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INSIDE

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Assess Quality and Compliance as Telehealth Use Expands

With healthcare organizations making so much use of telehealth now, how does one assess the quality of care provided through this technology? How can one ensure the facility is in compliance with the relevant requirements for coding and reimbursement?

The answers involve a mixture of holding telehealth to the same standards one would apply to in-person care, but also recognizing the use of this technology carries limitations and risks.

The healthcare community rapidly expanded its use of telehealth because of the restrictions necessary during the COVID-19 pandemic. HHS loosened restrictions to allow the use of commonly available meeting apps rather than dedicated telehealth platforms that previously were necessary to meet government requirements.[1]

To assess the quality of telehealth, leaders must apply a similar rubric to how they have always assessed the value of face-to-face or in-person care before the pandemic, says **David Dickerson**, MD, vice chair of the American Society of Anesthesiologists Committee on Pain Medicine. "In pain management, like many areas of medicine, we value safety, efficacy, and cost effectiveness. Telehealth cannot fully replace prepandemic care delivery, but it can add value and help us connect with our patients and assess and triage their needs," says Dickerson, section chief for pain medicine at NorthShore University HealthSystem in Evanston, IL. "Misapplied, it could diminish value as certain aspects of an assessment such as vital signs, key physical examination maneuvers, or specific treatments that cannot be delivered via telehealth."

The ability to escalate to in-person care when necessary may drive value. Follow-up surveys of patient experience after encounters is a good way to track patient engagement and the experiential relationship patients are maintaining with their clinicians and their healthcare systems, according to Dickerson.

Systems already are in place for those surveys and can be adapted to include additional telehealth-specific questions, he notes.

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Quality standards and performance metrics often are specialty-specific. Many intersections between compliance and quality standards were set forth through professional societies in partnership with CMS. But many standards and metrics did not anticipate a rapid adoption of telehealth, Dickerson says.

"Our workflows were developed prepandemic to optimize performance. Some of these workflows did not anticipate the need for a path to fulfill these requirements virtually or in a non-in-person encounter," Dickerson says. "Specific to pain medicine, we have had to redefine several of our workflows to ensure patients can virtually renew or complete pain agreements or complete screening surveys that help us address risks for opioid misuse or depression. Similarly, the reporting and auditing of these processes required revamping to ensure line of sight to performance of the new workflows."

Telehealth virtual encounters must comport with the applicable standard of care that an in-person encounter would require, says **John E. Morrone**, JD, partner at Frier Levitt in New York City.

"The quality standards are significantly more difficult for regulators to measure, as there is not a physical presence to inspect. Many traditional metrics, such as quality of office-based surgery, are evaluated based on the physical plant, equipment, staffing, and training," he says. "Telehealth is dependent only on the assessment of the physician-patient encounter."

Compliance programs should focus on patient satisfaction and chart review to determine the level of care provided. Morrone cautions that telehealth must be limited to that which is appropriate for a virtual encounter.

"The most significant pitfall involves provider deviation from the standard of care because they lack the understanding of the limitation of telehealth," Morrone says. "Fundamentally, if the physician would need to lay hands on a patient in a face-to-face encounter to provide the appropriate standard of care, that patient cannot be treated in a virtual encounter."

Watch Telehealth Documentation

Documentation for reimbursement can be challenging. "Compliance has many layers, but in regard to care delivery via telehealth clinical documentation for these encounters has not changed. Complexity-based billing can be challenged by the limitations we have in telehealth on conducting detailed physical examinations, a key portion required for complexity-based billing," Dickerson says. "Time-based billing may be a more effective way to qualify the documented effort an encounter required. As is currently done, this documentation can be audited internally and externally to ensure a compliant billing practice commensurate with services rendered."

Compliance programs for telehealth should be no different from currently existing programs that address in-person care, Dickerson says. However, he notes the COVID-19 pandemic has not affected all healthcare practices to the same extent.

"A balanced approached should seek to minimize reporting burdens on groups acutely impacted by the public health emergency while ensuring ongoing participation in

compliance activities that ensure [continuous] delivery of safe, effective, and ethical care," he says.

