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INSIDE

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Special Report: New Paradigms in Credentialing

Avoid peer review train wreck: Build compliance into your credentialing

New Medicare/Medicaid participation regs can derail your program

If you are not considering compliance requirements in your credentialing program, it's probably on track for derailment. New federal compliance guidelines for participating in the Medicare and Medicaid programs must now be considered before you extend hospital privileges. Furthermore, any physicians already on your staff who do not meet the new criteria may have to be kicked off or you risk losing your Medicare/Medicaid business.

Hospital Peer Review asked experts **Fay Rozovsky**, JD, MPH, and **Mark Kadzielski**, JD, to address the dilemma some hospitals may face due to the new guidelines and to propose steps you need to take to avoid compliance-driven credentialing pitfalls. Rozovsky is president of the Rozovsky Group, a consulting firm in Richmond, VA, as well as a member of *HPR's* editorial advisory board. Kadzielski is head of the West Coast Health Law practice and a partner in the Los Angeles office of Epstein Becker & Green.

Credentialing liability exposure, they say, can stem from acting too precipitously on compliance. "Compliance and quality don't coalesce very well," says Rozovsky. "In fact, they conflict."

Medicare compliance is based on law and accreditation standards. It has a punitive model — the federal sentencing guidelines. In contrast, hospitals have been working under a peer review model driven by quality issues since the 1986 Health Care Quality Improvement Act

Medical staff credentialing update

With this issue, *Hospital Peer Review* presents the first of three special issues on medical staff credentialing. This month's focus is on the need to coordinate between credentialing and compliance. ■

came along, which has to do with providing excellent care, not punishing noncompliance. The Act gave hospitals certain protections as long as they provided due process and took appropriate corrective action. Most state laws were changed to accommodate quality in hospitals, but in the ensuing 13 years much has changed.

Along came compliance, an initiative that is diametrically opposed to what the Health Care Quality Improvement Act told hospitals to do. Compliance is driven by a different agenda and doesn't have protections, Rozovsky says.

While the quality act looked at problems as being systemic and recommended not pointing fingers at individual practitioners, the new compliance initiative sees people as potential problems. It states, like the federal sentencing guidelines, that hospitals should disassociate themselves from anyone sanctioned for fraud and abuse. Your organization's new corporate compliance plan (CCP) probably is based on that premise — that you'll have no one on staff who's been tainted by fraud and abuse issues — and that's the rub. Some compliance-credentialing issues are starting to come to the surface, and our experts suggest you do some homework fast to rethink contracts, bylaws, and the rules and regulations of your medical staffs.

'But he's a good doctor . . . '

Consider this scenario: You have a very productive, highly qualified physician, but you find out he has been sanctioned by one of the federal funding programs. His name appears on the Office of the Inspector General's (OIG) List of Excluded Individuals/Entities. How do you remove him from your staff? Your bylaws were not written to accommodate such actions. Your contracts do not take that scenario into account. The doctor may have a legitimate complaint: "How dare you do this to me? Show me in my contract or in the medical staff bylaws where it says you can take such action." And he or she may have a good point.

"Compliance and credentialing policies often don't match up," says Rozovsky.

The OIG model compliance guidance for hospitals and the federal sentencing guidelines encourage an organization to disassociate itself from any contractor or employee who has been sanctioned by a federal program such as Medicare or Medicaid, has been debarred, or has otherwise been found culpable of misconduct under law involving the health care system.

What if the sanctioned doctor is a salaried employee or a contractor with credentials that accord him privileges under your bylaws, and your bylaws don't provide for disassociating him for other than quality purposes?

It can get even more complex when that physician whom you've been credentialing and granting privileges is a shareholder in your physician-hospital organization. Or he or she may have an adjunct affiliation or be a faculty member of your medical school. You may have various contracts with the physician. "How do you get yourself out from under that?" asks Rozovsky.

Suppose the physician is the focus of a federal review, and, according to the model compliance guidance, has to be removed because he or she could jeopardize the integrity of your compliance program. The physician could be the head of a medical foundation or the chair of a department, and now the physician is the focus of a government review. "He has his hand on the switch to such a degree that, pending the outcome of the investigation, you don't want his hand so close to the switch," she says. Do your bylaws allow suspension for that purpose?

Zero tolerance? Things could get ugly

Kadzielski agrees there could be a problem and says you could have a serious dilemma in store if your CCP guarantees that your facility is "as pure as driven snow. How can you tout zero tolerance for fraud and abuse on the one hand while allowing, within your midst, even one practitioner who has had a felony conviction for fraud, debarment for fraud, a civil judgment for fraud, or a licensure action, either pending or complete, related to fraud and abuse?" Eventually, he says, the following dialogue could take place:

Compliance staff to medical staff: "Get rid of the following doctors. Throw them off the staff now. We won't tolerate them on our staff. They're dirty."

Medical staff to compliance staff: "But they're excellent clinicians. They have nothing to do with fraud in our system. Whatever happened,

happened in a civil judgment, or in another state, or it was related to a billing misunderstanding. If we're going to get rid of any doctors, we have to give them fair process."

Compliance staff to medical staff: "If we had a contractor who was selling us devices, and we found a fraud report on him in the database, we'd terminate the contract. In the same way, we have to terminate those doctors."

Rozovsky points out that the situation could get ugly. In some instances where a doctor is the subject of scrutiny, he or she could become a *qui tam* relator, a whistle-blower. The physician may see that course of action as one way to redirect attention back onto the hospital. The hospital takes the hit instead of the physician, or at least it shares the physician's position. Another piece in this conundrum: If a doctor submits a bill to one of the federal health programs and the doctor's level of care is deemed substandard, that's considered a false claim under the False Claims Act. Your hospital now must look over its shoulder for instances like that, she says.

