Meaningful Use of HIT for Quality Initiatives

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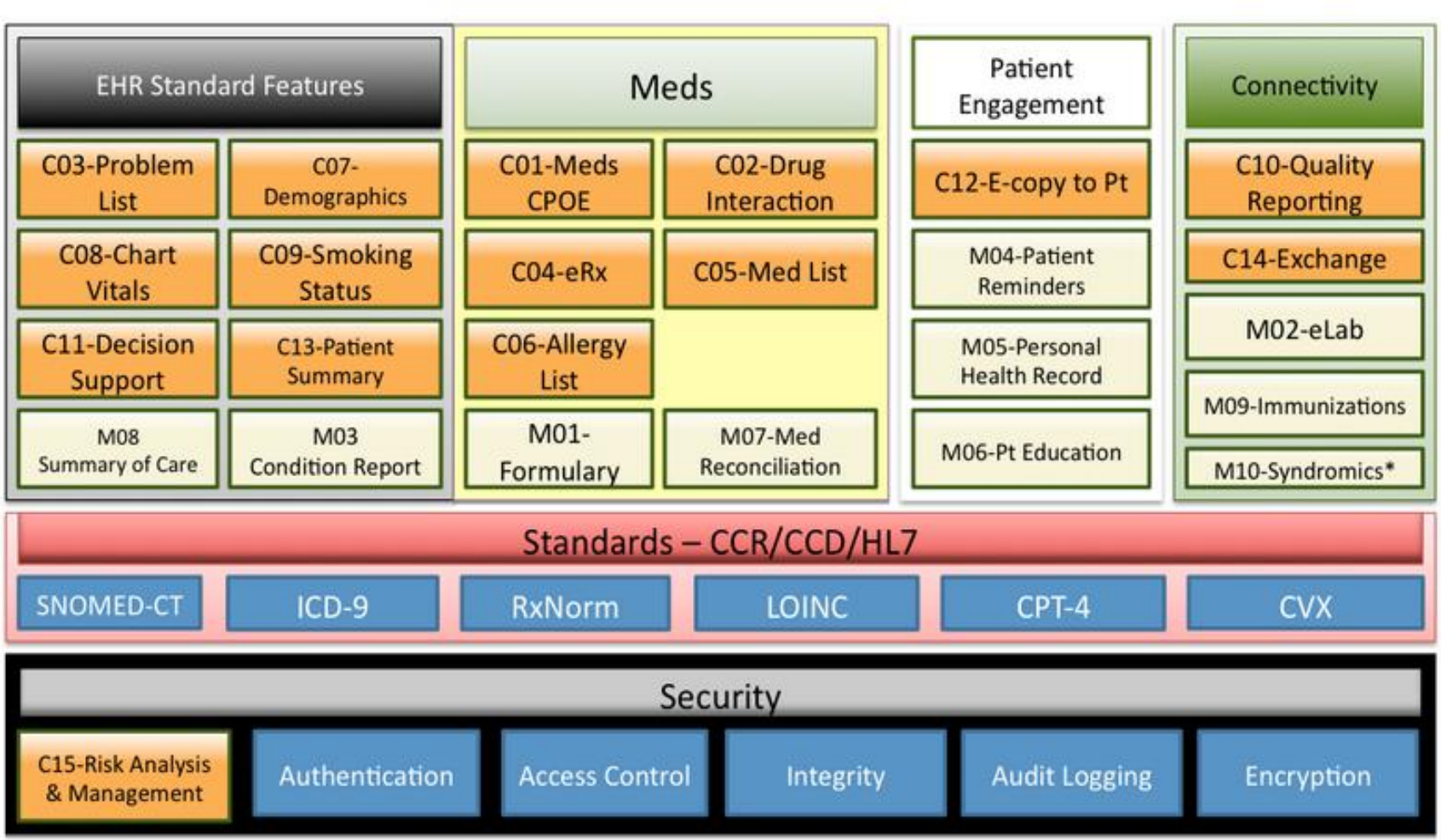
SISU's "Meaningful Users"

- Specialize in small rural/critical access facilities
- By the numbers:
  - 3 facilities in attestation currently (payment year 2011)
  - 3 more to attesting payment year 2011, by July 1st 2012
  - 5 plan to attest payment year 2012
- Project team includes:
  - Director, Team Lead, Nursing, Lab, Pharmacy, Medical Records/Coding, Programming/SQL

Meaningful Use – Stage One



24 Objectives…?

- Currently Sisu Team dedicates over 50% MU time on CQM
  - Early on CQMs quickly became their own project
  - QUEST project
    - Sisu, CSS, 4 Hospitals
- 15 individual quality measures
  - Eligible Hospitals must report on all measures
  - Defined by HITSP TN906
  - http://www.hitsp.org/ConstructSet_Details.aspx?&PrefixAlpha=5&PrefixNumeric=906

