Inpatient Psychiatric Facilities Quality Reporting Program

Support Contractor

FY 2015 IPF Data: Status, Opportunity, and Action Presentation Transcript

Moderator:
Deb Price

Speaker:
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Matt McDonough: Good afternoon, everybody, and thank you for joining us for today's Webinar.

My name is Matt McDonough, and I will be your Webinar Host for today. As you can see on the slide on your screen, audio for this event is available via your Internet Streaming and there's no telephone line that is required for today's event.

Obviously, what that means, is there is a one-way communication today. You're listening to us, but there's no way for you to be heard verbally on today's call, but rest assured, we do have a way for you to interact with us today, and that is using our "Chat Window," which is you will notice on the left side of your page today.

Now in that "Chat Window," if you'd like to send a question to our presenters today, simply type your question in the white "Chat Box" and click the "Send" button directly to the right of that "Chat Box."

Your Chat question will be sent to all of our presenters, and we will address questions as we have answers and as we have time today.

We will follow up at the end of today's presentation with some select questions from today's call, and there will be further instructions for submitting questions after today's call as well.

But please, if you do have a question for our presenters today, do ask it and submit it via that "Chat Window."

That's going to do it for my introduction and welcome to the WebEx today, so without further ado, I'm going to hand the floor over to Deb Price who will begin today's event.

Deb, take it away.

Deb Price: Thank you, Matt. Hello, and welcome to our Inpatient Psychiatric Facility Monthly Webinar. My name is Deb Price, and I will be your host for today's event.

Before we begin, I'd like to make a few announcements. Number one, this program is being recorded. A transcript of the presentation, along with the Questions & Answers, will be posted on our new Inpatient Website at www.qualityreportingcenter.com, that's www.qualityreportingcenter.com, within two days, and these minutes will also be posted to QualityNet at a later date.

The second announcement, if you registered for the event, a reminder email, as well as the slides were sent to you. And finally, if you didn't receive the email, no problem, because you can download the slides at that new web address at www.qualityreportingcenter.com.

And now I'd like to introduce our guest speaker, Reneé Parks. Reneé received her Bachelor of Science in Nursing from the University of Central Arkansas. She joined HSAG in 2012 and has over 20 years of experience in various clinical and management positions, including having served in the U.S. Army Nurse Corps.

Reneé also has provided numerous trainings and presentations to physicians, vendors, clinical office staff, and administrative staff. Reneé will now give you an update on the Inpatient Psychiatric Facilities (IPF) data.

Reneé, take it away.

Reneé Parks: Thanks, Deb, and welcome everyone to today's presentation. Today we will be going through the Fiscal Year 2015 IPF data. We'll look at the status, opportunities that you may have, and any actions that you may feel your facility can take in the future.

There are three parts to this presentation, overview of the Fiscal Year 2015 Annual Payment Update (APU), the Summary of the APU as well as requirements, and then we will take a look at the data sources that the presentation revolves around, as well as any trends and patterns that we can detect from these data.

IPFs can identify opportunities for improving care by comparing their data to the Summary Data of the IPF with similar demographics, as well as you can always download the facility, state, and national Report.

If you are following along on the phone, we're on Slide 3, and we do take your Survey Enhancements that you give us to heart. We have added the Acronym Slide as a result of this, as this slide was previously requested in some of our surveys.

These acronyms that are in this slide will be referenced in today's presentation and are here for your pleasure. The PSF (Provider Specific File), I wanted to call out, as this is the Fiscal Intermediary or the MAC contractors create a Provider Specific history file for each IPF beginning with their first Cost Reporting Period, and these are submitted to CMS quarterly, and this is what we like to call the IPF Universe.

An overview of the Program Requirements for Fiscal Year 2015 APU as the highlights are that you must obtain and be registered with QualityNet, maintain an Active Security Administrator, must have an active pledge, but also note that once you pledge, that Notice of Participation will carry forward.

