CMA OMSS ADVOCATE

A quarterly newsletter for members of the California Medical Association's Organized Medical Staff Section

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New Laws of Interest to Medical Staffs

Despite a barrage of Governor vetoes, the 2009 legislative session produced ample, and at times, significant changes to laws affecting medical staffs. A summary of the most significant legislation enacted, along (where relevant) with references to the most relevant ON-CALL document that discusses the topic in more detail, is available at http://www.cmanet.org/news/omss_advocate.asp.

CMA On-Call

Throughout this publication, you will find references to "CMA On-Call" documents. On-Call is an online library that contains over 4,500 pages of medical-legal, regulatory, and reimbursement information. On-Call documents are available free to individual CMA members at the members-only website, http://www.cmanet.org/member. Nonmembers can purchase On-Call documents for $2 per page in the CMA bookstore, http://www.cmanet.org/bookstore.

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Don't Let Your OMSS Membership Lapse; Renew Today!

OMSS membership for 2009 will expire on December 31, 2009 and CMA is now accepting membership renewals for 2010.

The CMA Organized Medical Staff Section (OMSS) represents over 130 California hospital medical staffs and advocates for strong medical staff self-governance and quality patient care. Our members know that OMSS memberships support CMA legislative advocacy, policy development, and legal action on medical staff issues.

For 2010, OMSS members will receive even more benefits and resources. These benefits include:

- Access to legal and policy experts for individual advice on a wide range of medical staff issues;
- Access to CMA's online library of medical-legal and other information of importance to physicians;
- The 2010 CMA Model Medical Staff Bylaws, updated to reflect state and federal law changes and new Joint Commission standards. The 2010 update also includes a model medical staff code of conduct and a new medical staff conflict of interest policy.
- Free registration for the designated OMSS representative and Chief of Staff for CMA's OMSS Annual Assembly and Educational Conference.
- Free subscription to CMA's OMSS Advocate—a quarterly newsletter on events and issues that impact medical staffs.

TAKE ACTION: To prevent any interruption in your OMSS membership benefits, please complete and submit your OMSS application and membership dues as soon as possible.

MORE INFORMATION: The 2010 OMSS application and list of benefits are available at http://www.cmanet.org.

California OMSS Delegation Participates in 2009 AMA-OMSS Interim Meeting

A delegation of physicians representing CMA's Organized Medical Staff Section participated in the 2009 AMA-OMSS Interim Meeting in Houston, Texas, from November 5-7. The California OMSS delegation introduced a resolution requesting that AMA develop materials for physicians that will assist them in developing models for regional medical corporations. This resolution was approved by the AMA House of Delegates. In addition, as a result of advocacy from the California delegation, the AMA report on the Model Code of Conduct report was sent back to the AMA governing council for further review and revision, taking into account the CMA model code of conduct policy as a model. The AMA-OMSS interim meeting also included educational presentations on accountable care organizations, employment contracting, and physician-led organizations.

TAKE ACTION: Mark your calendars for the AMA-OMSS annual meeting, which will be held June 10-12, 2010 in Chicago, IL. All medical staffs are encouraged to designate an OMSS representative to attend the AMA-OMSS annual meeting.

MORE INFORMATION: Materials from the AMA-OMSS interim meeting is available at the AMA website at http://www.ama-assn.org.

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Organized Medicine Requests Clarification on Joint Commission Definition of Physician

The American Medical Association, American Osteopathic Association, and state medical societies have sent a letter requesting that the Joint Commission clarify its revised definition of the term "physician" to be limited to individuals who have received a Doctor of Medicine or a Doctor of Osteopathic Medicine degree, or an equivalent degree of medicine following successful completion of a prescribed course of study from an international school of medicine.

The Joint Commission recently changed the definition of "physician" to align its definition of terms with the Centers for Medicare and Medicaid Services (CMS). The CMS definition relied upon by the Joint Commission is primarily for reimbursement purposes rather than any scope of practice, licensure, accreditation or other purpose. (See §1861 [42 U.S.C. 1395x] of the Social Security Act). However, the Joint Commission's definition does not make this distinction.

