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CMS to ease burden on credentialing, privileging of telemedicine providers?

Proposed change accepts third-party verification

Requirements for credentialing and privileging telemedicine providers are up in the air for now, following the May 26 release of a proposed rule from the Centers for Medicare & Medicaid Services (CMS).

When CMS approved The Joint Commission's application for continued deeming authority in November 2009, Margaret VanAmringe, MHS, The Joint Commission's vice president for public policy and government relations, told *Hospital Peer Review* there were certain areas the organizations still had to work on to come more in line. (See *HPR* cover story, January 2010.) At the time, VanAmringe expressed hope that CMS would change some of its standards to be more in tune with The Joint Commission's, specifically citing the area of telemedicine.

It looks like that's happening, with a change many say will reduce a significant burden on hospitals and critical access hospitals. CMS' proposed rule, much like The Joint Commission standards, would revise CMS Conditions of Participation (CoPs), allowing hospitals to accept third-party verification on credentialing and privileging of telemedicine providers (see http://edocket.access.gpo.gov/2010/2010-12647.htm).

"The Joint Commission had been notifying hospitals that as of July 15, they would no longer be permitted to credential and privilege telemedicine practitioners by proxy, which had been permitted under Joint Commission standards," says **Kevin J. Eldridge**, attorney in the health law group of Quarles & Brady LLP in Madison, WI. But in June, TJC delayed implementation of CMS telemedicine requirements until March 2011 for its accredited hospitals contingent on CMS' proposed changes

Will the changes ease workload on hospitals?

The Joint Commission "had allowed facilities that were receiving telemedicine services (those are called the originating sites, where the patient is located) to accept the credentialing and privileging of the consultant at what's called the distant site 'by proxy,'" says **Dale Alverson**, MD, president of the American Telemedicine Association (ATA) and faculty of the

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University of New Mexico. "That made sense because, one, it relieved the originating site, the smaller hospitals, of the burden of attempting to credential and privilege every possible telemedicine provider, which could be a fairly significant burden." CMS, however, had mandated that every telemedicine provider be fully credentialed and privileged at any site where they provided services.

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"So that was in conflict with The Joint Commission. And [CMS] was going to require The Joint Commission to come into compliance with their rules. This was a huge concern to the telehealth community, as well as those providing or receiving telehealth services," Alverson says. "CMS listened and came out with a notice of proposed rule-making that would allow hospitals and critical access hospitals to accept credentialing and privileging from the distant site." Comments on the proposed rule closed July 26, and most expect the final rule to come out in November.

To illustrate the burden of credentialing and privileging every individual telemedicine provider, Alverson says "we have 500 physicians on faculty here at our health sciences center. And let's say, for the sake of argument, they were all providing telemedicine services to every hospital in the state. That's 50. So you can do the math — 50 times 500. You'd have to do at least every two years 25,000 credentialing and privileging packages."

Many experts, including Eldridge, agree that the proposed rule will ease the burden for hospitals, especially for smaller, more rural critical access hospitals, and the comments on the proposed rule seem to support that, he says. "Even CMS agrees," he says. "In reversing its course on telemedicine, CMS admitted that its current process for credentialing and privileging telemedicine practitioners is 'duplicative and burdensome' for both hospitals and telemedicine."

A spokesperson from the National Association Medical Staff Services (NAMSS) told *HPR*, "the proposed rule appears to ease the upfront administrative burden of collecting credentialing data for distant-site hospitals. However, both the distant site and the originating site still carry the responsibility of ensuring that they are providing their medical staff with the best information for making privileging decisions. For the originating site, this means collecting and verifying all the data. For the distant site, this means ensuring that the originating site is in good standing with CMS and can be relied upon to produce a verified credentialing file and solid privileging decision."

Patrick Hurd, JD, senior counsel and leader of the Healthcare Industry Group with the law firm of LeClair Ryan in Norfolk, VA, isn't sure how the change will affect hospitals. "It remains to be seen," he says. "I do think it will help critical access hospitals, who are typically more reliant on telemedicine services. Based on my

work with clients to date, there remains much skepticism that the CMS rule will be of much help."

Elements of rule changes

The CMS proposed rule requires constant monitoring and communication between the originating and distant site. The distant site must be a Medicare-participating hospital. Internal reviews, adverse events, and grievances at the originating site must be shared with the distant site. Also, if any providers lose or have a change in their credentialing and privileging status, that would be shared as well with the distant site. Specifically, CMS' proposed rule stipulates that these criteria are met:

- "The distant-site hospital providing the telemedicine services is a Medicare-participating hospital";
- "the individual distant-site physician or practitioner is privileged at the distant-site hospital providing telemedicine services, and that this distant-site hospital provides a current list of the physician's or practitioner's privileges";
- "the individual distant-site physician or practitioner holds a license issued or recognized by the state in which the hospital, whose patients are receiving the telemedicine services, is located";
- "with respect to a distant-site physician or practitioner granted privileges by the hospital, the hospital has evidence of an internal review of the distant-site physician's or practitioner's performance of these privileges and sends the distant-site hospital this information for use in its periodic appraisal of the individual distant-site physician or practitioner. We are also proposing, at a minimum, the information sent for use in the periodic appraisal would have to include all adverse events that may result from telemedicine services provided by the distant-site physician or practitioner to the hospital's patients and all complaints the hospital has received about the distant-site physician or practitioner."

The Joint Commission's previous standards allowed by-proxy credentialing and privileging, and hospitals had the choice whether to handle it through a third party or on their own. With the CMS proposed rule, the same is true.

Hurd points out that in the proposed rule "the distant-site hospital's governing body has responsibility for assuring compliance with the CMS requirements, but the ultimate responsibility remains with the governing body of the hospital as to whether to rely on the distant-site hospital's credentialing and privileging information or conduct its own review."

Eldrige says that the current proposed rule brings CMS and The Joint Commission requirements more in line, but does not make them identical in every sense. "For example, CMS would permit privileging by proxy only between two hospitals, while existing Joint Commission standards permit privileging by proxy between Joint Commission-accredited hospitals and ambulatory care organizations."

Alverson, too, notes concern that CMS' rule covers only hospitals and critical access hospitals but does not include other facilities such as clinics or ambulatory care centers. The CMS rule applies only to hospital-hospital arrangements.