And this is the second year for APU Determinations for this program, unlike Inpatient Quality Reporting and Outpatient Quality Reporting; they have had several years ongoing with CMS and the Quality Reporting Programs.

For Fiscal Year 2015, these data were submitted earlier this year, and it will cover three full quarters of data. It will be interesting with next year's Fiscal Year 2016, as this will be the program's first full year of data.

Of the 1,946 IPFs that are in the PSF, there were, as we looked for the 2015 APU, 221 of those were closed facilities. And of the other remaining facilities open and having the ability to participate in the IPFQR Program, you had a success rate in receiving full APU at 98.2%, and you had 1.8% that either failed to meet one or more of the program requirements or elected to withdraw from the program.

Again, the data sources for this presentation primarily come from the Measures Data; however, we also looked at the Notice of Participation, the DACA, and the QualityNet Account, in order to ensure that everyone receiving the full APU for Fiscal Year 2015 was included.

And the primarily source, as I stated, is the Reporting Period of the Q2, Q3, and Q4 of 2013 data that were entered this year during the submission period.

The first year of the program was Fiscal Year 2014, and data for that period was two quarters, which was Q4 of 2012, when the program began with its first collection of data, and first quarter of 2013.

As we move to the next slide, you will notice a list of the measures that the presentation will focus on and the measures for the first two years of the program, and these are your Hospital-Based Inpatient Psychiatric Services (HBIPS) Measures, of which everyone I'm certain is familiar with now.

The Hours of Physical Restraint, Hours of Seclusion, Patients Discharged on Multiple Antipsychotic Medications, and for HBIPS-5, Patients who were discharged on medication and had appropriate justification. In Measure 6, you had a Continuing Care Plan that was created, and for Measure 7, you had that Care Plan that was created was also transmitted on discharge.

As we compare Fiscal Year 2014 data to 2015 data, the most inherent question is, are we getting better and can we show this? So for each measure, we calculated the measure changes from 2014 over 2015, and this was done based on an average change from a paired comparison.

So what did the paired comparison mean? That is a better comparison; we looked at each facility with data for Fiscal Year 2014 and those that also had data in Fiscal Year 2015.

If they were in one year reporting and not in the other, they're excluded. This refines the analysis for a clear picture of improvement as looking at the mean or median average for each year respectively and then comparing those year over year.

And with this, all six measures show improvement. Remember, for HBIPS-2 through -4, the closer to 0 indicates the lower the better, and for HBIPS-5 through -7, if you show an improvement, you'd want to look for higher rates.

As we move into the next slide, this is the first analysis. And this shows you for your HBIPS-2 and -3, your measures of improvement. And if you look, you will see your HBIPS-2 in Fiscal Year 2014, the rate - the paired rate was 2.24.

And then in 2014, closer to showing improvement, dropped to 1.72. Again, a good comparison and shows improvement per 1,000 days, so the closer to 0 the better.

And then as you look at HBIPS-3, which is your Seclusion Measure, excuse me, we go from .81 to .50, again indicating improvement year over year with this paired comparison.

Now, as we move to the next slide and look at your HBIPS Measures 4 through 7, their rates for improvement, and as you recall in your Public Reporting, HBIPS-4 and -5, those measures were blinded for the Fiscal Year 2014.

So on this particular slide, there are no data shown, but you do show improvement as we look at the HBIPS Measures for 2015 in that HBIPS-4 again closer to 0 is .10 in the paired average and then your HBIPS-5 Measure is .47, again closer to 0.

Now as we look at HBIPS-6 and -7 in those continuing Care Plans, whether they were created and/or transmitted, again, you show that we have improvement because for these you want higher numbers – so, again, showing improvement in all six of the measures. Now we're going to take a look at – we talked about the APUs, the IPF Universe from Fiscal Year 2015, and we've looked at each one of the measures year over year from 2014 into 2015.

Now let's really take a look at your Fiscal Year 2015 data, and we're going to take a look at these in a deeper dive on location, whether it – by state and you can compare them nationally.

