Impact of Recent Regulatory Changes in Medical Staff Bylaws

Proposed Amendments and Best Practices

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Background

- Hospitals and their affiliated entities are participating in one of the most heavily regulated industries in the country
- Some of the relevant regulatory standards that apply to medical staff professionals include:
  - Medicare/Medicaid Conditions of Participation
  - Hospital Licensing Act
  - Medical Practice Act
  - Nurse Practice Act
  - Acts applicable to all other credentialed practitioners
  - State Peer Review Statute
  - Patient Safety and Quality Improvement Act of 2005
  - HIPAA/HITECH
  - EMTALA
Background (cont’d)

- ADA, Title VII and other discrimination statutes
- HCQIA
- Data Bank
- The Joint Commission, HFAP, DNV, NCQA, CIHQ
- Accountable Care Act – ACOs/Medicare Shared Savings Program, Value Based Purchasing
- CMS standards on never events, hospital acquired conditions, readmissions
- County and city statutes and ordinances
- Applicable case law
Background (cont’d)

- Failure to comply with these standards can have the following adverse implications
  - Loss or restriction of licenses
  - Accreditation watch or loss of accreditation
  - CMS determination of “immediate jeopardy” or loss of Medicare eligibility
  - Professional liability under respondeat superior, apparent agency and corporate negligence theories
  - Civil, criminal fines
  - Loss of insurance or significant increase in premiums
  - Loss of managed care contracts, MSSP and other performance based payments
  - False Claims Act liability
  - You lose your job
Background (cont’d)

- Evidence of compliance is largely demonstrated in corporate and medical staff governance documents including
  - Corporate Bylaws, Rules, Regs and Policy
  - Medical Staff Bylaws, Rules, Regs and Policies
  - Code of Conduct/Disruptive Behavior Policy
  - Appointment/Reappointment applications
  - Peer review policies
  - Credentialing manual
  - Fair hearing procedures
  - Medical staff development plan
Background (cont’d)

– Impaired physician/allied professional policy
– Leave of absence and reinstatement policy
– Conflict of interest policy
– Anti-harassment policy
– ED Call Policy
– Department policies
Medical Staff Standards
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Medical Staff Standards

- Board consultation requirement with medical staff
- Medical staff eligibility standard
- Single, unified medical staff standard
- Standards for ordering tests
- Telemedicine
- Advanced practitioners
Governing Board Consultation Requirement

- Hospital governing boards are not required to include medical staff members.
- Hospital with no physician board members must consult directly with the individual who is assigned the responsibility for the organization and conduct of the medical staff.
- A multi-hospital system, using a single governing board, the consultation must be with the responsible physician of each hospital in the system.
- Governing body must:
  - Consult directly with the individual who is assigned the responsibility for the organization and conduct of the medical staff.
  - Direct consultation must occur periodically throughout the year (at least twice in a fiscal year).
    - “Direct Consultation” means that the board (or a subcommittee) meets with the medical staff leader(s) either face-to-face or via a live telecommunications system.
  - Include discussion of matters related to quality of medical care.
Governing Board Consultation Requirement

- Consultation factors
  - Scope and complexity of Hospital services
    - Specific patient populations serviced
    - Issues of patient safety
    - Quality assessment
    - Performance improvement
  - Hospital must be able to demonstrate (minutes, agenda, etc.) that its board is appropriately responsive to requests from medical staff representative for timely consultation on quality of care concerns
Governing Board Consultation Requirement

- Consultation factors
  - Consulting with multiple medical staff leaders simultaneously using a committee structure is acceptable so long as direct consultation occurs periodically throughout the year and includes discussion of quality of medical care provided to patients at each hospital
  - Consultation requirement can be met with a medical staff member on the board if:
    - Medical staff member is the same individual responsible for the organization and conduct of the hospital’s medical staff
    - There are periodic meetings throughout the year that includes discussion of quality of medical care
A hospital meets the consultation requirement with a member of the medical staff on the governing board if:

- The medical staff member is the same individual responsible for the organization and conduct of the hospital’s medical staff, and
- The membership includes meetings with the board periodically throughout the year and discussing matters related to quality of medical care.

