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MACRA Coming Soon, and Many Hospitals Not Ready

The Medicare Access and CHIP Reauthorization Act (MACRA) is aimed at physicians and their reimbursement, but hospitals will be affected by the implementation of this law as well. Many hospitals are not prepared for the increased data collection and quality assessments MACRA will bring, experts say.

MACRA was signed into law on April 16, 2015, and was heralded at the time for ending the reviled Sustainable Growth Rate (SGR) formula that threatened every year to drastically cut physician compensation. It also is seen as another way Medicare is moving away from traditional fee-for-service payments. MACRA limits aggregate Medicare physician payments to a 0.5% increase per year through 2019, and 4% of a physician's annual Medicare payments will be tied to one of two paths: either the Merit-Based Incentive Payment System (MIPS), or participation in Alternative Payment Models (APMs). (*The rule is available online at http://bit.ly/1VCRVQn.)*

With the trend in recent years for physicians to be employed or affiliated with hospitals, MACRA affects most of them to some degree. MACRA's bureaucratic burden may drive physicians further to sign up with hospitals.

> "MACRA'S BUREAUCRATIC BURDEN MAY DRIVE PHYSICIANS FURTHER TO SIGN UP WITH HOSPITALS."

The original plan was for the new system to be effective January 1, 2017, with physician performance that year determining bonus and penalty payments effective in 2019. However, CMS announced in September that though the January start date is still in place, it is providing four options that will allow providers some choice in how quickly they enter the new system. One of the options is the ability to choose an alternative payment model such as a Medicare Shared Savings accountable care organization (ACO).

CMS Acting Administrator **Andy**

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Slavitt wrote in a blog post that physicians will be able to "pick their pace" for how quickly they comply with the data requirements and have their payments adjusted accordingly. "In recognition of the wide diversity of physician practices, we intend for the Quality Payment Program to allow physicians to pick their pace of participation for the first performance period that begins January 1, 2017," he wrote. "During 2017, eligible physicians and other clinicians will have multiple options for participation. Choosing one of these options would ensure you do not receive a negative payment adjustment in 2019." (*Slavitt's full post is available online at http://bit.ly/2comQzM.*)

Slavitt outlined four options. In the first, the physician can choose to "test" the new quality payment program. Physicians will not be hit with a negative payment adjustment if they submit "some data" to the Quality Payment program, including data collected after the January start date. "This first option is designed to ensure that your system is working and that you are prepared for broader participation in 2018 and 2019 as you learn more," Slavitt wrote.

The second option allows the physician to participate for only part of 2017. Under this option, the physician's first performance period does not necessarily have to begin on January 1, 2017, and does not have to constitute a full year of data. Depending on the data submitted, the physician could still quality for a "small positive payment adjustment," Slavitt said. "For example, if you submit information for part of the calendar year for quality measures, how your practice uses technology, and what improvement activities your practice is undertaking, you could qualify for a small positive payment adjustment," he wrote. Physicians can choose from the list of quality measures and improvement activities available under the Quality Payment Program when deciding what data to report, giving them the opportunity to report the data most beneficial to them.

The third option is for physician practices that are more confident about their ability to report data immediately on January 1 and who expect the resulting payment adjustment to be neutral or in their favor. Those practices will submit data on quality measures, how the practice uses technology, and what improvement activities the practice is undertaking for a full calendar year beginning January 1. The data could qualify those choosing this option for "a modest positive payment adjustment."

The fourth option is the most divergent from past CMS statements on MACRA requirements. Physicians can opt out of reporting quality data and other information altogether if they participate in an Advanced Alternative Payment Model in 2017. Slavitt mentioned Medicare Shared Savings Track 2 or 3 as examples. Track 2 is a two-sided model, meaning physicians share losses but also can earn a higher share of savings. Track 3, added in 2015, offers a higher sharing rate than Tracks 1 and 2. For Track 3, CMS prospectively assigns practices to the ACO rather than using retrospective reconciliation for preliminary assignments. Physicians who receive enough of their Medicare payments through the Advanced Alternative Payment Model in 2017 or whose Medicare patients make up a large enough part of the practice that year would qualify for a 5% incentive payment in 2019.

Even with these changes, "the time to start planning for MACRA was yesterday," says Marc Mertz, MHA, FACMPE, vice president of GE Healthcare Camden Group, a consulting company in Los Angeles.

