

Peer Review and Quality Improvement in an Era of Possible Health Reform

Gerald N. Rogan, MD
Rogan Consulting, Inc.
Sacramento, California
916-978-9636

jerryroganmd@sbcglobal.net
www.roganconsulting.com



I have no relevant financial relationships to disclose in regard to the content of this presentation. My work in this area is pro-bono. I do not practice medicine in a hospital.

Thanks

- Thanks to Cheryl Payne and Michael Finne of Medical Peer Review
- “Medical Peer Review Services”
<mcjfinne@comcast.net>

My Background

- Emergency Physician 1973-1980 Board Certified 1980, recertified 1993
- General Practice, Urgent Care 1980-1998
- Medicare B Medical Director, California 1997-2003
- Health Care Services Consultant 2003-present

Teaching Objectives

From the RMC story and follow-up you will learn:

- Why peer review is important
- How it can be thwarted
- What needs to be done to make it work better
 - Provider action
 - Government action

OUTLINE

- **Part One:** The Story: What happened at Redding?
- **Part Two:** Disaster Analysis: What allowed it to happen?
 - Similar problems at other hospital medical staffs.
- **Part Three:** What has been done to prevent a similar occurrence?
- **Part Four:** What actions might you consider at your hospital medical staff?

PART ONE

THE RMC STORY

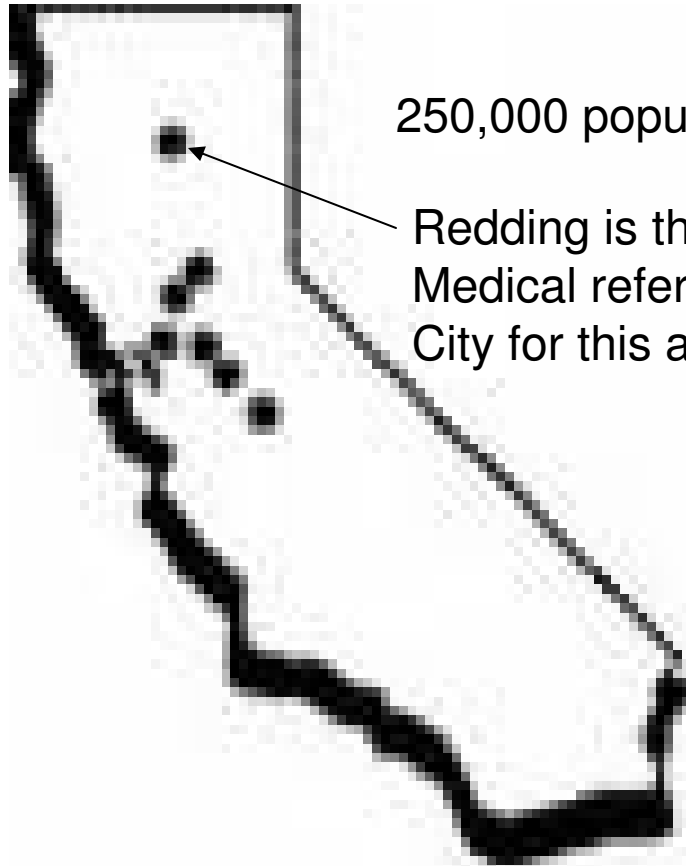
The RMC Story: Outline

- 1992 through 2002
- The Players
- Many unnecessary procedures
- 769 patients allegedly damaged
- Facilitated by Tenet Leadership
- Peer review was thwarted

RMC: The Players

- **Chae Moon MD, 58**, was the chief of cardiology at RMC, an internist specializing in cardiology
- **Fidel Realyvasquez MD, 57**, was the chief cardiac surgeon at the hospital.
- **Redding Medical Center** was a **Tenet Corporation** hospital
- **State Licensing and Certification (L&C)** oversees compliance of hospitals for the State
- **CMS Regional Office** oversees hospital provider enrollment for Medicare using L&C's information
- **The Joint Commission** accredits hospitals

Where: Rural California



250,000 population

Redding is the Medical referral City for this area.



RMC



RMC developed the leading cardiac surgery program, taking fly in patients.

RMC had “Star” Physicians

- Dr. Chee Moon performed 10-12 cardiac catheterizations daily and was quickly available to see patients.
- About 2400 cardiac catheterizations were done at the Redding Medical Center in 2002.
- Dr. Fidel Realyvasquez was a Stanford University trained expert surgeon with highly refined surgical techniques and a low complication rate.

