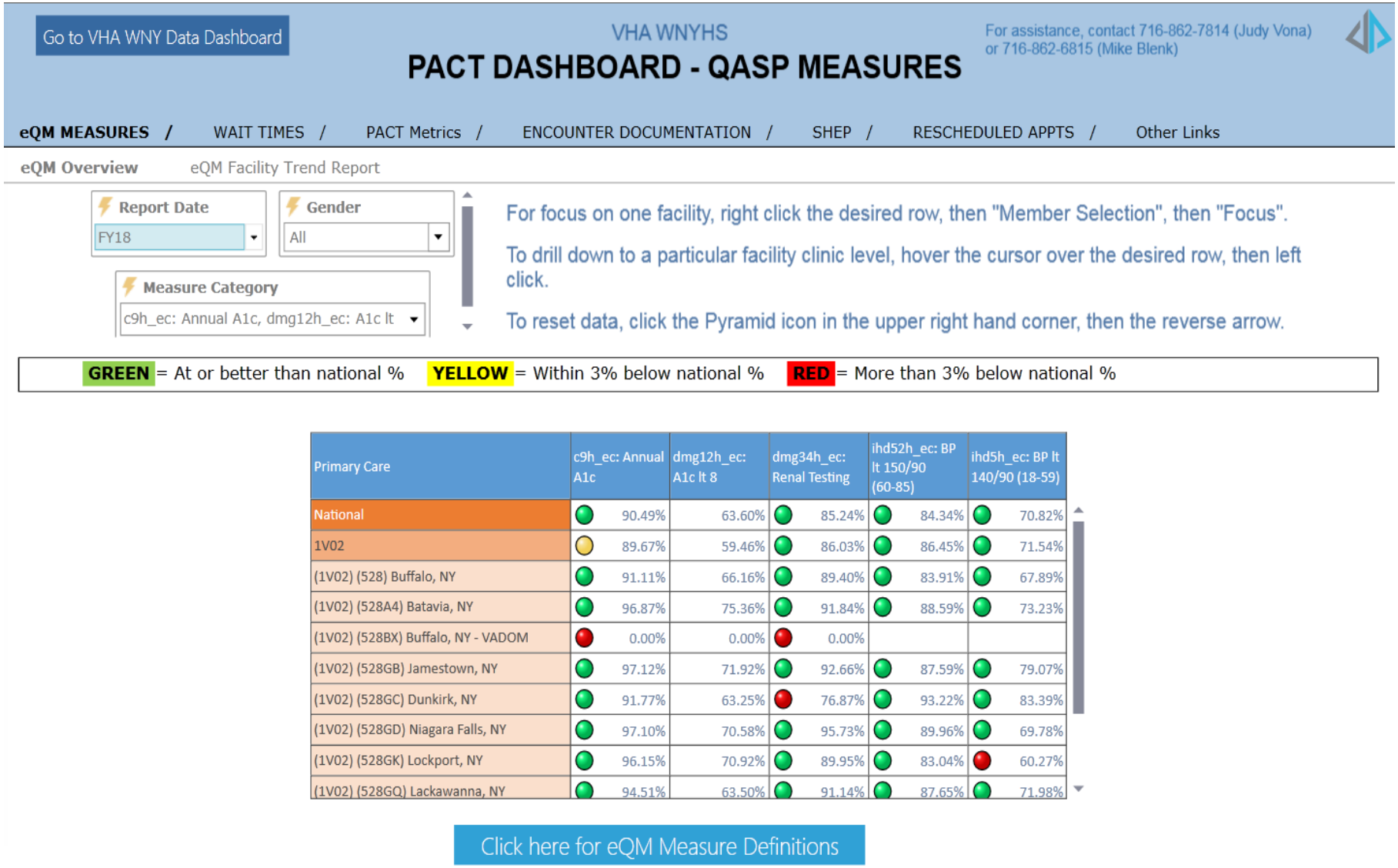
D.33 SAMPLE CBOC DASHBOARD, CURRENT PERFORMANCE MEASURES, AND EXTERNAL PEER REVIEW PROGRAM (EPRP) INFORMATION

The following is a sample of the VAWNYHS CBOC Dashboard (subject to revision) that Contractors will be able to access:



Primary Care	c9h_ec: Annual A1c	dmg12h_ec: A1c lt 8	dmg34h_ec: Renal Testing	ihd52h_ec: BP lt 150/90 (60-85)	ihd5h_ec: BP lt 140/90 (18-59)
National	90.49%	63.60%	85.24%	84.34%	70.82%
1V02	89.67%	59.46%	86.03%	86.45%	71.54%
(1V02) (528) Buffalo, NY	91.11%	66.16%	89.40%	83.91%	67.89%
(1V02) (528A4) Batavia, NY	96.87%	75.36%	91.84%	88.59%	73.23%
(1V02) (528BX) Buffalo, NY - VADOM	0.00%	0.00%	0.00%		
(1V02) (528GB) Jamestown, NY	97.12%	71.92%	92.66%	87.59%	79.07%
(1V02) (528GC) Dunkirk, NY	91.77%	63.25%	76.87%	93.22%	83.39%
(1V02) (528GD) Niagara Falls, NY	97.10%	70.58%	95.73%	89.96%	69.78%
(1V02) (528GK) Lockport, NY	96.15%	70.92%	89.95%	83.04%	60.27%
(1V02) (528GQ) Lackawanna, NY	94.51%	63.50%	91.14%	87.65%	71.98%

Go to VHA WNY Data Dashboard

VHA WNYHS

PACT DASHBOARD - QASP MEASURES

For assistance, contact 716-862-7814 (Judy Vona) or 716-862-6815 (Mike Blenk)

SHEP Metrics

Survey Date
DEC-FY18

For focus on one facility, right click the desired row, then "Member Selection", then "Focus".

To reset data, click the Pyramid icon in the upper right corner and then click the reverse arrow.

Facility District	6. In the last 6 months, when you contacted this provider's office to get an appointment for care you needed right away, how often did you get an appointment as soon as you needed?				9. In the last 6 months, when you made an appointment for a check-up or routine care with this provider, how often did you get an appointment as soon as you needed?				14. In the last 6 months, when you contacted this provider's office during regular office hours, how often did you get an answer to your medical question that same day?				38. In the last 12 months, did you and anyone in this provider's office talk at each visit about all the prescription medicines you were taking?				61. Overall the health VA facility
	N	Score	% Yes	Weighted %	N	Score	% Yes	Weighted %	N	Score	% Yes	Weighted %	N	Score	% Yes	Weighted %	N
All Facility District	6,806	48.5			14,796	56.9			8,582	50.0							19,976
1V02	412	68.2			1,085	66.2			567	63.6							1,372
(1V02) (528) Western New York HCS	50	62.8			138	67.9			77	55.1							174
(1V02) (528) Buffalo, NY	6	71.4			16	65.4			8	46.7							23
(1V02) (528A4) Batavia, NY	7	30.0			21	79.6			11	69.0							28
(1V02) (528GB) Jamestown, NY	3	.0			9	20.1			5	46.9							12
(1V02) (528GC) Dunkirk, NY	8	92.1			17	91.2			10	49.5							19
(1V02) (528GD) Niagara Falls, NY	6	75.3			18	95.4			8	81.3							20
(1V02) (528GK) Lockport, NY	4	82.3			15	60.0			4	76.1							17
(1V02) (528GQ) Lackawanna, NY	8	53.4			19	61.7			8	77.5							26
(1V02) (528GB) Olean, NY	8	84.3			23	62.7			23	47.0							29

The following is a list of the currently available Electronic Technical Manual (eTM) Performance Measures:

Status	Mnemonic	Measure Name
Active	acr1	All Cause Readmission
Active	ami8a_ec	Primary PCI Received Within 90 Minutes of Hospital Arrival (eMeasure)
Active	bfs3	Bereaved Family Survey (rolling 12 mo)
Active	bh90	Composite - Behavioral Health Screening
Active	c12	AMI - Outpt ASA at most recent visit
Active	c13	AMI - Outpt beta blockers at most recent visit
Active	c5	DM - Outpt Foot Inspection
Active	c6	DM - Outpt Foot pedal pulses
Active	c7n	DM - Outpt - Foot sensory exam using monofilament
Active	c9h	DM - Outpt - HbA1c Annual
Active	c9h_ec	DM - Outpt - HbA1c Annual (eMeasure)
Active	cas1	CA1 Submission Timeliness
Active	cbi0	CBI Scorecard- Composite Score
Active	cbi56	Response to CBI Metric Underperformance
Active	cbi64	E&M Coding Outliers: New Patient

Active	cemp99	Comprehensive Emergency Management Program (CEMP)
Active	chf14	HF - Outpt - LVEF LT 40 on ACEI or ARB
Active	chf7	HF - Outpt LVF documented
Active	chl1	Chlamydia Screening in Women ages 18-24
Active	chpa1	% Traditional Non-VA care provided through Choice Provider Agreements
Active	clab6	CLABSI - ICU and non ICU
Active	clab7	CLABSI - ICU
Active	clab8	CLABSI - Non-ICU
Active	con5	Active Consults lt 30 days
Active	con6	STAT Consults appointed within 48 hrs
Active	con7	Consults Pending lt or equal to 2 Business days
Active	cont3	Continuity of MH Care
Active	cpe6	Rating Quality Audit Review
Active	cpe7	C&P Exam Timeliness
Active	cpo1	Project Obligations
Active	csra1	Timely VA Comprehensive Suicide Risk Assessment
Active	csra2	Evidence of Clinical Impression of Acute Risk on VA CSRA

Active	csra3	Evidence of Clinical Impression of Chronic Risk on VA CSRA
Active	csra4	Evidence of Risk Mitigation on VA CSRA
Active	cvrm1	Diabetes - CV Risk Management
Active	cvrm2	Cardiovascular disease (CV) Risk Management
Active	dc10	Smoothing Discharges Within the Day
Active	delsf12	Change in symptoms in the first 90 days of mental health treatment (SF-12)
Active	dent2	Fluoride Treatment for Patients at High Risk for Dental Caries (Comprehensive Dental Care for Veterans)
Active	dent3	Periodic Oral Evaluation (Comprehensive Dental Care for Veterans)
Active	dent4	Periodontal or Preventive Maintenance/Recall (Comprehensive Dental Care Veterans)
Active	dent5	Primary Care Dental Provider Assignment (Comprehensive Dental care Veterans)
Active	dmg11h_ec	Outpt HbA1c less than 7 (eMeasure)
Active	dmg12h_ec	Outpatient HbA1c less than 8 (eMeasure)
Active	dmg23h	DM: HbA1c poor control (OP)
Active	dmg23h_ec	DM: HbA1c poor control (eMeasure)
Active	dmg27h	DM: BP LT 140/90 (OP)
Active	dmg27h_ec	DM: BP LT 140/90 (eMeasure)
Active	dmg31h	DM: Retinal exam, timely by disease (OP)

Active	dmg34h	DM: Renal Testing (OP)
Active	dmg34h_ec	DM: Medical attention for nephropathy - Renal Testing (OP)(eMeasure)
Active	dmg40	Blood Pressure Management- DM
Active	dmg51	DM: ASA included in current meds ages 50-59 (OP)
Active	dmg52	DM: ASA included in current meds ages 60-69 (OP)
Active	dmg53	DM: ASA included in current meds ages 50-69 (OP)
Active	dmg90_ec	Electronic Composite - Diabetes
Active	dms40_ec	PHQ-9 Utilization (eMeasure)
Active	dms40a_ec	PHQ-9 Utilization Rate (ages 18-44) (eMeasure)
Active	dms40b_ec	PHQ-9 Utilization Rate (ages 45-64) (eMeasure)
Active	dms40c_ec	PHQ-9 Utilization Rate (ages 65+) (eMeasure)
Active	e5eoc1	Percentage of deficiencies identified during EOC rounds that are closed timely.
Active	e5eoc2	Percentage of times Senior Management Team (or designee) attends EOC rounds
Active	e5eoc5	Percentage of times Facility Team Members attend EOC Rounds
Active	eai1	Equipment Accountability
Active	ed1	Admitted Pts Median Time ED arriv to ED depart-overall
Active	ed1_ec	Admitted Pts Median Time ED arriv to ED depart-overall (eMeasure)

Active	ed10	ED/UCC - Reduce Door to triage time
Active	ed11	ED/UCC - Reduce door to doc time
Active	ed2	Admitted Pts Median Time ED arriv to ED depart- rpt
Active	ed4	Admitted Pts Median Time ED arriv to depart-MH
Active	ed5	Decision to Admit time to ED depart- overall
Active	ed5_ec	Decision to Admit time to ED depart- overall
Active	ed6	Decision to Admit time to ED depart- rpt
Active	ed7	Decision to Admit time to ED depart-MH
Active	ed8	Reduce median ED / UCC LOS for non-admitted pts
Active	ed9	ED/UCC- Left without being seen (LWOBS)
Active	eeo10	Composite: EEO/Diversity
Active	eeo2	EEO, Affirmative Employment, Diversity and Inclusion Program
Active	emp2	Employment at discharge from VA `Grant` and Per-Diem homeless residential programs
Active	esat1	Employee Satisfaction in Primary Care
Active	expc1	Experiences of MH Care
Active	fe1	FE - Outpt - Screening for UI in past 12m
Active	fe3	FE - Outpt - basic fall history in last 12 mo

Active	fe81	% hospitalized pts with high delirium risk recognized
Active	fe9	Outpatient Functional Status Assessment
Active	fnct41	Rehab-Initial Rehabilitation Assessment
Active	gm90	Composite - Global
Active	hbips90	Composite - HBIPS
Active	hc22	HBPC pt caregivers w stress rcving intervention
Active	hc25	Annual assessment of caregiver strain - HBPC
Active	hc29	HBPC nutrition/hydration assessment by RD timely
Active	hc34	Timely pharmacist review post admission to HBPC
Active	hc35	HBPC environ safety/risk assessment by rehab ther w/in 30d
Active	hc36	Home oxygen safety (HBPC)
Active	hc37	Medication Education-HBPC
Active	hc38	Screened Annually for Depression (HBPC)
Active	hc39	Screened positive for depression w/timely SRE (HBPC)
Active	hc40	Positive depression screen w/ timely treatment plan (HBPC)
Active	hc41	PTSD Screening Using the PC-PTSD (HBPC)
Active	hc42	Screened pos. at required intervals f/ PTSD w/ timely SRE (HBPC)

Active	hc43	Timely SRE if positive PTSD or MDD screen (HBPC)
Active	hc45	Pneumococcal Immunizations Refused (HBPC)
Active	hc46	Influenza Immunization 18-64 (HBPC)
Active	hc47	Influenza Immunizations age 65 and older (HBPC)
Active	hc48	Influenza Immunizations Refused (HBPC)
Active	hc49	Pneumococcal Immunizations (HBPC)
Active	hcv1	HCV 1945-1965 Birth Cohort Testing
Active	hed90_1	Combined Composite - HEDIS Chart EPRP
Active	hed90_ec	Combined Composite - HEDIS electronic measures
Active	hias21	% Vets w/ MHICM-targeted dx receiving MHICM services
Active	hias72	% Vets w/ PRRC-targeted dx served by PRRC
Active	hmls3	% HUD-VASH vouchers result in permanent housing
Active	hop1	Median Time to Fibrinolysis
Active	hop18a	Median Time from ED Arrival to ED Departure for Discharged ED Patients-overall
Active	hop18b	Median Time from ED Arrival to ED Departure for Discharged ED Patients-Reporting Measure
Active	hop18c	Median Time from ED Arrival to ED Departure for Discharged ED Patients-Psychiatric/Mental Health Patients
Active	hop18d	Median Time from ED Arrival to ED Departure for Discharged ED Patients-Transfer Patients

Active	hop2	Fibrinolytic Theapy Received within 30 minutes of ED arrival
Active	hop20	Door to Diagnostic Evaluation by Qualified Med Professional (Median time)
Active	hop21	Median Time to Pain Management for Long Bone Fracture
Active	hop23	Head CT or MRI Scan Results for Acute Ischemic Stroke Patients Who Received Head CT or MRI Scan Interpretation within 45 Minutes of ED Arrival
Active	hop3a	Median Time to Transfer to Another Facility for Acute Coronary Intervention-Overall Rate
Active	hop3b	Median Time to Transfer to Another Facility for Acute Coronary Intervention -Reporting Measure
Active	hop3c	Median Time to Transfer to Another Facility for Acute Coronary Intervention -Improvement Measure
Active	hop4	Aspirin At Arrival
Active	hop5	Median Time to ECG
Active	hrf1	% of Veterans with a new assignment or reactivated HRF with a Safety Plan documented within 7 days before or after flag initiation, or documented on or before discharge
Active	hrf2	% of Veterans with a new assignment or reactivated HRF who received at least 4 mental health visits within 30 days of flag initiation
Active	hrf5	% of Veterans with a new assignment, reactivated, or continued High Risk Flag (HRF) who received a case review within 100 days after flag initiation
Active	hrf7	Care process composite for Veterans at high risk for suicide
Active	hrfa1	% of Veterans flagged as High Risk for Suicide who have received recommended interventions and follow-up
Active	htn10	HTN: Dx HTN BP GE 160/100 or not recorded (OP)

Active	htn11	HTN: No Dx of HTN BP LE 140/90 (OP)
Active	htn12	HTN: No Dx of HTN BP GE 160/100 or not recorded (OP)
Active	hud5	Number of Homeless Veterans (on a single night)
Active	hud6	Number of unsheltered homeless Veterans (on a single night)
Active	ie10	VISN Cross-Functional Programmatic Achievement in Integrated Ethics
Active	ie20	Facility Cross-Functional Programmatic Achievement in Integrated Ethics
Active	ihd20h	AMI Pts discharged w/AMI who recd persistent BB (OP)
Active	ihd40	Blood Pressure Management: AMI
Active	ihd51h	HTN: Dx HTN and DM with BP less than 140/90 (OP)
Active	ihd51h_ec	HTN: Outpatient BP less than 140/90 age 60-85 and dx DM (OP) (eMeasure)
Active	ihd52h	HTN: Dx HTN and no DM with BP less than 150/90 (OP)
Active	ihd52h_ec	HTN: Outpatient BP less than 150/90 age 60-85 and no DM (eMeasure)
Active	ihd53h_ec	Controlling High Blood Pressure (eMeasure)
Active	ihd5h	HTN: Outpatient BP < 140/90 age 18-59
Active	ihd5h_ec	HTN: Outpatient BP less than 140/90 age 18-59 (eMeasure)
Active	ihd6	AMI LVEF LT 40 on ACEI or ARB (OP)
Active	ihd90_ec	Electronic Composite - Ischemic Heart

Active	imm4	Influenza Immunization
Active	incs1	Incorrect Surgery Events
Active	ins2	Cyber Security and Privacy Training
Active	ip10	MRSA Facility Screening Rate
Active	ip11	MRSA ICU Screening Rate
Active	ip5	MRSA HAI, Small Facility: Non-ICU component
Active	ip6	MRSA HAI, Small Facility: ICU component
Active	ip8	MRSA HAI, Large Facility: ICU component
Active	ip9	MRSA HAI, Large Facility: non-ICU component
Active	ips1a	IPS Admission screening completed-overall rate
Active	ips1b	IPS Admission screening completed- adult (18-64 years)
Active	ips1c	IPS Admission screening completed - Geriatric (age 65 or older)
Active	ips2a	IPS Hrs of Physical Restraint Use - Overall Rate
Active	ips2b	IPS Hrs of Physical Restraint - Adult (18-64 years)
Active	ips2c	IPS Hrs of Physical Restraint - (age 65 and greater)
Active	ips3a	IPS Hours of Seclusion Use - Overall Rate
Active	ips3b	IPS Hours of Seclusion Use - Adult (18-64 years)

Active	ips3c	IPS Hours of Seclusion - Geriatric (age 65 or greater)
Active	ips6a	IPS justific for multi Antipsych DC Meds - Overall Rate
Active	ips6b	IPS justific for multi Antipsych DC Meds - Adult (ages 18-64)
Active	ips6c	IPS justific for multi Antipsych DC Meds (age 65 or older)
Active	ltcr1	Lost Time Claims Rate
Active	mdd40	Screened annually for depression
Active	mdd41	Screened positive for depression w/timely SRE
Active	mdd43h	Effective Acute Phase Treatment (12 weeks)
Active	mdd43h_ec	Effective Acute Phase Treatment (12 weeks) (eMeasure)
Active	mdd47h	Effective Continuation Phase Treatment (6 months)
Active	mdd47h_ec	Effective Continuation Phase Treatment (6 months) (eMeasure)
Active	meq2	Medical equipmnt preventive maintenance: Life Support
Active	meq3	Medical eqpmnt preventive mainten:non-life support
Active	mh17	Established MH Appts Completed within 30 days of Patient Indicated Date
Active	mh18	New MH Completed Appt within 30 days of Patient Create Date
Active	mhoo8	% loss to VHA care for pts with schizophrenia or bipolar dx
Active	mhpa1	MH Provider Survey--Timely Access MH Care

Active	mhpc3	MH Provider Survey--Collaborative MH Care
Active	mhpq2	MH Provider Survey--Quality of MH Care
Active	mhps4	MH Provider Survey--Job Satisfaction
Active	mhq3	Mental Health Domain Quality (MH Balanced Scorecard)
Active	mhsa1	MH Staffing Adequacy
Active	mhtc1	Qualified Veterans have an identified MHTC
Active	mop11	No Show Rate for All Clinics
Active	mop12	No Show Rate MH
Active	mop13	Cancelled by Clinic rate for All Clinics
Active	mov12	Weight management participants with 12 contacts in 12 months
Active	mov6	MOV- Eligible pts who participated in wt mgt pgm
Active	mpt1	% VHA pts using MH services
Active	mrec21	Written list of medications given at DC (Inpatient)
Active	mrec34	Consistent Medication List (Inpatient)
Active	mrec43	Med list given outpt
Active	mrec44	Essential medication list for review w/ all components contained in note (Inpt)
Active	mrec45	Essential med list for review includes active VA prescriptions (Inpt)

