A Roadmap For Medical Staff Corrective Action: How To Avoid The Many Pitfalls

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Presented by Sarah Coyne and Jon Kammerzelt

What is "Corrective Action?"

- Used broadly, it means the process of medical staff examination of a physician's professional competence or conduct under the process specified in the medical staff bylaws, with the potential of action on the physician's clinical privileges or medical staff appointment.
- Specifically, it means the section of the medical staff bylaws that sets out the process.
- Typically starts with a request to the MEC and ends with the governing board's affirmation of recommendations.
- The term "Corrective Action" unfortunately presumes something bad happened – it actually is frequently the case that the medical staff investigation conclusion is that there was no incompetence or unprofessional conduct.

Some General Truths About Corrective Action

- It is emotional and difficult.
- It can be very expensive.
- Many of the pitfalls can be avoided by good planning – updated fair hearing plan and relevant bylaws language and policies.
- One gets better with experience.
- There are many misconceptions about corrective action among medical staff and other hospital staff.
- One of the most common misconceptions is that corrective action is not the appropriate vehicle for reviewing behavioral issues and should be used only for quality issues.
- The intersection between an impaired provider policy and a peer review policy is tricky.

The Physician's Dilemma

- Most physicians involved in medical staff leadership/peer review take their fiduciary duties to patients seriously and want to do a good job.
- However, being human, they often recoil at the thought of:
  - "Ratting" someone out (especially for behavior – easier when it is quality of care).
  - Doing anything that could possibly result in a report to the NPDB.
- The typical cycle that occurs:
  - Concern about the behavior or quality issue.
  - Discussion at medical staff meetings.
  - Feeling that they have made a mountain out of a molehill and are being unnecessarily harsh.
  - Starting all over again when the next incident happens.

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A Note About Involvement of Human Resources

- Human Resources is often the first to learn of a problem, especially when:
  - The catalyst is a complaint from a co-worker.
  - The physician is employed by the hospital.
- There is a critical crossroads right at the beginning for an employed physician: Will the investigation be handled as a function of employment or medical staff membership – i.e., through corrective action.
- Practical tips:
  - Ensure that HR understands that medical staff has its own review and corrective action process.
  - Ensure that HR will communicate immediately with medical staff leadership so that a reasoned decision can be made.

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A Note About Hospital Administration

- The role of administration varies from hospital to hospital.
- Many hospitals have the CEO as an ex officio non-voting member of the MEC.
- Most of the time, the CEO is in attendance at MEC meetings and at the hearing – but not always.
- Recent unrest among medical staffs – pushing back on the involvement of administration.
- The risk is that administration will overstep and impede the medical staff's independent exercise of professional judgment and that can be problematic in many ways.

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Pre-Corrective Action

- Concern about a practitioner comes to leadership's attention in some way:
  - Peer/ staff report or reference.
  - Patient complaint/ lawsuit.
  - Licensing investigation.
  - Self report.
  - Falls out in quality assurance/ peer review/ utilization review.
  - Formal request for corrective action.

- Medical staff leadership has options prior to corrective action – refer to another committee, initiate some sort of monitoring, collegial intervention, resolve as not a real issue, determine that the issue is impairment and proceed under policy.

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Collegial Intervention

- Collegial intervention usually means sitting down to talk with the physician and identify problems with clear pre-conceptualized feedback and articulate expectations.
  - It could be interpreted to include written communications as well such as a performance improvement plan, or a letter of warning or reprimand.
- Practical Tips About Collegial Intervention:
  - Work it into your bylaws (identify who does it an that they can delegate).
  - Coordinate it with your code of conduct.
  - Make sure it is consistent with messaging from administration.
  - Prepare for it!
  - Document it.

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What if the Physician is a Current Danger?

- Summary suspension of some or all privileges.
- If summary suspension lasts longer than 14 days, the physician has the right to request a hearing.
- If the suspension lasts longer than 30 days, there will be a reporting requirement to the NPDB (more coming).
- The Corrective Action investigation/ process may run concurrently with a summary suspension.
- HCQIA contemplates "emergency" suspension with certain required parameters.

