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INSIDE

SPECIAL REPORT: VALIDITY OF QUALITY MEASURES

Usefulness of Quality Measures Questioned, May Be Misleading

Study finds only one in 21 valid, but reimbursement still threatened

Quality can be hard to define in any arena, and in medicine there can be so many variables that pinning down which hospital is better than another becomes a herculean task. That is one reason hospitals have been bombarded with a slew of quality measures and metrics that promise to distill all those variables into hard numbers and rankings that can be used to assess a hospital's quality and patient safety.

> "ONCE YOU HAVE THOSE HARD NUMBERS, COMPARING ONE HOSPITAL TO ANOTHER IS MUCH EASIER, RIGHT?"

Once you have those hard numbers, comparing one hospital to another is much easier, right?

That's the intention, but the reality appears to be much different. Quality measures commonly used to evaluate hospitals and other healthcare institutions are likely to misinform patients, misclassify hospitals, misapply finan-

HIGHLIGHT

This month's *Hospital Peer Review* focuses on the validity of the quality measures that are used to assess hospital quality and safety, and increasingly used to determine reimbursement rates. New research suggests that some of the most commonly used measures are not valid, yet they continue to exert substantial influence on hospitals. However, there are steps hospital quality and compliance leaders can take to ensure that the measures are as accurate as possible and a true assessment of the hospital's performance.

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EDITOR: Greg Freeman
MANAGING EDITOR: Jill Drachenberg,
(404) 262-5508 (Jill.Drachenberg@AHCMedia.com).

ASSOCIATE MANAGING EDITOR: Dana Spector,
(404) 262-5470 (Dana.Spector@AHCMedia.com).

EDITORIAL & CONTINUING EDUCATION DIRECTOR:
Lee Landenberger

cial data, and cause unwarranted reputational harm to hospitals, says **Bradford Winters**, MD, PhD, associate professor of anesthesiology and critical care medicine at Johns Hopkins Medicine in Baltimore. He is the lead author of a recent study that found only one of 21 quality measures reliably indicated a hospital's patient safety profile. The study focused on the Agency for Healthcare Research and Quality (AHRQ) patient safety indicators and the CMS hospital-acquired condition (HAC) measures.

In addition to carrying significant influence on reimbursement, the measures evaluated in the study are used to determine scores in widely publicized rankings such as *U.S. News and World Report*'s Best Hospitals, Leapfrog's Hospital Safety Score, and the CMS Star Ratings. A similar study from 2015 also concluded that "there is limited evidence that many 'quality' measures — including those tied to incentives and those promoted by health insurers and governments — lead to improved health outcomes." *(For more on those studies, see the story later in this issue.)*

The study findings mean the healthcare community should re-evaluate whether these measures should be used to compare hospital quality and safety, Winters says. The way the measures depend on billing codes to identify adverse events is proving to be invalid, he says, primarily because coding is not consistent from one facility to another.

They were originally intended to help a hospital assess its patient safety internally, using the billing codes to identify that the hospital had a high number of respiratory failures or some other issue so the problem could be addressed within the facility, Winters notes. Now these performance measures are used to calculate formulas for denial of reimbursement, but they lack the validity to justify that use, he says.

Winters and his colleagues used 80% as the threshold for validity, based on research that identified 80% confidence as the minimum necessary for a physician to make a clinical decision.

"With hospitals running on very tight margins, to deny reimbursement to a hospital based on a quality measure that is wrong at least 20% of the time, if not 40% to 60% of the time, is ludicrous," he says. "Hospitals shouldn't be punished based on a measure that lacks validity. There should be an open discussion about how these incentive programs are going to move forward."

Frustration Over Safety Scores

The Johns Hopkins research only confirms what many clinicians and quality professionals already knew. It is not difficult to find healthcare leaders who are frustrated over how these quality measures are used to indicate patient safety and quality. One example is the University of Texas MD Anderson Cancer Center in Houston, where **Thomas W. Feeley**, MD, head of anesthesiology and critical care and head of the Institute for Cancer Care Innovation, points to the highly publicized hospital rankings from *U.S. News and World Report*. The magazine ranks MD Anderson as No. 1 in "best hospitals for adult cancer," yet it is given a patient safety score of two out of a possible five.

The second ranked hospital, Memorial Sloan Kettering Cancer Center in New York City, has a patient safety score of 4/5, and

the third-ranked Mayo Clinic in Rochester, MN, has a 5/5 patient safety score. Johns Hopkins Hospital in Baltimore, at number six in the rankings, has a patient safety score of 1/5 — a rock bottom score that is hard to reconcile with the hospital's overall quality and reputation.

Feeley was not surprised by the Johns Hopkins study results showing the measures to be invalid.

