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INSIDE

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NOVEMBER 2017 Vol. 42, No. 11; p. 121-132

Physician Skepticism on Satisfaction Can Be Overcome

Achieving "buy in" from staff and hospital leaders is key to the success of any quality improvement effort, but it is common to meet resistance from those who doubt its value. When it comes to measuring and improving patient satisfaction, that skepticism often comes from physicians.

The common response from physicians, whether they say it out loud to hospital leaders or grumble quietly among their colleagues, is that their job is to practice good medicine and not to grovel for five-star ratings on a patient satisfaction survey. Left unchecked, that attitude can derail the initiative.

The healthcare industry has come to value patient feedback far more than in the past, using everything from the Hospital Consumer Assessment of Healthcare Providers and Systems (HCAHPS) survey to patient satisfaction surveys from consultants and vendors and online reviews. The focus on satisfaction may be reaching a level that prompts some physicians to rebel, says **Anthony D. Cox**, chairperson of graduate business programs in medicine and professor of marketing at the Indiana University Kelley School of Business in Indianapolis.

> THE FOCUS ON PATIENT SATISFACTION MAY BE REACHING A LEVEL THAT PROMPTS SOME PHYSICIANS TO REBEL.

He has long advocated for paying attention to patient satisfaction and other feedback, but Cox acknowledges that physicians can sometimes feel like "enough is enough."

"I still support the use of patient feedback to improve quality of care, but there is a lot of resistance among

Financial Disclosure: Author **Greg Freeman**, Editor **Jesse Saffron**, Editor **Jill Drachenberg**, Nurse Planner **Fameka Leonard**, AHC Editorial Group Manager **Terrey L. Hatcher,** and Consulting Editor **Patrice Spath** report no consultant, stockholder, speaker's bureau, research, or other financial relationships with companies having ties to this field of study.

HOSPITAL PEER REVIEW®
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Hospital Peer Review®
ISSN 0149-2632, is published monthly by
AHC Media, a Relias Learning company
111 Corning Road, Suite 250
Cary, North Carolina 27518.
Periodicals Postage Paid at Atlanta, GA 30304 and at additional mailing offices.
GST registration number R128870672.

POSTMASTER: Send address changes to:
Hospital Peer Review
AHC Media, LLC
PO Box 74008694
Chicago, IL 60674-8694

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SUBSCRIPTION PRICES:
U.S.A., Print: 1 year: $519. Add $19.99 for shipping & handling. Canada: Add $30 per year. Total prepaid in U.S. funds.
Printed back issues are $50 each
Online only: 1 year (Single user): $467

Discounts are available for group subscriptions, multiple copies, site-licenses, or electronic distribution. For pricing information, please contact our Group Account Managers at Groups@AHCMedia.com or (866) 213-0844.

ACCREDITATION:
Relias Learning LLC is accredited as a provider of continuing nursing education by the American Nurses Credentialing Center's Commission on Accreditation. Contact hours [1.25] will be awarded to participants who meet the criteria for successful completion. California Board of Registered Nursing, Provider CEP#13791.

This activity is valid 36 months from the date of publication.

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

Opinions expressed are not necessarily those of this publication. Mention of products or services does not constitute endorsement. Clinical, legal, tax, and other comments are offered for general guidance only; professional counsel should be sought for specific situations.

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physicians to the increasing prominence given to patient satisfaction in evaluating what they do. It is important to address those concerns in order to get the potential benefits from that patient feedback," Cox says.

If any initiative within a healthcare organization has a lot of resistance from physicians, it's going to be hard to make it successful, Cox says. Excessive or insensitive campaigns about patient satisfaction will only exacerbate tensions between hospital leadership and physicians, he says.

"They didn't get into this business to be a salesperson, and an excessive focus on patient reviews trivializes what they do," he says. "There often is a lot of distrust between physicians and hospital administrators. If they're battling, it's usually the patient who loses, so you don't want this to be another battlefield."

Reviews Tend to Extremes

Cox currently is researching physician resistance to patient satisfaction measurements and what factors most influence patients' perception of quality and satisfaction. Part of that research involves looking at online reviews, and Cox is finding that they tend to be bimodal, with a lot of one-star and five-star reviews.

"We're looking in particular at what drives a person to be so dissatisfied by their experience to go online and write one of those reviews. There are a number of frequently mentioned issues that don't come up on survey tools like HCAHPS, which is very narrow. It looks at certain aspects of what the patient experiences in their hospital bed, with no mentions of things like billing, which is a commonly mentioned issue in negative reviews."

Physicians feel pressured to make patients feel satisfied and provide positive feedback, which can create perverse incentives, Cox says. Some doctors may only act subconsciously to give the patient what he or she wants even if it is not the best medical decision, while others are fully aware that they face a choice of making the patient happy or risking a bad review.

