Quality at the Core

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by Anne Zender, MA

Is your hospital getting ready for the Joint Commission's core measures project? Some hospitals are already transmitting the necessary data as part of the pilot project. Here's how they are handling the challenges and deriving benefits.

If you're an HIM director, you probably already have enough to do daily. When work is piling up, who would volunteer to take on additional responsibilities—especially ones that could have a serious impact on your department's work load?

But in a number of states in 2001, some HIM professionals did just that. They participated in the Joint Commission on Accreditation for Healthcare Organization's hospital core measures project. Participating hospitals collected data related to three measures—acute myocardial infarction (AMI), heart failure (HF), and community-acquired pneumonia—and transmitted it to the Joint Commission on a monthly basis.

The collection and transmission of core measures data at accredited hospitals will be mandatory by July 1, 2002. The idea behind the pilot test was to give both the Joint Commission and healthcare organizations an understanding of what parts of the process worked and what needed work. (See "Core Measures 101" for more on the core measures project.)

For HIM professionals whose organizations were participating in the project, the pilot required additional work, additional staff, and additional time scrutinizing their data collection process. Despite these hurdles, they learned to make it work. They also gained an understanding of changes—however minor—their organizations could make to improve patient care. The *Journal of AHIMA* asked three healthcare professionals at participating organizations what they have learned during the project.

Our panelists are:

- **Cathy Allen-Thomas, RHIA**, director of quality management, Genesys Regional Medical Center in Grand Blanc, MI
- **Carol Melvin, RHIA,** manager of health information services, St. John's Mercy Hospital, Washington, MO
- **Rosemary Wood**, vice president for professional practice, Memorial Hospital of Rhode Island, Pawtucket, RI

Getting a Head Start

Q: How did your organization get involved with the core measures project?

Allen-Thomas: We had started to look at our own case management program, especially the AMI and HF patients. We'd found that the Joint Commission ORYX results were not producing very meaningful data for us. We contacted the state and they made the decision based on the size of hospitals that would be in the pilot.

Wood: There were a couple of advantages to our doing the project. For one thing, Rhode Island state law requires public reporting of clinical measures and some quality information. The legislation had a lot to do with our electing to participate. We looked at doing the project to try to find some common ground—how can we make this valuable and not use more resources? We knew we had to do performance review and wanted to be doing benchmarking. Any opportunity to benchmark was a good one, so we agreed to participate.

Melvin: We asked to participate because we wanted to see what was coming down the road and how we could prepare for that. I wanted an HIM perspective to figure out the impact it would have on our department. Initially, we weren't even sure if we could do it. Ordinarily a hospital is required to submit 50 records per month in two selected measures. We didn't have 50—

our patient sample was not big enough. So the Joint Commission made an exception for us. We submit everything we have, an average of 30 records per measure.

Q: Which core measures are you reporting? How did you select them?

Melvin: Our hospital has participated in projects with the Missouri Patient Care Foundation on HF and AMI. We decided if we truly wanted to use this as a learning experience and improve patient care, we should focus on something else. We picked pneumonia and HF and have done some excellent things.

Allen-Thomas: Because we were already assessing our case management programs in AMI and HF, these two areas were on the radar screen. For example, Blue Cross/Blue Shield has named our heart program a center of excellence. We spent a lot of time on the surgical side of this issue and we wanted to pay some attention to the medical side. It was another opportunity to start merging these goals. These are two of our larger populations, and we thought the measures would give us good information as well.

Wood: Most participants are only required to report two measures, but we are reporting all three. CMS (formerly HCFA) asked us to do a third because we're a pilot state for a CMS retroabstracting project to validate that the core measures will work. The state of Rhode Island will decide which core measures we will continue reporting. It's not a hospital decision because of the above-mentioned legislation.

So Much to Do, So Little Time

Q: What are the specific responsibilities for the project? How does it work for those who are responsible for implementation?

