

# CREDENTIALING CHALLENGES



**Idaho Ass'n of  
Medical Staff Services**

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# Preliminaries

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# Overview

## NEW IDAHO LAWS

- Streamlined Facilities Licensing and Inspection Act
- Medical Ethics Defense Act (Conscience Law)

## CREDENTIALING CHALLENGES

- Aging providers
- Impaired providers
- Non-physician practitioners
- Employees and contractors
- Competitors
- Exclusive contracts
- Closed staffs



# Please speak up and share!



Whatever is  
shared is  
hypothetical,  
of course...



# Streamlined Facilities Licensing and Inspection Act

**IDAPA 16 – IDAHO DEPARTMENT OF HEALTH AND WELFARE**  
**Division of Licensing and Certification – Bureau of Facility Standards**  
**16.03.14 – Hospitals**

**Who does this rule apply to?**

Medical professionals such as anesthesiologists, anesthesiologists, physicians, nurse practitioners, therapists, therapist assistants, technicians, pharmacists, physiatrists, physician's assistants, podiatrists, psychiatrists, radiologic directors and technologists, radiologist, radiotherapists, technicians, registered nurses, social workers, speech pathologists, audiologists, CEOs, administrators, dietitians, nurses, licensed independent practitioners, LPs, medical records practitioner, medical staff members, patients, and families, guardians, and advocates of these patients.

**What is the purpose of this rule?**

The purpose of the rule is to provide for the development, establishment and enforcement of standards for the care and treatment of individuals in hospitals and for the construction, maintenance and operation of hospitals that, in the light of advancing knowledge, will promote safe and adequate treatment of such individuals in hospitals.

**What is the legal authority for the agency to promulgate this rule?**

This rule implements the following statute passed by the Idaho Legislature:

Health and Safety -

Hospital Licenses and Inspections:

- Section 39-1307, Idaho Code – Rules, Regulations, and Enforcement

**Where can I find information on Administrative Appeals?**

Administrative appeals and contested cases are governed by the provisions of IDAPA 16.05.03, "Contested Case Proceedings and Declaratory Rulings."

**How do I request public records?**

Unless exempted, all public records are subject to disclosure by the Department that will comply with Title 74, Chapter 1, Idaho Code, upon requests. Confidential information may be restricted by state or federal law, federal regulation, and IDAPA 16.05.03, "Use and Disclosure of Department Records." The Department will post on the Division of Licensing and Certification's website, survey reports and findings of complaint investigations relating to a facility.

**Who do I contact for more information on this rule?**

Idaho Department of Health and Welfare – Bureau of Facility Standards – Accredited and Continuing Care Programs

450 W. State Street, 6th Floor  
Boise, ID 83702

P.O. Box 83720

Boise, ID 83720-0009

Bureau Phone: (208) 334-6226, option #4

Division of Licensing and Certification: (208) 364-1959

Fax: (208) 364-1888

Email: [fsb@dhw.idaho.gov](mailto:fsb@dhw.idaho.gov)

Webpages: <https://healthandwelfare.idaho.gov/Providers/ProvidersFacilities/StateFederalPrograms/NonLongTermCare/tabid/427/Default.aspx> and <https://facilitystandards.idaho.gov/IAC Archive 2024>

Zero-Based Regulation Review – 2024 for Rulemaking and 2025 Legislative Review

- Idaho hospital regulations are withdrawn, IDAPA 16.03.14, including—
  - .200 re governing body and bylaws
  - .250 re medical staff
- Hospitals must still comply with:
  - Medicare COPs
    - Hospitals: 42 CFR part 482
    - CAHs: 42 CFR 485.601 et seq.
  - Idaho Code 39-1301 et seq. (IC 39-1303 and -1305)
  - Accreditation standards.

# Idaho Credentialing Standards



*Miller v. St. Alphonus Reg. Med. Ctr.*, 139 Idaho 825 (2004)

- *Facts:* St. Als denied medical staff privileges due to physician's alleged history of disruptive behavior.
- *Held:* Court upheld St. Als' decision.
  - Medical staff bylaws do not constitute a contract.
  - IC 39-1395 requires that hospital must give the physician due process and ~~IDAPA 16.03.14.200 establishes standards for process, including formal appeal and hearing process.~~
  - Hospital must follow standards in regulations and med staff bylaws.
  - Hospital gave the process due in statute, statutes, regulations and bylaws.

Now that those regulations have been withdrawn, what are the standards that apply to credentialing process, including hearing?

# Idaho Credentialing Standards

- “Except as otherwise provided in this section, no provision or provisions of this section shall in any way change or modify the authority or power of the governing body of any hospital to make such rules, standards or qualifications for medical staff membership as they, in their discretion, may deem necessary or advisable, or to grant or refuse membership on a medical staff.”
- **“The process for considering applications for medical staff membership and privileges shall afford each applicant due process.”**

(IC 39-1395; *see also* IC 39-1392g)

- “A hospital or facility shall specify in its bylaws the process by which its governing body and medical staff oversee those practitioners granted admitting privileges. Such oversight shall include, but is not limited to, credentialing and competency review.”

(IC 39-1396)

# Idaho Credentialing Standards

- Must still comply with COPs
  - Hospitals: 42 CFR 482.12 and 482.22
  - CAHs: 42 CFR 485.627 and 465.631
  - *But these are not specific concerning standards or procedures.*
- Must comply with HCQIA due process standards if want HCQIA immunity. (42 USC 11112)
  - But HCQIA is not mandatory.
- Must comply with accreditation standards if seek accreditation.
- ✓ *May want to review medical staff bylaws and processes to determine they are still appropriate and not overly burdensome.*

# Provider Conscience Rights



# Medical Ethics Defense Act: Rendering Care

- Health care providers shall not be required to participate in a medical procedure, treatment, or service that violates such health care provider's conscience.

(IC 54-1304(1))

- “Health care provider” = any person, institution or payer who is authorized to participate in any way in any medical procedure, treatment, or service, *e.g.*, doctors, nurses, aides, APPs, MAs, techs, social workers, employees of hospital, clinic, nursing home or pharmacy, *etc.*
- “Conscience” = means the ethical, moral, or religious beliefs or principles held by any health care provider.

(IC 54-1303)

# Medical Ethics Defense Act: Discrimination

- No health care provider shall be discriminated against in any manner as a result of exercising the right of conscience.

