Understanding Changes to MBQIP

Getting to know the new measures and strategies to collect them

Understanding New Measures for MBQIP Series

Webinars every two weeks — Total of 6 webinars. Last webinar August 27, 2024

Each webinar will focus on one measure

All webinars will be recorded

Put Questions in chat box

Current Medicare Beneficiary Quality Improvement Project (MBQIP) Measures

MBQIP measures are divided into two categories:

- **Core MBQIP Measures** are those that all state Flex Programs are expected to support. Reporting on these measures contributes towards a CAH's Flex eligibility requirements.
- **Additional MBQIP Measures** are those that state Flex Programs can elect to support in addition to the Core measures, particularly in alignment with other partners or initiatives. While these measures are also rural relevant, they may not be as widely applicable across all CAHs. The MBQIP Measures resource includes a list of potential additional measures, but that list is not meant to be exhaustive. Flex programs can propose to work on other quality improvement topics within the four MBQIP domains. If there is not a nationally standardized or standardly reported measure currently available, Flex programs can propose a data collection mechanism.

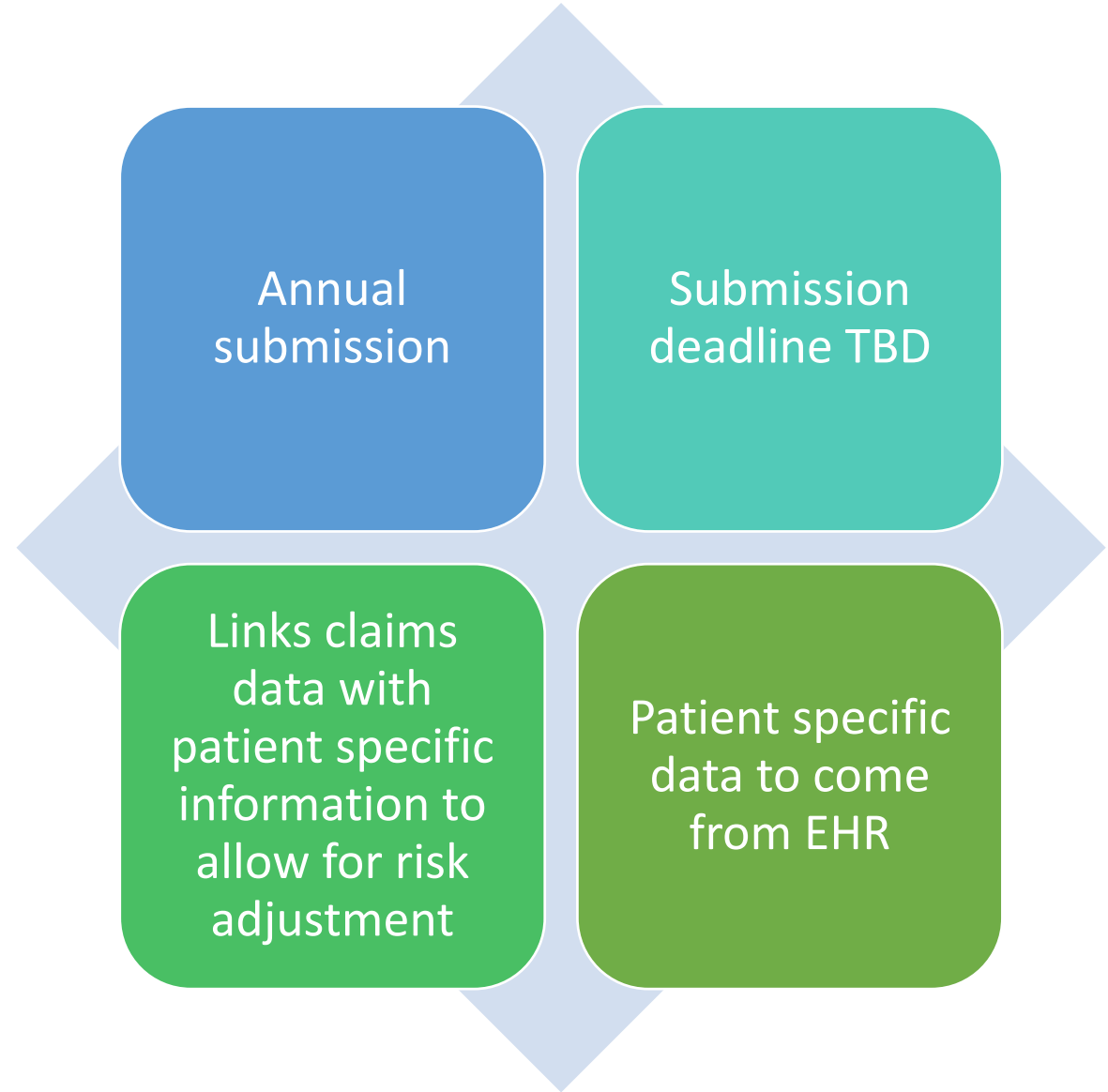| Core MBQIP Measures			
Patient Safety/Inpatient	***Patient Engagement***	***Care Transitions***	***Outpatient***
HCP/IMM-3 (formerly OP-27): Influenza Vaccination Coverage Among Healthcare Personnel (HCP) **Antibiotic Stewardship:** Measured via Center for Disease Control National Healthcare Safety Network (CDC NHSN) Annual Facility Survey	**Hospital Consumer Assessment of Healthcare Providers and Systems (HCAHPS)** *The HCAHPS survey contains 21 patient perspectives on care and patient rating items that encompass eight key topics:* • Communication with Doctors • Communication with Nurses • Responsiveness of Hospital Staff • Communication about Medicines • Discharge Information • Cleanliness of the Hospital Environment • Quietness of the Hospital Environment • Transition of Care *The survey also includes screener questions and demographic items. The survey is 29 questions in length.*	**Emergency Department Transfer Communication (EDTC)** *1 composite; 8 elements* • **All EDTC Composite** • Home Medications • Allergies and/or Reactions • Medications Administered in ED • ED provider Note • Mental Status/Orientation Assessment • Reason for Transfer and/or Plan of Care • Tests and/or Procedures Performed • Test and/or Procedure Results	**AMI:** • **OP-2:** Fibrinolytic Therapy Received within 30 minutes ← Retired • **OP-3:** Median Time to Transfer to another Facility for Acute Coronary Intervention ← Retired **ED Throughput** • **OP-18:** Median Time from ED Arrival to ED Departure for *Discharged* ED Patients • **OP-22:** Patient Left Without Being Seen

