NAVIGATING ADVERSE OUTCOMES

11th Annual ASC and
Health Care Management Symposium

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Summary of Reporting Requirements

Licensing Boards – New York

Office of Professional Medical Conduct (OPMC) (*NY Public Health Law§ § 230, 2803-e*)

- An Article 28 facility (e.g., am ASC or hospital) has an obligation to report to the OPMC within 30 days if it (1) becomes aware that a physician has engaged in misconduct; or (2) suspends, restricts, or terminates the employment, association or professional privileges, or denies request for clinical privileges, of a physician for reasons related in any way to alleged mental or physical impairment, incompetence, malpractice or misconduct or impairment of patient safety or welfare; or (3) it becomes aware of the voluntary or involuntary resignation or withdrawal of association or of privileges with such Article 28 facility to avoid the imposition of disciplinary measures.
- An individual physician (Physician A) is required to report to the OPMC if Physician A has reasonable knowledge that another physician has engaged in misconduct. Physician A is considered to have engaged in misconduct if he or she fails to report.

Note: The definitions of misconduct are described in Sections 6530 and 6531 of the New York Education Law.

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Licensing Board – New York

Office of Professional Discipline

Article 28 facilities are also required to report other practitioners licensed under the Education Law (e.g., nurses, physical therapists, dentists) ("Practitioners") if the Article 28 facility (1) suspends, restricts, or terminates the employment, association or professional privileges, or denies request for clinical privileges, of a Practitioner for reasons related in any way to alleged mental or physical impairment, incompetence, malpractice or misconduct or impairment of patient safety or welfare; or (2) the Practitioner the voluntary or involuntary resigns or withdrawals association or of privileges with such Article 28 facility to avoid the imposition of disciplinary measures.

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Licensing Boards – New Jersey

All Healthcare facilities in New Jersey are required to report to the Division of Consumer affairs if, for reasons relating to the health care professional's impairment, incompetency or professional misconduct, which incompetency or professional misconduct relates adversely to patient care or safety, the health care entity:

- Summarily or temporarily revokes or suspends or permanently reduces, suspends or revokes the health care professional's full or partial clinical privileges or practice;
- Removes the health care professional from the list of eligible employees of a health services firm or staffing registry;
- Discharges the health care professional from the staff of the health care entity; or
- Terminates or rescinds a contract with the health care professional to render professional services;

In addition, there are reporting requirements related to reporting the following: second opinion requirements, non-routine concurrent or retrospective review of admissions or care specifically tailored after a preliminary, review of care, non-routine supervision by one or more members of the staff, the completion of remedial education or training; and resignation and leaves of absence.

NJAC 13:45E-3.1

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Licensing Boards – New Jersey

In addition, health care professionals are required to shall file a report with the Division of Consumer Affairs if that health care professional is in possession of information which reasonably indicates that another health care professional has demonstrated an impairment, gross incompetence or unprofessional conduct which would present an imminent danger to an individual patient or to the public health, safety or welfare.

NJAC 13:45E-3.2

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Licensing Board – Connecticut

Any health care professional or hospital shall file a petition within 30 days when such health care professional or hospital has any information that appears to show that a health care professional is, or may be, unable to practice his or her profession with reasonable skill or safety for any of the following reasons: (A) physical illness or loss of motor skill, including, but not limited to, deterioration through the aging process; (B) emotional disorder or mental illness; (C) abuse or excessive use of drugs, including alcohol, narcotics or chemicals; (D) illegal, incompetent or negligent conduct in the practice of the profession of the health care professional; (E) possession, use, prescription for use or distribution of controlled substances or legend drugs, except for therapeutic or other medically proper purposes; (F) misrepresentation or concealment of a material fact in the obtaining or reinstatement of a license to practice the profession of the health care professional; or (G) violation of any provision of the chapter of the general statutes under which the health care professional is licensed or any regulation established under such chapter. *CGSA Chapter 368a, Section 19a-12e.*

Note: The reporting obligation is considered to be fulfilled if the hospital or health care professional refers to the applicable health care professional for intervention at an assistance program.

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Licensing Board – Connecticut

In addition to the foregoing, in regard to physicians, health care facilities and physicians must report if they have an information that shows that another physician may be unable to practice medicine with reasonable skill for the following reasons: (1) failure to adequately supervise a physician assistant; (2) failure to fulfill any obligation resulting from participation in the National Health Service Corps; (3) failure to maintain professional liability insurance or other indemnity against liability for professional malpractice; (4) failure to provide information requested by the department for purposes of completing a health care provider profile; (5) engaging in any activity for which accreditation is required in regard to MRIs; (6) failure to comply with the continuing medical education requirements.

In addition, health care facilities are be required to report within 15 days to the Department of Public Health if the staff membership or privileges of a physician are terminated or restricted. *CGSA § § 20-13d; 20-13c.*

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National Practitioner Data Bank (“NPDB”)

The Health Care Quality Improvement Act (the “Act”) requires that all hospitals and other health care facilities (each a “Health Care Entity”) report to the NPDB if:

- there is a professional review action that results in an adverse action for thirty (30) days or more against a physician or dentist the action is based on a physician's or dentist's professional competence or professional conduct that adversely affects, or could adversely affect, the health or welfare of a patient; or
- the acceptance of the surrender of clinical privileges, or any restriction of such privileges by a physician or dentist: (1) while the physician or dentist is under investigation by a Health Care Entity relating to possible incompetence or improper professional conduct, or (2) in return for not conducting such an investigation or proceeding.

