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Core Measures
Baptist Hospital of Southeast Texas
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Data sharing has become an important part of healthcare delivery. Whether it is laboratory or procedure results, patient health information is increasingly being shared. The use of data to evaluate the quality of patient care is now getting the attention it deserves. Data has always existed but no one knew what it meant. It was "hidden" in paper which was "hidden" in medical records. It was time consuming and expensive to count records one at a time to determine the quality of care. The data could not be aggregated, analyzed or turned into information which could affect the direction or the quality of healthcare.

Those days are gone. They went first with information which was looked at months after the healthcare was delivered. Healthcare companies laboriously review patient chars and count how many times patients had immunizations, or screening tests. Eventually, healthcare providers were given this information but in that it was 12 to 18 months after the event, they didn‟t care much.

With the advent of electronic health records (EHR), data sharing has entered a new era. With EHR data can be aggregated quickly. Information that once took days and weeks to collect can now be collected in seconds. Data can be analyzed quickly and treatment strategies can be developed as quickly.

The public reporting of quality data is increasingly becoming the standard for healthcare organizations and for healthcare providers. However, few organizations are publishing quality performance by provider name; SETMA began that in 2009. Ultimately, transparency at the provider level will become the national standard.

A brief history of healthcare accreditation organizations in healthcare

There are now dozens of organizations which offer one form of healthcare accreditation or another. The following are the oldest and perhaps principle ones:

1. The Joint Commission on Hospital Accreditation was founded in 1951 and had a significant change in focus in 1965 when it because the official organization for hospital accreditation.
2. The Accreditation Association for Ambulatory Care (1979)
3. Accreditation Commission for Health Care (1985)
4. Utilization Review Accreditation Commission (1990)
5. National Committee for Quality Assurance (1990)

These organizations publish standards for quality performance and provide surveys and often site visits for organizational accreditation. The fact that most of these accreditation organizations have only existed for the past thirty years or so, lets you know how young healthcare quality assessment is.

Healthcare Organizations which have voluntarily submitted to review by these accreditation bodies subject themselves to new standards of excellence. Hospitals do not voluntarily receive surveys; it is required. Eventually, the same will be required for all healthcare provider organizations (physicians, dentist, nurse practitioners and physician assistants) as well. SETMA has both AAAHC accreditation for ambulatory care and medical home, and NCQA recognition for medical home and diabetes care. There are about 250,000 groups of physicians in the United States and many more physicians who are in solo practice. Currently fewer than 3,000 groups have any form of accreditation or recognition for quality performance. Less than 1% of those publicly report quality performance by provider name.

Public Reporting

In that SETMA began pubic reporting on over 200 quality metrics by provider name in 2009, it was logical that when we were given our results on Hospital Cord Measures that we would publicly report those also. The following is an explanation of Core Measures and SETMA‟s results at Baptist Hospital of Southeast Texas for 2011. We hope soon to receive our results and to publicly report them from Christus St. Elizabeth and from the Medical Center of Southeast Texas. The Baptist Core Measures can be reviewed at www.jameslhollymd.com under *Public Reporting Core Measures*.

What are Core Measures?

Hospitals across the country adhere to a set of care processes called Core Measures, which were developed by The Joint Commission, the nation's predominant standards-setting and accrediting body for inpatient health care, to improve the quality of health care by implementing a national, standardized performance measurement system. The Core Measures were derived largely from a set of quality indicators defined by the Centers for Medicare and Medicaid Services (CMS). They have been shown to reduce the risk of complications, prevent recurrences and otherwise treat the majority of patients who come to a hospital for treatment of a condition or illness. Core Measures help hospitals improve the quality of patient care by focusing on the actual results of care.

Comparing Performance

Hospitals across the country are measured and compared by The Joint Commission against all other accredited institutions on their performance in these Core Measures. You will note there is a time lag of several months between when data is reported from hospitals and when it is posted for the public to review. Hospitals have to wait for state and national statistics to be compiled

before it can post its quality data for a given period. Hospitals report their results internally and more and more hospitals are beginning to share this data with the public.

What does each of the Core Measures stand for?

