EPRP UPDATE

2Q FY2023

2Q FY2023 Changes

- The slides in this presentation will serve to provide an overview of changes to the 2Q FY2023 data collection instruments and scoring.
- Although the most important points will be covered, please be sure to review all highlighted sections in the Word documents that have been provided by email.

CGPI

The following slides will cover some of the revisions and additions made to the definition/decision rules for CGPI

CGPI – Validation Module

ADVILLNS

During the past two years, is there documentation in the medical record the patient has an advanced illness diagnosis?

- A two year timeframe has been added to this question to align with HEDIS guidelines
- The definition/decision rules have been revised to clarify diagnoses and that a code is required to answer "1", yes.

CGPI – DM Module

FOOTINSP2

- Clarification has been added to the definition/decision rules to clarify what answer to select if the patient is onsite for a CVT visit
- **Note:** If a patient is onsite at a VA clinic for a CVT visit (telehealth connection to a provider at another facility) and a provider at the onsite clinic performs and documents a visual inspection of the patient's feet, select value 3.

CGPI – MH Module

DEMSEV

Was the severity of dementia assessed during the past year using one of the following standardized tools?

1. Clinical Dementia Rating Scale (CDR)
2. Functional Assessment Staging Tool (FAST)
3. Global Deterioration Scale (GDS)

99. Severity of dementia was not assessed during the past year using one of the specified tools

- Clarification has been added to the rules
- **In order to answer "1," the documentation must clearly indicate the severity of dementia was assessed using one of the specified tools, the date the assessment was completed, and the results of the assessment.**

CGPI – PI Module

PPSVAC23

- A revision to the definition/decision rules was made to provide guidance for pneumococcal vaccines given during the period from 10/1/2012 to 12/31/2015
- If a vaccine administration note during the period from 10/01/2012 to 12/31/2015 states "pneumococcal" vaccine was given with documentation of the manufacturer and lot number and the immunization summary indicates pneumococcal polysaccharide vaccine (PPV23 or PPSV23), select value 1.

CGPI – PI Module

PNEUNSP

- Guidance was added to the rules explaining where to find the "CVX code 109" for an unspecified pneumococcal vaccination
- The CVX code may be seen in the Joint Longitudinal Viewer (JLV) immunization summary by hovering over the pneumococcal, unspecified formulation hyperlink

CGPI

- There were no changes made to the CORE, CVD, OUTPT MED REC, and SHARED modules

CGPI Scoring Changes

- There were two scoring changes in CGPI
  - Chl1 is now an Accountability Measure
    - Bolded and eligible for reconsideration
  - Dmg27 (applicable only at Cerner facilities) is now a Quality Indicator
    - Non-bolded and not eligible for reconsideration

HBPC

HBPC - INPTADM

Revision of the rules was made to clarify the type of admission that is acceptable to answer "1" or Yes to this question

Admission to an acute or non-acute inpatient facility within the 30 days following HBPC admission is acceptable

Non-acute inpatient facility includes skilled nursing facilities and rehabilitation facilities

HBPC

- Changes made to the definition/decision rules for questions DEMSEV, PPSVAC23, and PNEUNSP match those covered in the CGPI slides

HBPC

There were no scoring changes for HBPC

Global Measures

Global Measures

- Two new questions have been added which ask about cognitive impairment documented within the first day of admission
- The purpose of adding the questions is to collect information about which provider documents cognitive impairment and if a care plan was documented related to cognitive impairment
- You will get these questions if you answer tobstatus3 or auditc as "97", the patient was not screened for tobacco/alcohol use within the first day of admission because of cognitive impairment

Global Measures - COGIMP

Question #22: cogimp

Did a physician/APN/PA document cognitive impairment within the first day of admission (by end of Day 1)?

1. Yes
2. No

The day of acute care admission is defined as Day 0 and the day after admission is Day 1.

•Examples of cognitive impairment include: Altered level of consciousness (LOC), altered mental status, cognitive impairment, cognitively impaired, cognitive impairment due to acute substance use, overdose, acute intoxication, confused; dementia, intubation and patient is intubated through the end of Day 1, memory loss, mentally handicapped, obtunded, psychotic/psychosis with documented symptoms, sedation

•If there is physician/APN/PA documentation within the first day of admission (by end of Day 1) of any of the examples of cognitive impairment above, select value "1" regardless of conflicting documentation.

