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INSIDE

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Early 2020 Quality Data May Need 'Compassionate Surveying'

The first half of 2020 was an extraordinary time for the United States. Quality leaders are beginning to assess how the COVID-19 pandemic response will affect the quality metrics of hospitals for months after the emergency subsides. What will those metrics look like?

They may not look great, and accreditors might be prompted to use a form of "compassionate surveying" when it comes to revelations of noncompliance during this period.

Even after the pandemic winds down, the experience is likely to leave a significant and lasting effect on quality metrics, says **Lauren Patrick**, founder and president of Healthmonix, a healthcare analytics company based in Malvern, PA.

There are several components to the effect on quality metrics, she says. First, what will the quality metrics show in terms of quality of care? Will quality, measured via the clinical quality measures that are reported, remain at the same level?

"Changes in the performance of clinical quality metrics may be affected in a variety of ways. Chronic care management and preventive care measures may suffer due to missed appointments, clinical transformations, and providers' focus on immediate issues during the initial period," Patrick says. "Focus on urgent care, first and foremost, may impact the focus on nonemergent care."

Metric Effects Uncertain

Secondly, there will be two factors that contribute to a change in the metrics, Patrick says. Depending on how well the quality protocols and standards of care are embedded in a practice at the beginning of the pandemic, there may be a temporary or longer-term decrease in those numbers, she explains.

"A decrease may be due to high-priority urgent care needs that cause a lack of focus on the quality actions that are normally included. A decrease may also be temporarily seen by physicians who are transforming their clinical practices to accommodate new strategies and protocols so swiftly,"

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Patrick notes. "As physicians quickly move to telehealth or shift roles due to layoffs or urgent care needs, workflows may need to be redesigned to accommodate the changes and ensure that outcomes continue to be achieved and documented."

Credit for Trial Participation

The Centers for Medicare & Medicaid Services (CMS) has not released revisions to the quality measure reporting requirements for 2020, Patrick notes. CMS issued guidance for completing 2019 reporting since it was due at the onset of the pandemic. Still, even in Registry Kick-Off meetings with CMS, there was little guidance as to what changes may occur for 2020, Patrick says.

"So far, we have heard that there will be one new addition to the quality payment program [QPP] for 2020, which is credit for participating in clinical trials connected to COVID-19. We do know that CMS is considering changes for 2020 reporting," Patrick says. "To date, CMS has remained tight-lipped on what those changes may be. When we have asked them directly, the response is that we will hear something 'very soon.'"

In the addition to the QPP, CMS announced clinicians may earn credit in the Merit-based Incentive Payment System (MIPS), the performance-based tracker that incentivizes quality and value, for participation in COVID-19 clinical trials.

To receive credit, CMS says clinicians must participate in a COVID-19 clinical trial using a drug or biological product and report their findings through a clinical data repository or clinical data registry.

"The new improvement activity provides flexibility in the type of clinical trial, which could include the traditional double-blind, placebo-controlled trial to an adaptive or pragmatic design that flexes to workflow and clinical practice. It also carries a high weight from a scoring perspective," CMS announced. "This means that clinicians who report this activity will automatically earn half of the total credit needed to earn a maximum score in the MIPS improvement activities performance category, which counts as 15% of the MIPS final score." *(Learn more at: https://go.cms.gov/3cWgp2r.)*

Patrick says the fact that CMS is not requiring reporting of some metrics for a while could produce negative effects. The saying "what gets measured gets done" may apply here.

"If we are not requiring the metrics to be tracked and reported, many may not receive the attention they have in the past, and the outcomes and processes that are being measured could decrease," she says. "If we essentially give a two-year pass to providers — 2019 and 2020 — and then attempt to reinstate the program again after that, we may lose the gains made over the program's history. Providers could be less likely to participate in the process of quality reporting."

'Compassionate Surveying' Needed

Similar concerns about what quality data will look like when surveyors look back on the pandemic period months from now come from **Patrick Horine**, chief executive officer at DNV GL Healthcare in Milford, OH, which offers hospital accreditation integrating ISO 9001

with the Medicare Conditions of Participation.

