Core Measures Meeting for Critical Access Hospitals
Presented by Vicki Tang Olson, RN, MS (175-minute Webinar) July 24, 2014

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Good afternoon ladies and gentlemen thank you for waiting. Welcome to Core Measures Meeting for Critical Access Hospitals. All lines are in listen only moment. Without further ado, it is my pleasure to turn the floor over to your host, Ms. Vicki Olson.

Good afternoon everyone, this is Vicki Olson and this is a core measure meeting. For today, we are going to see if we can get the slides to work. We are going to go over -- I will do a brief update a little bit on medication communication and be quick overall. Then we will talk about some of the specific measures coming up. So Robyn will go over and as well as [indiscernible] from the hospital core Association -- they will be going over the organization through August. We will have a brief break from 2:00-2:15 around there. Then we will go over CMS. The improvement work and [indiscernible] -- actually this will be five years this next time around. But there are some overall changes. A lot is the structure of the program. We will be reviewing that and [indiscernible] will be joining us to talk about some of the beneficiary protection changes with that program. We will have time at the end for questions and interaction with Robyn related to some of the [indiscernible] issues.

Here is our objectives. We will be talking about measure changes. For a little -- we will [indiscernible] for those of you on the safe road map. [Indiscernible - audio garbled].

We will review that and discussed the new measures do in August. [Indiscernible - audio garbled].

For the statewide quality and reporting measurement system these are the recommendations. We were in negotiations with the Department of Health and the community. We really did put things on hold. I really think [indiscernible] feedback and thinking through the implications of adding measures.

We decided not to add any new measures this year. Three cheers about that.

There has been feedback, and I think it is good feedback from [indiscernible] hospitals about the low fidelity him -- low-volume of some of the stated measures. There is [indiscernible] data associated with that. If it is of low-volume, MA not feel of value and is useful. -- As useful.

The two that were obvious where the AMI seven numb A and AMI 8 A. -- -- 7A and AMI 8A. We may consider that for the future for PCI hospitals.
The hospital measures recommendation process was to eliminate these measures so that you don't even have to pull the population. [indiscernible] work associated with these measures.

The major change -- as I talk about those recommendations, let me follow through too on the process.

The recommendations were shared with the Minnesota community measurement and the Department of Health at the end of May. Then the third week in June, of which I don't know if any of you participated in that -- or it is also offered by phone. So that the recommendations were shared in a public forum. Then it goes to the proposed -- the development of the proposed rule which is kind of where we are at this moment. Andy H is developing the proposed rule, and that will be released in August, usually by the seventh where the 15th or somewhere in that time. Then there is a comment period for completing and getting approved the final rule.

So that is where we are in the process for that 2015 measures that will be released in November of this year.

We did propose some changes and we have those planned at MGH and the Minnesota community measures have approved them. So, the hospital steering committee, those members, instead of being annual, they will be on that committee up through 2015. We have also changed it so the hospital steering committee will be a process throughout the year. Historically, they have had 2-3 meetings in the spring and then released their recommendations. We felt that putting that throughout the year gives us more opportunity [indiscernible] expert groups. Then feeding that information into the change review process.

It also does not put so much pressure in the springtime period of trying to put the measures together.

The other change is [indiscernible]. The Minnesota community measurement has shared a preliminary site of measures which will be developed by April 15. Because of the timeframe, it has not built into the hospital measures to do that. So, in 2015, the coming year, we will also be able to have a preliminary slate of measures. I think that gives everybody an opportunity to see that this is exactly what is being recommended and you can respond specifically to those specific measures. So, I think that will also give people a heads up and an opportunity for input. It is really adding a third step in the input process. Not only will we get the clinical expert groups are fighting feedback -- providing feedback and determining the preliminary site of measures. There will be the preliminary side of measures, the public forum and then another informal public commentary as well as the formal public period in August. There will be more opportunity for hearing what is going on throughout the year as well as [Indiscernible - audio garbled]. We are excited about that.

This is just a visual of the recommendations process. Where we are really trying to [indiscernible] the process. Typically it starts at -- MDH may identify a focus area.

Then they identify potential measures. Sometimes they provide specific measures for gaps or areas they would like to address. Then there is a steering committee that identifies potential measures and we convene a committee for session about those measures. We get feedback about those groups. Then that
team discussion since it is over -- happening over a year period. [ indiscernible ] as well as [ indiscernible ] measures. There we go into the [ indiscernible ] process.

Although we did not add for this year, really the sessions of the sub committee over the last two years, there are quite a few things in the queue for discussion. These would be things to be thinking about and giving feedback internally so we have opportunity to provide feedback. You can put that into the process.

There is readmissions. There is currently a meeting about doing the Minnesota [ indiscernible ] readmissions which would include readmissions to other facilities. I think that has been a recognized gap and that current data. Because it does not include readmissions from other areas. So, mama Mac has been an advocate of trying to get [ indiscernible ] readmissions measures -- [ indiscernible ] has been an advocate of trying to get [ indiscernible ] readmissions measures.

Patient safety, there are several measures. We have always try to align with CMS and there have been quite a few changes. With process measures and adding other measures and also the clinical quality measures. Then also MBQIP has the measures [ indiscernible ] that we have also included. CET communication has been part of the [ indiscernible ].

This is just another view of that, but it has identified clinical expert groups that we think may be good for providing feedback and [ indiscernible ] into the steering committee.

You can see a little more detail like for the patient safety measures which have, as discussion. Some are current measures. Once that are more orange are established current measures. The ones that are a little lighter, in yellow, are potential measures and development ones. There are possibilities, but it is -- there is no clear specific measure we are trying to get.

So, these would be more into the specifics. I guess a few more things about this. With the patient safety group, the [ indiscernible ] and the [ indiscernible ] application rate, those are ones that are current CMS measures. That goes into the CMS alignment grouping.

The [ indiscernible ] measure was one where there was thought about removing that. But the legislature in Minnesota identified gapping as a need for research.

So there is currently a group looking at state -- staffing and the relationship to the areas to rescue [ indiscernible ] measure.

We decided to leave that in with the idea that we would revisit that. That is a gap there. The two in yellow have more to do with -- because there is such a focus on patient safety culture, I will share more about that today. Should we have a measure that just says you have done it or you have not done it in the last 18 months? Will there be a lot result? Should we have a measure to -- so the hospital has a patient safety culture?
Then the falls, pressure ulcers and others drug events, those are things that people have been doing quite a bit as part of the MHA safe roadmap. That does not include all of our hospitals. Not all hospitals report. There is a lot more focused on harm [Indiscernible - low volume].

Stroke has to do with alignments with CMS measures. OB and pediatrics were areas where there were discussions about eliminating those. There were groups that had recommended those and we wanted to make sure they had opportunity to [indiscernible].

As you know, for the NHSN measures, it is a separate rule and not part of the statewide measurement system. The focus on infections is a little bit more of a gap.

Then there is the readmissions measure. You can see on the committees, those are potential areas that we have talked about that are hot topic areas.

Anyway, you can talk about them in your organizations.

I want to mention there was a team webinar a few weeks ago.

I don't know if you participated in that, because we are working on medication communication. I thought I would highlight this. You can certainly go out to the website. It is recorded in addition.

It talked about the importance of the patient safety culture coming up to the [indiscernible] that is slotted for October. I think it is helpful to be aware of this information. I think I will skip that slide and come back to it—back to it.