See the other articles in this and in the July and August issues of *Hospital Peer Review* for advice on how to proceed in these newly shark-infested waters. ■

Look to these credentialing sites

Each month you now have to access the Internet site of the Office of Inspector General (OIG) for the agency's List of Excluded Individuals/Entities to check credentials (**www.dhhs.gov/progorg/oig**). Here are other sites to visit while credentialing:

American Board of Medical Specialties:
www.abms.org
American Medical Accreditation Program:
www.ama-assn.org/amap
Federation of State Medical Boards:
www.fsmb.org/main.htm
Healthcare Integrity and Protection Data Bank:
www.hrsa.dhhs.gov/bhpr/dqa/hipmain.htm
Joint Commission on Accreditation of Healthcare Organizations:
www.jcaho.org
National Association of Medical Staff Services:
www.namss.org
National Committee on Quality Assurance:
www.ncqa.org
National Practitioner Data Bank:
www.npdb.com

New data bank rolls out

But hospitals cannot access HIPDB's information

The federal Department of Health and Human Services (DHHS) was projected to roll out its new Healthcare Integrity and Protection Data Bank (HIPDB) by May 19 or soon thereafter. Mandated by the Health Insurance Portability and Accountability Act of 1996, HIPDB requires the following entities to report fraud-and-abuse related adverse actions against providers, practitioners, and suppliers:

- health plans;
- government agencies, including the Department of Justice, DHHS, and others that administer payment for the delivery of health care services;
- federal and state agencies responsible for licensing, such as state medical boards;
- state law enforcement agencies;
- state Medicaid fraud control units.

The HIPDB is geared more toward health plans and integrated delivery systems than toward hospitals. In fact, it cannot be accessed directly by hospitals. It will be more sweeping in what it collects than the National Practitioner Data Bank (NPDB). HIPDB will track these kinds of final adverse actions:

- civil judgments;
- federal or state criminal convictions;
- actions by federal or state licensing agencies;
- exclusions from federal or state programs.

Data bank reports can be accessed only by entities entitled to query HIPDB: federal and state agencies, health plans, and CVOs authorized to query on behalf of health plans, but *not hospitals*, except in the case of self-query by hospitals that are reported there. Information there can be used against a physician in decisions regarding prosecution, contracting, or credentialing. The doctor's

name remains in the data bank forever. Even though you cannot access it directly, our experts recommend that, once it is up and running, you "piggyback" on a health plan and get your information that way.

The HIPDB is modeled on the NPDB and was launched by the same federal agency, the Health Resources Services Administration, Bureau of Health Professions, Division of Quality Assurance. There may be some coordination between the two data banks, and queries submitted to the HIPDB by health plans will be processed by both HIPDB and the NPDB.

State licensing board actions reported to the NPDB prior to August 1996 will not be in the HIPDB, but all subsequent state licensing board actions reported to the NPDB will be transferred to the HIPDB. Thus, the HIPDB will hold information as soon as it is operational; the NPDB was empty for a substantial length of time after it opened in 1990.

The HIPDB will contain immunity and confidentiality provisions identical to those of the NPDB, so credentialing committees will be able to adapt to its forms and terminology easily. You can read the proposed HIPDB regulations in the *Federal Register* [63 *Fed Reg* 58,341 (Oct. 30, 1998)]. Also, see HIPDB's Web page at **http:// www. hrsa. dhhs.gov/bhpr/dqa/hipmain.htm**. **(For additional information on NPDB and HIPDB, see *Hospital Peer Review*, January 1999, pp. 5-7.)**

HMOs will query the HIPDB when they make credentialing decisions regarding practitioners they hire. That reverses the typical credentialing scenario, in which health plans and managed care organizations rely upon the credentialing decisions of hospitals.

"It turns the credentialing flow on its head," says **Mark Kadzielski**, JD, a partner in the Los Angeles law office of Epstein Becker & Green. "It used to be that where, for example, a health system had three hospitals and an HMO, the HMO always piggybacked on data from the hospital. HMOs relied on the fact that a doctor was on the staff of a hospital. They would say, 'As long as you're a member in good standing of that acute care hospital medical staff, you can be in our HMO.' That's because hospitals were known to have state-of-the-art primary credentialing systems." As long as a doctor was on that staff, the HMO assumed he was thoroughly and properly credentialed and subject to extensive peer review.

"Now," says Kadzielski, "the HMO has access to the HIPDB and all its dirt, but hospitals do not. Now the HMO is the repository of information on dirty doctors, and hospitals need to find out from HMOs what's going on."

With HMOs credentialing doctors, and doctors applying to hospitals as members of HMOs, hospitals will expect that the doctor has been screened through the HIPDB and that if any dirt surfaced, the HMO will share it with the hospital.

But should you rely on those secondary sources? No, say most experts. Do your own primary verifications. HIPDB should be only one of the several sources you look to for credentialing. ■

Run a 'gap analysis' to fix problems

'We're seeing a major paradigm shift'

Consider this scenario: Your organization claims to have a good, Medicare-compliant system in place. Yet you see at the Internet site of the Office of the Inspector General (OIG) that one of your physicians has been excluded from participating in Medicare as a result of disciplinary action by the Health Care Financing Administration, the agency that administers Medicare.

What can you do to correct the situation? **Fay Rozovsky**, JD, MPH, and **Mark Kadzielski**, JD, both experts in this area, advise first that you refrain from panicking. Rozovsky is president of the Rozovsky Group, a consulting firm in Richmond, VA, as well as a member of *Hospital Peer Review's* editorial advisory board. Kadzielski is head of the West Coast Health Law practice and a partner in the Los Angeles office of Epstein Becker & Green.

