NorMet
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Key Upcoming Dates

Federal Fiscal Year (FFY) 2013, which begins Oct. 1, 2012 will see the start of the Medicare Value-Based Purchasing (VBP) Program affecting the Average Payment Update (APU) of Inpatient PPS Hospitals (whose updates will be decreased by 1.0% as a contribution to the VBP pool) and the commencement of the Medicare Readmissions Reduction Program (with reductions for hospitals with higher than expected risk adjusted rates capped at 1.0%). Jan. 1, 2013 will see the start of the reporting of new Medicare Inpatient Quality Reporting Measures (MRSA, Cdiff, the Stroke Set and Venous Thromboembolism Set); a possible reduction of 2% of the APU for lack of reporting of Medicare outpatient reporting measures, including some new measures, and a possible 2% reduction in the APU for lack of reporting of Ambulatory Surgery Center measures.

Hospital Value-Based Purchasing Domains

For FFY 2013, payment under Medicare Hospital Value-Based Purchasing will be based upon a hospital's performance on two domains: a clinical quality of care domain and a patient experience of care domain. In FFY 2014, a third domain, an outcomes domain, will be included in value-based purchasing. In FFY 2015, the Centers for Medicare and Medicaid Services (CMS) are proposing to add a fourth domain, an efficiency domain, to the mix. The efficiency domain measures spending per Medicare beneficiary and would include all Part A and Part B payments from 3 days prior to hospital admission through 30 days post discharge with certain exclusions. It would be risk adjusted for age and severity standardized.

Hospital Value-Based Purchasing Domain Weights

Measure Domain	FFY 2013 Final	FFY 2014 Final	FFY 2015 PROPOSED
Process	70	45	20
HCAHPS	30	30	30
Outcomes		25	30
Efficiency			20

This issue includes information about:

- Key Implementation Dates for Federal Quality Initiatives
- Electronic Health Record Clinical Quality Measures vs. Medicare Inpatient Quality Reporting Measures
- New Medicare Conditions of Participation
- New Joint Commission Standards
- Recent Comments by Dr. Shah at IPRO Meeting
- Million Hearts™ Campaign

Electronic Health Record Clinical Quality Measures and Inpatient Quality Reporting Measures

The March 7 Proposed Rule for the Electronic Health Record Payment Incentive contained a menu of 49 proposed Clinical Quality Measures (CQM) for hospitals to choose from in order to meet the requirement for 24 CQMs for Stage 2 of Meaningful Use (MU) in FFY 2013 or Stage 1 and 2 of MU FY 2014 and beyond. All but 9 of the proposed 49 measures had the same name as current Medicare Inpatient Quality Reporting Measures (IQR) or The Joint Commission (TJC) Core Measures. However, although the CQMs share the same name as many of the IQR and TJC measures, the two sets of measures differ significantly from one another. The measure sets use different specifications manuals, the core measures are chart-abstracted vs. the MU measures being obtained electronically from an EHR and the data code sets differ – ICD-9 codes, UB-04 billing for IQR measures vs. SNOMed, LOINC, and RxNORM for the MU measures.

The Proposed Rule for FFY 2013 Inpatient PPS contained no specific proposals related to Health Information Technology and Quality Reporting. However, the rule did contain discussion of two options. The first option is to select a date after which chart-abstracted data no longer can be used where it is possible to report the data via EHR technology and the second is to allow hospitals to submit the same measure for the IQR program based on either chart-abstraction or when available EHR based reporting.

ICD-10 Codes and Healthcare Acquired Conditions

CMS has drafted a crosswalk of ICD-9 codes to ICD-10 codes that define Healthcare Acquired Conditions. The crosswalk is found at http://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/HospitalAcqCond/icd10_hacs.html CMS proposed to delay the implementation of ICD-10 Codes until October 2014.

The Joint Commission (TJC) Requirements

Effective June 5, TJC revised its requirement for *waived testing*: Standard WT 04.01.01, EP 4. For instrument-based waived testing, quality control checks must be performed on each instrument used for testing per the manufacturer's instructions. Previously, the standard called for checks each day or more often if the manufacturer's instructions were more stringent.

Effective July 1, 2012, TJC strengthened its existing hospital, critical access hospital, and long-term care organization requirements for *influenza vaccination programs for all licensed independent practitioners and staff*. TJC also expanded the vaccination standard to include the ambulatory care, behavioral health care, home care, laboratory and office based surgery accreditation programs. In addition to establishing a vaccination program, the standard requires accredited organizations to set incremental goals for meeting a 90 percent coverage rate by 2020. Organizations will also be required to measure and improve staff vaccination rates.

TJC standards to address *patient flow through the emergency department* have been revised effective Jan. 1, 2013. The changes call for:

- hospitals to measure and set goals for the components of the patient flow process, including the throughput of areas where patients receive care, treatment and services (such as inpatient units, laboratory, operating rooms, telemetry, radiology, and PACU) and the efficiency of the non-clinical services that support patient care and treatment (such as housekeeping and transportation)
- hospitals to measure and set goals for mitigating and managing the boarding of patients who come through the emergency department (effective Jan. 1, 2014)
- individuals who manage patient flow processes to review measurement results to determine that goals were achieved
- hospital leaders to take action to improve patient flow processes when goals are not achieved
- when the hospital determines that it has a population at risk for boarding due to behavioral health emergencies, hospital leaders communicate with behavioral health providers and/or authorities servicing the community to foster coordination of care for this population (effective Jan. 1, 2014).

