

## Peer Review in Florida Since Constitutional Amendment 7 Passed

Until better clarification occurs with Amendment 7 through the courts, please consider the following information that is a collection of ideas generated by various hospitals and attorneys over the past couple of months:

1. There are numerous peer review legal protections still in place: (see Appendix)
  - Protections against liability
  - Protections against compelling testimony;
  - Protections against disclosing peer reviewers' names;
  - Protection against use of information in litigation;
  - Protections against disclosure of attorney-client and work product information

FHA has a power point presentation posted on the FHA website ([www.fha.org](http://www.fha.org)) which can be used to help educate the medical staff of the continued protections for peer review activities. It is located under key issues/medical liability.

2. Consider replacing the use of a peer review rating system with a narrative peer review system. Oftentimes the descriptives used in the rating system are overly broad and easily misinterpreted if read by a layperson. Instead, consider the use of concise narrative entries to document initial review conclusions and the need for further information. The facility may have to establish a method of summarizing the narratives for the reviewer(s) at reappointment. If the facility cannot eliminate the rating system, then at a minimum consider replacing negative descriptives with neutral terms; and avoid placing the rating levels with definitions on the permanent quality documents that are kept in the physician's quality review file.
3. Track the peer reviewer's identity by a separate method versus requiring that they place their signatures on each peer review document that is permanent to the reviewed physician's quality file.
4. Where possible, substitute oral discussions for written letters, forms and other documents. If there are multiple peer reviews of one case, limit all written conclusions/comments to one document.
5. Attempt to delete overly broad and negative language from your peer review forms. Begin to utilize more narrative entries on forms versus checks to generalized and overly broad descriptives. The form language currently established for peer review oftentimes is interpreted entirely different when read by persons unfamiliar with the peer review process.
6. Begin every peer review committee meeting with a rote comment that discussions are strictly confidential as between the participants in peer review

- committee. Encourage frank discussions among the members of the committee only. Direct members to avoid editorial comments directed at the physician and instead provide opinions and questions based on the facts of patient care and treatment. Consider instituting a requirement that peer review members sign a confidentiality statement at time of reappointment.
7. Review all draft copies of minutes of the peer review committees. Eliminate patient identification and details that lead to conclusions and actions. Instead, document the fact that the topic was discussed and the action to be taken. Consider keeping the committee attendee list on a separate document and not in the actual minutes. Develop a process by which the draft minutes are reviewed and determined “final” that does not include placing the signature of the reviewer.
  8. Audit peer review criteria, bylaws, medical staff rules/regulations, and quality improvement plans and procedures. Delete unnecessarily negative descriptors and overly broad terms. Replace them with more generic and neutral terms.
  9. Allow a more flexible peer review process for those cases that involve bad outcomes with anticipated litigation over the care and treatment. Consider having more committee discussion before the final conclusions and actions to be taken are documented on the permanent quality review form. Micromanage information to avoid unnecessary documentation of possibly detrimental facts and opinions.
  10. Review your Peer Review Policy and Procedure and eliminate any unnecessary detail that may serve as a “roadmap” to others outside the peer review process. Define the process in general terms without reference to committee names and sequence of different levels of reviews.
  11. Consider reporting all potentially compensable incidents, both serious and non-serious, to the hospital’s general counsel, defense counsel and the third-party claims administrator. Any investigative work conducted by the third-party claims administrator and/or the hospital risk manager will be done at the specific request and under the direction of defense counsel. Third-party claims administrator’s correspondence regarding assessments, evaluations, and/or investigation will be directed to defense counsel with copies to general counsel, hospital risk manager and to the excess carrier if it is a reportable claim.

Consider having an attorney present at root cause analysis meetings, to strengthen the privilege claim by adding attorney-client. Avoid the temptation to try to make everything attorney-client, because it would dilute the privilege; however, judicious use of the attorney-client privilege in the most sensitive settings might give an added layer of protection.

