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INSIDE

AHC Media

OCTOBER 2015 Vol. 40, No. 10; p. 97-108

'Immediate jeopardy' can happen to any hospital

Problems can slip through and result in CMS's worst finding

"Immediate jeopardy" are words you never want to see on a CMS survey report for your facility because it means you are on the brink of losing your accreditation for Medicare in a very short time, and that is only the worst of the ramifications. Immediate jeopardy also means higher fines, less time to correct problems, and extremely bad publicity.

But this only happens to hospitals that are in bad shape overall, where the administrators know that there are serious deficiencies that could lead to immediate jeopardy, right? Surely it can't happen to hospitals that are high quality and well run.

It can happen to those top-notch facilities, say the experts. It is possible for a serious deficiency to slip through the cracks and go unnoticed until a CMS surveyor makes a fateful note in the records.

> "IT IS POSSIBLE FOR A SERIOUS DEFICIENCY TO SLIP THROUGH THE CRACKS AND GO UNNOTICED UNTIL A CMS SURVEYOR MAKES A FATEFUL NOTE IN THE RECORDS."

Surveyors will declare immediate jeopardy when the facility is in noncompliance with at least one condition of participation (CoP) in a way that has caused or is likely to cause serious injury, harm, impairment or death to a patient. *(For more on what constitutes immediate jeopardy, see the story on p. 100.)*

A wide range of situations can result in immediate jeopardy, but

Financial Disclosure: Editor Greg Freeman, Managing Editor Jill Drachenberg, Associate Managing Editor Dana Spector, and Nurse Planner Fameka Barron Leonard report no consultant, stockholder, speaker's bureau, research, or other financial relationships with companies having ties to this field of study. Consulting Editor Patrice Spath discloses she is author of by Health Administrative Press, and a stockholder of both General Electric and Johnson & Johnson.

HOSPITAL PEER REVIEW®
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Hospital Peer Review®
ISSN 0149-2632, is published monthly by
AHC Media, LLC
One Atlanta Plaza
950 East Paces Ferry Road NE, Suite 2850
Atlanta, GA 30326.
Periodicals Postage Paid at Atlanta, GA 30304 and at additional mailing offices.
GST registration number R128870672.

POSTMASTER: Send address changes to:
Hospital Peer Review
P.O. Box 550669
Atlanta, GA 30355.

SUBSCRIBER INFORMATION:
Customer Service: (800) 688-2421.
customerservice@ahcmedia.com.
AHCMedia.com
Hours of operation: 8:30-6 M-Th, 8:30-4:30 F EST

SUBSCRIPTION PRICES:
U.S.A., Print: 1 year: $519. Add $19.99 for shipping & handling.
Online only: 1 year (Single user): $469
Outside U.S.A.: Add $30 per year. Total prepaid in U.S. funds.

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ACCREDITATION: AHC Media is accredited as a provider of continuing nursing education by the American Nurses Credentialing Center's Commission on Accreditation.

This activity has been approved for 1.25 nursing contact hours using a 60-minute contact hour.

Provider approved by the California Board of Registered Nursing, Provider #CEP14749, for 15 Contact Hours. This activity is valid 24 months from the date of publication.

The target audience for *Hospital Peer Review®* is hospital-based quality professionals and accreditation specialists/coordinators.

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examples include failure to count instruments and supplies in surgery, improper use of restraints, patient-to-patient violence or sexual assault, and medication safety failures, says **Susan G. Kratz**, JD, shareholder and chair of the healthcare practice group with the law firm Nilan Johnson Lewis in Minneapolis. CMS surveyors, or state surveyors acting on behalf of CMS, see the immediate jeopardy finding as a way to intervene in especially dangerous situations, she says.

"They're looking for a problem in which a patient could come to immediate harm, not just a possibility some time in the future," Kratz says. "But it is important to remember that it is not necessary for a patient to have been harmed already."

Infection control also is a common prompt for immediate jeopardy. Even something like poor compliance with handwashing protocols could result in immediate jeopardy, Kratz explains.

"It can be as simple as failure to follow a policy or it could be that you're not protecting patients from physical abuse or harm from staff or from other patients," she says.