Changes to Federal Medicare/Medicaid Hospital Conditions of Participation (CoPs)

A final rule issued in the May 16 Federal Register on the Medicare/Medicaid Conditions of Participation for Hospitals included a number of changes. The changes are scheduled to take effect July 16, 2012.

CMS will allow a single governing body to oversee multiple hospitals in a multi-hospital system. However, according to this same rule, CMS will require a member of the medical staff to serve on the governing boards of individual hospitals and health systems. In addition, CMS reinterpreted existing medical staff regulations stating that the CoPs have never allowed a multi-hospital system to elect to have a single, integrated medical staff. Both of the above provisions have been challenged by the American Hospital Association. Because of expressed concerns, in a memorandum to state survey agencies, CMS said surveyors should not assess compliance with the requirement that hospital governing boards include a medical staff member without receiving instruction from CMS.

The Final Rule also included a provision to eliminate the current criteria around infection control logs and continues to allow hospitals the flexibility for tracking and surveillance of infections while removing a requirement for a sole director over all outpatient services.

A proposed rule on the Medicare/Medicaid CoPs was issued May 4. The proposed rule has provisions requiring hospitals to offer all inpatients and outpatients an annual influenza vaccination, unless there are medical contraindications or the patient has already been vaccinated. Before receiving the vaccination, each patient (or patient representative) must receive education regarding the benefits, risks, and potential side effects. The patient would also have the option of using an interpreter of his or her choosing or one supplied by the hospital. The vaccinations would need to be offered annually from the time the vaccine is available on or after Sept. 1 until the end of February. The Medical Record would have to include documentation of all of this occurring. Comments on the proposed rule are due by July 5. The rule is expected to be finalized in early Fall in time for the 2011-2012 influenza session.

NYS Partnership for Patients

Upcoming offerings for the NYSPFP include: CLABSI Outside the ICU Setting July 18; The Technical & Socio-Adaptive Aspects of Preventing CAUTI July 18; Innovations in CAUTI and CLABSI Reduction August 8. For information go to: www.nyspfp.org

State Quality Issues Update

Observation Services

Working with the Healthcare Association of New York State, The Suburban Hospital Alliance of New York State initiated state legislation that corrects problems created by overly prescriptive and limiting state observation bed requirements issued earlier this year by the NYS Department of Health. The earlier state requirements called for observation services to be provided in a distinct unit overseen by the emergency department, which conflicts with Medicare observation service rules. The bill was passed prior to the adjournment of the 2012 State Legislative session and is awaiting the governor's signature at press time.

Bordetella Pertussis Vaccination for Parents and Caregivers

Another bill, A. 9381 and S. 6500 passed both the New York Assembly and Senate. This bill requires hospitals with a newborn nursery or obstetric services to annually offer (between September 1 and April 1) to every parent, person in parental relation, or other person reasonably anticipated to be a caregiver of a newborn treated in the hospital, a vaccination against Bordetella pertussis. The Healthcare Association of New York State had expressed concerns regarding provision of the vaccine to caregivers who are not patients and offered an amendment to allow the hospital to refer caregivers to their physician or a clinic to receive the vaccination. The bill is awaiting delivery to the Governor.

Internet System for Tracking Over-Prescribing (I-STOP)

This bill establishes a real-time registry/database with patient-specific controlled substance prescription information, mandates electronic prescribing, updates the controlled substance schedules, addresses education and awareness around abuse of controlled substances, and creates a safe disposal program for prescription drugs. Prescribing practitioners must consult the registry prior to prescribing a Schedule II, III, or IV controlled substance, with exceptions, and dispensing pharmacists must report patient-specific prescription information into the registry. The bill passed the Assembly and Senate and is awaiting delivery to the Governor.

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Surgical Care Improvement Project and VTE Prevention

On June 12, IPRO sponsored a webinar including a discussion on the Surgical Care Improvement Project measures and Venous Thromboembolism (VTE) Prevention. Dr. Dale Bratzler, DO, MPH, Professor and Associate Dean, College of Public Health of The University of Oklahoma; and Chief Quality Officer of the Oklahoma University Physicians Group spoke at the webinar. Dr. Bratzler reviewed the components of a new antibiotic guideline to be released in June, noting that there were not many changes in the new guideline. Cefazolin is the agent of choice for most clean operations and Cefazolin plus metronidazole may be preferred for colorectal surgery in some institutions. He noted that antibiotics should be discontinued within 24 hours commenting that perhaps that was the most effective antibiotic stewardship performance measure to date.

