Boone County Health Center
Dedicated. Caring. Here.

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Chart Auditor and Quality Improvement

Objectives

Clinic

1. Partnering With Your ACO and Payors to Close Patient Care Gaps
2. Utilizing CCM to Prevent Readmissions
3. Continuing Improvement Opportunities in the Post-Acute Care Setting

Hospital

1. Breaking Down the CMS Star Rating Program
2. Star Rating Measure Groups
3. Utilizing Your Electronic Health Record

Clinic

5 Clinic Locations

Boone County Medical Clinic-Albion

Nance County Medical Clinic-Fullerton

Spalding Medical Clinic

Newman Grove Medical Clinic

Veterans Memorial Clinic-Elgin

**Open 5 days/week, and a Saturday urgent care clinic in Albion

Partnering with Your ACO and Closing Care Gaps

- Data

- Resources

- Networking

Utilizing CCM To Prevent Readmissions

- Rounding at Hospital
- TCM
- ED follow ups
- Nurse Navigators
- Provider Referrals

- What's Next: Create a Multi-Disciplinary Team
  (Pharmacy, Social Services, Nutrition Services, Diabetic Educators, PT/OT/ST, Clinic Nurse, Provider)

Continuing Improvement Opportunities In the Post-Acute Setting

- Multidisciplinary team rounds during hospital stays

- Utilize resources from ACO (cost)

- Develop our CCM Program

- Track data on Nursing Home referrals

- Meet with area Nursing Homes and Assisted Livings

Hospital

Boone County Health Center

25 Bed Critical Access Hospital

Located in Albion, NE

8 Physicians, 9 Advanced Practice Providers

Annual Statistics:

- Deliver 75 babies
- 2,000 ER visits
- 586 Procedures/Surgery/Colonoscopies/EGDs

Breaking Down the CMS Star Rating Program

2020 and 2022 Boone County Health Center Received 5 Star Ratings

5 Star Methodology

https://www.qualitynet.org

Hospitals – Inpatient > Public Reporting > Overall Hospital Quality Star Ratings>Resources

Home / Hospitals - Inpatient / Public Reporting / Hospital Compare Overall Ratings /

Resources

| Overview | Data Collection | Hospital-Specific Reports | SAS Package | **Resources** |

Methodology Resources

Methodology

Preview

Data Release

2015 Dry Run

| File Name	File Type	File Size	
Comprehensive Methodology Report (v4.1) (02/26/2021) A description of the Overall Hospital Quality Star Rating methodology finalized in the Calendar Year (CY) 2021 Medicare Hospital Outpatient Prospective Payment System and Ambulatory Surgical Center Payment System Final Rule (CMS-1736-P) and implemented in April 2021.	PDF	1 MB	Download

(*Overall hospital quality star rating on care compare methodology report (v4.0)* 2021)
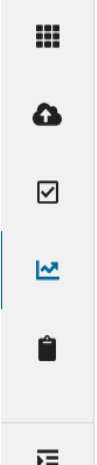
5 Star Methodology

