Implementation *Acute* Breakout Session Notes

April 26, 2012; 10:45am – 2:00pm ET

Attendees: Kristen Beatson, Zahid Butt, Amy Crow, Maureen Dailey, Pam Feeler, Karl Gumpper, Jan Henley, Teresa Hart, Tanna Jackson, Alyssa Keefe, Louise Kendall Webb, Evelyn Knolle, Deborah Krauss, Caterina Lasome, Ken McCormick, Meg McElroy, Ginny Meadows, Linde Merrow, Sarah Tupper

NQF Staff: Juliet Rubini, Farhia Mussa

Vignette : Phelps County Regional Medical Center – Pam Feeler and Linde Marrow

Pam Feeler, BS-ChE, RN-BC Nursing Informatics, Director of Nursing Informatics, and Linde Merrow, RN, MS, Administrative Director Clinical Quality and Measurement, represented Phelps County Regional Medical Center in Rolla, Missouri, discussed eMeasure implementation in a small community hospital.

- Initial steps in eMeasure implementation included:
    - Gap analysis with a quality reporting vendor
        - Had functionality in place, had implemented cpoe, much was not implemented, zero percent data capture implemented
    - Establishing a core team and ad hoc physician advisory committee
        - Clinical quality member
        - IT Applications
        - Project Manager
        - Nursing Informatics
    - Understanding measures thoroughly (important documents)
        - HITSP documents
        - HIS Vendor Best Practice Document
        - Testing Certification Documents
        - CMS Clarification Documents
- Identified documentation for each indicator - ensured the provider/clinician groups were present in the process, consolidated measures in process and documentation
- Standardized nomenclatures - clinicians were not/are not fully exposed to that. Important to the reporting side but groups made sure they minimized that involvement.
- Vital to make ensure data is validated and every piece of the data is captured
- Validation helped to drill down to the point where compliance could be improved
- Clinicians are becoming familiar with core measures but everyone in the organization needed more education. Each measure was specified to the group (i.e. ED measures for ED , etc)
- Challenges
    - Documentation per dictation were not conducive to eMeasure reporting, lack of contraindication.
    - Nurses have a problem keeping up with all these measures

- CPOE was implemented to make sure this is captured.

Vignette: Texas Health Resources – Amy Crow and Tanna Jackson

Tanna Jackson, Software Analyst III and Amy Crow, Project Consultant, from Texas Health Resources, in Arlington, TX, presented on eMeasure Implementation in a large integrated health system. Ms. Jackson started the discussion regarding EHR Quality Measure Reporting.

- EHR quality measure reporting has a number of benefits and challenges
  - Benefits
    - Patient population identification
    - Discrete data is easily reportable
    - Simplified abstraction
    - Electronic submission to vendor
  - Issues
    - Utilization of discrete documentation tools by the end user
      - Moving in to a level where data has to be documented discretely. There are limitations with software and vendors, along with philosophy differences on how providers interpret measures versus how vendors interpret them.
    - Transition from paper to electronic
    - Software development limitations
    - High effort for analysis, configuration, testing, and enhancing reports
  - Conducted gap analysis - evaluated CMS guidelines for each data element and evaluated EHR model configuration. Mapped discrete data elements and strategically placed elements into nurse and physician workflow. For example, order in order list; best practices for clinical documentation.
  - Performed a technical validation to ensure discrete validation showed up on report - manual abstraction conducted on data discrete on non-discrete locations. Technical vs. Clinical Validation
  - Created a bar chart of technical and clinical validation (Stroke and VTE)- Blue is report of discrete data, red how much data was in a discrete format after clinical validation. On the Stroke Correlation, 16% means there was no data in records.
  - Gap analysis – Two part evaluation of the location of data. Most of the data was in notes for providers. Conducted another analysis to find out options and incorporate it into workflow. Incorporated more high level detailed checks and balance system offering physicians a place to document if a patient fits into a specific criterion.

Questions

What specifications did you use; what were the best practices? Heavy IT involvement

- Response: Tanna Jackson, Phelps Regional Medical Center
    - Carried specification manuals to make sure that data aligned with what vendor provided versus what CMS needed to be captured. We went back to the vendor to make sure that those specifications were met.
- Response: Texas Health Resources
    - Quality staff was very involved in the process and there was a bridge between IT and clinical.

It sounds like there is a lot of trial and error. In terms of field testing with eMeasures and vendor tools, would you recommend we do that before it gets to your level? (American Medical Association)

- Response: Tana Jackson, Phelps Regional Medical Center
    - We have approved workflow, but in system there are 5 different ways to do the same thing. Even though we try to steer them in the right direction it is difficult to find if they are not reporting adequately. Biggest challenge is the exclusion criteria, it is a challenge to get physician to report this.

