



Current Issues in Negligent Credentialing

Part 2

Health Care Reform – P4P and Accountable and Affordable Care

- Private and government 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

Health Care Reform (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

Health Care Reform (cont'd)

- Payors, including Medicare and Blue Cross/Blue Shield, are adopting Pay for Performance and other quality metrics (value based purchasing 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
 - Joint Commission
 - Unions

Health Care Reform (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

Health Care Reform (cont'd)

- Not yet determined
- To be promulgated with the program's regulations
- Will include measures in:
 - Clinical processes
 - Outcomes of care
 - Patient experience
 - Utilization of services

Health Care Reform (cont'd)

- On January 13, 2011, the Centers for Medicare and Medicaid Services (CMS) issued a proposed rule to implement a Hospital Value-Based Purchasing Program (VBP Program) as required by section 3001(a) of the Patient Protection and Affordable Care Act (ACA).
- Under the VBP Program, CMS would pay not just for reporting quality data but for a hospital's performance with respect to the data.
- Under the VBP Program, beginning in FY 2013, CMS will pay acute care inpatient prospective payment system (IPPS) hospitals value-based incentive payments for meeting minimum performance standards for certain quality measures with respect to a performance period designated for each fiscal year.

Health Care Reform (cont'd)

- Excludes from the definition of “hospital,” with respect to a particular fiscal year:
 - a hospital that is subject to certain payment reductions related to the Hospital Inpatient Quality Reporting or IQR program;
 - a hospital cited for deficiencies characterized as posing “immediate jeopardy” to the health and safety of patients; and
 - A hospital not having a minimum number of applicable performance measures or cases for such applicable measures for the performance period in a given fiscal year.

Health Care Reform (cont'd)

- For the FY 2013 Hospital VBP Program, CMS proposes to use 17 clinical process-of-care measures as well as eight measures from the Hospital Consumer Assessment of Healthcare Providers and Systems, (HCAHPS) survey that document patients' experience of care.

Health Care Reform (cont'd)

- Acute myocardial infarction
- Heart Failure
- Pneumonia
- Healthcare-associated infections
- Surgeries

Health Care Reform (cont'd)

- Communication with Nurses
- Communication with Doctors
- Responsiveness of Hospital Staff
- Pain Management
- Communication About Medicines
- Cleanliness and Quietness of Hospital Environment
- Discharge Information
- Overall Rating of Hospital

Health Care Reform (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

Health Care Reform (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 quite critical of how many hospitals grant “core privileges” without determining current competency
 - CMS wants to see criteria developed for each clinical privilege and an evaluation as to whether the physician is qualified to perform each

