice Act

- Court made the following findings:
  - Hospital bylaws which required procedural due process rights in medical staff bylaws created a contract right
  - HCQIA immunity protections did not apply because the court found there were genuine issues of material fact which questioned whether abeyance (summary suspension) was taken imposed on in the reasonable belief that it was taken in the furtherance of quality care and after a reasonable effort to obtain the facts
    - Was imposed while cases were under investigation which was still pending

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Poliner – Court Decision (cont'd)

- Poliner was not given information about the cases nor an opportunity to give his side of the story. As per medical bylaws standard, not clear whether there was an imminent threat to patients

- Poliner also was threatened with suspension if he did not agree to the abeyance letter

- There was evidence that the hospital and certain physicians violated bylaws and HCQIA when forcing him to sign the abeyance letter and that some of them harbored animosity

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Poliner – Court Decision (cont'd)

- Court's denial of defendant's summary judgment on many counts allowed case to go to the jury which reached a verdict in favor of Poliner for $366 million.
  - Department Chair acknowledged that at the time he forced Poliner to sign the abeyance letter he did not yet have enough information to determine whether he posed a present danger to his patients. No such conclusion was reached.
- After mediation failed, trial court reduced award under the maximum recovery rule to $22.54 million.

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Impact of Poliner on Correction Action *Decisions*

- Key Lessons Learned
  - Abeyance letter was treated as a summary suspension. This form of corrective action rarely should be used and only where there is a documented, immediate and real tortious threat to patient care
  - Decision makers need to understand the summary suspension standard under the Medical Staff Bylaws and must make sure that standard clearly has been met before a suspension has been imposed

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Impact of Poliner on Correction Action *Decisions* (cont'd)

- As a general rule, you should always have at least two persons concur that a summary suspension is the only remedial action available to address the actual or perceived threat to patient care
- Make sure that direct competitors or anyone with an actual or perceived bias is not involved in direct decision making
  - Not always possible; may need to involve outside parties
  - Sometimes physician wants a physician in same specialty area to be involved at hearing stage – get a waiver

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Impact of Poliner on Correction Action *Decisions* (cont'd)

- You must always follow your Medical Staff and Corporate Bylaws
- Hearing and appellate review bodies should be able to look at the basis of the decision as a whole to determine if action was appropriate and should not be limited to a question of whether procedures were followed or procedural due process given

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Impact of Poliner on Correction Action *Decisions* (cont'd)

- Unless otherwise required by state or federal law, bylaws should not reference a right to "procedural or substantive due process"
  - Not required
  - Can create a higher standard
  - Courts confuse what is and is not due process
- Forcing a physician to make an immediate decision under threat of a greater sanction, with no opportunity to consult with a peer or legal counsel and without being advised of the background or right to rebut the charges is ill advised

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Impact of Poliner on Correction Action *Decisions* (cont'd)

- As a general rule, you should bend over backwards to accommodate physician on procedural issues such as extensions of time, access to records, access to counsel and related procedural issues
- Remember to incorporate HCQIA standards into bylaws
  - Was action taken in the reasonable belief that it furthered quality care
  - Was there a reasonable effort to investigate the facts before disciplinary action was imposed

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Impact of Poliner on Correction Action *Decisions* (cont'd)

- You must know the language and standards of state immunity and confidentiality standards so as to guide your procedures and decision
- Remember the state confidentiality and immunity statutes generally do not apply in federal courts to federal versus state claims, i.e., federal antitrust versus a state defamation lawsuit

– Remember the Golden Rules of Peer Review

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Impact of Poliner on Correction Action *Decisions* (cont'd)

– 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.

– Carefully review hospitals insurance coverage as applied to peer review process in order to maximize insurance protections to all peer review participants.

– If necessary, may need to consider formal indemnification of peer review participants, despite state immunity and insurance protection, if medical staff balks at peer review participation in light of Poliner decision

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Taking 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:

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

- 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

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Taking 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
- Physician-patient confidentiality
- Medical Records

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Taking 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

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Taking 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"

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

- Need to consult with your legal counsel before finalizing your plan
- Plan needs to be updated as forms and law changes

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EXHIBIT B

Definitions of Peer Review and Peer Review Committee

Source: Michael R. Callahan, JD. Reprinted with permission.

Definitions of Peer Review and Peer Review Committee

"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 credentialing and delineation of privileges for Physicians, Dentists and Podiatrists or Health Allied Professionals 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 applications and qualifications of Physicians, Dentists and Podiatrists or Health Allied Professionals, 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 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, when participating 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 Clinical Performance Improvement Committee, Infection Control Committee, Physician's Health Review Committee, the Governing Board and all other Committees when performing Peer Review functions, conduct or activities.

