Peer Review Report

News, analysis and commentary on Medical Staff credentialing, privileging, peer review and governance

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Major Document Restructuring Likely Needed

JCAHO Sets Rules For Required Bylaws Content

On July 11, the Joint Commission dropped the other shoe. And it was a boot.

For more than four years, JCAHO has struggled with the following questions: What must appear in bylaws? And what *may* appear in supplemental documents such as rules and regulations, policies and manuals?

The wait is over. After several rewrites, field reviews, postponements and major philosophical reversals, JCAHO has settled on a final approach.

The good news is that, continuing recent trends, JCAHO has been fairly clear. The bad news is that many medical staffs will have to make major revisions to their documents in order to comply. Literally everyone will have at least some tinkering to do because of some surprise, last-minute requirements.

In this article, I will first review the recent history of MS 1.20, the medical staff standard in question. Then I'll lay out the main new requirements of the standard. I'll next examine an example to see how the new requirements might apply. Finally, I'll discuss some of the implications of these changes.

(See MS 1.20, page 3)

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In this Issue:

Give the Doc the Docs

Foot Dragging Costs Hospital HCQIA Immunity

A hospital cannot play rope-a-dope on a document and Fair Hearing request and then hope to out-box a terminated physician at the courthouse.

An Iowa federal court in March upheld a $146,000 jury verdict in favor of a doctor where the hospital dallied over the doctor's request for documents and for a hearing. The opinion in *Estate of Blume v. Marian Health Center* gives us a chance to review some basics on fair hearings and to examine some new ideas.

You can download the full opinion from the Hot Topics section of our website, http://www.setterberglaw.com/.

The opinion is a bit short on clear details and a chronology. What seems to have happened is this:

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Foot Dragging . . . (cont'd)

The hospital took away Dr. Blume's privileges on the basis of an unspecified number of complaints and incident reports. Dr. Blume asked for copies of the complaints and reports. The hospital dragged its feet.

Dr. Blume also requested a hearing. The hospital replied, "When do you want one?" There is no clear statement about what happened next, but Dr. Blume never got his hearing.

He sued. At some point along the way, Dr. Blume died, and his estate took over the lawsuit. After a four-day trial last year, the jury returned a verdict in favor of Dr. Blume's estate. The hospital asked the court to throw the verdict out on the basis of federal immunity. The trial judge refused and wrote a 37-page opinion why.

As you know (if you read much Peer Review Report), a hospital and its participants may qualify for immunity from liability in physician termination suits. The federal Health Care Quality Improvement Act (or "HCQIA") grants this immunity if the defendants do four things.

Very loosely, they must first prove that what they did was based on a reasonable belief that it would improve health care. Second, they have to investigate the facts. Third, they have to provide a fair hearing or other procedure. Finally, the resulting decision has to be warranted by what they found out during the investigation and hearing.

Unlike our court system, peer review systems do not require much "discovery," i.e., mandatory pre-hearing disclosure of files, theories, testimony through depositions and the like. If other courts follow this case, however, stonewalling a pre-hearing discovery request that goes to the heart of the case may cost you immunity.

In *Blume*, the plaintiff had asked defendants for copies of the complaints and incident reports against him. By refusing to produce these one-sided versions of the facts, they denied Dr. Blume essential information he needed to defend himself. Worse, the denial deprived *the hospital* of the other side of the story. That, the court concluded, was a failure to properly investigate, in violation of the second prong of the HCQIA test.

Although the hospital loses if it fails only one prong of the test, the court found another prong deficient: Failure to provide a fair procedure. The hospital offered a hearing, and Dr. Blume accepted. At this point, most hospitals would schedule a hearing. For whatever reason, the hospital asked when he wanted one. For whatever reason, Blume never responded. The hospital never scheduled a hearing, and Blume took this failure to court.

The court said that the hospital failed to offer a fair procedure. Neither the HCQIA nor the bylaws requires a physician to ask twice, the judge said. The hospital should have just set a date. It didn't, hence the second HCQIA failure. The court again cited the failure to deliver the complaints and incident reports as contributing to this lack of a fair procedure.

This decision is far from settled law. Defendants have appealed the ruling, and that appeal is currently pending. It only binds federal courts in Iowa, so whether a local judge outside Iowa would adopt its reasoning is uncertain.

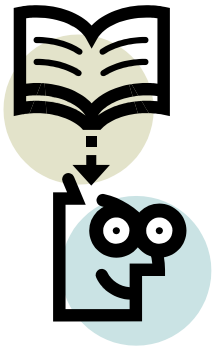
A few practical pointers do seem clear, however:

1. Where complaints and incident reports are at the heart of a case against a doctor, it is hazardous to play hide the ball. It is not only easy to work this gamesmanship into the technical "failure to investigate" rubric. It is also hard to work up a lot of sympathy for any party that won't subject the core of their case to the light of day. Just ask the Iowa jury.
2. Play by the book – the Fair Hearing "book" that is. If a physician requests a hearing, give him or her one. The HCQIA does say "place, time, and date" and so do most fair hearing plans. Pick a date if a physician won't collaborate on schedules. If you string things out, there might be just enough rope to hang you.