Code Properly

The proper coding of telehealth claims is the primary basis for compliance with CMS rules, says **Sean Kirby**, senior vice president at VisiQuate, a consulting and data analytics company in Santa Rosa, CA. Data-specific procedure codes and modifiers in their proper places provide a clear picture of whether the claim will be in compliance and result in full reimbursement or a denial from the insurance plan, he says.

"Analytics through exception-based anomaly detection can provide proactive alerts when any of these rules are not followed correctly," Kirby says. "Mitigating this risk before the claims are billed helps reduce compliance and reimbursement issues for providers."

Dickerson is cautious about one potential problem seen in other areas of healthcare, related to technology integration at the point of care. Overleveraging telehealth may contribute to healthcare disparities. Access to such engagement may be limited for patients with technology literacy issues or with limited access to the necessary video-capable devices.

"Maintaining fair market reimbursement for providers, creating a streamlined experience, and ensuring equity for patients of different socioeconomic status is important as we continue to utilize these platforms and workflows. Additionally, privacy and security must be ensured for patients," Dickerson says. "Patients should trust their clinicians when they request the patient come to the office for a medically necessary exam, lab, test, or procedure that telehealth just cannot provide."

Technology Provider's Quality Program

The requirements for a clinical quality management program in telehealth are mostly similar to those other healthcare organizations use, notes **Martha Garcia**, vice president of clinical quality and compliance for SOC Telemed, the largest provider of acute care telehealth services in the United States, based in Reston, VA. (There are multiple other companies providing telehealth technology services.)

"The care is virtual because of the element of technology, but it is still healthcare. Real, live physicians are providing it," Garcia says. "Those physicians have degrees, certifications, and training that is documented and vetted before they ever see a patient through a video camera for SOC."

Garcia suggests the same quality program used by the technology provider can be applied on the other side of the telehealth experience at the hospital. For her company, Garcia says quality assurance starts with earning accreditation from The Joint Commission.

Like brick-and-mortar hospitals, the telehealth provider has dedicated quality and clinical leadership, led by a chief medical officer. It also has dedicated chiefs for each medical specialty service line who are actively engaged in clinical practice.

Also, each specialty service has an active quality committee comprised of members of the practice. This committee is responsible for assessing clinical quality and ensuring current clinical practice guidelines, Garcia explains.

Regarding compliance, Garcia says SOC's revenue cycle management department focuses intently on the CMS rules for reimbursement.[2]

"Since we deliver eligible services by eligible providers to eligible originating sites, there are only two major restrictions in the CMS pre-COVID rules that SOC needs to navigate: geographic eligibility of the originating site and exemption for telestroke services," she says. "SOC sets billing rules in its systems to designate geographically eligible sites, codes telestroke consults appropriately, and audits paid CMS claims to ensure that ineligible services were not billed."

Track Outcome Measures

Since March 2020 and until the end of the national health emergency, CMS is reimbursing all SOC services, Garcia notes. The company's intensivist, neurology, and psychiatry groups regularly review changing standards. When appropriate, those groups institute immediate changes.

As new practice standards develop, physicians review and adapt them to a national telehealth practice. When these standards change, SOC Telemed works to assure client hospitals are aware of these changes and can implement them effectively.

The company's telehealth platform tracks performance on numerous factors on both sides of the telehealth visit, allowing it to measure performance and work to improve processes, Garcia says.

"For any quality program to be effective, key indicators of patient and staff safety and organizational

performance need to be measured and managed. They must be statistically valid performance measures of care, treatment, and services," she says. "For example, at SOC, we look at patient outcome measures such as hemorrhagic conversion in thrombolytic cases, reversal of commitment in psychiatry, and length of stay and complication rates for ICU."

The company follows the same requirements for focused professional practice evaluation and ongoing professional practice evaluation as hospitals, including a formal peer review process.[3,4]

Garcia believes following accreditation standards means she works for a company that strives for continuous quality and patient safety improvements.

"That doesn't change because the care is virtual in nature," Garcia notes. ■

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Consider Telehealth Privacy Concerns

Privacy is a major concern with telehealth, especially when using common consumer apps to communicate with patients, says **Savera Sandhu**, JD, partner with Newmeyer Dillion in Las Vegas.