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EXHIBIT C

Sample Physician Profile Report

Source: The Greeley Company

Sample Physician Profile Report

Physician Profile Report

Provider: John Smith, MD **Dept:** Medicine **Period:** Jan. 2005-Dec. 2005

Activity Data	
Admissions	200
Consults	12
Procedures	80
Total encounters	250
Transfusions (episodes)	100

Performance Data	Indicator Type	Phys Volume	Phys Data	Excellence Performance Target	Acceptable Performance Target	Target Source	Current Rating	Previous Rating
Clinical Quality:								
Risk Adj. Mortality Index: All DRGs	Rate	200	0.95	0.85	1.25	IS		
Risk Adj. Complication Index	Rate	200	1	0.85	1.25	IS		
Peer Review Results: Cases rated 3	Review	10	2	0	2	PRC		
Blood Use Not Meeting Criteria	Rule	N/A	0	1	4	PRC		
Pharm. Recommendations Accepted	Rate	20	90%	90	75%	P&T		
Risk Adj. Mortality Index: DRG 89	Rate	20	1.3	0.85	1.25	IS		
Risk Adj. Complication Index: DRG89	Rate	20	1.1	0.85	1.25	IS		
CHF Patients on ACEI at D/C	Rate	25	85%	95%	85%	P&T		
AMI Patients on ACEI at D/C	Rate	15	90%	95%	85%	P&T		
Service Quality								
ED page response w/in 30 minutes	Rule	N/A	0	1	4	PRC		
Incidents of delayed consultation	Rule	N/A	1	0	2	PRC		
Patient satisfaction with physician	Rate	50	65%	75%	50%	PRC		
Validated patient complaints on MD communication/responsiveness	Rule	N/A	0	0	3	PRC		
Patient Safety								
Compliance with Med abbreviations	Rate	20	80%	95%	85%	P&T		
Incidents of illegible medication orders	Rule	N/A	1	2	4	P&T		
Incidents of non-participation in pre-procedure timeouts	Rule	N/A	0	0	1	OR		
H&P report not dictated w/in 24 hrs	Rule	N/A	0	0	2	MEC		
H&P/OP report elements	Rate	20	100%	95%	85%	MEC		
Resource Utilization: General								
Severity Adj. LOS Index: All DRGS	Rate	200	0.9	0.85	1.25	UM		
Severity Adj.Cost Index:All DRGS	Rate	200	1.1	0.85	1.25	UM		
Delayed Starts in OR/Procedure Area	Rule	N/A	1	1	4	OR		
Sev. Adj. LOS Index:DRG 89	Rate	20	0.85	1.0	1.25	UM		
Sev. Adj.Pharm Cost Index:DRG 89	Rate	20	0.85	1.0	1.25	UM		
Peer and Coworker Relationships								
Validated physician behavior incidents	Rule	N/A	2	0	3	MEC		
Citizenship								
Medical Records Suspensions	Rule	280	0	0	3	MEC		
Meeting Attendance	Rate	8	75%	>70%	>50	MEC		

Excellent Performance
Acceptable Performance
Needs follow up



EXHIBIT D

"Court case demonstrates peer review, privilege suspension balancing act," Credentialing & Peer Review Legal Insider, May 2006

Source: HCPro, Inc.

Court case demonstrates peer review, privilege suspension balancing act

Hospital leaders, even those with years of experience, face a challenge in making the right decisions regarding credentialing and patient safety issues. Ambiguous language or policies can place decisions about peer review and possible substandard care in a jury's hands. This ups the ante for the individual hospital involved and puts a chilling effect on the peer review process for all hospitals.

Presbyterian Hospital in Dallas felt the sting of that challenge after the recent ruling handed down by a Texas federal district court. The court upheld the basis for a $366 million award to a physician who claimed that the hospital's summary suspension of his privileges led to financial, professional, and emotional distress.

"You can't look at these kinds of numbers and not be shocked by them," says **Todd Sagin, MD, JD,** vice president and medical director at The Greeley Company, a division of HCPro, Inc., in Marblehead, MA. "These are very substantial penalties, not just for the hospital, but for the individual physicians."

Lawrence Poliner, MD, the physician who filed the antitrust suit, was appointed as a member of Presbyterian Hospital's medical staff in January 1997. By the end of that year, the nursing staff had reported three incidents in the cardiac catheterization unit that suggested that Poliner was not treating patients effectively. He was undergoing internal peer review for the three incidents when a fourth occurred the following May. The department of internal medicine chair then allegedly confronted Poliner and instructed him to either cease performing cardiac catheterizations while his privileges were reviewed or face a temporary suspension of certain privileges. Poliner complied with the request.

When an audit by the peer review committee found what it determined to be evidence of substandard care, the committee voted to revoke Poliner's cardiac catheterization and echocardiography privileges.

Poliner was immediately offered a fair hearing. At the fair hearing committee's request, the hospital governing board restored Poliner's privileges with conditions. However, Poliner's request to remove the summary suspension from his record was denied. He filed suit against the hospital and 10 physicians on the peer review committee, claiming that the defendants were motivated by malice to eliminate him as competition.

Although seven of the 10 defendants were eventually dismissed from the action (leaving the internal medicine chair, cardiac catheterization lab director, cardiology chief, and hospital as defendants), the fallout of this most recent court decision remains the same: growing apprehension on the part of medical staff to serve on peer review committees and a cautionary effect on all hospitals that must conduct proper peer review.

"It's already had a chilling effect on the willingness of hospitals and medical staff leaders to actively confront substandard care," says **Robin Locke Nagele, Esq.,** partner at the Philadelphia-based law firm of Post & Schell.

Nagele says the case is emblematic of a problem faced by hospitals across the country.

"It is a worst-case scenario of how hospital and medical staffs are caught between a rock and a hard place," says Nagele. "On the one hand, you're faced with malpractice exposure and added scrutiny if you don't act proactively regarding physician mishaps and red flags. On the other hand, this case illustrates how hospitals face serious liability exposure from physicians that they're trying to hold accountable."

