FLEX Medicare Beneficiary Quality Improvement Project (MBQIP)

Background

The Office of Rural Health Policy (ORHP) created the Medicare Beneficiary Quality Improvement Project (MBQIP) as a Flex Grant Program activity within the core area of quality improvement. The primary goal of this project is for CAHs to implement quality improvement initiatives to improve their patient care and operations. MBQIP uses Flex funding to support Critical Access Hospitals (CAH) with technical assistance and national benchmarks to improve health care outcomes. CAHs opting to participate are requested to report a specific set of annual measures determined by ORHP (see page 2 for timeline and measures) and engage in quality improvement projects to benefit patient care.

Benefits of Participating in MBQIP

- Engage in quality improvement initiatives
- Improves patient care across a broad population
- Improves hospital services, administration and operations
- Allows for clear benchmarking and the identification of best practice CAHs
- Receive technical assistance regarding cutting edge quality improvement tools and models
- Prepare CAHs for the future where CAHs will likely have to report measures
- Fulfills the Quality Improvement portion of the Flex Grant

The passage of meaningful use and the Affordable Care Act heightened national attention on quality activities and reporting. In the environment of meaningful use, pay for performance, bundled payments, and accountable care organizations (ACO), CAHs may soon be compared with their urban counterparts to ensure public confidence in their quality of health services. This initiative takes a proactive and visionary approach to ensure CAHs are well-equipped and prepared to meet future quality legislation. Additionally, MBQIP fulfills the Flex grant Quality Improvement (QI) objectives regarding Hospital Compare reporting, and supporting participation in various multi-hospital QI initiatives. The main emphasis of this project is putting patients first by focusing on improving health care services, processes and administration.

To advance MBQIP, Flex funds may be used to support efforts around quality improvement activities related to select rural-relevant measures. Flex funds can be used to provide technical assistance for hospitals in reporting to Hospital Compare or support organizations or vendors who report hospital data.

ORHP recognizes that many hospitals currently report to Hospital Compare and engage in quality improvement initiatives often supported by state Flex programs. Early adopters are encouraged to look beyond their current measures and partake in Phase Two and Three measures (refer to next page).

Goals and Expectations

ORHP and its partners are charged with increasing current CAH Hospital Compare participation rates, and CAH dedication to QI initiatives. While participation in the project is voluntary, MBQIP seeks to increase attention on quality health care to all CAH Medicare beneficiaries, both inpatient and outpatient. The following goals aim to achieve this broader focus via MBQIP*:

- Increase CAH Hospital Compare participation for Phase 1 measures (Pneumonia and Congestive Heart Failure) to 100% by FY2012 to improve publicly available data and motivate CAHs to implement related quality improvement initiatives.
- Achieve CAH Hospital Compare participation for Phase 2 measures (Outpatient and HCAHPS) and non-Hospital Compare Phase 3 measures (Pharmacy Review of Orders and Outpatient Emergency Department Transfer Communication) to 100% by FY2013 to motivate CAHs to implement quality improvement initiatives.
- Achieve a CAH participation rate of 75% by FY2013 and 100% by FY2014 in a quality improvement initiative to be reported to respective states.

*****These goals are ambitious but the tangible benefits to CAHs should influence participation. We realize CAHs have individual priorities and staffing challenges that may preclude participation. Flex Coordinators should work with hospitals to understand their needs and challenges, and determine available resources.

Measures

Phase 1 Measures

- Pneumonia: Hospital Compare CMS Core Measure (participate in all sub-measures); AND
- Congestive Heart Failure: Hospital Compare CMS Core Measure (participate in all sub-measures)

Phase 2 Measures

- Outpatient 1-7: Hospital Compare CMS Measure (all sub-measures that apply); AND
- Hospital Consumer Assessment of Healthcare Providers and Systems (HCAHPS)

Phase 3 Measures

- Pharmacist CPOE/Verification of Medication Orders Within 24 Hours; AND
- Outpatient Emergency Department Transfer Communication

