NorMet
Northern Metropolitan Hospital Association
Representing Hospitals in the Hudson Valley Region

# Quality News

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This issue includes information about:

- Proposed Rules on Sepsis, Pediatric Care and Influenza Vaccinations
- Medical Home Certification for Hospitals offering Primary Care Services
- MOLST and Healthcare Decisions Day
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- Quality and Physician Data …and More

## State Issues Proposed Rules on Sepsis and Pediatric Care

In January, Governor Cuomo announced that NYS will lead the nation by becoming the first state to require all hospitals to adopt best practices for the early identification and treatment of sepsis. On February 13, the State took a step towards this goal by releasing two *proposed* rules: one on Sepsis Care and a second on Hospital Pediatric Care. These were developed largely as a response to the sudden death of 12- year old Rory Staunton who died in 2012 of septic shock.

The Sepsis Care rule calls for hospital governing bodies to take responsibility for having protocols addressing the identification and treatment of sepsis, to have these protocols approved by the State, and for hospitals to implement them within 45 days of State approval. The protocols must be periodically updated and appropriate staff trained in them. Hospitals will also be required to collect sepsis data and quality measures for internal quality improvement and to report data to the Department of Health for it to monitor compliance.

The Hospital Pediatric Care proposed rule includes provisions whereby a hospital must post a Parent's Bill of Rights indicating that no patient would be discharged from the hospital or emergency room until "critical value" test results (results that could reasonably be expected to suggest a life-threatening or significant condition that requires immediate medical attention) were completed, reviewed by medical staff, and communicated to the patient/guardian as appropriate. All communication must be clear and understandable to the patient/guardian. The hospital must ask the patient or guardian for the name of his primary care provider, if any, and forward critical value results to him/her. Hospitals must develop and implement policies and procedures for at least one parent/guardian to stay with a pediatric patient at all times.

Another provision of this proposed rule calls for all professional staff in the Emergency Room and Pediatric Intensive Care Unit to complete training in Pediatric Advanced Life Support or the equivalent.

NorMet is working with HANYS to submit comments on these proposed regulations. Comments will be accepted until April 1.

## Proposed State Rules for Influenza Vaccinations

This year, many hospitals attempted to implement a policy whereby patient care staff were required to either receive an influenza vaccination or wear a mask. Our hospitals had varying success in implementing these policies. The State issued proposed rules on this subject on February 13. The rules would require health care workers to either get an influenza vaccination or wear a surgical or procedure mask while in areas where they may come into contact with patients. This rule is open to a 45 day comment period but could be finalized as early as May 2013. If this is the case, the new rules would be in effect for the 2013-2014 flu season. Please consider this when ordering influenza vaccines for the upcoming season.

## The Joint Commission's New Accountability Measures

The Joint Commission has designed additional 2012 accountability measures. The new measures include:

-one measure for hospital psychiatric services:

- HBIPS-4a/HBIPS-5a Patients discharged on multiple antipsychotic medications without appropriate justification

-three perinatal care measures:

- PC-01 Elective Delivery
- PC-03 Antenatal Steroids
- PC-05a Exclusive breast feeding considering mother's choice

-two immunization measures

- IMM-1aPneumococcal immunization (PPV23) overall rate
- IMM-2 Influenza Immunization

Members will receive an update of this information to insert into their Quality Compendium so that it will be current.

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### Community Service Plans and Community Health Improvement Plans

Throughout the various counties, hospitals and local health departments are at different points in establishing and maintaining partnerships needed to develop their 2013 community service plan (CSP) and community health improvement plan (CHIP). Years ago, some health departments and hospitals established partnerships to work on these activities jointly and are well on their way to finishing the work on these plans; other counties may just be starting to establish the relationships needed for this to occur.

NYS Department of Health has released "The Prevention Agenda 2013-17", the State's health assessment and health improvement plan. The Agenda identified five priorities for 2013-2017: 1) prevention of chronic diseases; 2) promoting a healthy and safe environment; 3) promoting healthy women, infants and children; 4) promoting mental health and preventing substance abuse; and 5) preventing HIV, STDs, Vaccine Preventable Diseases and Healthcare Associated Infections. For each priority, the State identified focus areas, goals, objectives, and interventions for consideration.

A hospital's community service plan, covering years 2013-2015 and the local health department's community health assessment and community health improvement plan, covering years 2014-2017 are both due by Nov. 15th to the State. Hospitals and their local health departments are asked to work (or continue to work) together as both entities need to seek input from the community and involve multiple stakeholders for the development of their plans. Hospitals and local health departments must agree to at least two Prevention Agenda focus areas/goals to target. At least one of these must address a disparity.

The Affordable Care Act requires hospitals to conduct a community health needs assessment at least every three years. The Act also requires that the hospital's Community Health Needs Assessment and plan be completed, approved and posted on the hospital's website by the end of the hospital's taxable year.

In January, HANYS provided two webinars – the first focused on a general overview of the CSP and CHIP requirements and the Prevention Agenda and the second focused on data usage for the plans. Both are useful tools for those completing a CSP and CHIP.

