Katten
KattenMuchinRosenman LLP

New York State Association Medical Staff Services (NYSAMSS) Annual Education Conference

May 5-7, 2010

Developments in Negligent Credentialing and Strategies for Limiting Liability

Michael R. Callahan
Katten Muchin Rosenman LLP
525 W. Monroe • Chicago, Illinois
312.902.5634
michael.callahan@kattenlaw.com

Katten
Katten Muchin Rosenman LLP

Goals of Program

- What must a plaintiff establish in order to succeed in a negligent credentialing case
- Review of recent cases and their impact on a hospital's duty to protect patients
- How to successfully defend against these actions
- The importance of establishing and uniformly applying credentialing criteria as well as documenting grounds for exceptions to minimize negligent credentialing claims
- What impact does your state's peer review confidentiality statute have on the hospital's ability to defend against these lawsuits
- How to maximize your peer review protections as applied to physician profiling and P4P information

Environmental Overview

- Plaintiffs are looking for as many deep pockets as possible in a malpractice action
  - Hospital has the deepest pockets
- Tort reform efforts to place limitations or “caps” on compensatory and punitive damages has increased efforts to add hospitals as a defendant
- Different Theories of Liability are utilized
  - Respondent Superior
    - Find an employee who was negligent
  - Apparent Agency
    - Hospital-based physician, i.e., anesthesiologist, was thought to be a hospital employee and therefore hospital is responsible for physician’s negligence

Environmental Overview (cont'd)

  - Doctrine of Corporate Negligence
    - Hospital issued clinical privileges to an unqualified practitioner who provided negligent care
- Emphasis on Pay for Performance ("P4P") and expected or required quality outcomes as determined by public and private payors
- Greater transparency to general public via hospital rankings, published costs and outcomes, accreditation status, state profiling of physicians, etc.

Environmental Overview (cont'd)

- Required focus on evidenced-based guidelines and standards and the six Joint Commission competencies (patient care, medical knowledge, practice based learning and improvement, interpersonal and communication skills, professionalism and systems based practice) and ongoing and focused professional practice evaluation ("OPPE" and "FPPE") as a basis of determining who is currently competent to exercise requested clinical privileges
- The result of all of these evolving developments is an unprecedented focus on how we credential and privilege physicians as well as the volume of information we are requesting and generating as part of this ongoing analysis

The Tort of Negligence

- Plaintiff must be able to establish:
  - Existence of duty owed to the patient
  - That the duty was breached
  - That the breach caused the patient's injury
  - The injury resulted in compensable damages

Duty - Doctrine of Corporate Negligence

- Hospital, along with its medical staff, is required to exercise reasonable care to make sure that physicians applying to the medical staff or seeking reappointment are competent and qualified to exercise the requested clinical privileges. If the hospital knew or should have known that a physician is not qualified and the physician injures a patient through an act of negligence, the hospital can be found separately liable for the negligent credentialing of this physician
- Doctrine also applies to managed care organizations such as PHOs and IPAs

Duty - Doctrine of Corporate Negligence (cont'd)

- Restatement of this Doctrine and duty is found in:
  - Case law, i.e., Darling v. Charleston Community Hospital
  - State hospital licensing standards
  - Accreditation standards, i.e., Joint Commission and Healthcare Facilities Accreditation Program, NAMSS
  - Medical staff bylaws, rules and regulations, department and hospital policies, corporate bylaws and policies

Duty - Doctrine of Corporate Negligence (cont'd)

- Some questions associated with this duty:
  - How are core privileges determined?
  - Based on what criteria does hospital grant more specialized privileges?
  - Are hospital practices and standards consistent with those of peer hospitals?
  - Were any exceptions to criteria made and, if so, on what basis?

Duty - Doctrine of Corporate Negligence (cont'd)

- Were physicians to whom the exemption applied "grandfathered" and, if so, why?
- Did you really scrutinize the privilege card of Dr. Callahan who is up for reappointment but has not actively practiced at the Hospital for the last six years?
- Has each of your department's adopted criteria which they are measuring as part of FPPE or OPPE obligations such as length of stay patterns or morbidity and mortality data?

