Core Measures for CAHs

Presented by [Vicki Olson; Robyn Carlson & Laura Grangaard] (85-minute Webinar) [01-29-2014]

Vicki Olson: Hi everyone, this is Vicki, Program Manager at Stratis Health. We have great participation today, welcome to all of those of you who are with us. We have a busy agenda and lots of information to share with you about some of the changes in the ED transfer communications as well as a new measure, the CPOE verification of medication orders.

To start, I’ll do a little overview since there are a lot of changes that are somewhat confusing and I want to make sure everyone is on the same page. I have some information here about the PPS hospitals as well, so I’ll try to distinguish that, but I know many of you are part of healthcare systems and you’re working with both, so I decided to that information in.

One other thing about this webinar too, whereas we normally do like 90 minutes and having Q&A, because we have so much content we’ve decided to do two hours and the last hour will deal with Q&A. For those of you on the phone, I want to make sure you’re aware of that.

- Our agenda for today is to review the measure changes for calendar year 2014, so this is what gets plugged for this year and for future fiscal years.
- Reviews MBQIP goals and I can tell you a little more about plans coming on that.
- Review the phase three of the quick measures, which are those two measures… the ED transfer communications and CPOE pharmacy order verifications.
- To start let’s talk about measure removal

Let’s talk about the measure removal to start. We’ve been trying to keep the state measures aligned with the CMS changes and so all of these on the first page were removed by CMS, mainly because they were either topped out or there just wasn’t the evidence they felt to support these measures. These all end on January 1, discharges, so you would still collect the recorded report discharges for submission in February and May, but as of January 1, you can scrap data collection.

On the next page, immunization one as we talked about through the year, there are a lot of changes going on with that specification, so CMS decided to suspend that. State measures, and I have put the acronyms for them so it’s easier to describe what those are.

SQRMS stands for statewide quality reporting and measurement system. Those are the required measures by Minnesota. SQRMS decided they weren’t going to do the suspended idea so they’re removing that immunization, one is a pneumococcal immunization measure and if it’s reinstated, which is the whole idea when CMS suspends measures, the idea is that they can reinstate them without going through the rule making process in a three-month period with a three month notice. If that were to happen then state might reinstate it too, so it goes through a technical adjustment in terms of communicating that.
For PPS hospitals there’s a structural measure that was removed also from the registry.

Next, removal of measures that are related specifically to SQRMS are that, appropriate care measures, which feels like a major change because I know a lot of hospitals have used that as an ongoing monitoring of their quality program. The main reason for that is that there aren’t enough measures. Those are all or none measures and now that so many of the AMI and heart failure and pneumonia measures are being removed, there aren’t enough measures to do an all or none. That’s the rationale for that.

That will start with the January 1, discharges so you’ll still get it for a bit as we work through the 2013 data.

The CAC-3 Pediatric asthma, when the steering committee was reviewing that and the feedback they got was that there wasn’t the volume to support that measure, even in large systems there were less than 25. Therefore, that was removed as of third quarter 2013, so you will have no more data collections to do on that particular measure.

The next ones are more acclaimed. These measures might not directly affect your workload, but it’s helpful to know that pretty much the composite measures are those that have stayed in for some of the indicators of patient safety. Indicators in the in-patient indicators… there are a couple that have stayed in related to pediatric and OB because that was a particular focus in the past.

The pressure ulcer and PED DVT, these in-patient quality indicators 4, 5 & 6 are removed as well as 11, 12, 19 & 30. All of those indicators are removed from the state measures.

Next, part of the feedback, so when MAH and Stratis Health go out for the spring meeting, I think it was 2012 when started about the data burden, particularly to critical access hospitals where people were actually hiring people to do this measure and it felt pretty onerous. There was a recommendation from the steering committee to eliminate this measure for both PPS and critical access hospitals. The end decision was to keep it for PPS hospitals because they’re reporting it anyway for CMS purposes, but this would become voluntary for critical access hospitals. That was effective with July 1, 2013 discharges, so that’s up to you now as to whether or not you want to do any reporting for that one.

Now, the 2014 edition, how many of you were in the call in January, the annual statewide quality? The PCO1, this is a CMS measure that PPS hospitals have been reporting for a year and so, they would not need to do anything their CMS physician would meet the requirements for the state, but this is new for critical access hospitals. I know we talked in October about how you’re reporting this data to the department of 905 services, so you would be reporting this through the CMS website, so you would need to follow that data submission.

We’re certainly willing to connect with DHS and see if there’s a way they can use that same data and help coordinate that discussion. I’ve yet to get a contact person, but I believe someone has raised that in an email to me, so I’m asking them who their contact is. If any of you have that and you can send it to me, I would be willing to talk to DHS and the state, Minnesota community measurement and the hospital association to see if we can use the same data to avoid two data submissions.

I don’t know if the measure is exactly the same, that would be the other discussion whether there needs to be two different submissions because they’re actually a different measure. I would assume and my understanding was that they were using the same definition. This would start with January discharges, the PCO1.

The time to intravenous thrombolytic therapy for stroke patients. I talked a little about that measure and there were some materials given out at January webinar which you’ll find on the website. This is a new measure for both PPS and CAH and it would be submitted through the same mechanism that you’re submitting other stroke measures through.
It would be through the Minnesota Stroke Registry; however, there are different options and different levels of detail, if you just wanted to do the aggregate or patient level or if you’re actually participating in the stroke registry. On that site you have a choice. What Al mentioned on the January call is if you want to change that and go to a different level you can you just need to contact him and he can put you into a different portal. If you want to change the selection you made last year.

Those are the new measures for the state measures. Next, is for PPS hospitals, mortality and readmission, these are the new measures and I think it’s helpful for CAH to be tracking this because you know eventually these will come to you. As you’re working on your readmission work, you might be looking at both stroke and COPD patients that you might have and the same with mortality.

A couple others that are new for PPS is the safe surgery checklist. There is a safe surgery checklist on the outpatient side, which isn’t required for CAH right now, but it’s helpful to know that they’re moving that into the in-patient side as well. That’s data collection for 2014, but the data submission doesn’t actually happen until 2015.

These other two are FYIs for you to be in sync with what measures are becoming important nationally. The AMI payment per episode of care, so there is a Medicare spending per beneficiary measure. Now they’re getting down to specifics, how to, so here comes the AMI, heart failure and are being worked on, so you’ll probably see those in future years. Then the influenza vaccination coverage among healthcare personnel. That already exists for the in-patient and now they’re going to the outpatient side. At this point those are just for PPS hospitals.

