DSRIP BEHIND THE SCENES

Understanding the Measures, the Processes and the Data Validation

Robert Wood Johnson University Hospital | RWJBarnabas HEALTH
RWJ Barnabas Health

- 32,000 employees
- 9,000 physicians
- 1,000+ residents and interns
- 11 acute care hospitals
- 3 children’s hospitals
- A pediatric rehabilitation center
- A behavioral health center
- Ambulatory care centers
- 5 fitness and wellness centers
- Geriatric centers
- Homecare and hospice programs
- Medical groups and physician practices
- Accountable Care Organizations
RWJBarnabas Health

• The most comprehensive health system in the state
• Provide treatment and services for over 3 million patients, each year
• 283,000 inpatients and same day surgery patients
• 700,000 Emergency Department patients
• 2 million outpatients
• More than 23,000 babies delivered annually
RWJBarnabas Health and DSRIP

• Clara Maass Medical Center
• Community Medical Center
• Jersey City Medical Center
• Monmouth Medical Center
• Monmouth Med Center – Southern Campus
• Newark Beth Israel Medical Center
• RWJ University Medical Center
• RWJ University Med Center at Hamilton
• St. Barnabas Medical Center
RWJ University Hospital

• 965-bed academic medical center with campuses in New Brunswick and Somerville
• Offers Central New Jersey residents expanded access to the highest quality medical services.
RWJ University Hospital DSRIP

• PROJECT 6
• Care Transitions Intervention Model to Reduce 30-Day Readmissions for Chronic Cardiac Conditions

• The objectives for this project are:
  • 1) reduce readmissions,
  • 2) reduce admissions,
  • 3) increase patient satisfaction,
  • 4) improve medication management, and
  • 5) improve care processes
## The Measures

### Program Summary: DSRIP

**Care Transitions Intervention Model to Reduce 30-Day Readmissions for Chronic Cardiac Conditions (AMI/HF)**

### Metrics & Milestones

<table>
<thead>
<tr>
<th>Program Metrics</th>
<th>Data Source</th>
<th>Reporting Entity/Setting of Care</th>
<th>Reporting Period</th>
<th>DY3</th>
<th>DY4</th>
<th>DY6</th>
<th>Total DY3-DY5</th>
<th>P4P</th>
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<tr>
<td><strong>Stage III Measures</strong></td>
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<td>6.1 ACE/ARB for Left Ventricular Systolic Dysfunction¹</td>
<td>Chart/EHR</td>
<td>Hospital/Inpatient Care</td>
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<td>$ 133,731.00</td>
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<td>6.2 Controlling High Blood Pressure</td>
<td>Chart/EHR</td>
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<td>6.3 Post-Discharge Appointment for Heart Failure Patients</td>
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<td>6.4 Medication Reconciliation</td>
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<td>6.6 30-Day All-Cause Readmission Following HF Hospitalization¹</td>
<td>MMIS***</td>
<td>Department/Inpatient Care</td>
<td>Annual; April</td>
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<td>310,015</td>
<td>393,989</td>
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<td>6.7 30-Day All-Cause Readmission Following AML Hospitalization¹</td>
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<td>6.8 Heart Failure Admission Rate¹</td>
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<td>Department/Inpatient Care</td>
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<td>6.9 Timely Transmission of Transition Record</td>
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<td><strong>Stage IV Measures</strong></td>
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<td>Inpatient Utilization - General Hospital/Acute Care</td>
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<td>Department/Inpatient Care</td>
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<td>Mental Health Utilization</td>
<td>MMIS***</td>
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<td>22,514</td>
<td>$ 48,630.00</td>
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<td>Pneumococcal Immunization (PPV 23)</td>
<td>Chart/ EHR</td>
<td>Hospital/ Inpatient Care</td>
<td>Annual; April</td>
<td>10,807</td>
<td>15,309</td>
<td>22,514</td>
<td>$ 48,630.00</td>
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Measure:
Controlling High Blood Pressure (CBP)

Measure Description:
The percentage of patients 18–85 years of age who had a diagnosis of hypertension (HTN) and whose blood pressure (BP) was adequately controlled (<140/90) during the measurement year.

