2016 CLINICAL INFORMATICS SYMPOSIUM

- CONNECTING CARE THROUGH TECHNOLOGY -

The Changing Landscape of Quality Reporting

SEPTEMBER 30, 2016

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Texas Health Resources University

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2016 CLINICAL INFORMATICS SYMPOSIUM

REQUIREMENTS FOR SUCCESSFUL COMPLETION

Learning Outcome:
Attendees will gain knowledge and skills to assist them in the practice of nursing informatics in the clinical setting. Attendees will learn from presenter experiences with the ability to take content and ideas back to their respective health systems to make actionable changes. This knowledge will help drive patient care through the use of informatics.

To receive contact hours for this education activity, the participant must:

- Sign in on the roster
- Attend the entire program
- Complete the evaluation form

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Disclosures (Continued)

Once successful completion has been verified, a “Certificate of Successful Completion” will be awarded for 1contact hour.

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LEARNING OBJECTIVES

- To provide an overview of the rapidly changing quality reporting landscape
- To focus on electronic quality measures (eCQM) as a component of quality reporting
- To demonstrate how eCQMs fit into the quality reporting landscape
- Discuss the role of the informatics nursing in this changing landscape

JPS Health Network

JPS is the public health hospital system for Tarrant County in Fort Worth, Texas

- More than 6,500 employees
- 573-bed acute care teaching hospital with over 200 residents and fellows
- Over 40 primary and specialty care health centers
- 20 school-based health centers
- The county's only psychiatric emergency center
- The only Level 1 Trauma Center in the county
- Correctional Health services for Tarrant County

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The Triple Aim of Healthcare

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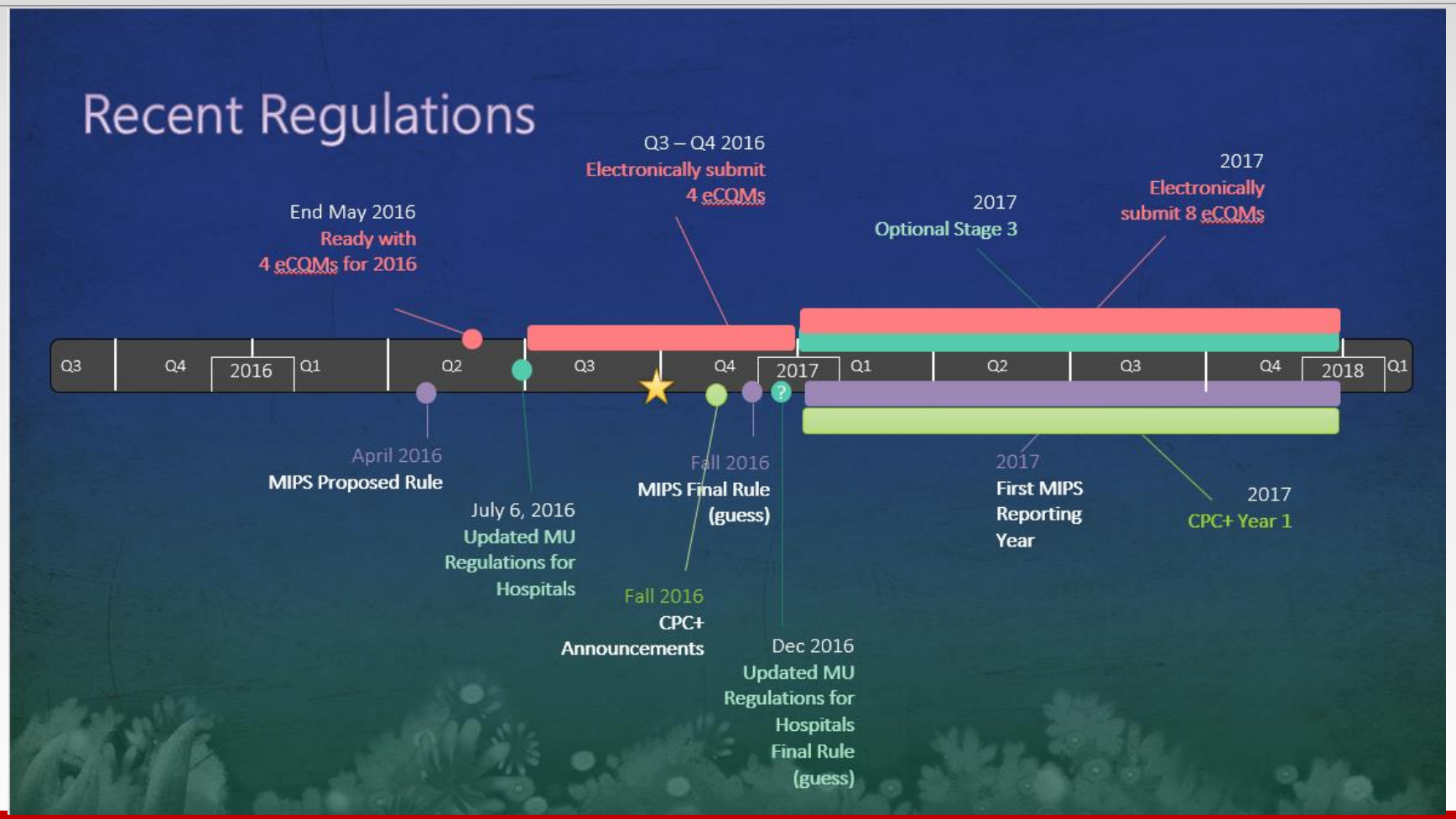
CMS Supports the Triple Aim

- Quality goals include: effective, safe, efficient, patient-centered, equitable, and timely care.
- Promotes and advances the use of health IT to promote health information exchange and improved outcomes for patients
- Utilizes quality measures reporting to quantify healthcare processes, outcomes, patient perceptions, and organizational structure and systems
- Uses quality measures in various initiatives: quality improvement, public reporting, and pay-for-reporting programs for specific healthcare providers.