Technology that was not developed specifically for telehealth still can be used safely, but some caution is warranted. Providers must make a good faith effort to protect the privacy of the patient when using telehealth.

"It's not as if providers can go sit at Starbucks and have a FaceTime call with a patient. There still needs to be privacy protections that are required under HIPAA," Sandhu says. "A good idea is to designate an area in which your physicians have access to technology to communicate with patients, an area away from the public. This might be a room in the hospital that is designated during certain hours for physicians to communicate privately with patients."

Sandhu also encourages telehealth-specific technology whenever possible rather than consumer apps like FaceTime, Zoom, or Microsoft Teams. Platforms developed specifically for telehealth contain built-in privacy safeguards, waivers, and encryption that will address some of the primary concerns.

Telehealth will continue to appeal to patients even after the pandemic is no longer an issue. Healthcare organizations still will make use of it if HHS makes the COVID-19 era regulatory changes permanent, or if the government at least does not impose the same regulatory barriers that stymied full use of telehealth in years past. More than 70 groups have asked Congress to extend and make permanent certain emergency telehealth policy changes.[1]

"As long as Medicare, Medicaid, and private insurance continue to accept telehealth claims, hospitals and other providers definitely will continue to use telehealth much more than they did in the recent past," Sandhu predicts. "One day, the public health emergency will no longer exist. Then, the question is whether we go back to the ways we did healthcare previously, with the same restrictions on telehealth, or whether we move forward with what we're doing now."

Assess Operations Now

Hospital leaders should take a close look at telehealth operations that were put in place months ago to respond to the COVID-19 crisis, says

Matthew R. Fisher, JD, partner with Mirick O'Connell in Worcester, MA. Many hospitals and health systems implemented systems quickly to address the pandemic, spurred on by the loosening of regulatory requirements.

Fisher notes one of the changes HHS made at the start of the pandemic was to allow the use of telehealth in any setting, rather than only in rural settings and in specified buildings. Facilities that previously did not use telehealth at all quickly established the new option by using commonly available consumer technology that was not necessarily HIPAA-compliant.

Now that the industry has a slightly better handle on the pandemic, Fisher commends reassessing those telehealth operations for potential problems.

"To the extent that those systems are still in place, I think that is where there could be the biggest risk. As telehealth becomes more of a standard part of healthcare delivery, at some point there is going to be a requirement that these systems comply with HIPAA. The government is not going to continue the softer approach that was necessary at first," Fisher predicts.

Any assessment and discovery of risks must be followed by a program that ensures adequate improvements are made in the telehealth operations. It is common for administrators to identify such risks, and then let the report sit on a desk without the follow-up necessary to make sure changes are made, Fisher observes.

"The question is what's being done to ensure that modifications toward a more compliant setup are actually occurring. We all know that habit becomes engrained very quickly. People are not always going to be worried about the risks of what they are doing," Fisher says. "If patients and clinicians got in the habit of just going to FaceTime, you want to make sure that is being cut off, and you're directing your telehealth business to the preferred service that meets all the privacy and security requirements."

The federal government may issue new rules on telehealth's role in value-based care soon, along with restrictions and possible safe harbors related to anti-kickback laws, according to Fisher. Hospital leaders should keep an eye on those developments and be ready to respond with the appropriate modifications to any telehealth program established in response to COVID-19, as they might not be compliant.

"There are pending telehealth bills before Congress. The one that seems to be getting the most traction is one that would permanently encode a lot of the expansion that occurred during the pandemic," Fisher says. "One of the key changes, however, is that it would not continue the lack of HIPAA enforcement. It would clearly state that HIPAA comes back full force for delivering telehealth."

(Editor's Note: There have been dozens of pieces of legislation regarding telehealth in front of the current Congress, dating back to before the COVID-19 pandemic. A sample of these is available online: https://bit.ly/2G6QMBc. The Telehealth Act, HR 7992, introduced in August 2020, is an omnibus resolution that would tie together several related proposals: https://bit.ly/3iarnn2.)

