Quality Corner Call

August 17, 2023

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Kansas
Department of Health and Environment

Upcoming Webinars and Educational Offerings

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2023 Upcoming Webinars

SHIP Informational Webinars

- September 14
- December 14

Quality Corner Calls

- October 19 – Best Practices – NRHA Awards, Full SHIP Grant Recognition, Most Improved
- November 21 – TBD

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Upcoming Offerings

Rural Hospital Workforce Issues Networking Group (virtual)

- August 22, September 12, October 24

MBQIP Basics (virtual)

- November 9

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Site Visits (In-person or Zoom)

MBQIP Reporting Reviews (5/quarter)

- Current requirements to continue receiving the SHIP grant
- Flex Monitoring Team reports reviewed
- Discussion of who reports what elements at your facility
- Clearing up any questions your facility may have about reporting of this data to meet the deadlines

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OP CART Change

Format
Change Type from:
Character
To:
Alphanumeric

Change Occurs from:
1
To:
1 – 5

Allowable Values
Change from:
M = Male
F = Female
U = Unknown
To:
Select all that apply:
1. Male
2. Assigned/Designated Male at Birth
3. Female
4. Assigned/Designated Female at Birth
5. LGBTQ
6. Unknown

Notes for Abstraction
Change to:
- Select any of the values that are applicable. The data element and values encompass both the patient's current gender identity and one assigned at birth.
- Consider the sex to be unable to be determined and select "Unknown" if the patient refuses to provide their sexual orientation and/or gender identity. If "Unknown" is selected, then no other value should be selected.

CMS Data Element Change

Starting with **July 1, 2023 encounters**, the Centers for Medicare and Medicaid Services (CMS) measure data collection question is changing from **"What was the patient's sex on arrival"** to **"What is the patient's sexual orientation and/or gender identity?"** The data element is being updated to be able to capture additional information to help evaluate health equity.

Refer to the CMS Hospital Outpatient Quality Reporting Specifications Manual and Release Notes Version 16.0a for further rationale on the change and the Data Dictionary Section for the specific data element (Sex) instructions.

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OP CART Change and Sex Data Elements

Below is a copy of the ListServe sent to the community on 6/30:

The new version of CART that contains the updated sex data elements that are effective July 1, 2023 will be delayed for the Inpatient Quality Reporting (IQR) and Outpatient Quality Reporting (OQR) programs.

Abstractions from CART cannot be completed starting with 3Q2023 until the new version is available.

A communication will be released once the sex data elements have been updated and are available in CART.

To sign up for ListServe, visit our website: https://qualitynet.cms.gov/listserv-signup

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Resources

- www.krhop.net
  - SHIP
    - SHIP 22-23
    - SHIP 23-24
  - MBQIP
    - Quality/MBQIP
    - Abstraction
- www.kha-net.org
  - Education
    - Education Brochures
    - Register for Healthworks/KHA Events Online https://registration.kha-net.org/

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MBQIP

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MBQIP's Tie to SHIP

Kansas SHIP Grant eligible PPS hospitals and CAHs must actively participate in the Medicare Beneficiary Quality Improvement Project [MBQIP] to qualify for full SHIP funding.

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Medicare Beneficiary Quality Improvement Project (MBQIP)
Hospital Data Submission Deadlines
Reporting Quarters Applicable to SHIP 2023-2024 Grants

Measure ID	Measure Name	Reported To	Submission Deadline by Encounter Period			
			Q4 / 2022 Oct 1 - Dec 31	Q1 / 2023 Jan 1 - Mar 31	Q2 / 2023 Apr 1 - Jun 30	Q3 / 2023 Jul 1 - Sep 30
Population & Sampling	Population & Sampling Submission (inpatient and outpatient)	HQR via HARP Log In	May 1, 2023	August 1, 2023	November 1, 2023	February 1, 2024
OP-2	Fibrinolytic therapy received within 30 minutes	HQR via Outpatient CART/Vendor	May 1, 2023	August 1, 2023	N/A Retired	N/A Retired
OP-3	Median time to transfer to another facility for acute coronary intervention	HQR via Outpatient CART/Vendor	May 1, 2023	August 1, 2023	N/A Retired	N/A Retired
OP-18	Median time from ED Arrival to ED Departure for Discharged ED Patients	HQR via Outpatient CART/Vendor	May 1, 2023	August 1, 2023	November 1, 2023	February 1, 2024
OP-22	Patient left without being seen	HQR via HARP Log In	May 15, 2023 (Aggregate based on full calendar year 2022)			
HCP/IMM-3	Influenza vaccination coverage among health care personnel	National Healthcare Safety Network	May 15, 2023 (Aggregate based on Q4 2022/Q1 2023)			
EDTC	Emergency Department Transfer Communication	QHi	Submit each month by the end of the following month			
HCAHPS	Hospital Consumer Assessments of Healthcare Providers and Systems	HQR via Vendor	April 5, 2023	July 5, 2023	October 4, 2023	January 3, 2024
Antibiotic Stewardship	CDC NHSN Annual Facility Survey	National Healthcare Safety Network	March 1, 2024 (Survey year 2023)			
Quality Program Assessment	National CAH Quality Inventory and Assessment	Healthworks	October 2, 2023			