Always a shock

Avoiding immediate jeopardy is the best strategy, of course, but there is no guaranteed way to do so, Kratz says. *(See the story on p. 107 for prevention strategies.)*

Immediate jeopardy findings are almost always a shock to the hospital, Kratz says. Hospitals may have passed recent surveys by The Joint Commission and state agencies with no problem and still find themselves facing the worst result from CMS, she says. The "highest-quality and best-run facilities" can still be hit with immediate jeopardy findings, she says.

"Usually it's for things you wouldn't expect. It's not a problem that you've identified and have been monitoring and working to improve," Kratz says. This absolutely happens to hospitals that have never had a deficiency and think that things are running great, and they're running all these quality metrics that are reassuring. Then CMS comes in and finds something that shocks the hospital."

The threat to patient safety and health is not always physical, notes **Ruth Ragusa**, RN, vice president of organizational effectiveness at South Nassau Communities Hospital in Oceanside, NY. Patients who feel threatened or neglected could prompt an immediate jeopardy finding, she says.

Current concerns can be targeted by surveyors, Ragusa says, and it is possible for a hospital that otherwise is performing well to slip up on a recent development or recommendation.

"Last year the hot topic they were looking at was glucometer testing because the CDC had put out some precautionary notes about how if staff don't follow proper procedures, there is a risk of exposing patients to bloodborne pathogens," Ragusa says. "A lot of organizations were reviewed closely for compliance with that."

Surveyors watched the staff work with glucometers to assess whether they were following the most recent guidelines, and they cited safety risks if any step was not

EXECUTIVE SUMMARY

A finding of immediate jeopardy in a CMS survey creates a crisis for a healthcare facility. The hospital must react quickly to avoid losing Medicare accreditation.

- Even high-quality hospitals can have an immediate jeopardy finding.
- A patient injury is not necessary for surveyors to declare immediate jeopardy.
- Fines are increased and the time for remedies is shortened.

done correctly, Ragusa says. New policies and procedures, combined with the vagaries of individual staff performance and a surveyor's subjective assessment, can easily lead to a serious citation, she says.

Ragusa points out that surveyors can find immediate jeopardy even if few patients are exposed to the hazard, and even if no harm has actually been done yet.

"They feel that if one patient is exposed, then there is a danger to other patients," she says. "The definitions are very broad and left up to the surveyor, so even a hazard that has not affected any patient can still get you in trouble. As long as the hazard exists, they can say it puts patients at risk."

Because immediate jeopardy is the result of a surveyor's subjective assessment, it is not uncommon for the hospital leaders to be frustrated and angry with the citation. With a citation for not counting surgical instruments, for example, the surgery department leaders may be confident that other policies and procedures ensure items are not left behind in the patient. And if there has been no report of patient harm, immediate jeopardy may seem like a gross overreaction.

If you know that the surveyors are considering immediate jeopardy, it is possible to discuss the issue with them and convince them that even if there is a problem, it is not serious enough to justify immediate jeopardy. But you usually don't get that opportunity.

"It is typical that the surveyors just announce to the hospital staff that they are issuing an immediate jeopardy finding," Kratz says. "Once that announcement has been made, the hospital has to correct the problem or they will be terminated from Medicare in 23 days."

Fix it fast

The notification of immediate jeopardy usually is only oral, Kratz notes. Don't wait for or demand written notification because that will only take up valuable time.

Speed is paramount, Kratz advises. If a surveyor cites immediate jeopardy, your number-one priority should be correcting that problem as quickly as possible. CMS will require a written report that the jeopardy has been abated, but it is possible to do so even before the surveyors leave the facility that day. Remember that this does not require correcting all of the deficiencies related to the citation; you only have to eliminate the immediate threat to patient safety and health.

This may mean writing a new policy, having it approved through the required process at the hospital, and training people on it immediately. If necessary, enlist the aid of the hospital CEO or president to get people and resources directed to this emergency effort. In other cases, the hospital may have to stop doing a particular procedure because a fix is not possible immediately. In that scenario, the aim is to show the surveyors that patients are no longer at risk because you are simply not doing the procedure in question.

If you cannot abate the immediate jeopardy before the surveyors leave, CMS must visit again to confirm the improvement on site. This will count as one of your two allowed revisits, and it may be wasted on just confirming the immediate jeopardy abatement if you have other deficiencies to address from the survey.

"Immediate jeopardy used to be rare, but it's becoming more common," Kratz says. "There is a lot of discretion that is given to the surveyors about what constitutes immediate jeopardy, so it is hard to know when this is going to happen to you."

