Electronic Clinical Quality Measures (eCQM)

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Objectives

• At the completion of this presentation the participant will explain the difference between the CQM and the eCQM measures.

• At the completion of this presentation the participant will understand the importance of documenting patient care activities in the EHR according to hospital policy to assure accurate data collection.
Background

• The Centers for Medicare and Medicaid Services (CMS) developed clinical quality measures, originally referred to as core quality measures in order to quantify the quality of care provided in the health care system.

• CQM measures for health care include data from:
  • Processes
  • Observations
  • Treatments
  • Outcomes

• Measuring and reporting CQMs helps to ensure care is delivered safely, effectively, equitably, and timely. A compilation of measures are used by CMS in various quality reporting and incentive programs.
What are electronic clinical quality measures (eCQMs)?

• As health care embraced the use of the electronic health record, CMS has encouraged hospitals to submit their data related to the clinical quality measures electronically whenever possible.

• This is a shift from all the data being collected manually from the health record and submitted.

• eCQMs use data from electronic health records (EHR) and/or health information technology systems to measure health care quality.

• Hospitals must establish documentation protocols to assure that all the requirements for the eCQM can be identified using this electronic data collection process.

• For the calendar year 2017 hospitals must submit a minimum of 8 of the 16 available eCQMs electronically.
Available Measures for eCQM data submission selection (by CMS measure number)

• Emergency Department-
  1- Median time from ED arrival to Ed Departure
     admitted patients*
  2- Admit decision time to ED departure for
     admitted patients*
  3- Median time from ED arrival to ED departure
     for discharged ED Patients

• AMI- Primary PCI received within 90 minutes of hospital arrival

• Childhood Asthma – Home Management Plan of care document given to parent/caregiver

* Also Required chart abstracted measure
Available Measures continued

- **Stroke**
  2- Discharged on antithrombotic therapy
  3- Anticoagulation therapy for atrial fibrillation/flutter
  5- Antithrombotic therapy by the end of hospital day two
  6- Discharged on Statin medication
  8- Stroke education
  10- Assessed for rehabilitation
Available Measures continued

• **Venous thromboembolism**
  1- Venous thromboembolism prophylaxis
  2- Intensive Care Unit venous thromboembolism prophylaxis

• **Perinatal**
  01- Elective delivery*
  05- Exclusive breast milk feeding
  **Newborn**- ENDI-1a – Newborn hearing screening prior to hospital discharge

* Also Required chart abstracted measure
eCQM measures for CY 2017

• The eCQM measures that are available for CY 2017 will be covered in the following slides. Each hospital must self-select at least the 8 that are most relevant to the facility. Those measures that can be either chart abstract or electronically submitted are defined in the individual measure set presentations.

• Check with your facility to determine what measures were chosen and to understand the EHR policies for proper documentation of the measures.
Stroke eCQM measures
Antithrombotic Therapy

• Ischemic stroke patients must have antithrombotic therapy prescribed by the end of hospital day two and

• These patients should also be discharged on antithrombotic therapy.
Anticoagulation therapy

• Ischemic stroke patients who have atrial fibrillation/flutter or a history of atrial ablation should be discharged on anticoagulation therapy secondary stroke prevention.

• Required chart abstracted measure
Statin Medications

• Ischemic stroke patients should be prescribed statin medication at hospital discharge.
Stroke Education

• There must be documentation in the medical record that all of the required stroke education elements were provided to the patient or his/her caregivers.
Stroke Education

• It is important that the stroke patients, their families and caregivers receive the necessary education to understand the medications and the lifestyle modifications to reduce risk or improve outcomes.

• This education includes:
  • Activation of Emergency Medical System
  • Follow-up after discharge
  • Medications prescribed at discharge
  • Risk factors for stroke
  • Warning Signs and Symptoms of Stroke
Activation of Emergency Medical System

• Call 911!

• Patients and families should not ignore the stroke warning signs even if there is only one which is mild or goes away. Someone should write down the time the symptom starts.

