Practitioner Peer Review Information: Access by Third Parties and by the Practitioner

Session Code: MN07
Time: 12:45 p.m. – 2:15 p.m.
Total CE Credits: 1.5
Presented by: Joanne Hopkins, JD, MSN
Overview

- What we learned from Kadlec v. Lakeview Anesthesia Associates
- The 2014 Christopher Dutsch case
- Principles of peer review confidentiality
  - Obtaining liability protections for disclosures
  - Practical guidelines for sharing peer review information with other health care entities
- Practitioner access to own peer review information
- Sample policy on disclosing and access

Compare:

Dr. Smith’s clinical privileges were terminated because he was performing unnecessary surgery.

Dr. Smith’s clinical privileges were terminated because he failed to document the clinical indications for surgery.
Automated Website Response

Dr. J. Smith
- Initial Appointment to Medical Staff: 1/1/95
- Current Appointment Cycle: 1/31/2013 - 1/31/2015
- Staff Status and Specialty: Active/Cardiology
- The above listed practitioner met the necessary criteria as defined in the Medical Staff Bylaws at the time of reappointment and is currently in good standing.

Form Letter Responses

This letter is written in response to your inquiry regarding Dr. J. Smith. Due to the large volume of inquiries received in this office, the following information is provided. Our records indicate that Dr. Smith was on the Active Medical Staff of the Hospital in the field of Anesthesiology from March 4, 1997 through September 4, 2001. If I can be of further assistance, you may contact me at . . .

NAMSS PASS Affiliation Letter – Option 1

Dates of Affiliation: 08/01/2010 to present
Facility/Location: HMS Hospital, San Diego, CA
Specialty: Pediatric Hospitalist
Staff Category: Active
Status: Good Standing

“Good Standing” means that no adverse professional review action as defined in the HCQIA has been taken regarding this practitioner. That means that there has been no reduction, restriction, suspension, revocation, denial, or non-renewal of the practitioner’s staff membership or clinical privileges. For purposes of this letter, a “restriction” is defined to mean that a mandatory concurrent consultation requirement has been imposed on the practitioner.

Information in this letter last updated by ___ on ______.
NAMSS PASS Affiliation Letter - Option 2

Same initial information as Option 1

“Good Standing” means as follows:
1. Our Hospital evaluates the six ACGME general competencies [listed out] as part of our appointment, reappointment, and privileging processes;
2. No adverse professional review action as defined in the HCQIA has been taken... (same as Option 1); and
3. Our Hospital is unaware of any health issues that might affect the practitioner’s ability to practice safely and competently.

What did we learn from Kadlec Medical Center v. Lakeview Anesthesia Associates, 527 F.3d 412 (5th Cir. 2008)?
- Fifth Circuit found no duty of Lakeview Regional Medical Center or Lakeview Anesthesia Associates to provide information to Kadlec
- BUT if either chose to respond to Kadlec or a third party, response must be correct – there is an affirmative duty not to misrepresent
- LAA did affirmatively misrepresent
- LRMC did not – information provided was correct, it just wasn’t all the information LRMC had...

- Action for negligence and gross negligence
- Neurosurgeon recruited by Baylor in 2011 with financial investment – joined private practice group but left after about three months
- Alleged substance abuse in residency and after relocated to Dallas area – allegedly requested but “dod[ed] at least 5 scheduled drug tests”
- Lawsuit alleges two unnecessary surgeries and a case where another surgeon attempted to intervene before Morguloff case on 1.1.12
Duntsch continued

• Alleged incorrect installation of hardware requiring additional surgery by another MD
• 2.2.12 operated on own roommate who told Baylor that Duntsch used drugs night before surgery – Baylor suspended clinical privileges and reinstated about one month later
• Next day, operated on patient who died of massive blood loss during surgery – Baylor suspended privileges again following which Duntsch resigned, as moving practice elsewhere

Duntsch continued

• Baylor provided Duntsch with letter stating all investigations have been closed and that there had been no summary or administrative restrictions or suspensions
• Obtained clinical privileges at Dallas Medical Center where he had a death in July 2012 and possibly two other problem cases
• Also operated at University General Hospital after left Dallas Medical Center

