Medicare Beneficiary Quality Improvement Project (MBQIP)
FAQs: Pharmacist CPOE/Verification of Medication Orders within 24 Hours

Reporting Timeline

Q: Can you clarify the reporting timeline for the Pharmacist Measure? Specifically, will hospitals follow the same data submission deadlines that they currently follow for the CMS Reporting Quarter dates?
A: The reporting quarters for data collection will be the same as the Hospital Compare quarters (Oct-Dec, Jan-Mar, etc), but the submission deadlines may differ. As soon as ORHP confirms that the PIMS system has been updated to allow for Flex Coordinator submission of this data, we will create a quarterly submission deadline schedule and share it.

Q: What is the first reporting quarter and submission deadline for this measure?
A: The first reporting quarter for this measure is October 1 – December 31, 2013. ORHP suggests that the first CAH submission deadline to get data to Flex Coordinators be set at March 7, 2014. It is our hope that the PIMS system will be updated for collection of this measure by early Spring, and if Flex Coordinators have data from their CAHs in early March, they will be prepared to submit the data as soon as PIMS is ready. We will determine a submission deadline schedule for each subsequent reporting period in the near future.

Data Submission Process

Q: Do CAHs have to use the sample CAH Tracking Tool in order to submit their data to the Flex Coordinators?
A: If the CAHs choose to do so (or if the Flex Coordinator requires its use in their state), they may use the ND developed CAH Tracking Tool to help them track their compliance internally, and easily pull their numerator and denominator to submit to the Flex Coordinator each quarter. ORHP is not requiring the use of this tool and a Flex Coordinator may elect to use it, create their own Excel form for submission, or simply have the CAHs email their data.

Q: In the sample CAH Tracking Tool provided, the data collection cells begin with January 1, 2013. Should we collect data back to January 1, 2013?
A: No, for purposes of reporting on this measure, the first reporting quarter begins October 1, 2013. If you are able to collect back to January 1, you are welcome to do so for your own internal tracking and improvement purposes.

Q: Should the hospitals be sending their quarterly data to Flex Coordinators rather than submitting it via CART Tool or other possible reporting mechanisms?
A: Yes, at this time submission to Flex Coordinators will be the method used. Each state can determine the best manner for collecting the data from their CAHs (Excel, email, etc). The CART tool was looked at as an option, but because this measure is collected by order and not by patient, it was not a method that would work.

Q: For state-level data submission, will the data be submitted for each CAH individually or as a state CAH total numerator/denominator?
A: Flex Coordinators will submit one spreadsheet for their state that includes the data for each CAH individually in the spreadsheet.

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Q: If not all of our CAHs report on this measure, do we just submit the data we do receive?
A: Yes, please submit data for all of your CAHs that submit data to you. If some of your CAHs do not submit data, please follow up with them to determine why they have not submitted data.

Q: One of my CAHs has confirmed that they have electronic order entry, but they do not currently have the capability to run the Pharmacist Verification Report in order to determine their numerator and denominator for submission of this measure. What does ORHP recommend we do in this case?
A: Please refer to the document "Data Collection through Pharmacist Verification Report" that is posted on the TASC website (http://www.ruralcenter.org/tasc/resources/medicare-beneficiary-quality-improvement-project-mbqip) for more information on how the CAH can discuss report options with their EHR or Pharmacy System vendor.

Q: Can you address the issue of CAHs having to report data to multiple resources? I anticipate hearing some concern about the fact that they'll now be submitting data to yet another source.
A: We are aware that many hospitals face reporting overload, so while this measure will have them submitting data to the Flex Coordinator rather than a source they are already using, ORHP has tried to make the submission process as easy as possible. Each state can determine which method works best for their CAHs for data submission (Excel, email, etc).

Flex Coordinator Role

Q: Can you please provide additional information regarding the Flex Coordinator role in the quarterly reporting process.
A: It will be up to each individual Flex Coordinator to determine which method they will use for the CAHs in their state to collect the hospital-level data each quarter. For statewide submission of the data, ORHP will provide the Flex Coordinators with a template Excel form to be used to compile the data from their CAHs. This spreadsheet will then be uploaded to PIMS on a quarterly basis for submission to ORHP. (Note: The Performance Improvement Management System, PIMS, is a HRSA data warehouse where grantees submit performance measures. CAHs and other non-grantees do not need to access PIMS in order to submit MBQIP data.)

Q: Should the Flex Coordinator inform ORHP of the status of CPOE in their state?
A: Yes, it would be very helpful if the Flex Coordinators could share with their ORHP Project Officer the status of CPOE (either full EHR or a stand-alone Pharmacy System) for the CAHs in their state.

Q: Should the Flex Coordinator keep track of which of their hospitals report on this measure? If so, should the Flex Coordinator also find out the reasons why a CAH does not submit data for this measure each quarter?
A: Yes, Flex Coordinators should monitor and track which of their CAHs are reporting on this measure the same as they should be monitoring and tracking CAH participation and reporting for all other MBQIP measures. If a CAH does not submit data, ORHP asks that the Flex Coordinator follow up with the CAH and determine the reason that no data was submitted (i.e. no EHR or stand-alone pharmacy system, inability to run report to determine numerator and denominator, etc). ORHP can include a space for Flex Coordinators to document the reasons for no data submission in the spreadsheet template that will be provided for state-level data submission.

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Additional Questions

Q: How will the data collected via this measure be used?
A: ORHP will use this process measure data to improve CAHs engagement of pharmacist utilization in medication management through order/verification practices which are proven to lead to improved clinical outcomes. CAHs will be able to use this data for internal quality improvement, and for benchmarking themselves against other CAHs statewide and nationally. ORHP will also work with partners such as TASC and FMT to gather and disseminate best practices to be shared among all CAHs.

Q: Does *my* CAH have to report on this measure?
A: Participation in MBQIP is voluntary, but we are asking that every hospital that is able, participate in and reports on this measure. If your CAH has the capability to run the pharmacist verification reports, then we hope that you will report your data.

Q: A while back, a few documents on small volume were shared. How do these documents relate to the Phase 3 Pharmacist measure ("How Small is Too Small" and "Eliminate the Denominator," posted on the TASC website at http://www.ruralcenter.org/tasc/resources/medicare-beneficiary-quality-improvement-project-mbqip**)? The documents give guidance that tells CAHs to "drop the denominator" or "infer performance". Please explain in light of what was said on the webinar regarding reporting numerator and denominators.**
A: With the number of medication orders that are likely to occur in a CAH, the denominator will not be that small for a full reporting quarter, which means the low volume won't be as much of an issue as it is with some of the other quality measures. Because we are counting orders and not patients, this will greatly increase the numbers - even a very low volume CAH will likely have 400-500 orders per month. This will give us good data, not skewed as much by low numbers which is the reason for dropping the denominator for some of the lower volume measures. Additionally, we are not doing any "sampling" with this measure. We are asking for 100% data collection (provided by automation), and this will help ensure a larger volume.