"One of the things I'm really concerned about when we go back out and do our on-site surveys, in light of the waivers and the concentrated focus on COVID-19 — there are going to be a lot of issues that are demonstrated noncompliance in a lot of different areas," Horine says. "It's probably going to require some level of compassionate surveying because there is going to be a lot of noncompliance issues that hospitals might otherwise have been more strict in following. We're going to want to see that there are corrective action plans put in place in short order to address immediate concerns, and then plans for long-term correction."

In particular, Horine is curious to see the effects on infection control during the pandemic. With the increased use of personal protective equipment, heightened awareness of hand hygiene, and the reduction in patient volume in many hospitals, some facilities could see a reduction in infections, he says.

"One would think their overall infections would be reduced in light of the enhanced practices, but it could be the opposite if all those precautions were just keeping their heads above water while the infection rates were going up," Horine offers.

Horine also wonders about the impact on value-based purchasing programs. CMS is providing waivers that ease the burden during the pandemic response, he says, but what is going to happen later when hospitals do not meet the expectations of value-based purchasing agreements?

"There are going to be a lot of challenges for hospitals and for CMS. Are they going to look at a different data collection period for assessment of that value-based purchasing?" Horine asks. "Will they forgo any penalties during this time with the hospitals so impacted? I don't think there is an easy answer, but it is going to have an impact no matter which way they go."

On a positive note, Patrick says hospitals and providers have done a tremendous job of adapting. Facilities have rapidly and aggressively adopted telemedicine, changed hospital and provider protocols to address COVID-19 needs, and prioritized urgent care while re-engineering a significant portion of the standard way they deliver healthcare services, she says.

The number of eligible cases for quality metrics will be down for this period, Patrick notes. Elective surgeries and procedures have been suspended. There has been a dramatic decrease in office visits, and routine care and preventive testing have taken a back seat to more urgent needs. That will mean lower populations are included in the measures. "While we may pause capturing some outcomes [as] we adapt to the new normal, hospitals should ensure that as the crisis subsides, we pick these back up. There may be new workflows that need to be created, and we may need to ensure that documentation is up to date," Patrick says. "New tools that have been adopted during this time will need to incorporate the quality metrics so that we don't place undue burden on physicians as we move forward."

Patrick suggests this is an opportunity to assess how ingrained the quality practices are within any organization. Consider an audit moving forward to ensure there are no lost processes in the urgency and transition. Assess gaps that have arisen, and institute appropriate improvement processes to bridge any gaps.

"Reviewing quality metrics from this period will show the extent to which quality practices are ingrained into the workflows, even at a time of crisis and change," Patrick says. "Comparing metrics and root cause analyses of these changes, or lack of changes, will certainly inform our practices going forward." ■

SOURCES

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- **Lauren Patrick**, Founder and President, Healthmonix, Malvern, PA. Phone: (888) 720-4100.

Accreditors Adjust to Realities of COVID-19 Response

Accrediting bodies and hospitals are adjusting to the changes and limitations brought on by the COVID-19 pandemic, with more emphasis on remote surveying and other accommodations.

Accreditation and compliance activities were hampered at many hospitals. Although some departments were busier than normal with COVID-19 patients, other areas were without patients because elective procedures had been canceled, notes **Patrick Horine**, chief executive officer at DNV GL Healthcare in Milford, OH.

Without the usual volume of patients, some hospitals reduced staff

to compensate. In many cases, those workers included the people who work with accreditation activities, Horine says.

Some staff with whom DNV GL interacts directly have either been furloughed or they are working at home, with limited (if any) access to their physical work environment, Horine reports. The accrediting body has been working to facilitate communication with these contacts and to work around the limitations they have with access to data.

"CMS [Centers for Medicare & Medicaid Services] has issued a number of waivers, so there is a lot that has been set to the side for now. The waivers have created a different dynamic for what we should have hospitals focus on," Horine says. "In light of the present circumstances, we want the focus to be on infection prevention measures and their responsiveness under emergency preparedness. Those are always important concerns under our program, but now there is more intense scrutiny on those aspects to ensure they are able to maintain a level of service while managing patients, staff, and visitors."

