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The Joint Commission Expands Data Sources for Telehealth Credentialing by Proxy

The Joint Commission (TJC) has expanded the pool of data sources from which an organization may obtain information when privileging telemedicine providers. However, legal experts caution there are risks when depending on others for credentialing information.

In January, TJC announced it has expanded the pool of data sources from which an organization may obtain information when privileging telemedicine providers, says **John Wallin**, MS, RN, associate director of TJC's standards interpretation group.[1]

The change allows organizations to obtain information from another TJC-accredited or a Medicare-participating organization when credentialing/privileging telemedicine providers. Sharing such information must be in accordance with applicable law/regulation.

"Historically, organizations were limited to obtaining information only from another Joint Commission-accredited organization," Wallin says. "This is the only change since these requirements were first introduced a number of years ago."

Wallin explains hospitals that use telemedicine providers have three options for granting such privileges:

1. Fully credential/privilege following the requirements found in the medical staff chapter.

2. The originating (patient) site uses credentialing information from the distant (provider) site if the distant site is a TJC-accredited or Medicare-participating organization.

3. The originating site may choose to use the credentialing and privileging decision from the distant site to make a final privileging decision. If this option is chosen, the organization must ensure the delineation of privileges granted at the originating site only reflect those services that will be provided to that entity.

Wallin says choosing either option 2 or 3 may be beneficial for these reasons:

• Reduces the credentialing and privileging burden for the originating

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site, especially where there are many licensed independent practitioners who might provide telemedicine services.

• Recognizes the distant site has more relevant information upon which to base its privileging decisions.

• Acknowledges the originating site may have little experience in privileging certain specialties.

"Regardless of which option is chosen, the information must still go through the organization's privileging process, as only the governing body can grant privileges," Wallin notes.

Once privileges have been granted, Wallin notes it is important to understand that all requirements found in the Medical Staff (MS) chapter of the accreditation manual will apply to the telemedicine providers, including the Focused Professional Practice Evaluation and Ongoing Professional Practice Evaluation requirements.

With the expansion and growing popularity of telehealth, any change that makes it easier to credential professionals for telehealth will be welcomed, says **Heather Pfeffer**, claims manager with Beazley, a specialist insurer in Chicago.

However, risk managers should be aware that credentialing by proxy has limits.

"From a risk perspective, one of the concerns is that while it is going to be easier for institutions using those telehealth providers to credential them by proxy, with the original institution responsible for all their credentialing and licensing, there are still licensing and regulatory standards that may be state-specific," Pfeffer says. "The biggest message is don't always rely on that originating institution to have all their T's crossed and their I's dotted. The user needs to make sure the provider is up to snuff with their requirements as well." Pfeffer anticipates a rise in telehealth malpractice claims. Simply because the number of telehealth visits increased so much in the past year, she predicts there will be a corresponding rise in claims. This could represent a liability risk for both hospitals involved in the credentialing by proxy and both facilities involved in the telehealth visit.

"To loop in as many deep pockets as possible, they're going to go after not only the provider and that institution, but also the originating institution for the credentialing and the provider where the patient received the telehealth visit," Pfeffer explains. "If the radiologist was in California but reading a film in Illinois, a plaintiff's attorney is going to loop all of them in."

Where state laws or other credentialing requirements vary, always err on the side of meeting the higher burden.

"This even crosses over into insurance because there can be very policy-specific credentialing requirements among different institutions. Even when you comply with The Joint Commission requirements, you need to always be thinking of any state-specific or insurance-related issues that also come into play," Pfeffer says. "You also have to have a lot of confidence in the other facility, that their providers are being reviewed on a regular basis and in the proper way. You're putting all your faith in the other institution's credentialing process, and you share just as much risk as they do."

Process Will Evolve

Pfeffer suspects the process for vetting the other hospital's

credentialing process will evolve as credentialing by proxy becomes more common.