There are 33 Core Measures altogether, in 4 categories (acute myocardial infarction, community-acquired pneumonia, congestive heart failure, and surgical care improvement project). Under each category, key actions are listed that represent the most widely accepted, research-based care process for appropriate care in that category.

It is important to note that these care recommendations are subject to the professional medical advice of each patient's physician and the particular health conditions of each patient. If a physician determines that a patient is not an appropriate candidate for a particular care process, the patient will not be included in the data. A good example is aspirin. Some patients are allergic to aspirin; for others, taking aspirin will make another medical problem worse. In these cases, the patient's physician may determine that aspirin should not be administered or prescribed for the patient. Therefore, the patients will not be included in the data.

The following are technical descriptions of all of the core measures.
Core Measures (Process of Care Measures)
Accurate as of March 1, 2012

Measure Designation	Measure Abbreviation	Explanation
Inpatient		
AMI measures speak to actions taken in the care of patients presenting with Acute Myocardial Infarction (AMI – commonly called "heart attack")		
AMI 1	ASA on Arrival	ASA =Aspirin.
AMI 2	ASA on Discharge	ASA = Aspirin. Patient is instructed to take aspirin daily at home following discharge.
AMI 3	ACE/ARB for LVSD	Patients who are diagnosed with left ventricular systolic dysfunction (LVSD – the heart, a pump, is not effectively pumping blood) are provided medications that improve the pump effectiveness. (These drugs are either classified as ACE inhibitors or an ARB).
AMI 5	BB at discharge	A beta-blocker (BB) is prescribed for the patient to take following discharge. Beta-blockers provide protection to the heart following an AMI.
AMI 8a	PCI w/in 90 minutes.	Percutaneous Coronary Intervention (PCI) should be implemented (if the patient is a candidate) in less than 90 minutes. This involves the patient being taken to the cath lab for procedure. The PCI time is calculated from the time the patient enters the facility until the time when "the lesion is crossed" and blood flow is restored.
AMI 10	Statin prescribed at discharge	If the patient is on a Statin at home, the Statin must be prescribed at discharge unless there is a medical reason for the patient to not continue on the medication.
PC AMI	Perfect Care AMI	AMI Patients received all applicable process measures.

Measure Designation	Measure Abbreviation	Explanation
HF=Heart Failure Sometimes referred to as "CHF" or Chronic Heart Failure		
HF 1	Discharge Instructions	The patient receives specific instruction regarding five important elements of care that must be addressed following discharge.
HF 2	LVF Assessment	LVF = Left Ventricular Failure. There are a variety of ways for a physician to measure the function of the left ventricle. Assessment must be performed during the hospitalization, or test results performed prior to admission may be used as part of the evaluation. (Results must be present in the patient record during the patient stay.)
HF 3	ACE/ARB for LVSD	See AMI 3 above.
PC HF	Perfect Care for Patients with Heart Failure	HF Patients received all applicable process measures.
IM=Immunizations		
IMM 1a	Pneumococcal Immunization (overall)	All patients who meet criteria are provided an opportunity to receive a Pneumococcal Vaccine prior to discharge.
IMM 1b	Pneumococcal Immunization (Age 65 and older)	All patients who meet criteria (Age 65 or older) are provided an opportunity to receive a Pneumococcal Vaccine prior to discharge.
IMM 1c	Pneumococcal Immunization, High Risk Population (Age 6-64)	All patients who meet criteria (Age 6-64 and determined to be high risk) are provided an opportunity to receive a Pneumococcal Vaccine prior to discharge.
IMM 2	Influenza Immunization	All patients who meet criteria are provided an opportunity to receive an Influenza Vaccine prior to discharge.
PC IMM	Perfect Care r/t Immunization Recommendations	All Patients who required immunizations received all applicable immunizations.
Outpatient Treatment		
OP 4	Aspirin at Arrival – OP AMI	All patients who meet the diagnosis of AMI receive Aspirin prior to transfer to a higher level of care.
OP 4c	Aspirin at Arrival – Chest Pain	Outpatients with Chest Pain receive Aspirin on arrival to the ED prior to transfer to a higher level of care.
PC OP CP	Perfect Care for Outpatients with Chest Pain	All patients with a diagnosis of CP received all applicable process measures.
OP 6	Timing of Antibiotic Prophylaxis	Outpatient surgical patients who require prophylactic antibiotics, were provided an antibiotic within one hour of the surgical incision.
OP 7	Prophylactic Antibiotic Selection for Surgical Patients	Outpatient surgical patients received the appropriate antibiotic to prevent infection.
PC OP Surgical	Perfect Care for Surgical Outpatients	All surgical outpatients received all applicable process measures.
OP 16	Troponin Results for ED AMI or ED CP	Troponin results were available for patients presenting with AMI or CP in time to insure appropriate treatment.
OP 19	Transition Record with Specified Elements Received by Discharged Patients	Specific outpatients seen in the Ed received appropriate discharge instructions.

