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INSIDE

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Legal Risks Abound in Peer Review; Good Process Required

Peer review is vital for ensuring quality care and compliance with standards, but it also brings a wide range of legal liability risks. Adopting the right peer review policies and procedures is only a start; one also must ensure that all parties are following them to the letter.

Every state has statutes mandating that hospitals take responsibility for the quality of care they provide, notes **Karen Owens**, JD, an attorney with Coppersmith Brockelman in Phoenix. Typically, that obligation is to be met by the hospital's organized medical staff. For example, Arizona's peer review statute tells hospitals to "require that physicians admitted to practice in the hospital … organize into committees or other organizational structures to review the professional practices within the hospital … for the purposes of reducing morbidity and mortality and for the improvement of the care of patients provided in the institution …"

> CRITICAL COMPONENTS OF PEER REVIEW IN HOSPITALS ARE THE SUBSTANTIVE REVIEWS THEMSELVES AND THE PROCEDURES FOLLOWED IN REVIEWING AND ACTING ON PHYSICIANS' QUALITY OF CARE. THERE ARE SIGNIFICANT OPPORTUNITIES FOR PITFALLS IN BOTH AREAS.

CMS, through its Conditions of Participation for hospitals in Medicare, similarly mandates peer review, as does The Joint Commission. Most states provide protection for the hospitals and physicians who must perform this difficult work of peer review by also mandating that the review work be confidential and that those who perform it (and sometimes the hospital itself) receive immunity. *(See the sidebar*

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story on page 39 for the fundamentals of a good peer review system.)

"Peer review work tends to be difficult to the point that confidentiality and immunity are needed to make sure it gets done at all," Owens says. "Peer review can cause the reviewers to suffer disruptions in referral patterns and generally cause unpopularity and discomfort. This is particularly true because medical staff leadership committees, often called medical executive committees, have the authority and obligation to recommend disciplinary actions against physicians whose quality of care poses risks to patients."

The fact that some disciplinary actions require reporting both to state medical boards and the federal National Practitioner Data Bank (NPDB) makes physicians whose quality is questioned much more likely to fight back, Owens says.

All state peer review statutes are different, she says. Some are very broad in scope, such as those in Arizona and Colorado, while others are so narrow as to be more or less unhelpful to the hospitals and doctors performing the reviews, as in Florida and Alaska, she says. Depending on the specific state statute involved, participating in peer review can expose a physician to defamation and other business tort claims, with potential damages commensurate with the unhappy physician's income and more.

Hospitals bear litigation risks as well, Owens says. Even in states with broad immunity provisions, a physician may sue for reinstatement of privileges.

"Beyond the business tort exposure, hospitals and physician peer review participants also are exposed to potential liability in two other expensive areas: antitrust and discrimination," Owens says.

HCQIA Provides Immunity

The federal Health Care Quality Improvement Act of 1986 (HCQIA) provides peer review participants qualified immunity from antitrust and business tort claims if they provide certain procedural protections for the physician who is the subject of the peer review, Owens explains. But HCQIA expressly declines immunity for discrimination claims.

"In any event, HCQIA does not include a confidentiality provision, so in the absence of a state law confidentiality requirement or privilege, peer review information can be obtained in a medical malpractice suit," Owens says. "In such cases, a patient's lawyer can turn the in-hospital peer review activities and materials against the physician who provided the care being examined in peer review, as well as against the hospital that is required to examine that care. Claims against the hospital typically allege negligent supervision and peer review."

As hospitals employ increasing numbers of physicians, human resources departments want access to peer review information or to supplant the peer review process in favor of sometimes quicker, more efficient employment termination actions, Owens says.

"This kind of cross-pollination is understandable, but fraught with potential liability. Depending on the state, sharing peer review information with a non-peer

review process in the hospital might be considered a waiver of peer review confidentiality and/or immunity. Conversely, a refusal to share concerns about physician quality with HR could subject a hospital to negligence claims."

Substantive Review Pitfalls

The two critical components of peer review activities in hospitals are the substantive reviews themselves, and the procedures followed in reviewing and acting on concerns about a physician's quality of care, Owens says, and there are significant opportunities for pitfalls in both areas. On the substantive review side, a medical staff committee's failure to use qualified personnel to conduct medical records reviews can lead to misunderstandings and incorrect judgments about the quality of a physician's care, she says.