DNV GL also is looking at how hospitals are maintaining quality of care in other areas of the hospital not related to COVID-19. There is concern that the reallocation of resources and staff reductions from less business could lead to adverse consequences, Horine says.

Time to Improve

Hospital quality leaders may even find this period will reveal areas for improvement that otherwise might have gone unseen, Horine predicts.

"It's a good opportunity for hospitals to see where their shortcomings are. There have been a lot of lessons learned in the pandemic and how hospitals respond to it, lessons on how they manage these patients, the physical environment, and lessons related to infection prevention," Horine says. "That's where we're focusing now and where CMS wants facilities to focus right now."

In addition to patient handling issues related to COVID-19, hospital queries to DNV GL have involved many issues related to personal protective equipment (PPE), such as how to clean it, how to keep it anyone from stealing it, and dealing with shortages while still caring for patients.

The future for surveys remains uncertain, Horine says. Limitations on travel and social distancing requirements make surveys difficult for CMS or any accrediting body. CMS has indicated it may conduct remote surveys for some as well as complaint surveys related to immediate jeopardy, he notes. CMS also announced the suspension of nonemergency survey inspections of nursing homes so it can better focus on infection control complaints. "As things start to open up, we can expect surveys to resume, but we have had to move a lot of surveys forward from when we normally would have done them. There is going to be a fair amount of catch-up to do, and CMS is very cognizant of that," Horine says. "With reaccreditation surveys, CMS has offered extensions. When we can safely return to on-site surveys, those probably will be the first priority."

More Remote Surveying

For DNV GL's annual surveys, it is working with CMS to conduct at least part of the annual survey, and possibly all of it, remotely, Horine notes.

"Once they lift the restrictions, CMS is going to require that a full on-site survey be done. They're not giving a free pass," he says. "If a provider does not go through with a full on-site survey after the pandemic has passed, [CMS is] going to terminate the provider agreement they've approved in the short term."

DNV GL also is using remote surveys for its certification programs, which are offered separately from CMS accreditation. Hospitals have

expressed interest in pursuing these certifications during the pandemic, partly because some employees have down time while the volume of non-COVID-19 patients is low, Horine explains. When the remote survey finds compliance issues that must be addressed, DNV GL may have to follow up with an on-site survey at a later date, Horine says.

"Some of these certifications are related to the care of COVID-19 patients also, such as the management of stroke patients who come in during the period and the use of ventricular assist devices [VADs]," Horine says.

"It's created a good opportunity for attention to these programs that aren't necessarily governed under CMS, but which have applicability in the treatment of COVID-19 patients," Horine continues. "They can demonstrate continued compliance even under these difficult times."

(Editor's Note: Hospital Peer Review *requested input from The Joint Commission, but a spokesperson replied that they were unable to provide comments.)* ■

Accrediting Bodies Offer Guidance on COVID-19 Response

DNV GL Healthcare and The Joint Commission (TJC) are offering guidance to hospitals on the compliance, quality, and patient safety issues that are critical during the response to the COVID-19 pandemic.

DNV GL Healthcare offers a self-assessment tool to help hospitals identify potential problems and paths to improvement, and the accrediting body says it can be used for any infectious disease.

Use is optional, but DNV GL says the results may be useful when discussing infection prevention during focused reviews. Using checklist questions within multiple areas, DNV GL's tool includes voluntary self-assessment checklists provided by the Centers for Medicare & Medicaid Services, as well as infection prevention and emergency preparedness issues.

• The DNV GL tool for acute care hospitals is available online at: https://bit.ly/3cRJags.

• The DNV GL tool for critical access hospitals is available online at: https://bit.ly/2YgKiWT.

• Other COVID-19 guidance from DNV GL is available online at: https://bit.ly/2xYLLXu.

TJC also is providing COVID-19 guidance, particularly regarding the use of face masks. It notes that no TJC standards prohibit staff from using personal protective equipment (PPE) brought from home, but that "homemade masks are an extreme measure, and should be used only when standard PPE of proven protective value is unavailable."