"Some physicians have felt pressure to prescribe opioids to patients who don't necessarily need them. Two HCAHPS questions were specifically about pain management and one of them asked if the hospital staff did everything possible to alleviate your pain. I've talked to a number of physicians, particularly emergency physicians, who thought the idea of pain as a vital sign has created an incentive to overprescribe opioids," Cox says. "Another example is patients who want antibiotics and will go home feeling better and more satisfied if they get that prescription, but the doctor knows they don't really [need] it. Doctors can find themselves in a dilemma."

Valid Methodology Concerns

Physicians are trained to be scientific thinkers and often criticize the methodology behind patient satisfaction metrics. Some of that is just sour grapes, with low-scoring physicians looking for a way to invalidate the survey, but Cox says criticism is sometimes valid. Those flaws may involve sample sizes, for example, or population demographics that influence satisfaction scores.

"I have a good friend with a

practice that includes serving parolees who have to go in for mandatory drug testing. Those folks do not give many fives on a satisfaction survey, because they are really unhappy to be there," Cox says.

Those concerns must be addressed because physicians cannot be expected to support a flawed survey tool that threatens their careers and incomes, Cox says.

Physicians also bristle at the idea of focusing more on patient happiness than on patient wellness, Cox says. Hospitals can inadvertently send the message that they are fixated on happiness by focusing too much on surveys, or by emphasizing their importance with ham-handed initiatives.

If there are methodology concerns, show how you're addressing them and retooling the survey or finding another tool. When there are issues with patient populations that are never going to give you a top score on a survey, you must find an effective way to factor that in to how you assess and use the results, he says.

"When those objections are acknowledged and administration shows that they're making a good faith effort to deal with them, you'll get a lot more buy-in. I've seen hospitals just tell physicians 'this is the way it is now and learn to deal with it,' but that never works," Cox says. "If all the objections are dismissed as sour grapes from people who can't get good satisfaction ratings, you're going to miss legitimate concerns and push physicians away. Acknowledge legitimate concerns even if you don't have an immediate solution."

Quality vs. Specs

Clinician skepticism usually comes from confusing quality with meeting specifications, says **Tom Davis**, MD, FAAFP, in St. Louis, who has worked with clinicians, organizations, and insurers regarding Medicare Advantage for 20 years, both as a practicing clinician and a consultant. Quality and specifications are not the same thing, he says.

Davis recalls an effort to improve infection control with more hand-washing when he worked in an outpatient setting.

"Without warning, our office was inundated with mandatory training, posters, screen savers about hand-washing, the whole drill. The emphasis was not on good patient care or outcomes. The emphasis was on making sure the patient saw you wash your hands, even verbally noting it to them, with no explanation given as to why it was important," he says. "Washing before laying hands on patients is polite and not doing so is drop-dead disgusting, but in the outpatient setting, there is no evidence that it affects any medical outcomes in any way. It is, however, a primary mover of patient satisfaction scores."

The effort failed in the end, Davis says, and even worse, it left physicians and staff feeling disheartened when they realized there was no science underlying it.

"We were not told these facts during the hand-washing promotion and once the educational program petered out less than three months later, we found them out offhand from a junior administrator, significantly undermining the efficacy of any future intervention," Davis says.

He suggests the lesson for hospital quality professionals is that you should pick your metrics sparingly for maximal effect. Tie them scientifically to patient outcomes and personalize them, because every clinician has been a patient, Davis says.

"Prepare any education promotion with 'pre-education' about these benefits before the program begins. Integrate them into grand rounds and noon conference lunches with respected thought leaders," Davis says. "Any promotion and metric measurement should be at least three years in length to establish its importance. Limit frivolous selection and promote the credibility of the leadership."

Create a Quality Culture

Physicians will respond more positively to quality initiatives if they are already involved in the organization's effort to promote a culture that emphasizes the patient experience, says **Omar Baker**, MD, co-president, chief quality and safety officer and director of performance improvement with Riverside Medical Group, which has 70 locations in northern New Jersey.

Baker focuses on delivering patient-centric care and has created a mandatory monthly seminar called CARES for all 800 staff, physicians, and managers to address that goal.

"It is our ingrained culture to always put the patient first with a focus on evidence-based care delivery and an emphasis on results that leads to the highest patient satisfaction scores. We value the patient perspective so much that we have patient focus groups at several locations, we encourage online surveys and feedback, and we continually monitor online feedback," Baker says. "We are in a consumer-driven industry, but our physicians must always do what's best for our patients and at Riverside, our motto is to treat our patients like family."

Physicians, staff, and patients all are seen as stakeholders in the care delivery model at Riverside,

Baker says, and although they consider patient feedback seriously, it is only one component they use to evaluate their performance and methods for quality and performance improvement.

