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INSIDE

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MAY 2021 Vol. 46, No. 5; p. 49-60

NCQA, CMS Push for Digital Quality Measures System

The National Committee for Quality Assurance (NCQA) released a report recommending the Department of Health and Human Services (HHS) and the Centers for Medicare & Medicaid Services (CMS) push for the creation of a digital quality measure system that could eliminate much of the redundancy in quality data reporting and improve the value of the data.[1]

The report also calls for HHS and CMS to take steps to improve health equity, which could be addressed in part by a better data reporting system. CMS is moving in that direction, and there are indications the agency is accelerating the effort, with bold goals and extensive plans for a new digital quality reporting system. The HHS Assistant Secretary for Planning and Evaluation has urged CMS to incorporate health equity data in its quality measurement and incentive programs. Health equity data is a factor included in value-based care models in some states.[1]

NCQA notes healthcare data and quality measures are fragmented across healthcare organizations and health plans, making it difficult to provide value-based care. A digital quality system would reduce the time and cost required for developing and implementing value-based care measures, according to the agency. NCQA also urged Medicare to strengthen value-based care plans as a way of improving health equity.

Need to Improve Quality Reporting

NCQA focuses on the quality assessment of health plans and relies on automated, validated data, says **Frank Micciche**, vice president of public policy and external relations with NCQA. All healthcare organizations and health plans should be able to rely on the same level of quality data.

"One of the things we're recommending is that various CMS programs improve their data quality. Obviously, Medicare and Star Ratings is the top-notch program in terms of their quality ratings and the data they

Financial Disclosure: None of the planners or authors for this educational activity have relevant financial relationships to disclose with ineligible companies whose primary business is producing, marketing, selling, re-selling, or distributing healthcare products used by or on patients.

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***Hospital Peer Review*® (ISSN 0149-2632) is published monthly by Relias LLC, 1010 Sync Street, Suite 100, Morrisville, NC 27560-5468. Periodicals postage paid at Morrisville, NC, and additional mailing offices. POSTMASTER: Send address changes to *Hospital Peer Review*, Relias LLC, 1010 Sync Street, Suite 100, Morrisville, NC 27560-5468.**

GST registration number: R128870672.

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use," Micciche says. "But there are plenty of CMS programs and value-based payment programs across the country, private and public, where the data are just whatever data you can get to them. It often is not validated and rarely audited."

The federal government is making billions of dollars of payments based on "pretty shaky data," Micciche says. NCQA is calling for validation and auditing to become standard parts of any public value-based program, and ideally for private programs, too.

"We would like to see the creation of an ecosystem that makes it easier and actually reduces the burden to feed data into this ecosystem. In the course of doing, you validate and audit data in a way that you can't right now," Micciche says. "That's a big leap. There's a long way to go before everyone can plug into a system like that, even if they're relatively sophisticated with their data. We and the rest of the healthcare data community have to create that interface."

CMS is most capable of facilitating progress in that direction, according to Micciche. CMS can incentivize the use of a digital ecosystem or even mandate it, which would be harder.

CMS Shoots for 2025

CMS announced during its 2021 Quality Conference in March that it was moving up its goal to report all quality measures digitally. Originally, the agency said it would be done by 2030; now, the date has changed to 2025. Micciche calls that a bold move and an ambitious goal.

"That fits very nicely with what we are trying to do. Whether folks can get there by then is a real question," Micciche says. "Even those with EHRs [electronic health records] and more sophisticated data systems or quality measures still aren't interconnected or interoperable. There's a long way to go, but we believe a smoother, more coordinated ecosystem is going to bring us to a point where data are just flowing as opposed to being entered and re-entered."

If data must be manually entered into the system, which Micciche says will be the case for many entities for some time, those data can be validated and redistributed to various other entities automatically.

"A current complaint from many health plans and other organizations is that they are reporting the same measure to five different entities or some version of the same information to five different entities," Micciche says. "That is chaos. Not only does it take up a lot of time, but it creates a sense of confusion over what target you're really aiming for with these data — the version you report to these guys, or the version you report to someone else."