Timeline

Project Period Years (September – August)	Measures**	Activities
Year 1: 2010-2011		Planning for the project (work with hospitals, determine technical assistance needs for data collection)
Year 2: 2011-2012	By September 1, hospitals have begun reporting on **Phase 1** measures	Plan for QI activities and assist with TA around data collection and analysis. Review first quarterly report data and plan QI activities, available Summer 2012. Hospitals Register for Outpatient Reporting by March 31, 2012
Year 3: 2012-2013	By September 1, hospitals have added **Phase 2** measures to their reporting	Review Phase 1 and Phase 2 quarterly report outcomes and plan QI activities and TA for Phases 1 and 2.
Year 4: 2013-2014	By September 1, hospitals have added **Phase 3** measures to their reporting	Review Phase 1, 2 and 3 quarterly report outcomes and plan QI activities and TA for Phases 1 (if necessary), 2 and 3.
Year 5: 2014-2015	Hospitals continue reporting on all Phases.	Plan QI activities and TA for Phases 1 (if necessary), 2 and 3.

** States already reporting Phase 1 measures may begin reporting and participating in QI activities for Phases 2 and 3.

Expectations of Flex Coordinators

By participating in this project, Flex Coordinators are expected to coordinate five key activities:

1. Outreach to hospitals to enroll them in to MBQIP
2. Assist hospitals in accessing needed technical assistance around data collection and reporting
3. Assist hospitals in analyzing their own and comparative data via Hospital Compare and the Flex Monitoring Team reports and any other tools in place at the state level
4. Determine funding allocation and appropriate partners to execute quality improvement activities
5. Provide support for technical assistance around quality improvement activities

Flex coordinators should seek other state partners (Quality Improvement Organizations, State Hospital Associations) already engaged in similar activities to establish partnerships or contracts related to QI activities.

Note: ORHP does not endorse any specific vendor, organization, firm or association for the purposes of any portion of this project other than the Flex Monitoring Team and Technical Assistance and Services Center who are federally funded through cooperative agreements.

Phase 1 Flex Coordinator Activities:

1. Watch Paul Moore's brief YouTube video on MBQIP (www.hrsa.gov/ruralhealth/about/video/index.html)
2. Work with the CAHs in your state to achieve 100% participation in MBQIP
3. Collect MOUs or consent forms and submit to your Project Officer in ORHP
4. Use the quality data results provided to you quarterly to assist your CAHs with targeted quality improvement activities
5. Continue to work with your CAHs to ensure that they are reporting Hospital Compare data each quarter (reporting deadlines are listed below)
6. Participate in MBQIP-related learning sessions

Concerns and Solutions

With a small case load, does it make sense to have CAHs publicly report?
Yes. Public reporting will expand in the future based on the Patient Protection and Affordable Care Act. In time, reimbursement across all hospitals will be tied to performance so it is to the advantage of CAHs to begin the process of publicly reporting to ensure preparedness for future federal requirements. Mindful of small case load, ORHP will roll the data up to ensure that small patient numbers is not an issue. Hospitals with small numbers report the data, but it will not be listed publicly, unless the numbers are statistically significant. Regardless, this should not deter hospitals from engaging in quality improvement initiatives. Furthermore, ORHP invites your leadership and opinions to also propose additional measures in MBQIP that are rural-relevant and will improve patient care.

Why are we using Hospital Compare when my state already has an existing data collection and reporting system?
By reporting to Hospital Compare or another single entity nation-wide, you will have access to benchmark data and comparative analysis to all participating organizations to enable the identification of key opportunity areas. It is anticipated that future CMS reimbursement will be tied to participation in Hospital Compare. You are not required to replace or duplicate existing data collection systems. You should design your current system to support data transmission in to Hospital Compare. We will work with existing network partners to adjust their indicator sets to conform to Hospital Compare specifications and minimize the administrative burden of publicly reporting.

What if hospitals are already reporting on Phase 1 measures, can we start projects on Phase 2 or 3?
Yes. According to a 2008 Flex Monitoring Team report, 70% of critical access hospitals are reporting on at least part of a measure to CMS. In states where hospitals already reporting complete measures to CMS in Phase 1, they may use available data to begin benchmarking and quality improvement activities. Hospitals

currently engaged in quality improvement initiatives around Phase 1 measures may work on future phase measures.

How will MBQIP be funded?
This project will be funded out of existing Flex program dollars within your state. These activities meet the Core Area of Quality Improvement requirements. Given that Flex funds are limited, we know that states will need to prioritize the needs of CAHs and fund activities to target those specific needs, and encourage states to set aside funds for MBQIP activities.

