Core Measures and Clinical Data

Objectives
At the end of the session the learner will be able to identify:
- Various types of clinical data that is collected and reported
- What Core Measures are and their purpose
- The importance and implications of public reporting
- Every individual’s role in improving patient outcomes

Topics of discussion
- What are core measures?
- How can we improve them?
- What is public reporting?
- Why does it matter?
- What is my role in improving patient outcomes?
Defining quality in healthcare

Institute of Medicine

“The degree to which health services for individuals and populations increase the likelihood of desired health outcomes and are consistent with current professional knowledge.”

Clinical Data

- Core Measures
- Mortality
- Infection
- Public Health
- Harm data (MN, PA and others, not WI yet)
- Registries (AMI, Stroke, Tumor)
- Organ/Tissue Donation
- Adverse Drug Reactions

Who requires reporting of clinical data?

- CMS (federal government)
- Joint Commission and other accrediting agencies
- State of Wisconsin
- US Department of Health and Human Services
- CDC Center for Disease Control
- Law enforcement (Sexual assaults, etc)
- National and state registries
- FDA Food and Drug Administration
Core Measures defined
- A core measure is a healthcare quality measure that utilizes the results of evidence based medicine research.
- These basic core measure principles imply that it is reasonable to expect that every patient with the given diagnosis will receive the baseline (core) care established through such research.

How are Core Measures chosen?
- Following well established quality improvement principles, the Core Measures represent high volume, high cost diagnoses associated with an increased rate of morbidity or mortality.
- The CMS goal is the same as most quality improvement projects: to do the greatest good possible for the most people.

Who generates this data?
- Core measures are abstracted and reviewed by clinical personnel within the institution
- Performance is assessed by comparing the care to the designated template
- Results are recorded electronically either directly to CMS or through another vendor
- Validation programs exist to ensure that the abstraction is accurate
How are Core Measures reported?

- The reported results represent the percentage of patients admitted with a specific diagnosis who receive the recommended care measure.

Number of patients receiving expected care
Total number of patients with given diagnosis = %

All or nothing scoring

- Appropriateness of Care measure calculations
- While there are many indicators in each of the core measure sets, many reports use only the appropriateness of care score which is obtained by counting all the patients who met every indicator in the measure set and dividing that number by the total number of patients with the diagnosis.

Appropriateness of Care Score

Example:
- In one month the facility has 10 patients admitted with pneumonia.
- Of these 10, only 2 receive all of the core measures recommended by CMS.
- Even though each indicator had a compliance rate higher than 67% the public would only see this facility's overall appropriateness of care score for pneumonia patients which is 20% for that month.
History of Core Measures

- The first CMS Core measure (then called the National Hospital Quality Measures) collection started in 2003.
  - Started with:
    - 10 AMI indicators
    - 4 CHF indicators
    - 12 Pneumonia indicators
    - 3 Surgical care improvement indicators
    - 2 Pregnancy related indicators measures
  - The only 2 outcome measures were morality for AMI and neonatal. (31 process + 2 outcome measures)
- Core Measures are revised frequently

In 2014 Core Measures:

- ED – 3 indicators
- Stroke – 7 indicators
- VTE – 5 indicators
- AMI – 4 indicators
- Pregnancy – 1 indicators
- Pneumonia – 1 indicators
- SCIP – 3 indicators

Other Core Measures

- Global Immunization Measure Set
- Outpatient Surgical
- Tobacco Cessation
- Pediatric Asthma
- Breastfeeding
- Hearing Screening
AMI
- Acute Myocardial Infarction (AMI)
- America’s biggest killer
- Each year 1.1 million have an AMI
- 2/3 do not make a full recovery

Heart Failure
- Accounts for more than 700,000 hospitalizations a year and is associated with high rates of mortality, morbidity and readmission.