"That is totally correct," he says. "When *U.S. News and World Report* started reporting numbers that made us look like we're not a safe hospital, we looked at the data and saw that it's all administrative claims data. It's about how well you code, not how safe your hospital is for your patients."

In response, MD Anderson devoted resources to making sure that when PSIs are flagged someone clinically reviews the cases. Feeley calls that "an incredible waste of money, just driving up the cost of healthcare." But he says it is necessary to ensure that the data reflects MD Anderson's quality of care as accurately as possible. MD Anderson's internal review made clear that the data just don't show what people think it shows, he says.

"So much of it was related to how we code, and sometimes we coded for billing reasons that aren't necessarily indications of patient safety problems," Feeley explains. "Measuring is important, but we're measuring the wrong things. When you measure from coding data, there inherently will be problems."

Billing Data Can Mislead on Safety

One example was postoperative respiratory failure. In a move to improve patient safety, many patients in a cancer care center are not extubated immediately after surgery. They're left on a mechanical ventilator so they can slowly emerge from anesthesia and allow clinicians to make sure the surgery went well. Yet when they get to the ICU, the physicians who see them there document postoperative respiratory failure because that is the best strategy for optimum reimbursement in a fee-for-service environment.

"That doesn't mean they had some awful thing go wrong," Feeley explains. "That meant that people were providing really outstanding care. But when that documentation gets to the coder and they note postoperative respiratory failure, that triggers a patient safety indicator. How ridiculous is that, that when doctors are doing a good thing the hospital gets penalized because the measure can't differentiate between that and the other postoperative respiratory failure that really is an error?"

Quality measures should be developed to focus more on outcomes, Feeley says. Several organizations are working toward that goal, but no wholesale change will come soon, he says.

"As long the scores are coming from coded data, the outcome will be the same," Feeley says. "Garbage in, garbage out."

Some Poor Outcomes Inevitable in Healthcare

The use of PSIs and process measures to determine quality and safety is inherently flawed, says **Donald E. Fry**, MD, executive vice president for clinical outcomes at MPA Healthcare Solutions, a healthcare analytics company in Chicago that has pioneered quality assessment and predictive models.

PSIs are self-reported and have no standardized definitions, while process measures can oversimplify the assessment of what represents quality care, he says. As an example, he notes that there are nearly a hundred variables that determine whether a patient gets a ost-operative infection, but the applicable process measure focuses on only a few. Those few variables, in effect, determine whether the hospital was in compliance, and infection control standards.

"The reality is that the cascading and interactive list of potential factors is such that you can be completely compliant with the things that government is measuring — hair removal, antibiotic administration, and so forth — and you will still have high infection rates," Fry says. "Similarly, you may fail to comply with all the processes in one or two of the sample cases and still have effective outcomes."

Fry also notes that the current measures can unintentionally hamper the effort to improve patient safety. The hospital that improves its detection and reporting of PSIs can damage its reputation and reimbursement, he says. More meaningful evaluation of provider performance would come from objective measures that are not self-reported, Fry says. The true measure of whether a facility's healthcare is suboptimal can only come from comparing performance to that of the collective group, he says, not from self-reported data that isolates the assessment of each hospital.

(See the story later in this issue for more concerns about self-reported data, and the story later in this issue for what type of data is most reliable.)

Assessments would be more reliable if they were based on fac-

tors such as a risk-adjusted, prolonged length of stay outliers, Fry suggests. If a patient stays in the hospital three standard deviations longer than the normal stay, that is invariably associated with a complication of care that also leads to increased resource utilization and increased morbidity, Fry says.

"One of the unfair things about current public disclosures about hospitals is that hospitals don't know really know what their outcomes are. Tracking patients after discharge is not easy. For example, 20% to 40% of readmissions occur at a hospital other than where the patient received the index care, and about 40% of emergency room visits after major operations occur at another hospital," he says. "If somebody dies 90 days after discharge without readmission, the doctors and certainly the hospital don't even know that has even happened."

Measuring quality of care with quantitative data will always provide an incomplete and potentially misleading assessment to the consumer, says **Peter Bonis**, MD, chief medical officer of clinical effectiveness with the Boston office of Wolters Kluwer Health, which provides data, software, and consulting for healthcare organizations. The intention is good, but such measures can never incorporate the many values that go into a hospital's quality of care and how consumers choose providers, he says.

"Even if things go well and you believe you are receiving high-quality care, you don't as a lay person have an external benchmark from which to know whether you received contemporary evidence-based care that was optimized to you as an individual," Bonis says.

Recent moves to tie quality measures to reimbursement will push hospitals to address the accuracy of quality measures more directly, Bonis expects, through the use of more chart review and other means of validating that the data produces a fair assessment of the hospital's experience.

