

Inpatient Psychiatric Facilities Quality Reporting Program

Support Contractor

FY 2015 IPF PPS Final Rule Transcript

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Deb Price: Hello, and welcome to the Inpatient Psychiatric Facilities Quality Reporting Program webinar. Thank you for joining us today. My name is Deb Price, and I am the education coordinator for the event.

This slide shows you how to use the Q&A feature for today's event. Move your mouse over the green WebEx navigation panel at the top of your screen, where a menu will drop down. Click the Q&A, and the Q&A panel will display on your screen.

Click the drop-down arrow next to Ask, and select all panelists. You type your question, and then click Send. Your question will be reviewed and addressed by a subject matter expert.

Before we begin, I'd like to make a few announcements. This program is being recorded. A transcript of today's presentation and the audio portion of today's program will be posted at QualityNet at a later date. Slides were sent out via the ListServe on Monday, as both a one-page, a one slide per page, and a three slides per page.

If you have not yet downloaded them, you can have another attendee forward them to you, or you can call us at 844-472-4477. Again, that number is 844-472-4477. Someone will send you the slides as we are progressing through the webinar.

All of our communication is via the IPF ListServe. If you are not currently receiving any updates, please make sure you register on our IPF ListServe. Next slide, please.

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Let me now introduce today's speaker, Renee Parks. Renee received her Bachelor of Science in Nursing from the University of Central Arkansas. She joined the FMQAI team in 2012. Ms. Parks has over 20 years of experience in various clinical and management positions, including serving in the US Army Nurse Corps.

Renee has also provided numerous trainings and presentations to physicians, vendors, clinical offices and administrative staff. Renee will now be giving you an update on the fiscal year 2015 IPF PPS final rule. Renee?

Renee Parks:

Thanks, Deb. I want to welcome everyone to today's presentation. Before we begin, I would just like to advance to slide 2 and share some dates with you that will be important for the IPF Program. These are our upcoming events of our webinars. As Deb said, if you are not a member of the ListServe, this is how we disseminate the information for the program.

Announcements will be coming out for the October 29th program shortly. This will focus on new measures. And in November, we will highlight the measured data from the fiscal year 2015. In December, we will be covering public reporting.

The learning objectives for today are that you would understand the program requirements and new measures and reporting timelines for 2015. Understand the program requirements needed also to receive your full annual payment update.

Slide 4, you will note that today's rule link is posted. This is an active link, and this went on display in the *Federal Register* on August 6th. The program section begins in section 8, or page 25 in the PDF, or page 45961 in the *Federal Register's* page numbers.

So we're talking about the Inpatient Psychiatric Program and the rule. So how does one participate in the program? As we move to slide 6, this slide shows all of the participation requirements. First off, you must receive payment under Medicare's Inpatient Psychiatric Facility Prospective Payment System. This is for free-standing hospitals, as well as those having psychiatric units in the critical access hospitals or in another acute care facility.

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You must have a registered QualityNet security administrator who will be active throughout the year. We highly recommend that you have more than one, because life events do occur.

Complete the online notice of participation that is on QualityNet Secure Portal. And the submission deadline for the notice of participation for the upcoming year will be August 15th of 2015.

You also must submit aggregate measure data for all of the web-based measures through the secure portal. And then those numerical values for all of the measures for each facility will be publicly reported. And lastly, to participate, you must sign and complete your Data Accuracy and Completeness Acknowledgement statement. These are the participation requirements.

As we follow on to slide 7, once an IPF is signed up through the notice of participation, you need not do that annually, as it will be carried forward. All of the information on the program, as well as resources and requirements, can be located at qualitynet.org.

For those IPFs that have wished to withdraw, you must do so no later than August 15th of 2015 for the annual payment update for 2016. As I stated on the previous slide, once you sign a notice of participation to participate, this is carried forward. The one caveat that you will need to do annually is to update the two contacts under the notice of participation tab in the secure portal and ensure that one of these contacts is identified to receive emails.