Active Medication List	Maintain Problem List
Advance Directives	Medication Allergy List
Clinical Decision Support Rule	Medication Reconciliation
Clinical Lab Test Results	Patient Lists
Clinical Quality Measures (CQMs)	Patient-Specific Education Resources
CPOE for Medication Orders	Protect Electronic Health Information
Drug Formulary Checks	Record Demographics
Drug Interaction Checks	Record Smoking Status
Electronic Copy of Discharge Instructions	Record Vital Signs
Electronic Copy of Health Information	Reportable Lab Results to Public Health Agencies
Electronic Exchange of Clinical Information	Syndromic Surveillance Data Submission
Immunization Registries Data Submission	Transition of Care Summary

Hospital Clinical Quality Measures MU Stage 1

Measure Number	Clinical Quality Measure Title & Description
ED-1 NQF 0495	ED Throughput – admitted patients: Median time from ED arrival to ED departure for admitted patients
ED-2 NQF 0497	ED Throughput – admitted patients: Admission decision time to ED departure time for admitted patients
Stroke-2 NQF 0435	Ischemic stroke – Discharge on anti-thrombotics
Stroke-3 NQF 0436	Ischemic stroke – Anticoagulation for A-fib/flutter
Stroke-4 NQF 0437	Ischemic stroke – Thrombolytic therapy for patients arriving within 2 hours of symptom onset
Stroke-5 NQF 0438	Ischemic or hemorrhagic stroke – Antithrombotic therapy by day 2
Stroke-6 NQF 0439	Ischemic stroke – Discharge on statins

Measure Number	Clinical Quality Measure Title & Description
Stroke-8 NQF 0440	Ischemic or hemorrhagic stroke – Stroke education
Stroke-10 NQF 0441	Ischemic or hemorrhagic stroke – Rehabilitation assessment
VTE-1 NQF 0371	VTE prophylaxis within 24 hours of arrival
VTE-2 NQF 0372	Intensive Care Unit VTE prophylaxis
VTE-3 NQF 0373	Anticoagulation overlap therapy
VTE-4 NQF 0374	Platelet monitoring on unfractionated heparin
VTE-5 NQF 0375	VTE discharge instructions
VTE-6 NQF 0376	Incidence of potentially preventable VTE

Stage One Struggles

- Low resources
  - Dedicated Quality/IT
- Confusion/Rumor/Error
  - “Anti Thrombolytic”
- Understanding workflow
- Measure Intent Vs. Definition
- Uniqueness of each facility
- Vendor support
- Ability to validate reports
  - For example…

1 Numerator, 15 Steps, 5 days…

oth medications. Overlap therapy must be administered for at leas
ional normalized ratio (INR) ≥ 2 prior to discontinuation of the pare
therapy or the patient must be discharged on both medications

o present with a confirmed acute VTE, parenteral anticoagulation i
use of its rapid onset of action. Because the oral anticoagulant war
of action, it cannot be used as mono-therapy for acute VTE. Pretre
oagulants prior to initiation of warfarin also avoids an early period
ity that can result from the selective inhibition of proteins S and C (
ives). Warfarin can be initiated on the first day of treatment after th
anticoagulant has been given.
res with the synthesis of vitamin K dependent pro-coagulant factor
well as some anticoagulant factors (proteins S and C). It takes seve
eve its effect because time is required for normal coagulation facto
asma. The adequacy of warfarin therapy is monitored by measurem
rmalized ratio (INR). The INR can sometimes appear prolonged (or
soon as 24 hours after the institution of warfarin due to a reductic
while factor II levels are still high and the patient is not in fact thera
. Because factor II has a half-life of 60-72 hours, a minimum of five
oagulation is recommended as —overlap therapy while warfarin i
eral therapy should also be continued until the INR is ≥ 2.0, even if
days, so that patients are fully anticoagulated during the period be
ts full effect

VTE3 – VTE Overlap Therapy

. Numerator (Overlap 5 or more days, INR greater than 2)

Inpatient admission or transfer

Enter VTE into problem list

Complete medication reconciliation

Complete VTE confirmed diagnostic test

Order and admin VTE overlap medication for 5 or more days

Check RXNORM value set for VTE prophylaxis for both drugs

Order and result INR lab test with result greater than 2

Discharge patient min 5 days from admission

Final Abstract VTE with POA flag

. Numerator (Overlap 5 or more days, INR less than 2, disch on Overlap)

Inpatient admission or transfer

Enter VTE into problem list

Complete medication reconciliation

Complete VTE confirmed diagnostic test

Order and admin VTE overlap medication for 5 or more days

Check RXNORM value set for VTE prophylaxis for both drugs

Order and result INR lab test with result less than 2

Order Discharge Overlap medication from RXM,POM

Discharge patient min 5 days from admission

Final Abstract VTE with POA flag

What about future stages?

- MU Stage One
  - 5500 unique data elements
  - ICD9, SNOMED, RXNORM, LOINC
- MU ‘Proposed’ Stage Two
  - 40,000 unique data elements
  - Building on structured data
- May be rule exceptions for Rural and Critical Access facilities

What to do now?

- Set realistic expectation for attestation
- Get all the resources you can
  - Are you using your Regional Extension Center?
- Research now
- Educate early
- Implement, Attest, Celebrate, and then worry about the next 4 Stages!!!

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