"You can't ever be too careful. If there is a claim, even though that provider is not physically sitting at your institution, the patient is part of your institution so you're going to have skin in the game," she says. "You may have to ask for an audit, or at least get a breakdown of details of their process, maybe annual or semi-annual reports on providers. Each institution's quality department is going to have to ask themselves what would make them confident, knowing what their own standards are."

Credentialing by proxy will not always be the right choice but can offer some benefits, says **Rose Willis**, JD, healthcare practice group chair at Dickinson Wright in Troy, MI.

"It reduces the workload and can offer some efficiency in terms of moving forward with a particular physician or physician group that you want to include in your telemedicine program," Willis says. "There are downsides, however. You have to be reliant on the other hospital's assurance that the Medicare credentialing requirements have been met, and that results in some Medicare or CMS liability in some situations."

Willis says the worst-case scenario would be hospital B submitting claims for a practitioner who did not meet the Medicare requirements for telehealth because hospital A misrepresented the credentialing, or simply did not create a proper credentialing process. "It works out to a false claims situation or an overpayment and reimbursement obligation to CMS," Willis says.

Willis suggests requesting a description of the credentialing process at the other hospital and comparing it to your own. If the other hospital's process is the same as your own or exceeds it, that suggests an administrator can trust the credentialing by proxy from the other hospital.

If the other hospital's process is inferior to your own in any way, Willis suggests examining each gap and determining whether that step or information is critical. If administration determines that it is not, document that the difference was addressed and why the determination was made that it was not critical.

Can Sharply Reduce Time Needed

The loss of control, and the potential liability that could result, should be considered carefully before using credentialing by proxy, says **Christopher Baratta**, JD, principal with Grant Thornton in Dallas.

COVID-19 rapidly accelerated telehealth use. Now, hospitals are trying to catch up with the credentialing process.

"The good news is that with the expansion of telehealth services that are reimbursable, and with patients and clinicians both wanting it from a flexibility and scheduling perspective, the credentialing time can go down with this option," Baratta says. "The conventional time for credentialing a physician is about 100 days. But with credentialing by proxy, that can go to 30 or 40 [days]. That's a plus, but you're taking on potential liability, and I don't know that all organizations are ready for that."

Quality leaders and those involved in the hospital's own credential process should oversee any effort to credential by proxy, says **David Reitzel**, JD, partner with Grant Thornton in Chicago.

"Having people who understand the process is super critical. The last year has taught [us] that there are ways to operate differently, and this is one of those areas where we can see benefits in streamlining that process," he says. "But the people who understand the traditional, in-house credentialing process should be the ones who drive this and ensure it suits your needs."

Credentialing by proxy should be part of an organization's enterprise risk management (ERM) program, Baratta says. This form of credentialing should be audited at least annually as part of the ERM program to ensure the hospital is doing everything necessary to maintain the integrity of the credentialing process, even when relying on information from another hospital.

Data security is another issue to consider. "Any time you are using telehealth, you need to make sure you are using a reliable platform and you are testing it regularly. As you expand that, you need to make sure that the providers have the requisite requirements from a laptop or PC that complies with your requirements," Reitzel says. "It's going to require some extra commitment from your IT teams to have that type of program for checking. It's like when you bring in third-party vendors because now this is a third-party physician who needs to undergo an IT and security check."

State Requirements Vary

It is important to remember that peer review requirements and protections also vary by state, says **Sue Boisvert**, BSN, MHSA, patient safety risk manager II with The Doctors Company, a malpractice insurer based in Napa, CA. Both organizations

involved in a credentialing by proxy arrangement will need to have a good understanding of how individual provider peer review is conducted, how negative findings will be acted on, and with whom the final responsibility for addressing results lies.

