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Accreditation Prep Should Be Constant, but Watch for Current Trends

Accreditation and compliance issues are constant concerns for quality improvement professionals, with new challenges frequently adding to the burden. The key to addressing the concerns is to take a long-term approach and not focus on upcoming surveys, several experts say.

Even so, it always is useful to keep in mind any current trends in what garners the interest of surveyors. Lately, that seems to be infection control, some data suggest.

The good news is that The Joint Commission (TJC) and other accrediting bodies have been relatively quiet in the past year or so, with few substantial changes to accreditation requirements, says **Larry Lacombe**, vice president of program development and facilities compliance for Medxcel, a company based in Indianapolis that provides facilities management services for healthcare facilities.

> THIS PERIOD OF RELATIVE CALM GIVES QUALITY PROFESSIONALS A CHANCE TO CONCENTRATE ON THEIR PAST ACCREDITATION EXPERIENCES AND ANY SHORTCOMINGS THAT MIGHT NEED ATTENTION.

This period of relative calm gives quality professionals a chance to concentrate on their past accreditation experiences and any shortcomings that might need attention, rather than being distracted with new rules and trying to play catch-up before the surveyors arrive, Lacombe says.

"You should be paying attention to a good understanding of what your last results were and that the findings identified were addressed sufficiently before the next survey. The surveyors

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come into the survey with the results from the last visit and basically start from there to see how you're doing," Lacombe says. "Addressing any of those findings should be a top priority when preparing for another survey, and if you're not scrambling to keep up with changing regulations, that can be a more effective process."

Know Your Own Policies

A common failing in accreditation efforts is not understanding your own organization's policies and procedures, Lacombe says. Surveyors will notice if leaders in the healthcare organization, as well as frontline employees, do not have an accurate idea of what some policies require, he says.

You also could be dinged for not meeting the more stringent standard you set for yourself, he explains.

"The standard in the industry may be less critical than what you have established as your own minimum, usually because it is what you were already achieving internally within the organization," Lacombe says.

"So, the surveyors will come in and instead of finding an issue with the standard, they will find an issue with your own policy because you have set a shorter time frame, more intervals of testing or inspections — something more aggressive than what the standard called for. They're going to hold you accountable to your own policies if they are more aggressive than the standard."

Inconsistency from facility to facility can be another accreditation pitfall, Lacombe says. This is a particular risk within health systems.

New Construction Brings Risk

New construction also can create compliance concerns, Lacombe notes. Compliance concerns are often overlooked as the hospital or health system conducts pre-construction risk assessments and begins establishing protocols for the process, he says.

There are many compliance issues involved with construction, including life safety and infection control, Lacombe says. They require the direct involvement of a quality and compliance professional all the way from pre-construction through the close-out.

Compliance and quality leaders should conduct weekly or bi-weekly meetings at the construction site, depending on how much work is being performed, Lacombe says. Conduct a walk-through of the construction area at least weekly, preferably daily, to spot-check for compliance issues, he advises.

Unfortunately, that doesn't always happen.

"Sometimes, that component is overlooked in the planning process, and sometimes it is recognized as a necessary part of the construction process, but it doesn't actually happen on a daily basis," Lacombe says.

"They're not doing the things they said they need to do based on what they risked out in that pre-construction phase. They're not doing the life safety rounds, ensuring that there is adequate fire protection, not partitioning the construction areas appropriately."

Hospital leaders often do not realize the shortcomings until they are pointed out by a surveyor, Lacombe says.

"You think you're doing it, and all of a sudden, somebody from the state comes in and does a walkabout of your construction site. They will ask how you're addressing a particular concern, and you know that you had a plan for that, but you realize you're not actually doing it," Lacombe says. "In cases like that, agencies will stop the construction — which costs you all kinds of money and time."

Infection Control on Radar

Lacombe's company keeps a database of survey results from the hospitals it works with, using that information to look for trends in what currently is being targeted by surveyors from CMS, TJC, and other accrediting bodies. Ligatures were a major concern for TJC in 2018, and the most recent data indicate a renewed focus on infection control among all accrediting bodies, Lacombe says.

"That includes not just air relationships and air changes, but also what you're doing with scopes. Are you cleaning scopes in a room that is dirty and putting clean tools back in the same spot where you cleaned them?" Lacombe explains.

