

# Maintaining Quality and Preserving Privilege for Telemedicine and Other Outsourced Providers

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The past decade has seen a dramatic increase in hospital outsourcing of physician services to external companies that supply and manage physician practices in specialties ranging from radiology, laboratory, and emergency medicine, to hospitalists and intensivists, to telemedicine providers crossing the entire spectrum of primary care and specialty services. The industry has seen explosive growth in the area of telemedicine—with various studies projecting the global market to reach between \$93.45 billion<sup>1</sup> and \$130 billion by 2025.<sup>2</sup> The growth in direct and telemedicine services has attracted substantial private equity investment, also helping to drive the growth of externally managed physician services.<sup>3</sup> And, according to a recent survey, the drive to deliver value-based care is pushing 90% of hospitals to consider outsourcing clinical services both as to hospital-based direct patient care and through telemedicine.<sup>4</sup>

Telehealth<sup>5</sup> and other nationally managed physician contractors typically specialize in providing a specific service and, through economies of scale and a singular focus, position themselves to manage services more efficiently and with comparable or higher quality than if the services were provided by an independent private practice. Furthermore, in rural and other underserved areas, telemedicine is often the only way that hospitals can provide patients with timely access to certain kinds of services.

Effective professional oversight of care provided by telehealth and other contract providers is a key component of the service—and often one of the selling points for the national outsourcing companies. Centralizing processes for credentialing, quality, and peer review arguably allows telehealth and other national providers to impose rigorous quality controls and achieve standardization of services that enables them to compete on metrics of quality and efficiency, and to reduce their own liability costs.

Hospitals also have an important stake in ensuring the effectiveness of a contract provider's credentialing and peer review processes. A hospital that outsources responsibility for its physician services still retains accountability for the quality of care pursuant to the Centers for Medicare & Medicaid Services (CMS) Conditions of Participation and Joint Commission accreditation requirements, and faces malpractice and negligent credentialing liability exposures if the quality of service falls below the standard of care. Furthermore, to the extent that hospitals rely on proxy credentialing of a distant site telehealth entity, the hospital is required to conduct internal review of the practitioner and to send performance information to the distant-site entity for use in its periodic review of the practitioner.<sup>6</sup>

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The use of telemedicine and other contract providers, however, creates challenges in terms of preserving privilege protection for the professional oversight function, particularly given restrictive judicial decisions such as a recent Pennsylvania Supreme Court decision denying privilege protection to a hospital and its contracted emergency medicine provider. This article discusses the current legal environment that presents obstacles to full privilege protection, and outlines and compares a range of practical solutions based on state law peer review privilege and the federal Patient Safety Quality Improvement Act (PSQIA).<sup>7</sup>

### The Limitations of Traditional State-Based Peer Review Protections

The privilege for peer review information is largely a creature of state law.<sup>8</sup> Currently, all 50 states and the District of Columbia have enacted peer review privilege statutes that protect against the discoverability and use of peer review information in litigation, primarily in medical malpractice litigation. State peer review privilege statutes typically protect the records of peer review proceedings, including statements made during committee meetings and other proceedings, and documents generated during such proceedings, although the specific provisions vary from state to state.<sup>9</sup> The statutes generally provide that peer review records remain confidential in subsequent litigation and cannot be used as evidence or sought through discovery in lawsuits involving malpractice and negligent credentialing claims.<sup>10</sup> Many peer review statutes contain provisions authorizing peer review committees to share peer review information with other entities involved in quality review, such as state agencies, accreditation organizations, and peer review committees of other provider entities, without waiving the privilege.<sup>11</sup> The confidentiality afforded by the peer review privilege enables physicians to speak candidly and to participate in a process designed to improve quality of care without fear that their words may expose them to liability in a future lawsuit.<sup>12</sup>