(IC 54-1304(6))

- "Discriminate" = any adverse action taken against, or any threat of adverse action communicated to, any health care provider as a result of exercising conscience rights, including but not limited to any penalty or disciplinary or retaliatory action, whether executed or threatened.

(IC 54-1303)

- ✓ *May apply to credentialing or corrective action against a health care provider?*

# Medical Ethics Defense Act: Whistleblowers

- No health care provider shall be discriminated against in any manner because the health care provider:
  - Alleges or discloses a violation of the Act to the provider’s employer, the Attorney General, a state agency, OCR, or other federal agency charged with protecting the right of conscience;
  - Testifies or assists in a proceeding concerning a violation of the Act;
  - **Discloses information the provider reasonably believes evidences:**
    - **A violation of any law, rule, or regulation;**
    - **A violation of any ethical guidelines for care; or**
    - **Gross mismanagement, abuse of authority, practices that may put patients at risk, or endangers public health or safety.**

**Broader than  
“conscience”  
objections**

(IC 54-1305)

# Medical Ethics Defense Act: Cause of Action

- Provider may sue for a violation of the Act and recover:
  - Injunctive relief (e.g., reinstatement, board certification, licensure, etc.);
  - Actual damages for injuries suffered; and
  - Reasonable costs and attorneys' fees.
- Damages are cumulative and not limited by other remedies available under state, municipal or federal law.

(IC 54-1307)

- ✓ *Beware possible application in credentialing or corrective actions.*
- ✓ *Beware potential whistleblower claims in addition to conscience claims.*

# Medical Ethics Defense Act: Free Speech

- DHW, Board of Medicine, and other department or board regulating the practice of medical care cannot take action against a provider for engaging in speech, expression or association that is protected by the First Amendment.

(IC 54-1306)

*Does this prevent public hospitals (e.g., county or district hospitals) from taking action against a provider for engaging in speech protected by the First Amendment?*

# Medical Ethics Defense Act: Exceptions

- EMTALA
- Protections under the Act don't apply if
  - an employee is unable to perform any essential function,
  - the employer cannot transfer the employee to a suitable alternative position for which the employee is qualified, and
  - the employer is otherwise unable to reasonably accommodate the employee without imposing an undue hardship on the employer.

(IC 54-1304(11)-(12))

Sounds like  
ADA or Rehab  
Act language.  
See later  
discussion

# Medical Ethics Defense Act: Disclosure to Employer

- A health care professional shall communicate to the health care professional's employer a conscience-based objection when it occurs or as soon as reasonably possible to allow an employer to make necessary staffing adjustments without delaying the provision of health care services.
- Employers may require an employee to disclose the employee's conscience-based objections at the time of hiring, but such disclosure shall not limit the rights protected by this chapter.
- Employer may require employee to provide conscience-based objections in writing.

(IC 54-1304(3)-(4))

- ✓ *Potentially applicable in credentialing matters?*
- ✓ *Should you ask this as part of credentialing process?*

# Medical Ethics Defense Act: Immunity

- No health care provider shall be civilly, criminally, or administratively liable for exercising the right of conscience.
- No health care institution shall be civilly, criminally, or administratively liable for exercising the right of conscience by a health care professional employed, contracted, or granted admitting privileges by the health care institution.

(IC 54-1304(3))

# Other Conscience Objections: Idaho

- A provider who for ethical or professional reasons is unwilling to conform to the desires of the patient or the patient's surrogate decision-maker may withdraw from rendering care if:
  - They first make a good faith effort to assist the patient in obtaining the services of another provider who is willing to provide the care requested by the patient; and
  - Must still provide life-sustaining or comfort care if requested by patient or patient's surrogate unless it would be nonbeneficial care.

(IC 39-4513(2) and -4514(3))

- Abortions (IC 18-611(2), -612).
- POSTs (IC 18-611(6))

# Other Conscience Objections: Federal



U.S. DEPARTMENT OF  
**HEALTH AND HUMAN SERVICES**

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## Conscience and Religious Freedom

[Conscience and Religious  
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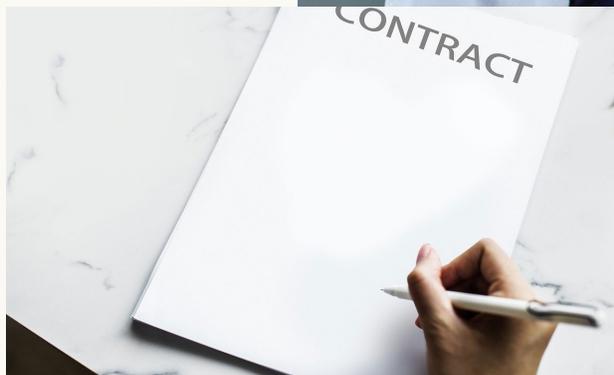
[Office for Civil Rights Speaker  
Request](#)

## Your Protections Against Discrimination Based on Conscience and Religion

- Remember other federal conscience objections, e.g.,
- 45 CFR part 88
  - Affordable Care Act § 1553
  - Church Amendments (abortion and sterilization)
  - Coates-Snowe Amendment (abortion training)
  - Others

Hart

# Employees and Contractors



# Employee v. Contractor

Some significant ramifications

- Federal and state wage claims
- ADA, ADEA, Title VII
- IRS tax liability
- Workers compensation
- Liability for person's misconduct
- Stark, Anti-Kickback and EKRA
- HIPAA obligations
- Other?