"Air pressurization as it relates from an OR to a corridor is another issue we're seeing. A lot of times, it's hard to control that even if you do testing and balancing on an annual basis, because if someone just opens a door during the survey it can throw the whole air pressurization out of whack."

Healthcare organizations may receive more findings in upcoming surveys from TJC related to infection control, Lacombe says, not because anything is new but because there has not been as much focus on that area in recent years and hospitals may have let their guard down.

"The number of findings you get from The Joint Commission is different now also because of the way they have changed their process, so it could be that the littlest thing now becomes a finding for the overall report," Lacombe says.

"An increase of 20% to 40% in findings from the previous survey is probably going to happen because of what we like to call findis-itis. They're simply noting more findings than they did before."

(See the sidebar above for more on TJC's findings.)

Confidence Can Help

Understanding your own documentation is another important point.

A surveyor typically asks for documentation immediately upon arrival, and that can set the level of expectations for the survey, Lacombe explains.

"In some cases, hospitals are very disorganized. When you're looking for documentation, it sets the survey off on the wrong foot because if you're not organized with your documentation, how organized are you going to be out in the facility?" he says.

Lacombe says it also is important

Fire Safety, Utilities Top List of Common Compliance Issues

Below are the top five issues cited by The Joint Commission (TJC) as "not compliant" during surveys and reviews from Jan. 1, 2018, through June 30, 2018.

The most commonly cited issues related to fire safety and utility systems:

1. Lack of compliance in supplying and maintaining fire extinguishing systems in the hospital — 88%;
2. Not properly managing the hospital's risks related to utility systems — 80%;
3. Not reducing infection risks often linked to medical equipment, devices, and supplies in the hospital — 74%;
4. Not providing a safe and effective hospital environment — 73%;
5. Not establishing and maintaining hospital facilities that help to reduce fire and smoke hazards — 72%.

TJC's full report on the most commonly cited issues, broken down by different types of healthcare facilities, is available online at: https://bit.ly/2XzT0wV. ■

to know your own program well and to be comfortable talking about it.

"You only get on the stage once every three years to talk about what you do, so it's good if you feel comfortable talking about it and can show the surveyor that you understand all the components and processes," Lacombe says. "Your confidence can go a long way toward demonstrating that this is a comprehensive program to ensure the best care and not simply an effort to meet the minimum requirements laid out by the accrediting organizations."

Equipment Maintenance a Hot Topic

One issue looming large in the industry is the continuing requirement for preventive maintenance on medical equipment, says **Eric Robinson**, vice president of operations at CME Corp., a national healthcare equipment company based in Warwick, RI, that assists healthcare organizations with compliance issues. Clinical engineering professionals are looking for ways to streamline the process because many organizations find compliance to be a costly endeavor, he says.

"They're looking at alternative maintenance plans and ways to eliminate the requirements for completions on noncritical pieces of equipment so biomedical engineers can spend their time on those critical, life-saving, or life-supporting pieces of equipment that require a lot of time for maintenance," Robinson says.

The patient experience continues to be a focus of accreditation and compliance activities, and Robinson says many hospitals are trying to improve the electronic medical records in ways that make the patient's experience more seamless as they move from one area to another.

Financial limitations continue to be a challenge for compliance efforts, Robinson says.

"Hospitals are always trying to find ways to save, and most quality improvement and compliance departments are running very lean already, as are all the other departments they work closely with. They don't have any FTEs [full-time equivalents] standing in a glass case waiting to be broken out in case of emergency," Robinson says.

"That makes it a challenge to respond to any upticks in volume."

Robinson cites the example related to the construction issues Lacombe discussed. Along with all the other issues related to construction, a new hospital wing or department must be outfitted with a great deal of new equipment, most of it brand new.

That influx of equipment creates a spike in demand across many departments, including engineering, IT clinical support, and maintenance, he says.

"That puts a significant demand on them to address all the needs associated with that spike of new equipment coming in to the building, getting it installed and tested so that it's good to go for the scheduled opening," Robinson says. "Those departments are getting stressed when these events take place, and that creates the opportunity for things to be missed."