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State peer review privilege protection is limited in a number of ways. Many state peer review statutes extend the privilege only to a specific set of enumerated providers—such as hospitals, professional societies, or other licensed facilities.<sup>13</sup> This approach limits the ability of physician practices, physician networks, Accountable Care Organizations, telehealth, and other provider entities that are equally motivated to engage in robust quality and peer review, but that are not themselves health care facilities. Restrictive judicial opinions, such as a recent Pennsylvania Supreme Court decision, *Reginelli v. Boggs*,<sup>14</sup> have exacerbated this inflexibility in state peer review privilege frameworks. In *Reginelli*, the court held that a physician practice group functioning as a hospital’s contracted emergency services provider did not qualify for peer review protection for its own internal peer review activities. The court determined that under the Pennsylvania Peer Review Protection Act<sup>15</sup> (PRPA), an entity must be “approved, licensed, or otherwise regulated to operate in the healthcare field” to qualify for the privilege. Because the contracted physician group itself was not licensed, even though the physicians were licensed providers, its peer review activities did not fall within the protection provided by the PRPA.<sup>16</sup>

In addition, since peer review privileges are created by state law, they are circumscribed by the states that have created them, making it difficult for a national provider entity to gain full protection. Many states define peer review activity as one that is engaged in by providers licensed to practice *in that state*.<sup>17</sup> Thus, it is unclear what privilege, if any, would be afforded to physicians licensed in other states that participate in

the peer review process. This creates uncertainty for telehealth companies and other national contractors who wish to maintain centralized peer review committees composed of providers licensed in many different states.

Furthermore, state peer review privilege laws are often not recognized as binding on federal courts, particularly in cases arising under federal laws as opposed to state contract or negligence laws.<sup>18</sup> Providers cannot always predict what forum they will be sued in, and what causes of action they may be required to defend. Creative plaintiff’s attorneys may be motivated to add federal claims to a state-based lawsuit to achieve federal jurisdiction and thereby avoid application of the state law privilege.

Finally, the scope of the peer review privilege varies from state to state. This kind of variability causes challenges in creating a peer review framework on a national scale and undermines contracting entities from being able to deliver the efficiencies of scale that is at the core of their business model.

All of these issues can prove particularly challenging for telehealth and other contracted provider entities that, unlike national providers that contract with hospitals to operate hospital-based departments, typically do not have a continuous presence with any particular hospital and often do not have a local office practice of any kind. A telehealth practice can be entirely “virtual,” with medical leaders who hold many different state law licenses and who participate from all over the country. In that setting, invocation of state law peer review protections is even more of a challenge.

## Designing Peer Review to Maximize State-Based Privilege Protection

Telehealth and other contract providers must understand the regulatory framework applicable in any state in which they provide services. Some states simply will not provide peer review protection to managed physician practices. In such states, telemedicine and contract providers should be prepared for the likelihood that much of the peer review information they generate in the course of their quality oversight activities may be discovered and used against them in malpractice cases and other court proceedings. There are steps that can be taken, however, to strengthen the claim of privilege.

### *Invoking Hospital Privilege Protection*

Physician groups that provide services under contract with hospitals can work with their hospital partners to attempt to bring peer review activities within the hospital’s privilege protection. Hospitals are mandated by licensure laws, CMS regulations, and accreditation standards to conduct ongoing peer and quality oversight of all practitioners, and generally the state law privilege protection will extend to all such activities. The rules and procedures governing such activities are set forth in the Hospital’s Medical Staff bylaws, rules and regulations, and sometimes in Medical Staff peer review policies and procedures.

When a hospital outsources the peer review function through an exclusive contract, it is important to make sure that the peer review activities performed by the outside contractor are fully aligned with applicable state privilege law as well as the procedures and standards that exist under the hospital’s

own bylaws and procedures. That means the external contractor's peer review activities should be authorized by a relevant hospital committee, and a reporting mechanism exists for demonstrating that the external contractor is engaged in carrying out the hospital's mandated peer review functions under delegated authority from the hospital.

