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New Psychiatric Unit/Facility Quality Reporting (IPFQR) Requirements

Psychiatric hospitals and hospitals with inpatient psychiatric units that bill under the Medicare Inpatient Psychiatric Facility PPS program have new reporting requirements effective Oct. 1, 2012. **These measures must be reported for ALL patients not just Medicare beneficiaries.**

The measures include:

- HBIPS-2: Hours of Physical Restraint Use
- HBIPS-3: Hours of Seclusion
- HBIPS-4: Patients Discharged on Multiple Antipsychotic Medications
- HBIPS-5: Patients Discharged on Multiple Antipsychotic Medications with Appropriate Justifications
- HBIPS-6 Post Discharge Continuing Care Plan Created
- HBIPS-7 Post Discharge Continuing Care Plan Transmitted to Next Level Provider Upon Discharge

CMS allows no sampling for HBIPS-2 and HBIPS-3. For these measures, facilities are required to collect information on the total number of minutes that each psychiatric inpatient is in physical restraints and/or in seclusion. Patient days for the full psychiatric unit population and event days must be collected (and reported) according to the age strata of the patient, therefore hospitals need to collect psychiatric census by age.

The initial patient population for the last four measures is the discharged patient population. For these measures, CMS allows facilities/units to provide information based upon a sample of patients. Information collected for this set of measures needs to be age stratified as well.

Although facilities/units need to collect patient level data, aggregate data is what is reported to CMS. The CMS web-based database will only accept this aggregate data between July 1, 2013 and August 15, 2013. The data will need to be reported according to age strata. Although the seclusion and restraint data will be reported in hours, CMS asks that providers not round the information but rather convert minutes to hours carried out to at least two decimal points.

Hospitals participating in this program must complete a notice of participation form between Jan. 1 and Aug. 15, 2013. The paper form will be available in January.

This issue includes information about:

- Psychiatric facility quality reporting
- Recommendations for Stage 3 of Meaningful Use
- IHI National Annual Forum Keynote
- Outpatient Quality Reporting
- Expansion of The Joint Commission Requirements
- Population Health …and More

Even hospitals that participate in Inpatient Quality Reporting need to register separately on QualityNet to participate in this program.

Providers who report psychiatric measures to the Joint Commission (TJC) will need to report their data separately to CMS; there are differences between what CMS requires and what is required by TJC. Inpatient psychiatric units not separately licensed, with services billed under the inpatient perspective payment system, ARE eligible to report to TJC, although these units are NOT eligible to report to CMS. Also, TJC has 7 measures rather than 6 in its psychiatric measure set. The TJH measure set includes HBIPS-1, a measure for admission screening for violence risk, substance use, psychological trauma history and patient strengths. CMS currently has no plans to include this measure in its psychiatric facility quality reporting.

Note, hospitals will be reporting in July on two quarters of activity, the 1st quarter Oct. 1-Dec. 31, 2012 and the 2nd quarter Jan. 1-March 31, 2013. CMS is currently using TJC's measure specification manual for psychiatric quality reporting. These manuals are updated each quarter usually six months before they are to be implemented. Providers should make sure that they are using the right manual for each quarter. Release notes summarize the changes between quarters.

On Dec. 6 and Dec. 20 CMS held webinars on psychiatric facility quality reporting. A recording of the Dec. 6 webinar and a copy of the slides are now available. The slides from the Dec. 20 webinar are available, although the recording of the webinar is not yet posted. CMS reported that the **next webinar on IPFQR would be held Jan. 10th at 2:00 p.m**. and that the information about this would be posted on the QualityNet home page under QualityNet News.

The April 2013 *Hospital Compare* Preview Reports are available Dec. 20, 2012 - Jan. 18, 2013. For more information, click here.

Final Rules: Outpatient and Ambulatory Surgery Center Prospective Payment Systems and Quality Reporting

On Nov. 15th, CMS issued in the Federal Register a final rule on hospital outpatient and ambulatory surgery center prospective payment and quality reporting. CMS had not proposed any new measures for the hospital outpatient quality reporting (OQR) program in this year's proposed rule. CMS did not include any new quality measures in the final rule.

CMS reiterated its decision to suspend three previously finalized measures:

1) OP-15, use of brain computer tomography in the emergency department for atraumatic headache -- public reporting is not planned prior to July 2013;
2) OP-19, transition record with specified elements received by discharged patients and their caregivers– suspended until further notice; and
3) OP-24, cardiac rehabilitation-patient referral from outpatient settings.

CMS also confirmed its removal of OP-16-Tropinin Results for ED Acute Myocardial Infarction Patients or Chest Pain Patients Received Within 60 minutes of arrival.

CMS did not propose any additional new measures for ASC Quality Reporting Program in this year's proposed and final OPPS rule.