The next are just FYI for you too. These are also for PPS hospitals. They did delay the implementation by a quarter, but you can see the topic areas are endoscopy and cataracts.

A couple other measures that are new and these are specific to CAH. We’ve talked before about the infection measures is separate than, it’s a separate reporting. Initially the reporting was going to be with the healthcare personnel for submission into the National Healthcare Safety Network NHSN, so that’s the CDC data collection system and then there was a change last year when we saw our CAUTI rates in Minnesota compared to the national in other states and we were quite behind on that, as well as the immunization system in Minnesota.

As they were working on trying to align their system to the CMS requirements it was taking longer to get that alignment, and that was the reason the measure was put on hold and CAUTI came up as the first measure to be implemented. This is a hospital-wide measure and for the PPS hospitals the CAUTI measure is still just an ICU measure, but we’ll go hospital-wide in 2015. So you’re a year ahead of the game in that regard.

This starts with January discharges and we’ve had the series of four webinars so hopefully you have participated in that. We still haven’t heard about SAMS at all. We’re still anticipating the new system, SAMS, being available soon, but not yet. We did seminars in conjunction with the hospital associations and they will be doing the reporting related facts and measures and Janet Lilleberg from Stratis Health did most of those presentations. If you have any questions you can have access to those presentations as well as calling Janet.

The MBQIP measure, the new ones, are the CPOE verification and medication within 24 hours. We just received information on that from who is overall managing that program nationally, in December. The ED communication measure, the specifications have changed now, to be aligned more nationally. That’s a measure that’s required as part of MBQIP, Medicare Beneficiary Quality Improvement Project starting in stage three, which was in December 2013.
So as other states are getting up and running, Minnesota because we were ahead of the game in implementing that measure need to now align to the national specifications, so there are changes and Robyn and Laura will go over those changes as well as the tools that will be available to you, when we piloted this that people thought were helpful.

Next is a review for you. What I did for the PPS hospitals and talk a little about the measurement applications partnership. There is a private/public partnership of a group that looks at measures before they go into the rule making process, so they are giving recommendations to CMS before they even end up in the rules. Now they’re having a commentary in addition to that, so you might have seen that come through back in December. I have that listed here in terms of how that fits in to the different rule making processes.

If you look at the in-patient, outpatient and state rules, the SQRMS program, I didn’t put 62J on here, because it’s been consistent but you can in December there was a pre-recommendation which was then put out for a comment period in January and the final report should come through in February, which informs the rules for this year. CMS is only considering rules that they’re recommending.

So, if you want to get ahead to see what’s coming that would be both an opportunity to identify what’s coming, as well as being able to share your comments into that comment period. Now, for the in-patient rule, that usually comes out April beginning of May and there’s a comment period and then it’s finalized in August. The outpatient rule, the proposed rule comes out around July, then there’s a comment period and then that’s finalized in November.

The state process is to get input at the beginning of the year for recommendations in April and May, and then in June there’s a public forum. There’s an informal comment period, the proposed rule happens in August with a formal comment period and then it’s finalized generally in November.

A little about the MBQIP Project (Medicare Beneficiary Quality Improvement Project) – this is a voluntary program. It’s a national program specific to CAHs and is administered by HRSA, the Health Resources & Services Administration as part of health and human services. The overall purpose and reason for it starting was to focus on quality improvement and opportunities in CAHs. If you were to Google the MBQIP or follow the link in the slide, you will be able to find more resources on it.

To review, there are three phases.

1. Pneumonia and heart failure measures, some of the in-patient measures
2. Outpatient 1-7 and HCAHPS
3. Pharmacist measure & ED Dept. Transfer Communication Measure

Those have a little bit slower startup, because of not having systems in place to be able to gather that data, so you’ll see some variation with the phase three measures. We probably didn’t emphasize phase one and two as much, because all CAH in Minnesota were reporting these measures anyway. The main difference is with the HCAHPS, for state measures, you need to have 500 admissions in the last year for the state to require you to submit data.

With MBQIP, the requirement is that all hospitals are up and running on HCAHPS, so we encourage you to do that if you haven’t already started.

Another goal besides the actual reporting is to work on improvements. So we have improvement focus and we decided with the office of health and primary care, and Judy Berg is here today. We looked at the data we had to identify what would make sense in terms of picking up, common topic and then being able to provide some resources to you to work on improvement.
It seemed with in-patients as we talked about earlier, is that many of the in-patient measures AMI, heart failure, and 23:09 are being removed, so there’s a lot of churn there. Some of the outpatient measures don’t really relate as well, in terms of having enough volume to be able to support those, so it made sense to look at the HCAHP measures and focus on where we might have the most improvement need.

The ones we were lowest on in Minnesota, if I look at the reporting period for 2nd quarter 2012 to the 1st quarter of 2013, as you know HCAHPS rolls questions into different composite measures, so there are five composite measures and the communication about medications was 66% and that was the lowest, so that was the rationale for picking this one to work on. I think the other synergy that it seemed to have is that medication seems to be a topic in multiple initiatives, so it seemed like one of those that might have you gain some improvement gains and with your readmission projects or with adverse drug events, just overall it seemed like a good topic area. It obviously can be somewhat of a challenge as well.

That was the rationale, just as other background and where we are with the other composite measures, communication with nurses was at 80%, communication with doctors we’re at 83%, responsiveness of hospital staff we’re at 73%, pain management was 71%, which would be another area of focus, and communication about medications is 66% as I mentioned. That’s also the lowest nationally, so with CAHs, 64% is the average for communication about medications.

That composite measure is a roll-up of two questions.

- Before giving you any new medicine, how often did hospital staff tell you what the medicine was for?
- Before giving you any new medicine, how often did hospital staff describe possible side effects in a way that you could understand?

Those could be the two things to impact.

What we’re going to do is provide a little more ideas on strategies and have more discussion about this measure, that a hospital association is doing a SAFE Care roadmap meeting, and I don’t know how many of you are signed up for those. There will be three meetings and they are listed... Redwood Falls, Alexandria and Grand Rapids. There will be three components to those meetings. Marilyn Grafston is going to go over the SAFE Care roadmap, which as you might remember is like putting all the roadmaps together from a critical access viewpoint, so pulling the pieces off the roadmaps that relate to CAH.

