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INSIDE

Board Members Involved in Quality Can Be Quality Resource

Quality improvement leaders should strive for a working relationship with hospital boards of directors and help the members gain the knowledge necessary to be meaningful champions of quality initiatives. However, that does not mean that board members should be expected to participate in the day-to-day efforts to improve quality and patient safety.

While there is no standard for what board members should know about quality, those who understand quality improvement issues make a more meaningful contribution to the hospital, says **Patricia McGaffigan**, RN, MS, CPPS, vice president of safety programs with the Institute for Healthcare Improvement in Boston.

"More engaged boards and boards that are involved in ensuring that patients are free from harm probably do a lot more conscientious work in their board meetings on safety and quality," McGaffigan says.

> ...IT IS CLEAR THAT THOSE WHO UNDERSTAND QUALITY IMPROVEMENT ISSUES MAKE A MORE MEANINGFUL CONTRIBUTION TO THE HOSPITAL.

In a recent report, McGaffigan and her colleagues surveyed a sample of board members and CEOs about their knowledge, understanding, and board activities related to safety and quality, and also asked unpaired safety and quality leaders (SQLs) what they thought of their own boards' knowledge, understanding, and activities related to safety and quality. They found that the board members and CEOs had similar patterns of self-reported knowledge, understanding, and activities

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related to safety and quality, but SQLs reported lower evaluations of their own boards and CEOs.

The results suggest room for improvement in governance and leadership practices at board meetings, the authors concluded. *(An abstract of the report is available online at http://bit.ly/2sUKVXh.)*

"Quality improvement and safety professionals can ask themselves if their board activities are consistent with what we think might be best or better in practice. Do we always have quality and safety meetings on the board agenda, for instance?" McGaffigan says. "Sometimes, quality professionals don't have great presence with their boards, and our research suggests that the board usually will benefit from more exposure to quality concerns, and by extension so will the hospital and patients."

Don't Have to Be Experts

However, McGaffigan points out that it is neither realistic nor necessary for board members to become experts on quality improvement, conversant in all the lingo and statistics. A working familiarity, coupled with an understanding of the impact quality issues can have on patient care and related hospital concerns, is a better goal, she says.

"Sometimes, we might think as clinical and safety professionals that the board has to know everything about quality in order to be a great board, and that might not be the case," McGaffigan says. "We're looking for including quality in board activities, and board members having a level of understanding that helps them do their jobs better. They are the ultimate ambassadors for safety and quality in the organization."

Most hospital boards exert little influence on quality and patient safety, says **Geoffrey W. McCarthy**, MD, MBA, DipAvMed, in Portland, OR, who serves on the board of a large tertiary care hospital after a career as an Air Force pilot. He draws on the Air Force culture of safety for his work on the board.

"I am skeptical that most hospital boards have a great influence on the conduct of operations within the hospital. If the hospital board did not exist, what would change in the hospital?" McCarthy says. "I think very little."

However, that's not how it should be. McCarthy says the better idea is for boards to be knowledgeable and engaged in quality.

"Getting to that point partly depends on getting the right people on the board. You can approach it from looking at the duties and responsibilities of the board as they pertain to quality, and then walk that back to the recruitment of board members," he says. "You can set up the construct of the ideal, highly engaged board that focuses more on safety than on finances, and work to achieve that."

No Best Practices for Boards

Lacking any national standards for board education or involvement in quality, healthcare organizations must work with their own boards to determine best practices says, says **Beth Daley Ullem**, patient advocate and governance expert and a board member with Solutions for Patient Safety and

Board Should Focus on Long-term Quality, Press Ganey Says

Hospital boards should have solid foundation in quality and patient safety, but that does not necessarily mean an intense focus on the day-to-day activities of quality improvement, according to recommendations from Press Ganey, the quality consulting company in Wakefield, MA.

Press Ganey recently released "A Proposed Quality Report Card for Boards," which establishes the top 10 quality metrics for boards. *(The report is available online at: http://bit.ly/2sremiw.)* Measures included in the Quality Board Report Card were derived from primary research capturing the insights of CEOs and senior leaders, and combined with Press Ganey data. More than 26 measures across safety, communication, teamwork, loyalty, engagement, value-based purchasing, and outcomes were narrowed to a list of 10 key metrics that help leaders manage and advance performance in safety, safety culture, clinical outcomes, patient experience, and high reliability.