Duntsch continued

• Surgeon who participated in Morguloff surgery provided letter to Texas Medical Board 6.23.13
• TMB temporarily suspended license 6.26.13 and entered an agreed order revoking license on 12.6.13, referencing care of six patients
• Five professional liability lawsuits filed including Morguloff
• “Gross negligence” requires “malice” or “specific intent by the defendant to cause substantial injury or harm to the claimant”

HCPro Credentialing & Peer Review Legal Insider (June 2014)
Sharing Peer Review Information in Duntsch

- What did Baylor ask about/learn in credentialing Duntsch from residency and fellowship programs?
- What did Dallas practice group disclose to Baylor?
- What did Baylor ask?
- What did OR staff, Duntsch’s APRN, and other practitioners disclose to Baylor about Duntsch?
- What did Dallas Medical Center or University General ask/learn in credentialing Duntsch?
- Could/should Duntsch have been reported earlier to the TMB?

Why the Reluctance to Disclose?

- Fear of being sued by subject practitioner
- Perceived benefit of just letting the practitioner “go away”
- Uncertainty over what and how much to disclose
- Should you disclose more than what is asked
- Fear of loss of confidentiality over information being disclosed
- Disclosure beyond basics may represent a change in practice
- Form responses provide time and cost savings
- Other?

Purpose: Provide guidelines for disclosing and sharing confidential peer review information that address these concerns

Practitioner Peer Review Information: Access by Third Parties and by the Practitioner
Copyright Joanne P. Hopkins, JD, MSN October 2014
1. Maintain confidentiality of what is being disclosed to third party.

- Examine your state’s peer review confidentiality statutes to determine if what you want to disclose is protected as confidential peer review – courts generally do not favor privileges.
- Usual information: specialty, dates of affiliation, staff category, department, privileges, disciplinary action.
- May also include: FPPE and OPPE results, PIPs, complaints, investigations, ...
- If information you want to disclose is protected as confidential, determine under what circumstances it may be disclosed without losing the confidentiality privilege.

Examining state peer review statutes:

- What type of health care entity is afforded peer review confidentiality (most focus on health care entities and committees)?
- What type of information is considered confidential? Just what is generated by the entity or committee, or does it include information received?
- Is confidential information still privileged if it is provided to a third party? All third parties or just some?
- If it can be provided to a third party, must it be provided in a particular way or for a particular purpose?

Example: Texas Medical Peer Review Committee Statutory Privilege

“Medical peer review committee”
- Committee of a health care entity, its governing board, or medical staff
- Operating under written bylaws approved by the governing board
- That is authorized to engage in medical peer review

[Texas Occupations Code Sec. 151.002]
“Medical Peer Review” includes:

- Evaluation of medical and health care services, including evaluation of qualifications or professional conduct of professional health care practitioners and of patient care they provide
- Complaints and evaluation of quality of care provided by practitioner
- Reports to other committees or Texas Medical Board that are permitted or required by law

[Texas Occupations Code Sec. 151.002]

What is privileged?

- Each proceeding or record of medical peer review committee (MPRC)
- Communications to MPRC (but not those gratuitously submitted to MPRC)
- Privileged information is not subject to subpoena or discovery and is not admissible in civil or administrative proceeding unless privilege waived or unless disclosure is required or authorized by law
- Waiver must be in writing and signed by committee officer

[TOC 160.007(a),(e)]

Texas Statutorily Permitted Disclosures by MPRC without Loss of Confidentiality

- To another medical peer review committee
- To appropriate state or federal agency (e.g., CMS)
- To a national accreditation body (e.g., Joint Commission)
- To the Texas Medical Board or another state’s licensing board

[Texas Occupations Code Sec. 160.007(c)]
Tennessee Peer Review Act
- Tenn. Code Ann. Sec. 63-6-219(e) protects information furnished to “medical review committee” or “peer review committee,” as well as any findings, conclusions and recommendations from committee proceedings
- Committee must have function of:
  - evaluating and improving quality of health care rendered by providers or
  - determining services were professionally indicated or performed in compliance with applicable standards of care [(c)]

Virginia Peer Review Statute
- Va. Code Ann. Sec. 8.01-581.17 protects proceedings, minutes, records and reports of certain committees
- Involved person may not be made a witness as to his or her knowledge of process
- Notes that the peer review privilege does not extend to “factual information regarding specific patient health care or treatment, including patient health care incidents…” (medical records are usually considered business records and discoverable subject to patient confidentiality laws)

