The Role of Quality and Collaboration in IT Networks

RHITND Conference
3/21/13
RWHC Background

- Founded in 1979.
- Non-profit coop owned by 37 rural hospitals (with net rev $1.4B & 2,000 hospital & LTC beds).
- 8 PPS & 29 CAH; ≈ 23 freestanding and 14 system affiliated.
- ≈ 70 employees (50 FTE).
- ≈ $11M RWHC budget (75% member sales, 17% non-member sales, 6% dues & 2% grants).
RWHC Shared Services*

Professional Services
Financial & Legal Services  Negotiation with Health Insurers
Medical Record Coding  Clinical Services & Recruitment

Educational
Professional Roundtables & Leadership Training
Nurse Residency Program & Preceptor Workshops
Lean Lab (with Lean Six Sigma Master Black Belt)

Quality Programs
Credentials Verification & Peer Review Services
Quality Indicators & Improvement Programs

Technology Services
WAN and Data Center Services
RWHC ITN Hosted EHR with Shared Staffing Model

* Partial List
RWHC ITN Background

- Incorporated as 501(c)3 in 2007
- HRSA CAHHIT and FCC Pilot Program Supported
- Horizontal Network—group of small hospitals working together to gain efficiencies & improve outcomes by sharing HIT and support staff
- Systems Hosted: HMS “complete EHR” (ONC-certified); MedHost ED EHR (ONC-certified); Merge PACS; Exitcare Discharge Instructions; 3M coding; etc.
- Six Hospitals Currently Participating: 5 use ITN hosted systems and shared staffing; 1 shared staffing only
- Redundant datacenters/broadband connections
RWTC Information Technology Network
Enhanced Network for Shared EHR

LEGEND
- Web Services
- EHR Services
- Primary Care Provider
- Specialty Care Provider
- Primary Care Clinic
- Specialty Care Clinic
- EMR Interface
- UPS Interface
- NIC Interface
- Internet Interface

Structural Assumptions
Shared Staffing Model

• 9 FTEs and 2 contracted Pharmacists
  – 24/7/365 Helpdesk
  – Onsite assistance for helpdesk tickets and other issues
  – Implementation project coordination
  – Server, Interface, Testing Environment Management
  – WAN and Citrix environment management
  – Report and Dashboard development
  – After hours remote medication verification
  – Meaningful Use facilitation
  – Collaborative vendor selection of new systems
  – Workgroups: Patient accounting, HIM, Materials Management, Lab, Radiology, Patient Care/QI
Benefits of ITN Participation

• Contain HIS/EHR Costs
  – Cost efficiency through volume purchasing and by sharing servers/datacenters
  – 20% less to implement through ITN rather than standalone

• Improve HIS/EHR Operational Effectiveness
  – Enhance support with shared staffing model
  – Provide redundancy for maximum uptime

• Achieve Internal EHR Goals
  – Better and more complete documentation
  – Enhanced compliance with ordering and referral policies
  – Better and secure access to the patient record
  – Reduced medication errors (early, late, missed, duplicate)
  – Higher core measure scores (discharge instructions, etc.)
ITN Network Success Factors

• History of Collaboration
• Comprehensive Communication Mechanisms
  – Workgroups
  – Onsite Presence
  – Technology (portals/helpdesk ticket management)
  – User Satisfaction Surveys
• Balanced Scorecard and Strategic Planning
  – Keeping everyone on the same page
• Customer Service and QI Focus
“Quality” Measures

Overarching goal: Improve patient outcomes and promote best practices in hospital settings

2003: “Starter Set” of 10 measures
- AMI, HF, PN all inpatient

By 2008:
- P4R (RHQDAPU) 2% reduction for not reporting
- expanded set to 28 and started claims based Mortality measures and penalties for HACs
“Quality” Measures

Fast fwd to FY 2015:
– More measures (now nearly 100) in these topics:
  • Inpatient and Outpatient Process and Outcome Measures
  • Mortality
  • Patient Safety and Healthcare Acquired Conditions
  • Patient Satisfaction
  • ETC!
Currently...