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Immediate jeopardy is fast track to disaster

A finding of immediate jeopardy in a CMS survey is the worst fear of peer review professionals, and rightly so. This survey finding puts you on a fast track to losing your Medicare participation and CMS won't wait long for you to correct the problems.

Immediate jeopardy is the most severe finding by a CMS surveyor, after the "standard" and "condition" levels. The standard level is when the surveyor finds noncompliance with one or more requirements that do not substantially limit the facility's ability to furnish adequate care and would not adversely affect health and safety if it were to continue. *(More information on CMS definitions and instructions to surveyors is available online at http://tinyurl.com/o6ddnv3.)*

The next step up is the condition level, involving noncompliance with either one standard representing a severe health and safety breach or several standards that together pose a severe risk. CMS lists five deficiencies that will result in an automatic condition level citation: restraint and seclusion failures, lack of a utilization review program, alcohol gel leading to a fire risk, failure to provide adequate emergency services, and any other problem causing an immediate threat to health and safety.

And there is immediate jeopardy. For this citation, a surveyor must document noncompliance with one or more requirements of participation that has caused or is likely to cause, serious injury, harm, impairment, or death to a patient.

With that citation, everything speeds up and the stages get much higher. Whereas you normally would have six months to remedy compliance deficiencies, an immediate jeopardy finding means your provider agreement could be terminated in as little as two days. (But at least one has to be a work day.) The longest CMS will wait is 23 days.

> "THE STANDARD LEVEL OF WHEN THE SURVEYOR FINDS NONCOMPLIANCE WITH ONE OR MORE REQUIREMENTS THAT DO NOT SUBSTANTIALLY LIMIT THE FACILITY'S ABILITY TO FURNISH ADEQUATE CARE AND WOULD NOT ADVERSELY AFFECT HEALTH AND SAFETY IF IT WERE TO CONTINUE."

However, CMS does not expect you to correct the overall deficiency in that time. You only have to "abate the jeopardy," which means eliminating the immediate threat to patient safety. When CMS determines that the immediate jeopardy has been removed, you have the standard six months to correct the underlying deficiency.

Immediate jeopardy also may result in state monitoring, which can begin immediately. Other remedies such as denial of payment for new admissions, imposing temporary management, and directed in-service training can be applied with only two days' notice.

An immediate jeopardy citation can be appealed through the informal dispute resolution process the same as any other deficiency finding, and you can file a formal appeal with an administrative law judge. In addition to disputing the surveyor's deficiency finding, you can dispute the severity of the deficiency so that it is reduced to less than immediate jeopardy. ■

Vigilance can help avoid immediate jeopardy

Because CMS surveyors are given latitude in how to assess deficiencies, immediate jeopardy is always a risk. But there are ways to reduce your chances of receiving the worst citation.

Close oversight of day-to-day activities by the hospital board and management can go a long way toward avoiding immediate jeopardy, says **Susan G. Kratz**, JD, shareholder and chair of the healthcare practice group with the law firm Nilan Johnson Lewis in Minneapolis. The goal is to catch potentially serious problems before CMS does.

"Constantly reviewing the

Medicare guidelines for the conditions of participation is an important strategy," she says. "It also is important to have accountability for the staff responsible for monitoring compliance and reporting to the board how things are going."

That oversight should be a primary focus for hospital leaders, says **Ruth Ragusa**, RN, vice president of organizational effectiveness at South Nassau Communities Hospital in Oceanside, NY.

"It's about constantly looking at practice and policy, and closing the gap," she says. "There are so many things the staff have to manage that it's just human nature for them to miss something. Hospital leaders have to step in and close that gap with education and training."

SOURCES

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New technology poses credentialing challenge

Medical technology is evolving at such a fast pace that hospital credentialing and privileging programs can't keep pace. The result is that too many surgeons are being allowed to use new devices and technology without proving their competency to the hospital.

Patients will suffer the consequences, experts say, and hospital quality leaders will be blamed for not keeping up with the times.

Credentialing surgeons in new technology is necessary whether the physician has been in practice for decades or is fresh out of a residency, notes **Robert Wachter**, MD, interim chairman of the Department of Medicine and chief of the Division of Hospital Medicine at the University of California, San Francisco. A surgeon may be highly experienced and skilled but still not be qualified to use a device or technology that just became available, he says.

