2014 Considerations for Health Care Organizations

For Consideration	Site Visit Review
Dual Leadership Structure	Health care organizations often have both an administrative structure and a medical/physician leadership structure. Both should be reviewed in category 1 (see Note 1.1). The site visit team may explicitly need to request the medical leadership organizational chart, as it may not be included with the applicant organizational chart. Both the administrative leadership and the medical leadership should be interviewed on-site separately and together.
Governance/Board of Directors (BOD)	Often in health care organizations, the BOD is very involved, so examiners should expect to read more in 1.2a about the board's involvement in the governance system. The site visit team should expect to interview someone from the BOD about governance issues. If the BOD is meeting during the site visit, examiners may be able to observe the meeting.
Community Health vs. Community Service	No distinction is made between the two terms (community health and community service) in the Business and Education Criteria; however, health care organizations are expected to go beyond community service and directly impact and improve the health of the communities they serve (e.g., through screenings, education, and prevention/cessation programs). See Note 1.2c(2). Note: the applicant defines its key communities.
Safety (Patient, Staff, Community)	Patient safety and the culture of safety have risen to be areas of national importance in health care. Scorebook comments on patient safety should be addressed in 1.1a(3) and 6.2c(1) and might also be commented on in 3.2a(1). Safety requirements for staff should be addressed in 5.1b(1) and environmental well-being for the community in 1.2c (examples might include consideration of medical waste or radiation safety).
Workforce Paid by a Third Party and Volunteers	See Note 5.1 for a summary of the many types of people included in the term "workforce." All persons who provide a service on behalf of the health care organization should be considered staff. All persons who provide a service on behalf of the health care organization may be interviewed, including medical, nursing, and ancillary services students. Note: Site visit team leaders may wish to request from the organization's official contact point (OCP) a list of all persons providing a service on behalf of the health care organization who were not included on organizational charts. They may request this list by asking for the internal employee and staff directory or by asking specifically for others not included on

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	the organizational charts.
Are Physicians Staff, Partners, Suppliers, Customers, Contractors, or a Little of Both?	Physicians play multiple roles within health care organizations, and health care organizations may call them staff, partners, suppliers, contractors, and even customers. Yet, they are definitely part of the organization's workforce (see Note 5.1 and the definition of "workforce") because they provide care in the name of the organization. In almost any health care organization, physicians as a segment are critical; therefore, it is fair to expect the organization to provide segmented data on their expectations, requirements, satisfaction, etc., as the applicant would be expected to do for any workforce segment. On-site, the team may encounter a relatively new type of physician workforce member. This physician is called a "hospitalist," and more and more health care organizations are utilizing them. Hospitalists are specialists *employed* by the health care organization to manage the care of hospitalized patients in the place of the admitting physician, who may be considered a supplier, contractor, or partner depending on how the organization chooses to designate him or her. The team may interview hospitalists as well as other physicians including residents and medical students.
Contractors Providing Services	Often within health care organizations, contractors may provide services in the name of the organization on-site (e.g., the Emergency Department or an outpatient clinic). From the applicant's response in 2.1a(4) and P.1b(3) of the Organizational Profile, examiners should be able to gain a clear understanding of what services are provided by the applicant and by contractors, and how the two entities interface. On-site, contractors can be interviewed if patients partake of these services thinking they are receiving the services of the health care organization. Assuming the interview questions answer site visit issues (SVIs); suggested questions may focus on what metrics the contractor measures and shares with the organization, what care is provided by the contractor, how the contractor communicates with the organization, etc. The site visit team might also explore how the applicant oversees how the contractor addresses requirements in categories 3, 5, and 6. The site visit team is trying to verify deployment of the applicant's approaches and to ensure that the contractor's approaches are aligned with the applicant's.
What Patient Data Can Examiners Review?	Examiners may view aggregated or blinded patient data on-site. The Health Insurance Portability and Accountability Act (HIPAA), the patient privacy act, prohibits the hospital from sharing data on an individual patient. Patient charts hanging on wall racks, at the end of a patient's bed, or on a staff member's desk should be avoided. Participating in rounding discussions of an individual patient is also prohibited. Examiners may not look at an individual patient's electronic health record when requesting a demonstration of the EHR system.
Publicly Reported Data	Numerous organizations including the Joint Commission, DNV, Healthcare Facilities Accreditation Program (HFAP), National Committee for Quality Assurance (NCQA) and Centers for Medicare and Medicaid Services (CMS) sponsor voluntary or required public recording of data.