Appendix B: Flowchart of Seven-Step Overall Star Rating Methodology

Figure B - 1. The Seven Steps of the Overall Star Rating Methodology

(*Overall hospital quality star rating on care compare methodology report (v4.0)* 2021)
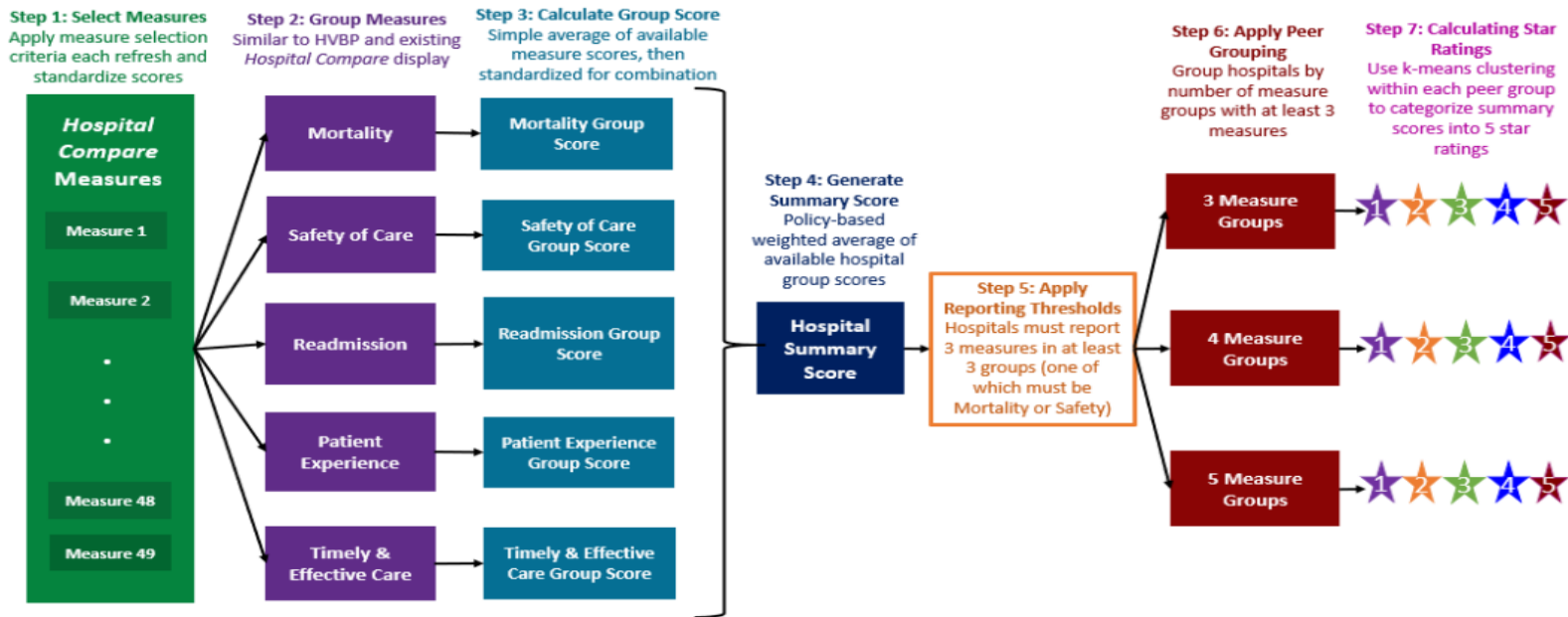
5 Star Reports

HARP Log In>Program Reporting>Claims Based Measures>Release Year>All Programs>All Reports>Export

Claims-based measures reports

View your Hospital Specific Reports (HSRs), Claims Detail Reports (CDRs), Facility Specific Reports (FSRs), and IPF-Specific Reports (ISRs).

Release year ⓘ	Program	Report	
2022	All programs	All reports	**Export**

(*Hospital Quality Reporting*, 2022)