"That's one of the things that we were commenting on. We'd like to see them not just restrict it to hospitals and critical access hospitals, but to any clinical site where services are provided through telemedicine and are covered services by CMS. So that there wouldn't be a restriction on credentialing and privileging at the ambulatory sites as well," he says.

Proposed rule may face challenges

Hurd says although the proposed rule would indeed shorten the time and expense of credentialing telemedicine providers, it could face some challenges. "Some of the challenges of the CMS proposed rule, as opposed to The Joint Commission [elements of performance] include the current reluctance among hospitals to share their credentialing and privileging with another hospital, especially if that hospital is a competitor. The CMS proposed rule requires the sharing of adverse information and complaints regarding the telemedicine physician — matters that currently remain under wraps even within the distant-site credentialing hospital.

"Also, although the credentialing and privileging committee of a hospital may receive information from its peer review committee as part of its review of the physician, it remains to be seen whether such information can or should be shared with the requesting hospital. It raises questions of privilege under varying state laws. There could be added complications if the physician at the distant-site hospital is under investigation by that facility but his or her privileges have not yet been revoked or suspended, delaying the sharing of information with the requesting hospital. On the other hand, if shared, beyond issues of confidentiality and privilege, it may result in refusal of privileges at the requesting hospital, creating additional and vexing legal and policy problems."

He recommends quality improvement departments familiarize themselves with the proposed rule and ensure "that medical staff executive com-

mittees, department chairs, or even the full medical staff are aware of these potential changes and begin to anticipate necessary revisions to bylaws, policies, and procedures." While there may be changes with the final rule, he also suggests hospitals that "may be in the position of receiving requests for adverse events, complaints, and other information on their credentialed physician staff" review their bylaws and policies "to assure that they accommodate the new challenges" of the new rule.

He also suggests that credentialing and privileging committees audit their current practices to assess whether under the current CMS provisions there have been any "significant difficulties and substantial delays in credentialing" to decide whether to continue independent credentialing and privileging or do it by proxy.

NAMSS is requesting clarification on parts of the proposed rule, including:

- how to verify whether the distant-site hospital is not only a Medicare-participating hospital but is in good standing;
- a further definition of "periodic appraisal" and whether that appraisal will be in accordance with standards for reappointment or must be a separate schedule for telemedicine providers.

Alverson questions: "How does the originating site document that they're accepting credentialing and privileging? Do they need a written document on file? What needs to be in place to satisfy CMS?"

Eldrige says as "CMS hammers out the final rule," hospitals may be confused "as to how to proceed with credentialing and privileging telemedicine practitioners."

Alverson says another area these changes may affect is licensing. "Interstate licensure and licensure portability is going to be another important area for exploration. And we're currently working with the Federation of State Medical Boards in that arena. So they're doing some pilot studies now of looking at how we can make it easier for telemedicine providers to offer services in other states."

CMS and the future of telemedicine

Alverson says CMS senior executive Barry Straube spoke to the board of ATA. "It was a sense of a greater interest in having dialogue between the users of telemedicine and advocates of telemedicine with other federal agencies like CMS," he says.

"I think [CMS is] seriously looking at the fact that we can improve continuity of care using telemedicine, we can detect problems earlier, we can intervene in a more timely manner and avoid subsequently more expensive care. Then the system begins to save money.

"And I think with health care reform, this is an important aspect of how do we improve access to care to all Americans, and one of the ways we can do that is look seriously at how we use health information technologies and telemedicine in a meaningful way. So I think they're taking that seriously." ■

HBIPS core measure set ready for public display

Freestanding psychiatric hospitals must report

According to many stakeholders of the hospital-based inpatient psychiatric services (HBIPS) core measure set, it's been a long time coming. Although the set has been an option for hospitals since 2008, work on it began more than seven years ago, and now it will be mandatory for freestanding psychiatric hospitals beginning Jan. 1, 2011.

This "is the first time we're requiring the use of a particular core measure set. Because that's the only set available" specifically to psychiatric hospitals, says **Frank Zibrat,** associate director, ORYX implementation, division of accreditation operations at The Joint Commission.

Zibrat says reporting on the measure set is mandatory only for freestanding hospitals, which The Joint Commission defines as those that are accredited separately from the general medical/surgical hospital and have their own Joint Commission ID number. Those hospitals accredited as part of a general medical surgical hospital will not be required to report on the set, although "we would encourage it," he says.

The core measure set contains seven components:

- admission screening for risk for violence to self or others, mood-altering substance use, trauma history and patient strengths completed;
- hours of physical restraint use;
- hours of seclusion use;
- patients discharged on multiple antipsychotic medications;
- patients discharged on multiple antipsychotic medications with appropriate justification;
- post-discharge continuing care plan created;
- post-discharge continuing care plan transmitted to next level of care provider upon discharge.

Of those, all but the first have been endorsed by the National Quality Forum, Zibrat says. Despite that, The Joint Commission has decided to move forward with all seven components of the set and, beginning in about January 2012, will publicly display the data on the six NQF-endorsed measures. "The same thing will hold true with all those internal Joint Commission applications that use the core measure data. We will only use the six NQF-endorsed measures. And we hope that at some point in the future, that one measure will be NQF-endorsed, and when it is then we'll go ahead and include it in the public display."

Representatives from the National Association of Psychiatric Health Systems (NAPHS), the National Association of State Mental Health Program Directors (NASMHPD), the American Psychiatric Association, and the NASMHPD Research Institute Inc. (NRI Inc.), among others, were part of the national stakeholders that approached The Joint Commission and asked for the development of a core measurement set for psychiatric inpatient treatment.

"One of our purposes here was to show that what is done in the psychiatric hospital can be measured with the same kind of rigor and evidence-based approach on the medical surgical side... What we've been saying is that we want to be part of — and we are really part of — overall health care. Therefore, we need to show that we can measure what we do on the same basis as they do in med /surg, and we believe this is a critical step in that direction," says **Mark Covall**, president and CEO of NAPHS.

Because previously there was no specific measure set for psychiatric care, there weren't any national benchmarks, Covall says. "[A] lot of our members at the time were saying, 'We're collecting a lot of information but it's really not actionable, it's not really helping us change practice. We're spending a lot of money in resources, but we're not able to really make a difference or change what we're doing to help patients.'