The letter requests that the Joint Commission make the appropriate change to the definition or add a footnote that states that the definition aligns the Joint Commission with the Centers for Medicare and Medicaid Services. The language reflects §1861 [42 U.S.C. 1395x] of the Social Security Act, and the definition is for purposes of reimbursement only. It is meant to neither expand nor retract any health care practitioner's scope of practice, licensure, or for any other purpose.

LEGAL UPDATE— Medical Staffs Bear the Burden of Proof When Suspending or Restricting Privileges for Applicants with Temporary Privileges

A Court of Appeal recently concluded that a medical staff peer review body erred in concluding that an anesthesiologist had the burden of proving that she did not mishandle controlled substances as part of the peer review action taken against her. In *Bode v. Los Angeles Metropolitan Medical Center (2009) 174 Cal.App.4th 1224, 94 Cal. Rptr.3d 890*, a physician who applied for medical staff membership was granted a 90-day temporary practice privilege while her application was pending.

During this 90-day period, issue arose concerning the mishandling of certain controlled substances, and the physician's temporary staff privileges were summarily suspended. The judicial review committee in this case was unsure as to whether to place the burden of proof on the physician or the peer review body so it decided the case in the alternative, that is, if the burden was placed on the physician, the JRC found, she failed to produce sufficient evidence of her qualifications for medical privileges. On the other hand, when it placed the burden of proof on the peer review body, the JRC found that the decision to suspend and not renew the physician's temporary privileges was not reasonable or warranted. The appellate review committee ruled as a matter of law that the physician was nothing more than an initial applicant who bore the burden of proof.

The trial court ruled that the appellate review committee erred when it placed the burden of proof on the physician and the Court of Appeal affirmed. The Court of Appeals concluded that once a physician has been granted privileges, even temporary ones, the medical staff assumes the burden of proof at any hearing to justify taking action against those privileges for a medical disciplinary cause or reason. The court's rational was as follows:

In the case of a first time applicant (such as Bode), a decision to reject an application due to a medical disciplinary cause or reason obviously must rely on reports of

OMSS Elects Executive Board Members

Elections for several OMSS Executive Board positions were held at the 2009 OMSS Annual Assembly. The OMSS Executive Board is responsible for the planning and oversight of section activities, and reports periodically to the House of Delegates and to the Board of Trustees. The 2009-2010 OMSS Executive Board members are:

Lytton Smith, MD (Chair). Dr. Smith is a family practice physician and is currently Chief of Staff at St. Jude Medical Center in Yorba Linda, CA. He previously served as Secretary for the OMSS Executive Board.

Damodara Rajasekhar, MD (Vice-Chair). Dr. Rajasekhar practices neonatal-perinatal and pediatric medicine and is the OMSS representative for Victor Valley Community Hospital in Apple Valley.

Marshall Morgan, MD (Secretary). Dr. Morgan practices emergency medicine and is currently serving as Chief of Staff at the Ronald Reagan UCLA Medical Center in Los Angeles.

Robert Pugach, MD (CMA Board of Trustees). Dr. Pugach is a urologist and serves as the OMSS representative for Community Hospital of Long Beach. He serves as Vice-Chair of the American Medical Association's Organized Medical Staff Governing Council.

John Luster, MD (Delegate). Dr. Luster practices family medicine and currently serves as Chief of Staff for Chapman Medical Center in Orange,.

Richard Rajaratnam, MD (Delegate). Dr. Rajaratnam practices head and neck surgery and currently serves as the Area Medical Director for the Southern California Permanente Medical Group.

William Carlson, MD (Alternate Delegate). Dr. Carlson practices family and emergency medicine and is the OMSS representative for Mad River Community Hospital in McKinleyville.

Richard Butcher, MD (Alternate Delegate). Dr. Butcher practices family medicine in San Diego and is the OMSS representative for Alvarado Hospital.