* The Federal Office of Rural Health currently has new MBQIP requirements under consideration. It is possible, additional items will be added. We will share more information as it becomes available.

Updated June 2023

FORHP

New MBQIP Measures

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Measures Under Consideration

- Antimicrobial Use and Resistance (AUR) Surveillance
- Electronic Clinical Quality Measure (eCQM) – Outpatient
  - ST-Segment Elevation Myocardial Infarction (STEMI) (OP-40)
- Electronic Clinical Quality Measure (eCQM) – Inpatient
  - Venous Thromboembolism Prophylaxis (VTE-1)
  - Global Malnutrition Composite Score (GMCS)
  - Safe Use of Opioids – Concurrent Prescribing (Safe Use of Opioids)
- Hospital Commitment to Health Equity
- Hybrid Hospital-Wide All Cause Readmission
- Screening for Social Drivers of Health
- Screen Positive for Social Drivers of Health
- Sepsis (SEP-1)

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eCQM: Safe Use of Opioids

- Safe Use of Opioids – Proportion of patients 18 and older prescribed, or continued on, two or more opioids or an opioid and benzodiazepine concurrently at discharge from a hospital-based encounter (inpatient or ED)
- Background – CMS IQR and Promoting Interoperability (PI) Program
- Submission – Annual, QRDA Category 1 File via HQR
- **Additional Information –**
  - eCQM data is not currently reported on *CMS Care Compare*
  - CMS indicated they will start public reporting of eCQM measures starting with CY 2021 data, available to the public as early as Fall 2022:
    - eCQM measures were included in the January 2023 Care Compare Preview Reports
    - The January 2023 preview reports indicate that the eCQM data will be released in the *Provider Data Catalog (but not on Care Compare)*
    - It is likely that future releases will be included on Care Compare
  - CAHs are required to submit eCQMs as part of PI. For more information on eCQM Reporting requirements: Critical Access Hospital eCQM Resource List

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Safe Use of Opioids – Concurrent Prescribing (Safe Use of Opioids)

Electronic Clinical Quality Measure (eCQM) – Inpatient

Measure Description:

Denominator: Inpatient hospitalizations that end during the measurement period, where the patient is 18 years of age and older at the start of the encounter and prescribed one or more new or continuing opioid or benzodiazepine at discharge. Exclusions include patients with cancer that begins prior to or during the encounter or are receiving palliative or hospice care during the encounter, patients discharged to another inpatient care facility, and patients who expire during the inpatient stay

Numerator: Inpatient hospitalizations where the patient is prescribed or continuing to take two or more opioids or an opioid and benzodiazepine at discharge

Measure Submission and Reporting Channel:

Annual, QRDA Category 1 File via Hospital Quality Reporting (HQR) platform.

- CAHs are required to report this eCQM for CY 2023 for the Medicare Promoting Interoperability Program

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Safe Use of Opioids – Concurrent Prescribing (Safe Use of Opioids)

Thoughts to consider:

- CAHs are required to report this eCQM for CY 2023 for the Medicare Promoting Interoperability Program
- PPS hospitals, eCQM reporting requirements are aligned between the Medicare Promoting Interoperability Program and the Inpatient Quality Reporting Program

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Hospital Commitment to Health Equity Measure

- **Background – New CMS Inpatient Quality Reporting (IQR) measure**
- **Submission – Annual attestation via HQR secure portal**
- **Description – Structural measure to assess hospital commitment to health equity across five domains:**
  - Domain 1 – Equity is a Strategic Priority
  - Domain 2 – Data Collection
  - Domain 3 – Data Analysis
  - Domain 4 – Quality Improvement
  - Domain 5 – Leadership Engagement
- **Additional information:**
  - Hospital score can be a total of zero to five points (one point for each domain, must attest "yes" to all sub-questions in each domain, no partial-credit)
  - First available reporting timeline is spring 2024 (reflecting CY 2023 activity)
  - Specifications and Attestation Guidance