"Telehealth claims are rare, as are negligent credentialing and peer review claims. Widespread telehealth use is a recent phenomenon due to COVID-19 and the subsequent easing of federal and state telehealth regulations," Boisvert says. "More organizations are using telehealth, and it stands to reason that they will also be considering credentialing by proxy. Hence, it is difficult to evaluate what, if any, effect the boom in telehealth utilization and, presumably, credentialing by proxy will have on downstream negligent credentialing and peer review allegations."

Boisvert notes credentialing by proxy is not a requirement; it is permissible. Therefore, the distant site has to be willing to enter into an agreement with the originating site for credentialing purposes.

A formal agreement in writing is required. Both facilities should work with their governing body and medical staff leadership to secure approval and reflect the process in bylaws, rules, and regulations.

If the originating and distant sites are located in different states, close collaboration and clear lines of authority and responsibility will be necessary to ensure all applicable rules and regulations are appropriately addressed.

"The originating site has the responsibility for ensuring the distant site credentialing process is rigorous and should develop a process to evaluate distant site credentialing quality and efficacy, such as review of credentialing policies and procedures or recredentialing a small provider sample and comparing the results," Boisvert says. "It is essential to involve the medical staff leadership in the decision process. Originating site providers will need to have a comfortable and collaborative relationship with the distant providers to facilitate safe and effective patient care."

Helps with New Telehealth Services

Boisvert advises hospitals to conduct a thorough risk analysis that assesses the risks and benefits of relying on credentialing by proxy specific to the organization, the service lines, and the stakeholders.

"If telehealth is a new service for the originating site, using credentialing by proxy provides a good opportunity for the originating site medical staff services to gain competency in the nuances of telehealth credentialing without significant additional workload," she says. "Credentialing by proxy is attractive when adding additional telehealth providers if the specialties are outside the current capacity of the medical staff credentialing process."

Consider, for example, a critical access hospital adding remote pediatric cardiology services. Medical staff services may not have the capacity to credential this specialty, and the medical staff may not have the expertise to determine the appropriateness of privileges requested and to evaluate the quality and efficacy of the clinical care provided. "When an originating site is adding a remote service with multiple providers who will rotate through such services as teleradiology or teleneurology, credentialing by proxy may be more expedient," Boisvert says. "Credentialing is time-consuming and can take months. Credentialing by proxy can speed up the process by several months." ■

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COMING IN FUTURE MONTHS

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New Telehealth Board Supports Credentialing by Proxy

Credentialing by proxy holds promise in streamlining the credentialing process by reducing the hours spent on paperwork and the length of time it takes to privilege telemedicine providers, says **Mandy Bell**, founding board member of the newly formed American Board of Telehealth and innovation officer of Avera eCare.

"This is especially important in rural and community hospitals where resources are limited and there may not be specialty peers to review credentials," she says.

Hospitals contracting for credentialing by proxy work with their medical staff office to help them understand they will receive only minimal information about the providers, as they are relying on the distant site to have completed a full review. They still are required to review this "skinny file" and run provider queries through the National Practitioner Data Bank, Office of Inspector General, and System for Award Management, as applicable.

Hospitals also must complete some internal review of these providers. At a minimum, this review must document and report back to the originating site all adverse events and complaints.

"The main downside of credentialing by proxy is less control of credentialing and privileging by the onsite medical staff. They will not receive a full packet of credentialing information to review, nor Ongoing Professional Practice Evaluation data from the distant site," Bell says. "Medical staff members should buy in and champion this for their facility. Bylaws often need to be revised to allow for this reliance."

The medical staff office needs education on this new process as well as staff time to work through the details with the distant site.

"While privileging by proxy won't work for every healthcare situation, it is a great option for facilities that contract for telemedicine services," Bell says. "Credentialing by proxy can save time and money, ultimately shortening the time to operationalize telemedicine." ■

SOURCE

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Change in Telemedicine Law Sparks Some Concern, But Most Users OK

A change in law related to the use of telemedicine has prompted some concern over when the technology can be used. However, hospitals and physicians are safe to continue with telehealth services under the COVID-19 public health emergency.