• Deluge of requirements
• Overburdened QI staff
• Public Reporting
• What does the data mean/prove?
  – Are patients safer?
• New stakeholder: Meaningful Use
  – De-centralized quality, increased interactions with others, including IT!
ITN as QI/IT prototype

• Used shared expertise to design templates for locating patient data electronically
  – Clinical Staff knew the workflow
  – Quality Consultant knew the metrics/data elements needed
  – IT knew processes for data storage and retrieval
Influenza Vaccination Protocol

• Best Practice/Quality Metric
  – Patient eligibility (who can get it)
  – Vaccine Status (do they need/want it?)
  – Generate an order (via approved protocol)
  – Reminder to RN to administer prior to discharge
  – eMAR entry as part of workflow
Retrieval and Export

• Data rests in SQL of the HMS database
• Programmer creates query to extract data and locate it to xml or csv file
• RWHC programs data within the file to populate the web-based data collection tool
• Automate the process to minimize “touch”
End Result

• Hospital QI staff now:
  – Maximize analysis and process improvement
  – Minimize redundant data entry
  – Move onto “next things” and lessons learned
    • Easy to build templates that are objective and do not contain physician “reasons” documentation
    • Integrating quality with adoption of EHR applications (easier with Lab, MAR; more difficult with CPOE, progress notes, etc)
ITN’s Meaningful Use Program

• Stage 1 MU Gap Assessments and Work Plans
• MU Dashboards for Compliance Tracking
  – 12 month rolling depiction of threshold compliance
  – Identifies variances (accounts out of compliance) for follow-up
• Health Information Exchange Test using WI Statewide HIE’s “Direct” Transport Mechanism
• Syndromic Surveillance Submission
• Immunization Submission in Process
• Patient Care Workgroup Collaborated to Design Decision Support Rule (pneumonia vaccination for patients >65)
• RWHC QI for Collection of the 15 Hospital CQMs
• Stage 2 Planning in Process
• 5 ITN Members Have Attested to MU; 1 is in Process
WHITEC’s Rural Hospital MU Program

• 43 Rural Wisconsin Hospitals Participating
• Free **MU Planning Assistance**
  – Incentive financial/value assessment w/tool
  – MU objective assessment w/tool
  – Onsite MU presentation and discussion
  – Informational resource through listserve
• Fee-based MU-related services:
  – Hospital QI Measure Assessment
  – Security/Risk Assessment
  – Attestation Assistance/Audit Readiness
Date WHITEC Hospitals Have/Plan to Attest to Meaningful Use

- Attested to MU in 2011: 15%
- Attested in 2012: 51%
- Plan to Attest in 2013: 19%
- Plan to Attest in 2014: 10%
- Unknown/Undecided: 5%
- Attested in 2012: 51%
Opportunities and Challenges Ahead

• Statewide HIE (WISHIN) Onboarding
  – Sustainability Issues
• Healthcare Connect Fund
• ICD-10
• Stage 2 Meaningful Use
  – Patient Portals
  – Summary of Care Record Exchange
  – New Standards (SNOMED/CCDA/RxNorm...)
  – New CQMs
Managing the Future

• Meaningful Use Stage 2 Measures
  – Converting current reporting format (xml) to new QRDA (Quality Reporting Data Architecture)
  – CMS did not have a “warehouse” for Stage One data, and are building one now that will receive Stage 2 data
  – EH’s will report on 16 of possible 29 measures covering at least three domains of care
Managing the Future

• Collaborating with QI
• Networking and stealing shamelessly
• Educating your vendor
• Creating and communicating your prioritized work list and don’t fear details
• Establish and maintain a sacred space and time for working together
Managing the Future

• http://www.youtube.com/watch?v=VSDxqlBfEAw
Your TO-DO list

• Find the QI lead in your organization
  – Make nice, swap acronyms and drinks
• Discover shared knowledge and deficits
• Gather resources
• Commit to time and space
• Identify and invite other stakeholders
Your TO-DO list

• Strategize:
  – Locating more data electronically
  – Achieving Stage One or Two MU
  – Creating “quality” quality reports
  – Vendor accountability

• Plan your work, work your plan

• Granular, published, transparent
GOOD LUCK!