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Credentialing & Peer Review
LEGAL INSIDER

Overcome barriers to the effective use of physician quality data

In recent years, hospitals have generated reams of data about physicians and their clinical practices in order to meet the requirements of accrediting bodies, third-party payers, and government regulators. Although these data can be useful for myriad purposes, organizing them and ensuring that they are analyzed and acted upon appropriately can be a real challenge.

Now that The Joint Commission (formerly JCAHO) requires the ongoing professional practice evaluation (OPPE) of medical staff members, it is important for the medical staff office (MSO) and the quality department to share information.

In addition, organizations must do so as a matter of course rather than in response to a particular event, as was often the case before OPPE's implementation. Nonetheless, there can be impediments to sharing information this way.

Overcome resistance to information sharing

"Traditionally, the quality department and the medical staff services office worked independently," says **Janet Wilson, CPMSM,** director of the Western Region Credentialing Service at Banner Health in Greeley, CO. Many hospital structures kept the two functions strictly separate, but The Joint Commission's OPPE requirement will compel hospitals with such a culture to change.

"Proper and effective ongoing analysis of quality data requires the two departments to establish a cooperative relationship and make the two departments symbiotic," says **Brian Dolan, MHSA, RHIA, CPHQ,** performance improvement coordinator with Hospital Corporation of America's Midwest Division, who is currently based in Overland Park, KS. He has helped several hospitals establish processes and structures to facilitate OPPE and improve hospital quality and accountability.

> **"Proper and effective ongoing analysis of quality data requires [the quality department and the medical staff services office] to establish a cooperative relationship."**
>
> *—Brian Dolan, MHSA, RHIA, CPHQ*

Dolan says locating the quality office and MSO in the same physical space can help establish symbiosis by forcing the departments to communicate regularly and establish a working relationship. Part of his job description—he answers to the directors of quality and medical staff services—is to bridge any communication gaps between the two departments.

But combining both offices into one space may not be viable in every facility—and sometimes the communication problems are not limited to the quality and medical staff offices. **Dorraine S. Young,** assistant quality manager at A.O. Fox Memorial Hospital in Oneonta, NY,

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reports that some departments are protective of quality information and may be reluctant to share it. And when departments fail to share quality data, they hinder the hospital from fulfilling its responsibility to provide quality care.

Young suggests enlisting a physician to champion the cause of information sharing. In her experience, pressure from a respected member of the medical staff is an effective tool to pry information loose from departments that have been unwilling to disclose their data.

Her facility has gone even further: The medical staff has established a Professional Performance Advisory Committee to examine quality data on an ongoing basis. The committee also reviews information relevant to quality, such as patient comments and complaints, concerns raised by colleagues, and incident reports. This committee is composed of physicians, the vice president of the hospital, and the directors of quality assurance and risk management.

"With the new [Joint Commission] requirements, the process of evaluating quality has to be more formal than it used to be," Young says. The committee has been very helpful in establishing a process to look at all quality issues. "Before, the quality department might notice a pattern but have no place to take it," she says. "Now they can bring anything that arises to the professional performance advisory committee and feel secure that it will be handled appropriately."

Dolan says some hospitals that he works in have established a similar committee, called the Quality and Peer Review Committee, composed of physicians as well as the directors of the credentialing, quality, and risk management departments.

These committees review quality indicators monthly, and MSOs are responsible for sharing relevant data among the medical staff members.

Address technological impediments

Electronic medical record (EMR) systems can enhance the availability of physician performance data. **Sue King, CPMSM, CPCS, CPHQ,** administrative director at Hillcrest Healthcare Systems in Tulsa, OK, says her hospital's system makes accessing and handling physician quality data simple. The quality department generates periodic reports on each physician, and these are sent to the MSO.

In the past, the physician's department head would review these reports with the credentialing committee when the physician's privileges came up for renewal, or in the event that the physician requested additional or different privileges. The only changes her facility has had to make to comply with the OPPE standard are that reports are generated more frequently and the department head now reviews them regularly.