Data Source:
Chart/ EHR

Measure Steward:
NCQA

DSRIP #: 31
NQF #: 0018
Measure Steward Version: 2013

Measure Calculation Description

Numerator:
The number of patients in the denominator whose most recent blood pressure (BP) is adequately controlled during the measurement year.

Adequate Control - For the patient’s BP to be controlled, both the systolic and diastolic BP must be <140/90 (adequate control). To determine if a patient’s BP is adequately controlled, the representative BP must be identified.

Follow the steps below to determine representative BP:
## THE MEASURES

<table>
<thead>
<tr>
<th>Project Title</th>
<th>Project Code</th>
<th>Payment Method</th>
</tr>
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<tbody>
<tr>
<td>Project 6 - Care Transitions Intervention Model to Reduce 30-Day Readmissions for Chronic Cardiac Conditions</td>
<td>6.2</td>
<td>Pay for Reporting</td>
</tr>
<tr>
<td>Project 7 - Extensive Patient CHF-Focused Multi-Therapeutic Model</td>
<td>7.3</td>
<td>Pay for Reporting</td>
</tr>
<tr>
<td>Project 8 - The Congestive Heart Failure Program (CHF-TP)</td>
<td>8.3</td>
<td>Pay for Reporting</td>
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<tr>
<td>Project 11 - Improve Overall Quality of Care for Patients Diagnosed with Diabetes Mellitus and Hypertension</td>
<td>11.8</td>
<td>P4P</td>
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<tr>
<td>Project 12 - Diabetes Group Visits for Patients and Community Education</td>
<td>12.6</td>
<td>P4P</td>
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<td>Universal Measure: Yes</td>
<td>Universal Code: NA</td>
<td>Payment Method: NA</td>
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</table>
NQF’s Roadmap to Health Equity

Full Story

THE MEASURES

Identify and Prioritize Reducing Health Disparities

Incentivize the Reduction of Health Disparities and Achievement of Health Equity

Invest in the Development and Use of Health Equity Performance Measures

THE FOUR I’S FOR Health Equity

Implement Evidence-Based Interventions to Reduce Disparities

NQF. Health Equity Roadmap. 2017
## THE MEASURES

<table>
<thead>
<tr>
<th>Portfolio Title</th>
<th>Owner Organization</th>
<th>Updated</th>
<th>Status</th>
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<td>QPID Focus Measures (2018)</td>
<td>AltaMed Health Services</td>
<td>Oct 07, 2017</td>
<td>Published</td>
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<td>QPS</td>
<td>Bellevue College</td>
<td>Oct 25, 2016</td>
<td>Published</td>
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<tr>
<td>Quality Measures for Diabetic Retinopathy</td>
<td>Precision for Medicine</td>
<td>Sep 08, 2015</td>
<td>Published</td>
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<td>Quality of Life measures</td>
<td>Stollwerks Inc</td>
<td>Jun 01, 2014</td>
<td>Published</td>
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<td>Quality of Life, Functional Status &amp; Health Outcomes</td>
<td>National Quality Forum</td>
<td>Apr 02, 2013</td>
<td>Published</td>
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<tr>
<td>Radiation Oncology</td>
<td>NEMG - Yale New Haven Health System</td>
<td>Jan 31, 2014</td>
<td>Published</td>
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<td>Readmission Measures</td>
<td>UCSF</td>
<td>Dec 07, 2011</td>
<td>Published</td>
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<td>Renal</td>
<td>National Quality Forum</td>
<td>Sep 27, 2017</td>
<td>Published</td>
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<td>Renal: ESRD and CKD</td>
<td>Arbor Research Collaborative for Health</td>
<td>Oct 12, 2011</td>
<td>Published</td>
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<td>RWJ UH DSRIP</td>
<td>Robert Wood Johnson University Hospital</td>
<td>Apr 25, 2014</td>
<td>Unpublished (Subscribed)</td>
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<tr>
<td>Safety: Healthcare-associated Conditions</td>
<td>National Quality Forum</td>
<td>Apr 02, 2013</td>
<td>Published</td>
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</table>

**Field Guide to NQF Resources:**
An online reference to help you quickly access NQF resources related to quality measurement.
### Relevant Website(s):

