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Latest CMS Star Ratings Include Welcome Changes

When CMS recently released its annual Hospital Quality Star Ratings, there were significant changes from previous ratings. Most quality leaders welcome the changes as long-needed improvements that will make the data more meaningful.

Hospital leaders had criticized previous ratings because they believed the methodology used to create them was flawed and produced inconsistent results that made the ratings misleading and not useful to consumers.

CMS rated 4,586 hospitals, with 13.5% receiving five stars, 988 receiving four stars, 1,018 receiving three stars, 690 receiving two stars, and 204 receiving one star. Sufficient data were unavailable for 1,181 hospitals.[1]

More Streamlined Approach

This year's report represents a pivot to a much more streamlined, straightforward, and predictive weighting system of the measures that go into the ratings, says **Beth Godsey**, MBA, MSPA, senior vice president of data science and methodology with Vizient in Chicago. Vizient was among many groups that provided input to CMS on how to improve the star ratings.

Godsey describes two major changes in the recent release:

• The discontinuation of latent variable modeling in the ranking methodology. This modeling created unpredictable measure weights that were difficult to interpret. CMS replaced that methodology with an equally weighted measure approach.

• New cohorts for providers in the rankings. Previously, CMS treated all hospitals as if they were equal in offerings, patients, and services. The new approach groups hospitals by the number of measure groups.

Latent variable modeling made it challenging for organizations to understand how they were evaluated, which makes it difficult to drive performance improvement.

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"It's challenging when you're not exactly clear how individual measures are weighted. In previous releases, it was difficult for organizations to understand the methodology," Godsey says. "In our conversations with CMS, we suggested an approach that allowed for a much more clear and simplistic way of assessing performance and weighting the measures, and they adopted that approach. Several organizations had supported a similar mindset of keeping it simple and making the process clear for healthcare organizations."

The new approach addresses some concerns about measures within the measure categories. The importance of measures would fluctuate with each star rating release, sometimes changing substantially from one year's release to the next.

"Hospital leaders were scratching their heads trying to figure out what changed and why this is less important than last year and whether they should change their priorities," Godsey says. "Now, all the measures within one domain are all equally weighted. Therefore, organizations have an understanding that they will see the same weighting next year. That gives organizations a bit of clarity and more predictability in what they will see in the methodological structure."

Those improvements should help quality leaders drive change in their organizations because they will have a better understanding of what leads to higher ratings. Hospital quality professionals are responding positively to the changes.

Hospital Cohorts Created

Godsey believes the creation of hospital cohorts is a major step in the right direction. Many groups had urged CMS to take this step to make the ratings more meaningful.

"There are still some opportunities in this space, but it does begin to create more of a like hospital comparison so that hospitals can compare themselves to similar facilities," Godsey says. "There are still some gaps that we think CMS should consider exploring. Some of

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the details involve whether you offer transplant services, cardiothoracic services, or whether you have high trauma volume or high levels of acuity in certain conditions or specialties."

The current methodology does not consider those factors. "While there is a step forward in their approach to creating cohorts of organizations based on some level of similarity, we think this level of additional refinement would be very value-added in the future," Godsey says. "We're certainly excited to see the latent variable modeling removed from the measure weighting. A more streamlined, predictive, transparent way of scoring measures will provide clarity and give hospitals more insight into where they have opportunities to improve, as well as where they're doing well."

While the cohorts are an improvement, the ability to see a true apples-to-apples comparison remains limited by how a hospital must meet minimum patient volume for some measures to be reported.

"The measures you have in a core domain with the star ratings program determine how you are grouped with hospitals that have similar numbers of measure weights," Godsey explains. "What has changed in that space is that organizations may see more fluctuation than in the past because they used to be evaluated with everybody. Now, they are evaluated within more of a like cohort of organizations. For some organizations that have a smaller volume, such as critical access hospitals or a specialty hospital that focuses only on orthopedics, their score may have fluctuated more than in previous releases. Their volumes in those specific measures are only reflective of only a small number of patients."

Hospitals Dropped in Ratings

Godsey has heard from hospital quality leaders wondering why they lost a star or two in the ratings this year. She says it often is explained by the change in the cohort methodology and the weights associated with some measures. Godsey suggests CMS explore defining cohorts that are based more on the types of services provided by the organization and patient volume.