A delay in MACRA implementation Is still possible but unlikely. *(See the story in this issue for the five top things to know about MACRA, and the story also in this issue for the rule's relationship to Meaningful Use.)*

Leadership should be evaluating the group's current performance under the proposed MACRA measures, and Mertz says the Medicare Quality and Resource Use Report (QRUR) is a good place to start because it shows how physicians compare to their peers on quality and cost measures. engagement and participation will be vital to groups' success under MACRA. Leaders of hospital-affiliated medical groups should be educating physicians on MACRA and the vital role they play in ensuring the group's success," Mertz says. "Regardless of whether the group falls under MIPS or APM, it will be imperative that individual physician and group performance be monitored on a monthly basis."

Share performance data with physicians and address underperformance, Mertz advises, and consider modifying physician compensation plans to include incentives for performance on MACRA-related measures.

Independent non-hospital employed physicians, especially solo physicians or those in small groups, will be most challenged by MACRA, Mertz says. Many of these groups lack the information technology or staffing resources to ensure success under MACRA. Most physicians will fall under MIPS, and they are likely to be the least able to absorb any reductions to their Medicare reimbursement, he says.

"Hospitals should be working now to educate the independent members of their medical staff on MACRA and its implications," he says.

Mertz also suggests considering the development of population health support organization (PHSO) services that can support these physicians with subsidized access to electronic health records, population health tools, and other resources to help them prepare for and succeed under MACRA.

CMS estimates in the rule that 87% of solo practitioners will see their payments decrease in 2019, the first year rates will be affected.

"For some independent physicians, MACRA may be the final straw that drives them to explore affiliation options," Mertz says. "Hospitals and health systems should expect to receive inquiries from physicians interested in employment and should have a strategy for responding to these requests."

MACRA allows solo practitioners to form "virtual groups" so they can

Five Things to Know About MACRA

Many hospitals and health systems are behind the curve because they focused on 2019 as the first year the increases or decreases from the MACRA would be applied to payments, notes **Dan Golder**, DDS, MBA, principal at Impact Advisors, a consulting group in Cody, WY. Data collection will begin for some providers in just a few months.

Understanding the rule is a challenge, he says. The rule is more than 900 pages long and very few physicians have the time or willingness to study it themselves. Providers will rely on their affiliated hospitals and other third parties to distill the information down to the essentials.

Golder offers this summary of the top five things to know about MACRA:

1. This is of immediate concern to all providers, as the first MIPS "performance period" begins in January, 2017.
2. MIPS must be budget neutral. In order for one provider to receive an incentive, another will have to pay a penalty.
3. MIPS is complicated, and it favors large practice groups at the expense of solo practices.
4. With MIPS, CMS can conduct an onsite audit at any time — and have unfettered access to your electronic health record and patients' protected health information (PHI). They can access PHI without the business associate agreement required under HIPAA or any other special permission.
5. Virtual groups, while mandated by law, were too complicated to set up for 2017 by CMS. The net result is that without the relief of virtual groups, the majority of small and solo practitioners may be even more unlikely to meet the MIPS standards during 2017, making them likely to see decreased payments in 2019.

"MACRA is going to be a shock to solo providers, and I'm afraid a lot of them, and a lot of group practices and hospitals, have put off taking a good look at the implications of this rule and what they need to do," Golder says. "Unless we see a delay from CMS very soon, they have a great deal of work to do just to analyze the future impact, and then they still have to develop a game plan for what they will do. I'm afraid we might see a lot of surprise and remorse in 2019 because they didn't prepare now." ■

SOURCE

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share the technological and administrative burden, but CMS has disallowed them for 2017 because it is not yet ready to oversee the groups.

Richard F. Bajner Jr., managing director of Chicago consulting firm Navigant, agrees that more physicians will seek shelter in hospitals when faced with the MACRA burden. Many hospitals have been aggressively marketing to physicians and practices, so it is likely they will find physicians more receptive to the idea of hospital employment or affiliation. Hospitals will have to rethink the way they show physicians the value of joining, with MACRA as a key point, Bajner says.

Smaller physician practices and solo practitioners will be most interested in avoiding the extra work and expense that MACRA will impose, so Bajner suggests that will become the best targets for marketing efforts.

"With larger hospitals, I'm more concerned that they will miss this opportunity to create a value proposition and use MACRA to their benefit. Smaller organizations will have to worry about having the systems in place to work with MACRA, but larger hospitals and health systems have an opportunity here," Bajner says.

At least half of hospitals and physician practices are not ready to comply with MACRA, says **Richard J. Zall**, JD, partner and chair of the healthcare department at the Proskauer law firm in New York City. MACRA is one of the most significant changes to healthcare in years, he says, and it will significantly influence quality improvement efforts and data collection at hospitals. Where, previously, physicians could earn bonuses and other incentives through various programs, MACRA now provides a more unified way to link quality to payment, he says.