So, for that HCAHPS safety culture, what they have found -- they did a research study and they found for [indiscernible] for the ark patient safety survey which I know many of you have done it is part of Stratis Health and getting patients involved in the patient safety survey. I thought it was interesting to see the correlation between the patient safety culture work and [indiscernible] as part of your HCAHPS So the higher score, the ark patient safety had 15 measure areas. 12 out of those 15 were related to a higher HCAHPS score. But, the HCAHPS is divided into composite areas.

Over all the HCAHPS score as [indiscernible] -- those are considered to be different. They are more patient satisfaction and experience.

Nationally too, they have identified those. So, those are not correlated with the MHA -- the ARC patient safety score.

Here is visual. You can see in the bottom -- across the bottom is the average of the ARC patient safety composite score. Then you can see the HCAHPS composite score.

These are the 12 that are highly correlated with the HCAHPS scores. When you look at them, it is not a big surprise. It has to do with culture and organizational learning and patient Stacy -- safety. Certainly staffing has to be responsive within units.
You can look at your scores in those areas too to see if there is opportunity. Potentially impact your overall performance.

Okay, I will go back a little bit about the safe road HCAHPS with medication communication.

They had meetings with [indiscernible] which all hospitals are participating in. Judy can jump in here too. Judy bird is the site coordinator for Minnesota. Judy was at the last meeting too. She is overall responsible for the implementation of [indiscernible], so Stratis Health works with the Department of Health as part of that project to be able to support critical access hospitals.

We talked about previously our goals. We decided to pick a measure for everyone so that we could work on it together. The measure was the HCAHPS medication composite. It has to do with new medications and explaining the purpose and the side effects of new medication.

As part of improvement for that project, I have really taken that out of state meetings and I have done it more with our MHA joint regional meetings. So, as we are going around the state, the three areas that I guess [indiscernible], Redwood Falls and Alexandria. As we are reading with the groups, we are adding it to the other improvement topics that we will be addressing as part of the MHA work.

Those meetings are coming up. That will be the beginning of August, so that first week of August. I want to make sure that you go back to your hospitals and make sure that either you or somebody will be responsible for that project and will be registering for those meetings. That you will be planning to attend.

So, the joint between MHA and Stratis Health. Last time I went through the strategies, the three main areas were to make sure that nurses are comfortable sharing medication information on new medication. Second is the trigger into the process so that there is some trigger when there is a new medication and that they are addressing that with the patient. The third packet is really making sure that the patient understands the information. So, looking at teach back as a strategy to ensure the patient understands.

There is some additional information about difficulty understanding what the side effects can be. Also there are cultural issues where nurses do not want to go much into detail because they fear that either the patient will refuse the medication or they might all of the sudden have all of these symptoms and side effects. Because they are hearing what they are. So, I think there are some additional things we will be talking about, but the expectation is to Inst -- to start those improvement cycles and to be thinking about exactly what you are planning to implement.

The meeting in February went through which of those areas you really want to start in and to start thinking of doing some improvement cycles related to that.
At these meetings, we will have some general discussion about where people are at and the things they are trying and [indiscernible]. There is always an advantage of having [indiscernible - audio garbled]. You can understand from each other and what people have implemented.

So, that is coming up. I think the next topic [indiscernible - audio garbled]. It is talking about measures that are due. I am going to turn it over to Robyn.

Hello Mac everyone, this is Robyn. -- Hi Everyone, this is Robyn. The measures we are going to be talking about are not CMS measures, they are the ones that are required -- the ones you are doing for the state. They are not all new. We have talked about this before, but the last time was January. Just as a reminder, hopefully you did not totally forget about these. But, we just want to remind you that August 15 is coming up.

First, I want to talk a little bit about the ED transfer communication. We will talk a little bit about these measures and then Mark is here from MHA. He has slides and he will show you the way you will be able to submit to them your [indiscernible] measures.

Not a lot to say about the ED transfer communication. The new thing starting the first quarter of 2014 - the thing to remember is that it is not just acute-care facilities anymore. You have that discharge submission -- it is a transfer to other healthcare facilities. I know that people are having issue with that, but that is the way the measure was written for in QS and that's the way -- NQS and that's the way it is.

If it helps, we know this is an issue and we are bringing it to the attention of people looking at the measure and possibly changing the measure. We are letting them know. People know this is difficult. A lot of times what we are hearing is that for a lot of people going back home, it is the nursing home and it is considered home.

Maybe they don't have that transfer information.

We are aware there are those issues and we are addressing those issues. Right now this is how the measure is written on this is how you should collect the data.

The other thing is [indiscernible].

We are saying 15 for the month and 45 for the quarter.

Hopefully that will help you if your numbers are big and you have a lot to do. With cutting down staffing size, hopefully that will help.

There have not been any changes to the data elements, but we were listening to everything people were saying and we know that some of it was not clear. We added a little bit -- other than [indiscernible], to make things clear.
I do not have an updated copy to give you today because it is still in the draft form, but we are waiting for final approval. I just want to mention again that there is nothing new. But, because people had difficulty understanding the webinar -- we are used to pretty detailed in the manual with what to do. We just agile -- added a couple of more notes.

We will have an e-mail sent out with them so that everybody knows the same thing.

There were a couple of issues around the nurse to nurse communication.

There was concern over maybe what that communication has to entail.

We just really said that it is just -- it does not have to be a full report. If the call is maybe just acceptable communication includes ensuring the availability of an appropriate bad and staff for the patient.

There has to be communication nurse to nurse. We had people concern there had to be a full-blown report of everything going on with the patient.

Then the issue came up that it was taking away from time with the patient. That takes place after the patient leaves.

It does not have to be a full-blown report, but there has to be communication. Maybe even if it is just, we want to send this patient, do you have room? That would be okay.

The other element has not changed at all. People were having trouble understanding what it was. That was the data element called impairment.

We got some feedback and we thought perhaps a better name would be sensory status.

Really what you are looking for is -- was the patient assessed for mental, speech, hearing and [indiscernible] impairment? We thought if we said that, it would be helpful. People were not sure what impairment meant.

It is worded differently, but it is the same.

A couple of more -- we try to add things that would let you know what is acceptable. So if you had a H&P that included [indiscernible], that would be an assessment of speech and hearing. Or if it's had oriented, that would be an assessment of mental status.

It is not like it is different. Hopefully you are doing it that way, but maybe it wasn't clear to everyone.

Just a reminder, that is due August 15.

The CP OE -- CPOE pharmacy verification.
We talked about the measure, but that it -- but at that point, we did not know how we would be sending it.

So you do have a handout, a couple of them. The first one is just kind of a reminder about what this is.

The one that says [ indiscernible ] CPOE verification orders, that one there. Just a background. A little bit about the background, on the middle point -- the middle part is the measure itself.

So the pharmacist CPOE verification of medication order within 24 hours consists of a numerator and denominator. The numerator is the number of electronically ordered medication orders for a patient admitted to a [ indiscernible ]. Terrified by a pharmacist or directly entered by a pharmacist within 24 hours.

That is the numerator.

The denominator is the total number of orders for patients admitted to [ indiscernible ] during the reporting period. Mac.

-- Period.

Exclusion criteria would be outpatient or [ indiscernible ]. Does not what they are looking for here.

Now, they revised the measure to have two methods of capturing data. The preferred method, and the one we discussed in January, the numerator and denominator are pulled from the verification report. So if you have the health record, I think the discussion [ indiscernible ]. The discussion was that your vendor would be able to get this verification report for you.