TAKE ACTION: The OMSS Executive Board encourages active participation from OMSS representatives on important issues impacting organized medical staffs. To contact an OMSS board member or to find out more about OMSS Executive Board meetings, please contact the CMA OMSS office at medstaffhelp@cmanet.org.

misconduct or other negative incidents that occurred in the past at some other health facility. If a hospital is considering rejecting an applicant based on such information, the hospital cannot reasonably be expected to prove those incidents, and it therefore makes sense to place the burden on the initial applicant to produce sufficient information to disprove them. In other situations, when a licensee is working at a health facility under some arrangement, a decision to terminate that arrangement for a medical disciplinary cause or reason in all likelihood is based on recent conduct occurring while the licensee was at that hospital pursuant to that arrangement. In such cases, the hospital can bear the burden of proof because it will have control over and access to all the relevant witnesses and information. (Id. at 1237.)

This case provides considerable guidance to peer review bodies taking action against individuals with temporary privileges.

MORE INFORMATION: For more information, see CMA ON-CALL document #1410, "Peer Review - Fair Hearing Requirements."

CMA to Develop Policy on Privileging Low and No Volume Physicians

The hospital privileging process has become more difficult for many physicians, due to factors such as:

- The continued growth of the hospitalist movement, which has created new professional relationships, resulting in an increasing number of "low volume" physicians.
- An increase in procedures performed in non-hospital settings that were previously only available in a hospital; and
- The growing number of office-based physicians with limited or almost no hospital-based clinical activity.

The Centers for Medicare and Medicaid Services' (CMS) general requirements must be followed when privileging physicians and the Joint Commission has accreditation standards for clinical privileges, but not specifically for low volume physicians, and has attempted to address low volume procedures and physicians with its Ongoing Professional Practice Evaluation.

The 2009 CMA House of Delegates approved a resolution to study the privileging process and report back with recommendations on establishing guidelines for privileging "low and no volume" physicians. As part of this study, we are asking medical staffs to share their bylaws, policies, and procedures for privileging low and no volume physicians.

TAKE ACTION: Please submit copies of your medical staff bylaws, policies and procedures that address privileging physicians who have low or no clinical activity at the hospital and the extent to which these physicians are allowed to participate in medical staff activities.

Disruptive Behavior and Self-Governance Revisions in 2010 Medical Staff Bylaws

The 2010 CMA Model Medical Staff Bylaws will include new sections on disruptive behavior and medical staff governance. These new sections were developed by the OMSS Assembly and approved by the CMA House of Delegates in October 2009.

The disruptive behavior policy has received a positive response from OMSS members because it meets the Joint Commission standard for a code of conduct policy, but still provides sufficient flexibility to ensure that the procedure does not result in inappropriate disciplinary action against physicians. Specifically, the policy provides brief examples to define acceptable and disruptive conduct; directs the Chief of Staff and the Department Chair to investigate the complaint and dismiss the complaint if it is without merit; and provides flexibility to determine consequences based on the nature of the complaint.

Physicians throughout California expressed concern about the potential lack of self-governance of their medical staffs and asked for specific guidance as to how they could regain that right in order to protect patient care. While CMA has already done much in the way of promoting self-governance, the OMSS believed that CMA policy needs to be expanded to include additional mechanisms to achieve it. Physicians throughout California made additional suggestions for mechanisms to enhance a medical staff's ability to be self-governing. The new bylaws include extensive provisions related to reforming the medical staff nomination and election process; increasing the transparency of Medical Executive Committee activities; establishing a stronger role for the medical staff with respect to providing input to hospital policy; and identifying and resolving potential conflict of interests among medical staff leadership.

TAKE ACTION: The 2010 edition of the CMA Model Medical Staff Bylaws will be available in January 2010. Remember to renew your OMSS membership to receive the 2010 Model Medical Staff Bylaws.