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Hospital Commitment to Health Equity

Measure Description:

Hospitals will receive points for responding to questions in five different domains of commitment to advancing health equity:

- Domain 1 – Equity is a Strategic Priority
- Domain 2 – Data Collection
- Domain 3 – Data Analysis
- Domain 4 – Quality Improvement
- Domain 5 – Leadership Engagement

Hospital score can be a total of zero to five points (one point for each domain, must attest "yes" to all sub-questions in each domain, no partial-credit)

Measure Submission and Reporting Channel:

Annual attestation via Hospital Quality Reporting (HQR)

- New CMS IQR program measure
- First available reporting timeline is Spring 2024 (reflecting CY 2023 activity)

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Hospital Commitment to Health Equity

Thoughts to consider:

- Not looking for perfection or to have a total score of 5
- The improvement will be to keep moving your total score up
- Maximum score of 5
- Unlike the 7 domains of an antibiotic stewardship program, you must answer "yes" to each question in a domain to obtain the point

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Hybrid Hospital-Wide All-Cause Readmissions

- Background – CMS IQR Measure
- IPPS 2024 Final Rule- measure will start incorporating Medicare Advantage patients (starting with data from 2025)
- Submission – Annual, patient-level file in QRDA 1 format to HQR
- Description – Hospital-level, all-cause, risk-standardized readmission measure that focuses on unplanned readmissions 30 days of discharge from an acute hospitalization
- **Additional Information –**
  - 1,113 CAHs met the threshold to have the *claims-based* HWR measure calculated for July 1, 2020-June 30, 2021
  - Hybrid HWR will be publicly reported starting with the July 2025 refresh of *Care Compare* (replacing the claims-based HWR measure)
  - Next **reporting deadline** is September 30, 2023 for July 1, 2022, through June 30, 2023 hospitalizations
- Reporting information; Measure Specifications

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Hybrid HWR- Clinical Elements and Linking Variables

Clinical Elements:

- ✓ Heart Rate
- ✓ Systolic Blood Pressure
- ✓ Respiratory Rate
- ✓ Temperature
- ✓ Oxygen Saturation
- ✓ Weight
- ✓ Hematocrit
- ✓ White Blood Cell Count
- ✓ Potassium
- ✓ Sodium
- ✓ Bicarbonate
- ✓ Creatinine
- ✓ Glucose

Linking Variables:

- ✓ CMS Certification Number
- ✓ Health Insurance Claims Number or Medicare Beneficiary Identifier
- ✓ Date of birth
- ✓ Sex
- ✓ Admission date
- ✓ Discharge date.

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Hybrid Hospital-Wide All Cause Readmission

Measure Description:

Hybrid measures differ from the claims-only measures in that they merge electronic health record (EHR) data elements with claims-data to calculate the risk-standardized readmission rate. The Hybrid HWR was developed to address complex and critical aspects of care that cannot be derived through claims data alone.

To report, hospitals submit a patient level Quality Reporting Data Architecture (QRDA) Category 1 file (the same type of file used for eCQM submission) that includes clinical variables and linking elements for each patient:

- Clinical variables (13): Heart Rate, Systolic Blood Pressure, Respiratory Rate, Temperature, Oxygen Saturation, Weight, Hematocrit, White Blood Cell Count, Potassium, Sodium, Bicarbonate, Creatinine, Glucose
- Linking elements (6): CMS Certification Number (CCN), Health Insurance Claims Number or Medicare Beneficiary Identifier, Date of birth, Sex, Admission date, Discharge date

Measure Submission and Reporting Channel:

Annual attestation via Hospital Quality Reporting (HQR)

- CMS IQR program measure
- Next available reporting deadline is October 2, 2023 for July 1, 2022 through June 30, 2023 hospitalizations.