• They must know when and how to contact emergency services. Every minute is important. Strokes are medical emergencies.
Follow-up After Discharge

• Patients more often fulfill follow-up appointments if they are made prior to discharge.

• These appointments may be with the PCP, rehabilitation services or home health.
Medications Prescribed at Discharge

- Patients and as appropriate, their families must have an accurate medication list and know when and how to take each medication.
- They need to know the reason for the medication and the possible side effects.
Risk Factors for Stroke

• The 10 risk factors that account for 90% of stroke risk are:
  1. History of high blood pressure
  2. Current smoking
  3. Abdominal obesity
  4. Diabetes
  5. Lack of physical exercise
  6. Poor diet- (high fat and sugars)
  7. More that 30 alcohol drinks a month or binge drinking
  8. Ratio of blood fats known as apo B to apo Al
  9. Heart disease- especially atrial fibrillation
  10. Psychosocial stress/depression

Warning Signs and Symptoms of Stroke

- Stroke symptoms are more likely to have a sudden onset but can occasionally develop gradually.

- These symptoms include:
  - Numbness or weakness in your face, arm or leg, especially on one side.
  - Confusion or trouble understanding other people.
  - Trouble speaking.
  - Trouble seeing with one or both eyes.
  - Trouble walking or staying balanced or coordinated.
  - Dizziness
  - Severe headache that comes on for no know reason.

Reference: www.strokeassociation.org
Documentation Reminder

• There must be clear documentation in the electronic record that specifies the patient and/or care giver was provided with educational measures during their stay or at discharge.

• This documentation must specifically demonstrate that each of the following are included in the written education material:
  • activation of emergency medical system
  • need for follow-up after discharge
  • medications prescribed at discharge
  • risk factors for stroke
  • warning signs and symptoms of stroke
Rehabilitation assessment

• Every stroke patient should be assessed for rehabilitation potential. Stroke rehabilitation should begin as soon as the diagnosis of stroke is established and life threatening problems are under control.

• Documentation of this assessment must be in the EHR.
Perinatal Care eCQM Measures
Elective Deliveries

• The American College of Obstetricians and Gynecologists (ACOG) and the American Academy of Pediatrics (AAP) have identified the risks of elective delivery for maternity patients who have not completed 39 weeks of gestation.
Definition of Elective Delivery

• An elective delivery is any delivery of a newborn(s) when the mother has no history of prior uterine surgery, is not in active labor or did not present with spontaneous ruptured membranes prior to medical induction and/or cesarean section.
Included in the Definition of Induction are:

- Induction of labor by artificial rupture of membranes- excluding artificial rupture of membranes after onset of labor
- Surgical induction of labor by cervical dilatation- excluding injection or suppository for abortion
- Medical induction of labor- excluding medication to augment active labor.
Elective Cesarean Section Approach Inclusions

- All types of c-section approaches are included in this measure set.
- Classical transperitoneal approach
- Lower uterine segment approach
- Peritoneal exclusion approach
- Vaginal cesarean section
- Obstetrical abdominouterototomy
- Obstetrical hysterotomy
Nursing Role

• The practitioner is responsible for determining the need for early elective induction.

• Nurses should review the prenatal records of their patients and discuss any early elective delivery case with the physician or midwife to determine the reason for the early delivery.

• Some facilities have implemented policies that elective inductions between 37 – 39 weeks must be approved by a physician leader or through the peer review process before the patient is admitted.
Exclusive Breast Milk Feeding

• The World Health Organization and others support the position that exclusive breast feeding for the first 6 months of neonatal life is beneficial for growth and development.

• This indicator collects the number of newborns exclusively breast fed during the entire hospitalization and the number of newborns whose mothers choose not to breast feed.

• The goal of this indicator is to increase the rate of exclusively breast fed newborns.
Neonatal eCQM

• **Hearing Screening Prior To Hospital Discharge**
  
  This measure assesses the proportion of births that have been screened for hearing loss before hospital discharge.