"Look at your current credentialing criteria — rules, regulations, bylaws, contracts," says Kadzielski. "What's in the letter that goes out to someone applying for appointment or renewal? What do the applications say?" The attorneys

Centralized systems are on credentialing horizon

'We'll wait till our state and JCAHO approve'

A major midwestern health system is currently working to create a central credentials support office for use by all hospitals in the area, not just those within that system. Its standards will exceed those of the Joint Commission and NCQA, and the cost will be about $40 to $100 per medical staff member per year. At that rate, credentialing a staff of 30 doctors would cost $3,000 at most. The support office would be present at the hospital during inspections, and verification turnaround time could be less than 10 days, eliminating the hassle of temporary privileges. **(See the January 1999 issue of *Hospital Peer Review* for its cover story on a Florida law that mandates a standardized credentials verification program for physicians.)**

Judith Wilbur, RN, director of risk management and quality assurance at Fremont-Rideout Health Group in California, says a centralized credentialing system — where you outsource to just one agency for credentials verification — makes sense "because we're all spending a lot of money and time doing primary source verification. But until the state of California and the Joint Commission assure us that outsourcing would meet all their standards, we have to do our own verifications." Fremont-Rideout Health Group comprises Fremont Medical Center in Marysville and Rideout Memorial Hospital in Yuba City. ■

suggest you assemble a multidisciplinary team within your organization and include medical leadership, your legal counsel, and the heads of risk management, medical staff services, and corporate compliance. Sit down and make sure everyone understands the complexity of the situation. Find out what your compliance plan says about this issue. Does it speak to credentialing?

Kathryn Biasotti, RN, compliance officer and director of risk and quality management at Barton Memorial Hospital in South Lake Tahoe, CA, and **Elizabeth Babbitt**, Barton's medical staff assistant, are in the midst of revising their facility's medical staff bylaws and credentialing procedures to take into account the new compliance-credentialing landscape, as is **Judith Wilbur**, RN, director, risk management and quality assurance, Fremont-Rideout Health Group, Marysville, CA. "We are looking at the compliance-credentialing 'crosswalk,' educating our staff, and beginning to introduce compliance issues to the board," says Wilbur. **(See next month's issue of *HPR* for an article explaining what these California quality professionals are doing to ensure their facilities' compliance and credentialing accuracy.)**

Rewrite your bylaws so that the requirements of being a medical staff member include Medicare participation as well as compliance with all federal, state, and local regulations, laws, and standards. An important part of new bylaw language should include a physician's voluntary relinquishment of privileges in the case of any sanction, felony conviction, Drug Enforcement Agency (DEA) violation, or failure to maintain liability insurance. The voluntary stipulation is important because if privileges are relinquished voluntarily, the action is not NPDB-reportable. Others will report the action to the data bank, but this way, the physician is not entitled to a hearing, and it's easier on the hospital — you don't have to go through the grief of the hearing and appeals process. Using the voluntary language makes dismissal instantaneous.

"The good old days of credentialing providers once every two years for purposes of reappointment are gone," says Kadzielski. He recommends establishing a policy of checking medical staff credentials on specific Internet Web sites on a twice-yearly basis. He says having that policy in place will go a long way to limit your facility's liability for negligent credentialing.

Run an internal review — a "gap analysis," suggests Rozovsky. "Ask yourselves, 'What are we saying in compliance that is not copacetic with what we're doing under the bylaws?' And vice versa." Set priorities, and deal with them one by one. Consider: If this were to happen, this would be the consequence under the bylaws. But under the CCP, it may be different. How do I bring the two together?

What you discover may mean revising your bylaws, rethinking contracts, and changing the rules and regulations of the medical staff. Your legal counsel's role in this is to review all contracts and boilerplate and make them "compliance-ready." The attorneys should also review bylaws, make them compliance-ready too, and give you regular legal updates in this volatile arena. You also will have to educate your executive board and medical staff credentialing committee — telling them the rules have changed from what they have been taking for granted for the past 13 years. "This is a major paradigm shift," says Rozovsky.

Regarding medical staff bylaws, **Patrick H. Reymann**, JD, with Buckingham, Doolittle & Burroughs in Akron, OH, says, "A good working document avoids a lot of problems and arms the leadership of the medical staff when someone refuses to follow the rules." Simplifying bylaws does not mean making them shorter, he explains. It means giving them more clarity and more usefulness. **(See the upcoming August issue of *HPR* for an article by Reymann on credentialing allied practitioners.)**

Where you start depends on where you're situated. If you are working at a large academic medical center, you have more databases to consider than just those of Medicare and Medicaid. If you have a research physician who is doing creative accounting and a CCP that says your organization has zero tolerance for that type of behavior, that may merit taking corrective action. You have to check the database of the NIH's Office for Protection from Research Risks (**oprr@od.nih.gov**) for updates of those physicians. **(In next month's issue of *HPR*, we report on two California facilities and what sites they check for their credentialing.)**

Jackie Kobierecki, RN, sits on the board committee for professional activities that does the credentialing at Affinity Health System in Oshkosh, WI. She says fraud and abuse questions were recently added to Affinity's standard application for reappointment. "We've never had a situation where a physician would answer yes to a question about fraud and abuse," she says, "but if, during an interview, signals are raised — malpractice at another facility or any licensure actions — the doctor is invited to a committee meeting to respond and provide more information."

What do they do when physicians answer no to questions about fraud? "We verify that by checking the Internet sites of the NPDB, AMA, and state of Wisconsin," Kobierecki says. Affinity's compliance team has the system's compliance plan in place, she says, but they now have to correlate the plan's elements with credentialing procedures.