### AHA Report Provides Strategies for Engaging Patients, Communities

A new report from the AHA Committee on Research, "Engaging Health Care Users: A Framework for Healthy Individuals and Communities", looks at promising strategies for engaging health care consumers to achieve the "triple aim" of improving population health and the individual care experience while reducing or controlling per capita health care costs. The report includes a framework and case examples for engaging health care users at various levels of the health care system, ranging from the individual to the health care team, organization and community. "Engaging patients, families and communities has the potential to be a 'game changer' in the transformation of the health care system in the United States," the report states. "Hospitals and health care systems can serve as laboratories for developing, testing, learning and disseminating new engagement practices. The impact of this type of engagement and the role that hospitals can play in leading this transformative element of system design in their own communities are foundational for achieving the Triple Aim in health care."

### CMS Addresses Regulations

On Feb. 7, the Centers for Medicare & Medicaid Services (CMS) issued a proposed rule to revise and clarify some existing Medicare regulations. CMS noted that the rule is largely aimed at reducing burden and eliminating obsolete regulations and seeks to modify a number of requirements for hospitals, critical access hospitals (CAHs), ambulatory surgical centers, transplant centers, and other providers. Key provisions of the proposed rule include the following changes to the hospital and CAH Medicare conditions of participation (CoPs):

- Governance: CMS proposes to rescind its current requirement that a member of the medical staff serve on the governing board. CMS would instead require periodic consultations between the governing board and a representative of the medical staff.
- Medical Staff: CMS would revise the CoPs to state that each hospital must have its own medical staff, precluding multi-hospital systems from having unified medical staffs.
- Dietetic Services: In the proposed rule, qualified dieticians would be able to order patient diets under the hospital CoPs.
- Outpatient Services: Proposed changes would clarify who may order outpatient services at hospitals.
- CAH Services: CMS proposes to remove requirements related to the development of "patient care policies" and onsite physician presence.

CMS is accepting comments on this proposed rule until April 8.

### Quality and Physician Data

CMS has plans to use the same process for quality performance evaluation of physicians as it has been using with hospitals: requiring the reporting of quality measures; publically posting what is reported; instituting a financial penalty for not reporting data; and then implementing a pay for performance program.

Physicians have had the opportunity to voluntarily report quality data since 2007. In January, 2013, CMS outlined the upcoming steps for physician quality reporting. These include posting on Physician Compare:

- 2012 PQRS Group Practice Reporting data no earlier than 2013; 2013 data not earlier than 2014
- composite scores for Group Practice Reporting data for diabetes and coronary artery disease no earlier than 2014
- patient experience of care measures collected in program year 2013 for posting no earlier than 2014
- program year 2014 measures for individual professionals (to be decided in future rule making) no earlier than 2015

Beginning in 2015, CMS will apply a payment adjustment to eligible professionals who do not satisfactorily report data on quality measures.

Currently, the Physician Compare website enables consumers to search for a Medicare physician by location and specialty; it reports basic contact information for the physician, whether or not the physician accepts Medicare assignment, any languages other than English the physician speaks, and information about where the physician received his/her education.

### Inpatient Psychiatric Facility Quality Reporting (IPFQR)

CMS has posted a Notice of Participation Form to be used as an interim option by facilities electing to participate in the Inpatient Psychiatric Facility Quality Reporting Program, until the web-based application becomes available. This form can be found here. The deadline to submit a Notice of Participation is August 15, 2013. Once a facility has agreed to participate and submitted a Notice of Participation, it is considered to be an active IPFQR Program participant until such time as the Facility submits a withdrawal form to CMS.

A reminder that all facilities, even those that already have a QualityNet account, must register for the IPFQR and identify a Security Administrator for participation in the program.

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### Insulin Pens

Due to reuse of insulin pen injectors on multiple patients, two NYS hospitals were recently required to contact more than 3000 patients for HIV, HBV and HCV testing. Insulin pen injectors were first used in the outpatient, community and home settings by diabetics to give themselves insulin more conveniently, reduce the risk of medication errors, and increase compliance. The pen injectors are now being used in the inpatient setting with increasing frequency and with ongoing reports of misuse. The pens have been found to be shared among patients with staff changing the needle and reusing them. This exposes subsequent patients to bloodborne pathogens through cross contamination.

Hospitals are now evaluating their policies for insulin pen use. In January, the VA issued a patient safety alert that prohibits the use of multidose insulin pen injectors on all patient care units with a few exceptions. These exceptions include when multidose pens are being used: to educate patients on their use prior to discharge; on patients participating in a research protocol; or to dispense directly to the patient as an outpatient prescription.

Take this opportunity to review and monitor the injection practices of your staff in all settings where insulin is administered. The One and Only Campaign created a poster and brochure for providers as a reminder about this.

### National Healthcare Decisions Day is April 16th

In 1990, 27 year old Terry Schiavo collapsed at home of a full cardiac arrest. She suffered major brain damage due to lack of oxygen, was in a coma for several months, and diagnosed as being in a vegetative state. In 1998, her husband petitioned the court to remove her feeding tube. He was opposed by Terry's parents. After 14 appeals, numerous motions, petitions, hearings, suits, action by the Supreme Court of Florida, and denials by the US Supreme Court to intercede, in March, 2005, Terry's feeding tube was removed. She died shortly thereafter.