Do you have thoughts, discussions on how much that exception data should be captured? (Ginny Meadows)

- Response: Tanna Jackson, Phelps Regional Medical Center
    - We don't have any patients on a clinical trial. Have a hard time documenting that discretely. Create a prompt for the physician to pick from list based on what is reported initially. Can't capture all exclusions but can capture some.

How as a facility should we structure ourselves. Do we need to get a quality person, what are types of organizational structures to support this work? (Caterina Lasome)

Response: Texas Health Resources

- Get a physician champion to be able to share this as a peer. Implement a reward system for physicians. One of the important things to look at is the size of the institution, quality of individuals who have good working relationships with the physicians. In a small institution this can be done with the quality staff.
- We treat our 14 hospital system as 1. It is a full time job to meet all hospital requirements, we incorporate quality staff and have 1.5 FTE for IT. (Tana Jackson)
- Involving all stakeholders. When going through all various criterion for Meaningful Us, all stakeholders were involved (Quality, IT, physicians, and additional clinicians documenting). Waste no time irrespective of the size of the institution. (Debbie Kraus)

In regards to timing issues, we are all learning together what the best practices are. It is important to have a team of folks who collaborate together on this so this not just an IT or physician led project. Is anyone aware of best practices? (Ginny Meadows)

- Having physician advocate is very important. (Jan Henley)
- Education, quality improvement boot camp for nurses. Have accountability. (Texas Health Resources)

Best practices for documenting measures a certain way. Do you ever see any time down the road where there will be consensus on physicians reporting data one way? Will you be able to sell a best practice? (Zahid Butt)

- Response: Texas Health Resources
    - This is a tough question to answer. There are some areas around the navigator. This is a very long term goal where there is a single source of truth. Have to get our heads above water.
- Response: Phelps Regional Medical Center
    - With the use of evidence based practices there are some measures that we can do that with. The intent is very meaningful to the physicians, and have been able to get some consensus around this.
- Response: Teresa Hart
    - We are doing this already. Mechanisms are implemented so that physicians communicate less with the coder. There are 59 active hospitals around the world where documentation systems have been standardized, within those systems standardizing documentation process. Medical reconciliation, discharge some areas where this is being achieved. Getting everyone to think the same thoughts. Allocation of resources are based on compliance and performance since they are not reimbursed but funded by the federal government. It is never easy but necessary to choose what will make the biggest impact; for us it was admission and discharge.
- Response: Jan Henley
    - Looking at developing documentation tool for structured data and the documentation process part of capturing measures. We have to make sure the measures are entered seamlessly so that data can be captured.
- Response: Texas Health Resources
    - Made sure there were templates for each module
- Response: Teresa Hart
    - General templates - depending on diagnosis providers can select from drop down-like menu. This is very helpful to providers for they can pick and choose what to use
- Response: Phelps Regional Medical Center
    - Have one place for physician to go - programmers are an important stakeholder to help guide physicians to the right path since they can't remember all of them

What are the mechanisms to enhance data and workflow capability? (Ginny Meadows)

- There is the expectation from clients that there is data we want physicians to document that they are not used to reporting. Is this true? Have you found ways around that?
    - Yes. The problem was in the note asking physicians to use the problem list. This process warrants a slow adoption rate. We look to our patients; this cannot be inferred from a checklist. (Tana Jackson)
  - *Do you all feel that the existing standards (SNOMED-CT, ICD-9) need to be captured in the workflow, and are they adequate? Can they be enhanced or improved for workflow documentation?* (Zahid Butt)
    - They are adequate. Whatever measures we are asked to report on, we use the corresponding codes. (Tanna Jackson)
    - It is a very difficult task to map measures with codes. NQF measures mapped codes although they may not be accurate at times. (Jan Henley)
    - We have received input from other sites using different vocabularies. SNOMED is more clinically focused and can give specificity to those clinical data. Moving coding to respecification of hospital measures. Had an initiative where we addressed respecification in HITSPI 1.1? Measure developers are putting these measures into HQMF. Trying to standardize specification on ambulatory and hospital side so that measures will be in HQMF format, we hope that this will help alleviate problems in Stage 1. (Debbie Kraus)
    - Standards aligned with specification and clinical measures (Zahid Butt)
    - CMS is aware and trying to listen and respond to challenges of what is going on in the practices, physician settings in code sets that are used to make it more user friendly and implementable as much as we can (Debbie Kraus)

Now that we are looking at electronic measures, should we determine new measures from workflow and those captured from EHRs? How about the last bullet, related to workflow and staffing. How should people address that, what are the challenges? (Ginny Meadows)

- Phelps Regional Medical Center:
    - Talked about core team, but also bring the bed side staff to the table early in the process is really important. We can build some things that are not important.

