



EPSTEIN
BECKER
GREEN

Medical Staff Hot Topics

2025 OHA Annual Meeting

Monday, May 19, 2025

Presented by



Steve Kleinman
Member of the Firm
Skleinman@ebglaw.com



Kimberly Parks
Senior Counsel
Kparks@ebglaw.com



Jeremy Morris
Member of the Firm
Jmorris@ebglaw.com



Avery Schumacher
Member of the Firm
Aschumacher@ebglaw.com

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The presenters have no real or perceived conflicts of interest related to this presentation.

Presentation Participation Format

Text “averys607” to 22333

- Interactive Q&A
- We will introduce each topic
- Then YOU vote on what we cover
- Feel free to ask questions in real time!



Medical Staff Topics

- Sharing peer review information
- Telehealth
- Conduct and impairment issues
- Medical staff documents
- Reporting obligations
- Corrective action
- TO BE DETERMINED



Topic 1: Sharing Peer Review Information

Options for further exploration:

- Drafting/interpreting verification letters
- Sharing PRI with hospital-affiliated physician employer (*i.e.*, medical group)
- Tips for protecting peer review privilege
- Sharing PRI within systems

What is a “Peer Review Privilege”?



A “Legal” Privilege is Inherently a State Law Issue

- What constitutes protected peer review is tightly defined by statute and/or case law
- If you know one state’s law, you know one state’s law
- The devil is in the details



Basic Concepts:

- Most state laws were enacted in the 1970s in response to professional liability insurance crisis
- Some states limit privilege to hospital setting
- Some states extend privilege to a variety of settings where health care is provided

What is a “Peer Review Privilege”?



GENERALLY (*i.e.*, not always):

- Extends immunity from damages for most state claims a practitioner would bring against the hospital and/or peer review participants
- Precludes use of PRI as evidence in civil cases; some state laws extend to criminal cases (but not Ohio)
- Doesn't protect information discoverable from other sources
- Courts believe in full and open disclosure of all facts, don't like privileges, and construe them very narrowly

IF YOU DO NOT RESPECT THE PRIVILEGE, NEITHER WILL THE COURTS

Ohio's Peer Review Privilege is at ORC 2305.25 *et seq.*

Sharing Peer Review Information



Should it be protected?



Will it be protected? Evaluate and consider the following:

What information is shared

How is the information shared

Who has access to the shared information

What purposes will shared information be used for

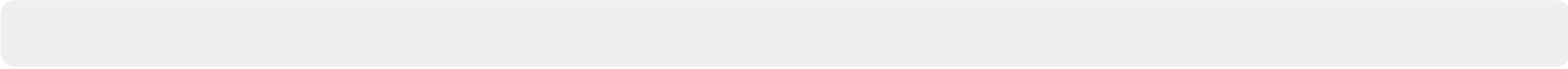


If not, can necessary information be extracted from the protected location to limit exposure?

POLL TIME - Pick your preferred topic for further exploration.

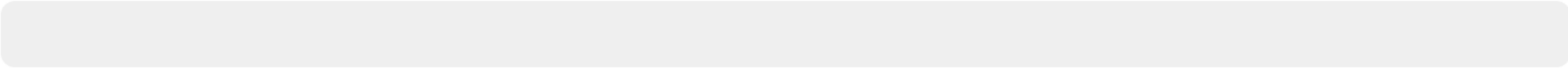


A. Responding to credentialing inquiries



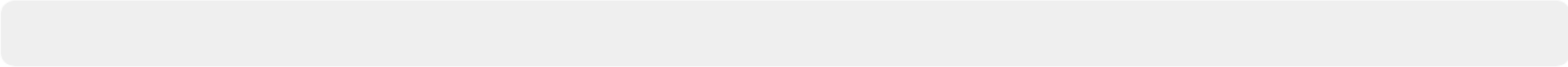
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B. Sharing PRI with medical groups



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C. Tips for protecting privilege



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D. Sharing PRI within systems



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A. Responding to / Interpreting Credentialing Inquiries

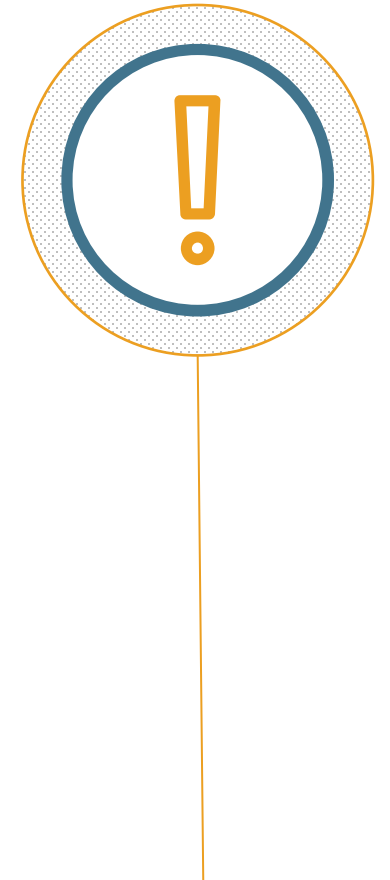
- *Kadlec Medical Center v. Lakeview Anesthesia Associates*
- Trial Court held there is a duty not to:
 - Misrepresent directly and
 - Omit material information
- 5th Cir. Ct. of Appeals held:
 - Duty owed when responding to physician inquiries about a physician's status at the hospital is limited to not directly misrepresenting facts
 - There is no affirmative duty to disclose negative information between health care providers

A. Responding to / Interpreting Credentialing Inquiries

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How do you:

- Respond to a verification request when an agreement has been reached to resolve a formal investigation / corrective action?
- Recognize a lawyer drafted verification letter and what might that mean?



B. Sharing PRI with Hospital Affiliated Medical Groups

Whether privilege applies at the “employment” level depends upon state laws and interpretive case law



E.g., in Ohio, it applies to all health care entities that conduct professional credentialing/quality review activities involving provider competence, professional conduct, or quality of care



E.g., in Kentucky, the law only applies in the hospital setting (if at all)



E.g., in South Carolina, protection applies to PRI shared with hospital subsidiaries, employees, agents, etc., and used for any purpose, including employment decisions or education



If protected, then the process considerations re sharing PRI within systems generally apply (see, option D under this topic)

B. Sharing PRI with Hospital Affiliated Medical Groups

- Are we allowed to share peer review information?