TIMELINE



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Recent Regulations Impacting eCQM Reporting

Final Hospital Inpatient Prospective Payment Systems (IPPS Rule) released in August 2016

Joint Commission Measures for 2017 released in September 2016

Medicare Incentive Payment System (MIPS) Proposed Rule released in April 2016, final rule due out by Nov. 1, 2016.

Why eCQMs

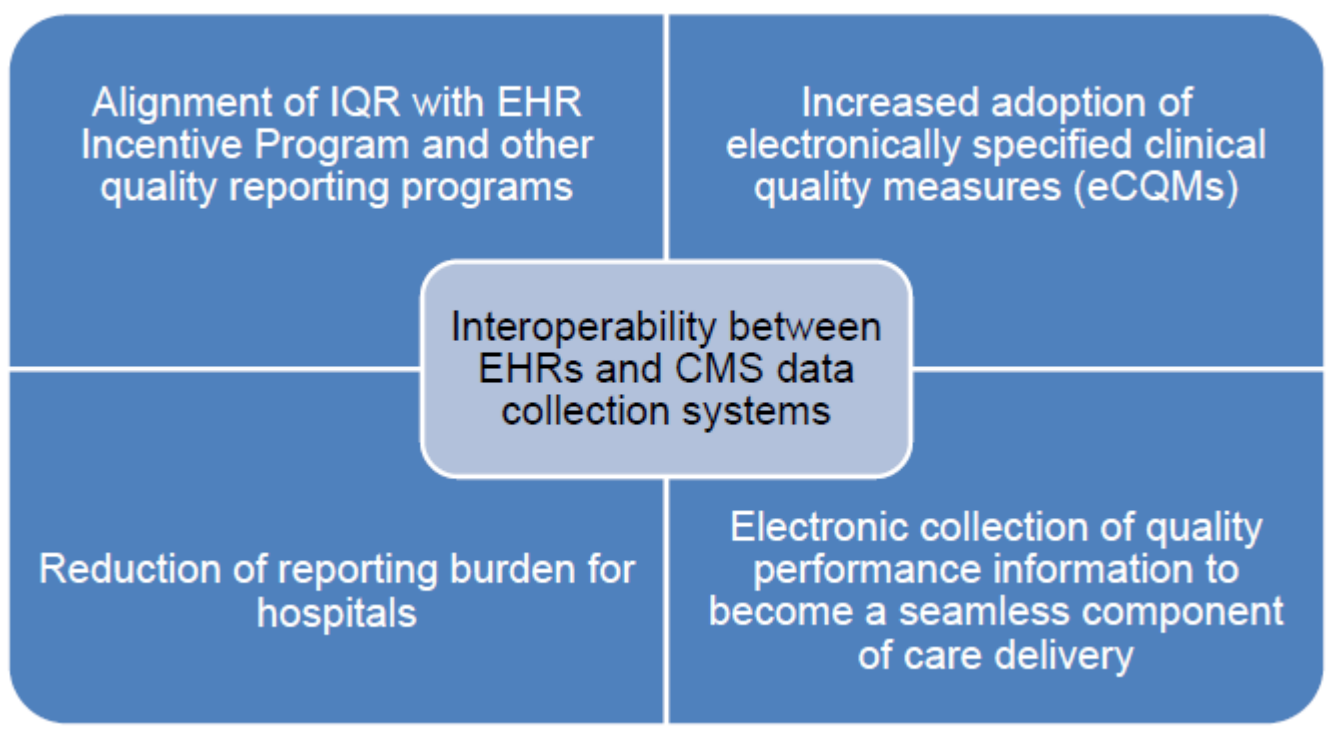
Quality reporting dates back to 1965 when Medicare was established

Since then a multitude of quality reporting programs have been implemented to assess the quality of care provided to Medicare patients

Historically, reporting was done through the evaluation of claims and manual reporting

The goal of electronic reporting is to avoid the limitations of measuring quality from administrative claims (which lack clinical detail) or from manual review of clinical records (which is time-consuming and yields small sample sizes)

CMS Goals for eCQMs



CMS Outlined eCQM Requirements in the 2016 IPPS Final Rule

The Inpatient Prospective Payment System (IPPS) 2016 Final Rule explicitly tied reimbursement to the submission of quality measures electronically (eCQMs) through the Inpatient Quality Reporting Program (IQR)

Hospitals **are required** to submit eCQMs for the CY16 reporting year

Hospitals must report on a minimum of 4 out of the 28 Inpatient Quality Reporting (IQR) clinical quality measures electronically

Hospitals will report on either Q3 or Q4 in 2016

The submission of these eCQMs will count for the EHR Incentive Program (Meaningful Use) as well

Electronic measures will not be reported publicly at this time

By electronically submitting eCQMS for the IQR program, hospitals avoid a reduction in the annual Medicare payment increase