Measure Designation	Measure Abbreviation	Explanation
PC OP ED	Perfect Care for the ED Outpatient	Patient in the emergency department received all applicable process measures.
PN measures are provided to patients with a diagnosis of pneumonia.		
PN 3a	Blood Culture within 24 hours of arrival for patients admitted to ICU	If a patient is admitted to ICU with a diagnosis of Pneumonia, blood cultures are performed within 24 hours of admission to the ICU.
PN 3b	Blood Culture in ER before first antibiotic	A blood culture (BC) should be drawn while the patient is in the emergency room (ER) before any antibiotics (Abx) are provided to the patient
PN 6	Appropriate ABX	Antibiotic (Abx) selection should follow evidence based guidelines.
PN 6a	Appropriate ABX ICU Pneumonia patient	Antibiotic (Abx) selection should follow evidence based guidelines.
PN 6b	Appropriate ABX Non-ICU Pneumonia patient	Antibiotic (Abx) selection should follow evidence based guidelines.
PC PN	Perfect Care of the Pneumonia Patient	Pneumonia patients received all applicable process measures.
SCIP = Surgical Care Improvement Project. The National Surgical Care Improvement committee has developed, in conjunction with the surgical and cardiac professional societies, best practice recommendations for the prevention of infection following a surgical procedure.		
SCIP Inf 1	Abx w/in 1 hour of surgery	Prophylactic antibiotic (Abx) should be administered no more than one hour prior to the start of the surgery (defined as the „cut time“).
SCIP Inf 2	Abx Selection	An appropriate antibiotic to prevent infection was administered.
SCIP Inf 3	Abx d/c“d w/in 24 hours of surgery	Antibiotic was stopped within 24 hours of the surgical procedure. Continuing antibiotics has not been proven to be effective in preventing infection; however, overuse of antibiotics can lead to antibiotic resistance. Antibiotics may be continued up to 48 hours following certain cardiac procedures.
SCIP Inf 4	BS control am day 1 & 2 cardiac	Blood Sugar (BS) should be controlled following surgery as an elevated blood sugar may increase the risk for infection. Blood sugar is measured in the early morning the first and second day following cardiac surgeries to insure that it is in the appropriate range.
SCIP Inf 6	Appropriate hair removal	Surgical site should not be shaved as shaving can leave microscopic cuts that increase the risk for infection. If hair needs to be removed, it should be clipped, not shaved.
SCIP Inf 9	Removal of Urinary Catheter before 2nd Post-op Day	Urinary Catheter is removed by the end of the second day following surgery.
SCIP Inf 10	Perioperative Temperature Management	Patients maintain the proper temperature in the operating room as recommended to prevent infection.
SCIP Card	BB periop when on BB at home	If the patient is taking a beta-blocker medication at home, it is important that it not be stopped prior to surgery. The medication can be given with a „sip of water“ prior to the scheduled procedure.
SCIP VTE 1	Appropriate VTE ordered	VTE = Venous Thrombo Embolism (commonly called