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Hybrid Hospital-Wide All Cause Readmission

Thoughts to consider:

- PPS hospitals required to report to meet the IQR program requirements and avoid a negative payment adjustment for encounters July 1, 2023 – June 30, 2024 with data due October 1, 2024
- Beginning with 2023-2024 data, CAHs that are not reporting Hybrid HWR data elements will no longer have readmissions rate calculated
- Hybrid HWR will be publicly reported starting with the July 2025 refresh of Care Compare (replacing the claims-based HQR measure)

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Screening for Social Drivers of Health

- Background – New CMS IQR measure
- Submission – Annual numerator and denominator submission through HQR
- Description – Percent of patients 18 and older admitted for an inpatient stay that are screened for all of the following health-related social needs (HRSNs):
  - Food insecurity
  - Housing instability
  - Transportation needs
  - Utility difficulties
  - Interpersonal safety
- **Additional Information –**
  - CMS is not requiring a specific screening tool be used, but all five areas of HRSN must be included. A list of suggested tools is available.
  - First available reporting timeline is spring 2024 (reflecting patients admitted in CY 2023)
  - Specifications and FAQs

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Screening for Social Drivers of Health

Measure Description:

Percent of patients 18 and older admitted for an inpatient stay that are screened for all of the following health-related social needs (HRSNs):

- Food insecurity
- Housing instability
- Transportation needs
- Utility difficulties
- Interpersonal safety

Measure Submission and Reporting Channel:

Annual numerator and denominator submission through Hospital Quality Reporting (HQR) platform via web-based data form.

- Hospitals are allowed to select their own screening tool, as long as it captures all five required areas
- First available reporting period is May 15, 2024 for calendar year (CY) 2023 data

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Screening for Social Drivers of Health

Thoughts to consider:

- PPS hospitals required to report to meet the IQR program requirements and avoid a negative payment adjustment for CY2024 data which would be due May 15, 2025
- What would you do with this type of data?
- Why gather data if there is little that can be done to improve the numbers from the hospital perspective?

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Screen Positive for Social Drivers of Health

- Background – New CMS IQR measure
- Submission – Annual numerator and denominator submission through HQR
- Description – Screen positive rate for social drivers of health calculated as five separate rates:
  - Numerators: Number that screen positive for each of the five HRSNs (see previous slide)
  - Denominator: Total number of patients 18 or older screened for an HRSN
- **Additional Information –**
  - Screen positive rate is not a measure of performance
  - Draft Specifications
  - Same timeline for reporting as the Screening for Social Drivers measure

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Screen Positive for Social Drivers of Health

Measure Description:

Denominator: Total number of patients 18 and older screened for an HRSN.

Numerator: Number that screen positive for each of the five HRSNs captured in the Screening for Social Drivers of Health measure.

- Food insecurity
- Housing instability
- Transportation needs
- Utility difficulties
- Interpersonal safety

Measure Submission and Reporting Channel:

Annual numerator and denominator submission through Hospital Quality Reporting (HQR) platform via web-based data form.

- Hospitals are allowed to select their own screening tool, as long as it captures all five required areas
- First available reporting period is May 15, 2024 for calendar year (CY) 2023 data

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Screen Positive for Social Drivers of Health

Thoughts to consider:

- PPS hospitals required to report to meet the IQR program requirements and avoid a negative payment adjustment for CY2024 data which would be due May 15, 2025
- What would you do with this type of data?
- “This measure is not an indication of performance”
- If hospitals are not reimbursed to solve these problems, is there potential to be penalized down the line if the numbers do not decrease?

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Next Steps

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Upcoming New MBQIP Measures

- Start to prepare now for 2024
- Don't panic – plenty of time to get ready
- Reach out with questions
- Watch for virtual training early 2024 on new measures

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CAH Quality Inventory and Assessment

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National CAH Quality Inventory and Assessment: Purpose

Information captured can support quality activities at the following levels:

- **Hospital-level** – Provide state and national comparison information related to QI infrastructure, processes, quality activities and measurement across different CAH service lines
- **State-level** – Provide timely, accurate, and useful CAH quality-related information to help inform technical assistance support for CAH improvement activities
- **National-level** – Provide hospital and state specific information to help inform the future of MBQIP and national TA and data analytic needs

National CAH Quality Inventory and Assessment: Development

Two Primary Objectives:

1. Gather an inventory of service lines and related quality measures that hospitals are tracking to identify trends and help inform Flex initiatives at the state and national levels
    - Advisory Group made up of State Flex staff, MBQIP subcontractors, and CAH quality experts providing input
2. Assess implementation of core elements of CAH quality infrastructure to identify gaps and opportunities for enhancement
    - Hosted a National CAH Quality Infrastructure Summit to identify key elements and criteria

Benefits of the Assessment for CAHs

CAHs will be able to:

- Assess their quality infrastructure across the core elements, and identify opportunities for improvement
- Benchmark and compare themselves to other CAHs in their state and nationally as it relates to quality infrastructure to set appropriate goals for improvement
- Work with State Flex Programs to identify peers in their state and nationally that have similarities or from whom they wish to learn more (e.g., those that share an EHR vendor, those with a service line your CAH is considering adding, etc.)
- Receive more targeted technical assistance from their State Flex Program based on service lines, CAH volume, quality reporting, and other key needs and opportunities

National CAH Quality Inventory and Assessment: Components

- Identification of Key CAH Characteristics
- Assessment of CAH Quality Infrastructure
- Inventory of CAH Service Lines and Related Quality Measures

Identification of Key CAH Characteristics

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CAH Characteristics

- Basic CAH Characteristics - e.g., Hospital System Membership (owned, managed, neither)
- Volume Metrics - e.g., Average Daily Census and Total ED Visits
- EHR Vendor and how they use EHR for quality reporting

Example Question

Q13. Do you use your EHR for collecting and/or reporting quality data? Please select "yes" or "no" for each of the following activities.

	Yes	No
Manual data abstraction	○	○
EHR pre-defined reports	○	○
Manually developed reports	○	○
Auto-upload from EHR to quality platform (CMS/CART)	○	○
Other EHR activities for collecting or reporting quality data (please list):	○	○

Assessment of CAH Quality Infrastructure

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Core Elements of CAH Quality Infrastructure

Leadership Responsibility & Accountability

Element: Actively demonstrate governance and administrative leadership support for improving quality.

Criteria:

- The organization's board engages in and supports quality improvement
- Organizational resources are adequately allocated to support QI
- Executive leadership oversees design and functionality of the QI program

Quality Embedded Within the Organization's Strategic Plan

Element: Ensure quality is an intentional component of the strategic plan process and strategic plan.

Criteria:

- Quality leaders participate in organizational strategic planning
- Quality is a core component of the organization's strategic plan
- Quality is reflected in all core components of the organization's strategic plan

Workforce Engagement & Ownership

Element: Develop and support a workforce that embeds quality in everyday work.

Criteria:

- The organization has formal onboarding and orientation that embed quality as a priority
- The organization has regular and ongoing professional development opportunities for staff related to quality
- Quality improvement is incorporated into standard work
- The organization embeds diversity, equity, and inclusion in workforce development

Culture of Continuous Improvement Through Systems

Element: Design and manage systems and processes in a manner that supports continuous QI.

Criteria:

- The organization uses standardized methods for improving processes
- Leadership incorporates expectations for QI into job descriptions and department and committee charters
- The organization has processes in place for continuous reporting and monitoring of QI data

Culture of Continuous Improvement Through Behavior

Element: Support QI behaviors in an adaptable organization that embraces innovation, motivation, and accountability.

Criteria:

- The organization monitors adherence to best practices such as evidence-based protocols/order sets in all areas
- The organization intentionally develops strong peer relationships with internal and external partners including those at the local, state, and federal levels
- Employees demonstrate initiative to achieve goals and strive for excellence
- Managers and leaders regularly evaluate behaviors to ensure they align with organizational values

Integrating Equity into Quality Practices

Element: Undertake intentional improvement activities to ensure a fair and just opportunity to be as healthy as possible for all community members.

Criteria:

- Managers use collected data and other available resources to identify inequities
- Leaders routinely assess quality interventions and processes to address identified inequities
- Units and departments implement specific health equity projects to improve care and lessen inequities

Engagement of Patients, Partners, & Community

Element: The CAH intentionally builds external relationships with patients, partners, and the community to enhance access and improve the care experience.

Criteria:

- The organization collects feedback from patients and families beyond patient experience surveys
- The organization collaborates with other care providers using closed-loop referral processes to help ensure quality of care
- The organization uses a variety of mechanisms to share quality data with patients, families, and the community
- Leaders synthesize and develop action plans in response to patient, family, and community feedback

Collecting Meaningful & Accurate Data

Element: Apply a multidisciplinary approach to identify key quality metrics, prioritizing complete and accurate data collection.

Criteria:

- The organization has a multidisciplinary process for identifying key quality metrics
- Leaders identify risks and opportunities based on analyses of key quality metrics
- The organization leverages health information technology (HIT) to support complete and accurate data collection
- The organization collects and documents race, ethnicity, and language (REL), sexual orientation and gender identity (SOGI), and health-related social needs (HRSN) data

Using Data to Improve Quality

Element: Use internal and external data comprehensively, meaningfully, and transparently to inform QI.