As hospitals rapidly expanded the use of telemedicine in the past year, Section 123 of the Consolidated Appropriations Act of 2021, enacted in December, gained attention. It includes a statement that, at first glance, seems to restrict who can receive telehealth services for mental health:

"Payment may not be made under this paragraph for telehealth services furnished by a physician or practitioner to an eligible telehealth individual for purposes of diagnosis, evaluation, or treatment of a mental health disorder unless such physician or practitioner furnishes an item or service in person, without the use of telehealth ..."[1]

The new law states that a practitioner must see the patient in person in the six months before the telehealth service. That caused some hospital leaders to think the law means telehealth can no longer be used for mental health services without seeing the patient in person first.

The law actually should not curtail the way the hospitals currently use telehealth for mental health services, says **Allison Cohen**, JD, shareholder with Baker Donelson in Washington, DC. The new requirement will not apply until after the pandemic public health emergency. "This is not directly applicable to how practitioners are furnishing services during the public health emergency because the originating site restrictions have been lifted until the public health emergency terminates. In response to the COVID-19 pandemic, Congress passed the Coronavirus Preparedness and Response Supplemental Appropriations Act that first authorized removal of some of the statutory restrictions on telemedicine, most importantly temporarily lifting the originating site restrictions on where the beneficiary must be located when receiving telehealth services,"

Cohen explains.[2] "This temporarily allows Medicare to cover telehealth services provided to patients in all areas of the country and in all settings, including their homes, for the duration of the COVID-19 public health emergency."

Additionally, the Consolidated Appropriations Act explicitly states the originating site geographic requirements do not apply "to an eligible telehealth individual for purposes of diagnosis, evaluation, or treatment of a mental health disorder" starting "on or after the first day after the end of the emergency period."[1]

Section 123 also expands Medicare payment for certain mental health services furnished through telehealth. It eliminates statutory geographic originating site requirements that generally require the beneficiary who is receiving the telehealth services to be in certain clinical sites, geographically located in a county outside a metropolitan statistical area, or in a rural Health Professional Shortage Area when receiving the services. Specifically, the legislation authorizes Medicare payment for telehealth services provided for purposes of diagnosis, evaluation, or treatment of a mental health disorder, even if patients are in urban areas or their homes. This, as long as the patient has received an in-person item or service reimbursable by Medicare from the physician or practitioner within six months before receiving the telehealth service.

"This means that Medicare will cover telehealth behavioral health services furnished to established patients of a qualified mental health practitioner without the limitations imposed by statutory geographic originating site requirements even after the waivers tied to the COVID-19 public health emergency are lifted," Cohen says.

Importantly, the changes in the Consolidated Appropriations Act, including the established patient requirement that is a prerequisite to furnish mental health services via telehealth to Medicare beneficiaries outside what are typically Medicare-eligible originating sites, do not take effect until after the COVID-19 public health emergency ends.

"Given that the requirement is inapplicable until after the public health emergency, practitioners who are not currently adhering to it would not be knowingly submitting false claims as long as they otherwise adhere to the Medicare requirements that remain while the COVID-19 waivers and regulatory flexibilities are still in place," Cohen says. ■

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Hospital Sees Quality Improvement with Expanded Telehealth Services

Virginia Mason Franciscan Health in Seattle ramped up its telehealth efforts to facilitate more virtual clinical and urgent care visits — more than 425,000 since March 2020 — with appointments ranging from annual check-ups to pre- and post-surgical check-ins. Notable results include improvements in quality of care and patient satisfaction.

Patients were reluctant to come in for physical visits during the COVID-19 pandemic, so Virginia Mason had to find a way to pivot and maintain connections with patients, says **Francis Mercado**, MD, ambulatory associate chief medical officer with Franciscan Medical Group, part of Virginia Mason Franciscan Health.