How will data be submitted or reported?
Measures such as Congestive Heart Failure, Pneumonia and HCAHPS, currently collected in Hospital Compare via the CART tool or other mechanism, will be reported via that route. ORHP is still determining an alternative data tool for the non-Hospital Compare measures.

Do CAHs have to register in order to submit and report their data?
Yes, CAHs will have to register with QualityNet. Most Critical Access Hospitals have already been reporting Inpatient Measures to Hospital Compare and a lesser number have been reporting Outpatient Measures and HCAHPS. CAHs that will be reporting measures for the first time as a result of MBQIP participation will need to register with QualityNet in order to submit data into the CMS data warehouse. This registration is very important, because if they are not registered, they will not be able to submit their data.

For outpatient data specifically, registration **must** be completed by March 31, 2012, for hospitals that wish to submit outpatient data for 2012. Because Phase 2 of MBQIP begins in a few short months, please get this message out to all of your CAHs so that their outpatient data from September to December of 2012 will be able to be submitted. Even if a hospital is not currently signed up for MBQIP, ORHP strongly encourages you to get all of your CAHs to register with QualityNet by the March 31 deadline so that if they do decide to report data in the future, they are registered and ready to do so.

In order to ensure CAHs are registered with QualityNet and ready to submit their quality data by the submission deadlines, we ask the Flex Coordinators to follow up with each of the CAHs in their state and encourage all CAHs to register by the March 31 deadline. Again, this is particularly important for those CAHs that will be reporting quality for the first time as a result of participation in MBQIP.

Below are links to more information on reporting inpatient, outpatient, and HCAHPS measures.

Inpatient:
http://www.qualitynet.org/dcs/ContentServer?c=Page&pagename=QnetPublic%2FPage%2FQnetTier3&cid=1138900291659

Outpatient:
http://www.qualitynet.org/dcs/ContentServer?c=Page&pagename=QnetPublic%2FPage%2FQnetTier3&cid=1192804530878

HCAHPS:
http://www.qualitynet.org/dcs/ContentServer?c=Page&pagename=QnetPublic%2FPage%2FQnetTier2&cid=1140537251096

What are the reporting deadlines for Phase 1 Hospital Compare Inpatient Measures?
The reporting deadlines are as follows:

Q4 / 2011	October 1 – December 31	Submission deadline: May 15, 2012
Q1 / 2012	January 1 – March 31	Submission deadline: August 15, 2012
Q2 / 2012	April 1 – June 30	Submission deadline: November 15, 2012
Q3 / 2012	July 1 – September 30	Submission deadline: February 15, 2013
Q4 / 2012	October 1 – December 31	Submission deadline: May 15, 2013

The deadline to register with QualityNet to submit outpatient data is March 31, 2012. What happens if a hospital does not register by the deadline, but decides they want to submit outpatient data?
If a hospital does not register to report outpatient data by the March 31, 2012, deadline, the hospital may still decide to register after the deadline has passed; however the registration will be for the following year of outpatient data reporting. For inpatient data, the hospital may register at any time, and they can begin submitting data immediately.

What happens if a state does not participate in MBQIP?
Although ORHP strongly encourages participation for the betterment of patient care and hospital services, this is a voluntary project. However, the benefits to quality improvement and the possibility of nation-wide knowledge sharing outweigh the decision to not participate.

Does MBQIP replace the CMS Core Measure program?
No, MBQIP does not replace the Core Measure program. If you are currently submitting Core Measures, continue this process.

How were these measures selected?
ORHP with the input of rural experts who have worked with or within CAHs (CAH quality administrators, Flex Monitoring Team, State Flex Coordinators and rural clinical experts) selected these measures.

Who will have access to the data? How will it be used?
There are two uses for the data. At the ORHP level the data will be aggregated and reported on the national level and analyzed annually. No individual hospital data will be used in this report out. Flex coordinators should use the data to determine the types of quality improvement activities to support through the Flex grant. Individual hospitals should be analyzing their data as they report it (monthly or quarterly) and state Flex coordinators are encouraged to work with hospitals to share the data among the CAHs in the state for benchmarking and for tying quality improvement activities based on the more current data.

ORHP will be working with CMS and Quality Improvement Organizations to gain access to the data at an earlier date than it is available publically. Additionally, it will allow those hospitals who might not meet threshold for numbers to have their data rolled into the aggregate.