"Boards have the responsibility of overseeing management, but not managing the operation. As one senior executive put it, 'The board needs to have its eyes on the horizon, because the senior team often has to focus on the icebergs in the water nearby,'" the report says. "Accordingly, boards should not be given the full range of data that CEOs and senior team members use."

The report suggests boards should focus on a small number of metrics that address the following questions:

1. Does the organization lag behind its competitors in important dimensions of quality?
2. Is the organization improving relative to the needs of patients?

The Press Ganey report also cautions that boards should be wary of rhetoric that suggests their organization is "the best," thinking more in terms of, "No matter how good we may be, our duty and our strategy is to try to get better."

Hospital boards' proficiency and dedication to quality can be assessed, Press Ganey says, using a report card with the following key elements:

- **Safety**
  - Serious Safety Event Rate (SEER);
  - Employee survey rating: I would feel safe being treated as a patient here.
- **Communication**
  - Inpatient survey rating: Nurse Communication;
  - Inpatient survey rating: Doctor Communication.
- **Teamwork**
  - Press Ganey Inpatient survey rating: Staff worked together to care for you.
- **Loyalty**
  - HCAHPS/Inpatient survey rating: Likelihood to recommend;
  - Employee survey rating: I would recommend this organization to family and friends who need care;
  - CGCAHPS/Medical Practice survey rating: Likelihood to recommend.
- **Outcomes**
  - Hospitalwide All-Cause 30-Day Readmission (Observed/Expected);
  - Hospitalwide All-Cause 30-Day Mortality (Observed/Expected). ■

The Center for Healthcare Value. She is a former board member with Children's Hospital of Wisconsin and Catalysis (formerly ThedaCare Center for Healthcare Value). She also is a co-author of the report with McGaffigan.

"We have national standards and best practices for so many things in healthcare, but the boardroom has often been overlooked, yet ultimately that is where the expectations, the compensation, and the performance metrics for the senior leadership team are set," Ullem says. "When I go into boardrooms, too often I see senior leadership compensation still based on just financial performance, philanthropic activities, and a few have trickled in quality performance."

Quality leaders can think in terms of what they want the board to understand, what they should be capable and motivated to engage on, and how to best integrate those issues in all interactions with board members, Ullem says. Ideally, quality leaders can be involved with onboarding and continuing education for board members, she says.

"A lot of hospitals are getting better at least putting quality on the agenda. If any hospital does not have quality as a part of every board agenda, and preferably as a top priority item, I don't want to be a patient at that hospital," Ullem says. "Boards are making progress in having quality on the agenda, but a lot still have it on the agenda infrequently or only on the board of the quality committee and not the board as a whole."

Ullem recalls a hospital that requires any new board members to serve on the board's quality committee for the first year, sending the signal that protecting patients and ensuring quality is a top priority.

Present Staff Engagement Data

Boards have traditionally focused almost exclusively on financial performance, notes **Thomas Lee**, MD, chief medical officer at Press Ganey, the quality consulting company in Wakefield, MA. *(See the story in this issue for advice on taking advantage of that connection.)*

"One of the reasons was that people on boards assumed that quality was pretty good and they constantly heard that it wasn't really measurable. They made the assumption that they had good people doing good things, and the more they did, the better," Lee says. "But that era began to end with the Institute of Medicine reports in 1999 and 2001, which made clear that we do have quality problems in healthcare and we can measure and improve them. Since then, there has been a steady improvement in boards getting tuned in to the importance of safety and other dimensions of quality."

Quality professionals should report engagement data to the board that shows how staff and physicians feel about the culture of quality and safety at the hospital, Lee says. These data should show the board whether the organization is committed to safety and quality, and values teamwork.

