MYTH VS. REALITY | THE FACTS ON LONG-TERM CARE TORT REFORM

KEY LINKS
- DHS DQA MEMO: http://www.dhs.wisconsin.gov/rl_dsl/publications/11-024.htm

OVERVIEW
Legislation has been introduced to repeal many of the provisions of January, 2011, Special Session, Wisconsin Act 2, relating to the confidentiality of health care services review, and the Health Care Quality Improvement Act.

Certain interest groups have focused most of their efforts on nursing homes, specifically targeting:
- The cap on non-economic damages (currently $750,000) that also applies to hospitals, doctors and other health care providers;
- The provisions that encourage quality improvement efforts, by falsely asserting that the law permits providers to hide or shields information relating to the care of a resident of a nursing home.
- The provisions that modified and limited the punitive damages law that applies to all litigation, but only seeking to remove the limits for one, targeted sector-the long term care provider community.

Initially, it should be noted that 2011 Act 2 did not make any changes to Chapter 50, the statute that governs the licensure and operations of nursing homes. The Department of Health Services’ rule making authority to establish and enforce regulations and standards for the care, treatment, health, safety, rights, welfare, and comfort of residents of nursing homes were not changed. Similarly, Wis. Admin. Code Ch DHS 132, the administrative rules relating to the licensure and operation of nursing homes, in no way was altered by the Act.

This white paper is intended to offer members of the news media and Wisconsin State Legislators the facts regarding the provision in Act 2 impacting the long term care provider community. On behalf of the more than 200 long-term care facilities we are proud to represent, WHCA/WiCAL would like take this opportunity to provide this resource to members in advance of a forthcoming article on the Quality Improvement Act from the Center for Investigative Journalism.

CLAIM: “Right now in Wisconsin it is difficult – if not impossible – to hold nursing homes accountable when residents are injured or die due to negligence....Under laws passed earlier this session, investigation reports and records can no longer be used in civil and criminal actions against negligent long-term care facilities. These reports – which are paid for with taxpayer money – contain important evidence of what happened and whether a nursing home injury or death was preventable. The Senior Citizen Protection Act (AB-345) would make this evidence available again to judges, juries or families who are searching for the truth and trying to determine if a resident was abused or neglected.”


FACTS: Act 2 did not restrict causes of action and did not strip access to reports and records precluding accountability. A resident’s medical record is the resident’s, and can be shared with anyone the resident authorizes, including a legal representative. While it’s not clear what reports Rep. Richards is referring to in this statement, all of the reports that were previously available are still available for review. Certain and limited reports, while still accessible, have been deemed inadmissible in court, but the admissibility of these were already determined on a case-by-case basis previous to the law change. This does not mean that lawyers, regulators or even prosecutors cannot access the documents, simply they are not able to rely solely on the document itself for proof of the matter asserted.

BACKGROUND: Wisconsin Act 2 created a new definition of an “incident or occurrence report” within Chapter 146’s section on health care service review, the statutes created decades ago to foster and encourage health care providers to engage in evaluation to improve quality and monitor utilization. The new definition of an incident or occurrence report “means a written or oral statement that is made to notify a person, organization, or an evaluator who reviews or evaluates the services of health care providers or charges for such services of an incident, practice, or other situation that becomes the subject of such a review or evaluation.” Critics of the provisions of Act 2 fail to apply or intentionally disregard the actual language of the definition, and assert that anything called an “incident report” is covered under the definition. As noted by the Department of Health Services, “like the health services review and evaluation reports prior to Act 2, an incident or occurrence report, as defined in Act 2, is generally not accessible to the Division of Quality Assurance.”
WHY WERE CHANGES NEEDED TO 146.38? The Health Care Services Review, sometimes referred to as "peer review," was originally enacted decades ago. It has required an update for some time to reflect today's health delivery system, where sharing data and information is recognized as a more effective means to improve quality and outcomes. The previous version was outdated in that it actually discouraged information sharing among and between providers, consultants and even state regulators out of fear that the effort to examine opportunities to correct would later be used against providers. See Braverman v. Colombia Hospital. The new law updated the process by clarifying what providers are covered, what activities are subject to confidentiality, and permitted collaborative efforts within the confidentiality protections. The quality improvement provisions allow greater collaboration, candid exchange of ideas and productive analysis of opportunities for improvement that will translate into higher quality of care for Wisconsin's elders.