There will also be a presentation by a consultant they’re using on patient engagement and the third part of that presentation will be discussing this medication communication, so I’ll be going out with Marilyn on those meetings, so we’ll have more discussion later about some improvement ideas.

Meanwhile, we still need targets and I think the last time we weren’t clear which time period to view, and as you know each HCAHPS got delayed a bit so we don’t have that report. You should look at your data from reporting period 2nd quarter of 2012 to 1st quarter of 2013. If you can email me what your goal is, we’d like you to identify an improvement target that you can get your organization behind, your physician staff and senior leadership on board for setting that as a goal to be able to improve. Then, when I go out and meet everyone, we can have discussions about some specific strategies that you can do in terms of meeting that improvement focus.

I’m going to answer some questions that came through on the chat line.

There was a comment about entering the ED data into the MAH portal and that will continue. Nothing will change related to that data submission into the hospital association.
Yes, you would need to go into the CMS portal, Quality Net, to be able to submit the PCO1.

Another question asks where you go to sign up for the roadmap meeting. They were just now sending out registration confirmations, so you can go to the MAH site and click on education.

In terms of what's on the agenda for these three meetings, there are those three topics mentioned earlier and there is actually a fourth, where you get to network with each other and pick your own topic.

1. Patient engagement
2. SAFE Care roadmap
3. Improvement on medication communication

Mark, do you want to speak to the early elected delivery? We're talking about PCO1, the early elected delivery measure and they said they might be doing that more for the HEN project.

Mark: Yes, that’s true.

Vicki Olson: When you're doing it for the, when the DHS is asking for that measure too, are they reporting that through you as well at MAH or is that directly to DHS?

Mark: I should find out. I suspect that right now it's double reporting, but I will check on that. We generally, for the hospital engagement network, keep that data here and do not forward it to anybody, on a hospital specific level. We do some aggregate reporting for CMS but we don't do any hospital-specific reporting, so I suspect that it is double reporting right now but I can’t definitively say.

Vicki Olson: So it sounds like we have three potential, the HEN project, DHS and now we have the SQRMS data requirements.

Guest: Is that the same for the ED transfer communication measure that you’ll be dual reporting?

Vicki Olson: No, there will the same reporting to MAH that you’ve been doing, at least at this point. Right now they're not asking for that data so we'll have to figure that out down the line, because they don’t have a national reporting tool at the moment, so there isn’t a requirement for that to go beyond our state at this point.

Judy: 32:50 - 33:50… It says it begins September 2013, so if we’re reporting to MAH we’re good/

Vicki Olson: Yes, at this point.

At this point, our submission to MAH is adequate. It might be that nationally 34:25 we might have to modify that, but because it’s required for the state of the state measure our current system probably meets the need. Before I transition to Robyn and Laura to talk about the ED transfer communication measure, I wanted to give a brief overview.

The next two measures are part of the MBQIP, ED transfer communication is also required by the state for reporting and given your feedback, we had an advisory group going back a year and a half that looked at the specifications and then did some coordination with the national U of M is the owner of the national 35:20. We provided input into that process and two of our hospitals and Tammy is here, who was one of our piloted, both of sampling methodology, the new stack as well as an Excel tool and Joanne from Wheaton also participated in the process.
We’re now ready, given that pilot and also now aligning with the national specifications which were written into the SQRMS rule to now roll out the ED transfer communication specifications. Then, as I mentioned the pharmacist one, we were waiting the CPOE verification by pharmacist, and for that measure we were waiting on more detail in order to really understand that measure. That came through in December. It’s still a new measure so it’s not a CMS measure it’s new specifically for CAHs and so I’m sure there will be learnings and at this point that data will be submitted to the coordinator, Judy, but they’re working on tools to be able to combine that, so the data submission is still in process in the works in terms of that measure.

We do have more information on the specifications, enough for you to get started in collecting that data.

**What does SAMS stand for?** It’s a new system that’s being developed that’s more web-based and doesn’t require the digital certificates. It’s a national healthcare safety network. It also doesn’t have to be updated every year. When people have secure digital certificates, for NHSN they have to have it reinstalled every year, which can be a burden and SAMS doesn’t need that.

**How many missions do you need to have before receiving the HCAHPS data?** The MBQIP reports that you’re getting that are on the secure Stratis Health portal. You have a password protected site that you’re going out to get your MBQIP reports and that’s where you would get your HCAHPS data as well and your outpatient data.

I can look through to see if there were any where the numbers were too low. I’ll gather that data so when I’m going out and doing the roadmap presentations I can have a sense for where everyone was on that particular measure. If you have questions you can contact me.

**Is that for facilities that have less than 200 admissions?** I think your question is about the requirements for HCAHPS, let me look, on the measurement summary you’ll see that under the in-patient, patient experience of care on page five, if you have greater than or equal to 500 admissions in the previous year for CAH, than the state requires you to report for the HCAHPS measure. For the MBQIPs they have put no lower limit on that.

I think if you listen to the HCAHPS education, they’ll say things about being statistically significant and you need a certain number, so that might be where you’re coming up with the 200, but for MBQIP they’re encouraging people to do HCAHPS survey no matter what number of admissions you have.

**Rhona:** I have a question about the HCAHPS submission. You said we had to submit our improvement for 2nd quarter 2012 to 1st quarter 2013, is that right?

**Vicki Olson:** Your goal for improvement on the composite, medication communication composite for HCAHPS.

**Rhona:** We didn’t start it until 3rd quarter 2013, so do we need to do something?

**Vicki Olson:** Do something about submitting a target?

**Rhona:** Yes.

**Vicki Olson:** I think we’re still interested in getting targets from everyone, recognizing that that’s older data now but the most recent data we have probably reported.

**Rhona:** So we should look at what we started in 3rd quarter 2013 and get a goal to you.

**Vicki Olson:** Actually, I would still use the goal of the most recent data. If you were to look at your data from 2nd quarter 2012 to 3rd quarter 2013 on that MBQIP report and then compare to
Stratis Health | 952–854-3306 | www.stratishealth.org

where you have more recent data, to where you are now and set a goal for where you’d like to improve.

Rhona: So it’s from the MBQIP not from the HCAHPS score.

Vicki Olson: It is from the HCAHPS score as its on your MBQIP reports.

Rhona: We didn’t submit any during that time.

Vicki Olson: Then use your most recent data.