Federal Privilege of Confidentiality?
- None exists...Health Care Quality Improvement Act is not a confidentiality statute (except as to NPDB information)...unless qualify as PSO
- There is a presumption against privileges in federal courts except in limited situations when would achieve a “public good transcending the normally predominant principle of utilizing all rational means for ascertaining truth” [Trammel v. U.S. (U.S. 1980)]
- Problem asserting peer review privilege in case filed in federal court/asserting federal case of action
2. Disclose information in a manner that affords liability protections or immunity for the disclosure.

- Primary concern is usually with defamation action by practitioner (defamation is unprivileged publication of false statements which result in injury to another) – libel is written, slander is oral
- Truth is a defense to defamation...

Liability Protections

- Examine your state statutes to determine if they afford immunity for reporting or disclosures in connection with medical peer review
- Immunity may be afforded for disclosures in “good faith” or “without malice”
- Availability of immunity may depend on context in which the disclosure is made – probably not absolute
- This is in addition to any release of liability

Example: Medical Peer Review Committee Privilege (Texas)

- Affords immunity from civil liability for a person who in good faith reports or provides information to a medical peer review committee
- Affords immunity for a person, medical peer review committee, or health care entity that without malice participates in medical peer review or provides information or assists a medical peer review committee

[(Texas Occupations Code Sec. 160.010)]
Health Care Quality Improvement Act's Immunity

- No person providing information to a professional review body regarding competence or professional conduct of a physician or dentist shall be liable in damages unless information is false and person providing it knew it was false.
- No requirement to comply with the four standards for a professional review action.
- Key: disclosure to professional review body.

Disclosures in Duntsch

- Practice group to Baylor? Request by Baylor medical peer review committee to practice group.
- Dallas Medical Center request to Baylor and Baylor disclosure in response? Baylor medical peer review committee to – to – Dallas Medical Center medical peer review committee.
- Somebody to Texas Medical Board? Medical peer review committee to TMB (plus most statutes afford separate immunity for reporting in good faith to licensing agency).

Mechanics of Disclosing or Sharing Information

- Use available statutory privileges of confidentiality to keep the information confidential.
- Use available statutory privileges of immunity for medical peer review to protect the person or entity disclosing.
- Texas Example: disclosure by medical peer review committee to medical peer review committee.
- HCQIA Example: disclosure to professional review body - protected unless false and person knows is false.
3. Require an authorization and release from the practitioner.

- Verify you have authorization and release of liability (although it may not be required to respond...)
  - Be sure it authorizes third parties to respond
  - Ideally is relatively current (consider within six months but check state statute)
  - Ideally dated after any “negative” information arose
  - Ideally specifically naming your health care entity
  - If from CVO, check that CVO is listed or referenced in authorization

Release of Liability – How Broad?

- Increasing use of release of liability which affords “absolute” immunity to responder for all acts including those in “bad faith”
- Recommend consulting with legal counsel on what is permissible under state law
- Option of requiring a release of liability “to the fullest extent permitted by law”

4. Identify what is being asked to determine how to respond.

- Answer specific questions and understand what is being asked?
  - Is Dr. Smith under probation?
  - Dr. Smith is under probation.
- Know how certain “interventions” such as Performance Improvement Plans are characterized, e.g., whether considered corrective or disciplinary action
- Some use option of pre-prepared letter for practitioner with “negative information” in lieu of tailored response – provided regardless of questions, but are you volunteering information that may not have been requested?
5. Focus on factual information that can be verified in peer review file.

- Truth is a defense to defamation
- Facts, facts, facts...
  - Dr. Smith’s clinical privileges were terminated because he was performing unnecessary surgery.
  - Dr. Smith’s clinical privileges were terminated because he failed to document the clinical indications for surgery.

Responding . . .

- Third party query by Kadlec on Dr. Berry:
  - Was he providing professional services pursuant to a contract? Had any action been taken under the contract to limit his services?
  - Was he exercising clinical privileges at the time his appointment term expired?
  - Had any complaints been received regarding his ability to exercise his clinical privileges?
  - Had any concerns been raised regarding possible impairment?

Responding . . .

