April 21, 2016

MHA

ADVISORY
Essential Policy & Regulation Updates
MASSACHUSETTS HOSPITAL ASSOCIATION

QUICK SUMMARY

- Pursuant to Chapter 52 of the Acts of 2016, **all acute care hospitals are now required to provide monthly reporting of infants and children (under the age of 11) who were treated due to an exposure of a controlled substance.**

- **The reporting period begins for all patients treated on or after April 1, 2016.**

- DPH issued guidance on how this information should be provided, which must be submitted through the DPH Health Care Facility Reporting System (HCFRS).

- While DPH did consult with physicians on the reporting guidance, we are concerned that there has not been broader discussion with the hospital community. So it is critical that hospitals please alert MHA of any concerns with the time frame and/or the data to be reported. ■

OVERVIEW OF MONTHLY REPORTING REQUIREMENTS

As part of the recently passed Substance Abuse Treatment, Education, and Prevention Law (Section 10 of Chapter 52 of the Acts of 2016), the Department of Public Health (DPH) was authorized to develop a monthly reporting system to track the number of infants and children exposed to a Schedule I through III controlled substance.

It is important to note that an earlier law required monthly reporting by acute care hospitals of all infants who were exposed to a Schedule I through VI drug. MHA worked with DPH and other provider groups to seek technical corrections to that law to ensure that the reporting was focused on treatment for infants and children exposed to certain controlled substances.

As the law provided DPH with discretion to develop and issue the reporting requirements without the need to issue regulations, DPH developed and issued this **Circular Letter**[mhalink.informz.net] and **Reporting Instructions**[mhalink.informz.net]. DPH has further decided to start the reporting process immediately, asking providers to start collecting and reporting on all infants and children (under the age of 11) who were born or treated within an acute care hospital on or after April 1, 2016. **All reports must be submitted within 60 days of the end of the month, so the April 2016 month should be reported no later than June 30, 2016**.

Due to the fact that there was not a broader discussion with hospital staff or advance notice of the new reporting criteria, it is critical that members please review the attached information and provide MHA's Anuj Goel (agoel@mhalink.org) with any specific concerns regarding this new requirement.

While MHA is supportive of this overall reporting requirement as we believe it will be critical to statewide or regional opioid prevention initiatives, we are very concerned with the immediate time lines and lack of advance planning for hospital staff to develop internal systems to report within the 60 days following the end of each month. In addition, the law limits the data to Controlled Substances within Schedules I-III, but DPH decided to include in the list below drugs that are within a Schedule IV. Finally, there are some data elements that already are reported within other databases that DPH may be able to collect from other agencies. We are therefore interested if members feel that there may be additional duplicative reporting requirements that should be considered. It would be very helpful if the membership would please provide any thoughts related to these points

or others to determine possible next steps. ■

DATA COLLECTION

With regard to the data to be collected, hospitals must develop a new internal system to collect the following information (using the specific ICD-10 codes outlined in the attached Reporting Instructions):

1) Aggregate number of infants born in the month that are exposed to a controlled substance as follows:

1. Aggregate number of all births (living or deceased) in the month for baseline data;
2. infants with neonatal abstinence syndrome from maternal use of drugs (opioids and benzodiazepines); and
3. infants who have mothers with drug dependence (specifically opioids and benzodiazepines).

2) Aggregate number of children (under the age of 11) treated within all locations under the hospital license in the month, broken down as follows:

1. ED visits for baseline data;
2. Observation stays for baseline data;
3. Inpatient admissions for baseline data;
4. Opium-caused ingestions;
5. Heroin-caused ingestions;
6. Methadone-caused ingestions;
7. Other opioid-caused ingestions;
8. Synthetic narcotics-caused ingestions;
9. Other narcotics-caused ingestions;
10. Unspecified narcotics-caused ingestions; and
11. Benzodiazepine-based tranquilizers-caused ingestions.

As part of the data collection process, DPH developed a separate reporting/collection grid on the HCFRS website that specifically provides for the reporting of the data elements outlined above. **Please note** that if your hospital has services on separate campuses or locations where you are required to submit information to the DPH HCFRS website using separate site IDs, you will then be required to split/separate your data and report based on the cases provided for that specific site.

Providers should also be aware that for the controlled substance treatments listed above, for children, you should only report the number of treatments where the primary diagnosis is one of the listed ICD-10 codes in the attached instructions. However, for the infant cases, you should be reporting on any treatment where the ICD-10 is listed as a primary or associated diagnosis.

If there are other clarifications that are needed on this new mandate, please e-mail either Anuj Goel (**agoel@mhalink.org**) or you can contact Kate Fillo at DPH (**Katharine.fillo@state.ma.us**). If you do contact DPH, please consider including MHA as a cc so we can track the issues that are submitted to the state on this issue. ■

BEST PRACTICES

Please note that in 2013, DPH issued this **Guidelines for Alcohol/SUD Screening Circular Letter**[mhalink.informz.net] that provides best practices for screening pregnant women and newborns for drugs during the pregnancy. This information may be useful for those who are seeking to develop or enhance their current screening programs to identify and then work with at-risk patients prior to delivery. ■