Breach of Duty

- The hospital breached its duty because:
  - It failed to adopt or follow state licensing requirements
  - It failed to adopt or follow accreditation standards, i.e., FPPE and OPPE
  - It failed to adopt or follow its medical staff bylaws, rules and regulations, policies, core privileging criteria, etc.
  - It reappointed physicians without taking into account their accumulated quality or performance improvement files

Breach of Duty (cont'd)

- It reappointed physicians even though they have not performed any procedures at hospital over the past two years and/or never produced adequate documentation that the procedures were performed successfully elsewhere
- It failed to require physicians to establish that they obtained additional or continuing medical education consistent with requirement to exercise specialized procedures
- It appointed/reappointed physician without any restrictions even though they had a history of malpractice settlements/judgments, disciplinary actions, insurance gaps, licensure problems, pattern of substandard care which has not improved despite medical staff intervention, current history or evidence of impairment, etc.

Breach of Duty (cont'd)

- It failed to grandfather or provide written explanation as to why physician, who did not meet or satisfy credentialing criteria, was otherwise given certain clinical privileges
- It required physician to take ED call even though he clearly was not qualified to exercise certain privileges
- Violated critical pathways, ACOG, ACR standards

Causation

- The hospital's breach of its duty caused the patient's injury because:
  - If the hospital had uniformly applied its credentialing criteria, physician would not have received the privileges which he negligently exercised and which directly caused the patient's injury
  - History of malpractice suits since last reappointment should have forced hospital to further investigate and to consider or impose some form of remedial or corrective action, including reduction or termination of privileges, and such failure led to patient's injury
- Causation is probably the most difficult element for a plaintiff to prove because plaintiff eventually has to establish that if hospital had met its duty, physician would not have been given the privileges that led to the patient's injury
- Plaintiff also must prove that the physician was negligent. If physician was not negligent, then hospital cannot be found negligent

Examples of Negligent Credentialing Cases

- Darling v. Charleston Community Memorial Hospital (1965)
  - First case in the country to apply the Doctrine of Corporate Negligence
  - Case involved a teenage athlete who had a broken leg with complications and was treated by a family practitioner
  - Leg was not set properly and patient suffered permanent injury
  - Hospital claimed no responsibility over the patient care provided by its staff physician

Examples of Negligent Credentialing Cases (cont'd)

- Court rejected this position as well as the charitable immunity protections previously provided to hospitals
- Part of the basis for the decision was the fact that hospital was accredited by the Joint Commission and had incorporated the Commission's credentialing standards into its corporate and medical staff bylaws

Examples of Negligent Credentialing Cases (cont'd)

- These standards reflected an obligation by the medical staff and hospital to make sure physicians were qualified to exercise the privileges granted to them
- Physician was found to be negligent
- The medical staff and hospital's decision to give privileges to treat patients with complicated injuries to an unqualified practitioner directly caused the patient's permanent injuries. Therefore, the hospital was held liable for the damages

Examples of Negligent Credentialing Cases (cont'd)

- Frigo v. Silver Cross Hospital (2007)
  - Frigo involved a lawsuit against a podiatrist and Silver Cross
  - Patient alleged that podiatrist's negligence in performing a bunionectomy on an ulcerated foot resulted in osteomyelitis and the subsequent amputation of the foot in 1998

Examples of Negligent Credentialing Cases (cont'd)

- The podiatrist was granted Level II surgical privileges to perform these procedures even though he did not have the required additional post-graduate surgical training required in the Bylaws as evidenced by completion of an approved surgical residency program or board eligibility or certification by the American Board of Podiatric Surgery at the time of his initial appointment in 1992

Examples of Negligent Credentialing Cases (cont'd)

- At the time of his reappointment, the standard was changed to require a completed 12 month podiatric surgical residency training program, successful completion of the written eligibility exam and documentation of having completed 30 Level II operative procedures
- Podiatrist never met these standards and was never grandfathered. In 1998, when the alleged negligence occurred, he had only performed six Level II procedures and none of them at Silver Cross

Examples of Negligent Credentialing Cases (cont'd)

- Frigo argued that because the podiatrist did not meet the required standard, he should have never been given the privileges to perform the surgery
- She further maintained that the granting of privileges to an unqualified practitioner who was never grandfathered was a violation of the hospital's duty to make sure that only qualified physicians are to be given surgical privileges. The hospital's breach of this duty caused her amputation because of podiatrist's negligence

