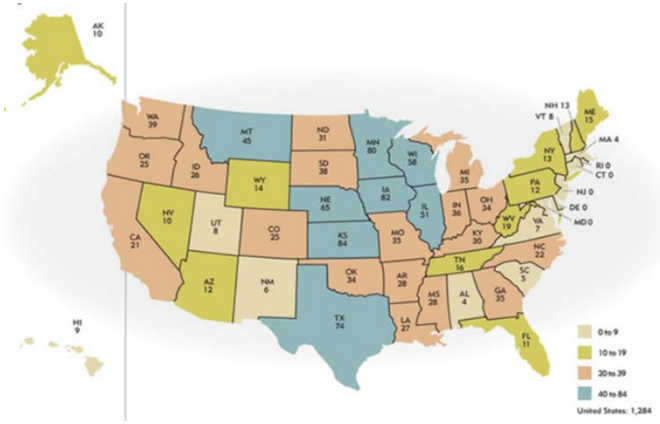

MBQIP Benchmarking

April 28, 2016

Mary Guyot

Principal

207-650-5830 (C)

mguyot@stroudwater.com

West Virginia Hospital Association

West Virginia Critical Access Hospital Network Association

Stroudwater

Agenda

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8:45 AM Welcome and Introductions

9:00 AM Managing the CMS Measure Specification Manual
MBQIP Status of New Measures, Discussion of Challenges and Processes
- OP-20 - Door to diagnostic evaluation by a qualified medical prof.
- OP-21 - Median time to pain management for long bone fracture
- OP-22 - Patient left without being seen
- OP-27 - Influenza vaccination coverage among healthcare personnel
- IMM-2 - IP Influenza immunization

10:30 AM Break

10:45 AM Newly added measure / OP-18
Updated Reporting Timeline

11:00 AM OP-1, OP-2, OP-3, OP-4, OP-5 and EDTC Benchmarking

11:45 AM WVHA Flex Coordination Needs Assessment for 2016-2017
Facilitated by Dianna Iobst

12:00 PM Networking Lunch and continued discussion re: 2016-2017

Agenda

STROUDWATER

12:00 PM	Networking Lunch and continued discussion re: 2016-2017
1:00 PM	Action Plan update & discussion Discuss what will be expected from each hospital regarding final action plan
2:10 PM	Review of StratisHealth and Rural Quality Improvement Technical Assistance (RQITA) Team Resources and Tools
2:30 PM	10 min break
2:40 PM	New Measure MBQIP Readiness Survey
3:00 PM	Closing – Next Mtg./July 28 with concentration on HCAHPS + potentially ½ day on the 29th for topic of interest such as: Discharge Planning CoP (Final Rule), Growing SB utilization, Session on SB Q&A other…
3:15 PM	Eval and Adjourn – Safe trip

8:45 – 9:00

Self-Introduction:

1. **Hospital**
2. **Name**
3. **Title**
4. **One thing you are thankful for**

9:00 – 10:30

Managing the CMS Measures Specification Manual

Know where to go look

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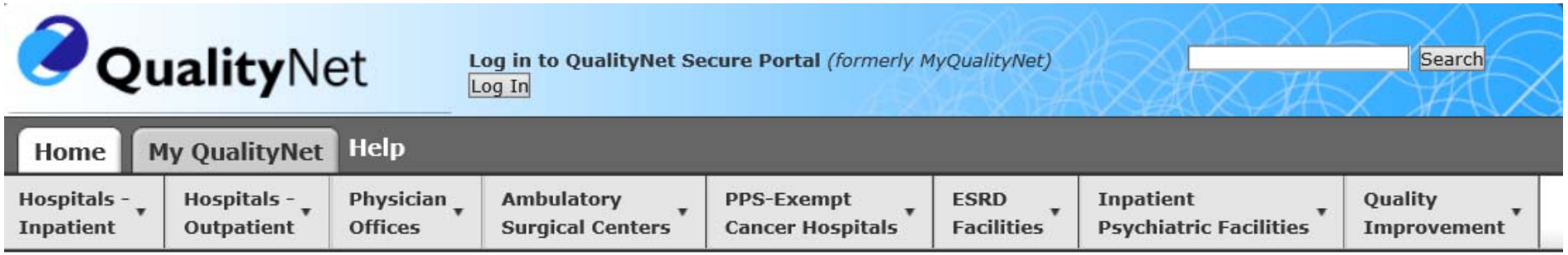
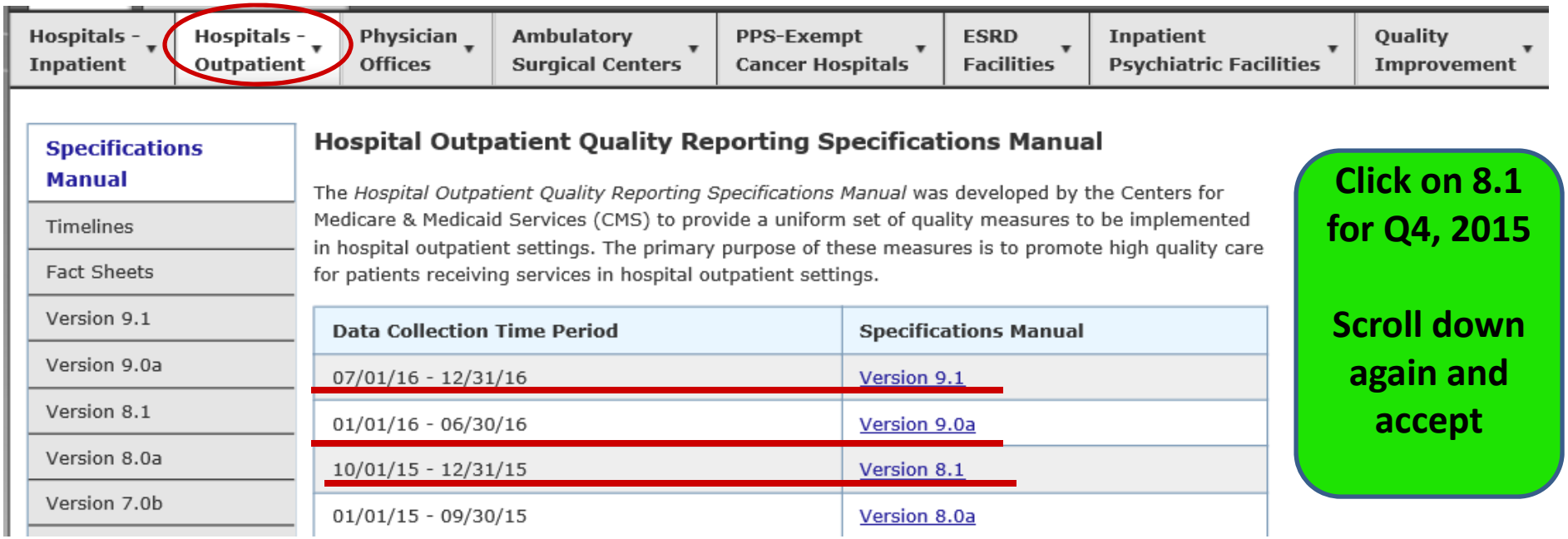
http://www.qualitynet.org/dcs/ContentServer?pagename=QnetPublic/Page/SpecsManualLicense



Scroll down and click on Accept Don't Accept



Click on 8.1 for Q4, 2015

Scroll down again and accept

Know where to go look

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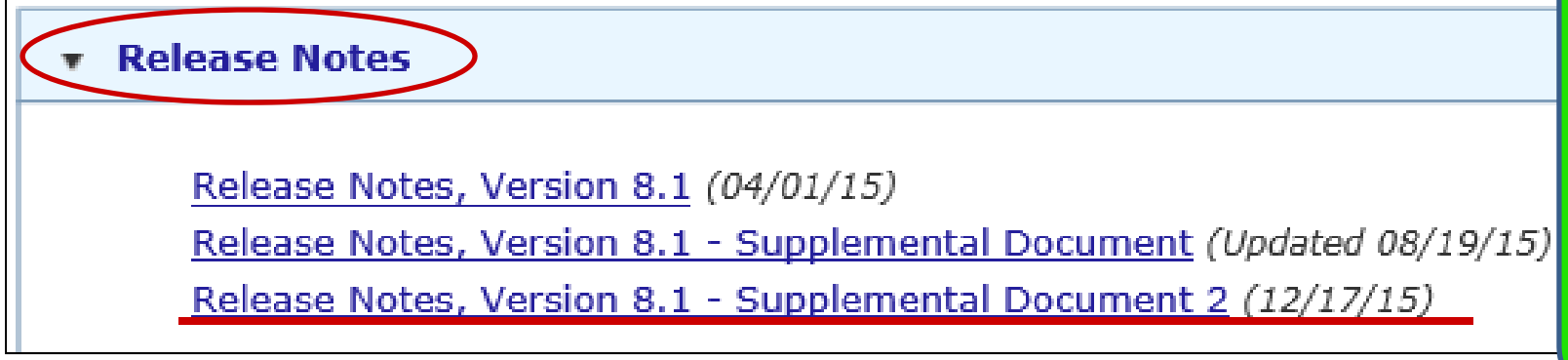
Hospital Outpatient Quality Reporting Specifications Manual, v8.1

For use in submitting data for encounters from **10/01/15 through 12/31/15**.

View and/or download individual sections of the Specifications Manual, (PDF documents, unless noted), listed below.

- Release Notes
- Introductory Materials
- Section 1 – Measure Information
- Section 2 – Data Dictionary
- Section 3 – Missing and Invalid Data
- Section 4 – Population and Sampling Specifications
- Section 5 – Hospital Outpatient Department Quality Measure Data Transmission
- Appendices
- Download Entire Manual

Know where to go look



Replace these tables in Appendix if you have printed the manual Share with report writer (IT or HIM)

Impacts: OP-1, OP-2, OP-3, OP-4, OP-5, OP-18, OP-21, OP-23
Rationale: These changes reflect revisions to the list of ICD-10 CM Diagnosis Codes used to identify patient population. - Description of Change(s):
Appendix A Table 1.1: Acute Myocardial Infarction (AMI) Diagnosis Codes
Remove current table and replace with new table. Refer to Hospital OQR Specifications Manual to review new table.
Appendix A **Table 1.1a: Chest Pain, Angina, Acute Coronary Syndrome Codes Remove** current table and replace with new table. Refer to Hospital OQR Specifications Manual to review new table.
Appendix A **Table 7.01: Mental Disorders**
Remove current table and replace with new table. Refer to Hospital OQR Specifications Manual to review new table.
Appendix A **Table 8.0: Ischemic and Hemorrhagic Stroke**
Remove current table and replace with new table. Refer to Hospital OQR Specifications Manual to review new table.
Appendix A **Table 9.0: Long Bone Fracture**
Remove current table and replace with new table. Refer to Hospital OQR Specifications Manual to review new table.

Know where to go look

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Introductory Materials

Table of Contents
Acknowledgement
Introduction
Using the Manual
Delivery Settings

Section 1 – Measure Information

Introduction

1.1 - Outpatient Acute Myocardial Infarction (AMI)

AMI Measure Set
AMI General Data Element List
AMI Specific Data Element List
AMI Population Algorithms
Measurement Information Form (MIF) and Flowchart (Algorithms)
(OP-1, OP-2, OP-3, OP-4, OP-5)

Note: Measurement Information Forms (MIFs) OP-4 and OP-5 are used for both AMI and Chest Pain.

1.2 - Chest Pain (CP)

CP Measure Set
CP General Data Element List
CP Data Element List
CP Population Algorithm
Measurement Information Form (MIF) and Flowchart (Algorithms)
(OP-4, OP-5)

1.3 - Emergency Department (ED)-Throughput

ED-Throughput Measure Set
ED-Throughput General Data Element List
ED-Throughput Specific Data Element List
ED-Throughput Population Algorithm
Measurement Information Form (MIF) and Flowchart (Algorithms)
(OP-18, OP-20, OP-22)

1.4 - Pain Management

Pain Management Measure Set
Pain Management General Data Element List
Pain Management Specific Data Element List
Pain Management Population Algorithm
Measurement Information Form (MIF) and Flowchart (Algorithms)
(OP-21)

Click on each "Measure Set" for list of sub-measures, general and specific data elements, algorithm (drawing and description)

It will refer to charts which you must review in Appendix to get the full picture

Know where to go look

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- **Section 2 – Data Dictionary**

Data Dictionary and General Abstraction Guidelines

- Introduction
- Interpretation of Data Dictionary Terms
- Data Dictionary Terms
- General Abstraction Guidelines

Alphabetical Data Dictionary

List of elements you will need to have access to from the medical record to abstract and for what measures does each element apply to

Alphabetical Data Element List

NOTE: Click on element name in list below to go to specified data element. *To be returned to the list, click data element name on any page.*

Element Name	Page #	Collected For:
Arrival Time	2-9	All Records
Aspirin Received	2-12	OP-4
Birthdate	2-14	All Records
Date Last Known Well	2-15	OP-23
Discharge Code	2-17	OP-1, OP-2, OP-3, OP-4, OP-5, OP-18, OP-20, OP-21, OP-23
E/M Code	2-19	OP-1, OP-2, OP-3, OP-4, OP-5, OP-18, OP-20, OP-21, OP-23
ECG	2-20	OP-5
ECG Date	2-21	OP-5
ECG Time	2-23	OP-5
ED Departure Date	2-25	OP-3, OP-18
ED Departure Time	2-27	OP-3, OP-18
Fibrinolytic Administration	2-30	OP-1, OP-2, OP-3
Fibrinolytic Administration Date	2-31	OP-1, OP-2
Fibrinolytic Administration Time	2-33	OP-1, OP-2
First Name	2-35	All Records
Head CT or MRI Scan Interpretation Date	2-36	OP-23
Head CT or MRI Scan Interpretation Time	2-38	OP-23
Head CT or MRI Scan Order	2-40	OP-23
Hispanic Ethnicity	2-41	All Records

Know where to go look

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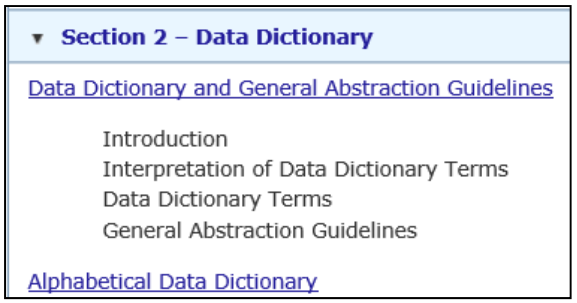

Data Dictionary (continued)

ICD-10-CM Other Diagnosis Codes	2-42	OP-4, OP-5
ICD-10-CM Principal Diagnosis Code	2-43	OP-1, OP-2, OP-3, OP-4, OP-5, OP-18, OP-21, OP-23
Initial ECG Interpretation	2-44	OP-1, OP-2, OP-3
Last Known Well	2-48	OP-23
Last Name	2-50	All Records
Outpatient Encounter Date	2-51	All Records
Pain Medication	2-52	OP-21
Pain Medication Date	2-54	OP-21
Pain Medication Time	2-56	OP-21
Patient HIC#	2-58	Collected by CMS for patients with a Payment Source of Medicare who have a standard HIC number
Patient Identifier	2-60	All Records
Payment Source	2-61	All Records
Physician 1	2-62	Optional for All Records
Physician 2	2-63	Optional for All Records
Postal Code	2-64	All Records

Element Name	Page #	Collected For:
Probable Cardiac Chest Pain	2-65	OP-4, OP-5
Provider Contact Date	2-67	OP-20
Provider Contact Time	2-69	OP-20
Race	2-71	All Records
Reason for Delay in Fibrinolytic Therapy	2-73	OP-1, OP-2
Reason for No Aspirin on Arrival	2-76	OP-4
Reason for Not Administering Fibrinolytic Therapy	2-78	OP-3
Sex	2-80	All Records
Time Last Known Well	2-81	OP-23
Transfer for Acute Coronary Intervention	2-84	OP-3

Know where to go look

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Section 3 – Missing and Invalid Data

Unable to be Determined (UTD) and Missing/Invalid Values

- Introduction
- Data Collection and the UTD Allowable Value
- Missing and Invalid Data
- Abstraction Software Skip Logic and Missing Data

Section 4 – Population and Sampling Specifications

Population, Sampling and Transmission

- Introduction
- Order of Data Flow
- Sample Size Requirements
- Sampling Approaches
- Transmission of Outpatient Population and Sample Data Elements