*Ensure providers are properly classified as employees v. contractors*

- *State common law standards*
- *DOL standards*
- *IRS standards*
- *Other?*

# Employee v. Contractor

*For example:*

## **“When Health Care Workers are ‘Employees’ Under the ADA**

While the ADA’s protections apply to applicants and employees, the statute does not cover independent contractors. Many workers in the health care industry are referred to as independent contractors.... However, whether a particular health care worker is an ‘employee’ covered by the ADA is a fact-based and case-specific determination that depends on a variety of factors. The mere fact that an individual is designated as an ‘independent contractor’ ... is not dispositive, nor is the existence of a document styled as an ‘employment agreement.’” (<https://www.eeoc.gov/laws/guidance/health-care-workers-and-americans-disabilities-act>)

# Are You An Employee Or An Independent Contractor?



## Indicators of an Employee

- Working for someone else's business
- Generally, can only earn more by working additional hours
- Typically uses the employer's materials, tools and equipment
- Typically works for one employer or may be prohibited from working for others
- Continuing or indefinite relationship with the employer
- Employer decides how and when the work will be performed
- Employer assigns the work to be performed

-OR-

## Indicators of an Independent Contractor

- In business for themselves
- Can increase profit through business decisions
- Typically provides their own materials, tools and equipment and uses them to extend market reach
- Often works with multiple clients
- Temporary relationship until project completed
- Decides how and when they will perform the work
- Decides what work or projects they will take on



*These are general concepts. All relevant facts about the work relationship should be considered as a whole, and the existence or absence of any particular fact does not require a particular outcome.*

# Employee/Contractor v. Med Staff Membership / Privileges

## MEDICAL STAFF MEMBERSHIP / PRIVILEGES

- **Privileges** = permission to render specified services at the hospital.
- **Medical Staff Membership** = organization of providers with privileges at the facility.
  - Responsible to help hospital in providing quality care and overseeing conduct of members.
  - Right to vote and participate in certain decisions concerning the medical staff and/or hospital.
- Med staff bylaws and policies establish conditions.
- Granted or denied by hospital board.
- Managed by medical staff leadership.

## CONTRACT

- Hospital may contract with providers to render services for hospital.
  - Employee
  - Independent contractor
- If rendering clinical services, must also have clinical privileges.
- Contract establishes terms and conditions.
- Usually executed and managed by hospital administration.

# Corrective Action: Contract v. Med Staff Action

## ACTION ON CONTRACT FOR EMPLOYEES/CONTRACTORS

- **Pros**
  - More efficient.
  - Admin is skilled at handling.
- **Cons**
  - No HCQIA immunity.
  - Maybe no peer review immunity.
  - Med staff may want to be involved.
  - Depends on contract terms.
  - Exposed to contract claim.

## ACTION BY MED STAFF

- **Pros**
  - HCQIA and peer review immunity.
  - Avoids breach of contract claim.
- **Cons**
  - Process is burdensome and expensive.
  - Med staff is inefficient and rarely adept.
  - Med staff may be conflicted.
  - Depends on bylaws terms and perhaps state law.

# Corrective Action: Contract v. Med Staff Action

## CONTRACTS

- Condition contract on unrestricted med staff membership and privileges.
- Robust performance standards.
- Robust termination provisions, e.g., cause and no cause.
- Termination of contract = automatic resignation of privileges without bylaws hearing.
- If there is conflict between contract and bylaws, contract controls.

## BYLAWS

- Confirm bylaws ≠ contract.
- Robust qualifications, responsibilities, standards.
- Confirm providers with a contract are subject to contract terms; contract trumps contrary bylaws.
- Automatic termination for certain items.
- Scaled back due process rights for certain providers or certain circumstances, e.g.,
  - Physicians v. non-physicians
- Precautionary suspensions.
- Exclusive contracts.
- Closed staffs.
- Restrict ability to reapply following adverse determination.

# Non-Physician Practitioners



# Non-Physician Practitioners

- Governing body must:
  - “Determine[s], in accordance with State law, which categories of practitioners are eligible candidates for appointment to the medical staff.” (42 CFR 482.12(a)(1))
  - Ensure “[p]atients are admitted to the hospital only on the recommendation of a licensed practitioner permitted by the State to admit patients to a hospital. If a Medicare patient is admitted by a practitioner not [an MD, DO, DDS, DMD, DPM or OD], that patient is under the care of a doctor of medicine or osteopathy.”

(42 CFR 482.12(a)(1) and (c)(2)).

- “The medical staff must be composed of doctors of medicine or osteopathy. In accordance with State law, including scope-of-practice laws, the medical staff may also include other categories of physicians ... and non-physician practitioners who are determined to be eligible for appointment by the governing body.”

(42 CFR 482.22(a))

# Non-Physician Practitioners

“(1) A hospital or facility may grant to physicians, physician assistants and advanced practice nurses the privilege to admit patients to such hospital or facility; provided however, that admitting privileges may be granted only if the privileges are:

- (a) Recommended by the medical staff at the hospital or facility;
- (b) Approved by the governing board of the hospital or facility; and
- (c) **Within the scope of practice** conferred by the license of the physician,

physician assistant or advanced practice nurse.

“(2) A hospital or facility shall specify in its bylaws the process by which its governing body and medical staff oversee those practitioners granted admitting privileges. Such oversight shall include, but is not limited to, credentialing and competency review.”

(IC 39-1396)

# Non-Physician Practitioners: Scope of Practice

## APRN

- Depends on—
  - Type of APRN, and
  - Decision-making model in regulations.

## PA

- Must have collaborating physician(s)
- Depends on—
  - PA's competence and competence; and
  - Facility bylaws or procedures, or collaborative practice agreement; and
  - Collaborating physician's training and experience.

# APRN: Scope of Practice

- **Certified Nurse Practitioner:** comprehensive primary care services, including but not limited to diagnosis and management of acute and chronic disease and the effects of illness.
- **Certified Registered Nurse Anesthetist:** full spectrum of anesthesia care and anesthesia-related care and services.
- **Certified Nurse-Midwife:** full range of primary health care services to women throughout the lifespan, including gynecologic care, family planning services, preconception care, prenatal and postpartum care, childbirth, care of the newborn and reproductive health care treatment of the male partners of female patients.

(IDAPA 24.34.01.002)

# APRN: Scope of Practice

Idaho uses a decision-making model, i.e., “to evaluate whether a specific act is within the legal scope of nursing practice, a licensed nurse shall determine whether:

- i. The act is expressly prohibited by [law];
- ii. The act was taught as a part of the nurse’s educational institution’s required curriculum and the nurse possesses current clinical skills;
- iii. The act is consistent with standards of practice published by a national specialty nursing organization or supported by recognized nursing literature or reputable published research and the nurse can document successful completion of additional education through an organized program of study including supervised clinical practice or equivalent demonstrated competency;
- iv. Performance of the act is within the accepted standard of care that would be provided in a similar situation by a reasonable and prudent nurse with similar education and experience and the nurse is prepared to accept the consequences of the act.”