Measure Designation	Measure Abbreviation	Explanation
		„blood clot.“) Chemical and mechanical measures have been defined that can prevent the formation of blood clots following surgery. This measure reflects that the physician has ordered treatment.
SCIP VTE 2	VTE 24 hours before/24 hours after	To be effective, activities to prevent clots should be started within 24 hours of the surgical procedure. Most often, the measures are put into place prior to the operation, but some medications are not started until after surgery. If prophylaxis is not ordered (SCIP VTE 1) then the measures can not be implemented.
PC SCIP	Perfect Care for the Surgical Patient	Surgical patients received all applicable process measures.
Stroke		
STK 1	VTE Prophylaxis	Patient receives appropriate chemical or mechanical measures to prevent clots or patient is up and walking without assistance by the second day.
STK 2	Discharged on Antithrombotic Therapy	Discharged on recommended Antithrombotic medications.
STK 5	Antithrombotic Therapy by end of Hospital Day 2	Antithrombotic medications are started in the hospital as recommended.
STK 6	Discharged on Statin	Stroke patients are discharged on Statin medication as recommended.
STK 8	Stroke Education	Education is provided to the Stroke patient that is appropriate to the diagnosis
STK 10	Assessed for Rehab	Stroke patients receive all necessary assessments to determine appropriate rehab treatment.
PC STK	Stroke Perfect Care	Stroke patients received all applicable process measures.

The following are SETMA‟s results for admission during 2011 at Baptist Hospital of Southeast Texas. The color coding lets you know whether or not SETMA meets the national benchmarks or not. Those in “green” meet or exceed the benchmarks. Those in “yellow” are a the low end of the benchmarks. And those in “pink or red” need improvement.

Core Measures

MEASURE	CASES	RESULT	NATIONAL TOP10	NATIONAL AVG	SYSTEM HIGH TARGET	SYSTEM LOW TARGET
Joint Commission Measures						
Appropriate Care Measure 10 (ACM-10)	67 / 68 (1)	98.53%	N/A	N/A	100.00%	95.00%
Appropriate Care Measure ICD-9 (ACM-10 ICD-9)	94 / 94 (0)	100.00%	N/A	N/A	100.00%	95.00%
Appropriate Care Measure Total (ACM-Total)	124 / 144 (20)	86.11%	N/A	N/A	100.00%	95.00%
Appropriate Care Measure Total ICD-9 (ACM-Total ICD-9)	158 / 158 (0)	100.00%	N/A	N/A	100.00%	95.00%
AMI ICD-9 (AMI ICD-9)	32 / 32 (0)	100.00%	N/A	N/A	100.00%	95.00%
ASA at Arrival (AMI-1) [Zynx]	29 / 30 (1)	96.67%	100.00%	98.86%	100.00%	96.23%
Statin Prescribed at Discharge (AMI-10)	22 / 23 (1)	95.65%	N/A	N/A	90.00%	80.00%
ASA Prescribed at Disch (AMI-2) [Zynx]	22 / 22 (0)	100.00%	100.00%	98.79%	100.00%	95.08%
ACEI or ARB for LVSD (AMI-3) [Zynx]	7 / 7 (0)	100.00%	100.00%	96.59%	100.00%	85.44%
Adult Smoke Cessation Advce/Couns (AMI-4) [Zynx]	7 / 7 (0)	100.00%	100.00%	99.62%	100.00%	94.14%
BB Prescribed at Disch (AMI-5) [Zynx]	26 / 26 (0)	100.00%	100.00%	98.57%	100.00%	94.23%
Median time to primary PCI (AMI-8) [Zynx]	0 / 4 (4)	0.00%	N/A	N/A	100.00%	90.00%
Primary PCI Recd w/in 90 min of Arrival (AMI-8a) [Zynx]	4 / 4 (0)	100.00%	100.00%	91.16%	100.00%	90.00%
HF ICD-9 (HF ICD-9)	29 / 29 (0)	100.00%	N/A	N/A	100.00%	95.00%
Disch Instructions (HF-1) [Zynx]	18 / 20 (2)	90.00%	100.00%	90.83%	93.80%	63.57%
Eval of LVSF (HF-2) [Zynx]	24 / 24 (0)	100.00%	100.00%	98.75%	99.20%	90.66%
ACEI for LVSD (HF-3)	7 / 7 (0)	100.00%	100.00%	95.46%	98.13%	83.73%
Adult Smoke Cessation Advce/Couns (HF-4) [Zynx]	3 / 3 (0)	100.00%	100.00%	99.10%	100.00%	89.62%

The following Core Measures are for groups of metrics and represent the area in which SETMA will focus our attention the most in the coming year. The categories are Perfect Care for Acute Myocardial Infarction, Heart Failure, Pneumonia and Perfect Care for Surgical Care.