"This was an effort to put together in one payment framework both the payment policies, quality improvement, and incentives around patient care management," Zall says. "We can see in the structure of MACRA where CMS is going, with incentives for physicians to move away from episodic fee-for-service payments that turn on what they do and how much they do, to value-based models in which the payment they receive depends on outcomes, quality measurements, and the total cost of care."

Quality professionals in hospitals have worried that MACRA would impose more data collection on top of the already overwhelming demand for metrics, and Zall says those fears are well-founded. To submit the periodic reports that are required to determine whether and how Medicare alters the reimbursement rate, hospitals and physician practices must collect a range of measurements in four areas. The first is quality of care and outcomes, followed by use of information health systems (similar to the Meaningful Use program), costs, and clinical practice improvement

"I don't think many physician practices or even hospitals are equipped to collect that information and be able to report it," Zall says. "The concerns about the administrative burdens of this are very real. It's one of the reasons there has been some talk of delaying it, but as of now it's starting in 2017 and a lot of people have a lot of ground to cover in order to be prepared."

Since most hospitals have a variety of arrangements with physicians, with some employed by the hospital, others employed by practices affiliated with the hospital, and some independent, decisions must be made about who is responsible for reporting MACRA data, Zall says. The hospital also must assess its information systems to determine if they are capable of organizing and transmitting MACRA data in the way CMS demands.

The hospital also must project the impact of MACRA.

"There will be winners and losers in this," Zall says. "The legislation requires MACRA to be budget neutral, so if some hospitals get more for meeting the data and quality requirements, other hospitals are going to get less. The spread is expected to be as much as 9% either way, getting that much less or that much more."

Assessing a hospital's potential performance under MACRA can seem daunting, but Bajner says the data in quality review and utilization review reports can useful.

"There is a lot of good detail in those reports, including performance on key quality and efficiency metrics that likely will correlate very strongly with performance under MIPS," Bajner says. "The next step is understanding what you can do to improve that so that you're receiving bonuses under MACRA instead of penalties."

Bajner sees an opportunity for quality leaders in hospitals to become the in-house "MACRA expert," a position that will bring attention from top hospital leadership because the facility's performance will have such a direct effect on the hospital or health system's bottom line. That effect also should lead to the in-house expert having considerable influence on any decision or quality improvement effort that affects MACRA performance.

MACRA will require healthcare organizations to use EHRs more effectively, says **Wayne Dix**, vice president for healthcare management at the consulting firm SSA & Company in New York City.

"It's going to have to be a broader use of electronic records in a way that captures the costs more effectively, to demonstrate resource consumption, outcomes, and value creation," Dix says. "There will have to be an increased investment in recordkeeping and the underlying technologies."

Dix questions whether MACRA will be in place long enough for hospitals to invest in a long-term strategy that may involve substantial investment in technology and other resources. Doubt about the longevity of the rule could make healthcare organizations hesitate, he says.

"They will want to know they can build toward something and that their investments are not in vain," Dix says. ■

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Meaningful Use Experience Can Help

One component of the Medicare Access and CHIP Reauthorization Act (MACRA) addresses performance on the use of electronic health records (EHRs), similar to the Meaningful Use program. An organization's experience with Meaningful Use could be valuable under MACRA, says **Julia Adler-Milstein**, PhD, assistant professor of health management and policy at the University of Michigan School of Public Health in Ann Arbor.

The performance category addressing EHRs is called Advancing Care Information (ACI). With this measure, physicians can choose to report how they use EHR technology in their daily practice. CMS will look for interoperability, information exchange, and compliance with Office of the National Coordinator for Health IT (ONC) standards. Those standards include allowing patients timely access to EHR information to view, download, and transmit, and the exchange of structured health information with other healthcare providers.

"It's a lot more information exchange, both with providers and patients," Adler-Milstein says. "Hospitals are going to be in a world where there is a lot more information going out and coming back in, and I think we're still learning how to do that well. From an IT perspective, things are going to get more complex as more information is moved around electronically."

Adler-Milstein notes that the components of MACRA focusing on quality, costs, and EHR utilization are not new, but the rule brings them together and presents the opportunity to make a healthcare organization's quality improvement efforts more cohesive.

"I don't think anyone is going to look at any one component and say that's something they haven't seen before or haven't been doing already," she says. "But MACRA does put them all under one umbrella, and the challenge is going to be putting together a cohesive strategy that makes the most of your resources."