Then we're going to also take a closer look at urban and rural facilities and then the bed size and the ownership.

So as we look at your Fiscal Year 2015 and HBIPS-2, you can see that they're – that the majority of the states are performing very well when you look at the numbers in your legend on the right lower corner.

Remember that the lower rate is better and how they – how did we come up, you may ask, with the three categories, or the strata, in the legend on the lower right-hand side?

These were based on Jenks Optimization Method, a method of statistical data classification that partitions data into classes using an algorithm that calculates groups of data values based on the data distribution.

So the Jenks Optimization Method seeks to reduce variants within the group, but maximize the variants between the groups, inner groups.

Now we will look at HBIPS-3, the hours of seclusion; remember, the majority of states, as you look at this map, are really performing well. Again, the lower number means better, and there is also variability within each state.

So this would be where you can as a facility download your facility, state, and national report.

As we move into the next slide and take a look at the HBIPS-4 measure, which are those patients discharged on multiple antipsychotic medications, there is varying performances among the states by rate.

And remember this number also you would want to be a lower number as well.

A lot of this is demographic information that you can drill down by your facility and take a close look. Your HBIPS-5, for those who were discharged on the antipsychotic medications and had documentation of appropriate justification.

And remember that the numerator for 4 becomes the denominator for 5, so the higher the rate the better and not as much variation within the rate for HBIPS-5 as we saw with HBIPS-4.

So this in my mind shows us that the – those patients who were discharged on the antipsychotic medications had documentation for the appropriate justification and that it was documented.

As we move into HBIPS-6, the post-discharge continuing care created, again looking at all 50 states, there is a variation, although small when you actually look at the Jenks Methodology for coming up with the three strata.

And there are again between the .77 and the .86 variations between the bands, and we did not put the extreme values on here, so it was less than .77 or greater than .86 for your HBIPS-6.

Now as we look at Measure 7, the final of the six measures from a geographic prospective, the post-discharge continuing care plan was transmitted to the next level of care, there is some variation again and shows more states in the middle to the upper performing band.

Again, the higher rates with this measure the better. Now let's take a little bit of a different look at the data. On Slide 18, this shows the distribution of the number of patients and the number of patient days.

And this is broken out by your Age Strata. So again, your HBIPS, 18 to 64 account for 68.75% of all patient days and then that same demographic accounts for 62.89% of the number of patients.

So again, large variation because of the age strata being 18 to 64. It would be interesting to take a look within them. We may be able to do that more so with the data that you will be submitting for the Fiscal Year 2017, where we will take a look at your payers, Medicare versus non-Medicare, the age strata by

demographics, as well as the diagnosis groupers to see what – where those bandings are occurring within the HBIPS.

Are they the 35 and less, or are they more inclined and clumped more towards the 50 years and older getting ready for retirement?

As we take a look at this next slide, this is the distribution of the percentage of hospital size by the geographic location, as defined by being rural or urban. And you will see here that we have defined the hospital size again, bed size by those with units that may be less than – have units or bed sizes within those units of less than 25. And then medium is defined as those from 26 to 50, and then large further defines those with the number of beds that are greater than 50.

So the small IPFs account for over 50% of the hospitals – of all hospitals combined in urban and rural areas, while the urban IPFs account for almost 76% of all of the IPFs across the nation.

Again, interesting demographics and ways to look at the data. Now as we move into this next slide, when we compared the total number of beds in each urban or rural geography, broken out into the strata small, medium, and large size hospital beds for psych units or free-standing facilities, we noticed that the total beds for the large facilities are roughly – among the U.S., are about 48,000 and in the urban areas, or as on the previous slide, translates to 24.52% of those hospitals were in the large banded category for the urban areas.

So even the percentages though they were greater than 50 beds. So across the U.S., total bed population for those large unit facilities are 48,116.

For total beds for small urban facilities, the total bed size across the U.S. was 7,300, and on the previous slide translated to 32 – almost 33% of the urban hospitals.