"Similarly, substantive reviewers should pay attention to the physician's total number of cases. If disciplinary action is being considered based on only a very small percentage of the total cases, the reason why should be explained," Owens says. "The same is true when cases are thinly spread over time. These and other factors should be taken into account when addressing not only whether, but how, to discipline proportionally so that patients are protected and the physician has a chance to improve his or her practice."

Courts tend to be reluctant to overturn medical staff disciplinary actions based on substantive medical or even professional conduct issues, Owens says. Many courts have made clear that they do

Four Rules to Follow in Peer Review

Hospitals can avoid legal liability in the peer review process by following four fundamental "do's and don'ts," says **Karen Owens**, JD, an attorney with Coppersmith Brockelman in Phoenix.

1. Follow the bylaws.

The most obvious "do" is to follow the procedures set forth in the medical staff bylaws, rules and regulations, and policies, Owens says.

"Too often these central documents are ignored, not followed carefully, or just plain misread," she says. "For this reason, it is very important to pay attention to these documents both when a peer review is underway and when it comes time for the bylaws committee to review the provisions. They matter."

Owens recalls a recent case in which the bylaws' fair hearing provision required that the chief of staff choose the hearing panel unless the chief of staff was conflicted by having participated in the peer review leading up to the adverse action that was the subject of the fair hearing. In that case, the vice chief would choose the hearing panel. If the vice chief was conflicted, Owens explains, the next member of the medical executive committee would choose unless conflicted, and on through the entire committee.

"However, in this case every committee member had participated in the peer review of the physician's practice. That left no one authorized by the bylaw to pick a hearing panel," she says. "The doctor argued that since no hearing panel could be picked, the disciplinary action could not go forward. The medical staff then revised the bylaws, but the matter is now in litigation."

2. Maintain confidentiality.

It seems self-evident, Owens says, but talking out of school about confidential peer review can lead to liability exposure faster than almost anything else.

"The classic doctor's lounge or golf course discussions are just so tempting. But they can form the basis of claims for defamation as well as anticompetitive behavior," she says. "It is well worth it to remind medical staff members again and again not only that they must maintain confidentiality, but of the potential consequences of talking out of turn."

This includes communicating by email. Owens says she has seen more than one case involving emails that went to unauthorized personnel inadvertently because the "cc" line was ignored when forwarding an email.

Also consider how communications can take place between medical staff and administrative or human resources functions of the hospital. There is no single answer, and hospitals with employed physicians should work with counsel to sort out how much information can be shared according to state laws, Owens says.

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not have the expertise to second-guess professional opinions by the hospital reviewers, she says.

"On the other hand, judges are extremely comfortable examining and second-guessing procedures and whether they have been followed," Owens says. "So it is not surprising that most court opinions overturning peer review disciplinary actions do so based on faulty compliance with the procedures set forth in the medical staff bylaws, rules and regulations, and related policies that govern how medical staffs do peer review."

This is particularly true in HCQIA cases, Owens says, where the focus is on whether the hospital and medical staff have substantially complied with the due process guidelines in the federal act. In these cases, if the court finds that the physician was offered fair procedure, the hospital and its peer reviewers have immunity from all state and federal claims except discrimination claims, she explains.

"If the court finds that the physician was not afforded fair procedure, all bets are off, so to speak," Owens says. "Unless a robust state immunity provision provides a cushion, the hospital and peer review participants are then exposed to potential defamation and even antitrust liability."

Write Good Policies, Follow Them

The keys to successful peer review are well-written, consistently implemented policies and a disciplined adherence to those, says **John C. Ivins Jr.**, JD, partner with the Hirschler Fleischer law firm in Richmond, VA.

"Well-written, specific hospital bylaws and related policies on issues like fair hearing plans and disruptive behavior are critical so that all physicians whose actions are the subject of peer review, and any possible adverse action concerning his or her privileges, know what is expected," Ivins says. "They also are key to helping the physicians believe, as the process is unfolding regarding them, that they are being fairly administered."

Many disputes arise when physicians on a medical staff believe that the peer review process is too subjective, too punitive, and unfair as it is being administered relative to them, Ivins notes. Often, these issues arise because the expectations of the medical staff are not clearly set forth in the hospital's bylaws and related policies.

