DEPARTMENT OF HEALTH & HUMAN SERVICES
Centers for Medicare & Medicaid Services
7500 Security Boulevard, Mail Stop C2-21-16
Baltimore, Maryland 21244-1850

Center for Clinical Standards and Quality /Survey & Certification Group

Admin Info: 13-06-Hospital

DATE: **November 9, 2012**

TO: State Survey Agency Directors

FROM: Director
Survey and Certification Group

SUBJECT: FY 2013 Patient Safety Initiative (PSI) Pilot Phase Update

Memorandum Summary

- ***Survey &Certification (S&C) PSI Aligned with, but Separate from Other Centers for Medicare & Medicaid Services (CMS) quality initiatives:*** The S&C PSI is a stand-alone CMS initiative to reduce healthcare associated conditions and preventable readmissions. It is aligned with, but must not be confused with similarly focused CMS initiatives, such as the following programs: *Partnership for Patient*s, value-based purchasing, shared savings, reportable quality measures, etc. State Survey Agencies (SAs) must avoid mentioning these other CMS initiatives when discussing the PSI with any outside parties, including hospitals surveyed under the PSI.

- ***PSI Pilot to Continue throughout FY 2013*:** The S&C PSI will continue throughout FY 2013 as a pilot utilizing a risk management and educational approach in interacting with hospitals. Modifications to the pilot include the following:

  - All three draft surveyor worksheets for infection control, discharge planning and quality assessment/performance improvement (QAPI) will be tested in each survey, to determine the extent to which they can be efficiently integrated.

  - As in FY 2012, there will be no enforcement actions, unless an immediate jeopardy is identified. However, there will also be no recording of standard-level deficiencies on the Form CMS 2567. Instead, surveyors will use the pilot surveys to help hospitals become familiar with the pilot tools as risk evaluation tools for future hospital self-assessment.

A Common Goal: All components of CMS are committed to the goals of reducing healthcare-associated conditions (HACs) in hospitals and unnecessary hospital readmissions. Fulfillment of these goals is significantly advanced by various parts of the Affordable Care Act, including section 3021, which established the Center for Medicare & Medicaid Innovation (CMMI) within CMS.

One well known and broad-based initiative is the CMMI *Partnership for Patients* (PfP), a voluntary public-private partnership to help improve the quality, safety, and affordability of health care for all Americans. The Partnership for Patients brings together leaders of major hospitals, employers, physicians, nurses, and patient advocates along with state and federal governments in a shared effort to make hospital care safer, more reliable, and less costly. CMS through CMMI has awarded $218 million to 26 state, regional, national, or hospital system organizations to serve as Hospital Engagement Networks (HENs). HENs help identify solutions already known to be effective in reducing HACs, and work to spread those solutions to other hospitals and health care providers.

HENs are developing voluntary learning collaboratives for hospitals and provide a wide array of initiatives and activities to improve patient safety. They conduct intensive training programs to teach and support hospitals in making patient care safer, provide technical assistance to hospitals so that hospitals can achieve quality measurement goals, and establish and implement internal systems to track and monitor hospital progress in meeting quality improvement goals.

Examples of other quality initiatives are the Value-Based Purchasing program for short-term acute care hospitals, which provides payment incentives for hospitals to improve quality. The Community Care Transitions program supports collaboration between hospitals and community-based providers to assure continuity of care as patients transition through different parts of the health care delivery system. There are also a variety of programs and demonstration projects aimed to improve care across the health care delivery system by providing new models for organizing health care providers, including the Pioneer Accountable Care Organization (ACO) program, the Comprehensive Primary Care Initiative, the Shared savings program, and the S&C PSI.

It is against this backdrop that we developed the S&C PSI, which focuses on three hospital Conditions of Participation (CoP) for infection control, discharge planning and QAPI, where we presume strong hospital programs will contribute to reducing HACs and preventable hospital readmissions.

Confusion of PfP and PSI Efforts: SAs have been conducting pilot-tests of new tools since September, 2011. In FY 2012, because the tools were still in pilot-test mode, CMS ensured that deficiency citations resulting from the surveys were classified at the "standard" level, rather than the more serious "condition" level. Despite this, confusion has arisen concerning the relationship between the *voluntary* PfP initiatives and the S&C PSI, where hospital participation is not voluntary. The fact that we initially used the PfP name for the S&C PSI makes such confusion all the more understandable.