The NCQA report says the digital quality utility it envisions aligns closely with the "secure, data-driven ecosystem to accelerate research and innovation" contemplated in the 2020-2025 Federal Health IT Strategic Plan.[1] NCQA's plan would support CMS' goal of requiring all quality measures to be reported digitally by 2030.

The authors cited the example of Electronic Clinical Data System (ECDS) measures, which are derived from digital resources such as EHRs, health information exchanges, and registries.

NCQA points out that the ECDS measures make it possible to measure individual member

outcomes in addition to general population outcomes.[1]

Star Ratings Set the Standard

NCQA says the Medicare Advantage (MA) Star Ratings program is a good example of how financial incentives and quality measurement improve patient outcomes in a value-based care model.

"MA has seen a surge in enrollment, while also improving quality, containing costs and premiums, and enabling individuals to choose from an array of high-quality plans," the report authors wrote.[1]

More than 80% of MA plans include complete or partially complete race and ethnicity data. On the other hand, most Medicaid and commercial plans do not routinely collect information on race or ethnicity, which makes it difficult for them to assess or address inequities.[1]

"Plans can serve as critical partners to effectively tackle the root causes of poor health and address disparities to improve the health of individuals and their communities," the NCQA report says. "This is reflected in the continued investment and increase in supplemental benefits offered by MA plans to address social determinants of health."[1]

If that interoperability is achieved, hospitals should be able to seamlessly exchange data not only with other hospitals but also with health plans, Micciche says.

"If we get this right, there is no reason it cannot apply to data between systems and hospitals, between hospitals and plans, between doctors and hospitals," he says. "A rising tide lifts all boats and hospitals are certainly one of those boats. This will be a major improvement for hospitals because making data flow more interoperably will allow all sorts of new connections that currently are just impossible."

CMS Making Right Moves

Micciche sees progress in working toward the goals of digital reporting of quality data and creating a more comprehensive system that facilitates the easy flow of information and reduces much of the redundancy and work burden of the current system. CMS' adoption of the Fast Healthcare Interoperability Resources (FHIR) as the foundational standard to support data exchange via secure application programming interfaces (APIs) was a major step forward.[2]

"I think FHIR is becoming the coin of the realm. For those who are in a position to strive for this digital quality ecosystem in which we enter data once and it gets shared around, they at least now know that CMS, the big driver here, is saying you need to move to this FHIR API that will allow connection between all sorts and types of entities."

CMS moving up its deadline for digital quality reporting also is progress, because nothing gets people moving like a hard deadline, according to Micciche.

"Moving it from 2030 to 2025 is a massive leap for a government to take. It's two different administrations, but I don't get the sense that this is a Biden administration decision so much as evidence that the career people at CMS believe it is doable by 2025," Micciche says. "If it is more than two or three years out before people have to start buying new systems, they kick it down the road to the next strategic plan. CMS moving that deadline forward is going to cause a lot of movement toward this digital capability."

Shift Needs Good Oversight

However, that movement has to be shepherded carefully, Micciche says. The adoption of EHRs is a good example of how a massive shift in technology was not shepherded well.

The government pushed for widespread adoption of EHRs with incentives and funding. Today, most any healthcare provider that wants an EHR owns one. But their contribution to improving data reporting and analysis is spotty, at best, Micciche argues.

"They meet some vague definition of interoperability, but they are not seamless. They do not communicate well. Even with a health system, they have a hard time communicating and sharing data," he says. "This needs to be scale of commitment, as well as policy leadership and funding, but it needs to be done in a way that gets us to far more interoperability than we have now."

The Office of the National Coordinator for Health Information Technology (ONC) will be a driving force in reaching this goal, with the new leadership setting fresh standards that will guide the industry to infrastructure improvements necessary to create the digital quality ecosystem. ONC also can encourage interoperability in ways that do not involve new standards or penalties.