• Pennsylvania has the Infant Hearing Education, Assessment, Reporting and Referral (IHEARR) Act- Act 89 of 2001 that requires the primary testing be done prior to discharge.

• If the parent refuses this screening, their refusal must be documented in the medical record and reported to the Department of Health.
Acute Myocardial Infarction (AMI)
eCQM
This measure focuses on the time from hospital arrival to primary PCI for patients who present with ST-segment elevation or LBBB.

Remember the time of arrival is the very first time documented on the medical record. It could be the triage time, first note, vitals document time or registration time.
Time to Primary Angioplasty

• The early use of primary angioplasty for patients with ST-segment MI (STEMI) has resulted in a significant reduction in mortality and morbidity.

• CMS has determined the prompt initiation of PCI for the qualifying AMI patients is 90 minutes or less.
Transferred Patients

• CMS understands this may not be possible in the case of a transfer from another facility so those patients are excluded from this indicator.

• It is still very important to do the primary angioplasty as soon as possible after the transferred patient arrives.
Another Exclusion

- Patients who did not receive PCI within 90 minutes and have a documented **Reason for Delay of PCI** will be excluded from this measure.
Nursing Role

• Getting the patient from arrival to primary PCI within 90 minutes requires very exact coordination between all members of the team.

• The ED and Cath Lab/OR must have good coordination and all the necessary ancillary staff must work together to be sure the patient gets the most timely and safe care possible.
Childhood Asthma eCQM
Home Management Plan

• There must be documentation in the medical record that a Home Management Plan of Care (HMPC) document was given to the pediatric asthma patient/caregiver.
• Pediatric asthma inpatients with an age of 2 through 17 years, and length of stay less than or equal to 120 days are included in this measure.
Requirements for the Home Management Plan

• The home management plan of care document should be a separate and patient-specific written instruction.

• The document must be present in the form of an explicit and separate document specific to the patient rather than components or segments of the plan spread across discharge instruction sheets, discharge orders, education sheets, or other instruction sheets.

• The plan must include:

• Methods and timing of rescue actions:
  • the home management plan of care addresses what to do if asthma symptoms worsen after discharge, including all of the following:
    1. When to take action, i.e., assessment of severity (eg, peak flow meter reading, signs and symptoms to watch for);
    2. What specific steps to take, i.e., initial treatment instructions (eg, inhaled relievers up to three treatments of 2-4 puffs by MDI at 20-minute intervals or single nebulizer treatment);
    3. Contact information to be used, when an asthma attack occurs or is about to occur.

• Appropriate use of long-term asthma medications (controllers), including the medication name, dose, frequency, and method of administration.
Requirements continued

• Appropriate use of rescue, quick-relief, or short acting medications of choice to quickly relieve asthma exacerbations (relievers), including the medication name, dose, frequency, and method of administration.

• Environmental control and control of other triggers:
  • information on avoidance or mitigation of environmental and other triggers.

• If an appointment for referral or follow-up care with a healthcare provider has been made, the home management plan of care is required to include the provider/clinic/office name, as well as the date and time of the appointment.

• If an appointment for referral of follow-up care with a healthcare provider has NOT been made, the home management plan of care is required to include information for the patient/caregiver to be able to make arrangements for follow-up care, i.e., provider/clinic/office name, telephone number and time frame for appointment for follow-up care (eg, 7-10 days).
1. It is very important to follow the policies of your hospital when documenting in the EHR as the eCQM data is taken from specifically identified data elements in the system.

A. True
B. False
Test your knowledge

2. For CY 2017 each hospital must select at least ______ of the eCQM measures for electronic submission.

A. 2
B. 4
C. 6
D. 8
Test your knowledge

3. The stroke education eCQM requires that the patient and/or caregiver receive written education that includes

A. Activation of the emergency system
B. Need for follow-up appointment
C. Medications at discharge
D. Warning signs of a stroke
E. All of the above.
The End!