Star Rating Measure Groups

Processes and Workflows

Star Rating Measure Groups

Mortality

Patient Experience

Readmission

Safety of Care

Timely & Effective Care
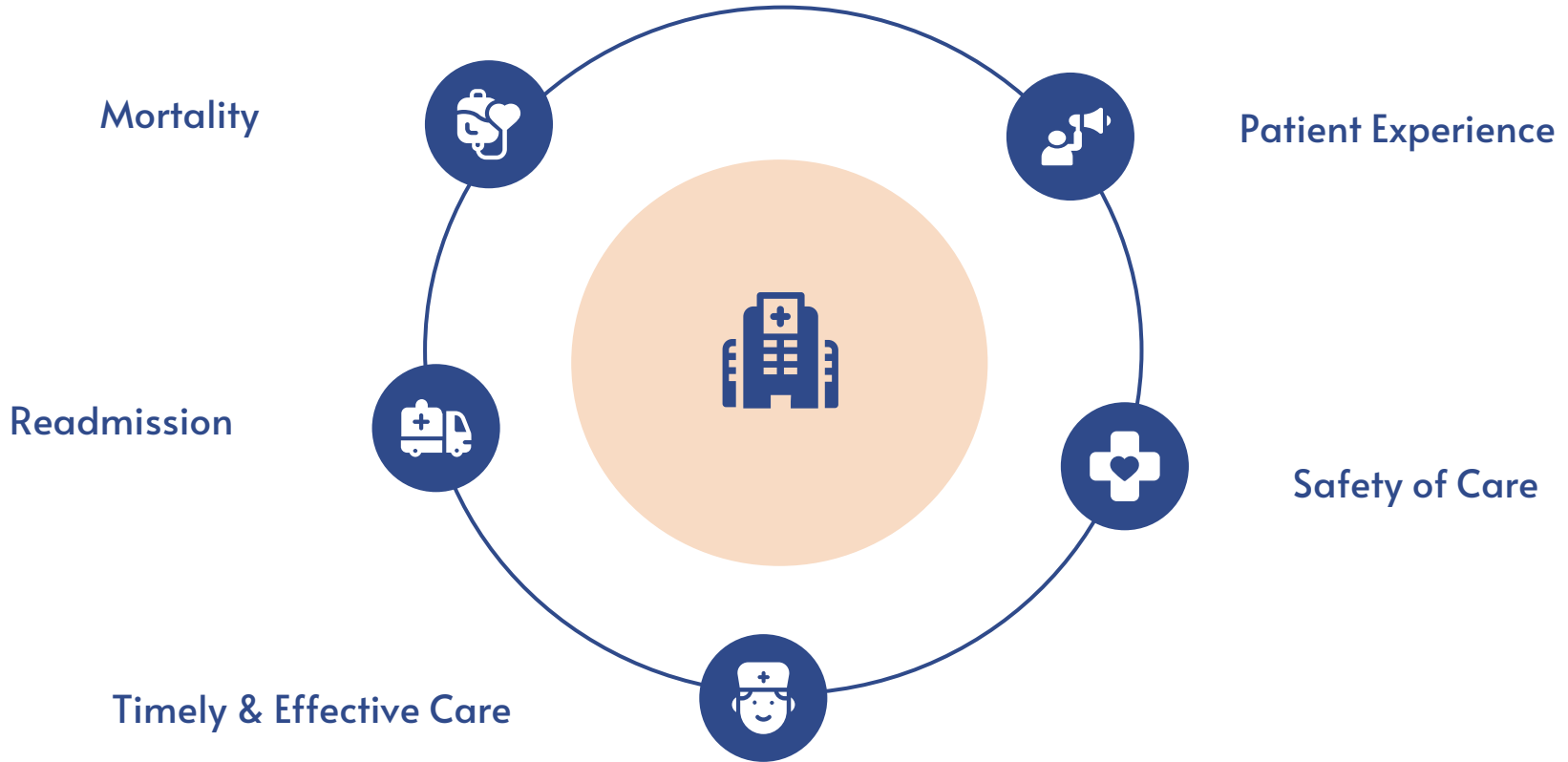
Mortality Measures

1. Chronic Obstructive Pulmonary Disease (COPD) Mortality Rate
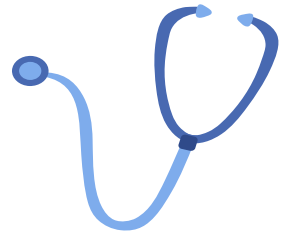
MORT-30- COPD

2. Heart Failure (HF) 30-Day Mortality Rate

MORT-30-HF

3. Pneumonia (PN) 30-Day Mortality Rate

MORT-30-PN

Readmission Measures

1. <u>READM-30-COPD-</u>Chronic Obstructive Pulmonary (COPD) 30-Day Readmission Rate
2. <u>EDAC-30-HF</u>-Excess Days in Acute Care after Hospitalization for Heart Failure
3. <u>READM-30-HIP-KNEE</u>-Hospital-Level 30-Day All-Cause Risk- Standardized Readmission Rate (RSRR) Following Elective Total Hip Arthroplasty (THA)/Total Knee Arthroplasty (TKA)
4. <u>EDAC-30-PN</u>-Excess Days in Acute Care after Hospitalization for Pneumonia (PN)

5. <u>READM-30-HOSP-WIDE</u>- HWR Hospital-Wide All-Cause Unplanned Readmission
6. <u>OP-32</u>- Facility Seven-Day Risk-Standardized Hospital Visit Rate after Outpatient Colonoscopy
7. <u>OP-36</u>- Hospital Visits after Hospital Outpatient Surgery

Readmission Measures

- **Utilization Review Committee Meetings**
  - All readmissions are captured and discussed.
  - Root causes are determined.
  - Case management RN manages these meetings.
  - Multidisciplinary team members including two Physicians, and one PA-C.
  - Information from UR meeting taken to med staff for review.

