CMS Measures and Opportunity for Improvement
Presented by [Kathy Geier] (30-minute Webinar) [06-19-2012]

Kathy Geier: Hi, I'm Kathy Geier, an RN, BS, CPHIMS and Director Quality Measurement and Reporting for Health East Care Systems. I'm going to be doing a presentation today on CMS Measures and our opportunity for improvement processes.

The objectives are to identify the roles and responsibilities of who receives the opportunities for improvement report and then we're going to define the whole process that we use here at Health East.

First, so that you kind of understand the amount of work that we're doing, I want to give you a little background about Health East. We have short-term acute hospitals. We have over 500 staff beds between the three hospitals and what I did was to take calendar year 2011 and compare it to 2012 year to date to give you an idea of the volume.

Back in 2011 we did about 44 records; these ladies here abstracted them all by hand. I had 4.6 FTE so I had some additional nurses at that time. I have clinical data analyst hours that are devoted to doing the reporting. I had about .2, so we were using about 4.8 FTE in 2011. In 2012, this is a combination of the abstracted and data entered. We have done to date about 7100 records and of that, about 3700 are manually extracted by the nurses and 3400 are entered by a data entry person.

As you can see on the slide I brought it down to 2.3 FTEs of nurses to do the manual data abstraction. I've added a .3 data assistant to do the entry and the clinical analysts support the same .2. So for this year we are doing it on 2.8 FTEs, so we've cut two full FTEs.

How did we do that?

It's been a journey and what I did is towards the end of 2011, I purchased additional monitors. So the nurses are now using two monitors, one to pull the medical record up and the other is to do data entry which has allowed them to increase the amount they can do significantly. It's also decreased the cost associated with copying data abstraction forms in having a copy center do it, so we're saving several hundred dollars a year just on copy costs.

We also work with our informatics department and this year in preparation, knowing that the ED inpatient/outpatient measures were coming, we got together with our folks and started working on a report so the data could be pulled into a report form which allowed us to have the data entry do those records.

Now you know nothing is perfect, so some of them fall out and that's been where the nurses step in at the end of the month and look at the ones that fell out, due to incompletion or quality issues and go in and clean it up.
We also have done some re-looking at sampling. We’ve done up to date pretty much 100% sampling, but with the increase in the number of managers, we have looked at our sampling and have added some additional sampling opportunities.

All of you recognize these measures. These are the two VTE members from Skip. I wanted to show you the journey that we’ve taken and I started back in 2008 and if you can tell, our 05’ is an opportunity for improvement. These are the ones that when you abstract the data after you ran it through whatever software you’re using, they fall out as having failed that measure. We call those opportunities for improvement to put a more positive spin on it than we failed.

In 2008 you can see we were in the triple digits around 240-250. In 2008 we didn’t take ownership for our opportunity for improvement, we just reported the data and if somebody took responsibility that was great but if they didn’t oh well, there’s always next month. Between 2009/2010 we started looking into this and taking it more seriously. We had a chief medical quality officer that came into place and took the responsibility of performance in all the CMS measures and refined our process.

You can see in 2009/2010 we were in the 50s, 1124 and so far year to date we’re in the single digit numbers and it won’t stay that way but we’re almost halfway through the year. You can see that by taking responsibility and having a senior level leader shepherding this really impacted how our service went. During this time period, because we had the chief medical quality officer, quality became one of the system goals which made everybody in the system responsible for how we performed here.

I took a little bit of form that we have at Health East, each year we go through and list the new measures and it goes to our medical executive committee, which helps us identify who we need to attribute those measures too. Who is going to own that measure now that it’s here? That has allowed us to get to the right provider through this attribution process, so if a medical director needs to have a crucial conversation with a particular individual, we can now identify them and we will have those conversations and have had those conversations.

It also helps us to identify what work group might be involved in the chance to fix an opportunity. So again, medical executive and physicians leadership taking responsibility has been key.

We do this OFI report which goes out to everybody, the VP and chief medical quality officer. We have clinical directors, which are directors on the units and floors. We have the medical directors, the site medical directors and also some of the work groups have medical directors, for example, surgery has one. It goes to our clinical nurse specialists, both our advanced practice nurses and to a quality consultant. Each of our hospitals has a quality consultant assigned to it that works with them around any improvements. It goes to pharmacy and various work groups as well as informatics department.

We’re always looking at where we can make it harder to pass than to fail.

Informatics has been key throughout this whole process as they hard code things into the electronic health records, CPOE, which is an ever growing list and grows monthly. This is a copy of the OFI report that we do that goes out a minimum of once a week. It may go out as often as twice a week. We use it as a communication tool and it goes to a whole list of individuals.

Part of this is generated electronically so we get the facility, the unit, account number, patient name and you get the start date and discharge date and from there my clinical data specialist goes in and puts in the measure lead comments. The comments are from the lead who is going through and figuring out why its failed and giving some indication to the people who will receive the report, just what the problem is.
In the staff column I just put title, but individual names are placed in there. So if it's a physician attributed, you want to know their name. If it’s a physician and a nurse then it will be a physician and nurses name. We don’t blind our data or opportunities. The amended column is if during the course of this communication and the review process we find that we’ve either A made a mistake and missed something or that within 30 days of discharge certain CMS measures can be amended in the medical record. If that happens they will indicate it’s been amended.

The comments on there are around that OFI, for example, on this one there was some question around our hospital’s documentation so Becky took a copy of that documentation and sent it to CMS to have them weigh in on did this lead, the definitions, the data of the guidelines and found out it was insufficient so it remained an opportunity.