TJC's guidance is available at: https://bit.ly/2Ybb03r. ■

Advice Offered on Preventing Pressure Injuries from N95 Masks

With healthcare workers sustaining injuries from the near-constant use of face masks, the National Pressure Injury Advisory Panel (NPIAP) is offering advice on mask injuries and how they can be prevented.

The NPIAP position paper combines current evidence in both pressure injury prevention and personal protective equipment (PPE) science, the group says. The position paper notes "pressure and shear, known to cause pressure injuries in patients, are now causing pressure injuries in healthcare providers who, because of the COVID-19 pandemic, are wearing PPE masks, face shields, and goggles for long periods at a time, day after day."

N95 respirator masks carry a particularly high risk for injury because they are required to fit the face tightly, the position paper says: "Skin injury can also occur as a result of friction and the accumulation of moisture under the mask."

The NPIAP collaborated with the European Pressure Ulcer Advisory Panel and the Pan Pacific Pressure Injury Alliance to develop an evidence-based guideline to help prevent pressure injuries caused by N95 masks. The position paper is available online at this link: https://bit.ly/2x6yxY1. ■

Peer Review Protections Weakened Across the Country

States are continuing to weaken peer review protections across the country, with courts interpreting statutes in ways that make hospitals more vulnerable. Some legislatures are rewriting laws to give more power to plaintiffs.

The Pennsylvania Superior Court, in *Leadbitter v. Keystone Anesthesia Consultants, Ltd.*, recently ordered a healthcare defendant to provide the complete, unredacted credentialing file of a hospital's orthopedic surgeon.

This was a change from how Pennsylvania courts previously addressed such discovery in medical malpractice cases, with hospitals assured that evaluations in credentialing files were protected from discovery as privileged materials. *(The ruling is available online at: https://bit.ly/2SjZj6O.)*

The court ruled the evaluations are considered protected "peer review" documents under Pennsylvania's peer review statute, but that protection was voided by the fact they were reviewed by a peer review "organization" rather than a peer review "committee."

Pennsylvania law defines a "review committee" as "any committee engaging in peer review" and a "review organization" as "any hospital board, committee, or individual reviewing the professional qualifications or activities of its medical staff or applicants for admission thereto."

The court explained, "Since St. Clair Hospital's credentialing committee is a committee that reviewed the professional qualifications and activities of Dr. Petraglia following his application for hospital privileges at St. Clair Hospital, the credentialing committee is a review 'organization.' Therefore, the PRPA [Peer Review Protection Act] privilege does not apply to the documents that the credentialing committee reviewed."

The court also noted that review of "a physician's credentials for purposes of membership (or continued membership) on a hospital's medical staff is markedly different from reviewing the 'quality and efficiency of service ordered or performed' by a physician when treating patients."

HOSPITAL PEER REVIEW LEADERS SHOULD CONSIDER WAYS THEY CAN BETTER PROTECT THEMSELVES FROM DISCOVERY OF PRIVILEGED MATERIAL.

There has been activity in the courts and legislatures in the last few years that have contributed to a gradual weakening of peer review protections nationwide, says **Sandra M. DiVarco**, JD, partner in the Chicago office of McDermott Will & Emery.

In many ways, these changes are not necessarily new, she says. Many states have experienced a shift in protections over time as court cases interpreted the statutes and regulations underlying the peer review privilege or additional legislation provided carve-outs and exceptions to the privilege, DiVarco explains.

"We're seeing a spectrum, from limiting the types of documents and information that are subject to the privilege and thereby exempt from discovery requests in litigation, all the way to the extreme in Florida. [There], patients were determined to have a right to all records regarding patient care incidents," she says. "The common feature is the eroding of the privilege and painting providers into a corner as they try to undertake review and promote quality assurance and performance improvement for clinical care."

The impact on hospitals could be significant, DiVarco says. "The absence of a meaningful peer review privilege reduces greatly the candor with which medical professionals are able to review performance and improve patient safety and the quality of care," she says. "Hospitals, and more importantly patient care, are disadvantaged if this important function is rendered ineffective."

Hospital peer review leaders should consider ways they can better protect themselves from discovery of privileged material, DiVarco recommends. In states where the peer review privilege has been significantly diminished, providers could consider participating in or forming patient safety organizations (PSOs) to avail themselves of the protections available under the Patient Safety and Quality Improvement Act, she suggests.