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But not all MSOs are so lucky. In facilities that aren't entirely computerized, or that did not design systems with an emphasis on quality data retrieval, EMRs may impede the proper sharing of data. "It has been a struggle to meet the intent of the Joint Commission requirements without placing an undue burden on the various hospital departments" that might possess relevant data, says Young.

At her facility, independent computer systems among various hospital departments impede integrating data into useful physician profiles. For example, the lab, the operating room, and the pharmacy have independent systems, as do several hospital outpatient departments. There is no way for quality or medical staff services to gain direct access to the data, Young says.

When computer systems are not integrated, quality data must be entered manually. This is labor-intensive, and it sometimes makes it difficult for the quality department and/or the MSO to gain access to relevant information in a timely manner, Young says.

Wilson notes that at a facility where she previously worked, she "could not manipulate the hospital's software" in a manner that provided her with access to the quality data she would need to comply with The Joint Commission's OPPE requirement. Well before the standard was implemented, she told the hospital's CEO that she "needed a bridge between the quality department and the medical staff office ... [so that we can] look at the physician quality information in a very structured format," she says.

As a result, she was able to hire Dolan to establish a database of physician quality data. Working full-time, he completed the project in four months, Wilson says. Naturally, refinements were and are still necessary, but the database renders the process of retrieving and properly analyzing quality data much easier, she says.

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Each department was charged to identify several quality indicators to include in the database, and each department's selected indicators were presented to the peer review committee for approval. To ensure that the information would be relevant and manageable, the facility tried to limit the number of indicators to four or five per specialty, Wilson explains.

The database also collects activity and volume records, incident-based information, and information collected from patient charts, such as legibility, use of abbreviations, timeliness of documentation, and appropriateness of history and physical, Dolan says. Once the database was set up, the MSO personnel required several training sessions.

"The MSO manages the database," Wilson says, "but the quality department controls it. The quality department knows what all the data mean."

Make physicians less defensive

Physician support is critical to the process. In order to get physicians to use the data for the benefit of their practice and to improve the quality of care they offer in the hospital, they must understand why the hospital collects the data and how it uses them.

Dolan suggests deputizing the chairs of the quality and/or peer review committees or another well-respected physician leader to sell the process to the medical staff.

It is important for physicians to recognize that the data are not "judging" them or their practice, and neither is the committee that analyzes the data, Dolan says. Instead, the data provide evidence of their practice patterns and identify areas where the physician may be an outlier from other physicians on the medical staff. Stress that the data merely provide the physician with notice of his or her status in comparison to peers at the same facility, and they offer the physician an opportunity for self-evaluation.

If the data indicate a physician should change his or her practice, the fact that the data are gathered and

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analyzed for all physicians in the same way should mitigate their defensiveness, King says.

Seize opportunities to improve

Dolan says one benefit to the OPPE requirement is that it will enhance the professional status of medical staff service personnel. Handling the database will demand MSOs to increase their technological proficiency.

"MSPs are now moving toward the electronic practice realm with increased need to understand software and data analysis," Dolan says. Beyond that, the need to manage quality data effectively will require "someone to step up and be a leader and delegate," he says. And medical staff service personnel are just the people for the job.

Dolan says the current healthcare climate requires "interventionalist medical staff management, as opposed to passive medical staff management." MSOs should be responsible for ensuring that data are communicated to department heads and that they filter through to individual physicians.

Among other duties, the MSO may be responsible for following up on evaluations and making sure physicians take appropriate action in response to the data they receive. These additional responsibilities may tax already understaffed MSOs, Dolan says, but individuals who are willing to assert leadership and promote the use of evidence-based data to improve quality are likely to find their professional lives enriched. ■

Court decisions trend toward disclosure

The quantity of information that hospitals must generate and analyze leads to an increased risk that information may be subject to disclosure and potentially used against the physician and/or the hospital.

Healthcare providers are concerned about protecting sensitive information—such as morbidity and mortality reports, quality assurance records, and peer review information—from disclosure in lawsuits. But the protection available is porous, and there is a discernible trend among courts to permit at least limited disclosure of information that may be relevant or necessary to prove a claim, says **Gregory Abrams,** an attorney in Oakland, CA.