Play the Long Game

Robinson urges quality professionals to strive for a steady approach to compliance and accreditation readiness, rather than scrambling in the last months to get everything in order. With a solid compliance program, surveyors should be able to walk into a facility at any time and get an accurate impression of the quality of care provided, he says.

"I think by taking a good look at your processes in an ongoing way, including your maintenance program, you can leave yourself in a better position by the time of your survey than if you went all out with your resources in the buildup to the survey," Robinson says.

"Part of that should include looking at whether you can risk-rank some of the preventive maintenance processes in order to free up time so that the crucial human resources can devote their time to the critical equipment that needs their attention. That lessens the angst associated with those surveys."

However, Robinson cautions that any decision to pursue an alternate maintenance program must be supported by research and documentation.

"If you don't have the documentation to show why you chose to pursue a maintenance program that is not strictly the norm, that is just an unforced error. It is easy to fall into the trap of deciding to alter how you do something without justifying why you're doing it," Robinson says.

"If you can show that, the survey team usually will not have any problem with your choice. They will ask why you made those changes, though, and you want to have data to show them that this equipment has shown no failure over the last five years of regular use within our healthcare facility, therefore we made the decision to risk-rank

it lower in our regular preventive maintenance needs."

Much of compliance and accreditation preparation comes down to determining where you should devote limited resources, Robinson says. Be sure to collaborate across departments.

"Tough choices have to be made sometimes, because you can't do everything to the extreme when you have limited resources," he says. "You may have to focus on areas that might be deficient and could create a citing event when the survey takes place."

Suicide a Top Concern

Behavioral health populations still are on the minds of surveyors and accrediting bodies, notes **Diana Scott**, senior director of accreditation at Vizient, a healthcare performance improvement company based in Irving, TX. Suicide and ligature risks in particular have been top concerns for CMS, she says.

"It's a group of patients that have in the past not had a lot of resources. It's a challenging population, and the efforts to improve care for them, particularly as it relates to preventing suicide, are drawing a lot of resources," Scott says.

"We know that evidence-based tools are the right way to approach this, but that means educating our staff on the right way to use these tools to identify these patients at risk and save lives through minimizing the environmental opportunity."

Other hot issues this year are infection prevention, specifically the reprocessing of medical devices and sterilization of instruments, Scott says. Hemodialysis also is getting attention as it relates to infection prevention, she says.

"We're also seeing heightened awareness of radiation safety because of some changes that are occurring with anticoagulation therapy and the protocols specifically associated with anticoagulants and episodes of bleeding," Scott says. "The Joint Commission is focusing on these areas because they have seen evidence of organizations having challenges with complying. Some of the issues, like requirements around sterile compounding, are a little newer only in the sense that there has not been much light shone on them in the past. A lot of organizations had been outsourcing compounding, and now, we're seeing more a trend of bringing that back in-house."

TJC released a new National Patient Safety Goal (NPSG) for anticoagulation therapy that becomes effective July 1, 2019. *(For more information on the NPSG, see the sidebar above.)* USP also is updating its guidelines for sterile compounding. *(More information on the sterile compounding update is available online at: https://bit.ly/2EV0JuR.)*

"There's a lot of new content and much more rigorous reviewing of sterile compounding," Scott

TJC's NPSG on Anticoagulation Therapy Effective Soon

The Joint Commission is revising its National Patient Safety Goal on anticoagulation therapy, effective July 1, 2019. The change will include performance requirements to reduce the risk of harm to patients using anticoagulants. The accrediting body says the change was prompted by an increase in adverse drug events associated with direct oral anticoagulants.

"The NPSG will include eight elements of performance (EPs) — specific actions, processes, or structures that must be implemented to achieve the NPSG — applicable to all Joint Commission-accredited hospitals, critical access hospitals, nursing care centers, and medical centers (accredited under the ambulatory healthcare program)," TJC announced.

The NPSG revision will require the healthcare organization to minimize risks by using evidence-based guidelines and approved protocols when initiating and monitoring anticoagulation therapy, reversing anticoagulation and managing bleeding events, and managing patients on oral anticoagulants during perioperative periods.

The revision also will require the healthcare organization to have a written policy for monitoring and adjusting anticoagulation therapy, starting with baseline lab tests and continuing with periodic testing during treatment.