"Our mission was to continue delivering high-quality care to our patients. If seeing them in person wasn't possible, we had to find another way. We knew that cancer wasn't taking a break, and diabetes wasn't taking a break," Mercado says. "We were already doing telemedicine services in some departments, with neurology doing telemedicine fairly frequently, for example. But in primary care, we [ran] just a few pilots, and mostly for follow-ups."

The health system had to train a few thousand physicians and staff in a matter of weeks, making sure they were adept at telemedicine and virtual visits.

"It was a little bit of an art form. Folks were used to seeing patients in front of them, doing a physical exam with a stethoscope, and they had to learn how to do similar things without the patient in front of

you," Mercado says. "We were able to achieve a lot of the same quality of care virtually, everything from making sure patients were checking their blood pressure and not having any side effects. It was an invaluable tool for us to continue providing good care to our patients."

Besides facilitating social distancing, virtual visits have been particularly beneficial for patients with barriers to care, including transportation issues, work schedule conflicts, childcare needs, or other barriers.

Good for Behavioral Health

Virtual visits even seemed to offer advantages over in-person visits for some patients. In behavioral health, patients were more comfortable and receptive with telehealth.

"With some types of care, there is a real inertia to starting that care process. A virtual visit eliminated the need to make that drive to a facility and see the behavioral health provider, a visit that might be difficult or prompt anxiety," Mercado says. "Adherence to their appointments and treatment regimens overall improved for behavioral health patients." Mercado concludes telemedicine favorably affects quality of care.

Wellness visits also benefitted from virtual sessions. The ease of telehealth made it possible for clinicians to check in on patients more often to ask whether they were following their diets, treatment plans, exercise regimens, testing schedules, and other care needs.

There is a substantial segment of the patient population that prefers a telehealth visit, especially if the appointment is for something minor such as a medication refill. Others remained concerned about exposure to COVID-19.

"There is still some hesitancy out there, even though we have assured people that we have no shortage of personal protective equipment and have implemented ways to social distance and be safe in our physical environments," Mercado says. "The availability of telehealth makes it possible for us to provide quality care to these patients while accommodating their concerns."

Mercado notes the quality improvements that come from increased use of telehealth do not happen automatically. They are the result of an intentional effort to use the technology in the most effective way.

"It's a different type of art form. We train to be sure we are providing the same level of care, making sure the patients are engaged," Mercado says. "It involves everything from making sure you are maintaining eye contact to eliciting a meaningful response from the patient. There can be a challenge in [optimizing] that interaction by a computer screen and still provid[ing] really good care." ■

SOURCE

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Pennsylvania Hospital Reduces CAUTI Rates with Education, Interventions

A Pennsylvania hospital is reporting good results from a quality improvement initiative aimed at reducing catheter-associated urinary tract infections (CAUTIs) in the ICU.[1]

The University of Pittsburgh Medical Center (UPMC) Williamsport uses a combination of education and practice-related interventions. The ICU reported no CAUTI events during the intervention period, and there also were improvements in the CAUTI incidence rate and documentation compliance.

The project began in 2018, when the hospital reported 13 CAUTIs, says **Holly N. Shadle**, DNP, CRNP, FNP-BC, nurse practitioner in the dermatology department at UPMC Susquehanna, also in Williamsport, PA. UPMC Williamsport and Susquehanna both are part of the UPMC Susquehanna health system.

The 13 CAUTIs were far above the hospital's benchmark of four or fewer each year. Six of the 13 infections occurred in the ICU. Shadle and the rest of the quality improvement team targeted a 30% reduction in CAUTIs, a 20% reduction in urinary catheter days, and a 75% compliance rating in catheter-related documentation in the ICU.

"A lot of the issues came down to things that seemed simple. They weren't always using sterile techniques the correct way, or they were collecting samples improperly or for the wrong reasons," Shadle says. "I started to think that education was an issue. As I dived into the research, I found that in many cases, education was one of the biggest things that had to be addressed."