Hospital governing boards may include medical staff members in addition to the one responsible for the organization and conduct of the medical staff.
Medical Staff Eligibility

- Medical staff must be composed of MDs or DOs
- Medical staff may include other categories of physicians (Dentists, Podiatrists, Optometrists, Chiropractors) and non-physician practitioners (APNs, PAs, CRNAs, PharmDs, RDs), in accordance with state law
- Other licensed health care professionals with a more limited scope of practice (PT, OT, SLT) may be granted privileges if their state law, medical staff bylaws and rules and regulations permit. Even if these professionals are not allowed to be members of the hospital’s medical staff, they may be given clinical privileges if they are appropriately credentialed and privileged and are acting within their scope of permitted practice under state law.
- The Board has the flexibility to determine, consistent with state law, which categories of practitioners, other than DOs and MDs are eligible for appointment to the medical staff.
Single / Unified Medical Staff

A unified and integrated medical staff of a multi-hospital system and its member hospitals may voluntarily integrate itself into a larger system medical staff.

Unified medical staff would be:

- Composed of medical staff members from each hospital in the system
- Each member would be eligible to take on leadership roles on various committees and subcommittees
**Single / Unified Medical Staff**

- Medical staff members of each separately certified hospital in a system must have voted by majority, in accordance with bylaws, either to accent or opt out of a unified and integrated medical staff structure
  - Practitioners holding only telemedicine privileges are ineligible to vote
  - Hospitals may require a “supermajority” vote if the same type of supermajority vote is otherwise required to amend medical staff bylaws, rules and requirements.
  - Vote may not be delegated to an executive committee of the unified medical staff.
- Board must agree to a unified and integrated medical staff.
Single / Unified Medical Staff

- A unified and integrated medical staff:
  - Has one set of bylaws, rules and requirements that describe the medical staff’s processes for self-governance, appointment, credentialing, privileging, oversight, peer review and due process rights.
  - Includes process for members of the medical staff of each separately certified hospital, to be advised of rights opt out of unified and integrated medical staff after majority vote
  - Takes into account each hospital’s unique circumstances, patient populations (low income, minority, rural populations, etc.) and services offered in each hospital
  - Gives due consideration to needs and concerns of members of the medical staff, regardless of practice location

- The hospital’s unified medical staff must have written policies and procedures that address how it considers and addresses needs and concerns expressed by members who practice at the hospital.
Standards for Outpatient Services

- Outpatient services must be ordered by a practitioner who meets the following conditions:
  - Is responsible for the care of the patient
  - Is licensed in the state where he or she provides care to the patient
  - Is acting within his or her scope of practice under State law
  - Is authorized in accordance with State law and policies adopted by the medical staff and approve by the board to order the applicable outpatient service.

- The standard applies to:
  - All practitioners who are appointed to the hospital’s medical staff and who have been granted privileges to order the applicable outpatient service
  - All practitioners no appointed to the medical staff, but who satisfy the authorization criteria.
Telemedicine

- For telemedicine providers, hospitals are no longer required to fulfill the credentialing and privileging requirements as if the practitioners are onsite.

- The governing board whose patients are receiving telemedicine services may choose to have its medical staff rely on credentialing and privilege decisions made by distant-site hospital or distant-site telemedicine entity if there is an written agreement and:
  - Distant-site hospital is a Medicare participating hospital (for a distant-site telemedicine entity, the medical staff credentialing and privileging process and standards must meet COP standards)
  - Individual distant-site physician is privileged at the distant-site hospital or entity providing the telemedicine services
  - A list of the distant-site physician’s on practitioner’s privileges is provided to the hospital
  - Individual distant-site physician holds a license issued or recognized by the state in which the hospital whose patients are receiving telemedicine services are located
Telemedicine

- Hospitals whose patients receive telemedicine services are required to specify in the agreement that:
  - The board of the facility has chosen to have its medical staff rely on the credentialing and privileging decisions of the distant-site hospital or telemedicine entity
  - The hospital will complete periodic internal reviews of the distant-site practitioner’s performance and shall send this information to the distant-site hospital for its use in its own appraisal of the practitioner
  - The information shall include, at a minimum, specific details regarding any adverse events that occurred and all complaints received regarding the distant-site practitioner
  - The facility complies with all governing body responsibilities
Telemedicine

- Medical staff bylaws may need to be reviewed to consider:
  - Criteria for determining telemedicine privileges
  - Qualifications for medical staff membership
  - A category for telemedicine staff
  - Granting telemedicine privileges without medical staff membership
  - Auditing credentialing by proxy
Advanced Practitioners

- Advanced Practitioners – Healthcare professionals other than licensed physicians who are granted clinical privileges to provide direct patient care services (PAs, APNs)