Active	mrec46	Essential med list for review includes remote active VA prescriptions (Inpt)
Active	mrec47	Essential med list for review includes non-VA med(s) (Inpt)
Active	mrec48	Essential med list for review includes expired VA prescriptions (Inpt)
Active	mrec49	Essential med list for review includes discontinued VA prescriptions(Inpt)
Active	mrec50	Essential med list for review includes pending med orders(Inpt)
Active	mrec51	Essential med list reviewed with pt/caregiver on admission (Inpt)
Active	mrec54	Essential medication list for review w/ all components contained in note (Outpt)
Active	mrec55	Essential med list for review includes active VA prescriptions (Outpt)
Active	mrec56	Essential med list for review includes remote active VA prescriptions (Outpt)
Active	mrec57	Essential med list for review includes non-VA med(s) (Outpt)
Active	mrec58	Essential med list for review includes expired VA prescriptions (Outpt)
Active	mrec59	Essential med list for review includes discontinued VA prescriptions (Outpt)
Active	mrec60	Essential med list for review includes pending med orders (Outpt)
Active	mrec61	Essential med list reviewed with pt/caregiver (Outpt)
Active	mrec90	Medication Reconciliation Inpatient Composite
Active	nic1	Home Based Primary Care (HBPC)
Active	nicexp6	Aggregate Obligations for selected HCBS (PVPM)

Active	nicexp9	% of LTSS Obligations for PCS Services_1
Active	nrm1	Minor Construction
Active	nrm2	NRM Allocation
Active	nrm3	NRM Obligated by June 30
Active	numi10	% Appropriate Post Hospital Admission (Continued Stay) BDOC
Active	numi11	Adjusted % Appropriate Post Hospital Adm (Continued Stay) BDOC (excluding BH)
Active	numi20	% of Appropriate Hospital Admissions
Active	numi21	Adjusted Percent of Appropriate Hospital Admissions (excluding BH)
Active	numi30	% of Appropriate Observations Stays
Active	nvcc1	NVCC Consults Missing Linked FBCS Authorizations
Active	oef1	OEF/OIF/OND SISI Vets Timely Contact post Notification of VA
Active	oef21	Timely Contact w/ Veterans being case managed per Pt Plan
Active	ome1	OMELOS Acute Care
Active	op4	Permanent Housing (PH) placements for MyVA
Active	opim1	Wait Times: Computed Tomography
Active	opim2	Wait Times: Mammography
Active	opim3	Wait Times: Ultrasound

Active	opim4	Wait Times: Nuclear medicine
Active	opim5	Wait Times: MRI
Active	opim6	Wait Times: Imaging for Nuclear Stress Test
Active	oryx90_1	Combined Composite - ORYX90_1
Active	ostp10	Osteoporosis Screening
Active	otat1	HIM Outpatient Coding Turn Around Time (TAT)
Active	p10	Hyperlipidemia scrn - Overall
Active	p19s	Immunization - Influenza (SCI&D)
Active	p24	CAP - Outpt - Pneumococcal Immunizations Refused
Active	p24s	Pneumococcal Immunization Refused (SCI&D)
Active	p25h	Influenza Immunizations age 65 and older (OP)
Active	p26h	Influenza Immunization 18-64 (OP)
Active	p27	Influenza Immunizations Refused
Active	p32h	Breast Cancer Screening including tomography for Women 50-74y (OP) HEDIS
Active	p33	Women age 45 and older screened for Breast Cancer (ACS Guidelines)
Active	p41h	Cervical Cancer Screening: Overall 21-64 yo
Active	p42	Cervical Cancer Screening Women age 21-29y

Active	p43h	Cervical Cancer Screening Women age 30-64
Active	p61h	Colorectal Cancer Screening Ages 50-75
Active	p61h_e	Colorectal Cancer Screening Ages 50-75 (eMeasure - All)
Active	p7	Tobacco - Outpt - Screened f/ Use - Nexus
Active	p7s	Tobacco - Screened f/ Use (SCI&D)
Active	pact15	Percent Primary Care Patients engaged in PC-MHI
Active	pact20	% Divisions meeting Primary Care Staffing Ratio of 3:1 (revised)
Active	pc17	Established PC Appts Completed w/in 30 days of Patient Indicated Dt
Active	pc18	New PC appointments completed within 30 days of Create Date
Active	pcc4	Palliative Care Consult gt 30 days Prior to Death
Active	pcc5	% of Veterans with High CAN scores with palliative care
Active	pcmh15	Mean Overall Rating of Hospital (IP)
Active	pcov2	MH Population Coverage
Active	pde1	% Inpatient and residential MH discharges with outpatient MH care engagement within 30 days post-discharge
Active	pmed1	% MH-dxed Vets who had an E& M visit
Active	pop6	% MH-service-connected Vets in the facility catchment w/ MH care
Active	prv90_1	Composite - Prevention EPRP

Active	psa1_ec	Non-Recommended PSA-Based Screening (eMeasure)
Active	psat10	Communication about medications (IP)
Active	psat10adj	Communication about medications (IP) (Adj)
Active	psat11	Communication with Doctors (IP)
Active	psat11adj	Communication with Doctors (IP) (Adj)
Active	psat12	Communication with nurses (IP)
Active	psat12adj	Communication with nurses (IP) (Adj)
Active	psat13	Discharge Information (IP)
Active	psat13adj	Discharge Information (IP) (Adj)
Active	psat15	Quietness of Hospital Environment (IP)
Active	psat15adj	Quietness of Hospital Environment (IP) (Adj)
Active	psat16	Willingness to recommend (IP)
Active	psat16adj	Willingness to recommend (IP) (Adj)
Active	psat17	Communication About Pain (IP)
Active	psat17adj	Communication About Pain (IP)(adj)
Active	psat4	Overall Rating of Hospital (IP)
Active	psat4adj	Overall Rating of Hospital (IP) (Adj)

Active	psat5	Shared Decision Making (IP)
Active	psat5adj	Shared Decision Making (IP) (Adj)
Active	psat6	Responsiveness of Hospital Staff (IP)
Active	psat6adj	Responsiveness of Hospital Staff (IP) (Adj)
Active	psat9	Cleanliness of Hospital Environment (IP)
Active	psat9adj	Cleanliness of Hospital Environment (IP) (Adj)
Active	psy32	% depression-dxed Veterans w/ psychotherapy visit for depression, weighted
Active	psy33	% depression-dxed & trtd Vets w/ 5 psychotherapy visits in 10weeks, weighted
Active	psy34	% SMI-dxed Vets w/ psychosocial tx for SMI
Active	psy35	% SMI-dxed&trtd Vets w/ 5 psychosocial tx visits in 10 weeks, weighted
Active	psy36	% SUD-dxed Vets w/ psychosocial tx for SUD
Active	psy37	% SUD-dxed&trtd Vets w/ 4 psychosocial tx visits in 8 weeks
Active	psy38	% PTSD-dxed Vets w/ psychotherapy visit for PTSD, weighted
Active	psy39	% PTSD-dxed&trtd Vets w/ 5 psychotherapy visits in 10 weeks, weighted
Active	ptsd51	PTSD Screening
Active	ptsd52	Screened pos. at required intervals f/ PTSD w/ timely SRE
Active	ptsd56	% PTSD-dxed patients receiving specialty PTSD outpt care

Active	pvc11h	Pneumococcal Immunizations (OP) EPRP sample
Active	pvc11s	Pneumococcal Immunizations (OP) EPRP SCI&D Sample
Active	rtele1	% of Rural Veterans who use Non-face-to-face Care
Active	sa17	Veterans screened for alcohol misuse w/ score GE 5 w/ timely counsel
Active	sa7	SUD - Outpt - Pts scrn Annually f/ Alcohol Misuse
Active	sc10	% Veterans - E-consults w Specialty Care
Active	sc17	Established SC Appts Completed w/in 30 days of Patient Indicated Dt
Active	sc18	New SC Appts completed within 30 days of Create Date
Active	sc1all	SIC: Informed consent- All
Active	sc2all	SIC: Informed consent- using Imed
Active	sc2ct	SIC:Informed consent using Imed- Cardiothoracic
Active	sc2gen	SIC: Informed consent using Imed- General Surg
Active	sc2neu	SIC:Informed consent using Imed- Neurosurgery
Active	sc2obg	SIC: Informed consent using Imed- OB/GYN
Active	sc2orth	SIC: Informed consent using Imed- Ortho
Active	sc2uro	SIC: Informed consent using Imed - Urology
Active	sc2vas	SIC:Informed consent using Imed- Vascular

Active	scid3	DM - HbA1c GT 9 or not done in past year (SCI&D)
Active	scid3_ec	DM - HbA1c GT 9 or not done in past year (SCI&D) (eMeasure)
Active	scid4	DM - BP LT 140/90 (SCI&D)
Active	scid4_ec	DM - BP LT 140/90 (SCI&D)(eMeasure)
Active	scid5	DM - Retinal exam, timely by disease (SCI&D)
Active	scid7	DM - BP GE 160/100 or not done (SCI&D)
Active	scid7_ec	DM - BP GE 160/100 or not done (SCI&D) (eMeasure)
Active	shepapgacx90	Access Composite_APG
Active	sheppc01	Access to Urgent Care (PCMH)
Active	sheppc01_Top2	Access to Urgent Care (PCMH) (SHEP Top 2)
Active	sheppc02	Days Wait for Urgent Care (PCMH)
Active	sheppc03	Access to Routine Care (PCMH)
Active	sheppc03_Top2	Access to Routine Care (PCMH) (SHEP Top 2)
Active	sheppc04	Received Information on After Hours Care (PCMH)
Active	sheppc05	Got After Hours Care (PCMH)
Active	sheppc06	Office Hours Medical Question Answered (PCMH)
Active	sheppc07	After Hours Medical Question Answered (PCMH)

Active	sheppc08	Received Reminders Between Visits (PCMH)
Active	sheppc09	Seen within 15 Minutes of Appt (PCMH)
Active	sheppc10	Provider Explained Things (PCMH)
Active	sheppc11	Provider Listened Carefully (PCMH)
Active	sheppc12	Provider Gave Easy-to-Understand Info (PCMH)
Active	sheppc13	Provider Knew Important Medical History (PCMH)
Active	sheppc14	Provider Showed Respect (PCMH)
Active	sheppc15	Provider Spent Enough Time (PCMH)
Active	sheppc16	Provider Followed-up with Test Results (PCMH)
Active	sheppc17	Discussed Reasons to Take Rx (PCMH)
Active	sheppc18	Discussed Reasons Not to Take Rx (PCMH)
Active	sheppc19	Provider Asked What Was Best (PCMH)
Active	sheppc20	Patient`s Rating of Provider (PCMH)
Active	sheppc20avg	Patient`s Mean Rating of Provider (PCMH)
Active	sheppc21	Discussed Prescription Medications (PCMH)
Active	sheppc22	Provider Up-To-Date on Specialist Care (PCMH)
Active	sheppc23	Discussed Health Goals (PCMH)

Active	sheppc24	Discussed Difficulties in Caring for Self (PCMH)
Active	sheppc25	Provider Discussed Depression (PCMH)
Active	sheppc26	Provider Discussed Worries/Stress (PCMH)
Active	sheppc27	Provider Discussed Probs/Mental Hlth/Subst Use (PCMH)
Active	sheppc28	Helpful Office Staff (PCMH)
Active	sheppc29	Courteous and Respectful Office Staff (PCMH)
Active	sheppcax90	Access Composite (PCMH)
Active	sheppcbh90	Comprehensive- Adult Behavioral (PCMH)
Active	sheppccc90	Care Coordination (PCMH)
Active	sheppccom90	Communication Composite (PCMH)
Active	sheppcos90	Office Staff (PCMH)
Active	sheppcsdm90	Shared Decision Making Composite (PCMH)
Active	sheppcsm90	Self Management Support (PCMH)
Active	sheppctrust01_Top2	Got Needed Service (PCMH) (SHEP Top 2)
Active	sheppctrust02_Top2	Easy to Get Service (PCMH) (SHEP Top 2)
Active	sheppctrust03_Top2	Valued Customer (PCMH) (SHEP Top 2)
Active	sheppctrust04_Top2	Trust VA (PCMH) (SHEP Top 2)

Active	shepsc01	Access to Urgent Care (SC)
Active	shepsc01_Top2	Access to Urgent Care (SC) (SHEP Top 2)
Active	shepsc03	Access to Routine Care (SC)
Active	shepsc03_Top2	Access to Routine Care (SC) (SHEP Top 2)
Active	shepsc06	Office Hours Medical Question Answered (SC)
Active	shepsc09	Seen within 15 Minutes of Appt (SC)
Active	shepsc10	Provider Explained Things (SC)
Active	shepsc11	Provider Listened Carefully (SC)
Active	shepsc12	Provider Gave Easy-to-Understand Info (SC)
Active	shepsc13	Provider Knew Important Medical History (SC)
Active	shepsc14	Provider Showed Respect (SC)
Active	shepsc15	Provider Spent Enough Time (SC)
Active	shepsc16	Provider Followed-up with Test Results (SC)
Active	shepsc20	Patient`s Rating of Provider (SC)
Active	shepsc20avg	Patient`s Mean Rating of Provider (SC)
Active	shepsc21	Discussed Prescription Medications (SC)
Active	shepsc28	Helpful Office Staff (SC)

Active	shepsc29	Courteous and Respectful Office Staff (SC)
Active	shepscax90	Access Composite (SC)
Active	shepsctrust01_Top2	Got Needed Service (SC) (SHEP Top 2)
Active	shepsctrust02_Top2	Easy to Get Service (SC) (SHEP Top 2)
Active	shepsctrust03_Top2	Valued Customer (SC) (SHEP Top 2)
Active	shepsctrust04_Top2	Trust VA (SC) (SHEP Top 2)
Active	smg10	Pts using tobacco offered meds (OP)
Active	smg10s	Pts using tobacco offered meds-SCI& D (OP)
Active	smg2mn	Tobacco used in past 12 mos - (OP Nexus MH)
Active	smg2n	Tobacco used in past 12 mos (OP Nexus non MH)
Active	smg2sn	Tobacco used in past 12 mos (SCI& D)
Active	smg8	Pts using tobacco provided w/counsel (OP)
Active	smg8s	Pts using tobacco provided w/counsel SCI& D (OP)
Active	smg9	Pts using tobacco offered referral (OP)
Active	smg90	Composite - Tobacco
Active	smg9s	Pts using tobacco offered referral SCI& D (OP)
Active	smie1	% SMI-dxed Vets using supported employment services

Active	sre1	Timely SRE if positive PTSD or MDD screen
Active	ssvf1	SSVF prevention
Active	statn1_ec	Statin Therapy for patients with cardiovascular disease (eMeasure)
Active	statn2_ec	Statin therapy for patients with cardiovascular disease: men (eMeasure)
Active	statn3_ec	Statin therapy for patients with cardiovascular disease: women (eMeasure)
Active	statn4_ec	Statin adherence for patients with cardiovascular disease (eMeasure)
Active	statn5_ec	Statin adherence for patients with cardiovascular disease: men (eMeasure)
Active	statn6_ec	Statin adherence for patients with cardiovascular disease: women (eMeasure)
Active	statn7_ec	Statin therapy for patients with diabetes (eMeasure)
Active	statn8_ec	Statin adherence for patients with diabetes (eMeasure)
Active	stk2_ec	Discharged on Antithrombotic Therapy (eMeasure)
Active	stk3_ec	Anticoagulation Therapy for Atrial Fibrillation/Flutter (eMeasure)
Active	stk6_ec	Discharged on Statin Medication (eMeasure)
Active	sub10	Alcohol Use Screening
Active	sub20	Alcohol Use Brief Intervention Offered or Provided
Active	sub40	Alcohol/Othr Drug Use Dis Tx Provid or Offrd at DC
Active	sud16	% Number of Veterans with opioid use disorder dx who received OAT

Active	sud4	% SUD-dxed Vets who used intensive SUD treatment
Active	sui2	Timely Secondary Suicide Risk Screening
Active	sui40	Primary Suicide Risk Screening While Screening for Depression
Active	sui51	Primary Suicide Risk Screening While Screening for PTSD
Active	tbi3	OEF/OIF/OND Veterans Traumatic Brain Injury Screen
Active	tbi5	Completion of CTBIE post positive screen for possible TBI
Active	telc1	Telephone Care
Active	tele1	Telehealth Use: HT, CVT, SFT
Active	tele10	Home Telehealth NIC Enrollment
Active	tele2	Telehealth Use - % unique Vets rcv`g HT
Active	tele3	Telehealth Use - % unique Vets rcv`g CVT
Active	tele4	Telehealth Use - % unique Vets rcv`g SFT
Active	tele7	Telemental health Unique Veterans
Active	tele9	Video Telehealth to Off Site Patients
Active	telr1	Telephone Responsiveness
Active	telr2	Telephone Abandonment Rate
Active	tob10	Inpatient Tobacco Use Screening

Active	tob20	Tobacco Use Treatment Provided or Offered
Active	tob40	Tobacco Use Treatment Provided or Offered at Discharge
Active	vsaa1	Veteran Satisfaction Survey--MH Appointment Access
Active	vspc2	Veteran Satisfaction Survey--Patient-Centered MH Care
Active	vte1_ec	Venous Thromboembolism Prophylaxis - All (eMeasure)
Active	vte2_ec	VTE Prophylaxis - ICU (eMeasure)
Active	vte6	Incidence Hospital Acquired Potentially- Preventable VTE
Active	wfd2	Diversity Hiring Goal
Active	wfd3	Diversity Hiring Goal-New Hires
Active	wh1	Women Assigned to Women`s Health PACT Team
Active	whdas2	Change in symptoms in the first 90 days of mental health treatment (WHO-DAS2)
Active	whmpm1	Male Veteran Enrollees Market Penetration
Active	whmpw1	Women Veteran Enrollees Market Penetration

VHA Office of Reporting, Analytics, Performance, Improvement & Deployment (RAPID)
Office of Performance Measurement (10A8)

The mission of the Office of Performance Measurement (10A8) is to support clinicians, managers, and employees in improving care to veterans.

What's New

- External Peer Review Program Guide
- EPRP FY19 Field Calendar
- Q3 FY18 Release Notes
- eTM Subscription Service
- FY18 Gender Report
- Interactive HEDIS Comparison
- Quarterly Composite Report
- SAIL - Patient Experience & Performance Measure Domain Updates for FY18- 10/04/17

  Click **here** to request the 10/04/17 SAIL recording
- Access To Care - Outpatient Compare Data
- Access To Care - Patient Experience Compare
- Combined Composite Report
- Combined Measure Master
- FY18 Catnums and Cohorts
- ICD 10 FY18 Catnums and Cohorts Appendix

Programs

- Patient Experiences
- Performance Measurement

Reporting

- Patient Experiences Reporting
- Performance Measurement Reporting

References

- FY18 NDPP Element 5b- Access Measure Baseline Scores
- FY18 ND & MCD DRAFT Performance Plan
- FY18 ND & MCD DRAFT Performance Plan
- FY17 Senior Executive Performance Plan
- FY17 SES Plan FAQs
- FY17 SES Plan Q&A
- FY18 Catnums and Cohorts
- ICD 10 FY18 Catnums and Cohorts Appendix
- Summary of Hospital Performance Rating Systems
- Electronic Technical Manual Home Page
- Data Use Agreements
- Joint Commission

  QSV Division of External Accreditation Services & Programs
- Performance Measure Report (PMR)

  (includes eQM Report)
- eQM Portal
- EPRP Resources
- PM PULSE page

Education & Training

- Patient Experience Learning
- Performance Measurement Training
- Training Calendar

Reviewed/Updated: 08/31/2018

For help with this page contact: RAPID Helpdesk

Department of Veterans Affairs

Reporting, Analytics, Performance Improvement & Development

Performance Measurement

External Peer Review Program Guide

RAPID — Office of Reporting, Analytics, Performance, Improvement & Deployment

Performance Measurement

PERFORMANCE MEASUREMENT

External Peer Review Program Guide

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Performance Measurement 10A8
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Version EPRP V v1 Sept 2018

TABLE OF CONTENTS

Section I: An Overview

1. External Peer Review Program (EPRP)
2. Who's Who and What Do They Do?
3. Let's Get Started: Measure Development
4. Data/Data Security

1

External Peer Review Program

All things are difficult before they become easy. — Unknown

This section will provide an introduction and overview of the External Peer Review Program.

For more than twenty-five years, the External Peer Review Program (EPRP) has been the key source of information documenting Veterans Health Administration (VHA) medical facilities' high quality of care to the nation's Veterans. EPRP is a critical part of a nationwide audit and feedback system, helping to drive improved quality performance by informing care providers and managers of specific opportunities for improvement and demonstrating improvement as it occurs.

VHA uses EPRP data for management, research and public reporting (e.g., Access and Quality in VA Healthcare; Centers for Medicare and Medicaid Services (CMS) Hospital Compare) (see Appendix A for Key Websites referenced throughout this document). VHA websites allow Veterans and members of the public to compare quality performance among VHA facilities and between VHA and private health care providers. Quality Insights, Inc. (formerly West Virginia Medical Institute (WVMI)) has partnered with VHA to develop and maintain this data source for system-wide quality management, as well as to ensure that the information provided is an accurate and complete "gold standard" for clinical quality and patient safety assessment. The data collection system is continuously monitored so that it accurately depicts the care Veterans receive. The quality control processes in place allow assessment of consistency and completeness of the information collected from VHA medical records and databases.

Data abstraction via the EPRP is detailed and guided by a contract between the VHA and the Quality Insights. Data abstraction is completed both remotely and on site at the various VHA Medical Centers (VAMCs) by credentialed individuals (abstractors) under contract with Quality Insights to provide this service.

VHA Medical Centers designate an EPRP liaison to assist with orienting the abstractor to the various documentation sources that are VAMC specific and with facilitating the data retrieval process. The liaison may secure proof of documentation of care through non-CPRS methods in order to enhance complete data review; but, the information must be part of the medical record. The liaison works on behalf of the VHA in general (and, specifically, the VAMC and VISN) to ensure that the abstractor has exhausted all available documentation sources.

The Process can be divided into 3 phases:

1 **Specification Phase.** Measure specifications originate from external organizations such as Centers for Medicare and Medicaid (CMS), The Joint Commission (TJC), National Committee for Quality Assurance's (NCQA) Healthcare Effectiveness and Data Information Set (HEDIS) as well as internally from VHA Program Offices such as the Offices of Mental Health and Community Care. Once a performance measure is approved, data collection questions (DCQ) are developed to guide what specific data is desired from the medical record. The Performance Measurement team works with the Program Offices, Lead Committees or Boards, other subject matter experts and the EPRP contractor, Quality Insights, to identify those data points that are needed to fully measure a particular concept. When the DCQ have been fully analyzed for inclusion, step 2 is implemented. The finalized DCQ can be viewed by quarter on the Quality Insights web application: https://secure.wvmi.org/EPRP_DBQ/.