Provider Sets High Standards

At Care Plus NJ, a provider of primary and behavioral healthcare for children and adults in Paramus, NJ, telehealth was in use before the COVID-19 outbreak, mostly as a way to avoid no-shows and appointment cancellations, says **Michelle Alkhalaileh**, LPC, chief information officer and security officer. When the pandemic hit, CarePlus NJ immediately expanded its licenses for the telehealth technology because leaders there anticipated a greater demand for remote care.

But as other healthcare providers seized on the relaxed guidelines to use FaceTime and similar apps, CarePlus NJ stuck to its standards for patient privacy and security.

"We were very strict about ensuring we were using a vetted platform that we knew was HIPAA-compliant and secure," she says. "We've always communicated strongly with staff about security. But with our staff working from home, we've ramped it up more and consistently messaged about things like ensuring you are in a private space, away from family members and others who may be in your household."

CarePlus NJ also emphasized the need for secure Wi-Fi connections. Further, staff are required to use headsets or earbuds to minimize the chance of anyone overhearing a patient during the telehealth visit.

"[Make] sure that home recording devices like Alexa and Google Home are disabled so they are not inadvertently recording and picking up bits of the conversation," Alkhalaileh says. "There also was important messaging about staff meetings and other interactions that did not involve the consumer, like staff meetings held over Teams or another application. We wanted to make sure CarePlus' business interests were protected, as well as the anonymity of our consumers."

CarePlus NJ also made arrangements for patients who were willing to use telehealth during the period of coronavirus isolation but did not have a computer or smartphone. Caregivers would be

working from home and providing telehealth, but CarePlus NJ opened some facilities to allow patients to come in and use telehealth connections.

"Regardless of whether the consumer is using telehealth from their own home or coming into one of our facilities, the consumer is consenting to the use of telehealth. There is an issue of informed consent around telehealth," Alkhalaileh says. "We did a tremendous amount of training to make sure staff were comfortable with their Surface Pro and understood how to use it, much of it one on one. Then we did recording training as we brought on more staff to the telehealth experience."

A team of administrative staff is available to help both caregivers and consumers with computer issues.

"It's a tremendous amount of work. Having a team available to help individuals get online and understand the system is very helpful," Alkhalaileh says. "We also use the program for group services, particularly with some of our substance use care. That was another logistical challenge to set up and get everyone on board."

CarePlus NJ also uses telehealth to provide emergency psychiatric screening in the community.

"Having the infrastructure, communicating, and being able to allocate the human resources are all key to making a significant telehealth program work," she says. "You're always going to have Wi-Fi and connection problems. Privacy issues are difficult to work out sometimes when you have multiple people in the home, but it can be achieved."

Alkhalaileh expects consumers to drive the future of telehealth. Unless regulators sharply restrict the use of telehealth again, she says consumers will demand it as a convenient option as long as they are confident of their privacy.

"If they previously relied on public transportation to get to the treatment center, they might say telehealth is a better option for them. They will expect us to make that possible," she says. "I think we're going to have to see how things go with the regulators and what consumers choose."

Be Ready for Patient Questions

Hospitals and health systems should be prepared to respond to patient concerns about telehealth privacy, says **Teri Dreher**, RN, CCRN, iRNPA, program director with NShore Patient Advocates in Chicago. They can explain that providers are required by law to use HIPAA-compliant, secure means of conducting telehealth visits and produce documentation showing their technology conforms to those requirements.

"Even though many HIPAA regulations have been relaxed by CMS during the pandemic for phone conversations between providers in the interest of fast communication and decisions regarding transition of care, they are rarely abused," Dreher says. Many safeguards that apply to online security are applicable to telehealth, says **Steve Durbin**, managing director of the Information Security Forum, a London-based authority on cybersecurity, information security, and risk management.

"Telehealth is coming into its own during the pandemic, but it should be used carefully. Many of the top tips for being safe online apply to this. Make sure you are using a service that is reputable; check out how the data you share will be used, including storage and destruction; only disclose relevant information that is absolutely essential," he says. "Most reputable telehealth providers will be able to point you to a code of conduct and use of data explanation. Seek out references from people you know who may have also used the service to get some hints and tips before you need to use the service." ■

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Tips and Best Practices for Telehealth

Despite the advantages of telehealth, this treatment modality poses some legitimate privacy concerns, says **Stephen A. Timoni**, JD, an attorney with Lindabury, McCormick, Estabrook & Cooper in Westfield, NJ.