The report on the updated NPSG is available online at: https://bit.ly/2SKfqrJ. ■

says. "Dialysis is similar in the way they are shining a brighter light in that area. Because that is a very immunosuppressed population, there is a great emphasis on the risk points for infection."

Back to Basics

Focusing on the survey process itself is a common mistake, says **Jodi Eisenberg**, MHA, CPHQ, CPMSM, CSHA, senior director of accreditation education programs at Vizient. The much better approach is to build a program that leaves you confident every day of the year so that no matter who walks in the door, you can be sure your hospital is doing the right thing, she says.

Even if you are worried about surveys, Eisenberg notes, much of the emphasis now in surveys and compliance is on the basics. "We're seeing findings on appropriate cleanliness, maintenance, and staff competency; product preparation; [and] adherence to manufacturer guidelines," Eisenberg says. "We're seeing gaps in those basic compliance pieces, and when you don't meet those basic requirements, that often [causes] bigger issues."

For instance, Scott says, sterile compounding requires an extremely clean environment, yet there are frequent findings regarding failure to garb appropriately, aseptic technique, and monitoring the environment.

Failing to meet those basic requirements is bad enough, but it could lead to more serious findings, Eisenberg explains. "One inadequacy may not seem like that much, but the more you fail to meet those basic requirements, the more that gap is widening so that you have the potential for errors in your sterile compounding to reach the patient and do real harm," Eisenberg says. "In disinfection and sterilization, if you have a gap in how you're processing an endoscope, you can miss a step, and the risk of impacting the patient rises."

Don't Assume Skills Competence

Scott cautions that quality and compliance leaders can easily become overconfident about the knowledge and skill level of employees after providing education on guidelines and best practices. Hospitals have moved to computer-based education, she notes, and that can offer substantial benefits in terms of volume and efficiency when there are many employees to train. But it also can bring risks.

"One of the pieces that we're missing now that we've gone to computer-based education is that we don't see a lot of hands-on verification — actual execution of the new learning," Scott says. "I think there is a need for reinforcement there because we all know from our quality education that the things you measure are the things that have a better likelihood of sustainability. Organizations can't monitor absolutely everything, so there has to be some prioritization to monitor areas where you have not been compliant in the past."

Eisenberg also stresses the need to educate employees about the reason for best practices and required procedures. "Make sure they know why you're telling them to do it this way, and also how to escalate or elevate when there is an issue that makes it difficult for them to complete the process in the way you expect," she says. "There can be competing priorities, and you need to be sure people know when and how to take that conflict to another level for resolution."

Staff also must deal with real-world practicalities that might not have been addressed in training. In high-level disinfection, for instance, employees might be taught to follow a specific protocol that includes the directions from a product manufacturer. However, employees may find that similar products have manufacturers' guidelines that are significantly different.

"If we're using multiple products, we have to follow different manufacturers' guidelines. Even though the products might be very similar, the guidelines might not be," she explains. "The complexities add to the need for vigilance because they increase the chances of steps being missed or handled inappropriately."

Hospitals also are encouraging employees and patients to speak up when they have questions or suggestions for improving processes, Scott says. "One of the things we're seeing is an effort to make every individual under that roof feel confident and free to bring things forward to improve those system processes," she says. ■

SOURCES

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CMS Revises Immediate Jeopardy Protocol to Speed Reaction

Responding to recent incidents in which patients were subjected to harm in ways that necessitated a fast response, the Centers for Medicare & Medicaid Services (CMS) is revising the way surveyors assess and respond to failures that place patients in "immediate jeopardy."

CMS Administrator Seema Verma posted a blog in which she announced revisions to the guidance to surveyors on immediate jeopardy. The new guidance requires them to complete a three-question template, which is shared with the facility. The goal is to immediately share the surveyor's observations with the facility so it can resolve the issue immediately, Verma explained. *(Verma's blog post is available online at: https://go.cms.gov/2tVGYAo. The new guidance to surveyors is available online at: https://go.cms.gov/2C7BMxO.)*

"Despite stringent safeguards, alarming stories continue to be reported about people, including some of our most vulnerable individuals, who have experienced harm in healthcare settings that is devastating to these patients and their families. These include cases of sexual, physical, or mental abuse; neglect and medical mistakes resulting in death; and serious and life-threatening injuries or impairments." Verma wrote.