Examples of Negligent Credentialing Cases (cont'd)

- Jury reached a verdict of $7,775,668.02 against Silver Cross
- Podiatrist had previously settled for $900,000.00
- Hospital had argued that its criteria did not establish nor was there an industry-wide standard governing the issuance of surgical privileges to podiatrists
- Hospital also maintained that there were no adverse outcomes or complaints that otherwise would have justified non-reappointment in 1998

Examples of Negligent Credentialing Cases (cont'd)

- Court disagreed and held that the jury acted properly because the hospital's bylaws and the 1992 and 1993 credentialing requirements created an internal standard of care against which the hospital's decision to grant privileges could be measured
- Court noted that Dr. Kirchner had not been grandfathered and that there was sufficient evidence to support a finding that the hospital had breached its own standard, and hence, its duty to the patient
- This finding, coupled with the jury's determination that Dr. Kirchner's negligence in treatment and follow up care of Frigo caused the amputation, supported jury's finding that her injury would not have been caused had the hospital not issued privileges to Dr. Kirchner in violation of its standards

Examples of Negligent Credentialing Cases (cont'd)

  - Jury verdict was affirmed. Petition for leave to appeal to Illinois Supreme Court was denied

- See also Larson v. Wasemiller (Minn. Sup. Ct. 2007)
  - For the first time, the Supreme Court of Minnesota recognized that the tort of negligent credentialing "is inherent in and the natural extension of well established common law rights"

Examples of Negligent Credentialing Cases (cont'd)

- Court noted that at least 30 states recognize this tort theory and only two states, Pennsylvania and Maine, have rejected the claim. Other related theories are direct or corporate negligence, duty of care for patient safety, negligent hiring and negligent selection of independent contractors
- Court further held that the tort of negligent credentialing was not pre-empted by the peer review statute

Examples of Negligent Credentialing Cases (cont'd)

Smithey v. Brauweiler (2008)

- Dr. Brauweiler was a family practitioner who applied for and received medical staff privileges at Sandwhich Community Hospital (now Valley West Community Hospital), including obstetrical privileges, in 1991.
- In 1995, he delivered a child by operative vacuum delivery. Delivery was successful but child needed resuscitation. Through no fault of physician, resuscitation was delayed leading to permanent brain damage. Lawsuit was filed in 1997 for alleged negligence against hospital and Dr. Brauweiler.

Examples of Negligent Credentialing Cases (cont'd)

- During deposition, physician testifies that a vacuum extraction would be a deviation of the standard of care if done at +1 station or higher.
- Dr. Brauweiler was reappointed each time with OB privileges, including the specific grant of operative vacuum and operative forceps delivery which were separate privileges in 2000. No adverse results in other vacuum delivery cases.
- In 2001, he delivered a child by vacuum delivery but this time, vacuum extractor was performed 22 times in 33 minutes because it kept popping off. Infant was presenting at +1 the whole time. OB was called and did a C section.

Examples of Negligent Credentialing Cases (cont'd)

Apgars were 2, 3 and 6. Infant diagnosed with hypoxic ischemic encephalopathy. Lawsuit was filed in 2003 against Dr. Brauweiler and amended in 2005 to include the hospital on a negligent credentialing claim.

- In 2002, he withdrew his OB privileges.
- Plaintiff's attorney argued that hospital was negligent in granting OB privileges to Dr. Brauweiler in the first place and especially after the 1995 case even though he was not at fault.
  - Plaintiff contended that the case should at least have called into question the physician's qualifications.

Examples of Negligent Credentialing Cases (cont'd)

- Hospital decided that it did not want to run the risk of losing at trial and settled case for almost $8 million.
- Defense not able to introduce the peer review record of hospital to establish that it met its duty because they were inadmissible under the Medical Studies Act.
- IHA has set up a round table discussion of expert defense and corporate attorneys to discuss how to best defend against these corporate negligence cases in light of more aggressive tactics by plaintiff's attorneys and problems caused by the MSA.