Riverside looks at structure, process, and outcomes continually to ensure it is delivering a superior patient experience. This is what the CARE model stands for in efforts to better serve patients:

• **Culture:** Riverside started more than 35 years ago and currently has more than 70 locations in Bergen, Hudson, Essex, and Passaic Counties.

• **Access and Accountability:** The Secaucus, NJ, headquarters is open 365 days a year from 7 a.m. to midnight. A medical provider is on call 24/7. There is one shared electronic medical record system that provides access to hospital, specialty, and primary care records. For accountability, all care team members are accountable for the health of their patients. Documentation must be legible and accurate, and communication is the key for teamwork.

• **Results:** The medical groups focus on providing value, defined as the highest possible outcome at the lowest possible cost.

• **Engagement:** Riverside is a strong advocate of education for all patients, caregivers, and community members. It offers free prenatal, breastfeeding, and diabetes education classes to the community.

• **Satisfaction and Safety:** Riverside strives to keep employees and patients happy and healthy, practicing what it preaches with annual wellness visits, flu vaccines, and other wellness habits. Riverside conducts patient satisfaction surveys and patient focus groups.

"Skepticism is overcome by understanding [that] medical care is evolving through innovation and technology and that patient satisfaction surveys and scores [are] important, but only one aspect of evaluating our model of care delivery," Baker adds. ■

SOURCES

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WSJ Casts Doubt on Value of TJC Accreditation

The Joint Commission (TJC) is not responding to a prominent newspaper investigation that questioned the value of its accreditation, leaving hospital leaders to assess the allegations.

One quality professional says the report may have raised some valid concerns, but also misrepresents how TJC accreditation works.

The *Wall Street Journal* based its conclusions on database analysis of hundreds of inspection reports from 2014 through 2016. The article notes that, though it is a private organization, TJC has a quasi-governmental role as the accrediting organization for almost 80% of U.S. hospitals. Twenty of The Joint Commission's 32 board members are executives at health systems it accredits or parent organizations of accredited health systems, the newspaper reports. Other board members are named by healthcare lobbying groups, such as the American Hospital Association and the American Medical Association. *(The* Wall Street Journal *article is available online for a fee at: http://on.wsj.com/2jaIpYY.)*

The following are two key allegations in the article:

• TJC typically takes no action to revoke or modify accreditation when state inspectors find serious safety violations. The database analysis indicated that about 350 hospitals in violation of Medicare requirements had Joint Commission accreditation at the time. More than one third with accreditation went on to have additional violations later in 2014, 2015, and 2016.

• In the time period studied, hundreds of hospitals with safety problems continued to display a "Gold Seal of Approval" and actively promote their accredited status. TJC did not take action to stop them.

TJC Media Relations Manager **Elizabeth Eaken Zhani** tells *HPR* that the organization has no comment on the newspaper article and declined our requests for a TJC representative to address some of the issues raised. Hospital leaders with concerns and questions about the article can contact their assigned TJC account executive, Zhani says.

Role of TJC Confused

The newspaper report attempted to illustrate valid concerns about the TJC accreditation process but at least partially misconstrued the role of TJC, says **Donna Fraiche**, JD, senior counsel with the law firm of Baker Donelson in New Orleans. She has spent most of her career representing hospitals with credentialing and peer review issues, especially compliance related to TJC accreditation.

The criticism of TJC in the article suggests the newspaper confused the roles of TJC and the Centers for Medicare & Medicaid Services (CMS) regarding accreditation and compliance, Fraiche says.

"Those are entirely different roles, and that seems to have been lost in the article," Fraiche says. "In the early days it was more of a self-policing situation, with hospitals volunteering to have The Joint Commission police them and ensure compliance with standards. In later years that has changed, and I think for the better."

That earlier approach was seen as sort of a closed system with hospitals keeping the information to themselves, whereas TJC has now evolved to more of an open system through which hospitals can publicly pledge to meet established quality standards, Fraiche says.

"Now we see hospitals much more willing to report when there is a problem, and that's what you want," she says. "One of the things the article was rough about was what the author perceived as a lack of transparency by The Joint Commission. I'm not sure what the author meant by that because there is an awful lot of transparency. I suppose if you're a plaintiff's lawyer and you want someone else to do all the homework for you and turn over all the dirt for you to exploit, then you could say there's not enough transparency."

Transparency in Question

Fraiche notes that some of that desire for more transparency probably comes from the fact that hospitals are allowed to investigate their own problems before TJC comes in to study the issue and makes information public. That is a good policy, she says.