Noting that "many stakeholders have voiced concerns that the guidance needs to be clearer and more consistent to identify serious quality concerns across states," Verma explained that "this new guidance clarifies what information is needed to identify immediate jeopardy cases across all healthcare provider types, which we believe will result in quickly identifying and ultimately preventing these situations." ■

Blockchain Can Be Used to Improve Credentialing Process

A cutting-edge technology could greatly enhance the peer-review process, according to one proponent. The blockchain technology most commonly associated with cryptocurrency like bitcoin could revolutionize how hospitals review and credential physicians, he says.

Few healthcare professionals are likely to have experience with blockchain, but the concept is not as daunting as it might seem at first, says **J. Mark Waxman**, JD, partner with the Foley & Lardner law firm in Boston.

Blockchains are essentially a type of database, Waxman explains. Each user can verify and update the file before making it accessible to the next user.

In this way, "blocks" of peer review information can be linked together in a "chain" with encryption that provides enhanced security. Users can also link to prior blocks of information.

Unlike more typical databases, blockchain can grant users access to all of the data or certain chains — restricting access to those who need to verify some parts of the chain, for instance, but who should not have access to other information.

Several health systems are considering blockchain for peer review, but none has implemented it so far, Waxman says.

"I think it makes all the sense in the world if you have a way of keeping track of a physician over the course of a career through this one resource that can be accessed by a lot of different people, in a limited way," Waxman says. "It would save a lot of time because you go to so many different places over the course of your career from medical school to residency, to jobs here and there. The notion of having one record that can be updated and accessed by the appropriate parties should be appealing."

Blockchain has the potential to greatly reduce the time and effort required for credentialing, he says.

"If you have everything you ever did before in one place that was current and attested to by the participants, that's good for the doctors and patients because the doctors get credentialed quickly," Waxman says. "It's good for the employer that doesn't have to pay for all that redundant work."

Waiting for First Big Step

Unfamiliarity with blockchain is the initial hurdle, followed by fears that it would mean

completely overhauling existing peer review systems, Waxman says. Implementation of blockchain for peer review would require a large hospital or health system committing to the idea and spending a couple of years educating stakeholders about it before going live, he says.

"The physician remains at the center of the process, initiating the process and allowing the blockchain to be used. Some of them will welcome the idea of a system that simplifies something they have to do over and over, while others may say electronic records turned out not to be what we all hoped they would in terms of improving efficiency and economy, and so they won't feel like trying this," Waxman says. "Once you get physicians on board, then it will depend on the willingness of others to participate. The educational process throughout a health system will probably be the way the whole thing really gets started."

Waxman suggests that interested healthcare leaders explore organizations such as the Blockchain Alliance, a coalition of companies and other organizations interested in ensuring the security of blockchain systems.

(The alliance website is at: https://blockchainalliance.org/.)

"The first thing is to realize you're not alone in finding this an intriguing concept. You can look at who else might be interested in your area and then go to leaders in your own system to explore how you might take this step," Waxman says. "This can help the physicians and the hospital or health system reduce the manual labor and costs required for reconciling all this credentialing data for plan participation. That has to be attractive to everyone involved."

Waxman has published a proposed agreement for a blockchain credentialing process. It is available online at: https://bit.ly/2VpJUAR. ■

SOURCE

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Health System Uses Predictive Analytics to Reduce Readmissions

Advocate Aurora Health, a large health system with dual headquarters in Downers Grove, IL, and Milwaukee, is reporting success with a program that uses predictive analytics to identify outpatients with an increased risk of unnecessary hospitalization. Those patients are then provided special intervention to prevent admissions.

The health system uses a predictive modeling platform that integrates 30 to 40 sources of data, explains **Tina Esposito**, vice president of information and technology innovation at Advocate Aurora Health.

The program was developed in 2012 as part of the health system's move to value-based care, Esposito says. Advocate Aurora Health has an accountable care organization with more than 1 million participants, so there is a strong incentive to prevent unnecessary hospitalizations.

"As we thought about how we could be successful for our patients in the new model of care, we realized there was a bit of a gap in understanding how they moved through our health system. In a fee-for-service world, you're very focused on today and the visit at hand," Esposito says.