However, hospitals cannot turn away from performing their required duties regarding proper peer review processes because of fear that such a decision might fall on their shoulders.

"We've got to continue doing proper peer review even in the face of cases with poor judgments like this one," says Sagin.

He believes that in this case, the jury and court did not have a full understanding of how peer review operates and, as a result, ruled in favor of the plaintiff.

"There were some minor lapses, but this was not a defective peer review process," says Sagin. "It's just a bad jury decision. Nevertheless, there were opportunities for [the defendants] to have done some things differently that might not have given the plaintiff the ammunition he found in this case."

Summary suspensions: Proceed with caution

The case also illustrates the dangers involved when a hospital summarily suspends a medical staff member's privileges.

"I've always counseled my clients about the use of summary suspensions," says Nagele. "A high standard must be met to justify such a person; such as an imminent threat to patients and others."

Unfortunately, given the emotional component to these situations, people often rush to take action before they fully know and evaluate all the facts. Nagele says Presbyterian Hospital's actions in this case were not unlike what many other hospitals would have done in response to a case like Poliner's.

"When bad incidents happen, there is often a rush to judgment," says Nagele. "There's a sense that we've got to do something right away. A case like this teaches you to be very deliberate in your thinking and your evaluation. [The peer review process] can be done and done appropriately."

She says hospitals can try to work with a physician under scrutiny to develop a voluntary arrangement during the investigation. However, this is not without risk, she adds. "There is a risk that the physician, as in this case, will claim afterwards that [he or she] felt pressured and that it was not a voluntary arrangement," warns Nagele. "That's not to say [voluntary arrangements] can never be crafted, but a great deal of care has to be put in up-front in the way it's designed and implemented."

According to Sagin, the language used for justifying the summary suspension in this case was not ideal in that it required that a "present danger" exist.

"The jury and the court seemed to focus on that phrase," he adds.

He notes a trend among medical staffs to characterize some summary suspensions as precautionary suspensions or broaden the rationale in their bylaws for a suspension if they continue to use the term summary suspension. For example, the grounds for a suspension might include potential harm to patients rather than only present danger.

"You want it to be clear that you have the ability to suspend when there is a significant trigger for a concern that patients might be at risk," says Sagin.

External peer review

Would the Presbyterian Hospital case have ended differently had an outside peer reviewer been used prior to asking Poliner to suspend his privileges?

"[The hospital] might have used external peer review in a timely and prompt fashion when it recognized the significance of the concerns," says Sagin. "This is always a useful tactic to defuse allegations of improper intent on the part of in-house peer reviewers."

However, there was no requirement that outside physicians conduct or participate in the review, he says.

Precautionary steps with regard to conducting peer review

- Ensure that the hospital's indemnification policy applies to medical staff leaders
- Understand your bylaws before suspending and fulfill any necessary criteria or due process
- Ensure that your fair hearing plan is updated in accordance with the HCQIA
- Review your external peer review policy
- Make sure that the hospital indemnifies all medical staff leaders against the costs attributable to defense and award in cases similar to the Poliner case

Presbyterian Hospital was found liable, because the jury believed that the hospital's doctors were motivated by something more than protecting patients, Sagin says.

"[Jurors] were led to believe malice existed because of some of the poor wording in the hospital's policies and procedures," says Sagin.

Sagin advises to make sure that you use optimal language when bylaws discuss investigations, suspensions, and corrective action. "[Policies and language] should be meticulous and clear and allow no room for confusion. You want them to say clearly what you intend them to say and afford as much protection as they can to all parties."

Although the $366 million award will undoubtedly have a chilling effect on physicians' and hospital leaders' willingness to participate in proper peer review, experts reiterate the importance of the peer review process. Although it's a balancing act between protecting physicians and protecting patients, the hospital's final responsibility tips the scale toward the patients it serves. "It's always been a challenge to encourage physicians to step forward to take on peer review and medical staff leadership responsibilities," says Nagele.

"But people do still step up. This is just another layer that must be worked through." ■

Insider *sources*

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EXHIBIT E

"Adopt proper procedures to ensure fair use of precautionary suspensions," Credentialing & Peer Review Legal Insider, June 2007

Source: HCPro, Inc.

Adopt proper procedures to ensure fair use of precautionary suspensions

Suspending a physician's privileges is a complicated and disruptive undertaking—for both the hospital and the physician. If not handled carefully and judiciously, a suspension could cause dissension among the medical staff members, interfere with the smooth operations of the hospital, and cause the hospital to incur significant legal costs. And of course, suspended physicians suffer financial losses and damaged reputations, and face potential consequences from licensing authorities, third-party payers, and other healthcare providers.

As a result, some hospitals see precautionary suspensions as a nonpunitive way of temporarily limiting the privileges of a physician that is more collegial than the traditional summary suspension. In essence, a precautionary suspension is an immediate limitation or denial of privileges prior to the completion of a professional review action. It is intended to last for a short duration.

The idea behind a precautionary suspension is to make the peer review process more flexible and impose a measure that protects patient safety but does not require a disciplinary measure and, in particular, avoids a summary suspension, says **Michael Eisner, Esq.,** a partner with Eisner & Lugli in New Haven, CT.

Further, a precautionary suspension, unlike a summary suspension, may alleviate the immediate need for a report to the National Practitioner Data Bank (NPDB). Used properly, a precautionary suspension can protect a physician's reputation and practice while protecting patients. But proper use of a precautionary suspension requires considerable advance thought and planning, specific bylaws provisions, and exacting compliance with procedures and regulations.