- Process for credentialing and privileging PAs and APNs is approved by the Board

- Process for credentialing and privileging PAs and APNs within the hospital includes:
  - Evaluation of the applicant's credentials
  - Evaluation of the applicant’s current competency
  - Defer recommendations
  - Input from individuals and committees, including MEC

- If the hospital utilizes RN First Assistants, Surgical PA or other non-MD/DO surgical assistants, the hospital must establish criteria, qualifications and a credentialing process to grant specific privileges to individual practitioners
New National Practitioner Data Bank Guidebook
Impact on Bylaw Standards
NPDB Guidebook Revisions

• NPDB Established by Title IV of Public Law 99-60, the Health Care Quality Improvement Act of 1986- “HCQIA” 42 USC Sec. 11101

• The laws governing the NPDB are codified at 45 CFR Part 60, Title IV of the Health Care Quality Improvement Act of 1986 (HCQIA), Section 5 of the Medicare and Medicaid Patient and Program Protection Act of 1987, and Section 221(a) of the Health Insurance Portability and Accountability Act of 1996.
NPDB Guidebook Revisions

• The National Practitioner Data Bank Guidebook “is meant to serve as a resource for the users of the National Practitioner Data Bank (NPDB).”

  – Intent is to assist the health care community and authorized users understand the requirements established by Title IV of Public Law 99-660, the Health Care Quality Improvement Act of 1986, as amended.

  – Authorized users include state licensing authorities; medical malpractice payers; hospitals and other health care entities; and physicians, dentists, and other licensed health care practitioners.
NPDB Guidebook Revisions

• 2001 NPDB Guidebook was the first complete revision of the NPDB Guidebook since 1996.
  – Intended to incorporate regulatory changes issued previously
  – 2001 Guidebook edition superseded all previous versions.

• 2015 Revised Guidebook Published
  – Incorporates legislative and regulatory changes since the last draft and reflects the entire range of NPDB policies, including those that have changed or expanded since the NPDB opened in September 1990.
NPDB Guidebook Revisions

• NPDB Reporting Requirements
  – Medical Malpractice Payments
  – State Licensure Actions
  – Adverse Clinical Privilege Actions
NPDB Guidebook Revisions - Timeline

• Release of the Draft Guidebook was announced in November 2013 and the period to submit comments to the Draft was open until January 2014

• AHA, TJC, NAMSS, and NPDB Guidebook Work Group, among others, issued comments on Draft Guidebook January 2014
  – Many identify issues of concern regarding reporting of voluntary surrender and definition of investigation raised in NPDB responses to Examples 16 and 17
NPDB Guidebook Revisions - Adverse Clinical Privilege Actions

• Hospitals and Healthcare Entities Must Report:
  – Professional Review Actions
    • Based on a physician or dentist’s professional competence or conduct that adversely affects or could adversely affect the health and welfare of any patient
    • That adversely affects the clinical privileges of a physician or dentist for more than 30 days
  – The acceptance of a physician’s or dentist’s surrender or restriction of clinical privileges, or the voluntary withdrawal of an application for renewal of a medical staff appointment or clinical privileges
    • While under investigation for possible professional incompetence or improper professional conduct, or
    • In return for not conducting an investigation, or
    • In return for not taking a professional review action
NPDB Guidebook Revisions - Investigation

- 2001 Guidebook Discussion of “Investigation”
  - “Investigations should not be reported to the NPDB; only the surrender or restriction of clinical privileges while under investigation or to avoid investigation is reportable. This would include a failure to renew clinical privileges while under investigation.”
  - A routine or general review of cases is not an investigation.
  - A routine review of a particular practitioner is not an investigation.
  - An investigation should be the precursor to a professional review action.
NPDB Guidebook Revisions - Investigation

• 2013 Draft Revisions re Investigations
  – NPDB Expands Definition
    • A *routine*, formal peer review process under which the health care entity evaluates, against clearly defined measures, the privilege-specific competence of all practitioners is *not* considered an investigation for the purposes of reporting to the NPDB.
    
    • If the formal peer review process is used when issues related to professional competence or conduct are identified or when a need to monitor a physician’s performance is triggered based on a single event or pattern of events this is considered an investigation for the purposes of reporting to the NPDB.
      