Don't wait until this problem bites you, advise the experts. Start thinking about these issues and changing the way your staff look at them. Some facilities are further along than others with their CCP, but they may not be ahead in the long run, says Rozovsky. Facilities with a generous budget and a leadership that embraced the concept of compliance early are further ahead in setting up their organizations' CCPs.

"But it's just those advance guards who may not have seen these other conflicting issues emerging," says Rozovsky. "Those who are jumping in later may actually have an advantage here. They can build their CCP from the get-go to accommodate credentialing." ■

Reporting: Who, what, how much, and when?

Once you engage that track, you can't return

You're following advice and running twice-yearly credentialing checks at Internet sources. What should you do if you hear that a member of your medical staff is the focus of a review by the feds or by a state Medicaid fraud investigation unit? Whom should you tell? How much should you share? When should you blow the whistle?

"The feds came out with guidance on self-reporting late last fall," says **Fay Rozovsky**, JD, MPH, president of the Rozovsky Group, a consulting firm in Richmond, VA. "Its advice was not to self-report unless you absolutely have to. Once you engage that track, you cannot return. You're opening Pandora's Box."

(Continued on page 95)

PATIENT SATISFACTION PLANNER™

Guest Editorial

Target educated patients

The more they know, the safer your facility

By **Neil Baum**, MD

Patient satisfaction, compliance, clinical outcomes, and medico-legal risk are all influenced by the way your staff communicate with patients — style, content, and timeliness. Here are some methods for improving patient communication and some tools to assist you in optimizing those important endpoints.

A smattering of education can be dangerous. This scenario is happening more and more as patients are becoming increasingly adept at surfing the Web: A patient shows up clutching an article he downloaded and says he wonders why his physician recommended invasive surgery instead of the latest minimally invasive technique.

There is a significant amount of information available on the Internet. Tell patients to beware, though. Much Web information is suspect.

A recent study of health care-related Web sites by the Health Information Management Systems Society found that over 25% of consumer health-related sites are owned by laypeople. Fewer than half of health-related sites are owned by organizations that are generally trusted sources of high-quality information. Approximately one-third or fewer provide information on the source of the content, and a tenth contain content that is more than one year old.

A recent Find/SVP survey pointed out that 49% of adult Internet users routinely search the Web for health information; however, 77% would prefer receiving the information from their personal physicians.[1] As health care providers, we need to be in a position to deliver this information.

More and more hospitals are involved in lawsuits where patients claim they didn't know enough — that the risks of a procedure and alternative therapies weren't adequately explained.

The patient education process has changed considerably since the days of "paternalistic" medicine. The argument used to be that patients would refuse treatment if the risks of the procedure were disclosed. In reality, the opposite is true. Patients who refuse treatment typically do so because the nature, purpose, and attendant risks of the procedure *haven't* been adequately explained. Patients want more information, not less.

Preoperative discussions often not retained

Several studies have pointed out that patients retain only a portion of the information provided to them. In a study to test patients' retention, only slightly more than half of the patients who underwent retinal detachment surgery were able to answer all questions correctly two to 11 days postoperatively, even though the information was discussed in detail with them prior to surgery.[2] Half of the patients who gave incorrect answers denied ever having had the discussion. Other studies have provided even worse results regarding retention of preoperative discussions of risks and alternative therapies.

When patients first learn they have a serious disease, their worlds change suddenly and drastically. How much information can we realistically expect them to remember under those circumstances? It is essential to provide high-quality, easy-to-understand, printed educational material and instructions that patients can take with them to discuss with a spouse, family member, or friend.

Adequately informed patients comply with instructions better than those who are poorly informed, and that translates into faster recovery and improved clinical outcomes. In a review of the follow-up patterns of women with abnormal Pap smears, 30% to 80% failed to return for colposcopy or didn't complete the recommended treatment and follow-up, thus exposing themselves to the risk of developing invasive cervical cancer.[3]

In a study to evaluate the effect of educational brochures on follow-up compliance, 75.4% of women who received an educational brochure about abnormal Pap smears completed treatment and follow-up, vs. 45.8% of women who did not receive the brochure.

There are pressing legal incentives for good patient communication in addition to ethical,

Patient Communication Tools

Vendor	Product	Description
Dialog Medical (800) 482-7963 www.dialogmedical.com	Urology Discussion $399 single user	Specialty-specific patient information with a large installed base of users: education, instructions, consent forms, drug information, authorizations, and diets
Lippencott-Raven; Mosby-Yearbook; W.B. Saunders (800) 401-9962 www.mdconsult.com	MDConsult $34.95 per month requires internet access	Web-based products. Contains library of general patient education and provides access to on-line reference books and practice guidelines
Clinical Reference Systems (303) 664-6485 www.patienteducation.com	Aduit Health Advisor $395 single user	Generates patient education handouts written in easy-to-read-and-understand language
Micromedex (800) 525-9083 www.micromedex.com	CareNotes $1,250 single user	Information on patient condition, including treatment, follow-up care, psychosocial issues, and continuing health concerns in English and Spanish
Medifor (800) 366-3710 www.medifor.com	Patient Ed $395 single user	More than 550 primary care topics: patient instructions, access treatment guidelines, medications, and chart documents
Patient Education Institute (319) 335-4613 www.patient-education.com	X-Plain $495	Patient-interactive modules that cover individual diseases and conditions

Source: Neil Baum, MD, New Orleans.

economic, and outcomes issues. Studies have repeatedly shown that the quality of communication between provider and patient is a primary determinant of malpractice lawsuits. A patient is much more likely to sue when he or she feels that a health care worker didn't adequately explain a procedure, its associated risks, or alternative therapies. A jury can find that a physician committed no malpractice and still award all the requested damages to the plaintiff on grounds that the physician failed to properly communicate the risks and alternatives associated with a procedure.