"That data is usually going to be painful to present. There is going to be five to 10% of employees who will say they wouldn't recommend the hospital to a family member and they wouldn't feel safe being treated there," Lee says. "The idea of just one employee feeling that way is really painful, but I think getting that feedback and being accountable for trying to improve, no matter how good you currently are, is an important part

Financial Focus of Board Can Be Used for QI

A hospital or health system board's focus on its fiduciary responsibility should not be seen as a competing interest with quality concerns, says **John Redding**, MD, senior manager with ECG Management Consultants in Chicago. To criticize a board as concerned only with money and not quality misses the connection between the two, he says.

"In the past, the board has generally focused more on the financial health of the organization and looking at opportunities to advance the organization through revenue optimization or cost reduction. The link between the financial performance of the health system or hospital and quality has not been fully understood by the executives," Redding says. "In the new value-based structures, the boards are starting to get more knowledgeable and more involved in quality, but it's far from a complete understanding. It's something that needs increasing focus and emphasis."

The financial interests of the hospital or health system always have been intertwined with quality issues, such as maintaining accreditation and avoiding lawsuits or harm to reputation from patient harm, he says. That connection can be used to the quality leader's advantage, Redding says, by making sure board members can see how quality improvement affects the financial picture.

"There has always been a link to the financial health of the organization through quality and safety. Quality provides a marketable brand for the organization," he says. "That becomes even more important now because in the past, consumers were not as educated about quality issues and quality was assumed. As networks are narrowed and people decide what outlets are going to be used, consumers and employers are having more informed discussions about the quality of services being offered." ■

of leadership and a governance."

Press Ganey recently released a report that stresses the difference between the role of boards and of management, and offers a quality report card for boards. *(See the story in this issue for more on that report.)*

Make Quality Dashboard Routine

Boards should review a quality and safety dashboard as a routine part of board meetings, McGaffigan suggests. Presenting quality and safety information in an effective way is key to encouraging board involvement, she says, and board members cringe when someone presents way too much information. They tune out quickly, McGaffigan says, and they dread "death by PowerPoint."

"This is a two-way opportunity for leaders and governance bodies to come together, to learn how they can work together to best lead and protect our patients and our workforce from harm," McGaffigan says. "I've asked quality leaders, 'How many of you have ever received education on how to communicate with governance organizations?' and not a single hand in the room went up. Quality leaders, boards, and CEOs could come together and define the most meaningful approaches to take in board meetings so that the valuable time is used wisely and prioritized."

When presenting quality and safety information, Lee follows the adage of "no data without stories, and no stories without data."

"You should be presenting the board with not just numbers but with the stories that bring the numbers to life and show what they really mean. Avoid what we call 'numbers that numb,' in which you have board members thumbing through page after page of numbers and zoning out because they don't know what they're supposed to be looking for or what the numbers mean," Lee says. "The data has to be brought to life."

Quality leaders can ask for feedback on how they communicate with the board, McGaffigan says. This doesn't have to be at the end of a board presentation, as that may not be the best use of board members' time, but the quality leader might ask the CEO, a friendly board member, or someone else present at the meeting for an assessment of how the information was presented and received.

McGaffigan also recommends a report from the American College of Healthcare Executives and the National Patient Safety Foundation Lucian Leape Institute. "Leading a Culture of Safety: A Blueprint for Success" is available online at: http://bit.ly/2rWpgJH. One of the report's suggested measures for determining a culture of safety is "the amount of time spent reviewing and discussing a transparent dashboard on quality and safety culture is equal to or greater than time spent on reviewing financial performance."

Boards are becoming more receptive to an emphasis on quality and safety, but workforce safety still is neglected in many cases, McGaffigan says.

"Boards just don't tend to look at workforce safety dashboards, yet that is our most important asset in the organization. Workforce safety is preconditional to making our patients safe," she says. "If the board is not focusing on the safety of the workforce and seeing what that means in relationship ensuring the safety of our patients, we have a real opportunity to raise awareness levels of the connection between those two elements."

Fed Measures Aren't Enough

Hospital boards can sometimes be misled by federal quality measures tied to reimbursement, 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. Prior to joining MPA, Fry was for 16 years a professor and chairman of surgery at the University of New Mexico in Albuquerque.