Data not available

### Owner Keywords:

Data not available

### Owner Organization:

Robert Wood Johnson University Hospital

Owner:

Andrew Thomas

Created Date:

April 25, 2014

Last Modified Date:

April 25, 2014

### Measures Within This Portfolio (7 Measures):

<table>
<thead>
<tr>
<th>Measure ID</th>
<th>Measure Description</th>
<th>Steward</th>
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<tr>
<td>0228</td>
<td>3-Item Care Transition Measure (CTM-3)</td>
<td>University of Colorado Denver Anschutz Medical Campus</td>
<td>Jan 07, 2015</td>
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<td>0277</td>
<td>Congestive Heart Failure Rate (PQI 08)</td>
<td>Agency for Healthcare Research and Quality</td>
<td>Jan 18, 2012</td>
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<td>0018</td>
<td>Controlling High Blood Pressure</td>
<td>National Committee for Quality Assurance</td>
<td>Jan 18, 2012</td>
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<tr>
<td>0081</td>
<td>Heart Failure (HF): Angiotensin-Converting Enzyme (ACE) Inhibitor or Angiotensin Receptor Blocker (ARB) Therapy for Left Ventricular Systolic Dysfunction (LVSD) (Multiple Formats Available)</td>
<td>AMA-PCPI</td>
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<tr>
<td>2907</td>
<td>Heart Failure (HF): Angiotensin-Converting Enzyme (ACE) Inhibitor or Angiotensin Receptor Blocker (ARB) Therapy for Left Ventricular Systolic Dysfunction (LVSD) (eMeasure)</td>
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<td>Mar 28, 2017</td>
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<tr>
<td>3050</td>
<td>Heart Failure (HF): Angiotensin-Converting Enzyme (ACE) Inhibitor or Angiotensin Receptor Blocker (ARB) Therapy for Left Ventricular Systolic Dysfunction (LVSD)</td>
<td>AMA-PCPI</td>
<td>Mar 28, 2017</td>
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<tr>
<td>0006</td>
<td>Hospital 30-day all-cause risk-standardized readmission rate (RSRR) following acute myocardial infarction (AMI) hospitalization.</td>
<td>Centers for Medicare &amp; Medicaid Services</td>
<td>Dec 09, 2016</td>
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</table>
THE MEASURES

#0018 Controlling High Blood Pressure, Last Updated: Oct 02, 2017

NATIONAL QUALITY FORUM

Measure Information

This document contains the information submitted by measure developers/stewards, but is organized according to NQF’s measure evaluation criteria and process. The item numbers refer to those in the submission form but may be in a slightly different order here. In general, the item numbers also reference the related criteria (e.g., item 1b.1 relates to subcriterion 1b).

Brief Measure Information

<table>
<thead>
<tr>
<th>NQF #: 0018</th>
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<tr>
<td>Corresponding Measures:</td>
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<tr>
<td>De.2. Measure Title: Controlling High Blood Pressure</td>
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<tr>
<td>Co.1.1. Measure Steward: National Committee for Quality Assurance</td>
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<tr>
<td>De.3. Brief Description of Measure: The percentage of patients 18–85 years of age who had a diagnosis of hypertension (HTN) and whose blood pressure was adequately controlled during the measurement year based on the following criteria:</td>
</tr>
<tr>
<td>- Patients 18–59 years of age whose blood pressure was &lt;140/90 mm Hg.</td>
</tr>
<tr>
<td>- Patients 60–85 years of age with a diagnosis of diabetes whose blood pressure was &lt;140/90 mm Hg.</td>
</tr>
<tr>
<td>- Patients 60–85 years of age without a diagnosis of diabetes whose blood pressure was &lt;150/90 mm Hg.</td>
</tr>
<tr>
<td>1b.1. Developer Rationale: One out of every three Americans have hypertension, or high blood pressure (Fields, 2004). Even with the availability of effective treatment options, more than half of Americans with hypertension are untreated or do not have optimal levels of blood pressure while under treatment (AHA, 2010). Improvements in quality or better control of blood pressure as related to this measure would help significantly reduce the probability of serious and costly complications, including coronary artery disease, congestive heart failure, stroke, ruptured aortic aneurysm, renal disease and retinopathy.</td>
</tr>
</tbody>
</table>

Robert Wood Johnson University Hospital
• EHR Data Abstraction

• Documents were built to capture specific data points based on specification in the data book.