New Core Measure Set

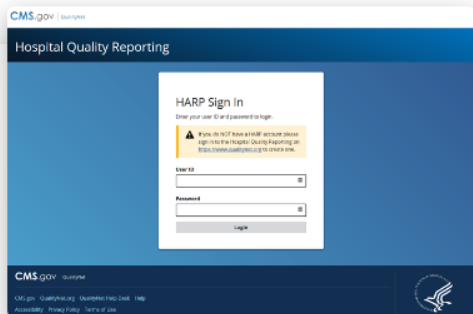| Proposed New MBQIP Core Measure Set				
Global Measures	**Patient Safety**	**Patient Experience**	**Care Coordination**	**Emergency Department**
▪ CAH Quality Infrastructure Implementation *(annual submission)* ▪ Hospital Commitment to Health Equity (required CY 2025) *(annual submission)*	▪ Healthcare Personnel Influenza Immunization *(annual submission)* ▪ Antibiotic Stewardship Implementation *(annual submission)* ▪ Safe Use of Opioids (eCQM) *(annual submission)*	▪ Hospital Consumer Assessment of Healthcare Providers & Systems (HCAHPS) *(quarterly submission)*	▪ Hybrid All-Cause Readmissions (required starting in 2025) *(annual submission)* ▪ SDOH Screening (required CY 2025) *(annual submission)* ▪ SDOH Screening Positive (required CY 2025) *(annual submission)*	▪ Emergency Department Transfer Communication (EDTC) *(quarterly submission)* ▪ OP-18 Time from Arrival to Departure *(quarterly submission)* ▪ OP-22 Left without Being Seen *(annual submission)*