"So that was one of the core reasons that led to this effort. Throughout the process of developing these measures, that was always something that was key. As we go forward and as we made decisions (for example, on whether we choose a measure or how we develop definitions), the issue is whether a measure is really going to help in changing practices so that people actually improve the care that's being delivered." He says with the HBIPS core measure set, the field will have common definitions, which will result in more meaningful data.

Since 2008, the measure set has gone through a number of modifications. For example, "instead of there being one measurement ratio on a couple of these measures, some are in fact being reported as two separate entities. Mostly that was to create more specificity and more opportunities for people to improve components of one of these scores," says **Frank A. Ghinassi**, PhD, clinical psychologist; vice president for quality and performance improvement, Western Psychiatric Institute and Clinic of UPMC Presbyterian-Shadyside; assistant professor in psychiatry, University of Pittsburgh School of Medicine; and chair of the Joint Commission technical advisory panel for the HBIPS performance measurement initiative.

Getting to zero on restraint, seclusion

Covall says the issue of restraint and seclusion "has become something that is very critical from the advocacy community standpoint because it's actually an issue of safety. The idea that you need to have less restraint and seclusion creates a much more positive outcome. The amount of restraint and seclusion that's being provided today has substantially decreased over the years, and this is a way to continue to measure that."

Ghinassi says the topic of restraint and seclusion comes "under the rubric of patient and staff safety issues and also it comes under the rubric of patient dignity and self-governance. The general consensus is that although restraint and seclusion have been a part of the history of psychiatric treatment, the present perspective of both consumers and providers of psychiatric care is that it is no longer seen as consistent with evidence-based care and treatment, and should be discontinued. We are moving more toward a patient-centric autonomy and recovery-oriented model where proactive collaboration between providers and consumers of care is the standard of practice."

Getting to zero is the ultimate goal, he says, and will involve earlier, more comprehensive discussion with patients on potential trigger situations and will involve clinicians and patients using prearranged behavioral plans.

With the introduction of these new HBIPS measures, he says, the various definitions used to report on restraint and seclusion have been more precisely defined in a clear "ratio measure based on hours of restraint and seclusion over total numbers of patient care hours; they have also been stratified by variables like age ranges, thus

allowing hospitals to focus on differences in use according to the different age groups. The hope is it's going to give people reasonable benchmarks against which to push for improvement." (To review the specifications on this measure and the others in the set see the manual: http://manual.jointcommission.org/releases/TJC2010B/.)

Using multiple antipsychotics

While Covall says the task force members with clinical backgrounds felt very strongly about the measures regarding the use of multiple antipsychotics, it is a "controversial" issue as there are still differing opinions about it in the medical community. "But the research literature suggests that [use of multiple antipsychotics] needs to be carefully reviewed because sometimes use of more than one antipsychotic medication really may not be having a positive impact on their overall recovery," he says.

Ghinassi says psychiatry still has much to discover in its study of the science of brain functioning, genetics, and human behavior and disorders. There are, however, a number of well-designed studies "that have supported monotherapy [using one medication from a class]" in the treatment of psychotic disorders.

"The empirical evidence as it stands, and again it isn't complete nor is it all conclusive, tends to support that the best practice algorithm would be to start with one medication. Make sure that you get it to its adequate dose for an adequate amount of time, and if that doesn't reduce symptoms and improve functioning (with a minimum of side effects) then one is advised to switch to a second single medication. The technical advisory panel has recommended three such adequate trials of monotherapy before a practitioner should consider more complex regimens," he says.

Zibrat says he's received many calls from clinicians who have patients who have been on multiple antipsychotic medications for a long time and wonder how to handle it. "That's the kind of call that we seem to be getting relative to the measures that address the use of multiple antipsychotics. What do we do if the patient has been on this for a long time? Do you start taking them away? A lot of physicians are reluctant to do that." (For more information on measure 5 and documenting appropriate "justification" of the use of multiple antipsychotics visit http://manual.jointcommission.org/releases/TJC2010B/DataElem0137.html.)

Ghinassi says he is encouraged by the implementation of the set and the move toward providing quality-of-care benchmarks in psychiatric care. Ghinassi says: "Organizations that elect to use this measurement set are deciding to take on a significant amount of extra work in that they have to comb through charts, compile reports, and ensure that data are reliable and valid. But all of this measurement and reporting effort is in service to one very important end. And that is continuously improving the quality and safety of the care provided in psychiatric hospitals and respecting the autonomy and dignity of the individuals seeking treatment."

He says it represents a key move forward in the science of psychiatry and the adoption of standardized performance measurement and national benchmarking.

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IPPS 2011 final rule implements PPACA

Payment reduction, ICD-10 coming

Probably the most incendiary change in the Centers for Medicare & Medicaid Services' inpatient prospective payment system (IPPS) rule for 2011 is an ultimate reduction in hospital payments. According to the American Hospital Association (AHA), the rule could decrease average inpatient payments by 0.4% and includes a 2.9% cut to offset the effect of documentation coding and DRG classification changes, which the AHA says does not reflect real changes in case mix.

Deborah Hale, CCS, president of Administrative Consultant Services LLC, a health care consulting firm based in Shawnee, OK, says this a "significant cut" and is "unfair because CMS has encouraged hospitals to improve documentation and coding for 'maximum' legal reimbursement, but then they penalize hospitals for doing so. If a hospital doesn't make improvements in coding and billing accuracy, they are still penalized the 2.9%."

The "bottom line," she says, "is that CMS projects an overall financial decrease of $311 million in FY11."

Coding, documentation

Also of significance is CMS' definitive decision to implement ICD-10 coding system effective Oct. 1, 2013, despite frenzied debates in the industry