"That speaks more clearly to patients and the community. If a patient is looking for an organization that has services they are looking for, they can specifically go to that cohort and evaluate the hospital within that cohort," she says. "It adds a bit more refinement to the cohorts that we think CMS certainly could explore."

Godsey also notes the star ratings remain hindered by the lack of contemporary data to determine the rankings. The lag between when data are reported and when it is made public can be two or three years. That means hospitals that are improving their quality metrics may not see that reported for years, with consumers basing decisions on where the hospital was a long time ago rather than today.

"[Hospitals] really need to know how they're doing now, not in the past. They would like their performance reported publicly to be reflective of today," Godsey says.

Changes Help Quality Leaders

The improved ratings methodology should bring some comfort to quality improvement leaders because they at least have a better understanding of how their performance will be evaluated now and in the future. There should be less anxiety about the methodology and the resulting score changes.

"That has given [administrators] some sigh of relief because they don't have to spend the time, effort, and energy to try to explain a more complicated algorithm to their board of directors or their C-suite executives," Godsey says. "Knowing how they are going to be measured, organizations can double down and address their opportunities for

improvement, showing staff how they are going to be assessed by CMS."

Different Impacts from Changes

The new methodology has resulted in some troubling star ratings for some hospitals, says **Kristen Geissler**, managing director with Berkeley Research Group in Baltimore. For instance, Geissler is working with hospitals that have gone from a five-star to a three-star rating.

"There were a lot of changes, but not all of them have the same impact as the others," Geissler says. "The change from latent variable modeling to measure domains has had the largest impact on the overall scores. The peer grouping helps a very small hospital not be compared to a teaching hospital. But for the average-size hospitals, that has not had as much impact on the overall scores."

Geissler says the changes promise more continuity and predictability, but it is unlikely CMS will not tinker more with the measures and methodology. Each release of the star ratings comes with the retirement of some measures and the addition of new measures.

"If a hospital was doing particularly well in measures that were retired, that could be hurtful to them. Conversely, if they were doing poorly on measures that are added, that could hurt them in that way," Geissler says. "That's always a potential impact from the updates on the star ratings."

Hospitals should evaluate which measures are eroding year after year. Study the individual measures within the domain and the overall score in that domain.

"Changing from the latent variable modeling to the simple average has allowed hospitals to do more evaluation of themselves. Before, it was so black-boxed that you couldn't understand the impact of the individual measures," Geissler says.

Still Need Fresh Data

The lack of contemporary data still confounds any effort to respond to peer group comparisons. Geissler does not expect any improvement soon with making the data more contemporaneous.

"I think it will be even more challenging in the next release because of the COVID-19 time frame. CMS has some proposals for suppressing data from the COVID-19 time frame. Though that is not final yet, we can make some good conclusions about the effect on the five star measures from what CMS has proposed," Geissler says. "We know January through June of 2020 data likely will not be used. The July through December of 2020 data is still in question."

With much of the current star ratings based on 2019 data, Geissler says the lack of 2020 data will create a lag in information available for the next round of ratings. "The main takeaway for hospitals today is the need to understand their performance today in all of the CMS measures. The patients they are treating today impact the five star measures for two and three years out. It is critical to understand current methodology and their trends over the past several years," Geissler says. "Understanding that now will help your ... performance for the next several years." ■

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Star Ratings Use Standardized Weighting of Measures

CMS explains the new 2021 methodology for its Hospital Quality Star Ratings uses "a simple average of measure scores to calculate measure group scores and Z-score standardization to standardize measure group scores" in five measure groups.[1]

The measure groups are safety of care (weighted at 22%), mortality (22%), patient experience (22%), readmission (22%), and timely and effective care (12%). CMS uses these groups to calculate a weighted average. The agency combines group scores into one facility summary score. When a hospital is missing a measure group, CMS redistributes weights proportionally among the other groups.

Then, facilities are assigned to one of three peer groups. CMS determines this assignment by how many measure groups the hospital

reported (three, four, or five). Leaders must report at least three measures within three measure groups to qualify for a star rating.

"Finally, hospitals are assigned to star ratings within each peer group using k-means clustering so that summary scores in one star rating category are more similar to each other and more different than summary scores in other star rating categories," CMS explains.[1] ■

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NPDB Reporting Protected by Law in Some Cases, Gray Areas Problematic

Hospitals enjoy substantial protection when reporting physicians to the National Practitioner Data Bank (NPDB) in many situations, with laws protecting against retaliatory lawsuits as long as the hospital was required to report and followed appropriate protocols.