Hybrid All-Cause Readmissions

Hybrid Hospital Wide Readmissions

Annual submission

Submission deadline TBD

Links claims data with patient specific information to allow for risk adjustment

Patient specific data to come from EHR

MBQIP Portal   **HOME**   **MEASURES**   **RESOURCES** ▾   **DEADLINES**   **NEWS**   **DICTIONARY**

HARP

Hospital Quality Reporting

LOGIN

Established by the Centers for Medicare & Medicaid Services (CMS), QualityNet provides healthcare quality improvement news, resources and data reporting tools and applications used by healthcare providers and others.

QualityNet is the only CMS-

NHSN

National Health Safety Network

LOGIN

The Centers for Disease Control and Prevention(CDC)'s National Healthcare Safety Network is the nation's most widely used healthcare-associated infection (HAI) tracking system.

In addition, NHSN allows healthcare facilities to track blood safety errors

MBQIP-DB

MBQIP Database

LOGIN

ARCHI is working in collaboration with the State Office of Rural Health (SORH) and Texas Hospital Association Foundation (THAF) to assist Critical Access Hospitals in reporting MBQIP measures.

ARCHI provides information on MBQIP measures, reporting process for all III Phases and how to use

🕐 **Upcoming Deadlines**

HCAHPS ≫
📅 *Jul 3rd*

EDTC ≫
📅 *Jul 15th*

OP-18 ≫
📅 *Aug 1st*

Stewardship

Patient Safety

Dec 2025

May 2025

eCQM

HCP

Patient Safety

Patient Safety

Jul 2024

HCAHPS

Patient Experience

Hospital Commit...   **Global**   May 2025

Feb 2025

Hybrid Hospital...

Care Coordination

Aug 2024

OP-18

Emergency Department

May 2025

OP-22

Emergency Department

May 2025

MEASURES

- ⊞ Core Measures
- ⊕ 📁 Care Coordination
- ⊕ 🟥 Emergency Department
- ⊕ 🟪 Global Measures
- ⊕ 🟦 Patient Experience
- ⊕ 🟩 Patient Safety
- ⊡ Additional Measures

Hybrid Hospital-Wide Readmission

CARE COORDINATION

Hospital-level, all-cause, risk-standardized readmission measure that focuses on unplanned readmissions 30 days of discharge from an acute hospitalization.

🏁 **Importance**

Returning to the hospital for unplanned care disrupts patients' lives, increases risk of harmful events like healthcare-associated infections, and results in higher costs absorbed by the health
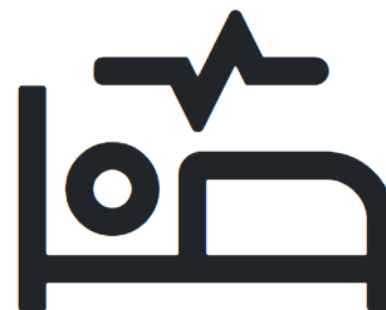
📪 **Data Reported To**

⚬⚫ HARP

🗄 **Data Source**

- Manual Chart Abstraction
- Retrospective data sources for required data elements include administrative data and

Why are we even worried about readmissions?

Why Readmissions?

