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2014 Quality Measure Reporting for Minnesota Hospitals

Presented by [David Hesse, MN Department of Health & Denise McCabe, MN Department of Health]  
(50-minute Webinar) [January 8, 2014]

Vicki Olson: Welcome to all of you to today's webinar and the annual update to the hospital measures that are part of the statewide quality reporting and measurement system. This is Vicki Olson, Program Manager at Stratis Health and I'm pleased to be your moderator today. This call is held annually to support Minnesota hospitals in understanding the changes for the Minnesota slate of measures for hospital quality reporting for PTS hospitals, critical access and children's hospitals.

We are offering this as a webinar today, in order to use the chat function, and we encourage you to enter questions as they come up. You should see a cloud so you can enter questions and we'll either answer them in between the presentations or at the end. An additional resource to you was an email that was sent out, which summarizes the changes and it gives you the links to many of the resources that will be mentioned today.

I'm joined today by Denise McCabb and David Hesse from the Health Economics Program at the Minnesota Department of Health, who will be giving an overview of the measures process and Al Tsai from the Strokes Program at the Minnesota Department of Health, who will be reviewing the specifications and new stroke measure. My role will be to summarize the changes for the hospital measures. We also have Mark from the Minnesota Hospital Association and Deana Welbrack from the Minnesota Community Measurement on the line to help answer questions.

Our objectives today are:

- To review the quality measure requirements and development of the system.
- To describe the 2014 changes and the deadlines that go with the changes.
- To understand the hospital quality measurements, recommendation process.
- To go over specifications of new stroke measure.
- To discuss the options available for data and submission of that stroke measure.

I'm going to pass it off to Denise, who will make other introductions.

Denise McCabe: Thank you Vicki, and to everyone else for joining us today. My name is Denise McCabb and I'm the Quality Reform Implementation Supervisor at the Minnesota Department of Health. I help administer the statewide quality reporting and measurement system or SQRM, as we also refer to it. Thank you for joining us today to learn about the 2014 reporting requirements.

I'd like to introduce my colleague, David Hesse, who will provide an overview of SQRM.
David Hesse: Good afternoon everyone. As Denise said my name is David Hesse and I’m working on the administration of SQRMS. This afternoon we'd like to provide some context of SQRMs, which is grounded in the 2008 health reform law. We want to explain program objectives and goals, describe the process and be able to update the measures on an annual basis, as well as offer some SQRM resources.

In 2008, Minnesota passed health reform legislation. At that time it was known that Minnesota residents received high quality care, as compared to residents in other states. However, there was a wide variation in costs and even quality with no evidence that higher cost or higher use of service was associated with better quality or better health outcomes for patients.

In 2008, when health reform law was being passed and now in 2013, we know that healthcare costs continue to rise and a greater share of healthcare costs are born by consumers. In 2010, healthcare costs increased three times the rate of per capita income and wages, so the question then becomes, what tools do consumers have available to choose how to spend their healthcare dollars? We believe the state quality reporting measurement system is one of these tools.

As part of the state’s nation leading health reform law, the commissioner of health was charged with developing a standardized set of measures to assess the quality of healthcare services offered by healthcare providers, establish standards for measuring health outcomes and publicly reporting the quality measure results.

The requirement of legislation lines our approach outlined by these objectives and goals. The creation of this approach is based on input from stakeholders, including providers. Ultimately, quality measurement must produce reliable and comparable measures while minimizing provider burden, avoiding duplications and employing a transparent process.

These objectives and goals are being implemented within a broader state and national context. The SQRMs hospital measures in particular, are highly aligned with other federal reporting requirements and MDH includes some SQRMs measures that has provider grouping being a peer grouping project.

It should be noted that as per statute the Minnesota Department of Health reviews the quality measurement, administrative roles and dependencies on an annual basis. In the spring MDH will invite interested stakeholders to submit recommendations on the addition, removal or modification of standardized quality measures to MDH by June 1s. Additionally, contractors and subcontractors such as Stratis Health work with stakeholders to develop and vet quality measure recommendations as part of a contract with MDH.

MDH invites public comment on a preliminary and final measure recommendation, as well as measures set that are published in the propose rule in mid –August.

Reporting requirements are included in the dependencies in Minnesota rules chapter 4654. A little background on the history, the first set of administrative rules established the SQRMS system in December 2009. It specifies a set of quality measures, outlined provider responsibilities to submit data on an applicable quality measures and outline how health plans may use quality measures.

Since its establishment, the measure set has been updated annually. Some measures have been added, some modified and some removed over time. Stratis Health will review specific changes during its portion of the presentation.

