Navigating the Stormy Waters: Strategies for Medical Staff Professionals to Ensure Smoother Sailing

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Agenda

Peer Review Immunity

Peer Review Access to PHI and Confidentiality

Social Media

LAWS AND STANDARDS AFFECTING PEER REVIEW

- Medicare Conditions of Participation
- The Joint Commission (or other accrediting agency)
- State Law (peer review, confidentiality, reporting)
- Health Care Quality Improvement Act / NPDB regs
- Federal Patient Safety and Quality Improvement Act
- Medical Staff Bylaws/ Policies
- A Mish Mash of Other Federal Safety and Confidentiality Laws
Medicare Conditions of Participation
Give the ORGANIZED MEDICAL STAFF responsibility for peer review.
- Not the Board.
- Not Hospital Administration.
- DEFINITELY not Human Resources.

Acknowledge the balance between governing body and medical staff creating a system of checks and balances for each individual practitioner.

Do NOT confuse employment disciplinary review with medical staff peer review – and don’t let anyone else confuse the two either!

Joint Commission: Performance Measurement
An ongoing process involving continuous evaluation of a practitioner’s performance.
- Focused Professional Practice Evaluation (FPPE)
- Ongoing Professional Practice Evaluation (OPPE)

(Focused Professional Practice Evaluation)

FPPE
Evaluating the privilege-specific competence of the practitioner who does not have documented evidence of competently performing the requested privilege

When is it used?
- When a provider is initially granted privileges;
- When new privileges are requested for an already privileged provider; and
- When poor performance involving a privileged provider is identified (through OPPE or other means, e.g., complaints)
FPPE Triggers

The triggers for performance monitoring must be clearly defined. Triggers may be single incidents or evidence of a clinical practice pattern.

Practice notes:
- Many policies we see do not have clearly defined triggers
- Policies sometimes fail to allow elevation to the corrective action process

FPPE Process

The performance monitoring process must be clearly defined and include each of the following elements:
- Criteria for conducting performance monitoring;
- Method for establishing a monitoring plan specific to the requested privilege;
- Method for determining the duration of performance monitoring; and
- Circumstances under which monitoring by an external source is required.

Collecting Information for the FPPE

Methodologies include:
- Periodic chart review;
- Direct observation;
- Monitoring of diagnostic and treatment techniques;
- Interviews/input with others involved in care.
  E.g., might monitor first cases of a high risk surgery
**OPPE**

Goals:
- Part of the effort to monitor professional competency
- To identify areas for possible performance improvement by individual practitioners
- To use objective data in decisions regarding continuance of practice privileges

**Need a “Clearly Defined” Process**

Need a clearly defined OPPE process to evaluate each professional
- “Clearly defined” includes, but is not limited to,
  • Who is responsible for reviewing performance data;
  • How often the data will be reviewed;
  • The process to be implemented to use the data and make decisions on privileges; and
  • How data will be incorporated into the quality file.

**Criteria Used in the OPPE**

Criteria may include the following:
- Review of operative and other clinical procedures performed and their outcomes;
- Pattern of blood and pharmaceutical usage;
- Requests for tests and procedures;
- Length of stay patterns;
- Morbidity and mortality data;
- Practitioner’s use of consultants;
- Other relevant criteria as determined by the medical staff.
Methodologies for Collecting Information
Methodologies for collecting information include:
- Periodic chart review
- Direct observations
- Monitoring of diagnostic and treatment techniques; and
- Discussion with other individuals.
Some types of data apply to all practitioners, and there might need to be specific data for other types of practitioners.

Possible Results After Evaluation
Determine the practitioner is performing well or within desired expectations and no further action is warranted.
Determine that an issue exists that requires a focused evaluation.
Corrective action, including summary suspension, as necessary.
Determine that zero performance should trigger a focused review whenever the practitioner actually performs the privilege.
Determine the privilege should be continued because the organization’s mission is to be able to provide the privilege to its patients.

Peer Recommendations
Peer evaluations:
- MS.07.01.03: In circumstances where there are insufficient peer review data available when evaluating an applicant for privileges, the organized medical staff uses peer recommendations. A recommendation(s) from peers reflects a basis for recommending the granting of privileges.
  • Peers: appropriate practitioners in the same professional discipline as the applicant who have personal knowledge of the applicant.
When Does Peer Review Cross Over to Corrective Action?