Avoid suspensions when possible

Many hospitals overuse suspensions, says **Todd Sagin, MD, JD,** national medical director of The Greeley Company, a division of HCPro, Inc., in Marblehead, MA. Naturally—and appropriately—hospitals react quickly to protect patients when there is an indication that a physician's clinical skills or interactions with others may adversely affect patient care. A suspension of the physician is a remedy that protects patients from harm. But most problems with physician competence or demeanor can be handled in a less confrontational and less disruptive way, Sagin says, even as the hospital keeps patient safety concerns at the forefront.

As part of its peer review procedures, hospitals can train department heads, medical executive committee (MEC) members, and other involved parties to work collegially and effectively with the subject physician to craft a solution that protects patients from any perceived potential harm—but that stops short of suspension. When a circumstance or report raises a red flag that a physician may have a problem, the hospital can consider the following options, as appropriate:

- Ask the physician to voluntarily stop performing the particular procedure at issue or discontinue treating a particular group of patients.
- Assign a proctor or monitor to oversee the physician's performance of certain procedures or care of certain patients. Eisner notes that as long as the proctor is overseeing care, rather than granting approval for procedures, no NPDB report is required.
- Require the physician to acquire additional training or experience in certain procedures or categories of patients.
- Take other informal steps designed to protect patients while the physician's competence in the area of concern is assessed and addressed, if necessary.

Sagin suggests that suspensions should be used only when there is good reason to be concerned and there is no more collegial way to address that concern. Even then, fairness to the physician and the interests of the hospital demand that the scope of any suspension be drawn as narrowly as possible while addressing the patient care concerns. All parties benefit if the investigation and resolution of the issue are concluded as expeditiously as is reasonable under the circumstances, he says.

Define 'precautionary suspension' clearly

Hospitals that seek the authority to use a precautionary suspension should be clear about what the term means in their organization and incorporate the definition into the bylaws or other supporting medical staff policy and procedure manuals. Because the way that the term is used and defined may affect the rights of both the hospital and the physician, it is critical that this issue be resolved before a precautionary suspension policy is implemented, Eisner says.

Some hospitals substitute the term "precautionary suspension" for "summary suspension"—that is, any suspension that takes effect immediately, before a definitive

decision on a corrective action has been reached. If the term "precautionary suspension" is used as a substitute for, or interchangeably with, "summary suspension," then a hospital must be aware of its obligations when imposing that sanction, notes Sagin. A physician's due process rights are triggered when a suspension has lasted for more than 14 days, and the hospital must initiate the hearing process promptly to retain immunity under the Health Care Quality Improvement Act (HCQIA). The facility must make appropriate reports to the NPDB if final resolution of the issue results in a limitation or loss of privileges for a period in excess of 30 days.

Other facilities make a distinction between "precautionary suspension" and "summary suspension," notes **Linda Haddad, Esq.,** a partner in the law firm of Horty, Springer & Mattern, PC, in Pittsburgh. At those facilities, a precautionary suspension usually means a stay of activity for administrative purposes to determine whether a problem exists and, if so, what next steps are appropriate. It should be used only if there is a legitimate concern that patient safety or hospital operations are at risk and only if there is no less-restrictive way to protect them, Haddad says. Hospitals should clearly set forth in their bylaws or peer review manuals that the precautionary suspension is not punitive but is a temporary, administrative remedy that implies no findings of incompetent medical practice or improper conduct.

Eisner points out that hospitals and medical staff members have the flexibility to move from one type of procedure to another if the facts warrant. An investigation undertaken during a precautionary suspension could lead to, by way of example, a) a summary suspension, b) termination of the suspension but initiation of formal corrective action, or c) termination of the suspension but initiation of collegial intervention.

Effective procedures protect all parties

Neither definition of "precautionary suspension" obviates a hospital's responsibility to conduct fair and objective peer review and to provide the subject physician with due process, Sagin notes. Although a precautionary, nonpunitive suspension can protect patients and the physician during an ongoing investigation, the process can be abused. Hospitals risk losing HCQIA protection, may incur liability from physician lawsuits, and may violate NPDB and state reporting requirements if they fail to establish clear procedures to handle precautionary suspensions.

It is crucial for hospitals to think through the implications of precautionary suspensions and adopt procedures that ensure that the process is efficient, fair, and effective, Eisner says. Precautionary suspensions are not meant to be a limbo into which a physician is thrust while a hospital decides what to do. Rather, a precautionary suspension must be of a limited duration and must conclude with either a decision that corrective action or collegial intervention is warranted or a finding that the concern raised about the physician's competence or conduct was misplaced, he says.