The regulations include a review process called immediate advocacy that aims to quickly resolve beneficiary concerns brought through oral (vs. written) complaints. Such complaints must be made within 6 months of the date of care; all parties must consent to use of oral advocacy. Immediate advocacy cannot be used for gross, flagrant, substantial or significant quality concerns.

The rule also limits the timeframe for filing a written complaint to three years and notes that electronic complaints are sufficient. Providers and practitioners must respond to a written complaint within 14 days (or sooner if the concern involves a gross or substantial quality of care issue or the circumstances warrant earlier receipt of the medical information).

Click here for a copy of the final rule.

Federal Committee Seeks Comment for Stage 3 MU Requirements

The Federal HIT Policy Committee, an advisory body to the Department of Health and Human Services, created a set of recommendations for Stage 3 meaningful use. CMS gave considerable weight to this committee's recommendations for both Stage 1 and Stage 2 meaningful use (MU) requirements.

The recommendations show a change from a setting specific focus to a collaborative, patient and family-centric approach. Many of the MU objectives recommended are the same but their thresholds are higher, with some menu objectives becoming core objectives. There are several new MU objectives recommended for comment. One which involves "closing the loop" calls for requiring referral providers to send information to requesting providers and hospitals to acknowledge the receipt of external information sent by referral providers. Another calls for hospitals to send electronic notifications within two hours of a significant healthcare event (e.g., ED arrival, inpatient admission, hospital discharge) to key members of the care team. Another would require providers to allow for patients to have the ability to request an amendment to their record online. The recommendations note a shift from retrospective/human chart reviews, to reviews based on concurrent machine automated data.

The recommendations also included 26 open ended questions including ones on: how to incorporate consumer data in Clinical Quality Measures (CQMs); whether to retool existing quality measures or design CQMs de nova (taking into consideration the richness of EHR data); how to develop CQMs for population management; and whether or not there should be an optional component of MU CQM requirements for institutions to initiate eCQMs important to their own organization.

Click here for a copy of the HIT Committee's recommendations. The committee has requested public comments on the recommendations. HANYS is partnering with the American Hospital Association (AHA) to submit them.

HANYS Guidance on NYPORTS Fall Reporting

At the request of HANYS members, the HANYS Statewide Steering Committee on Quality assisted in the development of HANYS Guidance, NYPORTS Fall Reporting to help hospitals determine whether or not a fall must be reported to the State Department of Health. Click here for a copy of this guidance.

The Road to Population Health: Key Considerations

On a Nov. 14th webinar hosted by Becker's Hospital Review, Amit Shah, MD and James Stanford, from Objective Health, a McKinsey Solution, discussed trends in population-based care delivery models.

Dr. Shah noted "the three building blocks for population-based models: 1) division and organization of population base where care is delivered to meet specific patient needs as indicated by patient segmentation; 2) a multidisciplinary care system that includes the establishment of clinical protocols and evidence-based care procedures, care coordination, case conferences and clinical performance reviews; and 3) supporting enablers which include intangible strengths and functions such as aligned incentives, joint decision-making, information transparency, clinical leadership and patient engagement."

Mr. Stanford talked about the need for healthcare providers to "modify and strengthen five traditional capabilities for a significant transition from one "old" function to the "new normal". These capabilities include: 1) a move beyond physician recruitment to clinical integration; 2) a transition from acute care excellence to managing the care continuum; 3) excel(ling) from payor contracting to risk management; 4) a move from cross subsidization to focused lines of business management and 5) a switch from business-to-business marketing to business-to-consumer marketing in which you identify, understand, reach, engage and influence consumers. Click here for the original article from Becker's Hospital Review about the webinar and click here for a copy of the slides.

Institute for Healthcare Improvement (IHI) Resources

Often the best resources found on a website are the ones found while you are searching for something else. Such was the case with the following. The IHI website (www.ihi.org) has a section labeled CMS Partnership for Patients resources. This page provides guides and a list of mentor hospitals for each quality and patient safety focus area. Mentor hospitals are listed by location, type of geographic area, type of hospital, and bed size. Specific program information is summarized and a contact with his/her contact information is also provided. All of the contacts have agreed to be available for information requests.

For more information contact your NorMet Quality and Safety Support Staff at (845) 562-7520, or
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Path to Quality Improvement and Innovation Discussed at IHI National Forum

The Institute for Healthcare Improvement (IHI) held its Annual National Forum on Quality in Healthcare on Dec. 11th and 12th in Orlando, Florida. Maureen Bisognano, President and CEO, IHI, gave the keynote presentation. Dan Heath, Senior Fellow at Duke University's CASE center and co-author of "Switch: How to Change Things When Change is Hard" and Don Berwick, MD, former President and CEO of IHI, also gave full group presentations to the 5,000 attendees.