(See the story later in this issue for more on how hospitals can strive for more accurate portrayals.)

"Right now there is not a whole lot of rancor about the question of accuracy because there was not much financial risk tied to the scores. Hospitals wanted to be ranked well, but there was always doubt about how much consumers really used this information to choose their healthcare providers," Bonis says. "But now with value-based care and risk-based contracts, I think we're going to see more disputes from hospitals as to whether or not the way they are being scored is correct." ■

Rely More on Risk-Adjusted Rates for Accuracy

Not all quality measures are the same, and risk-adjusted complication rates and mortality rates will provide a more accurate assessment of a hospital's quality and safety than other measures that represent simpler data, says **Evan Marks**, chief strategy officer with Healthgrades, a Denver-based company that offers healthcare provider quality scores to consumers.

Statistical significance, derived from those risk-adjusted rates, will be key in determining one hospital's quality over another's, he says. However, it is important to derive that statistical significance from a long enough time period. Healthgrades uses three years of payer or CMS data to evaluate the quality of care and outcomes for hospitals.

"A lot of people complain that that means the data is too old and doesn't reflect the current performance of the hospital. But even with a large hospital with large volume, there is little you can say about quality by looking at data from the last quarter," Marks says. "If you have 50 cases and one mortality in that quarter, does that represent what you can really expect from that hospital's performance? There are math problems behind all of this, and the fact is that you have to go back far enough to have enough data you can trust for a meaningful analysis." ■

SOURCE

- **Evan Marks**, Chief Strategy Officer, Healthgrades, Denver, CO. Email: erin.dupree@edelman.com.

SOURCES

- **Peter Bonis**, MD, Chief Medical Officer, Clinical Effectiveness, Wolters Kluwer Health, Boston. Telephone: (781) 392-2088. Email: peter.bonis@wolterskluwer.com.
- **Thomas W. Feeley**, MD, Head of Anesthesiology and Critical Care, Head of the Institute for Cancer Care Innovation at MD Anderson Cancer Center, Houston. Telephone: (713) 792-7115. Email: tfeeley@mdanderson.org.
- **Donald E. Fry**, MD, Executive Vice President for Clinical Outcomes, MPA Healthcare Solutions, Chicago. Telephone: (312) 467-1700. Email: dfry@consultmpa.com.
- **Bradford Winters**, MD, PhD, Associate Professor of Anesthesiology and Critical Care Medicine, Johns Hopkins Medicine, Baltimore. Email: armstronginstitute@jhmi.edu.

Study Finds Only 1 in 21 Quality Measures Valid

New research from the Johns Hopkins Armstrong Institute for Patient Safety and Quality in Baltimore suggests that most of the measures used by government agencies and public rankings to rate the safety of hospitals are not accurate or reliable. Of 21 quality measures studied, only one was deemed valid.

The study, published in the journal *Medical Care*, assessed the Agency for Healthcare Research and Quality (AHRQ) patient safety indicators and the CMS hospital-acquired condition (HAC) measures, both used in public rating systems.

(An abstract of the study is available online at http://bit.ly/1ZBixPZ.)

The research was conducted by **Bradford Winters**, MD, PhD, associate professor of anesthesiology and critical care medicine at Johns Hopkins Medicine, and **Peter Pronovost**, MD, PhD, director of the Johns Hopkins Armstrong Institute for Patient Safety and Quality.

Their study notes that, as part of efforts to achieve more transparency in healthcare in recent years, hospitals have increasingly been called on to report their performance on quality-of-care measures publicly. Some of the most prominent measures come from AHRQ and CMS: patient safety indicators (PSIs) and HACs.

The accuracy of those measures is compromised because they are derived from billing data input from hospital administrators and not clinical data obtained from patient medical records, the authors wrote. Hospitals code medical errors and other quality metrics inconsistently, making the resulting scores unreliable for comparing one hospital to another, they explained in the report.

The scores end up being more a reflection of how hospitals code data rather than a measure of quality, the authors concluded. To reach that conclusion, Winters and Pronovost analyzed 19 studies conducted between 1990 and 2015 that directly addressed the validity of HACs and PSI measures, as well as information from CMS, AHRQ, and the Maryland Health Services Cost Review Commission's websites. They compared errors listed in medical records to billing codes found in administrative databases, deciding that the measure was reliable if the medical record and the administrative database matched 80% of the time.

Sixteen of the 21 measures developed by AHRQ and CMS had insufficient data and could not be evaluated for their validity, leaving five measures that contained enough information for analysis. They were Iatrogenic Pneumothorax (PSI 6/HAC 17), Central Line-associated Bloodstream Infections (PSI 7), Postoperative hemorrhage/hematoma (PSI 9), Postoperative deep vein thrombosis/pulmonary embolus (PSI 12), and Accidental Puncture/Laceration (PSI 15). Of those five, only PSI 15 was found to be valid.