Concerns in an initial application for appointment to a medical staff
Concerns in a reappointment application
Peer review process/ FPPE/ OPPE/ Quality Assurance
Patient/staff complaints
Conduct considered below the standard of care, an imminent danger to the health and safety of patients, disruptive to hospital operations, unprofessional, and/or unethical

Corrective Action Appropriate?

Collegial intervention is kinder and gentler, and usually a good first step (unless egregious).
Everyone involved should keep detailed documentation of any actions taken prior to commencing corrective action.
Corrective action can be a point of no return in the hospital/physician’s relationship – can lead to claims, lawsuits.
The process should err on the side of fairness to the physician.

Medical Staff Bylaws – Corrective Action

The corrective action process must be followed EXACTLY as laid out in the Bylaws
– Bylaws should contain clear enumeration of grounds for corrective action
– Bylaws should contain a clear, specific plan laying out due process rights
PEER REVIEW IMMUNITY

**Policy**

Encourage health care providers to perform quality control reviews aimed at improving services, prospectively.
Encourage free and open discussion to improve treatment by providers.
Restrict the ability of physicians with quality issues to move from place to place.
Solution: immunity from civil liability for peer review.

**Federal Govt. Solutions**

Health Care Quality Immunity Act (HCQIA)
National Practitioner Data Bank (NPDB)
Health Care Quality Improvement Act

Two types of immunity:
- For those providing information in a professional review action (PRA) -- unless they lied.
- For those conducting the PRA, if taken:
  1. in the reasonable belief that it was in furtherance of quality health care;
  2. after a reasonable effort to obtain the facts of the matter;
  3. after adequate notice and hearing procedures are afforded to the physician involved; and
  4. in the reasonable belief that the action was warranted by the facts known.

Duty To Investigate

- Must be in furtherance of health care quality.
- Must involve a reasonable effort to discern the facts of the matter.
- Once the physician is under investigation, voluntary surrender of privileges triggers report to NPDB.
  - Policies should define clearly when investigations start.
  - If the resignation is to AVOID investigation, that is also reportable.

Adequate Notice And Hearing

Two kinds of notice
- Notice of the action (e.g. a recommendation to limit privileges)
- Notice of hearing
Each has very particular requirements that should be specified in the Bylaws.
In emergencies, HCOQA allows for PRAs that result in immediate suspension or restriction without prior notice or hearing (imminent danger) but then must follow specific parameters.
Several important timing parameters

- If a practitioner’s medical staff privileges are suspended for more than FOURTEEN DAYS the practitioner will have a right to request a hearing.
- Investigation should begin during the 14 days.
- Suspension or limitation of privileges for MORE THAN THIRTY DAYS means a report to the NPDB.
- Hearing must be AT LEAST THIRTY DAYS after physician requests it.

State Law

Second level of immunity available in many states.
Many states have separate reporting requirements.

Tips To Protect Immunity

- Follow timelines carefully.
- Document the process.
- Err on the side of fairness to the physician and document that.
- Document physician access to records, and opportunity to tell story/ be heard.
- Work to create a culture that supports peer review.
- No double jeopardy but prior incidents/ pattern are relevant and should be well documented.
ACCESS TO PHI AND CONFIDENTIALITY IN PEER REVIEW

Lots To Keep Confidential

Patient – Protected
Health Information

Reviewed Provider
Information

Confidential Statements
By Coworkers

For Patient Information – Aim for somewhere between....
Access to PHI for Peer Review

HIPAA allows use and disclosure of protected health information for review of practitioner quality/performance, under the “health care operations” exception.

- Subject to the minimum necessary standard.

Consider state confidentiality law – many have a parallel exception.

Redact whenever possible, to avoid the issue.

External Peer Reviewers Are Business Associates

The hospital may disclose PHI to external reviewers for the purpose of peer review. A business associate agreement must be in place. Only the minimum amount of PHI necessary to accomplish the purpose intended should be included – the rest should be redacted. If an external company does the redacting, a business associate agreement is needed. If it is a peer review company that sub-contracts with individual reviewing physicians, the company and the physician must sign a business associate agreement.
**HCQIA and Confidentiality**

HCQIA states that information that identifies the entity, practitioner or patient that is reported to peer review committees is confidential and shall not be disclosed (other than to reviewed practitioner) except:
- In the course of the PRA
- As necessary to query the NPDB
- In accordance with federal regulations or state law.

**Federal Patient Safety and Quality Improvement Act of 2005**

- Creates “Patient Safety Organizations.”
- Establishes federal safety and confidentiality for information reported to a PSO.
- Some state hospital associations have formed a PSO.
- If the hospital peer review/credentialing records are gathered in order to submit to a PSO, they are protected.
- But once disclosed to PSO they can’t be used at all, including for that hospital’s defense in litigation (unless all identified providers agree to the disclosure).