Micciche was particularly encouraged by the release of the CMS Measures Management System

Blueprint at the 2021 Quality Conference. The document outlines specific steps necessary to achieve interoperability.[3]

"The new director of ONC is indicating that he is very supportive of this goal. We are seeing strong signs that the government is activated on behalf of moving to this digital vision," Micciche says. "This isn't just words on paper. They're making those plans and charting a course that makes it doable. It doesn't mean we'll get there by 2025, but we feel great about the direction this administration is taking." ■

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Rapid Mortality Reviews Improve Quality and Patient Safety

Staff at a California hospital found rapid mortality reviews conducted soon after a patient death resulted in the treatment team identifying opportunities to improve the patient's care in more than 40% of the cases.[1]

The team conducting the rapid mortality reviews concluded this technique can offer advantages over the standard retrospective case reviews, provider surveys, and structured morbidity and mortality conferences.

The authors studied data from five years of patient deaths that occurred in the 24-bed medical ICU at the UCLA Medical Center.

Expanding Through Hospital

What started as a quality improvement effort in the ICU has now expanded because of the good results, says **Kristin Schwab**, MD, study co-author, co-director of the Post-ICU Recovery Clinic at UCLA, and medical director of UCLA Pulmonary Rehabilitation.

"It came about as part of our continual process to continue the care we provide in the ICU. We wanted to create a concrete and standardized process by which we could review all deaths and figure out how to improve care for people in the future," Schwab says. "It's now gone from our ICUs to other units in the hospital as well. Oncology is doing it with their patients, and it's moving to every other area of the hospital."

The project began in 2013 with patients who had died in the medical ICU in one week. By 2017, Schwab and colleagues were holding weekly meetings with the intention of reviewing every death on the unit. Over five years, the team reviewed 542 deaths, more than 80% of all deaths on the unit.

The weekly meetings are led by a facilitator drawn from a pool of quality-trained nurses and physicians who work to standardize the process. The facilitator is not someone who was involved in caring for the patient but reviews the patient's chart before the meeting, held in a private conference room in the ICU.

The facilitator leads an interview with the care team. Questions include "Was the death potentially preventable?" and "Are there any aspects of care that could have been improved?"

Frank conversations are encouraged. These discussions begin broadly before narrowing to standard questions and then detailed queries specific to the case.

"We look at the deaths through the lens of process improvement. It's important that it's not meant to be punitive in any way," Schwab says. "It is a standardized but relatively informal conversation with the entire care team. That includes the doctors, the nurses, and any consulting teams who were involved in the care."

Action Items Identified

The facilitator enters a summary of the interview into a database the hospital quality leaders can review. They may identify action items and make recommendations.

Most other rapid mortality reviews last only 15 minutes, but

Schwab says they often reveal meaningful information.

The rapid mortality reviews are not intended to catch anyone acting inappropriately but rather to identify potential areas of improvement. Schwab and colleagues determined only 7% of deaths were potentially preventable. However, in 40% of the cases, the treatment team concluded the patient's care could have been better.

The facilitators saw room for improvement in a slightly higher percentage of cases, more than 50%. Action items were more likely to be identified when the patient received resuscitation after an in-hospital cardiac arrest or was not receiving comfort care.

Common quality improvement issues identified included medical errors, hospital-acquired infections, delays in care, communication, teamwork, advance care planning, and procedural complications. Lack of protocols, resource availability, and throughput also were cited at a system level.

More than 10% of the issues identified in the rapid mortality reviews led to changes within the unit, with 29 separate changes during the five years. In one case, the review led the hospital to create a standardized checklist for inbound patient transfers. In another, the hospital altered the electronic health record so that one-time orders were differentiated from continuing orders.

Different Than M&M

The hospital's rapid mortality reviews differ from typical morbidity and mortality reviews in that they are held sooner after many patient deaths — every week, rather than monthly. The rapid mortality reviews also are conducted by the care team rather than an outside reviewer. "This is a discussion among the team that was on the ground actually providing care, and it's a face-to-face interview. Often, there are surveys or chart abstractions used for mortality reviews. That is a very different approach," Schwab says. "Without the face-to-face interview and the open-ended discussion, you end up missing a lot. This also benefits from including everyone who was involved — not just the doctors and nurses, but the ancillary staff as well."

MORE THAN 10% OF ISSUES IDENTIFIED IN THE RAPID REVIEWS LED TO CHANGES WITHIN THE UNIT.