"So our data had been very siloed in that way, with hospital data in one silo and home healthcare data in another, and we wanted to look at this in a much more holistic way. A primary first step was just getting our data organized in a way that would allow us to understand how care was being delivered in our system to the patient overall, rather than just episodes of care."

That required bringing on more experts in data analytics, and once the health system had a better grasp on its data, it began looking for ways to apply it to patient care. Population healthcare managers approached hospital leadership with the idea that they could be more successful if they could better leverage the data for patients at risk of certain utilizations.

Advocate Aurora Health leaders realized that they needed to use data that allow an intervention in time to make a difference in preventing hospitalization, not long after the opportunity was gone.

"We understand now that once you identify a high-cost patient, that patient doesn't necessarily stay high-cost, but a big realization was that the care managers were very dependent on claims data, and that is very latent data," Esposito says. "If you have latent data, by the time you see that something has occurred to the patient and try to dispatch a care manager or any other intervention, that patient likely has already regressed to some baseline level of spending. So you've now leveraged a resource that in all

likelihood isn't needed any longer but could have been effective months prior."

The health system first used the model on heart failure patients at high risk for unnecessary utilization.

The program is designed to be prescriptive in its approach, Esposito explains, focusing on a disease-specific action plan that can prevent unnecessary hospitalization. A key goal is reducing subjectivity in the care management process.

The pilot program determined that patients who are actively engaged with another care team in the health system, such as those addressing transplants or active cancer, are not a good fit for this approach.

The model includes educating patients about their conditions, symptoms to watch for and how to respond, and frequent contact from care managers by phone and in person.

"Part of the intervention is to get the patient ready to no longer need these regular phone calls. We think it is important to have these patients graduate to a level of self-management, because you will never have enough care managers to continue this attention indefinitely," Esposito says. The average length of time in the program was 70 days.

With 350 patients involved in the pilot, Advocate Aurora Health achieved a 23% reduction in hospitalization, ER use, and observational stays. Half of them achieved all the milestones in the model's prescriptive workflow.

Esposito says these were some of the key lessons from the pilot study:

- A predictive model alone does nothing to keep patients out of the hospital. Directed intervention with a disease-specific action plan is required to get results;
- Knowing a patient is at risk of an event doesn't necessarily mean you can do anything to prevent it;
- Connecting with patients early and often is essential;
- Focus on chronic disease self-management first;
- Provide care managers with clear objectives and milestones to ensure consistency across the team. Hiring for care managers focused on key attributes such as a commitment to improving patients' health, refined phone etiquette, and a personality that was engaging and authentic.

The health system plans to expand the approach to other conditions, such as COPD. Esposito says the program is an example of how data analytics can affect the bottom line, but only if used strategically.

"There is no ROI in analytics unless someone does something with the information you're providing them," Esposito says.

"The partnership with operations and clinicians has to be very, very tight to ultimately realize any value. Whatever analytic endeavor you're after, you have to make sure it's aligned to a very tangible business goal, rather than being just an academic exercise." ■

SOURCE

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Program Addresses Hazards Faced by Parkinson's Disease Patients

A hospitalwide initiative to address the hazards faced by Parkinson's disease patients has led Hackensack University Medical Center, part of Hackensack Meridian Health, to become the first acute care hospital awarded a disease-specific certification designation for Parkinson's from The Joint Commission.

A nervous system disorder, Parkinson's includes symptoms such as tremors and muscle rigidity, and can negatively affect speech, explains **Hooman Azmi**, MD, a neurosurgeon specializing in surgical treatments for Parkinson's. Seeking to reduce the risks faced by patients with this disease, Azmi led a team at the medical center.

"Parkinson's is a very special disease in that patients become very dependent on the administration of their medications. They have both motor and non-motor symptoms, which can be very dependent on the timely administration of medications," Azmi says. "Over time, this dependence can become stronger and they might require medication every two or three hours, and sometimes around the clock. Management of these patients becomes very difficult and revolved around maximizing their time without rigidity, being able to move, and with as little side effects from the medicine as possible."

More so than most other patients, Parkinson's patients require extreme attention to detail regarding medication regimens, Azmi explains. A patient may need a dose of

medication at 6:15 p.m., for instance, and it will not be acceptable to provide it at 6 p.m. or 6:30 p.m.