"PSOs present their own level of regulatory complexity, but they may provide an alternative for certain aspects of peer review the hospital desires to protect from discovery," she adds. ■

SOURCE

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Care for Caregivers More Important Now Than Ever

The extreme stress brought on by the healthcare industry's response to the COVID-19 pandemic has highlighted what should always be a concern: the need to care for the psychological well-being of physicians, nurses, and other healthcare workers.

The pandemic response has taken stress to new levels in facilities and communities. The emergency physician who served as medical director at a New York City hospital committed suicide. Her family told media outlets that it was prompted by the strain of working day after day with the onslaught of COVID-19 patients. A New York City paramedic also killed himself the same week, with the family reporting the stress of responding to coronavirus calls as the cause.

Not only is caring for employees' well-being the right thing to do, but it also directly affects the quality of care they provide patients. The issue has been studied in the context of clinician understaffing and other stressors, notes **Robert Morton**, BA, ARM, CPHRM, CPPS, assistant vice president of patient safety and risk management for The Doctors Company, a medical malpractice insurer in Napa, CA.

Nurses' vigilance and adherence to infection control practices, as well as their dedication to other quality of care issues, erodes when they are understaffed and do not feel they have the support of management, Morton says. Quality of care can be diminished when nurses, physicians, and others are overworked, forced to work with inefficient systems, and burdened with administrative requirements.

Situational awareness can suffer and clinicians can falter on their observance of patient safety practices like hand hygiene and cross-checking patient information. Overstressed clinicians are likely to record higher rates of error.

The Agency for Healthcare Research and Quality offers a Care for the Caregiver Program Implementation Guide online at: https://bit.ly/3cUw6XS.

Nurses Show Signs of Stress

The COVID-19 response has brought a range of stresses to nurses, some expected and some surprising, says **Linda Roney**, EdD, RN-BC, CPEN, CNE, assistant professor and undergraduate nursing program director at the School of Nursing and Health Studies at Fairfield University in Connecticut.

Roney says her nursing school already was addressing the problem of workplace stress and how it can affect the care delivered by nurses. Two years ago, she began to hear stories about how faculty members were concerned about the stress level of nursing students.

The school began a holistic health initiative that is purposeful in including pedagogy. The focus is on caring for the caregiver, offering wellness initiatives, and preparing emerging nurses for the stresses they would encounter on the job. In March, Roney heard from nursing graduates about the challenges they faced from the pandemic.

"Some of the challenges are what would be expected from, for instance, a pediatric nurse being transferred to work in an adult ICU [intensive care unit]. What wasn't expected was that we would hear from so many nurses who were being furloughed from their positions," Roney says. "These nurses were in a position of wanting to help, yet they couldn't work their full-time hours. This was a new type of stress that they didn't expect when they came out of nursing school."

Research has shown a direct link between the well-being of frontline healthcare employees and patient outcomes, Roney notes. *(Investigators recently published a*

paper about mental health outcomes among healthcare workers exposed to COVID-19. Read more online at: https://bit.ly/3cZl8Ar.)

"This was a problem pre-COVID-19 and well documented. Now, we're in a situation where nurses of all types are being tasked to take care of the sickest patients, with protocols evolving sometimes over the course of a shift," Roney notes. "It's more important now than ever to consider the effects on the care they are able to deliver to patients."

Employers should work to reduce the immediate impact of the COVID-19 pandemic on nurses and other clinicians. Roney adds that it is important to consider the long-term effects, too. The stresses faced by some employees could linger longer after the high volume of COVID-19 patients diminishes and healthcare workplaces return to normal.

"What will be the longstanding impact on their physical and mental well-being? We don't really know yet, but this is something we should watch for and not just decide at some point that the crisis is over and our employees are back to their normal selves," Roney suggests. "In many cases, those employees were stressed to begin with. There is a good chance that for some, the COVID-19 response is going to leave them with effects that will affect them and their patients for a long time."

Roney recommends instituting a program that includes regular communication with staff members, including rounding, and the generous use of employee assistance programs.