RHQDAPU Program Quality Measures for the FY 2014 Payment Determination

Acute Myocardial Infarction (AMI)
• AMI-1 Aspirin at arrival
• AMI-2 Aspirin prescribed at discharge
• AMI-3 Angiotensin Converting Enzyme Inhibitor (ACE-I) or Angiotensin II Receptor Blocker (ARB) for left ventricular systolic dysfunction
• AMI-4 Adult smoking cessation advice/counseling
• AMI-5 Beta blocker prescribed at discharge
• AMI-7a Fibrinolytic (thrombolytic) agent received within 30 minutes of hospital arrival
• AMI-8a Timing of Receipt of Primary Percutaneous Coronary Intervention (PCI)
• AMI Statin at Discharge **
Heart Failure (HF)
• HF-1 Discharge instructions
• HF-2 Left ventricular function assessment
• HF-3 Angiotensin Converting Enzyme Inhibitor (ACE-I) or Angiotensin II Receptor Blocker (ARB) for left ventricular systolic dysfunction
• HF-4 Adult smoking cessation advice/counseling
Pneumonia (PN)
• PN-3b Blood culture performed before first antibiotic received in hospital
• PN-4 Adult smoking cessation advice/counseling
• PN-5c Timing of receipt of initial antibiotic following hospital arrival
• PN-6 Appropriate initial antibiotic selection
Surgical Care Improvement Project (SCIP)
• SCIP-1 Prophylactic antibiotic received within 1 hour prior to surgical incision
• SCIP-3 Prophylactic antibiotics discontinued within 24 hours after surgery end time
• SCIP-VTE-1: Venous thromboembolism (VTE) prophylaxis ordered for surgery patients
• SCIP-VTE-2: VTE prophylaxis within 24 hours pre/post surgery
• SCIP-Infection-2: Prophylactic antibiotic selection for surgical patients
• SCIP-Infection-4: Cardiac Surgery Patients with Controlled 6AM Postoperative Serum Glucose
• SCIP-Infection-6: Surgery Patients with Appropriate Hair Removal
• SCIP-Infection-9: Postoperative Urinary Catheter Removal on Post Operative Day 1 or 2
• SCIP-Infection-10: Perioperative Temperature Management
• SCIP-Cardiovascular-2: Surgery Patients on a Beta Blocker Prior to Arrival Who Received a Beta Blocker During the Perioperative Period
Mortality Measures (Medicare Patients)
• MORT-30-AMI: Acute Myocardial Infarction 30-day mortality – Medicare patients
• MORT-30-HF: Heart Failure 30-day mortality Medicare patients
• MORT-30-PN: Pneumonia 30-day mortality - Medicare patients
Patients' Experience of Care
• HCAHPS survey
Readmission Measure (Medicare Patients)
• READ-30-HF: Heart Failure 30-Day Risk Standardized Readmission Measure (Medicare patients)
• READ-30-AMI: Acute Myocardial Infarction 30-Day Risk Standardized
• READ-30-PN: Pneumonia 30-Day Risk Standardized
AHRQ Patient Safety Indicators (PSIs), Inpatient Quality Indicators (IQIs) and Composite Measures
• PSI 06: Iatrogenic pneumothorax, adult
• PSI 11: Post Operative Respiratory Failure *
• PSI 12: Post Operative PE or DVT *
• PSI 14: Postoperative wound dehiscence
• PSI 15: Accidental puncture or laceration
• IQI 11: Abdominal aortic aneurysm (AAA) mortality rate (with or without volume)
• IQI 19: Hip fracture mortality rate
• Complication/patient safety for selected indicators (composite)
• Mortality for selected medical conditions (composite)
AHRQ PSI and Nursing Sensitive Care
• Death among surgical inpatients with serious, treatable complications
Cardiac Surgery
• Participation in a Systematic Database for Cardiac Surgery
Stroke Care
• Participation in a Systematic Clinical Database Registry for Stroke Care
Nursing Sensitive Care
• Participation in a Systematic Clinical Database Registry for Nursing Sensitive Care
Healthcare Associated Infections
• Central Line Associated Bloodstream Infection**
• Surgical Site Infection***
Hospital Acquired Condition Measures
• Foreign Object Retained After Surgery *
• Air Embolism *
• Blood Incompatibility *
• Pressure Ulcer Stages III & IV *
• Falls and Trauma: (Includes: Fracture Dislocation Intracranial Injury Crushing Injury Burn Electric Shock)*
• Vascular Catheter-Associated Infection*
• Catheter-Associated Urinary Tract Infection (UTI) *
• Manifestations of Poor Glycemic Control*
Emergency Department Throughput
• Median time from admit decision time to time of departure from the emergency department for emergency department patients admitted to inpatient status. ***
• Median time from emergency department arrival to time of departure from the emergency room for patients admitted to the facility from the emergency department. ***
Global Immunization Measures
• Immunization for Influenza ***
• Immunization for Pneumonia ***

***New for FY 2012 payment determination; **New for FY 2013 payment determination; ***New for FY 2014 payment determination.**

Source: Centers for Medicare & Medicaid Services

about delaying this.

James S. Kennedy, MD, CCS, is managing director of FTI Healthcare in Atlanta. "The fiscal year 2011 IPPS rule is the first salvo in the implementation of the Patient Protection and Affordable Care Act [PPACA]," he says. "The PPACA is a game-changer in how physicians and hospitals have to work together in order to provide more efficient, [high] quality delivery of health care.

"Medicare is trying to advocate and pay for quality and cost efficiency. Getting their arms around this has been difficult," he says.

Referring to the implementation of the ICD-10 coding set in 2013, he says "there are deficiencies within ICD-10 that do not transmit the specificity of disease that's essential in provider profiling and value-based purchasing. For example, there's only one code for coronary artery disease. Doesn't matter if it's one vessel, two vessel, three vessel… Now which person is going to be more likely to have an adverse event? Someone with one-vessel disease or someone with three-vessel disease?

"The ICD-10 code set does not address that. The message is that your readers need to scream loudly to CMS and to the ICD-9 coordination and maintenance committee before their meeting in September or October." What he sees in the preliminary ICD-10 code set are "some nonspecific codes that are problematic in severity and risk adjustment."

Additional changes

The current rule, Kennedy says, should highlight the need for specificity in physician definition of terms. For example, he says, "acute kidney injury" (often used interchangeably with "acute renal failure," which shares the same ICD-9-CM code) was changed from a major complication/comorbidity (MCC) to a complication/comorbidity (CC) and "therefore will not generate revenue for hospitals with patients who incur that condition, unless the physician links the term 'acute kidney injury' to an underlying cause.

"This will be very important, especially for tertiary medical centers caring for sicker patients so that their CMS-reflected databases reflect the severity of illness within their patient populations. There is also considerable confusion between the difference of the words acute renal insufficiency and acute renal injury, which physicians tend to use interchangeably with each other. And Medicare has put us on notice that we have to work with physicians to clarify the meanings of these words and the codes that are assigned to them," he says.