The research also revealed clinical decision support from the electronic health record (EHR) played a role in reducing infections. Bundled interventions seemed to reduce rates, according to Shadle's research, so she decided to take that approach.

"We had a removal protocol a long time ago, but it was really antiquated and wasn't really even policy anymore. No one was really using it, and a lot of our new nurses didn't even know that it existed," she says. "We decided to focus on the checklist, the education, and the removal protocol. That's how the bundle intervention was created."

Focus on Education

Shadle created a didactic with a PowerPoint and checklists that addressed why catheters are used and the entire process of using them and removing them. After the didactic, staff would demonstrate their skills in inserting and removing catheters, how to obtain a specimen, and everything else they needed to know to properly use catheters and prevent CAUTIs.

The hospital also created an electronic daily checklist in the form of an Excel spreadsheet to monitor catheters. Previously, staff had used paper checklists, but Shadle says they often were not completed, and the hand tally left a lot of room for error.

The Excel spreadsheet made the catheter documentation more uniform, and supervisors could easily check to see what rooms had not entered information.

"We were in the process of getting a new EHR at the time, so we could not build it into the medical record. The Excel spreadsheet was a good second choice for us," Shadle says. "Since then, we have been able to incorporate the documentation and the removal process in to the EHR, which makes it a lot easier for the whole hospital."

The 30% reduction in CAUTIs, a 20% reduction in urinary catheter days, and a 75% compliance rating in catheter-related documentation in the ICU were good results.

Instructing nurses in the proper techniques for catheter insertion and removal was key to that success. Although the nurses were experienced and these techniques were not especially challenging, they still benefited from a refresher course.

"Teaching nurses how to put in catheters doesn't seem like it's that important, but when we went back and looked at how important the education was, we realized how much that kind of basic education has an impact on overall quality and CAUTI rates," Shadle says. "Nurses in the ICU are very well equipped, but sometimes reminding them of how to do these very important foundational skills is such an important thing."

One of the aims of the project was to reduce the total catheter days. However, during the study period, that number went up. Initially, Shadle was disappointed by that. When she and her team studied the utilization ratio and the census, they saw the census had been higher, which meant a higher acuity of patients.

"We had more catheter days, which means more opportunities for infections, but the infection rate actually went down. We thought that was very promising," Shadle says.

The numbers from the ICU are holding steady, and the hospital

continues to hold skill fairs for nurses to refresh their knowledge and techniques with catheters and other care that can result in infections.

"I think it's changing how the whole hospital works," Shadle says. "It's going to be important for other things like ventilator-associated pneumonia. We can see big improvements throughout the hospital." Shadle says the improved results came at little cost, and the education program was not challenging.

"One of the beauties of this project was how simple it was. We weren't rewriting an entire program. We were just reminding people how to use the best procedures," Shadle says. "There was not a lot in direct costs, and it was simple to implement. Sometimes, keeping things simple is important for an effort to have longevity." ■

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Clear Masks Improve Patient Communication, But Surgeons Hesitant

Recent research at a hospital revealed patients preferred clear masks because they allowed them to see the clinician's face, but more than half of surgeons said they were unlikely to use a clear mask.[1]

The research included 200 patient perceptions of surgeon communication and trust in surgeons, plus quantitative assessments and qualitative assessments regarding patient impressions of the surgeon's mask.

Patients completed a survey after encounters with the surgeons that included Clinician and Group Consumer Assessment of Healthcare Providers and Systems questions. The researchers also asked about the patients' perceptions of surgeon empathy, trust, and the patients' impression of the surgeons' masks. "When surgeons wore a clear mask, patients rated their surgeons higher for providing understandable explanations (clear, 95 of 100 [95%] vs. covered, 78 of 100 [78%]; $P < 0.001$), demonstrating empathy (clear, 99 [99%] vs. covered, 85 [85%]; $P < 0.001$), and building trust (clear, 94 [94%] vs. covered, 72 [72%]; $P < 0.001$)," the authors wrote. "Patients preferred clear masks (clear, 100 [100%] vs. covered, 72 [72%]; $P < 0.001$), citing improved surgeon communication and appreciation for visualization of the face."