Joint Commission Task Force Reaches Consensus on MS 01.01.01 (Formerly MS 1.20)

At its June 2007 meeting, the Joint Commission's Board of Commissioners approved revisions to the hospital Medical Staff Standard MS.1.20 related to medical staff bylaws and associated rules and regulations and policies. The Joint Commission received concerns received from professional organizations and hospitals, specifically that the new standard required too many details in the bylaws; the cost and burden associated with changing bylaws; the potential for disrupting relationships between the medical staff and governing body; and the role of the medical executive committee.

The Joint Commission Board established an 18-member task force to analyze the potential impact of implementing the revised standard. The task force, which was convened in January 2008, consists of representatives from medical and hospital associations and hospital leaders representing administration, medical staff, and hospital trustees. The task force focused its discussions on several key issues, including:

- What needs to appear in the medical staff bylaws and how such decisions are made.
- The relationship between the organized medical staff and the medical executive committee.
- How to foster a collaborative and positive relationship among the management, medical staff, and governing body.
- How to manage conflict that may arise between the organized medical staff and the governing body, or between the organized medical staff and the medical executive committee, regarding medical staff bylaws, rules and regulations, and policies.
- The definitions of terms that appear in the standard.

The task force was guided by two principles in the development of its recommendation. These principles attempted to balance hospital executives' and medical staff representatives' concerns. The two principles are as follows:

1. The requirements set forth in Elements of Performance 12-36 must be in the medical staff bylaws. For those EPs involving a process, the medical staff bylaws must include the basic steps required for implementation of the requirement. Associated details may reside in the medical staff bylaws, rules and regulations or policies as determined by each hospital's organized medical staff and governing body.
2. If the organized medical staff delegates authority to the medical executive committee concerning the details related to EPs 9-33 (contained in rules or regulations), they must be informed of proposed amendments and have the opportunity to respond prior to submission of proposals to the governing body. For minor details contained in policies, they simply need to be informed about the amendment. A reciprocal process is proposed so that when the organized medical staff proposes an amendment, they consult with the medical executive committee before a proposed change is brought to the governing body.

In March 2009, the task force reached consensus and unanimous agreement on a totally new "draft" standard that would replace the current MS.01.01.01. Comments will be gathered for 6 weeks beginning on December 17, 2009 and ending on January 28, 2010.

The Joint Commission's Board of Commissioners has authorized a formal field review to provide all interested parties an opportunity to comment on the proposal. Hospitals are currently expected to be in compliance with Medical Staff standard MS.01.01.01 (the standard number changed due to the Standards Improvement Initiative) in the 2009 Hospital Accreditation Manual. The current standard will remain in effect until further notice. There is an indefinite moratorium on the implementation of Element of Performance 19 of the current MS.01.01.01.

TAKE ACTION: The Joint Commission is distributing the revised version of MS 01.01.01 for field review. To review the draft and submit comments, please go to http://www.jointcommission.org/Standards/FieldReviews/ms_01_01_01.htm

State Revives Regulations that Would Expand Scope for Nonphysician Practitioners

The California Department of Public Health (CDPH) issued a second 15-day comment period for proposed regulations that would expand the scope of practice of psychologists and potentially all other health care practitioners working in licensed health care facilities. Although the California Office of Administrative Law rejected the regulations in October, state law allows CDPH to submit a revised proposal within 120 days. While the portions of the regulatory proposal to weaken medical staff self-governance have now been abandoned by the Department, the proposed regulations still could, among other things, allow nonphysician practitioners to admit patients, perform medical examinations, place patients in restraints, complete medical records, coordinate care, and order transfers.

CMA continues to vigorously oppose the proposed regulations and has submitted comments outlining our serious concerns with the regulations as written.

More Information: The text of the proposed regulations is available at http://www.cdph.ca.gov/services/DPOPP/regs/Pages/DPH-05-010ScopeofPracticeinLicensedHealthFacilities.aspx.