"Some of their perception of quality is driven by the need to comply with process measures and so forth that Medicare puts out. They feel that if they're complying with Medicare process measures with patient safety indicators put out by Medicare, that they're doing well," Fry says. "Hospitals are too content in accepting the meaningless process measures that the government imposes on them and they don't really know what the true results of care are for their patients."

Fry advises quality professionals to emphasize quality outcomes when presenting to the board, results that are based on a risk-adjusted methodology and benchmarked to the region or municipal area. These data should be presented at least quarterly, and preferably monthly.

"This should go beyond what I consider the insignificant process measures that the federal government wants you to report to them. My concern is that too many

qualify officers feel that if they have fulfilled federal reporting criteria that their job is complete," Fry says. "You have to go beyond that and put together a comprehensive compendium of what you need to be doing. The quality officer is responsible for that, but the board and the administrative leadership need to understand that there is far more than what government is saying you need to report to them. Good quality officers know that, but their presentations to the board highlight that we are in compliance with what the feds want us to do, and I would argue that quality and safety mean more than that."

Draw on Board Experience

Even when boards are more focused on quality, they still tend to take passive roles, says **John Redding**, MD, senior manager with ECG Management Consultants in Chicago. They may be receptive to quality dashboards, but they often do not offer advice or get actively involved, he says, and quality leaders often do not solicit that input.

That could be a waste of potential resources, Redding says.

"Board members may be drawn from a wide variety of backgrounds — banking, legal, industries other than healthcare, but any industry has its own discussion about quality and many of them took a serious approach to measuring and improving quality well before the healthcare industry," he says. "When it is a passive discussion, it is easy for the issue to be trivialized or just accepted as an unfortunate problem with no real effort to improve. Engaging them in the discussion and encouraging them to draw on their own industry experience creates a more productive scenario in which they can see their value to improving quality." ■

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Smartphone Alerts for Lab Results Speed ED Discharge

Delivering lab results immediately to a specially provided smartphone helps physicians discharge patients significantly faster from the ED, according to recent research.

Chest pain patients whose attending emergency physicians received lab results delivered directly to their smartphones spent about 26 minutes less waiting to be discharged than patients whose lab results were delivered to the electronic patient record on the hospital computer system. *(An abstract of the study is available online at: http://bit.ly/2sKf7So.)*

For patients waiting for lab results, 26 minutes is significant, even if the smartphone process did not significantly shorten overall length of stay, says study author **Aikta Verma,** MD, MHSc, FRCPC, director of clinical operations in the Department of Emergency Services at Sunnybrook Health Sciences Centre, and assistant program director of the Emergency Medicine Residency Program at the University of Toronto.

The research focused on lab results for troponin levels, which are measured to differentiate between unstable angina and myocardial infarction in people with chest pain or acute coronary syndrome.

The results often determine if the patient stays in the hospital or goes home. In this study, the overall median interval from final troponin results to discharge decision was 79.7 minutes. For the control group (no smartphone), it was 94.3 minutes, and for the intervention group (smartphone) it was 68.5 minutes. The difference of 25.8 minutes is statistically significant, Verma notes.

The total ED length of stay was 345 minutes in the control group and 328 minutes in the intervention group, which the researchers did

not consider statistically significant.

There are many other results that also could be pushed to smartphones, Verma notes, including other critical lab results, radiology reports, and vital signs.

Lag Time Reduced

Verma notes there are not a lot of things that address the lag time between lab results being available and physicians reviewing those results, which is one component of the total length of stay in the ED. In most hospitals, physicians must visit a computer terminal periodically, log in, refresh the data, and check on patients' lab results.

The smartphone push alerts deliver the status of the results without the physician having to find the time to inquire.

"There is that lag of time when all the results are back and the patient is ready to be discharged, but the physician is busy doing other things and may not be aware that the results are ready and the patient is waiting for discharge," she says. "Without sitting at a computer and constantly refreshing, there is going to be a lag time between when the results are sent and the physician realizes they are ready. Pushing that information to the smartphone makes the physician aware immediately, so that he or she can read the results and act on them at the first opportunity."