Increase patient risk of complication

Increase cost that are absorbed by the healthcare system

Disruptive to patient lives

May indicate larger underlying issue

- Ineffective patient teaching
- Communication issues
- Need for better discharge process

Looking at how measure is captured -

Data allows for risk adjustment for each patient

Ability to utilize risk adjustment in provision of care

Potential to prevent readmission and improve health outcomes based on individual patient risk adjustment

- Identify patients at greater risk for poor outcomes
- Identify patients at greater risk for readmission while still inpatient

Traditional vs Hybrid Measure

- Traditional readmissions measures capture claims data
  - Provides data in terms of readmission rates
  - Number of readmissions / Total number of admissions
- Hybrid measure no actual measure score
- Continues to utilize claims data (6 linking variables)
- Addition of core clinical data elements (CCDEs)
  - Vital signs (6 elements)
  - Lab data (7 elements)

Data Elements

- Claims linking variables
  - CMS Certification Number (CCN)
  - Health Insurance Claim Number (HICN) or Medicare Beneficiary Identifier (MBI)
  - DOB
  - Sex
  - Admission Date
  - Discharge Date

Data Elements

- Vital Signs
  - Heart Rate
  - Respiratory Rate
  - Temperature
  - Systolic blood pressure
  - Oxygen Saturation
  - Weight

Data elements

- Laboratory test results
  - Hematocrit
  - White blood cell count
  - Sodium
  - Potassium
  - Bicarbonate
  - Creatinine
  - Glucose

Inclusion criteria

- An index admission is the hospitalization to which the readmission outcome is attributed and includes admissions for patients:
    - enrolled in Medicare Fee-For-Service (FFS) Part A for the 12 months prior to the date of admission and during the index admission (not applicable to VA hospitalizations);
    - aged 65 or over;
    - discharged alive from a non-federal short-term acute care hospital or VA hospital; and
    - not transferred to another acute care facility

Exclusion criteria

- Index admissions for patients who are:
  - Admitted to Prospective Payment System exempt Cancer Hospital (PCH)
  - Without at least 30 days post-discharge enrollment in Medicare FFS
  - Discharged against medical advice
  - Admitted for primary psychiatric diagnoses
  - Admitted for rehabilitation
  - Admitted for medical treatment of cancer

Review Measure Specifications	Access Patient Data	Define Measure Population Criteria	Extract Population Data
Understand the criteria outlined in the CMS measure specifications document to identify the target population. This may include specific patient demographics, diagnoses, procedures, or other clinical characteristics.	Use Electronic Health Record (EHR) systems and other hospital databases to access patient data. Ensure access to relevant and discernable data fields such as arrival and departure times, discharge disposition, medications prescribed, and other variables required for measure calculation.	Define the criteria for identifying patients within the target population for the measure. This may involve setting filters or criteria within the EHR system to identify eligible patients based on specified parameters.	Extract data for identified patients meeting the criteria outlined in the measure specifications. Utilize reporting tools or queries with the EHR system to generate the measure calculations that match the specification guidelines.

Gettting started

Information found in posted Telligen resource

Determine where data will come from

- Six linking variables
    - Admission / registration process
- Six Vital Signs
    - Clinical documentation
    - EHR
- Seven laboratory values
    - Laboratory reporting system

Essential that 6 linking variables are included. This links CCDEs to claims data

Six Vital Signs	Six Linking Variables	Seven Laboratory Test Results
Heart Rate	CMS Certification Number (CCN)	Hematocrit
Respiratory Rate	Health Insurance Claim Number (HICN) OR Medicare Beneficiary Identifier (MBI)	White Blood Cell Count
Temperature	Date of Birth (DOB)	Sodium
Systolic Blood Pressure	Sex	Potassium
Oxygen Saturation	Admission Date	Bicarbonate
Weight	Discharge Date	Creatinine
		Glucose

CCDEs should be in following values

CCDE	Unit of Measurement
Heart Rate	Beats Per Minute
Respiratory Rate	Breaths Per Minute
Temperature	Degrees Fahrenheit
Systolic Blood Pressure	Millimeter of Mercury (mmHg)
Oxygen Saturation	Percent (%)
Hematocrit	% Red Blood Cells
Weight	Pounds
White Blood Cell Count	Cells per Millimeter (Cells/mL)
Sodium	Milliequivalents per Liter (mEq/L)
Bicarbonate	Millimoles per Liter (mmol/L)
Potassium	Milliequivalents per Liter (mEq/L)
Creatinine	Milligrams per Deciliter (mg/dL)
Glucose	Milligrams per Deciliter (mg/dL)