# Physician Assistants: Scope of Practice

- “A [PA] shall collaborate with, consult with, or refer to the appropriate member of the facility health care team as indicated by:
  - the condition of the patient;
  - the education, experience, and competence of the physician assistant; and
  - the community standard of care.
- “The degree and nature of collaboration shall be determined by the facility or practice ... and shall be set forth in
  - facility bylaws or procedures for facilities that have credentialing and privileging systems or
  - in a written collaborative practice agreement for all other facilities and practices.”

(IC 54-1807A(2))

# Physician Assistants: Scope of Practice

- Facility bylaws or procedures or collaborative practice agreement “may provide for collaborative oversight to be provided by the employer, group, hospital service, or the credentialing and privileging systems of a licensed facility, but at a minimum shall require a physician assistant to collaborate with one (1) or more physicians licensed [in Idaho].”
- Collaborating physicians “need not be identified individually in the facility bylaws or procedures or collaborative practice agreement if more than one (1) physician works in the facility or practice.”

(IC 54-1807A(2))

# Physician Assistants: Scope of Practice

- “The facility or practice and each collaborating physician are responsible for ensuring that the medical services performed by the physician assistant are within the physician assistant’s scope of education, experience, and competence.”
- “Each collaborating physician shall collaborate with the physician assistant on the performance of only those medical services for which the collaborating physician has training and experience.”

(IC 54-1807A(4))

# Non-Physician Practitioners

*Should APPs or similar limited license practitioners be granted full medical staff membership like physicians?*

## PROS

- Promotes unity on staff.
- May facilitate APP satisfaction and commitment to med staff functions.
- May spread med staff responsibilities and ease burden on physicians.
- Helps ensure smaller hospitals have critical mass.
- May facilitate accreditation.

## CONS

- Physicians may not want to share or cede authority.
- May complicate bylaws as you distinguish APP's rights and roles.
- May give APPs rights that are not required or perhaps appropriate (*e.g.*, full voting, oversight of physicians, full hearing rights, *etc.*)

# Non-Physician Practitioners

*Should APPs or similar limited license practitioners be granted full “fair hearing” process like physicians?*

## PROS

- IC 39-1395 requires “due process”
- Accreditation standards likely require some “due process”

*But what process is due?*

- Promotes unity on staff.
- May facilitate APP satisfaction and commitment to med staff.

## CONS

- Full “fair hearing” process is burdensome and expensive.
- No HCQIA immunity.
- May consider expedited process, e.g., written request for reconsideration.

# Competitors



# Competitors

“An applicant for medical staff membership or privileges [or] reappointment to the medical staff ..., or a current member of the medical staff ... shall not be denied medical staff membership or privileges, nor shall membership or privileges be withdrawn, revoked, suspended or limited by such health care organization for the reason that:

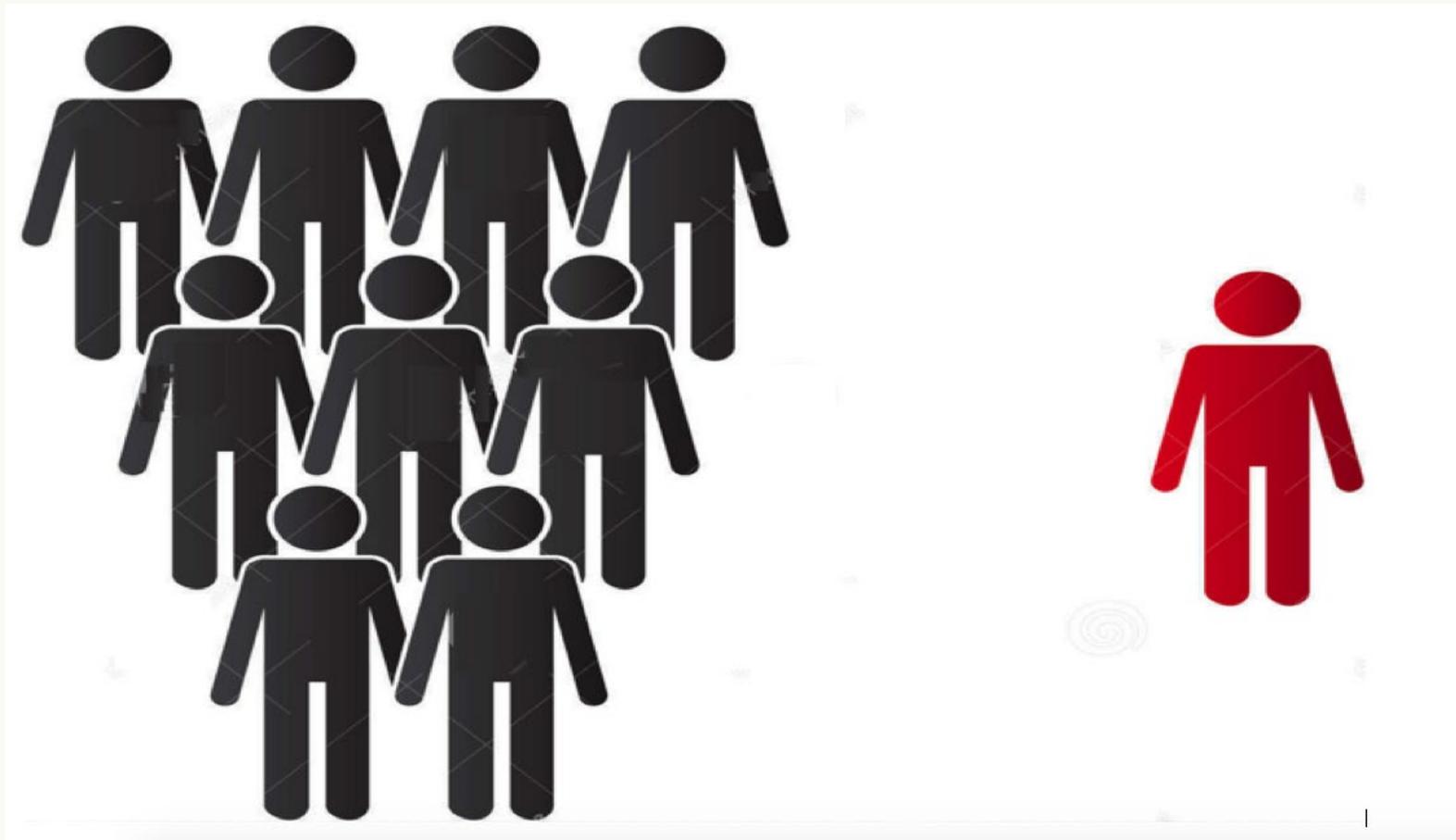
- (a) The applicant or current member of the medical staff holds an ownership interest in one (1) or more competing health care organizations;
- (b) The applicant or current member of the medical staff is affiliated with one (1) or more competing health care organizations; or
- (c) The applicant or current member of the medical staff is a competitor of one (1) or more members of the medical staff.”