In addition, patients are less likely to sue a physician or a hospital when they perceive those providers as caring and empathetic. The relationship you establish with the patient, along with the information and the manner in which it is relayed, have a profound impact on legal risk. Try to foster an environment of "shared decision making," where your staff provide complete, unbiased medical information and recommendations.

The ideal solution to patient communication problems is the use of automated communication tools. They go far beyond avoiding problems; they also increase compliance with instructions, improve outcomes, and heighten patient satisfaction. In addition, your facility's malpractice insurer may offer a premium discount for the use of a qualified patient education product. (*Editor's note: **www. dialogmedical.com/insurers.htm** contains a list of insurance providers known to offer premium discounts for the use of patient education software.)*

Various companies offer patient education solutions. Some are specific to medical specialties; others are more general. Some products generate handouts for patients to read and take home, while others are interactive teaching tools that require the patient to take a guided tour on the computer.

In most programs, the handout materials can be personalized so they appear to come directly from your facility. Many allow you to customize and edit the material. An advantage of the computerized patient education program is that it saves space. You don't need large filing cabinets and cumbersome pamphlet holders. Many programs contain over 500 different documents on a few diskettes or a CD-ROM. Some programs offer handouts with education only. Others contain discharge instructions, drug information, and consent forms. Evaluate the available options. **(See chart above for some of the available options.)**

The program you choose should include periodic updates as new patient education material becomes available — new drug information and patient education material on the latest products, procedures, and treatments.

Computerized patient education programs improve the efficiency of your staff. They no

longer have to search for a pamphlet or brochure on a particular topic, then interrupt patient care to make copies of the last form or handout material. Fresh, clean, and current materials enhance the quality of your organization. If you hand out a sheet that has been photocopied five times and is barely legible, your patients might begin to wonder about quality in other areas of your facility.

Obtain consent using documents that contain adequate disclosure of risks and alternative therapies in easy-to-understand language. Present the materials as an adjunct to a face-to-face conversation with the patient.

Deciding which risks to disclose can be tricky. "The difficulty arises from standards of disclosure that vary from state to state, confusing advice offered by attorneys, and physician fears that fully informed patients may elect to forgo recommended and/or necessary procedures," says **Mathew Howard**, MD, JD, an expert on informed consent. The best advice is to practice full disclosure. Some patient education programs provide procedure-specific consent forms that cover most of the risks and alternative therapies you need to disclose. However, they always should be reviewed before use to ensure that all of the risks and alternatives are disclosed to your satisfaction.

"Patients may still sue if problems arise," says Howard, "but the very fact that the patient was warned in advance means that the suit is less likely. . . . If a suit does occur, why find yourself second-guessed in court about whether the particular problem that arose in your case is frequent enough or serious enough that a reasonable patient should have been informed? Disclose everything in advance yourself, and avoid the question."

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Neil Baum, MD, practices in New Orleans and is the author of *Marketing Your Medical Practice — Ethically, Effectively, and Economically* (Aspen Publishers, 1991). ■

Patients' bills of rights get nods and nays

HIAA: Plans 'give short shrift to the uninsured'

The various proposed versions of a Patients' Bill of Rights are giving Republicans and Democrats an opportunity to go at one another. The Democrats say the Republicans' proposals are not strong enough. The Republicans say the Democratic plans cost too much money, are too burdensome on the managed care industry, and are overly restrictive.

The bill sponsored by Sen. James Jeffords (R-VT) includes provisions that:

- require health plans to pay for emergency department care if the patient believes an emergency exists;
- allow patients to go directly to gynecologists and pediatricians;
- safeguard medical privacy;
- grant restricted appeal rights to some — appeals would be allowed only when an insurer refused to pay for a procedure on the grounds that it was not necessary or was experimental.

Sen. Tom Daschle (D-SD) introduced a Patients' Bill of Rights earlier this year. The bill would:

- guarantee HMO patients' rights to receive emergency room care and access to medical specialists when needed;
- guarantee that physicians have the right to discuss all treatment options with their patients;
- enable patients to remain with their physician, even if their employer switches health plans;
- require independent, external review processes for patients who wish to appeal an HMO's refusal to cover a prescription or procedure;
- allow patients to sue their health plans if they suffer serious harm as the result of the insurance company's decision to delay or deny care.

A bipartisan bill also is on the table that would be substantially stronger than either of the other two in allowing external review of coverage disputes, in defining "medical necessity," and in giving enrollees greater rights to take health plans to court.

There is praise for and opposition to all the bills on the table, both partisan and nonpartisan.

Chip Kahn, president of the Health Insurance Association of America in Washington, DC, issued a statement in April saying patients' rights bills would financially benefit lawyers

and health care providers and would "weaken the ability of managed care plans to control costs and combat waste, fraud, and abuse." He also said they would "give short shrift to the uninsured" because they "would impose additional roadblocks to affordable coverage."

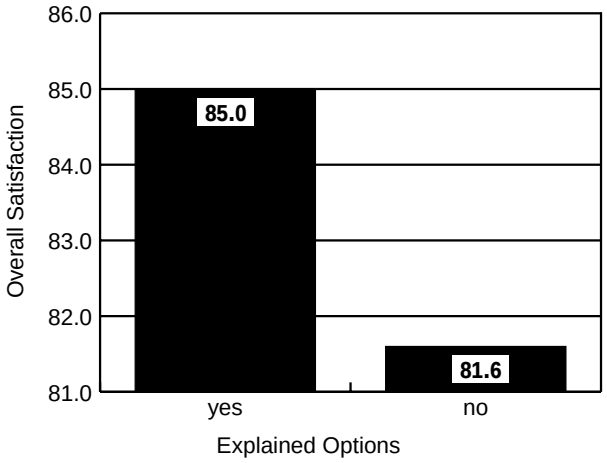
Meanwhile, the American Nurses Association (ANA) in Washington, DC, urges Congress to enact a "real" Patients' Bill of Rights and has posted a petition on-line for signatures (**www.nursingworld.org**). ANA president **Beverly L. Malone**, PhD, RN, said in a statement that her organization is "particularly heartened" by steps proposed to protect RNs from retaliation when they advocate for their patients' health and safety.