The hospital's refusal to produce documents was a failure to investigate, because it showed the hospital was not interested in hearing what the physician had to say about them.

When a physician asks for a hearing, schedule one in strict accordance with the bylaws.

MS 1.20: JCAHO Bylaws Content (cont'd)



The revised standard takes effect in 2009, but don't let that lull you into complacency. That deadline is only 16 months away. If your medical staff documents require major revisions, it can easily take that amount of time to complete the overhaul.

History

First, a little history. The four-year journey to the current standard began with some informal JCAHO interpretations in 2003. "You have to 'reference' your credentialing, privileging, appointment and hearing process in the bylaws," JCAHO said. "You can put full descriptions in other documents as long as they approved by the full staff or MEC."

What that meant, including "reference," was unclear. So, JCAHO in September 2004 announced its controversial "EP 19" (Element of Performance 19), which attempted to clarify what matter could be in supplemental documents and how that happens. Since the new EP only made matters muddier, a month later it tried again with a "Clarification."

Many lawyers advised the creation of supplementary documents. Now, much of that material has to go back into the bylaws.

The October 2004 clarification did a little better. JCAHO wanted the significant processes and steps of credentialing, privileging, appointment and hearings to be in bylaws and would only allow procedural details in rules and regulations or policies.

This caused a considerable uproar from hospitals and their lawyers. Many lawyers had advised the creation of many of these supplementary documents in order to slim down bylaws and streamline medical staff management. Now, they would have to put much if not most of it back.

JCAHO responded with several additional field reviews and rewrites over the next three years. In their most recent try published in August 2006, JCAHO proposed, "Put all this stuff wherever you want it."

The final rule a few weeks ago completely reverses field . . . again. Using clearer language, MS 1.20 came out about where it started in 2004.

Main New Requirements

So, what does the new MS 1.20 require?

MS 1.20 lists 25 things that must be in the bylaws.

Foremost, it specifies 25 things that must be in your bylaws. It uses language that is JCAHO's clearest to date. The 25 requirements are specifically enumerated in EPs 9 – 33. You may not agree with what they are, but it's pretty plain what JCAHO now expects. [You can download the full text of MS 1.20 from the Hot Topics section of our website, http://www.setterberglaw.com.]

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MS 1.20: JCAHO Bylaws Content (cont'd)

The "procedural details" of eight of these – EPs 26 – 33 – may appear in supplementary documents such as rules and regulations, policies or manuals. These pertain to, in the main, credentialing, appointments, discipline and fair hearings.

We'll come back to this "procedural details" idea in a minute. Suffice it for now to say that medical staffs that have moved their entire credentialing, discipline and hearing processes out of the bylaws and into standalone credentialing manuals, fair hearing plans and the like have some major restructuring to do.

Hospitals that moved entire processes out the bylaws into standalone manuals and policies have some major restructuring to do.

Another major change in MS 1.20 is that JCAHO has finally been clear about how the MEC can fit into all this.

The MEC, it says for the first time, may be empowered to approve these supplemental documents instead of putting them to a vote by the full staff. But the bylaws must specifically spell out that delegation as well as procedures for how the full staff may remove it. And also for the first time, it clearly states that bylaws have to be voted on by the whole staff. Most staffs have done it this way for years, but JCAHO has now formalized it.

JCAHO must think MEC/full staff conflict is in the air, because a number of further changes call for new bylaws dispute mechanisms. There must now be a way for the full medical staff to, in effect, jump the MEC and propose bylaws changes directly to the governing body. There must also be a way for the full staff to challenge MEC action on supplemental documents.

There are a few other changes that will require at least minor modifications. Bylaws must now spell out who's entitled to vote on bylaws issues. CMS has recently updated H&P requirements in the Medicare Conditions of Participation, and JCAHO now specifically includes that H&P requirement as bylaws content.

Procedural details may be placed (or remain) in supplementary documents

<u>How Does This Work? It's All In The "Procedural Details"</u>

One big job every staff will have in redrafting is deciding what qualifies as a "procedural detail" eligible to be transferred to (or kept in) a supplemental document. There will surely be tough questions here and there, but the basic ideas are not rocket science.