"It used to be that we could take surgeons right out of medical school and be reasonably confident that they were competent in a number of different procedures. The growing use of technology is changing that," Wachter says. "Given the changes in surgery and accreditation, there are surgeons who finish their training and really are not capable of independent practice and need further training."

Like early days of laparoscopy

The current challenges with credentialing new technology are reminiscent of the problems with credentialing laparoscopic cholecystectomy in the 1990s, Pradarelli notes. Surgeons adopted minimally invasive surgery with enthusiasm and it was not uncommon for them to operate on patients after only a weekend training course by the manufacturer. It wasn't long before there was a wave of malpractice cases alleging that the hospitals allowed unqualified surgeons to use new technology on patients.

"Some time after their two days of training in Italy, they were asked if they felt ready to do the surgery and a very small percentage of them said yes. When they were asked if they do the surgery now independently, a very large percentage said they did," he recalls. "We determined later that there was a substantial learning curve and you weren't really competent in that procedure until you had done about 50 cases."

The healthcare community will not find much help from government agencies when assessing new technology and surgeons' competence with it, says **Jason C. Pradarelli**, MD, a physician at the University of Michigan Medical School, and the University of Michigan School of Public Health in Ann Arbor. Pradarelli and colleagues recently authored an essay in the *Journal of the American Medical Association* on

EXECUTIVE SUMMARY

Emerging technology poses a challenge to the credentialing and privileging process. Standard procedures may be ill-suited to determining a surgeon's competence with new technology.

- Hospitals must develop their own criteria for credentialing new technology.
- Proctoring should be a key component, but it is not enough.
- Simulation and higher training standards will be necessary.

this challenge. (*The essay is available online at http://tinyurl.com/of5wqbx.)*

Although the Food and Drug Administration (FDA) strictly regulates new drugs, it exerts minimal oversight for new devices and no oversight for new surgical techniques, Praderelli says. That lack of oversight came to light recently when the da Vinci surgical robot was linked to numerous injuries and critics questioned whether surgeons had been adequately trained and properly credentialed by the hospitals. *(See the story on p. 103 for more on the da Vinci robot.)*

Get friendly with surgery chair

The best strategy for addressing this issue is to foster good communications between the credentialing body at the hospital and the chairs of relevant clinical departments, most notably the department of surgery, Pradarelli says. The goal is to stay abreast of what technology is emerging in that field so that the credentialing committee is not caught off guard when a surgeon wants to bring in the latest technology.

Once you know that surgeons at your hospital are interested in a certain technology, you can begin looking for guidance on how to credential them. Many specialty physician groups — the Society of American Gastrointestinal and Endoscopic Surgeons, for instance — have guidelines for ensuring that a physician is competent in a specific technology or device. A specialty group's guidelines won't be enough for hospital credentialing, but they will give you a starting point.

"There are times when the surgeon or physician might try out new technology or procedures without people above them in the credentialing body even knowing," he says. "Being aware of the innovations is the first step, and you also want a good relationship so that the chair of that department lets you know when new technology is coming to the hospital."

All of the specialty group guidelines emphasize training and proctoring, Pradarelli says. Mini-fellowships also are suggested in many cases. These steps are much more robust than a day or two of training at the device manufacturer, or a day in the cadaver lab, he notes.

Proctoring is not enough

That still may not be enough. The current credentialing process that relies on proctoring and peer review is inadequate for much of the new technology in healthcare, Wachter says. The usefulness of proctoring is limited, he notes, because collegiality among surgeons can make it difficult for one to say that another is not qualified.

"I think the answer has to lie somewhere with simulation and higher training requirements," he says. "The surgeon will have to undergo training that is much more substantial than a weekend course, prove their skills in simulation, and then you still don't want them doing this procedure alone when they get back to the hospital."

The credentialing committee will have to work with the department head to determine how much experience is enough for allowing the surgeon to operate alone. There may be empirical data with some procedures will provide a threshold, but in others the department head may have to determine a number based on past experiences and knowledge of the field, Wachter says.

But what constitutes new technology or a new procedure? That can be hard to define, so Pradarelli says that is one reason you must have good communications with the department heads. In some cases you will have to rely on that person to give you a heads up that there is a new technology for the credentialing committee to address, or that the use of a certain device changes the procedure in such a way that it should be considered new.