The information revealed in the rapid mortality reviews can be more useful than what might be gleaned from a monthly review.

"The recall bias can be so great if you wait weeks thereafter. The immediacy of it helps people with their recall and minimizing issues of memory," Schwab says. During the COVID-19 pandemic, the rapid mortality reviews still are held in the ICU conference room, but they include a virtual option for team members who were not in the hospital that day.

Schwab encourages other hospitals to adopt the rapid mortality review, calling it a relatively easy process to implement that can significantly affect care quality.

"Finding a leader for this who can frame this from the quality improvement lens is really important. It also is important to establish a regular time when everyone involved knows this is going to happen every week," Schwab says. "If you don't have the capacity to review every death per week, we found that the most high-yield cases are those with a cardiac arrest and CPR, or patients not receiving comfort care. Focusing on those first and then expanding from that can be a good approach."

Six percent of the deaths reviewed in the rapid mortality reviews were referred for further analysis in the morbidity & mortality conference. There are multiple avenues for cases to be referred to morbidity & mortality, so the rapid review represents one route for referral, Schwab says.

For cases that are referred, Schwab says there is direct communication between the rapid mortality review and morbidity & mortality teams to confirm the reason for referral. Case details from the rapid mortality review are conveyed to the other reviewers. ■

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- **Kristin Schwab**, MD, Co-Director, Post-ICU Recovery Clinic; Medical Director, UCLA Pulmonary Rehabilitation, UCLA Medical Center. Phone: (310) 825-9111.

Lung Health Program Revamped to Help Manage COVID-19 Pandemic

A Maryland hospital adapted an existing program encouraging lung health to respond to the sudden demands of COVID-19. The program helped reduce COVID-19 readmission rates by two-thirds.

University of Maryland Charles Regional Medical Center (UM CRMC) already was promoting a "Healthy Lungs = Healthy You" campaign when the pandemic hit. The hospital quickly pivoted to using the same educational program and resources to address the pandemic. By spring 2020, the program was fostering pneumonia prevention education and helping patients with COVID-19 infections continue their recovery after discharge.

Originally, the program was focused on patients with congestive heart failure (CHF) and chronic obstructive pulmonary disease (COPD) patients, explains **Anne S. Weekley**, MHA, BSN, RN, CSSGB, CPHQ, vice president for quality/patient experience at the UM CRMC.

Then, COVID-19 hit, and the quality improvement department realized the "Healthy Lungs = Healthy You" campaign could be adapted to address the emerging threats from the pandemic.

"Just before COVID, we were working to see that every patient in the ED and everywhere else, if they came in with a respiratory illness and didn't meet criteria to be admitted, they were educated on the use of an incentive spirometer and given one to take home. Our transitional nurse navigators followed up with them," Weekley says. "COVID comes along and we thought this would be an even better use of this program. We scrambled and put together a bag that had a toothbrush, toothpaste, mouthwash, a thermometer, the incentive spirometer, a pulse oximeter, literature on the pulse oximeter reading, and proning documentation."

The literature included a color-coded chart to show what the pulse oximeter readings mean, with green indicating good lung health, yellow suggesting more incentive spirometer work is needed, and red indicating the patient should return to the ED.

The literature also explained why oral health is important for these patients and why the oral care products should be used regularly.

Provide to All Testing Positive

The hospital provided those kits to all COVID-19 patients, including those who tested positive but were not admitted.

"We've heard from people saying that their mom got this kit when she had COVID. They'll call the transitional nurse navigator who's checking on mom to say that now the daughter is using the pulse oximeter and got a new toothbrush, but is there any way she could get a spirometer," Weekley says. "To hear that it has blossomed in the community like that, with family members embracing the education from that one kit, is very encouraging. They have the number for the nurse navigator. There have been times when relatives of the original patient called with their O_2 stats, and we told them to come in to the ED."

In some cases, the caller would protest he or she had just been to the ED a day or two before. Still, the nurse navigator explained the effects of COVID-19 can escalate rapidly and that the pulse oximeter readings indicated a return visit was warranted.