PerfectCare - AMI (PC-AMI)	29 / 31 (2)	93.55%	N/A	N/A	100.00%	95.00%
PerfectCare - HF (PC-HF)	22 / 24 (2)	91.67%	N/A	N/A	100.00%	95.00%
PerfectCare - PN (PC-PN)	24 / 28 (4)	85.71%	N/A	N/A	100.00%	95.00%
PerfectCare - SCIP (PC-SCIP)	51 / 64 (13)	79.69%	N/A	N/A	100.00%	95.00%
PN ICD-9 (PN ICD-9)	33 / 33 (0)	100.00%	N/A	N/A	100.00%	95.00%
Pneumococcal Vaccination (PN-2) [Zynx]	13 / 13 (0)	100.00%	100.00%	94.81%	92.03%	70.55%

SETMA performance for the following group of Core Measures is excellent.

BC Performed w/in 24 hrs of Arrival (PN-3a)	7 / 7 (0)	100.00%	100.00%	96.85%	90.00%	80.00%
BC Performed in ED Prior to Init Atbx Recd in Hosp (PN-3b)	23 / 25 (2)	92.00%	100.00%	96.39%	97.84%	89.16%
Adult Smoke Cessation Advce/Couns (PN-4) [Zynx]	4 / 4 (0)	100.00%	100.00%	98.38%	100.00%	87.04%
Init Atbx Recd w/in 6 hrs of Arrival (PN-5c)	18 / 19 (1)	94.74%	100.00%	95.77%	100.00%	90.00%
Init Atbx Sel for CAP in Immuno Pts (PN-6)	9 / 9 (0)	100.00%	N/A	N/A	100.00%	95.00%
Init Atbx Sel for CAP in Immuno Pts ICU (PN-6a)	3 / 3 (0)	100.00%	100.00%	77.18%	90.00%	80.00%
Init Atbx Sel for CAP in Immuno Pts non-ICU (PN-6b)	6 / 6 (0)	100.00%	100.00%	95.23%	90.00%	80.00%
Influenza Vaccination (PN-7) [Zynx]	10 / 11 (1)	90.91%	100.00%	92.06%	90.00%	80.00%
SCIP ICD-9 (SCIP ICD-9)	67 / 67 (0)	100.00%	N/A	N/A	100.00%	95.00%
Surg Pts on BB Rx Prior to Adm and Recd BB Periop (SCIP-Card2)	25 / 26 (1)	96.15%	100.00%	94.42%	90.00%	80.00%
Surgery Patients with Perioperative Temperature Management (SCIP-Inf10)	42 / 42 (0)	100.00%	N/A	N/A	90.00%	80.00%
Proph Atbx Recd w/in 1hr Prior to Surg Incsn Overall (SCIP-Inf1a)	39 / 40 (1)	97.50%	100.00%	97.38%	100.00%	90.00%
Proph Atbx Recd w/in 1hr Prior to Surg Incsn CABG (SCIP-Inf1b)	12 / 12 (0)	100.00%	100.00%	97.78%	100.00%	85.89%
Proph Atbx Recd w/in 1hr Prior to Surg Incsn Othr Card Surg (SCIP-Inf1c)	5 / 5 (0)	100.00%	100.00%	97.63%	100.00%	84.17%
Proph Atbx Recd w/in 1hr Prior to Surg Incsn Hip (SCIP-Inf1d)	9 / 9 (0)	100.00%	100.00%	97.50%	95.70%	86.66%
Proph Atbx Recd w/in 1hr Prior to Surg Incsn Knee (SCIP-Inf1e)	3 / 3 (0)	100.00%	100.00%	98.04%	98.41%	88.62%
Proph Atbx Recd w/in 1hr Prior to Surg Incsn Colon (SCIP-Inf1f)	8 / 8 (0)	100.00%	100.00%	94.72%	93.28%	78.55%
Proph Atbx Recd w/in 1hr Prior to Surg Incsn Vasc Surg (SCIP-Inf1h)	2 / 3 (1)	66.67%	100.00%	96.00%	98.84%	79.59%

It will take time until we all, provider and patient, learn how to interpret and understand all of these measures. The fact that we have started the process is indicative of our commitment to excellence in healthcare.