Section 5 – Hospital Outpatient Department Quality Measure Data Transmission

- Introduction and Guidelines for Submission of Data
- Transmission Data Element List and Transmission Data Element Pages
- Transmission Data Processing Flow
- Hospital Outpatient Clinical Data XML File Layout, XLSX
- Hospital Outpatient Population Data XML File Layout, XLSX

Know where to go look

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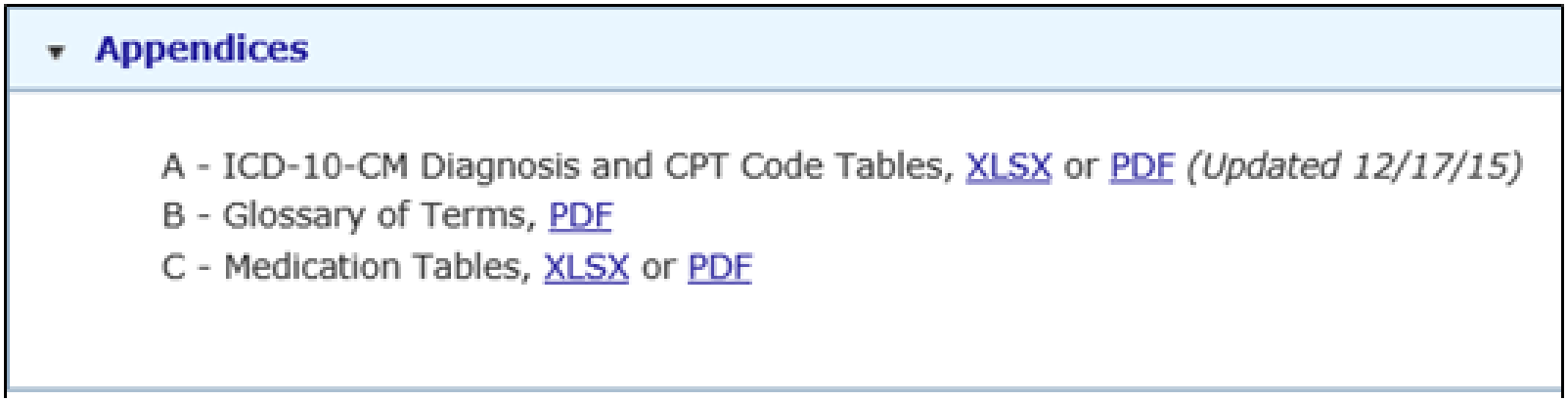

Click on A for Excel or PDF of the ICD-10-CM Diagnosis and CPT code tables:

OP Table 1.0: E/M Codes for Emergency Department Encounters

OP Table 1.1: Acute Myocardial Infarction (AMI) Diagnosis Codes

OP Table 1.1a: Chest Pain, Angina, Acute Coronary Syndrome Codes

OP Table 7.01: Mental Disorders

OP Table 8.0: Ischemic and Hemorrhagic Stroke

OP Table 9.0: Long Bone Fracture

Share the Data Dictionary with IT and/or HIM for report writing.

Know where to go look

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Appendices **(continued)**

A - ICD-10-CM Diagnosis and CPT Code Tables, XLSX or PDF *(Updated 12/17/15)*
B - Glossary of Terms, PDF
C - Medication Tables, XLSX or PDF

Click on B for PDF for Glossary of Terms
Click on C for Excel or PDF for the Medication Tables that apply to some of the core measures

Note: The medication tables are not meant to be inclusive lists of all available therapeutic agents. Discrepancies must be reported.

Index

Number	Name	Page
Table 1.1	Aspirin and Aspirin-Containing Medications	Appendix C-1
Table 1.2	Warfarin	Appendix C-2
Table 1.3	Fibrinolytic Agents	Appendix C-2
Table 9.1	Analgesic Medications	Appendix C-3

Download Entire Manual

Download Entire Manual, ZIP or EXE *(Updated 12/17/15)*

Download, print & update prn or place in favorites for easy access

Are we ready for the next phase

MBQIP
Open Discussion of Challenges and Processes

OP-20 - Door to diagnostic evaluation by a qualified medical prof.
OP-21 - Median time to pain management for long bone fracture
OP-22 - Patient left without being seen
OP-27 - Influenza vaccination coverage among healthcare personnel
IMM-2 - IP Influenza immunization

(Facilitated by Mary Guyot)

OP-20: Door to diagnostic evaluation by a qualified medical professional

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- Any issues with tracking this information for OP-20?
  - Arrival Time (greet time, quick reg. – paper or electronic)
    - **Note**: Arrival time should NOT be abstracted simply as the earliest time in one of the Only Acceptable Sources, without regard to other substantiating documentation. When looking at the Only Acceptable Sources, if the earliest time or later time documented appears to be an obvious error, this time should not be abstracted.
  - Outpatient Encounter Date (ED visit registration date)
  - Discharge Code (every ED visits except for those who expired)
  - Provider Contact Date
  - E/M Code (that demonstrates an ED visit vs other OP visits)
  - Provider Contact Time (in person visit time in triage or ED exam room – not necessarily documentation time from MD/DO/PA/APN)

- Ready to report to CART/Vendor for Q4, 2015 on June 1, 2016?

OP-20: Door to diagnostic evaluation by a qualified medical professional

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- Do you know what was your time for “door to healthcare medical professional” in:
  - Oct, Nov, Dec 2015 and
  - Jan and Feb 2016
- FYI – Hospital Compare reports the National Average for the time from door to seeing a provider in ED as:
  - High Volume ED = 33 minutes
  - Medium Volume ED = 26 minutes
  - Stroudwater’s experience with rural hospitals dedication to improve this timing are down to 15 + min

Any last points of discussion, recommendations etc

OP-21: Median time to pain management for long bone fracture

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- Any issues with tracking this information for OP-21?
  - E/M Code for an ED encounter (see next slide)
  - Outpatient Encounter Date (ED visit registration date)
  - Birthdate - >= 2 years (2 y.o or older only)
  - Patients with Pain Medication (see next slides)
  - [ICD-10-CM] Principal Diagnosis Code for Long Bone Fracture as defined in Appendix A, OP Table 9.0
    - See Q-Net Hospital Outpatient Quality Reporting Specifications Manual, v8.1 for Q4, 2015 and V9.0 for Q1 and 2, 2016 (at this time)
  - http://www.qualitynet.org/dcs/ContentServer?pagename=QnetPublic/Page/SpecsManualLicense

- **E/M Code Definition**: The code used to report evaluation and management services provided in the hospital outpatient department clinic or emergency department.

OP-21: Median time to pain management for long bone fracture

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- E/M (Evaluation & Management) Code for an ED encounter
  - Every ED visit should have an E/M if it is truly an ED Visit evidenced by ED registration – ED E/M code is required to bill the ED visit
  - The provider sees the patient and documents the chief complaint, HPI (history of present illness - how the injury happened, when, what else may be bothering the patient etc), examining the patient and ordering the radiology exams?
  - If all this is happening, then the E/M has been performed.
  - Exception - If the patient is sent to ED after being seen by a community provider who will bill an E/M code and the ED provider only orders/reads the X-ray, then no, don't bill a visit

- Excluded Population
  - Patients less than 2 years of age
  - Patients who expired
  - Patients who left the emergency department against medical advice or discontinued care

OP-21: Median time to pain management for long bone fracture

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- **Notes for Abstraction for Patients with Pain Medication**
  - For patients **aged 2 to less than 18 years**, if **oral**, intranasal, or parenteral pain medication (including anesthesia/analgesia) is administered, answer "Yes."
  - For patients aged 18 years or greater, if intranasal or parenteral pain medication (including anesthesia/analgesia) is administered, select "Yes." –
    EXCEPTION: For patients aged 18 years or greater, if initial medication administration is oral, select "No."
  - There must be documentation in the medical record the medication was administered in the emergency department, not just ordered.
  - There must be documentation in the medical record of the medication route either in the physician orders or the medication administration documentation.
  - Medication administration documentation must include the signature or initials of the person administering the medication

OP-21: Median time to pain management for long bone fracture

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- **Notes for Abstraction for Patients with Pain Medication (cont')**
  - If there is documentation in the medical record the patient received pain medication (e.g., self- administration, physician's office, or ambulance) prior to arrival, select "No."
  - If there is documentation of routine pain medications on the home medication list, it can be assumed these medications were taken within 24 hours prior to arrival. Select "No" to Pain Medication. EXCEPTION: If the pain medications are listed as taken on a PRN (as needed) basis, do not assume pain medications were taken within 24 hours prior to arrival unless there is documentation of administration in that time frame.
  - If there is physician/APN/PA or nursing documentation of a reason for not administering pain medication (e.g., patient unconscious, decreased respiratory rate, patient refusal), select "No."

- **Note:** Patient who **did not receive pain medication because there is documentation that they** received some before arriving to the ED, unconsciousness, low resp. rate, refusal, other conditions explaining oral etc… those will be abstracted but rejected for not meeting criteria therefore will fall out from the report. (will not be a negative for your hospital)

OP-21: Median time to pain management for long bone fracture

STROUDWATER

- Ready to report to CART/Vendor for Q4, 2015 on June 1, 2016?

- Do you know what was your time for ED arrival to administration of pain medication in:

  Oct, Nov, Dec 2015 and
  Jan and Feb 2016

- FYI – Hospital Compare reports the National Average for the median time to pain management for long bone fracture to be at 58 minutes

OP-22: Patient Left ED Without Being Seen

STROUDWATER

- Any issues with tracking this information for OP-22?
  - Which of you were tracking this before MBQIP?
  - Track all patients who left the ED without being evaluated by a physician/APN/PA?
  - Needs to have been signed in (paper or electronic), pre-reg. – if they agree to be seen then they leave, they count
  - If they ask who the provider is working and refuse to be signed in then they do not count – they were never registered to be seen
  - If they pre-reg. then see the provider who is working and they choose to leave, they count
  - If they pre-reg. but then decide not to wait any longer and leave, they count
  - If they were seen by the provider and leave AMA, they do not count
    - To select AMA, there must be explicit documentation that the patient left against medical advice.
    - Examples: Progress notes state that patient requests to be discharged but that discharge was medically contraindicated at this time. Nursing notes reflect that patient left against medical advice and AMA papers were signed – these are AMA and not LWBS

OP-22: Patient Left ED Without Being Seen

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- Ready to report all of 2015 on May 15 via the QNet Online tool? **Note:** this originally was to be posted Nov. 2016

See QNet website for training material: https://www.qualitynet.org/dcs/ContentServer?c=Page&pagename=QnetPublic%2FPage%2FQnetTier2&cid=1196690015199

- Outpatient Quality Reporting (OQR) Web-Based Measures, WMV-16 min. (10/02/15)

Note: For OP-22, pick 2017 for the payment year. In general for CMS, the payment year is two years ahead of the reporting/data abstracting year. Its assumed that the other years of choice is for look back. Next year it will be payment year 2018 to report 2016…

OP-22: Patient Left ED Without Being Seen

STROUDWATER

- Who knows what was their time for left without being seen in 2015?
- What was your time for left without being seen in:
  Jan 2016? Feb 2016?
- FYI – Hospital Compare reports the National Average for patients leaving without being seen to be at 2%

OP-27: Influenza vaccination coverage among healthcare personnel

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- Denominator
  - Employee HCP: Staff on facility payroll
    - Defined as all persons that receive a direct paycheck from the healthcare facility (i.e., on the facility's payroll), regardless of clinical responsibility or patient contact
  - Non-Employee HCP: Licensed independent practitioners (physicians, advanced practice nurses, and physician assistants)
    - Defined as physicians (MD, DO); advanced practice nurses; and physician assistants only who are affiliated with the healthcare facility, but are not directly employed by it (i.e., they do not receive a paycheck from the facility), regardless of clinical responsibility or patient contact. Post-residency fellows are also included in this category.

OP-27: Influenza vaccination coverage among healthcare personnel

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- Denominator (cont')

  - Non-Employee HCP: Adult students/trainees and volunteers
    - Defined as adult students/trainees and volunteers: medical, nursing, or other health professional students, interns, medical residents, or volunteers aged 18 or older that are affiliated with the healthcare facility, but are not directly employed by it (i.e., they do not receive a paycheck from the facility), regardless of clinical responsibility or patient contact

  - HCPs must be physically present in the facility for at least 1 working day between October 1 through March 31

OP-27: Influenza vaccination coverage among healthcare personnel

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- Denominator Categories:
  - Non-Employee HCP: Other Contract Personnel **[Optional]**
  - Defined as persons providing care, treatment, or services at the facility through a contract

- Examples of non-employee include:
  - Contracted HCP can include the following direct care providers:
  - Chaplains
  - Dieticians
  - Dialysis technicians
  - EKG technicians
  - EMG technicians
  - Home health aides
  - Laboratory: Phlebotomists
  - Nurses (through agency and travel employers)

OP-27: Influenza vaccination coverage among healthcare personnel

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- Denominator Categories:
  - Non-Employee HCP: Other Contract Personnel **[Optional]**

- Examples of non-employee include: (continued)
  - Nursing aides
  - Occupational therapists
  - Patient care technicians
  - Pharmacists
  - Pharmacy/medication technicians
  - Physical therapists
  - Psychologists
  - Psych techs/Mental health workers
  - Radiology – X-ray technicians
  - Recreational therapists/Music therapists
  - Respiratory therapists

OP-27: Influenza vaccination coverage among healthcare personnel

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- Denominator Categories:
  - Non-Employee HCP: Other Contract Personnel **[Optional]**

- Examples of non-employee include: (continued)
  - Speech therapists
  - Social workers/Case managers
  - Surgical technicians
  - Ultrasound technicians
  - Contracted HCP can include the following non-direct providers:
  - Admitting staff/clerical support/registrars
  - Biomedical engineers
  - Central supply staff
  - Construction workers
  - Dietary/food service
  - IT staff

OP-27: Influenza vaccination coverage among healthcare personnel

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- The numerator includes HCP who received an influenza vaccination during the time from when the vaccine became available (e.g., August or September) through March 31 of the following year
  - Influenza vaccinations
  - Received at this healthcare facility or elsewhere
    - Acceptable forms of documentation from elsewhere include:
      - A signed statement or form, or an electronic form or e-mail from a healthcare worker (HCW) indicating when and where he/she received the influenza vaccine
      - A note, receipt, vaccination card, etc. from the outside vaccinating entity stating that the HCW received the influenza vaccine at that location
      - Verbal statements **are not** acceptable

OP-27: Influenza vaccination coverage among healthcare personnel

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- Medical contraindications
  - for inactivated influenza vaccine (IIV), accepted contraindications include:
  - (1) severe allergic reaction (e.g., anaphylaxis) after a previous vaccine dose or to a vaccine component, including egg protein; or
  - (2) history of Guillain-Barre Syndrome within 6 weeks after a previous influenza vaccination.
  - Note: HCP who have a medical contraindication to live attenuated influenza vaccine (LAIV) other than the medical contraindications listed above, should be offered IIV by their facility, if available
  - Documentation is not required for reporting a medical contraindication **(verbal statements are acceptable)**

OP-27: Influenza vaccination coverage among healthcare personnel

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- Declinations
  - HCP who declined to receive the influenza vaccine
    - Documentation is not required for reporting declinations (verbal statements are acceptable)
- Unknown status
  - HCP with unknown vaccination status (or criteria not met for above-mentioned categories)

OP-27: Influenza vaccination coverage among healthcare personnel

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- Counting HCP in the Hospital
  - Hospital inpatient and outpatient counts should be combined and submitted on a single influenza vaccination summary data form
  - Includes inpatient and outpatient units/departments that
    - Share the same CMS Certification Number (CCN) as the hospital and
    - Are affiliated with the specific acute care facility (such as sharing medical privileges or patients), regardless of distance from the acute care facility
    - This does not apply to outpatient renal dialysis facilities

OP-27: Influenza vaccination coverage among healthcare personnel

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- Facilities would not count HCP working in:
  - Separate outpatient satellite physician clinics (unless they also physically work in inpatient or outpatient units of the hospital for at least 1 day between October 1 through March 31)
  - Patient care units within the hospital having separate CCNs (unless they also physically work in inpatient or outpatient units of the hospital for at least 1 day between October 1 through March 31)
  - Patient care units in having separate CMS CCNs include, but may not be limited to:
    - Inpatient rehabilitation facilities (IRF)
    - Inpatient psychiatric facilities (IPF)
    - Long term acute care facilities (LTAC/LTCH)
    - Skilled nursing facilities (SNF)