11 CA Hospitals Fined for Patient Safety Violations

The California Department of Public Health (CDPH) announced that on September 24, 2009, that eleven California hospitals have been assessed administrative penalties of $25,000 per violation for non-compliance with licensing requirements that caused, or was likely to cause, serious death or injury to patients. This last set of fines was the seventh of a series of penalties against hospitals pursuant to Health & Safety Code §1280.1, the provision that allows CDPH to assess fines where there has been a deficiency that constitutes an "immediate jeopardy to the health or safety of a patient." Deficiencies include a variety of patient safety violations, including surgical protocols that result in foreign objects being left inside a patient.

The violations that resulted in the most recent round of penalties included:

1. Alta Bates Summit Medical Center, Berkeley, Alameda County. The hospital did not follow its surgical policy and procedure, which resulted in a patient having to undergo a second surgery to remove a retained foreign object.
2. Coast Plaza Doctors Hospital, Norwalk, Los Angeles County. The hospital did not follow its surgical policy and procedure, which resulted in a patient having to undergo a second surgery to remove a retained foreign object.
3. Kindred Hospital, Ontario, San Bernardino County. The hospital failed to monitor a patient's status and medical needs.
4. Loma Linda University Medical Center, INC, Loma Linda, San Bernardino County. The hospital did not follow its surgical policy and procedure, which resulted in a patient having to

undergo a second surgery to remove a retained foreign object.

5. Los Angeles County/University of Southern California, Los Angeles, Los Angeles County. The hospital did not follow its surgical policy and procedure, which resulted in a patient having to undergo a second surgery to remove a retained foreign object.
6. Mendocino Coast District Hospital, Fort Bragg, Mendocino County. The hospital had inappropriately trained staff providing nursing care.
7. Redwood Memorial Hospital, Fortuna, Humboldt County. The hospital did not follow its surgical policy and procedure, which resulted in a patient having to undergo a second surgery to remove a retained foreign object.
8. Saint John's Hospital and Health Center, Santa Monica, Los Angeles County. The hospital did not follow its surgical services policies and procedures.
9. Sharp Chula Vista Medical Center, Chula Vista, San Diego County. The hospital did not follow its surgical policy and procedure, which resulted in a patient having to undergo a second surgery to remove a retained foreign object.
10. Tri-City Hospital District, Oceanside, San Diego County. The hospital did not follow its policies and procedures for fall prevention.
11. USC University Hospital, Los Angeles, Los Angeles County. The hospital failed to communicate laboratory test results to other hospital personnel and providers.

Protect Confidentiality of Patient Safety Committees. All California hospitals are required to be in compliance with applicable state licensure laws, including those related to patient safety and adverse events, such as Health & Safety Code §1279.6. That provision requires hospitals to develop, implement and comply with a patient safety plan for improving the health and safety of patients and reducing preventable patient safety events.

TAKE ACTION: Medical staffs should work with hospitals to regularly review patient safety plans to ensure compliance with state licensure laws. According to the law, the safety plan must, among other things, provide for the establishment of a patient safety committee as well as a process for a team to conduct analyses, including but not limited to, root cause analyses of patient safety events. It is critical that such a committee be a formally organized committee of the medical staff so that it can receive the confidentiality and immunity protections under California law.

MORE INFORMATION: For more information on California's legislation concerning patient safety, see CMA ON-CALL document #1540, "Medical Error and Adverse Events: Mandatory Systems and Reporting." For more information on peer review immunity protections, see CMA ON-CALL document #1425, "Peer Review Protections – Executive Summary."