(IC 39-1392g)

# Competitors

- May be able to limit roles in medical staff leadership or committee assignments, *e.g.*,
  - Not eligible for positions that would create a conflict of interest.
  - Not eligible for positions that would require disclosure of confidential info.
  - Other?
- Address through bylaws and policies, *e.g.*,
  - Standards or qualifications for leadership or committee assignments
  - Confidentiality
  - Conflict of interest
  - Other?

# Exclusive Contracts



# Exclusive Contracts

- Exclusive contracts are allowed in Idaho.
  - *See, e.g.*, IC 39-1392g (“Nothing in this section shall require a health care organization to grant privileges to an applicant for services that are subject to an exclusive contract or not offered in that .”)
- Beware conflicting privileges.
  - Existing providers with conflicting privileges.
  - Privileges of providers who leave exclusive group.
- Address exclusive contracts in—
  - Bylaws
  - Provider contracts
  - *Authorize exclusive contracts.*
  - *Automatically terminate or surrender of conflicting privileges without hearing process.*

# Closed Staff



# Closed Staff

- Governing body of hospital generally has authority “to make such rules, regulations, standards or qualifications for medical staff membership as it, in its discretion, may deem necessary or advisable, or to grant or refuse membership on a medical staff.”  
(IC 39-1392g(1); *see also* IC 39-1395)
- IRS may consider whether hospital maintains an “open medical staff policy” when evaluating if hospital operates for community benefit and qualifies for 501(c)(3) protection.  
(See IRS Rev. Rul. 69-545; <https://www.irs.gov/charities-non-profits/charitable-hospitals-general-requirements-for-tax-exemption-under-section-501c3>).
- May prompt litigation from excluded providers, *e.g.*,
  - Antitrust
  - Unfair competition
  - Breach of bylaws
  - Other?

# Closed Staff

- Most courts have upheld closed staff determinations if—
  - Supported by legitimate patient care or hospital operations purposes, *e.g.*, capacity of hospital; standardized processes; facilitating volume to maintain competency of providers; *etc.*)
  - Consistent with bylaws.
- Address closed staff situations in—
  - Bylaws
  - Provider contracts
  - *Authorize closed staff situations.*
  - *Automatically terminate or surrender of conflicting privileges without hearing process.*

# Impaired Practitioners



Impairment may be due to—

- Age
- Physical or mental illness
- Disability
- Substance abuse
- Other

# Impaired Practitioners

“**DISCIPLINE.** In addition to the grounds for discipline set forth in Idaho Code, every person licensed or permitted by the Board is subject to discipline upon any of the following grounds:

...

03. **Standard of Care.** Providing health care that fails to meet the standard of health care provided by other qualified licensees or permittees of the same profession, in the same community or similar communities, including but not limited to:

a. Being found mentally incompetent or insane by any court of competent jurisdiction.

b. Engaging in practice or behavior that demonstrates a manifest incapacity or incompetence to practice his or her profession.”

(IDAPA 24.33.01.300)

# Impaired Practitioners

## EMPLOYEES

- Americans with Disability Act (ADA) Title I
  - Persons who have or are perceived as having a disability.
  - Must make reasonable accommodations unless
    - Undue hardship, or
    - Direct threat to safety.
  - Limits questions that may be asked and when asked as part of employ process.
- State laws.
- No HCQIA immunity.
- *Let HR Dept handle employment situations; med staff office should coordinate.*

## NON-EMPLOYEES

- ADA
  - Title II: gov entities
  - Title III: public accommodation? (*Menkowitz v. Pottstown Mem'l Med. Ctr.*, 154 F.3d 113 (3d Cir. 1998))
- Rehab Act § 504 applies if receive federal money.
  - Cannot discriminate against person with disability who is otherwise qualified.
  - Must provide reasonable accommodation unless:
    - Undue hardship, or
    - Direct threat to safety.
- (*Fleming v. Yuma Reg. Med. Ctr.*, 587 F.3d 938 (9<sup>th</sup> Cir. 2009))
- No HCQIA immunity of these laws apply.
- *Use HR Dept as a resource.*

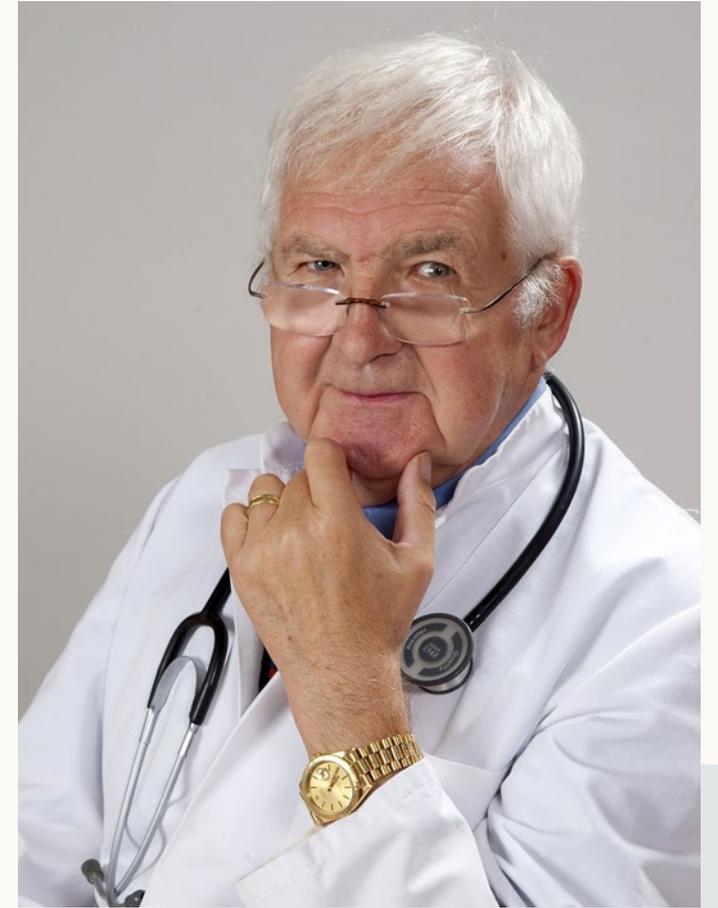
# Impaired Practitioners

- Focus on whether provider can perform the essential functions of privileges.
- Avoid—
  - General health history unrelated to essential functions.
  - Broad disability inquiries unrelated to core competencies.
- If disability is identified—
  - Avoid disability-based assumptions.
  - Conduct individualized assessments.
  - Consider ability to perform privileges.
  - Consider reasonable accommodations.
    - Discuss appropriate accommodations with the provider.
- Document legitimate safety concerns or undue hardship.
- Use HR Dept as resource.