The physician does not necessarily act on the results immediately when the push alert is received, but, at least, is aware much sooner that the information is available. In Verma's research, physicians did act on the information more quickly than they would have without the push alerts.

The system at Sunnybrook Health Sciences Centre also pushes critical lab results to the smartphones in addition to the troponin levels.

Implementing a push alert system first requires overcoming concerns about patient privacy and HIPAA compliance, Verma notes. The hospital addressed those concerns by providing dedicated smartphones to the ED physicians for use only on the premises, with software that enables remote wiping of the phone data if they are lost or stolen.

The phones stay in the hospital and are not dedicated to individual physicians. The doctor signs out a phone at the beginning of the shift, which can be used in all the normal ways a smartphone is used, in addition to receiving the push alerts. They are loaded with useful apps for ED physicians and can be used for calling or receiving calls from other doctors for consultations.

"Getting the physicians to use the phones, instead of their own smartphones, can be an obstacle itself. But if you make sure it has all the apps they like, and maybe some they didn't even know about before, they will be willing to use it when they see the benefit of the push alerts," Verma says. "They also may see the push alerts as interruptions and they already have enough interruptions in their day, so they're willing to just wait until they can get to a computer and look for the results."

The physicians at Sunnybrook Health Sciences Centre are not required to use the smartphones, and some did decline at first. They became more willing to use the phones when they started seeing that it produces results in terms of discharge times, Verma says.

"It's important to note that you don't have to have 100% participation to see benefits from the push alerts," Verma says. "There may be some physicians who just don't want to receive the push alerts, but the overall time for discharge can still be reduced significantly even when a portion of the physicians use them." ■

SOURCE

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Communication Challenges Can Threaten Quality

Language barriers may be commonly recognized as threats to quality of care and patient safety, and hospitals routinely provide resources to overcome that barrier. But communication challenges can come in many forms and hospitals often are blind to them, leading to serious risks, one expert cautions.

Communication also can be hampered by cultural differences and varying levels of health literacy, notes **Matthew Wynia**, MD, MPH, director of the Center for Bioethics and Humanities at the University of Colorado in Aurora. Even the more commonly recognized language differences are not always

effectively addressed, he says.

Wynia notes that communication failures were cited as root causes in 65% of sentinel events investigated by The Joint Commission in 2013, and some communication problems have nothing to do with obvious barriers such as speaking a foreign language.

In many cases, the clinician thinks he or she is communicating effectively, but is preventing the patient from providing important information by interrupting, cutting off statements, or leading the patient to address the physician's hypothesis rather than simply explaining the problem and symptoms. *(See the story in this issue for examples of communication breakdowns that affected the quality of care.)*

"Studies have shown that if you don't speak English or if you come from a background different than that of your doctors and nurses, you're more likely to be the victim of an error," Wynia says. "Many, many errors are the result of communication breakdowns and sometimes more than one communication error."

Physicians should strive for one full minute of listening to the patient without interrupting, Wynia says. One minute may not seem long, but in fact, most physicians interrupt far sooner, he says. Similarly, clinicians should ask open-ended questions rather than yes and no questions. That means not asking, "Do you have any questions?" but instead asking, "What questions do you have?"

"That puts them at ease and tells them it's okay if they have questions, that you expect them to have questions. You're not perfunctorily asking if they have questions and expecting them to

Communication Issues Hamper Quality of Care

These examples of how communication problems affected the quality of care for patients are provided by **Matthew Wynia**, MD, MPH, director of the Center for Bioethics and Humanities at the University of Colorado in Aurora:

- A woman, who reads at a fifth-grade level, gave birth, and in subsequent visits to her physician complained of persistent pain and bleeding. The doctor discussed how the problem can be addressed and she understood almost none of it, but the doctor was reassuring that there is a plan. She signed forms she hasn't read, and later underwent a surgical procedure without fully understanding what was to be done. When she came out from anesthesia, a nurse said, "I hope you're feeling OK after your hysterectomy," and that was the first time she understood what procedure had been performed.

"Someone probably used that word with her at some point, and it certainly would have been in the documents, but she never understood until that point," Wynia says. "The information may be very clear in the paperwork to you and me, but those things are written by lawyers and people are afraid to say they don't understand it."