OP-27: Influenza vaccination coverage among healthcare personnel

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- Most all information for OP-27 was obtained from the following site:

https://www.ruralcenter.org/tasc/resources/healthcare-professional-flu-measure-op-27-webinar

CAH Coordination Call Presentation [PDF - 2.84 MB]
Webinar Slides

Healthcare Personnel Flu Measure (OP-27) Reporting and Improvment for CAHs [PDF - 474 KB]
Webinar Questions & Answers

Webinar Recording [WEBEX 86min]
Note: You may need to download the Webex Player to view this webinar recording

OP-27: Influenza vaccination coverage among healthcare personnel

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- Were you participating in this prior to MBQIP? If so, what was your rate last year?
- If not, are you now all set up to report October 1, 2015 – March 31, 2016 vaccination rate on May 15 via the NHSN (National Healthcare Safety Network) website?
- Have you calculated your hospital's rate (%) yet? If so, what was it?
- FYI – Goal = 95% were vaccinated – present National Average is at 84%
- What is your process to get the highest %: policy, determine on who should be vaccination, designated champion, early start for promotion, gifts for early adopters etc…

IMM-2: IP Influenza immunization

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- Hospital Inpatient Measures - QNet
https://www.qualitynet.org/dcs/ContentServer?c=Page&pagename=QnetPublic%2FPage%2FQnetTier4&cid=1228775436944

Specifications Manual, Version 5.0b
For Discharges 10/01/2015 to 06/30/2016

Section 2.6 - Prevention
- 2.6.1 - Immunization (IMM)
- 2.6.2 - Substance Use (SUB)
- 2.6.3 - Tobacco Treatment (TOB)

IMM-2: IP Influenza immunization

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Appendices

- Appendix A - ICD-10 Code Tables
  - A.1 - PDF or XLS *(Updated 11/12/15)*
  - A.2 - *Reserved for future use*
- Appendix B - *Reserved for future use*
- Appendix C - Medication Tables PDF or XLS *(Updated 10/22/15)*
- Appendix D - Glossary of Terms *(Updated 10/22/15)*
- Appendix E - Overview of Measure Information Form And Flowchart Formats
- Appendix F - Measure Name Crosswalk
- Appendix G - Resources *(Updated 10/22/15)*
- Appendix H - Miscellaneous Tables *(Updated 10/22/15)*
- Appendix P - Preview Section

IMM-2: IP Influenza immunization

- **Performance Measure Name**: Influenza Immunization
- **Description:** This prevention measure addresses acute care hospitalized inpatients age 6 months and older who were screened for seasonal influenza immunization status and were vaccinated prior to discharge if indicated. The numerator captures two activities: screening and the intervention of vaccine administration when indicated. As a result, patients who had documented contraindications to the vaccine, patients who were offered and declined the vaccine and patients who received the vaccine during the current year's influenza season but prior to the current hospitalization are captured as numerator events.

IMM-2: IP Influenza immunization

STROUDWATER

- **Influenza (flu) is** an acute, contagious, viral infection of the nose, throat and lungs (respiratory illness) caused by influenza viruses. Outbreaks of seasonal influenza occur annually during late autumn and winter months although the timing and severity of outbreaks can vary substantially from year to year and community to community. Influenza activity most often peaks in February, but can peak rarely as early as November and as late as April. In order to protect as many people as possible before influenza activity increases, most flu-vaccine is administered in September through November, but vaccine is recommended to be administered throughout the influenza season as well. Because the flu vaccine usually first becomes available in September, health systems can usually meet public and patient needs for vaccination in advance of widespread influenza circulation.

IMM-2: IP Influenza immunization

STROUDWATER

- **Rationale**: Up to 1 in 5 people in the United States get influenza every season (CDC, Key Facts). Each year an average of approximately 226,000 people in the US are hospitalized with complications from influenza and between 3,000 and 49,000 die from the disease and its complications (Thompson WW, JAMA). Combined with pneumonia, influenza is the nation's 8th leading cause of death (Minino, 2004 National Center for Health Statistics). Up to two-thirds of all deaths attributable to pneumonia and influenza occur in the population of patients that have been hospitalized during flu season regardless of age (Fedson). The Advisory Committee on Immunization Practices (ACIP) recommends seasonal influenza vaccination for all persons 6 months of age and older to highlight the importance of preventing influenza. Vaccination is associated with reductions in influenza among all age groups (CDC Press Release February 24, 2010).
- The influenza vaccination is the most effective method for preventing influenza virus infection and its potentially severe complications. Screening and vaccination of inpatients is recommended, but hospitalization is an underutilized opportunity to provide vaccination to persons 6 months of age or older.

IMM-2: IP Influenza immunization

STROUDWATER

- The influenza vaccination is the most effective method for preventing influenza virus infection and its potentially severe complications. Screening and vaccination of inpatients is recommended, but hospitalization is an underutilized opportunity to provide vaccination to persons 6 months of age or older.

- **Type of Measure**: Process

- **Improvement Noted As**: An increase in the rate

- **Numerator Statement**: Inpatient discharges who were screened for influenza vaccine status and were vaccinated prior to discharge if indicated.

IMM-2: IP Influenza immunization

STROUDWATER

Included Populations:

- Patients who received the influenza vaccine during this inpatient hospitalization
- Patients who have an ICD-9-CM Principal Procedure Code or Other Procedure Codes from Table 12.9 for Prophylactic Vaccination against Influenza during this inpatient hospitalization
- Patients who received the influenza vaccine during the current year's flu season but prior to the current hospitalization
- Patients who were offered and declined the influenza vaccine
- Patients who have an allergy/sensitivity to the influenza vaccine, anaphylactic latex allergy or anaphylactic allergy to eggs, or for whom the vaccine is not likely to be effective because of bone marrow transplant within the past 6 months, or history of Guillian-Barre Syndrome within 6 weeks after a previous influenza vaccination

IMM-2: IP Influenza immunization

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- **Denominator Statement:**
  - Acute care hospitalized inpatients age 6 months and older discharged during October, November, December, January, February or March.

- **Included Populations**: Inpatient discharges 6 months of age and older
- **Excluded Populations**:
  - Patients less than 6 months of age
  - Patients who expire prior to hospital discharge
  - Patients with an organ transplant during the current hospitalization (Appendix A, Table12.10)
  - Patients for whom vaccination was indicated, but supply had not been received by the hospital due to problems with vaccine production or distribution
  - Patients who have a Length of Stay greater than 120 days
  - Patients who are transferred or discharged to another acute care hospital
  - Patients who leave Against Medical Advice (AMA)

IMM-2: IP Influenza immunization

STROUDWATER

General Data Elements Table

Name	Collected For:
Admission Date	All Records
Birthdate	All Records
Discharge Date	All Records
First Name	All Records
Hispanic Ethnicity	All Records
ICD-10-CM Other Diagnosis Codes	All Records
ICD-10-PCS Other Procedure Codes	All Records
ICD-10-PCS Other Procedure Dates	All Records
ICD-10-CM Principal Diagnosis Code	All Records
ICD-10-PCS Principal Procedure Code	All Records
ICD-10-PCS Principal Procedure Date	All Records
Last Name	All Records
Patient HIC#	All Records Collected by CMS for patients with a standard HIC#
Patient Identifier	All Records
Payment Source	All Records
Physician 1	Optional for all Records
Physician 2	Optional for all Records
Postal Code	All Records
Race	All Records
Sample	Used in transmission of the Joint Commission's aggregate data file and the Hospital Clinical Data file
Sex	All Records

Will also require status codes such as expired or AMA for disposition for transfers which is part of exclusions

IMM-2: IP Influenza immunization

STROUDWATER

- What processes have you put in place to make sure staff remembers to do assessment, give the medication and document?
- How do you deal with the physician who says to schedule them for an injection in their office vs during IP
- How do you deal with the provider request to wait until discharge?
- Let's discuss potential issues with giving the vaccine on admission and / or waiting at discharge and what can we do to prevent fall-outs

IMM-2: IP Influenza immunization

STROUDWATER

- Assuming you have been internally tracking, what was your rate in: Oct, Nov, Dec 2015, Jan and Feb 2016
- Do you do concurrent reviews?
- Do you address fall-outs?
- Ready to report Q4, 2015 in CART/Vendor by May 15, 2016?

Any last points of discussion, recommendations etc

But wait, an issue with reporting has been identified
To be discussed on the following slides

IMM-2: Identified submission issue, for Q4 2015 patients

STROUDWATER

- SBAR from HRSA MBQIP re: IMM-2 submission issue

- **Situation**:

  - In Fiscal Year 2015 (September 2015 – August 2016), the Federal Office of Rural Health Policy (FORHP), included IMM-2 as part of the Medicare Beneficiary Quality Improvement Project (MBQIP) required measure set. Year one of this three-year grant cycle is for capacity building, so not all Critical Access Hospitals (CAHs) are required to report on this measure till FY 2016.

  - However, for CAHs choosing to report IMM-2 for Q4 2015 submission due by May 15, 2016, we have identified that some CAHs are at risk of having their IMM-2 cases rejected from QualityNet due to the requirement to submit complete measure sets (which includes IMM-1).

IMM-2: Identified submission issue, for Q4 2015 patients

STROUDWATER

Background:

- IMM–1 and IMM-2 make up the Immunization Measure Set. In Q1 of 2014, CMS changed the status of IMM-1 measure to make it optional for all hospitals. IMM-1will no longer be available for data collection starting in Q1 2016.

- The architecture of the QualityNet database requires that all measures in any given measure set be submitted (i.e. cases that do not include the data elements for ALL of the measures in a measure set are rejected from the warehouse). The CMS CART tool does allow hospitals to change their measure preferences in that tool to only collect certain measures in a measure set. Thus, in CART, CAHs can opt not to collect measures (such as IMM-1), but the QualityNet database will not accept any of the cases in a measure set without collection of the data elements for all of the measures in that set.

Background: (cont')

- However, since IMM-1 is considered an optional measure by CMS, hospitals that do not collect the data on that measure have the option of going into QualityNet and changing their measures designation to 'unselect' IMM-1, in which case the warehouse would then accept the IMM-2 cases even if the hospital does not submit the IMM-1 cases.

- (NOTE – this was not an option for OP-4 and OP-18, because those are not voluntary for PPS hospitals, so hospitals cannot 'unselect' them in the measure designation).

IMM-2: Identified submission issue, for Q4 2015 patients

STROUDWATER

❑ Assessment:

- The additional burden to CAHs to collect the data for IMM-1 is minimal. If CAHs are reporting the IMM-2 measure, they do not have to pull any additional cases.
  - For IMM-1, there is one additional data element required: pneumococcal vaccination status.

- It is important to note that this is only a concern for Q4 2015 data submission (due May 15, 2016), as the IMM-1 measure will be removed entirely by CMS starting with Q1 2016.

IMM-2: Identified submission issue, for Q4 2015 patients

STROUDWATER

❑ Assessment: (cont')

- There are two options for helping ensure that CAHs who are collecting and submitting the IMM-2 measure get their cases accepted into QualityNet.
  1) Collect the IMM-1 measure for Q4 2015, which entails gathering one additional data element. For CAHs that have already unselected this measure in their CART measure preferences, they would need to go in and select that they want to collect on the IMM-1 measure.
  2) If a CAH changes CART measure preferences and does not collect the data element needed for IMM-1, PRIOR to ANY DATA SUBMISSION, they must go into the QualityNet Secure Portal and 'unselect' the IMM-1 measure in their QualityNet measure designation.

IMM-2: Identified submission issue, for Q4 2015 patients

STROUDWATER

- **Assessment: (cont')**

  - **# 1 or 2 MUST be done prior to any data submission to QualityNet. Once data has been submitted this cannot be changed.**

  - CAHs using a vendor tool for data collection are likely already collecting the data elements required for IMM-1 and/or the vendor is addressing the measure designations in QualityNet.

  - Timing. The last data submission period (Q3 2015) was outside of the flu season. IMM-2 is only calculated during Q4 and Q1. It is likely that many CAHs made no attempt to submit data during Q3 for the IMM-2 measure since it was outside of the seasonal timeframe, and FORHP did not require submission in that quarter.

IMM-2: Identified submission issue, for Q4 2015 patients

STROUDWATER

❑ Assessment: (cont')

- Many CAHs have not taken the extra step to change their measure preferences in CART – and thus, are already collecting the data element needed for IMM-1, so their cases are being accepted into the warehouse.

- It is unclear how many CAHs take the step of going into QualityNet and checking their case status reports to ensure all of their data was accepted into QualityNet. If CAHs have opted not to collect IMM-1, but have not checked to ensure their data was accepted, they may not realize their data was rejected.

IMM-2: Identified submission issue, for Q4 2015 patients

STROUDWATER

Recommendations/Next Steps:

- Although there is an option for CAHs to change measure designation in QualityNet, since this is only a concern for 4th Quarter, our recommendation is to encourage CAHs to collect the single additional data element for the IMM-1 measure. We anticipate many CAHs are already doing so, and it may be simpler and less confusing than having to change measure designation in QualityNet.

- CAHs are strongly encouraged to always check their Case Status Summary Report to ensure their data has been accepted to the warehouse. For instructions on how to generate the case status summary report you can look at the MBQIP Monthly (February edition) under Robyn Quips – page 4 https://www.ruralcenter.org/tasc/mbqip/mbqip-monthly
- If you have any additional questions re: IMM-2, please email TASC@ruralcenter.org

10:30 – 10:45

10:45 – 11:00

MBQIP (cont')
Open Discussion of Challenges and Processes

- Newly added measure / OP-18
- Updated Reporting Timeline

STROUDWATER

❑ OP-4: Aspirin on arrival

- To continue for those who never stopped
- To be restarted for those who had stopped
- Q3, 2015 was due Feb 1
- Q4, 2015 will be due June 1
- Any questions re: OP-4?

❑ OP-18: Median Time from ED Arrival to ED Departure for Discharged ED Patients

- Part of ED Throughput along with OP-20: Door to Diagnostic Evaluation by a Qualified Medical Professional and OP-22: Left Without Being Seen
- Was not required Feb 1 for Q3, 2015
- Q4, 2015 will be required June 1, 2016

OP-18: Median Time from ED Arrival to ED Departure for Discharged ED Patients

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- **Type of Measure**: Process

- **Improvement Noted As**: A decrease in the median value

- **Continuous Variable Statement**: Time (in minutes) from ED arrival to ED departure for patients discharged from the emergency department

- **Included Populations:**
  - Any ED Patient from the facility's emergency department

- **Excluded Populations:**
  - Patients who expired in the emergency department

OP-18: Median Time from ED Arrival to ED Departure for Discharged ED Patients

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- **Data Elements**:
  - Arrival Date & Time
  - E/M Code
  - ED Departure Date
  - ED Departure Time
  - ICD-10-CM Principal Diagnosis Code
- Patients seen in a Hospital Emergency Department (E/M Code on Appendix A OP Table 1.0) are included in the OP-18 and OP-20 Hospital Outpatient Population and are eligible to be sampled if they have: An E/M Code on Appendix A, OP Table 1.0

OP Table 1.0: E/M Codes for Emergency Department Encounters

Code	E/M Code Description
99281	Emergency department visit, new or established patient
99282	Emergency department visit, new or established patient
99283	Emergency department visit, new or established patient
99284	Emergency department visit, new or established patient
99285	Emergency department visit, new or established patient
99291	Critical care, evaluation and management

OP-18: Median Time from ED Arrival to ED Departure for Discharged ED Patients

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Outpatient Setting: Emergency Department

Set Measure ID #	Performance Measure Name
OP-18a	Median Time from ED Arrival to ED Departure for Discharged ED Patients – Overall Rate
OP-18b	Median Time from ED Arrival to ED Departure for Discharged ED Patients – Reporting Measure
OP-18c	Median Time from ED Arrival to ED Departure for Discharged ED Patients – Psychiatric/Mental Health Patients
OP-18d	Median Time from ED Arrival to ED Departure for Discharged ED Patients – Transfer Patients

- One would assume that OP-18 reported by Telligen will be the Overall Rate and will include the median time from ED Arrival to ED Discharge for all patients
  - The question has been posed to StratisHealth

- Either way, you will get the rest of the information to be used internally begin drill downs for longer median time from ED arrival to discharge

OP-18: Median Time from ED Arrival to ED Departure for Discharged ED Patients

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- Do you anticipate and issues with tracking this information?
- Any of you already tracking for best practice in operations?
  - If so, what is your experience (# of minutes)
- Ready to report Q4, 2015 by June 1, 2016 in CART/Vendor?
- FYI – Hospital Compare reports the National Average for Very High Volume ED length of stay = 173 min. (2.9 hrs)
  Medium Volume = 142 min (2.4 hrs)
  Stroudwater's experience for rural hospitals paying attention to this are 90 to 120 min (1 ½ hr to 2 hrs)

OP-18: Median Time from ED Arrival to ED Departure for Discharged ED Patients

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- **Rationale to decrease time from admission to discharge**
  - Can improve access to treatment,
  - Increase quality of care due to timely diagnosis and treatment,
  - Prevent prolonged patient waiting times,
  - Decrease LWBS rates,
  - Decrease suffering for those who wait,
  - Prevent overcrowded busy EDs,
    - If long time rate is due to overcrowding, this could create rushed and unpleasant treatment environments, and potentially poor patient outcomes
  - Improve physician and staff satisfaction

OP-18: Median Time from ED Arrival to ED Departure for Discharged ED Patients

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❑ Potential causes for increased time from admission to discharge (not all inclusive)

- Registration staff with too many responsibilities (all ancillaries, IP and ED registration)
- Triage process too time consuming and duplication in documentation
- Immediate bedding not used
- Staffing not appropriate to meet high utilization time
- Lack of protocols for nurses to initiate care
- ED providers slow to respond to ED call
- Ancillary with longer that necessary turn-around-times (TAT)
- Lack of efficiency by providers
- Unfamiliar with EHR hence increasing documentation time
- Delays in admission to Med/Surg
- Difficulty finding an accepting hospital due to lack of bed
- Psych patients often difficult to get approved for transfer
- Delays in transfers with long wait time for the ambulance
- Other??