Rhona: And then email that to you?

Vicki Olson: Yes. If there are no more questions we’ll move forward.

Robyn Carlson: Hi everyone, I’m the quality reporting specialist here at Stratis Health, for anyone who’s new on the line. What we’ll talk about now is the ED transfer communication. Let me apologize if I’m telling you some things that I came across on the call that was done in January. I missed that call but I want to highlight a few things.

First, anything that’s different now that we’re having you collect in the guide, any differences are starting with 1st quarter 2014, so you keep collecting what you are for 3rd and 4th quarter. Any of the changes will start with 1st quarter 2014. I think we used the word changes and I don’t want to get people excited because there really aren’t any big changes to the data that you’re looking at.

We did change the population. We’re allowing you to sample and that’s really the big change. Much of the other stuff is just more clarification, hopefully more on how you determine what you’re looking at or if you meet the data elements that are there. There’s not really change to the measure or additional data elements any of that, so don’t freak out about that.

I’m going to introduce Laura, but first we’re going to talk about the tool and how that came about is that there is a CMS special project that was done. It was eight QIOs that were working with a number of their CAH’s in their states on this ED transfer communication. You have to remember again that we’re the only state that you have had to be collecting this, so this is kind of new to everyone else. Other states and CAHs may have been doing it in one form or another but it hasn’t been mandated. I think we talked before in that you have been in the forefront of this.

Because you’re doing it for the state you had to report it through the state portal for the new project that these people had no way to do. There was nothing to report it in, so Stratis Health developed the tool that we’re going to talk about. You still have to report to the state the same way and they still want the same information, but what this tool can help you do is, if you’re used to answering questions in part, it’s like flowing like parts. It’s like this is the question, is it yes is it no? It will help you determine your numerator and denominator.

If you want to use this to answer these questions, after you answer it will flip out a report that will give you your numerators and denominators and then you send that to the state. It isn’t really taking away a step for you, but what I’ve found is that I think because we’re so used to this is a question and being able to do an answer, that people have had more trouble with this ED stuff because it’s been different.

It’s not the normal way of how we submit data. Maybe some people have looked at the Excel tool that was in there or just sent the data off and not really looking at what the question is and what you’re looking for here, so that’s where we redid the guide to make it look more like the spec manual and tried to keep everything in line with how we do things for CMS.
That’s the purpose of this tool. We think it might be helpful in helping you determine if you’re meeting those requirements for those measures.

Laura Grangaard is the research analyst here at Stratis and she’s the one who’s worked on the project, the CMS QIO project. She’s going to talk about the tool.

Laura Grangaard: Thanks Robyn. This tool and the guide that’s connected to it is on the registration page. My purpose today is to walk everyone through how to use the tool, because obviously if you can look at this it doesn’t look like your typical Excel document and it can be a little bit different to look at, at first, but hopefully you’ll find it’s very easy to use.

Also, take note that everything I’m going through here, in addition to being recorded and gone over, is in the guide so you can refer back to that if you want to use this. The first step here when you get the tool open is to make sure you save it. If you save it after downloading it you won’t see it. Save it someplace easy to find on your desktop or in a folder.

When you open it, what you see will depend on the version of Excel that you’re using. You may get a message, but the first thing you should do before using the tool is something called enabling macros. Macros is how this calculates things as you’re entering data and we’re running Excel 2007, so I’m enabling macros on this computer version. You want to go to Excel options. You want to go to the trust center and click on that. Then you want to go to trust center settings and on the left bar is something called macro settings near the middle.

You want to click enable all macros. It shows as not recommended and that’s because if you have that running all the time, things can happen, but this tool is safe to use, so you can enable all macros and then push okay. Then you want to get out of that and it will take you back to the main page. At that point you want to save your tool. I will also note that because of these macros and this is a little big so sometimes it takes a minute to save. Don’t panic and start x’ing out of that’s the case just give it a chance to finish.

Once it’s saved you want to close out of Excel and then you can reopen it wherever you’ve saved it on your computer. It will take a moment to reopen as well and then once it’s opened this is what we have. This is the tool itself, macros are enabled so everything will run. This is the introduction page and what you want to do is enter data into any of the gray spots. One says enter your critical access number. I’ll walk through this using sample numbers, so today we’ll be 123456.

Every time you enter any information you want to click enter and that will move you on to the next cell. These that look like buttons are just that, so you want to click on the button that says click here to start data collection. That takes us to the entry page and this is your patient entry page, and for every patient you enter information on for the ED transfer measures, you want to start at this page. Basically, this is a form where you will enter all the applicable information.

We’re in Minnesota and your patient’s name is Bob Smith. Medical record number, which is for your own benefit, so whatever you use to identify your patient numbers, which is going to be AABB today, but again will be whatever you deem it to be. The next one is patient discharge disposition and it says select from the dropdown list. You want to click on that and there are a few options for the patient discharge disposition. You want to select whatever is applicable to this particular patient.

In this case we’ll say they were discharged to an acute care facility. You will then enter the data patient encounter and we’ll say this patient was New Years Day, and you can enter this in a variety of formats, whichever works best for you. Click enter. Enter the name of the person doing the data collection. This is for if you have more than one person entering data, if you need to confirm something with that person.
The final one is year of data collection. This tool was created to be generic, so it will output data for four quarters of a calendar year. I will do 2014, and it will do 2014 for all those quarters and for 2015, if you’d like to enter data for patients in that year when that comes about then you will need to download a new tool and do that. This tool, since I’ve entered 2014 will now only be for 2014.

Once you’ve entered all the information there are buttons at the bottom. Clear content will clear everything you’ve entered so you can start over. Add new record is what I will click shortly to enter the information we added. View all records will take us to the record list of patients we’ve entered, assuming we’ve entered more than one and reports will actually run the report. I will do both of these in a moment after we’ve entered this new patient.

When you click add new record it will ask you if you want to add it to the database. There is something built in here such that if the patient medical record number and the patient date of encounter are exactly the same as something that’s already been entered then it will say it’s a duplicate record, so that’s to try and ensure that you’re not double entering. So you want to push yes, because you want to add this to your database and this takes you to a data entry form, which is what Robyn was referring to that’s a step-by-step guide.

On each line will say one is nurse to nurse communication, and there are specifics that say when you should select yes or no. What you’ll do is go through for each question and select the correct response for your particular patient that you’re entering for. Again, Robyn will go through the specific changes, but for the most part they are the same as they’ve always been.