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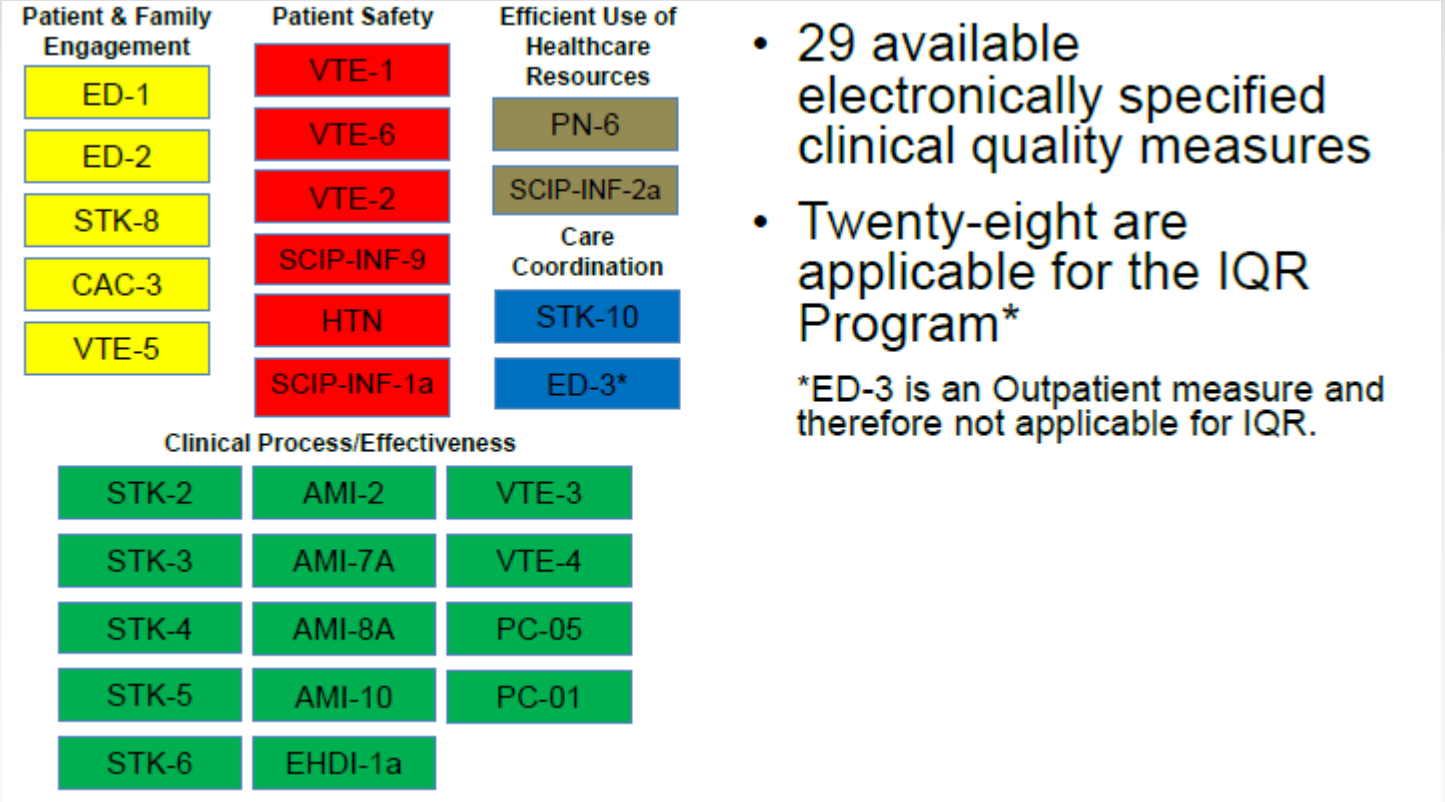
Quality Measures for 2016



- 29 available electronically specified clinical quality measures
- Twenty-eight are applicable for the IQR Program*

*ED-3 is an Outpatient measure and therefore not applicable for IQR.

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CMS eCQM Requirements in the 2017 IPPS Final Rule

The Inpatient Prospective Payment System (IPPS) 2017 Final Rule continues to explicitly tie reimbursement to the submission of quality measures electronically (eCQMs) through the Inpatient Quality Reporting Program (IQR)

Among other changes, CMS removed 13 previous eCQMs, leaving 15 eCQM measures

Hospitals **are required** to submit data for 8 eCQMs for the Reporting Year (RY) 2017 reporting year regardless of domain

Hospitals will report on all four quarters for 2017

The submission of these eCQMs will count for the EHR Incentive Program Meaningful Use (MU) as well

By electronically submitting eCQMS for the IQR program, hospitals receive the full annual percentage increase in Medicare payments

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Differences between 2016-2017

Comparison of 2016 and 2017 eCQMs

Retiring abstracted versions of STK-4 and VTE-5

Require chart-abstracted submissions of ED-1, ED-2, IMM-2, PC-01, Sepsis, VTE-6

For ONC 2015 Edition criteria we do not plan to certify retired measures (also not planning to update retired measure specs)

