Inpatient Quality Reporting Program

Support Contractor

Inpatient Psychiatric Facility Quality Reporting (IPFQR) Program: Influenza Vaccination Among Healthcare Personnel and IMM-2 Measures

Presentation Transcript

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Operator: This is Conference #17028637.

Mike Seckman: Hello, and welcome to the IPFQR Program Influenza Vaccination of Healthcare Personnel and the IMM-2 Measures. My name is Mike Seckman, and I'll be your virtual host for this program.

Audio for this event is being streamed over the Internet, so it will come right through your computer speakers or your headset, whichever you've got connected. No telephone is required to listen to this.

One thing we do want to make you aware of is that we don't have the ability to unmute lines for the attendees, so please don't use the raise hand option. We do want you to be able to communicate with

us, so down on the lower left-hand corner of your screen is a chat panel; enter your comment or the question you may have there. Make sure you address it to all panelists so everybody has a chance to answer your question and then click send.

Having said that, I'm going to turn the presentation over to our host today, Reneé Parks. Reneé, the floor is yours.

Reneé Parks: Thank you, Mike. Hello, and welcome everyone. Thank you again for joining us today.

As Mike said, my name is Reneé Parks, and I am the Program Lead for the IPF Quality Reporting Program. I will be your moderator today. I would like to take a moment to let everyone know that we have in attendance with us from CMS the IPFQR Program Lead, Dr. Jeff Buck as well as our IPF Program Technical Advisor, Rebecca Kliman.

Before we begin to dive in to today's presentation, I would like to cover a few housekeeping items. As many of you know, the slides for this presentation were posted to the *Quality Reporting Center* website prior to the event. The session is being recorded, and the slides, transcript, and webinar recording along with the questions and answers from this presentation will be posted on the *Quality Reporting Center* and *QualityNet* websites at a later date.

Today's webinar will consist of two parts. The first part will be a presentation on the Influenza Vaccination Among Healthcare Personnel Measure and the second will cover the IMM-2 Measure and best practices.

Our speakers for the Influenza Vaccination Among Healthcare Personnel Measure are Amy Webb and Elizabeth Kalayil from the CDC. Amy Webb is a public health analyst within the surveillance branch of the Division of Healthcare Quality Promotion at CDC. She is currently one of the subject matter experts for the National

Healthcare Safety Network working with facilities to support the submission of mandated and voluntary reported data into NHSN.

Elizabeth Kalayil is a public health analyst with Carter Consulting Incorporated and is based in the Immunization Services Division at CDC. She provides training and technical assistance to healthcare facilities on reporting healthcare personnel influenza vaccination. Elizabeth earned a Masters of Public Health Degree in International Health from Emory University.

And now it is my pleasure to turn the floor over to Amy and Elizabeth. Amy, the floor is yours.

Amy Webb: Thanks, Reneé. My name is Amy Webb, and I work as a contractor for the Division of Healthcare Quality Promotion at CDC. I will be presenting information during the first part of the webinar.

Today, we will talk about the Healthcare Personnel or HCP Influenza Vaccination Summary Measure. The measure is designed to ensure that HCP vaccination reported coverage is both consistent over time within a single healthcare facility and comparable across facilities. Facilities staff members can use the influenza vaccination summary measure to monitor influenza vaccination percentages among HCP.

The first objective of this presentation is to go over the steps of how to get started in the healthcare personnel safety, or HPS, component within NHSN. We will then go through the reporting requirements for the module. This is a list of the acronyms that will be referenced in the presentation.

There are two modules within the NHSN HPS component: the HCP Exposure Module and the HCP Vaccination Module. The influenza vaccination summary is located within the HCP Vaccination Module. For facilities to participate in the HPS component, they must either enroll in NHSN or add the inpatient psychiatric facility or

IPF unit as a location within the affiliated NHSN acute care or critical access hospital and activate the HPS component.

Many acute care and critical access hospitals will already be enrolled in NHSN due to other reporting program requirements with the inpatient quality reporting. Free-standing IPFs that are not subject to any other quality reporting program must enroll in NHSN if they wish to participate in the HCP Influenza Vaccination Reporting.