I’ll purposely skip some so you see what happens, all 27 questions. Once you’ve gotten to the bottom and you’ve entered everything, you want to click on save record. I missed one here. Every field is required for this to be completed, so because I didn’t complete something under patient contact it’s telling me that. I will complete that and then you can go back down and save the record.

Before I click save I just want to take note, you can click on any of these data specifications you see here in the blue hyperlink and that will take you to specific specifications for that as well. After you’ve entered patient information, you want to click save records and this will take a minute since we have all these macros running.

Robyn Carlson:

If you see the feed that Laura talked about regarding data specifications, that takes you to the pages in the guide, just like how, if you were entering in cards there was that question mark and you clicked on it to take you to the instructions. That’s what this does. The data specification will you through those to the page of instructions in the guide.

Laura Grangaard:

This has successful saved the data. You can click okay and it will take those to the record list, so when we’re on that main page, if you click the record list button that’s where it will take you. Once you’ve entered more patients you’ll have the record number, discharge, disposition, dates and the first one doing data collection for every record you’ve entered.

There are these button options at the top here that you can use that are self explanatory. You can open the records and look at it. You can go back to the record list from there. If you want to delete a record you need to make sure you’ve clicked on the record number and then you can delete it. It will give you a prompt in case you didn’t mean to and from this page you can add a new record, which will take us back to this main page. It auto populates everything. You can change the person doing data collection if need be, but the other fields shouldn’t change.

The year and the hospital should be the same. You’ll enter these middle four fields for each patient you’re entering for.
From any page, if you click the reports button, that will take you to the report page and will give you your numerator and denominator that you have been submitting to MHA. I'll click it to explain what it looks like. It calculates and then it shows you what the page looks like. There are four quarters. It gives the specifications for everything you've entered. For purposes, your reporting as you're reporting on the measures themselves, so when this tool was developed for the CMS special emanation project it was more, trying to get individual specifications that contribute to those measures.

These, like nurse to nurse communication, physician to physician aren’t what you’re specifically reporting to MHA. What you’re reporting to MHA is all data elements and there are examples you can look at, all EDTC1, 2 data elements, the description of what those are and the last thing it measures, like administrative patient information, vital signs, which all correspond to the MHA portal, which I can show you.

When you're looking at it at a glance it's hard to tell, but the records reviewed N=1, that's your denominator that you'll enter. Your numerator will show up in the appropriate column with each data element. In the example no one met that specification so it's zero. This one again is zero. For EDTc3 the vital signs is one and that is what you'll have to manually enter in, but it will calculate it for you. So again, numerators are the bottom data elements and the denominator is up top for each of the four quarters.

From this page you can go back to your record list by clicking this button. Print report will print off a hard copy. It should connect to your printer so you can print that to whatever your automatic printer is. This takes you back to the main data entry page and then refresh just if you're getting any error messages in here, you can push refresh and it will recalculate.

Finally, I'm going to pull off that portal and I'm assuming you're all familiar with this. Mark was kind enough to send me a screen shot of the portal so I can talk about how that corresponds to what we have here. You will enter the total number of patients in the portal, that's a denominator and then the number of patients in each of these as it corresponds to the measure. This pre-transfer communication is the administrative information, but the rest should correspond exactly to what the 1:01:56.

Now, that’s a quick overview of this. It’s a little easier to learn once you’re doing it yourself and again, we have the instructions in the manual. Are there any questions before we move forward?

Robyn Carlson: Before we open things up, Laura has shown you where to find the numerator and denominators. I think one of the things that we were lacking before is because we were reporting on all the data elements. This is where you can tell which part of that data element and maybe are we failing. Like, for the patient information. Maybe you always have everything but you don’t have the insurance information or the contact information. This is where you can run this and tell if there is one piece of this part where we’re really lacking.

Granted, this is a voluntary report and nothing of this goes anywhere. Everything you enter in here is your data. The only thing like Laura said is that you still have to put that data in the portal. The state wants that data, so this is all for you. Maybe this is the one piece that has always been missing before, is where you can see which one of the specific data elements you’re having problems with.

Tammy was one of our pilot project participants. They used this and gave us some feedback. We aren't trying to make more work for you, so again it’s totally voluntary if you want to use it but this is more of the flow of how I think you are used to entering data and because you need to do it, this is where you might be able to get some benefit from it.
Tammy: I have a couple comments. First, don’t let the tool intimidate you. It is easy to use. Then, when it was discussed about where you’re pulling the numbers and the denominator we would find at the top. We had to remember that if we had something in one of the subsets that wasn’t applicable then you had to change the denominator.

Robyn Carlson: Does this tool replace the current data? No. Maybe these were questions before we started discussing it. This is to help you collect the information so it won’t replace what you have to send into the state.

Laura Grangaard: This is just a tool for getting the information in a different way, which may be a little easier for you.

Robyn Carlson: Another question is, so we will be reporting this in two different sites? No. This is just a tool you can use to help you determine the data that you send to the state. You’re only going to be recording it into the state like you already are. I think the report you can run from this will provide you with some useful data. If you’re at 100% in all these things that’s great, but since that’s probably not the case, maybe this will help you determine where you’re not at 100%.

I have the guide up and we’re going to spend time walking through that. I’ll flip through pages, because not everything is changed and you’re probably used to that. I just want to get onto the areas where we have made some changes and clarifications.

Again, we tried to make this tool guide look like the information that is the spec manual. These are the measures, the rationale and Vicki worked on setting up the beginning, so we’ve tried to have it be like the manual. It might go into a little more explanation than what you had in the past guide, but due to time I want to show you where changes will be in abstraction.

When you’re going through this on your own and you have any questions you know how to get a hold of us.

On page 6, this is where we talk about the population and sampling. I think the biggest difference now and how you’re going to do this for 2014 isn’t just transfer to acute care facilities anymore. If you’ll see the patient population it’s transfers from the emergency department to these facilities. If you have values three the hospice, healthcare facility; value four is still the transfers to acute care facilities. Your general in-patient care and critical access hospital, transfer to cancer or children’s hospital, transfer to VA or Dept. of Defense.

These numbers correspond to what’s in the specs manual, but now five is the big one, the other healthcare facility. That will equate to all the things that fit under healthcare facility, which would be in the CMS spec manual. The big thing is going to be that it’s now the transfer to nursing homes.