However, there are situations in which reporting to the NPDB is not required but might still be the right thing to do when leaders are concerned about a clinician's threat to patient safety. In those circumstances, the protection against liability is not ironclad.

The NPDB requires facilities to report several pieces of information involving healthcare practitioners, healthcare entities, providers, and suppliers, including but not limited to: medical malpractice payments, federal and state licensure and certification actions, adverse clinical privileges actions, and adverse professional society membership actions.[1]

Protection for Required Reporting

A hospital or other healthcare organization reporting information that falls into those categories is protected by law as long as the reported information is accurate, says **Christopher J. Kutner**, JD, partner with Rivkin Radler in Uniondale, NY.

"In the matters in which I've been involved, the hospital or surgery center had no choice but to report. If they don't report something that is reportable, they could be subject to a civil fine by the OIG," Kutner says. "If someone is vindictive and reports something to the NPDB that they know is not true, they could be subject to a civil penalty. As long as the person reporting believes the information is true, there is immunity from liability. You can't be sued if you in good faith reported a doctor with information you reasonably believed to be accurate."

Healthcare organizations are only required to report actions taken against physicians and dentists, but they may report clinical privileges actions taken against other types of practitioners. The NPDB reports that the most commonly reported profession to the NPDB is actually

nurses, not physicians.[2] While there is substantial protection when reporting physicians to the NPDB, the situation is not as clear when reporting nurses, explains **Sarah E. Coyne**, JD, partner with Quarles & Brady in Madison, WI.

"It is not discretionary whether hospitals report to the data bank, although there are some circumstances where it is a complicated analysis whether the reporting obligation has been triggered," Coyne says. "A physician is unlikely to have a viable successful cause of action. This would not be the case for non-physician providers who are reported, as they are not a mandatory report, and there would not be associated immunity."

If it is clear reporting is required, the physician would not have a viable claim against the hospital for reporting, Coyne says. A report is mandatory when a hospital has taken adverse action on a physician's clinical privileges during a professional review of his or her competence or conduct. Specifically, when the health or welfare of a patient could have been affected, when clinical privileges are restricted for more than 30 days, or when a physician surrenders his or her privileges to avoid an investigation or the consequences of it.

"It is conceivable that a physician would have a viable suit for claiming that there was no basis to limit the privileges in the first place or in a complicated reporting situation for deciding that it is reportable. However, hospitals reporting in good faith, and limiting privileges in good faith, have immunity under the federal Health Care Quality Improvement Act [HCQIA]," Coyne says. "While the physician could bring the lawsuit, the hospital would have a very solid affirmative defense." Hospitals might hesitate to report to the NPDB if there is reason to doubt the mandatory reporting has been triggered. An NPDB report can affect a clinician for the rest of his or her career, and the threat of a lawsuit for a report that did not meet NPDB reporting requirements is a big deterrent.

Despite the protections that come with NPDB reporting, Kutner still advises caution. A lawsuit filed by a disgruntled clinician will require time and money, even if a court eventually dismissed the suit. Kutner advises obtaining an opinion from the NPDB before making the report. This opinion could discourage a clinician from claiming the report was improper.

"I worked with a surgery center that had to report a surgeon. We were very cautious and careful because we didn't want to be sued, even if the suit could be dismissed and [was] without merit," Kutner says. "We wanted to do it right. We contacted the NPDB, and the individual there could not have been more helpful and precise with her directions and assurance that we were doing the right thing. The NPDB will walk you through the response so that you have that additional defense for the reporter, showing that you did due diligence."

Kutner notes hospitals also are required to query the NPDB in some situations, aside from reporting.

Gray Areas Can Raise Questions

The situations involving a clear requirement to report (e.g., a malpractice settlement or a hospital investigation) are the easy ones to handle. But there are other scenarios that are not as clear.

"The gray areas include things like NPDB's category of 'adverse society membership action.' What does that entail?" Kutner asks. "Or 'negative actions against a provider within an institution?' Those are gray areas, and nobody wants to blackball a provider if you don't have to."

Typically, hospitals do all they can to allow the provider to move on without a report to the NPDB when there is room for doubt, Kutner says. That approach has been criticized in conjunction with high-profile cases in which a physician moved from one hospital and continued harming patients because the facilities allowed him or her to leave without reporting to the NPDB.

