Objectives

- Identify the roles and responsibility of who receives the Opportunity For Improvement report.
- Define the Opportunity For Improvement Review process.
Background

3 Acute Hospitals
* Over 500 beds

**CY 2011**
- Abstracted 4398 Records
- Clinical Data Specialists: 4.6 FTE
- Clinical Data Analyst: .2 FTE
- Total FTEs: 4.8

**CY 2012 (Jan. – May)**
- Abstracted/Data Entered 7,100 Records
  - 3685 Manually Abstracted Records
  - 3415 Data Entered Records
- Clinical Data Specialists: 2.3 FTE
- Data Management Assistant: .3 FTE
- Clinical Data Analyst: .2 FTE
- Total FTEs: 2.8

Accomplished this by going paperless, using 2 monitors and working with our Informatics Dept. to create reports to pull the ED Inpt and ED Outpt Throughput measure sets eliminating the manual abstraction and increased Sampling in 2011

CDAC Validation Scores consistently run 96-100% accuracy rate.

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**CMS Measures and OFI’s**

**SCIP VTE-1 and SCIP VTE-2**

<table>
<thead>
<tr>
<th>Indicator</th>
<th>2008</th>
<th>2009</th>
<th>2010</th>
<th>2011</th>
<th>Jan-May 2012</th>
</tr>
</thead>
<tbody>
<tr>
<td>Core SCIP - cases selected in sample</td>
<td>3128</td>
<td>3016</td>
<td>3034</td>
<td>1588</td>
<td>642</td>
</tr>
<tr>
<td>Core SCIP-VTE-1 - VTE prophylaxis ordered</td>
<td>88.04</td>
<td>91.82</td>
<td>92.17</td>
<td>97.32</td>
<td>98.38</td>
</tr>
<tr>
<td>Core SCIP-VTE-1 - OFI Group: VTE prophylaxis ordered</td>
<td>242</td>
<td>50</td>
<td>52</td>
<td>24</td>
<td>7</td>
</tr>
<tr>
<td>Core SCIP-VTE-1 - numerator</td>
<td>1781</td>
<td>516</td>
<td>612</td>
<td>870</td>
<td>424</td>
</tr>
<tr>
<td>Core SCIP-VTE-1 - denominator</td>
<td>2028</td>
<td>576</td>
<td>664</td>
<td>894</td>
<td>491</td>
</tr>
<tr>
<td>Core SCIP-VTE-2 - VTE prophylaxis timing</td>
<td>87.34</td>
<td>90.75</td>
<td>91.11</td>
<td>96.52</td>
<td>97.91</td>
</tr>
<tr>
<td>Core SCIP-VTE-2 - OFI Group: VTE prophylaxis appropriate timing</td>
<td>256</td>
<td>53</td>
<td>59</td>
<td>51</td>
<td>9</td>
</tr>
<tr>
<td>Core SCIP-VTE-2 - numerator</td>
<td>1766</td>
<td>520</td>
<td>605</td>
<td>883</td>
<td>422</td>
</tr>
<tr>
<td>Core SCIP-VTE-2 - denominator</td>
<td>2022</td>
<td>573</td>
<td>664</td>
<td>894</td>
<td>451</td>
</tr>
</tbody>
</table>

CY 2008 we did not have the current OFI Review Process in place.
CY 2009 and 2010 the process was created and evolved to current process and staff changes. 2011 Implemented CPOE and the 24 OFI related to not using Order Sets or Hard Stops (choose a response).
Assigning Provider Measure Attribution

With direction from our Medical Executive Committee
Provider Attributions Were Assigned to Each Measure

<table>
<thead>
<tr>
<th>National Quality Forum/ Joint Commission Quality Measures</th>
<th>ED Admit-Provider Attribution</th>
<th>Direct Admit-Provider Attribution</th>
<th>Additional Attribution</th>
<th>Unit to which measure is assigned</th>
</tr>
</thead>
<tbody>
<tr>
<td>Surgical Infection Prevention</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Antibiotic within 1 hour of incision</td>
<td>Anesthesia provider</td>
<td>Anesthesia provider</td>
<td>Surgery</td>
<td></td>
</tr>
<tr>
<td>Antibiotic within 24 hrs</td>
<td>Surgeon</td>
<td>Surgeon</td>
<td>Surgery</td>
<td></td>
</tr>
<tr>
<td>Cardiac cts 4-hr postop serum glucose</td>
<td>Surgeon</td>
<td>Surgeon</td>
<td>Surgery/Vital Signs</td>
<td></td>
</tr>
<tr>
<td>Appropriate line removal</td>
<td>Surgeon</td>
<td>Surgeon</td>
<td>SAU/Vital Signs</td>
<td></td>
</tr>
<tr>
<td>Colorectal memopostop normothermia</td>
<td>Anesthesia provider</td>
<td>Anesthesia provider</td>
<td>Surgery</td>
<td></td>
</tr>
<tr>
<td>Other bioperitoneal anastom &amp; tears</td>
<td>Surgeon</td>
<td>Surgeon</td>
<td>Anesthesiology Provider</td>
<td>SAU/Vital Signs</td>
</tr>
<tr>
<td>ICU prophylactic anti-coagulation</td>
<td>Surgeon</td>
<td>Surgeon</td>
<td>Surgery</td>
<td></td>
</tr>
<tr>
<td>Post-op Urinary Catheter Removal on Post-op Day 1 or 2</td>
<td>Surgeon</td>
<td>Surgeon</td>
<td>NURS Unit</td>
<td></td>
</tr>
</tbody>
</table>

Discussions are occurring regarding linking measures electronically to orders and time caring for patient to identify Provider attribution.

Who Receives The OFI Report?

- The OFI Report is sent out weekly to the responsible party by the Lead Clinical Data Specialist
  - VP and Chief Medical Quality Officer
  - Clinical Directors
  - Medical Directors
  - Clinical Nurse Specialists
  - Quality Consultants
  - Pharmacy
  - Workgroups
  - Informatics

The majority of the responsibility falls on our Clinical Nurse Specialists or Workgroups.
Identified Opportunities for Improvement (OFIs) are entered in the spreadsheet shown above for each CMS Measure Set. Next iteration will include Race as we look at Equitable Care.

8/6/2012

The OFI review process for a single month typically takes less than 4 weeks. Process OFI’s require interdisciplinary workgroup to work through the process change and implementation. Data is reported the first week of the following month.
Where Is All The Data Reported?

- Board
- Physician Scorecards
- Clinical Council Scorecards
- Quality Institute Council (System)
- Site Quality Council (Hospital)
- Senior Leadership
- Site Leadership
- Workgroups
- Informatics

Site Leadership owns the OFI’s and Measure Results. Action Plans regarding the OFI’s at each site is presented during the monthly Quality Institute Council meeting.

What Data Is Reported?

- Monthly CMS Measure Results
  - Rates, OFI’s, Numerator, Denominator
- Year To Date Scorecard for CMS Measure Results
  - Previous Year Rate, Current Year Rate to Date, # of months at 100, Red/Yellow/Green indicating VBP Performance against VBP Benchmarks
- OFI Report
  - Weekly and Monthly
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