"If you put everything in sunshine prematurely, before you allow hospitals and accreditation agencies to investigate what procedures were in place to address the issue and whether they were sufficient, you discourage real improvement," Fraiche says. "If you don't have the freedom to look in your own backyard before somebody comes in with a microscope, you miss the opportunity to have hospitals learn from their mistakes and you discourage them from reporting problems. Then, you will only hear about the dramatic cases and not the day-to-day things that are caught before they become serious problems."

> "IF YOU PUT EVERYTHING IN SUNSHINE PREMATURELY...YOU DISCOURAGE REAL IMPROVEMENT."

Fraiche disagrees with the article's suggestion that The Joint Commission is lax or that CMS should take over its operations. Both compliance tracks are necessary, she says.

When CMS surveys a hospital, it does not focus on whether the hospital complied with TJC accreditation efforts because it has its own standards that, though similar and parallel, are not the same, Fraiche notes.

"CMS has taken the position before that if you have Joint Commission accreditation they won't come in for unannounced surveys without cause, taking that accreditation as a seal of approval. But that's not a formal policy, and in recent years we've seen more of a competition between how tough The Joint Commission can be and how tough CMS can be," she says. "That leads to The Joint Commission having to answer to criticism by CMS about how they monitor hospitals, and I think that could mean we will see The Joint Commission coming down harder on hospitals in the future."

TJC Consulting Necessary

The *Wall Street Journal* article also questioned the propriety of TJC having a consulting arm that charges hospitals for compliance assistance, but Fraiche says the complexity of accreditation compliance necessitates having assistance available from people who thoroughly understand the system.

It's becoming more and more expensive for hospitals to comply with the plethora of regulatory responsibilities, and compliance officers are very busy both with day-to-day concerns and long-range

efforts, Fraiche says.

"A reporter looking in from the outside may say this is the fox guarding the henhouse, but I don't see it that way at all," Fraiche says. "I see it as a helpful resource you can use or not use. You can use private consultants or none at all, but it's perfectly reasonable to need that kind of assistance." ■

SOURCE

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AHA Urges CMS to Halt Quality Star Ratings, Calls Them Misleading

The American Hospital Association (AHA) is calling on CMS to immediately halt the use of star ratings on its Hospital Compare website, saying the ratings provide "an inaccurate, misleading picture of hospital quality."

AHA's Senior Vice President of Public Policy Analysis and Development, **Ashley B. Thompson**, sent a letter to CMS Chief Medical Officer **Kate Goodrich**, MD, asking her to suspend the "deeply flawed" ratings program. She also offered a long list of desired "regulatory relief."

The ratings program poses a "regulatory burden" that is "substantial and unsustainable" for hospitals, Thompson said.

In addition to ending the ratings program, the AHA also asked CMS to cancel Stage 3 of the meaningful use program, suspend the electronic clinical quality measure reporting requirements, and use only "measures that matter" rather than the 90 hospital quality measures currently tracked.

The letter noted that the AHA has long supported transparency and continues to share CMS's goal of making the data on Hospital Compare easier for consumers to understand.

"However, CMS's flawed approach to star ratings undermines this goal by providing an inaccurate, misleading picture of hospital quality. That is why a majority of Congress urged CMS to delay the reporting of star ratings last year, and why the AHA and others have repeatedly urged CMS to suspend the reporting of overall star ratings until the methodology is improved," Thompson wrote. The letter goes on to note that "CMS's own analysis shows that nearly 700 hospitals would experience a change in their star ratings, amplifying our concern about the reliability and accuracy of the chosen methodology. At a minimum, the AHA strongly urges CMS to remove the star ratings from Hospital Compare and not republish them until it corrects the errors and outside experts agree that the updated methodology is executed correctly."

The AHA has criticized the star ratings methodology before, and Thompson conceded in the letter that proposed updates from CMS correct some of those methodology errors. The updates, which were published in August 2017 under contract with the Yale New Haven Hospital System Center for Outcomes Research and Evaluation (YNHHS CORE), focus on measure selection and grouping, calculation of measure group scores using a latent variable model, and determination of overall star rating using k-means clustering.

The AHA addresses those proposed updates in the letter, but calls them insufficient to justify continuing the star ratings program. *(The AHA letter is available online at: http://bit.ly/2xILh4F.)* ■

Hospital Captures Patient Feedback From Online Reviews

Leaders at Miami (FL) Children's Health System/ Nicklaus Children's Hospital understand the importance of making the patient experience one that people remember — in a good way. But when they realized that standard feedback tools like the Hospital Consumer Assessment of Healthcare Providers and Systems (HCAHPS) survey weren't giving them the whole picture, they looked elsewhere, to online reviews.

