A Tough Act to Follow: Wisconsin's Quality Improvement Act Great for Health Care Providers

Sarah E. Coyne, JD

On January 27, 2011, Wisconsin Governor Scott Walker signed into law the Quality Improvement Act (QIA) as part of 2011 Wisconsin Act 2. Act 2 amended Wisconsin's statute protecting the review of health care services for quality issues, more commonly known as "peer review,"[1] as well as other relevant statutes. The QIA, part of a larger "tort reform" package, became effective February 1, 2011. The short version of the story is that the QIA enhances peer review protections, which is a good thing for health care professionals.

The revisions to this law are intended to encourage open and honest peer review (toward the ultimate end of improving quality and safety of patient care) by addressing the natural reluctance health care professionals have to speak freely if their comments are at risk of being disclosed to regulators or plaintiffs' attorneys. Providers are understandably hesitant to critique each other even in the most confidential of circumstances. The age-old battle to keep the record of that process private (and out of the hands of potential plaintiffs in particular) added to that inevitable discomfort.

> Physicians and other medical professionals may feel less pressure providing open and honest information to regulatory agencies without the fear of being forced to testify in a civil or criminal proceeding…

The revised law provides greater protection for peer review records including any investigations, inquiries, proceedings, and conclusions generated from individuals, organizations, or evaluators who review health services to improve health care quality, avoid overuse of services, or determine reasonable charges for services.[2] The term "health care provider" is expanded to include individuals; facilities, organizations and business entities; persons working under the supervision of individuals; and parents, subsidiaries and affiliate organizations.[3]

Confidentiality Protections

The new law provides significantly greater confidentiality protections to peer review records than previous Wisconsin peer review law. For example, peer review records may not be used in a criminal proceeding against a health care provider—even under subpoena. Also, peer review records may not be used in a civil action against any health care provider.[4]

The new law also affords protection to incident and occurrence reports. Incident reports are defined in the law as "written or oral statements—made to notify a person, organization or evaluator who reviews or evaluates the services of health care professionals or charges for such services of an incident, practice, or other situation—that becomes the subject of such a review or evaluation."[5] Incident and occurrence reports are given parallel protections to that of peer review records; these reports cannot be used in any civil or criminal action against any health care provider.[6]

Even peer review records and incident/occurrence reports that have been disclosed to an outside party must remain confidential and cannot be used in actions against any health care provider.

Peer review records and incident/occurrence reports may be disclosed to others under limited circumstances. Some of these circumstances remain intact from the prior law (with minor amendments[7]), some were repealed, and others were created.[8] The new law also makes technical changes to the reporting of information gleaned in a review process in statistical form in order to facilitate large studies of clinical practices.

Shared Records and Processes among Multiple Entities

Historically there has been ambiguity surrounding the sharing of peer review process

• • •

Sarah E. Coyne, JD, is a partner and national chair of the health law group at Quarles & Brady LLP, in Madison, Wis. She can be reached at 608.283.2435, sarah.coyne@quarles.com

and records between separate entities, eg, the employing physician clinic and a hospital at which that physician holds privileges. Many systems have addressed the problem by obtaining consent from each provider. The new law significantly eases this process by specifying that the protection applies to records of evaluators from multiple entities to help improve the quality of health care, avoid improper utilization of services of health care providers, or determine reasonable charges for such services. This language also appears to protect the records of joint processes between providers and payors. The law specifically allows disclosure of peer review records to the provider's employers, or the parent, subsidiary, or affiliate of that employer.[9]

Evidentiary Protections

The QIA includes improved evidentiary protections for health care professionals; data information collected by a regulatory agency (eg, Department of Health Services or Department of Regulation and Licensing) from a health care provider may no longer be admitted into evidence during a civil or criminal action against that provider.[10] Physicians and other medical professionals may feel less pressure providing open and honest information to regulatory agencies without the fear of being forced to testify in a civil or criminal proceeding or of having their testimony used against themselves or a colleague in court.

The QIA also prevents the use in criminal or civil procedures of reports or written statements provided to regulatory agencies. There is an important exception to this rule, which is that administrative proceeding reports, statements and records collected by a regulatory agency may be used against a health care provider in any **administrative** proceeding.[11] An example of an administrative proceeding is an action regarding state licensure of a provider.

Negligence Is not Criminal

Another benefit of the new law—which should allow physicians and medical professionals to breathe a sigh of relief—is that they cannot be criminally liable for their negligence if it occurred within the scope of their duties.

A provider who negligently harms a patient or who acts with inefficiency or unsatisfactory conduct, or who fails in good performance as a result of inability, incapacity, inadvertency, ordinary negligence, or good faith error in judgment or discretion, cannot be held criminally liable for these unintentional medical errors.[12] Negligence by health care professionals within the scope of their duties is now a matter only for civil court. The law applies to acts or omissions committed on and after February 1, 2011.

Public Information Related to Quality Indicators

The revised peer review law permits data collection entities—which gather health care information for the Department of Administration—to report (to DOA) quality indicators that specifically identify individual hospitals (based on the data the entity collects pursuant to Wis. Stat. Chapter 153).[13] The previous law prohibited these reports from identifying individual hospitals with quality indicators.

Conclusion

Taking a good hard look at problematic patient care outcomes and unprofessional conduct is the only tried and true route to quality improvement. You have to know what's "broke" before you can "fix it." Such review has been hampered for many years by the inevitable litigation demands as well as pressure from (well-intended) regulators. Health care professionals did not want to participate in meaningful peer review if they were essentially dooming themselves or a colleague to a malpractice verdict or a licensing restriction. Right or wrong, this is human nature. The QIA recognized and addressed this problem head on. This legislation will go a long way toward effecting robust and meaningful peer review and hopefully improved quality of care.

REFERENCES

1. Wisconsin Statute Section 146.38, entitled "Health care services review; confidentiality of information," in conjunction with Wis. Stat. § 146.37, are commonly known as Wisconsin's "peer review" statutes. Section 146.37 protects individuals participating in peer review of health care services from liability such that the reviewers are immune from lawsuits based on their participation in the peer review process. Wis. Stat. § 146.37 works together with Wis. Stat. § 146.38 which protects the confidentiality of information used and created in connection with the peer review process.

2. Wis. Stat. § 146.38(2).

3. Wis. Stat. § 146.38(1)(b).

4. Wis. Stat. §§ 146.38(2); 148.38(3t).

5. Wis. Stat. § 146.38(1)(bm).

6. Wis. Stat. §§ 146.38(2); 148.38(3t).

7. Wis. Stat. §§ 146.38(3)(a)-(c).

8. Wis. Stat. § 146.38(3m).

9. Wis. Stat. §§ 146.38(3), (3m).

10. Wis. Stat. § 904.16(2).

11. Wis. Stat. § 904.16(3).

12. Wis. Stat. §§ 940.03(3), 940.24(1), 940.24(3), 940.295.

13. Wis. Stat. § 153.05(3m).

advancing the art & science of medicine in the midwest

WMJ

WMJ (ISSN 1098-1861) is published through a collaboration between The Medical College of Wisconsin and The University of Wisconsin School of Medicine and Public Health. The mission of *WMJ* is to provide an opportunity to publish original research, case reports, review articles, and essays about current medical and public health issues.

Visit www.wmjonline.org to learn more.