# Late Career / Aging Practitioners

- We are experiencing longer life expectancy and physiological capacity.
- Evidence supports changes to cognition, dexterity, vision and hearing.
- Evidence indicates higher rate of poor outcomes.
- Physicians are retiring older, *e.g.*, average up from Aging 65 to Aging 68 in recent years.
- 26+% of physicians are aged 65 or older.
- May have lack of self-awareness.
- May not keep up with practice standards or options.

(<https://www.researchgate.net/publication/394960592> Can a doctor be too old to practice medicine)



# Aging Practitioners

## BALANCING CONCERNS

- Patient safety
- Liability for adverse outcomes
  - Vicarious liability for employees
  - Negligent credentialing
  - Litigation concerns
- COPs and accreditation standards that require facilities to evaluate and act on concerns
- ADEA, ADA, and Rehab Act § 504 liability
- Shortage of providers
- Experience, wisdom, leadership, mentorship that late career provider may have
- Standing and years of service to the facility and community
- Push back from medical staff

# Aging Practitioners

## EMPLOYEES

- Age Discrimination in Employment Act (ADEA)
  - Prohibits discrimination against individuals 40+ years old.
  - May consider bona fide occupational qualifications.
  - Unlike some industries, there is no exception for practitioners.
- Americans with Disability Act (ADA) Title I
  - Persons who have or are perceived as having a disability.
  - Must make reasonable accommodations.
- No HCQIA immunity.
- *Let Human Resources Dept handle concerns.*

## NON-EMPLOYEES

- ADA
  - Title II: gov entities
  - Title III: public accommodation
- Rehab Act § 504 likely applies if receive federal money.
  - Cannot discriminate against qualified persons with a disability.
  - Must make reasonable accommodations.

*But ensure they are not improperly classified...*

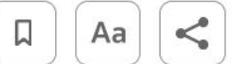
# Aging Practitioners

- ~~Mandatory retirement at certain age.~~
  - *Likely violates ADEA for employees.*
  - *Assumptions of decline in age may not apply to a particular physician.*
  - *Removes competent and needed providers from workforce.*
  - *Experience, wisdom, empathy, mentoring, and institutional knowledge may offset physiological deterioration.*

## Medical group pays \$6.9 million to end EEOC probe over mandatory retirement age

By Daniel Wiessner

December 19, 2023 3:28 PM MST · Updated December 19, 2023



# Aging Practitioners

- Mandatory assessments at certain age.
  - May create ADEA and ADA issues for employees
    - ADA limits post-employment tests.
  - Sample policy might address—
    - Age as well as other indicators for assessment.
    - Type of assessment (e.g., cognitive, visual, physical, etc.)
    - How often (e.g., annually, with 2-reappointment application, etc.)
    - Who performs the assessment.
    - Who pays for assessment.
    - Failure to participate in assessment → automatic surrender of privileges.
  - Beware that assessment may not be entirely reliable.
- *Involve HR Dept if provider is employed.*

Press Release  
02-11-2020

## EEOC Sues Yale New Haven Hospital for Age and Disability Discrimination

*Hospital Unlawfully Subjected Only Physicians Over 70 to Neuropsychological and Eye Exams, Federal Agency Charges*

NEW HAVEN - Yale New Haven Hospital, the teaching hospital of the Yale School of Medicine, violated federal law by adopting and implementing a discriminatory "Late Career Practitioner Policy," the U.S. Equal Employment Opportunity Commission (EEOC) charged in a lawsuit filed today.

According to the EEOC's lawsuit, the policy requires any physician who applies for or seeks to renew staff privileges at the hospital to undergo neuropsychological and eye medical examinations. Individuals under the age 70 are not subject to these requirements.

The EEOC said that those subject to the policy are required to undergo these tests at their age, without any suspicion that their neuropsychological or eye health is declining. By subjecting only these older hospital applicants and employees to these tests, the hospital violates the Age Discrimination in Employment Act.

Yale New Haven  
requires visual and  
neurological tests  
for physicians over  
age 70

# Aging Practitioners

- Carefully consider documentation that references age, retirement expectations, or makes age-based assumptions about competency.
- Use quality metrics, outcomes, and OPPE to monitor all practitioners.
- Require reports from peers.
  - See IC 54-1818, but peers hesitate to criticize peers.
- If identify potential problem—
  - Take appropriate informal or formal corrective action.
  - May require competency or skills evaluation if applied consistently across all ages consistent with ADA limits.

*Problem:  
these are  
reactive;  
patients  
at risk*

# Aging Practitioners

- If identify problem:
  - *Involve HR Dept if provider is an employee.*
  - Discuss voluntary action with the physician.
    - Self-evaluations and assessments.
    - Modified privileges, e.g., limit surgical services.
    - Withdrawal from call obligations.
    - Focus on outpatient services rather than inpatient care.
    - Reduced clinical loads with increased teaching roles.
    - Late career transition programs.
    - Other?
- But don't be surprised if provider lacks self-awareness

*Not reportable to NPDB if no pending action or threat of investigation*

# Aging Practitioners

- If identify potential problem, take additional action as warranted.
  - *Involve HR Dept if practitioner is an employee.*
  - FPPE or other evaluation.
  - Competency or skills evaluation.
    - Include in bylaws, polices and contracts, e.g.,
      - Who will pay
      - Who will perform
      - Consequences for failure to participate.
    - May not be reportable to NPDB if terminate automatically.
- Respond commensurate to the risk, e.g.,
  - Limit rather than terminate all privileges, modify duties, etc.
  - Other?