As concerns VTE, Dr. Bratzler noted that VTE includes deep vein thrombosis (DVT) and pulmonary embolism (PE). The best estimates indicate that 350,000 to 600,000 Americans each year suffer from DVT and PE, and that at least 100,000 deaths may be directly or indirectly related to these diseases. He noted that VTE remains a major health problem and that in addition to the risk of sudden death, 30% of survivors develop recurrent VTE within 10 years, while 28% of survivors develop venous stasis syndrome within 20 years. He discussed the six refined measures currently being reviewed by the National Quality Forum. These include:

- prophylaxis within 24 hours of admission or surgery, or a documented risk assessment showing that the patient does not need prophylaxis
- prophylaxis/documentation within 24 hours after ICU admission or surgery
- patients with overlap of anticoagulation therapy should have at least five calendar days of overlap and discharge with INR $\geq$ 2.0, or discharge on overlap therapy
- patients receiving UFH with dosage/platelet count monitoring by protocol/nomogram
- discharge instructions for patients on warfarin consistent with Joint Commission safety goals
- incidence of potentially preventable VTE – proportion of patients with hospital-acquired VTE who had NOT received VTE prophylaxis prior to the event

To receive a copy of the handouts from this webinar, contact us.

Dr. Shah Speaks at IPROs 28th Annual Meeting

On June 5, IPRO held its 28th Annual Membership Meeting. Nirav R. Shah, MD, MPH, Commissioner, New York State Department of Health, gave the keynote address at the meeting. During his presentation, Dr. Shah focused on the need for those of us working in the health care system and in health care organizations to "get out of our silos and work together". He noted that "primary care needs outweigh availability and inpatient care availability outweighs demand." He challenged those in the health care community to recognize the end of the fee for service system as we know it and a focus on prevention. The statewide health exchange with comparative marketplace options forthcoming will lead to 1 million more New Yorkers having health insurance coverage. The New York State Department of Health will be establishing an Office of Quality and Patient Safety to help bring the State's quality and safety initiatives forward. The State will emphasize health promotion and prevention as it works closely with the Centers for Disease Control and Prevention (CDC) and the Centers for Medicare and Medicaid Services (CMS) on the Million Hearts™ campaign. Dr. Shah noted that a "Center for Innovation" will work with primary care providers next year through the NYS Department of Health to improve the health of New York State residents. A statewide hypertension registry will be established. The State will take a more community-based approach to patient treatment. Dr. Shah acknowledged that providers were being bombarded with performance measures and that the State needs to simplify things for providers.

Web Conference with AHRQ and CMS on HCAHPS

On June 28, the Agency for Healthcare Research and Quality (AHRQ) and the Centers for Medicare and Medicaid Services (CMS) held a special web conference on HCAHPS and value-based purchasing (VBP). For Federal Fiscal Year 2013, beginning Oct. 1, 2012, thirty-percent of a hospital's score on VBP is dependent upon how well a hospital performs on the "patient experience of care domain" as measured by their patients' responses to their HCAHPS survey. There are eight dimensions to this domain. These include: communication with doctors; communication with nurses; responsiveness of hospital staff; cleanliness and quietness; pain management; communications about medications; discharge information and the overall rating of the hospital. CMS will be looking at how often patients choose the "top box" responses – e.g., the "always" response for always/never questions; the "yes" response for yes/no questions; and a "9 or 10" rating for a question using a ten-point scale.

HCAHPS continued

For FFY 2013, the VBP base period will be July 2009 - March 2010 and the performance period will be July 2011 - March 2012. To have a patient experience of care score a hospital must have had at least 100 completed surveys in the performance period. The patient experience of care score is comprised of a hospital's HCAHPS base score (with a total of 80 points) and its HCAHPS consistency points (with a total of 20 points). A hospital's base score is comprised of the total of its dimension scores. For each dimension of the patient experience of care domain, a hospital will get one score – either its improvement score or its achievement score, whichever is highest. The improvement score is the difference between the hospital's baseline score and its performance score. The achievement score is the difference between the hospital's performance score and the national median score. A hospital's HCAHPS consistency points are based upon the hospital's lowest performing HCAHPS dimension score during the performance period and how that score compares with the floor, the poorest performing hospital during the baseline period. For more detailed information about this issue go to http://www.cms.gov/Hospital-Value-Based-Purchasing/.

Million Hearts™ Initiative

Million Hearts™ is a national public-private initiative co-led by CDC and CMS. The goal of the campaign is to prevent 1 million heart attacks and strokes in the US over the next five years. The Initiative is focusing on two aims: empowering Americans to make healthy choices (such as preventing tobacco use and reducing sodium and trans fat consumption) and improving care for people who need treatment by encouraging a focus on the ABCS- **A**spirin for people at risk, **B**lood pressure control, **C**holesterol management, and **S**moking Cessation. These activities address the major risk factors for cardiovascular disease and can help to prevent heart attacks and strokes. For additional information go to: www.millionhearts.hhs.gov.

Million Hearts™ Benchmarks for Success

Indicator	Baseline	2017 Goal
Aspirin use for people at high risk	47%	65%
Blood Pressure Control	46%	65%
Effective Treatment of High Cholesterol (LDL-C)	33%	65%
Smoking Prevalence	19%	17%
Sodium Intake (average)	3.5g/day	20% reduction
Artificial Trans Fat Consumption (Average)	1% of calories/day	50% reduction