Without the kits in the community, those patients may have waited too long. UM CRMC is in a rural area and gives out about 100 kits per month. Since beginning the program, the hospital has provided about 700 kits to patients.

Kits Improved Over Time

UM CRMC also added items to the kit as the effects of COVID-19 were better understood. When it became clear blood pressure is an issue with systemic disease, the hospital added a blood pressure monitor to the kit, along with instructions on how to use it. A water cup was added to the kit to encourage patients to drink plain water.

Staff also created a "Healthy Lungs = Healthy You" video series to educate patients on the use of an incentive spirometer, along with the benefits of pursed lip breathing, deep breathing, oral hygiene, and movement. *(Learn more online at: https://bit.ly/3cxD1ZF.)*

UM CRMC has experienced a significant decrease in COVID-19 readmissions and pneumonia admissions since the beginning of the program.

The readmission rate for COVID-19 patients in February 2020 was about 25%. By December 2020, the rate had fallen to about

7%, according to Weekley. The UM health system has adopted the kit program at other hospitals. The system tracks the address, ethnicity, age, and sex of patients receiving the kits.

Data collection for the program indicates COVID-19 readmissions are highest among African American women between age 40 and 60 years, followed by Hispanic women in the same age group.

For African American men, readmissions were highest in the age 60 to 80 years range. Hispanic men age 40 to 60 years readmission rates mirrored those of Hispanic women of the same age.

Kits Are Expensive

Each kit contains about $130 worth of goods. Starting in March 2020, the cost of the kits has been covered by a grant from the Charles County Health Department and other sources. This has prevented UM CRMC from incurring substantial debt for the kits. The hospital does absorb the cost of printing the educational materials. The biggest challenge in the program has been acquiring the items to include in the kits. During the height of the pandemic, when many medical resources were in short supply, Weekley's team had to be innovative in finding enough items for the kits.

"For a time, we could not get thermometers, blood pressure [monitors], and pulse oximeters. Some of us with Amazon accounts were ordering as many as we could at a time because even our hospital supplier could not provide them," Weekley says. "Today, we can get access to pulse oximeters, but thermometers and blood pressure [monitors] are still hard to come by. When we start to run low and our supplier can't help, we all go back and order from Amazon."

The hospital also had trouble obtaining enough toothbrushes and toothpaste.

"We had people running out to the dollar stores to buy up all the toothbrushes, almost daily. At the beginning of the pandemic, it was like that. You just couldn't get certain items," Weekley says. "Initially, we tried to add little hand sanitizer bottles to the kit, but that quickly became impossible to find anywhere."

The program will continue after the pandemic ends, Weekley says, shifting focus back to the original CHF and COPD patients. Those patients and all major surgical patients currently receive the kits and education.

"At their pre-op visit, [patients] are educated on the use of the incentive spirometer and pulse ox. Once they go home, they can monitor themselves to prevent pneumonia. Then, [patients] are educated again in the surgery suite before they go back to the OR, just to remind them," Weekley explains. "When [patients] get up to the floor, they get the same thing, and we use their own pulse ox and their own incentive spirometer to teach them. We remind them to track these things when they get home."

Transitional nurse navigators call all high-risk patients after discharge

to make sure they are using the devices and to assess their pulse oximeter readings.

"It's a program that we've seen produce very good results in our population of COVID patients. We're seeing the same benefits with other patients who are high risk," Weekley reports. "It's definitely something we will continue." ■

SOURCE

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Care Improved by Providing Better Feedback to Hospitalists

Providing detailed feedback to hospitalists, including key quality metrics, can improve the quality of care they provide patients, according to the results of a program at a Wisconsin medical college.[1]

Quality metric scores and rank order lists can change hospitalist behavior, says **Ankur Segon**, MD, MPH, FACP, SFHM, associate professor of medicine and program director of the Hospital Medicine Fellowship at Medical College of Wisconsin (MCW).

The effort began in 2017 when Segon undertook a significant restructuring of the section to address issues of quality, faculty development, and morale. He launched performance feedback packets for faculty, drawing on his previous work involving the effect of dynamic feedback, especially on Hospital Consumer Assessment of Healthcare Providers and Systems (HCAHPS) scores.