*Problem:  
these are  
reactive;  
patients at risk*

# Disruptive Practitioners



# Disruptive Practitioners

- Idaho Medical Practices Act prohibits:
    - “Engaging in a pattern of unprofessional or disruptive behavior or interaction in a health care setting that interferes with patient care or could reasonably be expected to adversely impact the quality of care rendered to a patient. Such behavior does not have to have caused actual patient harm to be considered unprofessional or disruptive.”
- (IC 54-1814(26))
- Bylaws, policies and/or contracts likely require compliance with law.
  - May be used to warn physicians and PAs against misconduct.

# Disruptive Practitioners

- The Medical Practices Act also prohibits, e.g.:
  - “(7) Providing health care which fails to meet the standard of health care provided by other qualified physicians or physician assistants in the same community or similar communities, taking into account his training, experience and the degree of expertise to which he holds himself out to the public....
  - (13) Failing to safeguard the confidentiality of medical records or other medical information pertaining to identifiable patients, except as required or authorized by law....
  - (15) Abandoning a patient....
  - (17) Failing to supervise the activities of interns, residents, nurse practitioners, certified nurse-midwives, clinical nurse specialists, or physician assistants....
  - (28) Delegating professional responsibilities to:
    - (a) An unlicensed person when the licensee knows or has reason to know that such person is not qualified by training, experience, or license to carry them out; or
    - (b) A person licensed by this state to engage in activities which may involve the practice of medicine when the delegating licensee knows or has reason to know that the delegated activities are outside the licensed person’s scope of practice.”

(IC 54-1814)

# Disruptive Practitioners

- “A licensed physician or physician assistant possessing knowledge of a violation of section [I.C.] 54-1814, by any other physician or physician assistant licensed to practice medicine in Idaho shall with reasonable promptness report such knowledge to the board of medicine or its duly authorized committee, agency or representative, and failure to do so shall subject such person to disciplinary action by the state board of medicine as in its discretion the board shall deem proper....
- “However, notwithstanding the foregoing, no physician or physician assistant shall be required to report, nor shall any physician or physician assistant report, any information known, learned or discovered by that person as a result of participation in peer review or access to peer review records....”

(IC 54-1818)

# Impaired Practitioners



## EMPLOYEES

- ADA
  - Persons who have or are perceived as having a disability.
  - Must make reasonable accommodations unless
    - Undue hardship, or
    - Direct threat to safety.
  - Limits questions that may be asked and when asked as part of employ process.
- State laws.
- No HCQIA immunity.
- *Let HR Dept handle.*

## NON-EMPLOYEES

- ADA
  - Title II: gov entities
  - Title III: public accommodation?
- Rehab Act § 504 applies if receive federal money.
  - Cannot discriminate against person with disability who is otherwise qualified.
  - Must provide reasonable accommodation unless:
    - Undue hardship, or
    - Direct threat to safety.
- No HCQIA immunity of these laws apply.

*Don't go looking for a disability...*

# Disruptive Practitioners

- Address disruptive conduct in—
  - Medical staff bylaws
  - Medical staff policies
  - Practitioner contracts
- Address both—
  - Standards and descriptions, “including but not limited to...”
  - Consequences for violations, including informal or formal corrective action.
  - Process applicable to corrective action.

# Disruptive Practitioners

- Consider modified disruptive provider policy:
  - Disruptive conduct by employees or contractors may be handled by hospital administration consistent with contract.
  - Certain types of disruptive conduct for non-contracted providers will be handled by hospital administration, e.g., sexual harassment, etc.
    - Hospital administration more skilled at responding to such issues.
    - Matters do not involve clinical skills or judgment of medical staff.

✓ *Check your bylaws and accreditation standards.*

## Pros

- Hospital admin is more adept at handling such issues, including legal standards.

## Cons

- Med Staff may want to handle itself.
- Perhaps no NCQIA immunity if no due process.

# Resolving Credentialing Disputes



# Resolving Credentialing Disputes

- NPDB and/or Board of Medicine reports are often the key issue in resolving credentialing disputes with providers.

The screenshot displays the NPDB National Practitioner Data Bank website. At the top, it features the U.S. Department of Health & Human Services logo and navigation links for Home, About Us, Help Center, FAQs, and Sign In. The main header includes the NPDB logo and a search bar. Below the header, there are navigation tabs for 'For Health Care Professionals', 'For Organizations', and 'NPDB Resources'. The current page is 'Help Center - Organizations / Reporting / About Reporting the NPDB', with text size and print options. The main content area is titled 'Reporting to the NPDB' and includes a sidebar with links to 'About Reporting to the NPDB', 'What You Must Report to the NPDB', 'Submitting a Narrative', 'MMPR Form (MS Word - 183 KB)', 'Reporting Through an External Application', 'Reporting Adverse Clinical Privileges Actions (video - 4:34)', 'Reporting Infographics', 'Policy Corner', 'Help Center', and 'How to...'. The main text explains that reports in the NPDB are records of actions taken by authorized organizations regarding health care practitioners, entities, providers, and suppliers who do not meet professional standards. It also mentions that reports are permanently stored in the NPDB unless modified or removed. A section titled 'NPDB REPORTING GUIDES' lists 'When to report...' for 'CLINICAL PRIVILEGES ACTIONS', 'MEDICAL MALPRACTICE PAYMENTS', and 'STATE LICENSURE ACTIONS'. A 'Learn More' link is provided at the bottom.

# NPDB Reports

- Hospitals and other “healthcare entities” must (1) report to NPDB and (2) provide copy to state medical board of any action against physician or dentist if:
  - Action adversely affects clinical privileges for more than 30 days and is based on professional competence or conduct adversely affecting patient care;
  - Voluntary surrender or restriction of physician privileges
    - while physician is under investigation for incompetence or professional conduct, or
    - in return for not conducting an investigation;
  - Suspension in effect for more than 30 days; and/or
  - Revision or modification of such action.
- May report actions against other practitioners.