Also, if peer review is not a constant process that is pursued within the hospital as to all medical staff, then when adverse action is taken as to one physician — who is aware of similar actions not being pursued against colleagues — the process appears to be unfair, Ivins says.

"It is like 10 people speeding on the highway. All 10 may be guilty of breaking the law and creating unsafe driving conditions for those around them, but only one person's speeding can be addressed at a time," he says.

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3. Document everything.

There is much discussion in medical staff circles about how much to document peer review meetings and deliberations, Owens notes, but her view is that documentation should be detailed.

"While speakers' names should not be mentioned, it is important for the reasons that an action is taken to be documented in minutes. It is equally important for care to be taken to document all communications with a physician," Owens says. "Detailed explanations can make the difference between a conclusion that an action is warranted or not justified."

4. Don't hide anything from the physician.

This an important corollary to the rule about documenting everything, Owens says.

"It does no good, and can cause considerable harm, to refuse to provide a physician in peer review with important documents, particularly if they either form part of the basis for his or her problems, like external reviews of care, or if they tend to exonerate the physician," Owens says. "The sooner the physician sees important documents, the sooner the matter can be resolved short of litigation."

The same is true of communication generally, she says. Peer review is supposed to be a collegial process, and good communication can be the best way to keep it that way, she advises.

"Face to face communications are key. Always have at least two medical staff members or other personnel present to avoid 'he said, she said' problems later, and careful notes should be taken and put in the file," Owens says. "But it is worthwhile to keep lines of communication open as much and as long as possible. This is one of the best risk management tools available." ■

"If the rules are well understood and the application of the rules is applied as consistently as possible, any perceived inequities in the process can be minimized."

Understand Peer Review Roles

Those involved in peer review must clearly understand the scope of their responsibilities and strictly follow the bylaws and related policies, Ivins says. This is important from both the legal standpoint of contract law and adhering to the established contractual requirements governing medical staff privileges, and from the practical standpoint of the process appearing to be and actually being fair, he says.

There are two critical legal compliance issues, Ivins says. First, peer review must be structured to comply with the HCQIA, which provides hospitals with significant immunities from claims for damages arising out of the peer review process and professional review actions.

In addition to HCQIA, Ivins says hospital peer review should be structured and handled so as to best protect from discovery by a plaintiff's attorney in personal injury or medical malpractice litigation against the subject physician and/or the hospital. The information gathered in investigations, the details of discussions concerning such information and the information or processes that derive from those may ultimately serve as the basis for an adverse action taken with regard to a physician's medical staff privileges.

"This means following strictly the state law requirements of the applicable peer review statute. Most, if not all, states have some form of

Fair Hearing Process Can Require Outside Help

Exactly when an "investigation" begins under hospital bylaws can be crucial in the peer review process, says **John C. Ivins Jr.**, JD, partner with the Hirschler Fleischer law firm in Richmond, VA.

Hospital leaders should craft bylaws with their legal counsel that establish informal measures in a way that does not constitute initiating an investigation, he says. This can help avoid dilemmas regarding reports to the National Practitioner Data Bank (NPDB) and triggering the fair hearing process.

Often, once a matter has gone into extensive peer review, the hospital may conclude it would be best if the practitioner left the medical staff, Ivins notes, or the physician may conclude that his or her credibility has been questioned so much that it would be better to seek a position elsewhere.

"An impediment that can arise is where the physician is already considered to be under investigation. In that case, he or she cannot resign without the hospital having to file a data bank report reflecting that the physician resigned while under investigation," Ivins says. "Where efforts in informal resolution can be undertaken at an early stage, more options that are not considered being under investigation may be available for resolution. Otherwise, a fair hearing may end up being requested because the physician and his or her counsel find that an investigation is now underway."

Fair hearings are incredibly disruptive not only to the hospital and the medical staff, but to the hospital's administrative office, Ivins says. Most hospitals do not encounter fair hearings very often, so they are unfamiliar with the fair hearing plan and its many requirements, including specific notices, notice periods, contents of letters, and processes.

"One of the biggest problems hospitals face once the peer review process has gotten to this point is its failure to follow the strict requirements of its bylaws and related fair hearing plans," Ivins says. "The implications can be disastrous because such failures can result in losing the protections afforded under HCQIA."

The best way to address a fair hearing and to avoid many of these problems is to involve hospital counsel early, Ivins says. Experienced hospital counsel can ensure that the hospital follows all legal and contractual requirements and that the fair hearing process provides the due process that is to be afforded to the physician seeking the hearing.