Appropriate procedures should:

- **Provide for speedy investigation.** The ability to conduct an investigation expeditiously is critical, Sagin says. If the hospital cannot complete a proper investigation into the particular concern within a period of a few days—or a few weeks at most if the matter must be sent out for independent review—then a precautionary suspension is inappropriate in that instance. Haddad agrees that hospitals that have imposed a precautionary suspension must "move with all deliberate speed" to resolve the issue quickly, as a protracted investigation risks denying the physician his or her due process rights and may endanger the hospital's immunity under HCQIA.
- **Set appropriate timetables.** The precautionary suspension may not be used to avoid the corrective action process, Sagin says. The hospital should be prepared to either proceed to hearing or reinstate the subject physician's privileges within a brief period of time. To maintain full rights to the immunity that the HCQIA offers and to preserve the physician's due process rights, he counsels hospitals to advise physicians of their right to a hearing once the precautionary suspension has lasted for more than 14 days. Haddad notes that the precautionary suspension is meant to be a process that is the least harmful to the physician while the preliminary review is made. Therefore, if the physician complains that the precautionary suspension is unfair or somehow infringes his or her rights, and his or her objection cannot be resolved collegially, Haddad advises hospitals to move immediately to the formal investigation.
- **Adhere to reporting requirements.** A benefit of a precautionary suspension policy is that if the suspension is imposed for administrative purposes to allow the facility time to conduct an investigation, it is not considered a suspension that is based on a finding that patient safety is at risk, Haddad explains. Therefore, no report must be made to the NPDB. However, as Haddad points out, there may be other entities to which hospitals must report even precautionary suspensions. For example, the state medical board and/or the department responsible for licensing hospitals may need to be notified of certain activities, which may include particular incidents, investigations, reports from patients or hospital personnel, etc. It is important for hospitals to seek the advice of local counsel familiar with the laws and

regulations in the state in which the hospital operates to determine whether a reportable event has occurred.

- **Be set forth in the bylaws.** The hospital bylaws should address precautionary suspensions, noting that such suspensions are temporary administrative procedures that do not signal a conclusion that the physician poses a danger to patients or to the effective operation of the facility. The bylaws should designate a committee to investigate any concern that leads to a precautionary suspension, and they should also set forth the physician's fair process rights should the suspension endure beyond a set period of time. ■



EXHIBIT F

"Ruling on Texas hospital's peer review case emphasizes importance of keeping physicians in the loop," Hospitalist Management Advisor, June 2006

Source: HCPro, Inc

Ruling on Texas hospital's peer-review case emphasizes importance of keeping physicians in the loop

Providing a cautionary tale on the importance of giving physicians ample opportunity to address quality-of-care concerns during peer review, the Federal District Court for the Northern District of Texas recently upheld the basis for a jury's decision to award $366 million in damages to a Texas cardiologist who temporarily lost his rights to perform heart catheterizations. The physician's privileges were suspended while an *ad hoc* committee reviewed several of his cases that had raised red flags.

"This case was about what the jury perceived to be malice, not about the hospital missing this step and that step in the review," says **Constance Baker, Esq.,** a partner at the Baltimore law office of Venable, LLP (*www.venable.com*), which regularly handles peer-review cases. "The jury was skeptical that this was a true peer review and that there was a good-faith effort by the hospital to point out problems and to help the physician improve."

Although the district court upheld the jury's October 2004 decision, it ruled in March that the staggering $366 million in damages awarded by the jury should be sent to mediation to determine an appropriate damage award.

For hospitalists tasked with being on peer-review committees, there is a lesson in the *Poliner vs. Texas Health System* case, says Baker. "[You] should always ask if there is a way for the physician to improve, rather than [ask] how to get the physician out."

Abeyance letter signed under duress

According to court documents, nurses at Presbyterian Hospital of Dallas filed several reports, beginning in late 1997, expressing concerns about three catheterization lab procedures performed by Lawrence Poliner, MD. The hospital's internal medicine advisory committee (IMAC) was examining the cases when the catheter laboratory director became concerned about a fourth case while reviewing emergency angioplasties in his lab. The director said that, based on his review, Poliner had performed an emergency angioplasty on the wrong artery in one patient and missed a totally occluded left anterior descending coronary artery.

Soon after that discovery, Poliner was told to sign an abeyance letter and return it a few hours later, or the hospital would suspend his privileges immediately, court documents say. He was told that he did not need to consult an attorney and, after a hospital committee had reviewed 42 of his cases, Poliner was given only a few days' notice to prepare to defend 29 cases that had been tagged as "substandard," according to court documents.

"This left a bad taste in the jury's mouth," Baker notes. Further, although the IMAC decided to conduct an external review of the cases, Baker adds. "They didn't do one because it couldn't happen fast enough to meet their timetable."

Baker says the take-home messages for hospitalists and other physicians who agree to participate in peer reviews include the following:

- Understand and follow your hospital's bylaws
- Ask whether the peer-review process provides physicians with sufficient opportunities for improvement
- When the peer-review committee has reached a decision, ask whether it has imposed the least severe sanction rather than the most severe sanction
- Give physicians who are the subject of reviews sufficient time to prepare and respond to concerns
- Be vigilant about guarding against malicious intent in the peer review process
- Ensure that your hospital's bylaws are clear on when an investigation begins and on what is the appropriate standard for summary suspension

Poliner ruling an 'aberration'

While a hearing committee at Presbyterian Hospital ultimately recommended that Poliner's privileges be restored with conditions, he did not perform catheter lab procedures for five months and sued the hospital and physicians involved in the review for damages to his practice on grounds of antitrust, defamation, business disparagement, tortious interference with a contract, and other charges.

Barbara Blackmond, Esq., a senior partner in the Pittsburgh-based law firm of Horty, Springer & Mattern, PC (*www.hortyspringer.com*), calls the ruling on this case "an aberration" and says hospitals should not overreact to the judgment by being overly cautious about suspending privileges in the interest of patient safety. Hospitals win nine out of 10 peer review cases that go to court, she says.