- **Patients that are at risk for readmission are discussed at interdisciplinary rounds and determination is made on where the patient should be discharged to.**

- **Cerner 'Pop Up' turned on to alert when a patient has been hospitalized within the last 30 days**

- **Discharge planning on admission**

Readmission Measures

- Clinic nurses call patients 1-2 days post discharge.

- Improved collaboration with patients, families, social work, community resources, and providers.

- Discharge planning on admission

- Improved collaboration with patients, families, social work, community resources, and providers.

- Medicare Readmissions & All Payer Readmission measures on nursing department scorecard

Timely and Effective Care Measures

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

- Cerner is utilized to chart abstract and submit cases to CMS
- Monthly numbers added to SQSS reports for tracking
- Heat map report from SQSS to medical staff monthly
- OP-18 Detail report sent to ER supervisor and Director of Nursing with specific encounter and total ED times

OP-22-Patients Left Without Being Seen

- Report ran and all encounters are investigated
- Numbers added to SQSS for tracking
- Reported to med staff and QI meetings yearly with SQSS heat map reports
- QI scorecard

Timely and Effective Care Measures

IMM-3-Healthcare Personnel Influenza Vaccination

- Center for Disease Control (CDC)
- QI scorecard
- Scheduled hours to receive vaccine
- Communication via newsletter on the Intranet

OP-10-Abdomen CT use of contrast material

- Outpatient Imaging Efficiency (OIE) Measure
- Outpatient claims
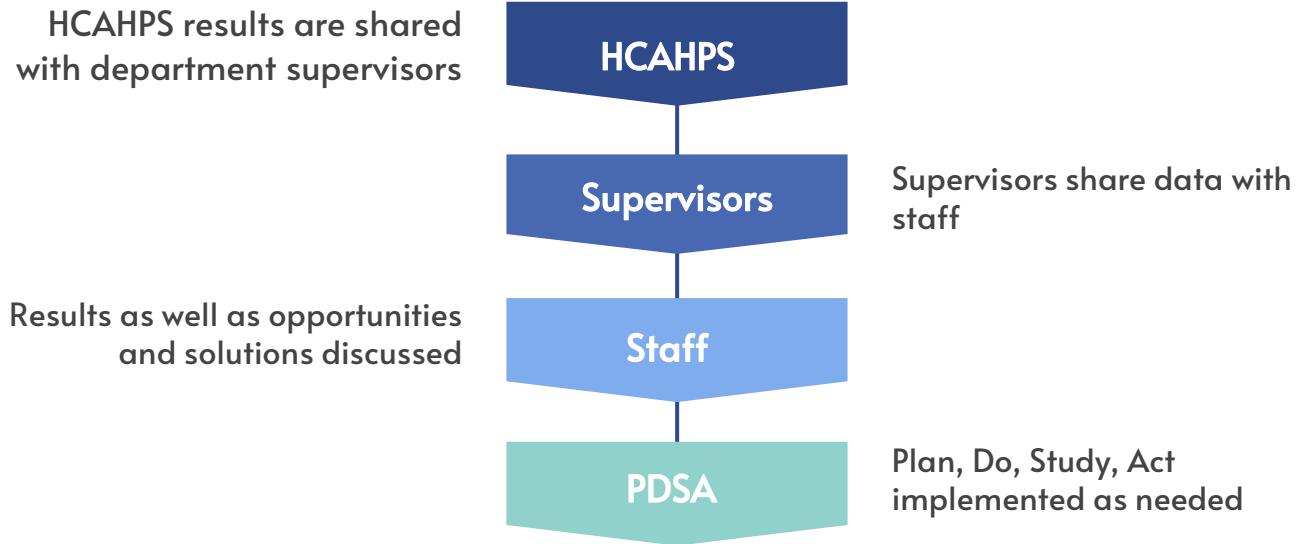- Reports sent to radiology supervisor