Telehealth involves the nontraditional electronic transmission of sensitive information among providers and patients through a wide variety of ever-changing technologies.

Thus, the potential for patient privacy breaches exists. Notwithstanding the precautions taken by hospitals to protect patient privacy, data breaches can occur, validating patient concerns.[1]

Providers should start by conducting a comprehensive telehealth survey and study. Timoni suggests such a process include the following steps:

- Identify the telehealth technology and equipment currently in use.
- Identify the situations where telehealth is used.
- Identify the parties who are communicating and exchanging health information.
- Identify and evaluate the key areas of potential exposure for patient privacy breach.
- Develop effective telehealth privacy and security policies and procedures.
- Regularly audit compliance with the established policies and procedures.

Best Practice Recommendations

To ensure telehealth privacy, Timoni offers these nine best practices:

- **Use telehealth platforms and systems that comply with federal and state privacy laws.** In advance of COVID-19, healthcare providers were required to use HIPAA-compliant technology for telehealth consultations. Although enforcement of this requirement has been temporarily relaxed, best practice dictates exercising efforts to comply with all federal and state privacy rules.
- **Authenticate the identity of all telehealth system users to ensure only authorized individuals can access health information.**
- **Develop and implement a patient education and informed consent program.** Patients must be made aware of and understand the risks associated with telehealth. Informed consent should include information about the telehealth system, the steps patients should take to improve the safety of their electronic interactions, an agreement that telehealth is an appropriate form of treatment, and the understanding that the patient can stop treatment at any time.
- **All telehealth visits should be well-documented and included in the patient's medical record.** This documentation should include the patient's informed consent acknowledgement.
- **Implement technical controls to guard against privacy security risks.** These may include data encryption, secure connections, password-protected screensavers, and using software and platforms that have been vetted and approved for use. Note that consumer videoconferencing platforms such as FaceTime and Zoom may not offer proper controls and safety features.
- **Document compliance by third-party organizations that provide components of the telehealth system (e.g., equipment and software).** Require vendors to provide documentation and use comprehensive contracts covering all key terms and conditions, including regulatory compliance.
- **Training programs should be established and required for all clinical practitioners who will use telehealth systems.** This training should include development of effective open and clear communication skills, such as including careful listening and

ensuring the patient understands the diagnosis and treatment options discussed.

• **Comply with state licensure laws.** All telehealth encounters should comply with rules concerning the location of the practitioner and patient, the nature of the services provided, and the provider of the service.

• **Identify and manage malpractice and privacy breach litigation risks.** This includes a review of applicable liability insurance coverage.

Avoid These Mistakes

Timoni highlights these five mistakes that providers should avoid:

• Not adequately coordinating the operation of the telehealth platform between the medical staff, administration, and IT department.

• Failure to provide effective telehealth training to hospital staff.

• Not regularly testing the telehealth system for regulatory compliance, potential technical issues, and communication failures.

• Failure to provide continuing and updated education and disclosure to patients.

• Failure to continue to plan in advance for telehealth demand and deployment of improved technology.

Apply FIPPS

Privacy and security protection in the digital world are achieved by development and implementation of operating policies that adhere to the widely accepted Fair Information Practice Principles (FIPPS), says **Jeffrey A. Zipper**, MD, chief executive officer of iRecovery USA in Boca Raton, FL, which uses telehealth to provide mental health and addiction care. FIPPS were developed in the early years of internet growth. They form the basis for current laws regarding data security and privacy. Zipper offers this illustration of how his organization applies the principles to telehealth:

• **The Collection Limitation Principle.** Keeps personal data collection in check and with the patient's lawful consent.

• **The Data Quality Principle.** If personal data are released, these should be relevant to the proposed purpose of the request, for intended recipients, on a need-to-know basis.

• **The Purpose Specification Principle.** Before releasing data, secure the specified reason for the request.