And again, the notice of participation remains in effect until one changes the status by either withdrawing or a facility closes the unit within an acute care facility, or a critical access hospital, or a free-standing facility.

For the new IPFs coming into the program, the first thing you'll need to do is establish a QualityNet security administrator. And the packet for that is located on qualitynet.org. You will need to have this and completed your Symantec's identification proofing through the secure portal in order to gain access for your facility to complete the notice of participation online.

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As stated previously, the deadline for the 2016 annual payment update for the reporting of the notice of participation is August 15th of 2015.

Now let's talk about participation requirements. The IPFs in this slide show the program requirements again and the deadlines for the fiscal year 2016. This is just a nice snapshot that shows everything and the timelines of which they are due by for the fiscal year 2016.

We do know that many IPFs may have a vendor to submit their measured data, but realize that the responsibility ultimately lies with the facility to ensure that all of that information is completed in a timely manner.

The Data Accuracy and Completeness Acknowledgement, or the DACA, is completed online through the QualityNet Secure Portal. And this will be done next year during the submission period of July 1, 2015 through August 15th.

As we move into slide 11, this will show you the reporting period for which the 2016 annual payment update will be made. On the far left side of the page, you will see all of the measures that will affect that and need reported on during the submission period.

These measures that you are currently well aware of, because they have been with the program since its beginning, are your HBIPS measures 2 through 7, and they will still be required moving forward. And in addition, there were two measures, substance one, which is your alcohol screening, and your follow-up after a hospitalization for mental illness is a claims-based measure.

So the IPF will not have to take action for reporting of this measure, and it will be calculated using Medicare fee-for-service claims, both A and B. We'll discuss this a little later. But the new measures that have been adopted for the 2015 final rule are the patient care experience and the electronic health record use. These were added and will affect your 2016 payment update.

We talked about the participation requirements, the timelines for reporting those; now let's move in to a little closer look for the measures. I want to highlight that this is an overview based on the final rule. As we stated at the beginning in our save-the-date slide,

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the October webinar will be focused more on a deeper dive for abstraction of each of the measures, where we'll review any changes to the current measures that were previously finalized and established and then do a deeper dive for each of the new ones.

So for this particular program in this presentation, this next slide on 13, if you're following along, is for all of the measures that will be required for fiscal year 2016. Again, the substance abuse, or the alcohol screening SUB-1, and the follow-up after hospitalization for mental illness is again a claims-based measure. So there will be nothing that you need to do.

And the claims for this measure are already in the warehouse, or most likely have already been billed, because they are from July 1st of 2013 claims through July 30th of 2014. So therefore, it's a whole year of claims, running the last six months of 2013 and the first six months of 2014. So all of these calculations will be done based on claims for the follow-up after hospitalization for mental illness.

As we stated earlier, the assessment for patient care experience and the use of electronic health records will be also added for the 2016 payment measures.

Now let's take a look at the measures that are—you look at the population size and may be able to obtain a random sample. Sampling is not required. However, if you do meet the sampling requirements, they're listed in the grid over to the right of this slide. And if you do not random sample, again, you should use 100% of your patient population. And this is for your HBIPS measures 4, 5, 6, and 7.

If you have less than 44 cases, you will need to submit 100% of those cases, because it does not allow for sampling.

Now for this measure set population, all of these measures for your HBIPS are inpatient psychiatric patients. Measures 4 through 7 focus around discharge elements. And 2 and 3 are really focused on your inpatient days. These are further stratified by the four age groups listed here, for children, adolescents, adults, and then your older adults.

This is a new measure that was previously adopted in your 2014 final rule. This is for your alcohol use screening. It's a numeric value

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that will be submitted via the QualityNet portal, in its numerator and denominator values. And individuals with mental health conditions experience substance abuse at a much higher rate as compared to the general population.