Wachter calls attention to a 2013 study that assessed the technical skills of surgeons new to bariatric surgery. Surgeons were asked to videotape their procedures and send their best examples for evaluation by experienced bariatric surgeons. The results were not encouraging, suggesting that standard credentialing procedures are inadequate. *(See the story on p. 103 for more about the study.)*

"Right now it's the Wild West here," Wachter says. "A new procedure comes out and hospitals are left to devise their own standards for what means the surgeon is qualified to operate alone. This is an area that has been woefully neglected in the safety and quality arena."

SOURCES

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- Robert Wachter, MD, Interim Chairman of the Department of Medicine and Chief of the Division of Hospital Medicine at University of California, San Francisco, CA. Telephone: (415) 476-5632. ■

Hospital settles lawsuit after credentialing surgeon on robot

The first lawsuit to be decided involving the da Vinci surgical robot suggests that hospitals are going to be held responsible if they do not properly credential physicians on emerging technology. The company making the device may be in the clear.

The da Vinci system was widely adopted after its 2000 FDA approval, and in 2013 the first of at least 26 lawsuits went to trial alleging death or injury from the use of the device. In *Taylor v. Intuitive*, the patient had undergone a robotic-assisted radical prostatectomy and suffered a rectal laceration among other complications. The patient died four years later and the plaintiffs contend that the injury contributed to his death.

The surgeon in that case was a board-certified urologist who had performed more than 100 open prostatectomies with good outcomes over a decade. He had one day of hands-on training at the company headquarters of Intuitive Surgical, the company that makes the da Vinci robot, and he had proctored on two cases with a more experienced surgeon. The Taylor case was the surgeon's third robotic procedure and the first in which he was not supervised by a more experienced surgeon.

Court documents indicate that the hospital's new robotics committee included Intuitive consultants and the credentialing requirements were based solely on the company's training program.

The hospital and surgeon acknowledged responsibility for the patient harm and settled malpractice lawsuits for undisclosed amounts. The case against Intuitive proceeded and a Washington state jury found in favor of the company, saying it was not responsible for the negligence that led to the patient's injury.

In particular, the court said that the company did not have an obligation to warn the hospital of the hazards associated with an insufficiently skilled surgeon using the device. The company must warn the physician, which it did, but determining the physician's competency was the hospital's responsibility.

The plaintiffs appealed, but the Court of Appeals of Washington, Division 2, affirmed the trial court's decision. The appeals court decision is available online at http://tinyurl.com/qcx6fqs. ■

Videotape review reveals flaws in tech credentialing

A recent study of surgeons credentialed to perform bariatric surgery suggests that current hospital methods for assessing competence in new and complex procedures are inadequate.

The study was conducted by lead author John Birkmeyer, MD, now a professor of surgery at the Dartmouth Institute in Hanover, NH, and colleagues. They focused on bariatric surgery because it is a complex procedure requiring a new set of skills, and one that is growing in popularity and profitable for hospitals. They studied 20 bariatric surgeons in Michigan who participated in a statewide collaborative improvement program. *(The study is available online at http://tinyurl.com/osn63zb.)*

Each surgeon submitted a single representative videotape of himself or herself performing a laparoscopic gastric bypass. Each videotape was rated in various domains of technical skill on a scale of 1 to 5 (with higher scores indicating more advanced skill) by at least 10 peer surgeons who were unaware of the identity of the operating surgeon, the researchers write.

Mean summary ratings of technical skill ranged from 2.6 to 4.8 across the 20 surgeons. That variability was troubling, says **Robert Wachter**, MD, interim chairman of the Department of Medicine and chief of the Division of Hospital Medicine at the University of California, San Francisco.

"That was the first lesson, that not everyone was well versed in the skill and has the technical ability," Wachter explains.

Then the researchers assessed variables such as readmission rates, return to the OR, surgical infection rates, and mortality rates, correlating those with the technical scores of the surgeons. They assessed relationships between these skill ratings and risk-adjusted complication rates, using data

from a prospective, externally audited, clinical-outcomes registry involving 10,343 patients.

They found that the bottom quartile of surgical skill, as compared with the top quartile, was associated with higher complication rates (14.5% vs. 5.2%) and higher mortality (0.26% vs. 0.05%). The lowest quartile of skill was also associated with longer operations (137 minutes vs. 98 minutes) and higher rates of reoperation (3.4% vs. 1.6%) and readmission (6.3% vs. 2.7%).