The health system tries to gather patient satisfaction data just as any hospital does, but leaders there also recognize that obtaining that information can be challenging, says **Roberto Prieto**, manager of web marketing for Miami (FL) Children's Health System. With pediatrics, it is not just the patient whose opinion matters but also the rest of the family, expanding the number of people who might have useful feedback.

After noticing online chatter about the hospital's reputation, Prieto and other leaders at Children's decided to take a more proactive approach to monitoring and managing online reviews. About two years ago, Prieto tested services that track online reviews and committed to one that the health system still uses.

Improved Results Over Two Years

The reviews are used to improve quality of care and patient satisfaction, which should result in improved reviews going forward, Prieto says. From Jan. 1, 2016, through Aug. 31, 2016, all of the Nicklaus Children's Hospital's locations received 946 reviews with an overall 4.1-star reputation rating. In the same period in 2017, all of the Nicklaus Children's Hospital's locations received 1,524 reviews with an overall 4.3-star reputation rating.

That is a 61% increase in reviews and an improved overall reputation rating.

The data gathered through the service provide a much more complete and accurate summary of online reviews than he ever could have created on his own, Prieto says.

"There are a lot of online review sites out there that I wasn't even aware of. We were hearing mostly positive reviews, but there were very negative things said from time to time," Prieto says. "We also were missing some reviews because we have a network of services, and if people didn't have the ability to specify that one clinic or service area that they had a problem with, they would leave a negative review for the health system or the hospital, when it was a more specific service area they were addressing."

The solution to that problem was to create individual profiles for different services located in the same building or campus, such as urgent care, rehabilitation therapy, plastic surgery, and imaging services.

"Once you have data that you can rely on, that you know is giving you a complete picture of what is being said online and directed to the individual service areas, then your people will pay more attention when you give them that feedback. They will take it seriously and you can more effectively hold them accountable for improving on the issues cited," Prieto says. "We can make this a regular report to service lines and clinics, to say that this is what your public perception is like on these sites, the ones that your customers use more."

Reviews Across Many Sites

Interestingly, reviews are not spread uniformly across all online sites. For his health system, outpatient reviews are more likely to appear on Google, Prieto notes, but clinic reviews are more likely to appear on the Vitals.com review site. The review aggregation service allows the health system to segment each business element and understand where each is being discussed more.

"We're able to get alerts when the system or hospital is mentioned, and if the review mentions a specific doctor or other clinic, we send that information to that individual along with all the other stakeholders like the chief or administrator in that area. Positive or negative, we always send them," Prieto says.

The two years of data from online review management come primarily from Facebook, Google, Vital, and Zocdoc, with another category compiling other, less often used sites.

Must Be Able to Respond

Prieto notes that it is important to officially claim your facility or health service on each site, in effect telling the site owner that you are the one represented by that part of their website, because you will not be able to respond to reviews until you do.

"If your brand is out there, you need to be able to reply. We were locked out in the early days, so we couldn't go in and reply as Nicklaus Children's Hospital telling them we want to help and here's the number to call," he says.

Before embarking on a program for online review management, Prieto advises having a clear idea what it entails and what you are going to do with the information. When he first started compiling the information and reporting it within the health system, there was confusion about what the data really represented. Some assumed it showed how the health system was being discussed on social media.

"I had to clarify that this isn't social media. It's online review sites, which differ in terms of how seriously you take the review and what weight it has with consumers," he says. "I would recommend that you have pre-approved scripted replies to use,

and when you post those replies you should make sure your customer relations department is aware. When you post a reply, the family might want to follow up or escalate the matter, and you want them talking to someone in customer relations who is familiar with the issue and can help them properly." ■

SOURCE

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ICU Diaries Help Patients, Families Cope With Stress and Aftereffects

An innovative diary system has helped reduce the incidence of post-intensive care syndrome (PICS) at a California health system. Nurses keep diaries during a patient's stay in the ICU to help him or her avoid problems that can be caused by the patient's memory being incomplete and sometimes confusing.

PICS affects patients after their discharge from the ICU with weakness, cognitive dysfunction, anxiety, depression, or post-traumatic stress disorder. It is common among patients who survive a critical illness and symptoms can persist long after they return home, with half of affected patients not returning to work in the first year. The symptoms also can affect family members.

Nurses in the University of California, San Diego (UC San Diego) Health system devised a strategy to identify and treat PICS early, hoping to increase patient satisfaction and increase post-ICU referrals.

The project came about when nurses started noticing that individuals would visit the ICU after a stay and be thankful, but remember little of their experience there, explains **Giang Huynh**, RN, BSN, CCRN, an assistant nurse manager at Jacobs Medical Center, part of the UC San Diego Health system. They did not remember the stress of being sick in the ICU, but they also did not remember the positive parts of the experience, such as milestones in the recovery process or support offered by family and staff.