So the intent of this measure is to assess the efforts of the IPFs to screen for the most common types of substance abuse. The age strata is not applicable in this measure. This slide shows the numerator includes the patients who were screened for alcohol using a validated screening tool or screening questionnaire for unhealthy drinking. And a tool is considered to be validated if it has been psychometrically tested for reliability, validity and sensitivity. And examples of these can be found at the National Institute on Alcohol Abuse and Alcoholism's website.

There are many of those resources and different tools out there. So when you're taking a look to see if you—one meets this criteria, make certain that is for screening and not diagnoses.

The denominator includes all patients hospitalized who are 18 years and older. There are a few exclusions for this measure. And those would be younger than 18 years of age, cognitively impaired, or admitted for less than 1 day or greater than 120.

Here are the population sizes and sampling sizes that go with this SUB-1 IPF measure. You can again use the entire population or use a random sample. Sampling is not required, and if you do not sample, you must use 100% of the population. And remember, this one is not broken down into the age strata.

As we advance to slide 18, this is the measure follow-up after hospitalization for mental illness. Continuity of treatment and appropriate follow-up care and management of chronic diseases such as mental illness, are known to reduce the risk of repeated hospitalizations. So proper follow-up treatment can lead to improved quality of life. This measure assesses those patients six years and older who were hospitalized for treatment of selected mental health disorders and who subsequently had an outpatient visit, or an intensive outpatient encounter with a practitioner, or received partial hospitalization services.

Again, these services are obtained. There's nothing that a facility need do. These will be calculated based on your Medicare fee-for-

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service Part A and B claims. And we will look at the follow-up within 7 to 30 days after the inpatient discharge.

Due to the lag in claims and such, this measure will examine July 1st of 2013 to June 30th of 2014 for this 2016 annual payment update. Again, just want to stress that there's nothing that needs to be done. And most of those claims have already been submitted, because the date has passed.

Now as we look at the new measure, finalized in the 2015 rule, this is a—the reporting of this measure will begin to provide information on a priority area for the Health and Human Services National Quality Strategy. It's currently available.

The intent was to develop a standardized survey of care as a successor to this measure. So this will be an attestation. Basically it will—you will, during the resubmission period or the reporting period of 2015, which will be July 1st of 2015 through August 15th, of 2015; it's when you will be going into the portal yet again and entering all of your numerical values for your other measures, you will simply click on this measure and it will ask - do you administer a patient experience of care using a standard collection protocol or structured instrument?

If yes, then you would simply give the name of the survey administered. Definitions of a routine assessment can be also located in the rule.

Now let's talk a little bit about electronic health records. This is the second measure for fiscal year 2016 that was finalized with your FY 2015 rule. This also is a structural measure, or web-based measure, that will be entered during the submission period of 2015.

This will begin to provide information again on another priority area for the Health and Human Services National Quality Strategy. And this further aligns CMS's quality reporting programs, as this measure has been adopted previously by the other quality reporting programs for CMS.

So the use of a certified electronic health record by IPFs can effectively and efficiently help providers improve their care delivery practices. And it supports the exchange of important information during transitions of care and could in the future enable the

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reporting of electronically specified clinical measures. These two measures were adopted this final rule and will affect your fiscal year 2016 annual payment update.

So when you get to the portal, there will be two questions that you will simply attest to. And under Section 1, it further defines which best describes the facility's level at which they use electronic health records. And just as a reminder, this excludes your billing system. Most of that has been automated and electronic for a while now.

So there are basically three statements. One, that you primarily use paper for an exchange of information, sometimes may use an electronic health technology. And then the second bullet, you most commonly use information of a non-certified EHR during the transition of care. And thirdly, that you use the exchange of health information using a certified EHR technology.

And the certified EHR technology simply means that it was certified under the Office of the National Coordinator for Health Information Technology Certification Program. And there is a list and a link if you go onto CMS's website. And you can obtain that information to know whether or not the EHR that you are looking at, if you are not currently implementing one in your facility, whether or not it will meet this standard certification program.