"It's a difficult feat to achieve. There are studies that show that most patients with Parkinson's come to the hospital for other reasons like pneumonia or elective surgery, and their Parkinson's gets lost in the shuffle," Azmi says.

"When they come to the hospital and we put them on a default medication regiment for five times a day or eight times a day, it can really wreak havoc with that patient's symptoms."

Even a 15-minute delay in medication timing can result in hospital-acquired complications resulting from falls, dysphasia, and other risks, Azmi says, which can result in longer hospital stays. Parkinson's medications also are sometimes not found in hospital formularies.

In addition, some common anesthesia medications, antiemetics, pain medications, and antipsychotics are contraindicated for these patients and can adversely affect Parkinson's disease symptoms if administered.

Hackensack University Medical Center addresses these risks first by placing a marker in the patient's electronic medical record (EMR). The Parkinson's alert is one of the first things a clinician sees when opening the EMR, and it triggers a series of best practices in the record for nurses, emphasizing the importance of medication timing.

The EMR also was revised to allow more appropriate medication timing for Parkinson's patients. Like other EMRs, it normally provides a prescriber with several common dosing and timing options for medications, such as twice a day or four time a day. Once the patient is flagged as a Parkinson's patient and the disease-specific medication is selected, the EMR now adds a button allowing the prescriber to customize the timing for that patient.

"That has to be supported by education for nurses and doctors about why these medications have to be ordered in a custom fashion. You have to ask patients exactly what time they are taking these medications and enter that in the EMR," Azmi says.

"Once we implemented that education, we saw a significant increase in the customized input of this information."

The hospital's EMR alerts clinicians to medications that are contraindicated for Parkinson's patients. The hospital also added common Parkinson's medications to its formulary even though the patients make up a relatively small percentage of the hospital's population and the drugs can be expensive.

"It's justified because we're providing better care and it can reduce the length of stay. We have seen that over the past two years, with the length of stay for a patient with Parkinson's dropping independent of the admitting diagnosis," Azmi says.

"That's a big accomplishment, and the savings can add up to the bottom line of the hospital."

Hackensack University Medical Center is part of a 16-hospital system and has the lowest readmission rates for patients with Parkinson's, and the lowest length of stay. It also has a slightly lower mortality rate for those patients.

Identifying Parkinson's patients is key to reducing the risks they face when hospitalized, Azmi says, and the EMR is not the only option. He suggests using other methods common for identifying risks, such as the fall risk wristbands and notices on patient doors and by the bedside.

Azmi explains that such efforts must be hospitalwide because Parkinson's patients are not grouped together in one unit. Because most come to the hospital for unrelated issues, they are placed on various units such as cardiac care or surgical.

"We need to involve champions that really care about improving care for these patients and are willing to drive this effort throughout the entire hospital," Azmi says. ■

SOURCE

- **Hooman Azmi**, MD, Neurosurgery, Hackensack University Medical Center, Hackensack, NJ. Phone: (201) 342-2550.

Study Says Employing Physicians Does Not Improve Quality

The trend toward vertical integration in the healthcare industry and more employment of physicians by hospitals and health systems does not improve quality on key metrics, according to a recent study.

The study from the Center for Health and Biosciences at Rice University's Baker Institute for Public Policy also found lower patient satisfaction scores for hospitals in concentrated markets. *(The study is available at: https://bit.ly/2E9FHeK.)*

Researchers studied the

performance of 4,438 hospitals on 29 quality measures reported on Hospital Compare from 2008 to 2015.

Hospitals with employed physicians had higher scores on only eight of the measures. Readmission rates were the same for physician-employed hospitals and other hospitals.

More physicians than ever before are employed by hospitals. The study notes that approximately 155,000 physicians were employed by hospitals in 2016, a 63% increase from 95,000 in 2012.

The researchers concluded that their "findings do not uphold the hypothesis that increased integration may result in better care, likely because structural integration (e.g., human resource management, financial management, etc.) through physician employment does not necessarily lead to clinical integration (e.g., coordinated patient services among providers or site, monitoring of 'best practices,' etc.)."

"Our results indicate that vertical integration improves quality for only a limited set of process of care and patient satisfaction measures," they wrote.