The “Star” Physicians were Top Billers

- Dr. Realyvasquez was the top billing cardiac surgeon in California, except Los Angeles and San Diego.
- Dr. Moon was the highest paid cardiologist in California, over \$1 million/year collected from Medicare B alone.
- Dr. Moon considered himself one of the nation's top 10 cardiologists.

Chae Moon, MD



RMC Profits

- Redding Medical Center generated pretax net income of **\$94 million** over the 12 months ended June 30, 2002.
- The highest profit of Tenet's 40 hospitals in California.
- The larger Mercy Medical Center, Redding reported pretax net income of about **\$5 million** in the same period.

What was the Problem?

- Dr. Moon would not work up chest pain patients before doing a cardiac cath
 - Inadequate history and exam
 - No pre-cath provocative tests (e.g. stress ECG)
 - If the cath was normal, Dr. Moon performed an intracoronary vascular ultrasound (IVUS)

The Wrong Diagnosis

- Dr. Moon read the IVUS to show dissecting coronary arteries and/or severe stenosis for which immediate bypass surgery was needed to save the life of the patient.
- The IVUS gain was turned up too high.
- Dr. Moon was interpreting artifact as “disease”

The Wrong Treatment

- Dr. Moon sent the patients to Dr. Realyvasquez for bypass surgery.
- Dr. RV performed the surgery without independently verifying the patient needed it.
- The patients thought the doctors saved their lives.
- During this time, 7 outside doctors complained to the Medical Board of California about Drs. Moon and RV performing unnecessary procedures on patients without cardiac disease.
- The California Medical Board did nothing.

Duration of Wrong Treatment

- Unnecessary cardiac cath and procedures continued between 1997 and 2002, from as early as 1992.
- During this time (1999) the Joint Commission certified RMC as fully compliant with its accreditation requirements, despite the absence of peer review in the cardiac services sections.
- Except for a 4 months between October 1999 and Feb 2000, the State (L&C) and CMS determined RMC fully complied with Medicare enrollment and State licensure requirements.

Eventual Discipline of Dr. Moon

- **6/27/2003**: medical practice temporarily restrained pending outcome of a criminal investigation
- **6/8/2007**: Dr. Moon's medical license was revoked by the California Medical Board
- Citations included false diagnosis of "multiple coronary dissections" and "unstable plaques."
- Many patients were normal
- The Medical Board cited "22 patients and 32 causes for discipline"
- <http://licenselookup.mbc.ca.gov/licenselookup/lookup.php?LicenseType=A&LicenseNumber=32120>

Eventual Discipline of Dr. Realyvasquez

- 10/30/2009: Dr. RV's license revocation was stayed for 3 years of probation.
- Probation requires that he
 - Take an ethics course
 - Take more specialty based education
 - Have his practice monitored.
- <http://licenselookup.mbc.ca.gov/licenselookup/lookup.php?LicenseType=G&LicenseNumber=33283>

What Was the Role of Peer Review in This Disaster?

- In 1999 L&C found RMC's medical staff did not perform peer review between 1997 and 1999 in the cardiac services sections.
- After 3 subsequent reviews during the next 4 months, RMC's medical staff never corrected their deficiency.
- Moon and RV were in charge of peer review for their respective sections.

Without Peer Review, What Can Happen?

- Lessons from the RMC Disaster
 - Star performers can make a lot of money for the hospital and themselves
 - There is no oversight for medical necessity
 - Quality may be very high, because many of the patients are not sick
 - Quality measures do not include measures of medical necessity
 - Peer review is our only hope.

Discovery of Negligent Care



*Man Playing Horn... Or Woman
Silhouette?*

*(hint: woman's right
eye is the black speck in front
of horn handle)*

REMEMBER

- L&C found RMC fully compliant
- CMS found RMC fully compliant
- The JC found RMC fully compliant
- RMC was promoting its cardiac services program as a center of excellence
- The Medical Board of California ignored physician complaints
- Upset physicians at RMC were intimidated

RMC: Discovery 2002

- Patient John Corapi and internist Patrick Campbell separately filed a Qui Tam law suit in 2002
- AUSA accepted the case from the relators (physician and patient)
- FBI and OIG investigated

RMC: Discovery 2002

- OIG referred the cases provided by the relators to expert cardiologists at Mayo, Cleveland Clinic and elsewhere
- Alleged negligence was discovered
- Judge issued a search warrant
- FBI raided the hospital and physicians offices – which was reported on national news

FBI RAID



Rogan Consulting, Inc.

In the News 2002

- **Redding, CA** - Approximately 40 FBI and DHHS OIG agents raided the offices of 2 California doctors on Wednesday, October 30, 2002. The raid was part of an ongoing investigation of **Dr Chae Hyun Moon, 55**, director of cardiology at Redding Medical Center (RMC), and **Dr Fidel Realyvasquez, Jr, 53**, chair of the cardiac surgery program at RMC.