A little information on the SQRMs website. You can find information about SQRMs on the site. It has been updated with the adopted rule from November 2013. There are resources at the end. I’d like to conclude by saying that MDH encourages hospitals to register for its health reform list serve to receive weekly email updates. We use this
list serve to make announcements pertaining to SQRMAs and provider peer groupings. The SQRMS website contains information required measures and measurement specification which is under the adopted rule tab. Thank you for your time.

**Vicki Olson:**

I’m going to do a brief update on what was different this year with hospital measures recommendation process and then I’ll go into the measurement changes. First, is our usual process for MDH, as David mentioned, which identifies what the focus is and then the hospital steering committee identifies the potential measures and then we convene the team.

The steering committee usually reviews the measures and grading. We added a step this year that I’m going to talk about. The steering committee then has that team discussion and comes up with a final slate of measures, which are the recommendations that are provided to the Minnesota Department of Health. We have another additional process this year as well.

I’d like to highlight that through the process of looking at the measures, this year we added staff where we asked for input from expert groups. These were existing groups. They are groups that MDH convenes, the Department of Health convenes and Stratis Health convenes, so these were existing groups that had expertise in various areas.

The hospital quality reporting steering committee identified different measures and then both sent those measures to these groups for specific recommendations and also more generally asked for recommendations, for either additions, modifications or deletions of measures. That feedback from the expert groups was then brought into the discussion and the slate of measures was recommended.

After that recommendation process there was a question about some of the arc measures. The steering committee had recommended deletion of quite a few of the AHRQs agency for health quality and research measures, mainly because those measures claim space they generally don’t include risk adjustment to the same level as with the chart abstracted measures. There can be some volume issues and for that reason it’s recommended to align with many of the CMS changes of reducing the number of the arc measures that are in the Minnesota’s plate of hospital measures.

We did an additional analysis, which included going through each of the measures and looking to see if they were endorsed by the National Quality Forums, if CMS was requiring that measure. HRQ has done some analysis as to whether those specific measures are helpful for comparison between hospitals from the measures they feel aren’t at that level, so we used their guidance on that.

We looked at some of the volume issues, the number of hospitals, impact of patient volume and additional considerations. From that we decided to keep five measures that the steering committee recommended be removed, we decided to leave those in. Two had to do with OB measures. Two were pediatric measures. Those have been recommended in previous years from specific groups, so we really wanted those groups to weigh in before those were formally removed. One measure was a composite measure IQI 91, mortality first selected by the co-conditions.

Generally, we’re leaving in the composite measures because they are a bit more robust and don’t have the same volume issues and include multiple conditions, in terms of 13:13 and both have been found to be more helpful. Based on that then gave that additional analysis to the Department of Health as part of the recommendations.

That goes through the specific changes to the measures that would be collected in 2014. So PCO 1 elected to 13:41 prior to 39 complete a week’s gestation and have been required for PPS hospitals starting in 2013, and it would now be added in 2014 for critical access hospitals.
So those PPS hospitals were already reporting. It would go into effect for third quarter discharges or starting July 1, 2013, but critical access hospitals would start with January 1, 2014 discharges. The second measure Al will be going over, the time to intravenous therapy for stroke patients and that will start January 1, 2014 discharges.

So two measures had already been removed as of May 2013, so we started the process of trying to do interim changes when there is an alignment with CMS, so these two measures have been removed by CMS, VTE 1 & 2 and OPE 16. VTE 1 was removed by CMS because it felt like it was redundant. VTE 2 and OPE 16, the true results, have been some concerns about screening tests that have been used that were giving false/positive and felt like it was a patient safety issue and this was also removed.

Additionally, the children’s asthma care is removed and this is also taking effect as of July 1, 2013. There would be no reporting of that measure for 2014 reporting. The reason for that was that the volume was so low, so one of the criteria the steering committee was looking at was the volume and even some of the large health systems and adding all the hospitals together as part of that system had very low volume and the steering committee also recommend this be removed.

There have been many changes that CMS has made, particularly to the process measures, so as naturally they are moving towards more outcome measures and eliminating process measures, these were all CMS measures that had been removed and in keeping with that alignment goal, these are also removed from the Minnesota slate of measures.

The appropriate care measures are all or none measures and have been in existence from the inception of the SQRMS process. What’s happened with the process measures with those being eliminated, there aren’t enough measures to do an all or none for the AMI heart failure pneumonia, and for that reason these measures have also been eliminated from the slate of measures.