Ms. Bisognano opened the forum noting that in health care we have changed our focus from asking patients "what's the matter" to asking them "what matters to you". She reminded us that both the right context and mechanisms are needed to produce (positive) outcomes.

Mr. Heath talked about the process of change noting that there were two parts of the brain, one being the rational, conscious, deliberate part and the other being the emotional, unconscious, automatic part. Each faction fights with the other one for control. He said that the second one, the emotional one, is responsible for change. We attempt to motivate people with data and information rather than realizing that emotion is the fuel for change. In his early work on change, John Kotter noted that to change people need to analyze and think first. In his later work, however, he felt differently remarking that in actuality, people need to see and feel something first before they change.

Mr. Heath commented that we enjoy spending time solving problems and therefore spend more time on answering the question "what went wrong and how can we prevent it" rather than focus on "what is going right and how can we improve it." He noted that sending congratulatory notes, giving certifications or balloons for good work or putting messages on a white board commending someone are all powerful motivators for change.

Don Berwick, MD, focused on the importance of using global brains to solve problems in health care by drawing on successes in other parts of the world. He noted the need for us to focus on palliative and end of life care as well as "authentic prevention".

A Human Factors Approach to Root Cause Analysis

There was a presentation at the recent IHI Annual National Forum on "A Human Factors Approach to Root Cause Analysis". Thomas Diller, MD, VP Quality and Patient Safety and Sharon Dunning, MBA, RN, Greenville Hospital System; George Helmrich, MD, Chief Medical Officer, Baptist Easley Hospital; and Scott Shappell, PhD, Professor and Chair, Embry-Riddle Aeronautical University spoke on the topic. They described the standardized taxonomy for analyzing events, then details of the taxonomy used in Common Cause Discovery. Common Cause Discovery aggregates root causes over time for all events.

The Human Factors Analysis Classification System (HFACS) is a system based on James Reason's Swiss Cheese Model of Accident Causation, developed by Scott Shappell and Doug Weigmann for the US Navy and Marine Corps Aviation and modified for use in healthcare. HFACS looks at the following:

Organizational influences
- Resource management
- Organizational climate
- Organization process

Supervision
- Inadequate supervision
- Inappropriate planned operations
- Failure to address known problem
- Supervisory violation

Precondition for unsafe acts
- Environmental Factors
  - Physical
  - Technical
- Condition of Operator
  - Adverse Mental State
  - Adverse Physiological State
  - Chronic Performance Limitation
- Personnel Factors
  - Communications, Coordination, Planning
  - Fitness for Duty

Unsafe Acts
- Errors
  - Errors, Skilled Based
  - Error, Decision
  - Error, Perceptual
- Violations
  - Routine
  - Exceptional

With the use of HFACS, actionable common causes were identified along with commonalities across departments/services/units. Unintended consequences were avoided and system solutions were developed. For further information about this process, contact our office.

Joint Commission Expands Performance Measurement Requirements

The Joint Commission will expand performance measurement requirements for accredited general medical/surgical hospitals from four to six core measure sets. The additional requirements will take effect January 1, 2014.

Four of the six measure sets will be mandatory for all general medical/surgical hospitals that serve specific patient populations addressed by the measures. The measure sets address acute myocardial infarction (AMI), heart failure, pneumonia and the Surgical Care Improvement Project (SCIP).

For hospitals with 1,100 or more births per year, the perinatal care measure set will become the mandatory fifth measure set. The Joint Commission will monitor the threshold of 1,100 births over the first four to eight quarters of data collection to reassess ongoing applicability. The Joint Commission expects that this threshold will be modified over time so that more hospitals are included and strongly encourages hospitals to consider adopting this measure set before the required effective date of January 1, 2014.

The sixth measure set (or fifth and sixth measure sets, for hospitals with fewer than 1,100 births per year) will be chosen by all general medical/surgical hospitals from the approved complement of core measure sets.

The Joint Commission expects that requirements will increase over time, depending on the national health care environment, emerging national measurement priorities and hospitals' ever-increasing capability to electronically capture and transmit data.

Although hospitals must modify and update measure set selections two months before the start of data collection on January 1, 2014, data received for the newly added measure sets and measures will not be incorporated into calculations for either Performance Improvement (PI) Standard PI.02.01.03 (which requires that the hospital improve its performance on ORYX accountability measures) or the Top Performers on Key Quality Measures™ program until sufficient data are received. This will provide hospitals a minimum of 12 months and up to 23 months of experience with the new measure sets before the data are included in performance calculations.

Performance measurement requirements for critical access hospitals and specialty hospitals, such as children's hospitals and psychiatric hospitals, will continue as currently defined until other applicable metrics are identified and implemented.