STATE OF MICHIGAN

IN THE SUPREME COURT

ESTATE OF DOROTHY KRUSAC, deceased,
by her Personal Representative John Krusac,

Plaintiff-Appellee,

vs.

COVENANT HEALTHCARE assumed name for
COVENANT MEDICAL CENTER, INC.;
COVENANT MEDICAL CENTER-HARRISON assumed
name for COVENANT MEDICAL CENTER, INC.;
Michigan Corporations, jointly and severally,

Defendants-Appellants.

Sup Ct No. 149270
COA No. 321719
Case No. 12-15433-NH-4
Hon. Fred L. Borchard

/

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/

AMICUS CURIAE BRIEF OF HEALTH CARE ADMINISTRATOR BRENDA KEELING, RN, CPHQ, CPUR

Respectfully Submitted By:

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INTEREST OF AMICUS CURIAE

This brief seeks to educate the Court about how health care administrators document facts related to incidents in a hospital or nursing care facility.

QUALIFICATIONS OF AMICUS CURIAE

Brenda Keeling, RN, CPHQ, CPUR, is President of Patient Response in Durant, Oklahoma, consulting with hospitals regarding regulatory compliance. Brenda began her career as a nurse in 1978, She is a Certified Professional in Healthcare Quality, and a Certified Professional in Utilization Review. She was a hospital administrator at Doctors Hospital at Renaissance in Edinburg, Texas until February 2014. See Curriculum Vitae attached as Exhibit A.

DUTY OF HEALTH CARE ADMINISTRATORS TO REPORT FACTS IN PATIENT MEDICAL RECORD

Upon review of the factual material of *Krusac v Covenant Medical Center, Inc*, we submit that health care administrators have an affirmative obligation under the law to include all pertinent facts regarding medical care in a patient's chart. All facts regarding a patient's care are considered a part of the medical record and should be accessible by the patient.

The purpose of peer review privilege is to see what happened with open eyes to see how to make things better. Peer review is not a fact finding mission. The purpose of peer review is to determine how to provide better care. In lay terms, the purpose of peer review is to reduce injuries and deaths related to medical negligence. The peer review process includes meetings to determine how a facility can render better care next time. It involves analyzing the facts that have already been collected so that improvements and remedial measures can be taken.

Hospitals must track and analyze instances of patient harm as a condition of participation in the Medicare program. Incident reporting systems are a common means that hospitals use to meet this condition. Incident reports are submitted to the Joint Commission or other accreditation organizations, as well as state and federal agencies for review.

In reviewing the briefs in *Krusac* it appears that the incident report contained facts not documented in the patient's medical record. This is problematic because medical caregivers have an affirmative duty to document all events related to patient care pursuant to standards set by the Joint Commission. The Joint Commission is a non-profit organization, which accredits more than 20,000 health care organizations and programs in the United States. In order to qualify for Joint Commission accreditation, a hospital must meet wide ranging standards, including standards regarding patient medical records. The Joint Commission Requirements Related to the Provision of Culturally Competent Patient-Centered Care Hospital Accreditation Program provide as follows:

> "...the record of care comprises all data and information gathered about a patient from the moment he or she enters the hospital to the moment of discharge or transfer. As such, the record of care functions not only as a historical record of a patient's episode(s) of care, but also as a method of communication between practitioners and staff that can facilitate the continuity of care and aid in clinical decision-making." [Exhibit B: Joint Commission Requirements Related to the Provision of Culturally Competent Patient-Centered Care Hospital Accreditation Program: Record of Care, Treatment, and Services – Overview; Joint Commission, January 2009, 15]."
>
> Standard RC.01.01.01 provides: "The hospital maintains complete and accurate medical records..." [Exhibit B].

> Standard RC.02.01.01 provides: The medical record contains information that reflects the patient's care, treatment, and services..." [Exhibit B].

Thus, documentation of objective facts that happen contemporaneously with medical care is not peer review and not subject to privilege. The Joint Commission requires that a patient's medical record be "complete and accurate" and include all "care, treatment, and services." Michigan law and federal law require that patients have access to their medical records. See MCL 333.26265 and 45 C.F.R. 164.524.

The facts of what happened in providing care to a patient should not be subject to privilege, because if that were the case, then a facility could alter the facts documenting poor care. The purpose of peer review is to look back at an event retrospectively and analyze patient harm and how to provide better care. Therefore, it is for this reason that any contemporaneous facts in an incident report are not privileged, because contemporaneous facts are required to be documented as a part of the patient's medical record and be accessible to patients. Contemporaneous facts are never peer review. Only analysis of the collected facts is peer review and privileged.