Next are the arc measures that were the final measures that are being removed. Several of these are part of the PSI and so they are part of a composite measure, but the rest are being removed. The feedback for the critical access hospitals as we’ve solicited input into the recommendations process was that for critical access hospitals they felt like the inpatient emergency department throughput was less of value for the information and also because of the data burden. For that reason this measure has been changed to voluntary data collection for critical access hospitals.

It is a CMS required measure for PPS hospitals, so they will continue to report that and also for the state measures, but for critical access hospitals this is voluntary and that would go into effect for third quarter 2013 discharges. Therefore, there will be no reporting of this measure required in 2014.

The specifications for the emergency department transfer communication is a measure that’s part of the Medicare beneficiary quality improvement program and critical access hospitals are the only hospitals that are required to report this. There have been some changes to the scope of this measure as MV clip is rolling this measure out nationally. We will be reviewing this at the January 29, critical access core measure meeting, so you will get more detail there but generally the change is to increase the scope so it doesn’t affect the acute care transfers, it’s all transfers from EDs from critical access hospitals.

In addition, to reduce the data burden we have put the plan in place and the specifications manual has also been updated so that the format aligns with CMS and it’s easier to find specific information. In addition, an Excel tool has been developed while data submission will still happen through the MHA website, but there’s now an Excel tool that will do more behind the scenes calculations for you, so as you enter
the patient data into the tool it will summarize it for you and make it easier to do the reporting to MHA.

These are some of the areas that were identified by the steering committee for future discussions, so these will be areas that will specifically be asking for input this next year…

- CMS stroke measures,
- VTE,
- readmissions,
- behavioral mental health,
- near sensitive conditions, and
- safety culture and infections

Here are some additional resources for you. These were also identified in the email that was sent out on Monday related to the summary of the changes in the statewide quality reporting and measurement system. The SQRMs timeline is on the Stratis Health website. The 2014 hospital measure summary, the document that we update during the year but then put out the final version, that’s been updated this week and is available also on the Stratis Health website.

There is also the ED transfer communication measurement guide that has the specifications that we’ll be reviewing at the core measures meeting for critical access hospitals on 1/29.

In the chat box there’s a question on the new medication measure that’s submitted to MDH, the office of health and primary care. We will be reviewing that also at the core measure meeting because that’s not part of the Minnesota slate of measures but is a measure related to MB clip for critical access hospitals and that measure is the CTOE verification of medication orders by a pharmacist within 24 hours. So because it’s not part of SQRMs or this presentation, but you will find it on the 2014 hospital measure summary and we will go over that also at the 1/29 meeting.

Another question… is the new measure required from critical access hospitals? The answer is yes it will be.

The emergency room department transfer communication for all transfers, it says only for transfers from the ED to all types of facilities and yes, it would not be inpatient transfers it would be ED transfers, but would include transfers to nursing homes and other facilities.

Another question is… will the ER transfer measures stay the same but have a different way to report? Other than that increased scope including additional transfers, the measures are essentially the same. There are seven. They’re all or none measures and the reporting will actually stay the same too, where you will go to the MHA website exactly as you do now and report the numerator and denominator. It’s just that there’s an additional tool to help you get to that numerator and denominator.

How did these measures align with primary care? The Minnesota Community Measures come from care quality measures as well as home care.

**Deana Welbrack:** Hi, this is Deana with Minnesota Community Measurement. These measures specific to a hospital, there are some measures as well and I think this question is referring to home health clinics. Vicki, I’m interpreting it that way. They are unique to the hospital setting versus the home healthcare setting. I know that through the Minnesota Department of Health there is the home healthcare portal and measurement system that is being setup.
I wouldn’t necessarily say that they’re the same at this time, but that long range we are always working with the Minnesota Department of Health to coordinate measures.

**Denise McCabe:** Hi, from the Minnesota Department of Health, and Deana thank you that’s accurate. I think those measures that someone entered into the chat were about healthcare homes and those are clinic measures, whereas the scope of this presentation is hospital measures.

**Vicki Olson:** Because there is a lot of communication that happens between Minnesota Community Measurements and the Minnesota Department of Health, the Hospital Association and Stratis Health, measures that relate to the clinic are part of the statewide quality reporting measurement system, so certainly there is an awareness of the big picture.

The next question is will Stratis email out an updated chart of measures? We did them on Monday as part of the overall statewide quality reporting and measurement email. We can send out the chart to our core measures group as well. It's on the Stratis Health website in addition and we'll be reviewing that as well at the core measures meeting.

Where do critical access hospitals report PCO1? That will be through CMS. It's a web-based measure so as you’re reporting CMS measures there will be the capability to enter that and also quality net.

We currently report PCO1 to quality net, both the state obtained status from quality net or will we double report? Because the information flows through hospital compare, you will not need to double report. That data will become public and through that public reporting the information is compiled and is part of SQRMs.