2 **Software Design and Development Phase**. The DCQ developed by Quality Insights and approved by VHA Performance Measurement team are then integrated into a software package that results in an 'instrument' to ensure the abstractors collect the data with consistent definitions and rules. When the software has been structured in such a way that all data being collected meets the intent of VHA and the scoring of the data answers the performance question, this phase is complete. Measures are reviewed at least quarterly for potential changes. However, software changes are made throughout the fiscal year if program weaknesses are identified and as measure specifications need clarification.

3 **Abstraction Phase.** This phase is divided into the abstraction, Data Accountability Checklist (DAC) Review, and Exit Conference. Quality Insights Abstractors are provided a list of cases for review (Pull List). With the aid of the data collection software, they review each medical record either remotely or onsite. Once the records are reviewed, those that did not meet measurement requirements are identified and presented in the form of a DAC. VAMCs are provided a maximum of four days to review the DACs and provide any additional information supporting that the record meets the measure requirements. Once the review is completed, the Abstractor and Liaison present findings to VAMC leadership and staff during an Exit Conference. This information contains the finalized results of the abstraction process and is forwarded for posting on the Performance Measurement databases.

2

Who's Who and What Do They Do?

Take Aways

- EPRP is a complex process involving many people across many organizations
- Primary staff are based in Performance Measurement and Quality Insights
- VHA facility Liaisons link the process to facility day–to–day operations
- Facilities identify a primary and secondary liaison
- Keeping in touch- email groups, Sharepoints…

As you can see, the EPRP process involves multiple steps and people. If you think about the 120+ VHA Medical Centers and the task of abstracting data from hundreds of thousands of medical records each year, one can truly appreciate the level of coordination and teamwork that is needed. This team is composed of many people both within VHA and Quality Insights. Within VHA are Quality Managers and their staff, dedicated EPRP Liaisons, Performance Measurement and Analytical staff, all responsible for the smooth abstraction, analysis, and reporting of data. Within Quality Insights are parallel staff (mainly the Abstractors), Regional Managers, Analytical and Development staff.

Organizationally, Performance Measurement is within Office of Reporting, Analytics, Performance Improvement and Deployment (RAPID) and reports to the Offices of the Under Secretary and Principal Deputy Under Secretary for Health. Performance Measurement provides resources and reports supporting clinicians, managers and others to improve care to Veterans. Quality Insights is contracted to provide data collection, analysis and reports to VHA to monitor care to Veterans.

The Program is authorized by the EPRP Contract that is administered through Performance Measurement. This VHA–wide contract provides oversite, funding, monitoring, and evaluation of the Program. Performance Measurement also establishes abstractor master accounts and ensures annual training is completed. Facilities provide the assigned abstractor with local Computerized Patient Record System (CPRS) access and a place to work while onsite.
The reference chart below provides a quick look at individual role responsibilities; detailed descriptions follow. *[Note: PM refers to Performance Measurement Team]*

VHA Staff	Quality Insights Staff	Role
COR/Program Manager (PM)	Program Director	Program oversight
Measure Coordinators (PM)	Development Group	Measure development and monitoring
Subject Matter Experts (Program Offices)		Supports/drives measure development
Analytics Team (PM)	Analytics Group	Sampling/Data/Reports
	IT Team	Maintain Quality Insights website access
Quality Manager (VISN/Facility)		Facility quality oversite
Facility Liaison (Facility)	Abstractor	Review/Exit Process
	Regional Manager	Consultation role
	Field Director	Oversight

Below is a list of roles and their specific responsibilities:

Abstractor (Quality Insights)

- Scheduling on-site visits for review and Exit conferences with facility
- Reviewing medical records
- Reviewing DACs with facility Liaison and make any changes as needed
- Participating in Exit conference, providing any explanations or answering questions
- Providing general guidance regarding the review process

Contracting Office Representative (VHA COR)

- Providing oversight of EPRP process and managing contract process
- Serving as contract point of contact and VHA side supervisor

EPRP Liaison (VHA facility based)

- Requesting/maintaining access to Quality Insights VHA EPRP Secure site (see Appendix B)
- Orienting the Abstractor to the VAMC staff and process
- Assisting in gaining local computer access
- Assisting in providing medical record information not found in CPRS
- Scheduling with Abstractor any onsite visits as needed
- Reviewing DACs within the 4-day timeframe and providing any missing information as found to the Abstractor for any changes
- Organizing and overseeing Exit conference

VHA Facility Quality Manager

- Providing oversight of local EPRP process
- Participating in monthly Exit conferences
- Providing guidance as needed

Quality Insights Regional Manager

- Provides general information and updates regarding the process
- Is the point of contact for the Abstractor and the next step in the chain for any questions for the EPRP Liaison
- Helps resolve disagreements between Abstractor and VAMC
- Provides quarterly review as part of Quality Improvement process
- Assist back-up abstraction as needed
- Participates in training, special study abstraction, and assist as needed

Quality Insights Program Director

- Provides oversight of program
- Works with VHA to identify and develop measures
- Reviews initial measurement results
- Monitors measurement data
- Provides feedback to Program Offices
- Serves as measurement consultant and point of contact for VHA COR

Quality Insights Director of Field Operations

- Manages field abstraction process and staff
- Provides training and orientation to new Abstractors
- Participates in all aspects of EPRP process
- Assists in resolution of any issues regarding abstraction
- Provides feedback to and from field staff

Quality Insights Development Team

- Assists Performance Measurement staff in development of DCQ and guidelines directing measurement
- Meets regularly to discuss changes, review new tools, and plan
- Program questions and make any edits as required

Quality Insights Analytic Team

- Notifies Quality Insights VHA Project Manager of any problems affecting EPRP
- Provides quality analysis

Quality Insights Website Helpdesk

- Provides assistance with any problems to users of Quality Insights website

VHA Program Manager (EPRP)

- Provides program oversight
- Works with VHA Program Offices and other Groups to identify measures
- Develops measurement specifications
- Pilots and focuses review of initial measurement results
- Monitors measurement data
- Provides feedback to Program Offices
- Serves as measurement consultant and point of contact for EPRP

VHA Performance Measurement

- Serves as liaison to Program Office
- Works with Quality Insights to develop VHA measure specifications
- Validates and monitors measure data
- Maintains e-Technical Manual and corresponding communications
- Provides data management, analysis and reporting
- Plans sampling of medical records
- Provides statistical support and monthly sampling for review

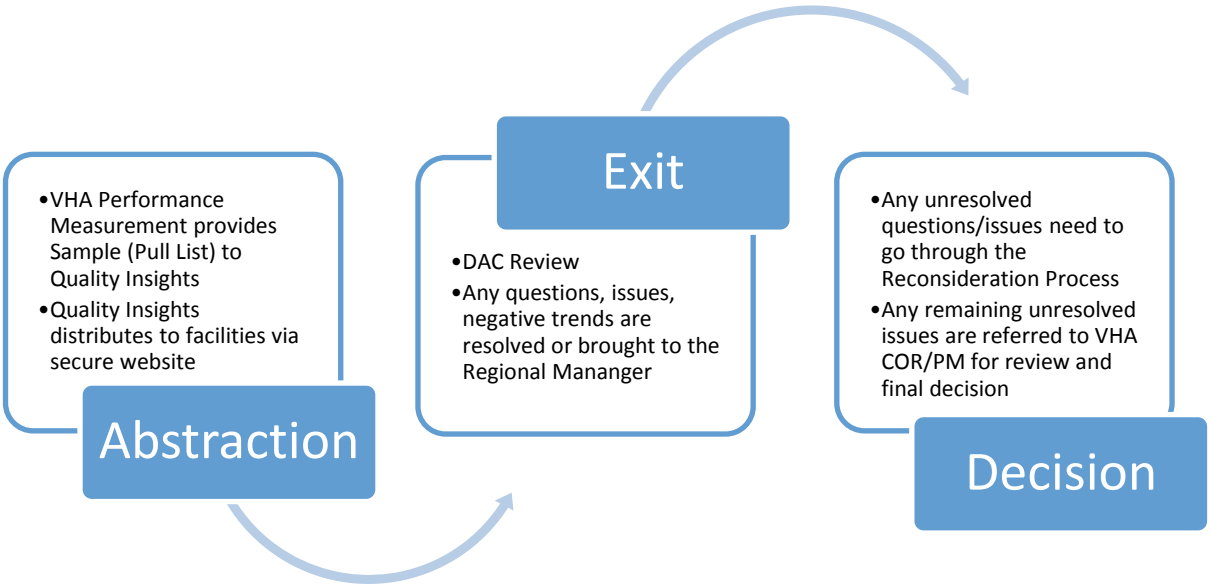
A note about Abstractors:

EPRP Abstractors are Registered Nurses (RN), Registered Health Information Administrators (RHIA), or Registered Health Information Technicians (RHIT). Initial training consists of a one week "boot camp". At the conclusion of the one-week session, abstractors are required to attain a minimum of 93% agreement rate on a gold standard abstraction. Following initial training, one-on-one field training with a Regional Manager includes where to find relevant documentation in CPRS and the DAC reconciliation process. Additional training is conducted by conference calls which include presentation of additional data collection instruments. New abstractors are closely monitored by the Regional Manager during the first several quarters of review.

Solving problems:

While the EPRP process typically runs smoothly, issues do arise periodically. If the Abstractor and facility Liaison are unable to resolve an issue at the facility level with assistance from the Regional Manager, the issue is forwarded to VHA COR/PM for a final decision. Decisions are a result of discussions between the Quality Insight's Field Director, VHA COR/PM and other staff as appropriate (Measure Coordinators, Program Office, TJC, etc.). The final decision is made and communicated by the VHA COR/PM.

Communication of questions/issues:



How to Stay In-Touch: Email Groups (see Appendix C)

Performance Measurement provides updates, education, and announcements in a variety of ways. The primary way is through email groups. There is a general email group that focuses on training announcements, general updates and information (VHA CO PMCC). Anyone can request to be added to that group. For information or requests to be added to the PMCC email group please contact Patricia Kearney at patricia.kearney@va.gov.

There is a specific group for EPRP liaisons only (VHA CO EPRP). **Liaisons should contact Patricia Kearney at patricia.kearney@va.gov to be added or deleted to this EPRP Liaison Mailgroup.**

3

Let's Get Started: Measure Development

Take Aways

- Measures come from external and internal sources
- Measure specifications are developed into instruments and algorithms
- Instruments are complex electronic forms that guide Abstractors through the data collection process
- Scoring Algorithms convert raw clinical data into useable data

Measure development specifications originate from numerous sources such as internal VHA Program Offices or external regulatory agencies such as CMS/TJC. Measures are developed often in response to a question, to monitor a new process or program, or to help VHA compare care to outside organizations.

The measure development process includes:

- Identifying specifications for selected measures
- Development of the instrument
- Development of the algorithm
- Testing and validating

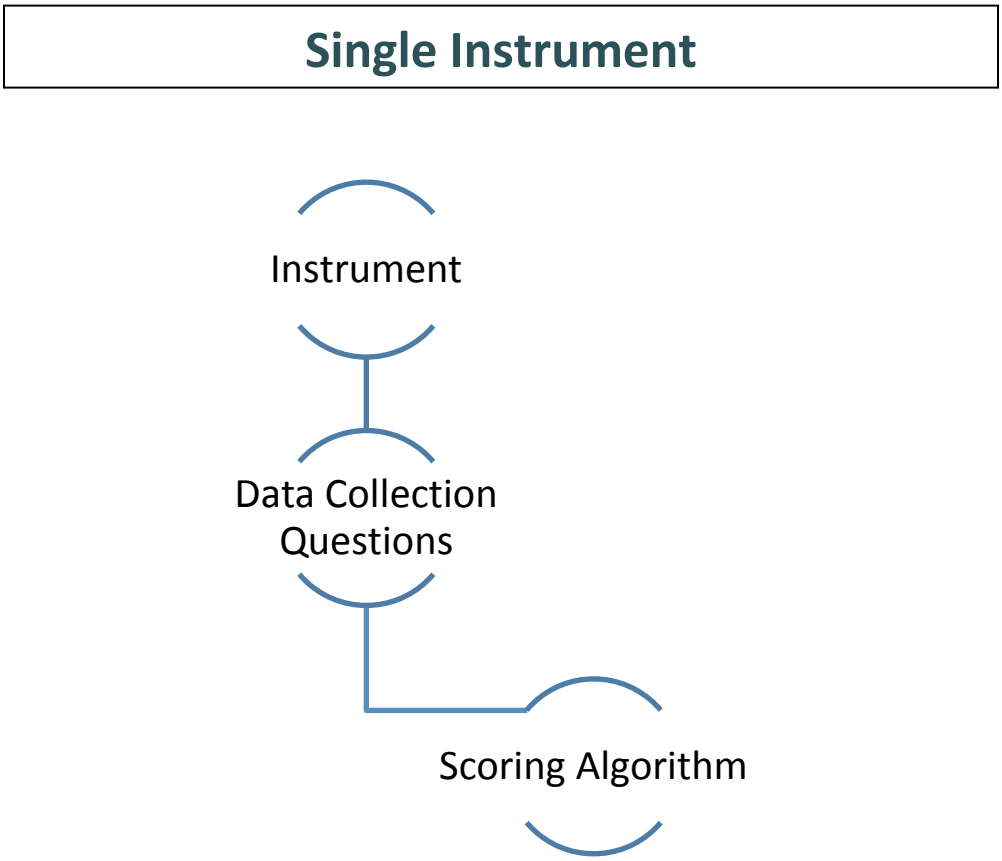
The EPRP Data Collection Questions are grouped into Instruments that are developed by the Performance Measurement team with the sponsoring group and Quality Insights. The Abstractors use these Instruments provided in a software package to gather data.

These Instruments are complex electronic forms that guide Abstractors through the collection of clinical data and forward the abstracted data to a central database for storage, analysis, and reporting. An Instrument consists of a set of questions and describes logic to enter responses to each question and determine the availability and sequence of questions necessary for accurate data collection.

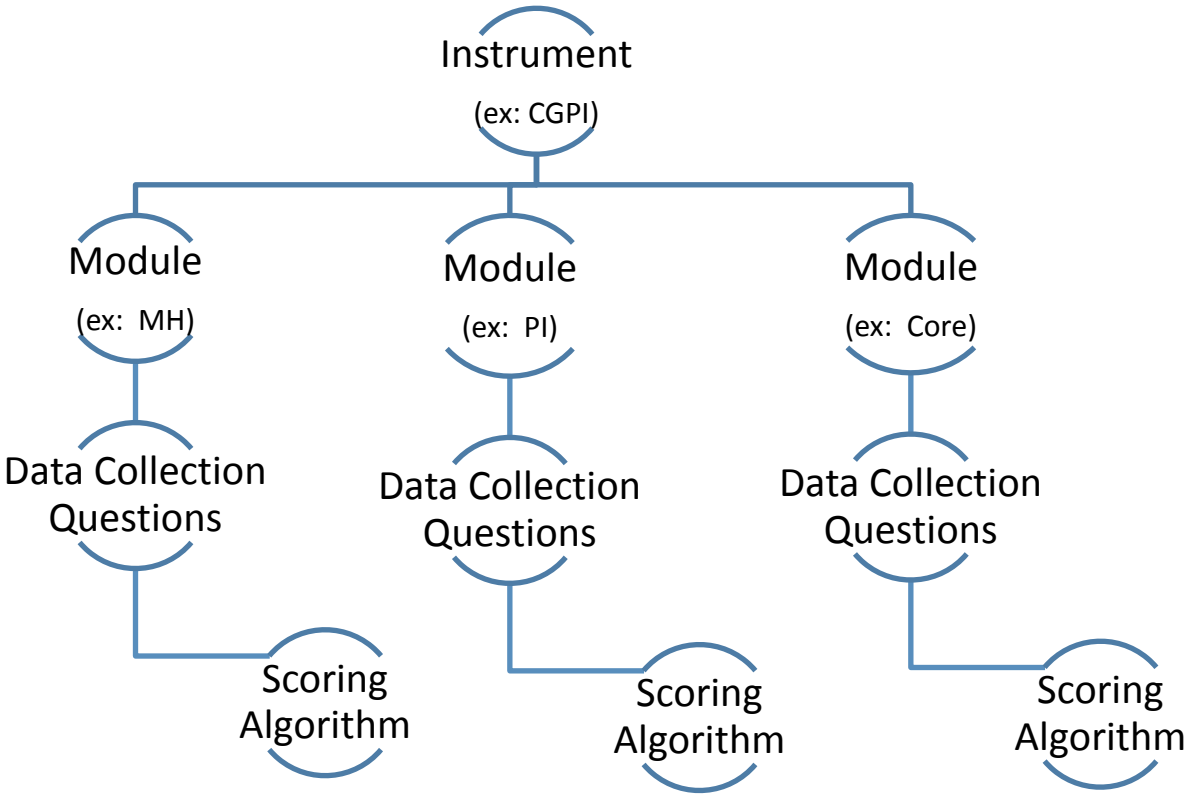
Just some terminology clarification:

Instrument - Software (data collection question in electronic form) containing question specifications including administrative fields, responses, logic flow, and definitions/decision rules to guide abstraction of the record. When Instruments become too large they are sometimes broken into **Modules** (groups of questions related to one area within the Instrument).

Scoring Algorithm - pictorial representation of how the measure is scored, identifying scored data elements.



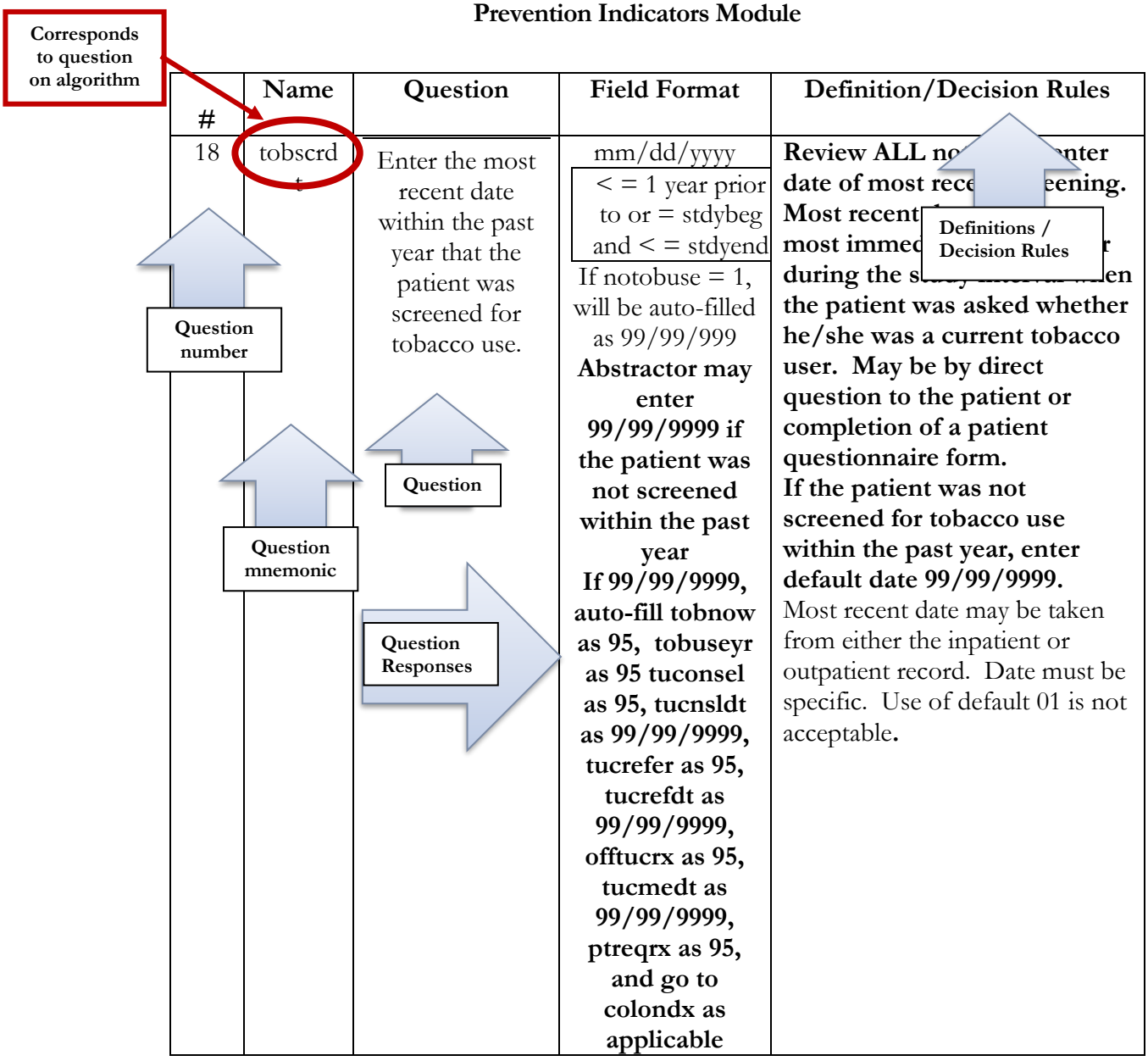
Instrument with Multiple Modules



Below is an example:

VHA EPRP Clinical Practice Guideline and Prevention Indicators (CGPI)

Prevention Indicators Module



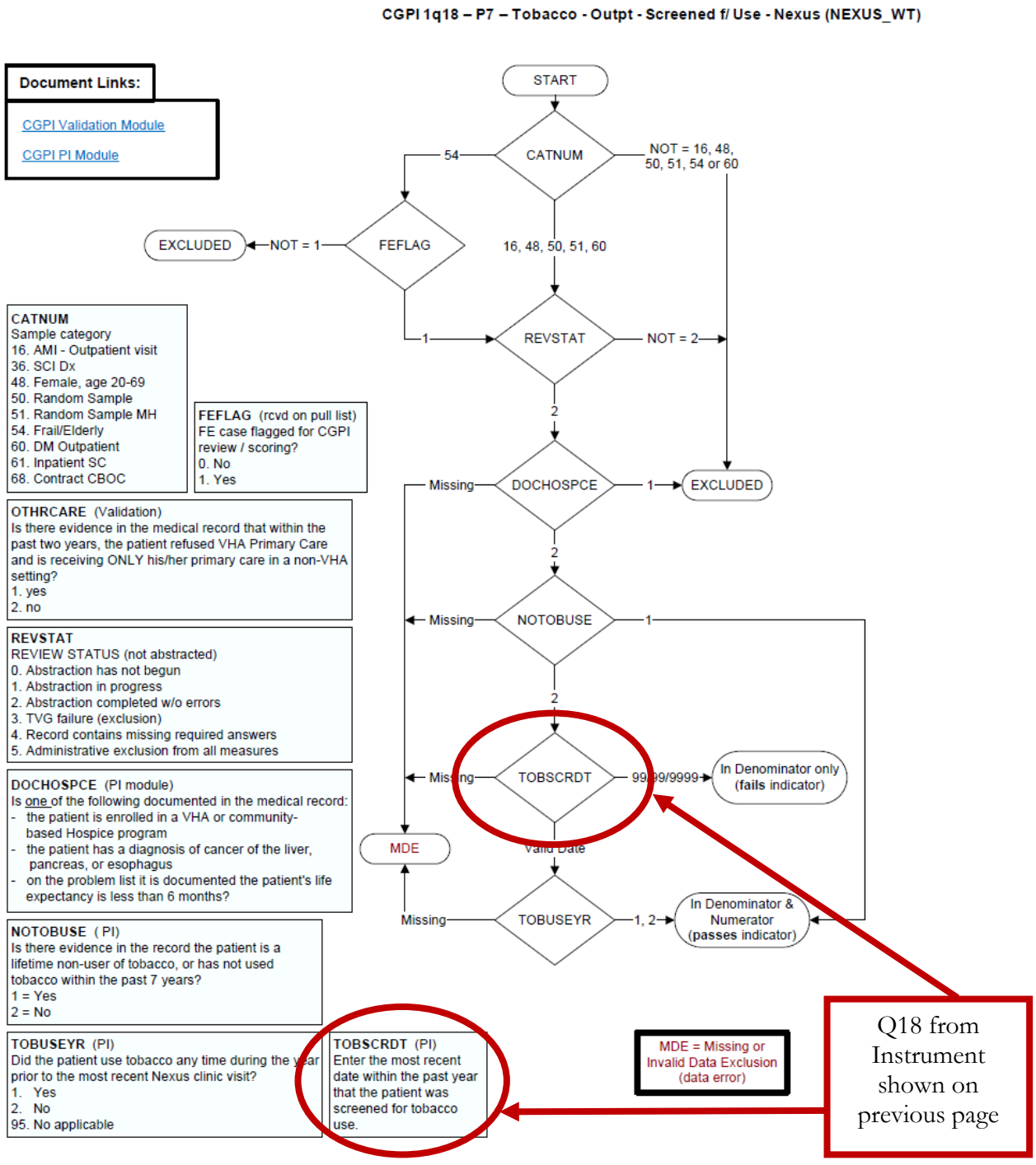
#	Name	Question	Field Format	Definition/Decision Rules
18	tobscrdt	Enter the most recent date within the past year that the patient was screened for tobacco use.	mm/dd/yyyy < = 1 year prior to or = stdybeg and < = stdyend If notobuse = 1, will be auto-filled as 99/99/999 **Abstractor may enter 99/99/9999 if the patient was not screened within the past year** **If 99/99/9999, auto-fill tobnow as 95, tobuseyr as 95 tuconsel as 95, tucnsldt as 99/99/9999, tucrefer as 95, tucrefdt as 99/99/9999, offtucrx as 95, tucmedt as 99/99/9999, ptreqrx as 95, and go to colondx as applicable**	**Review ALL no… enter date of most rece… eening. Most recent… most immed… r during the s… en the patient was asked whether he/she was a current tobacco user. May be by direct question to the patient or completion of a patient questionnaire form.** **If the patient was not screened for tobacco use within the past year, enter default date 99/99/9999.** Most recent date may be taken from either the inpatient or outpatient record. Date must be specific. Use of default 01 is not acceptable.