In a study, Segon and colleagues administered questions similar to the HCAHPS questions to inpatients. They created a website and entered the information. Then, the website would generate an email every day to the hospitalists with their own scores and comparative scores to the rest of the section, for nine months.

"We saw an improvement in the questions from the survey of about 5% based on that study," Segon says. "With HCAHPS, it is hard to move the scores, so any improvement is a really good improvement. I'm a believer in comparative dynamic feedback, as dynamic as you can make it, but it needs to be comparative to both goals and the threshold you're shooting for and your peers."

Clinicians are inherently competitive. When they see they are underperforming in comparison to peers, that can be a reflection point for how to do better. It also is positive reinforcement for top performers.

With that experience, Segon and colleagues created a feedback packet that MCW continues to use. All 46 hospitalist faculty receive a dashboard and rank order list every month.

MCW leaders supported the effort and provided necessary resources. They assigned a hospital data analyst who is familiar with the electronic health record (EHR) and other data systems, along with some web design experience. The data analyst spent about two weeks to create the initial algorithms and the process for mining the EHR for the necessary data. Then, it takes him about two hours to put together the feedback packets each month.

Originally, the packet included two components: the dashboard and the rank order list. The dashboard shows how each doctor is performing on several quality metrics, with section comparisons and the goals for that metric. The rank order list shows where the physician is performing on each metric in comparison to peers.

Some identification is masked to protect underperforming providers, but each clinician can see where he or she stands in relation to everyone else. The data analyst is vital to creating the rank order list.

"The dashboard was created through the department of medicine because it has a data support team. Their data person, who has a master's in statistics, said it took her about a week or two to work through

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the algorithms that generate the dashboard," Segon says. "Then, it takes her a couple hours a month to get the packet together. The actual putting together of the various elements of the packet — the rank order and the dashboard — is done by an administrative assistant who is in the division of internal medicine. It takes her about half a day every month."

Spreading out the work among different staff members helped make the program manageable.

Improvement on Many Measures

Segon says the hospitalist feedback contributed to improvement in many quality measures, although the effect is hard to isolate because the hospital was simultaneously implementing other improvements, such as adding FTEs.

"It was more about creating a culture of efficient, high-quality work, and the feedback packets were one part of that, although I think it was a very important part," Segon says. "It created a conversation around how we were doing around various quality metrics and gave us a launching pad to improve our metrics."

MCW saw an improvement in length of stay index, 30-day readmission rate, catheter-associated urinary tract infections, and central line-associated bloodstream infections. It also improved scores in the provider component of HCAHPS, attendance at care coordination rounds and the percentage of discharge orders placed by 10 p.m., and discharge summaries completed in 24 hours. There was a decline in the overall HCAHPS scores in the period studied with the feedback packets.

"I think because the feedback packets were focused more on providers — and we saw an improvement there, while the overall HCAHPS scores declined — there is a little bit of a story there regarding the effectiveness of what we did," Segon says. "It was pretty much an across-the-board improvement when you look at all the metrics. The improvement in the process type metrics was more than in the systems metrics. That ties into how there are certain things that are under the control of the hospitalists, like putting in early discharge orders, more so than in improving HCAHPS scores, which is more of a team-based effort."

Not a Standalone Project

To replicate these results, Segon suggests it is important to make the hospitalist feedback packet part of a broader quality improvement effort that includes making sure clinicians are seeing the right number of patients. He does not recommend it as a standalone project. "You have to make sure they are not understaffed and take away some of the non-value-added tasks from their workflow. You are improving the opportunity for the faculty to improve their engagement. Then, you can bring in tactics related to improving their performance and quality," Segon says.

Peer support and feedback is important, too. MCW leaders discussed high performers in quality metrics at quarterly section meetings, using that as a moment of celebration and an opportunity to share with the group any insight into how top performers achieve high scores on the metrics.

"You also want to be very clear about what metrics are more systems-based and which ones are more individual, hospitalist-based. Hospitalists can't change length of stay on their own," Segon says. "I was very up front about that, explaining that they would not be expected to improve something like readmission rates for the section. But they have a role to play in moving that metric in the right direction by some of the actions they can control. That messaging was very important."