I think another way that we particularly could look at this is there are roughly 31.3% freestanding IPFs across the U.S., and there are 64.5% that have psychiatric units within acute care facilities, and then there are 4.2% of those across the U.S. that are within psychiatric – have psychiatric units within the critical access hospitals.

So again, just another way to take a look at the demographic information. As we move into Slide 21, you show the private non-profit IPFs represent almost 50% of all IPFs, when combining rural and urban facilities.

Now let's take a look at the hospital beds by ownerships and by location. On this slide, you will see that the private non-profit bed size is approximately 29,000 beds, or approximately 50% of the IPFs in urban and rural geographies.

And also note that even though your government affiliated facilities are approximately 29,000 beds as well, that they are just under 23% of all of the IPFs nationally in the urban and rural geographies combined.

So now we're going to take a look at the rate by hospital size, meaning small, medium, and large.

As you recall back on Slide 9, when we compared the Fiscal Year 2014 rates to that of 2015, the HBIPS National Paired Average for 2015 was 1.72 for this comparison. So you will see in the different hospital size bands or categories and can be able to compare that as well as for HBIPS-3, the national paired average for Fiscal Year 2015 was .50.

Remember, you can always run your facility, state, and national reports where you can take a deeper dive at your facility and compare that as well.

For HBIPS-4 bed size compared with the national paired comparison average rate, back on Slide 9 and 10 – or 10 was .10, and that was on Slide 10.

For your HBIPS Measures 5 through 7, medium size IPFs are slightly lower than the small and large facilities, and remember for HBIPS-5, the national paired comparison average rate was .47, and for 6, that paired average was .80, and your HBIPS-7 national paired average rate was .70.

Again, you'll notice that the deltas between some of these is not a large variation when you actually take a look at the rates by hospital size as in point – as in HBIPS-7, when you're looking at .62 to .76, so your delta is .14.

Now as we go and take a further look at the – each of these measure rates by hospital ownership changes a little bit of the demographics and the rates, as you will notice here.

Again, the smaller – or the closer to 0 the rate the better. So each facility again, can run and drill down to the patient level or the abstraction level and may be able to identify some gaps in care or find out what is occurring: is there a trend, is the restraints or seclusion use higher at night, always on the weekends, a particular diagnosis code, really looking for those trends at the patient level.

And this will allow insight for possible Quality Improvement. As we take a look at 4, 5 – the rates for HBIPS-4, -5, -6, and -7 by hospital ownership, again the non-profit performed slightly lower than the private profit and government facilities.

And again, notice that HBIPS-4, which is lower, which is very good, closer to 0, and then your measures 5, 6, and 7, the higher rates are – mean that you've shown improvement.

So again, interesting to look at these measures by ownership. As we move into Slide 27, let's take a look at those same measure rates and break it out by urban and rural.

Interestingly enough, you see that the rural rates were slightly higher than those in the urban facilities for HBIPS-2 and HBIPS-3. Now as we look at that same measure rate defined by urban and rural, let's look at the last four measures, which are HBIPS-4, -5, -6, and -7.

And you will notice that for HBIPS-7, 4 through 7, that the performance rate between rural and urban is very close to 0 or very small. There's really not a lot of separation between the two types of geographies.

Great work. And now in summary, we have shown various ways to dissect and slice the data. The intent is to show you the overall trends that will allow you to take a closer look at your individual facility level data and even drill down then further to the patient level data.

This will allow you to compare your facility data to the trends and variables identified through this slide set, as well as from a state – facility, state, and national report, and this may be able and help – and helpful to identify gaps in care or potential ways that you can improve the care.

Because ultimately, it's all about better quality health care and outcomes for the IPF beneficiary.

And that concludes my portion of the presentation. And I will now turn the program back to Deb.

Deb Price: Thank you, Reneé, for the information you shared with us. Next slide, please. Thank you.