D. Ted Lewers, MD, vice chairman of the American Medical Association in Chicago, wrote in an April 16 letter to the *New York Times*:

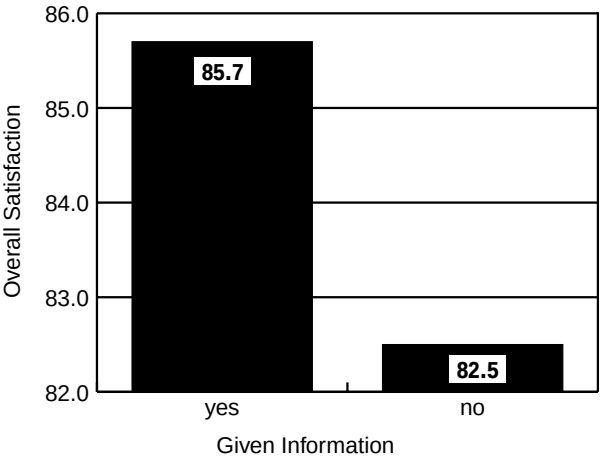
"The insurance companies spent more than $70 million to persuade Congress that they should not be held accountable if they fail to deliver what they promise. They refuse to concede that the question of what care is 'medically necessary' should be based on what is best for patients rather than on what is best for insurance company stockholders. Patients will not be protected if decisions about medical necessity are left to the sole discretion of a patient's health plan. The common-sense answer is to allow an independent doctor to mediate medical-necessity disputes. Although patient protections like this will increase premiums slightly, the increase will be spread out over 10 years, making the per month cost less than that of renting a videotape — a small price to pay." ■

Overall Satisfaction by Information Given About Life Continuation Options

(e.g., advanced directives, living will)



Overall Satisfaction by Information Given About Organ Donation



Source: Press, Ganey Associates, South Bend, IN.

Can patients handle the truth about their options?

Data reveal facing hard issues increases satisfaction

When you talk with a patient about life support options and organ donations, you are admitting the possibility of an adverse outcome — that not everyone leaves the hospital cured. It was once believed that such negative talk upset patients and should be avoided. But a recent study conducted by Press, Ganey Associates in South Bend, IN, shows that when issues like these are discussed a collaborative atmosphere is created that patients appreciate.

The study compiled survey data from 250,000 patients in nearly 500 hospitals. The questionnaire asked patients if the hospital had provided information on organ donation and on their options for continuing life, and if so, if they found it distressing. The analysis revealed that discussing life-and-death issues does not add negative stress, but rather creates an environment that contributes to patient satisfaction. The accompanying graphs **(see graphs, above)** show satisfaction rates are higher among patients to whom information is given than among patients who don't receive information. Communicating on hard issues was the first step in building strong relationships. ■

Be sure there isn't just one verification source

JCAHO names four primary source equivalents

Standards of the Joint Commission on Accreditation of Healthcare Organizations require primary source verification of credentials (MS.5-MS.7.2.1), but the agency accepts certain specific equivalents. The Commission has selected four agencies that a hospital can go to confidently because they maintain information that can be considered identical to primary source information. The following sources can be used by a facility or by a credentials verification organization (CVO) used by the facility:

- *The American Medical Association Physician Masterfile* for verification of a physician's medical school graduation and residency completion;
- *The American Board of Medical Specialties* for verification of board certification;
- *The Education Commission for Foreign Medical Graduates* for verification of graduation from a foreign medical school;
- *The American Osteopathic Association Physician Database* for verification of pre- and post-doctoral education and osteopathic specialty board certification.

A facility that bases its decisions in part on information from a CVO should "have confidence in the completeness, accuracy, and timeliness of that information . . ." and should "evaluate the agency . . . initially and periodically as appropriate," says **Robert E. Lee**, MD, PhD, associate director in the department of standards at the Joint Commission. "There are a good number of CVOs out there, but the Joint Commission doesn't publish any roster of approved CVOs as does the NCQA."

For more information about equivalent sources, call the Joint Commission's Interpretation Unit in the Department of Standards at (630) 792-5900. ■

(Continued from page 90)

Get legal advice, she says. If the OIG or FBI calls you or you receive a subpoena, immediately call your hospital attorney or compliance officer. Make sure the medical staff know what to do if they are approached, too. Everyone there should know an appropriate response, whether the tack of the investigator is, "If you don't cooperate, bad things will happen . . . " or "I'm just here to have a friendly chat . . . "

Who should be involved in this compliance-credentialing crosswalk? The quality professional is generally directly involved in taking this action, but it depends on the size and nature of the organization, says Rozovsky. Some quality directors are in charge of medical staff services; others are not. In today's environment, the quality professional probably is also doing credentials verification for the health plans at her hospital. How should you transfer information among two or more entities? Instruct middle management staff how to report information up the chain.

For many years, people in credentialing have felt frustrated: They did their work well, and yet decisions they disagreed with were being made by people above them. Now, with compliance at the top, credentialers have another venue in which to raise their concerns.