Another way to address the process and ensure a smooth, fair hearing is to engage an outside hearing officer to manage the process, Ivins says. Under most fair hearing plans, the hospital has the right to select a hearing officer to handle all issues of pre-hearing process, questions of discovery of information, and similar issues.

The physicians appointed to serve on a hearing panel are not generally

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statute that protects from discovery certain of the information learned through peer review," Ivins says. "Those statutes have different requirements and the courts within those states are constantly being asked to rule upon the coverage of those. Hospital counsel should be engaged to help structure the peer review process around these issues."

Throughout the peer review process, keep in mind the community and competitive relationship between those involved on the hospital side and the practitioner whose conduct is being reviewed, Ivins advises. Major issues can arise if physicians actively involved on the hospital side are direct competitors of the subject physician.

"These types of actual or perceived conflicts need to be avoided at all cost," he says. "Failure to consider those can ultimately taint the entire process with allegations of bias and perceived bad motives."

Many hospitals could make better use of informal resolution options, Ivins notes.

"Obviously, every situation is different, and at the end of the day peer review is about patient safety. So, if there is a threat that requires summary suspension and that is the level of intervention that is required, then that is what must be done," he says. "However, much of peer review pertains to nuances in clinical care and behavior that can be addressed through informal measures."

If the hospital can develop a culture of trust among its staff and can use informal measures effectively, Ivins says it can productively address issues with its physician staff that can make the practitioner and the hospital collectively better and can save thousands of dollars that otherwise would have to be spent in the fair hearing process, defending lawsuits, and hiring.

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comfortable serving in such a role and often do not understand their roles, Ivins notes. An outside hearing officer educates the appointed panel members concerning their roles as addressed in the bylaws and applicable law.

The panel is separate from the medical executive committee, Ivins explains. It should have its own counsel, and typically the hearing officer serves in this role. This may depend upon the language of the bylaws and the hearing plan.

During the fair hearing, the hearing officer makes procedural and other rulings consistent with the scope of his or her role as defined in the bylaws and hearing plan, Ivins says. Once the hearing is concluded, the hearing officer typically will assist the panel in preparing its report and recommendations to the medical executive committee.

"The expertise of the panel members is in the needed clinical and other assessments they provide, not in the preparation of a hearing report and recommendation," Ivins says. "The latter is much more the skillset of an experienced healthcare lawyer or hearing officer. By involving legal counsel to advise the hospital and medical executive committee at an early phase and by engaging an outside hearing officer to advise the hearing panel and handle the mechanics and process of the hearing, the hospital can greatly reduce problems that can otherwise arise in the fair hearing process." ■

Comply With Own Processes

The most common error in peer review is failing to comply with the hospital's own process, says **Callan Stein**, JD, partner in the Boston office of Barrett & Singal.

"The proceedings are quasi-judicial proceedings, and they should be treated as such. Strict compliance with the bylaws is critical, especially as it pertains to deadlines, notice requirements, and burdens of proof," Stein says. "A second common pitfall I have seen is a failure to sufficiently vet peer review committee members and eliminate any individuals who have an actual or even apparent conflict of interest, such as a competitor with the same specialty."

Always err on the side of caution when evaluating whether a committee member should be recused based on a conflict of interest, Stein says. Hospitals and medical staffs should include peer review processes in their bylaws that clearly delineate all appeal rights and all deadlines to ensure the physician in question has the right to be heard, he says.

Hospitals also should consider clear policies delineating which committees are peer review committees and which are not. *(For more on structuring processes, including fair hearings, see the sidebar story on page 41.)*

"In my experience, hospitals

typically do a pretty good job adhering to the peer review process. This, however, does not always spare them from litigation if the physician against whom disciplinary action was taken feels wronged," Stein says. "A disciplined physician can fairly easily bring colorable civil claims against a hospital simply by alleging that the process was undertaken in bad faith or with ulterior motive. That is usually sufficient to overcome a motion to dismiss, though it may be disproved during discovery, resulting in dismissal at the summary judgment phase."

In the worst litigation involving peer review, the real fault often lies not in the immediate instance of reviewing a physician's performance, but in years of failing to consistently adjudicate and punish similar, or even identical, conduct, Stein says.