Deaf patients also like clear masks, as reading facial expressions is an important communication cue. Still, in this study, surgeons were not as fond of the clear masks. Eight of 15 surgeons said they were unlikely to choose the clear mask over a standard mask.

The study was prompted by a surgeon's experience in which a patient asked the surgeon to lower her mask so he could see what she looked like, explains researcher **Ian M. Kratzke**, MD, study co-author and a general surgery resident at the University of North Carolina at Chapel Hill. With COVID-19, clinicians are wearing masks with every patient encounter rather than just in an operating room or other treatment scenario.

"[The surgeon] had done this big operation, and [the patient] didn't even know what she looked like. That kind of struck her as concerning that

she didn't have even that basic level of connection with her patient," Kratzke says. "We found clear masks and did this randomized control trial to see what patients were feeling about the patient perceptions of the surgeons."

Kratzke and colleagues expected patients to show some preference for clear masks because they allowed for better communication, but they were surprised at how much patients preferred the clear masks.

"For the surgeons wearing clear masks, about 95 of the 100 patients responded favorably on all the questions. With the covered masks, some of the responses dipped in to the 70s and 80s for favorability," Kratzke says. "For questions about things like whether the surgeon explained things well, the covered mask may have made it difficult for patients to hear. But with questions like whether you trust your surgeon, we saw a difference there, too. That suggests an influence on how connections are formed."

Kratzke and colleagues concluded that the increased use of masks is interfering with the relationship between clinicians and patients. The use of clear masks is a possible solution, although Kratzke and colleagues did not study the effectiveness of clear masks vs. covered or the benefits of any particular type of clear mask.

This research involved new patients with surgeons they had never met before, but Kratzke says there could be implications for other patient interactions in hospitals. With everyone in healthcare facilities wearing masks all the time, patients may feel less connection to clinicians. That could theoretically affect patient satisfaction scores, even if patients do not realize the masks are why they feel less connection to their caregivers.

Kratzke and colleagues intend to study the issue further, perhaps focusing on why patients trust the decisions of their surgeons less when their faces are covered. They will conduct interviews with patients to obtain more detailed responses than were possible with the survey. They also may study different settings for the physician and patient encounters. "The bigger picture is making sure that as providers, when we are interacting with patients, that we're cognizant that the mask may be making it more difficult to form that relationship," Kratzke says. "We may need to take extra time explaining things to make sure the patient understands. We have to recognize that the mask can be a barrier to our relationships. It's on the healthcare industry to find a way to address that." ■

REFERENCE

1. Kratzke IM, Rosenbaum ME, Cox C, et al. Effect of clear vs. standard covered masks on communication with patients during surgical clinic encounters: A randomized clinical trial. *JAMA Surg* 2021;156:372-378.

SOURCE

- **Ian M. Kratzke**, MD, UNC PGY-4 General Surgery Resident, University of North Carolina at Chapel Hill. Email: ian.kratzke@unchealth.unc.edu.

Hospital Attains QCDR Status, Improves Quality Metrics

Alteon Health, a physician-owned and physician-led acute care medical group based in Germantown, MD, recently became a Qualified Clinical Data Registry (QCDR), a Centers for Medicare & Medicaid Services (CMS)-approved vendor that is in the business of improving healthcare quality. QCDRs may include specialty societies, regional health collaboratives, large health systems,

or software vendors working in collaboration with one of these medical entities.[1]

"One of the ways QCDRs can help to improve the quality of care patients receive is by collecting clinical data from clinicians and reporting this data to CMS on their behalf for purposes of MIPS [Merit-based Incentive Payment System]. QCDR submission differs from qualified registry submission in that QCDRs can submit non-MIPS measures, called QCDR measures, as well as MIPS quality measures," CMS says.[1]

The QCDR status allows the medical group to develop unique performance measures with more granularity and more significance to the profession than traditional MIPS measures, says **Marvin Gallo, Sr.**, program manager of value-based programs with Alteon Health, which specializes in emergency medicine. The practice was assisted by Healthmonix in Malvern, PA, which provides value-based care analytics and other services.