- Exercise caution with opinions on whether practitioner “qualified” or “recommended” for another entity – is that reflected in peer review file?
- Recommend that requests for opinions dealing with clinical competence be referred to clinical staff, rather than handled by medical staff services personnel
- Distinguish between factual information in file and evaluations by other practitioners
Sample Policy Provision

Any responses to third party queries or evaluations prepared by a member of the Medical Staff in the member’s capacity as a Medical Staff or Department officer shall be forwarded to the Medical Staff Office for transmission to the requesting party and shall be subject to the approval of the CEO as agent for the Governing Board. Nothing in this provision is intended to limit the issuance of a peer reference or evaluation by a member in that member’s individual capacity.

6. Use written responses if possible.

- Benefit of written response is have exact record of what was disclosed (and what was not) – oral responses are subject to challenge
- If information provided orally, make a record
- Recommend maintaining copy of responses
- Look at state law on maintenance of peer review files or hospital records as to how long to maintain
- Generally, copy of response is not provided to subject practitioner by disclosing entity (but may be provided by receiving entity...)

7. Reinforce confidentiality in actual response.

- Use form cover letter to reinforce confidentiality (and any other significant statutory provisions)
- (Texas example) This information contains strictly confidential records and proceedings of a MPRC and is provided solely for purposes of medical peer review/professional review activity...may not be redisclosed without the consent of the committee...disclosure of this information is pursuant to Tex. Occ. Code Sec. 160.007(c), and is not intended to waive any applicable privileges of confidentiality.
   - Document status of hospital staff or others working with committee or professional review body as an “agent” (e.g., CEO, MSO staff, outside expert, proctors, observers)
   - Note are acting on behalf of committee or professional review body when communicating with third parties for purposes of peer review
     - B. Jones, Medical Staff Coordinator, as agent for Credentials Committee
     - Dr. A. Brown, Member, on behalf of Credentials Committee

9. Have a policy with guidelines for responding.
   - “Guidelines” for responding versus requirements
   - Elements of policy:
     - What is required before will respond (e.g., must be health care entity, authorization and release from practitioner)
     - Who responds and any approval required
     - What is disclosed and what is not
       - preliminary or non-final matters?
       - matters not known to practitioner?
     - When to consult with Administration or Legal

9. Policy continued
   - Policy may provide that entity will respond to questions asked or that will provide only designated information set out in policy
   - Address anything that will not be provided (such as recommendation as to whether practitioner should be granted privileges at another entity...)
   - Address how is information will be disclosed – in Texas, MPRC - to - MPRC
   - Consider addressing disclosure of OPPE data since seeing more requests in this regard
10. Aim for consistency in disclosures.

- Relationship between:
  - Reason for adverse action by Medical Staff
  - Narrative provided to Data Bank
  - Information provided to state licensing board
  - Response to third party query
  - Response to next third party query...
- “How did we answer this question the last time?”

Mediation and Settlements

- Address how will handle third party queries
- Example: Except as may be required by law, the Hospital and any member of the Medical Staff responding in that member’s official capacity shall provide only the following in response to a request for information received by the Hospital:...
  Nothing in this agreement is intended to apply to or limit any disclosure by a member of the Medical Staff in that member’s individual capacity.

Obtaining Information from Third Parties

- Use same statutory protections (if available) to request (i.e., MPRC to MPRC for Texas)
- State that results will be used solely for peer review
- State that information received will be maintained in a confidential manner (but do not promise confidentiality from practitioner…)
- Ask specific questions that elicit facts – remember suggested Kadlec questions on Dr. Berry…
Compare:

- Please provide any information that may be pertinent to our credentialing process.
- Has the practitioner been subject to any corrective or disciplinary action or has an investigation for such purpose ever been initiated? If so, please explain the action(s) taken and the reason(s) for the action(s).
- Has the practitioner been subject to any FPPE other than that applicable to all practitioners on an initial grant of clinical privileges? If so, please explain.