Joint Commission Standards on Focused and Ongoing Performance Monitoring

- Standard 3.10
  - Performance improvement. Medical staff is **actively** involved in measurement, assessment and improvement of the various PI standards
  - Medical Staff is now a provider of oversight for quality of care services and treatment
  - Is responsible for ongoing evaluation of competency and delineation of privileges

Joint Commission Standards on Focused and Ongoing Performance Monitoring (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 medical staff physician has the degree of training, education and experience required to perform each of the requested privileges and procedures

Joint Commission Standards on Focused and Ongoing Performance Monitoring (cont'd)

- Information about a practitioner's scope of privileges must be updated as changes in clinical privileges are made
- Medical staff and governing board must develop criteria that will be considered when deciding to grant, limit or deny requested privileges – ties in with CMS Conditions of Participation and concerns about use of core privileging not related to actual evidence-based privileging
- If privileging is unrelated to quality of care, treatment and services or professional competence, evidence must exist that impact of resulting decisions on the quality of care, treatment, and services is evaluated

Joint Commission Standards on Focused and Ongoing Performance Monitoring (cont'd)

- Emphasis is on three new concepts
  - General Competencies
    - Patient care (compassionate, appropriate, effective)
    - Medical/clinical knowledge (demonstrated knowledge and application of biomedical, clinical and social services)
    - Practice-based learning and improvement (is physician obtaining CMEs) (use of scientific evidence and methods to investigate, evaluate and improve practices)

Joint Commission Standards on Focused and Ongoing Performance Monitoring (cont'd)

- Interpersonal and communications skills (demonstration of interpersonal and communication skills to establish and maintain professional relationships)
- Professionalism (commitment to continuous professional development, ethical practice, reactivity to diversity and a reasonable attitude)
- Systems-based practice (is physician abiding by all policies, participating in EHR initiatives, modifying behaviors based on profiling data)

Joint Commission Standards on Focused and Ongoing Performance Monitoring (cont'd)

- Looks for a balance between clinical and professional behavior

- Focused Professional Practice Evaluation
- Ongoing Professional Practice Evaluation

Joint Commission Standards on Focused and Ongoing Performance Monitoring (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
  - Need adequate information to confirm competence
  - Core privileging

Joint Commission Standards on Focused and Ongoing Performance Monitoring (cont'd)

  - Effective January 1, 2008, a period of focused professional evaluation is implemented for all initially requested privileges

- A period of focused professional practice evaluation is implemented for all initially requested privileges (EP1)
  - Must develop criteria to evaluate performance of physicians when issues affecting patient safety and quality of care are identified (EP2)
  - Performance monitoring includes:
    - Criteria
    - Method for setting up a monitoring plan
    - Method for identifying duration of the plan
    - Identifying circumstances when an outside review will be sought (EP3)

Joint Commission Standards on Focused and Ongoing Performance Monitoring (cont'd)

- Evaluation consistently applied (EP4)
- Focused review triggers are defined (EP5)
- Need to focus on the particular issue or privileges in question to make sure physician is currently competent to exercise same. Cannot avoid review simply because physician has no problems with other privileges (EP6)
- Must develop standard and criteria for determining what form of monitoring is to take place (EP7)
- How is resolution of performance defined – results or timing (EP8)
- Resolution standard uniformly applied (EP9)

Joint Commission Standards on Focused and Ongoing Performance Monitoring (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)

Joint Commission Standards on Focused and Ongoing Performance Monitoring (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

Joint Commission Standards on Focused and Ongoing Performance Monitoring (cont'd)

- Pattern of blood and pharmaceutical usage
- Request for test and procedures
- Length of stay patterns
- Morbidity and mortality data
- Practitioners usage of consultants
- Other relevant criteria

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

Joint Commission Standards on Focused and Ongoing Performance Monitoring (cont'd)

- Problems identified during ongoing review should trigger a focused review or other intervention. Generally looking for patterns or trends
- "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

Joint Commission Standards on Focused and Ongoing Performance Monitoring (cont'd)

- Evaluation can be based on different sources of information such as chart reviews, direct observation, monitoring, consultations with other care givers, etc.
- Must have a clearly identified process to facilitate evaluation of each physician (EP1)
- Data to be collected is determined by each department and approved by the organized medical staff (EP2)
- Information from ongoing performance monitoring is used to continue, revoke or limit any or all existing privileges (EP3)

