NORTH DAKOTA'S PEER REVIEW LAW

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What does it mean for physician practices?

North Dakota's peer review law provides legal protections for peer review organizations, including a group of physicians operating a clinic or outpatient care facility, that conducts professional peer review.[1] Many physician practices and clinics, however, don't appreciate the benefits of instituting peer review within their organizations.

Frequently Asked Questions

WHY IS PEER REVIEW IMPORTANT?

Peer review is ultimately a way to protect patients and improve the quality of patient care. Under North Dakota's peer review law, "professional peer review" is defined broadly and means all procedures a peer review organization uses or functions it performs to monitor, evaluate, and take action to review the medical care provided to patients by health care organizations or health care providers and includes procedures or functions to:

- Evaluate and improve the quality of health care,
- Obtain and disseminate data and statistics relative to the treatment and prevention of disease, illness, or injury,
- Develop and establish guidelines for medical care and the costs of medical care,
- Provide to other peer review organizations information that is originally generated within the peer review organization for the purposes of professional peer review,
- Identify or analyze trends in medical error, using among other things a standardized incident reporting system, and
- Provide quality assurance.[2]

"Health care organization" includes hospitals, clinics, ambulatory surgery centers, groups of physicians operating a clinic or outpatient care facility, and any combination of these entities.[3] A "health care provider" means a physician or other individual licensed, certified, or otherwise authorized by North Dakota law to provide health care services.[4] A "peer review organization" means a health care organization or a committee of a health care organization which:

- Is composed of health care providers, employees, administrators, consultants, agents, or members of the health care organization's governing body; and
- Conducts professional peer review.[5]

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[1] N.D. Cent. Code §§ 23-34-01 to 23-34-06.
[2] N.D. Cent. Code § 23-34-01(5).
[3] N.D. Cent. Code § 23-34-01(1).
[4] N.D. Cent. Code § 23-34-01(2).
[5] N.D. Cent. Code § 23-34-01(3).

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PEER REVIEW FAQs (FROM PAGE 1)

Having a formal peer review policy and procedure in place provides legal protections for peer review records. "Peer review records" means:

- Data, information, reports, documents, findings, compilations and summaries, testimony, and any other records generated by, acquired by, or given to a peer review organization as a part of any professional peer review, regardless of when the record was created; and
- Communications relating to a professional peer review, whether written or oral, between:
  - » Peer review organization members,
  - » Peer review organization members and the peer review organization's staff; or
  - » Peer review organization members and other individuals participating in a professional peer review, including the individual who is the subject of the professional peer review.[6]

The term does not include original patient source documents (such as a patient's medical records).[7]

Peer review records are confidential and may be used by a peer review organization and the organization members only for conducting a professional peer review.[8] Peer review records are privileged and are not subject to subpoena or discovery or introduction into evidence in any civil or administrative action, except:

- Records gathered from an original source that is not a peer review organization,
- Testimony from any person as to matters within that person's knowledge, provided the information was not obtained by the person as a result of the person's participation in a professional peer review; or
- Peer review records subpoenaed in an investigation conducted by an investigative panel of the North Dakota board of medicine or subpoenaed in a disciplinary action before board.[9]

Any peer review records provided to an investigative panel of the North Dakota board of medicine or introduced as evidence in any disciplinary action before the board are confidential and are not subject to subpoena, discovery, or admissibility into evidence in any civil or administrative action and are not public records.[10]

While most of us are familiar with peer review in the hospital setting, other health care organizations, including a physician practice or clinic, can conduct professional peer review under the law. But many practices don't take advantage of the legal protections under the peer review law. When practices are asked if they discuss cases regularly, have morbidity and mortality conferences, receive patient complaints, or have experience with a physician who may be impaired, often the answer is yes. But when asked whether a practice has a formal peer review process with policies in place to address these activities, often the answer is no.

Without the legal protections afforded by having these policies and procedures in place, conversations, emails, and text messages about a patient's care, a patient complaint, or a provider's professional conduct are *not* protected under the peer review privilege. They may need to be disclosed in a subsequent lawsuit involving a patient's care.