"The technical skill of practicing bariatric surgeons varied widely, and greater skill was associated with fewer postoperative complications and lower rates of reoperation, readmission, and visits to the emergency department," the researchers concluded. The findings suggest that peer rating of operative skill may be an effective strategy for assessing a surgeon's proficiency, they said.

"It was staggering. Major, major differences in mortality, return to OR, many factors," Wachter says. "We credential proceduralists with no knowledge of any of that. We let them tell us that they're trained in the new procedure without any expert review of their skills, as was done in this study." ■

Arkansas doctors, hospitals fight over peer review law

Three Arkansas hospitals are continuing their fight against a 2013 law that governs hospital peer reviews, taking the case to the state supreme court. In part, the law requires that hospitals notify physicians that they are under review and allows them to have a lawyer.

The hospitals argued that the law was unconstitutional, in part because it attempted to supersede federal law. Pulaski County Circuit Judge Tim Fox recently denied the hospitals' claims and ruled that the Arkansas Peer Review Fairness Act was constitutional. He denied a request for a summary judgment from the hospitals.

Baptist Health Medical Systems, Washington Regional Medical Center, and Mercy Health system filed their notice of appeal, which means their next stop will be the Supreme Court of Arkansas.

The law in dispute is Act 766 of 2013, which created additional rules for peer reviews at hospitals, with supporters saying it added protection for physicians receiving a job performance review. The law requires hospitals to notify physicians of an investigation when it begins and allows those doctors to have their own attorneys present at the beginning of the process.

That gives Arkansas physicians more protection than is provided by the federal Health Care Quality Improvement Act. Under that law, hospitals can wait until a hearing is initiated to notify the physician even if an investigation has been going on for months before that point.

The hospitals challenging the law allege that it unnecessarily burdens the process, places additional demands on an already volunteer body of peer doctors, and makes the process more combative.

The Arkansas Hospital Association opposes the law but the Arkansas Medical Society supports it. **David Wroten**, executive vice president of the Arkansas Medical Society in Little Rock, says the law only adds common sense protection for physicians. The law protects not only physicians under review, but the physicians who are conducting the peer review, he notes.

"We believe this law brings needed due process to the peer review process, and it also helps eliminate conflicts of interest that pop up in peer review," Wroten says. "There are lots of stories of peer review being used, not by the hospital's medical staff, but by hospital administration to go after physicians who disagreed with it. When the hospital wants to remove a physician for any reason, peer review can be a useful tool."

That scenario can play out, for example, when a hospital wants to buy a clinic and the clinic refuses, Wroten says.

"So the hospital goes after the doctor to try to run him off the staff," Wroten says. "It's sham peer review. That's part of what we're trying to prevent."

One component of the law is particularly irksome to the hospitals.

EXECUTIVE SUMMARY:

Hospitals and physicians are arguing over an Arkansas law that governs how hospitals handle peer reviews. The law gives greater protection to doctors.

- The law was enacted in 2013.
- A court recently ruled it to be constitutional.
- Three hospitals are taking the case to the state supreme court.

Not only can the physician have an attorney from the beginning of the peer review, but the physician also can object to the attorney representing the hospital or the review committee.

Megan Hargraves, JD, the attorney representing the hospitals, filed a brief arguing that if the hospital kept the attorney despite the doctor's protest, that decision could be used against them if the doctor under review chose to file a lawsuit against the peer review group.

"Taken together, [Act 766] permit an individual physician, who is the subject of peer review, to force a hospital or its medical staff into using an attorney other than its preferred counsel during the review process," Hargraves wrote. "This unconstitutionally chills [the hospitals'] First Amendment right to select the attorney of their choice."

Wroten says the hospitals' arguments that the law is too burdensome don't hold water.

"It's really very simple: If you're investigating a physician, you have to let them know," he says. "You can't spring it on them at the last minute. If the hospital's legal counsel is involved, the physician can have a physician involved. It's simple due process and getting rid of conflicts of interest."

SOURCE

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Quality data may be skewed by other hospital readmissions

Readmission rates may not be an accurate measure of hospital quality if the analysis does not factor in the readmissions from other hospitals, researchers suggest in a new study.

A significant number of patients should be counted as readmissions but often are not because the prior admission was at another hospital, reports **Alisa Khan**, MD, MPH, of the division of general pediatrics at Boston Children's Hospital. She and her colleagues wrote that without including readmissions data from other hospitals, a facility's readmission performance cannot be adequately measured.