• **The Use Limitation Principle.** Personal data should not be released for purposes other than those specified, except when patients consent or by the authority of law.

• **The Security Safeguards Principle.** Protect personal data with reasonable security safeguards against protected personal information loss, disclosure, or unauthorized access.

• **The Openness Principle.** When it comes to managing personal data, organizations should operate under a general policy of transparency about any problems.

• **The Individual Participation Principle.** A patient should be able to see and amend any personal data collected within a reasonable time frame and at reasonable cost. Access denials may be contested.

• **The Accountability Principle.** A data controller should ensure compliance.

In addition, Zipper says a healthcare videoconferencing system and network should provide "end-to-end" encryption. The telehealth application should be built into the EHR environment. Use encrypted email and texts for communication with patients outside the EHR environment.

When it comes to patient privacy and access, integrating the video application into the existing healthcare system workflows is paramount, says **Tzachi Levy**, senior vice president of product and engineering at Vidyo, a telehealth technology provider in Hackensack, NJ. "During the frantic early stages of COVID-19, some healthcare organizations rushed to adopt standalone, simplistic video chat solutions outside of their medical workflows. These solutions were not integrated with the EMR system, leading to security risks, compliance issues, and disjointed user experiences for both provider and patient," he says.

An ideal telehealth implementation would start by understanding the existing clinical workflows and medical staff use cases. "Knowledge of clinical workflows and flexible platform application programming interfaces make the difference to enable a virtual experience seamlessly," Levy says. ■

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Questions Raised Over Clinician Discipline in COVID-19 Era

With clinicians and hospital administrators strained by the COVID-19 pandemic, some are raising questions about whether oversight of clinician quality and performance is falling through the cracks.

Emergency actions against physician licenses dropped 59% in April through June compared to the previous year, according to data from the Health Resources and Services Administration (HRSA), which oversees the National Practitioner Data Bank (NPDB).

An analysis of data from the Federation of State Medical Boards (FSMB) Physician Data Center from January to June of this year shows a 14% decline in disciplinary actions.

"A number of factors could contribute to the 14% decline we are seeing," says **Joe Knickrehm**, vice president of communications for FSMB. "This could be caused by a significant decrease in the number of in-person physician visits or a decrease in the number of patient complaints to state boards during this time frame. We have been in close contact with our member boards. While their operations were initially impacted early on in the pandemic, they have adapted to mostly all virtual meetings and workflows that have allowed them to continue their work without significant interruption."

FSMB does not have data on the number of furloughs at state boards, but "we have heard anecdotally that some boards may have been impacted," Knickrehm says. This could be another contributing factor to the decrease in disciplinary actions. "The FSMB has always strongly advocated for states to adequately fund their state medical boards in order to ensure their important work of public protection is allowed to move forward without impediment, especially during a global public health crisis," Knickrehm says.

There has been a significant decline in nonemergent surgeries, imaging, and routine care, which has permeated hospitals during the pandemic, notes **Elizabeth L.B. Greene**, JD, partner with Mirick O'Connell in Worcester, MA. This decline and the significant changes in hospital-based care during the pandemic have affected the statistics regarding clinician discipline in many states, she says.

That providers have adapted to care in the pandemic over time does not equate to them returning to their prepandemic levels of care, including surgeries, Greene says. She questions any assertion of a correlation between a significant reduction in action by some state licensing boards and a minimal reduction in disciplinary reports from hospitals during the COVID-19 crisis.

The correlation is unclear as hospitals are not the only source of disciplinary reports, Greene notes. Other sources, such as patient complaints, peer complaints, and law enforcement, may have been significantly affected during the pandemic, she says.

There have been backlogs at licensing boards that predate the COVID-19 crisis, and these have persisted. Greene also notes the statistics on disciplined physicians, especially those who lost their licenses, involve small numbers, so the statistical variations are more easily dramatized.

Greene says she does not see cause for alarm, at least not yet. "I suggest one must look at the region, the impact of the pandemic on hospital systems and medical providers in that region, the status of the licensing boards, and the cause of any significant decline in discipline," she says. "It is difficult to draw analogies between disciplinary actions in the first six months in one year as compared to another when the numbers of providers disciplined are small in most states, and where the conditions have changed so dramatically due to the pandemic."