Health Care Reform (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

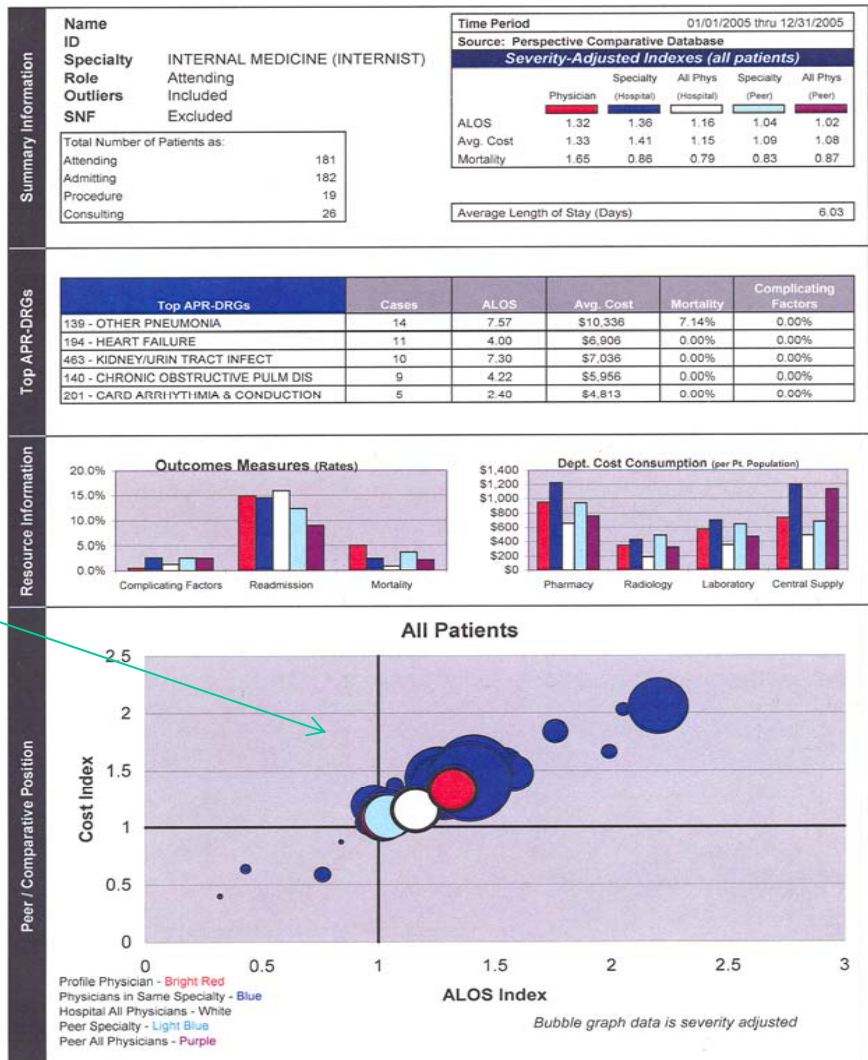
Variance Between Medicare Geo. Mean and Actual ALOS by Top 20 DRG's at Example Hospital

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

Example by Major Dx

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

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



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

Example by Major Dx

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

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



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Steps to Maximize Confidentiality Protection Under Peer Review Statute

- The relevant provisions of the Medical Studies Act are as follows:
 - All information, interviews, reports, statements, memoranda, recommendations, letters of reference or other third party confidential assessments of a health care practitioner's professional competence, or other data of health maintenance organizations, medical organizations under contract with health maintenance organizations or with insurance or other health care delivery entities or facilities, physician-owned insurance companies and their agents, committees of ambulatory surgical treatment centers or post-surgical recovery centers or their medical staffs, or committees of licensed or accredited hospitals or their medical staffs, including Patient Care Audit Committees, Medical Care Evaluation Committees, Utilization Review Committees, Credential Committees and Executive Committees, or their designees (but not the medical records pertaining to the patient), used in the course of internal quality control or of medical study for the purpose or reducing morbidity or mortality, or for improving patient care or increasing organ and tissue donation, shall be privileged, strictly confidential and shall be used only for medical research, the evaluation and improvement of quality care, or grating, limiting or revoking staff privileges or agreements for services, except that in any health maintenance organization proceeding to decide upon a physician's services or any hospital or ambulatory surgical treatment center proceeding to decide upon a physician's staff privileges, or in any judicial review of either, the claim of confidentiality shall not be invoked to deny such physician access to or use of data upon which such a decision was based. (Source: P.A. 92-644, eff. 1-1-03.)
 - Such information, records, reports, statements, notes, memoranda, or other data, shall not be admissible as evidence, nor discoverable in any action of any kind in any court or before any tribunal, board, agency or person. The disclosure of any such information or data, whether proper, or improper, shall not waive or have any effect upon its confidentiality, nondiscoverability, or nonadmissibility

Steps to Maximize Confidentiality Protection Under Peer Review Statute

(cont'd)

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

Peer Review:

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

Peer Review (Cont'd)

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

Peer Review (Cont'd)

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

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

- Goal is to maximize efforts to keep performance monitoring, quality and utilization data and reports and peer review records as privileged and confidential from discovery in litigation proceedings
- Need to identify the following:

Additional 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

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

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

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

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

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

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

Additional 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

Golden Rules of Peer Review

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

Golden Rules of Peer Review (cont'd)

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