Then easily from that you would be able to fill out the numerator and denominator. In case you are not capable of doing that and your system cannot do that, they came up with an alternative method.

That is the last paragraph on the bottom of the page. It is telling you the numerator is the number of electronically ordered orders for a patient admitted to MDH . By a pharmacist or directly entered by a pharmacist within 24 hours [ indiscernible ].

The denominator would still be reported as the total number of electronic medication orders for in patient during the reporting period.

The second page has an example.
Your sample there -- your hospital has a Monday-Friday coverage but no weekend coverage. There are 37 orders injured between the end of shift Friday and 8:00 a.m. on Monday morning.

The total number of electronically entered medication orders for inpatient [indiscernible] equals 208. -- 280. In this example, the numerator is 280 total orders -37 orders during the period of no coverage. That would equal 243 orders that work entered or reviewed by pharmacist within 24 hours.

So, that would be your numerator, that 243. The denominator would be the 280 because that was the total number of orders electronically entered.

Using those numbers, the percent compliance would be 86%.

Okay? Hopefully there is no one listening or here who is thinking, this is the first I have heard of this.

To prepare for this measure, and we hope that you already have, you would need to check with your vendor to see if you have capability to have that verification report. Then, you would use that to determine your values for entering into the system that Mark will show you.

Or you can report the measure from a computer generalized pharmacist verification report, or use a general method if you don't have the report.

We did not mention this, but the last time we had a call and we had people on the call -- the people that were listening were not able to hear the questions.

We would really like people to come up and talk.

If you talk really loud, you are okay.

[Indiscernible - comment or question from audience].

I don't see here where it -- it just says observation. I am thinking maybe we need to check.

[Indiscernible - low volume].

In the inclusion criteria. In patients admitted to in acute-care beds, [indiscernible] and observation.

[Indiscernible - low volume].

I think with other measures, what we have done is -- obviously it has to be an inpatient bed [indiscernible]. So, I guess when you are doing -- I would not think it would matter whether that patient has been in the bed and on medication. It is verifying that medication.
Why don't you go under that and we will do a double check just for clarification.

I am going to turn it over to Mark now and he will show you the portal and the way you will enter the data.

[Indiscernible - low volume].

With our observation [indiscernible] their own medications. What about that?

For people on the phone, we have had a couple of questions around the inclusion criteria for observation. The last one was just -- she was asking if a patient is an observation and they bring in their own medication and they self medicate.

It would not be prescribed by anyone and they would not have a prescription from the pharmacist. I would think that would not be included.

Does a physician order it?

The physician orders it and the pharmacist I think [indiscernible].

[Indiscernible - low volume].

We will check on observation. We will get that information out to you. I think it is helpful too to think of the intent. The idea that CPOE is a way to reduce patient errors. The second-level is having the pharmacist verified the physician is making -- is looking at all of the components and the drug/drug interactions. They double check errors in ordering and not just [indiscernible].

Anyway, kind of keep that in mind.

Go for it Mark.

Hopefully this will be straightforward. I have 12 slides, but I don't think it will take that long.

First of all, this site will be live by the end of today. So, you can go in after today and do this.

The first slide I have here, the first thing you need to do is log into the ED transcript communication site. You can also go in through the MHA portal. When you go through the MHA portal, it will list all the things you have access to to submit data. Mac this one has access to ED transcript communication and their staffing communication.

You with inches the ED transfer communication for this measure.

It would not be intuitive, but that's what you do.
Once you choose the ED transfer communication box, he will get this screen. Did I go too far?

That's okay. The first screen was just this without the data part. It will come up with your ED transcript communication data. When you go to enter data, the drop-down will have the choice of ED transfer communication or what we call the Medicare beneficiary quality improvement which is the CPOE measure. You want to click on the Medicare measure. You are going to get a screen to add data. I actually have the deal yet as my -- Medelia as my default hospital. We have deleted the data.

So you will get a separate window that is off to the side.

You will choose your report period with a drop-down box.

I chose the third quarter of 2013. Everything submitted by August 15 is both for quarter of -- fourth quarter of 2013 and first quarter of 2014. In three months, it will be the second quarter of 2014. We are just getting two quarters, but after this it will be quarterly.

The question after this is, do you have CPOE. If you choose no, that is the end of the submission and it does not go forward. So, this is really only for those that have CPOE .

I chose yes. The next question is, how is the data captured? Robin -- Robyn just went through the preferred method and the alternate method. If there is neither, that is the end of the submission. We hope that you use one or the other or the alternate. We put neither in there just in case.

-- In there Mac -- there just in case. If you hover over the methods, it will tell you what they are. It is just more information to help you.

I choose the preferred method and he gives you the numerator and the denominator. You cannot get out of this without having numbers in their. -- there. That is what the required part is. I just chose random numbers with 115/130. You hit the save button and here is your report.

This was a bug that we found yesterday that he gave us the same data on two lines. We fixed that and it will only be one line. It will show you all the data that you have submitted through this site. If you do fourth quarter 2013 and first quarter 2014, they will both be there. It will show you your numerator, denominator and your percentage of compliance.

There is nothing really tricky here, but if you have questions, I will gladly answer.

[ Indiscernible - comment or question from audience ].

I don't have access. [ Indiscernible - low volume ].

We have a list at East hospital -- each hospital. I am sure you know who the ED transfer person is. For now we will have you work through that person, but we will work that when you go to a portal, it will
ask for a new username. We don't have that functionality yet. For August 15, we will have to have you work through your ED transfer communications coordinator.

For the question -- the question, for those of you on the line, is if somebody wants to add a person from a certain CPOE rather than a marketing transfer. The answer is to use the ED transfer person. There will be [indiscernible] going forward.

[Indiscernible - low volume].

I looked at my ED transfer stuff, and I did not see that selection for me. Maybe I should have clicked on [Indiscernible - low volume].

[Indiscernible - multiple speakers].

It should be live by the end of today. It will be live by the end of today.

[Indiscernible - comment or question from audience].

Do we have to work in our old system to gather that data?

For those of you on the phone, there was a switch in EHR in February. The question was, do we have to go back to the old system to gather data? I will let Vicki or Robyn to answer that.

I think we recognized the fourth quarter. If people have the capabilities, the expectation is that people would submit it. You know, first quarter, we are thinking that we really want everyone to submit. It would be helpful to go back. I guess it depends on how much work it is. I don't know [indiscernible] or how important it feels from your standpoint.

From what I understand I think you are good if you submit what you are reasonably capable of submitting.

So, for somebody -- you would have a partial quarter. You would use the denominator for February and March and then obviously pick up the numerator that matches.

So, for fourth quarter, would you have them click the neither button. -- Button?

Right.

If you are doing CPOE, you click neither and it will end.

[Indiscernible - comment or question from audience].

Trudy said, for those of you on the phone who are with MDH, you shouldn't -- you should submit what you are reasonably capable of submitting. So, going back to the fourth quarter if you switched
EHR in February, you can reasonably say that you are not capable of re-creating the fourth quarter. But for the first quarter, you are reasonably capable.

Yes.

Okay, I have confirmation.

I have one more question. [Indiscernible - low volume].

Yes, so you are ready have a username and password. We can grant you access to ED transfer. Yes we can. So, you may or may not have my e-mail. Okay, so we can work on giving you access to that.

It is really people who do not have access to any of the porters -- portals.

West, can you open the lines -- Wes, can you open the lines?

If you have questions press 7 and Q.

Also, if you would like to enter your question into the chat, we will into your questions that come in that way.