Allen-Thomas: We have an information specialist who abstracts the information and enters the data. We set up a computer system and used the MedQuest software, which is available free of charge from CMS, to enter the data and send to the state. About half an FTE is needed monthly to review the monthly discharge data for AMI and HF information, collect it, and submit it. Then we had to figure out how to build the data into a quality program to get feedback. We built a scorecard for each indicator to trend by monthly and year-to-date data. The state can provide statewide information for comparison as well. And now we can get data from all five states participating in the pilot. The specialists take the data and work with it for case management purposes. They take the scorecard and share it with medical staff and coordinate an action plan if needed.

Melvin: At the beginning of the month, we run a report for the two diagnoses we are looking for. This produces a list of patients and medical record numbers, and discharge records are pulled. Then we are able to begin the abstracting process, which I've been doing manually. The results are sent in to the Missouri ORYX core measures pilot project by the Missouri Patient Care Review Foundation. They run them through edits. We can correct errors they find as well. Then they are sent on to the Joint Commission.

Wood: Initially, we found that the amount of detail required for the core measures slowed down our billing and coding. We split into doing the coding component up front and then hired a part-time abstractor to do the clinical core measures. We were able to hire a nurse who reports to the HIM director and who is also familiar with coding. She was trained in the full abstracting process.

Currently, after our coders are finished with records, we run a report that drives the list of charts that need to be abstracted by looking for certain codes. Once that and any other regular abstraction is complete, the abstractor gets a list of coding data to find medical records by number, discharge date, and month. She pulls charts and enters in the data required.

Q: What is the impact of participating in this project on the HIM department?

Wood: For us, this project was a significant change in the work load. Abstracting is more work; you need more information and detail. The project definitely requires additional FTEs to support it. According to our HIM director, implementing the pilot hasn't upset our department at all, but if we had not been able to hire the extra staff member, it would have been more difficult.

Melvin: I agree that it can significantly affect staff time—it has really impacted mine. My thought going into the project was that the most logical place for indicator completion was when coders were coding the record. But when I saw the amount of time it would take, I didn't want to take away coder time. So I have been completing the indicators. It takes me about 40 hours to do both HF and pneumonia charts, from start to finish.

We were very surprised when the pilot project began and we saw how many questions we needed to answer—at least 80 questions per record. The Joint Commission has reported to us that only Missouri and Michigan opted to answer questions related to both the Centers for Medicare and Medicaid sixth scope of work as well as the Joint Commission questions. I remember the first record—I did it with our quality manager and the HF program head. It took almost four hours to answer all of the indicator questions. Now I have gotten it down to about seven minutes per record.

On a more positive note, however, it did spur us to take a closer look at our documentation tools for pneumonia. We have tools for HF and AMI, but not for pneumonia, which had become our second top DRG. We had no consistency in treatment or documentation. When we agreed to participate, we looked at the indicators and Joint Commission standards and took them to our internal medicine and family practice departments and asked them to develop standards of care. Then we had to do the same with our pediatricians. We created standards of care and looked at documentation and an order sheet to support it.

Allen-Thomas: For our organization, one of the biggest things was to work with the HIM department to establish a link between our registration system and MedQuest so the registration information came across. Pulling the charts also made an impact. Staff wise, the biggest impact we found was on our information specialist, who had originally been hired as a quality resource for the entire department of medicine. Doing the pilot project meant it was no longer possible for her to be a resource for all departments. She couldn't do it all. So we did end up diverting some resources to support this project.

Q: How much of the information you are collecting is in an electronic format?

Allen-Thomas: We make a list of what charts we need and the HIM department pulls the charts for us. We go through the chart and use an Access database to input the information we need. Genesys is converting to an online medical record—we are in the middle of that process, so we are using both paper and electronic formats. Abstracting is done manually for both paper and electronic records. It takes about 20 to 25 minutes to do each chart. Finally, electronic data is not automatically fed into MedQuest. Much of the information is online, but we still have to abstract from the online data and put it into the MedQuest software.