Creeping Burnout

Cognitive overload and burnout already were serious problems for healthcare professionals. The COVID-19 response is highlighting just how bad those threats are, says **M. Bridget Duffy**, MD, chief medical officer of Vocera Communications in San Jose, CA, which provides communication services to healthcare organizations.

"Numerous studies have demonstrated how provider burnout is directly linked to quality and safety," Duffy says.[1,2] "Those who have emotional exhaustion, fatigue, and burnout have higher incidents of adverse events, medication errors, and bad outcomes in operating rooms." Research clearly indicates that the doctor or caregiver experience is directly related to the patient experience, she says.[3] If the doctor or nurse has nothing left to give, the patient experience and satisfaction score typically goes down in most institutions, Duffy says.

Nurses on Suicide Missions

Duffy has heard nurses share stories from the frontlines where COVID-19 outbreaks were widespread and other nurses were brought in from elsewhere to handle the volume. They refer to that as "suicide missions."

"They don't know whether they will survive flying in to help their peers in the trenches. It's truly a heightened state of anxiety. How does one do their best work under those conditions?" Duffy asks. "To hear it referred to like that I think is unprecedented." One of the biggest stressors for clinicians is how they have been robbed of some of the personal interactions with patients and family members, which are critical to making their work feel meaningful and to cope with some of the negative aspects of the jobs, Duffy says. She recalls one story in which a physician was stricken with COVID-19. His nurses went in the room twice a day to help him FaceTime with his wife, who could not visit.

But as the surge hit hospitals and the patient-to-nurse ratios jumped to 6:1 and then as high as 10:1, nurses could no longer find time for even that kind of interaction. "There isn't time for a nurse to hold up a phone and help someone FaceTime with a loved one, much less the horrific times when patients die alone because their loved ones can't be at their bedside," Duffy says. "Some caregivers have taken to printing a big photo of themselves and hanging it from their name badge, trying to give some humanity back as they provide care at the bedside while wearing masks and all this other equipment that creates a barrier between the two human beings."

Many nurses are forced into palliative care roles when they are not prepared. The sudden onslaught of so many dying patients will have lasting effects on them, Duffy says.

"I'm sure there will be cases of post-COVID post-traumatic stress syndrome. We will have a whole generation of doctors and nurses of all ages who will have stress that will have to be addressed on the other side of this," Duffy predicts. "This will be one of the most important topics that we have to address after this. The virus and the experience of those who fought it may frighten people from entering these professions. We will have to make changes to assure the physical and mental well-being of our healthcare workforce."

Benefits to Organization

The effects of the pandemic on physician and nurse well-being must

be monitored and addressed in the coming months and years, says **Gary Price**, MD, MBA, FACS, practicing physician and president of The Physicians Foundation, a nonprofit in Boston that supports physicians and educates the public about the challenges they face.

Physicians and nurses commit suicide and are at a higher risk of doing so than the general population.[4,5]

In addition to lower satisfaction scores and more errors, burned out physicians and nurses tend to retire earlier, he notes.[6,7]

"From the institution's standpoint, the most important point is that preventing physician burnout leads to better care of patients," Price says. "It protects a critical asset for any organization that hires physicians. It is going to be significant to their bottom line, not only because of the cost of replacing a physician they lose to burnout but also the difficulty of finding a physician to replace someone who leaves."

The issue of physician burnout is receiving more attention than in the past. Price added that COVID-19 is both a blessing and curse in that it is drawing attention to the negative effects of burnout while also possibly making the problem worse.

Organizations seeking to address burnout should start by publicly identifying the issue as important and implementing communication channels, Price offers.

Changes to working conditions can begin with addressing frustrations with the electronic medical record and, at least during the COVID-19 response, providing better access to personal protective equipment (PPE), he says.

Facilitating better communication among healthcare workers can help alleviate feelings of isolation and show that colleagues are feeling the same stresses, Price says.

Zoom Calls Help

Zoom meetings were part of the solution when the effects of COVID-19 began to show quickly in those who belong to Physician Performance, a 2,900-member association in Woburn, MA, comprised of different types of provider groups, including large faculty practice, community health centers, and solo and small group independent practices.