THE PROCESS

Robert Wood Johnson University Hospital | RWJBarnabas Health
THE PROCESS

• INTERNAL HOSP DATA
  • Leverage data that is already available internally
  • Example: CLABSI

• OUTSIDE VENDORS
  • Facilitate abstraction of measures
  • Example: evaluation of LVS function, elective delivery, cesarean section, antenatal steroids, and incidence of potentially preventable VTE.
<table>
<thead>
<tr>
<th></th>
<th>metric</th>
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<th>Annual: April</th>
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<td>6.6</td>
<td>30-Day All-Cause Readmission Following Heart Failure (HF) Hospitalization</td>
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<td>CMS</td>
<td>MMIS</td>
<td>Department/Inpatient Care</td>
<td>P4P</td>
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<td>6.7</td>
<td>30-Day All-Cause Readmission Following Acute Myocardial Infarction (AMI) Hospitalization</td>
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<td>CMS</td>
<td>MMIS</td>
<td>Department/Inpatient Care</td>
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<td>6.9</td>
<td>Timely Transmission of Transition Record</td>
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<td>AMA-PCPI</td>
<td>Chart/EHR</td>
<td>Hospital/Inpatient Care</td>
<td>P4P</td>
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</table>
THE VALIDATION

- Random manual chart review to ensure that results pulled by query of the EHR are accurate.
- Review of all charts that do not meet the measure criteria.
- Review all MMIS data if its outside our “forge threshold” for our internal data.
  - Manually review first 10 charts that do meet measure criteria.
  - If less than 100% accurate, review another 10 charts and submit an appeal to NJ DSRIP.
THE VALIDATION

Measure:
Timely Transmission of Transition Record

Measure Description:
Percentage of patients, regardless of age, discharged from an inpatient facility to home or any other site of care for whom a transition record was transmitted to the facility or primary physician or other health care professional designated for follow-up care within 24 hours of discharge.

Data Source:
Chart/EHR

Measure Steward:
AMA-PCPI

DSRIP #:
80

NQF #:
0648

Measure Steward Version:
2009
THE VALIDATION

Measure Calculation Description

**Numerator:**
Patients for whom a transition record was transmitted to the facility or primary care physician or other health care professional designated for follow-up care within 24 hours of discharge.

Transition record - a core, standardized set of data elements related to patient’s diagnosis, treatment, and care plan that is discussed with and provided to patient in printed or electronic format at each transition of care, and transmitted to the facility/physician/other health care professional providing follow-up care. Electronic format may be provided only if acceptable to patient.

Transmitted - transition record may be transmitted to the facility or physician or other health care professional designated for follow-up care via fax, secure e-mail, or mutual access to an electronic health record (EHR).

Primary physician or other health care professional designated for follow-up care - may be a designated primary care physician (PCP), medical specialist, or other physician or health care professional

**Denominator:**
Of the New Jersey Low Income attributed population, all patients, regardless of age, discharged from an inpatient facility (i.e. hospital inpatient) to home/self care or any other site of care with a diagnosis of care or working diagnosis of Congestive Heart Failure (CHF) Appendix A-30. See Table 80.1 for codes to identify patients discharged from an inpatient facility.
THE VALIDATION

- Manual review of all charts that do not meet measure criteria
- Check for follow up appointments
- Check if follow up medical provider has access to Relay Health (HIE) or Hospital Records
- If all is negative then the patient does not meet criteria.
- If validation shows that patient does not meet measure criteria, a resolution is discussed and implemented.
  - For the case of Timely Transmission of Records, provider will be offered HIE registration.
THE CONCLUSION

• Understand and follow your measures
• Develop an automate your data collection process
• Develop and maintain a process to validate your data
• Evaluate the whole process frequently
• Finally, your measures, your data collection, your validation process and your evaluation must improve the patients experience of care, improve the health of the community and reduce the overall cost of healthcare.