Answer (per Ohio law): Nothing in this section precludes health care entities from sharing information, documents, or records that were produced or presented during proceedings of a peer review committee or created to document them as long as the information, documents, or records are used only for peer review purposes. ORC 2305.252(A).

- Promotes best clinical practices and patient safety; prevents forum shopping.
- Include provisions regarding sharing of peer review information in:
 - Medical Staff documents (*i.e.*, sharing between System hospitals)
 - Applications for appointment, reappointment, and/or privileges (*i.e.*, sharing between System hospitals)
 - Sharing of information policy or agreement (*i.e.*, sharing between System hospitals and System medical group, *etc.*)



C. Protecting Peer Review Privilege

- Know the scope of your state's peer review privilege (see next slide for Ohio's)
- Educate and remind peer review participants of confidentiality requirements
- Limit recipients of peer review related emails
- Distribute and collect materials at each meeting
- Clearly label privileged documents
- Do not share PRI with HR (unless permitted in your state, and/or the decision is calculated)
- Involve hospital counsel when third parties are involved

C. Protecting Peer Review Privilege

- Ohio's Peer Review Privilege (ORC 2305.25 *et seq.* extends protection to a health care entity:
 - **“Health care entity”** means an entity, whether acting on its own behalf or on behalf of or in affiliation with other health care entities, that conducts as part of its regular business activities **professional credentialing or quality review activities** involving the **competence of, professional conduct of, or quality of care provided by health care providers**, including both individuals who provide health care and entities that provide health care.
- **“Peer review committee”** means a utilization review committee, quality assessment committee, performance improvement committee, tissue committee, credentialing committee, or **other committee that does either of the following**:
 - Conducts **professional credentialing or quality review activities** involving the **competence of, professional conduct of, or quality of care** provided by health care providers, including both individuals who provide health care and entities that provide health care;
 - Conducts any other attendant hearing process initiated as a result of a peer review committee's recommendations or actions.



C. Protecting Peer Review Privilege

- Ohio's Peer Review Privilege (ORC 2305.25 *et seq.*)
- Immunity:
 - No health care entity shall be liable in damages to any person for any acts, omissions, decisions, or other conduct within the scope of the functions of a peer review committee of the health care entity.
 - No individual who is a member of or works for or on behalf of a peer review committee of a health care entity shall be liable in damages to any person for any acts, omissions, decisions, or other conduct within the scope of the functions of the peer review committee.
- As contrasted with other privileges (*e.g.*, attorney/client or physician/patient), the peer review privilege is **not waivable**.
- Peer Review Privilege not applicable to:
 - Criminal actions
 - Federal claims (*e.g.*, discrimination, *etc.*)



C. Protecting Peer Review Privilege

Ohio's Peer Review Privilege (ORC 2305.25 *et seq.*)

Proceedings and records of a **peer review committee** must be held in confidence and **are not subject to discovery** in any **civil action** against a health care entity or health care provider:

- Individuals cannot testify as to what they said or heard in a peer review proceeding.
- Information available from other sources must be obtained from the original source.
- May only be used for peer review purposes (*e.g.*, not employment, risk management, education, *etc.*)
 - *E.g.*, a newspaper article in a quality file is protected in that file; you need to get the article from the newspaper.
- A civil trial court order to produce peer review protected files, information, materials is immediately appealable.
 - *E.g.*, sharing peer review information with Human Resources for employment purposes means that the information is now available/discoverable from the Human Resources "file".



D. Sharing PRI within Systems

- Are we allowed to share peer review information?
 - **Answer (per Ohio law):** Nothing in this section precludes health care entities from sharing information, documents, or records that were produced or presented during proceedings of a peer review committee or created to document them as long as the information, documents, or records are used only for peer review purposes. ORC 2305.252(A).
- Promotes best clinical practices and patient safety; prevents forum shopping.
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The actual sharing and use of PRI will determine whether PRI is protected by the state's privilege



D. Sharing PRI Within Systems

Policy should define/include all of the following:

PRI to be shared and events that trigger sharing

All affiliates among which PRI will be shared

Restrictions and procedural steps for sharing PRI

Penalties for improper disclosure

Potential triggering events include:

Denial of a provider's application

Commencement of a formal corrective action

Automatic, voluntary, or summary suspension/restriction

Resignation while under or to avoid investigation

Topic 2: Telehealth and Your Medical Staff

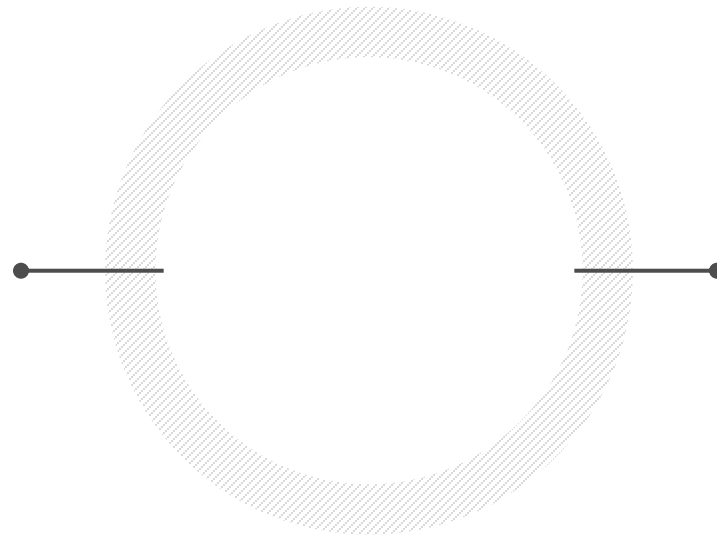
Options for further exploration:

Telehealth prescribing – New DEA rules
Telehealth accreditation standards (TJC)
 Credentialing by proxy
 Licensure and scope of practice

Telehealth Overview

What is it?

Broadly - the use of electronic information and telecommunication technologies to support long-distance clinical health care, health-related education, health administration, and public health.



Definition varies depending on the context and source (e.g., reimbursement regulations and requirements, state law, professional licensure rules, etc.)