12. Incident reports should contain facts and observations, not speculation. Any documents created that fall within the broad scope of Amendment 7 should be free from speculation, hyperbole and, to the extent possible, opinions.
13. If you create documents which use statistics showing trends in incidents (e.g., in board reports, presentations) include narrative explanations and benchmarks to place the statistics in context. Be mindful of what use a plaintiff's attorney might make of statistics that you may think are innocuous. Remember, while we know that a high number of incidents reported is a good thing, this information can be easily misused. If you state the number of incidents reported, use another benchmark, such as the number of patient days, and include a narrative explanation ("Incident reporting is good for risk management, and we strive to encourage it. . .") In other words, include enough in the document to prevent plaintiffs' attorneys from abusing it, and hopefully discourage him from using it at all.
14. A hospital whose written policy indicates that the purpose for peer review is "to determine if the standard of care was met," may want to consider changing the purpose to a more general statement relating to general quality improvement.
15. In order to protect other patients' privacy and to try to prevent "fishing" expeditions, hospitals may consider having all patients sign upon admission, the following:

In accordance with the hospital's Privacy Practices and to protect the confidentiality of my protected health information, I hereby direct that disclosure of my protected health information be restricted. Specifically, no documentation of any information related to my stay or treatment, including but not limited to any documents or other materials prepared for peer review, risk management, or quality assurance purposes, is to be disclosed under any circumstances, redacted or otherwise, to anyone not affiliated with the hospital, for any purpose other than payment or licensure/accreditation requirements, without my express written consent or the express written consent of my authorized representative.

I understand that this Directive in no way limits my right to access any and all records related to my own medical care and treatment in the health system.

Patient Signature: \_\_\_\_\_ Date: \_\_\_\_\_

Witness: \_\_\_\_\_

Printed Name and Title of Witness: \_\_\_\_\_

## **Risks To The Hospital And Its Medical Staff Leaders If Peer Review Is Not Performed**

There is increased risk to the hospital under statutes, Medicare, and JCAHO if it fails to perform peer review. Also, the medical staff could find itself outside the scope of insurance coverage when they are named for failure to perform peer review. The following requirements for peer review should be considered:

### **1. 395.0193 F.S. Licensed facilities; peer review.**

(2) Each licensed facility, as a condition of licensure, shall provide for peer review of physicians who deliver health care services at the facility. Each licensed facility shall develop written, binding procedures by which such peer review shall be conducted. Such procedures shall include:

- (a) Mechanism for choosing the membership of the body or bodies that conduct peer review.
- (b) Adoption of rules of order for the peer review process.
- (c) Fair review of the case with the physician involved.
- (d) Mechanism to identify and avoid conflict of interest on the part of the peer review panel members.
- (e) Recording of agendas and minutes which do not contain confidential material, for review by the Division of Health Quality Assurance of the agency.
- (f) Review, at least annually, of the peer review procedures by the governing board of the licensed facility.
- (g) Focus of the peer review process on review of professional practices at the facility to reduce morbidity and mortality and to improve patient care.

### **2. 766.110 F.S. Liability of health care facilities.**

(1) All health care facilities, including hospitals and ambulatory surgical centers, as defined in chapter 395, have a duty to assure comprehensive risk management and the competence of their medical staff and personnel through careful selection and review, and are liable for a failure to exercise due care in fulfilling these duties. These duties shall include, but not be limited to:

- (a) The adoption of written procedures for the selection of staff members and a periodic review of the medical care and treatment rendered to patients by each member of the medical staff;

### **3. Medicare Conditions of Participation**

#### **• 42 CFR 482.12 Condition of Participation: Governing Body**

The hospital must have an effective governing body legally responsible for the conduct of the hospital as an institution....

- (a) Standard: Medical Staff. The governing body must:
  - .....(5) Ensure that the medical staff is accountable to the governing body for the quality of care provided to patients;

- **42 CFR 482.21 Condition of Participation: Quality Assurance**  
The governing body must ensure that there is an effective, hospital-wide quality assurance program to evaluate the provision of patient care.

(a) Standard: Clinical plan. The organized, hospital-wide quality assurance program must be ongoing and have a written plan of implementation.

.....(3) All medical and surgical services performed in the hospital must be evaluated as they relate to appropriateness of diagnosis and treatment.

(c) Standard: Implementation. The hospital must take and document appropriate remedial action to address deficiencies found through the quality assurance program. The hospital must document the outcome of the remedial action.

(AHCA views the following as evidence a hospital does not meet these standards: Invasive procedures resulting in mortality or morbidity are not routinely reviewed, tracked, and trended. Serious issues dealing with quality of care, professional technical performance, and professional standards of practice that are referred to medical staff committees are not investigated and analyzed timely or sufficiently and lack resolution and corrective action in order to reduce risk of injury to patients. The hospital does not have a continuous and consistent process to assess data collected to determine the level and performance of existing activities and procedures; priorities for improvement; and actions to improve performance. Medical staff activities are not integrated into the hospital processes to assess data collected to determine performance improvement.