Obtaining Information

- Ask third party to note in response that information being provided in response to specific request (not gratuitously): This information is being provided solely for purposes of peer review by your facility and in response to your committee’s written request.
- Inquiry should originate from committee or professional review body and response should be directed to committee or professional review body (or whatever is appropriate under state statute)
- Provide current authorization and liability release

Practitioner Access to Own Peer Review Information

- This deals with access at any time but particularly...
  - If complaint filed by hospital staff
  - In course of investigation for purposes of corrective action
  - Practitioner concerned with unfavorable third party query response
  - Distinguish from access rights during hearing and appellate review in event of adverse action which should be governed by fair hearing plan
Practitioner Access to Own Peer Review Information

- Check state statutes to determine if they establish any right of practitioner to access some or all peer review information
- For example, Texas requires physician be provided with written copy of MPRC’s recommendation and final decision, including statement of basis for decision, if committee takes action that could result in censure, suspension, restriction, limitation, revocation, or denial of membership or privileges in a health care entity. [Texas Occupations Code Sec. 160.007(d)]

Written Policy on Access and Disclosure

- Address access:
  - By practitioner
  - By hospital staff and medical staff
  - By third parties, such as accreditation and licensing agencies
  - In the event of subpoena
- Recommend guidelines not absolute requirements if possible
- Requires advance planning
- Provides for consistency in handling

Sample Policy on Access and Disclosure

**Purpose**: Promote confidentiality in accordance with state law and establish procedures and guidelines for access and disclosure to medical peer review information

**Policy**: Medical peer review records and proceedings will be handled and maintained in confidential manner in accordance with procedures and guidelines to extent feasible

**Definition**: Establish what is considered confidential for purposes of policy
Sample Policy on Access continued

1. Access by Hospital and Medical Staff personnel for official functions
2. Access by third parties (include sample cover letter)
   • What information
   • What not to provide
3. Access by practitioner
   • Review v. copies
   • Distinguish hearing/appellate review situation
4. Subpoenas
5. Requests by accreditation or agency surveyors
6. Waiver of privilege of confidentiality

Summary of Guidelines on Disclosing and Sharing Peer Review Information

1. Maintain confidentiality of what is being disclosed to third party.
2. Disclose information in manner that affords liability protections or immunity for the disclosure.
3. Require an authorization and release from the practitioner.
4. Identify what is being asked to determine how to respond.

Summary of Guidelines continued

5. Focus on factual information that can be verified in peer review file.
6. Use written responses if possible.
7. Reinforce confidentiality in actual response.
9. Have a policy with guidelines for responding.
10. Aim for consistency in disclosures.
Questions? Thank you!

This presentation is solely for general educational purposes. Neither the information on the slides nor the speaker’s statements during the presentation should be interpreted as legal advice.

Joanne P. Hopkins, JD, MSN
P.O. Box 162834
Austin, Texas
512.327.4647
jhopkins@texas.net
www.hopkinshealthlawyer.com
NOTE: This policy is provided by the speaker as a sample for educational and discussion purposes only in connection with the presentation Practitioner Peer Review Information: Access by Third Parties and by the Practitioner at the 38th Annual NAMSS Educational Conference & Exhibition. Any use should be reviewed by legal counsel to accommodate state law.

**Purpose:** To promote the confidentiality of Hospital and Medical Staff credentialing and peer review files, Medical Staff department/committee documents, and other Medical Staff documents dealing with medical peer review for the protection of the practitioner, the Medical Staff and the Hospital, and in accordance with state law.

To provide procedures/guidelines for access and disclosure of medical peer review records and proceedings.

**Policy:** All Hospital and Medical Staff records and proceedings of medical peer review will be consistently handled and maintained in a confidential manner in accordance with the procedures/guidelines in this policy to the extent feasible. See Article ___ in the Medical Staff Bylaws.

**Definition:** [define what is considered confidential medical peer review information under state law and court cases]

**Procedures/Guidelines:**

A. **Access by persons performing official Hospital or Medical Staff functions.**

1. Access to information contained in Hospital and Medical Staff records is permitted to the extent necessary to perform official functions and is limited to: Hospital CEO, CMO, CNO, Medical Staff Chief of Staff, Medical Staff Chief of Staff Elect, and appropriate Clinical Department Chairs (or designee).

2. Access to information contained in Hospital and Medical Staff records is permitted to perform department/committee or Board of Directors functions and is limited to members of: Medical Executive Committee, Peer Review Committee, Credentials Committee, and Board of Directors.