Greene says she does not believe there is a reason for patients or hospital administrators to be overly concerned about quality of medical care related to the frequency of disciplinary actions against physicians. It appears the vast majority of the decline in discipline is related to the changes in practice during the pandemic.

The best approach to this issue is to maintain regular oversight of clinicians as much as possible despite any added challenges from the pandemic, Greene suggests.

"Credentialing and risk management professionals will want to continue to perform their routine inquiries when onboarding providers, including obtaining information from the prior hospitals where they practiced. The routine databanks that are queried, including but not limited to the NPDB, should be queried," Greene says. "Addressing quality issues continues to be important, regardless of the pandemic, when staffing permits. Hospital quality leaders will want to continue to attend to patient complaints and incidents. To the extent possible, when there are

concerns or issues with a provider, following your routine best practices is advised whenever possible."

Greg Hammer, MD, a pediatric intensive care physician, pediatric anesthesiologist, and professor at Stanford University Medical Center, says he has heard speculation that hospitals are reluctant to report discipline issues because of a shortage of doctors during the COVID-19 response. He doubts that is true.

"I don't think there's any more of a shortage of doctors now compared to five or 10 years ago. Clearly, in New York City, at the height of the COVID problem, there was a shortage of physicians there, and doctors went to help out. But generally, I don't know of any shortage of doctors in other states where this lack of physician discipline is supposedly a problem," Hammer says. "During the peak of COVID, I think you had a great deal of inequity in terms of the supply and demand of physicians, and New York had a local shortage. But around this area of California, it was almost the opposite. We stopped doing elective surgeries in February or March, and that cut our surgery schedule to one-quarter of what it is normally."

(Editor's Note: A January 2019 poll conducted by the California Health Care Foundation revealed one-third of Californians surveyed believed their communities are not staffed with enough primary care physicians or specialists: https://bit.ly/3kW4SUB. A 2019 map created by the California Health Care Foundation indicates there is an overall physician shortage in the state, but not every area is the same: https://bit.ly/3n2t8Xa.)

Similarly, other physicians saw their patient visits drop dramatically as healthcare organizations restricted non-essential appointments, Hammer notes. That substantial drop in workflow for physicians means there were far fewer patient interactions. Hammer surmises that may play a role in the occurrence of fewer disciplinary actions. Fewer interactions with patients means fewer opportunities for discipline problems. "Additionally, you have a tremendous backup in discipline actions by the state medical boards, which doesn't have anything to do with COVID. When we see a recent reduction in discipline, we don't necessarily know that it is a true indicator of what is going on now or in recent months," Hammer says. "I can believe that state medical boards are understaffed ... but to say that any recent reduction is attributable to COVID might not be substantiated. There are hotbeds for COVID, but I don't think it accounts for any national decline in reporting."

Hammer says he is confident hospitals are vigilant about monitoring clinicians and responding appropriately to concerns. But he says there are times when a physician who is bringing in a lot of revenue is treated with kid gloves.

"We had a surgeon who brought a lot of patients to the center ... It's not that he made mistakes, but he behaved poorly and probably should have been fired long before he was. But he was filling a lot of beds, and it was a profitable enterprise," Hammer says. "That happens in exceptional cases where you have exceptional revenue to bear. But there is so much emphasis on quality and safety now in hospitals that I don't think mistakes are being ignored. There's too much at stake."

(Editor's Note: At the time of publication, a request to the National Council of State Boards of Nursing for similar discipline data on nurses remained pending. Hospital Peer Review *will work to obtain these data, learn more from the HRSA about the NPDB data referenced in this article, and report an update in an upcoming issue.)* ■

SOURCES

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- **Joe Knickrehm**, Vice President, Communications, Federation of State Medical Boards, Washington, DC. Phone: (202) 601-7803.