Even PSI 15 warranted skepticism because the data was so heterogeneous, the authors reported. In all five measures analyzed, the most common reason for discrepancies between medical records and administrative databases was coding errors.

The researchers said they hope their work will lead to reform and encourage public rating systems to use measures that are based on clinical rather than billing data.

"This systematic review finds that there is limited validity for the PSI and HAC measures when measured against the reference standard of a medical chart review," the authors concluded. "Their use, as they currently exist, for public reporting and pay-for-performance, should be publicly re-evaluated in light of these findings."

Earlier research also has cast doubt on the validity of quality measures. In a 2015 report, researchers from the University of Massachusetts Medical School in Worcester and Swedish Cherry Hill Family Medicine Residency in Seattle, determined that little evidence supported common quality measures leading to improved outcomes.

(The study is available online at http://bit.ly/1WXyO55.)

"These measures are often based on easily measured, intermediate endpoints such as risk-factor control or care processes, not on meaningful, patient-centered outcomes; their use interferes with individualized approaches to clinical complexity and may lead to gaming, overtesting, and overtreatment," the authors concluded. They called for more focus on patient-centered performance measures such as medication reconciliation in the home after discharge, screening for addressing fall risks, and the patient's self-assessment of health status over time.

"Quality measures should reflect that a provider has elicited, explored, and honored patient values and preferences, and not merely indicate whether a test or intervention has been performed," the authors wrote. "To do otherwise strikes at the heart of patient-centered care. Because most healthcare interventions carry risk of causing harms, measures should reflect overutilization as well as underutilization of care." ■

Self-Reported Data May Be Inaccurate

In addition to the vexing problem of quality measures that unfairly downgrade a hospital's quality and safety scores, common quality measures also can boost a hospital's scores higher than they deserve, says **David Friend**, MD, MBA, chief transformation officer and managing director of the Center for Healthcare Excellence & Innovation with BDO USA, a consulting company based in Chicago. That can be the result of simple error or intentional efforts to beat the system, he says.

Any data that are self-reported and used to assess the organization's reports should be looked at with skepticism, he says. Some of the reporting tools are complex, so it is inevitable that errors can slip into the data by mistake, he says. Some incorrect data, however, are provided deliberately.

"There is a greater level of fraud in reporting this data than anyone wants to acknowledge," Friend says. "In healthcare, a lot of quality metrics are self-reported on some level, and those measures are less reliable than objective measures. It may be unintentional or intentional, but sometimes the numbers don't you tell you the way it really is. That is why we have accountants who do audits and why we have the Internal Revenue Service to check your numbers instead of just taking your word that they're accurate."

With increasing pressure to score well and not lose reimbursement, some hospitals may intentionally game the system, says **Peter Bonis**, MD, chief medical officer of clinical effectiveness with the Boston office of Wolters Kluwer Health, which provides data, software, and consulting for healthcare organizations. He gives the example of a quality measure that says patients should have a blood pressure of less than 140/80. A hospital could engineer a process for patients who have a slightly higher blood pressure, using medications to lower the blood pressure below the threshold even though the medication might not be truly necessary, he says.

"When everything rides on that

CMS Releases Quality Measure Development Plan

CMS posted a draft Quality Measure Development Plan (QMDP) in 2015 and recently announced the final version, which incorporates comments from healthcare leaders.

The QMDP is a strategic framework for clinician quality measurement development to support the new Merit-based Incentive Payment System (MIPS) and advanced alternative payment models (APMs), **Kate Goodrich**, MD, MHS, director of the Center for Clinical Standards & Quality, explained in a post announcing the release of the final version. *(The final QMDP is available online at http://go.cms.gov/1SXM5ZF. Goodrich's blog post announcing the final plan is available online at http://1.usa.gov/1W4g5nu.)*

Suggestions from healthcare leaders during the comment period resulted in the following additions to the final QMDP:

- Identification of known measurement and performance gaps and prioritization of approaches to close those gaps by developing, adopting, and refining quality measures, including measures in each of the six quality domains:
  - Clinical care;
  - Safety;
  - Care coordination;
  - Patient and caregiver experience;
  - Population health and prevention;
  - Affordable care.
- CMS actions to promote and improve alignment of measures, including the Core Quality Measures Collaborative, a work group convened by America's Health Insurance Plans (AHIP). On February 16, 2016, CMS and the collaborative announced the selection of seven core measure sets that will support multipayer and cross-setting quality improvement and reporting across our nation's healthcare systems.
- Partnering with frontline clinicians and professional societies as a key consideration to reduce the administrative burden of quality measurement and ensure its relevance to clinical practices.
- Partnering with patients and caregivers as a key consideration for having the voice of the patient, family, and/or caregiver incorporated throughout measure development.
- Increased focus and coordination with federal agencies and other stakeholders to lessen duplication of effort and promote person-centered healthcare. ■

one number, there can be a great deal of pressure to apply a quick fix and save your reimbursement rather than pursuing the usual course of changing the patient's diet and exercise," Bonis says. "When you have measures, people will manage to those measures. People get good at it and when you implement a new measure you see a flattening of that data. It doesn't mean you've really improved anything; it just means people have focused on that and managed to those measures."