ED transfers to a nursing home; only new nursing home admissions or does it include transferring a patient back to the nursing home? It would include all transfers, as long as that patient was an ED patient and was transferring out, whether there’s a new home transfer or if they were going back to their same home. It would be the same.

No more submission of AMI heart failure or pneumonia measures in 2014? Even though the all or none, which is actually a calculation, that those have been eliminated. There are still measures in those three conditions that will continue to be reported. There are two AMI measures, 7a and 8a, and one heart measure evaluation of LVF function and one pneumonia measure, initial antibiotic selection for community acquired pneumonia and immuno competent patient.

Another question regarding not receiving the email I sent on Monday. If you didn’t receive the email, you can contact Mary Montoury and we can resend that to you.

Are there any exclusion's to reporting at PCO1 elective delivery? There are and Robin will go through PCO1 in the core measure meeting on 1/29. You will get more information there. It will be part of the manual as well but I can’t talk about it off the top of my head.

With that I’m going to pass it to Al Tsai to talk about the new stroke measures.

**Al Tsai:** Hi Vicki and good afternoon to everyone. I’m the program director for the Minnesota Registry Program and here at the Minnesota Department of Health, I’ve been asked to administer the stroke related measure. We have a new measure and I’d like to spend a few minutes giving everybody a short overview of some of the changes.
Before moving forward I'll preface this by saying that we do have a data submission guide available to everyone, which will have all of this information in much greater detail, so if you miss something or don’t think of a question you can refer to that and contact any of us with your questions.

I want to make one clarification that I saw in an earlier slide and that is that these measures would be required for discharges starting in January, but we are requiring the stroke measures to be reported for discharges beginning Q3 2013, so please note that.

Most of you are very well aware that we’ve been collecting on the door to imaging less than 25 minutes measure. That will continue. Nothing has changed with that so when we look at our data many hospitals are way up to date on that. The new measure here is to tend to IV thrombolytic therapy, which is also referred to as IV TPA or door to needle time is the most common way people refer to it, but those are all interchangeable.

I just want to remind people that the NIH stroke scale had an evaluation measure that was dropped in 2011/2012. The goal for this measure is door to needle time is less than 60 minutes and this is the American Heart Association target stroke programs goal. It’s also a 32:25… coalition. We’re also using this measure or metric to measure the impact of our pending role out of our Minnesota statewide stroke system. It’s very much a common measure nationally and we’ll be reporting it at the percentage that meets this time goal.

The inclusions for this measure are those that have a scan stroke TIA or classify with a stock not otherwise specified or if they’re been discharged from your ED or facility with an IC9 code, which is a typical stroke code. We’ve done some correlational analysis of these two variables, the IC9 code and final code diagnosis. It’s very close, but sometimes ischemic strokes are noted on the medical record as a stroke but you don’t get an IC9 discharge code and vice versa. Very infrequently it happens but that’s why we ask you to look at both your discharge notes and IC9 billing records.

So it’s included in, of those that have ischemic strokes yes they were stroking out otherwise, best advice. And, for this measure there was a received IV TPA at your hospital. Here are the exclusions, which are very similar to the door to imaging one but there are some slight differences. These are specific to the door to needle time to IV TPA measure. Must be age less than 18 otherwise they’re excluded. They are excluded if admitted solely for elective credit and must be age less than 18 otherwise they’re excluded. They are excluded if admitted solely for elective credit and 34:23. If they were enrolled for a clinical trial related to stroke or if they’re an in-hospital stroke they’re excluded. If any of the following are missing or unknown, so when they arrived in the ED, if their time last known well was missing or if their date and time of TPA administration isn’t in the record, those will all exclude those patients.

If the patient received TPA greater than 4 ½ hrs after the less than well time, those should also be excluded. Finally, if there’s a documented reason of eligibility or medical reason, if there’s a delay in the treatment, so if the patient received TPA in more than 60 minutes after arrival but there was a reason that was documented in the record, that patient also will be excluded from the denominator.

I just wanted to mention that there are a few other exclusions in the door to imaging measure that do not apply to this new kind of IV TPA measure. They are listed. If the patient expired in the ED, received comfort care while in the ED. If the last known well time was greater than 3 ½ hours to arrival. If the symptoms resolved or if they were a transfer to your facility those are all exclusions for the door to imaging measure but not for the IV TPA measurement.