The project began in 2018, with the practice looking for quality metrics that would be more useful for improving care.

"One of the things that stood out for me was the fact that quality metrics that are specific to emergency are really topped out and may not be as relevant anymore. They have not been updated in a long time," Gallo says. "If we really wanted to succeed, there were only a couple things we could do. The one we decided on in early 2020 was to become our own Qualified Clinical Data Registry."

To qualify as a QCDR, the applicant must have substantial experience with managing data and creating reports, as well as specialty-specific expertise.

"CMS likes to only give QCDR status to organizations that demonstrate they truly have the expertise, so we involved a group from within Alteon. We have over 1,700 providers, and we selected 20 providers who truly stood out for the quality work they've done with our hospital partners," Gallo says. "The effort involved everyone from our chief medical officer, our chief performance officer, all the way down to our providers who are working on the front lines."

The project took 90 days, which Gallo says is relatively fast, but Alteon already had in place much of the quality improvement structure and data-gathering resources.

"We were already working in the quality space, so really all we needed to do was a deeper selection and create a framework to be more specific for the QCDR requirements," he says.

A challenge was helping individuals understand what the QCDR application process involved and how it affects the organization.

"A lot of providers are not really privy to the nuances concerning the quality payment program. They might be more focused on their patient care and really taking care of the patient, rather than understanding how documentation practices or prescription habits may affect their bottom line," Gallo says. "That was the biggest lift for us. We kicked off a training campaign for all of our providers. Thankfully, our leaders are well-versed in value-based care and the quality payment program."

Hospitals could follow the same path to acquiring QCDR status, Gallo says, which would allow them to create quality metrics that might be more specific to the type of care they provide.

"I would encourage other organizations to look at those specific measures rather than focusing totally on the CMS MIPS measures," he says. "It would allow them to fill the gaps more easily." ■

REFERENCE

1. Centers for Medicare & Medicaid Services. A brief overview of Qualified Clinical Data Registries (QCDRs). https://go.cms.gov/2QzyP3A

SOURCE

- **Marvin Gallo, Sr.**, Program Manager, Value-Based Programs, Alteon Health, Germantown, MD. Email: marvin.gallo@alteonhealth.com.

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 was the recent change to The Joint Commission rules regarding telehealth credentialing?**

   a. It has expanded the pool of data sources from which an organization may obtain information when privileging telemedicine providers.
   b. It has restricted the pool of data sources from which an organization may obtain information when privileging telemedicine providers.
   c. It relaxed the requirements for telehealth credentialing.
   d. It strengthened the requirements for telehealth credentialing.

2. **What is one of the risks of credentialing by proxy?**

   a. One must trust that the other institution's credentialing program is adequate.
   b. One must agree to indemnify the other institution for any liability related to credentialing.
   c. Clinicians cannot be held liable for issues related to credentialing.
   d. Clinicians can refer all liability related to credentialing to the secondary facility.

3. **When Virginia Mason Franciscan Health in Seattle ramped up its telehealth efforts to facilitate more virtual clinical and urgent care visits, which specialty seemed to benefit most?**

   a. Emergency medicine
   b. Behavioral health
   c. Neurology
   d. Oncology

4. **In the project that reduced catheter-associated urinary tract infections (CAUTIs) in the ICU at UPMC Williamsport, what was the percentage reduction in CAUTIs during the study period?**

   a. 10%
   b. 20%
   c. 30%
   d. 40%