The consequence of not doing this can be loss of privilege protection. In the *Reginelli* case, the court held that the peer review activities of the hospital's contracted emergency medicine provider did not qualify for the privilege under the PRPA.<sup>19</sup> In its analysis, the court rejected the hospital's argument that the peer review privilege attached to the peer review activities of the contractor's medical director, who was essentially fulfilling the function of a department chair in conducting ongoing quality assurance relative to physicians in the emergency medicine department.<sup>20</sup> The court pointed out that the record contained no evidence that the medical director was a member of the hospital's peer review committee or that she was engaged in peer review on behalf of the hospital.<sup>21</sup> To the contrary, the contracted provider in that case argued that it was conducting peer review on its own behalf and not as hospital peer review.<sup>22</sup> Thus, because the hospital's and the contractor's peer review activities were not clearly aligned, no privilege protection was available.

Hospitals and contracting providers can better position themselves to argue that the privilege should apply to the contractor's peer review activities by ensuring that those activities are integrated and aligned in a fully transparent way with the hospital's mandated peer review functions.

Telemedicine and contract providers should also carefully review the applicable state peer review statute and take the same precautions as any other provider seeking to benefit from the privilege.

### Invoking the Privilege Protection of the Licensed Practice

In states where the peer review laws clearly do extend privilege protection to physician practices, practice management companies that are seeking to conduct peer review at a national level can create a system in which a national team works in coordination with peer review committees that are created at the local practice level.

To the extent permitted by applicable state law, each local practice can adopt a peer review policy and establish its own peer review committee under the direction of a local chair and reporting to the local practice's governing body. Each of the local committees can then authorize the formation of a national peer review committee that has representation from all the local committees and provides peer review evaluation, recommendations, and advice to the local practice committees. The relationship between the national committee and the local committees will vary, depending partly on state law and partly on the culture and objectives of the national team. In some instances, the information reviewed by the national committee may be completely de-identified as to the involved providers and reviewed only in aggregate form, to foster the development of best practices and protocols. In other instances, the national committee may provide one-on-one evaluation and recommendations to a local peer review committee on a completely confidential basis, in a peer review consultant capacity. In yet other instances, the local committees and national committee may want to develop a peer review sharing agreement that will authorize the sharing of fully identifiable information (as to providers) between and among the local and national peer review committees to enhance the quality improvement objectives of the entire national enterprise.

Careful attention to the specific state law requirements for all the jurisdictions in which the practices are located is an important component in setting up the framework. For instance, if a contractor with nationwide operations wants to have a centralized peer review committee actively involved in support of local practice peer review, it should analyze whether information can be shared between local practice peer review committees and the centralized committee under the state statutes applicable in each state of operation. If so, a resolution of the group practice can authorize the group's peer review committee to share peer review information with the centralized committee and specify the policy and procedures applicable to the centralized committee's peer review activities.

Telemedicine and contract providers should also carefully review the applicable state peer review statute and take the same precautions as any other provider seeking to benefit from the privilege. Peer review records should be segregated by the committee possessing them and marked and treated as privileged. Providers should ensure that peer review committees document requests for information from external sources as information requested by the peer review committee for purposes of peer review, to ensure that such documents fall within the privilege. Peer review records should be treated as privileged during discovery and in litigation and should not be used. In responding to discovery, parties should object to producing protected information on the basis of the privilege, where applicable, and identify privileged documents on the privilege log. The details will be dictated by the specific statutory privilege and interpretive case law applicable in the state, and providers should consult with counsel to make sure they are taking all necessary precautions.

## Using Federal PSO Privilege Protection for Peer Review

The alternative to the patchwork of state peer review privilege protections is to invoke the federal privilege protections of the PSQIA, which provides powerful privilege protection for “patient safety work product” (PSWP) defined to include the analysis and deliberations that occur within a “patient safety evaluation system” (PSES) of either (1) a “patient safety organization” (PSO) that has been federally certified and listed by the Agency for Healthcare Research and Quality (AHRQ) or (2) a provider that participates in a patient safety reporting system with a PSO. Unlike the state law peer review protections, the federal privilege that attaches to PSWP preempts state law, crosses state lines, extends to all types of licensed health care providers, and its privilege protections are subject to extremely limited exceptions. The PSQIA “announces a more general approval of the medical peer review process and more sweeping evidentiary protections for materials used therein” than has ever existed under state law.<sup>23</sup>

To invoke the federal PSQIA privilege protections for peer review activities, a health care provider enters into a contractual relationship with a PSO to collect and report PSWP that will facilitate analysis designed to improve the quality and safety of clinical care. Once a PSO contract is entered into, both the PSO and the provider are expected to create their own PSEs, within which each will conduct deliberations and analysis to improve the quality and safety of medical care—either for the specific provider or for the benefit of the industry at large (or both).