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MS 1.20: JCAHO Bylaws Content (cont'd)

Credentialing, discipline and hearings are all "processes". Each of these processes has steps. Steps have "procedural details." For example, for credentialing, there is a data collection step, a verification step and a decision step. The steps of each process have to be in the bylaws. If the medical staff chooses, it can put the procedural details in the bylaws as well, or it can delegate to the MEC the power to put them in a manual or policy. The nearby diagram shows how this structure looks in theory and applies in practice to the credentialing example.

The Credentialing Process Example: "Steps" and "Procedural Details"

Step 1: Collection	Step 2: Verification	Step 3: Decision	Where Must This Appear?
Example: "We will collect info re licensure, education, training, competence [etc.] . . .	Example: "We will verify info through sources identified by the MEC in the Credentialing Manual. At a minimum, these are . . .	Example: "We will make our decision based on the following criteria: Evidence of ability, peer references, performance data . . .	This *MUST* be in the bylaws
Procedural Detail: Collection Examples: • Form content • Who collects • Timing	Procedural Detail: Verification Examples: • Who's contacted • File assembly	Procedural Detail: Decision Examples: • Who reviews • How/when • Notice to doc	This *MAY* be in the bylaws or in a credentialing manual or policy

How much detail must you use to describe each step in a process? JCAHO doesn't say, but I would err on the side of inclusion, particularly if there is a standard inherent in the step. For example, on what basis will you make a credentialing decision during the "decision" step? New MS 4.15 requires a minimal list; you might have others. Viewing the bylaws as the "constitution" of medical staff governance, putting those standards in the bylaws is the right way to go. Stated in other words, a standard for decision seems hardly a "procedural detail" that may safely be relegated to the credentialing manual.

Each of these steps has lots of "procedural details". Continuing the credentialing process example, such details include: Who collects the data? Where is it stored? Whom do you contact during the verification process? What committees does it go to? What are the time limits? These are the things that a medical staff may put into a separate credentialing manual or policy.

As mentioned, a medical staff may delegate these details to the MEC to work out, as long as the bylaws say so. If the bylaws don't delegate that authority, all matter must appear in bylaws for approval by the full medical staff.

Implications

The biggest and most important implication – I can't overstress this – is that every medical staff at every JCAHO-accredited hospital in the country will have some changes to make in the next year or so. There are enough brand new requirements that at least a tweak here and there will be necessary at every facility.

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MS 1.20: JCAHO Bylaws Content (cont'd)

For those who have created policies and manuals for credentialing, discipline and hearings, major overhauls are likely. Few medical staff documents will fit neatly into JCAHO's new rubric of "processes and steps in the bylaws, procedural details elsewhere." Modest to severe realignment of matter between bylaws and other documents will be necessary.

Many staffs may decide that the process of division among several documents is too difficult and will result in a hodge-podge of documents that are too difficult to follow. These staffs may choose simply to reincorporate everything back into the bylaws. This is certainly not necessary, but it is an allowable choice and one that a staff might defensibly choose to make.

Some hospitals may choose to put everything back into the bylaws for the simplicity of a single document. This is unnecessary but defensible.

One place where there is probably still a good deal of room for a separate document is the credentialing process. It shouldn't be too hard, or too much to ask, to put the important parts of your selection process into the main bylaws document. At the same time, the "procedural details" of this process can be quite detailed and appropriately fit into a credentialing manual. This allows the MEC to fine-tune the workings of this process without a bylaws amendment.

By contrast, trying to split the fair hearing plan into a bylaws segment and a procedural detail segment may be confusing, risky, possibly misleading and unfair and not at all efficient. The Joint Commission has made these risks clear by being more specific than ever about required bylaws content on matters such as hearing scheduling, panel composition, hearing conduct and appeals.

The same is true of splitting aspects of the discipline process. Once a staff has enumerated the bylaws requirements for automatic and summary suspensions, regular suspensions, reductions, denials and restrictions of membership and privileges, there may be little left to sensibly relegate to a separate policy or manual.

A potential negative side to the latest changes is the Joint Commission's assumption that medical staffs need an arsenal of weapons to use against their own MECs. There may be a few places in the country where an MEC is at constant odds with its full membership, but I doubt there are many. The new requirements run the risk of giving troublemakers a few too many ideas on how to disrupt a staff.

It is unclear why JCAHO thought it was necessary to require an arsenal of weapons for a staff to use against its own MEC.

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MS 1.20: JCAHO Bylaws Content (conclusion)

If anything, JCAHO should have required an express dispute resolution mechanism between the medical staff and the governing body in the bylaws. (New Leadership Standard 2.40, in addition to vagueness, is not a bylaws requirement.) JCAHO has long resisted such a move, adopting a "work it out, boys" attitude toward the question. The number of times a medical staff has refused to implement a bylaws change that threatens a hospital's accreditation, however, is probably far greater than the number of squabbles within the medical staff itself.