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Steps of Corrective Action (1 of 2)

- Bylaws will spell out process.
- Written request for corrective action.
  - Make them robust and detailed, with attachments. This is the basis on which your notification to the physician will be judged. If you do not make it robust, there will be arguments over things that should be discounted because they were not in there.
  - Make sure it cites to the correct portion of the bylaws and follows any parameters in the bylaws.
  - Have it signed by whoever is specified in the bylaws – if nobody is specified make sure it is at least co-signed by a medical staff leader. An administrator may sign as well.
  - Ideally the written request is hand-delivered to the doctor by a medical staff leader. The request should indicate on it that it was hand-delivered.

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Steps of Corrective Action (2 of 2)

- Medical staff leadership (e.g. MEC) convenes and considers the available information and decides:
  - We have enough information to make a recommendation.
  - We do not have enough information to make a recommendation – convenes an investigating committee.
- The MEC should evaluate bias/ conflicts before making any decision on how to handle the request for investigation of corrective action.
- The MEC should decide who should select the members of the investigating committee. Often it is the VPMA or COS – who should call and explain this to the potential physicians, none of whom should be competitors or partners of the physician in question.
- The bylaws may say how many should be on the investigating committee - if in doubt, go with 3.
- Ultimately, investigating committee will recommend to MEC and MEC will adopt, modify, or reject recommendation (unless MEC has acted on its own).

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Tips About The Investigative Committee

- Pick someone (counsel, medical staff coordinator) to organize the meetings of the investigative committee – first one should be in person, after that they might have to be by phone.
- At first meeting, have them sign a confidentiality statement and impress the importance of confidentiality. Have them decide who they want to interview, including the physician. Help them to reach out to those individuals and schedule them – interviews should be in person with all members of the committee if possible.
- Be aware of timelines in the bylaws – in general the whole process should not take more than a month.
- Make sure they are armed with the bylaws and the request for correction action so they know what their mission is.
- They should ultimately come to a consensus or at least majority and recommend possible courses of action.
- The physician's input to the investigative committee is crucial and should be actively considered by the MEC.

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Possible Actions

- Suspension of privileges (summary or not).
- Restriction of privileges.
- Revocation of privileges.
- Reduction in staff category.
- Revocation of medical staff appointment.
- Requirement of proctoring/ training/ observation/ monitoring.
- Letter/ Warning.
- Doing nothing.
- The sky is the limit.

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Ultimate Adverse Recommendation by MEC

- The MEC technically does not have to defer to the investigative committee's recommendation, but usually does.
- An adverse recommendation by MEC will entitle physician to request a hearing.
- Bylaws will spell out which actions are “adverse actions” which will essentially be recommendations for curtailing/ limiting privileges or appointment.
- Bylaws will spell out timing and process for requesting a hearing.
- The governing body and hospital administration are apprised at this point (usually administration is involved and governing board is aware well before this).

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HEARING

The Hearing Nuts And Bolts

- Physician may be represented by an attorney (or someone else).
- Some sort of tribunal:
  - Mutually acceptable arbitrator
  - Hearing Committee of physicians not in direct competition
  - Hearing Officer

- Physician may call and examine witnesses, present evidence, submit a written statement, and upon conclusion receive a written decision.
- Court reporter/ other recording mechanism.
- More in the "Hearing Tips" section – coming up.

What Happens After The Hearing?

- Hearing panel or officer issues a report within the timelines in the Fair Hearing Plan.
- Physician and MEC both receive a copy of the report.
- If adverse, usually goes straight to governing board for consideration (approval, rejection, or modification).
- If governing board decision is adverse, most Fair Hearing Plans allow for appeal to the board – this is NOT necessary for HCQIA immunity.
- If upheld on appeal, the life cycle comes to an end – the next step would be for the physician to bring a lawsuit alleging some sort of wrongful limitation of privileges – HCQIA immunity would be a strong defense but does not prevent the lawsuit from being filed.