•If there is physician/APN/PA documentation within the first day of admission (by end of Day 1) that the patient was psychotic, symptoms of psychosis (e.g., hallucinating, non-communicative, catatonic, etc.) must also be documented for the patient to be considered cognitively impaired.

Global Measures - CAREPLAN

Question #23: careplan

Is there physician/APN/PA documentation of a plan of care related to cognitive impairment within the first day of admission (by end of Day 1)?

1. Yes
2. No

Read the assessment (impression) and plan section of the physician/APN/PA and other progress notes or consults for documentation of a plan of care related to cognitive impairment.

- For example, if the physician documents in the admission note (day of admission) "Cognitive impairment—will consult neurology for further evaluation," select value "1".
- If there is no documentation of a plan of care related to cognitive impairment within the first day of admission (by end of Day 1), select value "2".

Global Measures - ADDTXREF

- A change was made to the definition and decision rules for question, addtxref, for consistency in the rules

ADDTXREF

- Was a referral (i.e. an appointment with date and time) for addictions treatment made for the patient prior to discharge?

- **For the purposes of this data element, documentation must indicate that a referral (i.e., an appointment with date and time) was made for ongoing evidence-based addictions treatment by a physician or non-physician (such as nurse, psychologist, or counselor)**.
- Outpatient counseling may include proactive telephone counseling, group counseling and/or individual counseling.

Sepsis

SEPSIS - HYPOTNS

HYPOTNS

During the time frame from (computer to display sepresdt/seprestm - 6 hours) to (computer to display sepresdt/seprestm + 6 hours) is there documentation initial hypotension was present?

- Criteria for determining initial hypotension:
  - Two hypotensive blood pressure readings at different times within specified timeframe
    - systolic blood pressures <90, or
    - mean arterial pressures (MAP), <65 or
    - a decrease in systolic BP by >40 mm/Hg

- Clarification has been added to the rules
- **Note**: The hypotensive BP readings must be prior to the completion of the target ordered volume of crystalloid fluids.

SEPSIS - SEPSHK

- An addition has been added to the rules of unacceptable documentation
- **Do not use physician/APN/PA documentation of a severe sepsis or septic shock exam or assessment being performed.**

For example:

"Septic shock assessment completed" is not acceptable.

SEPSIS

- There are additional minor wording changes and modifications throughout the definition/decision rules to align with CMS updates

HOP

HOP - DCCODE

What was the patient's discharge disposition from the outpatient setting?

- If documentation is contradictory, use the latest documentation. Example: Nursing discharge note documentation indicates that the patient was discharged to home. A later Social Services note states "Home with Hospice." Select "2".

An update has been made to the rules for clarification

- **However, if there is documentation that further clarifies the level of care, that documentation should be used to determine the correct value to abstract, even if it is not the latest.**

HOP - CTMRITM

- The list of acceptable scans with examples in the rules has been updated
- CT Angiography (CTA) and Magnetic Resonance Angiography (MRA) of the head or brain is acceptable for abstraction.

Example:

- CTA ordered per stroke protocol. Unenhanced CT image relayed to ED physician at 13:18; CTA final report at 15:00. Head CT or MRI Scan interpretation time is 13:18.

GM, Sepsis and HOP Scoring Changes

- Hop18c was changed to an Accountability Measure
  - Bolded and eligible for reconsideration
- The GM, HOP and Sepsis changes will be effective for discharges on or after 1/01/2023
  - You will get these records with the 2/21 pull lists

Colonoscopy Follow-Up

Colonoscopy Follow-Up - COLONRPT

COLONRPT

A minor change to the question was made to include the Cerner Electronic Health Record as a possible source where the colonoscopy procedure report is found in the medical record

- If the procedure report/note is found in CPRS or Cerner EHR, enter value 3.
- If the procedure report/note is only found in VistA imaging or JLV, enter value 4.

Transitions of Care

Transitions of Care DCCOMP

DCCOMP

Clarification was added for DCCOMP6

Testing results, documentation of pending tests OR no tests pending (refer to D/D rules)

Note: Test results are not required to be in the same section of the discharge information document

CAT, CTR, Delirium Risk and Inpatient Medication Reconciliation

There are no changes to these instruments.

Thank you!

- Thank you for taking the time to review this presentation and updated database questions
- Your continued efforts to complete thorough and accurate abstraction for our customer is greatly appreciated
- Please send any questions about updates to your Regional Manager via the Q&A portal