Blackmond says the court in the Poliner case did not properly interpret the Health Care Quality Im-provement Act of 1986 (HCQIA), which provides immunity to hospitals and physicians in conducting peer review. In fact, many judges have difficulty understanding the HCQIA, she says.

She notes that the HCQIA allows for the immediate suspension of a physician's privileges for up to 14 days while the care that the physician provides to patients is evaluated, and allows for indefinite suspensions when there is the threat of imminent harm to patients.

The ruling in the Poliner case, however, should be a wake-up call to medical staffs to revisit their procedures so they better document the reasons why a physician could be perceived to be a risk to pa-tients, Blackmond advises. Be sure that your hospital's peer review process builds in enough communication steps to allow the physician to respond to concerns and evidence, she says.

Tip: Use the sample peer review issue inquiry letter on p. 8 to inform a physician of the key issues regarding a peer-review case and to request that he or she respond within a certain time frame (usually two weeks). If the physician fails to respond, most medical staffs send a second letter and allow two more weeks for a response.

The Poliner case is one in which the court placed too much weight on the physician's economic interests as opposed to patient safety, Blackmond says.

Although hospitals' top priority should be protecting patients, Blackmond and Baker agree, the peer-review process demands that participants constantly balance what is in patients' best interests with fair treatment of the physician. ■

Editor's note: To view the court's ruling on the Poliner case, go to www.aapsonline.org/judicial/polinerdec.pdf.



EXHIBIT G

"Texas case focuses attention on voluntary suspensions," Medical Staff Briefing, June 2006

Source: HCPro, Inc.

Texas case focuses attention on voluntary suspensions

A U.S. District Court on March 27 found sufficient evidence to support the jury's findings in *Poliner v. Texas Health Systems,* which in August 2004 awarded $366 million in damages to a physician plaintiff over the suspension of his cardiac catheterization privileges.

The case has caused apprehension among hospital leaders nationwide due to the scale of the damages, which could incite other plaintiffs to seek excessive judgments, legal experts say. The case also has hospital medical staff leaders questioning the use of voluntary suspensions.

Note: Although the court upheld the jury's findings in the case, the award will be reduced due to a Texas law that prohibits plaintiffs from receiving damages for more than one injury in a case. The plaintiff is now seeking $70 million in damages. However, if the parties cannot resolve the amount in mediation, the case may be retried or appealed.

The plaintiff in the case, Lawrence R. Poliner, MD, alleges that he was coerced into agreeing to an abeyance—a voluntary suspension of his privileges—by defendant James Knochel, MD, chief of internal medicine at Presbyterian Hospital in Dallas. Poliner contends that Knochel threatened to suspend his privileges if he refused to sign the abeyance letter, although Knochel did not have grounds to suspend Poliner's privileges under the hospital's medical staff bylaws.

Under Presbyterian Hospital's bylaws, the imposition of a summary suspension is only authorized when there is "present danger" to patients. Under the Health Care Quality Improvement Act of 1986 (HCQIA), the statute that provides immunity for hospitals and physicians in cases of peer review and suspensions, the standard for summary suspension is "imminent danger." In the Poliner case, the jury found that that standard was not met.

At trial, the defendants admitted that they did not have grounds for a summary suspension at the time of the abeyance. That admission formed the basis of the plaintiffs' case, says **Catherine M. Ballard, Esq.,** a partner at Bricker & Eckler in Columbus, OH. "You can't impose a summary suspension unless you have grounds."

Medical staff leaders should be aware of what their hospital's bylaws say about summary suspensions, Ballard advises.

Note: See sample bylaw language addressing summary suspensions on p. 3.

The case

As first reported in the October 2004 **MSB,** Lawrence R. Poliner, MD, the physician who filed the suit, was appointed as a member of Presbyterian Hospital's medical staff in January 1997. By the end of that year, the nursing staff had reported three incidents in the cardiac catheterization unit suggesting that Poliner did not effectively treat patients.

Poliner was undergoing internal peer review for the three incidents when a fourth incident occurred the following May. The department of internal medicine chair then allegedly confronted Poliner and instructed him to either cease performing cardiac catheterizations while his privileges were being reviewed or face a temporary suspension of certain privileges. Poliner complied with the request. When an audit by the peer review committee found what it determined to be evidence of substandard care, the committee voted to revoke Poliner's cardiac catheterization and echocardiography privileges.

Poliner was immediately offered a fair hearing. The hospital governing board, at the fair hearing committee's request, restored Poliner's privileges with conditions. However, Poliner's request to remove the summary suspension from his record was denied. He filed suit against the hospital and 10 physicians on the peer review committee, claiming that the defendants were motivated by malice to eliminate him as competition.

Seven of the 10 defendants were summarily dismissed from the action, leaving the internal medicine chair, director of the cardiac catheterization lab, chief of cardiology, and hospital as defendants. Poliner has since settled out of court with the director of the cardiac catheterization lab and the chief of cardiology for undisclosed amounts.

Case lessons

Legal experts say the case poses a dilemma to hospitals, which have an interest in protecting patients against potentially unfit physicians.

Robin Locke Nagele, Esq., partner at the Philadelphia-based law firm of Post & Schell, LLC, says the case is emblematic of a problem faced by hospitals nationwide. "It is a worst-case scenario of how hospital and medical staffs are caught between a rock and a hard place," Nagele says.