If you are unsure of your facility's status within NHSN, please email nhsn@cdc.gov for more information. Please follow the link on this slide for more information on enrollment.

During the enrollment process, facilities may choose to participate in any of the NHSN components. If you are an IPF unit, you will need to make sure that your IPF unit has been added as a location within the affiliated NHSN acute care or critical access hospital.

The HCP Influenza Vaccination Data will be recorded as a unit within the affiliated acute care or critical access hospital. If a facility is already enrolled in NHSN and wishes to participate in the HPS component, the facility must activate the component within NHSN.

For IPF units residing within an acute care or critical access hospital, the HPS component will likely already be activated as your affiliated acute care or critical access hospital has been reporting HCP Influenza Vaccination Data for the CMS Acute Care Facility Reporting Program.

If your facility is not enrolled in NHSN, you must designate an individual to be your NHSN facility administrator and then complete the five-step enrollment process. If your facility is already enrolled in NHSN, you must get in contact with your NHSN facility administrator and ask him or her to activate the HPS component. If you are unsure of your facility's status within NHSN, please email nhsn@cdc.gov for more information.

Free-standing IPFs must complete a five-step NHSN enrollment process. First, they must read the NHSN Facility Administrator Guide. The next step is to register by agreeing to the NHSN Rules of Behavior and then registering your facility using your CMS Certification Number or CCN.

The third step involves registering with the Secure Access Management Services or SAMS after reviewing and accepting the SAMS Rules of Behavior and submitting identity proofing documentation. We will further discuss SAMS a little bit later in the presentation.

After receiving your SAMS Card, facilities will need to login to SAMS, select NHSN Enrollment, and submit the enrollment information. This last step involves signing the consent form and sending it back to CDC. More details about the process can be found using the link on this slide.

The entire enrollment process takes an average of 30 to 60 days. The majority of that time is spent waiting for the SAMS group to process your identity proofing information during Step 3. This process sometimes takes longer when a large number of individuals are going to the SAMS processing at the same time. Therefore, we recommend that you allow for adequate time to complete the NHSN Enrollment Process prior to entering your healthcare personnel influenza vaccination data into NHSN.

As a reminder, HCP data must be submitted for the IPFQR Program by May 15, 2016. If a facility is already enrolled in NHSN, they must make sure to activate the HPS component. To activate the HPS component, the facility administrator logs in to the Secure Access Management Services System or SAMS. Please note that only the NHSN facility administrator can activate a new component.

Next, click on NHSN Reporting from the SAMS login page. From the Home Page, the facility administrator will select Add/Edit

Component under the Facility tab. Next, the facility administrator will check the HPS component box.

The facility administrator can then add the name, phone, email, and address for this person so that he or she can be reached if CDC and NHSN have updates or questions about the HPS component.

After the facility has been enrolled in NHSN, the NHSN facility administrator can add additional users. Upon being added as a user, choosing NHSN facility, all new users in NHSN will receive an e-mail with the details to register with the Secure Access Management Services System or SAMS.

After receiving an invitation to register, individuals need to complete and submit identity verification documents to CDC. You will receive confirmation once these documents are approved, and a SAMS Grid Card will be delivered to your home address. You will then be able to access NHSN using your SAMS credentials.

You can find information about the SAMS process using the link on this slide. And now, I will turn the presentation over to my colleague, Elizabeth Kalayil.

Elizabeth Kalayil: Thank you, Amy. My name is Elizabeth Kalayil, and I work as a contractor in the Immunization Services Division.

Now, we will review the specific reporting requirements for the HCP Influenza Vaccination Summary. The denominator includes payroll employees who are defined as all persons receiving a direct paycheck from the healthcare facility regardless of clinical responsibility or patient contact. Please note that all HCP included in the denominator must physically work in the IPF for one day or more from October 1 through March 31.

The second denominator category consists of non-employee licensed independent practitioners, specifically physicians, advanced practice nurses, and physician assistants who are

affiliated with the healthcare facility but are not on the facility's payroll regardless of clinical responsibility or patient contact. This category also includes post-residency fellows.