That was the case with Christopher Duntsch, MD, PhD, who practiced medicine in Dallas for two years and operated on 37 patients. Thirty-three were injured. At least two hospitals quietly ended Duntsch's privileges but did not report him to the NPDB. Duntsch became the first doctor in the United States to be sentenced to life in prison for his practice of medicine.[3] His case may be an extreme example of what happens when hospitals choose not to report to the NPDB.

"When it comes to issues of clinical competence, I think there is more of an inclination to report. The more common cases in which hospitals struggle and decide not to report is when the surgeon is just obnoxious or demeaning to staff," Kutner says. "They don't want to keep him around, but it doesn't impact his clinical abilities. But once there are questions of clinical competence and patient safety, I think you'll find that hospitals get on the phone with the NPDB, make sure they are on solid ground, and err on the side of reporting."

With physicians, it is a common misunderstanding to think the professional can leave while under

investigation and thereby avoid a NPDB report. Kutner recalls one case in which a surgeon was under investigation by a hospital and tried that.

"Unfortunately, he was not counseled well, and he left after he was under investigation, and he knew that. He resigned his privileges saying, 'I've had enough, and I'm out of here,'" Kutner recalls. "The hospital had no choice in the matter and had to report that this physician resigned while he was under an investigation."

Protocols for reporting to the NPDB and how investigations will be conducted should be included in the hospital's bylaws, says **Kathy H. Butler**, JD, officer with Greensfelder, Hemker & Gale in St. Louis. All processes leading up to an NPDB report should follow a prescribed process, including a time to allow the clinician to respond to allegations.

When a hospital is concerned but does not conduct a formal investigation that would trigger a report to the NPDB — and the physician resigns — there can be a question of whether the resignation itself is reportable. Butler says if the clinician clearly resigned to avoid an investigation, that is reportable. However, it can be hard to prove the intent of the resignation.

"It's subject to interpretation. If a physician resigns before an investigation is initiated, it can be argued that the resignation was not an attempt to avoid the investigation," Butler says. "But the data bank recently broadened its definition of an investigation. That makes those resignations harder to ignore if you're going to strictly follow the rules."

Another situation that raises questions is when a physician employment agreement ends and the privileges automatically terminate. This termination of privileges is not reportable to the NPDB because it is automatic, not the result of any affirmative action against the physician.

"Similarly, if you lose your privileges because you lost your insurance, and you're automatically terminated because that is specified in the bylaws, that is not reportable," Butler says.

Hospitals also find it difficult when deciding whether to report a non-physician for matters that would be required reporting with physicians.

According to Butler, in many of those situations, there will be state licensing board requirements to report the clinician.

How can administrators protect themselves when they need to take action with a clinician's performance?

"It sounds cliché, but the most important thing is to follow the process specified in the medical staff bylaws, or other related policy, to the letter. The issue is that very often, these situations are convoluted, and the bylaws do not contemplate the specific decisions facing medical staff leadership," Coyne says. "In these situations, it is vital to involve legal counsel to assist in crafting a strategy that will be consistent with and defensible under the bylaws."

Experienced legal counsel also can suggest how to manage the collateral consequences, such as division and conflict among the medical staff, disclosure of information, messaging regarding departures, or changes in privileging status. Counsel can recommend when to discuss these matters in a closed session and the appropriate level of documentation throughout the process.

Also, hospital medical staff always should act in the best interest of patients. That should be the driving force behind any actions. Regardless of whether there is an NPDB report should not drive the process or decisions.

"The NPDB is viewed as a hammer by many physicians, a potential threat to their careers. Certainly, there are significant concerns and consequences for any physician who is reported," Coyne says. "It is important, however, for hospital medical staff to remember that the NPDB is supposed to be about protecting patients, not targeting physicians."

Coyne recommends these best practices:

• If the corrective action section of the bylaws and fair hearing plan have not been updated recently, direct experienced legal counsel to review them.

• With employed physicians, evaluate at the outset whether this is an administrative process through employment vs. a medical staff professional review action under the bylaws.

• Resist the temptation to accept the facts at face value or as they first appear. A reasonable factual inquiry is one of the requirements for immunity. If at all in doubt, convene an investigative committee to carefully examine the facts.

• Be aware of the arc. In reviewing professional competence or conduct, there is a natural tendency to be outraged and aggressive initially. Then, over time, one might come to believe the entire thing is an overreaction, that leadership is making a mountain out of a molehill. "This is a very normal human response to the intensity of the proceedings, but it should not rule the day," Coyne says.