Hospital leaders are justified in their concerns that scoring systems such as the CMS Star Ratings produce an unfair comparison, Friend says. In addition to the accuracy of the raw data, the ratings may not provide the comparison that consumers assume, he says. Consumers typically do not consider factors such as whether a hospital or physician cares for much sicker patients than another provider, for instance, and be misled by a discrepancy in their death rates.

"Data without context is meaningless," Friend says.

Hospitals can't opt out of these scoring systems for compliance reasons and because the country is pushing for more transparency in healthcare, Friend notes. Consumers increasingly are demanding the ability to compare and shop around for healthcare in the same way they do with other services and products, he says.

What hospitals are going to have to do is provide that all-important context. They will have to be actively working to tell their story, particularly when they think the data doesn't necessarily reflect the whole picture," Friend says. "They have to embrace it. If they try to fight it, they're not going to be very happy and they're not going to win that battle." ■

SOURCE

- David Friend, MD, MBA, Chief Transformation Officer and Managing Director, Center for Healthcare Excellence & Innovation, BDO USA. Chicago. Telephone: (212) 404-5562. Email: dfriend@bdo.com.

Precise Coding Is Best Defense with Quality Measures

Hospital quality leaders will be left frustrated knowing that so much rides on quality measures that have been proven invalid, but more accurate measures are not coming any time soon. The best defense in the meantime is to optimize your hospital's coding, says **Bradford Winters**, MD, PhD, associate professor of anesthesiology and critical care medicine at Johns Hopkins Medicine in Baltimore. He is lead author of a recent study that found only one of 21 quality measures reliably indicated a hospital's patient safety profile.

"Try to improve your coding process, particularly with present-on-admission indicators. That seems to improve the accuracy of how one of these measures reflects your own hospital's quality and safety," Winters says. "Failing to pay close attention to present-on-admission coding can leave the hospital looking responsible for outcomes and adverse events that are not the hospital's fault."

Hospitals should make coders aware of how their coding influences reimbursement and public scores, emphasizing what an important part of the organization they are and why attention to detail is so important, Winters suggests. But clinicians also must be reminded that their documentation can make or break the coding process.

"Coders are not clinicians. They read the chart and try to determine based on what's in the chart what ICD-9 — now ICD-10 — codes apply. If the doctors and nurses don't do a good job of documenting whether something was present on admission, exactly what happened, and exactly what the complication was, the coders have to make an interpretation. The more information the clinicians provide, the better job the coders can do and hopefully you get more valid results with these measures."

That advice is seconded by **Thomas W. Feeley**, MD, head of anesthesiology and critical care and head of the Institute for Cancer Care Innovation at the University of Texas MD Anderson Cancer Center in Houston.

"If your coding is really good and subject to appropriate screening, peer review — and I would suggest physician peer review — of the data being put out there to the public, then you might be in the position you can achieve while we rely on these measures," Feeley says. "But if you're a consumer trying to compare hospitals, how do you know if any one hospital is doing a good job of screening their data or not?" ■

TJC Allows Docs to Text Orders, Still Use Caution

In a move that was welcomed by many healthcare professionals used to texting as a routine part of their lives, The Joint Commission recently rescinded its five-year ban on the texting of orders. Some caution is still necessary, however.

TJC now permits licensed practitioners to text orders through a secure text messaging platform, but hospitals may have to do some research and shopping around to find the texting platform that meets the TJC requirements. Hospitals must implement a secure messaging platform that includes a secure sign-on process, encrypted messaging, delivery and read receipts, date and time stamp, customized message retention time frames, and a specified contact list for individuals authorized to receive and record orders, TJC said in its announcement. *(The announcement is available online at http://bit.ly/1VXYIV7.)*

Hospitals also must specify how text orders will be documented in a patient's electronic health record. In addition, TJC suggests hospitals take these steps if they are going to allow texting:

- Develop an attestation documenting the capabilities of their secure text messaging platform.
- Define when text orders are or are not appropriate.
- Monitor how frequently texting is used for orders.
- Assess compliance with texting policies and procedures.
- Develop a risk-management strategy and perform a risk assessment.
- Conduct training for staff, licensed independent practitioners, and other practitioners on applicable policies and procedures.