Heat Map Example

PI Outcome	Nov 2012	Dec 2012	Jan 2013	Feb 2013	Mar 2013	April 2013	May 2013	June 2013	July 2013	Aug 2013	Sept 2013	Oct 2013	Nov 2013	Dec 2013
To get organization-wide number of late charges to less than 200 (hide chart)	2055	1898	1313	847	779	573	475	357	278	169	197	186	209	151

(Bainbridge, 2023)

Patient Experience Measures

1. Communication with nurses
2. Communication with doctors
3. Responsiveness of hospital staff
4. Communication about medicines
5. Discharge information
6. Care transition
7. Cleanliness/Quietness of hospital environment
8. Overall rating of hospital

Patient Experience Measures

HCAHPS results are shared with department supervisors

HCAHPS

Supervisors

Supervisors share data with staff

Results as well as opportunities and solutions discussed

Staff

PDSA

Plan, Do, Study, Act implemented as needed

Patient Experience Measures

Communication about medicines

- Nursing , providers, pharmacy, and RT completes education
- Consult to pharmacy

Communication with nurses/Responsiveness of hospital staff

- Strong, dedicated, consistent nursing staff
- Low turnover rates
- Great overall culture of nursing staff
- No travelers
- Staffing ratios
- Everyone answers call lights

Safety of Care Measure

I. <u>COMP-HIP-KNEE</u>- Hospital-Level Risk-Standardized Complication Rate (RSCR) Following Elective Primary Total Hip Arthroplasty (THA) and Total Knee Arthroplasty (TKA)

Utilizing Your Electronic Health Record

Boone County Health Center

Rated 5-Stars
Centers for Medicare & Medicaid Services

Cerner
Domain B

Background Information and Resources

- IQR and OQR Specification Manuals
- Data Dictionaries
- eCQI Resource Center
- Specifications example below of eCQM Discharged on statin

Terminology

- code "Birth date" ("LOINC Code (21112-8)")
- valueset "Comfort Measures" (1.3.6.1.4.1.33895.1.3.0.45)
- valueset "Discharge To Acute Care Facility" (2.16.840.1.113883.3.117.1.7.1.87)
- valueset "Discharged to Health Care Facility for Hospice Care" (2.16.840.1.113883.3.117.1.7.1.207)
- valueset "Discharged to Home for Hospice Care" (2.16.840.1.113883.3.117.1.7.1.209)
- valueset "Emergency Department Visit" (2.16.840.1.113883.3.117.1.7.1.292)
- valueset "Ethnicity" (2.16.840.1.114222.4.11.837)
- valueset "Hemorrhagic Stroke" (2.16.840.1.113883.3.117.1.7.1.212)
- valueset "Ischemic Stroke" (2.16.840.1.113883.3.117.1.7.1.247)
- valueset "LDL-c" (2.16.840.1.113883.3.117.1.7.1.215)
- valueset "Left Against Medical Advice" (2.16.840.1.113883.3.117.1.7.1.308)
- valueset "Medical Reason" (2.16.840.1.113883.3.117.1.7.1.473)
- valueset "Non-Elective Inpatient

(*Discharged on a statin medication,* 2020)

Background Information and Resources

- VSAC (Value Set Authority Center)
  https://vsac.nlm.nih.gov
- ONC JIRA Tickets (Office of the National Coordinator for Health Information Technology)
  https://oncprojectracking.healthit.gov/wiki/olp/learning-resources-194969613.html
- CMS Help Desk Tickets
- Cerner Service Requests
- Internal Task List
  All team members have shared access in a shared folder.

Processes

- Monthly internal EHR reports.
- Concurrent and retrospective monitoring. Notify providers and nursing of documentation needed.
- Interdisciplinary rounds.
- Collaborate with EHR vendor to identify where documentation pulls from the chart to reports.
- Educate providers and nurses where to document in the chart.
- Collaborate with providers, nursing, IT, and EHR vendor on workflow.

THANKS!

What questions do you have?

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References

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