Diaries Introduced to ICUs

Family members, on the other hand, often remembered the experience in much more detail but, understandably, their memories focused on the fear and stress of seeing a loved one so sick. They also had no way to document their support and encouragement.

Huynh worked to address the issue with **Heather Gunter**, RN, MSN, MBA, CCRN, an assistant nurse manager at Sulpizio Cardiovascular Center, also part of the UC San Diego Health system. Daniel Walls, RN, BSN, also worked on the project.

The health system offers a post-ICU clinic to help patients and family members deal with the lingering effects of an ICU stay, so increasing referrals to that clinic was a goal of the project, in addition to identifying and mitigating PICS.

The nursing team created a series of classes to educate staff about PICS, the use of ICU diaries, and the post-ICU clinic. The diaries were a new process added to the ICUs, with nurses and family members encouraged to write in each patient's diary about clinical progress and milestones. *(More information on ICU diaries is available online at: icu-diary.org.)*

"Diaries have been shown to help reduce patients' memory gaps and distorted thoughts regarding the ICU stay, which helps reduce the overall risk and effects of PICS. The diaries can help patients who were heavily sedated or comatose reconstruct the narrative of their illnesses, which can be important because it is disturbing to have a gap like that in your memory, especially when it involved a critical time in your life and recovery," Huynh says. "The diaries also help family members cope with the stress of having a loved one in ICU."

The nurses conducted ICU diary workshops in May 2016 and had a diary initiation kickoff party on June 1, 2016. The program had to be approved by administration, particularly risk management, which had concerns about what information would be entered in the diaries. The diaries must not contain clinical information that would be more appropriate in the medical record, or any information protected by privacy rules.

Referrals Increase After Diaries

There were no ICU referrals in the pre-diary period of February 2016 to the diary implementation on June 1, 2016, but there were nine referrals from that date to Jan. 1, 2017. That represents a projected 108 visits per year and $10,152 in revenue.

Each diary is a 45-page spiral-bound notebook with an easy-to-clean plastic cover and the title "Your Stay, Your Story." The diaries start with a letter addressed to the patient, family members, and friends, and there is an instructional page exemplifying the type of information appropriate to include in the diary, recommending that all entries use language that is personal and meaningful to the patient, with care taken to maintain the patient's dignity. The diary provides 30 pages for daily notes, along with diagrams and explanations of medical terms for the patient and family members.

To be eligible for the ICU diary program, patients must be in the ICU longer than 48 hours, speak English, and have a positive score using the Confusion Assessment Method for the ICU (CAM-ICU) or have a Richmond Agitation-Sedation Scale (RASS) of -2 or greater during the ICU stay.

Nurses Write Each Day

ICU nurses are expected to write in each patient's diary daily, but other staff are encouraged to add notes as well.

"They write notes [that] are very non-medical, in layman's terms. The first entry might say, 'You're in the hospital because your breathing became difficult and we had to put a tube in your throat to help you breathe. Your family members are at your bed side and holding your hand,'" Huynh says. "It's not clinical information about intubation and hemoglobin levels. Most important is the message of caring, and the staff's excitement for the patient reaching a milestone like getting a foot out of bed for the first time."

One note recounted how the staff put a basketball hoop in a patient's room and celebrated the first time he made a basket from his bed.

Family members can use the ICU diary to note their positive thoughts and encouragement, with children and grandchildren writing notes on Father's Day and other holidays, for instance. Some families use the diary as a scrapbook, and include photos and children's handprints.

"Some of our patients are here for months and months, and they can go through a couple of diaries," Gunter says. "It helps fill in the gaps of things they missed when they were sedated, and it creates a timeline for them. But it also gives this message of caring, a record of how much support they had during this period even if they were sedated and didn't know." ■

SOURCES

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CMS Offers Guidance on Inpatient Engagement Necessary for Hospital Certification

CMS recently issued an advance copy of guidance to state survey agency directors that outlines how to determine whether a hospital seeking Medicare certification, or going through a continuing certification survey, is "primarily engaged in providing inpatient services" under the Social Security Act. That definition is key to compliance.

The new guidance amends Appendix A of the State Operations Manual used by survey agencies when conducting the hospital survey and certification process, highlighting two key factors that surveyors should consider: average length of stay (ALOS), and average daily census (ADC).

CMS explains that "generally, a patient is considered an inpatient if formally admitted as an inpatient with the expectation that he or she will require hospital care that is expected to span at least two midnights," so surveyors should use an ALOS of two as one of the benchmarks considered for hospital certification. Because the Social Security Act refers to the provision of care to "inpatients," the CMS guidance says that "hospitals must have at least two inpatients at the time of the survey in order for surveyors to conduct the survey."