(42 USC 11133; 45 CFR part 60.12)

# Idaho Board of Medicine Reports

A health care organization in Idaho shall report to the Board if it takes one of the following professional review actions against a physician that lasts more than 30 days:

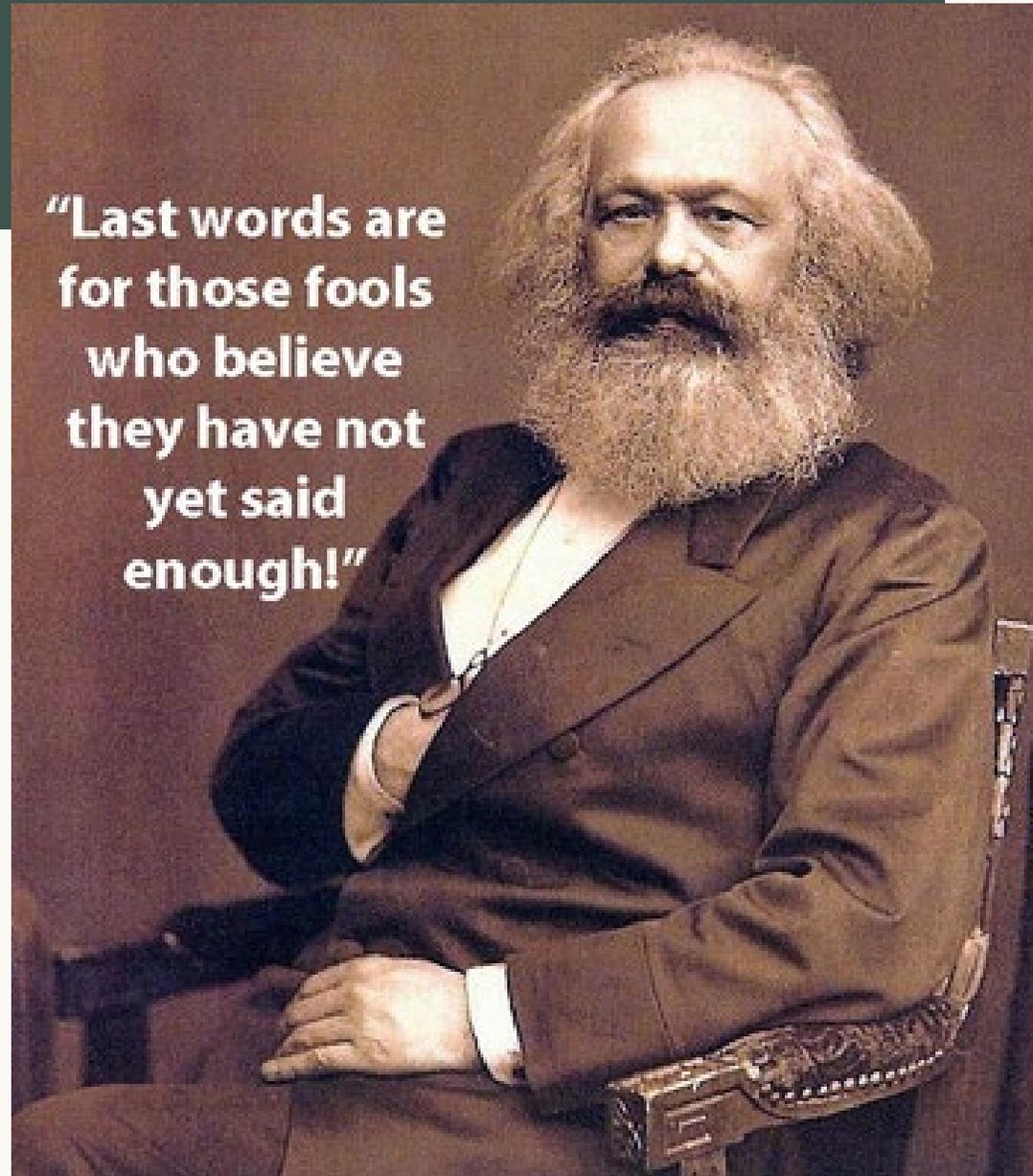
- Restriction, revocation, suspension, reduction or surrender of privileges;
- Denial of a request for initial privileges;
- Submission to monitoring of the physician's physical or mental condition; delivery of medical services; other than to assess and monitor the physician's qualifications for new or additional privileges;
- Termination or suspension of employment lasting longer than thirty (30) days.
- Accepts one of the foregoing actions:
  - While the physician is under investigation or to avoid investigation by the health care organization relating to the professional competence or professional conduct of the physician or
  - In exchange for the health care organization not conducting such an investigation or initiating a professional review action, if the sanction lasts longer than thirty (30) days.

# Reports

- No NPDB or BOM reports necessary if action—
  - Not against a physician.
  - Does not adversely affect privileges.
  - Not based on the professional conduct or competence that could adversely affect patient care.
  - Physician withdraws initial application before final determination by board.
  - Lasts < 31 days, except surrender of privileges—
    - While investigation is pending or
    - to avoid an investigation.
  - Administrative action, e.g., automatic termination due to loss of license.
  - For NPDB, termination of employment without due process hearing.

Practically,  
may have  
limited  
window to  
resolve the  
matter by  
avoiding  
NPDB and/or  
NPDB report.

# Final Words



# 1. Follow the process in credentialing and corrective actions

- Courts usually do not second guess facility's credentialing or corrective action if:
  - Followed standards in bylaws and statutes.
  - Based on legitimate, documented reasons
    - Patient care or facility operations
    - NOT arbitrary or capricious
    - NOT improper motive, *e.g.*, discrimination, anti-competition, retaliation, *etc.*
- From legal liability standpoint, the process is usually more important than the decision.

## 2. Document concerns and actions, especially informal action.



- **Your job: make sure the action is documented in the file!**

- Complaints
- Discussions
- Warnings or reprimands
- OPPEs and FPPEs
- Response, e.g., failure to comply
- Appropriate minutes
- Reviews and privilege determinations
- Others?

**Maintain  
the peer  
review  
privilege!**

### 3. Maintain the peer review privilege!

- Idaho has very strong peer review protections:
  - Peer review immunity.
    - Protects participants from liability. (IC 39-1392c)
  - Peer review privilege.
    - Keeps info confidential. (IC 39-1392b; IRE 519)
    - Used to keep providers from raising peer review matters in a lawsuit. (*Verska v. St. Alphonsus Reg. Med. Ctr*, 151 Idaho 889 (2011); *Montalbano v. St. Alphonsus Reg. Med. Ctr*, 151 Idaho 837 (2011))
  - “Peer review” is very broad and includes credentialing, corrective action, and anything else addressing patient care, quality, or qualifications of practitioners. (IC 39-1392a)
- Take great care to maintain the peer review privilege!

# Questions



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