ACI replaces Meaningful Use for physicians and Medicare, but the old program still applies to hospitals and other eligible professionals. In a CMS blog post announcing the rule, CMS Acting Administrator **Andy Slavitt** and now-former ONC National Coordinator **Karen DeSalvo**, MD, said the new ACP approach will be more flexible than Meaningful Use. They also said ACI will reduce the administrative burden and improve patient outcomes in these ways:

- Physicians can select the measures that reflect how technology best suits their day-to-day practice with an EHR.
- ACI provides multiple paths for success.
- The new program aligns with the Office of the National Coordinator for Health Information Technology's 2015 Edition Health IT Certification Criteria.
- APC emphasizes interoperability, information exchange, and security measures, and requires patients to access to their health information through programming interfaces.
- Reporting is simplified. Unlike the Meaningful Use program, ACP does not require an all-or-nothing approach to EHR measurement or quality reporting.
- ACP reduces the number of measures from 18 to 11, and it no longer requires reporting on the Clinical Decision Support and the Computerized Provider Order Entry measures.
- The new program exempts certain physicians from reporting when EHR technology is less applicable to their practice. Some solo physicians also are allowed to report as a group. ■

SOURCE

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Final Rule Changes Quality Initiatives, and More

The Inpatient Prospective Payment System (IPPS) final rule for the 2017 fiscal year comes with some noteworthy elements, including requirements for new data collection, changes to several quality initiatives, and a change to the Two-Midnight rule.

The final IPPS rule will be effective for inpatient discharges taking place on and after Oct. 1, 2016. The final rule permanently removes the -0.2% payment cut related to the "two-midnight" payment policy established in 2014, a cut that has been controversial since its inception. To make up for what some providers have said were significant losses from that reduction, CMS also finalized an increase of about 0.8% for inpatient payment rates in an effort to offset the financial impact over the past three years. Not all of the changes were so beneficial to hospitals, however. The final rule almost doubles the reduction in payments related to documentation and coding overpayments, from -0.8% to -1.5%.

Quality data also becomes more important. Hospitals that do not submit quality data will lose 25% of the Market Basket update (2.7%), and hospitals that are not meaningful users of EHR could use 75% of the Market Basket update.

In addition, CMS is requiring hospitals to submit four quarters of data on eight of 15 electronic clinical quality measures (eCQM) as part of the Inpatient Quality Reporting (IQR) program. This data requirement begins in 2017 and includes such metrics as breast and cervical cancer screening statistics.

CMS also changed some Hospital-Acquired Conditions Reduction Program policies. One significant difference is that the program scoring methodology has been changed from current decile-based scoring to a continuous scoring methodology.

The final rule also addresses MS-DRG problems spawned by the transition from ICD-9-CM to ICD-10-CM/PCS. The transition resulted in a significant number of replication issues that resulted when mapping from ICD-9-CM to ICD-10-PCS. *(For more information on the final rule and changes, go to http://go.cms.gov/1MFN9Po.)* ■

Step Toward Bundled Payments

The IPPS rule could easily be retitled "Get Ready for Bundled Payments," says **Susan Nedza**, MD, MBA, senior vice president of clinical outcomes management with MPA Healthcare Solutions, a healthcare analytics consultancy in Chicago. An emergency medicine physician, Nedza previously was a regional chief medical officer at CMS and a senior executive at the American Medical Association. She says the final rule is similar to the Medicare Access and CHIP Reauthorization Act (MACRA), but with a great deal more complexity.

"For the folks in the quality area, the link between the hidden quality metrics and the financial bottom line of the institution is where you need to focus," Nedza says. "It's clear that if you miss certain targets, a health system can be at risk for 1% of its Market Basket Update, which can be significant dollars, based on the Medicare volume and the patient population they serve."

Several metrics can play into that risk, including targets for hospital-acquired conditions, value-based purchasing, and avoiding hospital readmissions. The more direct ties to financial outcomes will generate more interest from finance leaders at the hospital than quality professionals have ever seen, Nedza says. She says that could be a challenge for many hospitals.

"It's a challenge because it's not an area where there are a lot of linkages at this point. Most of the quality metrics have been more compliance-based, where you had a minimum to submit and there was either an upside or no penalty," she says. "But now we're talking about these metrics being tied more directly to finances, with a real possibility of a negative effect."

That increased scrutiny from financial executives ties into the move toward bundled payments, Nedza explains. She sees substantial alignment in the final rule with what CMS is doing in its bundled payments program, including more administrative- and claims-based quality metrics. With acute myocardial infarction, for instance, Nedza notes that the IPPS final rule includes metrics that are also being proposed in the bundled payments program.