Scoring Algorithms convert a collection of raw clinical data elements into useable data. The Scoring Algorithms are in a flowchart format, representing the steps of measure calculation pictorially. Each Scoring Algorithm is a schematic that shows how to generate denominators and numerators to score the measure. Performance Measurement communicates question and measure changes prior to the start of each new quarter. Quality Insights reviews these changes as well as those applicable from external comparator systems to which VHA reports and modifies questions and measure calculation algorithms accordingly. These changes are reviewed by Performance Measurement and Quality Insights a second time for accuracy and consistency.

Below is an example of a Scoring Algorithm:

Both Instruments and Scoring Algorithms are updated, tested, and validated quarterly to ensure consistent and accurate review.

The elements of the Instrument and their interrelationships are shown in greater detail in the Abstraction section of this manual.



4

Data / Data Security

Take Aways

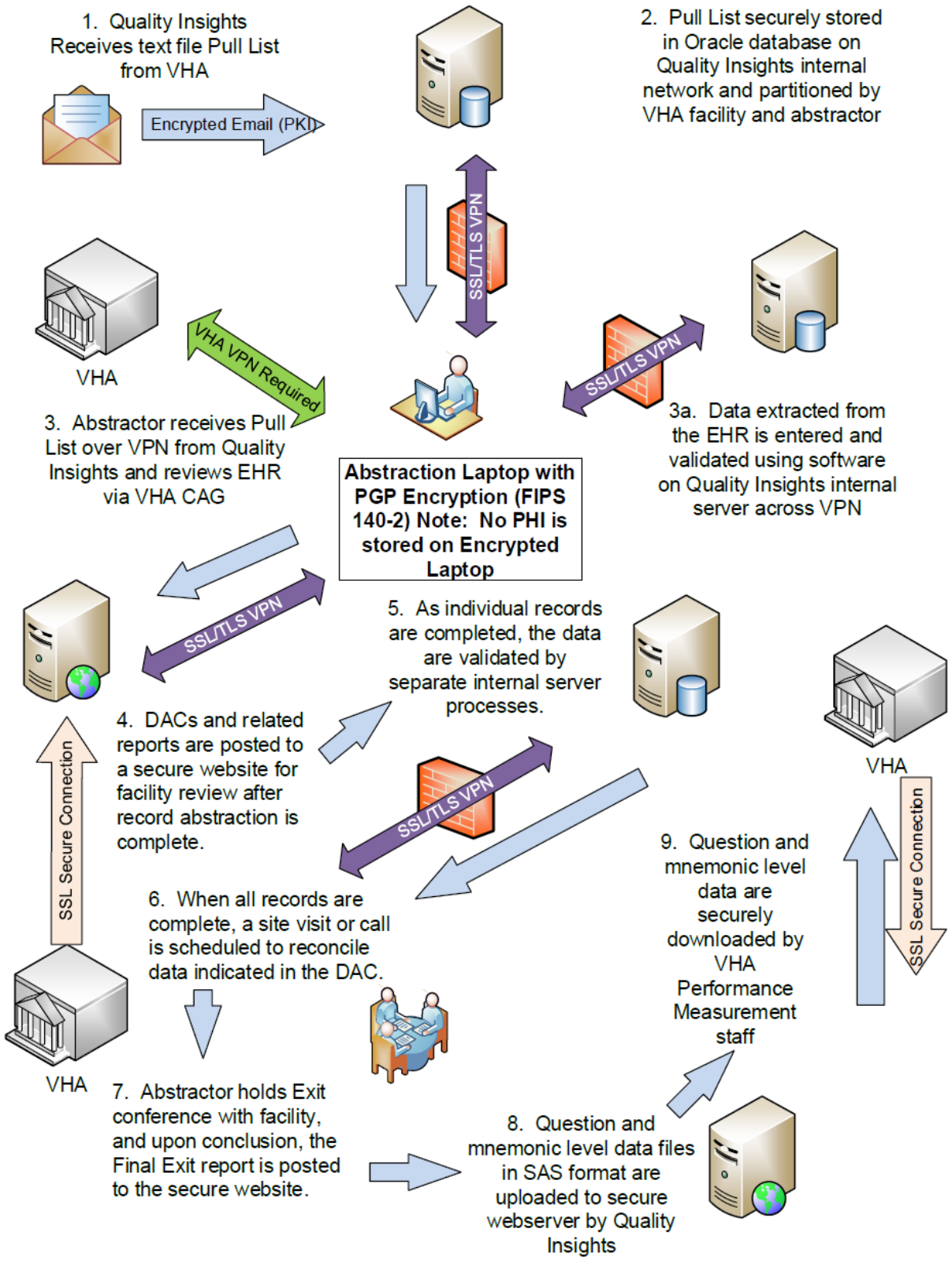
- Federal Regulations are followed to ensure data confidentiality and quality assurance
- Data is used for performance measurement and improvement
- Data is transmitted daily, monthly, and quarterly through secure tunnel

Data security is critical in today's virtual world. EPRP ensures confidentiality of both sensitive patient medical, patient identifiable, and quality assurance data in accordance with Federal Regulations.

The data collected provides facilities with an immediate report of findings; this includes a daily uploading of data at the completion of the facilities' monthly review (Exit Conference). The data (raw and scored) is transmitted to Performance Measurement through a secure tunnel daily, monthly, and quarterly, as scheduled.

The data collected through the EPRP process is used for internal and external monitoring and reporting. Performance Measurement maintains a variety of useful reports that are discussed in detail later in this manual (see Section III.10).

A schematic of the data transmission process is pictured on the following page.


1. Quality Insights Receives text file Pull List from VHA
Encrypted Email (PKI)
2. Pull List securely stored in Oracle database on Quality Insights internal network and partitioned by VHA facility and abstractor
SSL/TLS VPN
VHA
VHA VPN Required
3. Abstractor receives Pull List over VPN from Quality Insights and reviews EHR via VHA CAG
SSL/TLS VPN
3a. Data extracted from the EHR is entered and validated using software on Quality Insights internal server across VPN
Abstraction Laptop with PGP Encryption (FIPS 140-2) Note: No PHI is stored on Encrypted Laptop
SSL/TLS VPN
4. DACs and related reports are posted to a secure website for facility review after record abstraction is complete.
5. As individual records are completed, the data are validated by separate internal server processes.
VHA
SSL Secure Connection
SSL/TLS VPN
6. When all records are complete, a site visit or call is scheduled to reconcile data indicated in the DAC.
9. Question and mnemonic level data are securely downloaded by VHA Performance Measurement staff
SSL Secure Connection
VHA
7. Abstractor holds Exit conference with facility, and upon conclusion, the Final Exit report is posted to the secure website.
8. Question and mnemonic level data files in SAS format are uploaded to secure webserver by Quality Insights

Section II: The Process

5. Sampling
6. Abstraction
7. The Data Accountability Checklist (DAC)
8. The Exit Report and Exit Conference
9. Reconsiderations

5

Sampling

Take Aways

- Sampling is conducted by a Statistician/Program Analyst within Performance Measurement
- Sampling is categorized into Outpatient and Inpatient

Sampling is a critical step in the EPRP process. It is based upon sound statistical principles, and sizes and methods may vary based upon specific Catnums (i.e., the category number used during EPRP to identify patient cohorts for sampling). Sampling is conducted by a Statistician/Program Analyst within Performance Measurement. The resulting samples (called Pull Lists) are then provided to Quality Insights for distribution, abstraction, and scoring.

This chapter provides a brief overview of both the outpatient and inpatient sampling processes. Full details can be found in the EPRP Sampling and Catnum and Cohorts documents located on the External Peer Review Program (EPRP) Resources website. And training on these and other EPRP topics can be found on the Performance Measure Training page.

Outpatient Sampling

The EPRP outpatient sampling design is based on several working principles:

- Collect clinical data on a random sample of established VHA users;
- Maintain the ability to generate valid estimates at the VISN level;
- Maintain the ability to generate valid estimates at the facility level for the greatest number of quality measures;
- Use available financial resources to efficiently distribute cases across the VHA system for as many measures as possible, and;
- Report annual facility estimates within approximately +/- 6 points of the true facility rate (based on 95% confidence intervals).

In general, a fixed number of NEXUS (i.e., the outpatient clinic stop codes that most accurately identify extensive users of the VHA system) cases are randomly sampled from each health

facility (Sta3n) regardless of the population available. There is some variation in the fixed allocation across VHA facilities, but the allocation is similar each month. Additional EPRP outpatient goals were initiated in FY11, and were designed to improve sampling. They included: 1) link patients to a facility where most of their primary care (PC) services were obtained in the prior year, 2) fully utilize augmented data in scoring of all outpatient measures, and 3) increase the proportion of patients sampled from CBOCs.

Example from CGPI Exit Report:
Cases are selected from a specific time period designated as the "study interval." To qualify for outpatient abstraction, the patient must have been seen by an MD, DO, APN, PA, or Psychologist in one of the NEXUS clinics within twelve months from the first day of the study interval. All cases selected for review must also have had another visit anywhere in VHA within the past two years. The "NEXUS clinics" include primary care and specialty clinics as well as selected mental health clinics. Although all applicable data is collected, mental health patients whose primary care is received in a non-VHA setting are excluded from VHA designated indicators.

Due to the inherent over-representation of cases from small sites and the under-representation of cases from large sites, cases are weighted based on patient characteristics such as gender, diabetes, and acute myocardial infarction (AMI) status. Weighting corrects for the unequal number of available cases within each organizational level (i.e., CBOC or facility) and protects against biased or inaccurate scores. This may lead to scores that do not seem mathematically correct (i.e., 8 out of 10 may not = 80%, but 67% or 87% depending on the weights of the cases that pass and fail the measure). Specifics about weighting are found in the EPRP Sampling document. Cases with the same patient characteristics at the same facility will have the same weight in a given sampling month.

The Joint Commission (TJC) ORYX Measure Sampling Requirements

Sample sizes for the TJC ORYX Measures are measure-specific. VHA performs monthly sampling and must ensure that its initial patient population and sample sizes adhere to the measure-specific requirements (e.g., for the Global Measures, populations less than 51 are not sampled, 100% of the patient population is required, but for populations 51-254 patients, a sample of 51 patients is required, etc.). Inpatient reviews usually occur 1-3 months after discharge when coded information has been transmitted to the Corporate Data Warehouse (CDW) by the facility and is identifiable for inclusion on the Pull List.

Monthly Initial Patient Population (size "N")	Minimum required sample size "n"
Great than or equal to 510	102
255-509	20% of Initial Patient Population
51-254	51
Less than 51	100% of initial Patient Populations required

Pull List

As noted, the samples are referred to as Pull Lists in the EPRP process and are essentially considered the denominator in the scoring process. The Pull List contains the names of the patient records to be reviewed (abstracted) (see example below). Once Quality Insights receives the Pull Lists, the abstraction process begins. The following chapters will provide greater details about each of the subsequent steps in the EPRP process.

- The first Pull List of each quarter is pulled during the first full week of the first month of the quarter
- The second Pull List is pulled during the 1st full week of the second month of the quarter
- The third Pull List is pulled during the last week of the second month of the quarter

Please see Dates and Timelines in Section III.12 for a complete calendar and explanation.

Example of Pull List Downloaded from Secure Quality Insights Website (*fictitious site*)

These documents or records, or information contained herein, which resulted from a medical record review conducted as per the External Peer Review Program, are confidential and privileged under the provisions of 38 U.S.C. 5705, and its implementing regulations. This material can not be disclosed to anyone without authorization as provided for by that law

THE EXTERNAL PEER REVIEW PROGRAM

VAMC (123): VA USA HCS

CGPI Pull List Date: 07/09/2018

CONTROL	SSN	Name(Last, First)	SEX	CATNU	BIRTHDT	DISCH	STDYBEG	STDYEND	FILELOC
1819001788			Male	51	11/24/1947		06/01/2018	06/30/2018	Main123
1819001789			Male	60	02/05/1945		06/01/2018	06/30/2018	123A
1819001790			Male	60	03/18/1959		06/01/2018	06/30/2018	123B
1819001791			Male	51	09/05/1990		06/01/2018	06/30/2018	123C
1819001792			Female	54	08/15/1934		06/01/2018	06/30/2018	123A

6

Abstraction

Take Aways

- Abstractors review medical records from a Pull List generated by VHA's sampling process.
- Data Collection Questions are designed to guide the Abstractor to collect data accurately
- Only the official medical record can be used for abstraction.
- The time period from Pull List release to the "Last Day to Exit" is approximately 30 days.

Abstractors review medical records for data elements that meet the measure specifications. For example, veterans are expected to be screened for tobacco use. The abstracted data elements are scored using Algorithms that determine if cases pass or fail the related tobacco measures.

Performance Measurement produces lists of records to be reviewed, called Pull Lists (see Sampling section). EPRP Abstractors collect relevant information for patients on the Pull List using Data Collection Questions developed by Quality Insights in conjunction with Performance Measurement measure coordinators and subject matter experts. The abstracted data is entered into software and scored using Algorithms that convert the raw data into usable quality measures. Abstractors review medical records via remote access to the Computerized Patient Record System (CPRS). Remote data is accessed via Joint Legacy Viewer (JLV) when appropriate. Abstractors are notified by an email generated by Quality Insights that the Pull List is available for review and they can begin abstraction. Abstraction must be completed, data reconciled and an Exit Conference completed within approximately 30 days. Please see the EPRP Field Calendar for Pull List dates and the Last Day to Exit each Pull List. Only the official medical record may also be reviewed for relevant information (e.g. progress notes, laboratory reports, radiology reports, reports of procedures and discharge summaries). Abstractors may not take documentation from Clinical Reminders or Mental Health Assistant (MHA) unless the source populates a signed progress note.

The Abstractor's response to each Data Collection Question is guided by associated Definition/Decision rules. An example of a question and associated Definition/Decision Rules is below:

#	Name	Question	Field Format	Definition/Decision Rules
18	tobscrdt	Enter the most recent date within the past year that the patient was screened for tobacco use.	mm/dd/yyyy < = 1 year prior to o = stdybeg and < = stdyend If notobuse = 1, will be auto-filled as 99/99/999 **Abstractor may enter 99/99/9999 if the patient was not screened within the past year** **If 99/99/9999, auto-fill tobnow as 95, tobuseyr as 95 tuconsel as 95, tucnsldt as 99/99/9999, tucrefer as 95, tucrefdt as 99/99/9999, offtucrx as 95, tucmedt as 99/99/9999, ptreqrx as 95, and go to colondx as applicable**	**Review ALL notes and enter date of most recent screening.** **Most recent date: the date most immediately prior to or during the study interval when the patient was asked whether he/she was a current tobacco user. May be by direct question to the patient or completion of a patient questionnaire form.** **If the patient was not screened for tobacco use within the past year, enter default date 99/99/9999.** Most recent date may be taken from either the inpatient or outpatient record. Date must be specific. Use of default 01 is not acceptable**.**

Abstractors review all relevant medical record documentation. For example, when abstracting a CGPI record, the Abstractor reviews all notes for the study year and older notes as applicable. For inpatient topics, the Abstractor reviews all notes for the admission specified on the Pull List. The rules for some questions include guidance as to which data sources may be abstracted. Suggested Data Sources serves as a guide for the Abstractor but does not limit them to only looking in those documents. 'Only Acceptable Sources' instruct the Abstractor to only collect data from specific sources.

For example:

> ONLY ACCEPTABLE SOURCES**:** *Emergency Department record nursing unit admission assessment/admitting note; observation record; procedure notes (e.g., cardiac catheterization, endoscopies, surgical procedures)

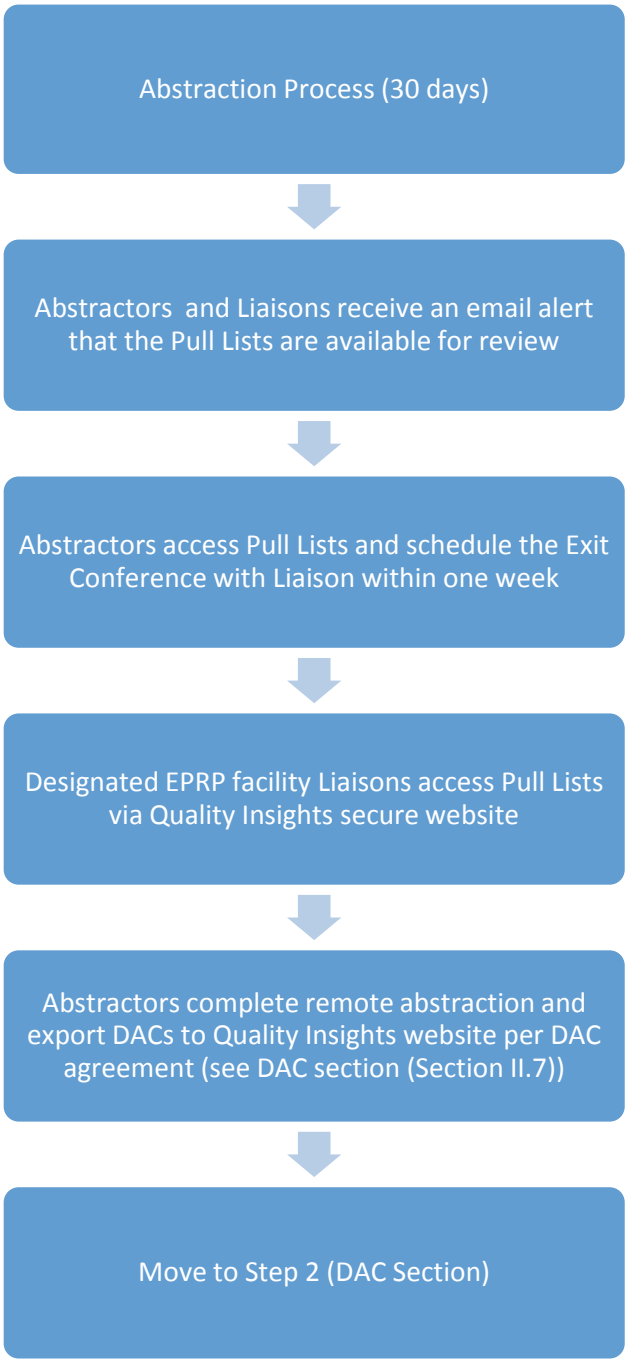
Some rules include 'Excluded Data Sources' (i.e. data cannot be abstracted from these sources).

The Data Collection Questions software utilized by the Abstractor has many built in parameters to help ensure accurate abstraction. For example, date parameters ensure that only actions or

services provided on a date within the acceptable timeframe can be entered. There are also features that prevent the collection of conflicting data. Warnings let an abstractor know if a value entered may be outside of an expected range (e.g., a weight of 600 lbs.).

In addition to the abstraction guidance in the rules and the software parameters, the DACs provide facility staff an opportunity to find documentation that was overlooked or not abstracted during initial review. Below is a diagram of the Abstraction Process, which will be discussed in detail in the following section.