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Where Do Lawyers (On Both Sides) Fit In?

- The bylaws and Fair Hearing Plan should be clear that the physician does not have a right to counsel being present until the hearing – up until that point, it is internal.
- Probably best for hospital/ medical staff counsel not to be present at those meetings either – but certainly may be involved.
- It is common to have the hospital's counsel represent the MEC but watch out for diverging interests – it is possible that separate counsel will be necessary.
- At the hearing, each side is represented by counsel.

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Hearing Tips (1 of 2)

- Finding a hearing panel is a nightmare. Start early and be clear whose job it is. Scheduling the hearing is even more of a nightmare.
- Scheduling witnesses is a nightmare – there are bound to be cancellations and gaps. Try to manage this in advance with clear instruction to witnesses.
- Having a hearing officer, whether or not there is a separate hearing panel of physicians, is wonderful. Otherwise things are chaos. The best hearing officers are attorneys who understand medical staff practice.
- Decide in advance whether witnesses will be "sequestered" or whether they may sit in the hearing room before they are called.

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Hearing Tips (2 of 2)

- Decide in advance whether witnesses will be permitted to testify by phone.
- Plan for more time than you think the hearing will take.
- Organize the exhibits in advance with the other side – each exhibit should be numbered and each page should be Bates stamped. Make a set of binders for every member of the panel, the hearing officer, the lawyers and the witness. (Leave it at witness stand).
- The hearing must be recorded – establish in advance whether hospital will pay or whether the costs will be split (rare for physician to bear sole cost although physician does pay for his/ her lawyer). A court reporter is best.
- Prepare witnesses WELL and warn everyone that they will hear things they do not like, and to keep a poker face.

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Have Your Documents Up To Date!

- Corrective Action portion of Bylaws.
- Fair Hearing Plan.
  - Clear identification of "adverse actions" that will trigger right to request a hearing.
  - Clear process for identifying witnesses and exchanging documents.
  - Clear identification of the burden of proof which should be on the physician to prove the recommendation is "arbitrary and capricious" by "clear and convincing evidence."
  - Clear identification of what constitutes waiver of hearing rights (e.g. don't let physician stall forever agreeing to the physicians on the panel or the hearing officer – at some point that is waiver).

Important Enough To Rate Its Own Slide

- LET THE PHYSICIAN TALK!!!!
- At every turn in the road, the medical staff leadership should be willing to hear the physician's side of the story:
  - Written statements (whether or not that opportunity is in the bylaws).
  - Submission of external materials prior to the hearing.
  - Meeting with the investigative committee.
  - If requested, more meetings (within reason) with whole MEC.
- Always err on the side of fairness to the physician. Otherwise the whole process gets mired down in that issue rather than the merits.

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HEALTH CARE QUALITY IMPROVEMENT ACT

Health Care Quality Improvement Act

- Critically important to structure your bylaws corrective action process around HCQIA and follow it to the letter.
- If that is done, medical staff peer reviewers will have IMMUNITY.
- The idea is to encourage frank peer review by limiting civil liability.
- If health care providers as a professional review body meet the standards set forth in HCQIA, then there is no civil liability for:
  - The professional review body itself (committee).
  - Any person on that committee.
  - Any person designated / contracted to that committee.
  - Any person who participates or assists the committee.

HCQIA Protects Those Involved In Professional Review Actions

- Professional Review Action (PRA): An action or recommendation by a professional review body which is taken or made during a professional review activity, and:
  - Based on a physician's:

    (i) Competence or

    (ii) Professional conduct;

    and
  - Which affects (or may affect) adversely the physician's clinical privileges or membership in a professional society.
- A professional review action includes a formal decision to not take action or make a recommendation.

HCQIA Immunity

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

Several Important Timing Parameters From HCQIA

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

Adequate Notice Under HCQIA

- Two separate notices required under HCQIA:
  - Notice of Adverse Action Recommendation (And Right to Request A Hearing).
  - Notice Of Hearing (After practitioner has requested it).