IQR eCQMs 2016	IQR eCQMs 2017
AMI-2	AMI-2 (retired)
AMI-7a	AMI-7a (retired)
AMI-8a	AMI-8a
AMI-10	AMI-10 (retired)
CAC-3	CAC-3
ED-1	ED-1
ED-2	ED-2
HTN	HTN (retired)
Hearing Screening	Hearing Screening
PC-01	PC-01
PC-05	PC-05
PN-6	PN-6 (retired)
SCIP-INF-1a	SCIP-INF-1a (retired)
SCIP-INF-2a	SCIP-INF-2a (retired)
SCIP-INF-9	SCIP-INF-9 (retired)
STK-2	STK-2
STK-3	STK-3
STK-4	STK-4 (retired)
STK-5	STK-5
STK-6	STK-6
STK-8	STK-8
STK-10	STK-10
VTE-1	VTE-1
VTE-2	VTE-2
VTE-3	VTE-3 (retired)
VTE-4	VTE-4 (retired)
VTE-5	VTE-5 (retired)
VTE-6	VTE-6 (retired)

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Electronic Quality Measures for 2017

ED-1 CMS55v5 *Median Time from ED Arrival to ED Departure for Admitted ED Patients*	**ED-2** CMS111v5 *Admit Decision Time to ED Departure Time for Admitted Patients*	**ED-3*** CMS32v6 *Median Time from ED Arrival to ED Departure for Discharged ED Patients*	**STK -2** CMS104v5 *Discharged on Antithrombotic Therapy*	**STK-3** CMS71v6 *Anticoagulation Therapy for Atrial Fibrillation/Flutter*	**STK-5** CMS72v5 *Antithrombotic Therapy by the End of Hospital Day Two*
STK-6 CMS105v5 *Discharged on Statin Medication*	**STK-8** CMS107v5 *Stroke Education*	**STK-10** CMS102v5 *Assessed for Rehabilitation*	**AMI-8a** CMS53v5 *Primary PCI Received Within 90 Minutes of Hospital Arrival*	**VTE-1** CMS108v5 *Venous Thromboembolism Prophylaxis*	**VTE-2** CMS190v5 *Intensive Care Unit Venous Thromboembolism Prophylaxis*
PC-01 CMS113v5 *Elective Delivery*	**PC-05** CMS9v5 *Exclusive Breast Milk Feeding*	**CAC-3** CMS26v4 *Home Management Plan of Care Document Given to Patient/Caregiver*	**EHDI-1a** CMS31v5 *Hearing Screening Prior to Hospital Discharge*	* ED-3 is an Outpatient measure and is not applicable for IQR aligned credit.	

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eCQMs for Hospitals is Just the Beginning…

- CMS also proposes to align reporting programs for providers under the proposed MIPS program under MACRA. (MACRA/MIPS)
- CMS will combine the Physician Quality Reporting Program (PQRS), Meaningful Use for providers, and the Value-Based Payment Modifier under MIPS.
- 75% of a provider's score will be based on quality reporting and a bonus will be received if reporting directly from an EHR—provider's will utilize QRDA III (provider level data)

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Moving towards value-based payments

MIPS (Merit-Based Incentive System): starts with 2019 payments based on performance in 2017.

- Encourages "alternative payment models" (APM) such as ACOs and PCMH
- CMS will apply a positive, negative, or neutral payment adjustment to each MIPS Eligible Clinician based on performance across four categories:
  - Quality
  - Advancing Care Information (MU)
  - Resource use
  - Clinical practice improvement activities
- Physicians, PAs, NPs, Clinical nurse specialists, Certified registered nurse anesthetists will be covered by MIPS

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How do eCQMs work?

- All data is entered into the EMR by providers as part of their workflow and then extracted to a QRDA I (Quality Reporting Data Architecture—patient level data) format for reporting
- All information must be entered into the patient record as discrete data
- There is no abstraction allowed for eCQMs
- The data goes to CMS and CMS will do the calculations for the denominator and numerator and send results back to the hospital

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Creating eCQMs

eCQM configuration requires a specific format and build defined by CMS and is very time and labor intensive