How do we show them that there is a Return on Investment? (Ginny Meadows)

- Phelps Regional Medical Center:
    - All physicians know that there are some benefits. Also learning their practice and what they bring is important for their involvement.

- *Pay for performance is different based on the type of setting the physician is practicing in. For in-patient setting, physician should come back to understanding that practicing clinical guidelines is what is being measured. Is that an accurate way to frame that issue? (Zahid Butt)*
    - Response: Texas Health Resource
        - Yes that is an accurate way to frame it. We have to emphasize that this an evidence-based practice, physicians are not interested in knowing that this is done for reporting. Patients are educated and are aware of the latest research, physicians should ensure that they use clinical guidelines to make recommendations.
    - Response: Defense
        - There is a change in terminology from best practice to calling it 'leading practices'. Evidence based needs to be baseline.
    - Response: Jan Henley
        - How can we set it up that measure developers are counted so that they won't be punished when the bar is moved.
    - Response: Texas Health Resources
        - Leading is a better term than best since best has only one definition.
    - Response: Debbie Kraus
        - Struggling with electronic specification definition and how that is incorporated into the EHR?
    - Response: Phelps Regional Medical Center
        - There is no way of tracking updates on the clinician side unless it is published.
    - Response: Medisolv, Inc.
        - Differentiating contraindication for patients and documentation of why some things are not done.
- *This can only be done in 2 ways, if they are challenged or if it is in a checkbox. Need to identify problem patient has early on. If patients are identified up front in the problem list there is better decision support. It is that whole paradigm which everyone is working towards, other option is to ask after the fact.(Zahid Butt)*
    - Response: Louise Kendall Webb:
        - I am an ED doc in Florida, we implemented a system and have experienced a 40% loss in productivity. When can we find time for our patients if there is more time for documentation and less for patient care. Our studies contradicts/conflicts with the patients we are presented with. The CDS may not be appropriate to the type of patients we are seeing. We have to focus on usability, having a lot of trouble with the vendor we have and to make it usable. If steps are not followed the right way, expectations may fall short.
    - Response: Ginny Meadows
        - ED is the most difficult setting.
- Response: Phelps Regional Medical Center
    - Need to change culture and educate clinicians that this is a tool to improve outcome.
- Response: Medisolv, Inc.

    - We have heard about the sandbox and thinking outside the box. But the sandbox is getting narrow and narrower. Hospitals unfortunately don't have as much flexibility. Easy to say and hard to accomplish.
- Response: Texas Health Resources
    - Think outside the box but ask the vendor to make improvements on functionality so they are aware of the impact.
- Response: Medisolv, Inc.
    - Big conflict of interest since there is a financial incentive. No one is looking at clinical rational since they are looking to get attestation. Need clinical and IT input.

Collaborative Questions

What are the mechanisms to enhance data and workflow capability? What are the challenges and what are our recommendations to mitigate those problems?

- One solution may be to use mapping, on an interim basis, to bridge gap prior to folks getting use to coding. (Zahid Butt)

How do we get around challenges? How do we think about that?

    - We have not required physicians to be knowledgeable about coding. They document problems but we do not expect them to be knowledgeable about the details. (Phelps Regional Medical Center)
- *Behind the scenes do you use those for mapping?*
    - Yes, we do use them for mapping, but physicians are not involved in that process. (Phelps Regional Medical Center)
    - We use the same process; coders go in after the physicians and enter the codes. (Texas Health Resources)
- All participants agreed that one recommendation would be to use SNOMED-CT and ICD for mapping

What's on our wishlist? (Zahid Butt and Ginny Meadows)

- Need sufficient time to develop measures, implement them correctly, address them before collecting data
- Before retooling measures come up with denovo measures.
- Documentation (discussed earlier)
- We have to constrain choice and not make them a free for all
- Organization structure (discussed earlier)
- Communication between staff
- Effort must be multi-stakeholder in terms of organization
- Advanced technology (discussed earlier), structured and unstructured data to bridge gap so it moves to structured.
    - Phelps: Sometimes having structured data does not tell the complete story although it may be easy to use.

- It would be helpful to field test measures so kinks are identified.

Summary of Discussion Points

Best Practices

- Collaborative team of multi-stakeholders
- Strong physician leadership/champion
- Allow time for education
- Engage bedside clinicians early and often

Gaps

- Evidence based practice vs. specification – timelines of evidence and trailing specification
- Inability to use unstructured data in an efficient way for eMeasures reporting
- Cultural and technical issues with capturing structured data for sufficient eMeasure reporting

Recommendations

- Field testing for eMeasures
- Leading vs. best practices
- Develop cultural and technical solutions for capturing data within clinician workflow
- Usability testing to ensure that we are accommodating workflow (simulation centers or labs)
- Specifications and standards should be consistent with code sets (SNOMED-CT and ICD)