IHI Issues Action Plan on Patient Safety

The Institute for Healthcare Improvement's (IHI) National Steering Committee for Patient Safety (NSC) recently released its national action plan, aimed at helping health-care organizations reduce preventable medical harm.[1]

Safer Together: A National Action Plan to Advance Patient Safety includes evidence-based practices, case studies, and recommended interventions. The report was the result of work by federal agencies, safety organizations and experts, and patient and family advocates. It includes four areas: culture, leadership and governance, workforce safety, and learning systems. There are implementation tactics, case examples, tools, and resources. This action plan is intended to return focus to patient safety and

medical errors, says **Patrick Horine**, MHA, who served on the IHI NSC that wrote this report. The Institute of Medicine's 1999 report, *To Err is Human: Building a Safer Health System*, brought attention to patient safety.[2]

Patient safety is more of a constant focus than it was before the IOM report, Horine says, but it has plateaued as a priority for healthcare organizations.

"We've done more on the preventable issues, but eradicating patient harm has not happened. Keeping this to the forefront of the mindset of leadership was a key issue for us," says Horine, chief executive officer at DNV GL Healthcare in Milford, OH, which offers hospital accreditation. "We brought together so many different parties because we wanted to look at this from all perspectives, which includes patient safety and healthcare worker safety."

The protection of healthcare workers was a key component of the plan, even though most of it was developed before the COVID-19 pandemic.

"This is something that DNV GL is going to be asking hospitals about more in the future. It goes well beyond patient/staff ratios. This is really about the psychological and physical impacts, what it is doing to contribute to patient outcomes as well as the well-being of staff," Horine says. "I never would have foreseen the psychological impact that COVID has had on healthcare workers. Patients are dying, and [clinicians are] doing everything they can for them, to no avail. That has a real impact."

The IHI report also focuses on the involvement of the hospital or health system board. "What level of involvement do we have at the board level? They might get summaries and highlights at the board level, but how aware are they of safety and quality issues? What do they need to be committing more resources to?" Horine asks. "That level of understanding and participation from the board level is a primary concern." ■

CE QUESTIONS

1. **Select the proper recommendation regarding telehealth services established in response to the COVID-19 pandemic.**
   a. Review those services now for compliance issues, as there is less pressure from the pandemic.
   b. Document those practices, but there is little concern for compliance.
   c. Any program established in the pandemic period is protected from compliance issues.
   d. Telehealth services established during the pandemic should be abolished, and new programs established.

2. **Joe Knickrehm, vice president of communications for the Federation of State Medical Boards, suggests the 14% decline in physician disciplinary action may be attributed to:**
   a. some state medical boards shut down and took no action during the COVID-19 pandemic.
   b. a significant decrease in the number of in-person physician visits or a decrease in the number of patient complaints to state boards during this time.
   c. physicians were less stressed because of the decreased workload and, therefore, performed better during this period.
   d. hospitals were reluctant to report physician discipline problems because they needed physicians to treat COVID-19 patients.

3. **Which is true regarding how to assess the quality of telehealth care?**
   a. Healthcare organizations must apply a similar rubric to how they have always assessed the value of face-to-face or in-person care before the COVID-19 pandemic.
   b. Healthcare organizations must apply a new rubric designed for the post-pandemic world of healthcare.
   c. It is sufficient to rely on patient feedback to assess the quality of telehealth care.
   d. It is sufficient to rely on physician assessments of telehealth care.

4. **Select the proper recommendation regarding technology for telehealth.**
   a. Use only technology that was developed specifically for telehealth.
   b. Use consumer apps like FaceTime with no concerns.
   c. Use consumer apps like FaceTime, but with precautions and limitations.
   d. Technology specifically developed for telehealth is no safer than consumer apps like FaceTime.

REFERENCES

1. Institute for Healthcare Improvement. *Safer Together: A National Action Plan to Advance Patient Safety*. https://bit.ly/3jcDCAQ
2. Institute of Medicine (US) Committee on Quality of Health Care in America. *To Err is Human: Building a Safer Health System*. Kohn LT, Corrigan JM, Donaldson MS, editors. Washington (DC): National Academies Press (US); 2000. PMID: 25077248.

SOURCE

- **Patrick Horine**, Chief Executive Officer, DNV GL Healthcare, Milford, OH. Phone: (866) 523-6842.

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