If a hospital does not have at

least two inpatients at the time of a survey, the surveyors will review data for the past 12 months. If the hospital does not have a minimum ADC of two inpatients and an ALOS of two over the preceding 12 months, "the facility is most likely not primarily engaged in providing care to inpatients and the CMS Regional Office must look at other factors to determine whether a second survey should be attempted." If the data show the hospital met the minimum at some point in the prior year, the surveyors will schedule a survey for another date.

CMS also advises surveyors on determining whether to conduct a second survey, recommend denial of an initial applicant, or terminate a current provider agreement. Surveyors should consider the number of provider-based off-campus EDs, as an unusually large number may suggest that a facility is not primarily engaged in inpatient care, according to the guidance.

Surveyors also should consider the number of inpatient beds in relation to the size of the facility and services offered, the guidance says, along with the volume of outpatient surgical procedures compared to inpatient surgical procedures.

The guidance also lists these points to consider:

- If the facility considers itself to be a "surgical" hospital, are procedures mostly outpatient? Does the information indicate that surgeries are routinely scheduled early in the week, and does it appear this admission pattern results in all or most patients being discharged prior to the weekend? For example, does the facility routinely operate in a manner that its designated "inpatient beds" are not in use on weekends?
- Patterns and trends in the ADC by the day of the week. For example, does the ADC consistently drop to zero on Saturdays and Sundays, thereby suggesting that the facility is not consistently and primarily engaged in providing care to inpatients?
- A review of staffing schedules should demonstrate that nurses, pharmacists, physicians, etc., are scheduled to work to support 24/7 inpatient care versus staffing patterns for the support of outpatient operations.
- How does the facility advertise itself to the community? Is it advertised as a "specialty" hospital or "emergency" hospital? Does the name of the facility include terms like "clinic" or "center" as opposed to "hospital"?

The full CMS guidance is available online at: http://go.cms.gov/2x017UK. ■

Promising Time for Careers in Healthcare Quality, Report Says

Now is a good time to be in the business of healthcare quality, according to a report that says the healthcare industry increasingly needs professionals who can use the growing amount of data to improve care and safety. Already a "flourishing market" for quality professionals, the healthcare field will continue to offer more opportunities, the report says.

The Global Healthcare Quality Management Detailed Analysis Report 2017-2022 from MarketResearchReports.biz says demand for healthcare quality management is likely to increase as a result of government mandates compelling healthcare providers to improve the quality of patient care they offer, the rising volume of unstructured data in the healthcare sector, and the demand for reducing healthcare costs and risk of medical errors. *(The report can be accessed for a fee online at: http://bit.ly/2fxuJme.)*

The report differentiates between web-based and on-premise quality management.

"Of these, the demand for the former segment rose at a massive pace in the coming years. Cloud and web-based solutions provide flexibility of working even from remote areas, which is a key factor aiding growth witnessed in this segment," according to the report.

In terms of application, the global healthcare quality management market can be bifurcated into risk management and data management, the report says. Of these, the data management segment held dominance in 2016.

"The staggering volume of disparate data generated within the healthcare sector and the subsequently rising demand for quality-based reports have enabled the segment to exhibit impressive growth over the last few years," the report says.

Demand for quality management is seen most prominently in ambulatory care centers, hospitals,

home healthcare agencies, ACOs, assisted living facilities, and nursing homes.

"Of these, the demand for healthcare quality management is expected to grow at a significantly high pace in hospitals," the report says. "Factors such as the rising focus on patient safety and the rising willingness among patients and their families to spend on advanced healthcare are likely to fuel the demand for healthcare quality management in hospitals."

The prevalence of stringent legislation and accreditation requirements have fueled the demand for healthcare quality management in North America, the report notes.

"In addition, factors such as the growing volume of patient data, the rising adoption of IT technologies across the healthcare sector, and regulations implemented to minimize clinical risks have supported the healthcare quality management market's growth in North America," the report says. ■

Research Shows Link Between Quality and Readmission Rates

New research using CMS data is confirming the relationship between quality care and lower readmission rates.

Researchers studied readmissions of more than 2.7 million Medicare patients over age 65, treated at more than 4,700 hospitals between 2014 and 2015. They found that hospitals in the highest performance quartile for quality had significantly lower 30-day readmission rates than those in the lowest quartile.

Those with the lowest quality scores had a readmission rate of about 25%, while the highest performers had a readmission rate of about 23%, according to data published in the *New England Journal of Medicine*. *(The report's abstract is available online at http://bit.ly/2xJqtIM.)*

"An absolute difference of two percentage points may seem to be small relative to the overall readmission risk, but it indicates that for every 50 patients who are admitted to a hospital in the lowest-performing quartile rather than in the highest-performing quartile, there is one additional readmission," the report says.