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	For example the Joint Commission and CMS require reporting of clinical process measures called core measures. They share 30 core measures organized in 4 condition-specific bundles – acute myocardial infarction (AMI), pneumonia (PN), heart failure (HF), and surgical care improvement project (SCIP). The Joint Commission has 2 additional categories. Given a 50-page limit and an organization's key factors and strategic plan, applicants may not include all measures in their application. NCQA uses Healthcare Effectiveness Data and Information Set (HEDIS) measures for health results of screening and tests related to preventive health care and condition-specific care for insured populations. Item 7.1 asks applicants to include and indicate results for key measures that are publicly reported and/or mandated by regulatory, accreditor, or payor requirements. See the second Note 7.1 for specific examples. Site visit teams should verify publicly reported or mandated results, both those included in the application and identified on-site, as appropriate depending on the organization's key factors. On-site, examiners may ask to review a complete set of measures, followed by an interview with the quality staff to verify and clarify the meaning of the results. Any major concerns uncovered by the site visit team should be discussed on-site by the team leader and NIST monitor with the highest-ranking officer (HRO) and noted on the HRO Interview Form. CMS has shifted to a prospective pay-for-performance reimbursement model called Value-Based Purchasing (VBP) that financially incentivizes/penalizes hospitals based on their performance on specific measures for their Medicare population. Examiners should review these core measures (thirteen measures from the 4 bundles) and outcomes results (3 measures) provided by the applicant in the Updated Results, in order to determine if the applicant's results are at or above the achievement threshold (50th percentile) or meeting/exceeding benchmark performance (90th percentile). For FY 14, these measures account for 70% of the organization's overall VBP performance and are typically reported in 7.1. In addition, 8 aggregated measures of patients' experience of care (HCAHPS) account for the other 30% of an organization's VBP performance. These measures are reported in 7.2. Achievement threshold and benchmark comparisons are based on a national baseline reporting period. Note: Organizations must have at least 10 cases for at least four core measures and at least 10 cases for 2 of the three outcomes measures to be rated under the VBP process during the reporting period. In addition, certain types of hospitals are exempt from VBP including pediatric, rehabilitation, cancer, and psychiatric hospitals as well as long term care facilities.

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Process and Outcome Results for 7.1a Patient-Focused Health Care Results	Process results refer to percentage compliance with clinical therapies, guidelines, standards of care, and practice parameters related to patient care. Outcome results refer to the patient's health status and might include complications, reoccurrences, mortality, or functional status data.
Process Results Related to Patient Perspectives on Care Reported in 7.2 Customer-Focused Outcomes	CMS also requires Hospital Consumer Assessment of Healthcare Providers and Systems (HCAHPS; pronounced "*h caps*") results for measures of the patient's perspective on hospital care. HCAHPS survey results relate to 18 core questions about critical aspects of patients' hospital experiences (communication with nurses and doctors, the responsiveness of hospital staff, the cleanliness and quietness of the hospital environment, pain management, communication about medicines, discharge information, overall rating of hospital, and would they recommend the hospital). These core questions are aggregated into the 8 Domain HCAHPS measures. Portions of a hospital's reimbursement are at risk for poor performance. Site visited applicants will provide the last two year's reports from CMS along with their Updated Results prior to the site visit. On-site, examiners will receive current results for these measures, as well. The team should look at all of this data to determine data trends, whether the applicant's results are at or above the achievement threshold (50th percentile) or meeting/exceeding benchmark performance (90th percentile), and what the applicant is doing to close any gaps in its results.
Information Management	Many organizations are now moving to electronic health records (EHR) to improve patient safety and the effective sharing of patient information across multiple sites and providers. As part of the federal Meaningful Use (MU) incentive program, hospitals are receiving financial incentives to implement EHR systems. EHR systems do vary widely across the country. Examiners will need to understand how the applicant designs and implements its systems to share patient information, including the breadth of sharing of information. On-site, the team should ask for a demonstration of how the data systems work together. In health care organizations that do not have integrated systems, the site visit team may see data produced in different ways. The team should also ask the organization about whether the organization is receiving financial incentives under MU for its EHR.
Magnet Hospitals	Magnet status is recognition of an organization's efforts to promote nursing excellence, the satisfaction of nurses, and the sharing of best practices. The recognition, given by the American Nurses Credentialing Center (subsidiary of the American Nurses Association), is certainly a strength but does not mean that the hospital gives good care across the board. Magnet status refers only to nurses and not to other staff.
Delivery System and Payment	Providers and payers have introduced various delivery system and payment models in efforts to improve quality and coordination across a patient's continuum of care, reduce costs, and in some models, improve population health. One

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Models	example is accountable care organizations (ACOs) in which health care organizations come together voluntarily to care for a designated population of Medicare patients and share savings and losses. Other examples include risk arrangements between providers and payers in which payments depend on the achievement of specific measurement targets, bundled payments in which providers are paid for an entire episode of care rather than fragmented portions, and patient-centered medical homes in which all care is coordinated through a primary care provider. A single entity such as a hospital or physician practice organization may participate in more than one of these models simultaneously. _____ On-site, the team should make sure they have a clear understanding of all the key stakeholders, the reporting relationships among these various stakeholders, and the roles each of these providers play in achieving the mission of the applicant.