• Ensure the clinician knows the entire basis of the problem. Communication with the clinician is not only the right thing to do from a fairness perspective, it is essential to a proper and compliant process — and to immunity. Make sure the clinician receives appropriate information and can tell his or her side of the story. ■

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When Hospitals Must Query the NPDB

Hospitals might face quandaries over when they must report clinicians to the National Practitioner Data Bank (NPDB), but it is important to remember queries to the NPDB also are required.

Under Title IV of the Health Care Quality Improvement Act, the law that governs NPDB reporting and protections from liability, hospitals must query the NPDB when physicians, dentists, and other healthcare practitioners apply for medical staff appointment.[1] The same requirement applies when they seek clinical privileges. Additionally, hospitals must query the NPDB every two years on physicians, dentists, and other healthcare practitioners who are part of the medical staff or who hold privileges.

Failing to follow those requirements puts the hospital at risk of liability, says **Christopher J. Kutner**, JD, partner with Rivkin Radler in Uniondale, NY.

"One reason hospitals can be reluctant to report to the data bank is that they may be afraid to acknowledge that they hired or provided privileges to somebody who really shouldn't have had them," he says. "When someone applies for initial privileges at a hospital, the hospital must inquire with the data bank whether they have any history that would prevent granting them privileges. In addition, if a doctor already has privileges and wants to expand on those privileges and do something else, that also triggers the hospital to query the data bank and find out if there is anything in this person's past that would require us to decline this expansion on privileges."

Failure to query the NPDB when required can give a plaintiff attorney an opening to claim the hospital is responsible for a patient injury because the physician should not have been privileged.

"If a provider commits malpractice, there is a lawsuit, and the plaintiff's attorney finds out that this doctor had a history — and also finds out that that the hospital did not query the data bank before granting privileges — there's another pocket that can be picked for purposes of settlement," Kutner says. "Hospitals and surgery centers are very cautious about this, putting it on autopilot to check the data bank at the appropriate times. That is good practice." ■

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Health Information Exchange Improves Quality of Data

Healthcare quality researchers have demonstrated a single electronic health record (EHR) may not be a complete source of relevant clinical information.

The authors of a recent study suggested adding standards-based data from a health information exchange (HIE) can improve quality of care.

"Including longitudinal data often results in performance rate improvements, although any change can be viewed as a more complete measure calculation that includes all relevant data," the researchers wrote. "Reviewing these improvements and interoperability's role in quality calculation contextualizes the impact to efficient care, patient safety, and value-based payment programs."[1]

More Data Are Better

The research was aimed at proving what seemed logically true, that accessing more data would improve quality metrics, explains **Laura K. McCrary**, executive director of the Kansas Health Information Network in Topeka.

The research involved data from 53 institutions, looking at 14 ambulatory quality measures, says **John D'Amore**, MS, strategic advisor and board director with Diameter Health, a medical data company in Farmington, CT. All the quality measures concerned prevention or outcomes over one year, such as managing blood pressure or diabetes.

Many measures are used in value-based programs nationally, including HEDIS measures that affect health plans. They also are electronic clinical quality measures (eCQMs) that are used as part of reporting for the Merit-based Incentive Payment System, which is how Medicare handles value-based purchasing.

"We looked at how often a measure changed when you added changes from a health information exchange. We know that patients see many doctors in a year and we documented that as part of this research as well," D'Amore says. "Particularly older and more complex patients see many physicians in a year, possibly going to the hospital, urgent care, specialists, all sorts of healthcare providers. These organizations may use different EHRs, or the same brand of an EHR but different instances of the product, and the information is not integrated between them."

D'Amore and McCrary, along with other research colleagues, sampled patients randomly, determining how a quality measure would be calculated based on only the information from an EHR, and then again on how the measure would be calculated using the EHR and additional information from an HIE.

Many Changes with HIE

Researchers found that across all 14 quality measures, 15% of the calculations changed when adding data from the HIE.

"That is a large sum. It quantified something we suspected because an individual EHR does not have all the data, all the time, for all the patients," D'Amore says. "It has a lot of information for the episode of care that provider recorded, but it really may not have that full longitudinal perspective of care provided at other areas of service. That 15% change across the board often resulted in improvements in individual quality measures."