We’ve gotten a question regarding a situation with holiday and transferring some of their patients out of ED into their in-patient facility. We’ll talk about that off. This is transfer to another acute care facility.

I think the big thing is that your population is now changing. The exclusions are basically the same. Their home hospice expired and it’s not documented. That’s the big thing now is that you have more patients in your population. Sample size requirements, we didn’t really have sampling before and now we do.

I will let you read down to see how you can read quarterly but basically we’re talking about how you have to do at least 45 for the quarter.
If you want to do it at the one time, choose 45 or you can do 15 per month. Random sample, we don’t tell you how to do it just that you have to do it, but you only have to do the 45. I think that will help some people, because that’s where we heard some people had some big numbers, especially now that we’re adding transfers to nursing homes.

While I’m thinking about it, let me bring this up since some have asked… what if the person was in the nursing home, then goes to the ED and then goes back to the nursing home? Some people thought when we were working on this with the QIO special project that maybe they were going home, because that’s where they resided. As far as what you would say as far as the discharge status, would be transferring to another healthcare facility, so it’s still five and that would be included.

Let me say also, we know that what you could find are some issues around patients who are going to the nursing home, especially when it gets to the physician status. Let’s say that everyone is aware of that but it’s a value right now.

We needed to be aligned with the NQF measures and what the measures were nationally, which is why we had to change our population.

The next few pages are the measures itself and as I’ve said, we’ve set them up to look like what the measures look like in the specifications manual, but I’m not going over the measures themselves today, I’ll talk about the data elements and point out where the changes are with that. These measures haven’t really changed.

If we scroll to page 16, this is the nurse to nurse communication. That data element was there before and it’s here now. I think we might have added a couple notes for abstraction to make it clearer. There were some issues. What we minimally want is the date and time that the nurse verbal communication was given. It doesn’t really allude here to what communication it has to be, so if the only communication was that someone is coming and maybe getting a room number, it’s saying that you have documentation that there was nurse to nurse communication.

The other data elements are describing the what, the vitals, the contact, the reporting and the H&P. This is just indication there was communication, because I know we had some issues in the past where some people said, they don’t really give report if you want to tell that, or they don’t do that until after the patient has left, because they’re taking care of the patient. It might be where maybe people were putting no, when there maybe was just a phone call from nurse to nurse saying hey, do you have a bed? That’s okay here.

This isn’t really new but I think it’s just that we’ve been talking about it and this is what’s meant behind it.

On page 17, this is the physician to physician communication and this has changed due to the fact that the thought is, if you’re transferred to the other healthcare facilities, there might not be the physician to physician communication. What’s here now is you have a yes if there’s documentation, that there was a physician to physician discussion. No if there’s no documentation and now you have an N/A, select this option if the transfer is to a non-acute healthcare facility.

That’s what we’ve done to address the fact that it seems like right now, maybe that doesn’t always happen. So we didn’t want everybody failing that communications measure because of something that doesn’t seem like it’s happening right now.

I think the notes for abstraction are the same. We’re looking for documentation that there was communication between two providers, physicians. The big thing about these two is that right now they’ve occurred prior to the patient leaving. I think we say here, must include minimum leave and names of the two providers, as well as the date and time of communication. From looking at people’s records, you don’t always have doctor X call or doctor Y called at 1530. Sometimes you have that while sometimes you don’t.
Sometimes what I think you’ll see is in the body of their notes, like the H&P, the doctor will say I contacted Dr. So and So and he accepted the patient for transfer. I know we aren’t supposed to assume, but when you read that note if he’s telling you that he accepted that patient for transfer than you pretty much know that communication happened before the patient was transferred. Look at the date and time of that dictation and that’s acceptable.

With some of these things, maybe it’s a little more lax than what we sometimes are with CMS measures, but the intent is that you want to know there was documentation and communication, so if you don’t know specifically that that phone call was made at 1:00 o’clock… if you know from what you’re reading that that’s happened before the patient left than that’s the big deal and what we’re looking for here.

I think the next values are patient name, address… we have an N/A for if this information isn’t available. We have the same kinds of notes for abstraction around that. If the patient is neurologically altered they can’t answer the question. That reminds me and I don’t know if this was exact before, but N/As are considered to be yeses. If you’re answering these questions as N/As then you aren’t going to fail the measures with N/As because they're considered to be yeses.

It’s not applicable so we don’t want you to fail this, but they're counted as part because it was easier in the flow to make them to be counted as part.

On page 26, patient age, I think some of this context is the same so we don’t really need to go over that. Insurance; when we get to some of the vital signs, pulse is the same, respiratory rate is the same, blood pressure. I don’t believe anything is different. You’ll see when you look at these pages because everyone should be familiar with what the specs manual looks like, and we’ve set them up like this.

It tells you the definition, the question, allowable values and suggested data sources, etc. Hopefully it will be helpful to you seeing it like this on the slide, as opposed to how the guide was setup before.

Neurologic assessment is the same. Medications, allergies, all the same. I mentioned at the beginning that most of these data elements, there isn’t a change in how you collect them.

On the tool itself just says N/As so you would need to look at the guide to see what would fit for N/A. (Background talking) Looking at page 20…1:22:00… we’re contacted about the N/As and we’re looking at the notes for abstraction and different reasons for N/As, why the N/A doesn’t matter. If it’s one of these things than you can record it as N/A. A question was asked, if they would ever want to know that.

If we’re selecting N/A but we aren’t giving the reason behind it, right now that’s not required and I’ve never been part of a discussion where that’s been asked, so I have to say I don’t know. I guess that’s something where, if you have a lot of people that are refusing than there may be an issue, but right now…

Temperature, neurologic assessment, there are no issues around that. Medications, allergies and reactions, and as I think about it, remember this is all about whether there was documentation that this information was sent. That's the first thing is to establish if there was documentation that this data was sent. Then you may have to work on the issues about whether the information was collected.

If nothing was sent… if you’re looking at your records and there’s no indication that any of this was sent then all of these things would be no, except for maybe the communication. You might be able to pick up the physician to physician communication or nurse to nurse communication, but then if you’re going through your record and you have no documentation that this stuff was sent than these will all be no.
That was one of the things that we found out in the QIO study, where we did this throughout the country. It was, oh yeah, everybody thinks you’re doing these things yet there wasn’t any documentation that it was sent, so some of the initial numbers looked low. But you have to look at it because maybe it’s saying all these things were done, but there was no documentation and that’s the first step. You guys are already passed that, because we’ve been doing this for some time.