"When a physician is disciplined for conduct he or she has been doing for months or even years, it can lead the physician to feel singled out such that litigation is appropriate," Stein says.

Notify Practitioners Promptly

Hospitals can run into trouble with peer review by failing to follow the medical staff bylaws, particularly regarding notifying the practitioner of potential adverse action, says **Christopher Metzler**, PhD, chief growth officer and CEO of FHWFit, a global healthcare conglomerate in Washington, DC.

Metzler often works with hospitals and peer review committees to improve their processes. *(See the sidebar story on the right for more on mistakes he's seen hospitals make.)*

Avoid 'Hypothetically' and Lounge Gossip

There are so many ways the peer review process can go off the rails. Some are obvious, but some may not seem risky until they result in a disgruntled physician suing the hospital.

Poor documentation from peer review meetings also is a common factor in litigation, says **Christopher Metzler**, PhD, chief growth officer and CEO of FHWFit, a global healthcare conglomerate in Washington, DC. Too often, hospitals create brief, incomplete notes and use cryptic references that only make sense in the moment, he says. Then, months later, the participants are expected to remember details of the peer review and explain the references that no one understands, he says.

"If there are detailed notes, counsel can use those to refresh someone's memory much later when there is litigation," he says. "You should have someone taking notes who is experienced in recording minutes of a formal proceeding, rather than just having the physicians there make some notes. The physicians are there to do the technical review and they shouldn't be charged with taking notes because they're not going to do a good job."

Peer review committees also must have a solid process for preserving documentation, he says. Especially in any peer review meeting in which adverse action against a physician was even discussed, even if no action was taken, all patient charts pertaining to that review should be photocopied immediately and preserved as part of the review documentation, he says.

Physicians also must be careful about discussing peer review, Metzler says. People can let their guard down in the doctors' lounge and chat about what they've seen in records or what the peer review committee is considering. That's a very bad move, Metzler says.

"As a member of the peer review committee, you are an agent of the hospital and if you have conversations in the doctors' lounge or anywhere else that is inappropriate, you can lose immunity," he says. "It's very important that physicians under the strict confidentiality of peer review matters."

Even small slips can give the appearance of impropriety in peer review, Metzler says. He once worked with a peer review committee in which one of the physician reviewers was using her personal stationery to communicate peer review business.

"I had to explain that in peer review you are acting as the agent of the hospital in monitoring quality of care, and so any communication must be on the hospital's or medical committee's stationery. She said it was OK because everyone knew she was on the peer review committee," Metzler says. "No, that doesn't matter. You cannot do that. It gives the wrong impression about who this information is coming from, and puts you at risk."

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"I'm surprised over and over by the number of peer review committee members who have never read or who have not recently reviewed the medical staff bylaws," Metzler says. "The problems arise with issues as simple as giving the practitioner advance notice of a hearing or a meeting, or failing to notify them of their rights after an adverse action. That is extremely dangerous from a liability standpoint."

Metzler also points out that disclosing a potential conflict of interest is not enough to avoid peer review litigation when a physician feels the process resulted in an adverse economic effect.

"I've seen cases where the chair of the committee was a direct competitor. You just can't do that," Metzler says. ■

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Physicians in the peer review process also should have a clear understanding of their focus and not wander into areas that are not of their concern, Metzler says.

"If they are addressing one topic and come across something else, they may wish to raise that with an administrator at some point, but the peer review process is not the place," Metzler says. "Stick to the charge that you have and the patient records under review. Understand the scope of the committee's purpose and its powers."

Metzler also cautions against appearing to have prejudged the results of peer review. Those involved in the peer review process should never say things like, "Hypothetically, if it happened this way then we should do this."

"They should be concerned only with getting the facts and not appear to have come even to a preliminary conclusion about anything," Metzler says.

"I once had a physician say, 'Hypothetically, if the physician did these things…' and he thought it was okay because he says 'hypothetically.' But I said, 'We're all sitting here and saw you use air quotes when you said that, so we know you have prejudged this case and we have to reconstitute an entirely new committee.'" ■

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Strict Safety Briefings Reduce CAUTIs, CLABSIs, and Falls

Baptist Memorial Hospital-Memphis (TN), a flagship hospital for Baptist Memorial Healthcare System, was experiencing a problem familiar to many hospitals: It could make quality improvements, but had difficulty making those improvements stick; there was a lack of bedside accountability.