Search Warrant Justification

- *According to affidavits filed in US District Court in Sacramento in support of the search warrants, Moon and Realyvasquez were investigated for allegedly performing unnecessary invasive coronary procedures on patients, including heart catheterizations, angioplasty, and open heart surgeries.*

TENET Stock (THC)



Source: C. Schwab

Rogan Consulting, Inc.

30

Results from Law Enforcement



Results

- AUSA dropped its proposed criminal charges against Moon and RV
- Moon's medical license was suspended then revoked for negligence
- RV temporarily agreed not to practice medicine and is now on probation
- ~\$500 million in damages are paid
- RMC is kicked out of Medicare
- Hospital administrators at RMC are fired

Financial Retribution

- Moon and RV each pay \$1.4 million
- They admit no wrongdoing-see Dr. Moon's response to the revocation at the end of the State revocation reference.
- RV and his group authorized their insurance carrier to pay \$24 million to 642 patients who claimed they underwent unnecessary bypass surgeries or procedures at RMC.

Tenet Pays a Fine

- Tenet and RMC paid **\$395 million** to end their civil liability, which involved a total of 769 patients.
- Their insurance company refused to reimburse Tenet for Tenet's loss, alleging Tenet was a fraudster.

RMC Sold

- July 16, 2004--Tenet Healthcare Corporation (NYSE:THC) sells Redding Medical Center in Redding, Calif., to Shasta Regional Medical Center, LLC, an affiliate of Hospital Partners of America Inc.

RMC SOLD



Payment to Qui Tam Relators

- Whistleblowers Joseph Zerga, and Rev. John Corapi each receive \$2,712,281.
- Whistleblower Dr. Patrick Campbell accepts \$4,457,938.

PART TWO: **DISASTER ANALYSIS**



Why No Disaster Analysis?

- No agency of government was willing to review the RMC case to determine how it happened and what can be done to prevent a recurrence.
- The following agencies refused:
- L&C, State AG, OIG, QIO, CMS, JC, CMA
- The cause of health care disasters are ignored, unlike Katrina, 911, Challenger, Airplane crashes

Disaster Analysis

- 3 physicians filled the void
- The JC blocked discovery of its files
- Lawyers defending against Tenet helped us
- Dr. Rogan filed a FOIA with L&C and CMS
- CMS RO 9 assisted us.
- L&C attempted to block us then gave up under threat of a lawsuit.
- L&C has destroyed some of its files

Authors

- **Gerald N. Rogan MD**
former Medicare B
Director CA.
- **Frank Sebat, MD**
intensivist at RMC,
Board of Trustee
Member
- **Ian Grady, MD**
Trauma surgeon,
RMC, Chief of Patient
Safety Committee



Analysis Questions

- How could negligent care continue at an accredited hospital for more than 6 years?
- Did an institutional or government safeguard fail us?
- Are we vulnerable to repeat disasters?

Findings

- Peer review is required under 42 CFR 482.21 and similar State regulations.
- Peer review was not performed in cardiac services at RMC between 1997 and 2002
- Tenet falsely assured the RMC safety committee that peer review was being conducted.
- RMC leaders fabricated the virtual California Heart Institute for peer review and QA
- State and Medicare requirements were not met
- Requirements for peer review were not enforced by L&C or CMS in 1999 even though both agencies recognized the deficiency

3 years of Negligence after Discovery

- The JC accredited RMC in 1999 for 3 years when it knew its standards were not met –JC document was on file at L&C
- L&C licensed RMC in 2000 without the required peer review – documents found by me via the FOIA
- CMS accepted L&C's recommendation and re-enrolled RMC for 3 more years – documents were found by me via the FOIA
- Discovery by the RMC Patient Safety Committee was thwarted – evidence from Dr. Ian Grady, chair of the Safety Committee
- Qui Tam was filed in 2002: Public record
- FBI provided the missing peer review in 2002-3

Not a Unique Anecdotal Case

- Our disaster analysis team discovered 7 other cases followed by no disaster analysis: system failures remain unexplored
- Our analysis of the National Practitioner Data Bank information and the Lumetra report supports widespread failure of peer review
- Common theme – no or inadequate peer review
- Profit motive, “star” performers
- Short term gain, long term loss
- Patient safety thwarted