I guess we do have one question. Is there a compliance goal for CPOE?

I would say this is more of a question for Judy.

[Indiscernible - low volume]. I have not been told a compliance goal.

I think we are working on reporting to start with. Generally the focus is to get everyone to report. Then, we will look at a goal. My sense is that the goal will be 100%.

[Indiscernible - multiple speakers].

I think Judy that you are reporting the percentage of critical care access hospitals that are using CPOE and this measure.

Right, we have a goal for 100% hospitals reporting.

Right.

But the compliance goal is the question.

For the compliance goal, I have not heard [Indiscernible - low volume].
I think we were interested in getting the data too. So, this first reporting. Back in August will be to get that information. Perhaps we will be able to address that more specifically. Good question.

Before we take any more questions, this is Robyn, I just want to mention -- Mark brought it up, but you did get a handout with the submission deadline. Because we were -- it was a little late in starting with the CPOE and getting it up and running. That is why if you look toward the bottom of the handout, what Mark was talking about is that for the August 2014 deadline, it is fourth quarter 2013 and the first quarter of 2014 if you are able to do that. Then you can see the rest of it every three months.

We will switch to the -- from the 15th to the 31st. Once it gets to --

Once we get into January of 2015, then the timeframe changes. You are used to -- we try to align with CMS so was the 15th of the month. Then we needed to align more with what [indiscernible] wanted. We went it -- we went to the end of the month. You will have to do it earlier following CMS stuff. Look at it like that.

Then the ED traffic communication as well. That will be the 15th and will be the same until we get to 2015.

Then you will notice their Carter for 2014 and fourth quarter -- the third quarter for 2014 and the fourth quarter of 2014 will be due January 31, 2015.

There is a question on the phone. The phone is from Andrea Hudson. The floor is yours.

This is an Andrea, this is Mary Wilson. Robyn, what are the disputed -- the dispensation codes? You mentioned a hospital transferring to a swing bed and a nursing home are included.

It is 4 A, B and C. So, that is transfer to another acute-care, transfer took Ritalin -- to a critical access hospital, transfer to a cancer or Children's Hospital, transfer to a veterans hospital. 3 is hospice. So transfer to a healthcare facility for hospice. Five numb is transfer to another healthcare facility such as a nursing home, skilled nursing facility, rehab center. Any other kind of [indiscernible] facility.

Is that 4?

That is five numb.

So we are really looking at two numb, 3 and five numb.

There is no -- two, three and five.

There is no to anymore. I think that -- two anymore. I think that is hospice now. You need to look at the guidelines.
Okay.

So it is a hospice facility and not a home.

Think about this. This person is transferring to another facility. Is the facility getting the information that what happened in the ED?

I am looking at the disposition codes and I think 1 is home, HCAHPS -- I am pulling data and actually running a report that actually list those codes as disposition codes. But, I don't know if those codes have changed.

This the -- well, see, the issue is that CMS changed about two manuals ago and went from the code that you did for the UB whenever and now it went to this. Those codes for billing were changing more frequently than CMS wanted to change the spec manual. So, these are the codes that are kind of from the spec manual and that’s what we went with here.

Even for your [ indiscernible ] in general, if you are running reports and pulling off of what might be a your billing, it will not be eight 2 for your fraction. You need to use the discharge disposition in effect manual.

It may require that you go to the chart and not what was told for you.

Is there a crosswalk somewhere? [ Indiscernible - low volume ].

I don't want to say interpretation, but in the spec manual where they have the values, you really kind of goes in and tells you what is included. Even though you know that it is that CMS umbrella, but CMS [ indiscernible ] is here and extraction is here, as far as I know there is not a cross [ indiscernible ].

[ Indiscernible - comment or question from audience ].

[ Indiscernible - low volume ].

[ Indiscernible - comment or question from audience ].

If you cannot fully disposition code out of the EMR [ Indiscernible - low volume ].

Yes.

[ Laughter ].

We were just discussing that it is difficult to run a report when the discharge dispositions are different. I sympathize.

Word is assisted living fall?
[Indiscernible - low volume].

Yes.

[Indiscernible - comment or question from audience].

Somebody was asking where assisted living fit in. It is CMS extraction world, assisted living is considered home. We have a question on the chat. If we are not able to report by August 15, is it better to answer neither or report when the data is available?

So let's say by November 15 --

[Indiscernible - comment or question from audience].

I think we should just go forward. I think the data submission date is the data submission date.

What we are saying is if you are not able to report by the 15th, we would like you just to go in and put neither to show that you did not forget to do anything. Then subsequently, going from there.

I think there are still a few hospitals that did not have CPOE capability. If you do not have CPOE, you would first answer that question, and that would also stop the process. You would have completed your submission.

The way this is set up is that if you don't have CPOE, you still have to come in each quarter and say that you don't.

The reporting we are running into a lot of difficulty with our reports. They are trying to work out the reports.

[Indiscernible - comment or question from audience].

Okay.

Or the alternate method of calculating based on pharmacy coverage errors.

[Indiscernible - comment or question from audience].

If you are having difficulty getting reports from your electronic record, and you are unable to report by the deadline that you choose -- yes you have a CPOE and the neither if you are unable to create the report. There would be an expectation that someday you would be able to.

It is a struggle right now. We just merged with another facility [Indiscernible - low volume].
I have a question on the denominator. With the alternative method, you do not have -- we do not have pharmacy coverage 24/7 [ indiscernible - low volume ]. In the example you showed, [ indiscernible ] over 24-hour period. What would that look like [ indiscernible ]?

So, the question is, if you are trying to use the alternate method and the pharmacist is not there -- they are there seven days a week, but not 24 hours a day, what would be in the denominator?

I think that is why we are not thrilled with the alternate method. It does not feel like it rings the measure to the levels that we are used to with some of our other abstractions. If you feel assured that you can reliably come up with some business rules about those pharmacy hours and with the pharmacist would have terrified, then I would use whatever business rules you come up with to calculate the measures.

If you feel it is still variable and you cannot really reliably say that the pharmacist verified the orders, then I would choose neither and tells you can really get a report that provides reliable data for yourself.

[ Indiscernible - comment or question from audience ].

Then you can kind of figure it out based on your flow. Yes.

Another question too about the quarter dates. The first quarter --

The first quarter 2014 would be January, February, March.

So January 1-March 31?

Yes.

Yes, fourth quarter would be October-December 31. At least we are keeping the most the same.

[ Laughter ].

A.

Are there -- thank you.

Are there any other questions around how to get into the portal?

[ Silence ].

Are there any more questions online?

As reminder, for if question or comment press 7 or Q.
[Silence].

If there are no other questions, we will move to the next discussion.

Thank you Mark.

If you look at the agenda, I think -- I just want to remind everyone that for the first quarter of 2014, that is the first due date for the hospitalwide khadi -- COTE.

If your infection prevention is the person about hospitals that is doing that. Maybe you want to go back in remind them that the first Carter -- the first quarter data is due by August 15.

I guess if you go back and have questions around that, you can contact us.

The next measure that I want to remind you guys of that is due and new for you for the first quarter is the perinatal care measure.

This measure is one -- you are doing it because it is required by the state, but you are going to enter it through QualityNet. I can show you how to do it because I don't have access and I cannot bring it up.

Back in the day when it was my task and you were going to enter [indiscernible], it is going to be in that area. You will go under the web-based measure and that's where you should find it.. I don't want the discussion right now, but I know there are issues around the portal.