And actually, there was a study done in 2008 by SAMHSA, the Substance Abuse and Mental Health Services Administration, back in 2008. That they looked at and found that five states had already implemented complete EHR systems and 18 other states had incorporated various portions. So we believe that these numbers are higher today, because that was roughly a few years ago.

Now let's take a look at the measures for the 2017 program measures that will affect your 2017 APU. Again, the first six measures you're very familiar with. So why do we want to discuss the 2017 APU determination today and now? That's because the data for this APU are based on your calendar year 2015, which is just around the corner, and time flies. And we are already almost into October. So with less than three months to go, or a little over three months, we will be collecting information on these measures that will affect your 2017 APU.

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On the next slide, slide 23, you will notice the SUB-1, or the alcohol use screening, and the follow-up after hospitalization for mental illness that was previously adopted last year and finalized for 2016, along with the two new measures recently finalized in this rule.

So all of those measures will be incorporated. And moving forward with each subsequent year, plus in addition, we now have the five measures listed below - the IMM-2 or the influenza immunization, the influenza vaccination coverage among healthcare personnel. And your TOB-1, which is your screening, your TOB-2, which is those patients who received a screening, but then took it further for counseling and/or treatment was at least offered, which is further defined in TOB-2a, which is those patients who received the screening, received the counseling, and then received treatment.

As we move into slide 24, these are the new measures, and we will take a closer look at these individually. Again, these are highlighting the measures that were finalized for calendar year 2015 that will affect your 2017 annual payment update.

So let's take a look at this first measure, IMM-2. It's an influenza immunization. And this works toward reducing the rate of influenza infections but will also afford consumers and others useful information, perhaps when choosing among different facilities. This is a chart-abstracted measure but yet again, will be implemented during the submission period in 2016 for these particular measures with your numerical values and your numerators and your denominators, which we'll take a look at on the next slide.

Here the numerator includes discharges that were screened and vaccinated if warranted are indicated prior to discharge. Your denominator is all patients, six months and older, discharged during the flu season. And remember this is for 2017 annual payment update. So it will be the flu season, not that we're about to embark in, but the flu season next year. So that will begin with October, November, and December of 2015 and go through January and February and March of 2016.

There are some exclusions—those who expire, those who had an organ transplant during the current hospitalization, and those who have lengths of stay greater than 120 days or are transferred to another acute care facility, and lastly may leave against medical advice. These are exclusions.

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Now let's take a look at the influenza vaccination coverage among healthcare personnel. This is the one measure that again will affect your 2017 payment update. And it was NQF endorsed. And this further aligns CMS's programs, as this measure has been previously adopted in the other quality reporting programs such as IQR, outpatient, ASC, so this is a measure that works well and gives a lot of information.

More education around this will be provided next year in coordination with NHSN and the CDC. This is also not reported through QualityNet on the secure portal. This one will be reported through NHSN's website. And we will give more information as we educate at the beginning, in the first half of 2015, surrounding how to go about doing that.

So the influenza vaccination coverage among healthcare personnel, this is the numerical—it's a numerator and denominator value. And they will fall into one of four categories when you are looking at the numerator values. They either received their vaccination at the facility or somewhere else and can provide you documentation. They were determined to have a medical contraindication. They can decline the influenza vaccine. Or their status is basically unknown. They will all fall into one of these four categories. There is no exclusion for population or persons for this measure.

Now let's take a look at the denominator for this measure. The denominator is the number of healthcare personnel working in the facility for at least one working day. And this is between, again, October 1, 2015 through March 31, 2016, to affect your annual payment update of 2017. And there are some calculations, and we will go into further education on this, as I stated earlier, next year.

This is a screenshot of the CDC website. And there is a registration process that must be completed before you can enter any of these data. And we highly recommend that you complete that process before the flu season begins next year. Again, more to come on this, as far as an education process.