Also, a review of facility documents, incident reports, clinical records, interviews with staff, the bylaws of the medical staff, bylaws of the governing body, and recredentialing documentation indicate the hospital is not consistently implementing appropriate and timely corrective action when deficiencies are found through the quality assurance program.)

- **42 CFR 482.22 Condition of Participation: Medical Staff.**  
The hospital must have an organized medical staff that operates under bylaws approved by the governing body and is responsible for the quality of medical care provided to patients by the hospital.

(a) Standard: Composition of the medical staff.

.....(1) The medical staff must periodically conduct appraisals of its members.

(2) The medical staff must examine the credentials of candidates for medical staff membership and make recommendations to the governing body on the appointment of the candidates.

(b) Standard: Medical staff organization and accountability.

The medical staff must be well organized and accountable to the governing body for the quality of the medical care provided to patients.

(AHCA has cited hospitals for this standard not being met when facility

documents indicate that medical staff appraisals of its members is not an outcome oriented appraisal system, and when members of the medical staff are not typically or consistently evaluated regarding training, experience, demonstrated competence, quality assurance data, adherence to the medical staff bylaws and rules and regulations, and compliance with state laws and the hospital's policies and procedures.)

#### **4. Joint Commission Accreditation Manual for Hospitals**

- **Standard MS.1.10**

The organized medical staff provides a mechanism to ensure a uniform standard of quality patient care, treatment, and services.

- **Elements of Performance for MS.1.20**

Continuing surveillance of the professional performance of all individuals in the department who have delineated clinical privileges

The continuous assessment and improvement of the quality of care, treatment, and services

A description of indications and procedures for automatic suspension of a practitioner's medical staff membership or clinical privileges

- **Standard MS.2.10**

The organized medical staff provides oversight in the process of analyzing and improving patient satisfaction.

The organized medical staff monitors the quality of medical histories and physical examinations.

The organized medical staff has a leadership role in hospital performance improvement activities to improve quality of care, treatment, and services and patient safety.

Use of information about adverse privileging decisions for any practitioner privileged through the medical staff process.

- **Elements of Performance for MS.3.20**

Findings of the assessment process that are relevant to an individual's performance. The organized medical staff is responsible for determining the use of this information in the ongoing evaluations of a practitioner's competence.

- **Standard MS.4.40**

Relevant practitioner-specific data are compared to aggregate data if such data are available for that practitioner.

Morbidity and mortality data is such data are available for that practitioner

Each reappraisal includes information concerning professional performance, including clinical and technical skills and information from hospital performance improvement activities, when such data are available.

- **Standard MS.4.70**

A hospital performance improvement committee, the majority of whose members are the applicant's peers

Peer recommendations are obtained from a practitioner in the same professional discipline as the applicant with personal knowledge of the applicant's ability to practice

- **Standard MS.4.90**

There is a process that defines circumstances requiring a focused review of a practitioner's performance and evaluation of a practitioner's performance by peers.

Circumstances under which external peer review is required

Evaluation of individuals with clinical privileges whose performance is questioned as a result of the measurement and assessment activities

- **Standard PI.1.10**

The hospital collects data to monitor its performance.

Relevant information developed from the following activities is integrated into performance improvement initiatives.

Risk management

Utilization management

Quality control

- **Standard PI.2.20**

Undesirable patterns or trends in performance are analyzed.

All serious adverse drug events, if applicable and as defined by the hospital

All significant medication errors, if applicable and as defined by the hospital

All major discrepancies between preoperative and postoperative (including pathologic) diagnoses

Adverse events or patterns of adverse events during moderate or deep sedation and anesthesia use

Staffing effectiveness issues

- **Standard PI.2.30**

Processes for identifying and managing sentinel events are defined and implemented.

Reporting sentinel events through established channels in the hospital and, as appropriate, to external agencies in accordance with law and regulation

Conducting thorough and credible root cause analyses that focus on process and system factors.

Creating, documenting, and implementing a risk-reduction strategy and action plan that includes measuring the effectiveness of process and system improvements to reduce risk.