The third required denominator category consists of non-employee adult students, trainees, and volunteers who are aged 18 and over. This is defined as medical, nursing, or other health professional students, interns, medical residents, or volunteers aged 18 or older who are affiliated with the healthcare facility but are not on the facility's payroll regardless of clinical responsibility or patient contact.

The fourth denominator category consists of non-employee contract personnel. Reporting for this category is optional at this time. Contract personnel are defined as persons providing care, treatment, or services at the facility through a contract and who do not fall into any of the other denominator categories. Some examples include dialysis technicians, occupational therapists, admitting staff, and pharmacists.

Please refer to Appendix A of the HCP Influenza Vaccination Summary Protocol for a suggested list of contract personnel.

The numerator includes healthcare personnel who received an influenza vaccination during the time from when the vaccine became available, for example August or September through March 31 of the following year. Please keep in mind that the reporting timeframe for the denominator, the number of healthcare personnel working in the facility, is from October 1 through March 31. The reason that the numerator and denominator cover different time periods is to account for potential delays in vaccine availability.

There are five numerator fields in the NHSN Module, and these are mutually exclusive. The first numerator category is healthcare personnel who received an influenza vaccination either at this healthcare facility or elsewhere. Please note that these are two separate fields in the NHSN Module.

The first field includes healthcare personnel who received an influenza vaccination at this healthcare facility since influenza vaccine became available this season. The second field includes healthcare personnel who are vaccinated outside this healthcare facility since influenza vaccine became available this season and provided a written report or documentation of influenza vaccination.

Acceptable forms of documentation include the signed statement or form; an electronic form or email from the healthcare worker; or a note, receipt, or vaccination card from the outside vaccinating entity. Verbal statements are not acceptable for this module.

The second numerator category is healthcare personnel who have medical contraindication to the influenza vaccine. For this measure, for inactivated influenza vaccine, accepted contraindications include a severe allergic reaction after a previous vaccine dose or to a vaccine component including egg protein or a history of GBS within six weeks after a previous influenza vaccination.

Healthcare personnel who have a medical contraindication to live attenuated influenza vaccine other than a severe allergic reaction to a vaccine component or history of GBS within six weeks after previous influenza vaccination should be offered inactivated influenza vaccine by their facility if it's available. Therefore, the medical contraindications stated above are the only accepted contraindications for this module.

Documentation is not required for reporting the medical contraindication, and verbal statements are acceptable.

The third numerator category is healthcare personnel who are offered and declined to receive the influenza vaccine. Documentation is not required for reporting declinations.

The fourth numerator category is healthcare personnel with unknown vaccination status or they did not meet any of the criteria for the other numerator categories.

If you have any questions about NHSN, please send an email to user support at nhsn@cdc.gov. You should also include HPS Flu Summary in the subject line of the email and specify IPF as this will help us to better assist you.

Please note that training materials will be posted on the NHSN website later this year and CDC will also be delivering more comprehensive training webinars for IPF later in the year. This concludes the slide presentation for the webinar.

Reneé Parks: Now we will have time for a few of the questions that have come in during the presentation, and so I'd like to thank Amy and Elizabeth for the presentation and make this conversational so that we can allow you to highlight some of the information from the selected questions that have come in during the presentation.

One of the questions that we have received is, why is the word Summary included in the Healthcare Provider Influenza Vaccination Measure and is this the same as the CMS Measure?

Elizabeth Kalayil: Yes, this refers to the same measure. Summary data referred to the data that are captured throughout the entire influenza season, so NHSN uses the name Healthcare Personnel Influenza Vaccination Summary Measure in all of its trainee documents.

Reneé Parks: Great. Thank you, Elizabeth. And now for the next, another question that we received is, why are only free-standing IPFs addressed in the activation and enrollment decision tree on Slide 9?

Amy Webb: Sure, the decision tree refers to only free-standing IPFs on Slide 9 because IPF units do not need to enroll nor activate the HPS component unless their affiliated acute care hospitals or critical access hospital is not already enrolled in NHSN. So IPF units can simply be added as a location within the already enrolled NHSN acute care or critical access hospitals.