OP-18: Median Time from ED Arrival to ED Departure for Discharged ED Patients

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❑ Potential data gathering to help identify cause of delays

- Time from ED registration to discharge to home by provider
- Time from ED registration to admission to Med/Surg by provider, by hospitalist if they have to approve, by shift, by house supervisor if used
- # of ED and other OP visits by hour of the day for registration
- ED visits per hour of the day for nursing staff analysis
- Nursing hours per ED visits (NHPV)
- Time from registration to ED exam room
- Time to ED provider by providers
- TAT for each ancillary type
- Time from ambulance notification to time of arrival
- Other??

Reporting Schedule for MBQIP Measures for 2015-2016

ID	Measure Name	Data To Be Reported Next By
OP-1	Median Time to Fibrinolysis	*June 1, 2016 for Q4, 2015
OP-2	Fibrinolytic Therapy Received Within 30 minutes of ED Arrival	*June 1, 2016 for Q4, 2015
OP-3b	Median Time to Transfer to Another Facility for Acute Coronary Intervention	*June 1, 2016 for Q4, 2015
OP-4	Aspirin on Arrival	*June 1, 2016 for Q4, 2015
OP-5	Median Time to ECG	*June 1, 2016 for Q4, 2015
OP-18	Median Time from ED Arrival to ED Departure for Discharged ED Patients	*June 1, 2016 for Q4, 2015
OP-20	Door to diagnostic evaluation by a qualified medical professional	*June 1, 2016 for Q4, 2015
OP-21	Median time to pain management for long bone fracture	*June 1, 2016 for Q4, 2015
OP-22	Patient left without being seen	*May 15, 2016 for all of 2015
OP-27	Influenza vaccination coverage among healthcare personnel	*May 15, 2016 for October 1, 2015 – March 31, 2016
IMM-2	IP Influenza immunization	*May 15, 2016 for Q4, 2015

MBQIP Measures are Reported Where?

ID	Measure Name	Data Reported To
OP-1	Median Time to Fibrinolysis	QNet via OP CART/Vendor
OP-2	Fibrinolytic Therapy Received Within 30 minutes of ED Arrival	QNet via OP CART/Vendor
OP-3b	Median Time to Transfer to Another Facility for Acute Coronary Intervention	QNet via OP CART/Vendor
OP-4	Aspirin on Arrival	QNet via OP CART/Vendor
OP-5	Median Time to ECG	QNet via OP CART/Vendor
OP-18	Median Time from ED Arrival to ED Departure for Discharged ED Patients	QNet via OP CART/Vendor
OP-20	Door to diagnostic evaluation by a qualified medical professional	QNet via OP CART/Vendor
OP-21	Median time to pain management for long bone fracture	QNet via OP CART/Vendor
OP-22	Patient left without being seen	QNet via Secure Log In
OP-27	Influenza vaccination coverage among healthcare personnel	National Healthcare Safety Network Website
IMM-2	IP Influenza immunization	QNet via OP CART/Vendor

Sampling - MBQIP Measures for 2015-2016

ID	Measure Name	Sampling
OP-1	Median Time to Fibrinolysis	O-80 (Submit All)
OP-2	Fibrinolytic Therapy Received Within 30 minutes of ED Arrival	O-80 (Submit All)
OP-3b	Median Time to Transfer to Another Facility for Acute Coronary Intervention	O-80 (Submit All)
OP-4	Aspirin on Arrival	0-80 (Submit All)
OP-5	Median Time to ECG	O-80 (Submit All)
OP-20	Door to diagnostic evaluation by a qualified medical professional	0-900/qtr. (21/mo or 63/qtr.) > 900/qtr. (32/mo or 96/qtr.)
OP-21	Median time to pain management for long bone fracture	O-80 (Submit All)
OP-22	Patient left without being seen	No sampling – report all cases
OP-27	Influenza vaccination coverage among healthcare personnel	No sampling – report all cases
IMM-2	IP Influenza immunization	See next slide
HCAHPS	IP Satisfaction	Sampling determined by certified vendor
EDTC	Emergency Department Transfer Communication	See next slide

Sampling - MBQIP Measures for 2015-2016

ID	Measure Name	Sampling
IMM-2	IP Influenza immunization	**Quarterly** 0-5 - Reporting encouraged 6-152 - 100% of initial pt. pop 153-764 – 153 765-1529 - 20% of initial pt. pop >1529 – 306 **Monthly** < 51 - 100% of initial population 51-254 – 51 255-509 - 20% of initial pt. pop >509 - 102
EDTC	Emergency Department Transfer Communication	**Quarterly** 0-44 - submit all cases 45 - submit 45 cases **Monthly** 0-15 - submit all cases > 15 - submit 15 cases

Upcoming Data Submission per StratisHealth

STROUDWATER

- MBQIP Data Reporting Reminders Upcoming Data Submission Deadlines and CART Version (when applicable)
- https://www.ruralcenter.org/tasc/resources/mbqip-data-reporting-reminders

- **April 30, 2016**
- Emergency Department Transfer Communication (EDTC):
  - Patients seen Q1 2016 (January, February, March)
  - Submission process directed by state Flex Program
  - Note: EDTC Data Specifications were updated in early January for use with Q1 2016.

- **May 1, 2015**
- CMS Population and Sampling (optional)*
  - Patients seen Q4 2015 (October, November, December)
  - Inpatient and outpatient
  - Entered via the Secure Portal on QualityNet

Upcoming Data Submission per StratisHealth

STROUDWATER

- MBQIP Data Reporting Reminders Upcoming Data Submission Deadlines and CART Version (when applicable)
- https://www.ruralcenter.org/tasc/resources/mbqip-data-reporting-reminders

- **May 15, 2016**
- CMS Inpatient Measures:
  - Patients seen Q4 2015 (October, November, December)
  - CART version – 4.17.1 (See updates below)
  - CMS Hospital Inpatient Reporting Specifications Manual version 5.0b

- **May 15, 2016**
- Healthcare Personnel Influenza Vaccination:
  - For the dates October 1, 2015 – March 31, 2016
  - Submitted to National Healthcare Safety Network (NHSN)

Upcoming Data Submission per StratisHealth

STROUDWATER

- MBQIP Data Reporting Reminders Upcoming Data Submission Deadlines and CART Version (when applicable)
- https://www.ruralcenter.org/tasc/resources/mbqip-data-reporting-reminders
- **May 15, 2016**
- CMS Outpatient Web-Based Measures:
  - Includes MBQIP measure OP-22: Patient Left Without Being Seen – full calendar year 2015
  - CMS Hospital Outpatient Reporting Specifications Manual version 8.1
  - Entered via the Secure Portal on QualityNet

- **June 1, 2016**
- CMS Outpatient Chart-Abstracted Measures:
  - Patients seen Q4 2015 (October, November, December)
  - CART version – 1.13.1 (See updates below)
  - CMS Hospital Outpatient Reporting Specifications Manual version 8.1

Upcoming Data Submission per StratisHealth

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- **UPDATES!**
  - New versions of both Inpatient and Outpatient CART have now been released.
  - If you installed CART Inpatient version 4.17 and Outpatient version 1.13 before the April 5, 2016 release, you will need to download the patch for both the inpatient and outpatient tool that will convert that install to the latest version.
  - If you hadn't installed yet, there is no need to download the patch, just install the latest version, CART Inpatient 4.17.1 and CART Outpatient 1.13.1.
- *Population and sampling refers to the recording of the number of cases the hospital is submitting to the QualityNet warehouse, this is done directly thru the QualityNet Secure Portal. Reporting of population and sampling data is not required in order for your data to be submitted to CMS.

StratisHealth Resource Review

STROUDWATER

- Data Submission Deadline for MBQIP 2015-2016

https://www.ruralcenter.org/tasc/resources/mbqip-data-submission-deadlines-charts

  - See handout in your packet

Measure ID	Measure Name	Reported To	Submission Deadline by Encounter Period				
			Q3 / 2015 Jul 1 - Sep 30	Q4 / 2015* Oct 1- Dec 31	Q1 / 2016 Jan 1 - Mar 31	Q2 / 2016 Apr 1 - Jun 30	Q3 / 2016 Jul 1 - Sep 30
OP-1	Median time to fibrinolysis	QualityNet via Outpatient CART/Vendor	February 1, 2016	June 1, 2016	August 1, 2016	November 1, 2016	February 1, 2017
OP-2	Fibrinolytic therapy received within 30 minutes	QualityNet via Outpatient CART/Vendor	February 1, 2016	June 1, 2016	August 1, 2016	November 1, 2016	February 1, 2017
OP-3	Median time to transfer to another facility for acute coronary intervention	QualityNet via Outpatient CART/Vendor	February 1, 2016	June 1, 2016	August 1, 2016	November 1, 2016	February 1, 2017
OP-4	Aspirin at Arrival	QualityNet via Outpatient CART/Vendor	February 1, 2016	June 1, 2016	August 1, 2016	November 1, 2016	February 1, 2017
OP-5	Median time to ECG	QualityNet via Outpatient CART/Vendor	February 1, 2016	June 1, 2016	August 1, 2016	November 1, 2016	February 1, 2017
OP-18	Median Time from ED Arrival to ED Departure for Discharged ED Patients	QualityNet via Outpatient CART/Vendor	Not Required February 1, 2016	June 1, 2016	August 1, 2016	November 1, 2016	February 1, 2017
OP-20	Door to diagnostic evaluation by a qualified medical professional	QualityNet via Outpatient CART/Vendor	Not Required February 1, 2016	June 1, 2016	August 1, 2016	November 1, 2016	February 1, 2017
OP-21	Median time to pain management for long bone fracture	QualityNet via Outpatient CART/Vendor	Not Required February 1, 2016	June 1, 2016	August 1, 2016	November 1, 2016	February 1, 2017
OP-22**	Patient left without being seen	QualityNet via Secure Log In	May 15, 2016 (Aggregate based on full calendar year 2015)		(anticipated) May 15, 2017 (Aggregate based on full calendar year 2016)		
OP-27***	Influenza vaccination coverage among health care personnel	National Healthcare Safety Network	N/A	May 15, 2016 (Aggregate based on Q4 2015/Q1 2016)		N/A	
IMM-2	Immunization for influenza	QualityNet via Inpatient CART/Vendor	Not Required February 15, 2016	May 15, 2016	August 15, 2016	November 15, 2016	February 15, 2017
EDTC****	Emergency Department Transfer Communication	As directed by state Flex Program	October 31, 2015	January 31, 2016	April 30, 2016	July 31, 2016	October 31, 2016
HCAHPS	Hospital Consumer Assessments of Healthcare Providers and Systems	QualityNet via Vendor	January 6, 2016	April 6, 2016	July 6, 2016	October 5, 2016	TBD

11:00 – 11:45

MBQIP Benchmarking of Available Data

- OP-1, OP-2, OP-3, OP-4, OP-5
- EDTC

State OQR Performance (Q4/2014-Q3/2015)

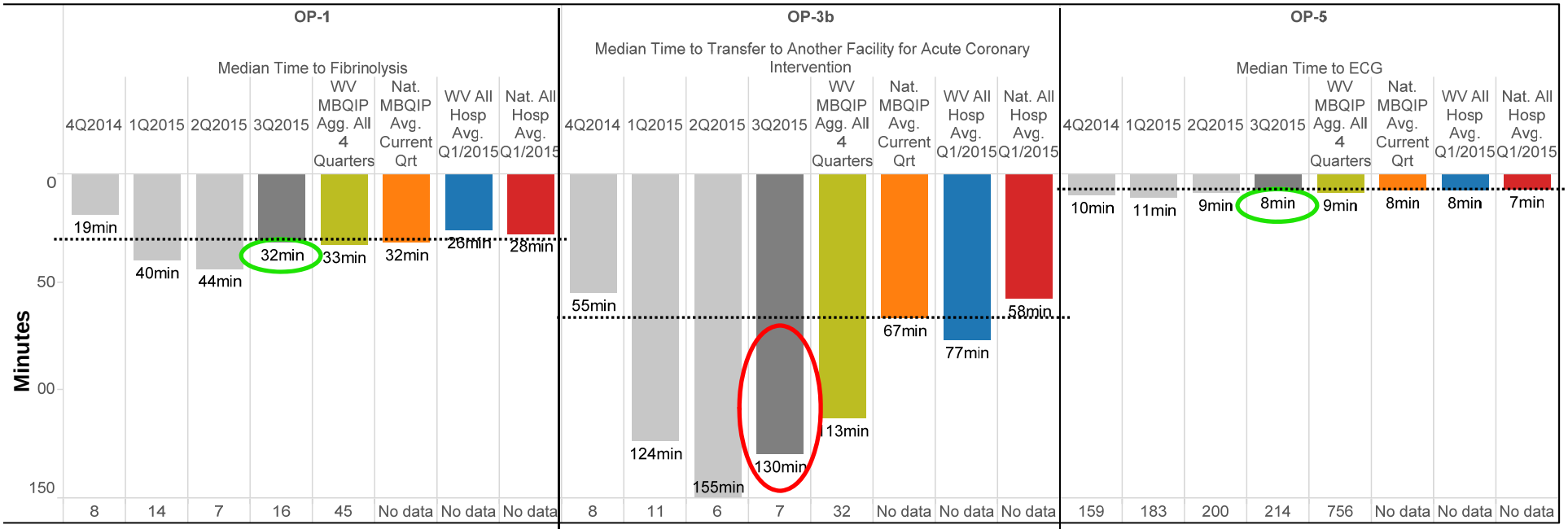
- For **Percentage Based OP Measures**, the WV CAH Network Average was ***higher than*** the National Average for **OP-2** and **OP-4**.
- For the **Time Based OP Measures**, **OP-1** and **OP-5** were **even** with the National Avg, while **OP-3b** had a **longer (worse)** Median Time than the National MBQIP Average.