"Another area of concern is that Medicare will be investigating over the next year the term encephalopathy. Encephalopathy is a difficult word that doesn't have a standard definition, yet physicians use this word interchangeably with altered mental status and acute delirium. How risk-adjustment methodologies factor in the term 'encephalopathy' will have some outcome for hospitals that use coded databases."

According to Hale, new quality measures for the FY12 update include:

- eight hospital-associated condition (HAC) categories, so that hospital-specific rates for these HACs will be posted to Hospital Compare;
- postoperative respiratory failure;
- postoperative pulmonary embolus or deep venous thrombosis;
- not finalizing any new registry-based measures at this time.

Moving forward, documentation will be more important than ever. "It's important for your audience to have a strong working relationship with the coding staff given that the numbers they type in their computer is what defines what bucket a patient gets placed in. Misplacing that patient in the incorrect bucket does not reflect well with Medicare Hospital Compare," Kennedy says. "It's very important that your audience communicate their risk-adjustment methodologies with the coding staff so that what the physician writes on paper is accurately transmitted and translated into accurate quality data for their hospitals." ■

Proposed OPPS revises physician supervision

The Centers for Medicare & Medicaid Services (CMS) once again has changed the requirements for physician supervision, always an area of contention and confusion, in its proposed 2011 outpatient prospective payment system (OPPS) rule.

In response to comments from critical access hospitals last year about a conflict on the topic between the Conditions of Participation (CoPs) and EMTALA, CMS first said critical access hospitals (CAHs) would not have to follow the final rule's requirements for physician supervision. After evaluation, however, CMS decided not to exclude CAHs from meeting the supervision requirements.

"The proposed rule addresses the disconnect between the CoPs and the supervision rule under

Proposed list of nonsurgical extended duration therapeutic services includes:

- intravenous infusion for therapy/diagnosis; initiation of prolonged infusion (more than 8 hours), requiring use of portable or implantable pump;
- hospital observation service, per hour;
- direct admission of patient for hospital observation care;
- intravenous infusion, hydration; initial, 31 minutes to 1 hour;
- intravenous infusion, hydration; each additional hour (list separately in addition to code for primary procedure);
- intravenous infusion, for therapy, prophylaxis, or diagnosis (specify substance or drug); initial, up to 1 hour;
- intravenous infusion, for therapy, prophylaxis, or diagnosis (specify substance or drug); each additional hour (List separately in addition to code for primary procedure);
- intravenous infusion, for therapy, prophylaxis, or diagnosis (specify substance or drug); additional sequential infusion, up to 1 hour (List separately in addition to code for primary procedure);
- intravenous infusion, for therapy, prophylaxis, or diagnosis (specify substance or drug); concurrent infusion (List separately in addition to code for primary procedure);
- subcutaneous infusion for therapy or prophylaxis (specify substance or drug); initial, up to 1 hour, including pump set-up and establishment of subcutaneous infusion site(s);
- subcutaneous infusion for therapy or prophylaxis (specify substance or drug); each additional hour (List separately in addition to code for primary procedure);
- subcutaneous infusion for therapy or prophylaxis (specify substance or drug); additional pump set-up with establishment of new subcutaneous infusion site(s) (List separately in addition to code for primary procedure);
- therapeutic, prophylactic, or diagnostic injection (specify substance or drug); subcutaneous or intramuscular;
- therapeutic, prophylactic, or diagnostic injection (specify substance or drug); intravenous push, single or initial substance/drug;
- therapeutic, prophylactic, or diagnostic injection (specify substance or drug); each additional sequential intravenous push of a new substance/drug (List separately in addition to code for primary procedure);
- therapeutic, prophylactic, or diagnostic injection (specify substance or drug); each additional sequential intravenous push of the same substance/drug provided in a facility (List separately in addition to code for primary procedure).

Source: Centers for Medicare & Medicaid Services

the more general provider-based rule. The CoPs only require that CAHs have a nurse on the premises (with a physician/practitioner on call) when there are patients in the hospital. Because observation services are therapeutic (at least theoretically), the physician supervision rule would require that a physician be on the campus," says **Duane Abbey**, PhD, CFP, president, Abbey & Abbey Consultants Inc.

In general, says **Adrienne Dresevic**, of The Health Law Partners PC, "for on-campus services, direct supervision means the supervising physician or non-physician needs to be present on the campus of the hospital or CAH and immediately available to provide assistance. For off-campus remote locations, the supervising physician or non-physician needs to be present in the off-campus location."

Those services that CMS has defined as nonsurgical extended-duration therapeutic services "will require direct supervision during an initiation period, followed by a minimum standard of general supervision for the duration of the service. Thus, the services are not exempt from supervision but after the initiation period are subject to a lower level of supervision," she says.

Such services had to meet four criteria:

- must be of extended duration, frequently extending beyond normal business hours;
- not a surgical service;
- consist of a significant monitoring component, which is typically conducted by nursing or other auxiliary staff;
- are low risk, such that it would not require direct supervision often during the performance of the procedure. *(See box, above, for list of services.)*

"CMS explicitly did not include chemotherapy or blood transfusions in the proposed list because it believes these services require the physician or non-physician practitioner's recurrent physical presence in order to evaluate the patient's condition in the event it is necessary to redirect the service," says Dresevic.

The supervising physician or non-physician practitioner must deem when the patient is "stable" and the service can continue under general direction "without their physical presence on the hospital campus or in the provider-based department of the hospital. CMS provides that the determination of when to move from direct to general supervision is up to the discretion of the supervising physician or non-physician practitioner. Thus, it is left to interpretation (but it should be the supervising physician's interpretation). CMS is considering whether the point of transfer from direct to general should be documented in the medical record or identified in a hospital protocol," says Dresevic.

How should hospitals document this to comply with supervision requirements? Abbey says: "This is probably the biggest overall compliance issue. Hospitals, both CAHs and short-term acute care hospitals, will need to set up documentation systems that show exactly what physician or practitioner was available to meet any given aspect of the supervision requirements."

Dresevic suggests using sign-in sheets or time logs to document physician presence on campus "during an at-issue time period. Time sheets and logs can also be incorporated into various physician contracts." ■

Q&A with St. Luke's new chief quality officer

Chief medical officer and executive vice president at Golden, CO-based HealthGrades, **Samantha Collier**, MD, MBA, is changing hats and moving inhouse. In September, Collier took the position of vice president and system chief quality officer at St. Luke's Health System. *Hospital Peer Review* asked her opinion on the field of QI with her unique background.