- A Cuban man collapsed at his girlfriend's door. She told first responders, then hospital clinicians, that he mentioned feeling "intoxicado." The caregivers assumed that meant he was intoxicated and let that influence the diagnosis and treatment. It was not until two days later that the scan revealed he had a large epidural hemorrhage. He was left paralyzed. In fact, "intoxicado" has more complicated meaning in the Spanish language and Cuban culture, including the feeling of having been poisoned or feeling nauseated.

"His treatment would have been different if they had known he had an intracranial bleed right away, but they didn't because they attributed his symptoms to intoxication until it was too late," Wynia says. "This is why you cannot assume you know what someone is saying in another language. It is not even enough to simply have someone on staff who speaks that language. You need a trained translator who can understand the nuances of words and can help you understand information that may be vital to that person's healthcare."

The resulting lawsuit resulted in a settlement over $71 million. *(More information on that case is available online at http://bit.ly/1xONNvK.)*

- A man with stomach cancer refused chemotherapy after surgery and physicians never explored why, assuming it had something to do with his religion or culture. Three months later, his granddaughter visited and realized that the only reason he declined chemotherapy was that the doctors explained it would be provided through a surgically implanted port. He refused because such a port would prevent him from cleansing himself for daily prayers, but if the doctors had known that, they could have provided chemotherapy without the port. They never asked why he was refusing, and assumed religious or cultural objections to the chemotherapy itself. ■

say no so you can walk out," Wynia says. "I often tell them something like, 'that was a lot of information and I don't really expect you to absorb it all on the first go-round, so what questions do you have?' You don't want to put the onus on them to say they don't understand."

Low literacy, as it pertains to reading and writing overall, is an issue that clinicians are becoming more aware of, but health literacy is not yet as well recognized, Wynia says. Health literacy addresses an individual's familiarity with health concepts and ability to understand information, particular directions for medication use and other self-care.

Clinicians live in a world of specialized language and information that is assumed generally known, he says, and they must consciously work to communicate with people for whom that is not the case.

"I've made the argument that every healthcare encounter is a cross-cultural encounter," he says. "Most of us are not in healthcare, and when you enter healthcare you are entering a different culture. We use language in a way most people don't, and we make assumptions about what people know and want."

Even well-educated adults may have low health literacy, Wynia notes. Research has shown that low health literacy is associated with increased hospitalization, greater emergency care use, lower use of mammography, lower receipt of influenza vaccines, higher risk of mortality for seniors, and poorer overall health status among seniors, he says.

Wynia suggests looking for these red flags that could indicate a low literacy level, or other difficulties in understanding information:

- "I forgot my glasses, so I can't read this right now."
- "Let me bring this home so I can discuss it with my children."
- Difficulty explaining medical concerns.
- Inability to name medications, or explain purpose or timing of administration.
- Clowning around, using humor.
- Becoming angry, demanding.
- Being passive, asking no questions.

Wynia advises more use of the "teach back" method with patients, in which the clinician asks the patient to repeat or explain the information provided. Do not ask, "Do you understand what I just explained?" because the patient is likely to say yes whether that is true or not. Instead, ask questions such as, "What will you tell your spouse or your daughter about your condition when you get home?" or, "Would you please explain that back to me so I can be sure I explained it correctly to you?"

To minimize the risk from communication issues, Wynia recommends using the Communication Climate Assessment Toolkit available through the Agency for Healthcare Research and Quality. It is available online at: http://bit.ly/2rLAKAh. ■

SOURCE

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Changes to Readmissions Rule Will Help, But No Panacea

A significant number of hospitals are set to benefit from changes in how CMS calculates penalties under the value-based Hospital Readmissions Reduction Program (HRRP), but the proposed rule won't solve all their problems related to readmissions, says **Bill Bithoney**, MD, formerly CEO, CCO, and CMO at Sisters of Providence Health System in Springfield, MA, and now a managing director at BDO International consulting in New York City.