Telehealth in Ohio (ORC 4743.09, effective March 23, 2022)



Licensure:

- No separate license in Ohio
- HCPs can provide telehealth services under their general license
- Scope of practice limitations are the same as in-person



Patients Outside of Ohio:

- Physicians, PAs, and APRNs may provide services to patients out of state, but must be licensed (or otherwise permitted to practice) in the state where the patient is located
- Rules of that state apply
- Applies even when the service is for an established patient traveling outside of Ohio



Standard of Care:

- HCPs practicing via telehealth are held to the same standard of care as those providing in-person care
- May use synchronous or asynchronous technology if standard of care is satisfied
- HCP may deny a patient telehealth services and require an in-person visit

State Medical Board of Ohio Telehealth Standards

OAC 4731-37-01, EFFECTIVE FEB. 28, 2023

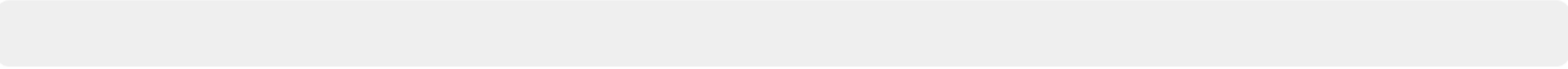
- Applies to physicians, PAs, dietitians, RCPs, and genetic counselors
- Establishes general telehealth standard of care requirements including:
 - Establishing patient identity and location in Ohio
 - Consent for telehealth treatment
 - Privacy and security
 - Record keeping/documentation and accessibility
 - Appropriate evaluation, diagnosis, and treatment
 - Availability for or recommendation of follow-up care
- Establishes telehealth requirements for:
 - Formal consultation
 - Non-CS and CS prescribing
 - Use of remote monitoring devices



POLL TIME - Pick your preferred topic for further exploration.

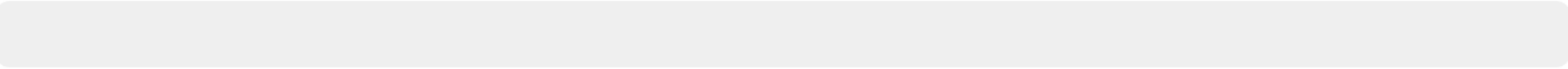


A. Telehealth prescribing



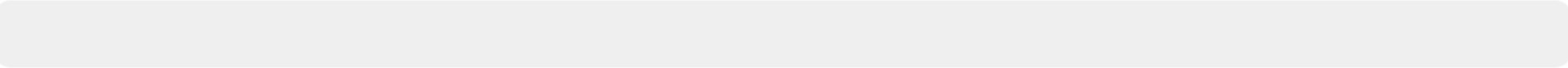
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B. Telehealth accreditation standards (TJC)



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C. Credentialing by proxy



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D. Licensure and scope of practice



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A. Telehealth Prescribing

Before COVID-19:

DEA: Required prescriber to conduct at least one in-person exam of patient before prescribing, with limited exceptions (e.g., cross coverage, or where patient was physically located in a DEA-registered hospital, clinic, or physician's office).

SMBO: Required prescriber to personally physically examine and diagnose a person prior to initially prescribing, dispensing, etc., any controlled or non-controlled substance, with some exceptions.

During COVID-19:

DEA: Waived the in-person requirement; an initial in-person exam is not required to prescribe Schedule II-V CS, where telehealth visit is conducted with an audio-visual, real-time, two-way interactive communication system. Was set to expire May 12, 2023.

SMBO: Suspended enforcement of its rules regarding provision of telehealth and in-person services and the requirements for prescribing controlled substances through Feb. 27, 2023; OAC 4731-11-09, effective Feb. 28, 2023, defers to federal exceptions.

Current Status:

DEA: Issued a Temporary extending telemedicine prescribing flexibilities through Nov. 11, 2023; this was extended through Dec. 31, 2024, and then again through Dec. 31, 2025. **In Jan. of 2025 DEA / HHS Issue One NPRM and Two Finals Rules on Remote Prescribing.**

SMBO: OAC 4731-11-09 continues to defer to federal exceptions.

A. Telehealth Prescribing

- Where an in-person exam HAS occurred:** Prescribing via telehealth is permissible so long as the prescriber complies with:
1. State and federal law, including that the prescription is issued for a legitimate medical purpose, and the prescriber is acting in the usual course of his/her professional practice; and
 2. General telehealth standards outlined in the SMBO's telehealth rule at OAC 4731-37-01.

- Where an in-person exam HAS NOT occurred [through Dec. 31, 2025]:** Requirements 1&2 above apply, and:
3. The prescription is issued pursuant to a communication between the Practitioner and patient using an interactive audio-visual communication system.

New rules are expected to go into effect Jan. 1, 2026.

A. Telehealth Prescribing – Proposed DEA Rules

Proposed Rule Regarding Special Registration for Telemedicine Providers and Companies

- Three types of special registrations
- National PDMP
- Would require audio-video connection (with limited exceptions)
- Would require prescribers to capture pictures of patients with ID during initial visits
- Would require special registrants to maintain a State Telemedicine Registration for every state in which a patient is treated by registrant, subject to limited exceptions

Comment period closed March 18, 2025.

Final Rule Regarding Access to Buprenorphine Treatment Via Telemedicine

- Dramatically expands access to those who are seeking OUD treatment
- Allows treatment through audio only telemedicine, without an in-person assessment, for up to 6 months
- Eliminates some of the burdensome recordkeeping requirements

HHS has delayed the effective date until Dec. 31, 2025, due to the Trump administration’s “regulatory freeze.”

Final Rule Regarding Veterans’ Access to Controlled Substances Via Telemedicine

- Allows VA prescribers to prescribe controlled substances to VA patients, without an in-person visit, in instances where another VA practitioner has provided one
- Includes additional conditions similar to those included in the Special Registration NPRM (e.g., PDMP checks)

HHS has delayed the effective date until Dec. 31, 2025, due to the Trump administration’s “regulatory freeze.”

B. Telehealth Accreditation Program (TJC)

- Launched by The Joint Commission (TJC) effective July 1, 2024.
- Developed for organizations that exclusively provide telehealth services, but hospitals and other healthcare organizations that have written agreements to provide telehealth to another organization's patients are eligible to apply.
- Impact: This program replaces previous telehealth and technology-based accreditation products in the Ambulatory Health Care and Behavioral Health Care and Human Services Accreditation Programs for organizations meeting the new eligibility criteria

B. Telehealth Accreditation Program (TJC)

- Contains many of the same standards (e.g., for information management, leadership, medication management, patient identification, documentation, credentialing and privileging, etc.).
- Requirements specific to the new program include:
 - Streamlined emergency management requirements to address providing care and support remotely rather than in a physical building.
 - New standards for telehealth provider and patient education about the use of telehealth platforms and devices.
 - New standards chapter focused on telehealth equipment, devices and connectivity.
- Standards may be filtered based on telehealth modality or service provided.