History and physical is clear. Reason for transfer plan of care, nursing notes.

Page 36… the data element impairments, and I don’t a lot of questions about this anymore, and you have now been doing it for a while so maybe you’ve got it figured out. We had some people when we worked on the special study that weren’t sure what we were looking for regarding impairment. After talking about it we added a couple notes for abstraction and what we’re really looking at and what they were telling us they wanted for impairment was documentation that the patient was being assessed for mental, speech, hearing, vision and sensation.

If you’re looking at where it has ENT within normal limits. They were telling us that’s an assessment that speech and hearing were done. If in your 1:25:42 if the physician is saying oriented. That would be an indication that mental status was assessed. Really, I think where you’re going to find this information is in the H&P. The physicians note in the ER that they’re going through the systems. That’s what is being looked for in this question right here.

Catheters are the same. Immobilizations and respiratory support is the same. Maybe we want to talk about, page 41, test procedures performed. I think this is the same. Does the medical record documentation indicate information was sent on any test and procedures done in the ED? Yes if there’s documentation that information and all the tests and procedures selected in the ED prior to transfer were sent. No, if there’s no documentation that things were sent and N/A if they weren’t done.

That may be the same, but on page 42, there is test or procedure results and there may be some wording changes in this section. You want to know if the medical record documentation indicates that results were sent from completed tests and procedures done in the ED. So yes if there’s documentation of results being sent either with the patient or communicated to the receiving facility when available. No, if there’s no documentation of any of those things and N/A if no tests or procedures were done.

The notes for abstraction, if results are not available at the time of transfer then the documentation needs to reflect that the results are not available and indicate, what is the plan to communicate them to the receiving facility when they are available. Like for example, the nurse will call them when they’re completed or that they’re going to be available in the EHR when complete. Every test or procedure done should either have the results done or this documentation stating that it’s not available or the plan for communication.

Therefore, if you have a shared medical record with the receiving facility, then test procedures done and results are considered to be sent. If results aren’t sent at the time of transfer and there isn’t a shared medical record with the receiving facility, then you have to have documentation including a plan on how those results will be communicated. This was always the intent of this measure, I think maybe things got reworded to try and make it clearer, so hopefully I didn’t confuse you.

I have some questions that are written.

If we admit to our facility they aren’t part of the population? No. We’re looking for transfers.
What about discharge to a nursing home, is that a number five? Yes. Four abstraction and discharge dispositions five. I believe it's transfer to other healthcare facilities and that's where nursing homes are included. We tried to make our discharge disposition align with the CMS manual.

Nursing home transfers... 1:30:00 patients from the nursing home return to their home in the nursing home? Yes it does.

You say we will have a hard time identifying those patients. I don’t think so. If they come in the ED... remember, this tool is for patients in your ED and then wherever they’re transferred to. I think you should be able to identify them. Maybe I’m misunderstanding your question.

Does this include patients transferred to psyche and detox? If it falls under category five, other healthcare facility, then it would be yes.

We are a small facility and do not have 45 transfers. Then you just do however many you have. It’s 45 max or however many you have.

Just to clarify, if the nursing home is their home we still have to do this? Yes, if they’re transferred to another healthcare facility.

A majority of our patients go to our attached nursing home so do we need to document nurse to nurse communication? Yes.

Does there need to be physician to physician communication? Well, I can’t answer that but we’re still looking. You have to think about the Y of this, which is about whatever happens in that ED, gets communicated to where these people are going.

We are aware and I think you posted this question before we got to it, but we know there’s an issue with the physician to physician communication. That’s why we’re letting that be an N/A for now. It may not always be, but we don’t want you to fail everything because of that. We realize that situation, but maybe that will be something in the next year or next couple years where it’s not good to be an N/A.

You won’t be penalized for that, and everybody is aware of that right now. Physician to physician doesn’t really happen when they’re going back to the nursing home.

What if the doctor doesn’t give the accepting doctor’s name just as on-call MD? I’m pretty sure that’s a no, and every time we’ve talked about it we say we want the name. If that changes we’ll get something out to everyone, but my thought right now would be a no.

I’m filling in on this call so is this tool? You don’t have to use this tool, it’s optional. If you think it will help you get the information the state needs or it may help you get information for your own quality improvement purposes you can use it. You don’t have to use the tool that we’ve gone over here.

Do you have a standardized form we can use? If you’re talking about for this, we’ve shown it for you.

Sherri: I submitted my fourth quarter ED transfers today, so my question is this. In the future, I know you said we don’t have to use the tool, but is it still numerator denominator submission?

Robyn Carlson: Right. What you’re giving to the state is the same as what you’ve done all along. This tool may just be an easier way for you to collection that information. You just need to print report and put it out there.
Maybe it’s helpful for quality improvement, but what you’re giving to the state is still the same information.

Sherri: Thank you.

Robyn Carlson: I think we’re done with the ED transfer part.

Now we’ll talk about what’s next on the agenda, which is the MBQIP phase three, pharmacist verification.

Tammy is talking about the tool and when you’re getting N/As, how it’s going to look on the report.

Tammy: Or even what you’re going to submit for your data.

Robyn Carlson: I thought N/As were just being left in. What we’re talking about is the tool where Laura was showing you where the N/A values were and where you would pick that information to report to the state. Tammy was asking if for N/As you had to change something. I think the consensus is that you don’t, because N/As aren’t taken out of the values they are just considered to be yes answers.

Someone just asked about transfers. If they’re in your ER and transfer into your facility. That’s not part of this population. We want transfers to another facility.

We would like to review oral restrictions. We’ve struggled with that in the past.

We’re back with the guide, going to page 40, talking about oral restrictions. Does a medical record documentation indicate information was sent regarding any oral restrictions placed on the patient? Yes, if there’s documentation that restrictions were placed and information was sent. No, that oral restrictions were placed and information was not sent and N/A if no oral restrictions were placed.

Inclusion guidelines would be like if there’s documentation about NPO or patients on clear liquid, soft diets, that would fit under the oral restrictions.

1:39:26… unable to hear question

It’s not saying that this has to, who has to give these communications. It doesn’t say this has to be physician documentation, so you’re just looking for documentation about anything that would fit under what we consider to be oral restrictions.