I can't tell you what it looks like and I can't take a screenshot because I can't get it. I can't bring it up. Right now I cannot look to see if you have done your population sampling or entering your PPO 1. I am trying to call the helpdesk to get that fixed.

So, we are working on that.

What we did give you is the paper tool.

PPF hospitals have been entering this for about a year. Some have told me they found the paper trail kind of helpful.

Once you get in an entry into the care site and QualityNet, you are entering a numerator, denominator and an exclusion. There are three numbers you have to enter.

The paper tool kind of goes through the steps to figure out -- when you are looking at the patients individually, is this patients in the numerator and the denominator or is this an exclusion.

So with the paper tool, you are not really entering the tool anywhere. It is not going anywhere and you can throw it in the garbage if you want to.
This is where you can enter numbers and that's why we gave it to you.

It is not on QualityNet. It is not on the secure site, but it is hard to find. We gave you a copy in case you find this helpful.

Now, I am saying this is due August 15. If you can get in, enter it.

That is for which quarter?

This will be the first quarter.

The PCO 1 will be first quarter 2014.

The question was, if you don't have any delivery, should you enter zero? The answer is yes.

[ Indiscernible - comment or question from audience ].

Yes, I believe there is a difference with PCO two numb. -- PCO2.

I think people are submitting something to MDH, but this is different.

Has anybody done it or collected it?

[ Indiscernible - low volume ].

Is it bad to do for you guys?

[ Indiscernible - low volume ]. I think it is the entering into the portal -- we used to collect it and have a vendor. We closed [ indiscernible ] for a while [ Indiscernible - low volume ].

I do have an abstraction question.

Just a second. Hold that.

I think what I really want to bring -- I really want to bring it to people's attention. I talked about this in January when there was discussion of the measures starting with first quarter. That is sometimes when we have the issue. I am sure you guys realize that.

January 2014 was a while ago. The first quarter is not due for a while. There is a big gap. Hopefully a lot of people did not lose this in the meantime. Just a reminder that this is one of the things that is due.

Robyn, has the measure specification on quality gone somewhere?
I think it is maybe a two-page thing. It is not like the others and there is not a lot there. Sometimes when you asked questions about it and QualityNet, they refer you to that Joint Commission page. On our site, there is not a lot. It would be under the web-based measures and the structural measures if you were looking for that in the manual.

I think there is also a link to the Joint Commission.

Right, there is also a link to the Joint Commission site. Does anybody else have questions?

With this number be different than the one injured mama -- injured [ indiscernible ] -- entered [ indiscernible ]?

This should be the same as the hospital engagement measure. They were trying to align with the CMS measures.

[ Indiscernible - comment or question from audience ].

[ Indiscernible - comment or question from audience ].

Right, that is what PCO 1 is. The early elective --

[ Indiscernible - comment or question from audience ].

Really?

[ Indiscernible - comment or question from audience ].

For those of you on the line, it sounds like which you are entering into that MHA portal is just one number. It is more like a numerator.

[ Indiscernible - comment or question from audience ].

Right. Okay. So, I guess it is a little different than the MHA portal then.

[ Indiscernible - comment or question from audience ].

But you do not enter that for the MHA? The number delivery between 30?

[ Indiscernible - low volume ].

So basically that discussion is to things. What you enter for MHA and what you have to enter for this requirement.
I will have a record -- a conversation with [indiscernible] about that. [Indiscernible - audio garbled]. I will put that on my list.

Should we see if there are any more questions?

There was one question way back to the other one that we missed. They were wondering if they have gotten [Indiscernible - low volume].

Let me go back here.

The written material about the CPOE?

Yes.

We gave something out in January and I don't think there has been anything else. The handout that I was reading from today -- there was a handout today about the CPOE information -- I'm sorry, I read your question differently. There is one for today and maybe there was one from the last meeting in January.

I think in January we had the same specifications, but it was not -- but it was without the alternate method. As well as a slide presentation that we shared that Krista had done.

Okay, we have questions. If we do not [indiscernible] at our facility, do we just put zeros?

If you do not do OB, you still need to go into the PCO 1 area and put zero. I think we talked about that.

[Indiscernible - comment or question from audience].

There is no population sampling for that. So, you would have to go into the PCO 1 site and put that zero there.

Some said they abstracted PCO 1 for quarter one and she would recommend following the paper [indiscernible]. There was not [indiscernible].

[indiscernible].

I have heard from people too that it has been helpful in the past.

[indiscernible]. As we mentioned, under the web-based measures are structural measures in the manual. There are just two pages and it does not go into great detail. There is a link to the pages in the Joint Commission manual which goes into more detail.
Someone yesterday and can you comment on the perinatal measure. When I pull it up in the web-based measure and selected through year 2015, it says the performance for the first quarter. Can you clarify?

You can get into it when I went -- when I can't, and that's good. The last time I was able to get into the perinatal measure, there was no information yet with how to do the first quarter for 2014.

I am going to have to check on that because I cannot get into see what it looks like. So, I cannot tell you right now -- I can try to find out what is supposed to be doing.

I don't know if there is a glitch in the site. Lisa, it might be that they did not update the site yet. When I could get in before the portal, it was only set up to record for the 2013 time. Mac. I will -- time period. I will have to check on that to see if I can get some information.

Are there any questions online?

Yes, there is a question from Linda. The floor is yours. When that, if your phone is -- Linda, if your phone is muted, please un-mute.

That is pretty much it.

I did not say a lot. Go back and tell your people it is due on the 15th. If you have questions, they can contact us.

Be aware for your CODI, that is specific for the hospitals that we are doing hospitalwide and the CMS measure is just for ICU.

You want to make sure it is hospitalwide?
Yes, the measure is hospitalwide and not just ICU. Definitely not for inpatient, right?

[ Indiscernible - comment or question from audience ].

It would include [ Indiscernible - low volume ].

I would not think this would be a surprise. There has been -- you know your infection person -- there has been -- if they are on [ indiscernible ] calls and if they are in [ indiscernible ], they are probably aware of this.

Janet and I did this with a series of call for MHA from November-January I think. How to get set up in HSN and everybody should be connected in HSN by now. Hopefully looking at safety.

Okay, so we are a little early. Why do we take a 15 min. rate and reconvene at 5 min. after. For those of you on the phone, we will start at 2:05.

Okay we will get started now. I will put everyone on mute for just a moment.

Hello everyone we will start with our next section which wraps up the changes with [ Indiscernible ] that is the beginning. CMS organizes their works in chunks of work and they called us scope of work. Typically there three years but this would will be five years. What we would like to do is share some of the changes that are going on. I will do a brief summary of some of the topic areas and then I will talk about some of the structural changes which are the more significant change. My first slide you will see the overall structure. We will go through each of these areas so we will talk a little about the BSCC and what I want to do is when you see on the right hand side the green areas that are QIN and QIO. I will go over some of the topic areas under that area so QIN stands for quality innovation network. We will be talking about some of the differences here. For our quality improvement work. The topic remains similar. The focus is for the first area on prevention. This is a lot of the primary care clinic work. This also is a specialty improving cardiac health. The scope we worked on the million heart campaign with the cardiac screening criteria and focus areas. A little more focus on diabetes. The immunizations, I should’ve taken off of here because it is not part of this, it was originally. You can cross that off and I’ll correct it later. And then the whole connection with each IT HIT. The first area is more the prevention into better health care for communities the first goal has with to do with reducing harm. Reducing infections, which we know we don't do a lot of in Minnesota. I was in the PPF meeting earlier this week and for PPF hospitals [ Indiscernible - low volume ] there is a third program for required hospital programs. That program overlaps with measures that are in purchasing. Reduce affection measures as well as the PSI 90. It puts a lot of emphasis on scope measures even though it does not directly relate to [ Indiscernible - low volume ] it's important to know what a high priority is nationally because certainly it can impact you. It is good that everybody is getting onto HSN . For PPF hospitals, the performance period, you have to be on top of those performance period so even MRSA and CDI, particularly the smaller hospitals do have it CDI survey. Those will be in the performance
period next January. So as you are working with your colleagues, important for you to know this is a big priority.