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HCQIA Requirements For A Fair Hearing

- Physician may be represented by an attorney (or someone else).
- Some sort of tribunal.
  - Mutually acceptable arbitrator.
  - Hearing Committee of physicians not in direct competition.
  - Hearing Officer.
- Physician may call and examine witnesses, present evidence, submit a written statement, and upon conclusion receive a written decision.
- "Appeal" rights common but not essential for HCQIA.

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Tips To Protect Immunity

- Do a very thorough analysis of the facts – this is always an area of attack.
- Follow timelines carefully.
- Document the process doggedly and thoroughly.
- Err on the side of fairness to the physician and document that.
- Document physician access to records, and opportunity to tell story/ be heard.
- Work to create a culture that supports peer review.
- No double jeopardy but prior incidents/ pattern are relevant and should be well documented.

HCQIA and Confidentiality

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

National Practitioner Data Bank

To Report Or Not To Report

- Often hospital medical staffs struggle with which actions might be reportable and to where.
- The scariest reporting obligation, from a physician's point of view, is the NPDB.
- Both payors and providers query the NPDB before deciding whether to approve credentials.
- "Dings" in the NPDB are black marks that hinder the physician's ability to obtain privileges/ payor credentialing.

What Must Be Reported To The NPDB?

- Hospitals and other health care entities must report adverse clinical privileges actions to the NPDB.
- Any professional review action that adversely affects the clinical privileges of a physician or dentist for a period of more than 30 days; OR
- The acceptance of the surrender of clinical privileges, or any restriction of such privileges by a physician or dentist:
  - While the physician or dentist is under investigation by a health care entity relating to possible incompetence or improper professional conduct; or:
  - In return for NOT conducting such an investigation or proceeding.

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Actions Considered Adverse

- Privileges limitation or restriction.
- Medical staff membership limitation or revocation.
- Network / plan participation and panel membership.
- Summary suspension lasting longer than 30 days even if not finalized.
- IF BASED ON PROFESSIONAL COMPETENCE OR CONDUCT.

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What Is A Restriction?

- Denials or restrictions of clinical privileges for more than 30 days that result from professional review actions relating to the practitioner's professional competence or conduct that adversely affects (or could adversely affect) the health or welfare of a patient - MUST be reported to the NPDB.
- This includes denials of applications for initial privileges.
- A restriction is the result of a professional view action based on clinical competence or professional conduct that leads to the inability of a practitioner to exercise his or her own independent judgment in a professional setting.

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Threshold Eligibility Criteria

- A denial of clinical privileges at appointment or reappointment that occurs solely because a practitioner does not meet a threshold criterion for that privilege should NOT be reported to the NPDB.
- Such denials are NOT deemed the result of a professional review action relating to the practitioner's professional competence or conduct and should not be reported to the NPDB.
- Rather, these are decisions based on eligibility.

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Withdrawal Of Application

- Voluntary withdrawal of an initial application for medical staff appointment or clinical privileges prior to a final professional review action generally should not be reported to the NPDB.
- However, if a practitioner applies for renewal of appointment or privileges and voluntarily withdraws that application while under investigation for possible incompetence or professional misconduct, then the withdrawal of the application must be reported.
- Applies regardless of whether practitioner KNEW he or she was under investigation – TELL THE PROVIDER WHAT IS GOING ON.

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Nonrenewals

- Generally not reported to NPDB.
- However, if practitioner decides not to apply for renewal of medical staff appointment or privileges while under investigation for professional competence or conduct – that is considered a surrender while under investigation and must be reported to the NPDB.
- Regardless of whether the practitioner was aware.

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Investigations

- The fact of an investigation need not be reported to the NPDB.
- A surrender of clinical privileges or failure to renew clinical privileges while under investigation or to avoid investigation must be reported.
- NPDB made a big effort to expand the scope of "investigation" in its updated manual – it runs from "the start of an inquiry until a final decision on a clinical privileges action is reached."
- Not limited to how investigation is defined in the bylaws.
- NPDB distinguishes a ROUTINE formal peer review process in which a "health care entity evaluates, against clearly defined measures, the privilege-specific competence of all practitioners." That is NOT an investigation for the purpose of reporting.
- But an investigation of a specific practitioner is different.