The issue is particularly important now with the growing focus on hospital comparisons and quality measures, Khan wrote. Studies find that approximately 20% of adult readmissions are to a different hospital, the research report noted. Same-hospital readmission rates underestimate mean all-hospital readmission rates by approximately 5% in adults with heart failure and those who have undergone surgery, with the degree of underestimation varying across hospitals. The researchers note that little is known about the prevalence of different-hospital readmission among pediatric patients. To evaluate the importance of including different-hospital readmission rates in pediatrics, they estimated the prevalence of 30-day pediatric different-hospital readmission, assessed the effect of different-hospital readmissions on hospitals' estimated readmission performance, and identified patient and hospital characteristics associated with different-hospital readmission.

To identify 30-day hospital readmissions accurately, the researchers analyzed 701,263 pediatric patient discharges from 177 New York hospitals between 2005 and 2009. Discharges were monitored for same-hospital readmissions, different-hospital readmissions, and all-hospital readmissions.

Data showed that of the 31,325 all-hospital readmissions recorded, 13.9% were readmissions to different hospitals within 30 days of the initial admission, the researchers reported. These data translated to one of seven pediatric readmissions going to a different hospital. Different-hospital readmissions were most prevalent among non-children's hospitals, lower-volume hospitals, and urban hospitals. Patients readmitted to different hospitals within 30 days of their initial admissions were more likely to be younger, white, privately insured, or have specific chronic conditions.

Using only same-hospital readmissions to calculate penalties resulted in 20 of the studied hospitals receiving unwarranted penalties, the researchers said. A better practice would be to use data sets that incorporate all-hospital readmissions, they suggested.

"Using such data sets to provide hospitals with centrally estimated readmission rates at timely intervals would allow hospitals to better assess their quality improvement efforts and anticipate rates used in accountability programs," the researchers said.

An abstract of the study is available online at http://tinyurl.com/pbdyumb. ■

Primary care doctors troubled by hospital quality metrics

Half of the nation's primary care physicians view the increased use of quality-of-care metrics and financial penalties for unnecessary hospitalizations as potentially troubling for patient care, according to a new survey from The Commonwealth Fund and the Kaiser Family Foundation.

Fifty percent of primary care physicians say the increased use of quality metrics to assess provider performance is having a negative impact on quality of care. Far fewer (22%) see quality metrics as having a positive impact on quality.

Similarly, 52% say programs that impose financial penalties for unnecessary hospital admissions or readmissions are having a negative effect on quality of care, while just one in eight (12%) say such programs have a positive effect. Nurse practitioners and physician assistants view quality metrics and admissions penalties somewhat more favorably, but still are more likely to see negative effects than positive ones.

The findings are from a new brief based on the 2015 National Survey of Primary Care Providers, which captures the experiences and views of primary care physicians, nurse practitioners, and physician assistants related to recent changes in healthcare delivery and payment, including accountable care organizations (ACOs), medical homes, and increased use of health information technology.

Many primary care providers see the increased use of health information technology (IT) as improving quality of care. Half of physicians and nearly two-thirds (64%) of nurse practitioners and physician assistants see the advance of health IT having a positive impact on practices' ability to provide quality care to their patients. Fewer physicians (28%), nurse practitioners, and physician assistants (20%) say health IT is having a negative impact on quality.

"SIMILARLY, 52% PERCENT SAY PROGRAMS THAT IMPOSE FINANCIAL PENALTIES FOR UNNECESSARY HOSPITAL ADMISSIONS OR READMISSIONS ARE HAVING A NEGATIVE EFFECT ON QUALITY OF CARE, WHILE JUST ONE IN EIGHT (12%) SAY SUCH PROGRAMS HAVE A POSITIVE EFFECT."

More primary care physicians view the spread of ACOs as having a negative (26%) rather than positive (14%) impact on quality, though the majority either sees no impact or is not sure. Three in 10 (29%) primary care physicians say they currently participate in an ACO. Among those who participate, views are more favorable, though still mixed (30% positive, 24% negative).