Once the IPF unit is added as a location within the NHSN acute care and critical access hospital, the IPF unit's specific CCN can be associated with the location so that all HCP influenza vaccination data that are entered into NHSN for the IPF can be sent to CMS appropriately. More information about how to map an IPF unit and add an IPF unit's specific CCN can be found at a link provided at the end of today's slide deck.

Reneé Parks: Thanks, Amy, and I think this one is yours as well. It's when completing and submitting identity proofing documentation, what are the actual requirements for that?

Amy Webb: The users will submit identity proofing documentation as part of the SAMS process. So this includes an identity verification form and supporting documents such as a photocopy of your driver's license or a passport. More information about the SAMS process can be found at a link provided at the end of today's slide deck.

Reneé Parks: Thank you, Amy. And now we have several questions regarding why is the reporting period for the denominator different from that of the numerator?

Elizabeth Kalayil: Yes, the numerator includes healthcare personnel who received an influenza vaccination during the time for when the vaccine became available, for example August through September through March 31 of the following year. Please keep in mind that the reporting timeframe for the denominator, which is the number of healthcare personnel working in a facility, is from October 1 through March 31. So the reason the numerator and denominator cover different time periods is to account for potential delays in vaccine availability.

Reneé Parks: Great and another question that kind of ties into that for the data entry is do I need to report data each month?

Elizabeth Kalayil: Well healthcare personnel influenza vaccination summary reporting in NHSN consists of a single data entry screen per influenza season. So this can be entered at any time during the influenza

season, which is defined by NHSN as July 1 to June 30; therefore, monthly reporting in NHSN is not required.

So entering a single influenza vaccination summary report at the end of the reporting period for the influenza season will meet the data requirements for NHSN participation.

Reneé Parks: Thank you; that's very good information to know, and then something very similar, a question is which month and year should I select on the monthly reporting plan for the HCP Vaccination Module?

Elizabeth Kalayil: Facilities and units can select any month within the current influenza season, so it's fine if they enter a single summary data report for one month, for example, March 2016.

Unlike the other NHSN components and modules, when the influenza vaccination summary is selected on one reporting plan, the information is automatically updated on all the other reporting plans for the entire influenza season. So adding other reporting plan after that initial plan has been added for the flu season is not necessary.

Reneé Parks: Great, thank you. And we have several questions, and they varied, but they all are around the types of healthcare providers and whether they are counted or not. So, the first one is should I count healthcare providers who are not working with patients but because of staff meetings and other types of meetings in the facility are physically in the facility but do not have direct patient care?

Elizabeth Kalayil: You should count healthcare personnel who physically work in the facility and who perform any work duty in the facility for at least one day from October 1 to March 31 and who meet protocol definitions and that's regardless of clinical responsibility or patient contact.

So for example, you should count a healthcare worker who has official responsibilities in the facility for at least one day from

October 1 through March 31, such as attending regularly scheduled meetings. However, you would not need to count healthcare personnel who are not officially in the facility for their work duties; for example, if they're only coming in to the facility to have lunch.

Reneé Parks: Great information. Thank you. And then next is similar, should I count an employee who starts working at my facility after October 1 or perhaps leaves his/her physician after October the 1?

Elizabeth Kalayil: Yes, all employees or non-employee licensed independent practitioners and all non-employee students and volunteers who are 18 and older, specifically work at the facilities for at least one day or more from October 1 through March 31, regardless of the exact stop and start dates, should be counted.

Reneé Parks: Great. Should a healthcare worker who was vaccinated at his or her doctor's office, say in August, should they be included in the count?

Elizabeth Kalayil: Yes, this healthcare worker should be counted in the numerator since the influenza vaccine for a given influenza season may be available as early as July or August. A stricter reporting period for the measure, which is October 1 through March 31, applies to the denominator.

So, this healthcare worker would be required to provide documentation of influenza vaccination and would be counted in the vaccinated outside of the healthcare facility category. But if the healthcare worker did not provide acceptable documentation as described, he or she would be counted as unknown.

Reneé Parks: Great, thank you, Elizabeth. And we have time for one more question and then we will resume the presentation for the IMM-2. And if you have not had an opportunity for your question to be addressed, please continue to submit those through the Chat feature and we will get to those as the questions and answers will

be reported and answered and submitted for your viewing on the website at a later date.