### **Disclaimer**

This information is being provided for the purpose of general guidance only and should not be considered legal advice. FHA makes no guarantee as to the sufficiency of this information in a specific situation. An attorney should be consulted for legal advice.

### **Appendix**

#### **395.0193 Licensed facilities; peer review.-**

(1) State-mandated peer review process shall, in addition to receiving immunity from retaliatory tort suits pursuant to s. 456.073(12), be protected from federal antitrust suits filed under the Sherman Anti-Trust Act, 15 U.S.C.A. ss. 1 et seq.

(5) There shall be no monetary liability on the part of, and no cause of action for damages against, any licensed facility, its governing board or governing board members, peer review panel, medical staff, or disciplinary body, or its agents, investigators, witnesses, or employees; a committee of a hospital; or any other person, for any action taken without intentional fraud in carrying out the provisions of this section.

See also 395.0191(7) Staff Membership and Clinical Privileges.

(8) The investigations, proceedings, and records of the peer review panel, a committee of a hospital, a disciplinary board, or a governing board, or agent thereof shall not be subject to discovery or introduction into evidence in any civil or administrative action against a provider of professional health services. A person who was in attendance at a meeting of such group or its agent may not be permitted or required to testify in any such civil or administrative action as to any evidence or other matters produced or

presented.

See also 395.0191(8) Staff Membership and Clinical Privileges.

**395.0197 Internal risk management program.-**

(4) The incident reports are part of the workpapers of the attorney defending the licensed facility in litigation relating to the licensed facility and are subject to discovery but are not admissible as evidence in court.

(c) ... The annual report is confidential and is not available to the public pursuant to s. 119.07(1) or any other law providing access to public records. The annual report is not discoverable or admissible in any civil or administrative action, except in disciplinary proceedings by the agency or the appropriate regulatory board.

(7) Any of the following adverse incidents, whether occurring in the licensed facility or arising from health care prior to admission in the licensed facility, shall be reported by the facility to the agency within 15 calendar days after its occurrence:

... These reports shall not be available to the public pursuant to s. 119.07(1) or any other law providing access to public records, nor be discoverable or admissible in any civil or administrative action, except in disciplinary proceedings by the agency or the appropriate regulatory board...

**766.101 Medical review committee, immunity from liability.-**

(3)a There shall be no monetary liability on the part of, and no cause of action for damages shall arise against, any member of a duly appointed medical review committee, or any health care provider furnishing any information, to such committee, or any person, including any person acting as a witness, incident reporter to, or investigator for, a medical review committee, for any act or proceeding without intentional fraud

(5) The investigations, proceedings, and records of a committee as described in the preceding subsections shall not be subject to discovery or introduction into evidence in any civil or administrative action. No person who was in attendance at a meeting of such committee shall be permitted or required to testify in any such civil action.

**766.1016 Patient safety data privilege.-**

Reports made to patient safety organizations, including all health care data, interviews, memoranda, analyses, root cause analyses, products of quality assurance or quality improvement processes, corrective action plans, or information collected or created by a health care facility or a health care practitioner as a result of an occurrence, shall not be subject to discovery or introduction into evidence in any civil or administrative action.

Any person who testifies before a patient safety organization or who is a member of such a group may not be asked about his or her testimony before a patient safety organization or the opinions formed by him or her as a result of the hearings.

**Health Care Quality Improvement Act of 1986–**

Professional review bodies shall not be liable in damages under any law of the US or

any State. No person providing information shall be liable in damages unless the person knew the information was false.

**HIPAA 45 CFR § 164.524.-**

Protection for work product:

Access of individuals to protected health information

Standard: Access to protected health information

(1) ...an individual has a right of access to inspect and obtain a copy of protected health information about the individual... except for:

*(ii) Information compiled in reasonable anticipation of, or for use in, a civil, criminal, or administrative action or proceeding; and...*"

HIPAA requires the "De-identification" of Protected Health Information by the removal of 18 patient identifiers before providing records without a patient's consent.

Patient Identifiers Include:

Date of Admission;  
Date of Discharge;  
Hospital Record Number;  
General location where patient resides;  
Birth Dates; and  
Age of Patients above 89 years of age.

**Protection from Disclosure of Peer Review Committee Members' Names.-**

All Children's Hospital vs. Davis, 2<sup>nd</sup> DCA, 590 So.2d 546, Dec. 18, 1991.

For more information, please visit [www.fha.org](http://www.fha.org)