Q: What did you learn about quality of care and quality improvement being a part of HealthGrades?

I had the opportunity to work with hundreds of hospitals. I learned that there is a growing divide between the belief that your organization delivers the highest-quality care and the objective results that demonstrate great quality. A recent survey showed that most hospital executives and board members believe their organization has top quality, yet numerous studies demonstrate this is not the case.

It's hard for physicians, nurses, and administra-

CNE QUESTIONS

9. According to Kevin J. Eldridge, CMS' proposed changes make their requirements identical to The Joint Commission's on credentialing and privileging of telemedicine providers.
A. True
B. False

10. Of the seven measures within the HBIPS core measure set, how many have been endorsed by the National Quality Forum?
A. seven
B. six
C. five
D. four

11. When will CMS implement the ICD-10 coding system?
A. 2011
B. 2012
C. 2013
D. 2014

12. Under the 2011 proposed OPPS rule, critical access hospitals will be exempt from following physician supervision requirements.
A. True
B. False

Answer Key: 9. B; 10. B; 11. C; 12. B.

CNE INSTRUCTIONS

Nurses participate in this continuing education program by reading the issue, using the provided references for further research, and studying the questions at the end of the issue. Participants should select what they believe to be the correct answers, then refer to the list of correct answers to test their knowledge. To clarify confusion surrounding any questions answered incorrectly, please consult the source material. After completing this semester's activity with the **December** issue, you must complete the evaluation form provided in that issue and return it in the reply envelope provided to receive a credit letter. ■

tors to embrace quality gaps because we know lives are at stake. However, I learned that better is possible and that the best face their biggest gaps head on with courage and humility.

The most important quality role model is the CEO. The CEO sets the tone and the pace of organizational acceptance and change. I always ask one question of CEOs to predict the organizational capability for rapid change and meaningful quality improvement — who do you believe is the most accountable person for quality in your organization? If the CEO names themself, then I know this organization is on the path from good to great. If the CEO names someone else, then it's likely the status quo will remain.

Q: What will your priorities be at St. Luke's? Both specific and conceptual.

As the system chief quality officer (CQO), I am responsible for ensuring that St. Luke's does not have a gap between its reputation for high quality and its actual quality results.

Specific goals and targets will be determined after a full gap analysis is performed.

• Reduce harm, preventable complications and mortality.

• Ensure alignment of medical staff with organizational strategic quality goals.

Conceptual:

• Establish, drive, and monitor a shared quality vision for the health system that will accelerate the health system's progress toward achieving its mission of "improving the health of people in our region" and its vision of "transforming health care by aligning with physicians and other providers to deliver integrated, seamless, and patient-centered, quality care across all St. Luke's settings.

• Lead the development and execution of consistent, innovative, and reliable clinical processes across the system and the continuum, that result in seamless, patient-centered integrated care and a sustainable competitive advantage.

• Elevate St. Luke's performance such that it becomes a nationally recognized leader in quality, safety and value.

• Establish St. Luke's as a benchmark Accountable Care Organization.

• Develop and establish quality and safety organizational accountability (performance measurement, performance feedback, performance improvement).

Q: What do you think are the most important skills a QI director should have? And how in today's health care system, can QI directors "make their mark"?

The most important skill a QI director should have is being able to execute on plans and staying focused on achieving those milestones and goals. Many QI directors spend too much time collecting, scrubbing, and sorting data. Too little time is spent using this data to guide the execution of performance improvement.

QI directors can "make their mark" if they work confidently and collaboratively with key stakeholders to develop the right quality goals and metrics and then stay focused on achieving these goals through diligent execution. There is no success without execution. The QI director can take the lead in this area and really stand out.

Q: I read St. Luke's just was awarded the VHA's leadership award for clinical excellence based on patient care in four clinical areas: heart attack, heart failure, pneumonia, and surgical infection prevention. Why do you think the hospital received the award? Any specific initiatives on improving quality that you can point to?

St. Luke's is proud of its many accomplishments,

CNE OBJECTIVES

Upon completion of this educational activity, participants should be able to:

- Identify a particular clinical, legal, or educational issue related to quality improvement and performance outcomes.
- Describe how clinical, legal, or educational issues related to quality improvement and performance outcomes affect nurses, health care workers, hospitals, or the health care industry in general.
- 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.

COMING IN FUTURE MONTHS

■ Efforts to disclose errors can lead to decreased costs, claims

■ Update on TJC's med rec requirements

■ Creating an informed consent policy

■ More on ICD-10

and the VHA award is just one of them. As with most hospitals and health systems, there are many key quality and safety initiatives that have been successful and some that are not so successful. I believe that St. Luke's was awarded for their successes and that the executives and staff balance this well-deserved recognition with the need for better. We don't get it right all the time. A big reason I joined the organization is that St. Luke's does believe in better and the staff bring courage and humility to their quality improvement and view of their performance.

Q. How do you think your background will help you in your role as chief quality officer? Does it help to have a clinical background?

I don't know how one would be successful as a CQO without a strong clinical background. Certainly my status as an actively practicing hospitalist provides me with both up-to-date clinical knowledge and experience and enhanced credibility with the medical staff. My experience as an executive vice president at HealthGrades has provided me with a strong business and performance management experience with successful execution. My role as chief medical officer at HealthGrades provided me the experience of innovation, performance transparency, and consumerism. Also, the CMO role allowed me to work with the best and the worst of hospitals. I worked with Dr. Pate at one of the best in Houston. I followed him to St. Luke's to do even better.

Q. Are you knowledgeable about certain change management systems, and do you think QI directors should be?

Yes. There are various change management processes, but they all tend to follow a similar philosophy. I do think QI directors and anyone involved in QI/PI should have a basic understanding of a change management process because this will increase the likelihood of alignment, accountability, and success.

Q. Do you think the current move toward value-based purchasing and EMR implementation and the health care reform, all of this, does it really get at quality improvement or utilization and finances?

I think all the various initiatives mentioned are aimed at increasing accountability in health care. It's a significant part of our GDP and growing economic concerns, yet we know little about the value we provide. I believe, as does St. Luke's CEO, Dr. David Pate, that the sustainable competitive advantage will lie with those organizations that take the lead to define and consistently demonstrate value. ■

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PATIENT SATISFACTION PLANNER™

Ranking 95th percentile in patient satisfaction

Hamilton Ambulatory Surgery Center in Dalton, GA, has received the Summit Award from Press Ganey Associates for the fourth year in a row. The award recognizes health care facilities that rank in the 95th percentile or higher in patient satisfaction for three or more consecutive years, which means that Hamilton has achieved those scores for seven straight years.

