American Hospital Association

Federation of American Hospitals

The Joint Commission

National Association of Psychiatric Health Systems

NRI - National Association of State Mental Health Program Directors Research Institute

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VIA EMAIL: Patrick.Conway@cms.hhs.gov

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Patrick Conway, M.D.
Deputy Administrator for Innovation and Quality
CMS Chief Medical Officer
U.S. Department of Health and Human Services
200 Independence Avenue, SW
Washington, DC 20201

Dear Dr. Conway,

We are writing to express concerns from members of the psychiatric-provider community about two measures which were supported by the National Quality Forum (NQF) Measure Application Partnership (MAP) in January 2015 as measures under consideration (MUC) for inclusion in the Inpatient Psychiatric Facilities Quality Reporting program (IPF QR). The measures are 1) Transition Record with Specified Elements Received by Discharged Patients (NQF #0647); and 2) Timely Transmission of Transition Record (NQF #0648). The measure steward for both measures is the American Medical Association—Physician Consortium Performance Improvement (AMA-PCPI). Given their inclusion on the MUC list, the Centers for Medicare & Medicaid Services (CMS) could formally propose the measures for the IPF QR as soon as the upcoming fiscal year (FY) 2016 Inpatient Psychiatric Facility Prospective Payment System (IPF PPS) proposed rule.

We absolutely agree with the importance of effective care transitions in providing high-quality behavioral health care. However, we are concerned that NQF #0647 and #0648 overlap with the continuity of care measures currently in use in the IPF QR and Joint Commission programs. As a result, the addition of NQF #0647 and #0648 in the IPF QR would not address an unmet programmatic need, and could disrupt important improvement efforts that use data from the care continuity measures already in the IPF QR program. We urge CMS not to include NQF #0647 and #0648 in the IPF QR at this time.

Two NQF-endorsed measures related to continuity of care (HBIPS-6 and HBIPS-7) have been required by CMS for inclusion in the IPF QR program since its inception in FY 2013. They were publicly reported by CMS for the first time in April 2014.

The core element of both the HBIPS and AMA-PCPI measures is the development and transmission of a post-discharge continuing care plan. Both outline specific components that must be included. Overlapping elements include: reason for hospitalization, principal discharge diagnosis, current medication, and plan for follow-up care (next level of care recommendations).

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We have attached a side-by-side comparison of the HBIPS and AMA-PCPI measures. As outlined below, we feel there are several compelling reasons why the HBIPS measures should be retained as the measures in the continuity of care domain and not replaced with the AMA-PCPI measures.

1. The HBIPS measures were developed with significant input from the psychiatric field and fully tested for validity and reliability in the psychiatric setting by both CMS and The Joint Commission (TJC). They are endorsed by NQF. They have been available from The Joint Commission, as a condition of accreditation for psychiatric hospitals, for seven years. Based on a commitment to the importance of continuity of care, hospitals using the measures have developed important strategies to improve care at the point of discharge.

2. Since the HBIPS measures were developed for use in psychiatric specialty facilities (those covered by the CMS requirements for the IPF QR program), they focus on elements of specific importance in the care of psychiatric patients, known to be related to outcomes, and having historically lower rates of compliance. An example of this is the rigorous communication of details pertaining to medication (including name of medication, dosage, and indication for use) and recommendations for continuing care based on an overview of the current hospitalization. In contrast, the AMA measures pertain to all patients who are discharged from a general hospital or observation unit, skilled nursing facility, or rehabilitation facility. The AMA-PCPI measures have never been tested in the psychiatric population and contain elements that do not apply to this population. Moreover, national comparative rates for the HBIPS measures are much more meaningful because all users are psychiatric inpatient specialty providers (rather than all hospitals, skilled nursing facilities, and rehabilitation hospitals). The value of the information to the public could be compromised.

3. Due to their widespread use, there is an extensive database in existence for the HBIPS measures that can be used for further analysis and refinement. Changing the requirement at this time would make the existing data irrelevant to the IPF QR program as well as hinder the quality initiatives that facilities have started to address their performance in the area of continuity of care.

4. The use of the HBIPS measures has promoted significant improvements in IPFs, and their continued use would help the field close the remaining performance gap. The HBIPS measures have been required of psychiatric hospitals accredited by The Joint Commission since 2011, although hospitals had the option of reporting the measures since October 2008. Within The Joint Commission reporting system, the overall performance of IPFs on HBIPS-7 began at 56% in the fourth quarter of 2008 with 155 facilities, improving to 85% in the second quarter of 2014 with 663 facilities. All units in general hospitals reimbursed under the IPF PPS system were added to the measure pool in October 2012. Overall compliance reported by CMS in April 2014 for HBIPS-7 was 62.7%. By comparison, one-third of these facilities also reported to The Joint Commission for the same time period and had a compliance rate of 87.8%. This translates to a compliance rate of only 44% for the two-thirds of psychiatric facilities that began using the measures based on the CMS requirement. In short, there remains significant additional room for improvement, and we believe the continued use of the HBIPS measure would help foster such improvement.

5. The inclusion of IPF PPS facilities in the CMS Quality Reporting initiatives is still very new. Facilities have been challenged to report to CMS a very significant number of measures with complex data specifications using local data systems that are not well-developed along the lines of certified EHRs. It has been a very steep learning curve. The quality of publicly reported data needs time to improve and stabilize. Changing measures of the same domain of care without compelling reasons to do so has the potential to impede provider progress toward the goals of quality care and improved electronic tracking systems (EHRs).

6. If CMS replaced the current HBIPS measures with the AMA measures, psychiatric hospitals would still need to report information on the same dimension of care in a different way to The Joint Commission. The use of such competing measures adds to reporting burden, creates

confusion and potential inaccuracy in interpreting performance results, and diffuses the valuable learning that is possible when large numbers of providers report data in exactly the same way. There has been a long tradition of trying to align measure specifications between CMS and The Joint Commission as much as possible while keeping the focus of the measures specific to the patient populations.

In summary, we fully support CMS's goal of improving care transitions in IPFs. However, the addition of NQF #0647 and #0648 to the IPF QR would not address an unmet programmatic need, and could disrupt important improvement efforts that use data from the care continuity measures already in the IPF QR program. We recommend that the IPF QR program continue to require IPFs to use HBIPS-6 and HBIPS-7 to assess important elements of transition of care at the point of discharge. We further recommend that the AMA transition measures not be adopted for use in the IPF QR program.

We appreciate the need to continually assess and improve measures in public quality reporting programs. We would be happy to work with CMS and the HBIPS measure steward (TJC) to identify and test refinements that would potentially strengthen HBIPS-6 and HBIPS-7.

If you have questions, please contact Kathleen McCann, R.N., Ph.D., at 202/393-6700, ext. 102, or Kathleen@naphs.org.

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