St. Joseph Hospital, Towson, Maryland, 2010

- “Marquee” doctor, Mark G. Midei is cited for allegedly placing unnecessary intracoronary stents based on a patient complaint.
- Federal investigation of 369 patients.
- The US Senate finance committee is investigating.
- Was peer review done?
- Did the cardiologist read his own films to determine medical need?
- St. Joseph is fully accredited by the JC (2008).
- Hospital Compare shows St/ Joseph is about equal to Johns Hopkins: medical necessity is not measured

Encouragement to Perform Peer Review

- CME for peer reviewers
- Assurance of fair jurisprudence
- Outside peer review upon request
- Early correction of negligence
- CQI and accountability v. “blame and shame”
- Active surveillance based on triggers
- Confidential reporting
- Physician safety officer position at the institution

Enforcement of Peer Review: Options

- TJC: improvement via FPPE – but the JC has no law enforcement authority, accreditation is voluntary
- Accountability for department chairs to assure peer review is done – but what if the department chair is a “star performer”?
- Intermediate sanctions against the medical staff and hospital for failure to perform peer review on repeat audit
- Suspicion of immediate patient jeopardy where peer review is absent—automatic medical record review by third parties
- Audit of stakeholders by third party payers
- Fines for ineffective or failed peer review
- Hospital department closure in egregious cases
- Public reporting of state survey results

Part Three: Legislative Action



Legislative Actions to Gain Enforcement

- Federal: TJC was denied deemed status under a new federal law
 - TJC accreditation performance is now subject to HHS oversight
- California: legislature may make peer review more just
- No legislative action is proposed to impose fines or intermediate sanctions.

California Executive Branch

- Lumetra and we have documented a peer review deficiency.
- So far L&C believes it can do nothing more to enforce peer review
- L&C has written a letter to me in response to my proposals. (Copy available).
 - L&C expects private citizens to ask agencies of government to work together to fix the problem.

Legislative Needs

- Intermediate Sanctions
- Stakeholder education: sanctions for failure to comply
- New state enforcement power where needed
- Public demand for peer review enforcement to assure patient safety
- Follow the money
- Disaster analysis

CA Government Action?

- Proposed: CA SB 700, AB 1235, SB 1094 - will help a little to protect whistleblowers.
- Conclusion: Improved patient safety through appropriate peer review will remain a grass roots effort fostered by the actions of professionals acting locally.
- Our government will not lead this effort.
- Our patients will depend on their doctors, nurses, and hospitals as usual.

Part 4: What can you do?

- Do not expect our government to fix this problem.
 - The government is not even interested in providing disaster analysis services, as is done for airplane crashes.
 - Quality measures do not include measures of medical necessity.
- The medical profession and our institutions will have to take care of our professional obligations.

Mayo Clinic Anecdote

- Tradition and Heritage:
- *The best interest of the patient is the only interest to be considered.* – Dr. Mayo
- The needs of the patient comes first.
- Medicine is a cooperative science.

Better Value through Peer Review

- Peer review begets improved quality.
- Improved quality begets better value by reducing errors.
- Better value reduces health care costs and fosters access for more patients.
- Medicare P4P Version 1 (since 1965): The worse the care, the more we pay.
- Medicare P4P version 2 (since 2006): no extra pay for readmissions for certain preventable complications.

Summary

- Peer review can reduce short term profits.
- Peer review protects patients.
- Peer review may avoid big losses long term.
- Peer review can lower costs for payers.
- Peer review can improve quality.
- Peer review must be just-sham peer review intimidates righteous physicians.
- Enforcement and encouragement is required
- Routine disaster analysis should be done as is required for airplane crashes.

Teaching Summary

From the RMC story, you have learned:

- **Why peer review is important** – *it improves quality and protects against disasters*
- **How it can be thwarted** – *by the hospital, by big egos, by fear and intimidation, by go along to get along, by an impotent medical staff, by “sham” peer review to suppress whistleblowers.*
- **What needs to be done to make it work better**— *incentives, intermediate sanctions, dignified professional accountability, disaster analysis, public disclosure of compliance failures.*

More Information

- ***Coronary: a true story of medicine gone awry***
-- By Stephen Klaidman
- Full RMC Disaster Analysis:
www.roganconsulting.com
- State Testimony: Google *Gerald Rogan Testimony*
- More Information at: Public Citizen report
<http://www.citizen.org/publications/release.cfm?ID=7659&secID=1158&catID=126>
- KRITIKUS FOUNDATION: Fixing Peer Review
- <http://www.allianceforpatientsafety.org/>

Public Citizen

May 27, 2009

Hospitals Drop the Ball on Physician Oversight
Failure of Hospitals to Discipline and Report
Doctors Who Endanger Patients

- Alan Levine
- Dr. Sidney Wolfe, M.D.
- www.citizen.org/hrg