THE ABSTRACTION PROCESS



7

The Data Accountability Checklist (DAC)

Take Aways

- Data Accountability Checklists (DACs) provide a list of all measures that fail for each case (patient) on the Pull List and allow an opportunity for the facility staff to find data that may have been missed or not considered appropriate by the Abstractor on initial review
- DACs are available on the Quality Insights secure website in advance of the monthly Exit Conference.
- The number of days that DACs are available prior to the Exit Conference (2-4 days) is determined by DAC Agreement negotiated between the Abstractor and facility Liaison. The agreement also notes the venue for the Exit Conference i.e. telephone, onsite, or a combination of telephone and onsite.
- Prior to the Exit Conference, documentation found by the facility during review of DACs is considered by the Abstractor and data is changed when appropriate (DAC reconciliation).

The Data Accountability Checklists (DACs) are an important part of the EPRP abstraction process. DACs are generated for each case from the data the Abstractor enters and:

- Shows which measures do not pass or;
- Shows that all measures do pass; and
- Shows which cases are excluded from all measures.

DACs allow facility personnel to review records for documentation the Abstractor may have missed and that will allow measures to go from fail to pass or from fail to exclude.

The DAC process starts with a negotiated agreement between the liaison and abstractor (see Appendix D). The agreement determines how the Exit Conference will be held (onsite, by phone or a combination of phone and onsite) and how many days (2-4) in advance of the Exit Conference the DACs will be available for review. The current EPRP contract specifies onsite exit conferences. However, **with approval from the EPRP COR,** facility staff may elect to have all or some of the Exit Conferences by telephone. The agreed upon number of onsite visits per quarter (1, 2, or 3) is stipulated in the DAC agreement. Performance Measurement requires a minimum of one onsite exit for each facility per year.

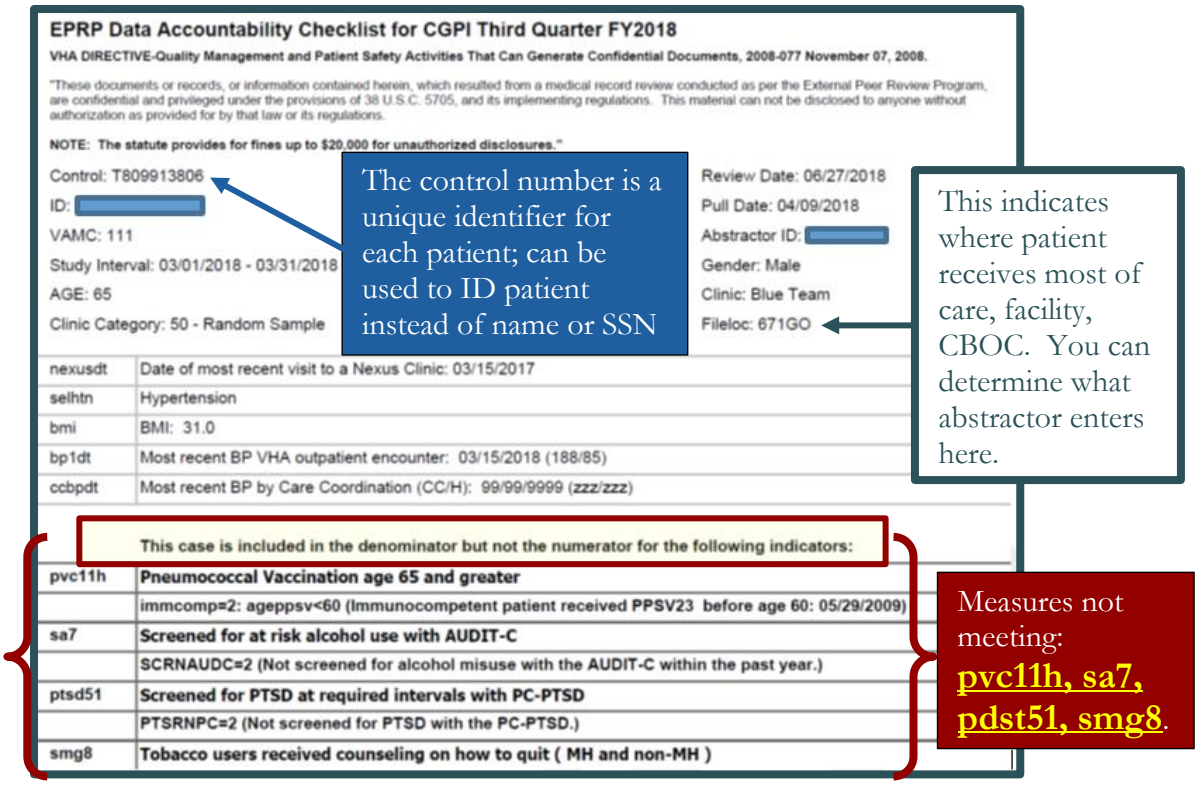
The DAC Agreement specifies the number of days in advance of the Exit Conference the facility will be able to access the DACs on the Quality Insights secure website. **The number of days may not be greater than 4 nor less than 2 days and may be different for each measure set**. For example, the number of days for CGPI DACs may be 4 and the number of days for VTE DACs may be 2. The EPRP Abstractor is responsible for completing the DAC Agreement Form (see Appendix C) after an agreement has been reached and will provide a copy to the Liaison. A new DAC Agreement form should be completed when:

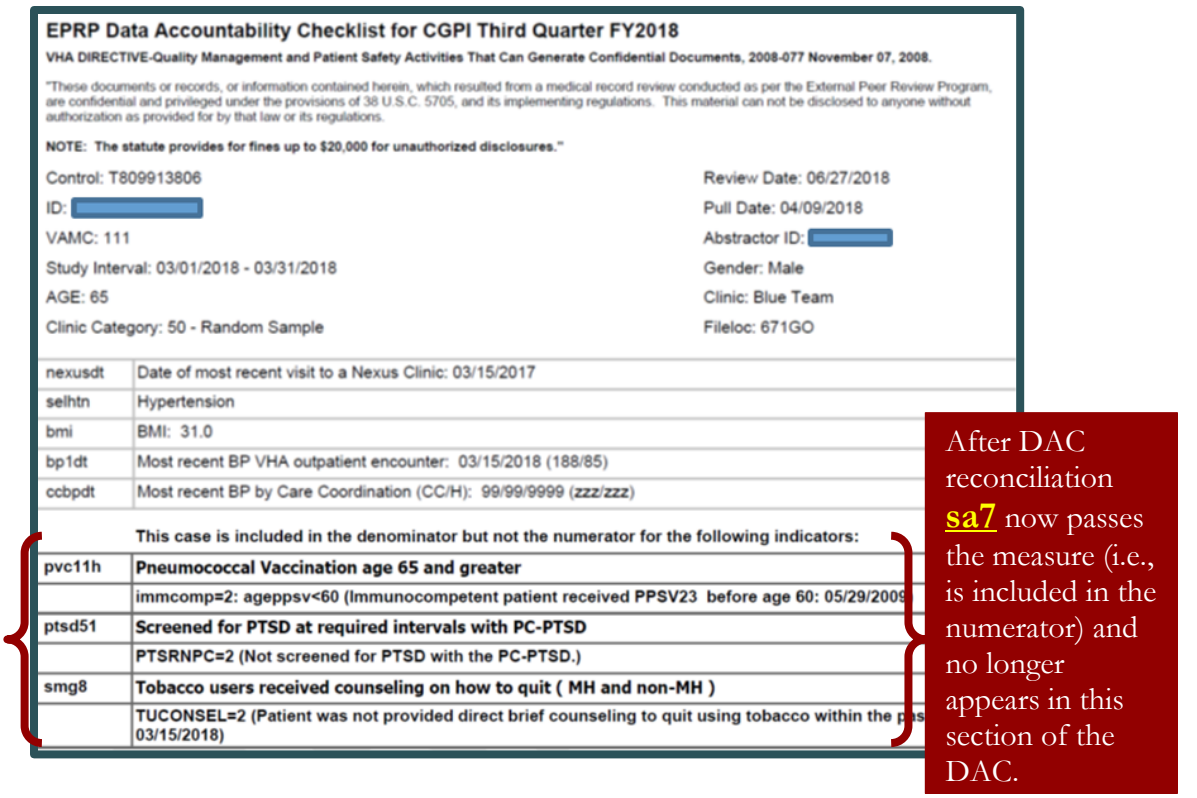
- There is a change in the EPRP abstractor or the liaison or back up liaison;
- A change in the number of DAC days or the how the Exit Conference is held is requested; and
- At the beginning of each new fiscal year.

The EPRP Abstractor will export the DACs to the Quality Insights secure website in accordance with the negotiated DAC Agreement (Appendix C): https://eprp.wvmi.org/Home.aspx. This process triggers an automated email message that alerts the Liaison that DACs are available. DACs may then be distributed to team members for review as per facility procedure. The Abstractor will also export a Preliminary Exit Report at the same time the DACs are exported. This report will provide a preview of measure scores prior to the DAC reconciliation process. The Preliminary Exit Report is also accessed via the secure website.

Following the review of DACs by facility personnel, the DACs are reconciled with the EPRP Abstractor. DAC reconciliation can be accomplished in several ways. If the Abstractor makes onsite visits, DAC reconciliation may be done at that time. DACs may also be reconciled by phone or via email exchange. It is important to remember that Abstractors do not have encrypted email so no Personal Health Information (PHI) can be included in the communication. The control number assigned to each case on the Pull List should be used to identify the patient. The Abstractor considers additional data located by facility staff and changes his/her data when appropriate. If the Abstractor does not feel a change in data is warranted, he/she will provide an explanation. The EPRP Regional Manager should be consulted when the Abstractor and Liaison do not agree on whether documentation produced by the Liaison is sufficient to change the Abstractor's data. **DAC reconciliation should be completed at least one hour prior to the Exit Conference in order to allow the Abstractor time to finalize data, export the Exit Reports and prepare for the Exit Conference.**

Prior to the Exit Conference, the Abstractor will export Final DACs that will reflect any changes made to the data during the DAC reconciliation process. It is important to review Final DACs since changes to data may not affect the measure as anticipated. Changes to the data may also cause different measures to fail.


EPRP Data Accountability Checklist for CGPI Third Quarter FY2018
VHA DIRECTIVE-Quality Management and Patient Safety Activities That Can Generate Confidential Documents, 2008-077 November 07, 2008.
"These documents or records, or information contained herein, which resulted from a medical record review conducted as per the External Peer Review Program, are confidential and privileged under the provisions of 38 U.S.C. 5705, and its implementing regulations. This material can not be disclosed to anyone without authorization as provided for by that law or its regulations.
NOTE: The statute provides for fines up to $20,000 for unauthorized disclosures."
Control: T809913806
ID:
VAMC: 111
Study Interval: 03/01/2018 - 03/31/2018
AGE: 65
Clinic Category: 50 - Random Sample
Review Date: 06/27/2018
Pull Date: 04/09/2018
Abstractor ID:
Gender: Male
Clinic: Blue Team
Fileloc: 671GO
The control number is a unique identifier for each patient; can be used to ID patient instead of name or SSN
This indicates where patient receives most of care, facility, CBOC. You can determine what abstractor enters here.
nexusdt Date of most recent visit to a Nexus Clinic: 03/15/2017
selhtn Hypertension
bmi BMI: 31.0
bp1dt Most recent BP VHA outpatient encounter: 03/15/2018 (188/85)
ccbpdt Most recent BP by Care Coordination (CC/H): 99/99/9999 (zzz/zzz)
This case is included in the denominator but not the numerator for the following indicators:
pvc11h Pneumococcal Vaccination age 65 and greater
immcomp=2: ageppsv<60 (Immunocompetent patient received PPSV23 before age 60: 05/29/2009)
sa7 Screened for at risk alcohol use with AUDIT-C
SCRNAUDC=2 (Not screened for alcohol misuse with the AUDIT-C within the past year.)
ptsd51 Screened for PTSD at required intervals with PC-PTSD
PTSRNPC=2 (Not screened for PTSD with the PC-PTSD.)
smg8 Tobacco users received counseling on how to quit (MH and non-MH)
Measures not meeting: pvc11h, sa7, pdst51, smg8.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Control: T809913806
ID:
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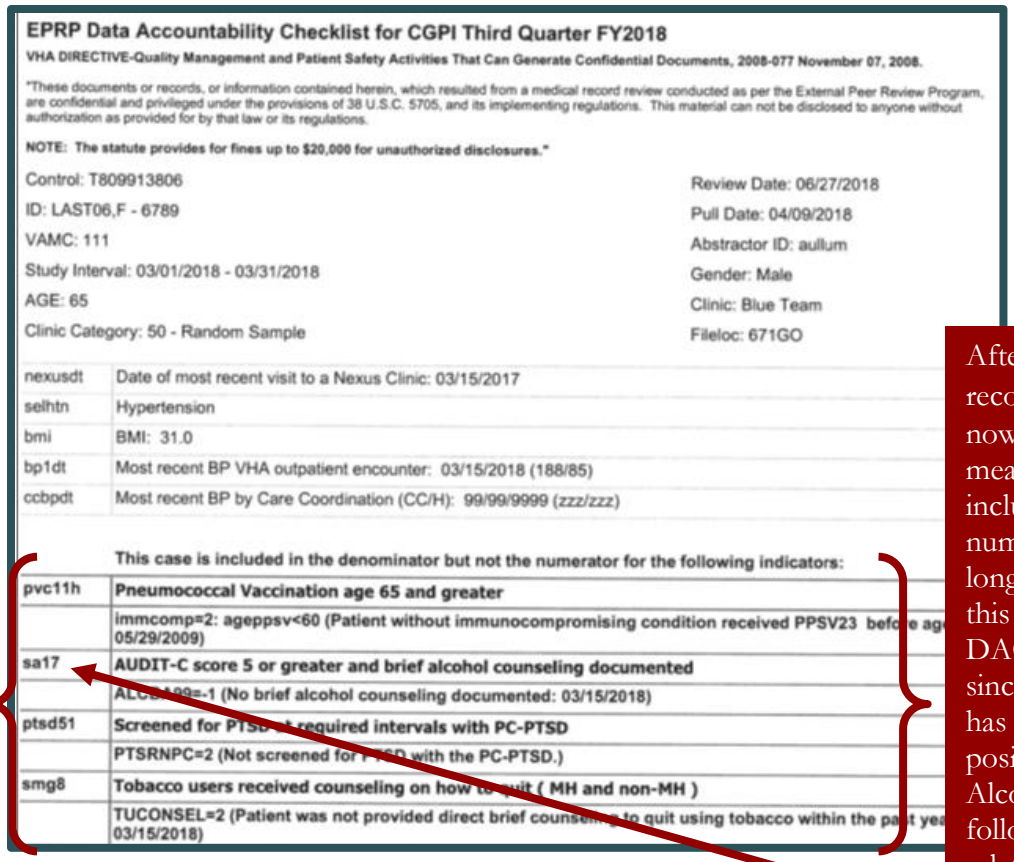
Study Interval: 03/01/2018 - 03/31/2018
AGE: 65
Clinic Category: 50 - Random Sample
Review Date: 06/27/2018
Pull Date: 04/09/2018
Abstractor ID:
Gender: Male
Clinic: Blue Team
Fileloc: 671GO
nexusdt Date of most recent visit to a Nexus Clinic: 03/15/2017
selhtn Hypertension
bmi BMI: 31.0
bp1dt Most recent BP VHA outpatient encounter: 03/15/2018 (188/85)
ccbpdt Most recent BP by Care Coordination (CC/H): 99/99/9999 (zzz/zzz)
This case is included in the denominator but not the numerator for the following indicators:
pvc11h Pneumococcal Vaccination age 65 and greater
immcomp=2: ageppsv<60 (Immunocompetent patient received PPSV23 before age 60: 05/29/2009
ptsd51 Screened for PTSD at required intervals with PC-PTSD
PTSRNPC=2 (Not screened for PTSD with the PC-PTSD.)
smg8 Tobacco users received counseling on how to quit (MH and non-MH)
TUCONSEL=2 (Patient was not provided direct brief counseling to quit using tobacco within the p
03/15/2018)
After DAC reconciliation sa7 now passes the measure (i.e., is included in the numerator) and no longer appears in this section of the DAC.



EPRP Data Accountability Checklist for CGPI Third Quarter FY2018

VHA DIRECTIVE-Quality Management and Patient Safety Activities That Can Generate Confidential Documents, 2008-077 November 07, 2008.

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Control: T809913806 | Review Date: 06/27/2018
ID: LAST06,F - 6789 | Pull Date: 04/09/2018
VAMC: 111 | Abstractor ID: aullum
Study Interval: 03/01/2018 - 03/31/2018 | Gender: Male
AGE: 65 | Clinic: Blue Team
Clinic Category: 50 - Random Sample | Fileloc: 671GO

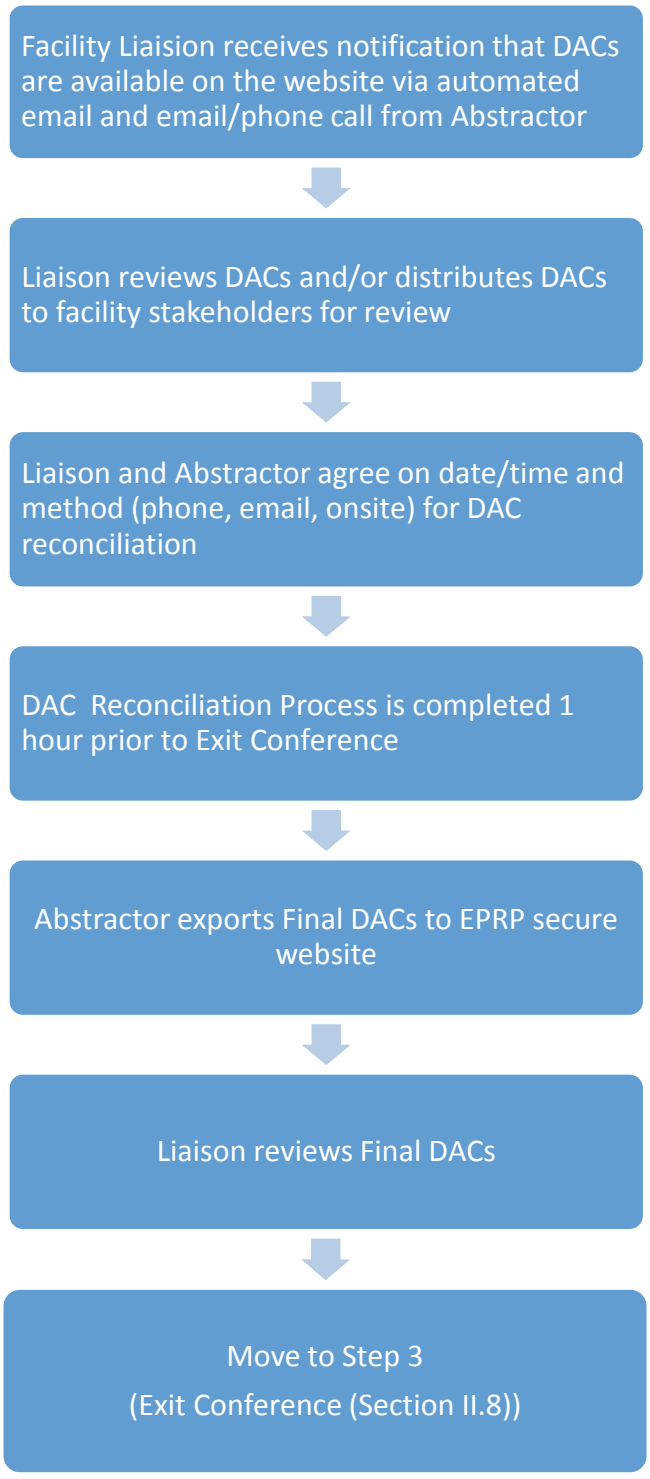
nexusdt	Date of most recent visit to a Nexus Clinic: 03/15/2017
selhtn	Hypertension
bmi	BMI: 31.0
bp1dt	Most recent BP VHA outpatient encounter: 03/15/2018 (188/85)
ccbpdt	Most recent BP by Care Coordination (CC/H): 99/99/9999 (zzz/zzz)

This case is included in the denominator but not the numerator for the following indicators:

pvc11h	**Pneumococcal Vaccination age 65 and greater**
	immcomp=2: ageppsv<60 (Patient without immunocompromising condition received PPSV23 before age 05/29/2009)
sa17	**AUDIT-C score 5 or greater and brief alcohol counseling documented**
	ALCSA99=-1 (No brief alcohol counseling documented: 03/15/2018)
ptsd51	**Screened for PTSD at required intervals with PC-PTSD**
	PTSRNPC=2 (Not screened for PTSD with the PC-PTSD.)
smg8	**Tobacco users received counseling on how to quit (MH and non-MH)**
	TUCONSEL=2 (Patient was not provided direct brief counseling to quit using tobacco within the past year 03/15/2018)

After DAC reconciliation **sa7** now passes the measure (i.e., is included in the numerator) and no longer appears in this section of the DAC. However, since the patient has screened positive for Alcohol Use, the follow-up measure related to counseling **sa17** in now failing since counseling was not documented.

THE DAC REVIEW PROCESS



8

The Exit Report and the Exit Conference

Take Aways

- An EPRP Exit Report for each abstraction topic is sent to the secure website following DAC Reconciliation.
- The Exit Report provides a summary of the outcome of monthly abstraction and includes the numerator, denominator and score for each measure.
- Scoring Algorithms, Exit Report Guides, and Case Level Reports are available to assist with understanding the reports
- A monthly EPRP Exit Conference is conducted either onsite or by telephone.
- The Exit Conference must be scheduled in accordance with the "Last Day to Exit" as detailed on the EPRP calendar.
- The EPRP Abstractor has references and knowledge that can help make the Exit Conference useful and interesting.

Abstractors should visit the assigned VHA medical centers at least annually (and no more than monthly) after negotiating the visitation date with the assigned VHA EPRP Liaison. If more than one Abstractor is assigned to abstract at a facility, only one Abstractor will conduct the onsite visit. The date of the Exit Conference should be confirmed with the EPRP Abstractor as soon as possible after release of each Pull List. Quality Insights is required to make the dates of all Exit Conferences available to the VHA COR/PM one week before the Exit Conference (see The EPRP Field Calendar).

The onsite visit shall take place during normal business hours when visiting the facility unless otherwise agreed upon by the Liaison. Abstractors may not be on VHA premises without the Liaison or assigned back-up person present. Telephone, Web or Videoconferencing Exits may occur in lieu of onsite visit with the consent of the COR. The facility will provide office space, an analog phone line for access and access to CPRS.