"What that means is that this becomes almost a transition point, where to meet the stated goal of transferring risk the metrics are going to be more administrative-based and usable in a bundled structure," Nedza says. "That's different from what most of who grew up in the quality world are used to. We're more used to process measures. The linkage is going to continue to increase."

One of the most talked-about

changes is a welcome change to the Two-Midnight rule, imposed in 2014 in response to patients staying in observation status for three or four days when they should have been inpatient. The rule was supposed to prompt a decline in the number of long observation stays and an increase in the number of inpatient admissions, and CMS tried to offset the cost through a 0.2% reduction in inpatient payments. That reduction was strongly opposed by hospitals, including some that sued CMS.

As a result, CMS gave in and removed this adjustment for 2017 and also retroactively eliminated the reductions back to 2014.

Nedza says compliance with the Two-Midnight rule was difficult from a practical standpoint and unfairly threatened a hospital's finances.

"It became increasingly more complicated to try to fix this, and we almost lost sight of what the original intent was," Nedza says. "In a bundled payment model, none of this matters because the hospital and physician will be held responsible for the costs. You can put them in inpatient or you can put them in observation status, but what really matters is the aggregate costs for that patient."

There are similar points regarding the quality metrics. The 30-day readmission metrics are going to be extended to 90 days in the bundles, so the risk will be transferred to the providers, Nedza says. That puts more emphasis on quality and less on the data gathering and reporting metrics, she says.

"This is an example of moving from a regulatory requirement to a real quality improvement model," Nedza says. "For quality professionals, this means expanding the scope to partners outside the hospital. You're going to have financial risk associated with what happens to patients after discharge, and a significant portion of the potential for improvement is going to be in that post-acute care space."

Nedza advises quality professionals to start considering how current metrics can be used in a bundled context and measuring a 90-day period. That can show the infrastructure you will need and the stakeholders you need to convene, she says.

She also suggests developing closer ties with the finance department, particularly with the goal of understanding the financial impact of the patients who failed to meet quality measures in the past. Who were the patients that caused the 30-day readmission measure to be suboptimal or optimal?

"We've seen over the years that a lot of quality improvement programs increased perceived quality on performance measures, but also resulted in reduced costs," Nedza says. "You need to do an inventory with physician leadership and hospital leadership of what they are currently collecting and try to identify the things that are actually allowing them to save money while not compromising quality. It's a paradigm shift." ■

SOURCE

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Hospital Overcomes Us-vs.-Them with Doctors

After serving as a tanker and cavalryman for almost four decades in the U.S. Army, becoming the Commanding General of U.S. Army Europe, the Seventh Army, and spending more than three years in combat, **Mark Hertling**, Lieutenant General, U.S. Army (Ret.) needed a new challenge.

He found one worthy of his experience. Hertling is now taking on the formidable task of bringing hospital administrators and physicians together to work more harmoniously. Hertling is senior vice president for global partnering, leadership development, and health performance strategies at Florida Hospital, which has 28 facilities across the state. He provides leadership training that participants say is unique in its approach and highly effective.

Hertling draws on his military experience to make physicians and hospital administrators better leaders, and in the process, they learn to work more cooperatively and effectively. The end result is improved quality and better patient outcomes, he says.

The gap between physicians and hospital administrators is a well-known problem that most hospital leaders just accept as inevitable, but it doesn't have to be that way, Hertling says.

"We focus on the key issue of trust and how to generate that trust," Hertling says. "The element of trust is so much of what we do in the military, because if you're about to ask somebody to do something that his mind, body, and spirit is saying he doesn't want to do, they really have to trust you in the extreme. What we're seeing in healthcare is that physicians don't trust nurses, they both don't trust administration, they all don't trust each other."

Hertling's program addresses what he says is a primary cause of the distrust: Physicians and nurses see them-

selves as professionals dedicated to medicine and caring for patients, but they see hospital administrators — no matter how well meaning and capable — as business people who could just as well be working in a manufacturing company instead of a hospital. Administrators, in turn, may see clinicians as ignorant of the real-world business realities that make it possible for them to provide care. Neither assessment is entirely accurate, Hertling says, but he says nevertheless it is important to understand that division.

When Hertling first came to Florida Hospital, he was shocked to see how physicians were not involved in management and administrative decisions. That left them feeling alienated and not impressed when a C-suite executive made a tour once in a while to see what was actually happening in the hospital.

"Look for ways to build partnership with your frontline physicians. Find ways to include them more, rather than less," Hertling says. "That's how you build trust."