3. Access to information contained in Hospital and Medical Staff records is permitted to the extent necessary to prepare documents, reports, profiles for appointment, reappointment, FPPE, OPPE, and other medical peer review and is limited to: Medical Staff Services Department staff, Quality Management personnel, and Risk Management personnel.
4. Requests under Section A.1-3, shall be made to Medical Staff Services Department staff who shall arrange for access to the appropriate information.

5. Any requests to review information other than as listed above under Section A.1-3, will be noted by Medical Staff Services Department personnel in a written log, including date of review, names of practitioner files reviewed, and purpose of review, and shall require prior approval by the Hospital CEO or Medical Staff Chief of Staff (or designee) which shall also be noted in the log. The documentation shall be maintained by and in the Medical Staff Services Department for a period of at least five years from the date of access.

6. Any review of Hospital or Medical Staff records shall take place in the Medical Staff Services Department in the presence of the Medical Staff Coordinator or a Credentialing Specialist or in a committee meeting. Copying of documents is not permitted except for use in committee or other authorized meetings.

B. Access by persons or organizations outside of Hospital:

1. Requests for medical peer review information from other hospitals/health care entities will be responded to with the most recent data available regarding staff status, appointment/reappointment dates, and specialty area in which privileges have been granted. This information may be provided based on a written or oral request, but the response shall be in writing. A signed authorization and release of liability from the subject practitioner is preferred but not required.

2. Requests for practitioner information other than the information noted in Section B.1 above (ex: disciplinary actions, quality data, etc.) must be in writing. The request must state the reasons for the request and include an authorization and release of liability signed by the practitioner dated within the previous six months.

   a. Responses shall be made by the Medical Staff Services Department on behalf of the Medical Executive Committee directly to a medical peer review committee (or its representative or designee) at the requesting hospital/health care entity. All responses shall be in writing.

   b. The information shall be marked as “privileged and confidential – records and proceedings of medical peer review committee” (or an equivalent statement) and include a statement that the disclosure is solely for purposes of medical peer review, made pursuant to [insert relevant state statutory citation], and is not intended to waive any applicable privileges of confidentiality. [Recommend attaching sample letter with appropriate statutory language.]

NOTE: This policy is provided by the speaker, Joanne P. Hopkins, JD, MSN, as a sample for educational and discussion purposes only in connection with the presentation Practitioner Peer Review Information: Access by Third Parties and by the Practitioner at the 38th Annual NAMSS Educational Conference & Exhibition. Any use should be reviewed by legal counsel to accommodate state law.
c. All requests for information about practitioners whose file contains adverse information or information that may have a negative effect on a practitioner’s membership or privileges at another hospital/health care entity should be reviewed by Administration and/or Hospital legal counsel prior to submitting a response [list anyone else who must approve].

d. A copy of all requests and responses under Section B.2 above shall be maintained in the subject practitioner’s file.

3. Third parties will not be provided with opinions or recommendations as to whether a practitioner is qualified or recommended for medical staff membership or clinical privileges at the requesting hospital or health care entity. [consider listing anything that will not be disclosed unless required by law]

4. [OPPE data for other entities]

5. Any request from a third party that is not a hospital or health care entity, as defined in Section 151.002(a)(5) of the Texas Occupations Code, must be approved by ______________ before a response is provided to verify that confidentiality of the information can be maintained.

C. Access by the practitioner.

1. A practitioner may have copies of any documents in the practitioner’s own credentials and peer review files which the practitioner submitted (that is, the initial application, application for reappointment, request for privileges, or correspondence from the practitioner to the Hospital or Medical Staff) or copies of correspondence which was addressed directly to the practitioner.

2. A practitioner shall also have the right to review Medical Staff records related to the practitioner’s meeting attendance, CME, suspensions for failure to complete medical records, and patient care activity reports. If the practitioner believes there is an error in these records, the practitioner may submit a written explanation of the error or the corrected information.

3. The practitioner’s review of records under this Section C shall take place by appointment in the Medical Staff Services Department during normal business hours with a Medical Staff officer or designee present such as the Medical Staff Coordinator or a Credentialing Specialist. Original documents may not be removed from the Medical Staff Services Department, but may be copied by Medical Staff Services Department personnel at the request of the practitioner if the practitioner is entitled by this policy to obtain copies.