National provider entities such as telehealth and other contract providers can use the PSQIA framework to create strong privilege protections for their own patient safety activities—including the collection and analysis of clinical data for purposes of improving the quality and safety of care delivered by their providers. Some national providers opt to contract with one of the existing AHRQ-listed PSOs to create a system for collecting, reporting, and analyzing patient safety data in a manner that enables the participating providers to gain privilege protection for their own peer review deliberations and analysis. Other national providers have opted to create their own “Component PSOs” that are distinct organizational units of the parent organization working directly with each of the health care provider units to collect and analyze patient safety under the PSO privilege.<sup>24</sup>

In each case, the PSO privilege protection for provider “deliberations and analysis” within its “patient safety evaluation system” provides the safe and protected space in which peer review deliberations and analysis can occur.<sup>25</sup> Moreover, the privileged PSWP can be shared with other affiliated providers in the system, both directly or under the sponsorship of the PSO, such that PSWP can be aggregated and analyzed to improve the quality and safety of practices generally throughout the national entity. PSWP also can be shared with hospitals with whom the telehealth and other providers are contracted, so long as those hospitals also enter into participation agreements with the same PSO and agree to the confidentiality restrictions surrounding the disclosure and use provisions

that are designed to ensure that the PSWP is used only for the purpose of improving the quality and safety of patient care, and not for other purposes.

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## Conclusion

National contract providers such as telehealth entities and providers of hospital-based services face significant hurdles in achieving robust privilege protection for their peer review, quality, and safety oversight. For a host of reasons, they do not fit the traditional model for which state peer review privileges were designed: they operate across state lines, in a wide range of provider settings, and have neither the corporate nor the governance structure of an institutional provider with a medical staff.

Notwithstanding these challenges, contract providers can find creative ways of accessing both state law peer review privilege protections and the federal PSQIA protections by setting up their peer review/quality oversight systems within a framework that has been designed to support the claim of privilege in specific terms. Which path providers will take to achieve the privilege protection depends on a variety of factors, including the nature and scope of the professional services provided, the particular state laws applicable to those services, the nature and scope of the peer review/quality oversight to be conducted and the technology platform that supports those activities, the specific nature of the peer review information and/or PSWP that would be generated and how it would be used, and the parties with whom that information would be shared, both within the organization and external to the organization. Careful consideration of these factors is important to formulating a workable strategy for effective privilege protection. **C**



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## Endnotes

- 1 *Global Telemedicine Market 2018 to Surpass \$93.45 Billion Value by 2026 in Health-care IT Industry at a CAGR of \$17.7%*, REUTERS, Aug. 16, 2018, <https://www.reuters.com/brandfeatures/venture-capital/article?id=47241>.
- 2 Alex Kacik, *Global Telemedicine Market to Eclipse \$130 Billion by 2025*, MODERN HEALTHCARE, July 16, 2019, <https://www.modernhealthcare.com/care-delivery/global-telemedicine-market-eclipse-130b-2025>.
- 3 See Samantha Liss, *Private Equity Sees Ripe Opportunity in Healthcare This Year*, HEALTHCARE DIVE, Mar. 25, 2019, <https://www.healthcaredive.com/news/private-equity-sees-ripe-opportunity-in-healthcare-this-year/548831/>; Joanne Finnegan, *Private Equity Companies' Acquisition of Physician Practices Likely to Accelerate*, FIERCE HEALTHCARE, Jan. 10, 2019, <https://www.fiercehealthcare.com/practices/private-equity-companies-acquisition-physician-practices-likely-to-accelerate>.
- 4 Jeff Lagasse, *Hospital Costs Should be Cut 24 Percent by 2022 to Break Even, Outsourcing May Help, Survey Says*, HEALTHCARE FINANCE, May 8, 2018, <https://www.healthcarefinancenews.com/news/hospital-costs-should-be-cut-24-percent-2022-break-even-outsourcing-may-help-survey-says>.