Wood: We rely heavily on the HIM department, which designed the system and screens to collect this and all other data and keep it together. But before we transmit any information, we also work with the outcomes department to do clinical review of any outliers. We look at performance issues and uncover issues that are confusing. We pull together the core measures and clinical abstracts and performance measures.

For us, even before the pilot began, much of our information was already electronic, including ORYX. Before the core measures, we did an initial conversion of our billing system around Y2K issues.

An Opportunity for Education

Q: What changes or improvements has your organization made as a result of the pilot—in other words, what have you learned?

Wood: We have used the project as a way to reinforce our data quality review and clinical reviews as well. For instance, once our abstractor is finished, our IS department runs a preliminary report to reveal any outliers or cases that need further investigation—for example, to uncover possible clinical issues related to things like appropriate use of drugs, timing, contraindications, etc. The quality management team gets involved if they have concerns about care.

When there's a problem for any measure, for example, if a drug was not given, and our physician reviewer can't explain it, we notify our quality management/performance improvement committee. A letter goes to the physician. We use it as an opportunity to educate them on standards of care. Nursing might be notified also.

For data quality, we do multiple checks to make sure there are no errors or missing data. The director of HIM and the abstractor do an internal filter of the data, then run another report and make sure the data is clear and clean. We also perform

clinical validation. Then we notify IS and they transmit the data to our vendor (our Medicare PRO) who does a quality check one moretime.

Melvin: We made some significant improvements in the way we treat pneumonia. Some of these improvements were put in place prior to the data collection; sometimes we have revised them as we went along. We made a change for one question for pneumonia—were cultures for blood or sputum done prior to administration of an antibiotic? We put a culture in the written time frame. If it is not done within the first hour, we start medication. We put primary pneumonia antibiotics as part of our floor stock so there's no delay finding them. We revised the nursing assessment form to ask if the patient has had influenza and pneumonia vaccines. We hadn't been consistent on having patients referred for smoking cessation, so we changed the discharge instruction sheet to show whether smoking cessation referral had occurred.

We learned the importance of giving feedback to the Joint Commission—which is part of the idea of the pilot test. Because of the number of questions we had to answer, one consistent message we gave to the Joint Commission was that if it expects hospitals to answer this number of questions, we can't afford to do it. It's too time consuming. At a meeting in December with the Joint Commission, we were told that as a result of the feedback we were able to provide, both CMS and the Joint Commission have agreed to measure the same indicators. This will greatly reduce the number of questions we have to answer, which will be limited to the actual indicators. This is big news!

We're also learning how we can adapt our existing information systems and software to this process. Ideally, our health information systems department will be able to customize our abstracting software programs to build this into our normal processes without slowing coders down.

Allen-Thomas: We haven't learned much new clinically, but we've proven things we already suspected were true. When it came to discharge information, we learned we weren't covering every aspect of the process. For AMI and HF, we revised the discharge instructions to include factors such as drugs, contraindications, special instructions and follow-up, and diet on the form. This way we ensure that we are not forgetting to cover certain components. For example, if a patient is a smoker, we give them instructions to quit smoking.

In today's environment of limited resources, this project has been a balancing act for us. We have found that our case managers were following AMI patients and collecting data on their own previously. The data they were collecting was manual and it was not always accurate. After the pilot began, our case managers stopped collecting data. They can now spend their time directly caring for patients. We're putting them back to working with patients versus doing manual data collection. And the centralized data has been more consistent and we're collecting on 95 percent of our patients. We're very pleased with that.

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Core Measures 101

The Joint Commission's core measures project is part of the organization's efforts to improve the quality of patient care by implementing a national standardized performance measurement system that focuses on the results of the care provided. Although these efforts date back to the 1980s, they took the shape we recognize in 1997 with the roll-out of the ORYX initiative, which is mandatory for hospitals and long-term care organizations.