Criteria:

- The organization shares data transparently both internally and externally
- The organization incorporates external data sources to inform QI efforts
- Leaders act on and clearly communicate the data results from quality initiatives
- The organization uses benchmarking to identify where quality can be improved

Which of the following standardized methods does your facility utilize? Select all that apply:

- Plan-Do-Study-Act (PDSA) (Model for Improvement)
- Lean
- Six Sigma/DMAIC (Define, Measure, Analyze, Improve, and Control)
- Root Cause Analysis
- Failure Mode and Effects Analysis (FMEA)
- Just Culture
- None of the above

Where does hospital leadership incorporate expectations for quality improvement? Select all that apply:

- In all clinical staff job descriptions
- In all non-clinical staff job descriptions
- In project and/or committee charters
- In roles and responsibilities for Board members
- None of the above

Inventory of CAH Service Lines and Related Quality Measures

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Inventory

- Service Provision (in all domains of the hospital/entities they own, including swing beds, labor and delivery, behavioral health, and many more)
- Quality Measures by service line/area *outside of MBQIP measures* (Inpatient, Outpatient, Mental Health, Specialties, Other services)

Next Steps

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Receiving Information

- September 11 – **October 2**
- Email from Healthworks with link to online portal for the Assessment and support materials
- Support materials
  - PDF of the Assessment – to review/collect data with your team prior to going online to fill in the Assessment
  - Instructions Document – step-by-step through all questions to explain further how to fill out the questions
  - CAH Fact Sheet – overview of information about the Assessment

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The Assessment Process

After receiving email from Healthworks:

1) Review the PDF of the Assessment questions
2) Work with your team to gather the answers
3) Log on to the online portal to submit answers

- Estimated time to completed – 60-90 minutes to gather and submit the data
  - May vary depending on experience, knowledge of the facility and quality initiatives, etc.
- Confirmation – after submitting Assessment online, CAH quality contact will receive email that includes responses submitted

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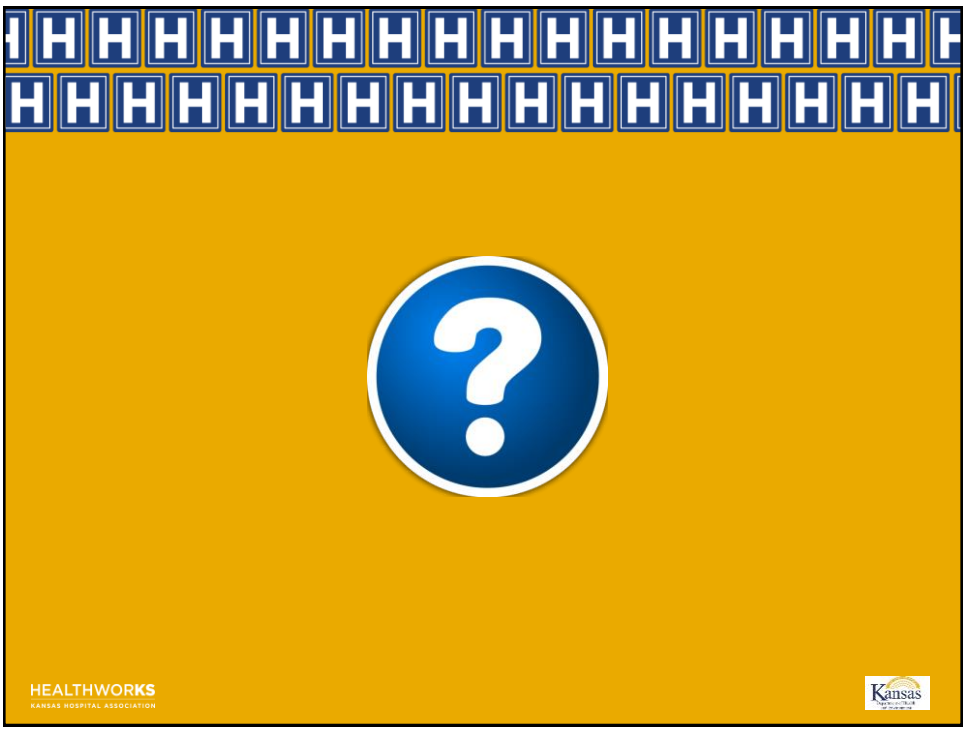

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