4. A practitioner may not review any other Hospital or Medical Staff records and proceedings, including without limitation, committee minutes, third party requests

NOTE: This policy is provided by the speaker, Joanne P. Hopkins, JD, MSN, as a sample for educational and discussion purposes only in connection with the presentation Practitioner Peer Review Information: Access by Third Parties and by the Practitioner at the 38th Annual NAMSS Educational Conference & Exhibition. Any use should be reviewed by legal counsel to accommodate state law.
and responses, incident reports, staff complaints, peer recommendations, or other internal/external recommendations solicited or written on behalf of the Hospital or Medical Staff. In the event of a hearing or appellate review, the provisions in the Fair Hearing and Appellate Review Plan of the Medical Staff Bylaws shall control as to what documents the practitioner is entitled to or may access.

5. Under no circumstances may a practitioner access the Hospital or Medical Staff records of another practitioner except in the course of performing committee functions (see Section A).

D. **Subpoenas.**

All subpoenas of Hospital and Medical Staff records shall be referred to the Risk Manager and the Hospital’s legal counsel. A log of all subpoenas received and the information provided and the date the response was sent shall be maintained by the Risk Manager for a period of at least five years from the date of response.

E. **Requests by Accreditation or Agency Surveyors.**

1. Facility surveyors (from The Joint Commission, NCQA, Department of State Health Services, Federal Health Care Financing Administration, CMS, or any other accrediting or licensing agencies) shall be entitled to inspect records covered by this policy.

2. The inspection of records shall take place on the facility’s premises, during normal business hours, and in the presence of appropriate Hospital, Medical Staff and/or Medical Staff Services Department personnel.

3. Any request for copies of documents must be made in writing and the requesting entity shall be asked to note their authority on the request for obtaining copies. The Hospital should consult with legal counsel if there is a question on the entity’s right to copies. Copies of the written request for documents and a list of documents provided shall be maintained by the Medical Staff Services Department for a period of five years from the date of providing the copies.

F. **Waiver of Medical Peer Review Committee Privilege.**

The privileges of confidentiality afforded to the records and proceedings of any medical peer review committee may only be waived in writing in a document signed by the chair or vice-chair of the committee and the CEO. An individual member or agent of a committee may not waive any privilege of confidentiality through the intentional or unintentional disclosure of the records and proceedings of the committee. Any attempt to waive the privileges of confidentiality except as provided above shall not be effective. See Article ___ of the Medical Staff Bylaws.

NOTE: This policy is provided by the speaker, Joanne P. Hopkins, JD, MSN, as a sample for educational and discussion purposes only in connection with the presentation Practitioner Peer Review Information: Access by Third Parties and by the Practitioner at the 38th Annual NAMSS Educational Conference & Exhibition. Any use should be reviewed by legal counsel to accommodate state law.
NOTE: This policy is provided by the speaker, Joanne P. Hopkins, JD, MSN, as a sample for educational and discussion purposes only in connection with the presentation Practitioner Peer Review Information: Access by Third Parties and by the Practitioner at the 38th Annual NAMSS Educational Conference & Exhibition. Any use should be reviewed by legal counsel to accommodate state law.
ATTACHMENT: SAMPLE LETTER TO RESPOND TO THIRD PARTY REQUESTS FOR MEDICAL PEER REVIEW INFORMATION - NOTE: THIS LETTER IS TEXAS SPECIFIC

[Include privileged and confidential medical peer review header]

Date

[How sent]

TO: ______________________________________

FROM: [name] __________________________
Medical Staff Services Department, _____________ Hospital
On behalf of the Medical Executive Committee

DATE:

The following is in response to your request of [date] on behalf of the medical peer review committees of your health care entity’s medical staff. The information being provided [below] [which is attached] constitutes privileged and confidential records and proceedings of the medical peer review committees of the Medical Staff of _____________ Hospital (Hospital). It is being provided solely for the use of your medical peer review committees in medical peer review and professional review activity, and it may not be re-disclosed without the written consent of this Hospital.

The information is being provided to your committees pursuant to Section 160.007(c)(1) of the Texas Occupations Code, which authorizes the disclosure of this type of confidential information between medical peer review committees. Disclosure is not intended to waive any applicable privileges of confidentiality.

[set out information or attach – each page if attached should be stamped with confidential header]