WHAT DOES PEER REVIEW INVOLVE?

To conduct peer review pursuant to federal and state law, a physician practice or clinic must adopt and adhere to written policies and procedures governing its peer review committee.[11] COPIC has developed a peer review checklist of what is required under North Dakota law as well as template peer review policies and procedures to assist practices in establishing their peer review programs. These template policies should be reviewed by an attorney who can add information specific to the practice.

The federal HCQIA law applies to both hospitals and group medical practices that provide health care services and follow a formal peer review process for the purpose of furthering quality health care.[12]

[6] N.D. Cent. Code § 23-34-01(4)(a).
[7] N.D. Cent. Code § 23-34-01(4)(b).
[8] N.D. Cent. Code § 23-34-02(1).
[9] N.D. Cent. Code § 23-34-03(1).
[10] N.D. Cent. Code § 23-34-03(2).
[11] 42 U.S.C. § 11112; 45 C.F.R.§ 60.3; N.D. Cent. Code § 23-34-01(5); N.D. Cent. Code § 23-34-06(2).
[12] 42 U.S.C. 11151(4).

PEER REVIEW FAQs (FROM PAGE 2)

Federal HCQIA grants immunity from damages liability with respect to actions taken by professional review bodies, to the review body, any member or staff to the body, contractors, and participants, provided they:

- Made a reasonable effort to obtain the facts of the matter.
- Took the action warranted by the facts.
- Took the action in furtherance of quality health care.
- Followed appropriate notice and hearing procedures that were fair to the physician involved.[13]

Any person who provides information to a professional review body is not liable in damages under any state or federal law, as long as that person does not knowingly provide false information.[14] North Dakota's peer review protections are very similar to HCQIA. Under North Dakota law, a person furnishing peer review records to a peer review organization with respect to any patient treated by a health care provider is not, by reason of furnishing the records, liable in damages to any person or for willful violation of a privileged communication.[15] A health care organization, health care provider, or member of a peer review organization is not liable in damages to any person for any action taken or recommendation made regarding a professional peer review, if the organization, provider, or member acts without malice and in the reasonable belief that the action or recommendation is warranted by the facts known to the organization, provider, or member of the peer review organization.[16]

Ideally, medical practices will address any issues through peer review *before* it reaches the stage where they determine that a physician is unsafe to practice. In North Dakota, a licensee subject to the jurisdiction of the North Dakota board of medicine (physician or PA) having actual knowledge that a licensee may have committed any of the grounds for disciplinary action by law or board rules is required to report that to the medical board.[17] A physician who obtains information in the course of a professional peer review, however, is not required to report pursuant to this section.[18] Grounds for disciplinary action include:

- The use of alcohol or drugs to such a degree as to interfere with the licensee's ability to safely practice medicine.
- A physical or mental disability materially affecting the ability to perform the duties of a physician in a competent manner.
- A continued pattern of inappropriate care as a physician.
- The lack of appropriate documentation in medical records for diagnosis, testing, and treatment of patients.[19]

Peer review allows a more full and fair assessment of a provider, and an opportunity for them to address any educational deficiencies or behavioral health issues so they can practice safely and don't need to be reported to the medical board.

While it is very unlikely that a provider's care will rise to the level of reporting an adverse professional review action to the medical board, a practice's policy needs to address the due process requirements under federal HCQIA and North Dakota's peer review law.[20] This allows for a fair hearing for the provider if a peer review committee recommends that the practice's governing board take an adverse professional review action.

The practice will need to identify what peer review activities fall within the policy. Some examples include the review of:

- ✓ patient safety incidents, including near-misses
- ✓ unscheduled patient returns
- ✓ patient complaints
- ✓ cases identified through screening by quality indicators
- ✓ reported unprofessional conduct
- ✓ concerns regarding a possible impaired provider

[13] 42 U.S.C. § 11112(a).
[14] 42 U.S.C. § 11111(a)(2).
[15] N.D. Cent. Code § 23-34-06(1).
[16] N.D. Cent. Code § 23-34-06(2).
[17] N.D. Cent. Code § 43-17-01(2); N.D. Cent. Code § 43-17.1-05.1(1).
[18] N.D. Cent. Code § 43-17.1-05.1(4).
[19] N.D. Cent. Code § 43-17-31(1).
[20] 42 USC § 11111(a)(1); 42 USC § 11112(a); N.D. Cent. Code § 23-34-06(2).