Some hospitals that volunteered to participate in the PfP have reported surprise and dismay when SA surveyors presented to conduct surveys that were identified as part of the PfP initiative,

particularly when those surveys resulted in deficiency citations. Although CMS takes no subsequent enforcement action in deemed hospitals when only standard-level deficiencies are cited, hospitals nevertheless view the issuance of citations alone as punitive and inconsistent with their understanding of the collaborative and voluntary nature of the PfP.

Alignment of PfP & PSI Efforts: To better align the S&C PSI effort with the non-punitive, educational approach of the PfP, we are restructuring the pilot for FY2013 so that its educational, non-punitive risk evaluation approach is clearer. During the remainder of the PSI pilot no deficiency citations will be issued, unless an Immediate Jeopardy is identified, at which point the pilot survey would be converted to a regular survey, following normal enforcement practices. For PSI pilot surveys the survey team will instead use the survey entrance and exit conferences to educate the hospital on the three draft tools, including their potential use for ongoing hospital self-assessment.

The exit conference in particular will be used to provide detailed feedback on the survey findings, to enable the hospital to assess and address its risk for noncompliance with the CoPs going forward. A copy of the completed worksheets submitted by the SA to CMS' contractor, Acumen, must also be provided to the surveyed hospital, to further assist it in its risk evaluation efforts. On the other hand, no Form CMS 2567 will be issued to the hospital. We will be distributing revised versions of the draft tools that will make the risk evaluation nature of this pilot clearer.

Keeping PfP & PSI Identities Separate: Despite the above modifications to the PSI initiative, it remains that participation in the PfP is voluntary for hospitals, but participation in a PSI pilot survey is not. In order to avoid weakening hospitals' commitment to the PfP program, SAs must be careful to clearly identify their activities only as the S&C PSI and must refrain from any statements that suggest the PSI is a component of the PfP.

FY 2013 Pilot Implementation

Starting in October 2012, each SA will be expected to survey one or more hospitals, utilizing all three surveyor draft tools, for QAPI, infection control and discharge planning, on each survey. The FY 2013 Mission and Priority Document will identify the specific number of surveys to be conducted by each SA.

SAs must continue to submit completed surveyor worksheets electronically to CMS' contractor, Acumen, for data collection and analysis. As noted above, there will be no citations for standard- or condition-level non-compliance identified during the FY 2013 Pilot Phase surveys. Surveyors will utilize the worksheets to identify areas at risk of future non-compliance and report that information at the exit conference to the hospital, but no citations will be issued. A copy of the completed worksheets submitted to Acumen must be furnished to the hospital for its information.

Although no Form CMS 2567 will be issued to the hospital, SAs will nevertheless be required to complete and upload a Form CMS 2567, including the Form 670 data, to the national data base for each pilot survey. The survey will be classified in the Automated Survey Processing

Environment Complaints Tracking System (ASPEN ACTS) as a complaint survey and the narrative will state only that the survey was conducted as part of the Survey and Certification Patient Safety Initiative. SAs' reimbursement will be based on the effort expended by the SA, as reported on the Form 670. Timely upload of the survey kit is therefore essential. In the case of failure to upload the survey kits, CMS will estimate the State's cost from available data near the end of the Fiscal Year, input funding for such costs into the payment management system, and consider the expenses to be paid in full.

Any situation identified as an Immediate Jeopardy during the PSI survey will result in the conversion of the survey to a regular survey for which standard survey and enforcement procedures will apply.

An updated PSI Pilot Protocol and Frequently Asked Questions document is attached. All previous versions are hereby superceded.

Any questions or comments related to this memorandum or the S&C PSI in general should be directed to the following dedicated mailbox: pfp.scg@cms.hhs.gov.

Effective Date: Immediately. This policy should be communicated with all survey and certification staff, their managers and the State/Regional Office training coordinators within 30 days of this memorandum.

/s/
Thomas E. Hamilton

Attachment: Patient Safety Initiative Pilot Protocol & FAQ

cc: Survey and Certification Regional Office Management