The number of changes was significant and could seriously affect value-based care programs that are based on quality measurement. The results were validated across not just one EHR or one site but 53 institutions, D'Amore notes, with all the major EHRs represented. "We think it's a pretty powerful finding," he says.

D'Amore says the research speaks to the importance of longitudinal data collection before trying to calculate a quality measure. "If you don't get all the data, you can often get the wrong quality measurement," he says.

McCrary says payors have long known accurate quality metrics depend on looking at all the available data sources for patient care. However, in the past, it was difficult for hospitals and health systems to integrate information from many sources.

"From a technology perspective, or even manually, there just wasn't any way for a hospital, a health system, or an ambulatory practice to gather all the information about their patients from the different locations where they received care and then compute the quality measures in at least a fairly easy and not-too-burdensome manner," McCrary says. "Being able to compute the quality measures off the data already gathered by the HIE seemed to be a really simple way to

help our provider community to compute quality measures and get much more accurate results than what they were getting out of their own EHR system."

More important than value-based care revenue, according to McCrary, is how the revised calculation of quality metrics will allow healthcare organizations to provide better care to patients.

One quality measure related to patient safety, high-risk medication use in older adults, actually devolved when adding the HIE data. Still, McCrary says that can be useful to know if the EHR-only data were providing an overly positive assessment.

In one patient record studied, a physician prescribed a high-risk medication to the patient without knowing another physician at a different location also had prescribed a high-risk medication.

"That is an example of how when you get more information, you can provide better care to the patient," McCrary says.

As useful as EHRs can be, it is important to remember they do not provide a complete picture of the patient's care. "Your electronic health record doesn't necessarily have all the data on people who are going to seek care at multiple institutions, which is the majority of your patients," D'Amore says. "Once you start from that position ... it creates pressure to ask what are the means by which I can get more comprehensive, longitudinal data on this patient."

Most Can Access HIE

D'Amore notes the opportunity to engage with an HIE will vary by location and other factors. Another approach is to take full advantage of an EHR to exchange data readily with others. "This isn't something that is theoretical or something that needs to be waited on for five or 10 years for the technology to catch up. The EHR standards that have been promulgated and the $40 million spent on meaningful use in the past decade actually allow for this to happen today," D'Amore says.

A decade ago, healthcare leaders assumed quality metrics always should be derived from the EHR. That have may been a legitimate goal at the time, considering how institutions could share data. Now, this latest research confirms the local EHR alone is insufficient for painting a full picture of the patient and the patient's experience.

Most healthcare organizations across the country can participate in an HIE. "In many of those cases, the data from the HIE is coming directly into the patient's chart," McCrary says.

"When the query is done to the HIE, the data is brought back and it's available to the clinician right there. For many hospitals and health systems, we're starting to see a pretty heavy utilization of that data as it becomes more important to know all the diagnoses of the patient, to know all the procedures the patient had, to know all the lab results and allergies."

Questioning Value-Based Measures

The research also calls into question the accuracy of the quality measures used in value-based programs, according to McCrary. When reimbursement is tied to a metric that has been demonstrated to be inaccurate, the efficacy of that model for rewarding or incentivizing providers comes into question. "We've been financially incentivizing based on metrics that are not accurate. I would hope the provider community would recognize this and make some sort of statement that it is important to look more broadly at the care sites the patient has been at before you evaluate the quality of an individual doctor," McCrary says. "Instead, we're evaluating the ability of the hospital or the physician to go out and get data from other doctors to put in their EHR system. Consequently, we're not evaluating whether the quality of care provided to the patient is the best."

D'Amore agrees, saying that when all is done, the quality metric should reflect the quality of care provided to the patient, not the institution's data-gathering efforts.

"Everyone talks about how to move away from fee-for-service and toward value-based care. This is the fundamental thing, the pillar," D'Amore says. "If you can't measure quality accurately, robustly, rigorously, and with high confidence, you can't transition to value-based care because nobody has confidence in what you're actually doing." ■

REFERENCE

1. D'Amore JD, McCrary LK, Denson J, et al. Clinical data sharing improves quality measurement and patient safety. *J Am Med Inform Assoc* 2021; Mar 13;ocab039. doi: 10.1093/jamia/ocab039. [Online ahead of print]. https://bit.ly/3v9W2ry

SOURCES

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- **Laura K. McCrary**, Executive Director, Kansas Health Information Network, Topeka. Email: lmccrary@khinonline.org.