Respectfully submitted,

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EXHIBIT A

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EDUCATION

American Sentinel University – Master of Science in Nursing, Case Management (2013-2014)

East Central University – Bachelor of Science in Nursing (1986-1988)

Murray State College – Associate Degree in Nursing, Registered Nurse (1976-1978)

CERTIFICATIONS

Certified Case Manager – Case Management Society of America (September 2012 – May 2017)

Certified Professional in Health Care Quality - Healthcare Quality Certification Commission, License 00015322 (August 2010 – December 2014)

EXPERIENCE

Contributing Author (2013 –Present)
Athena Forum, LLC (125 Crofton Hill, Rockville, Maryland 20850)

Vice President of Education (August 2011 – February 2014)
Doctors Hospital at Renaissance (5501 South McColl Road, Edinburg, Texas 78539)

President/CEO (July 1995 – Present)
Patient Response, Inc. (32 Albert Pike Road, Durant, Oklahoma 74701)

- Regulatory Compliance
- Case Management
- Medicare Conditions of Participation
- Department of Health Surveys
- Quality/Performance Improvement Consultation

EXHIBIT B

The Joint Commission 2009 Requirements Related to the Provision of Culturally Competent Patient-Centered Care
Hospital Accreditation Program (HAP)

The Joint Commission views effective communication, cultural competence, and patient-centered care as important elements of providing safe quality care. The individual's involvement in care decisions is not only an identified right, but is a necessary source of accurate assessment and treatment information. The Joint Commission has a number of standards that support the provision of care, treatment, and services in a manner that is conducive to the cultural, language, health literacy, disability, and learning needs of individuals:

- Advance Directives (Standard **RI.01.05.01**)
- Complaint/grievance resolution (Standard **RI.01.07.01**)
- Contracted services (Standard: **LD.04.03.09**)
- Documentation of needs and data collection of data (Standard **PI.01.01.01, PI.04.01.01, RC.01.01.01, RC.02.01.01**)
- Effective communication including interpreter and translation services (Standard **RI.01.01.03, PC.04.01.05**)
- Effective communication throughout hospital (Standard **LD.02.01.01, LD.03.04.01**)
- Environmental appropriateness (Standard **EC.02.06.01**)
- Ethics/equal standard of care provision (Standard **LD.04.02.03, LD.04.03.07**)
- Informed consent (Standard **RI.01.03.01**)
- Law and regulation compliance (Standard **LD.04.01.01**)
- Orientation of staff (Standard **HR.01.04.01**)
- Patient assessment (Standard **PC.01.01.01, PC.01.02.01, PC.01.02.11, PC.01.02.13, PC.02.03.01**)
- Patient education (Standard **PC.02.03.01**)
- Patient involvement in care (Standard **RI.01.02.01**)
- Performance improvement opportunities (Standard **LD.03.02.01, LD.03.05.01, LD.04.04.01, PI.03.01.01**)
- Planning for services to meet patient needs (Standard **LD.03.03.01, LD.04.03.01, LD.04.04.03, LD.04.04.07, PC.01.03.01, PC.02.02.01**)
- Resource provision (Standard **LD.04.01.05, LD.04.01.07, LD.04.01.11, LD.04.04.03, LD.04.04.05**)
- Staff competence (Standard **HR.01.05.03, HR.01.06.01, LD.03.06.01**)
- Staff qualifications (Standard **HR.01.02.01, HR.01.02.05, HR.01.07.01**)
- Values, beliefs respected (Standard **PC.02.02.03, PC.02.02.13, RI.01.01.01, RI.01.01.03, TS.01.01.01**)

This document identifies Joint Commission standards and elements of performance (EPs) that are related to the provision of care that support effective communication, cultural competence, and patient-centered care. Some of the standards listed directly address issues related to issues related to the language, cultural, disability, or learning needs of patients, while other standards serve as hospital supports for the provision of culturally competent patient-centered care. Standards are organized by chapter. Please note that the standards listed in this document are not always listed in their entirety; many elements of performance for these standards are not included. Please refer to the 2009 Standards to see the full text of theses standards and elements of performance.

EP 2. The hospital identifies the inpatient units for staffing effectiveness data collection based on an assessment of relevant information or risk including the following:

- Type of setting
- Patient population served
- Knowledge about staffing issues likely to affect patient safety or quality of care
- Existing data (for example, incident logs, sentinel event data, performance improvement reports)
- Input from clinical staff who provide patient care

Note: If the hospital has only one unit, it need not apply these criteria

Record of Care, Treatment, and Services (RC)

Overview

The "Record of Care, Treatment, and Services" (RC) chapter contains a wealth of information about the components of a complete medical record. A highly detailed document when seen in its entirety, the record of care comprises all data and information gathered about a patient from the moment he or she enters the hospital to the moment of discharge or transfer. As such, the record of care functions not only as a historical record of a patient's episode(s) of care, but also as a method of communication between practitioners and staff that can facilitate the continuity of care and aid in clinical decision-making.

Whether the hospital keeps paper records, electronic records, or both, the contents of the record remain the same. Special care should be taken, however, by hospitals that are transitioning from paper to electronic systems, as the period of transition can present increased opportunity for errors in recordkeeping that can affect the delivery of safe quality care.

Standard RC.01.01.01

The hospital maintains complete and accurate medical records.

EP 12. The hospital tracks the location of all components of the medical record.

EP 13. The hospital assembles or makes available in a summary in the medical record all information required to provide patient care, treatment, and services.

Standard RC.02.01.01

The medical record contains information that reflects the patient's care, treatment, and services.

EP 1. The medical record contains the following demographic information:

- The patient's name, address, date of birth, and the name of any legally authorized representative
- The patient's sex
- The legal status of any patient receiving behavioral health care services
- The patient's language and communication needs

EP 4. As needed to provide care, treatment, and services, the medical record contains the following additional information:

- Any advance directives
- Any informed consent, when required by hospital policy (See also RI.01.03.01, EP 13)
- Any records of communication with the patient, such as telephone calls or e-mail
- Any patient-generated information