Executive Director **Deb Schoenthaler** says one of the first signs of stress was the physicians' requests for information about how to respond. They were unusually stressed by the uncertainty of the pandemic's scope, how they should respond, the lack of PPE, and other issues, she says.

"It was important for us to set up an independent communication channel that could support those physicians, particularly those in one- or two-person practices, with updates on things that were changing in clinical care but also just getting them information about changes in payor reimbursement, coding requirements, and related issues," Schoenthaler says.

The physicians were candid about their concerns about a possible decline in patient care quality, not only because of the social distancing restrictions but also due to everyone's stress, Schoenthaler adds.

One of the first steps was to create a weekly Zoom call to communicate across a group of about 350 physicians. The process was daunting at first because of the technological challenge in communicating to so many people in a live format.

"We weren't quite sure how it was going to work out, but it's been an amazing experience working with them. We usually have at least one or two people from a majority of the practices participating," Schoenthaler reports. "We wanted to use these Zoom meetings ... to help them understand how to triage their patients as they began to close their offices and needed to direct their patients to the correct site for care."

Physician Performance helped the physicians determine the best way to divert patients for care when their offices closed, whether that was sending them to urgent care or an emergency department. Participants also discussed best practices for setting up phone contacts with patients and the use of telemedicine for those who chose that path.

The availability of testing was another hot topic, in addition to how accurate it was and when it was appropriate to use the scarce tests.

Further, reimbursement issues were a big worry. The calls included discussions of the requirements for billing with the new or increased use of phone contacts or telemedicine.

"There were really two major stresses: how were physicians going to care for their patients amidst all these changes, and how were they going to survive financially," Schoenthaler says. "As the crisis continued and we had these weekly calls, we started to include subject matter experts in topics like palliative care and gerontology. The goal was to provide supportive tools that would help bring down their stress levels and ensure that their patients still received quality care."

The calls also allowed physicians to collaborate and share ideas about how to cope with the crisis. This was important, Schoenthaler says, because physicians collaborate extensively in normal times, relying on each other to inform and discuss options.

"Their world suddenly got much smaller. They were not able to stop by another physician's office and chat about a problem for five minutes," she says. "The Zoom meetings gave them the opportunity to share across all of the participants. If one has found a great way to do outreach to elderly patients, that physician can share it with others."

Another healthcare company is using telemedicine to provide care for stressed employees. VITAS Healthcare, a Miami-based company that provides end-of-life care, offers the service free of charge, says **Diane Psaras**, chief human resources officer.

VITAS partnered with a telemedicine provider to provide 24/7 access to virtual healthcare appointments with board-certified physicians from home via phone, an app, or on the web.

"When our employees are feeling well and confident, and their families have the medical support they need, they can focus on providing the best possible hospice care amidst one of the most challenging times our nation has ever faced," Psaras says.

Caution with Hero Title

A frontline healthcare worker's burnout can directly affect more people than the condition would for those who work in other professions, according to **Jarrett Jedlicka**, vice president and principal for healthcare with Ceridian, a company in Minneapolis that provides human capital management.

A clinician who is overly stressed, exhausted, or worried will be carrying out tasks every day at work, sometimes hundreds of times in a shift, which could directly affect the health of another person, he argues. That means caring for the well-being of clinicians is about more than just that employee, he adds. "There is such a focus on the patient, but what can get lost is that there is another factor that has so much effect on how the patient fares — that is the caregiver," Jedlicka says. "We have a society that is so consumer-driven that sometimes we lose sight of how critical the health of that caregiver can be. First responders are all taught to protect themselves first because they can't be of help to anyone else if they get hurt. As organizations, we can overlook that sometimes."

Jedlicka notes that even the current trend of praising healthcare workers as heroes can be detrimental. "Hero as a recognition is great. But hero also implies that these people are superhuman and don't need to be cared for," Jedlicka says. "We have to be conscious that these are real people with lives outside of what they're doing in the hospital. We need to be careful not to create these unrealistic expectations that this RN [registered nurse], doctor, dietician can just go nonstop all the time. You can call them heroes, but remember that they're really human."