Reducing healthcare acquired conditions in nursing homes. And the focus on coordination of care. These were all topic areas in our current scope of work and those continue as a higher priority. And the third aim is that care at lower cost. A lot of this value based purchasing program value modifier with us position recording comes important. You will see a big focus here on physician reporting. Trying to get physicians offices into PQRS. As well as the value modifier which is very effective for quality payment and things like the value based purchasing programs where clinics for clinics. And there might be some other projects that come to these ideas. For cost. Value based purchasing also fit into here that work still continues there is a connection where they are identifying quality improvement needs.

Clinical review change.

Are any of you have a liaison? Two of you? In the medical case review area you are that people who get correspondence in our case review work. So the QIO program since the early 90s had two components one is the quality component technical assistance piece of which the work that Robin and Vicki and Mary has been talking with you about. And then there is a medical case review piece for rich things like hospitals discharge appeals or Medicare coverage ending in a swing bed or beneficiary complaints where they're asking for review of their care. This is what QIL has done since the inception of the program. Earlier separating those two parts. So one body of QIL will do the quality improvement work. Is called the beneficiary [Indiscernible - low volume] do you have this as a separate handout, I talking about slide 43 that shows on the far left the BFCC version. That is the short or long name for case review. Status health will no longer be doing the case review body of work. No one organization can do both parts [Indiscernible - low volume] they change radically how the case review program goes forward. It used to be an entity in each state had that body of work now they are we journalizing that so it's going to be five regions. Status health is in area for the entity that will assume the medical case review responsibility is called Kepro. This is split between the two structures. Beneficiary starting August 1 KEPRO is the entity. Who will assume responsibilities for reviews if the patient once a second opinion? Or a second opinion I medical coverage in a swing bedsheet and. Or if you have a question about the quality of care they receive. KEPRO Will be doing all of those starting August 1. This is the information we need. If it's not you and your hospital to have anything to do with issuing an important message please ask that you take those back to the organization people that have that responsibility. It might be a utilization review or case management you will best now those entities. I ask you to take this back because this information and the cell phone the pre-her, and of the TDY number they need to get on your important message. If you have swing beds it needs to get on the notice of Medicare coverage.

KEPRO is a nonentity for us. They have three of the five regions that the country seems split into for the BFCC case review work. They are the Midwest and the South East corner another organization [Indiscernible - low volume] Minnesota is in what is called area or region for. And as you can see,
KEPRO office is in Tampa. They seem a little opposite end of the country but that is where all of our medical records information has been or is in the process of being shipped. On August 1 phone numbers that you currently have on your important message or notice of Medicare noncoverage. Are phone lines will be coded to KEPRO. So if the beneficiary calls that number instead of KEPRO. KEPRO will answer that call. They will take it up life for a window of time during the business hours. After that window, it will go to voicemail message that will redirect the caller to their phone number. Eventually our phone was will go away. It takes a bit of time to get these forms updated and hopefully get old copies out of circulation and find with that template might reside. There is a mechanism in the short window of time for caller who uses our old phone numbers, they will get to KEPRO. Any questions?

If you have a question or comment please plus press the number seven.

This next slide talks about other places where you might have status health information. The Bill of Rights is intended to give patients an avenue to know what their rights are if we have a concern about their care that some of the places you should have KEPRO information work

please use the chat function if you would like to ask the question.

Does the hospital still send them copy of the denial letter? What I did not mention was hospital issues notice of noncoverage. I mentioned important message but the hospital issued notice about coverage have a statement on their that you fax that to Stratis Health and some that to KEPRO. If they're going to change that process they will let you know. We don't have any information to tell us that they are. So thank you for asking. [ Indiscernible - low volume ]

there is an option to fax. There is a link on the website with their contact information. If you have a home care associated with this ABNs do not have those are not included. Any questions or we will go on and talk about the recording centers. This is just a repeat.

The left-hand side and Robin will talk about [ Indiscernible - low volume ]

if you are looking back on this slide it's got the program contract structure. The second part there the value intended recording center. This is where your going to get technical support. There are five centers and value incentive quality recording centers.

In your hand out there are the five and I think the ones that were most pertain to you is the hospital inpatient psychiatric facility [ Indiscernible - low volume ] this contract has been awarded to Florida. Where you currently would go to question where you had outpatient questions. This will be your inpatient report. It says this contract provide national outreach and technical assistance to hospital inpatient departments medical hospitals. The contractor also educate hospitals and to Ryan QIO and. What this means of, this is where you go for support. Any I don't know how to do cart questions, as of August 1, the way it stands now, support around the inpatient and outpatient program isn't coming from the state level or Stratis Health. We don't have, there was an email that came out, we just have what you have. There was a call yesterday did anybody listen to it? There was a call yesterday and we
don't know exactly who sent out the information goes we didn't have it but we believe it was all
different kinds of providers talking about the program changes for the next work. Happened was I
think they were overloaded with evil trying to get on and people could not get on. The program did
start half an hour late but because Obama technical to difficulties there adding two more calls. They
weren't really geared so I don't know when it's to come out. [ Indiscernible - low volume ] if we find
out when there was another when we will let you know. Somebody here said they could not get an.
And neither could we. Back to inpatient support. They have not really given us a contact number so
unless you hear different and can tell you, that email or phone number that you are using to contact
them for outpatient support, I guess I would try that. The second one is now for hospital out patient
and ambulatory service centers. We just found out yesterday during that call that it was also awarded to
1020 1020 Tran 20. Again any other questions on out patient tool?

The next viqr is regarding validation support. You are not of the process but just so you are aware there
will be another center involved with validation questions.

The next one is for a po center and then not has been awarded yet. Last time I looked at my email I did
not know who have that center. Who was awarded that contract. The next one is for appeals. As far as I
know it hasn't been announced. That would be appeals that don't apply to. [ Indiscernible ] then there is
one entitled monitoring and evaluation Center. I don't know who is given that contract. But the
explanation is the contract support team has to monitor and evaluate the hospital. CMS quality
reporting programs [ Indiscernible ]. That is pretty much what I know about that center.

We have emailed information from the last newsletter saying this is what's happening. We did not
really know much at the time. You're getting this information at the same time we are. To put it
bluntly, were not support anymore for the hospital program, hospital reporting program. You can call
until the 31st, then after that you need to follow the other channels. Maybe next week there will be
more information. Use the number and emails that you use for outpatient.

If they can still contact us for [ Indiscernible ] questions. Yes, that is the contact that we have with the
state. So you can still contact us for that.

Is this change for five years? 1020 [ Indiscernible ]

the other thing I emphasize is that there will be a focus on improvement, as I mentioned the focus was
towards purchasing for sufficient reporting as far as ambulatory surgery centers. But it also does
include critical access hospitals. The focus on improvement for inpatient and outpatient measures does
still continue obviously in order to improve the measures you need to understand them. That piece will
still be in place. I think it's a data submission and the actual recording piece.