      – The term “investigation” is “not controlled by how that term may be defined in a health care entity’s bylaws or policies and procedures.”
NPDB Guidebook Revisions - Investigation

• NPDB Responses to Examples in Draft raise concerns regarding whether OPPE and FPPE constitute an “investigation”
  – TJC
    • “The Joint Commission does not consider OPPE or FPPE ‘investigations’… The Joint Commission has concerns with such a characterization…”
  – Work Group
    • “We submit that, if HRSA adopts the position in its Guidebook that the surrender of privileges while under a department review process such as an FPPE, that this will represent a substantial departure from prevailing interpretation…”
  – AHA
    • “A hospital should be able to define investigation in the Medical Staff bylaws consistent with the statute and regulations”
NPDB Guidebook Revisions - Investigation

- NPDB Issues Final Revised Guidebook April 2015
  - Retains expansive definition of "investigation"
    - may look at a health care entity's bylaws or
    - other documents to assist determination of whether an investigation has started or is ongoing, **but**
    - NPDB retains the ultimate authority to determine whether an "investigation" exists
  - "In other words, an investigation is not limited to a health care entity's gathering of facts or limited to the manner in which the term ‘investigation’ is defined in a hospital's by-laws.”
NPDB Guidebook Revisions - Investigation

- Retains distinction between:
  - “routine” process which evaluates *all practitioners* against clearly defined measures - not reportable
  vs.
  - “formal, targeted” process when issues related to a *specific practitioner’s* professional competence or conduct - reportable
When does an “investigation” begin and end, and does it matter if physician is aware?

- “an investigation is not limited to a health care entity's gathering of facts. An investigation begins as soon as the health care entity begins an inquiry and does not end until the health care entity’s decision making authority takes a final action or makes a decision to not further pursue the matter.”

- A practitioner’s awareness that an investigation is being conducted is not a requirement for reporting to the NPDB.
NPDB Guidebook Revisions - Investigation

• Implications for Medical Staff Bylaws
  – The definition of “investigation” in your bylaws should be reviewed and clearly defined
  – Bylaws should differentiate “investigation” for corrective action or professional review action purposes vs. OPPE/FPPE
    • Department to perform OPPE/FPPE and Medical Executive Committee initiate investigation
    • Review OPPE/FPPE Policy to ensure consistency
  – State laws should be reviewed for definitions of investigation, if any.
NPDB Guidebook Revisions - Summary Suspensions

• A summary suspension must be reported if it is:
  – In effect or imposed for more than 30 days
  – Based on the professional competence or professional conduct of the physician, dentist, or other health care practitioner that adversely affects, or could adversely affect, the health or welfare of a patient, and
  – The result of a professional review action taken by a hospital or other health

• 2015 Guidebook adds that summary suspensions that have not lasted more than 30 days but are expected to last more than 30 days, and that are otherwise reportable, may be reported to the NPDB.
  – If the summary suspension ultimately does not last more than 30 days, it must be voided.
NPDB Guidebook Revisions - Summary
Suspensions

• It does not matter what it is called
  – “The NPDB recognizes that suspensions are often called ‘immediate, summary, emergency, or precautionary’ in medical staff bylaws. Regardless of the name, the suspension is reportable if it is based on concerns for patient safety and it lasts more than 30 days.

• Voluntary Surrender of privileges during a suspension
  – must be reported even if that suspension has not been confirmed by the medical executive committee or other group that is required under the medical staff bylaws to review suspensions.
NPDB Guideline Revisions - Proctors

• 2001 Guidebook had no specific provision regarding when the assignment of a proctor was to be reported
  – Discussion was limited to Example 3

• 2015 Guidebook adds subsection regarding proctors
  – Whether the action must be reported to the NPDB depends on the role of the proctor. If, the physician cannot perform certain procedures without proctor approval or without the proctor being present and watching the physician or dentist, the action constitutes a restriction of clinical privileges and must be reported to the NPDB.
  – Question: does the assignment of a proctor to simply observe the subject physician constitute a reportable event?
• Implications for Bylaws
  – Provisions regarding what type of action constitutes grounds for hearing state that hearing is required for imposition of “significant consultation or monitoring requirements”
    • See Williams v. Columbus Clinic (2015) 332 Ga.App. 714
      – “The [bylaws], however, identif[y] as an adverse action the [i]nvoluntary imposition of significant consultation requirements where the supervising Practitioner has the power to supervise, direct, or transfer care from the Practitioner under review.”
    • See also California Hospital Association Model Medical Staff Bylaws, 2011 edition, Sections 7.4-4 et seq.
Additional Issues/Best Practices