The center's patient satisfaction scores range from the 95.6 percentile to the 98.1 percentile, says Kristi House, RN, BSN, director of the center.

Achieving such consistent scores starts with the design of the center, House says. From its beginning, the center was created to present a warm, comfortable setting, she says. "We're trying to help with anxiety and stress," House says.

The design includes comfortable furniture, "warm" colors such as olive green, and a large family waiting area, she says. "We let the family get involved in the process as much as possible, up to the point of going to the OR, basically," House says.

Additionally, when patients are discharged and receive their instructions, they also receive a letter asking them to complete a survey, she says. "It has my number on it, and if they have any problem, they can call," House says. Including a self-addressed stamped envelope has helped boost the response rate to 42%, she says.

In addition to the questions compiled by Press Ganey, the center's administrators have added a couple, House says. One area added was waiting time and delays, because patients can become dissatisfied easily in those areas, she says. Patients are asked, "Were you given information about why delays are occurring?" and "Were you updated throughout the process?" Also, the center asks about IV sticks, which are a source of patient anxiety, House says. Patients are asked, "Do you think your nurse was skilled?"

By addressing these areas, "I think we've added some comfort through [addressing responses to] the questions about the process," House says.

Members of the surgery center staff also make follow-up calls the day after surgery to assess how patients are doing and to see if they were satisfied with their experience at the center.

Every member of the staff is committed to the patient care experience from registration to physicians to administration, House says. "We listen, respond, and respect the patient's needs," she says.

Some of the strongest positive patient reactions are to the billing department, with the center sometimes receiving cards and letters mentioning the positive experience with that area, House says. "It's weird when someone mentions a billing person by name," she says. "You don't get that often" in medical care, House says.

The reason for the positive feedback? When a patient hasn't made a payment in 45 days, staff members make an attempt to contact them before taking any action to turn over the account to collections, House says. The result is that the center receives more payment, she says. Also, depending on the type of payment, some patients are offered discounts for timely payments, House says.

It all starts with a happy staff

Another sure way to keep patients happy: Keep your staff happy, House says.

"Of course if they're happy, they do a better job of caring for patients," she says.

At Hamilton ASC, the lounge/break area is not separated for physicians, she says. "We all congregate in the same area," House says. "They listen to opinions from staff about things that will work better. It's very open." Managers also solicit opinions from staff on improving patient care and staff morale, she says.

Staff members who go beyond their normal job duties are recognized with a "whatever it takes" card. Recipients of the card can be nominated by other staff members, physicians, or managers, House says. Also, staff members who are mentioned by name in positive comments from

patients are recognized with the cards, she says. "It encourages them to go out of their way to be kind to all our patients," House says.

The cards offer a reward of a meal from the hospital cafeteria, a movie ticket, or a gift certificate to the gift shop, she says. It's important that "they have some value to them," House says.

Also, interdepartmental relationships are fostered through an ongoing game at the center, she says. A box in the lounge posts questions, and staff must find answers by talking to people in other departments, House says. For example, the question "What do the colored letters on the patient file stand for?" might send staff to the business office to get an answer. "It helps them understand what others' jobs are," she says. Staff members who compile all of the correct answers receive a reward comparable to the "whatever it takes" cards, House says.

The center's administrators also plan a group outing once or twice a year, she says. Recently, staff attended a minor league ball game on a weekend, and family members were invited, House says. "I think that helps with morale here," she says.

Despite their success with patient and staff satisfaction, the center isn't stopping its efforts to improve. Press Ganey provided an analysis of the areas of greatest increases and decreases. "We look at areas we need to maybe improve on," House says.

The administrators take the patient satisfaction scores and discuss them at staff meetings, along with patient comments. "We say, 'This is the way we're being viewed,'" House says.

The administrators and staff are always looking to improve, she says. "Even though we won [Press Ganey recognition] four times, we want to meet and exceed that level if we can," House says. "We don't want to get complacent with it." ■

15-minute policy results in few refunds

Payouts are for waits of 20 minutes or so

Representatives at Emerus Emergency Hospitals, a licensed emergency specialty hospital company based in The Woodlands, TX, have been telling patients at several of its "24-hour EDs" for months now that if they are not seen by a physician within 15 minutes, the hospital will pay for their $1,000 visit. So far, the new policy is working quite well, say Emerus representatives.

"In the first six weeks at two facilities we saw 1,500 patients, and only four left without a bill," says Randy Park, MD, director of the facility in Aubrey, TX. "All of those patients were seen in less than 20 minutes, but it was still more than 15 minutes."

If anything, such "failures" serve to strengthen patient satisfaction, says Hemant Vankawala, MD, FACEP, who is a partner and medical director of the Emerus facility in McKinney, TX. "If you wait only 17 minutes and the visit is free not only are you not upset, but you're impressed that we did what we said we would do," Vankawala says.

Park says, "We were looking for ways to let the public know about the changes we have made in our practice of emergency medicine and how it might benefit them. In looking at our performance, it appeared we could make this claim with minimal risk to ourselves because we were already meeting it."

When a patient comes into the ED, front office staff register them. "If they look like they're in distress, they will page back to the nurse, and they will immediately go to the back," Park says. "If they're relatively stable, they will formally register in the waiting room and wait to be called to the back, but even a complete registration process is only a few minutes."

The offer is made to all patients, regardless of insurance status. When the registration process is complete, the patient is given a stopwatch to time how long it takes to see a physician, he says.

There are several aspects of the Emerus approach that make it easier to deliver on the 15-minute promise. For example, Park notes, Emerus employs a significant amount of cross-training. "Our work environment is good, and people will do other chores, which eliminate a lot of time losers," he says.

In a traditional ED, the doctor sees a patient, orders labs and EKGs, and a different person performs each of those tasks, Park points out. As a result, you have to wait for one person to finish a test before the next one can be conducted. "We cross-trained our nurses so that one nurse does all those things, and there's no waiting between

the order and the steps," he says. "Those hand-offs and waiting for ancillary persons to arrive are critical in a lot of EDs."