And how they should add questions around or administrator. I don't believe that's going to be there.
Don't call Mary about that. Is not part of what our world is going to be. I suggest helpdesk.

[ Indiscernible - speaker to far from microphone source ] any questions?
I think overall this recording piece is being centralized its state focus ending up on improvement support.

[ Indiscernible ] there is an art to having somebody not ask a dumb question.

For those of you online [ Indiscernible ].

Is meaningful use the undertone to this? [ Indiscernible ] is a be a need to validate report their putting out there.

They have been very consistent the alliance of some of the clinical practice measures and the quality measures I think we were always wondering exactly how can you put all these measures some of the measures is they eliminated some of the measures [ Indiscernible - unable to understand speaker ] sepsis as an abstract measure, at least in this proposal, I think it depends. There are some measures that were suspended that have been removed and are now coming back as ECQM measures. It does feel like a focus is electronic measure. And much more focus on outcome measure. I think it's still going to remain an abstract [ Indiscernible ]

there is much more connection even putting the new value based purchasing measures together they really put all of the value incentive programs together as well as their putting all the reporting together and apparently Florida is getting the major responsibility for those. There is some alignment of trying to get all these deficiencies and connections. There is quite a bit of language written into the specific work of talking about trying to reach those connections so definitely a focus on CMS is part of trying to help connect the dots looking between them recording programs. There are some hospital measures with the hospitalization program so looking were integrated. Obviously there is more the help system focus I'm sure your part of that system.

The meeting for use in the proposed rule also I think we want to spend some time talking about the core measure meeting. We want to round up and identified need that was led by the hospital. There was a leadership change and when we started this chunk of work it's worked a little bit we've added a little bit more on some of the improvements for purchasing and we will try to bring in the statewide it measures. We have logged discussions about that. Now we're thinking they will still have a need for improvement you still need to figure out what that structure is. You prefer the time period or do you like to just keep it [ Indiscernible ] what's your preference. We are just it in the feedback. I think the obstruction support is extremely valuable and there was a need for that. That need continues. It's hard to have both functions [ Indiscernible ] some people really like the obstruction part and don't feel as much a need for some of the other topic areas. We have gone back and forth about that piece of it we're thinking it will be more separate.

[ Indiscernible - low volume ] we have not heard any details so I think our assumption now is if you were to get together and talk about these questions that would be a kind of independent activity. It was previously, that need was felt. We certainly want to encourage people to figure out things that work for them. When it comes to reporting, we don't know exactly what the expectation is of us. Or assumption. Because CMS grantors were pretty clear that the reporting function was centralized. Were assuming
then that things we are talking about, we are also anticipating we will get more specifically over time note phone numbers and directions. We are starting to hear a few more things from Florida about FMQAI [Indiscernible - low volume].

The comment was, there was interest in joining together with PPF hospitals and not having them separate from abstracting questions.

Because people in critical access hospitals [Indiscernible - low volume]

[Indiscernible - question being asked] is helpful to have others to network with and have those kinds of conversations. When potential ideas are focused on improvement and you're trying to do something on improvement we can have the meeting on improvement and then independently you can add onto that meeting and doing obstruction question. [Laughter]

I used to be it for one half and now that we have merged with a larger vendor or hospital, I would like to see the whole picture. Even though I will have anything to do with it would still like to see the whole picture with all of the quality is.

The comment really is, often times you are connected to all the different quality works that are going on and it would include sections euthanized happy coming get the full picture. [Indiscernible]

I think the other question I had is, we also have [Indiscernible] it gives critical access hospitals, I think also with your resources being limited, we have these meetings that we do that has been focusing on improvement. Were kind of bringing [Indiscernible] into those meetings. Plus it's nice then because he don't have as far to go.

There is going to be judgments about some of the work, I know because you do wear multiple hats, and it is often times [Indiscernible]. If you belong to the hospital engagement network you know you have to finish what you're working on for in the equip. We are also talking about going forward trying to do more overall medication initiative. Instead of doing all the ticket medication things. Con of looking at medication as an overall process from beginning to end and the impact on readmissions. We will now be focused on the HCAP about medications and new medications. I think an hour conversations. [Indiscernible - low volume] there will also be an expert on CMS part where there is a big focus on getting all critical access hospitals to report. We were already reporting so we were ahead of the game in that. And that was quite a blessing because I think some states really struggled with trying to achieve that goal. Being ahead of that, once again [Indiscernible - low volume] the expectation of CMS is that critical access hospitals work on inpatient and outpatient measures with recording and improvement. The positive part about that is that you are already reporting. Think the measurement which sometimes with initiative that is the challenge getting additional resources to do some of the measurements. [Indiscernible - low volume] [Indiscernible - unable to understand speaker] when I look at the out patient measures it seems like outpatient four and five, the aspirin use and the ECG, that seems to be to measures that you can relate more to. We have the easy transfer communications I don't know how you feel about the topic area or how your senior relationship with
see as a priority for improvement. [ Indiscernible - low volume ] antibiotic and heart failure eventually those will go way to.

[ Indiscernible - unable to understand speaker ] in thinking we will because of the state responsibility. We still are responsible for working with community measurements on providing hospital recommendations. We will need to keep up with what is happening at the inpatient and outpatient program. And also we will have to communicate what the expectations are for the state. So the answer is yes, I think so.

We will have to see because the funding isn't quite as. I will probably have to create my own cheat sheet anyways.

We did add measures for consideration, I think the message to PPF hospitals for value purchasing. [ Indiscernible ] this takes a while to improve you can't just do this overnight. Hopefully that is helpful. Because we all know there will be changes down the way. Especially for the last three years giving hospitals report clearly I think the message is now we need to improve on all of those measures. That's why we are having conversations about what is most useful and what is the most meaningful for critical access hospitals to focus on. Open for ideas. You can also put them on your evaluation to.

[ Indiscernible - unable to understand speaker ] there was a question about the discharge code? There was a PDF code. Any questions about any the changes with CMS?

If you have a question or comment please press seven with a Q on your telephone keypad.

Thank you for all of the work in support. What a great resource you have been and we want you to know [ Indiscernible ] you all know things are getting more integrated and some of you might have that responsibility to but there is some overlap to get people involved. We will be able to capitalize and expander area of expertise and support. Some of the asked me how do we get access to [ Indiscernible - low volume ]

so this is only for the situation where you have access to that and eight a portal MHA portal site.

Email Mary RI and we can give you got information.

While we are waiting, are there any other questions? Let me talk about the portal. I was going to say it's up and running. It is running for some people so maybe you guys on the phone, when I'm done talking let us know how it has worked for you. I think I said before. I can get into the portal and I have access to some screens but I don't have access to everything I did in the past. I am hearing from some people, if anybody submitted data, that's what we want to know. What I have heard from people is that when you send your data off, you cannot just send the file, you either have to do it one at a time individually or you need to create a zip file and it can be sent that way. Apparently there's been difficulties around that. So my recommendation is this. All patient data is due next Friday. Try and send it right away. Because you got to call the help desk for help I would say you're not going to for sure get an answer. You're probably going to have to leave a message and they are swamped. So I don't
know when they can get back to you. It couple of people asked if they thought there was going to be an extension not said anything to indicate that. Sometimes in the past but have done that but they may not make the decision until the day before or the day of. So you cannot count on it. It's one thing if you're trying and they are not getting back to you. This nothing you can do if you cannot get it in but I wouldn't say weight because we really don't know. Somebody asked, somebody put in their population and sampling prior to the portal shut down. So you are wondering that was still in. I could not answer that because that's part of the site that I cannot get into.