- 5 This article uses the terms "telemedicine" and "telehealth" broadly and generically to refer to the provision of health care services remotely through some form of electronic communication device, as opposed to providing direct, in-person care.
- 6 42 C.F.R. § 482.22(a)(4)(iv).
- 7 42 U.S.C. § 299b-12-299b-26.
- 8 While the federal Health Care Quality Improvement Act, 42 U.S.C. § 11101 et seq. (HCQIA), enacted in 1986, provides important immunity protections for hospitals that take adverse privileging actions against physicians based on incompetent or unprofessional conduct, it does not provide privilege protection for the records created during the course of such peer review proceedings.
- 9 See, e.g., 63 PA. STAT. § 425.4 (providing that the proceedings and records of a review committee shall be confidential and shall not be subject to discovery or introduction into evidence in any civil action against a professional health care provider arising out of matters that are the subject of evaluation and review by such committee).
- 10 *Id.*
- 11 See e.g., OHIO REV. CODE § 2305.252(A) (health care entities can share 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).
- 12 See, e.g., *Brem v. DeCarlo, Lyon, Hearn & Pazourek, P.A.*, 162 F.R.D. 94, 97 (D. Md. 1995) (the Maryland legislature enacted its peer review statute to combat the reluctance of physicians to participate in the process).
- 13 See, e.g., S.C. CODE ANN. § 40-71-10, § 40-71-20; § 44-7-392 (peer review statutes only applicable to committees of a state or local professional society or to licensed hospitals).
- 14 181 A.3d 293 (Pa. 2018).
- 15 63 PA. STAT. § 425.1-425.4.
- 16 The court also held that the peer review activities of the contractor *performed on behalf of the hospital* did not qualify for the privilege under the PRPA. See further discussion, *infra*.
- 17 See e.g., ALA. CODE § 6-5-333 (requiring a peer review committee to be composed of physicians licensed to practice in Alabama); ARK. CODE ANN. § 20-9-501 (for the privilege to attach, the members of the peer review committee must be licensed to practice in Arkansas).
- 18 See, e.g., *Johnson v. Nyack Hosp.*, 169 F.R.D. 550, 560 (S.D.N.Y. 1996) (declining to adopt a federal peer review privilege in a case involving a race discrimination claim); *Robertson v. Neuromedical Ctr.*, 169 F.R.D. 80, 83-84 (M.D. La. 1996) (declining to adopt a federal peer review privilege in case involving an Americans with Disability Act claim).
- 19 *Reginelli*, 181 A.3d at 304.
- 20 *Id.* at 304-305.
- 21 *Id.* at 304.
- 22 *Id.*
- 23 *KD v. United States*, 715 F. Supp. 2d 587, 594 (D. Del. 2010).
- 24 A "Component PSO" is defined in the regulations as a PSO that (i) is a unit or division of a legal entity (including a corporation, partnership, or a Federal, State, local or Tribal agency or organization) or (ii) is owned, managed, or controlled by one or more legally separate parent organizations. 42 CFR § 3.20 (Definitions – Component Organization and Component PSO). There are specific regulatory requirements pertaining to separation, nondisclosure and avoidance of conflict of interest that Component PSOs must adhere to. 42 CFR § 3.102(c)(2).
- 25 The PSQIA privilege protection attaches to PSWP, which is defined to include any data, reports, records, memoranda, analyses (such as root cause analyses) or written or oral statements that (1) could result in improved patient safety, health care quality, or health care outcomes and (a) are assembled or developed by a provider for reporting to a PSO and are reported to a PSO, or (b) are developed by a PSO for the conduct of patient safety activities, or (2) identify the deliberations and analysis of, or identify the fact of reporting pursuant to, a patient safety evaluation system. 42 U.S.C. § 299b-21(7).