Physician leadership often involves sending two or three physician leaders off to a program somewhere, and when they return there is no plan for integrating what they learned into their interactions with others, Hertling says. Even if they are motivated, they're "a voice in the wilderness" because everyone else is still working with the same assumptions and prejudices against others at the hospital, he says.

The Florida Hospital program is called a physician leadership course, but Hertling says physicians can't become better leaders if they don't understand and relate well to everyone else. When Hertling was first organizing the leadership program at Florida Hospital, the chief medical officer (CMO) asked how many participants he wanted and Hertling said about 50 people. The CMO said no problem, he could round up 50 physicians for the course. But Hertling explained that he didn't want just physicians; he wanted a mix of doctors, administrators, and nurses.

"We wanted about 35 physicians from all specialties, 10 nurses, and five administrators," Hertling says. "If you put 50 physicians in a room they become a self-licking ice cream cone in terms of their complaints and gripes. You have held each other accountable and start a conversation."

The integration of the leadership course made it different from the other leadership programs she has attended over 22 years in healthcare, says **Linnette Johnson**, RN, BSN, MSN, assistant vice president of surgical services at Florida Hospital Orlando. There was a mix of 47 physicians, administrators, and nurses.

"Normally that doesn't happen," Johnson says. "In healthcare historically, no matter where you work, being able to relate to each other and communicate in a positive way has been difficult. There can be an us-versus-them relationship between doctors and nurses, doctors and administrators, and you can reinforce that when you provide leadership education to just one segregated group at a time."

The integrated approach to leadership training fits well with the modern consumer's higher expectations, Johnson says. Many patients are well-informed about their conditions and treatment, and they also expect all of their clinicians to work harmoniously for the best outcome. Any hint of an adversarial relationship, or disrespect from once clinician to another, will be noted and reflected on patient satisfaction surveys, she says.

The program emphasizes leadership, respect, communication, and the effective presentation of information and opinions.

"As we went through the discussions and exercises in the program, it was partly about breaking down those silos of nurse, doctor, administrator," Johnson says. "We were able to say we all have the same goal, doing our best for the patient, and start working on ways to trust each other, treat each other with respect, and get along."

The course takes eight months to complete and ends with a group trip to the Gettysburg battlefield in Pennsylvania, where Hertling applies lessons learned to the experience of those in battle. Johnson says the benefits are seen when quality improvement efforts involve different groups of people working together.

"We look for physicians who have been through the course because we know they will have the right approach. And the program reminds us that we have to do our part to make this collaboration work, too," Johnson says. "We can't say we want physicians to be leaders and get involved, and then have secret little meetings behind closed doors."

Upon completing the course, Hertling gives each participant a "challenge coin," derived from a military tradition in which one receives a coin with the unit or organization's insignia that can be used as identification if challenged, and more importantly as a reminder of what the group stands for. Johnson has used her challenge coin to remind others of the lessons they learned in the leadership program.

"If I'm in a meeting and a physician I went through the course with isn't really participating, not leading or adhering to the things we learned, I'll get out my coin and discreetly show it from across the room," Johnson says. "The couple of times I've done it the physician really recognized the meaning right away and got back to what we learned. That lateral accountability to each other is important."

The program addresses communication issues that affect most nurses at some point, says **Karen Purnell-Engram**, MBA, BSN, RN, vice president and chief nursing officer for the hospital's Winter Park, FL, campus. She worked for years in an obstetrical unit where the nurses and physicians knew each other well and had a good rapport, but when she moved on to other positions she found that communicating with other physicians could be quite different and frustrating.

In the leadership program, Purnell-Engram learned skills that made it easier to cross the nurse-physician divide.

"We were able to learn what characteristics are important for being a leader and how to work with other people," she says. "It was interesting as the program went on to see how we changed our attitudes and changed how we talk to each other. After going through the program and teaching my frontline team some of the things I learned, that really began to change the culture of my team at the hospital."

Anesthesiologist **Fred Mansfield**, MD, was in the second round of the course and says it helped him become a better physician. The 360-degree evaluations in the course were particularly useful, he says.

"I learned that you have to walk in someone else's shoes before you complain. You have to ask why they aren't able to do what you want," Mansfield says. "Physicians and administrators walked away from a lot of sessions saying, 'I had no idea that's why they do what they do.' There were a lot of epiphanies like that in the sessions." ■

SOURCES

- Mark Hertling, Lieutenant General, U.S. Army (Ret.); Senior Vice President, Global Partnering, Leadership Development and Health Performance Strategies; Florida Hospital. Telephone: (407) 303-9964. Email: ark.hertling@flhosp.org.
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Hospitals and Physicians Benefit from Collaboration

A hospital in New York and an orthopedic physician practice have achieved a symbiotic relationship that includes a successful bundled payment initiative, and both parties say this kind of cooperation should be a goal for more healthcare organizations.