CMS has proposed a change that would have it consider a hospital's proportion of dual-eligibles when determining penalties under Medicare's Hospital Readmission Reduction Program (HRRP), a change welcomed by hospitals that have long argued dual-eligible patients are more expensive for hospitals and skewing readmissions figures for safety-net hospitals.

The proposed rule has a good chance of moving forward because it is budget neutral, Bithoney says. However, accounting for dual eligibles may not solve all the problems that safety net hospitals face with readmission penalties, Bithoney says.

"There are many other reasons that readmissions may be higher in hospitals caring for poorer people," Bithoney says. "Some have suggested adjustments based on linguistic minorities that hospitals and health systems care for in disproportionate numbers, as well as other census data. It has been said that

when it comes to your health, your ZIP code may be more important than your genetic code, and you can see that in increased mortality and increased readmissions."

As defined by the proposed rule, a dual-eligible patient has full-benefit dual status in the State Medicare Modernization Act during the month he/she was discharged from the hospital. "The State MMA file is considered the most current and most accurate source of data for identifying dual-eligible beneficiaries since it is also used for operational purposes related to the administration of Part D benefits," the rule explains.

The rule offers two ways to calculate a hospital's proportion of dual-eligible patients. The first defines the proportion of full-benefit dual-eligible beneficiaries as the proportion of dual-eligible patients among all Medicare fee-for-service (FFS) and Medicare Advantage inpatient visits, which CMS calls the best comparison of social risk factors among hospitals. That method "represents the proportion of dual-eligible patients served by the hospital, particularly for hospitals in states with high managed care penetration rates," the rule says.

The other option defines the proportion of full-benefit dual-eligibles as Medicare FFS hospital episodes of care, which CMS says it included because the HRRP payment adjustment applies only to Medicare FFS payments and is based on excess readmissions among only those cases.

CMS suggests using data from the Medicare Provider and Analysis Review (MedPAR) to identify total hospital stays, but says it also will consider using data from the CMS integrated data repository. CMS then proposes stratifying hospitals into five peer groups, broken down by their proportion of dual-eligible patients because quintiles create "peer groups that accurately reflect the relationship between the proportion of dual-eligibles in the hospital's population without the disadvantage of establishing a larger number of peer groups."

CMS also could correct for behavioral health diagnoses and patients with minimal social support, Bithoney says. He recalls being informed about a recent case in which a patient was discharged after having both legs amputated and had to climb four sets of stairs to his apartment.

"He was just learning to get around after his hospitalization, and he had little to no social support in the way of family and friends, or social services. You can easily predict that that patient is going to be readmitted soon," Bithoney says. "The social aspects of recovery, and the effects of social isolation, are never taken into account."

The cumulative effect of certain diseases also could be considered, Bithoney says. It is well known that some conditions combine to affect the situation far more than might be suggested by simply tallying up the effects of each disease, he says.

"With the triad of heart disease, diabetes mellitus, and renal failure, those diseases interact with each other in a way that predicts readmission much more frequently than you might expect from the summative score of having each of those diagnoses separately," Bithoney says. "CMS could adjust for that patient population in considering readmissions, but currently that effect is not factored in to the evaluation."

Hospitals that serve a higher proportion of dual-eligibles might need to rethink their financial risk management plans in light of the rule, he says. It may no longer be necessary to include CMS readmission penalties as a given, or at least not at the same level, he says.

Some hospital leaders would not be happy with the proposed rule leveling the playing field with regard to dual-eligibles, Bithoney says. Wealthier hospitals may have some trepidation about the change because it narrows the gap performance gap between them and safety net hospitals, he says.

"Hospitals that have fewer dual eligibles might find themselves with penalties from CMS, whereas they did not have penalties previously," Bithoney says. ■

SOURCE

- **Bill Bithoney**, MD, Managing Director, BDO International, New York City. Email: bbithoney@bdo.com.

Quality Payment Program Delaying Some Requirements

CMS is attempting to lower the burden of the Quality Payment Program (QPP) for small practices and other clinicians, with a proposed rule that would update the physician payment programs created as a part of the Medicare Access and CHIP Reauthorization Act (MACRA). The changes could be important for hospitals and health systems with affiliated physician practices.