The dilemma is that hospitals face malpractice exposure and added scrutiny if they don't act proactively when confronted with physician mishaps and red flags, but also face serious liability exposure from physicians whose privileges are suspended, Nagele says.

"If every medical staff and every court treated suspensions as something that could only be initiated once the danger to patients had been proven, we'd have a lot more patients harmed in this country and we wouldn't be performing our duty to provide a safe environment for patients," says **Todd Sagin, MD, JD,** vice president and national medical director of The Greeley Company, a division of HCPro, Inc., in Marblehead, MA.

However, suspension of physician privileges is a dangerous area of potential liability for hospitals because many hospitals are too quick to suspend without proper and careful investigations, Sagin says.

Dangers of abeyance

Ballard warns of the dangers inherent in seeking an abeyance. "I do not recommend abeyance because it isn't protected under HCQIA," she says. Most physicians are likely to say the abeyance was coerced, as happened in the Poliner case, she explains.

Tip: Sagin says hospitals should draw the following lessons from the Poliner case:

- Voluntary abeyance is not a good tactic
- When hospitals suspend a physician's privileges, they should make clear that the purpose is to protect patients and that there is reason to suspect that patients may be in danger
- Investigations that follow a suspension should occur promptly and with extreme care, to avoid true or perceived conflicts of interest
- Participants in the peer review process must be adequately indemnified by the hospital for this work

Sagin says hospitals should consider voluntary suspension of privileges a poor protection against lawsuits from physicians. Formally suspending privileges —even if done merely as a precaution to protect patients while an investigation is underway—provides a safer route to the same end.

"What many of us have been doing in bylaws is clearly defining suspensions as something that can be done as a precaution whenever there is evidence to call a physician's competence into question,' " Sagin says. Whenever the medical staff and board can't with a high degree of confidence vouch for the competence of a physician who has privileges, there is reason to suspect that patients are in imminent harm.

The Poliner case demonstrates inherent dangers that hospitals face when juries are asked to decide whether a hospital is liable for damages under HCQIA, says Ballard.

Although hospitals have a much higher percentage of prevailing in HCQIA cases than plaintiff physicians, "everything depends on whether you've given the doctor procedural due process," she says. "The court is not the expert on quality of care, and they will defer to the board. The courts look at due process."

Although the Poliner case is troubling to hospitals and medical staff leaders due to the size of the damages awarded, Sagin says the protections offered by HCQIA have not been significantly challenged by the case. "HCQIA generally provides good immunity, and the judgment in this case is an aberration," Sagin says. He notes that the protections of HCQIA resulted in summary judgment for the defendants on several of the charges. "However, once the plaintiffs were able to get before a jury on some of the charges, the possibility for an irrational decision was set in motion."

The future of Poliner

For the recent ruling, Poliner sought to claim damages from the hospital and its chief of internal medicine in the amount of $70 million. The judge ordered the parties to use mediation to attempt to come to a settlement, but a lack of a settlement could force a retrial, defense attorneys say.

The court could order a new trial on the basis of "passion and prejudice" by the jury, as the defense has argued. Or if the court orders a settlement that the plaintiff finds unsatisfactory, there would be a new trial before any appeal. "This is not end of game or end of story," Sagin says.

Sagin believes the decision could be overturned on appeal. "Sooner or later, a court is going to visit this judgment and note that this was an outrageous amount of money to grant for the harm that was done. Most external parties looking at this can't conceive of how the jury reached these numbers. This raises the question of whether the jury was so inflamed by the plaintiff's case that it lost sight of the facts and a reasonable response."

Overall, the most serious threat from the Poliner case to hospitals and medical staff is the enticing figure of $366 million for plaintiff lawyers, Sagin says.

In the meantime, the effects of the Poliner case can be alleviated if hospitals and medical staff learn from the events that took place at Presbyterian Hospital. ■



EXHIBIT H

"Physician performance improvement: Right framework for peer review," Medical Staff Briefing, June 2007

Source: HCPro, Inc.

Physician performance improvement: Right framework for peer review

Editor's note: This article is an excerpt from the new HCPro book, Effective Peer Review: A Practical Guide to Contemporary Design, *Second Edition, written by Robert Marder, MD; Mark A. Smith, MD, MBA, FACS; and Richard Sheff, MD. For more information or to order a copy of the book, go to* www.hcmarketplace.com.

The Joint Commission has tasked medical staffs with conducting ongoing professional practice evaluations (OPPE). To effectively implement OPPE, the medical staff must first decide how to measure physician competency.

OPPE and effective peer review is not just about measuring competency. It is also about responding to the data to improve patient care.

Measuring physician quality is often viewed as a difficult, if not impossible, task. However, other industries have found ways to measure quality. For example, consumer rating services view quality as the sum of several parts. When a consumer guide rates the quality of an automobile, it creates an overall quality rating by first determining the key performance areas that define a quality car and then rating each area.

Breaking down the vague concept of a "quality" car to comparisons such as engine size, acceleration, interior roominess, seat comfort, exterior design, amenities, warranty, and resale value allows for a more reliable estimate of quality than just a summary opinion.

To measure quality, quality must be defined in a measurable way. This may sound a bit circular, but defining the measurable dimensions of performance for a product or service allows you to measure quality.