Leaders at South Nassau Communities Hospital in Oceanside, NY, and of Orlin & Cohen Orthopedic Associates (OCOA) recognized that by working together they could improve quality and patient satisfaction, says **Mark Bogen**, senior vice president of finance and chief financial officer at South Nassau.

Bogen worked closely with **Craig Levitz**, MD, chief of orthopedics at the hospital and managing partner of OCOA, which has projected revenues of $75 million this year. Levitz has been extensively involved with quality improvement projects at the hospital, and also with purchasing decisions regarding implants.

Most of the orthopedic surgeons operating at South Nassau are employed or affiliated with OCOA, giving Levitz influence over them and the way they operate. That was a significant benefit when the hospital and OCOA wanted to work more efficiently.

"In a lot of hospitals you would have a great many surgeons who are not affiliated with each other, so any improvement project is going to be like trying to herd cats," Bogen says. "In addition, our joint replacement surgeons are key to us being part of the Medicare bundled payment program, which we joined a year ago."

Medicare encourages bundling for 48 conditions under the Bundled Payments for Care Improvement (BPCI) Initiative, and knee and hip procedures have been the most popular procedures for voluntary bundling. South Nassau voluntarily joined BPCI under the demonstration project, but mandatory bundling took effect in April. Any bundled payment initiative requires more communication and cooperation among caregivers because they are responsible for outcomes for 90 days after discharge. That gives everyone an incentive to work together more than they might have in the past.

South Nassau worked with OCOA to assess patient needs accurately, directing many patients to the hospital's sub-acute rehab, home care, or transitional care units. OCOA surgeons can be involved in a patient's care from the original testing all the way through rehab.

"That allows a greater control over the post-surgical process," Bogen says. "So far the results have been excellent from a quality perspective, and the bundled payment requirements are tied in so directly to quality outcomes. Patient satisfaction also has increased nicely."

As a result of the improved outcomes under the BPCI, both parties benefitted financially. South Nassau

received a bonus under the Shared Savings Plan that was near the maximum allowed, and OCOA received a significant portion, Bogen says.

Levitz notes there can be tension and animosity between a hospital and physicians, because the hospital tries to exert some influence over how they practice and the physicians try to maintain their autonomy. Levitz and Bogen worked to avoid that adversarial relationship and treat each other as partners with mutual interest.

"It's not a situation where doctors and the hospital each want as much they can, no matter how it affects the other," Levitz says. "We saw that with the bundling we were in this together and it benefitted both of us to respect each other's interest. If there was a deal that was good for us but bad for the hospital, we would pass it up because we didn't want to hurt our partner. South Nassau did the same for us."

Similarly, Levitz also offers another piece of advice for hospitals and physicians entering into a partnership: Be careful about drawing a line in the sand.

"There are always egos at play in medicine and everybody thinks the grass is greener on the other side," Levitz says. "So hospitals say if you don't do it this way, you can find another hospital. And physicians say if you don't do what we want, we're leaving."

Ultimatums like that rarely work out well for either party, Levitz says. Sometimes the better part of valor is to achieve a lesser goal in the moment in order to preserve your long-term goal, he says.

"When there is $5 million on the table, people are reluctant to take $3 million," he explains. "But sometimes you should take $3 million to ensure there are more $5 million deals in the future."

The hospital's success with orthopedic bundling has led to the possibility of participating in other bundles. That decision would not be made lightly, Bogen says, because many of the other procedures that can be bundled are more difficult to manage than orthopedics. The hospital also would want to partner with a physician practice in the same way it did with OCOA, and finding that kind of synergy is not easy, Bogen says.

"This experience with Orlin and Cohen has given us a taste of what happens during the whole episode of care, rather than just what happens in the four walls of the hospital during an inpatient stay," Bogen says. "There's no doubt we will take that knowledge and apply it elsewhere. The question is just where and when."

Bogen says he and other hospital leaders were shocked to learn how much of healthcare costs are incurred outside the hospital, showing the need for post-acute partnerships. The orthopedic bundling experience showed him that a project like this can't be an administrative mandate. There must be clinical leadership if the program is to be successful, he says.