The question was about, if there wasn’t any formal things saying anything about oral restrictions but there was documentation in the chart that the patient ate… I don’t think that’s anything. I guess if that’s all I had then I would put N/A, that there were no oral restrictions. For saying that there were restrictions, because that’s really the question, no to so much the documentation. We would be looking for something regarding a certain kind of diet or if they were no liquids or NPO.

We’re looking for some mention about diet. If you don’t have anything about that then I would take that to mean there’s no oral restrictions and I would record that as N/A.

It was asked if the person was intubated or had a tube. I wouldn’t make that assumption. I don't know that everybody would do that.

We will check on if there are any additional guidelines for oral restrictions.
I was wondering what a standardized transfer form that would have all the elements as to help us from missing any data. I know there are facilities who have made forms like that. I will see if we can share them.

Now we’ll talk about part of the phase three MBQIP, pharmacist verification of medication orders within 24 hours. What you’ve been provided as a handout is the presentation that we listened to that was given from the federal office of rural health policy. It was provided to us; the rural flex department across the country, but it really explains the measures why behind it and gives you what you have to collect.

We decided to give this out. There are some pages that say the rural flex department has to do this, etc. We thought this would be good in case you had to explain to people in your facility why you have to do this. What Mary has here, there are also a couple webinars that were done, explaining this process and the reason behind it. You also have those available to you and there’s also a YouTube video. We thought it would be helpful for everyone.

Now, since I’m short on time, what I want to hit today is the what you have to collect portion or what you’ll need to start collecting.

On the pharmacist CPOE verification of medication orders within 24 hours. What the measure is; is that you have a numerator which is the number of electronically entered medication orders for an in-patient admitted to a CAH, verified by a pharmacist or directly entered by a pharmacist within 24 hours. That’s your numerator.

The denominator is going to be your total number of electronically entered medication orders for an in-patient admitted to a CAH during the reporting period. So what you’ll have to submit are numerator and denominator. Your inclusions and exclusions, included would be in-patients admitted to an acute care bed, swing bed or an observation patient. Excluded would be outpatients or ED patients, so you’re really looking for in-patients.

Critical access hospital role… what you need to think about is if you don’t have the computerized medication order entry you can’t even do this now. So you don’t have to do anything except for thinking about getting this, but for right now if you don’t have it then you don’t have it.

At the bottom it says the Office of Rural Health Policy recognizes there are still a number of critical access hospitals that do not yet have computerized medication order entry, but I think everyone is moving that way. So those agencies that may not be ready to collect data for this measure in the first reporting period of phase three and that’s okay. As soon as you get that then you can begin reporting, even if it’s a while into phase three.

For people who are here, does anyone not have it or who has it? Not everyone has it. There is the pharmacist verification report. This report can be generated by a computerized pharmacy system or your EHR and this will provide you with all the data elements required to report on this measure. This is telling you what should be included in that report.

Date for each order
Time ordered
Time verified
Whether no verification was required
Total number of orders verified or entered
Total number of orders entered

Apparently, these reports will give you what you need.

The first step is do you have a computerized pharmacy system vendor? Either an EHR or pharmacist system vendor, yes or no?
If no, consider getting one and you can’t report on this measure at this time. If yes, than you want to check on the availability to generate this pharmacist verification report. If the report is available and it has the required data elements that were on the other slide, then you have what you need to report to this measure. If the report is available but not every data element is included, than talk with your pharmacy vendor or EHR to find out how to get those data elements.

If you don’t know about the report you need to find out.

Next is a sample of what the report is. It seems like it’s fairly easy. It has the date and times. If it needs to be verified. When and the status. So it shows you the sample and what you would be reporting.

Next is a sample of a tracking template. If you had the previous report, this is a sample that we were shown on how you can track your numerators, denominators and getting your scores.

The last page is contact information from the office of Rural Health Policy, but don’t contact them. Someone asks when this should start. This presentation just came out in December, and they’ve been talking about it for a while, but there wasn’t really a mechanism for how to do this. It’s just now coming out, so what I’ve been going over is basically what we know.

It seems that in some of the information I got said that reporting mechanism should be ready in early 2014 for stage two submit data for the first reporting quarter of phase three, which they’re saying is October through December of 2013. Maybe it will start fourth quarter, but right now there isn’t a way to report it. My suggestion then would be to find out whether you have this pharmacy report and if you do, there’s the sample tracking and maybe start to pull together your information.

Then, when we find out where and how to send it, we’ll let you know.

*Even though we wouldn’t necessarily be looking at recording it, we’d still be looking at Jan 2014 as a start point?*

Right here it says data collection start would be fourth quarter of 2013. I think maybe we would try to align that with the same quarter as CMS submission. So fourth quarter 2013 is due May so that’s maybe what we’re looking at but it’s iffy. We don’t really know yet, but let’s think that until we know differently.

We believe it will be reported to the flex office of rural health services.

Someone asked where this gets reported to. We’re still working that out. Judy says she’s just hearing about the information at the same time. This presentation was presented to them in December as well, a lot of the particulars haven’t been figured out but I don’t know that we knew how many of you in CAHs were tracking on this phase three. You obviously were on the ED transfer communications because we’ve had to do that for a while, but we didn’t know for sure how much people were tracking on this other part, so we wanted to get it out there so it wouldn’t be a shock in May.

I’m sorry we don’t have more for you, but just know this is there and as soon as we know more we’ll get it out there to you.

**Sherri:** I just wanted to say, when you were asking about CAHs with CPOE. We do and what we do here is we have a pharmacist on site Mon-Fri from 6:30 a.m. to 3:30 p.m. and then we go to a remote pharmacy.

**Robyn Carlson:** Okay.
Sherri: So I’m thinking that we would be able to pull this data from our EHR.

Robyn Carlson: Right, I think that’s what they’ve been talking about, that you could get it from the EHR or from your pharmacy information.

Vicki Olson: This is good conversation because it’s part of the point of the measure which is looking at your pharmacy coverage and how you might go in that seven day a week coverage by working with the remote or other organizations to get that 24 hour/7 day a week coverage.

Sherri: Right. Our remote pharmacy takes over on the weekends when our pharmacist isn’t here and then we also have cameras for identifying patient home meds and things like that. I think we’re doing well with this already and that’s nice to know.

Robyn Carlson: Thanks for sharing that.

I think we’ll conclude and wrap up the webinar. Thanks to everyone for attending.