So, the next and last question before we get into the IMM-2 presentation is, a healthcare worker was granted a religious or personal belief exception to receiving the influenza vaccination according to her hospital's policy. How would I categorize this healthcare worker?

Elizabeth Kalayil: So, a healthcare worker who declines to receive vaccination for any reason other than the two specified medical contraindications for healthcare personnel influenza vaccination reporting, should be categorized as "declined to receive the influenza vaccine."

Reneé Parks: Great, thank you. I want to thank Amy and Elizabeth for presenting on the influenza vaccination coverage among healthcare personnel.

And now for the second half of the presentation for IMM-2 Measure and best practices. Our next presenter is Evette Robinson. Evette is the Program Coordinator for the IPFQR Program at HSAG. She has nearly 15 years of cross-functional experience in the healthcare industry ranging from biomedical and clinical research to strategic planning and revenue cycle management, consulting for a variety of healthcare providers.

Evette earned a Master of Public Health degree in Health Management and Policy from Emory University. And now it is my pleasure to turn the floor over to Evette for this last portion of this webinar.

Evette Robinson: Thank you, Reneé. I would also like to extend an additional thank you to Amy and Elizabeth for presenting information about the influenza immunization among healthcare personnel and the NHSN. That was very informative information for us all.

Before I dive into the IMM-2 Measure, I would like to review some of the upcoming webinars for the IPFQR Program. Next month on

the 21st, we will review the proposed rule. Then on June 18, we will discuss the non-measure data and structural measures, and finally on July 16, we will discuss the data reporting and submission review.

This slide includes a list of acronyms that will be referenced throughout this presentation.

The IMM-2 Measure is a prevention measure that captures acute care hospitalized inpatients, age 6 months and older, who were screened for seasonal influenza immunization status and were vaccinated prior to discharge if indicated. This is a global measure designed to increase the screening for seasonal influenza immunization status and vaccination of patients hospitalized in an acute care setting prior to discharge.

At the conclusion of this webinar, we hope that the attendees will understand the IMM-2 immunization measure's components, mainly the included and excluded population, primary data elements, notes for abstraction, and the fiscal year 2017 reporting time frame as well as population and sampling guidelines. In addition, we hope that attendees will glean some insight into strategies to increase vaccination rate among IPF patients.

This slide highlights some of the statistics pertaining to influenza rates in the United States. During the 1990 through 1999 flu seasons, approximately 226,000 people in the United States were hospitalized with complications from influenza. And between 3,000 and 49,000 died from the disease and its complications.

Combined with pneumonia, influenza is the nation's eighth leading cause of death, and up to two-thirds of all deaths attributable to pneumonia and influenza occur in the population of patients who have been hospitalized during flu season, regardless of age. Influenza vaccination is the most effective method for preventing influenza virus infection and its potentially severe complications.

Vaccination is associated with reductions in influenza among all age groups. So screening and vaccination of inpatients is recommended. But hospitalization is found to be an underutilized opportunity to provide vaccination to persons 6 months of age or older.

In a morbidity and mortality weekly report published in December of 2014, the CDC estimated that influenza vaccination presented approximately 7.2 million illnesses, 3.1 million medically-attended illnesses, 90,000 hospitalizations associated with influenza, and 16.9 percent overall of adverse health outcomes associated with influenza during the 2013 through 2014 flu season.

And specifically those estimates pertain to that time period from October 1, 2013 through the end of May 2014. It's notable that between the studies referenced here and in the prior slide, there has been a shift in focus from the number of hospitalizations and death caused by the flu to the number of illnesses and hospitalizations prevented by the influenza vaccination. This reflects increased focus on prevention measures in public health and the aim to identify opportunities to continuously improve upon the immunization rates of patients prior to discharge.

As with many of the measures in the IPFQR Program, IMM-2 is a chart-abstracted measure. The numerator is comprised of all inpatient discharges who were screened for influenza vaccine status and were vaccinated prior to discharge, if indicated. The denominator consists of all acute care hospitalized inpatients, age 6 months and older, discharged during the months of October, November, December, January, February, or March of the given flu season.