There was no statistically significant difference in other quartile comparisons and the median readmission rate was about 15%, the researchers found. ■

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Statement of Ownership, Management, and Circulation
UNITED STATES POSTAL SERVICE® **(All Periodicals Publications Except Requester Publications)**

1. Publication Title	2. Publication Number	3. Filing Date
Hospital Peer Review	0 1 4 9 – 2 6 3 2	10/1/17
4. Issue Frequency	**5. Number of Issues Published Annually**	**6. Annual Subscription Price**
Monthly	12	$519.00

7. Complete Mailing Address of Known Office of Publication *(Not printer) (Street, city, county, state, and ZIP+4®)*: 950 East Paces Ferry Road NE, Ste. 2850, Atlanta Fulton County, GA 30326-1180 — Contact Person: Journey Roberts; Telephone *(Include area code)*: (919) 377-9913

8. Complete Mailing Address of Headquarters or General Business Office of Publisher *(Not printer)*: 111 Corning Rd, Ste 250, Cary, NC 27518-9238

9. Full Names and Complete Mailing Addresses of Publisher, Editor, and Managing Editor *(Do not leave blank)*

Publisher *(Name and complete mailing address)*: Relias Learning LLC, 111 Corning Rd, Ste 250, Cary, NC 27518-9238

Editor *(Name and complete mailing address)*: Jesse Saffron, same as publisher

Managing Editor *(Name and complete mailing address)*: Jill Drachenberg, same as publisher

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12. Tax Status *(For completion by nonprofit organizations authorized to mail at nonprofit rates) (Check one)*
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13. Publication Title: Hospital Peer Review — 14. Issue Date for Circulation Data Below: September 2017

15. Extent and Nature of Circulation			Average No. Copies Each Issue During Preceding 12 Months	No. Copies of Single Issue Published Nearest to Filing Date
a. Total Number of Copies *(Net press run)*			85	81
b. Paid Circulation *(By Mail and Outside the Mail)*	(1)	Mailed Outside-County Paid Subscriptions Stated on PS Form 3541 (Include paid distribution above nominal rate, advertiser's proof copies, and exchange copies)	57	56
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c. Total Paid Distribution *[Sum of 15b (1), (2), (3), and (4)]* ▶			67	62
d. Free or Nominal Rate Distribution *(By Mail and Outside the Mail)*	(1)	Free or Nominal Rate Outside-County Copies included on PS Form 3541	3	4
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e. Total Free or Nominal Rate Distribution *(Sum of 15d (1), (2), (3) and (4))*			8	9
f. Total Distribution *(Sum of 15c and 15e)* ▶			75	71
g. Copies not Distributed *(See Instructions to Publishers #4 (page #3))* ▶			10	10
h. Total *(Sum of 15f and g)*			85	81
i. Percent Paid *(15c divided by 15f times 100)* ▶			89%	87%

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c. Total Print Distribution (Line 15f) + Paid Electronic Copies (Line 16a) ▶		
d. Percent Paid (Both Print & Electronic Copies) (16b divided by 16c × 100) ▶		

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17. Publication of Statement of Ownership

☑ If the publication is a general publication, publication of this statement is required. Will be printed in the November 2017 issue of this publication. ☐ Publication not required.

18. Signature and Title of Editor, Publisher, Business Manager, or Owner: Chief Operating Officer — Date: 20-Sep-2017

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CE QUESTIONS

1. **According to Anthony D. Cox, chairperson of graduate business programs in medicine and professor of marketing at the Indiana University Kelley School of Business in Indianapolis, what is true of online reviews of healthcare providers?**

   a. They tend to be bimodal, with mostly one-star and five-star reviews.
   b. They tend to be almost exclusively one-star reviews.
   c. They tend to be almost exclusively five-star reviews.
   d. They tend to be spread evenly across the five star options.

2. **Why does the American Hospital Association say CMS should immediately halt the use of star ratings on its Hospital Compare website?**

   a. The ratings are redundant with other scoring systems.
   b. The ratings provide "an inaccurate, misleading picture of hospital quality."
   c. Few hospitals note the ratings or respond to them.
   d. Few consumers note the ratings or respond to them.

3. **In the ICU diaries used at the University of California, San Diego Health system, who writes in the diaries?**

   a. Primarily the ICU nurse, but other staff and family are encouraged to write.
   b. Only the ICU nurse is allowed to make entries.
   c. Only family members are allowed to make entries.
   d. Primarily the patient's physician, but nurses also are allowed to write.

4. **What type of information is included in the diaries?**

   a. Informal, non-clinical comments about the patient's experience and progress.
   b. Clinical information that is essentially a summary of the medical record.
   c. Data summarizing the patient's condition for that day.
   d. Preapproved comments that are the same for each patient that day.

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.