Text ordering was formally prohibited by TJC in 2011, the statement noted, because the organization was concerned about the use of unsecure text messaging. It also was concerned that texting applications were unable to verify the identity of the person sending the text or to retain the original message as validation of the information entered into the medical record, TJC explained in the announcement.

> "THE DIFFERENCE BETWEEN A SECURITY BREACH AND A HIPAA VIOLATION IS BEING ABLE TO PRODUCE DOCUMENTATION SHOWING THAT YOUR CONDUCT WAS REASONABLE LEADING UP THE INCIDENT, AND THAT THE BREACH WAS NOT THE RESULT OF YOUR FAILURE TO PERFORM YOUR DUTY."

TJC is not in a position to approve or disapprove any particular messaging system, notes **Allen Briskin**, JD, senior counsel with the law firm of Pillsbury Winthrop Shaw Pittman in Los Angeles. That means the hospital is obligated to ensure and document that secure messaging system fits into its overall privacy and security compliance program, Briskin says. Even with TJC's blessing, it is not enough to announce that texting orders is now allowed at the hospital, and even specifying what messaging system to use still doesn't fulfill the hospital's obligations, he says.

Hospitals will have to analyze whether text orders can be incorporated in such a way that they comply with the institution's existing policies and procedures, Briskin says.

"One of the biggest problems with security in any organization is that individual activities or technologies aren't adequately integrated into the whole," he explains. "No one adequately analyzes how one piece fits into the larger whole, and your ability to manage the whole. That can lead to problems from the wrong people using the system, people using the system incorrectly, or doing something that inadvertently opens a security breach."

Choosing the platform, or platforms, for text messaging will be one of the first challenges, Briskin notes. The hospital should investigate potential messaging platforms and devices, and Briskin emphasizes that the process must be thoroughly documented. If any compliance or legal challenges occur later, the hospital must be able to show that it conducted due diligence in determining what systems were most appropriate and secure. That will be particularly important if there is an allegation that the hospital failed to comply with HIPAA.

"The difference between a security breach and a HIPAA violation is being able to produce documentation showing that your conduct was reasonable leading up the incident, and that the breach was not the result of your failure to perform your duty," Briskin explains.

Personal Devices Pose Challenges

Advances in secure texting technology led to the policy change, but TJC did not specify whether personally owned devices, such as smartphones and tablets, can or should be used for texting orders. That is likely to be a thorny issue for hospitals, Briskin says, because the natural inclination will be for clinicians to use the smartphones and tablets that they already use for personal texting. That is not necessarily a good idea, he says.

If personal devices are allowed, they still will have to use the text messaging platforms that the hospital approved, Briskin notes. It is unlikely that a hospital will conduct its due diligence on text messaging platforms and allow clinicians to use the most commonly available apps, he says, because they are not designed to provide the kind of security that is necessary for text ordering.

In addition, clinicians may be unwilling to use their own devices once the hospital explains what it requires for that privilege, Briskin says. If a device is used to store or transmit protected health information (PHI), the hospital must have the ability to access that device remotely and erase all data on it in the event it is lost or stolen, he says. That is a common security feature applied to employer-issued laptops, smartphones, and tablets, but clinicians may balk at the idea of allowing that kind of access and control of their personal devices, Briskin says.

> "ONCE THOSE RISKS ARE UNDERSTOOD BY CLINICIANS, THERE LIKELY WILL BE MUCH LESS INTEREST IN USING THEIR OWN DEVICES."

"You can use your personal device to access our information assets, but you're consenting to the installation of technology through which we can wipe your device if you need to," Briskin says. "That may sound reasonable to the individual at first, thinking you're not going to lose your phone and understanding why the PHI has to be wiped. But then they're going to think about how much control of their personal devices and data they're giving to their employer and may not like that at all."

PHI on Device Creates Risk

People typically have so much data on their devices, some of a personal nature and some simply resources like music and photos, that the idea of allowing their employers to access the device will seem intrusive, Briskin says. Even clinicians who are not bothered by the employer having access may think twice before consenting to a remote wipe of the device if it is lost, he notes. Not everyone backs up their devices regularly, and losing all your tunes and pictures would be no small matter.

Once those risks are understood by clinicians, there likely will be much less interest in using their own devices, Briskin says. The use of personal devices, and the access that it gives the employer, also will be more problematic with a unionized workforce.

The hospital also could take on potential liability by having access to the user's personal information, Briskin says. If the employer has access to any data on the device that could be considered PHI, it is reasonable to conclude that the hospital is obligated to protect that PHI just as it does a patient's PHI, he says. HIPAA does not require that the PHI be obtained in the course of providing healthcare services, so the data on a clinician's phone could qualify. State laws also could obligate the employer to protect other, non-PHI information on the device, Briskin notes.