In the next couple of slides, I will describe the included populations for the numerator and denominator followed by the respective excluded populations.

The IMM-2 Measure numerator includes five groups of patients: patients who received the influenza vaccine during the inpatient hospitalization; patients who have an ICD-9 principal procedure code or other procedure codes from Table 12.9 for prophylactic vaccination against influenza during the inpatient hospitalization; patients who received the influenza vaccine during the current year's flu season but prior to the current hospitalization in question; patients who were offered and declined the influenza vaccine; and finally, patients who have an allergy or sensitivity to the influenza vaccine, anaphylactic latex allergy, or anaphylactic allergy to eggs, or for whom the vaccine is not likely to be effective because of bone marrow transplant within the past six months, or history of Guillain-Barré syndrome within six weeks after a previous influenza vaccination. The denominator of the measure includes all inpatient discharges for patients 6 months of age and older.

There are no excluded populations for the numerator; however, there are seven exclusions applicable to the denominator [including the following]: patients who are less than 6 months of age; patients who expire prior to hospital discharge; patients with an organ transplant during the current hospitalization, again referencing Appendix A, Table 12.10 of the Specs Manual version 4.4a; patients for whom vaccination was indicated but supply had not been received by the hospital due to problems with vaccine production or distribution; patients who have a length of stay greater than 120 days; patients who are transferred or discharged to another acute care hospital; and finally, patients who leave against medical advice.

There are six primary data elements for the IMM-2 Measure, four of which are listed on this slide. The first is influenza vaccine was given during this hospitalization. Number two is that influenza vaccine was received prior to admission during the current flu season and not during the current hospitalization. It is important to document accurately of course for all these measures but particularly for allowable value two, documentation should include

when and where the patient received the prior vaccination. And it may be helpful to enlist the help of family or close friends in gathering these historical data.

For allowable value three, it pertains to documentation of patient's or caregiver's refusal of influenza vaccine. Number four, there was documentation of an allergy or sensitivity to influenza vaccine, anaphylactic latex allergy, or anaphylactic allergy to eggs, or the vaccine is not likely to be effective because of bone marrow transplant within the past six months, or a history of Guillain-Barré syndrome within six weeks after a previous influenza vaccination. For allowable value four, it is important to distinguish between an anaphylactic allergy to eggs versus mild allergy to eggs. A mild allergy to eggs would not qualify for value four, whereas an anaphylactic allergy to eggs would.

The remaining two primary data elements include five, none of the above/not documented or unable to determine from medical record documentation. And number six, only select this allowable value if there is documentation that the vaccine has been ordered but has not been made available by the hospital due to problems with vaccine production or distribution and allowable values one through five are not selected.

Listed here are some notes for abstraction with respect to the collection of data. The retrospective data sources for required data elements will include the administrative data as well medical record documents. Some hospitals may prefer to gather data concurrently by identifying patients in the population of interest. And this approach can provide opportunities for improvement at the point of care, the point of service. Complete documentation should include the principal or other ICD-9 diagnosis and procedure codes, which require retrospective data entry.

For fiscal year 2017, the IMM-2 Measure reporting period for the IPFQR Program will begin in the fourth quarter of 2015 and end

with the first quarter of 2016, specifically October 1 of this year through March 31 of next year. The data submission for these data is the same as with many of the other IPFQR Program measures, which would be July 1 through August 15 of 2016.

This table outlines the monthly and quarter samples sizes that are allowed for this measure. Please note that if there are five or less patients in a quarter, then a facility may submit the actual values or zero during the submission period.

In the next several slides, we will review some best practices that may assist in the design and implementation of processes and protocols that can enable IPFs to meet the IMM-2 Measure requirements.

This is an adaptation of the U.S. Public Health Services “5 As,” which are Ask, Advise, Assess, Assist, and Arrange, used in tobacco intervention. For the purposes of IMM-2, we reference this to draw parallels in protocol and practice across measures, and we have adapted it to “4 As,” the first being to Ask, record the immunization status in an electronic health record as a vital sign as applicable. Number two is Advise. You can advise the patient to obtain vaccination, ideally personalizing it to the patient specific circumstances. The third A is Assess the patient’s motivation to obtain the vaccination; for example, by asking, “Would you like to receive the influenza vaccine at this time?” And then the fourth A is Assist. The “5 Rs” would apply for those who actually want to receive the influenza vaccination. We want to make sure that is the Right person, the Right medication, Right route, the Right dose, and Right time are implemented in administering the vaccine. This is of course to prevent any medication errors. But for those who do not wish to receive the influenza vaccination, then motivational interviewing may be used to assist them at this time.