- California Appellate Court Case raises question of when bylaws language compels hearing for summary suspension
  - *Dhillon v. John Muir Health* (2015)- California Court of Appeal
    - Physician summarily suspended for 13 days for failure to comply with MEC directive to attend anger management
    - California Business and Professions Code Section 809 provides for hearing only if action is reportable under Section 805
Additional Issues/Best Practices

• Under California reporting statute, summary suspension reportable only if lasts more than 14 days, therefore no right to hearing unless suspension beyond 14 days

• Bylaws say “suspension of Medical Staff privileges” is grounds for hearing - no reference to length of time

• Court of Appeal decision on technical appellate issue suggests that physician entitled to hearing because bylaws simply more generous than state law in granting hearings for suspended physicians

• Case accepted for review by California Supreme Court
  – Has caused reviews of bylaws for any medical staff using similar wording re suspension without reference to reporting statute
Best and Evolving Practices
Definitions

- **Best/Evolving Practices**
  - Include definitions for “peer review” and “peer review committee” consistent with state confidentiality protections in order to maximize confidentiality/privilege protections (see attached examples)
  - If participating in a PSO, consider adding definitions for “patient safety evaluation system” and “patient safety work product” (see attached examples)
  - Definitions of “adverse” decisions should be limited to actions that require a state or Data Bank report or limited to what triggers a hearing under the Bylaws
  - Decide what constitutes an “investigation” for Data Bank reporting purposes
Nature of Medical Staff Membership

- Best/Evolving Practices
  - Physicians, as a general matter, have no legal, statutory, constitutional right to medical staff membership/privileges. Therefore, hospitals can develop initial screening/eligibility criteria on front end to deny applications/appointment to “non-qualifying practitioners” including decisions based on economic factors such as whether physician is employed by a competitor or has a financial interest in a competing facility, i.e., surgicenter. See comments re: Pre-Application Process.
Qualifications for Membership

- Best/Evolving Practices
  - Should reference obligation to comply with applicable Code of Conduct/Disruptive Behavior Policies
  - Should reference requirement to comply with reporting requirements concerning malpractice suits, sanctions, loss of privileges, licensure, reduction on liability insurance and other regulatory requirements within a defined period of time
Qualifications for Membership (cont’d)

- Board can grant board certification exceptions where physician filling specialized need

- Consider granting an extension of time
  - Consider reducing membership category instead of termination albeit under some form of continuous review
  - Consider grandfathering option
  - Need to justify any exception and apply standard uniformly
Insurance Requirements

- Best/Evolving Practices
  - Obtain coverage schedule in addition to certificates of insurance – includes limits and exclusions
  - Obtain five (5) year coverage history
  - Find out if coverage schedule applies at multiple hospitals and if claims made/occurrences
  - Get insurance company rating and make sure company is certified by the State
  - Consider requiring tail or prior acts coverage if they leave Medical Staff
  - Require report if coverage reduced to explain basis of reduction
ED Coverage

- Best/Evolving Practices
  - Bylaws, Rules and Regs should reflect ED response times and on call responsibilities consistent with EMTALA, trauma center and other statutory requirements
  - Physician should identify back up coverage if not available
  - Need to decide what Medical Staff categories have ED coverage responsibilities
  - Place requirement in Bylaws
  - Delegate coverage schedule to Department Chair BUT subject to MEC review and approval
ED Coverage (cont’d)

• Remember that ED call is a duty and **not** a privilege. Can be removed without triggering hearing rights

• If patients who are admitted or are referred out of hospital for no justifiable reason, ED call duty can be revoked – no hearing rights

• ED call can be provided to an exclusive group for pay consistent with regulatory standards

• Make sure that physician identifies back up in advance of going out of town
Ability to Work with Others/Health Status

- Best/Evolving Practices
  - Establish separate Physician Wellness Committee
  - Avoid use of corrective action/disciplinary procedures
  - Be mindful of reporting requirements re: state and Data Bank
  - Implement progressive remedial action standards
  - Implement a Bylaw standard to require evaluation if there is a reasonable suspicion of impairment
  - Refusal to be evaluated can result in recommendation for remedial action
  - Consider adding a requirement for physical/fitness for duty evaluation for practitioner 65 years or older on yearly basis
Ability to Work with Others/Health Status (cont’d)