C. Telemedicine Credentialing by Proxy



Generally, practitioners/APPs must be credentialed by and have clinical privileges at each hospital (and provider-based location) where they provide services (including by telemedicine).



Hospital and CAH CoPs allow credentialing by proxy: permits the hospital where the patient is located to rely on the privileging and credentialing decisions made by the “Distant Site Hospital” or “Distant Site Telemedicine Entity,” provided certain requirements are met.



Requirements for the mandatory written agreement are complex.

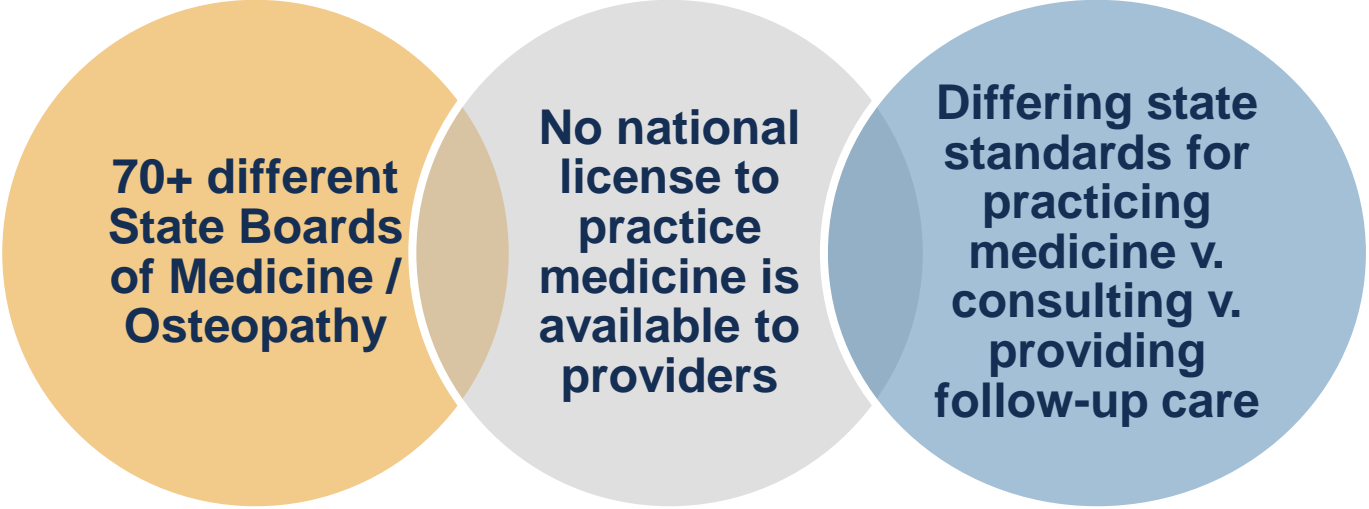
C. Telemedicine Credentialing by Proxy

The written CBP agreement must cover the following according to the CoPs:

- Medicare-participating DSH/DSTE must use a credentialing/privileging program compliant with traditional Medicare standards.
- Individual practitioners providing telemedicine services to Originating Site are privileged at DSH/DSTE.
- DSH/DSTE provides Originating Site with a list of telemedicine practitioners' current privileges.
- Individual practitioners are licensed/authorized to practice in the state of Originating Site.
- Originating Site reviews practitioner services and submits reports to the DSH/DSTE for use in evaluations, including all adverse events and complaints related to the services.
- For contracts with DSTE only, the DSTE furnishes telemedicine services in a manner that permits the Originating Site to comply with all applicable CoPs.
- The parties must share information regarding credentialing decisions, as well as periodic updates of practitioner reviews/assessments.

D. Licensure and Scope of Practice

“States have a compelling interest in the practice of professions within their boundaries, and that as part of their power to protect the public health, safety, and other valid interests, they have broad power to establish standards for licensing practitioners and regulating the practice of professions.”
Goldfarb v. Virginia State Bar, 421 U.S. 773, 792 (1975).



**70+ different
State Boards
of Medicine /
Osteopathy**

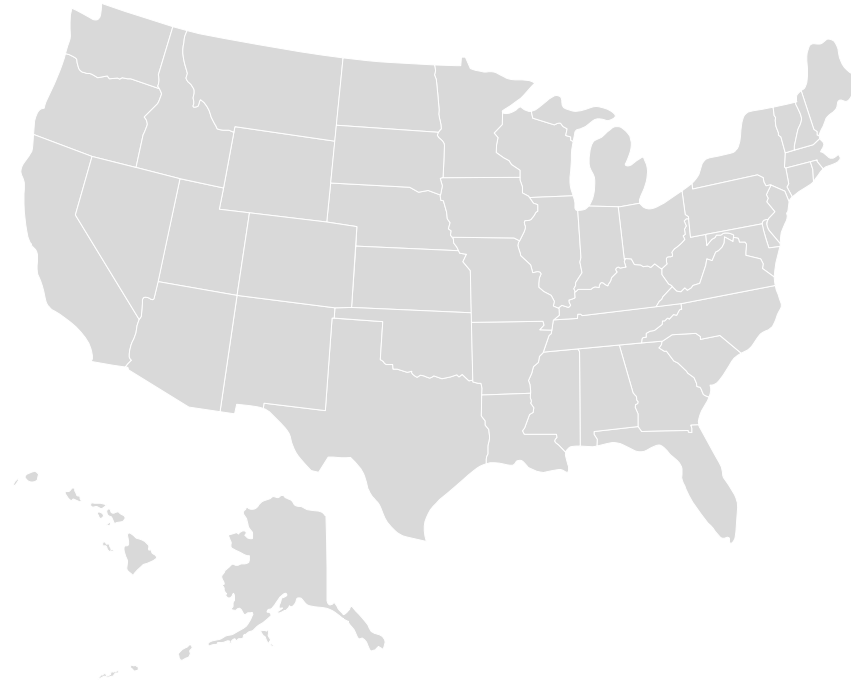
**No national
license to
practice
medicine is
available to
providers**

**Differing state
standards for
practicing
medicine v.
consulting v.
providing
follow-up care**

D. Licensure and Scope of Practice

Individual states monitor and regulate the provision of care services to patients located within that state's geographic boundaries

State professional licensure rules run counter to the practice of telehealth, which transcends geographical boundaries



Health care professionals who provide telehealth services are generally subject to the licensure rules of:

- (1) the state(s) in which their patients are physically located; and
- (2) the state(s) in which they are located.

