Preparing Critical Access Hospitals (CAHs) for the New World of Hospital Measurement

Annette Kritzler
Hospital Program Manager

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Objectives

• Describe the MN Health Reform Initiative
• Describe the 2010 MN hospital quality measures required by the new rule
• Explain the implications for Critical Access Hospitals (CAHs)
• Describe the 2011 changes for hospitals
Overview

The Basics of Minnesota’s Health Reform Initiative and Its Implications for Rural Hospitals

• In 2008, the state legislature passed and Governor Pawlenty signed significant health care reform legislation into law
• Follow details about the law, and sign up for email alerts at:

http://www.health.state.mn.us/healthreform
Minnesota Health Care Reform Initiative

• Based on Institute for Healthcare Improvement’s (IHI) Triple Aim to simultaneously:
  – improve the health of the population
  – improve the patient/consumer experience
  – improve the affordability of health care

Health Reform Implementation Update June 2010
http://www.health.state.mn.us/healthreform/
Population Health

• Statewide Health Improvement Program (SHIP)
  – SHIP will improve health and reduce demands on the health care system by decreasing the percentage of Minnesotans who are obese or overweight or use tobacco
  – 40 grants awarded
Market Transparency and Enhanced Information

• Improve transparency of health care quality, cost, and value with the goal of promoting quality improvement, better chronic disease management, and more efficient resource use
  – Statewide Quality Reporting System
  – Provider peer grouping
Care Redesign and Payment Reform

• Health Care Homes
  – Minnesotans with complex or chronic conditions will receive coordinated care through health care homes
  – Redesign of primary care
Care Redesign and Payment Reform, continued

• Baskets of Care
  – Baskets bundle together health care services that are currently paid for separately.
  – Initial 8 baskets of care:
    • Diabetes
    • Pre-diabetes
    • Preventive care for children and adults
    • Asthma care for children
    • Obstetric care
    • Low back pain
    • Total knee replacement
Supporting e-Health Activity

Legislates a state mandate that:

- all health care providers have interoperable electronic health records by 2015
- uniform health data standards are established by 2009
- a statewide plan is developed to meet the 2015 mandate
- an electronic prescription drug program is established by January 2011
MN Statewide Quality Reporting and Measurement System

• Final rule for 2010 published December 28, 2009

http://www.health.state.mn.us/healthreform/measurement/index.html
Measure Revisions

- Annual review
- MN Community Measurement (MNCM) and MN Hospital Association (MHA) submit recommendations on addition, removal, or modification of standardized quality measures to MDH by June 1 each year.
- The Commissioner will take these recommendations into consideration in determining changes to be made to the Statewide Quality Reporting and Measurement System
Quality Measurement System (2010)

• Measures required for reporting beginning January 2010 (2009 dates of service) and every year thereafter
  – From CMS/Joint Commission core measures:
    • AMI (measures 1, 2, 3, 4, 5, 7a, 8a)
    • Heart Failure (measures 1, 2, 3, 4)
    • Pneumonia (measures 2, 3b, 4, 5c, 6, 7)
    • Surgical Care Improvement Project (measures SCIP-Inf 1, 2, 3, 4, 6, 7, plus Card 2, VTE 1, 2)
Quality Measurement System (2010)

• Measures required for reporting beginning January 2010 (2009 dates of service) and every year thereafter (continued)
  – From Agency for Healthcare Research and Quality (AHRQ) Inpatient Quality Indicators
    • Abdominal aortic aneurysm volume and mortality (IQI4, IQI11)
    • CABG volume and mortality (IQI 5, IQI 12)
    • PTCA volume and mortality (IQI 6, ISI 30)
    • Hip fracture mortality (IQI 19)
Quality Measurement System (2010)

• Measures required for reporting beginning January 2010 (2009 dates of service) and every year thereafter (continued)
  – From Agency for Healthcare Research and Quality Patient Safety Indicators
    • Pressure ulcers (PSI 3)
    • Deaths from surgical complications (PSI 4)
    • Postoperative PE or DVT (PSI 12)
    • Obstetric trauma (PSI 18, 19)
Present on Admission (POA)

- Required by PPS hospital for Medicare patients only
- MHA strongly encourages all hospitals to use POA indicator on bills for all patients
- Example: If POA used, patients admitted with a pressure ulcer from another facility would not be in the pressure ulcer calculation
Quality Measurement System (2010)

• Measures required for reporting beginning January 2010 (2009 dates of service) and every year thereafter (continued)
  – A newly created HIT measure using survey data
  • Hospital’s adoption and use of health information technology in its clinical practice
Proposed Quality Measures (2011)

- Addition of appropriate care measure (ACM) for acute myocardial infarction (AMI), heart failure, and pneumonia topic measure sets
Proposed Quality Measures (2011)

• ACM Definition:
  – The ACM is a pass/fail measure at the individual patient level that asks whether eligible patients have received ALL of the appropriate care for the condition they are being treated for. A patient is included if eligible (meets denominator criteria) for at least one of the measures in a topic (heart failure, acute myocardial infarction, or pneumonia). Within each topic, a patient must meet numerator criteria for each measure in which the patient meets denominator criteria to be considered as having appropriate care (pass).
Appropriate Care Measure (ACM)

- Publicly reported only on Minnesota Hospital Quality Report (MHQR) Web site
- CMS no longer uses this measure
- State proposed this measure for inclusion in 2010 revisions
Proposed Quality Measures (2011)