In January 2016, the hospital implemented daily 15-minute safety briefings, and that began turning the tide.

Daily safety briefings are not a new concept, of course, but Baptist Memorial found a way to make them particularly effective.

These stand-up meetings were facilitated by senior leaders and huddle notes were provided to every department for 24/7 dissemination, says **Michelle Smith**, MSN, RN, NEA-BC, chief nursing officer with Baptist Memorial Hospital-Memphis. After joining the hospital in October 2015, she found that the organization had a serious problem with hospital-acquired conditions (HACs), including catheter-associated urinary tract infections (CAUTIs), central line-associated bloodstream infections (CLABSIs), and falls, with higher rates than she had seen before.

Smith led the hospital's efforts to implement best practices for reducing those HACs. The implementation was so successful that the reduced rates of CAUTIs and CLABSIs at Baptist Memorial helped reduce the state's overall rates, Smith says.

With a daily census exceeding 500 inpatients, Baptist Memorial was experiencing more than 100 CAUTIs and CLABSIs per year in 2015. That number was reduced to

the teens in 2016, and was down to single digits in 2017 — a reduction of about 85%. Falls with harm were reduced from eight in 2015 to three in 2016.

Safety Briefings Begin

But implementing the best practices was successful only because managers and frontline staff were held accountable, Smith says. In her prior position, she became familiar with the concept of daily safety briefings and implemented them at Baptist Memorial. The safety briefings are held Monday through Friday, from 8:30 am to 8:45 am, and are attended by managers and any employee who wants to attend, including those from nonclinical departments.

Each daily meeting is attended by 100 to 150 people. Smith is trying to schedule safety briefings on weekends also, but currently there is a problem with data access that makes that difficult.

Smith and her colleagues focus the safety briefings on reducing those problem HACs. Length of stay also is studied because patients are more likely to experience the other conditions the longer they are admitted, she says.

The key to making a difference with safety briefings, Smith and her colleagues soon found out, was to talk about real people and not just data.

"We talk about individual patients and what happened to them, the effect this condition is having on a real person down the hall," Smith says. "We're not just talking about rates per 1,000 patient days. That patient … on 3-East is somebody's father, a real person. We make it real for the managers and the staff, talking about how this patient is suffering right now because of this CAUTI or this fall, and what we could have done to prevent that."

The meeting is focused on learning from experiences, and the leaders specifically avoid shaming or discussing discipline during the meeting. Smith makes a point of beginning and ending each meeting with a positive story or anecdote about patient care.

"At that briefing, the managers have to talk about what happened on their watch, what went well and what didn't, whether there was opting out behavior in which our policies and procedures are not followed," Smith says. "Sometimes they just have to be transparent and say someone didn't do what they were supposed to do. We keep it positive during the meeting, and any coaching comes between the meetings, not in that setting."

Focus on Real People

The reduction in HACs has resulted in a tremendous cost savings to the hospital, helping it meet its margins for the past two years, Smith says.

She notes that CLABSIs can cost the hospital $50,000 each, and recent research suggests CAUTIs can cost as much as $10,000. *(See the sidebar story on page 46 for more on that research.)*

"When you look at reducing CLABSIs from 110 in a year down to 17, that's a huge cost savings," Smith says.

The HAC numbers were so high initially partly because clinicians and managers did not associate the data with the experiences of individual patients, she says.

"That's why we always talk about these things now in terms of someone's journey and try to tug at the heartstrings a little bit," she says.

"Before, the quality department was left out there on their own, responsible for these numbers and really without a lot of support for making the improvements that would change them. Now I'm joined at the hip with our quality director, who provides me with the data I need, but I'm in a position to hold people accountable for their behavior either in a positive way, or if we need to do some coaching."

Smith points out that the safety briefings are limited in scope to the specific HACs the hospital wants to address. It is a mistake to let safety briefings morph into more general managerial discussions, she says.

The 15-minute time limit is strict, and it's a stand-only meeting. The safety briefing is held in a designated "safe room" where people are encouraged to be forthcoming about failures and concerns. It is equipped with boards depicting current numbers, strategies, and annual goals.

"We do not turn ours into an operations meeting and try to boil the ocean. We keep it very specific to our improvement strategies and everything else can be discussed at another time," she says. "But for it to really work, you have to have a culture in which someone can say their patient fell and they didn't do all they could to protect them."