"I think the urge for convenience will lead to employers trying to figure out ways to let people use their personal devices. That desire to use your own phone and not carry around a second device will be very strong," Briskin says. "The second wave will be switching to a separate device after both the employer and employees realize the obligations and potential risks of using a personal device for this kind of data." ■

SOURCE

- **Allen Briskin**, JD, Senior Counsel, Pillsbury Winthrop Shaw Pittman, Los Angeles. Telephone: (213) 488-7167. Email: allen.briskin@pillsburylaw.com.

TJC Launches New SAFER Scoring Matrix

The Joint Commission (TJC) is launching a new matrix for identifying deficiencies cited during surveys, hoping the new format will help hospitals prioritize and focus corrective actions.

TJC will began using the Survey Analysis for Evaluating Risk (SAFER) matrix with psychiatric hospitals in June, and will introduce it to all other accredited programs on January 1, 2017. The SAFER matrix will be part of the facility's Accreditation of Survey Findings Report. The SAFER matrix replaces the current scoring methodology, which includes Category A and Category C as well as direct and indirect impact elements of performance (EPs), says **Carrie Mayer**, MBA, certified master black belt in Accreditation and Certification Operations with TJC. The change allows surveyors to perform real-time, on-site evaluations of deficiencies instead of using those predetermined EP categorizations, she says.

"In the current process, we use a lot of predefined categories, predesignating our standards and elements of performance," Mayer says. "What we found is that what the surveyor actually finds on site and scores under a particular EP could really vary in risk or severity. In our attempt to predefine these categories and predefine the risk, we've lost some flexibility for allowing differences in risk from what surveyors see on site."

The SAFER matrix allows more of a real-time evaluation of risk, Mayer says. The new matrix provides one comprehensive visual representation of survey findings in which all Requirements for Improvement (RFIs) are plotted according to the likelihood of the issue to cause harm to patients, staff or visitors, in addition to how widespread the problem is, based on the surveyor's observations, Mayer explains.

"A single observation could reveal a widespread problem, such as a general failure to perform recommended high-level disinfection or proper storage of endoscopes," TJC explains in the post announcing the matrix. "Combined, these characteristics give a more clearly defined sense of the risk of a deficiency. As the risk level of a deficiency increases, the placement of the standard and EP moves from the bottom left corner (lowest risk level) to the upper right (highest risk level)."

> "THIS ALLOWS THE SURVEYOR TO MORE ACCURATELY PUT THE FINDINGS IN CONTEXT, AS THEY RELATED TO THIS PARTICULAR ORGANIZATION."

A graphic depiction of the matrix and more information on how it used is available online at http://bit.ly/1NNpzk0.

TJC's description of the matrix includes this example: "A surveyor placed Environment of Care (EC) Standard EC.01.01.01, EP 1, in the row "Moderate," as it was determined (based on the deficiency observed) that it could occasionally cause harm to a patient, visitor, or staff member, and in the column "Pattern," as the issue was noted multiple times throughout the survey and could affect a few or some people and/or settings.

Surveyors will follow the same standards and survey process, but under the new system they will also determine how likely the deficiency is to harm the patient, visitor, or staff member, Mayer says. They also will provide an assessment of how large or small in scope the finding is — whether the deficiency was found in an isolated area or throughout the hospital.

"This allows the surveyor to more accurately put the findings in context, as they related to this particular organization," Mayer says.

The announced change has prompted some anxiety among accredited facilities, but primarily only because it is different from the procedure with which compliance leaders are familiar, Mayer says. The effect on hospitals should be negligible, she says, except that it will provide a more accurate picture of the survey findings. The new matrix is simpler and more relevant, she says.

"I don't think it's a huge change. I don't think it should cause any panic," she says. "It's a good change. It simplifies the process where there are so many predesignations, making it one system to classify the risk. This doesn't change any standards or how the survey works; just how the surveyors communicate what they found."

TJC is planning to provide blank SAFER matrices to hospitals soon, along with all the definitions and guidance that surveyors will use, to use in mock tracers.

The new matrix will change post-survey follow-up activities, Mayer says. Eliminating the "A" and "C" designations means that Opportunities for Improvement (single observations of noncompliance at

Category C EPs) will no longer exist. Instead, all observations of noncompliance will be documented within the matrix. The new approach also eliminates Measures of Success (MOS), the quantifiable measures typically related to an audit determining whether an action is effective and sustained for certain Category C EPs.

"The level of required follow-up will be based on where the findings fall within the matrix," Mayer says. "Today all of that is predefined, but now the post-survey follow-up will be customized by where the findings fall within the matrix."