The rule would delay certain requirements of the programs for a year and either exempt some providers from participation or provide more flexibility for eligible providers to meet QPP requirements.

The administrative burden is an unfortunate consequence of the QPP initiative that allows providers to choose from the Advanced Alternative Payment Models (APM) or the Merit-based Incentive Payment System (MIPS). The system replaces Medicare Meaningful Use, the Physician Quality Reporting System, and the Value-based Payment Modifier.

Under the proposal, CMS would exclude eligible clinicians who bill less than $90,000 in Medicare Part B charges or who see fewer than 200 Part B beneficiaries. That is substantially different from the 2017 low-volume thresholds of less than $30,000 in Part B charges or fewer than 100 Part B beneficiaries.

CMS is responding to protests from the healthcare industry that **Matthew Amodeo**, JD, partner with the Drinker Biddle law firm in Albany NY. Physicians were happy to be rid of the sustainable growth rate formula that was replaced by the QPP initiative, but many found the MIPS reporting overwhelming, he says.

"It's a very big hardship on small practices to do this reporting, and also for rural practices which tend to coincidentally be smaller, but they also have patient populations that are sicker and costlier. They tend to have more chronic conditions, more comorbidities, limitations on their access to the case, so it's challenging to these physicians already on a cost basis," Amodeo says. "They have high demands on their time from these patient encounters, so these additional reporting burdens on top of that can have a real impact. It's administratively a burden and cost-wise too much of a burden."

CMS responded by changing the requirements so that about another 135,000 physicians would be exempt from compliance, Amodeo says, and about half of those are from small practices. That brings the total number of exempt physicians in the country to about 835,000, he says.

CMS also has proposed keeping the cost portion of the total score at a 0% weight for 2018 reporting instead of increasing it to 10% weight as originally planned.

The physician also would still be able to use 2014 Edition Certified Electronic Health Record Technology (CEHRT) for the 2018 performance year instead of moving to the 2015 edition.

"CMS is becoming much more responsive to industry input, much more flexible, and reacting to what is really happening in healthcare on a day-to-day basis," Amodeo says. "This is good evidence of that." ■

SOURCE

- **Matthew Amodeo**, JD, Partner, Drinker Biddle, Albany NY. Telephone: (518) 862-7468. Email: mattew.amodeo@dbr.com.

COMING IN FUTURE MONTHS

- Errors from Cognitive Bias
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CE QUESTIONS

1. In the research by Patricia McGaffigan, RN, MS, CPPS, how did the quality knowledge levels of board members and CEOs compare with that of safety and quality leaders (SQLs)?

a. The board members and CEOs had similar patterns of self-reported knowledge, understanding, and activities related to safety and quality, but SQLs reported lower evaluations of their own boards and CEOs.
b. The board members had much higher patterns of self-reported knowledge, understanding, and activities related to safety and quality than CEOs, but SQLs reported higher evaluations of their own boards and CEOs.
c. All of the surveyed groups had lower levels of knowledge than expected.
d. All of the surveyed groups had higher levels of knowledge than expected.

2. What does John Redding, MD, suggest regarding the background of most hospital board members?

a. Most board members come from an industry background with different insights into quality and safety, but they cannot be applied to healthcare.
b. Most board members come from an industry background with different insights into quality and safety, and that knowledge can be applied to healthcare.
c. Most board members come from industry backgrounds with no emphasis on quality and safety.
d. Most board members come from industry backgrounds with poor performance in quality and safety.

3. In the research by study author Aikta Verma, MD, MHSc, FRCPC, how did the use of smartphone push alerts for lab results affect patient discharge in the ED?

a. Patients were discharged 26 minutes faster, which Verma calls significant.
b. Patients were discharged 26 minutes faster, but Verma says that is an insignificant difference.
c. Patients were discharged 46 minutes faster, which Verma calls significant.
d. Patients were 46 minutes faster, but Verma says that is an insignificant difference.

4. How long does Matthew Wynia, MD, MPH, advise physicians to listen to a patient before asking questions?

a. 30 seconds
b. One minute
c. 90 seconds
d. Two minutes

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.