I'd like to remind everyone that this webinar has been approved for one continuing education credit by the Boards listed on this slide. There have been questions coming in ,and this slide and the following slide will help you with your questions.

Next slide, please. We now have an online CE Certificate Process and, there are two methods for receiving your CE. The first one is if you registered for the webinar through this site, a survey will automatically pop up at the end of the webinar.

It's not going to be until all of us are done speaking, then we click on "Stop the Meeting," and a survey pops up. If you are attending the webinar as a group, so that means that you didn't register yourself, please forward the survey to other attendees.

In order to receive your certificate, you're going to need to complete the survey, and at the end, you click "Done," and then "Done" will take you to a page where you register into our Learning Management Center.

One time you're going to have to register with your name and your e-mail, and you will receive an automatic reply to that e-mail. If you don't receive an automatic reply, then you're going to have to contact us or have your IT Staff open to the LMC Domain.

Next slide, please. Okay. Now we'd like to open the floor for our Subject Matter Experts to review questions that came in during the event. We're going to start with Rhonda.

Rhonda, do you have any questions you want to start us off with?

Rhonda: I do. Thanks, Deb. The first one is, "Which slides represent benchmarks?"

The answer is benchmarks are not provided for the measures, only the national rates. IPFs can compare their data to their peers based on the hospital characteristics in this presentation. For measures – the HBIPS-2, -3, and -4, the lower the better, and for HBIPS-5, -6, and -7, the higher the better.

You can also run your facility, state, and national report.

The next question, “Were hospitals with less than 10 cases removed from the calculation?”

The answer is no, all hospitals with data submitted are included in the paired analysis.

The next question is, “What about the facilities that have closed?”

And that’s based on Slide 5. The answer is, an unknown number of facilities have been closed for some time, but only just now were accurately identified as such in our PFS, and PFS is now on our acronym list.

Therefore, these do not necessarily represent recent closures. Facilities that were identified as closed that were on the PFS have been removed. This is completed by working with the facility, the state survey and certification, along with the Medicare Administrative Contractor to remove them from this list and thereby removing them from the contact list compiled by the Inpatient Psychiatric Facilities Quality Reporting Program.

Also, facilities close their units for various reasons. There’s a process that must be followed when this occurs, so that the IPF unit or facility is removed from the PSF and then the contact list for not meeting the program requirement.

Rhonda, I’ll now turn it over to you.

Thanks, Rhonda. Another question, “What were the reasons that 31 facilities failed?”

And this is in reference to Slide 5. Facilities that failed failed one or more of the program requirements, such as Notice of Participation, failing to have a Security Administrator, data submission, and the Data Accuracy Completeness Acknowledgment.

The next question, “What are the target hours for HBIPS-2 and HBIPS-3?” HBIPS-2 is the measure about hours of physical restraint and HBIPS-3 is the hours of seclusion. So the target would be 0.

The next question, “Only 10% of patients are discharged on one or more antipsychotic medications and only 47% of those were appropriately justified. How can we as providers improve this rate? What are the desired rates?”

For patients discharged on multiple antipsychotic medications, the score should be as low as possible, and those being discharged on antipsychotic medications should also have a documented reason.

The most likely cause is lack of documentation of justification, so encouraging your physicians to document justification will improve those rates.

On the FSN Report for Fiscal Year 2015, the National Rate for HBIPS score is 7.87.

I’ll turn it back over to Deb Price.

Deb Price: Thank you, Rhonda. 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.

We hope that you’ve heard useful information that will help you in your IPFQR Program. A transcript and the Questions & Answers will be posted to our new Quality Reporting Center website. Again, that is

www.qualityreportingcenter.com, and they will also be posted on QualityNet at a later date.

If we did not get to your question or if you have additional questions for us, please use the Q&A tool located at qualitynet.org. Again, that's – if you need to ask more questions, please us the Q&A tool at qualitynet.org, and an IPF Subject Matter Expert will send you a timely response.

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