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Guidelines For Investigation

- For NPDB reporting purposes, the term "investigation" is not controlled by how that term might be defined in a health care entity's bylaws or policies and procedures.
- The investigation must be focused on the practitioner in question.
- The investigation must concern the professional competence or conduct of the practitioner in question.
- To be considered an investigation, the activity generally should be the precursor to a professional review action.
- An investigation is considered ongoing until the health care entity's decision-making authority takes final action.
- A routine or general review of cases or even of a specific practitioner is NOT an investigation.

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Temporary Privileges

- No distinction is made for corrective action regarding temporary privileges.
- If temporary privileges are for a specific amount of time and everyone agrees on that, and they expire while under investigation – no report.

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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; and
  - The result of a professional review action taken by a hospital.
- Summary suspensions that have NOT lasted more than 30 days but are EXPECTED to last more than 30 days and are otherwise reportable MAY be reported to the NPDB. If the summary suspension lasts 30 days or fewer, a void report should be submitted.
- The procedural rights of the practitioner are provided AFTER a summary suspension, not before.

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Proctors

- It is a tough question whether proctors must be reported to the NPDB if the proctoring requirement is imposed for more than 30 days.
- If the proctor cannot perform certain procedures without proctor approval, it is a reportable restriction.
- If the proctor is just reviewing records after a procedure, it is not reportable.
- Routine proctoring for new privileges would not be based on professional competence or conduct and is not reportable, even if the proctor must be present.

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Residents and Interns

- Residents and interns generally do not have clinical privileges and therefore a restriction of their practice is not an "adverse action" reportable to the NPDB.
- EXCEPTION: If they are functioning outside the scope of their graduate education e.g. moonlighting.

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NPDB Sanctions For Failing To Report

- If NPDB suspects a hospital has not reported when required to do so, the Secretary of DHHS will open an investigation and provide written notice to the hospital.
- The hospital can request a hearing.
- If the hearing is denied for untimeliness or lacking a sufficient statement of facts, or if the hospital does not prevail at hearing, the sanctions include:
  - Publication of the hospital's name in the Federal Register; and
  - Loss of the hospital's HCQIA immunity for three years (starting 30 days after publication).

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Things That Are Not Reportable

- Employment actions.
- Hospital administrative actions (such as discipline for failure to maintain insurance or board certification).
- Automatic revocation of privileges (for the above reasons and others, e.g. failure to complete medical records).
- A physician's surrender of privileges for personal reasons, unrelated to professional competence or conduct.

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Reports to NPDB

- Initial Report: NPDB will send a verification.
- Correction Report: To correct an error or omission – NPDB will send a verification.
- Revision-To Action Report: When a restriction previously reported is lifted or otherwise changes – unless that expiration or change was foreshadowed in the initial report.
- Void Report: Withdraws the entire report, if the report was submitted in error or the physician has prevailed on appeal.

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The Subject Physician's Statement

- The physician may not change the fact or the content of the report.
- The physician may submit a rebuttal statement that will become a part of the report and will be released to those who query.

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Examples

- A physician applies for medical staff membership and is approved by the credentials committee but withdraws his application before the governing board weighs in. The physician is not under specific investigation, just general credentialing.
  - NOT REPORTABLE.
- An employed physician is terminated through the HR process and pursuant to his employment contract, his medical staff privileges automatically terminate although the medical staff did not act on his privileges.
  - NOT REPORTABLE.
- A physician applies for expanded privileges and is denied by the credentials committee and the board on the basis that he lacks the skills.
  - REPORTABLE.

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Any Questions?

Sarah Coyne
(608) 283-2435
Sarah.Coyne@quarles.com

Jon Kammerzelt
(608) 283-2438
Jon.Kammerzelt@quarles.com