Now let's take a look at another new measure finalized this year. This is your tobacco use screening. And research also suggests that persons with mental illness and substance abuse disorders are twice as likely to smoke as compared to the rest of the general population. It also demonstrates that effective cessation support

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across the care continuum can be provided with minimal additional effort and without any harm to the mental health recovery process.

The adoption of this measure is believed to encourage the uptake of tobacco cessation. And it benefits for consumers useful information when selecting facilities. This is a chart-abstracted measure, again. But it will be entered in numerical—through a numerator and denominator values on the QualityNet website through the portal.

So this assesses all patients who are screened within the first three days and takes a look at those who are admitted for tobacco use and may have admission and screen those for the use of tobacco, whether that be the smokeless type, pipe, cigars, anything that they consumed within the previous 30 days.

Here are the definitions of the numerator and the denominators. The patients who were screened within the first three days of admission will be in your numerator. And then your denominator will be the number of hospitalized patients, 18 years and older, excluding those who are less than 18, cognitively impaired, have a stay that is equal to or less than 3 days and/or greater than 120.

Finally, those who have documentation that they are admitted for comfort measures only. They are also excluded and removed from the denominator.

Now let's take a look at another subset of those patients who were screened for tobacco utilization. So these are broken out into Tobacco-2A and -2B. And how we define this for ease is the Tobacco-2 is all the patients who were offered and received or offered and refused the cessation medication and practical counseling. Further defined in Tobacco-2A to have all inclusive of the things above, meaning that they were screened, they had counseling, they were offered; in Tobacco-2A, these patients received the medication during the first three days following admission. So they acknowledged it and then went into treatment for that.

As we move into slide 34, this defines the numerators and the denominators, along with the exclusions that they're looking for, for this particular patient population. So for the Tobacco-2, the numerator is the patients who received or refused practical

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counseling and refused medications during the first three days. And then 2A will be all of those patients who went on and received tobacco cessation medications during the first three days.

The denominators for both of these measures are the number of hospitalized patients who were identified as tobacco users, and that there are some exclusions that would be taken and removed from that denominator - those who are less than 18 years old, again cognitively impaired, or they're not current tobacco users, refused or were not screened for tobacco use during the stay, or the stay was less than or equal to 3 days, or greater than 120. And again finally, the patient is admitted and is on comfort measures that are documented. They are also excluded from this measure.

So in addition to the new measures, you're really looking at other additions that will affect your fiscal year 2017 annual payment determination. This is really looking at population and sampling counts. So it's believed to be vital to IPFs to accurately determine and submit to CMS their population and sampling size, in order for CMS to assess IPFs' reporting completeness and the total population.

So this actually looks at both your Medicare and your non-Medicare populations. This will be submitted during the submission period in 2016. It will affect your 2017 annual payment update, and it is a web-based measure, structural measure.

They also for this, there is the sampling that is performed as we looked at previously, when we were looking at the program requirement for HBIPS 4 through 7 and your substance or alcohol screening 1. Failure to report this will be subject to a 2% reduction in their 2017 annual payment update.

So we talked a little bit about for the program, the participation rate, the requirements, and the new measures in order to meet all of those program requirements. So you may be thinking - how do these measures come into effect?

So the next couple of slides will further define how measures are adopted. So the measures must meet one of six priority domains. And these domains are outlined in the National Quality Strategy and are required by the Affordable Care Act. Some of this information was also in an article published in JAMA on June 5th,

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titled, "The Future of Quality Measurement for Improvement and Accountability."

And this was co-authored by three physicians, and Dr. Patrick Conway was one of those. So this further defines how measures come about and what is being looked at from those six domains that are listed here. It's clinical care, patient experience and engagement, population and community health, safety, care coordination, along with cost and efficiency.

The goal is to identify measures that meet the needs of the payers, policies and the public and that ultimately benefit those accessing health care, or ultimately the beneficiary. So the Department of Health and Human Services, they're aligning the measures around patient-centered outcomes that span across multiple settings.

