CAHs, Quality Measurement and MBQIP

Ira Moscovice
Mayo Professor and Director
University of Minnesota Rural Health Research Center

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A Performance Monitoring Resource for
Critical Access Hospitals, States, and Communities

Flex Monitoring Team | University of Minnesota
University of North Carolina at Chapel Hill
University of Southern Maine

Overview of Presentation

- Rural relevant quality measures
- Why public reporting of quality measures is important for CAHs
- Using quality measure results to improve quality of care in CAHs

CAH Reporting to Hospital Compare

- 71% of CAHs publicly reported data on at least one inpatient process measure for 2009
- By state, CAH reporting on inpatient measures ranges from 11% to 100%
  - Six states with 100% of CAHs reporting
  - Six states with less than half of CAHs reporting
- 16% of CAHs publicly reported outpatient data
- 35% of CAHs publicly reported HCAHPs data

Reasons given for not reporting to Hospital Compare

- It's only the small states that have high CAH participation
- The measures are not "rural relevant"
- We have our own quality measurement system
- CMS does not require CAHs to participate

It's Not Just the Small States

- It's not just the states with few CAHs that have high Hospital Compare participation rates…
- Several states with large numbers of CAHs have very high participation rates:
  - Wisconsin 96.6% of 59 CAHs
  - Nebraska 93.8% of 65 CAHs
  - Minnesota 93.7% of 79 CAHs
  - Oklahoma 90.9% of 33 CAHs
  - Iowa 86.6% of 82 CAHs
- Statewide quality reporting initiatives, efforts by State Flex Programs/SORHs, QIOs, and state hospital associations make a difference in CAH participation

Rural Relevance of Quality Measures

- Current work:
  - Evaluating the relevance of the current and proposed CMS outpatient quality measures
  - Developing an up-to-date list of rural relevant inpatient quality measures for CAHs

Criteria for Assessing Rural Relevance

- Prevalence/volume in CAHs
- Usefulness
  - Internal usefulness for QI processes
  - External usefulness for public reporting and for value-based purchasing
  - Usefulness for care coordination
- Ease of data collection
  - Calculation using claims data
  - Effort required for medical record abstraction
  - Feasibility of using EHRs

CMS Current and Proposed Outpatient Measures

- Emergency Department (ED)
- Outpatient Surgery
- Imaging (e.g., CT scans, mammography)
- Structural measures (e.g., use of health information technology)
- Measures for specific clinical conditions: diabetes, cancer, and heart failure
- Other measures (e.g. vaccination, medication reconciliation)

Rural Relevance of Outpatient Measures

- Current AMI/chest pain measures and transfer communication measures being considered by CMS were developed for and field-tested in rural hospitals
- Several new ED measures for 2013 address ED waits and timeliness of care; overcrowding and wait times are not as much of a problem in rural EDs as in urban EDs
- New transition record measure is rural relevant

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Rural Relevance of Outpatient Measures

- Imaging measure issues/concerns
  - Scientific basis not clear in some cases
  - Some measures are not endorsed by NQF
  - Responsibility of hospital vs. ordering physicians?
  - Procedures done in many small rural hospitals, but volume is still relatively low
  - Focus on utilization rates rather than quality?

Rural Relevance of Outpatient Measures

- Condition-specific measures address diabetes, heart failure and cancer
- Most are PQRI measures and endorsed by NQF
- These are common OP diagnoses in rural hospitals, but patients are not necessarily seen in the hospital OP department for the services addressed by these measures
- What are the roles of the OP department, primary care physicians, and specialists in providing these services?

Rural Relevant Inpatient Measures

- Analyzed several sets of measures on important rural hospital quality measurement topics identified in earlier University of Minnesota/Stratis Health work and NRHA meeting on quality metrics
  - CMS Hospital Compare, hospital acquired conditions, and HIT meaningful use measures
  - NQF endorsed measures
  - AHRQ measures
- Used Hospital Compare data, AHRQ discharge data and literature to assess prevalence/volume in CAHs

Rural Relevant Inpatient Measures

- Assembled expert work group to review and rate the quality measures
- Core measures that are relevant for all CAHs
  - Inpatient process of care measures for specific medical conditions (e.g., pneumonia, heart failure)
  - Cross-cutting measures (e.g., HCAHPS, medication reconciliation, care transitions)
- Measures for CAHs that offer surgery and obstetrics

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Why CAHs Should Publicly Report Quality Data

- Public reporting of quality data provides an important opportunity for CAHs to assess and improve their performance on national standards of care
- As we move toward a health care system that pays for high-quality care, CAHs will need to publicly report on quality measures to demonstrate the quality of the care they are providing
- HIT "meaningful use" will require all hospitals, including CAHs, to report data on selected quality measures to CMS to qualify for reimbursement incentives

Why CAHs Should Publicly Report Quality Data

- The long term viability of the Flex Program depends on having national data on program effectiveness
- Existing state and multi-state quality reporting and benchmarking efforts are important and should continue, but comparable national data are needed
- All CAHs need to report on a core set of measures the same way so the data are comparable nationally; should not be that difficult to accomplish but requires compromise
- Public reporting of quality data provides a richer environment for CAH benchmarking and QI

Using quality measure results to improve quality of care in CAHs

- The Flex Medicare Beneficiary Quality Improvement Project (MBQIP) will identify areas where CAHs can improve their quality performance and focus QI activities on those areas
- MBQIP will involve cooperative efforts of ORHP, FMT, TASC and State Flex Programs
- Benefits for State Flex Programs and CAHs of participating in MBQIP include technical assistance regarding QI tools, models and best practices

Using quality measure results to improve quality of care in CAHs

- Areas of focus and quality measures to be reported to MBQIP
  - Phase 1: Hospital Compare pneumonia and heart failure measures
  - Phase 2: Hospital Compare outpatient AMI/chest pain measures, outpatient surgical measures (if applicable) and HCAHPS
  - Phase 3: Pharmacist CPOE/24 hour verification of medication orders and outpatient transfer communication measures

Using quality measure results to improve quality of care in CAHs

- There is an evidence base on QI programs and strategies that have improved quality of care and could be replicated in CAHs
  - Current FMT project is identifying evidence-based QI programs/strategies for pneumonia, heart failure, AMI, and surgical care improvement, using literature and interviews
  - Information on these programs/strategies will be disseminated to State Flex Programs and CAHs through a series of policy briefs with links to resources

Additional Information

- Flex Monitoring Team Website
  www.flexmonitoring.org
- Ira Moscovice
  mosco001@umn.edu