Data Collection Details

1. You must **submit all 6 linking variables on 95% or more of discharges** with a Medicare Fee for Service (FFS) claim for the same hospitalization during the measurement period.
   - The CCDE submitted must be the first values captured during the hospitalization.
2. **Report vital signs for 90% or more of the hospital discharges** for Medicare FFS patients, 65 years or older in the measurement period (as determined from the claims submitted to CMS for admissions that ended during the same reporting period).
   - For vital signs results, it is the first captured value in the EHR 24 hours before the inpatient admission. If not available, then first vitals collected 0-2 hours after admission.
3. **Submit the laboratory test results for 90% or more of discharges** for non-surgical patients, meaning those not included in the surgical specialty cohort of the Hybrid HWR measure.
   - For laboratory test results, it is the first captured value in the EHR 24 hours before the inpatient admission. If not available, then first laboratory test results collected 0-2 hours after admission.

CCDEs

Example of CCDE Collection

If a patient had vital signs taken and laboratory tests ordered and drawn at an emergency department at 8:00 AM on January 15, labs resulted at 9:00 AM on January 15, and was then admitted to an inpatient unit at 12:00 PM on January 15, the measure would use the vitals taken at 8:00 AM and the labs resulted at 9:00 AM.

Alternatively, if a patient is admitted to an inpatient unit at 12:00 PM on January 15, with no vitals taken or labs resulted in the 24 hours prior, and then has vitals taken at 1:00 PM and labs resulted at 2:00 PM on January 15, the measure would use the vitals taken at 1:00 PM and the labs resulted at 2:00 PM.

Measure Reporting Details

The following are data elements for the measure necessary for reporting the measure and collecting data. For more detailed data refer to the measure specifications.

Measure Encounter Period: This measure is reported annually reflecting July 1 – June 30th encounter period.

Measure Submission Deadline: This measure is submitted annually. Data is due September 30 three months after the end of the encounter period in June. Data submission deadlines on a federal holiday or weekend (Saturday or Sunday) will default to the first business day thereafter in this document where applicable.

Measure Reporting Platform: This measure is submitted annually via the Hospital Quality Reporting (HQR) system via patient-level file in QRDA I format.

When the data starts coming in...

How might we use it??

Questions???

Quick Announcements

HCAHPS Measure

Upcoming Events

- **CNO Bootcamp**

  - **August 1-2, 2024 – Austin, Tx**

- **Frontline Staff Documentation Workshop**

  - **August 30, 2024 – Austin, Tx**

  - **Physician Documentation Webinar Series TBD**

- **Frontline webinar series on Quality Improvement**

  - **July 24 – Social Determinants of Health / Health Literacy**

  - **July 31 – Basics of Quality Improvement**

  - **Aug 7 – Healthcare Mistakes and Their Impact**

  - **Aug 14 – Trauma Informed Care**

  - **Aug 21 – Workplace Violence**

Who To Contact

- **Regional Coordinator with SORH**
- **EVA CRUZ** Rural Health Coordinator | State Office of Rural Health
- 512-936-7880 / eva.cruz@texasagriculture.gov

- **Need access or have issues with MBQIP Portal?**
  - **Sherry Jennings, MSN, RN** | Director Quality Texas A&M Rural and Community Health Institute | Texas A&M Health
  - ph: 979.436.0391 | sherry.jennings@tamu.edu

- **Need quality improvement technical assistance, all questions in general or want to schedule a site visit?**
  - **Sheila Dolbow, MSN, RN, CFN, CPHQ /** Quality Improvement Manager
  - Texas Hospital Association Foundation
  - 512-970-9829 / sdolbow@tha.org