There also will be two new fields in the Evidence of Standards Compliance portion of the survey report. They are related to leadership involvement and preventive analysis, Mayer notes. She suggests studying those two new fields to consider what TJC will expect if there are deficiencies there.

The matrix also should help quality and compliance leaders present survey findings to hospital administration in a more effective way, Mayer says. The matrix will be embedded within the survey report, providing a sort of dashboard report on the survey.

"Right now our accreditation reports can be very lengthy, making it very difficult to pick out what the surveyors found and what is most risky among what they found," Mayer says· "This matrix is going to put that information up front in a way that should be much easier to understand." ■

SOURCE

- **Carrie Mayer**, MBA, Certified Master Black Belt, Accreditation and Certification Operations, The Joint Commission, Oakbrook Terrace, IL. Telephone: (630) 792-5298. Email: cmayer@jointcommission.org.

AHA Continues Fight Against OIG Reviews

The American Hospital Association (AHA) is continuing its campaign against the ongoing hospital compliance reviews conducted by the Department of Health and Human Services (HHS) Office of Inspector General (OIG), which it says are not conducted fairly.

Melinda Reid Hatton, JD, senior vice president and general counsel of the AHA, recently sent a letter to OIG following up on earlier criticisms of the compliance reviews.

"We continue to be very troubled by the OIG's decision to extrapolate its findings despite the numerous legal defects that we previously identified in these audits, the very damaging effects on hospitals' reputations from publication of these alleged Medicare overpayments, and the similarly negative impact on the financial condition of our members that results from repayment of the vastly overstated amounts," she wrote in the letter.

(*The most recent letter is available online at http://bit.ly/25o5f0A. The earlier letter is available online at http://bit.ly/1WmLjWR.)*

AHA contends that the audits waste HHS resources and are unduly burdensome to hospitals, use extrapolation in a way that compounds OIG's erroneous interpretations of Medicare rules and policies, and allow Medicare Administrative Contractors to collect overpayments in violation of the Medicare statute and agency rules.

OIG has responded to the AHA's previous complaints, saying that determining overpayment through sampling and extrapolation, rather than reviewing each claim, is "both economical and in the best interest of the provider and the Government. OIG uses a conservative method under which overpayment estimates will almost always be lower than the estimates that would result from reviewing every claim."

(*The OIG's response is available online at http://1.usa.gov/1WmJdWO.)*

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- Measure compliance with top safety efforts
- Risky: Cut-and-paste in EHRs
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HOSPITAL PEER REVIEW
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CE INSTRUCTIONS

To earn credit for this activity, please follow these instructions:

1. Read and study the activity, using the provided references for further research.
2. Log onto AHCMedia.com, go to "My Account" to view your available continuing education activities. *First-time users must register on the site.*
3. Pass the online tests with a score of 100%; you will be allowed to answer the questions as many times as needed to achieve a score of 100%.
4. After completing the test, a credit letter will be emailed to you instantly.
5. Twice yearly after the test, your browser will be directed to an activity evaluation form, which must be completed to receive your credit letter.

CE QUESTIONS

1. In Winter's research, what threshold was used to determine the validity of the quality measures studied?

a. 60%
b. 70%
c. 80%
d. 90%

2. In Winter's research, what did the authors conclude was the primary cause for the lack of validity in quality measures?

a. The scores end up being more a reflection of how the hospitals code data rather than a measure of quality.
b. The clinical standards underpinning the measures are outdated.
c. The patient populations involved with the measures are too small.
d. The measures are not endorsed by their respective specialty organizations.

3. What did TJC say about what texting devices can be used?

a. Only hospital-provided and owned devices may be used.
b. Personal smartphones can be used, but not personal tablets or laptops.
c. Only personal devices may be used.
d. TJC did not specify whether personally owned devices, such as smartphones and tablets, can or should be used for texting orders.

4. How will TJC's SAFER matrix change post-survey activities for accredited facilities?

a. It will have no effect.
b. More work will be required regarding Opportunities for Improvement (single observations of noncompliance at Category C EPs).
c. The level of required follow-up will be based on where the findings fall within the matrix.
d. The time allowed for responding to deficiencies will be shortened.

CE OBJECTIVES

Upon completion of this educational activity, participants should be able to:

1. Identify a particular clinical, legal, or educational issue related to quality improvement and performance outcomes.
2. Describe how clinical, legal, or educational issues related to quality improvement and performance outcomes affect nurses, healthcare workers, hospitals, or the healthcare industry in general.
3. Cite solutions to the problems associated with quality improvement and performance outcomes based on guidelines from relevant authorities and/or independent recommendations from clinicians at individual institutions.