Defending Against a Corporate Negligence Claim

- Existence of duty and breach of duty and causation is usually established through expert testimony
- Expert must establish that duty was not met, i.e., that hospital adopted and followed all standards as reflected in its bylaws and procedures, and/or no breach occurred and/or if there was a breach, it did not cause patient's injuries

Defending Against a Corporate Negligence Claim (cont'd)

- Courts and juries may be less likely to hold in favor of the plaintiff even if, for example, a physician's lack of qualifications or history of malpractice actions raises the issue of whether privileges should have been granted, as long as some action was taken, i.e., physician was being monitored or proctored or was under a mandatory consultation
- A judge and jury will be more likely to find in favor of the plaintiff if the hospital did absolutely nothing with respect to the physician's privileges

Defending Against a Corporate Negligence Claim (cont'd)

- It will be important for hospital to establish that there is not necessarily a black and white standard on what qualifications are absolutely required before issuing clinical privileges although such a position, at least for certain privileges, may have been established, i.e., PTCAs
- Also, the hospital should argue that even if a physician was identified as having issues or problems, a reduction or termination of privileges is not always the appropriate response. Instead, the preferred path is for the hospital to work with the physician to get them back on track by implementing other remedial measures such as monitoring, proctoring, additional training, etc. (See Golden Rules of Peer Review at p. 69)
- Attempt to introduce physician's peer review record to establish that Hospital met it's duty

Defending Against a Corporate Negligence Claim (cont'd)

- You must evaluate whether your peer review statute does or does not allow introduction of peer review record into evidence for this purpose
- Denying a plaintiff access to this information usually makes it more difficult to prove up a negligent credentialing claim
- Most statutes do not permit the discovery or admissibility of this information because to do so would have a chilling effect on necessary open and frank peer review discussion. There is no statutory exception that allows a hospital to pick and choose when I can or cannot introduce information into evidence

Defending Against a Corporate Negligence Claim (cont'd)

- In Frigo, hospital's attempt to establish that duty was met by showing, through the peer review record, that podiatrist had no patient complaints or bad outcomes was denied because prohibition on admissibility into evidence was absolute
- Court stated, however, that this information was somewhat irrelevant because the Hospital clearly did not follow its own standards

Other Preventative Steps to Consider

- Conduct audit to determine whether hospital and medical staff bylaws, rules and regulations and policies comply with all legal accreditation standards and requirements
- If there are compliance gaps, fix them
- Determine whether you are actually following your own bylaws, policies and procedures

  Remember: Bylaws, policies and procedures and guidelines are all discoverable. They also create the hospitals internal standard. If you do not follow your bylaws and standards, you arguably are in breach of your patient care duties
- If you are not following your bylaws and policies, either come into compliance or change the policies
- Update bylaws and policies to stay compliant

Other Preventative Steps to Consider
(cont'd)

- Confer with your peers. Standard of care can be viewed as national, i.e., Joint Commission, internal or area-wide so as to include the peer hospitals in your market. If your practices deviate from your peers, this will be held against you as a breach of the standard of care
- It is very important to understand from your insurance defense counsel how plaintiff's attempt to prove a corporate negligence violation as well as how these actions are defended
  - These standards have a direct impact on hospital prophylactic efforts to minimize liability exposure

Other Preventative Steps to Consider
(cont'd)

  - What testimony must plaintiff's expert assert to establish a claim and what must defense expert establish to rebut?
  - Every state has its own nuances and you must understand them in order to defend accordingly

- Does your state peer review statute allow for the introduction of confidential peer review information under any circumstances either to support a plaintiff's claim or to defend against it?
- If the file information would help the hospital, can the privilege be waived in order to defend the case? Realize that plaintiff also would have access. Will this help or hurt you?

Other Preventative Steps to Consider
(cont'd)

  - The answers to these questions are important because the hospital may want to create a record of compliance with its duty that is not part of an inadmissible peer review file. This effort must be coordinated with internal and/or external legal counsel

- Otherwise, take steps for maximizing protections under peer review confidentiality statue.