And as I've previously shared, many of these measures, and influenza vaccination for one, have been adopted throughout many of the quality reporting programs for CMS. That's just to name one.

For the process to adopt the new measures, it takes roughly three years for measure development to come to fruition. And CMS has developed this process. And I'm not going to read the slide to you. You're perfectly capable. But in order for all of these things to occur under the second bullet as outlined, they basically come up with a measure, and they go through testing for validity, reliability, and then refine the measures. They appear on what's called a measures-under-consideration, or a MUC, list. And all of the measures that are introduced in the proposed rule and either are ultimately finalized or not, come from the MUC list.

So how do you find out about this? Become involved with your state and national associations, because they're well-informed and can keep you well-informed as well.

Some measure topics for future consideration, the intent is to propose the addition of a readmissions measure to the program in the future, and welcome the recommendations for the adoption or other outcome measures for this program. Some of the measures that are currently undergoing testing for future consideration and are on the MUC list are suicide risk, violence risk, drug use, alcohol use, as well as metabolic screening.

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To that, we talked about the measures, and we talked about how they evolve and become part of a program. Once all of that is done, you've entered all your data. Where does that go? Ultimately this will be in the public domain under public reporting.

Each facility will be allowed to have a preview period; roughly in this year, we anticipate it to begin around December 31. Once the preview reports are out there for all of the facilities and the measures for the reporting year, we'll send out a ListServe for each one of you to be able to pull your facility's preview report down, take a look at it, and then following in April, this will be released on *Hospital Compare*.

As opposed to similar to last year, this year there will be no reporting period for corrections to be made. This is why we stress during the submission period that someone really take a look at the facility's data to ensure that they're accurate, because ultimately, they will end up on public display. And to view your data, you can run the facility's state and national reports.

The public display menu graph on slide 42 shows you the payment determination year that it is affecting, when it will go on public display, and the quarters that will be publicly displayed and the public will have access to.

So this shows 2016 and 2017. Again, it's very important for each one or multiple people at facilities to be on the ListServe, so that you can receive the most up-to-date communications regarding the IPF Program.

Now let's take a look at annual payment update. You do all of this, and then we're going to share with you for your annual payment over the next couple of years. Those who do not meet program requirements are subject to a 2% reduction in their annual payment update. Any reduction only applies to that payment year.

So the annual payment determinations for 2015 are being finalized, and congratulations to the vast majority, as you were successful in reporting and meeting all program requirements. So excellent job, and again, congratulations.

There are special circumstances that can occur. And we'll discuss those in the next couple of slides. We talked about the annual

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payment update. This is called the reconsideration process. If you feel that you received a 2% reduction and there are circumstances that surround that, you are certainly able to file what's called a reconsideration request.

This information was previously finalized in the IPPS LTCH Final Rule in 2014. I want to point out, the vast majority this does not apply to. The reconsideration request must be submitted to the CMS support contractor no less than 30 days from the receipt of the annual payment update notification letter.

CMS will notify the facility, once they receive the reconsideration request, within 90 days of their decision.

This is just a quick reference. All of this information is located on qualitynet.org. Select the Inpatient Psychiatric Facilities tab, click on the APU Reconsideration in the drop-down menu, and in the first paragraph I believe there is a reconsideration request form link that you can highlight. You must complete the form in its entirety and submit it to the CMS Support Contractor. If it's not filled out entirely and completely, it will not be accepted.

This on slide 49 is a copy of the reconsideration request form. As you can see, it's a two-page document, not lengthy. And this is also on qualitynet.org. And once you complete this form, submit it to the support contractor, you will receive a confirmation email that we are in receipt of your request. If you do not receive an email notification that we have received it, you need to follow up. Because that is your alert and your notice that it is in the appropriate hands and is being processed. And then CMS will notify you of their decision within 90 days.

And with that, it concludes today's presentation, the high-level overview of the fiscal year 2015's final rule. And with that, I will turn it back over to Deb.