In a large traditional hospital, each department such as the lab is separate from the ED, notes Vankawala. The focus of those departments is to run inpatient services, he says. The radiology tech is accountable to the department of radiology, and the nurse is accountable to the nursing department, he says.

"In our facilities everyone is immediately accountable to the corporate vision, which is to provide high-quality ED care," Vankawala says. "Everyone reports up through the ED."

Park adds, "Our radiology tech is right in the department with us." Park and Vankawala are experienced, board-certified ED physicians who have worked in a variety of clinical settings, from busy trauma centers to tents in New Orleans for Hurricane Katrina.

From a practice standpoint, says Vankawala, he actually had to re-set his "internal clock" in the new environment. "In a traditional setting, if you saw someone in abdominal pain, you'd order labs and CAT scans, and that would take four to six hours," he notes. In that time, most patients would get better or stay worse and be admitted, Vankawala says. "In our ED, I get them back every 45 minutes," he says. "That's a good problem to have."

Because of that system, "the average dwelling time in our department is less than 50 minutes," Park says. In addition, he acknowledges, the Emerus facilities do not have to cope with poor bed availability on the inpatient side. The compensation program for physicians allows for a lighter patient load, notes Park. ■

Make a good first impression: It's critical

Improving patient satisfaction is "a high priority" for the patient access department at Advocate Illinois Masonic Medical Center in Chicago, according to Michael F. Sciarabba, MPH, CHAM, the hospital's director of patient access services.

"We believe strongly that we have an important role in transforming the patient experience," says Sciarabba. "A positive first impression is critical to that end."

Patient access staff, says Sciarabba, are the ones who "guide our patients through the complex world of health care. As a critical support department, improvements must be continuous to positively impact the patient's impression of the hospital and our department."

In light of this, any process and technology improvements made by patient access must always consider the impact on patient satisfaction. "Still, the ability of patient access departments to meet established organizational survey goals are complex and challenging," says Sciarabba.

Here are some successful approaches to improve satisfaction:

Create a patient access team.

This was recently implemented at Methodist Charlton Medical Center in Dallas, with the goal of providing timely patient access to health services in all areas of the hospital. The team places specific emphasis on the emergency department.

All members of the patient access team meet every two weeks to act on and review initiatives to improve patient throughput. They also monitor dashboard metrics related to patient throughput across the organization.

"We look forward to working collectively as a team to improve process efficiency and efficacy," says Jeanette Foulk, the hospital's director of admitting/discharge.

The patient access team includes the hospital's president, vice president of operations, critical care director, inpatient director, representatives from care management, human resources, the emergency department, the hospitalist medical director, chief nursing officer, admitting/discharge director, ED director, and the cardiology/radiology services director.

Here are the patient access team's goals:

- Quantifiably assess barriers to excellence, and recommend resources to eliminate these.
- Drive systemic accountability toward achieving best-practice benchmarks and processes for ongoing monitoring.
- Provide recognition to individual members for meeting milestones toward metric benchmarks.
- Recommend organizational changes and policies and procedures in support of patient access and flow.
- Implement action steps through teamwork to "hardwire" sustainable change and excellence across the organization.

• Create a culture of organizational change related to improving access to health care services for communities served.

• Use kiosks to survey customers.

Emory University Hospital Midtown in Atlanta recently piloted patient satisfaction kiosks. These allowed the access department to survey patients about particular areas of registration. Two kiosks were placed in corners of the waiting area to allow privacy and avoid a "backup" in the area.

"We used the data to determine if improvement was needed, and to reward staff who were mentioned for doing a great job," says Elease Brown, assistant director of patient financial services. "We reviewed these data with our staff. Collectively, we brainstormed to develop ways to improve satisfaction. If our budget allows it in the future, we may pursue it again."

Upon completion of registration, patients were encouraged to go to the kiosk to complete the survey. If time did not permit, the patient was invited to return to complete the survey. Here are some of the registration questions patients were asked:

• Were you pre-admitted (registered via phone) for today's visit? If you spoke with a staff member by phone, how courteous was the person you spoke with?

• Please rate your overall satisfaction with your registration experience today at Emory University Hospital Midtown.

• Please rate the ease of the registration process and waiting time in the registration area?

• What was the degree to which you were informed about delays in the center?

• How well were billing and insurance questions handled?

• Please rate the comfort of the waiting room.

• How helpful was the staff at the registration reception desk?

• How courteous was your registration representative today?

"We tried to capture most aspects of the registration experience," says Brown. "There was an option to enter comments and leave a contact number as well. We chose to have candy kisses as our token of appreciation for completing the survey, because they were less costly due to volumes." Other tokens considered were parking passes and coupons for movie theaters, the hospital cafeteria, and local restaurants.

Weekly summary reports were received. "We reviewed them to see which areas our patients were most satisfied or dissatisfied with," says Brown. "While most of the ratings were high and comments were positive, we did receive some that required our attention."

Surprisingly, patients also gave some unsolicited comments about other areas. "Admissions and physical therapy were the only areas involved in the pilot, but I guess patients needed an avenue to express their concerns about other areas as well," says Brown.

Give patients tokens of appreciation.

Emory's access department is "constantly looking at ways to improve patient satisfaction," says Brown. One small way of doing this involves "wowing" patients with tokens.

"These are things to let them know who we — admissions — are," says Brown. "Each patient, in all registration areas, is offered an emery board with our logo. They are a big hit, even with the men."

Also, patients are given a personalized, handwritten thank you card when they make a payment. This helps with upfront collections in all areas of admissions, including the emergency department, pre-registration, inpatient, and outpatient departments.

"Our pre-registration staff members will mail the cards, along with the receipt, to patients who make upfront payments via phone," says Brown. "We've received positive comments about the thank you cards."

Use role playing.

When a new patient access employee is hired at the Cleveland Clinic in Independence, OH, he or she attends an eight-hour customer service training program including a lot of role playing. The new hire interacts with "patients" who are nervous or angry about various situations, says Susan M. Milheim, senior director of patient financial services.

Each year, employees attend a four-hour "refresher" course. Training staff act as the patients, using real-life examples provided by front-line staff or customer service representatives. One scenario involves a patient who has come in as a direct admit and is irate because he thinks waiting for a bed is taking much too long.

"Role playing is very important. It gives the employee the opportunity to practice their newly learned skills," says Milheim. "The role playing is videotaped and available for employee review for future reference or a quick refresher." ■