D. Licensure and Scope of Practice

- Various interstate compacts are attempting to address telehealth cross-state licensure issues
- As of March 1, 2025:
 - 40 states plus the District of Columbia have enacted the Interstate Medical Licensure Compact (IMLC)
 - 43 states have enacted the Nurse Licensure Compact (NLC)
 - 37 states plus the District of Columbia have enacted the Physical Therapy Compact (PT Compact)
 - 41 states plus the District of Columbia have enacted the Psychology Interjurisdictional Compact (PSYPACT)
 - 37 states plus the District of Columbia have enacted the Counseling Compact
 - ***Others!***
 - Audiology & Speech-Language Pathology Interstate Compact
 - Occupational Therapy Compact



Topic 3: Conduct and Impairment Issues

Options for further exploration:

- Aging practitioner policies
- Handling residency program faculty conduct issues
- Handling impairment issues
- Tools of the trade

Conduct and Impairment Issues

- Physician Impairment = Any physical, mental or behavioral disorder that interferes with ability to engage safely in professional activities.
- May be handled by HR, the Medical Staff, or both
- Medical Staff governing documents are instructive:
 - Practitioner/APC Wellness (Impairment) Policy
 - Practitioner/APC Conduct Policy
 - Practitioner/APC Peer Review Policy
- HCQIA immunity applies to professional review actions based on competency and/or professional conduct

Ohio's Confidential Monitoring Program (CMP)

OAC Chapter 4731-16 (Impaired Practitioners)

- **Effective Date:** October 3, 2023.
- **Overview:** The State Medical Board of Ohio (SMBO) introduced the CMP to provide a confidential, non-disciplinary pathway for healthcare professionals to seek help for impairing conditions, including:
 - Substance use disorders
 - Mental health disorders (new)
 - Physical conditions (new)
 - Other potentially impairing illnesses (new)
- **Impact:** The CMP replaces previous programs like the One-Bite Program, offering a more comprehensive and supportive approach to practitioner well-being.

Ohio's Confidential Monitoring Program (CMP)

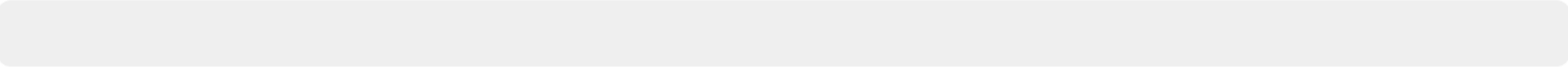
Key Features:

- **Eligibility:** All SMBO licensees and applicants are eligible to participate.
- **Confidentiality:** Participation is confidential unless there is non-compliance with the program terms, in which case OhioPHP is required to report to SMBO.
- **Administration:** Managed by the Ohio Professionals Health Program (OhioPHP), an independent nonprofit organization approved by SMBO.
- **Monitoring Agreements:** Individualized agreements may include therapy, group support, toxicology testing, and self-assessments, typically ranging from 1 to 5 years.
- **Cost Structure:** OhioPHP utilizes a sliding-scale fee structure to accommodate financial circumstances.

POLL TIME - Pick your preferred topic for further exploration.

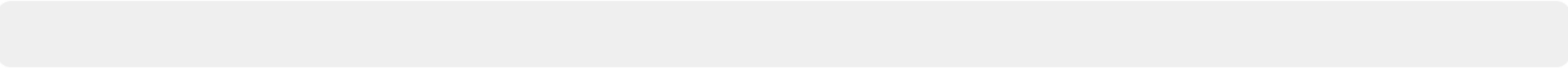


A. Aging practitioner policies



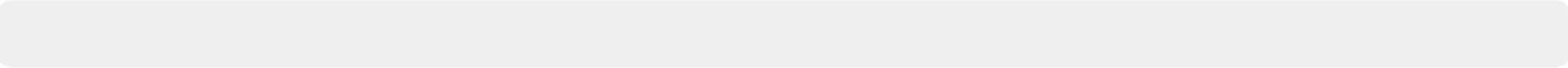
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B. Faculty conduct issues



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C. Handling impairment issues



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D. Tools of the trade



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A. Aging Practitioner Polices

The aging practitioner is one of the most difficult issues.

- Act based upon the behavior and/or clinical competence and not because of age.
- Discussions regarding retirement plans can be easily misconstrued.

A. Aging Practitioner Polices

EEOC v. Yale New Haven Hospital, no. 3:20-cv-00187 (D. Conn. 2020) – Ongoing

- **The Suit:** The U.S. Equal Employment Opportunity Commission (EEOC) filed suit against a Yale Hospital in Feb. 2020, challenging the hospital’s “Late Career Practitioner Policy” as violating the Age Discrimination in Employment Act (ADEA) and the Americans with Disabilities Act (ADA).
- **Policy at issue:** Requires hospital practitioners over the age of 70 to pass neuropsychological and eye medical examinations to renew clinical privileges and does not require suspicion that ability has declined.
- **Implications:** This case continues to be one to follow – the holding will be instructive as to how hospitals can handle aging practitioners:
 - Test only where there is reasonable grounds for suspicion?
 - Test all applicants for appointment/reappointment over a certain age?

Trial date has been set for November of 2025 – Stay tuned!



B. Residency Program Faculty Conduct Issues

Residency director has the responsibility to assure program faculty meet professionalism standards.

Considerations:

- What process applies / who handles it? Can or should the Medical Staff be involved?
- Will the process be protected?

C. Handling Impairment Issues

- Many organizations have practitioner wellness committees, and/or practitioner wellness/ impairment policies.
- Options for handling include:
 - Collegial intervention / remediation mechanisms (practitioner wellness committee involvement)
 - Formal corrective action (MEC involvement)

C. Handling Impairment Issues

Informal remediation - general guideline: Seek to resolve the matter in a way that protects patients but is only as restrictive as necessary with respect to the practitioner.