"But increased hospital market concentration is strongly associated with reduced quality across multiple measures," the researchers wrote.

"With this result in mind, regulators should continue to focus scrutiny on proposed hospital mergers, take steps to maintain competition, and reduce counterproductive barriers to entry." ■

CMS Changes Nursing Home Compare, May Drop Star Ratings

The Centers for Medicare & Medicaid Services (CMS) recently announced significant changes to Nursing Home Compare and the Five-Star Quality Rating System. The agency also says that it is considering abandoning the star ratings for hospitals completely.

The Nursing Home Compare website and Five-Star Quality Rating System are aimed at helping consumers, families, and caregivers compare nursing homes. CMS says the recent changes are meant to make the tools more accurate.

"Our updates to Nursing Home Compare reflect more transparent and meaningful information about the quality of care that each nursing home is giving its residents," CMS Administrator Seema Verma said in announcing the changes.

"Our goal is to drive quality improvements across the industry and empower consumers to make decisions, with more confidence, for their loved ones," Verma said.

Nursing Home Compare gives each nursing home a rating between 1 and 5 stars, with one Overall 5-star rating for each nursing home, and a separate rating for health inspections, staffing levels, and quality measures.

The recent changes include revisions to the inspection process, new staffing information, and new quality measures.

CMS is lifting the "freeze" on the health inspection ratings instituted in February 2018, which it implemented to avoid some facilities being surveyed under the old process and others under the new process implemented then.

CMS also is setting higher thresholds and evidence-based standards for nursing homes' staffing levels.

Under current standards, facilities that report seven or more days in a quarter with no registered nurse on site are automatically assigned a one-star staffing rating. Beginning in April 2019, the trigger for an automatic downgrade to one star will be reduced from seven days with no RN on site to four days.

CMS also is implementing changes intended to improve how it identifies differences in quality among nursing homes, raise expectations for quality, and incentivize continuous quality improvement.

CMS also recently updated the ratings for hospitals on Hospital Compare, the first time in almost 15 months. Consistent with previous years, most hospitals received two to four stars and few received the lowest rating of one star or the highest rating of five stars. *(Hospital Compare is online at: https://bit.ly/1MimgOq.)*

However, CMS indicated that it is considering scrapping the basis of the whole star ratings system.

It opened a public comment page soliciting feedback on potential changes to the ratings program, including eliminating the latent variable model altogether.

(The public comment page is online at: https://go.cms.gov/2C5kEIY. The comment period ended on March 29, 2019.)

In what it called a "long-term" approach with changes that wouldn't be made before 2020, CMS said it's considering "replacing LVM (the latent variable model) with an explicit approach (such as an average of measure scores) to group score calculation." ■

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CE QUESTIONS

1. **What does Larry Lacombe suggest should be a top priority when preparing for a survey?**
   a. Any findings of noncompliance from your most recent survey
   b. The issues most cited by patients and families
   c. The issues most commonly cited at other hospitals in your community
   d. Requirements on which you have never had a finding of noncompliance

2. **What does Eric Robinson say is important when you risk-rank preventive maintenance?**
   a. Avoid telling the surveyor.
   b. Be prepared to show your research and documentation for your decision to risk-rank some preventive maintenance.
   c. Do not risk any preventive maintenance that might be assessed by surveyors.
   d. Never risk-rank in such a way as to deviate from the manufacturer's recommended maintenance.

3. **Why does Tina Esposito say data analytics from up to 40 data sources helps more with reducing unnecessary utilization than claims data?**
   a. The claims data are latent, and the other data allow more timely intervention.
   b. The data from the multiple sources are more accurate than claims data.
   c. Claims data sometimes are not available for all patients.
   d. Claims data often are skewed by the payer's reimbursement policies.

4. **Why do Parkinson's patients face special risks when hospitalized, according to Hooman Azmi, MD?**
   a. The disease is not well known to most clinicians.
   b. Each patient's condition is different, with less consistency than seen in other diseases.
   c. Patients' medications must be carefully timed, which can be overlooked or difficult to achieve in hospitals.
   d. Parkinson's patients can be combative and resistant to following a care plan.

CE OBJECTIVES

Upon completion of this educational activity, participants should 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.