Most states have statutes that provide some limited protection to peer review documents, but courts often apply these statutes narrowly. And there is no federal privilege protecting documents generated through the peer review process from disclosure, Abrams explains. So a smart plaintiff's attorney will strive to find a federal law violation such as an EMTALA claim to allege when bringing a medical malpractice suit. In this way, the plaintiff can take advantage of the fact that there is no federal peer review privilege, Abrams says. The following are samples of several recent court decisions that illustrate the many situations in which courts have allowed disclosure of sensitive data:

- ***Zamarano v. Wayne State Univ.*, 2008 U.S. Dist. LEXIS 39378, May 2008.** The plaintiff is a physician who was terminated from her employment as a professor and neurosurgeon at Wayne State University Medical Center. She brought suit alleging that she was terminated because of her sexual orientation and further alleged that the defendants continued to harass her and prevent her from gaining employment at other institutions. The defendants sought to introduce the plaintiff's peer review records, asserting that these documents support their claim that legitimate reasons, not discrimination, led to her termination. The plaintiff moved to prevent the disclosure of her peer review records, but the court held that they were relevant to the proceeding and permitted their introduction into the record.
- ***Vezina v. United States*, 2008 U.S. Dist. LEXIS 24437, March 2008.** This wrongful death suit was brought under the Federal Tort Claims Act because the treating physician was an employee of the U.S. Department of Health and Human Services. The plaintiff sought the treating physician's peer review data, credentials committee minutes, and records relating to the treating physician, including his "physician file." The court, citing the absence of a federal privilege

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protecting such documents, allowed the plaintiff access to them.

- ***P.J. v. Utah*, 247 F.R.D. 664, 2007 U.S. Dist. LEXIS 87633, November 2007.** This suit arises from a case in which parents opted, against physician advice, to investigate treatment options other than chemotherapy when their child was diagnosed with cancer. The child's doctors reported the parents to child protective services, and the state moved to take legal guardianship of the child. The parents removed the child from the state to avoid this result and later sued the state on numerous grounds, including allegations that the medical providers made omissions and misrepresentations to the juvenile court based in part on a desire to get the patient enrolled in a protocol before a diagnosis had been confirmed. The court concluded that information regarding the treatment protocol was relevant and discoverable, as were documents relating to an individual doctor's application for a position as a reviewer where she likely would have discussed the protocol and the patient's case. The plaintiffs were allowed to review the doctor's personnel record subject to a protective order to be negotiated by the parties. The defendants were ordered to produce information regarding the Institutional Review Board protocol.
- ***Rodas v. Swedish American Health Services*, 2007 U.S. Dist. LEXIS 60799, August 2007.** This case alleged wrongful death of the plaintiff's neonate. The hospital branded all quality materials, including all data about infant deaths that was collected in the normal course of hospital business, as peer review material under the aegis of the state's protective statute. The plaintiffs sought this information, and the court held that information that is gathered before a peer review is initiated is not entitled to the protection of the statute. The court allowed discovery of this material.
- ***Belbachin v. County of McHenry*, 2007 U.S. Dist. LEXIS 53727, July 2007.** A woman of Algerian descent who had been living in the Chicago area was denied entry at London's Heathrow airport and sent back to the United States, where immigration authorities detained her upon arrival. She was incarcerated in the county jail and suffered numerous mental and physical health emergencies during the period of her detention, including panic attacks, respiratory distress, and suicidal ideation. She received hospital treatment to relieve her symptoms but was released back to the county jail, where she committed suicide on the 10th day of her detention. Her family sued, alleging civil rights violations, violations of the Americans with Disabilities Act, and a variety of state law claims. After the plaintiff's death, the hospital where she was treated conducted a core team meeting and a root cause analysis meeting to discuss the patient's case and identify strategies to prevent a similar case in the future. The plaintiff sought the records of these meetings, and the court granted the plaintiff access to them.