eCQM for Stroke-4

eMeasure Title	**Thrombolytic Therapy**		
eMeasure Identifier (Measure Authoring Tool)	91	**eMeasure Version number**	5.0.000
NQF Number	0437	**GUID**	2838875a-07b5-4bf0-be04-c3eb99f53975
Measurement Period	January 1, 20XX through December 31, 20XX		
Measure Steward	The Joint Commission		
Measure Developer	The Joint Commission		
Endorsed By	National Quality Forum		
Description	Acute ischemic stroke patients who arrive at this hospital within 2 hours of time last known well and for whom t-PA was initiated at this hospital within 3 hours of time last known well.		
Copyright	Measure specifications are in the Public Domain. LOINC(R) is a registered trademark of the Regenstrief Institute. This material contains SNOMED Clinical Terms (R) (SNOMED CT(C)) copyright 2004-2014 International Health Terminology Standards Development Organization. All rights reserved.		
Disclaimer	These performance measures are not clinical guidelines and do not establish a standard of medical care, and have not been tested for all potential applications. The measures and specifications are provided without warranty.		
Measure Scoring	Proportion		
Measure Type	Process		
Measure Item Count	Encounter, Performed: Non-Elective Inpatient Encounter		
Stratification	None		
Risk Adjustment	None		
Rate Aggregation	None		
Rationale	The administration of thrombolytic agents to carefully screened, eligible patients with acute ischemic stroke has been shown to be beneficial in several clinical trials. These included two positive randomized controlled trials in the United States: The National Institute of Neurological Disorders and Stroke (NINDS) Studies, Part I and Part II. Based on the results of these studies, the Food and Drug Administration (FDA) approved the use of intravenous recombinant tissue plasminogen activator (IV r-tPA or t-PA) for the treatment of acute ischemic stroke when given within 3 hours of stroke symptom onset. A large meta-analysis controlling for factors associated with stroke outcome confirmed the benefit of IV t-PA in patients treated within 3 hours of symptom onset. While controversy still exists among some specialists, the major society practice guidelines developed in the United States all recommend the use of IV t-PA for eligible patients. Physicians with experience and skill in stroke management and the interpretation of CT scans should supervise treatment. The European Cooperative Acute Stroke Study (ECASS) III trial indicated that intravenous r-tPA can be given safely to, and can improve outcomes for, carefully selected patients treated 3 to 4.5 hours after stroke; however, as the NINDS investigators concluded, the earlier that IV thrombolytic therapy is initiated, the better the patient outcome. Therefore, the target for IV t-PA initiation remains within 3 hours of time last known well. The administration of IV thrombolytic therapy beyond 3 hours of stroke symptom onset has not been FDA approved.		
Clinical Recommendation Statement	The administration of thrombolytic agents to carefully screened, eligible patients with acute ischemic stroke has been shown to be beneficial in several clinical trials. Intravenous recombinant tissue plasminogen activator (IV r-tPA or t-PA) should be used for the treatment of acute ischemic stroke when given within 3 hours of stroke symptom onset.		
Improvement Notation	Improvement is noted as an increase in rate		
Reference	del Zoppo GJ, Saver JL, Jauch EC, Adams HP. Expansion of the Time Window for Treatment of Acute Ischemic Stroke With Intravenous Tissue Plasminogen Activator: A Science Advisory From the American Heart Association/ American Stroke Association. Stroke. 2009;40:2945-2948.		
Reference	Guyatt, G. H., E. A. Akl, M. Crowther, D. D. Gutterman, H. J. Schuunemann, Therapy American College of Chest Physicians Antithrombotic, and Panel Prevention of Thrombosis. "Executive Summary: Antithrombotic Therapy and Prevention of Thrombosis, 9th Ed: American College of Chest Physicians Evidence-Based Clinical Practice Guidelines." [In eng]. Chest 141, no. 2 Suppl (Feb 2012): 7S-47S.		
Reference	Jauch, E. C., J. L. Saver, H. P. Adams, Jr., A. Bruno, J. J. Connors, B. M. Demaerschalk, P. Khatri, et al. "Guidelines for the Early Management of Patients with Acute Ischemic Stroke: A Guideline for Healthcare Professionals from the American Heart Association/American Stroke Association." [In Eng]. Stroke (Jan 31 2013).		

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Required Terminology Mapping

Data Criteria (QDM Data Elements)

- "Diagnosis, Active: Hemorrhagic Stroke" using "Hemorrhagic Stroke Grouping Value Set (2.16.840.1.113883.3.117.1.7.1.212)"
- "Diagnosis, Active: Ischemic Stroke" using "Ischemic Stroke Grouping Value Set (2.16.840.1.113883.3.117.1.7.1.247)"
- "Encounter, Performed: Emergency Department Visit" using "Emergency Department Visit SNOMEDCT Value Set (2.16.840.1.113883.3.117.1.7.1.292)"
- "Encounter, Performed: Non-Elective Inpatient Encounter" using "Non-Elective Inpatient Encounter SNOMEDCT Value Set (2.16.840.1.113883.3.117.1.7.1.424)"
- "Intervention, Order: Comfort Measures " using "Comfort Measures SNOMEDCT Value Set (1.3.6.1.4.1.33895.1.3.0.45)"
- "Intervention, Performed: Comfort Measures " using "Comfort Measures SNOMEDCT Value Set (1.3.6.1.4.1.33895.1.3.0.45)"
- "Laboratory Test, Performed: INR" using "INR LOINC Value Set (2.16.840.1.113883.3.117.1.7.1.213)"
- "Laboratory Test, Performed: Partial Thromboplastin Time" using "Partial Thromboplastin Time LOINC Value Set (2.16.840.1.113762.1.4.1045.25)"
- "Laboratory Test, Performed: Platelet Count" using "Platelet Count LOINC Value Set (2.16.840.1.113883.3.117.1.7.1.267)"
- "Laboratory Test, Performed: Prothrombin Time" using "Prothrombin Time LOINC Value Set (2.16.840.1.113762.1.4.1045.24)"
- "Medication, Administered: Thrombolytic (t-PA) Therapy" using "Thrombolytic (t-PA) Therapy RXNORM Value Set (2.16.840.1.113883.3.117.1.7.1.226)"
- "Medication, Administered not done: Patient Refusal" using "Patient Refusal SNOMEDCT Value Set (2.16.840.1.113883.3.117.1.7.1.93)"
- "Medication, Administered not done: Medical Reason" using "Medical Reason SNOMEDCT Value Set (2.16.840.1.113883.3.117.1.7.1.473)"
- "Medication, Order: t-PA ingredient specific" using "t-PA ingredient specific RXNORM Value Set (2.16.840.1.113762.1.4.1021.6)"
- "Medication, Order not done: Patient Refusal" using "Patient Refusal SNOMEDCT Value Set (2.16.840.1.113883.3.117.1.7.1.93)"
- "Medication, Order not done: Medical Reason" using "Medical Reason SNOMEDCT Value Set (2.16.840.1.113883.3.117.1.7.1.473)"
- "Physical Exam, Performed: Baseline State" using "Baseline State SNOMEDCT Value Set (2.16.840.1.113883.3.117.1.7.1.417)"
- "Physical Exam, Performed: Diastolic Blood Pressure" using "Diastolic Blood Pressure LOINC Value Set (2.16.840.1.113883.3.526.2.1045)"
- "Physical Exam, Performed: Systolic Blood Pressure" using "Systolic Blood Pressure LOINC Value Set (2.16.840.1.113883.3.526.2.1044)"
- "Physical Exam, Performed: Time of Symptom Onset" using "Time of Symptom Onset SNOMEDCT Value Set (2.16.840.1.113762.1.4.1045.14)"
- "Procedure, Performed: Intravenous Thrombolytic (t-PA) Therapy" using "Intravenous Thrombolytic (t-PA) Therapy SNOMEDCT Value Set (2.16.840.1.113762.1.4.1045.15)"
- "Risk Category Assessment: National Institute of Health Stroke Scale" using "National Institute of Health Stroke Scale LOINC Value Set (2.16.840.1.113883.3.117.1.7.1.269)"
- Attribute: "Ordinality: Principal" using "Principal SNOMEDCT Value Set (2.16.840.1.113883.3.117.1.7.1.14)"