Under most compliance programs, if a staffer sees something aberrant — for example, she finds a report on the *Federal Register* saying a doctor at her facility has been excluded from Medicare — she should bring the information to a medical executive or the credentialing committee. If the entity says, "We'll let him carry on — we won't worry about that," the staffer might feel her job is on the line if she proceeds further. But now, most CCPs empower her in that case to go above those to whom she ordinarily reports and register her concerns via internal 800 hotlines. If an internal number is not available, the OIG's hotline [(800) 447-8477 (TIPS)] is available to the staffer, so it is best to have the internal line available.

How peer review looks at these issues is going to change over the long haul. "This is an interesting new landscape," says Rozovsky.

Will a finding of abuse, fraud, or waste of Medicare or Medicaid funds now be deemed unprofessional conduct by a licensing body

Special Report: Credentialing

JCAHO questions DC hospital's hiring policy

Investigation prompted by media report

Howard University Hospital in Washington, DC, must change the way it admits and assesses the competence of doctors, says an order issued in February by a committee of the Joint Commission on the Accreditation of Healthcare Organizations in Oakbrook Terrace, IL. JCAHO voted not to sanction the hospital, but demanded improvements in the hospital's management and credentialing methods and asked for a progress report in six months.

The Joint Commission's investigation was prompted by a report in *The Washington Post* last fall about a physician whose practice at the hospital was suspended for 15 months, then reinstated, after questions were raised about her treatment of women with high-risk pregnancies. Staff obstetrician / gynecologists alleged that the doctor had made "bad diagnoses, inadequately monitored high-risk patients, left some patients unattended, and failed to plan timely deliveries for patients with life-threatening medical problems." Some mothers and babies who had been treated died during delivery or soon after, stated the report.

The physician denied responsibility and sued Howard University Hospital after she was suspended, arguing that foreign-born doctors there discriminated against her because she is an African-American woman. Early last year, the university reinstated her and settled the lawsuit, but the Joint Commission still wants to see improvement. ■

under state law? Even if the abuse has nothing to do with care, if it's "just" a billing error, will that be grounds for taking away or suspending a license?

"This will have a tremendous impact on health care," she says. "A light bulb has gone on: Something driven by a concern for ethical issues and fraud and abuse matters has profound operational and risk issues at other levels." ■

ORYX Update

JCAHO backs off a bit on ORYX deadline

To resolve discord, 2002 is new reporting target

The Joint Commission on Accreditation of Healthcare Organizations in Oakbrook Terrace, IL, is making an attempt to gradually iron out perceived problems with its ORYX initiative. At a recent meeting between Joint Commission officials and representatives from state hospital associations and the American Hospital Association (AHA), it was decided that hospitals will be required to report ORYX core measure data beginning no sooner than 2002 — a revision of its original mandate to begin reporting this year.

Back in January, 17 state hospital associations sent a letter, accompanied by a supporting letter from the AHA in Chicago, to Joint Commission president **Dennis S. O'Leary**, MD, expressing concern about the new system for electronically collecting performance and outcomes data. **(See the cover story in the March 1999 issue of *Hospital Peer Review*.)** Concerns centered mainly on core measures and a perceived lack of input from hospitals on the initiative in general. Other state hospital associations, while not signatories to that letter, sent their own individual letters to the Joint Commission containing concerns about ORYX as well. **Julia Roberts** at the Joint Commission "can't say just how many [additional] letters there were," but one was from the Healthcare Association of New York State (HANYS).

O'Leary responded by immediately calling for meetings with the associations to address their concerns. At the first such meeting in late February, discussions focused on identifying core measures, and it was agreed that there would be active field input to determine the priority measurement areas. Expert panels including representatives from both the Joint Commission and the hospital associations will establish appropriate objectives for measure sets, and there will be field review of the sets. Implementation of the measures will be phased in over the next couple of years with active participation by the state hospital associations.

The group also agreed that the number of ORYX measures required in the first stage of the initiative should be capped at between six and 10,

and meeting participants affirmed a need to establish regular two-way communication between the Joint Commission and the hospital associations.

"The Joint Commission is being very responsive to those concerns. . . . but of course all the issues haven't yet been unraveled."

Cathy Ciccone, HANYS

Cathy Ciccone, vice president of quality initiatives and research at HANYS in Albany, is her association's representative to the ongoing ORYX meetings. HANYS was not one of the signatories to the January letter to the Joint Commission, but "that letter identified our concerns as well," she says. HANYS communicated its own concerns separately. "The Joint Commission is being very responsive to those concerns. It's going well, but of course all the issues haven't yet been unraveled. What we're doing is building a framework that will resolve many of the issues that have been identified."

In mid-March, the Joint Commission sent letters to the CEOs of all state hospital associations and state medical societies to solicit input regarding priority areas for core measure sets. Similar letters went to other professional organizations, purchaser groups, and consumer organizations. It was hoped that the top six priority measurement areas could be established in time for the mid-May annual State Hospital Association Forum.

A Core Measurement Implementation Group, lead by **Gary Carter**, president of the New Jersey Hospital Association in Princeton, met in late March. The newly formed group's purpose is to:

- develop a plan for implementing core measures by 2002;
- identify priority measurement areas;
- recommend clinical expert panel members to determine clinical logic and objectives for measure sets;
- provide advice on industry concerns and challenges;
- develop a process for field review of measures recommended by the panel.

For more information, call the ORYX Core Measures Line at (630) 792-3200. ■

THE QUALITY - CO$T CONNECTION

Your RCA: How do you select events for analysis?