CMA OMSS Member Hospitals *(as of 12/22/09)*

Alameda County Medical Center - Highland
Alvarado Hospital
Arrowhead Regional Medical Center
Barstow Community Hospital
Brotman Medical Center
California Pacific Med Ctr - Pacific Campus
Centinela Hospital Medical Center
Chapman Medical Center
Childrens Hospital Central California
Childrens Hospital of Orange County
Chinese Hospital
Citrus Valley Medical Center - IC Campus
City of Hope National Medical Center
Community Hospital Monterey Peninsula
Community Hospital of Long Beach
Community Hospital of Los Gatos
Community Hospital of San Bernardino
Community Memorial Hospital - San Buenaventura
Contra Costa Regional Medical Center
Desert Regional Medical Center
Doctors Hospital of Manteca
Doctors Medical Center
Dominican Hospital - Santa Cruz/Soquel
Downey Regional Medical Center
Eden Medical Center
El Centro Regional Medical Center
Emanuel Medical Center
Fallbrook Hospital District
Feather River Hospital
Fountain Valley Regional Hosp & Med Ctr - Warner
Frank R Howard Memorial Hospital
Fremont-Rideout Consortium
Garden Grove Hospital & Medical Center
Good Samaritan Hospital - San Jose
Greater El Monte Community Hospital
Hi-Desert Medical Center
Hoag Memorial Hospital Presbyterian
Hollywood Presbyterian Medical Center
Huntington Hospital
John F Kennedy Memorial Hospital
John Muir Medical Center - Concord Campus
John Muir Medical Center Walnut Creek Campus
Kaiser Foundation Hospital - Panorama City
Kaiser Foundation Hospital - Harbor City
Kaiser Foundation Hospital - Riverside
Kaiser Foundation Hospital - San Diego
Kaiser Foundation Hospital - Sunset
Kaiser Foundation Hospital - West Los Angeles
Kaiser Foundation Hospital Bellflower
Kaweah Delta Medical Center
LAC/Harbor UCLA Medical Center
LAC/Rancho Los Amigos National Rehab Ctr
Lancaster Community Hospital
Little Company of Mary - San Pedro Hospital
Little Company of Mary Hospital
Lodi Memorial Hospital
Loma Linda University Medical Center
Lompoc Valley Medical Center
Long Beach Memorial Medical Center
Los Angeles Community Hospital
Lucile Salter Packard Children's Hospital at Stanford
Mad River Community Hospital
Marina Del Rey Hospital
Mark Twain St. Joseph's Hospital
Memorial Hospital Los Banos
Menifee Valley Medical Center
Menlo Park Surgical Hospital
Mercy General Hospital
Mercy Hospital - Folsom
Mercy Hospital - Bakersfield
Mercy Medical Center - Redding
Methodist Hospital of Southern California
Mills-Peninsula Extended Care (MPH)
Mission Hospital Regional Medical Center
North Bay Medical Center
Norwalk Community Hospital
Novato Community Hospital
O'Connor Hospital - San Jose
Orange Coast Memorial Medical Center
Pacific Alliance Medical Center, Inc
Pacific Hospital of Long Beach
Palomar Medical Center
Parkview Community Hospital Medical Center
Presbyterian Intercommunity Hospital
Providence Holy Cross Medical Center
Queen of the Valley Hospital - Napa
Redlands Community Hospital
Redwood Memorial Hospital
Ridgecrest Regional Hospital
Riverside Community Hospital
Riverside County Regional Medical Center
Saddleback Memorial Medical Center
Saint Agnes Medical Center
Saint Francis Medical Center of Lynwood
Saint John's Pleasant Valley Hospital
Saint Joseph Hospital - Orange
Saint Jude Medical Center
Saint Luke's Hospital
Saint Mary Medical Center
Saint Mary Regional Medical Center
Saint Rose Hospital
San Antonio Community Hospital
San Joaquin General Hospital
San Ramon Regional Medical Center
Scripps Memorial Hospital - Encinitas
Scripps Memorial Hospital - La Jolla
Seton Medical Center
Sharp Grossmont Hospital
Sierra View District Hospital
Simi Valley Hospital and Health Care Svcs - Sycamore
South Coast Medical Center
Stanford Hospital
Sutter Coast Hospital
Sutter Lakeside Hospital
Sutter Roseville Medical Center
Tri-City Medical Center
Tri-City Regional Medical Center
UCLA Medical Center
Ukiah Valley Medical Center / Hospital Drive
University of California Davis Medical Center
University of California Irvine Medical Center
Verdugo Hills Hospital
Veterans Home of California
Victor Valley Community Hospital
Washington Hospital - Fremont
Washington Township Medical Group, Inc
Watsonville Community Hospital
West Hills Hospital & Medical Center