Some of the keys to integration of a new or updated protocol or processes pertaining to the IMM-2 Measure may include cultivating

a champion or someone who would be the driver, encouraging others to adopt process changes conducive to meeting the measure requirements. An IPF may also choose to establish an implementation committee or something along those lines, which could be integral to ensuring that protocols are in place and that process flows are conducive to increasing the rate of screening for influenza immunization of patients prior to discharge.

There is also an opportunity to define a specific preparation period, including building the case for increasing the influenza immunization rates prior to discharge, as well as providing training and support before and throughout the process to clinical staff who are involved.

To further clarify some of these keys to integration, we conducted a literature review and identified a couple of studies that demonstrated the importance of some of these best practices. Please note that presentation of the following examples is not an endorsement of any particular facilities and while the following examples are not specifically with inpatient psychiatric facilities, we do hope that this portion of the presentation provides an opportunity for best practice information based on literature findings to be helpful to those efforts in IPFs to implement protocols and processes that support meeting the IMM-2 Measure requirement.

Now you may notice in your handout, that this slide and the next slide are switched, and we apologize for that error. However, in the handout, this is slide number 42 and provides a broad overview of first case study that we will review. Stroger Hospital, formerly known as Cook County Hospital, is a public urban teaching hospital in Chicago that provides primary, specialty, and tertiary healthcare services to approximately 5 million residents of Cook County, Illinois.

A multi-year study of the use of clinical decision support, or CDS, to increase influenza vaccination was published in a journal of the

American Medical Informatics Association in 2008. The journal article can be found at the web page listed at the bottom of this and the next two slides.

At Stroger Hospital, a CDS-based intervention was developed to increase influenza vaccination of hospital patients. The study evaluated the use of the CDS-based intervention during the maturation of its electronic medical record and included a pre-selected order of influenza vaccine administration for all patients prior to discharge.

Some of the key to successful implementation of CDS at Stroger Hospital included: workflow integration; healthcare worker-system interaction, meaning the interaction between healthcare workers and the clinical decision support system that was created including the integration of the electronic system of physician order entry; an understanding of and accounting for the local culture with respect to implementing new processes; and the transition of most processes to the electronic system.

Also listed here are a couple of the key findings that were described in this journal article. For example, by year 3, more than half of the patients not vaccinated before hospitalization were vaccinated during their hospital stay. And after integration of the electronic medication administration record, there was a dramatic increase in nurses' administration of the vaccine.

There were several interventions implemented in this study, including: educational sessions for the nursing staff; an institutional – an institutionalized standing orders policy; clinical decision support process, which included a pre-selected order triggered by the discharge patient order; and updates to the information system capacity, which included, for nurses, medication orders that populated the electronic medical administration record or e-MAR and for physicians, the computerized physician order entry was made available for medications, including vaccinations.

The next example we'd like to describe here is with Maine Medical Center, which is Maine's premier referral hospital and a community hospital for greater Portland. Maine Medical Center was rated the fourth safest hospital in the United States, and the nursing staff was recently rated in the top six percent in the world for nursing excellence. From September 2004 through June 2006, a protocol for influenza vaccination was established in the inpatient setting, and it affected a major cultural change facilitated by institutional leadership.

Some of the keys to the success of the inpatient immunization program at Maine Medical Center included: generating organizational buy-in from the top down; partnering between the project team and providers, nurses, and pharmacists; appointing a project manager to facilitate progress and nursing and physician champions to generate the passion for the topic with peers; and allowing ample pre-implementation planning to address regulatory and compliance issues. A link to this article is found at the bottom of this slide, and this article does include a full list of the changes made and lessons learned over the course of this program.