Deb Price:

Thank you, Renee, for the information you shared with us today. Before we have our subject matter experts read questions that you sent in, I want to remind you that today's webinar has been approved for 1 continuing education credit by the boards listed in front of you on slide 50. Next slide, please.

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We now have an online CE certificate process, and there are three ways to receive your credit. First way is if you register for this webinar through WebEx. As soon as the WebEx is over, a page will display with the survey. Please take the survey. As soon as the survey is over, you click Done, and another page will open, and you have to register as either a new user or as an existing user. And there is a one-time registration required. Once you have attended one of our webinars, you are no longer a new user, and you're existing.

The second way to get a certificate is if you did not receive the survey, don't worry, because we will be sending out a link to all participants within the next 48 hours. You will not receive that today. You'll receive it probably tomorrow or Friday. Again, just take the survey that's sent to you and the same thing. If you're a new user, you click on that, or an existing user.

If there are people in the room with you, you can pass that survey to them, and the same thing will occur. They will have to register as a new user also.

The third way to receive your certificate is if you do not receive the email survey in the 48 hours, don't worry, because in approximately three weeks, this entire presentation will be placed into our Learning Management Center, and it will be a course that you can take. So you would take the course and get your certificate that way in about three weeks. Next slide, please.

We now have about 15 minutes for our subject matter experts to read some of the questions that have been sent in from you attendees. Rhonda, do you want to begin with the questions and then pass the ball to Wanda?

Rhonda:

Certainly. Thank you. First of all, I want to thank you for your excellent questions today. Questions about the specifications for the new measures will be collected and used in the educational presentations scheduled for October 29th. Questions about the specifications will be answered on that day within the presentation, or at the end during the question-and-answer session.

One of the questions - when will the paper tools for the new measures be available?

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The paper abstraction tools for 2015 data collection will be posted late in December of 2014, or January of 2015. The paper tools that are currently posted for 2014 will be updated to reflect that they cover the entire year, instead of just the first three quarters of 2014.

Another question was - for fiscal year 2017, how will IPF facilities report the number of healthcare personnel who get vaccinated for influenza?

Reporting for this measure will begin for the 2015-2016 influenza season. So that's October 1, 2015 to March 31, 2016. And we've had lots of questions about that. So it is October 1, 2015 to March 31, 2016, with a reporting deadline of March 15, 2016.

A single vaccination count for each healthcare facility by CMS certification number, the CCN will be reported. A percentage of healthcare personnel who are vaccinated will be calculated and publicly reported. And operational guidance document to assist with reporting this measure is posted on the CDC website, and the support contractor will be providing additional education jointly with the CDC.

Wanda, I'll turn it over to you to go through more of our questions.

Wanda:

Thank you. I'll answer a couple of questions that have been received about the current measures that are being abstracted, the HBIPS measures.

If the physician that the patient is referred to for follow-up care has access to the EMR, do we need to list the documents that are part of our continuing care plan within the medical record?

The data elements state that the EMR should contain documentation that the next level of care provider has access to the EMR. You do not need to list the documents that are part of the CCP, but you must document that the next physician has access.

There will also be an update to the specifications, as the HBIPS measures have been developed by The Joint Commission, there are updates that are coming in 2015 that we will review during the October 29th education session.

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So here's a question. If alert and oriented is documented anywhere in the chart, would the abstracter answer No to cognitively impaired?

So the data element is cognitive impairment. The answer is if there is any documentation that the patient is alert and oriented during the hospitalization, answer No to this data element.

For 2014, this data element applied to the entire hospitalization. But for 2015, this data element is being removed and allowable value added to another data element to cover impairment during the first three days only.

The audit tool—another question. The audit tool scores the patient risk for unhealthy alcohol use as none, low, moderate and high. However, the data element alcohol use status only lists low or moderate risk in the allowable values. If the validated tool indicates by score that there is unhealthy alcohol use, moderate or high-risk, allowable value 2 can be selected.