I believe if you put it in prior to portal you can get in now. Somebody entered the code prior to the shutdown and she just checked and it's still there. We are hopeful that would be the case for everybody. It might just be the one thing that they did tell us which would still be there was any of the files you had in your secure file. Anything that Mary sent you on a secure site. If you did not save those, those are gone. Anything that was in your secure file. Again if it's not saved prior to the shutdown and the new portal. It won't be there.

The question is will Mary be sending the report that we had the hospital data. That won't the coming anymore.

I don't know what these new centers are going to do around education. I don't know what they will send you but the thought maybe is the kind of report at this point right now. We can send you stuff that will go maybe directly to your. I don't even know if they don't know yet. The reports that you would use instead of the hospital profile reports would be, those are ones that are only available during that preview time that you do the drop down menu. So they aren't anything that gets pushed by CMS. When you go into the new portal there is a place to run reports there is also a secure file transfer at the top and that's where you get downloaded reports from CMS.

Lisa said she upload her own cases this morning and it looks like it went through. You have to upload one file at a time or the zip file and she said definitely do that file is easier.

It sounded like Mary was talking about a report and it took a while. It might be, those would've been two days later.

It sounds like it takes a while to get the report. I think somebody else said they got an email in the report was done.

Somebody also said you need to select payment 20 2015 to get [ Indiscernible - low volume ]

we weren't sure what the date frames were before it only gave you one option and when you do that it will come up to let you do data. That will be her first thing. Remember. We were accepted. Sometimes is just telling you want to make sure they are all there but are they all their good. Sometimes the message will just tell you once is to get some we were rejected right away. Some people are having issues they said they uploaded these individually it seems like. Is not just one issue everybody's having. Everyone is having something different so my suggestion is to go back and see what your issue might be. For some of us as the day goes on. In case you have to go over there they are taking some time. I
cannot bring the portal up or show you anything. Because of the security site. Has anybody tried to login? I don't think the logging it is difficult.

[ Indiscernible - question being asked ]

We had someone say they were in originally and could not get back. The username change to so when she tried her username with a she could get in. All caps.

[ Indiscernible - question being asked ]

Asking about the operating system. The browser. I think that is one thing they were supposed to fix because there was a problem in the past about Java. I have heard a lot of questions around the portal the ones I had have been you guys trying to send your files do it one at a time or making a zip file.

We got a browser not supported message. We have a site that all of our government stuff comes to. And we have not been able to get on our corporate site. We are talking about your operating systems. I think that was both to have taken care of by the portal. That was supposed to be a non-issue. So I don't know.

If you reap port from multiple sites

I think maybe we don't have that issue. Courtney might take care of several different hospitals, so I don't know that is the issue but that was one of the things when you are doing your portal you had to figure out which website you were going to be working from. [ Indiscernible - low volume ] with the new functionality be positive they are working on it.

We wish we could've done it [ Indiscernible - low volume ] don't be afraid to call the help desk. I called yesterday and today never had to wait. If you can go back this week or the being at half next week try again. Thank you for sharing. We only know what is happening when you guys tell us. Because we can never get in your the ones that the sum the data off so I have not heard from anybody who has had a vendor. I don't know about any issues around vendors having difficulty getting and. We will take that is positive thing.

That is what we know about the portal, not a lot, but go in and try it. Some people are having success and it does seem like quality care is helpful. It seems like they are being able to explain and help people. I guess we can open it up for questions for anything. If you have them.

[ Indiscernible - question being asked ] That vast, the state has decided that you have to do the ED indication measure. If you want to do them fine but you don't have to. For global that was ED and immunizations together. So when you did your population, 1020, [ Indiscernible ] . Second quarter is April, May, June. The immunizations do not [ Indiscernible ] . Do we still have to do adults? When I ask CMS, they don't ask questions or penitential they don't care what you doing. The CMS answer is immunizations are required. They don't say stop it's not done when immunization is given. In the two
quarters for second and heard quarter you really wouldn't have anything because it goes faster once you put the date. But all I can tell you is CMS instruction is [ Indiscernible ].

It is time-consuming, but I just have to tell you the instructions on that. It is constant. For CMS ED immunizations are required measures. You better have 20 of each. That the answer they are giving. They are not going to do with state. I don't know that there is anybody to check. I think you just do it because it's are required measure.

That is something we can bring up to the steering committee and articulate a little bit more appropriately. After August 1 if you have questions like this them what.

Because it relates to the state measure it would still consent.

[ Indiscernible - question being asked ] The measures are still supposed to be [ Indiscernible ] if you want to submit them.

Were talking about the measure which is now voluntary. If you said that you are submitting it in measures designation. Measures designation is and a secure site quality net. If you always said you were submitting that information I decided not to. It's just going to reject your case because it is looking for that. You need to go into Messieurs. staff measures designation. It will reject it if you have already submitted data.

I think originally at the start of the quarter I did not check it.

My understanding is that you could fix that. I guess if your case is being rejected you will have to check with quality net. This is the issue that sometimes, when other measures are made voluntary but you can still do them and everyone is doing different things. It would just be easier if everybody did everything the same.

When you're in cart before you answer and you check out all the measures that you going to do. If you're no longer going to do that on check it and then cart not be expecting you to answer it. Because everything you've checked and cart will let you answer. If you uncheck it cart will be expecting it.

You've got to do it in both places. If you're not owing to do a measure that you have been doing is got to go into the secure site of quality net. You will uncheck and take out the ones that you are no longer going to enter. Because the system is set up to say that if you can it do it is looking for that. If you send them a file that does not have an answer it will reject it because it will come back and say it's rejected because he did not answer the question. You will then have to do it in cart as well. If you look in cart that question will be there for you to answer.

[ Indiscernible - question being asked ] Any questions from the phone line?

How the process works is that you submit your quality and the net goes to [ Indiscernible ] MHA takes it and submits it. CMS uses it in a sense of however it be used. I think it'd to pay attention to that but
not from an improvement standpoint. They are not tracking it as part of the inpatient program that is required for PPF hospitals. How is it changed over the years. We do extensive analysis. Because it's a voluntary program. Bottom line. You not required? It was one of our [ Indiscernible ] we were lucky because all along everything was like you're probably going to have to it some point anyway so now you are ahead of anybody who hasn't. So we always work with you to make sure of reporting. There was a scope of work there were that was not part of the task. So when the scope of work changed they really had to struggle to get everybody reporting and that wasn't an issue.

PPF [ Indiscernible - question being asked ] They don't identify the gestational age so I refer to the prenatal and in one particular case the prenatal was in the clinic today's before delivery so they came in at 37.3 days they came in and were admitted today's later. The documentation set 39 weeks. So there's a discrepancy. I have a real problem with referring to that prenatal because everyone I look at I kind of cross over to prenatal and I'm seeing some significant discrepancies in what is being presented at the time it converse is what is in the clinic. I told it was not my job. But it bothers me. That was my question. This one Dr. who never gives the gestational age.

If you look on the link because they are still looking at the joint commission measure the not answering a lot of questions about it. I don't feel double asking that.

Does anybody else on the line have any thoughts about that?

1021 [ Indiscernible - unable to understand speaker ].

The question about conflicting information about gestational age. And that the NHA roadmap might have roles about that.

Any other questions? People on the fun we will be sending you an evaluation. Thank you for joining us.

[ Event concluded ]