**State Laws Generally**

Define the peer review “entity”
- committee, how formal, how organized

Define the body of documentation protected
- inquiry/investigation of the peer review entity
What Records Are Potentially Protected Under State Law?

- Notifications/ Requests for Peer Review Entity to review.
- Records (minutes) of the Peer Review Entity’s investigations, inquiries, proceedings, and conclusions.
- Usually NOT items prepared for other purposes but considered by the Peer Review Entity.
- NOT facts that were already known.

Records of investigations, inquiries, proceedings, and conclusions

State laws often prohibit their use in any civil or criminal action against the health care provider or any other health care provider.

Outside entities

State law will vary on whether outside entities may gain access to peer review records without consent:
- The Joint Commission
- State Regulatory Agencies
- Payers Also Credentialing The Reviewed Provider
Mandatory Release of Records – State Laws Vary On:
1. Release to the health care provider whose services are being reviewed or evaluated, upon request of the provider (Usually can see their own records)
2. To any person, with the consent of the health care provider whose services are being reviewed or evaluated (Usually can direct their own records)
3. To the person requesting the review or evaluation, for use solely for the purpose of improving the quality of health care, avoiding the improper utilization of the services of health care providers, and determining the reasonable charges for such services

Mandatory Release of Records – State Law Will Vary On:
4. Release to a court pursuant to a subpoena for actions relating to sexual exploitation by a therapist (very narrow exception)
5. Release to the appropriate examining or licensing board or agency, when the organization or evaluator conducting the review or evaluation determines that such action is advisable

Employers
Tricky issue:
- Provider on medical staff but employed by an outside entity.
- Peer review reveals potential danger for the individual or third parties.
- Check state law regarding permissible release of peer review records.
- Think creatively about ways to warn without disclosing peer review records.
Practical Tips For Preserving Protection

Have a clear and very broad policy. Broad authority in Medical Staff Bylaws. Define internal processes to deputize those who may act on behalf of peer review committee (committee chair, Chief of Staff, VPMA etc.). Mark and stamp peer review documents as protected. Educate about need to keep the documents and information restricted to the peer review setting only.

SOCIAL MEDIA

Most Providers Use Social Media

According to a 2011 Journal of General Internal Medicine survey:

- 94% of medical students;
- 79% of residents; and
- 42% of practicing physicians reported some use of online social networks, nearly all for personal reasons.
AMA Opinion 9.124

Professionalism in the use of social media:
- Cognizant of standards of patient confidentiality
- Use privacy settings to safeguard
- Watch boundaries for interacting with patients
- Separate personal and professional content
- If colleagues are posting inappropriately, notify them and take other action as appropriate.

Federation of State Medical Boards

- Physicians should not interact with current or former patients on personal social networking sites.
- When discussing medicine online, be sure it is in a secure professional network only.
- Physicians should refrain from discussing anything about a clinical experience, and should never refer to patients at all including room numbers or inventing code names, and no pictures.
- No online unprofessional behavior or evidence of unprofessional behavior.

Advice

Don’t post PHI on Facebook!
Okay, we’re done here.
Endless stories...
Rhode Island physician wrote on Facebook about clinical experiences, without using patient names or intending to reveal patient information.
– Patient’s injuries were such that third party was able to identify the patient.
Clinical privileges terminated; state licensing board issued administrative penalty.

Endless stories... (continued)
Numerous stories of providers posting photos and x-rays of patients online.
The emotion around peer review can make it more tempting for someone in the process to want to refer to it in social media.

Harder Issues
Among practicing physicians surveyed, 35% said they had received a “friend” request from a patient or family member.
The AMA’s Council on Ethical and Judicial Affairs published guidelines in 2011 suggesting physicians need to “maintain appropriate boundaries of the patient-physician relationship” online and to consider separating professional and personal content online.
Mentioning the reviewed practitioner on social media

While there is not the same kind of rigorous protection of physician identity that there is of patient identity, the peer review team should be educated NEVER to identify the reviewed physician through social media.

Tips

- Have the peer review policy include a prohibition on discussion outside of the committee – specifically include social media.
- Encourage committee members not to mention the process even in general terms.
- Never permissible to disclose PHI to a general audience on social media without authorization.
  - Potential that patient could be identified by posting, no matter how unlikely you think that is, is not worth the risk.

QUESTIONS?