Supplemental Data Elements

- "Patient Characteristic Ethnicity: Ethnicity" using "Ethnicity CDCREC Value Set (2.16.840.1.114222.4.11.837)"
- "Patient Characteristic Payer: Payer" using "Payer SOP Value Set (2.16.840.1.114222.4.11.3591)"
- "Patient Characteristic Race: Race" using "Race CDCREC Value Set (2.16.840.1.114222.4.11.836)"
- "Patient Characteristic Sex: ONC Administrative Sex" using "ONC Administrative Sex AdministrativeGender Value Set (2.16.840.1.113762.1.4.1)"

Required Mapping Information

	A	B	C	D	E	F	G
1	NIH Value Set Authority Center U.S. National Library of Medicine						
2	CMS ID	NQF Number	Value Set Name	Value Set OID	QDM Category	Definition Version	Expansion Version
3	CMS91v5	0437	Baseline State	2.16.840.1.113883.3.117.1.7.1.417	Physical Exam	20150430	MU2 Update 2015-05-01
4	CMS91v5	0437	Comfort Measures	1.3.6.1.4.1.33895.1.3.0.45	Intervention	20150430	MU2 Update 2015-05-01
5	CMS91v5	0437	Comfort Measures	1.3.6.1.4.1.33895.1.3.0.45	Intervention	20150430	MU2 Update 2015-05-01
6	CMS91v5	0437	Comfort Measures	1.3.6.1.4.1.33895.1.3.0.45	Intervention	20150430	MU2 Update 2015-05-01
7	CMS91v5	0437	Comfort Measures	1.3.6.1.4.1.33895.1.3.0.45	Intervention	20150430	MU2 Update 2015-05-01
8	CMS91v5	0437	Diastolic Blood Pressure	2.16.840.1.113883.3.526.2.1045	Physical Exam	20150430	MU2 Update 2015-05-01
9	CMS91v5	0437	Emergency Department Visit	2.16.840.1.113883.3.117.1.7.1.292	Encounter	20150430	MU2 Update 2015-05-01
10	CMS91v5	0437	Ethnicity	2.16.840.1.114222.4.11.837	Individual	20121025	MU2 Update 2015-05-01
11	CMS91v5	0437	Ethnicity	2.16.840.1.114222.4.11.837	Individual	20121025	MU2 Update 2015-05-01
12	CMS91v5	0437	Hemorrhagic Stroke	2.16.840.1.113883.3.117.1.7.1.212	Condition/Diagnosis/P	20150430	MU2 Update 2015-05-01
13	CMS91v5	0437	Hemorrhagic Stroke	2.16.840.1.113883.3.117.1.7.1.212	Condition/Diagnosis/P	20150430	MU2 Update 2015-05-01
14	CMS91v5	0437	Hemorrhagic Stroke	2.16.840.1.113883.3.117.1.7.1.212	Condition/Diagnosis/P	20150430	MU2 Update 2015-05-01
15	CMS91v5	0437	Hemorrhagic Stroke	2.16.840.1.113883.3.117.1.7.1.212	Condition/Diagnosis/P	20150430	MU2 Update 2015-05-01
16	CMS91v5	0437	Hemorrhagic Stroke	2.16.840.1.113883.3.117.1.7.1.212	Condition/Diagnosis/P	20150430	MU2 Update 2015-05-01
17	CMS91v5	0437	Hemorrhagic Stroke	2.16.840.1.113883.3.117.1.7.1.212	Condition/Diagnosis/P	20150430	MU2 Update 2015-05-01
18	CMS91v5	0437	Hemorrhagic Stroke	2.16.840.1.113883.3.117.1.7.1.212	Condition/Diagnosis/P	20150430	MU2 Update 2015-05-01
19	CMS91v5	0437	Hemorrhagic Stroke	2.16.840.1.113883.3.117.1.7.1.212	Condition/Diagnosis/P	20150430	MU2 Update 2015-05-01
20	CMS91v5	0437	Hemorrhagic Stroke	2.16.840.1.113883.3.117.1.7.1.212	Condition/Diagnosis/P	20150430	MU2 Update 2015-05-01
21	CMS91v5	0437	Hemorrhagic Stroke	2.16.840.1.113883.3.117.1.7.1.212	Condition/Diagnosis/P	20150430	MU2 Update 2015-05-01
22	CMS91v5	0437	Hemorrhagic Stroke	2.16.840.1.113883.3.117.1.7.1.212	Condition/Diagnosis/P	20150430	MU2 Update 2015-05-01
23	CMS91v5	0437	Hemorrhagic Stroke	2.16.840.1.113883.3.117.1.7.1.212	Condition/Diagnosis/P	20150430	MU2 Update 2015-05-01
24	CMS91v5	0437	Hemorrhagic Stroke	2.16.840.1.113883.3.117.1.7.1.212	Condition/Diagnosis/P	20150430	MU2 Update 2015-05-01
25	CMS91v5	0437	Hemorrhagic Stroke	2.16.840.1.113883.3.117.1.7.1.212	Condition/Diagnosis/P	20150430	MU2 Update 2015-05-01
26	CMS91v5	0437	Hemorrhagic Stroke	2.16.840.1.113883.3.117.1.7.1.212	Condition/Diagnosis/P	20150430	MU2 Update 2015-05-01