I'll go ahead and turn it back over to Rhonda for more questions.

Rhonda: Thanks. I just want to reassure everyone that I see that more questions have come in while we were doing the question-and-answer. Your questions will be answered, and you will get answers, or we will go over them at the next session in October.

Could someone please send a screenshot of where the tobacco measure specifications are found? The spot on The Joint Commission website referred me to QualityNet.

So that can be found both the tobacco and the SUB measures can be found on www.qualitynet.org under the IQR tab. Click on the Specifications Manual in the drop down. Those measures are found in the Inpatient Manual. So that's perhaps why you're confused, or couldn't find it, not confused.

Someone asked, is HBIPS 2 and 3 required for APU? The APU is—HBIPS 2 and 3 are required for APU. The APU does, just not the submission of the aggregate population count for those measures that allow sampling, these counts will be required. They're referring to slide 35.

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When do the SUB-1 data have to be entered? I'm sorry?

When do the SUB-1 data have to be entered, data collected from January 14 onward, and for what date range?

The SUB-1 data are to be collected starting January 1 of 2014 through December 31 of 2014. And these data will be submitted via the secured portal July 1 of 2015 through August 15 of 2015.

The slides will not be emailed. Someone wanted to know if the slides would be emailed. They will not be emailed. But they will be available out on QualityNet, www.qualitynet.org, under the Inpatient Psychiatric Facilities tab. And you drop down to Webinars/Calls, and the slides will be available shortly after this presentation.

Wanda, I'm going to turn it back over to you. We've got about four minutes left.

Wanda:

Another question was again about cognitively impaired. Does cognitively impaired include the dementia diagnosis?

If you refer to the data element, cognitive impairment, the term confused is listed as an inclusion in the data element. So documentation of dementia would be acceptable. Dementia, remember for 2014, this must be present during the entire hospitalization.

In 2015, this data element will be updated. It's going to be revised by The Joint Commission.

So for health care, for the measure on the healthcare vaccination, is it hospital-wide, or is it just psychiatric personnel, those employees working within the IPF?

Reporting for this program is just for the IPF. So it is just the employees working within the IPF.

How can we find out which alcohol screening tools are approved for SUB-1?

Remember, the SUB and the TOB measures are found within the IQR Specifications Manual. So as they are updated, they will also

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be updated for psych. So in 2015, there is a new manual out there for IQR. An addendum will be posted shortly for that manual to account for final rule changes and changes by The Joint Commission.

But as the SUB and TOB measures are updated, they will also be updated in the IQR Specifications Manual, which will be used for the IPFs. So the HBIPS measures are available on The Joint Commission website, but the TOB and SUB measures are in the IQR Specifications Manual on QualityNet.

Deb Price: Thank you, Wanda. And we have time for one more question.

Rhonda: Wanda, I have one, if it's okay.

Wanda: Sure, go ahead.

Rhonda: And I just want to reinforce to everyone, we had someone ask a question, and then they said that they wanted to pardon their ignorance. But we know we have new facilities out there, so I'd just like to reinforce to everyone that no question is an ignorance question or as I say, a dumb question.

This person wanted to know what APU was or is. And it's annual payment update. And like I said, if you're new to this program or any of the reporting or paper reporting, paper—what is it called, Renee?

Renee Parks: It's pay for reporting. It's not pay for performance.

Rhonda: Right. With this program, we know that we use a lot of acronyms. And so please, don't hesitate to ask us these questions. So APU is annual payment update.

So I'll end with that.

Deb Price: Okay. Thank you. This concludes our program for today. I'd like to thank all of our speakers and participants for the valuable information and questions you provided us. We hope you have heard useful information that will help you in your IPF Quality Reporting Program.

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If we did not get to your question, please use the question-and-answer tool located at www.qualitynet.org. A subject matter expert will send you a timely response. Thank you again, and enjoy the rest of your day.

END