Now we’ll move on to the data submission method. Hopefully you’re all familiar with this URL. You login to the Minnesota stroke registry tool and to give you a little heads up.
The security new URL is stroke.mn.gov and we’re calling it Minnesota Stroke Central and if you put that into your browser and bookmark it, that should direct you to the new page which will be up shortly. This will be our new landing page for all things stroke data related. So, if you’re part of the stroke registry program than this is the same place where you’ll be entering your data and submitting your SQRMs data related to stroke.

Then, once we roll out our statewide stroke system, we’ll be launching an electronic application for designation and this is where you’ll do that as well. If you don’t have an account or don’t know who has an account, please contact me and we can get you that information straight away.

You’ll see on the URL that once you login you’ll see that there are one of three types of accounts. First is if you’re a participating hospital of the Minnesota Stroke Registry program and that means you either use this tool to answer your data directly or you use the guideline patient management tool. For hospitals that are participating in that program there will be no change at all. Don’t change anything you’re doing fine.

For most of you who are using this tool, your version of it is called AMSRT Quality, there are three data elements, which are the ones listed in the slides. Did the patient receive IV TPA at your hospital? If so, what time? If they received it more than 60 minutes after arrival, was there a reason for that delay? I’ve provided a screenshot of the data entry form. There are three data elements at the very bottom of the screen, which we’ve already added. They are ready to go for you.

Very few hospitals are using a version of the tool called MSRT summary, where they enter in numerators and denominators for each quarter. What we’ve done is we’ve added those data fields and what I’ve shown on this first slide door to needle, it’s actually labeled DTN. You simply put your time period at the top for the period you want to report on and then enter the numerator and denominator for each measure.

We’ve kept the NIH stroke scale measure for those who are still behind on data collection. That last component at the end will be taken offline as well.

That’s a basic overview. I wanted to circle back and mention that we do have a data submission guide that’s available from the resources section of the tool and we’ll put that out somewhere else online, but if you can’t find that contact me and I’ll make sure you get it straight away.

Vicki Olson: Thanks Al. There is one question. Is the MD race to diagnosis of TIA and the patient meets the criteria for TPA, age, timeframe, etc and TPA isn’t given, does this record fall out?

Al Tsai: If TPA is not given? The denominator only includes those patients that received TPA, so yes that patient would be excluded from the measure.

Vicki Olson: Okay. Another question being asked is… How can we change which report we’re using to submit information? I’m assuming they’re talking about the stroke registry options and if that’s what’s being asked, Al, how would you switch to a different application?

Al Tsai: They need to contact me by either email or by phone where we can make that change in the system manually. It has to be done through that mechanism.

Vicki Olson: Thank you.

Julie had a question about the memo from MDH dated 12/9 that states, the data line, the removal date for six hospital measures where the hospitals report on these during the first half of 2014.
Therefore, the question is, do we still need to report these for the first half of 2014 or will these end with 2013, just try again? The answer is yes you will continue to report. For those to be clear measures, the idea was to align with CMS and CMS is removing those as of 2014 discharges, so you would still collect that data and submit it for third and fourth quarter of 2013, February and May submission dates.

For Dan, my patients put in observation do not need to be extracted? I’m assuming that’s for the ED transfer communication measure? If it is then they wouldn’t be included.

Al Tsai: If I remember off the top of my head, those patients are excluded by choice. You don’t have to abstract those patients.

Janelle Thompson: Just going back to the other presentation. We were wondering, what is the nurse sensitive condition?

Mark: That would be, and I’m somewhat doing this off the top of my head, but it would be the deaths with patients that had serious treatable complications for surgical patients.

Vicki Olson: It is harmonized with PSO4, death among surgical patients. It’s a pain measure correct?

Mark: Yes.

Vicki Olson: So it is a claims based measure and if you were to go to the arch site then you would see the specifications, the HRQ agency for health care research and quality. If you went to that website you would see specifications for that particular measure.

Janelle Thompson: We’re just trying to make the connection between the wording of nurse sensitive condition and that measure. Thank you.

Vicki Olson: I think what’s identified in that specification are particular conditions that they feel like are sensitive to nursing care and how quickly the patient is intervened, so they’ve identified various conditions that would relate to things like they feel nursing could impact.

Mark: Yes and there’s another organization NDNQI, which is another organization that has some nurse sensitive conditions and that is the one we’re talking about, that’s surgical patients with serious treatable complications is one that NDNQI lists as nurse sensitive. That’s where that’s coming from.

Vicki Olson: If there are no more questions then we’ll wrap up this webinar. You’ll find in the slides information related to contact and any of us are available if you have additional questions that come up. Again, as I mentioned, we’ll have more conversations at the core measure meeting.

Mary will be sending out evaluations and we appreciate your feedback. I hope you all stay warm. This concludes today’s call.

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