Segon does not advise tying any significant portion of a clinician's compensation to performance-based metrics. It may be reasonable

to designate a token portion of compensation tied to quality metrics, but no more. "It can be reasonable to have group-based incentives tied to metrics like that because that is a way to empower people," Segon suggests. ■

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HCAHPS, Other Satisfaction Scores May Suffer from COVID-19 Effects

Hospitals may see a dip in the Hospital Consumer Assessment of Healthcare Providers and Systems (HCAHPS) survey, the national, standardized, publicly reported survey of patients' perspectives of hospital care administered by CMS, because of how COVID-19 affected the experience of patients in the past year.

The HCAHPS survey asks 29 questions about recent hospital stays, with 19 core questions about such critical aspects of the experience as communication with nurses and doctors, the responsiveness of hospital staff, cleanliness, quietness, and education about medications. The survey also asks for an overall rating of the hospital (i.e., whether they would recommend it to others). The survey is administered to a random sample of adult patients between 48 hours and six weeks after discharge.

Hospitals may take a hit in the next round of HCAHPS results because of the COVID-19 pandemic, says **Matt Dickson**, vice president for product strategy and general manager with Stericycle Communication Solutions in North Richland Hills, TX, which provides patient engagement services to healthcare providers.

The company regularly conducts its U.S. Consumer Trends in Patient Engagement Survey to gauge satisfaction in areas that may influence HCAHPS results. The company recently asked 500 U.S. consumers about their experience during the pandemic. *(Read more at: https://bit.ly/3szUiah.)* These were some of the key findings:

- There was a 13% decrease in patient satisfaction with provider communications since the beginning of the pandemic.
- Provider COVID-19 policies and procedures were not effectively communicated before scheduled appointments (37% of respondents).
- Virtual waiting rooms were preferred over physical waiting rooms during the pandemic (81% of respondents).
- There was a 10% increase in the number of patients seeking mental health treatment during the pandemic.
- Sixty-seven percent of respondents used telemedicine or virtual channels at least once since the pandemic began.

Some effects of the pandemic have been talked about at length, such as the expanded use of telehealth. But the survey uncovered some other issues. "One of the interesting things we found, and it is kind of counterintuitive, is that people are feeling more rushed now than they had historically when they attended an appointment," Dickson says. "One would think that during the pandemic, people want to minimize the time they spent in a doctor's office, but we found that there was a 35% increase in people who said they felt rushed during an appointment."

Even more alarming, particularly as it may affect HCAHPS scores, is what drove this feeling of rushing.

"Many people were telling us their providers were not spending adequate time with them and were making assumptions about what was wrong with them and the right course of treatment," Dickson reports. "We can see how that might have a noticeable impact on HCAHPS scores, particularly with how patients perceive their communication with nurses and doctors during their stay."

These survey results may be a "canary in the coal mine" for HCAHPS survey results, Dickson says.

"We are seeing that the number of people who are satisfied with communications crashing and the number of people who are very dissatisfied accelerating. People are feeling more rushed, and we know very specifically that those sentiments affect those HCAHPS scores in relation to doctors and nurses," Dickson says. "I would imagine that those two things would portend that those HCAHPS scores would be

more negative than they have been historically."

Before the pandemic, 73% of patients surveyed said they were very satisfied with the communication with their healthcare providers. During the pandemic, that figure nosedived to 60%. The number of patients who said they were not satisfied at all tripled.

"The lesson is that you have to double down on communication, trying to make it more effective, more tailored. Much of the communication has been focused solely on COVID-19 responses, and limitations and requirements, and now the vaccination effort," Dickson says. "It's time to start thinking rather aggressively about how to re-engage consumers. For those patients affected by the limits on elective surgeries, for example, what do you need to do to re-engage with them, make them feel welcome, and communicate effectively with them?"

The survey results revealed intriguing information about the "channel of choice" among consumers, Dickson says. There is a disconnect in how patients say they want to communicate with healthcare organizations and what communication techniques actually result in patients acting.