With ORYX, the Joint Commission receives aggregated data quarterly on measures selected by hospitals. However, because organizations could use a number of different performance measurement systems, data was not standardized, and it was difficult to make comparisons between organizations. The core measures program represents a move toward standardized measures of evidence-based data.

To launch the core measures project, the Joint Commission enlisted the help of state hospital associations. Five interested state associations (Connecticut, Georgia, Rhode Island, Michigan, and Missouri) were selected at random and asked to select performance measurement systems and 10 to 25 hospitals that were interested in participating in the pilot test. From there, 83 hospitals were selected to participate in the pilot.

The Joint Commission had initially selected five core measures to investigate. Two of them (pregnancy and related conditions and surgical procedures and complications) were delayed. Each hospital was asked to choose two of the three remaining measures to report. Data is collected and transmitted electronically to the Joint Commission, generally through a third party such as a Medicare PRO.

The performance measure data acquired during the pilot is not available to the public, according to the Joint Commission's Web site. In the future, the organization says it will use the data to "monitor trends and identify patterns."

Jared Loeb, PhD, the Joint Commission's vice president for research and performance measures, says that while the information won't be used to make accreditation decisions, the organization hopes to eventually use the data to educate providers about performance improvement. "Our surveyors will look at how organizations are using the data for performance improvement," Loeb says. "We hope to use the data for cyclical monitoring and to provide education and counseling in the future."

In many ways the pilots have already proved educational, Loeb and Sharon Sprenger, RHIA, CPHQ, MPA, project director for core measures identification and evaluation, agree. For example, at the start of the pilot project the Joint Commission acknowledged that the data collection burden on healthcare organizations required immediate attention. This burden was a particular concern for HIM departments because the medical record is a source document for almost all of the measures.

Throughout the process, Sprenger says, the Joint Commission has listened to participant feedback and taken steps to try to reduce that burden. These steps, she says, include working with the Centers for Medicare and Medicaid Services (CMS) to collect elements in common with those collected by the government; collecting data where possible from UB-92 forms; and constructing some measures so that they would share common elements or require fewer elements.

"The measures today are in many cases quite different from the measures introduced in the beginning of the pilot," says Loeb. He adds that organizations participating in the pilot project reported finding the work load decreasing with time.

In mid-2002, collecting data on core measures will be mandatory for accredited hospitals. According to the Joint Commission's Web site, the timeline includes these dates:

- **December–May 2002:** Measurement systems embed core measure sets. Watch the "Performance Measure-
ment System Matrix" on the Joint Commission Web site, www.jcaho.org. The matrix will be updated as measurement systems embed the sets and are verified by the Joint Commission
- **January–June 2002:** Hospitals formally select core measures. If a hospital serves patient populations that correspond with two or more core measure sets, it should select two of the initial four sets and is no longer required to collect data on six non-core measures. If a hospital can only identify one core measure set, it will collect data on that core measure and reduce non-core measurement reporting from six to three measures. If a hospital cannot identify any core measure sets, it will continue to collect and transmit non-core data
- **July 2002:** Begin data collection for July discharges
- **January 2003:** Core measure data from third quarter 2002 due to Joint Commission

Preparing for the Core Measures

How should you prepare for implementing the core measures? In a presentation at AHIMA's 2001 National Convention, Lynda Hyde, RHIA, offered the following suggestions:

- Work with your performance measurement system vendor to find out if it will be implementing core measures. Review and determine if these measures will meet your needs.
- Find out when the vendor will be able to support these measures. Find out what plans they have for training and support.
- Create a timetable to ensure that your processes are in place to collect the core measure data.
- If additional electronic interfaces are needed, allow enough time to test and have available within the Joint Commission's timeline.
- Create a test system with test cases before "going live."
- Look at present documentation to select measures, identify source documents, and look at improvements to your process.
- Keep current with developments at the Joint Commission and the AHIMA Web sites.

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