Medicare Beneficiary Quality Improvement Project (MBQIP): Improving Care Through Information
Hospital OQR **State Performance**
Report Run Date: 2/26/2016
Reporting Period for Clinical Process Measures: Fourth Quarter 2014 through Third Quarter 2015 Discharges

State OQR Performance (Q4/2014-Q3/2015)

STROUDWATER

State Performance Time based Measures-*Fewer* minutes are better



OP-1 was even with the National MBQIP Average

Improved

OP-3b had a ***longer (worse) Median Time*** than the National Average by 63 minutes

Improved

OP-5 was even with the National MBQIP Average

Improved

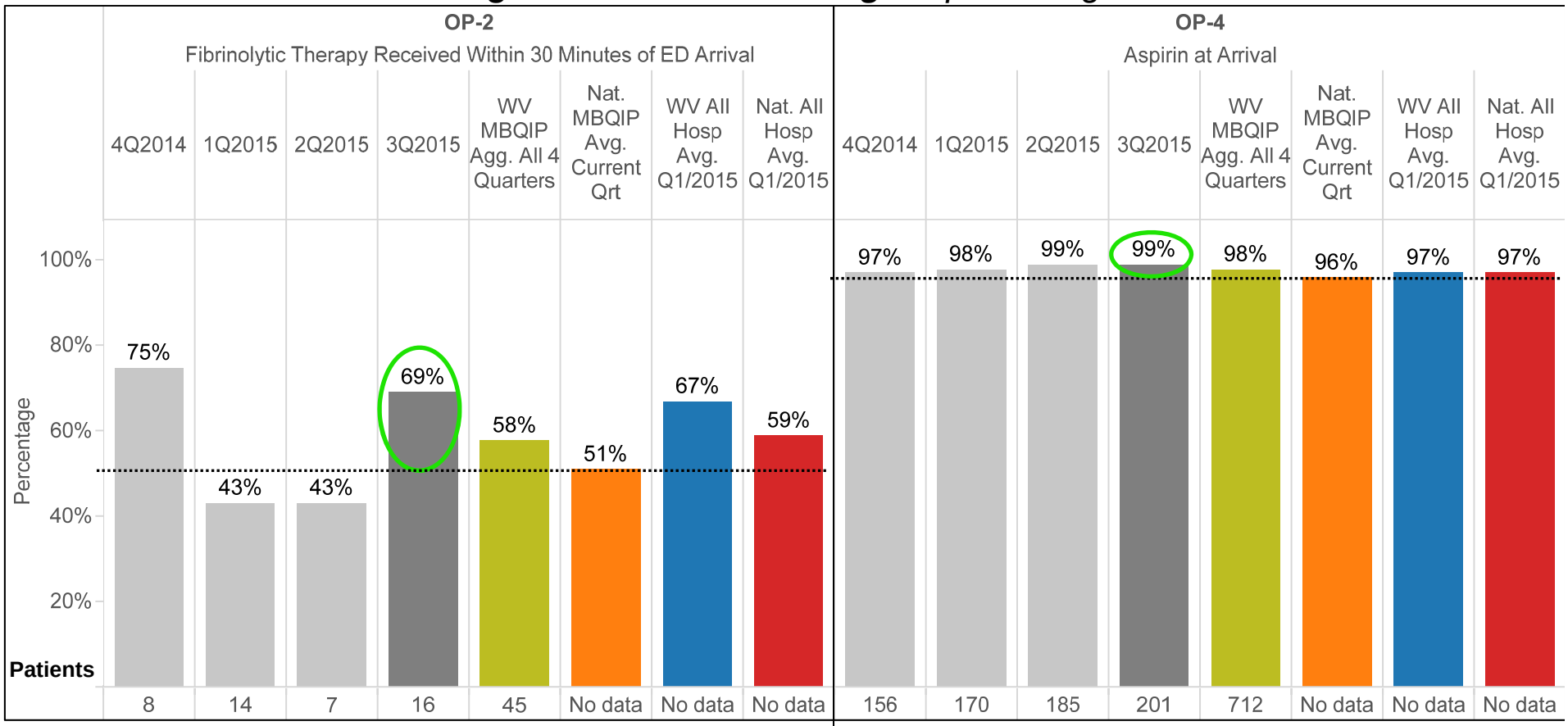
Medicare Beneficiary Quality Improvement Project (MBQIP): Improving Care Through Information
Hospital OQR **State Performance**
Report Run Date: 2/26/2016
Reporting Period for Clinical Process Measures: Fourth Quarter 2014 through Third Quarter 2015 Discharges

MBQIP = CAH
All Hosp = PPS & CAH hospitals

State OQR Performance (Q4/2014-Q3/2015)

STROUDWATER

State Performance Percentage-Based Measures-*Higher* *percentages are better*



OP-2 was ***higher*** than the National MBQIP Average by 18% points

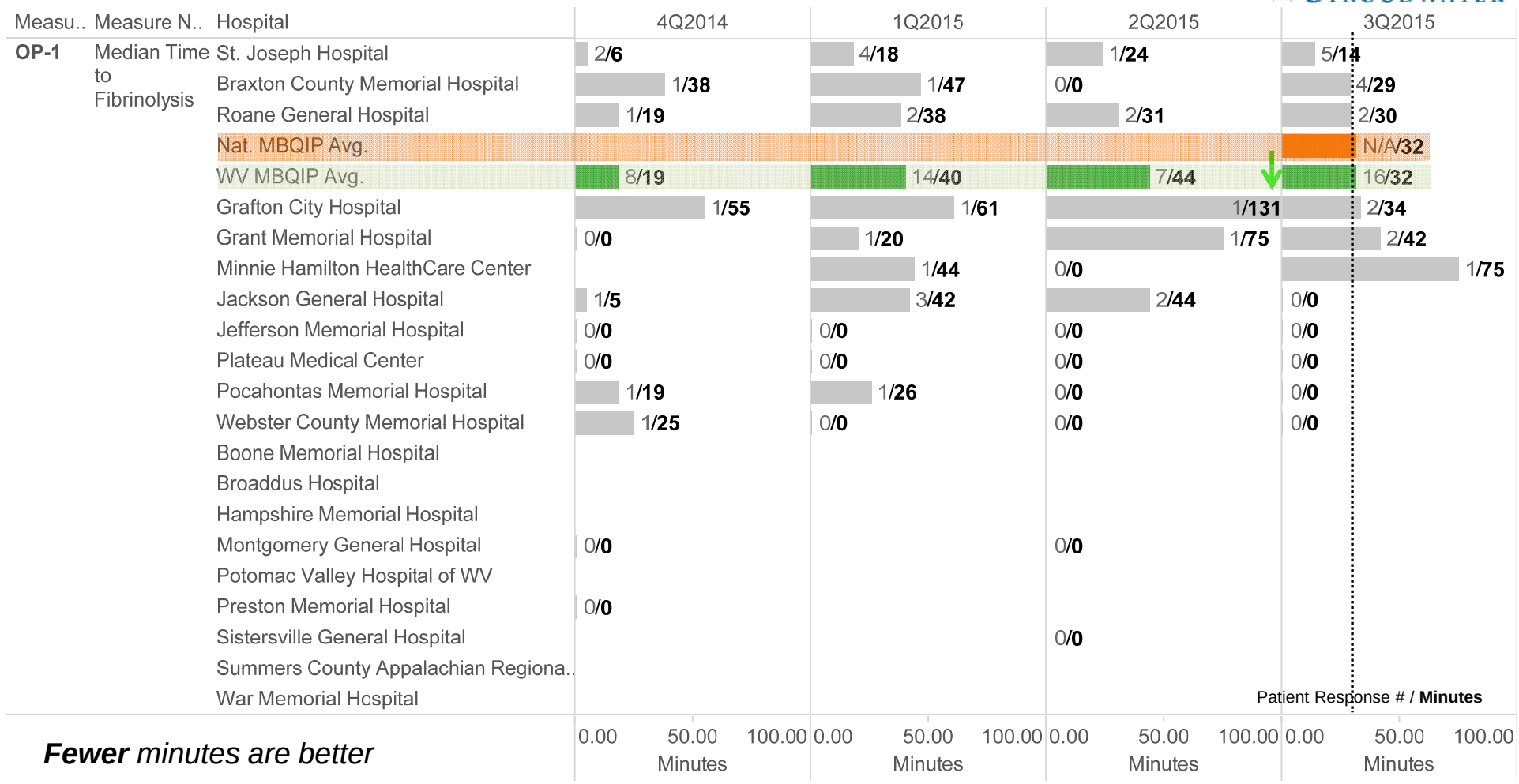
OP-4 was ***higher*** than the National MBQIP Average by 3% points

Improved

Report Run Date: 2/26/2016
Reporting Period for Clinical Process Measures: Fourth Quarter 2014 through Third Quarter 2015 Discharges

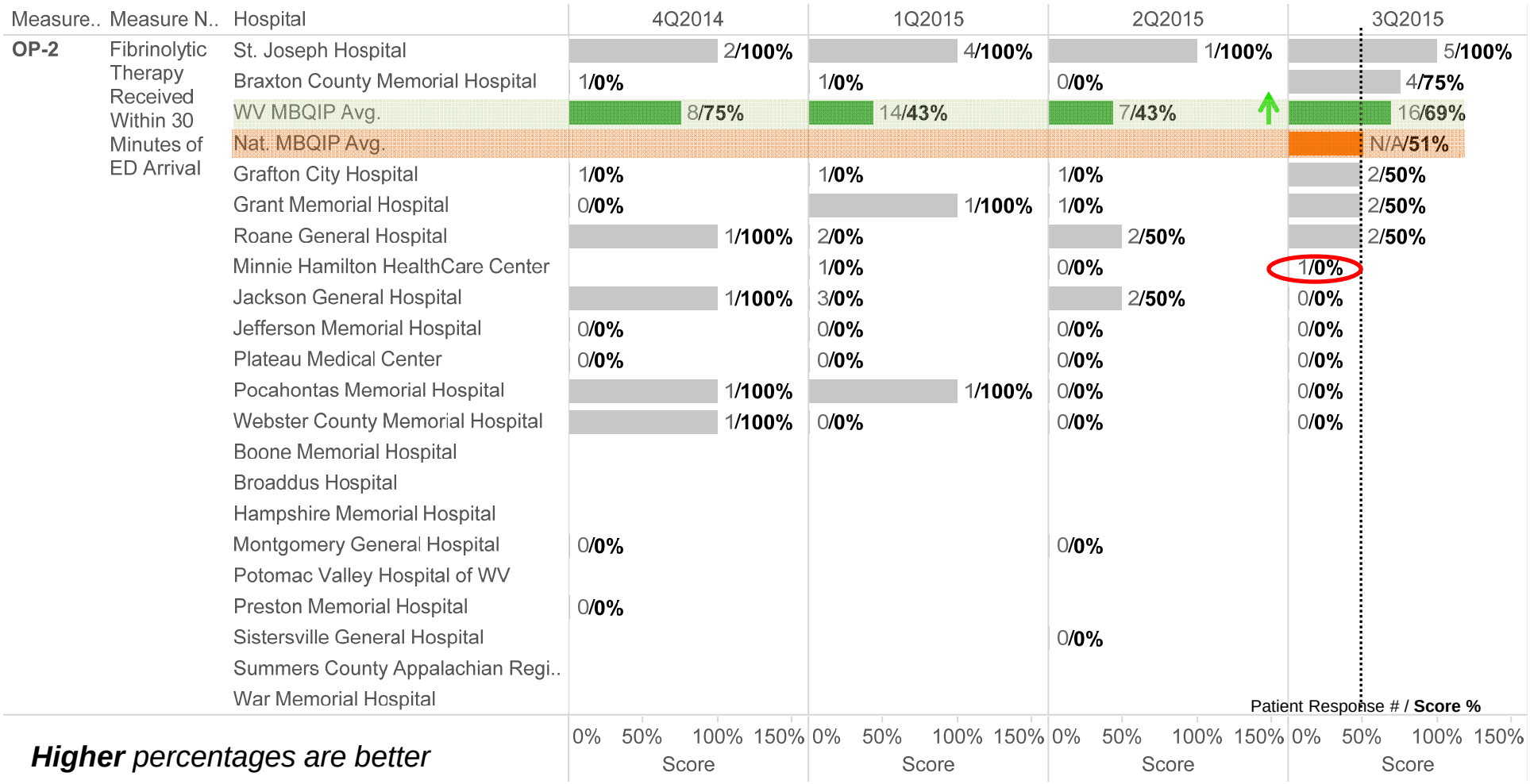
MBQIP = CAH
All Hosp = PPS & CAH hospitals

OP-1 OQR Performance (Q4/2014-Q3/2015)



3 CAHs had shorter (better) OP-1 minutes than the average National MBQIP score of 32 minutes in Q3-2015 and 3 WV CAHs had longer (worse) Median times to Fibrinolysis
5 CAHs reported Zero (0/0) eligible patients

OP-2 OQR Performance (Q4/2014-Q3/2015)



2 CAHs had a higher (better) percentage than the average National MBQIP score of 51% in Q3-2015

1 WV CAH reported 0% with 1 eligible patients

5 CAHs reported Zero (0/0) eligible patients

OP-3b OQR Performance (Q4/2014-Q3/2015)

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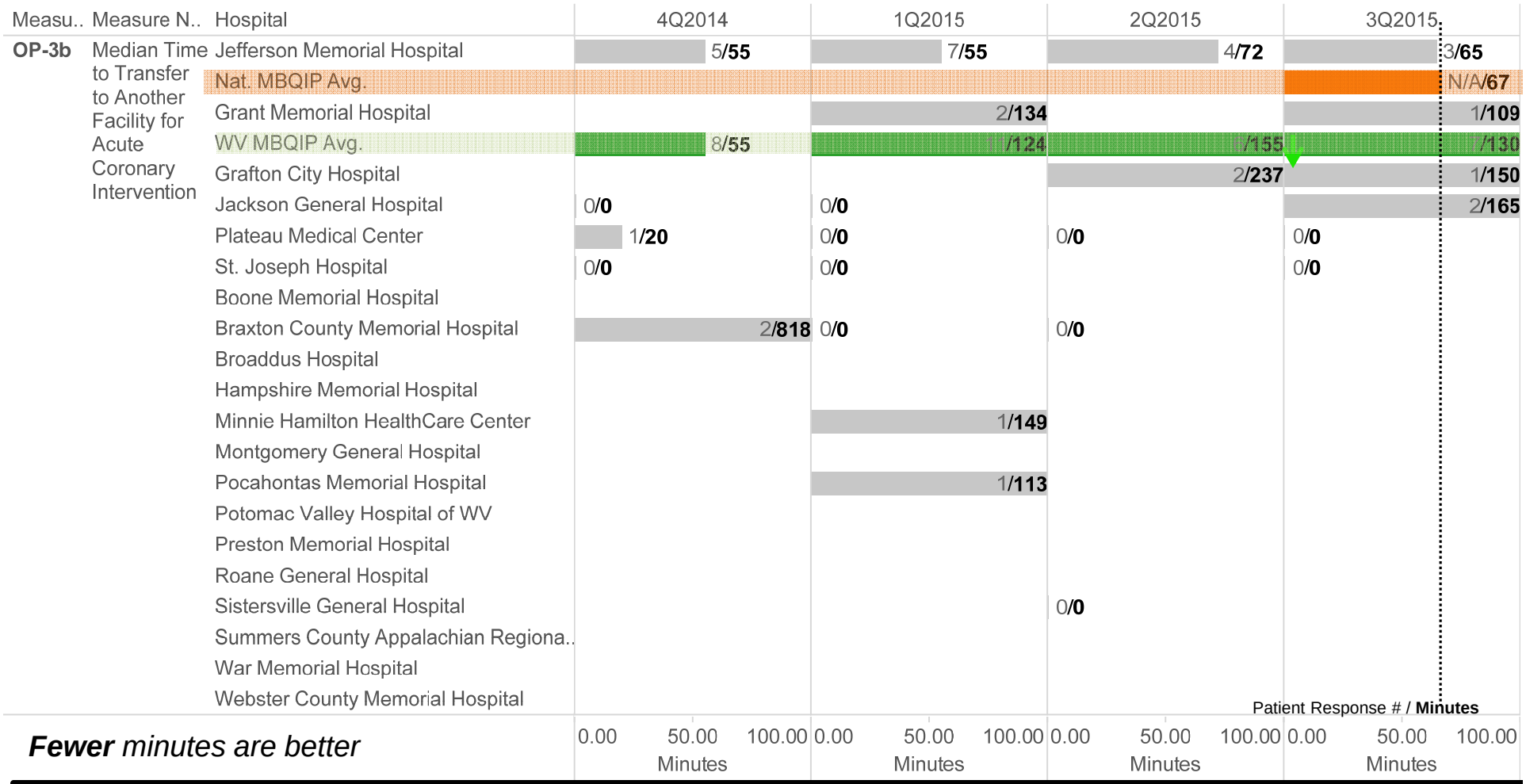
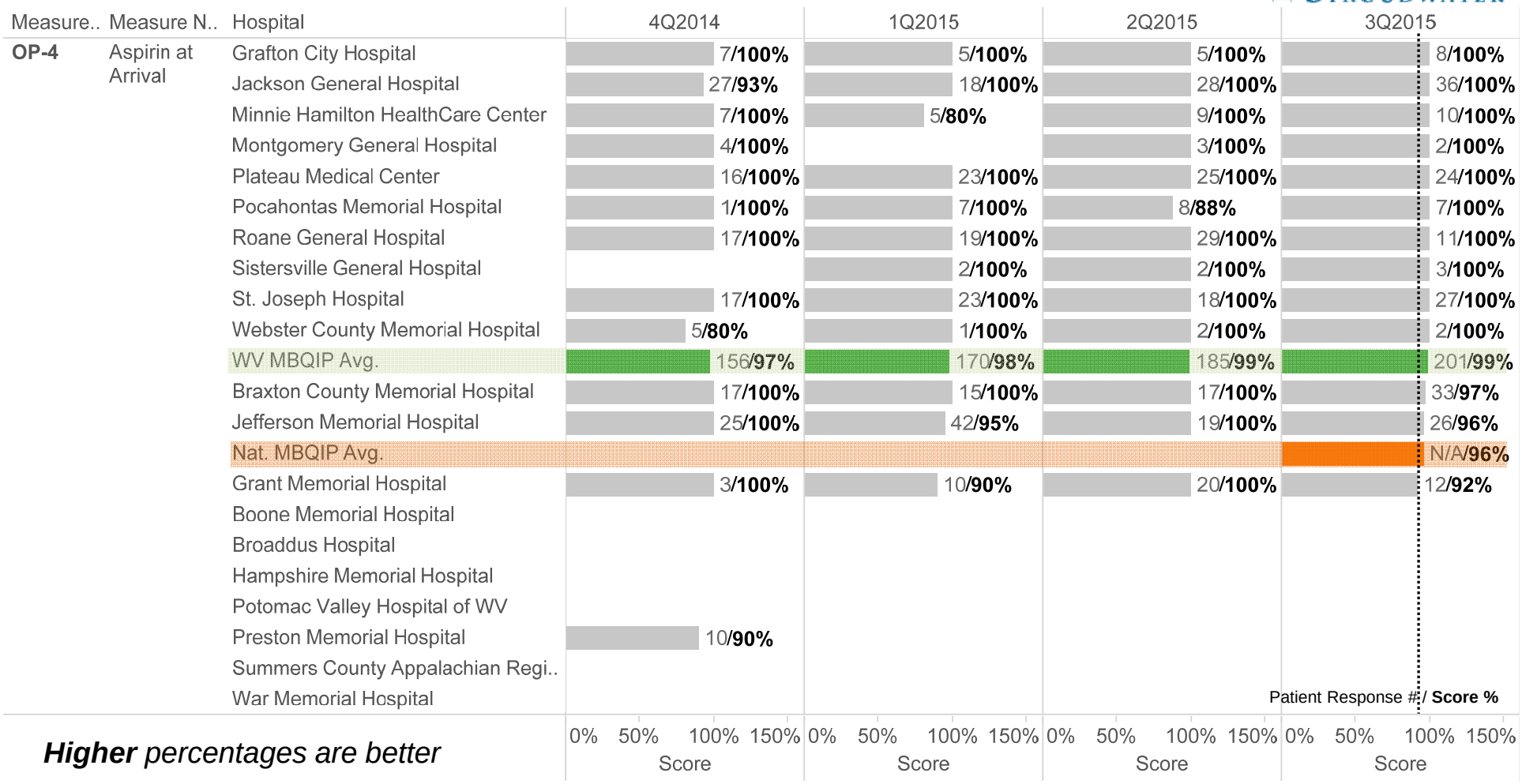