When asked what type of communication they prefer with healthcare providers, 37% said email. Another 30% said by phone, and 28% said by text. But for patients who had missed an appointment during the pandemic and rescheduled it, the survey asked about what triggered rescheduling. Even though 37% said they preferred email communication, only 2% of respondents said an email had triggered them to reschedule, Dickson reports. "The far and away leader for getting people to take action and reschedule an appointment was a phone call, with 56% of our respondents saying a phone call was what got them to take that action," he says. "You have to have these aggressive outreach campaigns if you want them to really take action to reschedule these elective surgeries and other things that were delayed. Now is the time to be very proactive about engaging with consumers."

Another area of concern involves a heightened desire for mental health services during the pandemic, Dickson says. Before the pandemic, about 16% of survey respondents were using mental health services, but that number went up to 26% during the pandemic.

Not only did the number increase, but the patterns of demographics of those using mental services also shifted. Prior to the pandemic, the demographic most likely to use mental health services was patients age 55 years and older. During the health emergency, ages ranged from 35 to 54 years.

Dickson suggests healthcare professionals may need to change their approach to mental health as the pandemic wanes. The survey revealed 23% of respondents had missed at least one appointment with a provider, of any type, because of their state of mental health during the pandemic.

Here, it is important again to consider communication preferences and how those vary by age. The Stericycle survey showed patients age 25 to 44 years prefer texts, while an older demographic wants to receive a phone call. Patients in the middle prefer email.

"You have to have effective strategies based on demographics and not a one-size-fits-all approach," Dickson says. "But at the same time, you have to tailor your approach based on outcomes and not just stated preferences. That's where a lot of health systems fall down today, by not closing that loop. They just look at how the patient says they want contact and flood that channel with communication, as [opposed] to looking at whether they're really inducing action, and what they might need to change."

The method of communication might need to change according to what kind of information clinicians are trying to provide. For an appointment reminder, the patient's preferred channel might most effectively reduce no-shows. However, when it comes to re-engaging patients in their healthcare, the preferred channel might not be the method that produces results.

"A key finding for hospital administrators, particularly those focused on quality, is reminding their staff that now, more than ever, is the time to slow down a little bit and spend more time with patients. Make sure they feel like they are getting complete answers, all the information they are seeking, and not feeling rushed," Dickson says.

It is important to maintain a strong, proactive strategy for patient engagement. What Dickson sees more often is a reactive strategy, in which clinicians put out a general message with a phone number or website.

"It is not very tailored to the individual, and it certainly is not speaking to things like saying 'pre-pandemic, you were going to have this procedure, and let's see what we can do to get you back in the process and ensure your long-term health,'" Dickson explains. "That takes more effort, but that's what makes patients feel you are communicating effectively and actually care." ■

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CE QUESTIONS

1. **In the rapid mortality reviews conducted in the ICU at UCLA Medical Center, what is one factor contributing to their success?**

   a. Participation by a C-suite executive, such as the CEO
   b. Participation by a family member of the deceased patient
   c. A facilitator who was not involved in the patient's care but who has reviewed the case
   d. The discussion is led by the physician most involved in the patient's care

2. **What was a key finding of the U.S. Consumer Trends in Patient Engagement Survey?**

   a. Patient satisfaction with communication from healthcare providers increased 17% during the COVID-19 pandemic.
   b. There was a 13% decrease in patient satisfaction with provider communications since the beginning of the COVID-19 pandemic.
   c. Surveyed patients cut back on their use of telehealth services during the COVID-19 pandemic.
   d. The patients' preferred choice of communication proved to be the most effective for all forms of patient contact.

3. **CMS announced during its 2021 Quality Conference in March that it was moving up its goal to report all quality measures digitally by:**

   a. 2025.
   b. 2022.
   c. 2026.
   d. 2023.

4. **What is a good step forward toward interoperability of digital quality measures?**

   a. CMS' adoption of Fast Healthcare Interoperability Resources
   b. The funds provided in the recent $1.9 trillion COVID-19 pandemic relief package
   c. CMS statements suggesting participation will be mandatory for hospitals and health systems
   d. President Biden's promise to move the healthcare industry to more interoperability