- Implement progressive remedial action standards
- Implement a Bylaw standard to require evaluation if there is a reasonable suspicion of impairment
- Refusal to be evaluated can result in recommendation for remedial action
- Consider adding a requirement for physical/fitness for duty evaluation for practitioner 65 years or older on yearly basis
Compliance with Quality/Utilization Metrics

- ACO,P4P, Value Based Purchasing and ACO standards need to be incorporated into privileging/credentialing standards as a condition of appointment/reappointment on Medical Staff and/or ACO/CIN
Medical Record Completion

- Best/Evolving Practices
  - Physician not reappointed and privileges lapse if records not completed – has to reapply
  - Repeat offenders will be reported to Data Bank
  - Where incompletions relate to lack of H&P, discharge summary, treatment plan or other substantive portion of record, as opposed to a missing signature, physician can be reported according to the Data Bank
Medical Staff Categories

- Compliance Gaps
  - Wrong treatment of podiatrists as allied health practitioners
  - Utilization requirement as a condition of Active Staff membership is not defined or uniformly enforced or is out of date
  - Credentialing process not the same for all categories
  - Standard on geographic distance or response time to treat patients not uniformly enforced or is overly restrictive
Medical Staff Categories (cont’d)

- Best/Evolving Practice
  - Creation of new category where physician is a Medical Staff member but has no clinical privileges – need not go through formal appointment/reappointment process
  - Creation of Telemedicine Staff
  - Creation of Hospitalist Staff
  - Adding APN, PAs to medical staff if permitted by state law and Board
Pre-Application Process

- Best/Evolving Practices
  - Process should be reflected in Bylaws as required
  - Physician or physician committees should not be given the right to decide who is given or not given an application
Appointment (cont’d)

- Best/Evolving Practices
  - Language which places burden on applicant to produce any and all information requested at any time during the process
    - Failure to produce information results in withdrawal of application
    - No hearing rights
    - Cannot reapply for one year
Appointment (cont’d)

- No hearings for denied applicants unless decision reportable to State or Data Bank
- Use “absolute waiver of liability” standard in Bylaws and waiver forms (see attached example)
  - Fall back is reference to the state standard
- Require physician to attest that information provided is current and accurate – “my assistant prepared the application” is not acceptable
- Peer references should include physicians who are not partners or members of group practice
Reappointment

- Best/Evolving Practices
  - See Appointment Best Practices
  - Required disclosures through conflict of interest forms or activities with competitors
  - Request Quality/Utilization Scorecard
  - Request information on loss of membership in ACO, PHO, IPA, professional societies
Exclusive Contracts

- Best/Evolving Practices
  - Incorporate right to enter into exclusive contracts and applicable hearing rights into Bylaws
  - Incorporate a provision which states that when Bylaws conflict with exclusive/employment contract, then contract prevails
  - Determine whether to include a “clean sweep” provision, i.e., no hearing rights if contract terminated
Exclusive Contracts (cont’d)

• Consider adding the ability to offer a hearing if termination decision should be reported to Data Bank
  – Joint Commission has taken the position that termination based on quality/competence/conduct issues requires a hearing even if employed
  – Providing a hearing gives you HCQIA immunity protections
  – Fairness dictates that if reporting a physician they should be offered a hearing opportunity

• Provide advance notice to MEC regarding the proposed exclusive arrangement and Board’s reasoning
Remedial/Corrective Action

Best/Evolving Practices

- Collegial Intervention (See attached example “collegial intervention” provision)
  - Goal is to address quality/behavioral issues and attempt to resolve as early on as possible.
  - Department Chairs/Section Chiefs are required to engage in one on one discussions, “coffee cup communications”, with the physician to identify issues so as to avoid/prevent future problems.
  - Must be attempted and documented before considering request for remedial action.
  - Collegial Intervention is not a substitute for established peer review process – it is part of the process.
Remedial/Corrective Action (cont’d)

- Remedial action should only be requested when other measures have failed as part of the peer review process.
  - Collegial intervention
  - FPPE
  - Monitoring, proctoring, mandatory consultations
  - Re-education
  - Other actions which do not trigger hearing or state or Data Bank reports

- A resignation which occurs during the peer review process, as opposed to when remedial/corrective action is requested, is not reportable.

- Peer review process should not be defined or treated as an investigation.
Remedial/Corrective Action (cont’d)

- Only Department/Committee Chairs, Medical Staff President and CEO should be able to request remedial action.