The objectives of the onsite visit are:

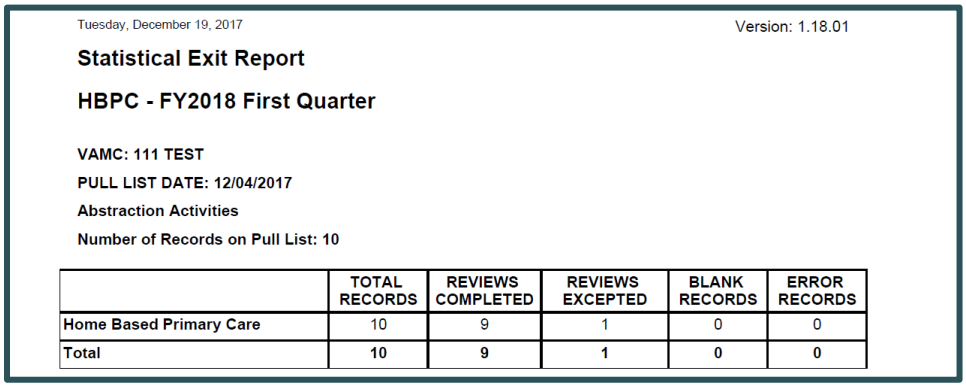
- Review with the Abstractor any data elements not found during remote review (DAC review). The facility EPRP Liaison may provide relevant documentation from the official medical record missed in the offsite abstraction. These data will

be entered into the data collection instrument by the Abstractor during the onsite visit when appropriate (see DAC Section II.7).

- Present the facility-level findings to facility stakeholders, including senior leadership and QM. After completion of the DAC reconciliation process, the Abstractor will export a Final Exit Report for each topic to the Quality Insights secure website. The Exit Report includes aggregate data from the facility's monthly review.

The following reports are available on the Quality Insights secure website prior to the Exit Conference.

The Statistical Report shows the disposition of the records: reviews completed, excepted (do not review), blank, and any records in error status.



Tuesday, December 19, 2017 Version: 1.18.01

Statistical Exit Report

HBPC - FY2018 First Quarter

VAMC: 111 TEST

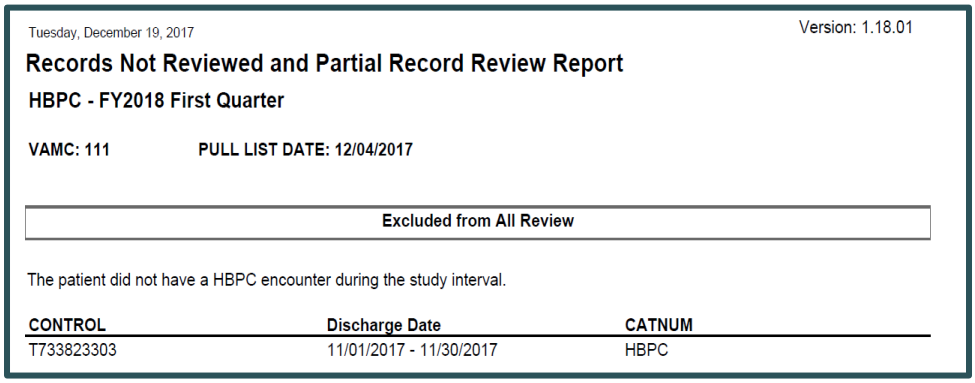
PULL LIST DATE: 12/04/2017

Abstraction Activities

Number of Records on Pull List: 10

	TOTAL RECORDS	REVIEWS COMPLETED	REVIEWS EXCEPTED	BLANK RECORDS	ERROR RECORDS
Home Based Primary Care	10	9	1	0	0
Total	**10**	**9**	**1**	**0**	**0**

The Do Not Review Report lists (by control number) the records that were excluded by topic Validation. This report provides a brief explanation of why the record was not included in the review.



Tuesday, December 19, 2017 Version: 1.18.01

Records Not Reviewed and Partial Record Review Report

HBPC - FY2018 First Quarter

VAMC: 111 **PULL LIST DATE: 12/04/2017**

Excluded from All Review

The patient did not have a HBPC encounter during the study interval.

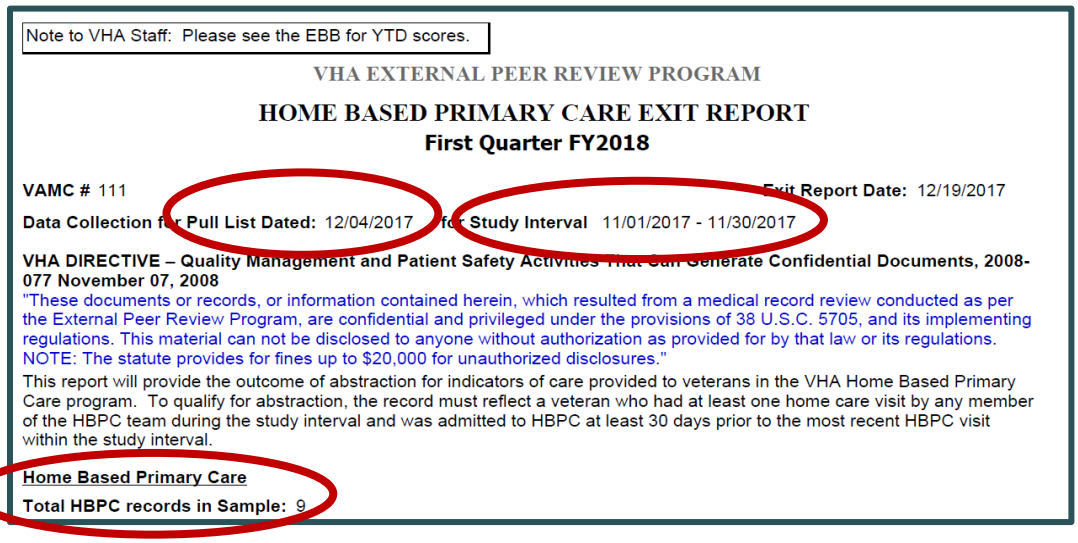
CONTROL	Discharge Date	CATNUM
T733823303	11/01/2017 - 11/30/2017	HBPC

There is an Exit Report for each review topic that provides the numerator, denominator and score for each EPRP measure:

- A Preliminary Exit Report is available when the DACs are exported.

- The Final Exit Report is available after DACs have been reconciled and the Abstractor has finalized the data.

At the top of each Exit Report there is a summary of what is included in the report as well as information about how cases are selected for review. Additional information includes: the Pull List date, the study interval and the total number of records abstracted.



Note to VHA Staff: Please see the EBB for YTD scores.

VHA EXTERNAL PEER REVIEW PROGRAM

HOME BASED PRIMARY CARE EXIT REPORT
First Quarter FY2018

VAMC # 111 **Exit Report Date:** 12/19/2017

Data Collection for Pull List Dated: 12/04/2017 **for Study Interval** 11/01/2017 - 11/30/2017

VHA DIRECTIVE – Quality Management and Patient Safety Activities That Can Generate Confidential Documents, 2008-077 November 07, 2008
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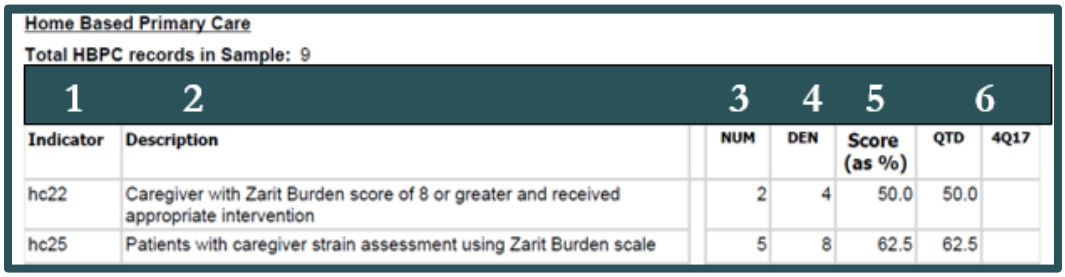
This report will provide the outcome of abstraction for indicators of care provided to veterans in the VHA Home Based Primary Care program. To qualify for abstraction, the record must reflect a veteran who had at least one home care visit by any member of the HBPC team during the study interval and was admitted to HBPC at least 30 days prior to the most recent HBPC visit within the study interval.

Home Based Primary Care

Total HBPC records in Sample: 9

Column headers in the body of the Exit Report:



Home Based Primary Care

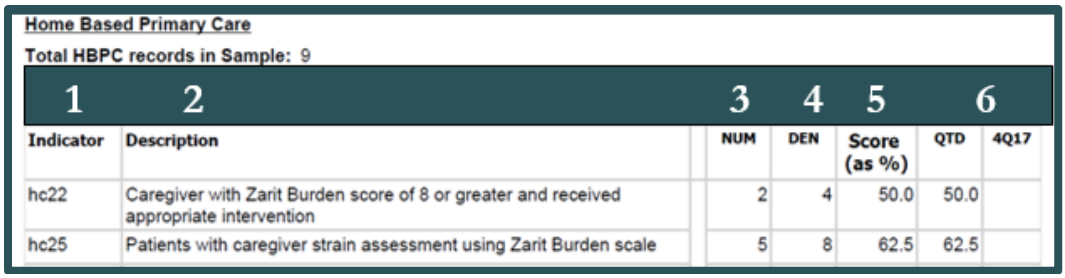
Total HBPC records in Sample: 9

1	2	3	4	5	6	
Indicator	**Description**	**NUM**	**DEN**	**Score (as %)**	**QTD**	**4Q17**
hc22	Caregiver with Zarit Burden score of 8 or greater and received appropriate intervention	2	4	50.0	50.0	
hc25	Patients with caregiver strain assessment using Zarit Burden scale	5	8	62.5	62.5	

1. Mnemonic: short name for the measure, for example, ips1a or c9h.
   - The mnemonic appears in the **Indicator** column of the Exit Report.

2. Measure description, for example
   - Nutrition/hydration assessment by registered dietician within 30 days
   - HTN and DM: BP < 140/90 age 60 – 85

3. The Numerator (NUM) is the number of cases that "pass" the measure.
   - A DAC is created for each case that is <u>not</u> included in the Numerator, indicating what element was failed.
   - For some measures it is not a good thing to be included in the Numerator, for example: HTN: BP > = 160/100 or not recorded.
   - A down arrow beside the measure description indicates a lower score is better (↓).



Home Based Primary Care

Total HBPC records in Sample: 9

1	2	3	4	5	6	
Indicator	**Description**	**NUM**	**DEN**	**Score (as %)**	**QTD**	**4Q17**
hc22	Caregiver with Zarit Burden score of 8 or greater and received appropriate intervention	2	4	50.0	50.0	
hc25	Patients with caregiver strain assessment using Zarit Burden scale	5	8	62.5	62.5	

4. The Denominator (DEN) includes all the cases that are scored for each indicator. The Denominator does not always equal the total number of records reviewed since some cases will be excluded from the Denominator by the Scoring Algorithm.

5. What is represented by the number in the Score column depends on the measure. In many cases it is simply the Numerator divided by the Denominator.

   - On the CGPI report, the scores are weighted (see Sampling Section II.5)
     - Verification of the weighted scores is possible using the Combined Measure Master Report found on Performance Measurement page.

   - In some cases, the score does not represent a numerator and denominator.
     - For example, the "score" for ed1 is the median time from ED arrival to ED departure for admitted ED patients.

6. The Exit Reports display
   a. the scores for the current Pull List (column 5)
   b. the quarter to date score
   c. the cumulative score for the previous quarter
   - These three columns can help you track progress over time as you review the report.

- Measures that appear in bold print on the report are considered Accountability measures and eligible for reconsideration.

- The Joint Commission Core Measures are italicized (bolded if used for Accountability).

- Pilot Indicators generally appear in a section separate from other quality indicators and/or are labeled as such.

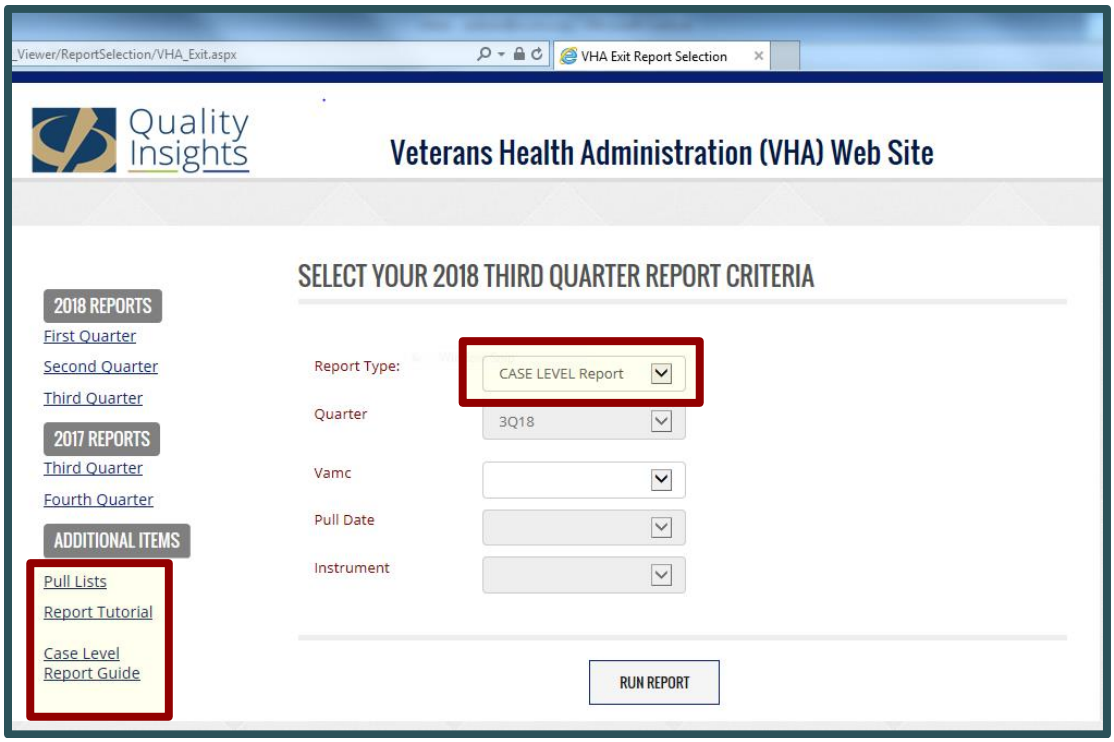
- Measure scores are generated by Scoring Algorithms (not by EPRP Abstractors).

- Links to the Scoring Algorithm are in the Performance Measurement eTechnical Manual (eTM).
  - The Scoring Algorithms are also on the Quality Insights website (no password required to access).

- An Exit Report Guide for each topic is also available on the Quality Insights website that is a "plain language" version of the Scoring Algorithms.

- The Exit Report Guide is a guide to interpreting the scoring, not a guide to abstraction.

- Case Level Reports are available on the EPRP secure website (password protected)
  - These reports essentially "drill down" through the cases included in a measure and show how each case scored and the reason for fallout, when applicable.
  - A tutorial is available on the website to guide you through the use of this feature.



Exit Conference

The EPRP Abstractor will work with the facility Liaison to set a date and time for an Exit Conference to be held at the conclusion of the monthly Pull List review. Things to consider when scheduling:

- The "Last Day to Exit" per the EPRP calendar
- Number of days for DAC review per the DAC Agreement

Deviation from scheduled review/Exit: *Occasionally, something may interfere with the planned onsite visit and/or Exit Conference such as The Joint Commission survey or Office of Inspector General (OIG) visit. It is important to notify the VHA COR/PM as quickly as possible to discuss rescheduling the Exit Conference with respect to EPRP deadlines.*

EPRP Liaisons are generally responsible for *arranging* the Exit Conference, e.g.,

- Inviting attendees
- Arranging for the meeting room

- Setting up a VANTs line or Skype call if some attendees will join remotely

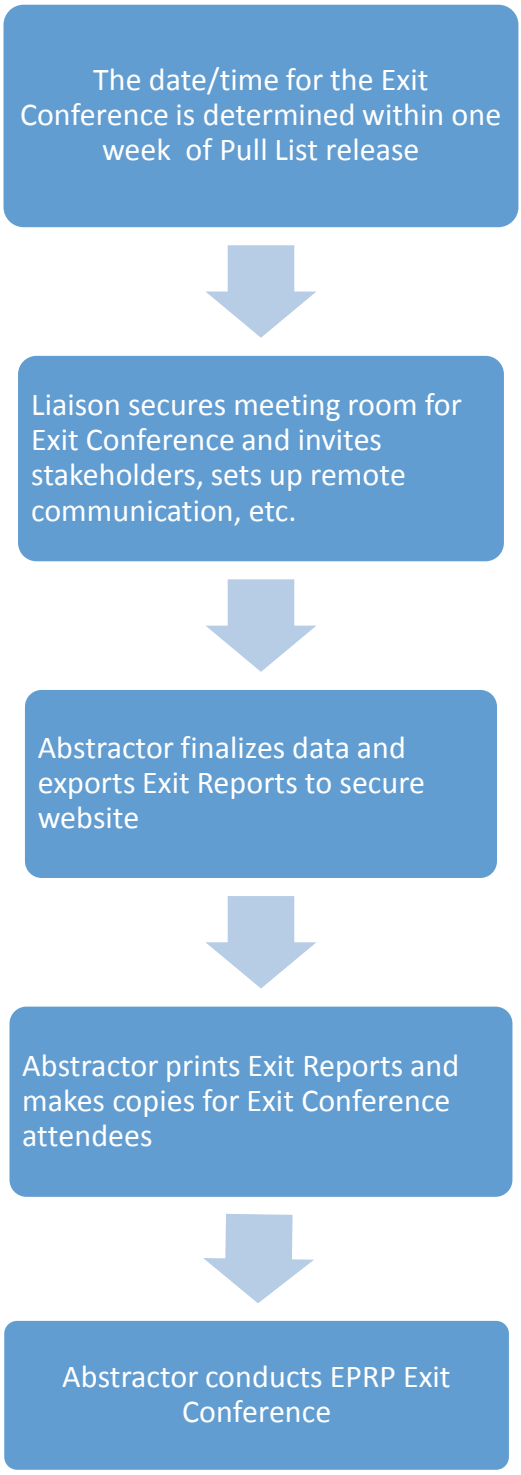
If printed copies of the Exit Reports are desired, it is the Abstractors responsibility to print the reports and make copies.

The EPRP Exit Conference should be designed to meet the facility's needs. The EPRP Liaison determines the format of the Exit Conference but the EPRP Abstractor should have some suggestions about what might be helpful and of interest. EPRP Abstractors are trained to do more than just read the numbers on the report. For example, at the first Exit Conference of each quarter, the Abstractor can provide an overview of the changes effective for the current quarter, such as:

- Changes to existing questions and rules
- New measures
- Deleted measures
- Changes to measure Scoring Algorithm
- The Abstractors can also discuss things like
  - Precisely what information the questions are seeking
  - Why the documentation doesn't meet the intent of the questions they must answer
  - How documentation could be improved to meet the intent of the questions
  - What is included in the numerator and denominator of the measures

Work with the Abstractor to be sure you get the most benefit from the Exit Conference. Once the Exit Conference has started, the Abstractor cannot make any changes to the data. If the Liaison feels a change is needed, they will need to follow the process for requesting reconsideration (see Section II.9).

THE EXIT CONFERENCE PROCESS



9

Reconsiderations

Take Aways

- Reconsideration may be requested if additional supporting documentation is found after the Exit Conference or when the facility disagrees with the data the Abstractor has entered.
- Measures eligible for reconsideration are in bold print on the Exit Reports.
- Requests for Reconsideration are sent to the EPRP COR and must be sent within two working days following the Exit Conference. The timeline becomes narrower in the last month of each quarter. (See EPRP Filed Calendar).
- If accepted for reconsideration, supporting documentation for the case is sent to Quality Insights following the process outlined above.
- Quality Insights notifies the facility Liaison of the reconsideration determination via email.

As detailed earlier in Section II: The Process, the DAC Reconciliation process allows facility personnel a chance to present documentation to the Abstractor that may have been missed or deemed inappropriate for inclusion in the data during remote review. If facility personnel and the Abstractor do not agree on whether data is appropriate for inclusion and/or the facility finds additional documentation after the Exit Conference, reconsideration may be requested. It should be noted that the Abstractor cannot change the data once the Exit Conference has started.

Process for Reconsideration of EPRP Reports and findings:

- Only Accountability measures are eligible for reconsideration and are in **bold print** on the EPRP Exit Reports.
- There are no reconsiderations of Quality Indicators or Pilot Measures.
- All initial requests must be e-mailed to the EPRP COR via Outlook (Eva.Sowinski@va.gov) **within 2 working days following the Exit Conference**.
  - This e-mail must include:
    - Name and Number of the facility requesting reconsideration
    - Indicator mnemonic and descriptor
    - Contact name and phone number
    - Pull List type and Date
    - Exit Report date in which the case was reviewed
    - Short synopsis of the issue about which reconsideration is requested

No patient specific data may be forwarded over Outlook and is not needed at this stage of reconsideration. An initial review is completed by VHA COR/PM. If it is readily apparent that reconsideration does not change the outcome or if the request is past two working days of the Exit conference, the case ***is not*** accepted for reconsideration. Notification to this effect is made via email.

Note: E-mail requests for reconsideration that contain patient specific information are not accepted. Instead, the facility is asked to resubmit the request minus the patient specific information. The e-mails are filed for tracking and trending.