Pneumonia
- Pneumonia accounts for nearly 600,000 Medicare patient hospitalizations with more than 4.5 million inpatient days each year.
- It is also the principal reason for more than 500,000 emergency room visits a year for Medicare patients.
SCIP
- Surgical care measures are focused on reducing complications of surgery.
- It is reported that 22% of preventable deaths are related to surgical complications.
- Approximately 500,000 surgical site infections occur annually. If infection occurs the patient is 60% more likely to go to ICU and 5 times more likely to be readmitted for further care.

VTE
- VTE - Surgical patients also develop venous thrombosis 20 times more often than medical patients. Pulmonary embolism causes 300,000 death a year and is the third leading cause of hospital deaths.

Checkpoint clinical measures
- AMI
- CHF
- Pneumonia
- SCIP
- HCAHPS
- Perinatal
- CMS 30 day readmission
- Error prevention
- Mortality
- Stroke
- Infections
Outcome Quality Measures

CMS has shifted it's focus from reporting compliance with the recommended process of providing care sharing the outcomes of care with the public.

The first two outcome measures that were reported were:
- Readmission rates and
- Death rates

for patients having a heart attack, congestive heart failure and pneumonia.

Public reporting of data

- Hospital Compare
  - http://www.medicare.gov/hospitalcompare/search.html
- Checkpoint
- Metastar (QIO Quality Improvement Organization)
  - https://www.metastar.com/web/
- State Vital Statistics Office
  - http://www.dhs.wisconsin.gov/stats/vitalstatistics.htm

What is Value Based Purchasing?

Also known as "P4P" or "value-based purchasing," this payment model rewards physicians, hospitals, medical groups, and other healthcare providers for meeting certain performance measures for quality and efficiency.
What is “Meaningful Use?”

- Federal financial incentive program for hospitals and providers
- Entities need to show they’re using certified Electronic Health Record technology in ways that can be measured significantly in quality and in quantity
- Three stages
  - Stage One – Data capturing and sharing 2011-2012
  - Stage Two – Advance clinical process 2014
  - Stage Three – Improved outcomes 2016
- Financial incentives are provided at each stage upon attestation

Meaningful Use 2014:

- Hospitals and CAHs must report on 16/29 measures covering 3/6 domains in order to receive Meaningful Use funds
- Providers must report on 9/64 measures covering 3/6 domains in order to receive Meaningful Use funds

6 domains of core measures

- Patient and Family Engagement
- Patient Safety
- Care Coordination
- Population and Public Health
- Efficient Use of Healthcare Resources
- Clinical Processes/Effectiveness
What is POA?

- Present on Admission
- A condition that is present at the time the order for inpatient admission occurs.
- Conditions that develop during an outpatient encounter, including emergency department services, observation, or outpatient surgery, are considered as present on admission.

What is HAC?

- Hospital Acquired Condition
- An undesirable situation or condition that affects a patient, that arose during a stay in a hospital or medical facility.

Hospital Acquired Conditions

- Foreign object retained after surgery
- Air embolism
- Blood incompatibility
- Pressure Ulcer stage III or IV
- Falls and trauma with serious injury
- Vascular associated infections
- Catheter associated infections
- Manifestations of poor glycemic control
Why are Core Measure results important?

1. To provide the best care to each patient every time he/she is admitted to the hospital.
2. To assure the community that the hospital provides high quality care.
3. With the public reporting of quality measures compliance and cost of care, the patients can now choose the facility they think will best meet their needs.

4. The Board of Directors is charged with assuring quality care and must have a tool to determine how the facility is doing in regard to providing care for the community.
5. Facilities that maintain higher percentages of compliance with the core measures receive higher reimbursement from Medicare and other payers.

Benefits of providing quality care

1. Decreased operational costs through improved care processes and shortened lengths of stay.
2. Increased patient satisfaction
3. Meeting accreditation or regulatory requirements.
4. Demonstrating an enhanced reputation in your community by showing your hospital’s commitment to quality health care.
Quality Care takes Teamwork

- It is important that everyone understands and supports the indicators included in each core measure bundle.
- Some of the indicators are physician driven
- Some are nursing measures.

Thank you for participating!

Two more webinars:
- Feb 7
  - Patient Satisfaction
- Feb 14
  - Risk Management