- Request should not specifically request a particular action.

- If MEC believes the request has merit, meaning the record shows that collegial intervention and other non-reportable remedial measures have not succeeded in addressing the problem, then request can go forward and you are now in the investigation stage.
  - Physician’s resignation at this stage is reportable.

- MEC should appoint an Ad Hoc Committee rather than conduct investigation on its own.

- Ad Hoc Committee should be composed of members from same Department or who have similar expertise.
Remedial/Corrective Action (cont’d)

- Members should not have had a role in peer review process leading up to remedial action request.
- Where possible, avoid appointing a direct competitor or someone with a known bias as a Committee member.
- Whatever information is collected to support the request should be shared with the Committee AND the physician sufficiently in advance of physician’s meeting with the Committee.
- Physician meeting should be required before Committee makes a recommendation.
Remedial/Corrective Action (cont’d)

- Committee should not be limited in the form of remedial action requested even if such action was not previously successful.

- Committee should attempt to engage the physician in the design of any action plan.
  - This effort is a good way to evaluate physician’s judgment and acceptance of whether to accept responsibility and commitment to improve.

- Committee should prepare written report to explain basis and reasons for recommendation. If recommending action which triggers hearing rights, i.e., suspension, termination, report should detail and explain why lesser forms of remedial action, in the opinion of the committee, will not suffice.
Remedial/Corrective Action (cont’d)

- MEC, before making final recommendations, should consider meeting with the Physician.
- MEC not limited in the form of recommended action.
- MEC should clearly describe in writing its rationale based on the information presented.
- If recommendation triggers hearing rights then proceed to a hearing – recommendation should not go to Board because it ultimately will make final decision on appeal.
Fair Hearing

Best/Evolving Practices

- Hearing Committee
  - To avoid the appearance of a conflict of interest, if possible, do not appoint employed physicians or physician under contract with the Hospital.

- Appointment of Hearing Officer
  - Given the high stakes at issue for both sides, an experienced hearing officer can greatly facilitate the hearing particularly if attorneys are given the right to direct and cross examine witnesses.
  - Hearing officer should not have any conflicts of interest, i.e., should not have previously represented the hospital, the physician or the medical staff.
Fair Hearing (cont’d)

• Should offer to have physician pay half of the fee although this suggestion usually is declined.

• Hearing officer should sign a HIPAA business associate agreement.

  ▪ Pre-Hearing Procedures

  • Bylaws should require that there be a pre-hearing process to address procedural issues and disputes so as to facilitate a smooth hearing.

  • There should be a record of these proceedings and the hearing officer should prepare a written decision.

  • Challenges to hearing committee members through a voir dire or similar process should be addressed at this time – no automatic challenges to proposed members should be provided to either side.
Fair Hearing (cont’d)

- Role of legal counsel
  - Consider limiting role of legal counselor to acting as an adviser to his/her client with the right to make procedural objections but no right to direct/cross examine witness.
  - Role can be expanded by hearing committee if physician not able to handle.

- Burden of proof – hearing
  - Burden should be on the medical staff to show that the adverse recommendation is supported by a preponderance of the evidence – i.e., a majority of the evidence.
Fair Hearing (cont’d)

- Hearing committee should be required to make written findings of fact and detailed explanation to support recommendation.

- Both parties should be given the right to appeal hearing committee recommendation.

- Appellate Procedures
  - Burden of proof – appeal
    - Is the hearing committee recommendation supported by a preponderance of the evidence?
    - Was the adverse recommendation arbitrary or capricious?
    - Did hospital and medical staff substantially comply with its bylaws/fair hearing plan?
Fair Hearing (cont’d)

• Board should appoint an appellate committee of the board which has at least one physician member rather than have the entire board participate.

• Any board member, including hospital administrators who had a role in the recommendation and process leading to the adverse decision, should recuse themselves and not participate on the committee or when the board renders its final decision.

• Oral argument should be at the discretion of the board and not a matter of right.

• Parties should be required to submit written memos setting forth the basis for accepting or contesting the hearing committee’s recommendation.
Fair Hearing (cont’d)

- Committee should have access to the complete administrative record and be required to review it in advance of its recommendation to the Board.

- Committee should be required to prepare written findings to support its recommendation tied to burden of proof standard.

- Remaining Board members should at least review hearing committee recommendation, memos from the parties and Appellate Committee recommendation and report before rendering final decision.
QUESTIONS?