27	CMS91v5	0437	Hemorrhagic Stroke	2.16.840.1.113883.3.117.1.7.1.212	Condition/Diagnosis/P	20150430	MU2 Update 2015-05-01
28	CMS91v5	0437	Hemorrhagic Stroke	2.16.840.1.113883.3.117.1.7.1.212	Condition/Diagnosis/P	20150430	MU2 Update 2015-05-01
29	CMS91v5	0437	Hemorrhagic Stroke	2.16.840.1.113883.3.117.1.7.1.212	Condition/Diagnosis/P	20150430	MU2 Update 2015-05-01
30	CMS91v5	0437	Hemorrhagic Stroke	2.16.840.1.113883.3.117.1.7.1.212	Condition/Diagnosis/P	20150430	MU2 Update 2015-05-01
31	CMS91v5	0437	Hemorrhagic Stroke	2.16.840.1.113883.3.117.1.7.1.212	Condition/Diagnosis/P	20150430	MU2 Update 2015-05-01
32	CMS91v5	0437	Hemorrhagic Stroke	2.16.840.1.113883.3.117.1.7.1.212	Condition/Diagnosis/P	20150430	MU2 Update 2015-05-01
33	CMS91v5	0437	Hemorrhagic Stroke	2.16.840.1.113883.3.117.1.7.1.212	Condition/Diagnosis/P	20150430	MU2 Update 2015-05-01
34	CMS91v5	0437	Hemorrhagic Stroke	2.16.840.1.113883.3.117.1.7.1.212	Condition/Diagnosis/P	20150430	MU2 Update 2015-05-01
35	CMS91v5	0437	Hemorrhagic Stroke	2.16.840.1.113883.3.117.1.7.1.212	Condition/Diagnosis/P	20150430	MU2 Update 2015-05-01
36	CMS91v5	0437	Hemorrhagic Stroke	2.16.840.1.113883.3.117.1.7.1.212	Condition/Diagnosis/P	20150430	MU2 Update 2015-05-01
37	CMS91v5	0437	Hemorrhagic Stroke	2.16.840.1.113883.3.117.1.7.1.212	Condition/Diagnosis/P	20150430	MU2 Update 2015-05-01
38	CMS91v5	0437	Hemorrhagic Stroke	2.16.840.1.113883.3.117.1.7.1.212	Condition/Diagnosis/P	20150430	MU2 Update 2015-05-01
39	CMS91v5	0437	Hemorrhagic Stroke	2.16.840.1.113883.3.117.1.7.1.212	Condition/Diagnosis/P	20150430	MU2 Update 2015-05-01

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Building and Implementation

- The build requires global terminology mapping for all measures—such as ethnicity, payor—address this build first
- Then, break it down, do one measure at a time.
- What is already mapped with ICD codes, Rx Norm?
- Determine what you need to map based on workflow
- Once build is complete use validated test scripts to test your build of eCQM
- Utilize testing tools provided by your vendor (if available) to the fullest before you move the build to prod

Testing eCQMs

- Once you confirm that your build is correct, you need to test with CMS tools.
- CMS encourages testing with the Pre-Submission Validation Application through the *QualityNet Secure Portal*.
- This testing allows submitters to catch and correct errors prior to data submission to the Centers for Medicare & Medicaid Services (CMS)
- It takes time to set up a user to access the QNet to use the tool, so leave yourself ample time to get this done

Beyond eCQMs

In the IPPS Final Rule, CMS outlined the full quality measure set a hospital must report on. Submitting eCQM does not eliminate the requirement to submit data for the remaining chart-abstracted, web-based, and claims-based measures. In the 2017, in addition to eCQMs, hospitals must report on:

- 6 National Healthcare Safety Network (NSHN) measures including CAUTI, CLABSI, AND SSI
- 6 chart-abstracted measures including influenza immunization and SEPSIS
- If a hospital choses to report on the ED eCQMs, they still must continue to report ED-1 and ED-2 as abstracted measures
- 20 claims-based outcome measures including mortality, readmission and patient safety measures
- 11 claims-based payment measures
- HCAHPS is a required
- 2 structural measures--Patient Safety Culture and Safe Surgery Checklist

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What are the differences between abstracted measures and eCQMs?