Stave off sentinel events by evaluating lesser ones

By **Patrice Spath**, ART
Brown-Spath Associates
Forest Grove, OR

The 1999 performance improvement standards of the Joint Commission require facilities to conduct a root-cause analysis (RCA) for all sentinel events that result in patient death or serious permanent injury. Unexpected clinical occurrences also should be analyzed to determine which of these events represent significant "near-miss" situations. A significant near-miss situation is one that could have — but by chance or through timely intervention did not — result in patient death or injury. Other events that may signal the need for further analysis include:

- a patient death or loss of function following a discharge "against medical advice";
- an unsuccessful suicide attempt;
- minor hemolysis following transfusion;
- medication errors that result in the need for treatment with another drug or increased resource use;
- adverse occurrences involving employees or visitors.

These less serious adverse events also may be considered sentinel events because they signal that something important is happening in the process of patient care. By actively looking for the root causes of these undesirable situations, organizations can obtain the information necessary for taking appropriate preventive actions.

The Joint Commission expects facilities to define the situations that require a formal RCA to be conducted. It is fairly easy to describe the unexpected events that result in patient death or permanent injury. The difficulty lies in determining what other types of sentinel or serious occurrences should trigger an RCA.

Any type of incident may foreshadow more serious events. That's why an RCA is conducted in

Incident Screening Check List

		Points Given for "Yes" Answer	Assigned Points
1)	Did one or more "safety barriers" fail?	10	
2)	Did the occurrence cause additional use of a significant amount of resources (extended stay, medical/surgical interventions, etc.)?	10	
3)	Did the occurrence involve a significant violation of established patient safety rules?	10	
4)	Is the occurrence reportable to federal or state agencies?	10	
5)	Is the occurrence likely to prompt significant media attention?	10	
6)	Is the Joint Commission likely to become aware of this occurrence?	10	
7)	Is this occurrence likely to prompt legal action?	10	
8)	Has the same/similar occurrence happened one or more times in the past year?	10	
9)	If nothing is changed in the process, is the same/similar occurrence likely to happen in the future?	10	
10)	Is there a strong indication of systematic or programmatic issues or of organization-wide implications?	10	
	TOTAL SCORE (total scores for each "Yes" answer)		

Source: New York Patient Occurrence Reporting and Tracking System.

many high-risk technical industries for any unusual occurrence, regardless of severity or complexity. Health care facilities generally lack sufficient resources to conduct formal investigations of every "semi-serious" incident. Organizations must somehow identify those incidents that are manifestations of larger problems within the system of patient care and that, if corrected, will likely result in improved processes throughout the facility.

The Joint Commission expects organizations to conduct an RCA for all events that, by definition, require such analyses. The standards are silent on how these events are to be defined, so organizations have used a variety of methods. Following are the three most common strategies:

• Incidents are categorized according to their severity level.

A cut-off point is established and RCA is conducted for all events that fall into the higher levels of severity. Shown in **Figure 1 (see chart, inserted in this issue)** is the incident scoring system used by the New York Patient Occurrence Reporting and Tracking System (NYPORTS). Many facilities, not just those in New York State, are adopting this classification system. Although there is some room for individual interpretation, the definitions are more objective than those of most other scoring systems. If this, or a similar, incident classification system is used, the facility's leaders should define which events require

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- Conduct a cost-effective RCA: Avoid crisis functioning by striking pre-emptively
- Survey: RNs confirm what you've known for a while about cost containment
- Y2K update: Make sure your Medicare claims are compliant
- How two California facilities are walking the compliance-credentialing crosswalk

an RCA. Data are gathered about those incidents not requiring analysis and used in the facility's ongoing performance measurement activities.

• The quality manager or risk manager screens all potentially serious events and gathers additional details. The form shown in **Figure 2 (see chart, inserted in this issue)** can be used to solicit additional details about the event to be used in determining whether an RCA is warranted. This form is completed by the unit or department manager, or, in the case of incidents involving physicians, the medical staff department chairman. A leadership group usually including the chief executive officer, the nurse executive, the medical staff president or his or her designee, and the quality or risk manager reviews each potentially significant incident to determine if there is a process improvement opportunity. If actions have already been taken that are thought to be likely to prevent recurrence of a similar event, then no further analysis may be necessary. Otherwise, the leadership group may choose to initiate a formal RCA.

• Any incident that results in increased resource use — for example, initial or prolonged hospitalization or need for additional treatment — is reviewed by a leadership group similar to that described above. An incident screening checklist **(see chart, p. 98)**, is used to determine the extent of the analysis to be conducted. All questions answered yes receive a pre-established number of points. The total possible score for an event is 100. The leadership group must decide what score is considered high enough to subject the occurrence to a formal RCA investigation. If you wish to use a screening tool such as this check sheet, the questions and corresponding weights can be adjusted according to your own organizational priorities.

Patient safety improvement cannot be achieved if organizations conduct RCAs only when harmful sentinel events occur. In many facilities, such events happen very rarely. That's why the Joint Commission requires that "significant" incidents also be subjected to formal investigation. By evaluating less harmful events, caregivers can identify where additional safeguards are needed to further reduce the likelihood of a fatal sentinel event.

(Editor's note: See the July issue of Hospital Peer Review *for a blow-by-blow description of how to conduct a root-cause analysis. Next month's* Quality-Co$t Connection*: How to involve the governing board in your organization's commitment to patient safety improvement.)* ■

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NEWS BRIEF

Slammed health plan appeals

Aetna U.S. Healthcare of California will appeal a San Bernardino jury's award of the largest-ever punitive damages against a managed care organization. The jury ordered Aetna to pay the widow of a cancer patient $116 million on top of the $4.5 million it awarded her for medical damages and loss of companionship and support (*Goodrich v. Aetna U.S. Healthcare of California Inc., Calif. Super. Ct., No. RCV020499, 1/20/99*). The jury found the health plan had acted with fraud, malice, and oppression against the plaintiffs, and violated the terms of its contract with the patient by refusing to cover experimental treatment he needed to battle a rare form of stomach cancer. ■

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