Leapfrog Group Focusing on Health Equity as Quality Metric

The Leapfrog Group is making changes to the 2021 Leapfrog Hospital Survey and Leapfrog Ambulatory Surgery Center (ASC) Survey to address healthcare equity and ethical billing practices. The findings on the new questions will not be scored or publicly reported by facility for the first year.

Leapfrog also is changing some rules for submitting 2021 surveys, intended to provide flexibility to healthcare organizations still struggling with COVID-19 cases. The changes include offering a 30-day submission deadline extension, smaller samples for some metrics, and different reporting periods for certain survey sections.

There also will be a new section on Nurse Staffing and Skill Level, along with updates to the Hand Hygiene section and the Computerized Physician Order Entry (CPOE) tool.[1]

With the new question on healthcare equity, Leapfrog is encouraging hospitals to analyze their quality and safety data by race, ethnicity, or language, says **Leah Binder**, president and CEO of The Leapfrog Group. If they do, Leapfrog asks what they do with that information and any gaps that are discovered.

"This is the first year that we have asked this set of questions. Whenever we ask something new on the survey, we don't report by facility on that metric," Binder says. "But next year we will because we think the issue of healthcare disparities is urgent. We've seen this year a high level of awareness from both inside and outside of healthcare about what a problem this is."

Leapfrog's overall goal is to study what could change in the delivery of healthcare services to improve outcomes. The revised survey tries to determine what is causing disparities. Leapfrog is asking the same question of ASCs, Binder says, because the problem is ubiquitous.

"There may be racism, unequal treatment, unconscious bias, or other forces at work within an organization that may be causing care to be delivered in different ways," Binder says. "We do know there is enough research to suggest there is a problem, and we can address it. We want health systems to start identifying this problem and look for models to address it."

Binder says Leapfrog is learning about healthcare equity disparities along with hospitals and health systems. She does not suggest there is any simple or quick remedy.

"But we all have to learn really fast. This is outrageous, and we need to solve this problem," Binder says. "We are asking hospitals what they have been doing to address it, and we hope they have been addressing it. This isn't a new phenomenon, but we're going to find out who's addressing it, who's doing a good job of that, and use that information as practice insights to share with the rest of the healthcare system." ■

REFERENCE

1. The Leapfrog Group. Summary of changes to the 2021 Leapfrog Hospital Survey & responses to public comments. Published March 8, 2021. https://bit.ly/2SLVsm7

SOURCE

- **Leah Binder**, President and CEO, The Leapfrog Group, Washington, DC. Phone: (202) 292-6713.

Report: U.S. Nurse Workforce to Play Pivotal Role Over Next Decade

The U.S. nurse workforce must become larger, more diverse, better educated, and properly resourced over the next decade to adequately handle several looming challenges, according to a recent report.[1]

The report authors said stronger education programs, more diversity and inclusion, protection of mental well-being, and expanded practice authority are keys to help nurses respond to what lies ahead: caring for a rapidly aging population and responding to the ever-growing number of natural disasters and public health emergencies.

Nurses also will be vital in snuffing out structural inequities that cause poor health, according to the report authors. They paid special attention to social determinants of health, nonmedical factors like access to transportation, quality food, and good-paying jobs that affect physical and mental well-being. ■

REFERENCE

1. National Academies of Sciences, Engineering, and Medicine. *The Future of Nursing 2020-2030: Charting a Path to Achieve Health Equity*. 2021. https://bit.ly/3cbIV1X

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CE QUESTIONS

1. **What is one change in the latest Hospital Quality Star Ratings from CMS?**

   a. The discontinuation of latent variable modeling in the ranking methodology
   b. The addition of latent variable modeling in the ranking methodology
   c. The elimination of cohorts for providers in the rankings
   d. The inclusion of data less than six months old

2. **Which is not a measure group in the Hospital Quality Star Ratings from CMS?**

   a. Mortality
   b. Safety of Care
   c. Readmission
   d. Emergency department time to discharge

3. **Before reporting a clinician to the National Practitioner Data Bank (NPDB):**

   a. notify the physician.
   b. contact the NPDB for guidance.
   c. announce the intended report to appropriate colleagues and supervisors.
   d. discharge the clinician's privileges or employment.

4. **In a recent study, what was the only quality measure that did not benefit from adding data from a health information exchange?**

   a. Breast cancer screening
   b. High-risk medication use in older adults
   c. Cervical cancer screening
   d. Diabetes annual eye exam

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.