The Era of Pay for Performance

- 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

The Era of Pay for Performance (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

The Era of Pay for Performance (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
  - JCAHO
  - Unions

The Era of Pay for Performance (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

The Era of Pay for Performance (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

The Era of Pay for Performance (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

The Era of Pay for Performance (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

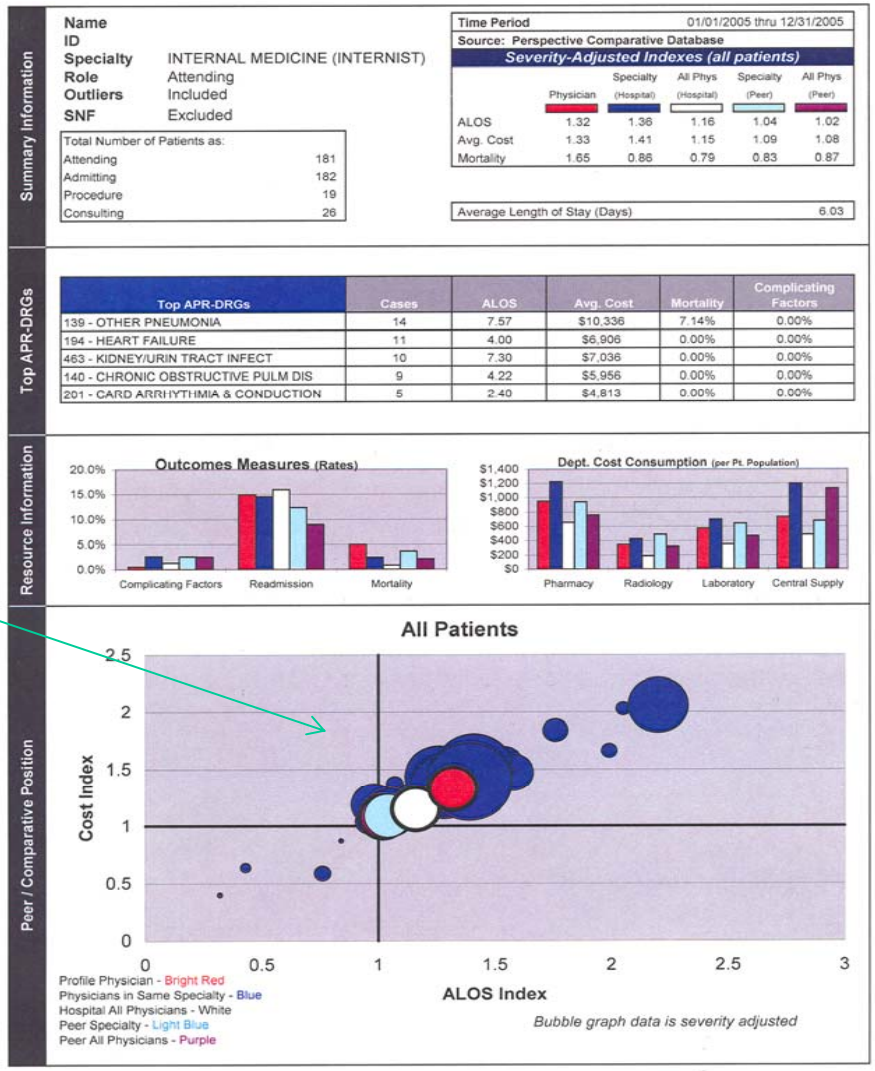
MEDICARE ONLY

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



Summary Information

Name
ID
Specialty INTERNAL MEDICINE (INTERNIST)
Role Attending
Outliers Included
SNF Excluded

Total Number of Patients as:	
Attending	181
Admitting	182
Procedure	19
Consulting	26

Time Period 01/01/2005 thru 12/31/2005
Source: Perspective Comparative Database
Severity-Adjusted Indexes (all patients)

	Physician	Specialty (Hospital)	All Phys (Hospital)	Specialty (Peer)	All Phys (Peer)
ALOS	1.32	1.36	1.16	1.04	1.02
Avg. Cost	1.33	1.41	1.15	1.09	1.08
Mortality	1.65	0.86	0.79	0.83	0.87