Thus, to adequately measure physician performance, a comprehensive physician competency framework is needed. There are three steps to measuring physician competence:

- Select a competency framework
- Set specific competency expectations
- Define measures for competency, based on expectations

Step 1: Selecting a competency framework

The first step in choosing a framework is defining the aspects or dimensions of physician performance that are important to your medical staff.

When asked what defines good performance, physicians tend to mention good procedure outcomes, low mortalities, low infection rates, appropriate medication use, and accurate diagnoses.

However, such expectations represent only one aspect of physician performance: technical quality of care.

A comprehensive framework goes beyond that to the broader definition of physician performance.

There are at least two well-developed frameworks for measuring physician competence. The first is a framework that was originally taught by Howard Kirz, MD, in courses offered by the American College of Physician Executives on managing physician performance in group practices, and later adopted by The Greeley Company, a division of HCPro, Inc., for use by medical staffs. In its current form, the framework is composed of six physician performance dimensions:

- **Technical quality:** Skill and judgment related to effectiveness and appropriateness in performing the clinical privileges granted
- **Service quality:** Ability to meet the customer service needs of patients and other caregivers
- **Patient safety/rights:** Cooperation with patient safety and rights, rules, and procedures
- **Resource use:** Effective and efficient use of hospital clinical resources
- **Relationships:** Interpersonal interactions with colleagues, hospital staff members, and patients
- **Citizenship:** Participation in, and cooperation with, medical staff responsibilities

The second framework, called the general competencies, was developed by the Accreditation Council for Graduate Medical Education (ACGME) and adopted by the American Board of Medical Specialties and The Joint Commission. It was created to define methods for evaluating resident competency during training that go beyond measuring technical skills.

This framework also has six categories, which The Joint Commission has defined as follows:

- **Patient care:** Practitioners are expected to provide

patient care that is compassionate, appropriate, and effective for the promotion of health, for the prevention of illness, for the treatment of disease, and at the end of life

- **Medical knowledge:** Practitioners are expected to demonstrate knowledge of established and evolving biomedical, clinical, and social sciences, and to apply their knowledge to patient care and the education of others
- **Practice-based learning and improvement:** Practitioners are expected to be able to use scientific evidence and methods to investigate, evaluate, and improve patient care
- **Interpersonal and communication skills:** Practitioners are expected to demonstrate interpersonal and communication skills that enable them to establish and maintain professional relationships with patients, families, and other members of healthcare teams
- **Professionalism:** Practitioners are expected to demonstrate behaviors that reflect a commitment to continuous professional development and ethical practice, an understanding of and sensitivity to diversity, and a responsible attitude toward their patients, their profession, and society
- **Systems-based practice:** Practitioners are expected to demonstrate both an understanding of the contexts and systems in which healthcare is provided and the ability to apply this knowledge to improve and optimize healthcare

The ACGME initially defined six competency categories and subsequently created specific expectations to be measured in each category. The Joint Commission has adopted the six definitions almost verbatim, but has yet to define the measurable expectations.

The sidebar above describes the reasons for choosing each framework. This should be done through an active discussion at a medical executive committee meeting, not as a passive rubber-stamp approval of your hospital and medical staff performance improvement plan. Then, this framework should be incorporated into your medical staff policies and measurements. Examples of how to do this are provided in later chapters of this book.

Whichever framework you choose, if you are accredited by The Joint Commission, you must adopt a comprehensive physician competency framework to meet its standards. If you are not Joint Commission–accredited, you still should adopt a physician competency framework because it is a best practice and will provide the basis for rational physician competency measurement.

Step 2: Setting specific competency expectations

Once the framework has been defined, the next challenge is to decide the specific expectations that would best help your physicians understand how to achieve excellence in all areas of competency covered by the framework. Instead of creating a laundry list of expectations, use your framework as a differential diagnosis to ensure that you develop expectations for the performance dimensions that are most important.

How do you develop these expectations? In general, expectation statements should be relatively broad. The specific measures will define the expectation more precisely. The most important thing to remember is that most expectations should be measurable.

For example, for The Joint Commission's *patient care* competency, or the Greeley Company's *technical quality* dimension, one expectation could be as follows:

> *Achieve patient outcomes that meet or exceed generally acceptable medical staff standards as defined by comparative data, medical literature, or peer review activities.*

This expectation could be measured by severity-adjusted outcomes data (e.g., mortality, complications, etc.) or by individual case review for unexpected deaths.

Although every expectation does not need direct measurement, keeping the need for measurement in mind when you are describing your expectations will make them easier to define.

Step 3: Defining measures for competency based on the expectations

Once the specific expectations are set, the real challenge is to measure them. Some physicians may use expectation statements to guide their approach to patient care and not require any measurement to spur performance improvement. These physicians are similar to drivers who always follow the posted speed limit.

However, for some (if not most) individuals, measurement is necessary to ensure improved performance. For example, although speed limit signs are posted on most roads, we still have police officers who measure performance (and some-

times provide feedback in the form of a speeding ticket). Otherwise, many individuals would likely not comply. In healthcare, when practice guidelines were first measured regarding prescribing ACE inhibitor medications at discharge for patients with congestive heart failure, most physicians thought they were in compliance. Then they received their performance data. Despite good intentions, many physicians were surprised to find that they were routinely performing at a lower level than they had assumed.

Because of the broad definition of physician competence, the methods for measuring expectations will vary and may go well beyond the traditional use of patient charts. ■


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