Although new MS 1.20 represents a lot of work, it also represents an opportunity. Many hospitals have yet to implement last year's requirement (effective this year) for the new twin credentialing data collection tasks, Ongoing Professional Practice Evaluations and Focused Professional Practice Evaluations. New privileging requirements ought to have been incorporated by now into both governing documents and privilege delineations. And if your medical staff has not reviewed or refreshed its medical staff documents in a while, it's probably time for an overhaul anyway.

If you've been putting off document revision, now's the time. You finally have as big a reason as you'll need to get going.

Look at revision less as a burden and more as an opportunity.

See this issue's Commentary, page 8.

Quick Hits:

- Late last year, CMS announced substantial revisions to the hospital conditions of participation relating to H&Ps, verbal orders and restraints.
- A jury has held a hospital in Hurricane, WV liable for negligent credentialing. Putnam General Hospital awarded privileges to Dr. John King in 2002. Dr. King is accused of having performed more than 100 acts of medical malpractice in the following six months, including unnecessary and botched surgeries. The hospital will now face liability in 122 malpractice lawsuits. The physician has surrendered his license, left the state and changed his name.
- A federal district court in Wisconsin has refused to dismiss a doctor's disability lawsuit based on denial of medical staff privileges. The physician, who has bipolar disorder and sleep apnea, based his claim under that part of the Americans With Disabilities Act that forbids disability discrimination in places of public accommodation. The court agreed with the physician that the hospital was a "public accommodation" that constituted a place where all qualified doctors could come to practice. The case, *Hetz v. Aurora Medical Center*, now proceeds to pretrial discovery and trial.

All materials cited in Quick Hits are available on our website's Hot Topics section. Go to http://www.setterberglaw.com

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Commentary

Opportunity knocks. Answer the door.

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Last month's JCAHO announcement on bylaws requirements has elicited the full range of predictable reactions, mostly unprintable. Many hospitals – they generally pick up the tab for bylaws revisions – will complain that revisions are expensive (they needn't be), time-consuming (only if you make it so) and wasteful bureaucracy (not if you do it right).

I know most of you would rather schedule elective gum surgery than contemplate this, but medical staff document revision can be an opportunity. I'll wait until you're done laughing to continue.

I know I'm often the most enthusiastic person in the room when helping medical staffs with revision projects, but my years doing so teaches that there are significant collateral benefits:

1. Getting Compliant. In addition to the major allocation issues in the MS 1.20 change, JCAHO made major changes last year in the credentialing process. Privileging requirements also changed. CMS issued significant changes late last year in what bylaws have to contain, on pain of loss of Medicare participation. Because of the extent of the surprises in all these, no staff will likely escape a revision project of *some* magnitude just to stay in compliance.

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2. Getting Up To Date. Despite that many concepts like temporary privileges, disaster privileges, telemedicine, streamlined committees and departments have been around for a few years, there are still places with locum tenens privileges and 10 departments. Leaders need to get rid of outmoded structures or step forward for a punitive wedgie.

3. Getting Together. This is not just a Kumbaya moment. It is an operational reality. When medical staff leaders and administration get together to work on medical staff documents, good things happen. One meeting I attended began with a routine discussion and ended with resolution of a major (non-bylaws) issue that had been festering for years. All because there was a table, and the two sides were seated there at the same time.

4. Getting Easier. This is a chance to make things simpler. Are your documents readable English? Why not? Technology has also made life easier, if only medical staffs would join the party. Are your medical staff documents in electronic form? Do they have indices and tables of contents that instantly flip you to the desired page? If there is a related manual or policy, is it hyperlinked electronically, or do you make readers go find hard copy?

5. Getting Educated. Medical Staff leaders come and go, on average, every 4 to 6 years. Who is teaching new ones what the bylaws say, or might be improved to say? Shouldn't this new crop of leaders get to write their own play, since they will have to perform it for years to come? There is nothing like a revision exercise as a boot camp for their challenges ahead.

6. Getting On The Same Page. Hospitals that are part of an alliance or under common ownership could enjoy enormous benefits from singing from the same hymnal. Those who don't are probably missing important efficiencies and, quite possibly, legal protections. Even where there is no common ownership but substantial staff overlap, wouldn't it be nice to have one set of bylaws at both your hospitals. Team up! Make it a joint effort! Split the costs! Have a party!

So, get busy. And cancel that gum surgery . . .

Richard A. Setterberg Co., L.P.A. publishes and distributes **PEER REVIEW REPORT** free to inform clients and others about issues and developments concerning medical staff matters. It is not legal advice. For further information on issues or topics in this newsletter as they may apply to particular facts, please contact the editor at (513) 733-1759 or rich@setterberglaw.com.

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