Among the other survey findings:

- A third (33%) of primary care physicians see the increased use of medical homes as having a positive impact on quality, more than twice the proportion who see a negative impact (14%). An even larger share (40%) of nurse practitioners and physician assistants view the impact as positive. Those who participate in medical homes are more likely to take a positive view than those who don't: 43% of physicians and 63% of nurse practitioners and physician assistants practicing in medical homes have a positive view of their impact on quality of care.
- Most (55%) of the nation's primary care physicians are currently receiving financial incentives based on quality or efficiency measures, an indication of the reach of ongoing efforts by public and private payers to reward providers for quality of care rather than for the amount of services delivered to patients.
- Nearly half (47%) of physicians and just over a quarter (27%) of nurse practitioners and physician assistants say the recent trends in healthcare are leading them to consider an earlier retirement. This continues a 20-year trend of physician dissatisfaction with market trends in healthcare. ■

Patient satisfaction surveys seriously flawed, report says

The patient satisfaction surveys used by CMS to assess hospitals are not valid, according to a new report by the Hastings Center, the nonpartisan research center on bioethics.

It is increasingly common for patient-satisfaction surveys to be used as indicators of healthcare quality, as well as to influence the reimbursement paid to providers. But the Hastings Center authors argued that the surveys could eventually compromise the quality of care and raise healthcare costs.

"The pursuit of high patient-satisfaction scores may actually lead health professionals and institutions to practice bad medicine by honoring patient requests for unnecessary and even harmful treatments," they wrote. "Patient satisfaction is important, especially when it is a response to being treated with dignity and respect, and patient-satisfaction surveys have a valuable place in evaluating healthcare. Nonetheless, some uses and consequences of these surveys may actively mislead healthcare."

The authors of the report, *Patient-Satisfaction Survey on a Scale of 0 to 10*, are a resident physician in the Department of Psychiatry at the New York University School of Medicine, and a professor of bioethics and psychiatry in the Department of Bioethics at Case Western Reserve University School of Medicine in Cleveland. *(The Hastings Center report is available online at http://tinyurl.com/ohaudwj.)*

"Good ratings depend more on manipulable patient perceptions than on good medicine," the report states. "In fact, the pressure to get good ratings can lead to bad medicine."

The healthcare community should reconsider whether the focus on patient satisfaction is actually generating improvements or leading the industry astray, the authors said. Though patients should have the opportunity to share feedback about their experience, the concept of "patient satisfaction" remains poorly defined, they said. Surveys often blend healthcare quality and patient satisfaction, resulting in patients requesting, and ultimately receiving, treatments that are not medically necessary.

"Certainly, eliciting the patient's perspective is essential to shared decision-making and important to healthcare quality," they wrote. "Yet placing such an emphasis on the patient perspective risks giving patient-satisfaction surveys the power to pressure providers to "satisfy" their patients at all costs.". ■

251 hospitals get 5 stars for patient satisfaction

A total of 251 hospitals received the highest score on the new five-star rating system for patient satisfaction that CMS announced recently.

CMS announced the new rating system as part of an effort to standardize rating systems across its website. Hospitals could preview the ratings in 2014, but the list was finalized this year.

In addition to the 251 five-star hospitals, there were 101 hospitals that received the lowest one-star ranking. Another 582 received two stars; 1,414 received three stars; and 1,205 received four stars.

The rankings are available online at http://tinyurl.com/pwdqvb7. ■

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CNE QUESTIONS

1. When will CMS surveyors cite a hospital for immediate jeopardy?

A. When the facility is in noncompliance with at least one CoP in a way that has caused or is likely to cause serious injury, harm, impairment or death to a patient.
B. When the facility is in noncompliance with at least three CoPs in a way that has caused or is likely to cause serious injury, harm, impairment or death to a patient.
C. When the facility is in noncompliance with at least one condition of participation CoPs in a way that has caused serious injury, harm, impairment or death to a patient.
D. When the facility is in noncompliance with at least one CoP in a way that may impair the delivery of quality healthcare.

2. According to says Susan G. Kratz, JD, when you try to abate the deficiency that resulted in immediate jeopardy?

A. Within six months
B. Within 30 days
C. Within 7 days
D. Before the surveyor leaves the facility

3. In addition to training and proctoring, what does Robert Wachter, MD, recommend for credentialing surgeons in new technology?

A. Simulation
B. Endorsement by the manufacturer
C. A personal attestation by the physician about his competence
D. A recommendation by an experienced physician

4. What is one part of the Arkansas peer review law that hospitals object to?

A. The physician can object to the hospital's choice of counsel.
B. The physician can dictate when a peer review may take place.
C. The hospital's peer review records are not protected from discovery.
D. The hospital can only use peer physicians employed by the hospital.