High Expectations for Meetings

Smith implemented the safety briefings with two weeks of training sessions to make expectations clear about the briefings and why they could improve the HAC rates.

Managers were told that staff must notify them immediately of all HACs, around the clock, and Smith will confirm that when a manager reports an event at the morning safety briefing. She wants to hear, "Yes, they called me at 2:42 this morning to notify me."

"The expectations are high. I make it clear that they don't need to be walking in at 8:30 a.m. with their purse over their shoulder. They need to be ready at 8:30 to make a report and discuss these issues," Smith says.

"It was a little scary at first, but they've really embraced it now. I have directors and a doctor who can run the meeting without me, so we always do it every single day."

The meetings are never canceled for any reason. If The Joint Commission comes for a survey or half the staff is absent because of a snowstorm, the daily safety briefing is still held, Smith says.

Baptist Memorial also has made an effort to involve disparate groups in the hospital to improve patient safety related to issues such as falls.

For instance, that means including housekeeping, security, and chaplains in patient safety efforts.

"We don't want patients sitting on the side of the bed or left alone in the bathroom, and we know that on the day they're going home they tend to get a little overconfident," Smith says. "We've had nonclinical people go find a nurse and report that the patient was sitting on the side of the bed so we could intervene before a fall." ■

SOURCE

- **Michelle Smith**, MSN, RN, NEA-BC, Chief Nursing Officer, Baptist Memorial Hospital-Memphis (TN). Phone: (901) 226-0548. Email: michelle.smith@bmhcc.org.

CAUTIs More Expensive Than Previously Thought

Catheter-associated urinary tract infections (CAUTIs) generally are thought to cost hospitals about $1,000 each, but new research suggests the actual cost may be much higher.

Research published in the American Journal of Infection Control indicates the true cost could be more than $10,000 per CAUTI.

Researchers Christopher S. Hollenbeak, PhD, professor of surgery and public health sciences at Pennsylvania State University, and Amber L. Schilling, PharmD, MEd, research analyst at the Penn State College of Medicine, reviewed existing literature on CAUTIs in the United States between 2000 and 2017.

The data were limited, but "we can conclude that the prevailing notion of a CAUTI costing approximately $1,000 is an underestimate and an oversimplification of its true economic burden," Hollenbeak and Schilling wrote. "Many factors can increase the attributable cost well above $1,000."

Costs reported in the four studies ranged from $876 to $10,197, adjusted for the equivalent of 2016 dollars, they reported.

The broad range was attributable to the different settings in which the CAUTIs occurred, they explained. The lower cost was associated with adult patients in an inpatient setting and calculated from the hospital's perspective, and the higher costs were from ICU patients and calculated from Medicare's perspective.

The researchers concluded that the true cost of a CAUTI is determined by the patient's acuity, the population, and whether the cost is calculated from the viewpoint of the hospital or Medicare. An abstract of the study is available online at: http://bit.ly/2F6B3jW. ■

CHI Goes to Data to Improve Quality and Safety

The nation's third-largest nonprofit healthcare system realized double-digit improvement in several key quality and safety measures in just 12 months by starting with its data.

Catholic Health Initiatives (CHI), based in Englewood, CO, has 100 hospitals operating in 17 states and has seen significant improvements in several quality measures. For example, catheter-associated urinary tract infections (CAUTIs) were reduced 38% in 2016 and an additional 19% in 2017, while pressure ulcers were reduced 22% in 2016 and 13% in 2017. Postoperative hip fractures fell 41% and 33% in those respective years.

Those results came after CHI leaders realized the problem was not a lack of data, but what they were doing — or, rather, not doing

— with it, says **Jim Reichert**, MD, PhD, CHI's vice president of analytics and transformation.

"We were bringing in a lot of data from our different facilities across the country into our data warehouse, but we really weren't putting the data together in a way that was useful for quality improvement," Reichert says. "The markets would come forward each quarter and share their own quality and safety performance measures with national, but national couldn't compare one hospital with another or see if any one hospital was improving on a particular opportunity over time."

Move Toward Transparency

An additional problem was that the national office would create new quality improvement goals every year, but local facilities would balk at some of them, saying they were already performing well on those measures and shouldn't waste resources on marginal improvements.