There are a couple others on there that are informatic nurses hard stop issues and that has to do with our electronic health record and CPOE, so that’s a tool issue not really a person issue. Then on the bottom the last one is the ‘hairy’ rule. There was no indication as to the method, so it wasn’t amended or updated and nothing came into the legal medical record so it remained an opportunity.

What we’re going to do beginning this month is Health East is focusing on equitable care, so in addition to the columns you see there we’re going to add a race column. We will see if these opportunities have anything to do with race, to see if we need to do something different, something better. That’s our new journey.

**Guest:** How often does the report go out?
**Kathy:** It does go out a minimum of once a week. Some, depending on the measure, may only be a week old or two weeks if we’ve done sampling. The goal is that these get taken and sent out so they fall within that 30 days from discharge. All opportunities are reviewed prior to that 30 day timeline.

**Guest:** Are we doing concurrent or retro?
**Kathy:** We do retrospective. Our system allows us to be that current because we don’t have to write it down and then data enter, it’s just a one time thing and that’s allowed us to be much more current in our retrospective reviews.

This is a real high level process flow. What happens is the nurses extract the data where the date is entered. It’s processed and then the OFI is already identified. The lead reviews it. If there’s no OFI identified then there’s no change to that record. If we do find one she’ll go through, create that spreadsheet and then she sends that report off to that long list of appropriate groups.

We send it to ED, respiratory, surgical, cardiac, all our clinical specialists, medical directors around 50-75 people every time it’s sent out. It goes to the group, the group then over the individual will review it and try to identify a cause. The causes will be either, human or 14:22 as a process.

If it’s a human error the person’s coached and provided just in time education. That’s a critical role that our clinical nurse specialist and medical director play is if it is an individual, but they will have that coaching session and education to try and help that provider just in time. If it’s something that can be corrected or amended legally as a medical record, it gets amended, sent back and one of the data specialists will review it, validate that that information has been included in the medical record and they will make the necessary changes.

If it’s a process issue then we look at it and say who needs to be there? It’s an interdisciplinary group always and it depends on what the failure was, so if it includes pharmacy it would be pharmacy and informatics. It would be the clinical data specialist
who really understands that measure and then maybe it would possibly be a medical
director. So the opportunity defines who’s going to sit around the table.

When is the process, you can’t make any changes and so the OFI stands as is, but
then we will continue to work on fixing that process and getting it implemented and sent
out to the different sites.

Typically an OFI, to get it through the whole process takes about four weeks and that’s
if it’s an individual OFI. If it’s a process it can take anywhere from six to eight weeks,
depending on what the issue is. One example around a processed OFI that we recently
had is that informatics, unbeknownst to us went in and changed the CHS discharge
documentation.

Lo and behold we started to fail and we could identify that within about two weeks of
the change happening, because of being so current, so we pulled together the
informatics group, the data specialist, fixed it and immediately went back up to 100%.
So, its really beautiful when you have everyone engaged and everybody involved in
creating the change and it can happen very quickly.

So who gets all this data?

It goes to the board, our quality care committee and board gets it. It’s on all of our
physician’s score cards and that is transparent, where any physician can look at any
other physician’s scores. It’s on our clinical council score cards, which are like Ortho,
the ones that pertain to Ortho as well as ones pertaining to cardiac would show up on
cardiac, etc. Those are also transparent.

It goes to the quality institute council, a system-wide council that brings in senior
leadership from the different sites that meet once a month. We go over our scores and
what we’re doing about it. The site quality council also meets monthly and that’s for the
individual site and they look at their opportunities and work on what can be changed to
make improvement.

It goes to senior leadership, which means it goes to the C-sweeps and to site
leadership. It goes to all work groups that are involved and to informatics. Ultimately it’s
the site leadership that takes responsibility for this and what they do is ask the quality
institute council where all the sites are represented, they share their action plans, their
successes and failures. They try to find best of breed or info that we can spread and be
successful across the sites.

When all the data is done, the month is done and all data abstracted, any fix that can
fixed is, we send out a group of documents. We send out a monthly CMS scorecard
and with the product we use we can run just the month and we’ll put the three sites on
there so that each site can see how the other sites are performing and hopefully that
ignites conversation amongst the sites as to what they’re doing.

The OFI report goals like you saw and on that monthly report is your number of OFIs,
your numerator and denominator as well as rate. Then we do a year-to-date scorecard
at Health East which is updated monthly and includes the previous year end, the
current year-to-date, the number of months at 100, which is important to the clinical and
site leaders to know.

With the value based purchasing performance we have red/yellow/green just for those
measures, so we can identify that red means we aren’t hitting the threshold, yellow
means we are hitting the threshold and green means we’re at benchmark or greater.
Then the OFI report goes out weekly and at the end of the month.
We also take off that OFI report, we did some education and included in this bundle also we call it the quality scoop which is our department newsletters, done for education purposes. For example, if we found that something in the skip measures that was happening at all sites that was consistent, we would include that in our quality scoop as a piece of education.

Now, with the October measures coming out with behavioral health and then we have the new VTE and the stroke ones coming in January, we will be using that newsletter also to start introducing the groups to these news measures. In fact, I’m getting it primed and ready to go for when the date comes.

Typically, when we know the new set of measures are coming out, the data specialists will attend the appropriate work group and start talking to them about how these are the measures, this is what it means, this is the kind of documentation we need and they’ll bring in informatics, do we need to change any verbiage in our record. We did that with our ED inpatient and outpatient throughput, so we had all the verbiage in place and ready to go when the measures started.

We didn’t have a lot of failures there, out of the gate.

I certainly invite any of you who want to contact us. You can contact either myself or Becky, the lead clinical data specialist and we will be happy to answer any questions.

I’m going to end this part now and open it up for discussion.

If you have any questions, please contact Stratis Health at info@stratishealth.org.