CMS notes that even if the medical director designates another physician to serve on the QAA committee, the medical director is ultimately responsible. So medical directors and their designees must have a keen interest in all aspects of both the QAPI program and QAA committee.

The QAA Committee
Every nursing facility that participates in the Medicare or Medicaid program must have an operational QAA committee. It must meet at least quarterly, or more often as indicated. In addition to the medical director, the QAA committee must include the director of nursing, an infection preventivist, and at least three other members of the staff, one of whom must be the owner, administrator, board member, or another person who serves in a leadership role.

The responsibilities of the QAA committee include evaluating the effectiveness of the QAPI program, developing and implementing plans of action to correct known deficiencies, and analyzing data collected by the QAPI program and other areas such as drug regimen reviews. If there is an unanticipated resident death, an injury of unknown origin, or some other adverse outcome that possibly could have been prevented, those items fall squarely under the ambit of the QAA committee for analysis, discussion, and recommendation. Near misses should also be brought to the QAA committee for analysis so as to prevent possible harm in the future.

Every physician — indeed, every member of the QAA committee — must recognize the importance of being able to have frank, candid discussions about the root causes of an avoidable and unexpected resident outcome. That is precisely why the federal regulations created a “privilege” against discovery of certain internal deliberations each QAA committee conducts.

Note that not everything that finds its way into the QAA committee is privileged and thereby shielded from discovery. For example, an incident report is not privileged. Even though some lawyers still advise providers that incident reports are privileged, remember that they are not.

QAA Documents and Privilege
The first case in the federal courts dealing with whether incident reports sent to the QAA committee are privileged and can be shielded from discovery by surveyors was the Jewish Home of Eastern Pennsylvania v. HHS (413 Fed. Appx. 532 [3d Cir. 2011], cert denied, 132 S.Ct. 837 [2011]). (By way of full disclosure, I successfully argued this case when I represented CMS.) In that case, the facility’s lawyer claimed that the incident reports the surveyors asked for were privileged. He therefore claimed the deficiencies related to multiple resident falls, described in the incident reports, could not be used as a basis for the enforcement action by CMS (i.e., a civil money penalty).

After a formal appeal, the Administrative Law Judge (ALJ) agreed that even if the documents were sent to a QAA committee for subsequent analysis, the incident reports were not privileged. The provider then appealed the ALJ’s decision to the Health and Human Services (HHS) Departmental Appeals Board, which affirmed the ALJ decision.

Undaunted, the provider further appealed to the U.S. Court of Appeals for the Third Circuit, which held there is no privilege for incident reports. The court noted that the privilege over QAA documents and privilege over incident reports sent to the QAA committee are privileged and can be shielded from discovery by surveyors. However, there is a yawning chasm between an incident report that merely recites a factual account of what happened and the subsequent deliberations by the QAA committee. The latter are privileged.

In its most recent guidance to surveyors in the SOM, CMS states that “Protection from disclosure is generally afforded documents generated by the QAA committee, such as minutes, internal papers, or conclusions. However, if those documents contain the evidence necessary to determine compliance with QAPI/QAA regulations, the facility must allow the surveyor to review and copy them” (SOM, Appendix PP, F841; https://go.cms.gov/2VTlbgW).

Medical directors and all members of the QAA committee must recognize that once “internal papers” are given to a surveyor (or anyone outside the QAA committee), the privilege against discovery is waived. The plaintiff’s lawyers can seek those internal papers and deliberations in the course of litigation against a facility. Disclosing a QAA committee’s internal papers to a surveyor evades the privilege that normally shields internal deliberations from discovery. Such a practice would have a chilling effect on the QAA committee’s ability to have frank and candid discussions about avoidable adverse outcomes and near misses.

A Balancing Act
The regulations dealing with the QAA committee state that “a State or the Secretary may not require disclosure of the records of such committee except insofar as such disclosure is related to the compliance of such committee with the requirements of this section.” So if a facility can demonstrate compliance with the regulation without disclosing privileged or otherwise protected confidential information, that should satisfy a surveyor’s legitimate need to determine if substantial compliance exists.

I recommend that the QAA committee separate its internal papers and privileged information from the routine nonconfidential documents; the latter can be provided to surveyors. For example, items such as the QAA committee’s attendance list, agenda, and related documents could be given to surveyors to demonstrate compliance while keeping the internal deliberations separate and shielded from surveyors. According to CMS, as long as the facility can demonstrate that it has “identified its own high risk, high volume, and problem-prone internal incidents related to resident fall incidences,” the facility can provide that information to surveyors without waiving the privilege necessary to protect the confidentiality of the deliberations.

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quality deficiencies, and [made] a ‘good faith attempt’ to correct them,” it should be able to demonstrate substantial compliance without the need for disclosing internal deliberations. So I suggest keeping separate sets of documents to both (1) satisfy regulatory requirements and (2) maintain the QAA privilege.