An additional helpful link to various academic resources can be found here on this slide. And this slide includes resources pertinent to both the IMM-2 and the influenza among healthcare personnel measures.

And at this time, we'd like to open the floor for questions.

Reneé Parks: Thank you, Evette. That was very informative and great information. Hopefully, everyone was able to take away some pearls. And not too many questions pertaining to IMM-2 as most of the questions coming in were from the healthcare provider influenza vaccination coverage. But the one question that we did have was, is there any clinical guidance, or are there any tools available, to gauge the number of vaccinations that would need to be ordered by an IPF in preparation for the upcoming flu season?

Evette Robinson: Well, at this time, there is not a calculator or tool available to estimate those volumes of vaccinations to order prior to flu season. However, IPFs may make an informed guess based on historical admission data, since the goal is to ensure screening and immunization, where appropriate, of inpatients prior to discharge. So, IPFs will, of course, need to involve their pharmacists in the planning and ordering of any medications.

Reneé Parks: Thanks, Evette; very good answer, and pharmacists always have great information on historical data. One of the items I would like to point out before we move on is the email address for any questions was brought to our attention, and it has changed in the last couple of days. And that is – it is the new email is ipfqualityreporting@area-m.hcqis.org. So again, that email for those of you who have questions, would be ipfqualityreporting@area-m.hcqis.org.

I would also like to ask if there are any facilities on the phone listening that have best practices, that they would be willing to share in an upcoming future webinar, we would greatly appreciate it if you would give us an email or give us a call. And we would be happy to give you some time, so that you could share your best practice, so that it could be highlighted in the goodness that everyone would have an opportunity to learn from your successes.

I also want to thank our CMS Program Lead, Dr. Jeff Buck and our Technical Advisor, Rebecca Kliman for being in attendance on the call today and addressing some questions as they have come in. And now, I will turn it back to Evette to conclude and go over a few of the resources and our CE process for today.

Evette Robinson: This is a reminder that resources pertaining to these and other measures are available to you through the qualitynet.org and qualityreportingcenter.com websites.

This slide is a reminder that today's webinar has been approved for one continuing education credit by the boards posted on this slide.

And as many of you know, we do have an online CE certification process. If you've registered for this webinar through ReadyTalk®, a survey will automatically pop up when the webinar closes. We will also be sending out the survey link in an email to all participants within the next 48 hours. If there are others listening to this event but who are not registered in ReadyTalk®, please pass the survey along to them.

This is what the survey will look like. It will pop up at the end of the event and will be sent to all attendees within 48 hours who registered with ReadyTalk®. Please click "Done" at the bottom of the page when you are finished.

This is what will pop up after you click "Done" on the survey. If you've already attended our webinars and received CEs, then click Existing User. And if this is your first webinar for credit, then click New User.

For those who click the New User link, this is the screen that will appear. Please register a personal email, like a Yahoo or a Gmail, since these accounts are typically not blocked by firewalls. And remember your password since you will need to use this for all of our events.

Finally, this is what the Existing User screen looks like. Please use your complete email address as your user ID and the password you used to register.

Finally, I would like to again thank our guest speakers, Elizabeth Kalayil and Amy Webb from the CDC for providing their knowledge and insights into the influenza for healthcare personnel measure as well as the NHSN Program. As was mentioned at the beginning of the webinar, a recording of this presentation along with the transcripts, slides, and questions and answers will be posted both on the qualitynet.org and qualityreportingcenter.com website.

As always, you can contact us, the IPF Program Support Contractor at the email address or phone number listed on this slide, if you have any questions about this measure or any other measures pertinent to the IPFQR Program. Should you have any questions for Elizabeth or Amy, please be sure to contact them through the email address that was listed on slide 22.

This concludes the IPFQR Program Webinar for April 2015, regarding the Influenza Vaccination Among Healthcare Personnel and the IMM-2 Measures. We thank you all for your time and participation.

END

This material was prepared by the Inpatient Value, Incentives, and Quality Reporting Outreach and Education Support Contractor, under contract with the Centers for Medicare & Medicaid Services (CMS), an agency of the U.S. Department of Health and Human Services. HHSM-500-2013-13007I, FL-IQR-Ch8-04272015-01