In 2002, 15-20% of Americans had completed some form of an advance directive. After the Schiavo case, 95% of adults were aware of the need for advance directives but only 29% had completed one.

National Healthcare Decisions Day is April 16 and is devoted to increasing the number of people who have completed an advance care directive: identified a healthcare spokesperson, had a conversation with this person, and completed a health care proxy form. There are many tools to use to motivate and educate your patients and staff about this topic. Click here for information on how to start the conversation and here for more information about hosting community conversations on the topic and obtaining resource material to do this.

### HANYS Quality/IT Symposium

HANYS members are invited to participate in a special joint session of the HANYS HIT Strategy Group and the HANYS Statewide Steering Committee on Quality Initiatives to be held April 5th from 10 a.m. to 2 p.m. The evolving topic of electronic clinical quality measures (e-CQMs), the measures reported through Electronic Health Records that will ultimately be used to tie payment to quality outcomes, will be examined during this educational session.

Speakers include national leaders such as Jacob Reider, M.D., the Chief Medical Officer, HIT Office of the National Coordinator who will speak about linking payment to quality and Chantal Worzala, Ph.D., Director of Policy, American Hospital Association who will speak about the overlap between CQMs reported in meaningful use and for Medicare programs, focusing on what to expect in the transition from manual abstraction to eCQMs. Daniel Rosenthal, M.D., M.Sc., M.P.H., Director of Healthcare Analytics, Inova Health System, Fairfax, Virginia, will speak on making sense of eCQMs as a clinician and overseer of a new Electronic Health Record system.

Although geared primarily toward hospital quality and information technology professionals, all staff involved in these topics are invited to attend.

The session will be held at The Conference Center at The Academy of Medicine, Hosack Hall, located at 1216 Fifth Avenue, Manhattan, adjacent to The Mount Sinai Medical Center. You can register online.

### Primary Care Medical Home Certification for Hospitals

The Joint Commission is now offering a new Primary Care Medical Home (PCMH) certification option for accredited hospitals and critical access hospitals (CAHs). Surveys for this add-on certification option can be conducted in coordination with the regular on-site accreditation survey or separately. The PCMH certification option is designed for hospitals/CAHs that have ambulatory care services that include the provision of primary care services offered by a primary care clinician. The requirements address operational characteristics related to patient-centered care, comprehensive care, coordinated care, access to care and a systems-based approach to quality and safety. Hospitals that seek the PCMH certification option must comply with existing accreditation requirements as well as additional PCMH-specific standards that address human resources, leadership, medication management, and provision of care, performance improvement, record of care, and patient rights and responsibilities. Surveys for the PCMH certification option will add at least one additional day to the survey and will be fee-based. For more information visit the Joint Commission website.

### Advanced Illness Management and MOLST

As hospitals move towards population health and accountable care organizations, the need to provide advanced illness management (AIM) becomes more pronounced. Hospitals are in a unique position to implement best practice strategies to integrate AIM into the normal continuum of care and to help ensure that the wishes of the patient are carried out during disease progression. Studies evaluating clinical, satisfaction and process measures have found that: patients receiving palliative care have improved quality of life and fewer major depressive symptoms; family and caregivers are five times more likely to have post-traumatic stress disorder and 8.8 times more likely to have prolonged grief disorder if the patient dies in the ICU compared to at home with hospice; Medicare patients with AIM use 13.5 days of hospital care in the last two years of life compared to 23.5 as the national average; and patients who receive palliative care incur far lower ($6,900 less in one study) hospital costs during a given admission than a matched group of patients who received the usual care.

A key palliative care intervention that NY hospitals have employed that greatly contributes to their ability to provide AIM is the Medical Orders for Life Sustaining Treatment (MOLST). MOLST was adapted from Oregon's Physician Orders for Life-Sustaining Treatment. The MOLST form combines resuscitation instructions and instructions for other life-sustaining treatments and helps hospitals comply with NYS Public Health Law. Although MOLST was originally developed to be used in hospitals and long-term care facilities, in 2005 it was approved for use in all health care facilities in the State. In 2008 the State authorized the use of the form as an alternative form for issuing non-hospital orders not to resuscitate and not to intubate.

MOLST is based on effective communication of patient wishes; documentation of medical orders on a bright pink form; and translation of patient goals for care into medical orders. eMOLST was created to facilitate the broader use of MOLST in NYS. eMOLST is an electronic MOLST form that can be completed on a computer, printed for a patient, stored in an electronic medical record and transmitted to a registry of forms. eMOLST is a secure web-based application that allows authorized health care professionals to access the system and create, review and renew, and update and view patients' MOLST forms. The eMOLST application streamlines the workflow to complete the requirements for a legal medical order with automated user feedback for quality review, notification of missing information, and training tools for users. eMOLST is also available on tablets such as the iPad and Android powered devices.

Here is additional information about MOLST and about eMOLST.