- Considerations:
 - Patient safety
 - Work environment
 - Reporting obligations (State and Federal)
 - Medical Staff Governing Documents and Policies
- Informal remediation:
 - Resolve matters informally when possible
 - Document, document, document informal resolutions
 - Often undertaken prior to initiation of formal investigation



C. Handling Impairment Issues – NPDB Reports



If a physician is the subject of a professional review action that may require the physician to undergo drug or alcohol treatment, the hospital must still report an adverse action



The hospital should never report the fact that a physician entered into a voluntary treatment program



A leave of absence for the purpose of drug and/or alcohol treatment with no adverse professional review action is not reportable

D. Tools of the Trade



- Collegial Intervention & Informal Remediation
- Practitioner Wellness/Impairment Policies
- Voluntary Agreement Not to Exercise
- Summary Suspension Process
- Formal Corrective Action Investigation/Process
- Automatic Suspension & Automatic Termination

Topic 4 – Medical Staff Documents

Options for further exploration:

Unified Medical Staffs
Bylaws standardization
Consistency of action provisions
Name that Medical Staff document

Medical Staff Documents Govern the Medical Staff



Medicare hospital/critical access hospital CoPs.

Hospital/critical access hospital accreditation standards: ACHC, DNV, TJC.



Applicable state laws and rules/regulations with respect to professional licensure, scope of practice, hospital licensure, *etc.*

Medical Staff Documents

Medical Staff Bylaws: Provisions required by The Joint Commission (TJC); Associated details reside in applicable Medical Staff Policies. How DNV and ACHC differ.



Medical Staff Credentials Policy

Sets forth details with respect to credentialing, appointment, and privileging of Practitioners.



Medical Staff Organization Policy

Sets forth information regarding Medical Staff Departments/Sections, *etc.* (if any), standing Medical Staff committees, and meeting logistics.



Medical Staff Fair Hearing Policy

Sets forth the Medical Staff fair hearing and appeal process.



Practitioner/APP Conduct Policy

Sets forth the procedure for addressing unprofessional conduct by a Practitioner or APP.



Practitioner/APP Wellness (Impairment) Policy

Sets forth the procedure for addressing Practitioner or APP impairment.



Practitioner/APP Peer Review Policy

Sets forth the “peer” case review process for Practitioners and APPs granted clinical privileges.



Advanced Practice Provider (APP) Policy

Sets forth details with respect to credentialing and privileging of APPs.



Other: Non-Privileged Allied Health Professional Policy

(if needed); Initial FPPE/OPPE Policy (aligned with Peer Review Policy); Rules & Regulations (clinical in nature).

POLL TIME - Pick your preferred topic for further exploration.



A. Unified Medical Staffs 0%

B. Bylaws standardization 0%

C. Consistency of action provisions 0%

D. Name that medical staff document 0%

A. Unified Medical Staff (UMS)



B. Bylaws Standardization

- Standardization occurs when individual Medical Staffs within a system choose to adopt a uniform set of Medical Staff documents
- Helps address inefficiency/inconsistency in CVO and MSO processes
- What prompts standardization?
 - Merger forces integration
 - Unified Medical Staff prompts standardization
 - Individual Medical Staffs choose to adopt uniform documents






B. Bylaws Standardization

Sections that can be standardized include:

- Medical Staff definitions
- Qualifications for Medical Staff appointment and/or privileges
- Basic obligations of Medical Staff appointment and/or privileges
- Medical Staff categories
- Formal corrective action and summary suspension processes
- Grounds for automatic suspension & automatic termination
- Hearing/appeal process
- Procedures for credentialing, appointment/reappointment, and privileging
- Peer/case review process
- FPPE and OPPE procedure
- Procedure for addressing Practitioner/APP conduct and impairment matters
- Procedure for adopting and amending the Medical Staff Bylaws, Policies, and Rules & Regulations
- Others

B. Bylaws Standardization

Sections that remain individualized include:

-  Medical Staff Officers
-  Medical Staff Departments/Sections (or Divisions) and Department Chairs/Section Chiefs (or Division Chiefs), etc.
-  Medical Executive Committee
-  Other standing Medical Staff committees
-  Sections that account for hospital and critical access hospital differences in:
 - CMS Conditions of Participation
 - Accreditation standards

C. Consistency of Action Provisions

If Practitioner's appointment and/or privileges are automatically suspended or automatically terminated, in whole or in part, at an Affiliate Hospital(s), the Practitioner's appointment and/or Privileges at this Hospital shall automatically become subject to the same action without recourse to the procedural due process rights set forth in these Bylaws and the Fair Hearing Policy.



Grounds for automatic suspension of Medical Staff appointment and/or privileges must be set forth in the Medical Staff Bylaws



Grounds for automatic termination of Medical Staff appointment/privileges must be set forth in the Medical Staff Bylaws

C. Consistency of Action Provisions



Summary suspension or voluntary agreement not to exercise while under investigation



Limitation, suspension, or termination of appointment and/or privileges based on professional conduct or clinical competency concerns



Resignation or failure to seek reappointment or regrant of privileges while under investigation or to avoid investigation



Withdrawal of an initial application for appointment and/or privileges for professional conduct or clinical competency concerns



D. Name That Medical Staff Document!



Where would you find information regarding:

- Approval of the Medical Staff Bylaws, Medical Staff Policies, Medical Staff Rules & Regulations?
- The types of Medical Staff categories?
- The procedure for granting telemedicine, temporary, and disaster privileges?
- Standing Medical Staff committees?
- The procedure for formal corrective action and summary suspension?
- The Medical Staff hearing and appeal process?
- The procedure for conducting case review?
- Who is eligible for Medical Staff appointment and/or clinical privileges?
- Baseline qualifications for Medical Staff appointment and clinical privileges?
- Requirements regarding H&Ps?
- Requirements regarding Qualified Medical Personnel (QMPs)?