A great deal of confusion and misinformation is centered on the understanding of "incident report." Regarding nursing homes, incident reports, or more appropriately, "event reports" are not sent to the Department of Health Services. Event reports are completed after an event to gather information to both comply with regulatory mandates and standards of practice, to identify what happened, and what clinical interventions should be implemented. This information is included in a resident's medical record. A resident's medical record contains extensive information, including nursing documentation describing "all incidents or accidents, including time, place, details of the incident or accident, action taken, and follow-up care." Wis. Admin. Code DHS 132.45(c)(4)(a). For example, if a resident falls, information regarding that fall is contained in the resident's medical record. These are not the "incident reports" as defined in Act 2. Briefly, an incident or occurrence report is used for quality improvement efforts or utilization review efforts; whereas an event report is contained in the resident's medical record and identifies the care provided to the resident.

The disregard of the actual definition is further compounded by the fact that all providers are subject to the Wisconsin Caregiver law complete and submit a form titled "Misconduct Incident Report." Again, just because the term "incident" is contained in this form does not in and of itself place a document into the confidential category that prohibits covered providers from using it for purposes other than Health Care Services Review. Nursing homes have the most stringent reporting expectations when it comes to allegations of possible abuse, neglect, or theft of property. They are required to immediately notify DHS of any allegation, take action to protect residents, thoroughly investigate the matters, and submit detailed results of the investigation within five days. If any individual, at any time forms a reasonable suspicion that a crime has been committed against a resident, they are obligated to report to both DHS and local law enforcement. Wisconsin Act 2 made no change regarding the reporting and investigation expectations, nor did it affect the accessibility of the reports and results.

Misconduct incident reports sent to DHS are reviewed on two levels. The Office of Caregiver Quality conducts a review as to the actions or omissions of the caregiver, and may take action if the conduct constituted misconduct, including referrals to law enforcement agencies as appropriate. The DHS Division of Quality Assurance also conducts its own investigation of the nursing home's compliance and may send a surveyor to the nursing home for further investigation. The accessibility of both reviews remains unchanged.

CLAIM: "(AB-345) also removes arbitrary limits on punitive damages and pain and suffering claims against negligent long-term care facilities for egregious actions by the facility, its executives and employees." Source: Rep. Jon Richards' Press Release

FACT: Until the passage of Wisconsin Act 2 there was no limit on the level of damages that could be sought or recovered in legal actions against Wisconsin's LTC providers, despite there being caps for nearly every other health care provider group. The exposure to unlimited liability has contributed to an environment that fosters litigation and instability in the availability and affordability of professional liability insurance coverage. Wisconsin Act 2 extends to LTC facilities the same limits on non-economic damages that previously applied to hospitals, physicians and other care providers. The extension has established an equal playing field for all health care providers and plaintiffs in which the same event occurring in any health care setting would be subject to the same standard.

There is no limit on economic damages. Non-economic damages are capped regardless of the setting to $750,000. While punitive damages are limited to twice the total compensatory damages determined. The latter is not LTC or even health care specific and applies to all lawsuits brought in this state, yet the legislation to repeal the limits on punitive damages is oddly and narrowly aimed at a single sector, the LTC provider community. To repeal the damage limits to only one subset of the health care sector is without basis and will only further drive this provider community closer to financial collapse.

FOR MORE INFORMATION CONTACT: WHCA/WiCAL at (608) 257-0125.