All but 1 CAH had a longer (worse) Median time to transfer to another facility for ACI than the average National MBQIP time of 67 minutes. The WV average decreased to 130 minutes but is still longer than the National Avg.
2 CAHs reported Zero (0/0) eligible patients

OP-4 OQR Performance (Q4/2014-Q3/2015)

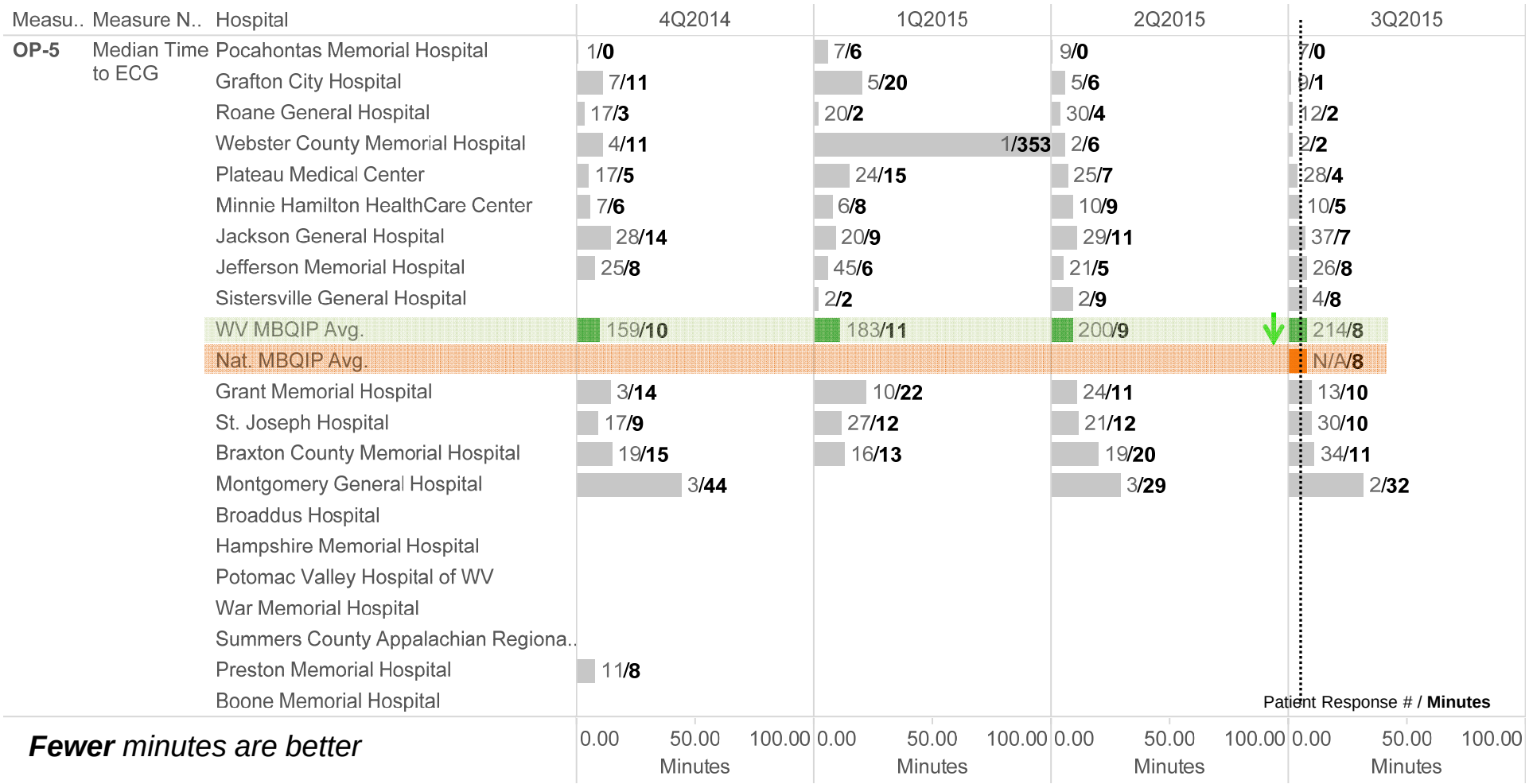


10 CAHs were at 100%

1 CAH was below the National MBQIP Avg. by 4% points- important to continue working on this as a standard even though this is removed from MBQIP effective 10/1/15

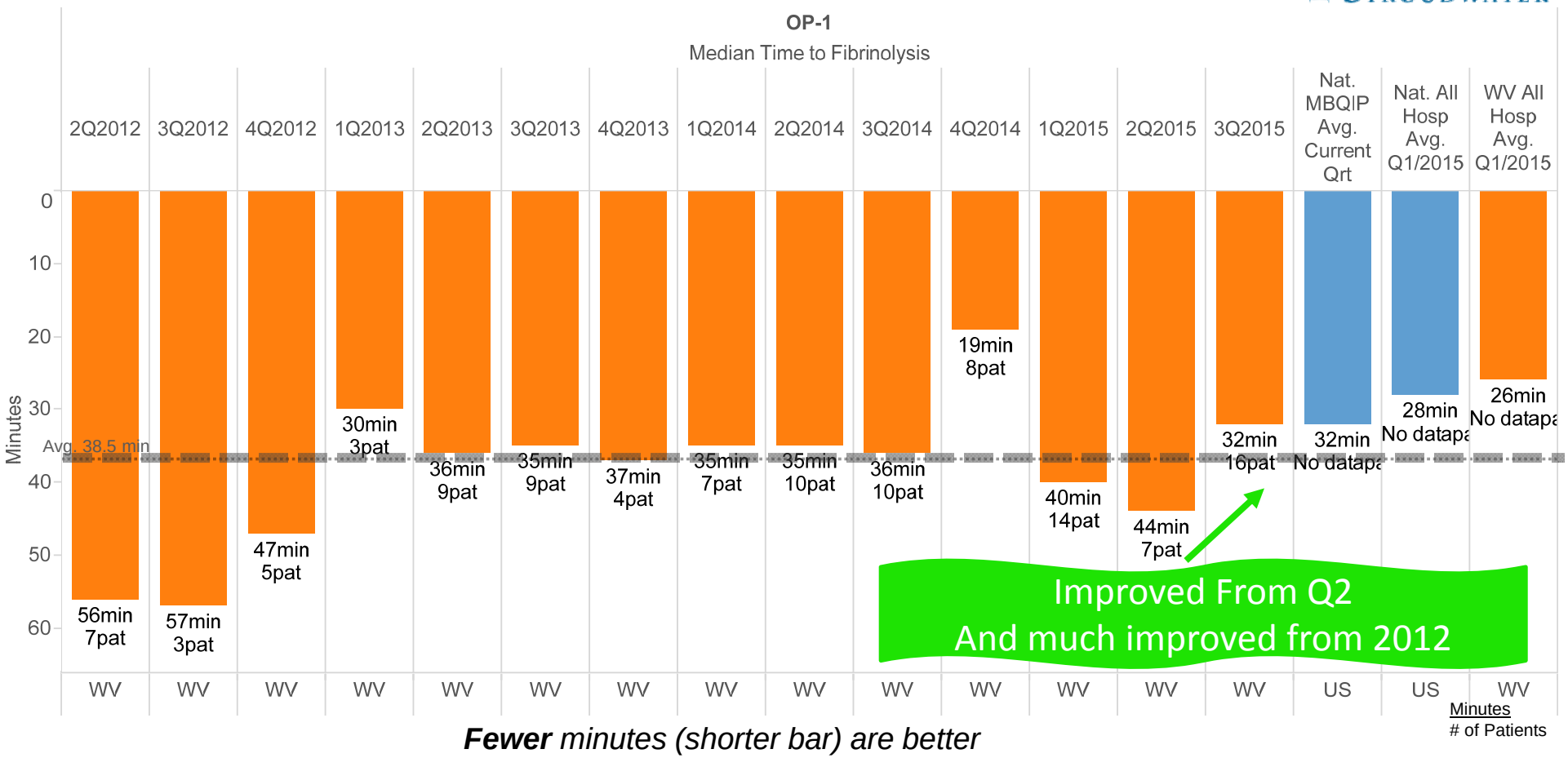
OP-5 OQR Performance (Q4/2014-Q3/2015)

STROUDWATER



9 WV CAHs had shorter (better) minutes than National MBQIP average with two more at the 10 min standard.
2 WV CAHs still took more than 10 minutes to perform an ECG for patients with chest pain in Q3 2015! This must be corrected!

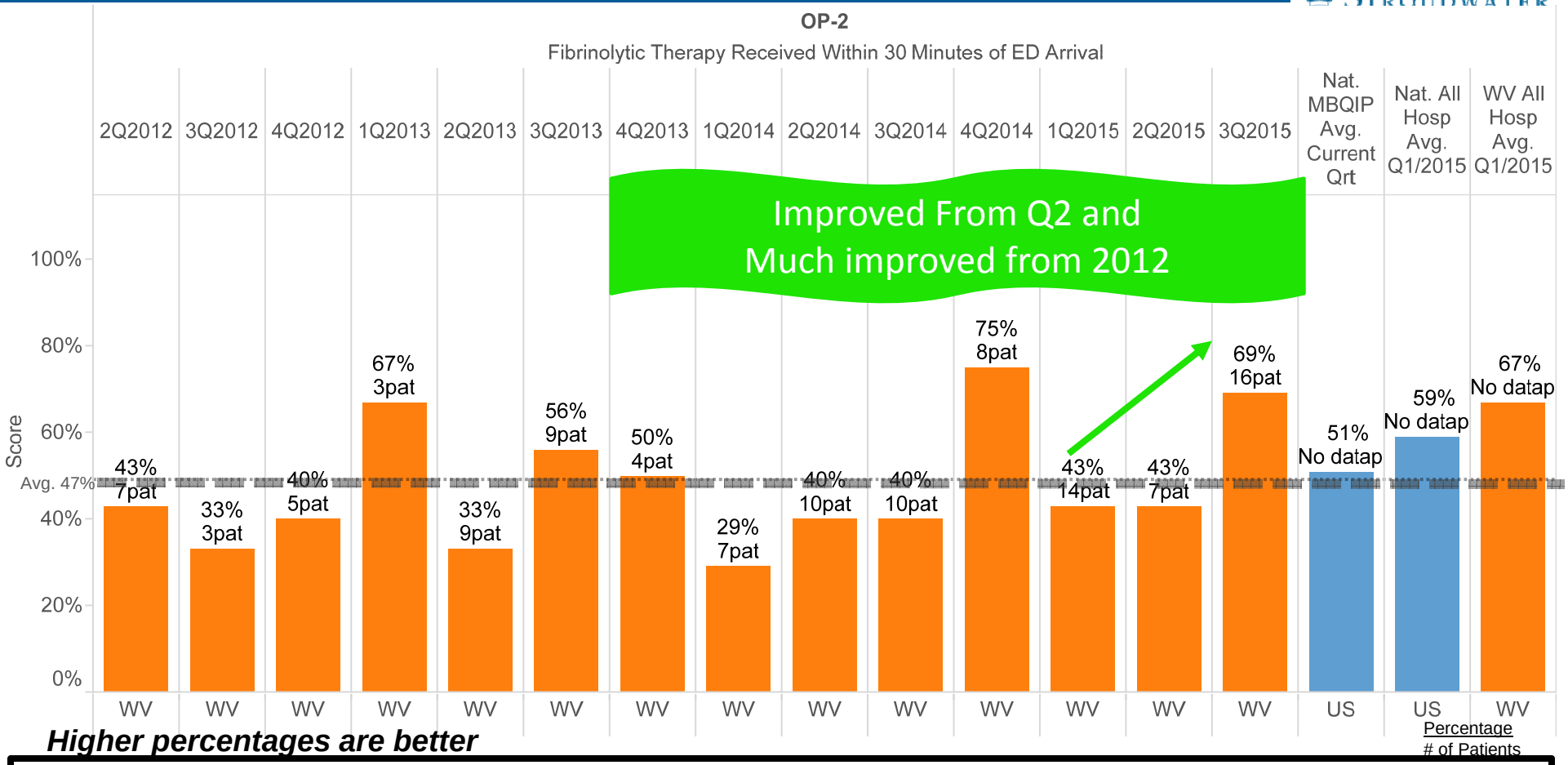
OP-1 OQR Historical Performance (Q2/2012-Q3/2015)



***Fewer** minutes (shorter bar) are better*

Historically WV MBQIP OP-1 averaged 38.5 minutes.
Q3-2015 was at 32 minutes which is even with the National MBQIP Avg
The latest Q1-2015 "All Hospital" benchmark data from hospital compare shows 28min for the National hospitals (CAHs and PPS), and 26min for all WV hospitals.