"So we set up standard reporting across the enterprise, making it transparent so that everyone could see everyone else's results," Reichert says. "We also realized that we needed risk-adjusted data and standard definitions in metrics that would be used for all of the measures. We could create percentile ranks that in near-real time could let the facilities know how they were performing on their mortality measures, infections, patient experience, and patient safety events."

At around the same time, CHI also was implementing a strategy for focusing on "Living Our Mission" measures, nine areas that the healthcare system would use to measure success among all its facilities. Those nine areas are service to the poor and vulnerable, employee engagement, physician satisfaction, quality, patient experience, safety, growth, transformation, and operating earnings before interest, depreciation, and amortization.

"These were nine measures from the board down that every facility in our organization would be measured against," Reichert explains.

Of those nine, the analytics group was tasked with three of them: quality, safety, and patient experience. Those are composite measures, so quality consisted of mortality and hospital-acquired infections; safety included the Patient Safety and Adverse Events Composite known as PSI 90; and patient satisfaction was derived from Hospital Consumer Assessment of Healthcare Providers and Systems (HCAHPS) scores.

"We would give monthly reports on how each facility was doing with each measure and how that mapped out to the division, and we also distributed a quarterly report that the board would use," Reichert says. "The goal was to align the board with senior-level management and the facilities to actually get alignment around these measures of interest and make steady, gradual improvements in care."

CHI also committed to a longer focus on quality improvement with a three-year plan rather than introducing new goals each year.

"I think that was significant because there are always early adopters who move the needle quite soon, the middling adopters, and the later adopters who are slower to change," Reichert says. "The three-year change allowed everyone to get on the bus and make movements in the right direction before we turned the tables on them and gave them a whole new set of priorities."

Bottom-Up Communication

One challenge involved transparency. Everyone involved supported the idea of transparency, but achieving that was difficult when there was little agreement over the sources and meaning of data, Reichert says.

"There are people in each facility or market who are the analytic folks, the data domain experts for their market, so if you give a report to the leaders in that market they are going to take it to their own experts and ask if it is correct. We had to do a top-down and a bottom-up approach where we establish relationships with those folks," Reichert explains. "We provided a ton of education and communication to build those relationships between national analytic resources and the local markets so we could get on the same page."

Reichert says a key component of quality improvement for a large organization is having single sources of truth for quality data, and CHI relied on several vendors, including SAS in Cary, NC, to provide that basis from which to work. It also is important to use benchmarks from outside the organization and not fall prey to the idea that your own healthcare system is large enough to be its own source of quality measures without comparing itself to others.

Reichert also advises quality improvement leaders to modernize their data management as much as possible. "A lot of organizations still do a significant amount of quality work in Excel and manual spreadsheets, and the sooner you get

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out of that the better. Centralizing and automating the data processing will make it more likely for you to move forward with quality improvement because you're not using so many resources for just data wrangling and data prep," Reichert says.

"You can put those resources toward care improvement, which is where it really needs to be." ■

SOURCE

- **Jim Reichert**, MD, PhD, Vice President of Analytics and Transformation, Catholic Health Initiatives, Englewood, CO. Phone: (303) 298-9100.

CE INSTRUCTIONS

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

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CE QUESTIONS

1. **According to Karen Owens, JD, hospitals and physician peer review participants are exposed to what potential liability beyond business tort exposure?**

   a. Antitrust and discrimination
   b. Malpractice claims only
   c. Libel only
   d. Antitrust and libel

2. **What does Callan Stein, JD, say is the most common error in peer review?**

   a. Failing to notify credentialing authorities
   b. Failing to comply with the hospital's own process
   c. Involving too many people
   d. Waiting too long to implement the peer review

3. **In the safety briefs at Baptist Memorial Hospital-Memphis (TN), what is one strict rule?**

   a. Only senior level managers can attend.
   b. Only clinical leaders can attend.
   c. The meeting is limited to 15 minutes.
   d. The meeting is held only on Mondays and Thursdays.

4. **What was one change recently employed at Catholic Health Initiatives?**

   a. Quality improvement initiatives were put on a three-year timetable.
   b. Quality improvement initiatives were changed from three years to implementing new goals every year.
   c. CHI eliminated a system that allowed facilities to compare their performance to other CHI facilities.
   d. CHI discontinued comparing its quality metrics to organizations outside CHI.

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.