If accepted for reconsideration, the facility is notified by e-mail and must then provide hardcopy of the following (via overnight and tracked delivery) to Quality Insights:

- Name of facility requesting reconsideration
- Contact name and number
- E-mail address to send updated reports, if necessary
- Pull List date under which the case was reviewed
- Exit date
- Short synopsis of the issue where reconsideration is being asked
- Copy of the Data Accountability Checklist (DAC) with the indicator and mnemonic in question
- Supporting documentation that will serve to provide Quality Insights with a full picture of the patient situations (including applicable ED notes, MD progress notes, admission H&P, discharge summary or anything else identified as required to be submitted)

  - Send to:

    Quality Insights
    Attn: Anna Sites
    3001 Chesterfield Place
    Charleston, West Virginia 25304

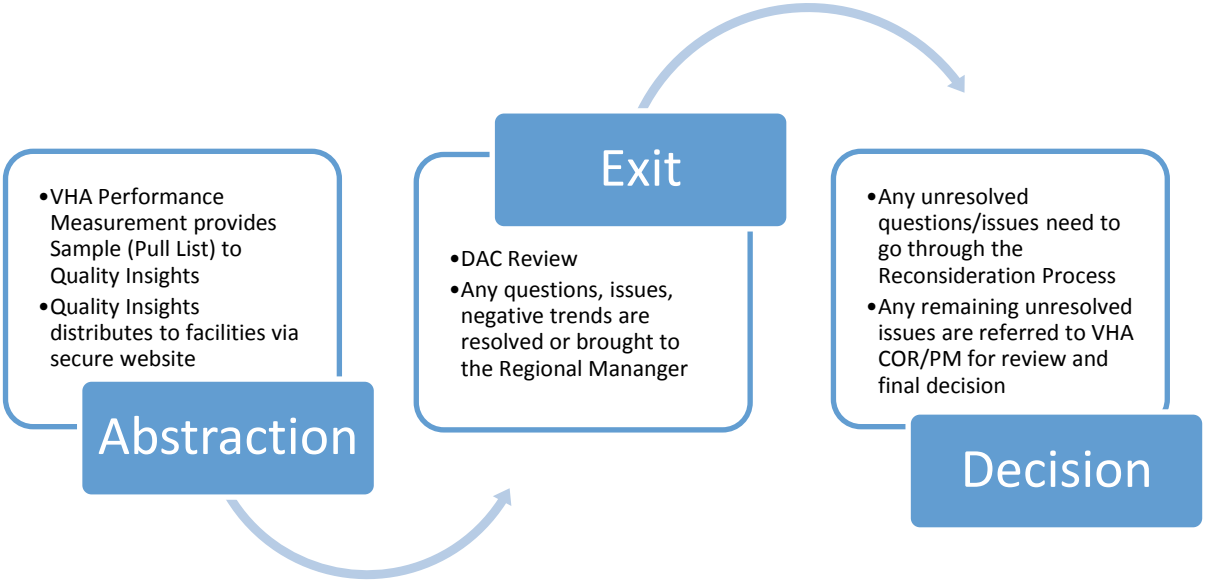
At the end of the quarter, the timeline for request for reconsideration and submission of supporting documentation becomes narrower still because of the need to "lock down" the data for the validation process**. In these months (December, March, June and September), the complete documentation as outlined above must be received by Quality Insights the day following approval.** These dates are posted on the Pull List schedule for the fiscal year.

Quality Insights reviews all accepted reconsideration cases and determines if the data provided meets the specification for compliance as outlined in the VHA Technical Manual. Quality Insights discusses any request that cannot be clearly determined with the Program Manager and a final determination is made.

When a final determination has been made, Quality Insights provides (via e-mail) the requesting facility and Program Manager with the final outcome of the reconsideration. If the outcome results in a change in the Exit Report, the e-mail also outlines that change and timeframe when an updated exit report will be provided to the facility.

If you are unable to resolve the case at the facility level with assistance from the Regional Manager, the issue is forwarded to VHA COR/PM for a final decision. Decisions are a result of discussions between the Quality Insights Field Director, VHA COR/PM and other staff as appropriate (Measure Coordinators, Program Office, TJC...). The final decision is made and communicated by VHA COR/PM.

Communication of questions/issues:



Section III: The Data

10. Reports
11. Quality Control and Improvement
12. Dates and Timelines

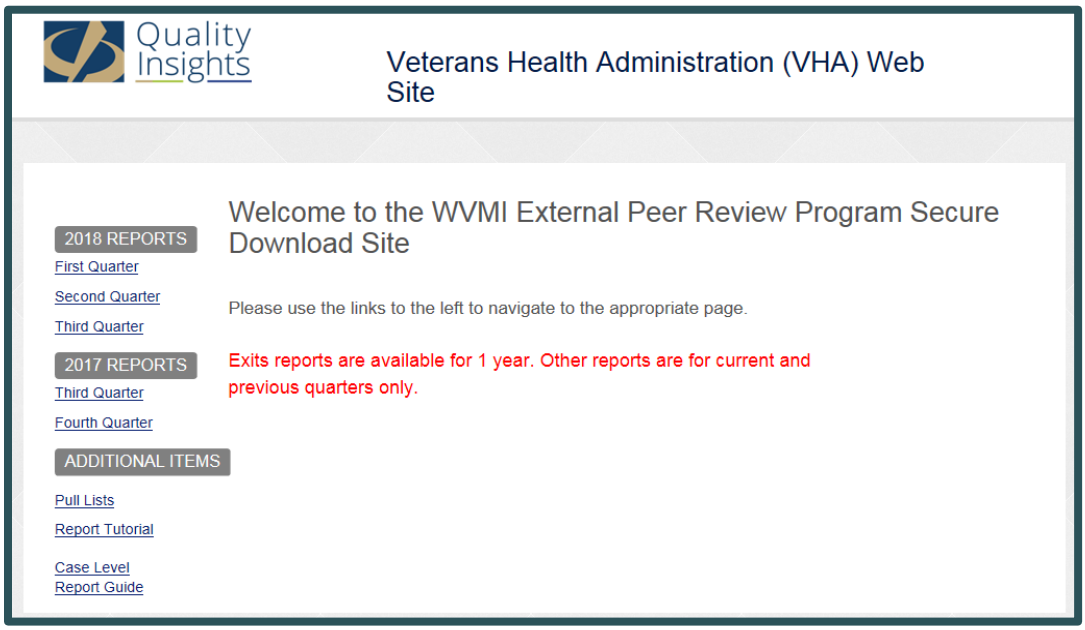
10

Reports

Take Aways

- VHA Performance Measurement creates a variety of reports available
- Reports can be accessed via the Performance Measurement Reporting page
- Reports should be reviewed closely to ensure data is accurate
- Short descriptions of each report

There are several reports that are instrumental to the success of the EPRP process and subsequent performance improvement initiatives. As noted in the preceding chapters, Quality Insights provides the DAC and Exit reports, two key reports to help ensure that patients are receiving the appropriate care based on measure specifications and resulting scores for each measure. These reports can only be accessed by the EPRP liaison (and proxies) via the secure Quality Insights website.



Once the Quality Insights Exit Conference is completed within the facility, Quality Insights transmits the facility data to Performance Measurement. This data is then reported in several reports that are described in greater detail below and on the Performance Measurement Reporting page. Some of the main reports that are refreshed daily and include preliminary results within a day or two after the Quality Insights Exit Conference include: the Combined Measure Master (CMM), the Combined Composite Report (CCR), and the Quarterly Composite Report (QCR). Data is considered preliminary until it is finalized in the quarterly reports. There are rarely any major changes and this data is available immediately for being acted upon in quality improvement efforts.

Many of the EPRP measures are considered accountability measures and are reported as part of the Strategic Analytics for Improvement and Learning (SAIL) Report. The accountability measures are also typically reported to external entities such as The Joint Commission and Centers for Medicare and Medicaid Services (CMS) (e.g., Hospital Compare) for transparency. Or are used for comparative purposes against national measure data collected by The Healthcare Effectiveness Data and Information Set (HEDIS) measures, which is a tool used by more than 90 percent of America's health plans to measure performance on important dimensions of care and service. Links to many these comparative reports and other non-EPRP measures can be found via the Access to Care website.

Ultimately, the finalized EPRP measure data is reported in the CMM, CCR and QCR as well as several reports that are only presented quarterly, for example: the Performance Measure Report (PMR), HEDIS Report, CBOC Report, and Gender Report.

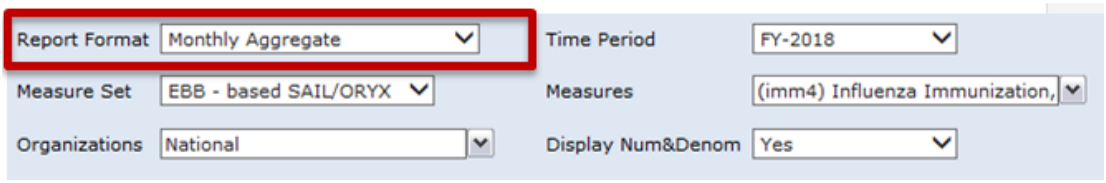
These quarterly results are usually available within the month following the end of the calendar quarter (e.g., FY 2019 CY quarter is October 2018-December 2018; therefore, the finalized results would be expected by the end of January FY 2019) (see the Dates and Timeline Section (III.12)for more details regarding when data is reported).

PERFORMANCE MEASUREMENT REPORTS

Combined Measure Master (CMM)

The CMM combines the ability to filter different functional views of Performance Measures with the ability to see the data in different time aggregations, which is especially useful for verifying Exit Conference results and estimating SAIL performance until final reports are posted. The CMM User Guide provides detailed instructions for gaining the most benefit from this tool.

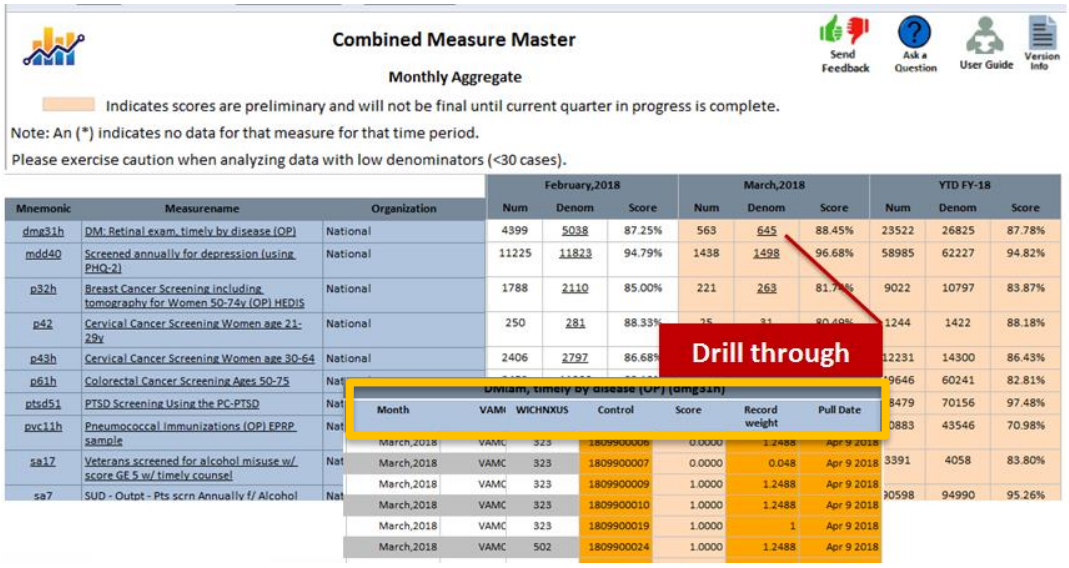
This report should be accessed at least after each Quality Insights Exit to ensure that the data has been uploaded from Quality Insights correctly. Any variances should be reported immediate to VHA EPRP COR, Eva Sowinski. Also, if DACs have been submitted for reconsideration, this report should again be monitored to ensure that any scoring corrections have been applied correctly. To view and verify data monthly, select "Monthly Aggregate" from the CMM "Report Format". After selecting appropriate Measure Set, Time Period, and Measures, select" Run Report".



Compare Exit Report results to the results here. Note. All preliminary data in this report and the CCR and QCR are highlighted in peach until finalized.

			October,2017		December,2017		
Mnemonic	Measurename	Organization	Denom	Score	Num	Denom	Score
sub10	Alcohol Use Screening	National	7137	95.45%	13601	14133	96.24%
sub20	Alcohol Use Brief Intervention Offered or	National	1203	81.63%	1784	2190	81.46%

In addition to identifying discrepancies and reconsideration revisions, the key benefit here is that this data is reported within a few days of the facility Exit Conference. This allows for immediate action to be taken for quality improvement initiatives. Additionally, all underscored denominators can be drilled to the patient level by left clicking on them. This drill through provides Control Number obtained from the Pull List/DACs and does not include PHI, thereby allowing all users to drill through. This drill through also identifies the month in which the data was reported, pass/fail Scores as 1/0 respectively, assigned Record Weights used in the outpatient samples, and the Pull List month while in the preliminary stage. Utilizing the drill through can be particularly important when trying to locate data that has a one or two month lag, and is therefore reported after the typical close of the quarter (see Dates and Timeline Section (III.12) for more details).



Another feature of the CMM, is that it also includes a "Rolling 12 Aggregate" as a CMM "Report Format" option. The benefit to this is that SAIL uses a Rolling 12 Months of data when calculating the ORYX and HEDIS Combined Composite Scores (ORYX90_1, HED90_1 and HED90_ec). Note. This example uses measures/mnemonics as of FY18; which can and change. The Combined Composite Report (CCR) and the Quarterly Composite Report (QCR)

must be viewed with caution when comparing to the SAIL data as these reports only include the relevant data for the quarter and FY to date. **They do not use a rolling 12 months like the SAIL Report does.**

Combined Composite Report (CCR)

In the CCR, you have the ability to view the HEDIS and ORYX combined composite scores included in SAIL (ORYX90_1, HED90_1 and HED90_ec) as well as view the individual composites and component measure scores. Additionally, the data from the current quarter in progress is included in order to provide the most up-to-date scoring possible.

Note. Any measure with an "_ec" suffix refers to an Electronic Clinical Quality Measure, abbreviated as eCQM or eQM within the VHA. eQMs are captured electronically and not via the current chart abstraction EPRP process. They are becoming increasingly prevalent and are beginning to be required for accreditation purposes. Additionally, eQMs are a critical element of Performance Measurement and several measures have been recently added as accountability measures in the SAIL Report. More details about eQM development, assessment, and reporting can be found via the Performance Measurement eQM Portal. More details regarding their role as accountability measures can be found within the SAIL Report data definitions document that are produced by the VHA Support Services Center (VSSC). Quarterly eQM data is also reported in the Performance Measure Report (PMR). This data is reported using FY quarters, and is finalized 30 days after the close of the quarter (e.g., Q11 FY2018 is finalized January 31, 2019).

Quarterly Composite Report (QCR)

The QCR provides the ability to view the HEDIS and ORYX composite scores included in the Combined Composites described above, as well as view the individual component measure scores. Additionally, the data from the current quarter in progress is included in order to provide the most up-to-date scoring possible. This report also includes the Medication Reconciliation Composite (mrec90), which is not included in SAIL or as part of a Combined Composite or in the CCR.

QUARTERLY REPORTS

These reports include data related to quality indicators, performance standards, monitors, and metrics as used by various national offices such as the ADUSH for Operations and Management (10N), ADUSH for Clinical Operations (10NC), the ADUSH for Administrative Operations, the Office of Finance, the ADUSH for Health for Quality, Safety and Value and for local VISNs or Networks and Medical Center leadership and Quality Management Officers.

HEDIS Report

This report contains the HEDIS-like performance measures data related to prevention, outcomes, process, and screening and is used for monitoring performance. This report provides summary data for the measures, with the drill down, or detail reports available

through a link. Of note, the VHA compares itself to some HEDIS measures annually. The Interactive HEDIS Comparison can also be found on the Performance Measurement Reporting page.

CBOC Report

The Community Based Outpatient Clinics (CBOC) Report examines outpatient quality composites and individual quality measures for Veterans receiving care in hospital/independent outpatient clinic and CBOC settings at the National, VISN, and facility level. The composites within this report are Diabetes, Ischemic Heart Disease, Prevention, Behavior Health, and Tobacco. The performance data available in this report represents finalized data for all measured types presented in a spreadsheet format.

Gender Report

This report examines outpatient clinical composites and individual measures for men and women Veterans. The composites within this report are Diabetes, Ischemic Heart Disease, Prevention, Behavioral Health, and Tobacco. Quarterly and Year To Date (YTD) cumulative results are provided at different levels of the organization (National, VISN, and facility). This report provides summary data for the measures, with the drill down, or detail reports available through a link.

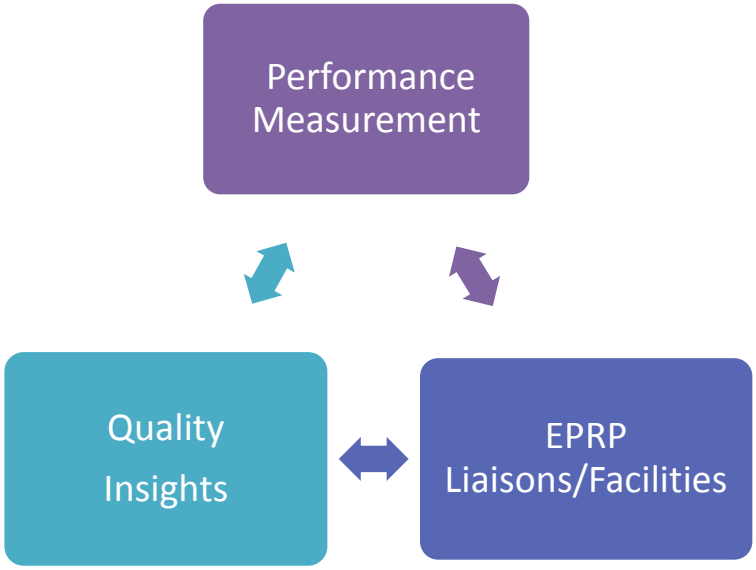
11

Quality Control and Improvement

Take Aways

- Quality Control and Improvement of EPRP requires ongoing monitoring and feedback
- Performance Measurement, Quality Insights and Facility Liaisons each have important roles in the process

As described in the preceding Sections, the EPRP process involves multiple steps and people. To maintain validity and consistency, a formal quality control process is in place. However, everyone involved in the EPRP process has an important role in providing ongoing evaluation and feedback.



The Quality Insights and Performance Measurement teams ensure the measures are developed to required Regulatory/Accrediting agencies and/or VHA Program Office specifications. Performance is assessed by Quality Insights and EPRP Liaisons via the abstraction, review, reconciliation, and reconsideration processes. At all steps of the process, data is validated in some way by Performance Measurement, Quality Insights and/or EPRP Liaisons. This occurs by ensuring that the Catnums and Cohorts are correctly represented during the sampling process with feedback regarding potential errors (or exclusions) provided by Quality Insights and EPRP

Liaisons. EPRP Liaisons validate the Quality Insights review by reconciling the Data Accountability Check Lists (DACs), Exit Report data, and submitting any discrepancies for reconsideration. Performance Measurement validates the data received by Quality Insights before posting the preliminary results daily and again prior to and after the data has been finalized for the quarterly reports. The EPRP Liaisons play a crucial role in this validation process by notifying Performance Measurement when they identify any inconsistencies in these reports. This ongoing collaboration and feedback ensures that errors are corrected, improvements in processes are implemented, and data are accurately reported.

Quality Insights also performs Interrater Reliability of the abstraction process by conducting ongoing statistical surveillance of patterns of Abstractor responses to each item of data collected and testing for deviations from historical response patterns and expected frequencies across all VHA facilities. A Statistical Process Control (SPC) technique with exact binomial probabilities is used. In the analysis, an Abstractor's response frequencies for a specific response level in the current quarter are compared with their average frequencies over prior quarters.

Any significant variation in the same item across multiple Abstractors or medical centers is considered a "common" outlier and is investigated to see if there is a systemic cause requiring correction. Performance Measurement reviews these quarterly reports with Quality Insights and implements measure revisions and training as necessary to the abstractors and EPRP Liaisons.

Quality Insights and Performance Measurement Specialists and Data Analysts meet biweekly and on an ad-hoc basis to ensure that measure specifications are adhered to, changes are communicated and implemented timely, and feedback is utilized to ultimately improve all aspects of the EPRP process. Any concerns about the process should be reported to the VHA EPRP COR/PM.

12

Dates and Timelines

Take Aways

- Important dates to remember
- Definitions of the various types of quarters and years (EPRP Quarters and Fiscal Year (FY) Quarters)
- Sample EPRP Field Calendar
- Where to find data once a quarter is closed

There are multiple timelines involved in the performance measurement process. They involve collaborative efforts between Performance Measurement, Quality Insights, Regulatory Agencies and VHA Program Offices for obtaining specifications and reporting, VISNs and Facilities, as well internal reporting. Due to the inherent complexities in developing and evaluating performance measures, all of these may impact the EPRP process. Therefore, it is especially important to understand the timeline involved in the EPRP process that occurs between the Quality Insights Abstractor and VHA facility.

The EPRP process occurs monthly and takes approximately 30 days (plus an additional two working days for the reconsideration process) to complete. As previously noted in the Sampling Section II.5, the clock starts with the Pull List and ends with the Exit Conference. The EPRP Field Calendar is posted on the Electronic Technical Manual (eTM) home page and provides an overview of the critical steps and dates each fiscal year (FY). A screenshot of FY2018 is shown below.

EPRP FY2018 Calendar

Quarter	Study Month	Pull list Date	What's Pulled **	Last day to Exit	Last day to request Reconsideration
FY18 Q1	September 2017	October 10, 2017	(Sept VTE; Aug HOP/GM/HBIPS)	November 9, 2017	November 14, 2017
	October 2017	November 6, 2017	(Oct VTE/CGPI/HBPC; Sept HOP/GM/HBIPS)	December 8, 2017	December 12, 2017
	November* 2017	December 4, 2017	(Nov VTE/CGPI/HBPC; Oct HOP/GM/HBIPS)	January 5, 2018*	January 8, 2018*
	December 2017	January 8, 2018	(Dec VTE/CGPI/HBPC; Nov HOP/GM/HBIPS)	February 9, 2018	February 13, 2018

The Study Month refers to the month that is being assessed for the outpatient Clinical Practice Guideline and Prevention Indicators (CGPI) measures and the ORYX Venous Thromboembolism (VTE) measures. The Pull List Date is the date that Performance Measurement sends Quality Insights the records to be abstracted. The "What is Pulled" column provides more details about what other records are included in that review. As you will note, there is a 2-month lag for pulling The Joint Commission Global Measures (GM), Hospital Based Inpatient Psychiatric Services (HBIPS), and Hospital Outpatient (HOP) measures. The "Last Day to Exit" is just that: Each facility must hold their Exit Conference by that date. Therefore, it is important for the EPRP Liaison and Quality Insights Abstractor to negotiate the Exit date within one week of release of the Pull List by Performance Measurement. Typically, facilities allow four days for the reconciliation/exit process to occur. When looking for supporting documentation:

- The study interval review period always begins the 1st day of the month and usually extends to the end of the month (some extenuating circumstances may cause the review period to be stopped prior to the end of the month).
- The initial point for calculation is the beginning date of the "study interval" review period as noted on the EPRP Pull List and Exit Reports. From that date, count backward the specified number of months or years (depending on the measure).

Any issues that are not resolved between the Liaison and Abstractor should be discussed with the Regional Manager before the Exit Conference. Any unresolved issues after the Exit Conference should be sent to the VHA COR/PM for reconsideration as discussed in Section II.9.

A Little About Timing

Below is a chart showing the various calendars and timelines.