Every court that has addressed the issue of the privileged nature of the QAA committee’s internal documents has agreed: the privilege exists, and neither the government nor private litigants may compel a facility to disclose privileged QAA material. For example, a federal district court held that “Congress has explicitly created a QAA Privilege. This privilege prevents both states and the Secretary [of HHS] from discovering the records of QAA Committees…” In short, federal statutes prohibit the Secretary and his subordinates from gaining access to the documents created by any QAA Committee” (United State of America v. Lilburn Geriatric Center, U.S. District Court, Northern District of Georgia, 2002).

Not everything that finds its way into the QAA committee is privileged and thereby shielded from discovery.

Yet another court that addressed the issue of privilege and a facility’s QAA committee held that “it is not the existence of the facts of an incident or accident that must be kept confidential in order for the [QAA] committee to effectuate its purpose; it is how the committee discusses, deliberates, evaluates, and judges those facts that the privilege is designed to protect” (Centennial Healthcare Management Corp. v. Mich. Dept. of Consumer & Industry Services, 254 Mich. App. 275, 657 N.W.2d 746 (2002)).

Although it may be challenging, it is not impossible for facilities to meet the necessary goals of having a demonstrably effective QAA committee while simultaneously protecting its internal deliberations from discovery by surveyors and other litigants.

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Pandemic from page 1

COVID-19 test be cancelled to help alleviate the testing shortage that the Department of Public Health had at that time.

“I guess I dodged a bullet.”

However, after two days the antibiotics did not seem to be having an effect. My patient was now placed on a nasal cannula and started on a couple of liters of oxygen support. I was wracking my brain about what to do next, I silently cursed myself for cancelling the COVID-19 test. It seemed to be consistent with her symptoms, but I did not want to believe that it was the most reasonable explanation.

Still, as I was composing a message to my case manager about redoing the swab, a secure message popped up on my phone — from my case manager. The Department of Public Health had already swabbed and processed the sample despite my cancellation request. Now the results had come back: my patient was positive for COVID-19.

“All right.

The next few days were chaotic for everyone. The patient was moved to the isolation ward that the SNF had planned to create should patients test positive. The nursing home staff were put on high alert now that there was a positive case. Between phone calls to my parent organization to discuss my exposure risk, as well as communicating with the Department of Public Health to find out what I should do next, I found myself making a quick phone call to the patient’s family to tell them the news. They were gracious with me, grateful for the update. I told them that I would continue supportive care as best I could. In the end, they thanked me for taking care of the patient.

“I hope she can pull through.”

The patient was lethargic over the next few days, though she seemed to be breathing without much distress. Her oxygen needs did not increase, and she was awake enough to be responsive to the nurses around her. Over time, as I made more telemedicine visits with her, she slowly worsened. First, she would refuse to open her mouth when fed. Then she began to look more tired, at times not opening her eyes for an entire day. As her oxygen requirement went from two to four liters, I grew fearful that she would need more care than I could provide at the SNF.

“I’m not sure how much longer this can last.”

I dreaded calling the family on a Friday to discuss goals of care. It was a long and hard conversation, but we decided to avoid a hospital transfer and maintain her code status as do-not-resuscitate/do-not-intubate in hope that her situation would stabilize. It took one day to see that this was not going to be the case. Her oxygen requirements had increased to eight liters, and she was now completely unresponsive. The family answered the phone and asked me how I was doing. I could not muster more than a quick, “Fine,” before a short silence took place. I took a deep breath, then told the family what they had feared: “Your mother is going to die.” I expected tears on the other side. Instead, they told me that they were prepared for this and wanted to know if they should contact the rest of the family. I slowly discussed the details of the patient’s comfort and transition to hospice. The family agreed, and wanted me to continue to be the attending on record for the case, rather than turning the care over to a hospice organization.

“It’s the least I can do.”

At the end of our conversation, they thanked me again for my hard work. After the call ended, I sighed and collapsed into my hands. I sobbed, thinking about how difficult it was going to be for the family. The patient, who was a mother, a grandmother, an aunt, and a great-aunt to this gracious family, would die alone. No visitors had been allowed for a month for fear of further spreading the virus. This woman must have thought that her family had abandoned her, being only surrounded by strange people in masks and yellow gowns, speaking in a language that she did not understand.

“I wish things could have been different.”

The patient slowly declined over the next few days, with her breathing becoming more labored and skin taking on a mottled appearance. The family worked with the nursing staff to have a video of the patient sent to their other relatives. More morphine was given to help with her air hunger, and more lorazepam was given for agitation. She died the following Friday. I could only grieve for a moment when it happened. As I tried to take stock of my swirling emotions at that moment, I could not stop thinking about something else. I could not stop working.

“I have an entire wing of COVID-19 patients to take care of now.”

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