The COVID-19 response is drawing even more attention to the risk of burnout among healthcare providers, and Jedlicka hopes there will be a lasting benefit after the pandemic subsides.

"In unprecedented times, there is an unprecedented opportunity for greatness," he says. "People are rising to the challenge, but we also need to think about the structural changes that are needed to support our caregivers. To deliver top quality care, our caregivers need to receive top quality support."

(Editor's Note: The American College of Emergency Physicians eulogized Lorna Breen, MD, FACEP, on April 27: https://bit.ly/2YyTkPt. EMT John Mondello took his own life on April 24. Learn more about him at: https://bit.ly/3ddwBMO.) ■

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Tips for Helping Stressed Caregivers

Caregivers often put work demands, patients, and family members first, even at the cost of their own self-care, observes **Laura Hamill**, PhD, chief science officer and chief people officer at Limeade, a company in Bellevue, WA, that assists employers with improving the employee experience.

This others-first mentality is seen even more during the COVID-19 outbreak, Hamill says. "At the intersection of feeling engaged and mission-driven, but feeling stressed and under-supported, caregivers are at a greater risk for burnout," she says.

Recovery and burnout prevention are organizational issues, Hamill says. It is the organization's responsibility to prevent and alleviate employee burnout. Further, organizations must enable employees to care for themselves and recover from work daily, she adds.

Hamill suggests healthcare organizations can help alleviate employee burnout by:

• Acknowledging organizations play a role in burnout prevention and recovery;

• Establishing a culture that supports employee recovery and support;

• Educating employees on recovery and providing voluntary training;

• Providing adequate conditions to encourage recovery;

• Educating leaders to understand that people thrive when they know their company cares.

On the managerial level, Hamill says managers can support their direct reports by:

• Remembering people recover differently;

• Incorporating recovery moments for employees to restore resources;

• Setting recovery norms by role-modeling behaviors that encourage work-life integration;

• Setting holistic check-ins;

• Reminding people that it is not taboo to ask for help or admit they are struggling with stress and work overload.

Hamill says employers should remind caregivers who are feeling overwhelmed at work that they can use these recovery activities:

• Take short breaks. Even five minutes alone or a quick walk around the desk area can help one feel better equipped to deal with job stressors.

• Schedule recovery time on the calendar for a few minutes before or after important shift changes.

• Build rapport with the manager or a trustworthy colleague to foster open dialogue about job roles, responsibilities, and company culture. Putting a strong support system in place is vital. ■

SOURCE

- **Laura Hamill**, PhD, Chief People Officer, Chief Science Officer, Limeade, Bellevue, WA. Phone: (888) 830-9830.

CE OBJECTIVES

After completing this activity, participants will 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.

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CE QUESTIONS

1. **What might surveyors likely find from hospitals in the months after the COVID-19 pandemic subsides?**
   a. There will be a lot of noncompliance issues on requirements that hospitals might otherwise have been stricter in following.
   b. There will be fewer noncompliance issues on most requirements because hospitals were stricter during the pandemic.
   c. There will be more administrative issues related to surveys, such as documentation, because compliance and accreditation leaders were furloughed.
   d. There will be fewer administrative issues related to surveys, such as documentation, because compliance and accreditation leaders had diminished workloads during the pandemic.

2. **What is the current trend regarding state laws affording protection of peer review data from discovery in legal proceedings?**
   a. Most states have been strengthening the peer review protections afforded healthcare defendants.
   b. There has been activity both in the courts and legislatures in the last few years that have contributed to a gradual weakening of peer review protections nationwide.
   c. Both state laws and court actions have weakened peer review protections for nonprofit hospitals, but not for-profit hospitals, which still have substantial safeguards in place.
   d. There has been activity in the courts and legislatures to clarify the meaning of peer review statutes and the associated protections, but the effect on healthcare defendants has been neutral.

3. **What is one cause of increased stress for nurses during the COVID-19 response?**
   a. The public does not recognize the stress caused by the pandemic.
   b. Nurses have been pushed into palliative care roles for which they are unprepared.
   c. Nurses have not been allowed to work with their usual coworkers.
   d. Management has made no effort to recognize the additional stress of their working conditions.