EPRP FY2018 Field Calendar Chart Abstraction Process Dates, Reporting Schedule Relationship to The Joint Commission Reporting Calendar Year (CY) Quarters, Veterans Health Administration (VHA) Fiscal Year (FY) Quarters, External Peer Review Program (EPRP) Quarters

	Sep-17	Oct-17	Nov-17	Dec-17	Jan-18	Feb-18	Mar-18	Apr-18	May-18	Jun-18	Jul-18	Aug-18	Sep-18
Calendar Year (CY) Quarters[1]	…Q3CY17	Q4 CY17			Q1 CY18			Q2 CY18			Q3 CY18		
Fiscal Year (FY) Quarters[2]	…Q4 FY17	Q1 FY18			Q2 FY18			Q3 FY18			Q4 FY18		
EPRP Quarters[3]	Q1 FY18			Q2 FY18			Q3 FY18			Q4 FY18			Q1 FY19…
Abstraction and Reporting[3,5,6] Schedule													
Pull List[4] Date	10/10/2017	11/6/2017	12/4/2017	1/8/2018	2/5/2018	2/26/2018	4/9/2018	5/7/2018	5/29/2018	7/9/2018	8/6/2018	8/20/2018	10/9/2018
Month Reviewed													
CGPI[5]	N/A	Oct-17	Nov-17	Dec-17	Jan-18	Feb-18	Mar-18	Apr-18	May-18	Jun-18	Jul-18	Aug-18	N/A
HBPC[5]	N/A	Oct-17	Nov-17	Dec-17	Jan-18	Feb-18	Mar-18	Apr-18	May-18	Jun-18	Jul-18	Aug-18	N/A
The Joint Commission (ORYX Measures)													
VTE[5]	Sep-17	Oct-17	Nov-17	Dec-17	Jan-18	Feb-18	Mar-18	Apr-18	May-18	Jun-18	Jul-18	Aug-18	Sep-18
Global[5,6]	Aug-17	Sep-17	Oct-17	Nov-17	Dec-17	Jan-18	Feb-18	Mar-18	Apr-18	May-18	Jun-18	Jul-18	Aug-18
HBIPS[5,6]	Aug-17	Sep-17	Oct-17	Nov-17	Dec-17	Jan-18	Feb-18	Mar-18	Apr-18	May-18	Jun-18	Jul-18	Aug-18
HOP[5,6]	Aug-17	Sep-17	Oct-17	Nov-17	Dec-17	Jan-18	Feb-18	Mar-18	Apr-18	May-18	Jun-18	Jul-18	Aug-18

The "numbered notes" in the table are defined below:

1 The Calendar Year (CY) begins January 1 and ends December 31. Data is reported to external agencies (e.g., The Joint Commission) based on the CY quarters usually 6 months after the close of the quarter so there is sufficient time to close the quarter and process the data.

2 VHA operates on a Fiscal Year (FY), beginning on October 1 and ending September 30.

3 EPRP Quarters vary by one month from the VHA FY quarter in order to allow sufficient time for record review, data processing, and reporting. The EPRP reporting cycle differs from the fiscal year due to contracting issues.

4 The Pull List includes the sample of records to be reviewed for a given time period. The sample is determined by designated Catnums and Cohorts and Sampling processes established by measure specifications and VHA Performance Measurement. The Abstraction Process begins once the VHA Data Analyst provides the Pull List to the Quality Insights (QI) Abstractors.

5 Most measures are posted in their corresponding review month (e.g. Clinical Practice Guideline and Prevention Indicators (CGPI outpatient), Home Based Primary Care (HBPC), ORYX Venous Thromboembolism (VTE). There is no review of the CGPI or HBPC measures in September. Therefore, FYQ1 data for these measures includes the months of October and November only. Due to established sampling procedures, there is a lag of 1-2 months for when some of the ORXY samples can be pulled. This results in a variation among the months of data being reported during each FY Quarter. Performance Measurement Reports reflect the months as indicated in the table above. Performance Measurement forwards this data to VSSC for inclusion in the SAIL report so that there is reporting alignment; however, the SAIL Report includes a rolling 12 months of data, whereas Performance Measurement Reports do not.

6 Once an EPRP/FY quarter is closed, the scores are considered final and the quarter cannot be reopened to add additional data. Therefore, for the Global Measures (GM), Hospital Based Inpatient Psychiatric Services (HBIPS), and Hospital Outpatient (HOP) measures, the data will get posted in the next available "open" month. August and September data are posted in the month of September; November and December data are posted in the month of December; February and March data are posted in March; and May and June data are posted in June.

Additional Note: Although not included in the EPRP process, it should be noted that the Electronic Quality Measures (eQMs) are reported based on FY quarters and are closed out 30 days after the close of the quarter (i.e., eQM FYQ1 incudes data from October, November, and December and is finalized on January 30). Calendar reports on a FY Quarterly basis.

Section IV:
Pulling It All Together

13. How You Can Participate

13

How Can You Participate in the Process?

As you can see, this is a complex process and the team is composed of many people both within VHA and Quality Insights, and EVERYONE is part of the team. Here are some ways you can help keep the process moving smoothly and improve performance and quality:

- Provide feedback – notify appropriate staff immediately when issues arise
- Ensure you and your staff understand the resources and processes
- Be proactive - visit regulatory website regularly (TJC, NCQA)
- Identify the Abstractor and Regional Manager as first line for questions/concerns
- Use the DAC Review process to educate and reinforce measure specifications
- Use the Exit Conference to educate, look for opportunities to improve and celebrate successes
- Right people at the right point in the process
- Be mindful of timelines
- MUST have a liaison back-up and login to your Quality Insights account at least once every 3 months so your password does not expire
- Review your data monthly and use RAPID reports and resources

Appendices

Appendix A: Key Websites

VHA Internal Websites

Access and Quality in VA Healthcare
https://www.accesstocare.va.gov/

CBOC Report
http://vaww.car.rtp.med.va.gov/programs/pm/pmReportsCBOC.aspx

Combined Composite Report (CCR)
http://VHAww.rs.rtp.med.VHA.gov/Reports/Pages/Report.aspx?ItemPath=%2fEBB+Reports%2fCombinedComposite

Combined Measure Master (CMM)
http://VHAww.rs.rtp.med.VHA.gov/Reports/Pages/Report.aspx?ItemPath=/EBB+Reports/EPRPAggregate

Electronic Quality Measures: eQM Portal
https://eqm.VHA.gov/COR/

Electronic Technical Manual (ETM)
http://vaww.car.rtp.med.va.gov/programs/pm/pmETechMan.aspx

External Peer Review Program (EPRP) Field Calendar
http://VHAww.car.rtp.med.VHA.gov/programs/pm/pmETechMan.aspx

External Peer Review Program (EPRP) Resources
http://vaww.car.rtp.med.va.gov/programs/pm/pmEPRP.aspx

Gender Report
http://vaww.car.rtp.med.va.gov/programs/pm/pmGenderReporting.aspx

HEDIS (Healthcare Effectiveness Data and Information Set) Report
http://vaww.rs.rtp.med.va.gov/Reports/Pages/Report.aspx?ItemPath=%2fEBB+Reports%2fHEDIS

Performance Measurement Home
http://VHAww.car.rtp.med.VHA.gov/default.aspx

Performance Measurement PULSE
https://www.vapulse.net/community/performance-measurement/overview

Performance Measure Report (PMR)
http://reports2.vssc.med.VHA.gov/ReportServer/Pages/ReportViewer.aspx?/PMR/PerformanceMeasures/PerformanceMeasureReport&rs:Command=Render

Performance Measurement Training
http://VHAww.car.rtp.med.VHA.gov/programs/pm/pmLearning.aspx

Performance Measurement Reporting
http://vaww.car.rtp.med.va.gov/programs/pm/pmReports.aspx

Quarterly Composite Report (QCR)
http://VHAww.rs.rtp.med.VHA.gov/Reports/Pages/Report.aspx?ItemPath=%2fEBB+Reports%2fEPRPComposite)

Strategic Analytics for Improvement and Learning (SAIL) Report
https://securereports2.vssc.med.VHA.gov/ReportServer/Pages/ReportViewer.aspx?%2fMgmtReports%2fSAIL%2fSAIL&rs:Command=Render

VHA-The Joint Commission Measure Crosswalk
http://VHAww.rs.rtp.med.VHA.gov/ReportServer/Pages/ReportViewer.aspx?%2fPerformance+Reports%2fMeasure+Management%2fVHA-TJCcrosswalk&rs:Command=Render

VHA Support Services Center (VSSC)
https://vssc.med.VHA.gov/VSSCMainApp/

VHA RAPID Performance Measurement Helpdesk Link
https://VHAww.car.rtp.med.VHA.gov/hd/helpTicket.aspx?requestID=0&d1Type=2

External Websites

Centers for Medicare and Medicaid Services (CMS)
https://www.cms.gov/

CMS Hospital Compare
https://www.medicare.gov/hospitalcompare/Data/About.html

Healthcare Effectiveness Data and Information Set (HEDIS)
http://www.ncqa.org/hedis-quality-measurement/hedis-measures

National Committee for Quality Assurance (NCQA)
http://www.ncqa.org/

Quality Insights Home Page
https://eprp.wvmi.org/Home.aspx

Quality Insights EPRP Data Collection Specifications Downloads
https://secure.wvmi.org/EPRP_DBQ/

Quality Insights (EPRP Liaison Password Protected)
https://vhaeprp.wvmi.org/webregistration/login.aspx?SiteID=2

Specifications Manual for Joint Commission National Quality Measures (HBIPS)
https://www.jointcommission.org/specifications_manual_joint_commission_national_quality_core_measures.aspx

Specifications Manual for National Hospital Inpatient Quality Measures (ED, IMM, STK, SUB, TOB, and VTE)
https://www.jointcommission.org/specifications_manual_for_national_hospital_inpatient_quality_measures.aspx

The Joint Commission
https://www.jointcommission.org/

Appendix B: How to Request Access to Quality Insights VHA EPRP Secure Site

Who should have access?

Those VHA facility staff members serving in EPRP liaison positions

Each facility:
Is provided 3 access accounts
MUST have a designated Primary AND Secondary liaison

Please submit any changes, additions and /or deletions to COR/PM (Eva Sowinski)

How to get access…

1. Facility Quality Manager sends email to EPRP COR (eva.sowinski@va.gov) requesting addition/deletion of an individual

2. EPRP COR approves request and provides access request form in a return email to Quality Insights

3. Requesting individual completes and faxes request to Quality Insights

4. Quality Insights provides the EPRP COR with login information
EPRP COR sends login information to individual

REMEMBER:

- ✓ Must login to Quality Insights site at least once every 90 days
- ✓ Remember that the information on this site contains PHI
- ✓ Must notify EPRP COR if access is no longer required
- ✓ Must submit request access form within 30 days of receiving the form
- ✓ If form is not completed it will be returned until completed
- ✓ If you lose access due to inactivity you can request that your account be re-instated one (1) time per fiscal year
- ✓ Required annual VHA Training for Privacy and Information Security **(VHA10176 and 10203)** must be maintained

Appendix C: How to Stay In-Touch: Email Groups

Performance Measurement provides updates, education, and announcements in a variety of ways. The primary way is through email groups. There is a general email group that focuses on training announcements, general updates and information (VHA CO PMCC). Anyone can request to be added to that group. For information or requests to be added to the PMCC email group please contact Patricia Kearney at patricia.kearney@va.gov

There is a specific group for EPRP liaisons only (VHA CO EPRP). **Liaisons should contact Patricia Kearney at patricia.kearney@va.gov to be added or deleted to this EPRP Liaison Mailgroup.**

Appendix D: Data Accountability Checklist (DAC) Agreement

VAMC#/NAME:	**Abstractor:**
Regional Manager :	**Date :**

EPRP Liaison Name :	**Liaison Phone:**
Liaison email :	
Liaison Backup Name :	**Back Up Liaison Phone:**
Backup Liaison email:	

Exit Conference Information
Place an X in front of **one** line below to indicate how exit conferences will be conducted

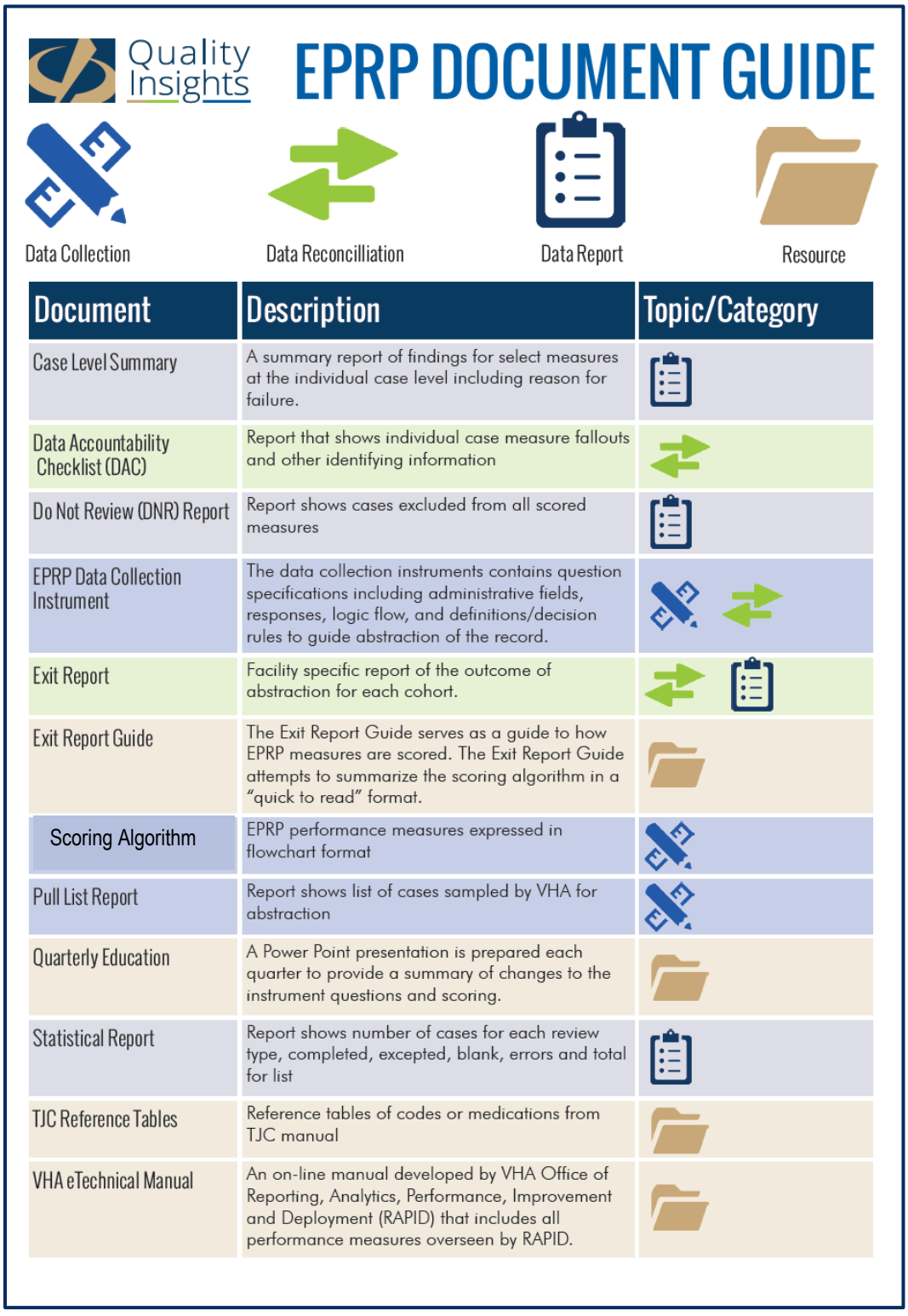
	Onsite only	**Indicate number of days onsite per visit:**

	Telephone only

	Combination onsite and telephone	**Indicate number of onsite visits per quarter:**	**Indicate number of days onsite per visit :**

TOPIC	**Number of DAC Days** Specify 2, 3 or 4 days for each applicable topic	**Topic**	**Number of DAC Days** Specify 2, 3 or 4 days for each applicable topic
CGPI		***HBPC***	
Global Measures		***Hospital OP Measures (HOP)***	
HBIPS		***VTE***	

Appendix E: EPRP Document Guide



Document	Description	Topic/Category
Case Level Summary	A summary report of findings for select measures at the individual case level including reason for failure.	
Data Accountability Checklist (DAC)	Report that shows individual case measure fallouts and other identifying information	
Do Not Review (DNR) Report	Report shows cases excluded from all scored measures	
EPRP Data Collection Instrument	The data collection instruments contains question specifications including administrative fields, responses, logic flow, and definitions/decision rules to guide abstraction of the record.	
Exit Report	Facility specific report of the outcome of abstraction for each cohort.	
Exit Report Guide	The Exit Report Guide serves as a guide to how EPRP measures are scored. The Exit Report Guide attempts to summarize the scoring algorithm in a "quick to read" format.	
Scoring Algorithm	EPRP performance measures expressed in flowchart format	
Pull List Report	Report shows list of cases sampled by VHA for abstraction	
Quarterly Education	A Power Point presentation is prepared each quarter to provide a summary of changes to the instrument questions and scoring.	
Statistical Report	Report shows number of cases for each review type, completed, excepted, blank, errors and total for list	
TJC Reference Tables	Reference tables of codes or medications from TJC manual	
VHA eTechnical Manual	An on-line manual developed by VHA Office of Reporting, Analytics, Performance, Improvement and Deployment (RAPID) that includes all performance measures overseen by RAPID.	

Appendix F: Policies

Documentation Handbook: VHA Handbook 1907.01: Health Information Management and Health Records (March 19, 2015)

1907_01_HK_2015-03
-19 Doc hdbk.pdf

The Joint Commission Accreditation Directive
http://vaww.oqsv.med.va.gov/functions/integrity/accred/jointcommission.aspx

Appendix G: Glossary

Abstractor	Independent contract for Quality Insights; collects data from official medical record that is used to score EPRP measures; presents summary of outcome of abstraction to facility leadership at Exit Conference.
Algorithm (Scoring)	Illustration of the step by step process of scoring for that measure.
Case level Summary	A summary report of findings for select measures at the individual case level including reason for failure.
Catnum	Represent the category number used to identify patient cohorts for sampling.
CBOC	Community-based Outpatient Clinic
CGPI	Clinical Guidelines and Prevention Indicators. EPRP data collection instrument for care of chronic diseases and prevention indicators in the outpatient setting.
CMS	Centers for Medicare and Medicaid Services
Cohorts	Patients grouped together by shared characteristics, for example, women or diabetic patients.
COR/PM	Contracting Officer Representative/Project Manager
Corporate Data Warehouse (CDW)	Centralized storage area for data elements used in medical records.
CPRS	Computerized Patient Record System
DAC Negotiation Form	Documents the venue for the exit conference and the number of DAC days for each topic. Completed by EPRP abstractor in collaboration with the facility liaison.
Data abstraction	Manual medical record review for data elements that meet measure specifications.
Data Accountability Checklist (DAC)	Report that shows individual case measure fallouts and other identifying information.
Do Not Review (DNR) Report	Report shows cases excluded from all scored measures.
EPRP Data Collection Questions (DSQ) / Instrument	The data collection questions instruments contain question specifications including administrative fields, responses, logic flow, and definitions/decision rules to guide abstraction of the record.
Electronic Technical Manual (eTM)	The eTM provides the most up-to-date, real-time information related to the measure specifications. It is an online catalog that allows users to filter measures by fiscal year (FY), measure status, report type and reporting site.
Exit Conference	Abstractor presents the outcome of abstraction to the facility liaison and other facility stakeholders.
Exit Report	Facility specific report of the outcome of abstraction for each cohort.
Exit Report Guide	The Exit Report Guide serves as a guide to how EPRP measures are scored. The Exit Report Guide attempts to summarize the scoring algorithm in a "quick to read" format.
External Peer Review Program (EPRP)	VHA system-wide contract that oversees and provides for the review of medical record for quality assurance/improvement.
HEDIS	Healthcare Effectiveness Data and Information Set: designed to allow consumers to compare health plan performance to other plans and to national or regional benchmarks; increasingly used to track year-to-year performance.
Joint Legacy Viewer (JLV)	Department of Defense (DoD) based computerized medical record that

	allows VHA staff to see DoD patient records.
Liaison	Individual assigned to oversee, monitor and assist with the medical record review process at the facility level.
Measure Specifications	EPRP performance measures expressed in flowchart format.
Mental Health Assistant	Clinical reminder designed to assist in screening of patients for various mental health concerns; populates a note into CPRS once completed.
Mnemonic	Short name for a measure, e.g. ips1a or c9h.
National Council on Quality Assurance (NCQA)	NCQA works to improve health care quality through the administration of evidence-based standards, measures, programs, and accreditation. Primarily drives HEDIS measures.
Pull List	List of cases compiled monthly for medical record review.
Pull List Report	Report shows list of cases sampled by VHA for abstraction
Quality Insights, Inc. (QI)	QI (formerly West Virginia Medical Institute (WVMI)) is the contractor responsible for measure specification, instrument/algorithm development, review and processing of data for VHA EPRP.
Quarterly Education	A Power Point presentation is prepared each quarter to provide a summary of changes to the instrument questions and scoring.
RAPID	Office of Reporting, Analytics, Performance, Improvement and Deployment (10A8). Performance Measurement is under RAPID. Its mission is to support clinicians, managers, and employees in improving care to veterans. Services include EPRP (External Peer Review Program) and The Joint Commission Contract Management related to Performance Measurement, measure/metric development and reporting, product development and support, etc.
Reconsideration	Reconsideration may be requested if additional supporting documentation is found after the exit conference or when the facility disagrees with the data the abstractor has entered.
Regional Manager	Quality Insights employee; provides support to abstractors and is a point of contact for facility liaison. Assures coverage of each pull list; helps resolve disagreements between abstractor and liaison.
SAIL	Strategic Analytics for Improvement and Learning Reporting
Specification	Detailed set of elements and conditions used to abstract data from medical record.
Statistical Report	Report shows number of cases for each review type, completed, excepted, blank, errors and total for list.
The Joint Commission (TJC)	TJC is regulatory agency monitoring quality of care for inpatient population.
TJC Reference Tables	Reference tables of codes or medications from TJC manual.
VHA eTechnical Manual	An on-line manual developed by VHA Office of Reporting, Analytics, Performance, Improvement and Deployment (RAPID) that includes all performance measures overseen by RAPID.
West Virginia Medical Institute (WVMI) now Quality Insights, Inc	Contractor responsible for measure specification instrument/algorithm development, review and processing of data for EPRP. Previous name