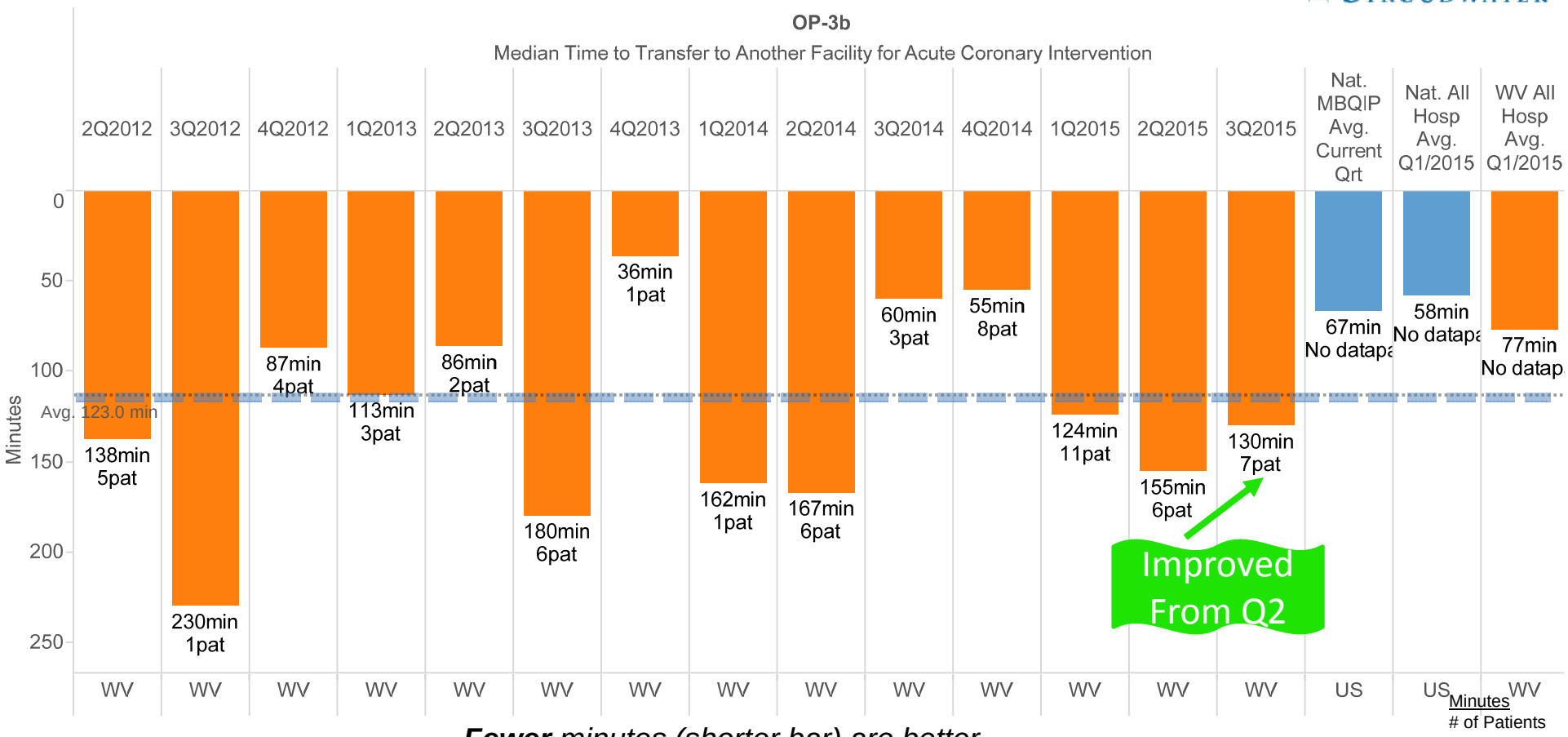
OP-2 OQR Historical Performance (Q2/2012-Q3/2015)



Higher percentages are better

Historically WV MBQIP OP-2 averaged at 47%.
Q3-2015 was at 69% which is better than the National MBQIP score of 51%
The latest Q1-2015 "All Hospital" benchmark data from hospital compare shows 59% for the National hospitals (CAHs and PPS), and 67% for all WV hospitals.

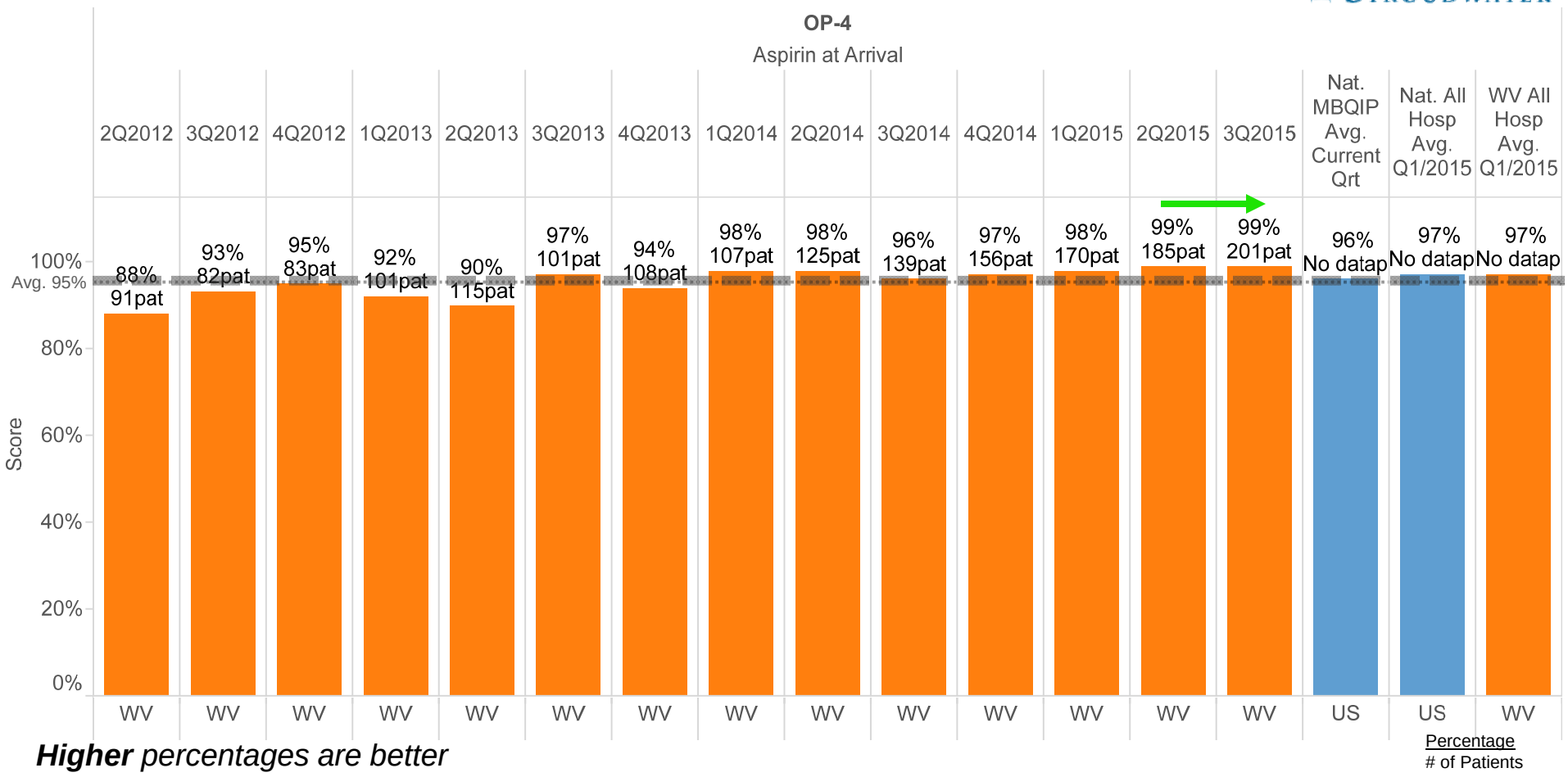
OP-3b Historical Performance (Q2/2012-Q3/2015)



***Fewer** minutes (shorter bar) are better*

Historically WV MBQIP OP-3b averaged at 123.0 min.
Q3-2015 was at 130 minutes which is longer (worse) than National MBQIP Avg of 67
The latest Q1-2015 "All Hospital" benchmark data from hospital compare shows 58min for the National hospitals (CAHs and PPS), and 77min for all WV hospitals.

OP-4 OQR Historical Performance (Q2/2012-Q3/2015)

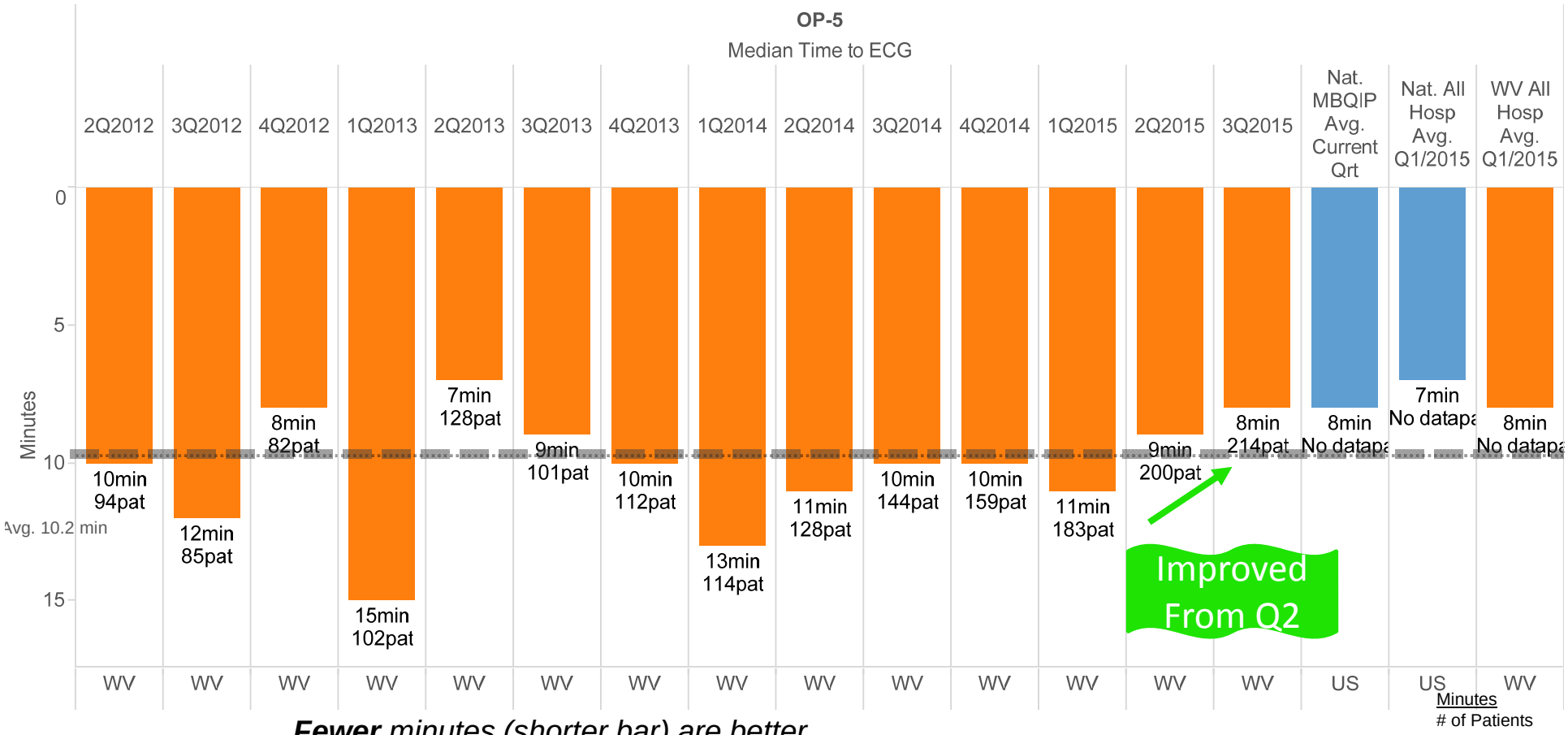


***Higher** percentages are better*

Historically WV MBQIP OP-4 Averaged 95% - will not be measured from Oct. 1 on but still need to report for Q4-2015.

OP-5 OQR Historical Performance (Q2/2012-Q3/2015)

STROUDWATER



***Fewer** minutes (shorter bar) are better*

Historically WV MBQIP OP-5 averaged 10.2 min.
Q3-2015 was at 8 minutes which is even with the National MBQIP Avg
The latest Q1-2015 "All Hospital" benchmark data from hospital compare shows 7min for the National hospitals (CAHs and PPS), and 8min for all WV hospitals.

ED Transfer Communication (EDTC)

Q4-2015 EDTC Review

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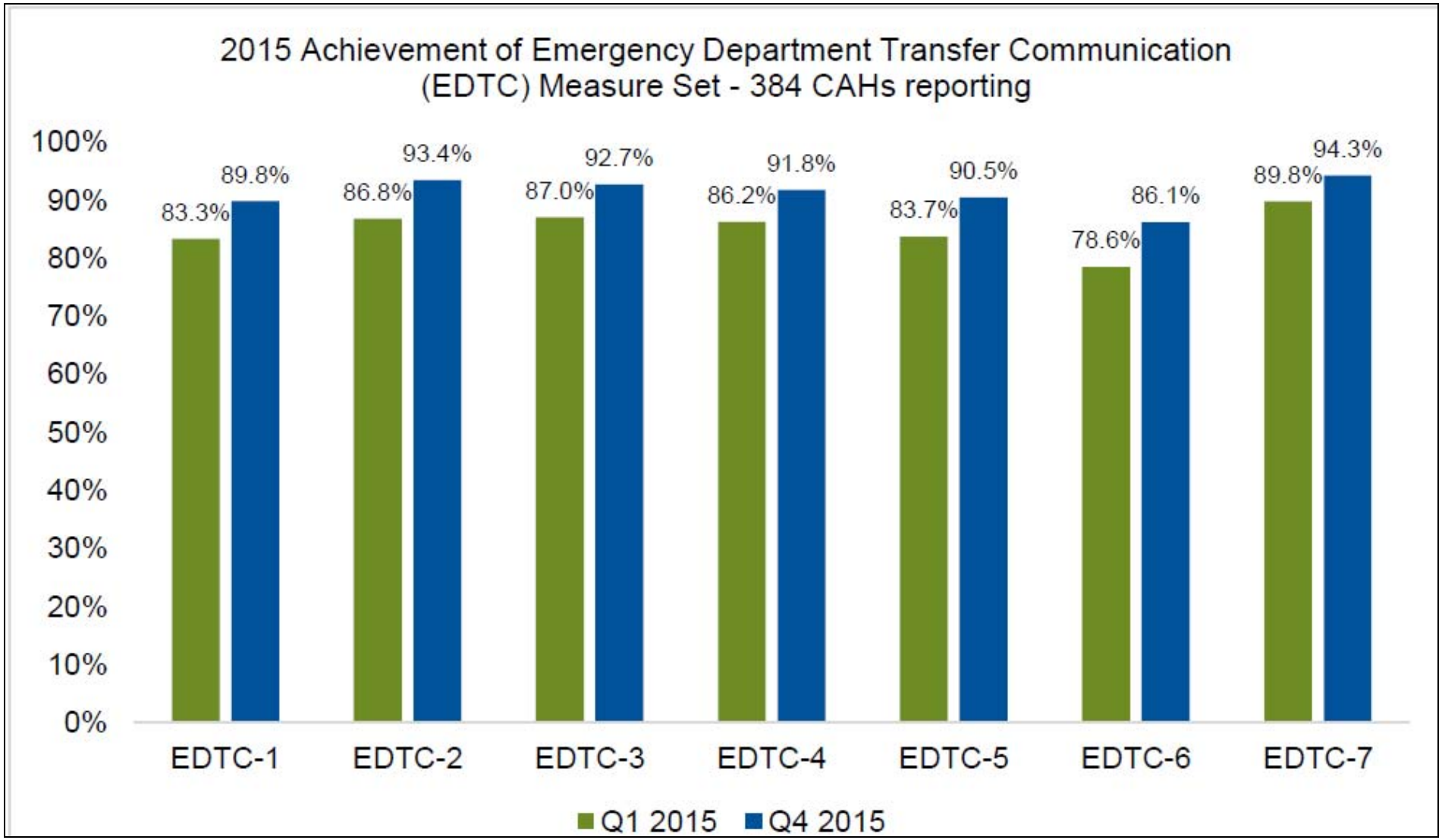

Q4-2015 EDTC Review

Better than or Equal to Nat. Avg.