Topic 5: Reporting Obligations

Options for further exploration:

Resignation while under investigation
Voluntary agreement not to practice
Senate Bill 109 – New Ohio sexual misconduct reporting law
Standards for HCQIA immunity

Reporting Obligations – NPDB Reporting

The Health Care Quality Improvement Act (HCQIA) of 1986 established the National Practitioner Data Bank (NPDB)

HCQIA extends immunity from damages to individuals and entities who participate in the peer review process, in return for reporting “incompetent” physicians to the NPDB



NPDB Guidebook first issued in 2001; second edition in 2015; third edition in 2018

Contains HRSA’s interpretation of reporting obligations; does not have the force and effect of law

Very aggressive with respect to what constitutes an “investigation” and what constitutes a “reportable” event

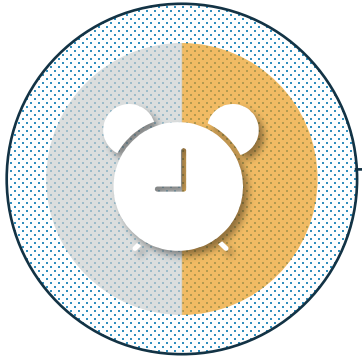
Reporting Obligations – NPDB Reporting

A Healthcare Entity Must Report

A professional review action that **adversely affects** the clinical privileges of a physician for a period of **more than 30 days**, including:

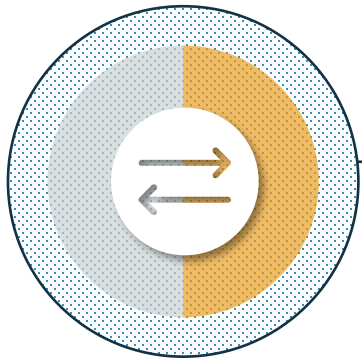
- Reduction, restriction, suspension or revocation of privileges
- Denial of privilege based on professional review (excluding denials based on failure to meet specific threshold criteria or an initial application withdrawal before a final professional revision decision)
- A practitioner's surrender of, or failure to renew, privileges while under or to avoid investigations
- Summary suspensions that are the results of a professional review (in effective for more than 30 days), regardless of whether the action is final

Reporting Obligations – Medical Board Reports



Timing of Reports:

- NPDB: Generally, within 30 days of the action
- SMB: Check state law



Reporting Relationship:

- If an NPDB report is required, there will likely be a required report to the SMB
- A SMB report does not always mean an NPDB report is required (check state law)

POLL TIME - Pick your preferred topic for further exploration.



A. Investigations 0%

B. Voluntary agreement not to practice 0%

C. Ohio Senate Bill 109 - Reporting sexual misconduct 0%

D. Standards for HCQIA immunity 0%

A. Resignation While Under Investigation



- The term “investigation” is not defined by HCQIA.
- NPDB Guidebook says that it interprets the word “expansively”
 - It commences when the entity begins an inquiry and ends when the decision-making authority takes final action; but
 - Initial FPPE applicable to all physicians is not an investigation.
 - If the activity is a precursor to a professional review action, NPDB considers the review an investigation.
 - If the process is a targeted process based on professional competency issues, the NPDB considers the process part of an investigation.

A. Resignation While Under Investigation

FPPE – an investigation or not?

Shifting Approach

Where an FPPE related to professional competence or conduct is initiated by a peer review committee or body below the MEC level, prompted by reasons other than routine review, and the practitioner resigns:

- 1 **Noticed shift:** Reportable
- 2 **Previously:** Not reportable, because only the MEC of the Board conducts “investigations”



A. Resignation While Under Investigation



Example: Dr. McGee is on a Hospital's medical staff. The MEC initiates a formal corrective action investigation. Dr. McGee resigns from the medical staff totally unaware that the investigation has been initiated. Is this reportable to the NPDB?



Example: What if Dr. McGee just lets his clinical privileges lapse instead of resigning from the medical staff? Note, he is still unaware he is under investigation.

> **NPDB Guidebook:** Yes.

> **Practical Takeaway:** This feels unfair. So be very clear in your governing documents as to when an investigation begins and act promptly in notifying the physician.

> **Same answer:** NPDB says it is reportable, but this seems unfair.

B. Voluntary Agreement Not to Practice



The MEC has initiated the formal corrective action process. The MEC has determined that it has grounds to impose a summary suspension. Dr. McGee is advised that he may either voluntarily agree not to exercise his privileges while the investigation is being conducted or he may take the summary suspension (thereby giving him the ability to contest it in a fair hearing process). Dr. McGee voluntarily agrees not to exercise his privileges. Is this reportable to the NPDB?

B. Voluntary Agreement Not to Practice

- **NPDB Guidebook:** Yes, because this constitutes an agreement to restrict clinical privileges while under investigation.

Q&A 22 (Oct. 2018 Update): “[T]he agreement not to exercise privileges is reportable if other reportability conditions are met. NPDB regulations state that “acceptance of the surrender of clinical privileges or any restriction of such privileges . . .while under investigation” is reportable. An agreement not to exercise privileges is a restriction of privileges. Any restriction of privileges while under investigation, temporary or otherwise, is considered a resignation and must be reported.”

- **Another position:** No, because the statute does not authorize reporting based upon a restriction in this situation (unless the physician resigns).

C. Ohio Senate Bill 109 – Reporting Sexual Misconduct to SMBO

1. Health care facilities must report the beginning of any investigation regarding a Medical Board licensee related to allegations of sexual misconduct or criminal misconduct to the Medical Board within 30 days.
2. Medical Board licensees must report allegations of sexual misconduct involving a Board licensee within 30 days.
3. Medical Board licensees are also required to report certain criminal misconduct (*felonies, misdemeanors committed in the course of medical practice, offenses of violence, or sexually oriented offenses*) involving a Board licensee to the Medical Board within 30 days.
4. Persons who have knowledge that a licensed medical professional committed a sexual offense against a patient of the licensed medical professional must report that knowledge to law enforcement authorities within 30 days.
5. Medical Board licensees will be required to notify patients, in writing, if they are on probation for sexual misconduct involving a patient or key third party, or for other conduct involving patient harm.

C. Ohio Senate Bill 109 – Reporting Sexual Misconduct to SMBO

6. Pelvic, prostate, or rectal examinations (“intimate exams”) may not be performed on an anesthetized or unconscious patient unless the exam is within the scope of a surgical procedure, diagnostic examination, treatment of the patient, the patient or the patient’s legal representative gives specific informed consent for the exam, or the exam is conducted by a SANE nurse.
7. The Medical Board may now summarily suspend a licensee upon the receipt of verifiable information that the licensee has been charged with a felony and the conduct at issue may form the basis of disciplinary action under Ohio law.
8. A licensee whose license or certificate to practice a health care occupation in another jurisdiction is suspended, revoked, or surrendered shall also have his/her license or certificate to practice in Ohio automatically suspended.
9. The Medical Board is also authorized to provide status updates to complainants, upon request, if the Board verifies the complainant’s identity.