Note: ORHP anticipates that Quality Improvement Organizations will collaborate with states to provide technical assistance, training, and/or data reports regarding results of Hospital Compare measures specified in this strategic plan. According to Title 42 Public Health Part 480.140 provision (Disclosure of quality review study information), parts (d) and (e): A QIO may disclose quality review study information with identifiers of particular practitioners or institutions, or both at the written consent of, the identified practitioners(s) or institutions(s); and An institution or group of practitioners may redisclose quality review study information, if the information is limited to health care services they provided.

For more information about MBQIP, please contact Megan Meacham (mmeacham@hrsa.gov).

Appendix: Measure Definitions

Phase 1 Measures

- Pneumonia: CMS Hospital Compare Core Measure (participate in all sub-measures);
  - PN-3b: Blood Cultures Performed in the Emergency Department Prior to Initial Antibiotic Received in Hospital
  - PN-6[2]: Initial Antibiotic Selection for CAP in Immunocompetent Patient

- Congestive Heart Failure: CMS Hospital Compare Core Measure (participate in all sub-measures)
  - HF-1: Discharge Instructions
  - HF-2: Evaluation of LVS Function
  - HF-3: ACEI or ARB for LVSD

Note: As of January 1, 2012, CMS retired some measures and moved others into Global Immunization Measures. While it is not currently required that CAHs participating in MBQIP report on the new Global Immunization Measures, ORHP highly encourages CAHs to do so.

Phase 2 Measures

- Outpatient 1-7: Hospital Compare CMS Measure (all sub-measures that apply);
  - OP-1: Median Time to Fibrinolysis in the Emergency Department
  - OP-2: Fibrinolytic Therapy Received Within 30 Minutes of ED Arrival in the Emergency Department
  - OP-3: Median Time to Transfer to another Facility for Acute Coronary Intervention in the Emergency Department
  - OP-4: Aspirin at Arrival in the Emergency Department
  - OP-5: Median Time to ECG in the Emergency Department
  - OP-6: Timing of Antibiotic Prophylaxis (Prophylactic Antibiotic Initiated Within One Hour Prior to Surgical Incision) in Surgery
  - OP-7: Prophylactic Antibiotic Selection for Surgical Patients in Surgery

- Hospital Consumer Assessment of Healthcare Providers and Systems (HCAHPS)

Phase 3 Measures

- Pharmacist CPOE/Verification of Medication Orders Within 24 Hours
  Numerator: Number of patients whose medication orders are directly entered (CPOE) or verified by a pharmacist within 24 hours.
  Denominator: Number of patients with at least one medication in their medication list (entered using CPOE) admitted to a CAH's inpatient or emergency department during the reporting period.

- Outpatient Emergency Department Transfer Communication (Seven Elements)
  - Pre-Transfer Communication Information
  - Patient Identification
  - Vital Signs
  - Medication-related Information
  - Practitioner generated information
  - Nurse generated information
  - Procedures and tests

  Link for Measure:
  http://www.qualityforum.org/Publications/2009/09/National_Voluntary_Consensus_Standards_for_Emergency_Care.aspx

Partnership for Patients and MBQIP

The Partnership for Patients: Better Care, Lower Costs, is a new public-private partnership that will help improve the quality, safety, and affordability of health care for all Americans. It brings together leaders of hospitals, employers, physicians, nurses, and patient advocates along with state and federal governments in a shared effort to make hospital care safer, more reliable, and less costly. The key goals of the Partnership for Patients line up with the work critical access hospitals will be engaging in when signed up for the Medicare Beneficiary Quality Improvement Project.

What does joining the Partnership for Patients commit me to?

As a hospital it means committing to work to attain the goals of the initiative to achieve safe, high quality care by utilizing tools and processes that improve safety for patients through:

- Making achieving the goals of harm reduction and improved care transitions to reduce readmissions a priority of your Board of Directors, senior leaders, clinicians, and staff;
- Supporting clinicians and staff and engaging patients and families in order to make care safer, improve communication, and increase coordination by implementing proven systems and processes; and
- Learning from and sharing with others your experiences with making care safer and more coordinated.

To find out more about Partnership for Patients and to sign up, visit: www.healthcare.gov