Abstracted:

- Sample size
- Data documented in patient record
- Chart Review by abstractors
- Mediate discrepancies
- Extracted to ORYX vendor, validated, calculated
- Post discharge analysis

eCQMs:

- All patients
- Structured/discrete data is entered into EMR by providers
- Data is codified to CMS standards
- Data is sent from EMR to CMS via QRDA I reports
- CMS does all calculations

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How do we successfully meet so many diverse quality measures?

The key to success is complete and concise provider documentation and an accurate problem list for optimal reporting.

A new model is needed

- In order to meet the challenges of changing quality reporting requirements, a new paradigm is needed
- More that ever before the silos between quality, clinical documentation improvement, and IT have to go away
- A collaborative effort is needed
- Informatics nurses are uniquely situated to support this effort—nurses are abstractors, clinical documentation improvement specialists, case managers, and IT professionals

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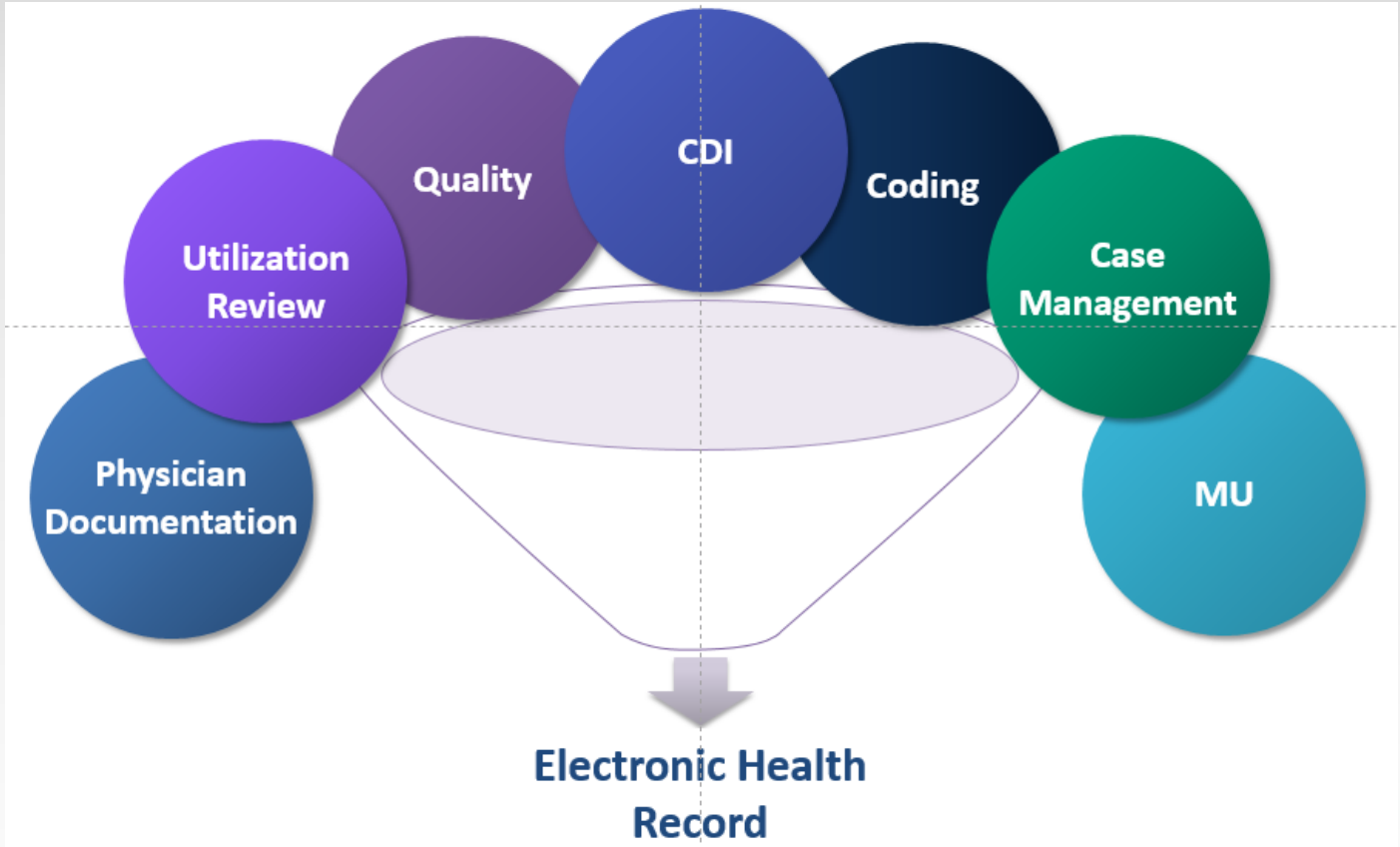
More than ever before, we need to work collaboratively to enhance patient care and improve quality scores



Key steps that we are taking now…

- Move from departmental initiatives to overall quality initiatives
- Educate leadership and providers about the changes in Quality Reporting
- Meet continually with the Quality, HIM and IT teams to understand the interdependencies, and create continuous improvement in processes and data
- Meet with our provider groups to be sure they are aware and understand how the changes in quality reporting impact them
- Orient physicians to the connectivity of the process and provide as much efficiencies as possible
- Measure and celebrate success!

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QUESTIONS & DISCUSSION

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