Average Length of Stay (Days) 6.03

Top APR-DRGs

Top APR-DRGs	Cases	ALOS	Avg. Cost	Mortality	Complicating Factors
139 - OTHER PNEUMONIA	14	7.57	$10,336	7.14%	0.00%
194 - HEART FAILURE	11	4.00	$6,906	0.00%	0.00%
463 - KIDNEY/URIN TRACT INFECT	10	7.30	$7,036	0.00%	0.00%
140 - CHRONIC OBSTRUCTIVE PULM DIS	9	4.22	$5,956	0.00%	0.00%
201 - CARD ARRHYTHMIA & CONDUCTION	5	2.40	$4,813	0.00%	0.00%

Resource Information

Outcomes Measures (Rates)
20.0% 15.0% 10.0% 5.0% 0.0%
Complicating Factors Readmission Mortality

Dept. Cost Consumption (per Pt. Population)
$1,400 $1,200 $1,000 $800 $600 $400 $200 $0
Pharmacy Radiology Laboratory Central Supply

Peer / Comparative Position

All Patients
Cost Index
2.5 2 1.5 1 0.5 0
0 0.5 1 1.5 2 2.5 3
ALOS Index
Profile Physician - Bright Red
Physicians in Same Specialty - Blue
Hospital All Physicians - White
Peer Specialty - Light Blue
Peer All Physicians - Purple
Bubble graph data is severity adjusted

Report Generation Date: 4/24/2006

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

Summary Information

Name
ID
Specialty CARDIOLOGIST
Role Attending
Outliers Included
SNF Excluded

Total Number of Patients as:	
Attending	159
Admitting	160
Procedure	56
Consulting	177

Time Period 01/01/2005 thru 12/31/2005
Source: Perspective Comparative Database

Severity-Adjusted Indexes (all patients)

	Physician	Specialty (Hospital)	All Phys (Hospital)	Specialty (Peer)	All Phys (Peer)
ALOS	2.20	1.36	1.16	1.04	1.02
Avg. Cost	2.06	1.41	1.15	1.09	1.08
Mortality	0.89	0.86	0.79	0.83	0.87

Average Length of Stay (Days) 10.96

Top APR-DRGs

Top APR-DRGs	Cases	ALOS	Avg. Cost	Mortality	Complicating Factors
194 - HEART FAILURE	15	13.27	$23,831	6.67%	6.67%
201 - CARD ARRHYTHMIA & CONDUCTION	14	8.36	$13,028	0.00%	0.00%
175 - PERCUT CARDIOVASC W/O AMI	10	9.60	$20,500	0.00%	0.00%
198 - ANGINA PECT & CORONARY ATH	7	2.86	$5,422	0.00%	0.00%
139 - OTHER PNEUMONIA	6	13.00	$19,595	0.00%	0.00%

Resource Information

Outcomes Measures (Rates)
20.0% 15.0% 10.0% 5.0% 0.0%
Complicating Factors Readmission Mortality

Dept. Cost Consumption (per Pt. Population)
$3,000 $2,500 $2,000 $1,500 $1,000 $500 $0
Pharmacy Radiology Laboratory Central Supply

Peer / Comparative Position

All Patients
Cost Index
2.5 2 1.5 1 0.5 0
0 0.5 1 1.5 2 2.5 3
ALOS Index

Profile Physician - Bright Red
Physicians in Same Specialty - Blue
Hospital All Physicians - White
Peer Specialty - Light Blue
Peer All Physicians - Purple

Bubble graph data is severity adjusted

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.

Report Generation Date: 4/24/2006

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 nonadmissability

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 credentiality 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.

Other Forms of Remedial Action (cont'd)

- Reduction in staff category
- Removal from ER call duty
- Probations
- Reprimand
- Conditional Reappointments
- Physician's Assistance Committee

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.

Other Forms of Remedial Action

- Mandatory consultations which do not require prior approval
- Proctoring
- Monitoring
- Retraining/Re-education
- Voluntary relinquishment of clinical privileges at the time of reappointment
- Administrative suspensions, i.e., medical records
- Retrospective or concurrent audits

Other Forms of Remedial Action (cont'd)

- Reduction in staff category
- Removal from ER call duty
- Probations
- Reprimand
- Conditional Reappointments
- Physician's Assistance Committee