D. Standards for HCQIA Immunity

Immunity from Damages Will Be Granted If a ‘Professional Review Action’ Is Found to Be Reasonable

If “reasonable,” then the immunity provision applies to:

- the professional review body,
- any person acting as a member or staff to the professional review body,
- any person under contract or other formal agreement with the professional review body, **and**
- any person who participates with or assists the professional review body

Immunity provision applies to ALL claims except

- Civil rights claims
- Federal or state initiated antitrust action



D. Standards for HCQIA Immunity

- To be considered good faith peer review (to qualify for HCQIA protection), peer review should be carried out:
- With a reasonable belief that the action was in furtherance of quality care
- After a reasonable effort to obtain the facts of the matter
- After adequate notice and hearing procedures or such other procedures as are fair to the practitioner under the circumstances
- In the reasonable belief that the action was warranted by the facts known after such reasonable effort to obtain facts and after meeting the requirements of paragraph (3).

Topic 6: Corrective Action

Options for further exploration:

Who handles corrective action investigations

Procedural due process

Options for corrective action

External reviews

Corrective Action

Generally, corrective action is the process whereby the Medical Staff examines a physician's professional competence or conduct under the procedure set out by the Medical Staff Bylaws, where there is a potential for action against the physician's clinical privileges or Medical Staff appointment.

Authority for initiating/requesting CA is defined by the bylaws, typically to include:

- Any Appointee,
- Any Medical Staff committee,
- The President,
- The chair of the Board of Directors, or
- The Board of Directors

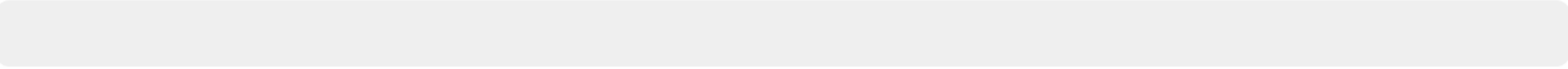
Corrective Action

- General standard: Corrective action is appropriate when a practitioner's clinical competence or professional behavior is:
 - in violation of the standards or aims of the Medical Staff,
 - disruptive to the operations of the hospital, or
 - resents the threat of harm to a patient in the hospital.

POLL TIME - Pick your preferred topic for further exploration.



A. Who handles CA investigations



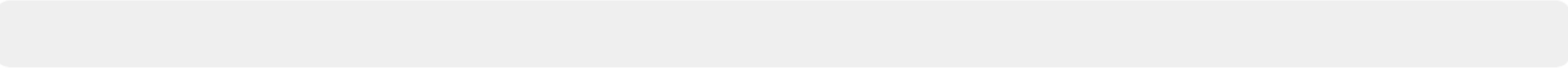
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B. Procedural due process



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C. Options for CA



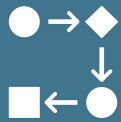
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D. External reviews



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A. Who Handles Corrective Action Investigations



Generally – CA starts with a request to the MEC and ends with the Board’s approval/adoption of recommendations



Typically, the investigation of whether to recommend/take CA will be handled by the MEC; the Board *may* handle an investigation if the MEC fails to act



If permitted by the Bylaws - The MEC may appoint an investigating committee to investigate the concerns identified by the request for CA, and to make a recommendation to the MEC on CA

B. Procedural Due Process

- Procedural due process is the key to all peer review activities
- The processes defined in the Bylaws should provide for procedural due process
- Considerations:
 - Was an ad hoc committee established?
 - Were the members advised of their responsibilities?
 - Did legal counsel provide assistance?
 - Who were the witnesses?
 - What information was reviewed?
 - How was the physician a part of the process?
 - Were participants cautioned about the importance of maintaining confidentiality?

C. Options for Corrective Action



- Limitation, suspension, or revocation of privileges
- Summary suspension of privileges
- Reduction in staff category or revocation of appointment
- Requirements around proctoring/training/monitoring
- Warnings
- Closure without action
- Other options

D. External Reviews



- Why use an external reviewer?
 - Lack of internal expertise
 - Internal conflicts of interest, competition
 - Lack of consensus among internal reviewers
 - Other circumstances that could compromise review
- Where indicated, external reviews support a fair process (i.e., procedural due process)
- Notice provisions: Bylaws may require that physicians be notified when their cases are going to external review, and require that the physician be allowed to see the results

Topic 7: TO BE DETERMINED BY YOU!

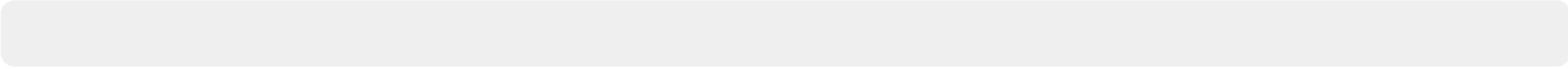
Options for further exploration:

Miscellaneous questions/hypos from the audience (be prepared to participate!)
Panelists share interesting recent fact patterns

POLL TIME - Pick your preferred topic for further exploration.

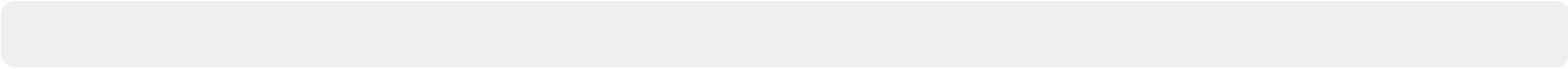
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A. Miscellaneous audience questions / hypos



0%

B. Panelists share stories



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A. Miscellaneous Audience Questions/Hypos



B. Panelists Share Stories



Any Questions?



Steve Kleinman

Member of the Firm

Skleinman@ebglaw.com



Kimberly Parks

Senior Counsel

Kparks@ebglaw.com



Jeremy Morris

Member of the Firm

Jmorris@ebglaw.com



Avery Schumacher

Member of the Firm

Aschumacher@ebglaw.com