- Measures required for reporting beginning January 2011 (2010 dates of service) and every year thereafter
  - From CMS/Joint Commission core measures:
    - Outpatient (ED) AMI/chest pain (measures OP 1, 2, 3, 4, 5)
    - Outpatient surgery measures (measures OP 6, 7)
    - Patient experience – Hospital Consumer Assessment of Healthcare Providers and Systems (HCAHPS)
      
      (This measure is not required for hospitals with fewer than 500 admissions in the previous calendar year.)
Proposed Quality Measures (2011)

• AHRQ Measures
  – Composite measure of hospital inpatient mortality for specific conditions
    • AMI
    • HF
    • Stroke
    • GI hemorrhage
    • Hip fracture
    • Pneumonia
Proposed Quality Measures (2011)

• AHRQ Measures
  – Composite measure of patient safety indicators related to hospital inpatient mortality
    • Pressure ulcer
    • Iatrogenic pneumothorax
    • Selected infections due to medical care
    • Postoperative hip fracture
    • Postoperative pulmonary embolism or deep vein thrombosis
    • Postoperative sepsis
    • Postoperative wound dehiscence
    • Accidental puncture or laceration
Proposed Quality Measures (2011)

• AHRQ measures
  – Composite measure of pediatric patient safety indicators related to hospital inpatient mortality
    • Accidental puncture or laceration
    • Pressure ulcer
    • Iatrogenic pneumothorax
    • Postoperative sepsis
    • Postoperative wound dehiscence
    • Selected infections due to medical care
Proposed Quality Measures (2011)

• Pediatric AHRQ Measures
  – Heart surgery volume and mortality
  – Central venous catheter-related bloodstream infections
  – Home management plan of care given to patient/caregiver for pediatric asthma
Proposed Quality Measures (2011) cont’d

• Pediatric AHRQ Measures
  – Infection rate for late sepsis or meningitis in neonates
  – Infection rate for late sepsis or meningitis in very low birth weight neonates
What are the implications for rural and Critical Access Hospitals?
Implications for MN Hospitals

• The new system includes required reporting by all Minnesota hospitals:
  – Measures are predominantly either CMS/Joint Commission chart review measures or AHRQ measures derived from claims
• No additional reporting by PPS hospitals
  – Measures already required by CMS for annual payment update (APU)
• Critical Access Hospitals (CAHs) required to report all measures
  – Voluntary to date, though majority of CAHs were reporting to Hospital Compare
CAH Reporting Statistics

• 79 CAHs
  – Quarter 2, 2009
    • 71 CAHs reported data to warehouse on at least one topic
    • 69 CAHs publicly reported data (on Hospital Compare)
CAH Reporting Statistics

- Q3 2009
  - 74 CAHs reported data
- Q4 2009
  - 73 CAHs reported data
  - 79 (100%) CAHs have signed pledge to have data publicly reported on Hospital Compare
Data Transmission Process

Hospital abstracts data from medical records using either vendor tool or CART

Submission of data to the QIO Clinical Warehouse

Uploaded to Hospital Compare for public reporting only if a hospital gives written authorization by signing the Pledge of Participation

Populate Minnesota Hospital Quality Report (MHQR) Web site and MDH Web site – additional authorization needed to publish Appropriate Care Measure (ACM)
Hospital Quality Alliance

- Hospital Quality Alliance (HQA) data (on Hospital Compare)
  - Data pulled by Minnesota Hospital Association and Minnesota Department of Health for:
    - Minnesota Hospital Quality Report
    - Minnesota Infection Reporting
      - Includes CAHs
    - MN Quality Measurement
CAH Education of New Measures

• Educated CAHs using FLEX dollars from ORHPC
• Series of 5 conference calls
• 72/79 CAHs participated in at least one call
• 20/79 participated in all 5 calls
• 250-300 technical assistance calls fielded
Building Data Measurement Capacity

- Provided context for new MN Health Care Reform Statewide Reporting and Measurement System finalized December 28, 2009
- Provided education on measures and their impact on work of CAHs
- Provided training for outpatient measures
### Conference Call Topics

<table>
<thead>
<tr>
<th>Conference Call</th>
<th>Date</th>
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<tbody>
<tr>
<td>#1 – Overview of Rule</td>
<td>October 2009</td>
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<tr>
<td>#2 – Final requirements and implications for CAHs</td>
<td>January 2010</td>
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<td>#3 – Navigating QualityNet website and using the CART module to abstract outpatient data</td>
<td>January 2010</td>
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<td>#4 – Review and answer frequently asked questions</td>
<td>February 2010</td>
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<td>#5 – Outpatient specifications review by ED physician</td>
<td>May 2010</td>
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Watch For... Difference in CMS/State Requirements

- **State**
  - Requires reporting of all cases even if only one case in a quarter for a topic

- **CMS**
  - Not required to submit cases if 5 or less in a quarter for a topic
Validation

• CMS changed validation
  – No validation for Q4 2009 data
  – No validation for CAHs ongoing
  – 800 PPS hospitals nationwide randomly selected for validation for one year

• MDH still considering how to move forward with a state-based process
Using the Data for Quality Improvement/Patient Safety

• Use the data
  – Share with medical staff, administration, front line staff
• Identify measures that need improvement
• Use the PDSA cycle to make improvements
Going Forward

• Conference call with Dr. Clint McKinney for physicians on identifying and treating chest pain/AMI patients in the ED (July)
Going Forward

• Three additional calls over the next year focused on areas of need identified by the CAHs
• Technical assistance
QUESTIONS?
Stratis Health is a nonprofit organization that leads collaboration and innovation in health care quality and safety, and serves as a trusted expert in facilitating improvement for people and communities.