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National Practitioner Data Bank

- Typically, it is considered that a professional review action has not occurred until the physician or dentist has been offered a hearing and the hearing is complete or the physician or dentist waives his or her right to a hearing.
- In the case of summary suspension, the suspension must be reported once the suspension has been in effect for thirty (30) days even if the fair hearing has not yet occurred.
- The Act lays out many of the requirements for the fair hearing.

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Other Reporting Considerations

- Drug Enforcement Administration (DEA)
- State Narcotics Boards
- State incident reporting obligations (e.g., NYPORTS; NJ Patient Safety Act)
- US Department of Health and Human Services, Office of Civil Rights ("OCR")
- State Attorney Generals (for incidents involving personal information)
- Accreditation Agencies

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Scenarios

Was that Supposed to be the Right or the Left?

Dr. Smith is a high volume surgeon at Feel Better ASC in New York and also an owner. The Medical Director has noticed that in the last few months, there has been in increase in the number of post operative infections associated with Dr. Smith's cases and at least one return to the OR to repair an intestinal perforation. The cases were all reviewed by the QAPI Committee with no deviation from the standard of care noted. Nevertheless the trend was concerning. Then on a very high volume day, Dr. Smith performed the wrong procedure on a patient. The mistake is only noted after the patient was in the recovery room. An immediate review of the record indicates that a "time out" did not occur and upon interview, the anesthesiologist (who is responsible for initiating the time out) reported that Dr. Smith had specifically instructed that no time outs occur because the schedule was so tight. Dr. Smith alleged that it was the pre-operative staff who brought in the wrong patient, and not his fault.

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I am in Charge!

We Do It Best ASC in Connecticut is committed to performing only orthopedic procedures. The Medical Director, who also performs procedures at the ASC, schedules a routine orthopedic procedure on a 78 year old woman in good health, but when the case presents in the OR, it is actually not an orthopedic procedure listed on the ASC's list of approved procedures or in the surgeon's clinical privilege list. The procedure is, however, similar to an orthopedic procedure and arguably within the skills and competency of the Medical Director. When the scrub nurse and anesthesiologist question the procedure, the Medical Director begins to curse at them because of the presumed impertinence of questioning him. The Medical Director is notorious for his vicious temper and there have been a number of complaints regarding throwing of equipment and demeaning comments to all staff. Unfortunately, the administrator is out on a sick day, so the scrub nurse and anesthesiologist feel they have no recourse but to allow the procedure to move forward. The procedure is successful but the scrub nurse and anesthesiologist are outraged and write a letter to the governing board of the ASC.

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When There is Smoke There is Generally Fire

The administrator at Improve Now ASC in Connecticut is informed that Nurse Kindness has been showing up consistently late for work. When interviewed, the Nurse explains that she is going through a difficult divorce and is facing significant child care challenges. This is one of the most talented nurses, so the administrator lets its slide. Then Nurse Kindness gets into an altercation with a technician who questions her process for "wasting" unused narcotics (this is technically the anesthesiologist responsibility but Nurse Kindness is always willing to help the busy physician staff). The administrator reviews the narcotic logs, which seem consistent, and again shrugs off the incident. Two weeks later, Ms. Jones shows up at the ASC asking for Nurse Kindness who has been helping Ms. Jones obtain dilaudid at such a reasonable price. When questioned, Nurse Kindness denies any such allegations.

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Nothing Really Went Wrong, But ……

A QAPI Committee at We Are Great ASC in New York notes that over the past year, Physician Easy Going has been having a gradual increase in the number of complications and "near misses" on his cases. None of the incidents – alone – rise to the level of a serious concern or had any permanent bad outcome. Physician Easy Going is very popular with the other surgeons and staff, so no one wants to say anything. After one case, in which the anesthesiologist intervened to prevent a potential medication error (once again no patient harm), the Medical Director determines that something needs to be done and proposes a potential corrective action to the Governing Board in accordance with the Medical Staff Bylaws.

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Is it Really a Problem?

The Nursing Director at Perfect You ASC in New Jersey noticed that one of the anesthesiologist, who was an independent contractor, was behaving a little erratically and seemed exhausted all of the time.   Reports of minor mistakes started trickling in but none of them were sufficiently significant to warrant a full scale investigation. Then one day, one of the nurses observed that there was a vial of propofol in the anesthesiologist's bag. Since propofol is not a controlled substance, it was not subject to the rigorous oversight and daily "counts" that would have revealed missing vials.   The Medical Director began an investigation and the anesthesiologist alleged that she worked at multiple facilities and carried propofol from place to place. Three days later, the anesthesiologist was found unconscious in the ladies room with a syringe of propofol still in her arm, and the vial is from a lot attributed to the ASC.

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Questions