"There has to be a partnership. The clinicians have to take the lead in this," Bogen says. "You also need technology to support it, and a strong care management system that looks outside the hospital rather than being so hospital-centric all these years." ■

SOURCES

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- **Craig Levitz**, MD, Chief of Orthopedics, South Nassau Communities Hospital, Oceanside, NY. Email: slevitz1@aol.com.

Patients and Families Can Teach Safety

Researchers from Boston Children's Hospital in Massachusetts and several other institutions have concluded that it is feasible to engage patients and families in patient safety education.

Their research involved bringing together clinicians with patients and family (P/F) members from hospital advisory councils to discuss error disclosure and prevention. Participants were surveyed before after the discussion to assess their experiences and attitudes about collaborative safety education including participant hopes, fears, perceived value of learning experience, and challenges. They found both groups worried about "power dynamics dampening effective interaction," the researchers write.

"Clinicians worried P/F would learn about their fallibility, while P/F were concerned about clinicians' jargon and defensive posturing. Following workshops, clinicians valued patients' direct feedback, communication strategies for error disclosure, and a 'real' learning experience," the researchers reported in *BMJ Quality and Safety*. "P/F appreciated clinicians' accountability, and insights into how medical errors affect clinicians. Half of participants found nothing challenging, the remainder clinicians cited emotions and enormity of 'culture change,' while P/F commented on medical jargon and desire for more time."

The researchers concluded that both groups found the experience valuable and they offer recommendations on conducting such a program. An abstract and link to the full study are available online at *http://bit.ly/2bQGvpc*. ■

Nursing Home Five-Star Quality Ratings Updated

CMS has updated the Nursing Home Compare Five-Star Quality Ratings to incorporate new measures that it says will provide more information for patients and family members. Five of six new measures will be used in the Five-Star Quality Rating calculations.

The new measures address discharges, emergency visits, and re-hospitalizations.

Nursing homes receive four different star ratings on the Nursing Home Compare website (each ranging from 1 to 5 stars): one for each of the components — health inspections, staffing, and quality measures — and one for an overall rating, which is calculated by combining each of the three component star ratings. Five of the six new quality measures will be incorporated into the calculations for the Five-Star Quality Rating.

The following are the five new measures that will be used:

1. Percentage of short-stay residents who were successfully discharged to the community (Medicare claims- and Minimum Data Set (MDS)-based).
2. Percentage of short-stay residents who have had an outpatient ED visit (Medicare claims- and MDS-based).
3. Percentage of short-stay residents who were rehospitalized after a nursing home admission (Medicare claims- and MDS-based).
4. Percentage of short-stay residents who made improvements in function (MDS-based).
5. Percentage of long-stay residents whose ability to move independently worsened (MDS-based).

CMS is not including the sixth new quality measure regarding anti-anxiety/hypnotic medication measure until it identifies relevant nursing home benchmarks. ■

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CE QUESTIONS

1. Which of the following is true of MACRA?

a. The rule is effective January 1, 2017, with physician performance that year determining bonus and penalty payments effective in 2019.
b. The rule is effective January 1, 2017, with physician performance that year determining by the end of 2017.
c. The rule is effective January 1, 2019, with physician performance that year determining bonus and penalty payments effective in 2021.
d. The rule is effective January 1, 2019, with physician performance that year determining by the end of 2019.

2. What does Marc Mertz, MHA, FACMPE, say will be a likely result of MACRA?

a. Hospitals and health systems will find it more difficult to recruit physicians and to acquire physician groups.
b. Hospitals and health systems should expect to receive inquiries from physicians interested in employment and should have a strategy for responding to these requests.
c. There will be an increase in physicians leaving hospital employment for independent practice.
d. Physician groups will cap the number of physician members they allow.

3. In the leadership program presented by Mark Hertling, Lieutenant General, U.S. Army (Ret.), what do participants say is one element that made it effective?

a. The program was divided so that only physicians attended together, and then hospital administrators took the course separately.
b. The program was integrated so that physicians, administrators, and nurses took the course together.
c. The course was relatively short, lasting only six weeks.
d. Participation was required by the hospital.

4. What is one-way South Nassau Communities Hospital in Oceanside, NY, and Orlin & Cohen Orthopedic Associates (OCOA) achieved a benefit from the Shared Savings Plan?

a. South Nassau worked with OCOA to assess patient needs accurately, directing many patients to the hospital's sub-acute rehab, home care or transitional care units.
b. South Nassau worked with OCOA to recruit more experienced orthopedic surgeons.
c. South Nassau discontinued its voluntary participation in the orthopedic bundling initiative.
d. South Nassau opened a new surgical center using only surgeons from OCOA.