Implementing Peer Review at Your Medical Practice

Practices that have successfully utilized peer review and had positive experiences share common themes. Foremost, these practices have developed a culture of understanding that the purpose of peer review is not to hinder or punish practitioners. Instead, they believe it allows them to continually improve the quality of care, treatment, and services provided as well as protect the safety of the patients they treat and ensure the best possible outcomes.

When implementing peer review, it can be important to dispel a common misunderstanding among physicians that all reviews of a physician will be reported to the medical board.

The reality is that they are reported only if:

The findings of an investigation indicate that a physician lacks competence or has exhibited inappropriate professional conduct

AND

The professional review committee recommends an action to adversely affect the person's membership or privileges with the practice

AND

After a fair hearing process, the governing board takes a *final professional review action* that adversely affects the clinical privileges of the physician for more than 30 days or accepts the surrender or any restriction of clinical privileges while the physician is under investigation or in return for not conducting such an investigation or proceeding.[21]

Recommendations for additional education or treatment for behavioral health issues where there is no final adverse action would not need to be reported. Knowing this enhances the participation of clinicians. An example of how peer review facilitated a practice's improving its patient safety follows:

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[21] 42 U.S.C. § 11133(a).

IMPLEMENTING PEER REVIEW (FROM PAGE 4)

CASE STUDY

A middle-aged patient complaining of persistent hacking cough a week after recovering from influenza was worked into a busy clinician's schedule during the afternoon. The patient was evaluated and treated with a codeine cough suppressant and told to return if symptoms worsened. Just five hours later, the patient felt much worse and went to the emergency department and was diagnosed with bi-lobar pneumonia and admitted to the ICU due to hypoxia, hypotension, and presumed sepsis.

The peer review committee at the clinic reviewed the medical care and noted that vital signs had not been performed at the time of the clinic visit. Although there is no way to know definitively whether the vital signs would have been abnormal, they presumably would have been and could have provided a clue that the patient was more severely ill than he appeared. The peer committee investigated further and learned that vital signs had not been performed on nearly half of acute visits not just for this doctor, but clinic-wide. They discovered a workflow challenge for acute visits that made it difficult for medical assistants to check vital signs and this system failure was subsequently corrected. Now, nearly 100% of acute visits to the clinic have vital signs checked, which almost certainly has improved patient safety and outcomes.

In this case, and in many other examples, peer review protections have helped physician practices and clinics, with physicians' buy-in and assistance, identify and address problems to prevent adverse patient outcomes. The medical literature is rich with examples where proactive peer review, such as in the case above, and a culture of patient safety has resulted in a reduction in medical liability claims.

Many practices have found that the protections under peer review promote a culture of patient safety and continuous improvement, and when the practices work to educate their practitioners about how and why the peer review process works, they can help facilitate use of this valuable tool.

Peer Review Resources

COPIC promotes professional/peer review as a way to improve medicine in our communities. This process can be used as a tool for improving patient safety as case reviews can provide learning opportunities regarding preventable harm for patients going forward.

In order for physician practices and clinics to use peer review, COPIC's Legal Department has developed state-specific peer review toolkits that contain:

- **Peer Review Checklist** of what's required (consistent with state and federal peer review laws)
- **Confidentiality Agreement—Peer Review Participant**
- **Peer Review Policy** and **Fair Hearing/Corrective Action Policy** a practice can tailor to meet its needs.
- **Practitioner Behavior Policy**
- **Practitioner Health Polilcy**

Access COPIC's peer review resources on our website at **www.callcopic.com/peerreview**

Please note: COPIC has developed templates to assist practices in establishing a formal Peer Review process through appropriate policies and procedures. These templates are consistent with the requirements for Peer Review under state and federal law but should be reviewed by an attorney who can add information specific to the practice.