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4Q2015

Measure Code	Measure Name	Nat. MBQIP Avg. Current Quarter	WV MBQIP Avg.	Broaddus Hospital	Boone Memorial Hospital	Braxton County Memorial Hospital	Grafton City Hospital	Grant Memorial Hospital	Hampshire Memorial Hospital	Jackson General Hospital	Jefferson Memorial Hospital	Minnie Hamilton HealthCare Center	Montgomery General Hospital
EDTC-1	Administrative Comm	88%	89%	89%	73%	100%	96%	100%	54%	67%	89%	98%	84%
EDTC-2	Patient Information	90%	97%	96%	100%	100%	98%	98%	100%	98%	76%	100%	100%
EDTC-3	Vital Signs	90%	97%	96%	100%	100%	93%	89%	100%	91%	91%	93%	100%
EDTC-4	Medication Information	88%	93%	96%	100%	58%	80%	89%	93%	73%	89%	98%	100%
EDTC-5	Practitioner Information	87%	97%	96%	100%	100%	100%	100%	80%	91%	89%	100%	100%
EDTC-6	Nurse Information	82%	94%	87%	100%	100%	93%	93%	98%	89%	87%	98%	89%
EDTC-7	Procedures and Tests	92%	99%	96%	100%	100%	100%	100%	100%	93%	93%	100%	100%
All EDTC	All Measures	66%	74%	82%	73%	58%	64%	69%	34%	49%	62%	87%	73%

Measure Code	Measure Name	Nat. MBQIP Avg. Current Quarter	WV MBQIP Avg.	Plateau Medical Center	Pocahontas Memorial Hospital	Potomac Valley Hospital of WV	Preston Memorial Hospital	Roane General Hospital	Sistersville General Hospital	St. Joseph Hospital	Summers County Appalachian Regional Hospital	War Memorial Hospital	Webster County Memorial Hospital
EDTC-1	Administrative Comm	88%	89%		100%	100%	98%	62%	100%	100%		100%	84%
EDTC-2	Patient Information	90%	97%		100%	100%	100%	100%	98%	98%		100%	87%
EDTC-3	Vital Signs	90%	97%		100%	100%	98%	100%	96%	100%		100%	100%
EDTC-4	Medication Information	88%	93%		100%	98%	100%	100%	98%	100%		100%	96%
EDTC-5	Practitioner Information	87%	97%		100%	98%	100%	100%	98%	100%		100%	100%
EDTC-6	Nurse Information	82%	94%		100%	93%	98%	87%	91%	100%		100%	82%
EDTC-7	Procedures and Tests	92%	99%		100%	100%	100%	100%	98%	100%		100%	100%
All EDTC	All Measures	66%	74%		100%	91%	93%	56%	89%	98%		100%	56%

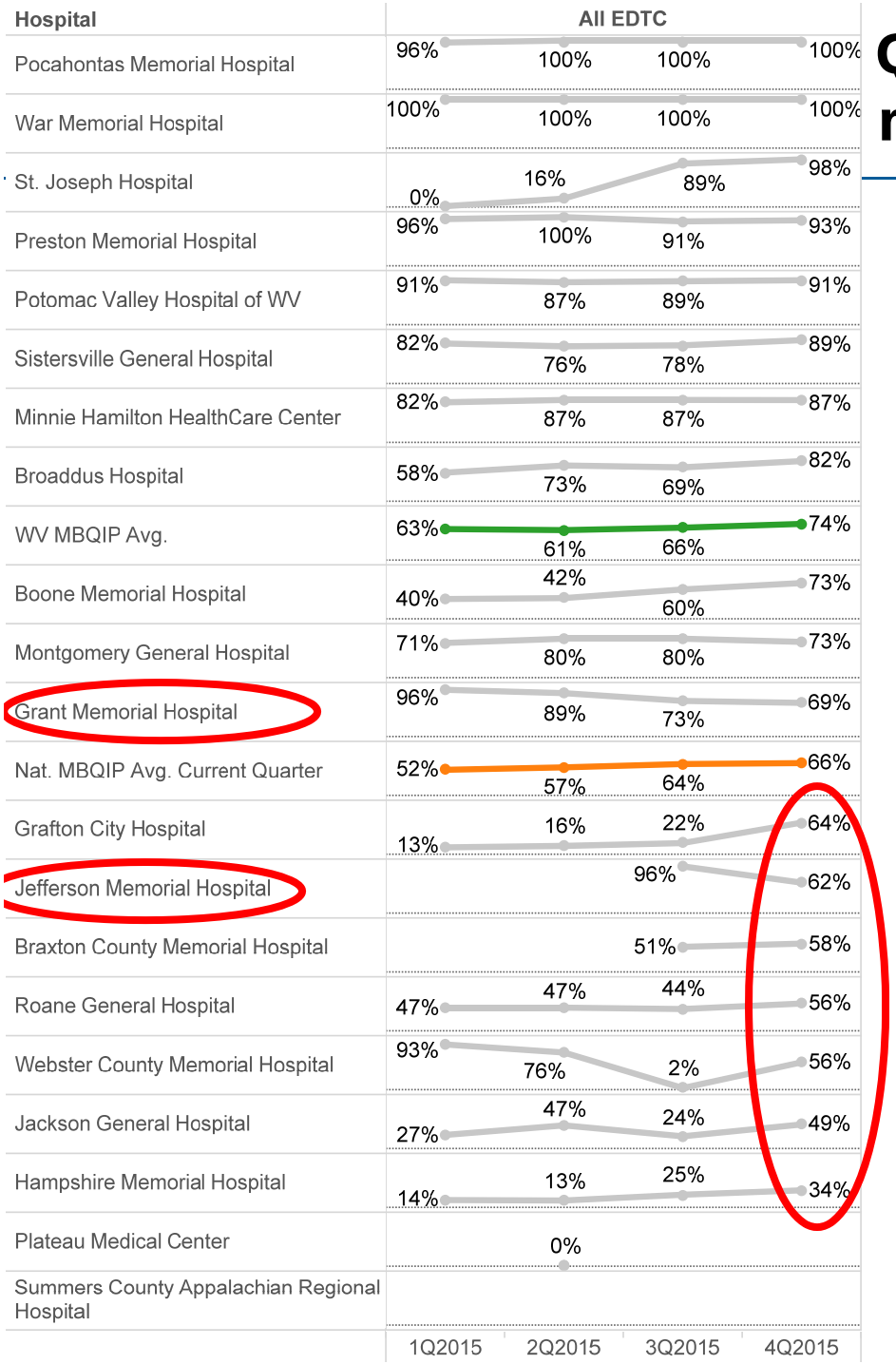
Why no data ?

Why no data ?

The **All EDTC Measures** is not a summation of EDTC 1-7. The All EDTC numerator is a system calculated number that counts how many cases met ALL communication criteria, so this number will not be larger than the lowest numerator found in EDTC 1-7, and will most likely be lower.

Source: Self Reported

Q1-Q4 2015 "All EDTC" sub-measure Trends



Graph shows the "All EDTC" sub-measure score for ID hospitals for the past four quarters.

* The state and national roll-up for the All-EDTC sub-measure is not inclusive of every reporting CAH, as some CAHs did not report this data element.

= less than 65%

Hospitals sorted by score in Q4-2015

Source: Self Reported

EDTC Abstraction & Reporting Tools

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- StratisHealth EDTC Data Collection Guide
  (Last updated in Jan 2016)
  http://www.stratishealth.org/documents/ED-Transfer-Data-Specifications-Manual-12.2015.pdf
- Updated Paper Abstracting Tool
- Updated Appendix B: List of Data Elements (Y, N, NA)
- Updated EDTC Chart Abstraction Quick Tool
- Stroudwater's 2015-2016 EDTC Excel Spreadsheet Data Collection & Reporting Tool (until further notice)

Note: Please email Dianna Iobst who passes on all she needs to me if you have ANY questions or in need of the tools above.

Next Step

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- Reporting timeframe:
  Email the **FLEX Report Tab** (***only***) from EDTC excel spreadsheet provided by Stroudwater by the last day of the month following the end of the quarter:
  - April 15, 2016 for Q1, 2016 (done)
  - July 15, 2016 for Q2, 2016
  - October 15, 2016 for Q3, 2016

- **NOTE:** File your reports as follows :
  - CNN#WVHospitalName EDTC QX.20YY
  - Email a copy of the Flex Report tab from excel to Gregg Lathrop, Stroudwater Analyst (glathrop@stroudwater.com) within above timeline
  - **Also notify Gregg and Dianna if you were not able to participate for some reason or other to prevent having them tracking you down!**

ED Transfers Communication – Measure Elements

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- EDTC SUB-1: *Administrative Communication*
  - Healthcare Facility to Healthcare Facility communication
  - Physician to physician communication

- EDTC SUB-2: *Patient Information*
  - Name
  - Address
  - Age
  - Gender
  - Significant others contact information (name & tel.#)
  - Insurance (company name and policy #)

ED Transfers Communication – Measure Elements

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- EDTC SUB-3: *Vital Signs*
  - Pulse
  - Respiratory rate
  - Blood pressure
  - Oxygen saturation
  - Temperature
  - Glasgow score or other neuro assessment for trauma, cognitively altered or neuro patients only

- EDTC SUB-4: *Medication Information*
  - Medications administered in ED
  - Allergies & Reactions
  - Home medications

Update:
Clarification – allergy reaction is not required

ED Transfers Communication – Measure Elements

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- EDTC SUB-5: *Practitioner Generated Information*
  - History and physical
  - Reason for transfer and/or plan of care
- EDTC SUB-6: *Nurses Information*
  - Assessments/interventions/response
  - Sensory Status (formerly Impairments)
  - Catheters
  - Immobilizations
  - Respiratory support
  - Oral limitations
- EDTC SUB-7: *Procedures & Tests*
  - Tests and procedures done
  - Tests and procedure results sent

WVHA Flex Coordination Needs Assessment for 2016-2017 (with Dianna Iobst)

NETWORKING LUNCH

12:00 Noon to 1:00 PM

1:00 – 2:10

Hospitals to Report Action Plan Update
Setting Expectations for July Action Plan Report

1. Boone Memorial Hospital
2. Braxton County Memorial Hospital
3. Broadus Hospital
4. Grafton City Hospital
5. Grant Memorial Hospital
6. Hampshire Memorial Hospital
7. Jefferson Medical Center
8. Minnie Hamilton Health Care Center
9. Montgomery General Hospital
10. Pocahontas Memorial Hospital
11. Potomac Valley Hospital of WV
12. Preston Memorial Hospital
13. Rhone General Hospital
14. Sistersville General Hospital
15. St. Joseph Hospital
16. Summers County Appalachian Reg.
17. War Memorial Hospital
18. Webster County Memorial Hospital

Action Plan Update

2:10 – 2:30

StratisHealth Resource Review
Rural Quality Improvement Technical Assistance (RQITA) Team

StratisHealth Resource Review

STROUDWATER

- MBQIP Monthly e-Newsletter

  https://www.ruralcenter.org/tasc/mbqip/mbqip-monthly

- MBQIP Monthly is produced in support of the Federal Office of Rural Health Policy by Rural Quality Improvement Technical Assistance, a program by Stratis Health. The last 3 months (Jan/Feb/March) version of MBQIP Monthly are available for download at the website above. Past editions of MBQIP Monthly may be obtained by emailing: tasc@ruralcenter.org

StratisHealth Resource Review

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- MBQIP Monthly e-Newsletter

MBQIP Monthly April 2016 [PDF - 779 KB]

- CAHs Can! Rural Success: Neosho Memorial Regional Medical Center
- Data: CAHs Measure Up - Progress on EDTC Measures
- Tips: Robyn Quips - Tips and Frequently Asked Questions: New CART Versions, IMM-2 Risk of Case Rejection
- Tools and Resources: Helping CAHs Succeed in Quality Reporting & Improvement

MBQIP Monthly March 2016 [PDF 1.2 MB]

- CAHs Can! Rural Success: Mount Desert Island Hospital, Bar Harbor, ME
- Data: CAHs Measure Up - Internally Monitoring OP-22
- Tips: Robyn Quips - Measure Sets, Paper Tools, Current EDTC Spec Manual, Due Date Change
- Tools and Resources

StratisHealth Resource Review

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- MBQIP Monthly e-Newsletter

MBQIP Monthly February 2016 [PDF 833 KB]

- CAHs Can! Rural Success: Wabash General Hospital, Mount Carmel, IL
- Data: CAHs Measure UP - ED Transfer Communication Measure reporting on the rise
- Tips: Robyn Quips - Get your data accepted by QualityNet warehouse
- Tools and Resources: Helping CAHs Succeed in quality reporting and improvement

MBQIP Monthly January 2016 [PDF 877 KB]

- Welcome to MBQIP Monthly!
- CAHs Can! Rural Success: Bigfork Valley Hospital (MN) and HCAHPS
- HCAHPS Reporting Snapshot
- EDTC Measure Updated for Nurse to Nurse Communication
- Tools and Resources

StratisHealth Resource Review

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- Quality Improvement Implementation Guide and Toolkit for Critical Access Hospitals (cont')

https://www.ruralcenter.org/tasc/resources/quality-improvement-implementation-guide-and-toolkit-critical-access-hospitals

Quality Improvement Implementation Guide and Toolkit for Critical Access Hospitals [PDF 947KB]

Brainstorming Tool [Word 33KB]
Internal Quality Monitoring Tool [Excel 531 KB]
Internal Quality Montiroing Tool video tutorial [WMF 23min]
Project Action Plan Template [Word 23 KB]
Quality and Patient Safety Meeting Agenda/Minute Template [Word 35 KB]
Rapid Tests of Change Tool [Word 25 KB]
Rapid Tests of Change Tool - Example [PDF 168 KB]
Ten Step Quality Improvement Project Documentation Template [Word 30 KB]

StratisHealth Resource Review

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- MBQIP Reporting Guide – New Guide from 4/2016
  https://www.ruralcenter.org/tasc/resources/mbqip-reporting-guide

- **Table of Contents**
- Overview
- About MBQIP
- Current MBQIP Measures
- Purpose of This Guide
- How This Guide is Organized
- Quality Data Reporting Channels for MBQIP Required Measures
- Getting Started in QualityNet (with training video)
- CMS Outpatient Measures
- CMS Inpatient Measures
- HCAHPS
- National Healthcare Safety Network (NHSN)
- Emergency Department Transfer Communication (EDTC)
- Acronyms

StratisHealth Resource Review

New Info

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- These are links to the NHSN resources:
- 5-Step Enrollment for Acute Care Hospitals/Facilities - http://www.cdc.gov/nhsn/acute-care-hospital/enroll.html
- Training Resources for NHSN Users Already Enrolled - http://www.cdc.gov/nhsn/acute-care-hospital/hcp-vaccination/index.html
- Healthcare Professional Flu Measure (OP-27) Webinar (Dec 9, 2015) https://www.ruralcenter.org/tasc/resources/healthcare-professional-flu-measure-op-27-webinar

2:30 – 2:40

2:40 – 3:00

New Measure MBQIP Readiness Survey (Individual Hospital Team Assessment)

Why Action Plans & Why Share?

3:00 – 3:30

Expectations for the July Meeting

West Virginia [Hospital Name]

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MBQIP Measure(s)	Activities	Outcome

1. **Column 1: PI/QI MBQIP Team Meeting (1 or more team based on the measures) to meet and make a list of MBQIP measures that were in need of an action plan.**

2. **Column 2: Discuss and document what are the actions/activities you used to improve each applicable measure.**

3. **Column 3: Document Outcome (could be staff acceptance, improved collaboration, new approved P&P and/or process and yes, what was your internal score (from CART/Vendor for most recent available data by mid-July.**

Add new activities going forward if not where you need to be

Is it Time for a Networking "Do-Over"?

1. **Next Meeting: July 28**
    - **Final Benchmark**
    - **MBQIP status**
    - **HCAHPS Team Work**
    - **Final Action Plan Report**

2. **Topics of interest in ½ - ¾ day on 7/29 for continued education/discussion re such topics as: Discharge Planning CoP (Final Rule), Short session on SB Q&A, Post Discharge Calls process and tools….**

3. **Closing Comments**

4. **Safe Travels!**