2012 Flex Conference

Flex Medicare Beneficiary Quality Improvement Project

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Flex Medicare Beneficiary Quality Improvement Project

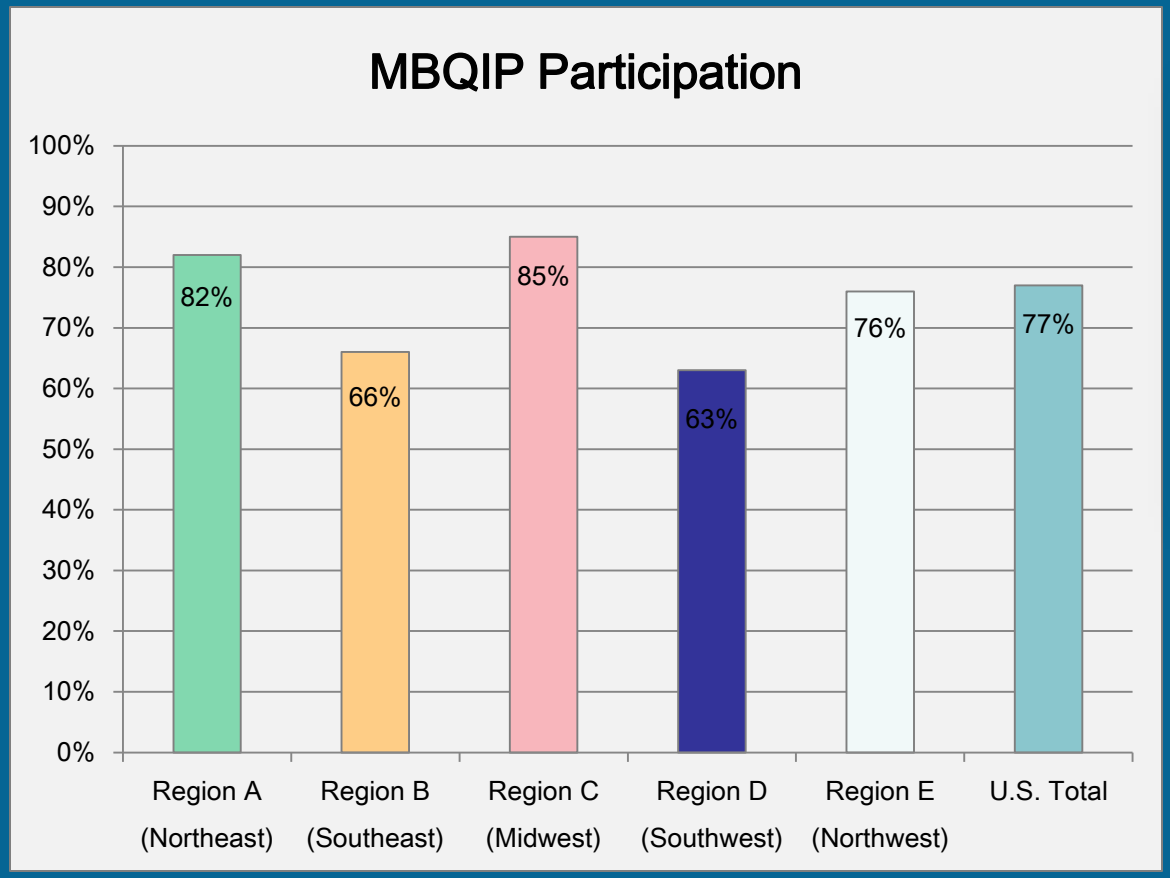
- Pilot Project under Quality Improvement
- Common Metrics
- Demonstrating Improvements
- Sharing Best Practices
- Official Start: Sept 2011

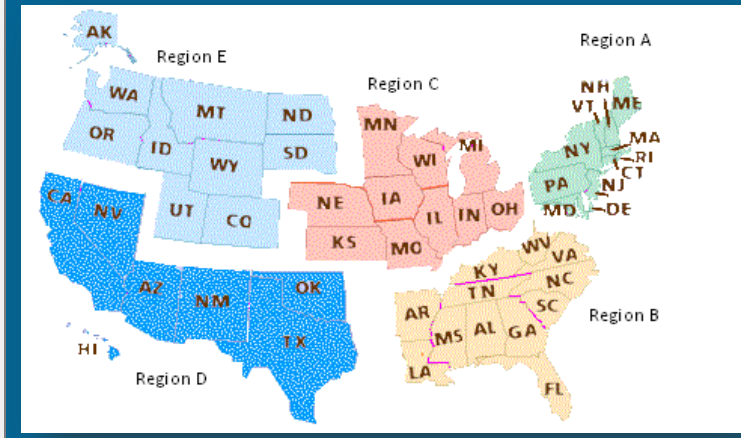
http://www.hrsa.gov/ruralhealth/about/video/index.html

Or

www.Youtube.com [MBQIP]

MBQIP Participation by ORHP Region





- Region A: 54 of 66 CAHs (82%)
- Region B: 156 of 236 CAHs (66%)
- Region C: 477 of 559 CAHs (85%)
- Region D: 118 of 187 CAHs (63%)
- Region E: 214 of 281 CAHs (76%)
- US Total: 1019 of 1329 CAHs (77%)

WHY NOW???

At least 3 reasons….

WHY NOW ???

www.Youtube.com [MBQIP]

Perception vs Reality?

JAMA

Quality of Care and Patient Outcomes In Critical Access Rural Hospitals

"Compared with non-CAHs, CAHs had fewer clinical capabilities, worse measured processes of care, and higher mortality rates for patients with AMI, CHF, or pneumonia."

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JAMA

"Patients admitted to CAHs had higher 30-day risk adjusted mortality rates for all 3 conditions than patients admitted to non-CAHs."

JAMA

"More than a decade after major federal and state efforts to save US rural hospitals, these findings should be seen as a call to focus on helping these hospitals improve the quality of care they provide so that all individuals in the United States have access to high-quality inpatient care regardless of where they live."

JAMA

"Engaging in the process of collecting and reporting data is an important step toward developing an internal quality improvement strategy."

CAHs need to "tell" their own story!

WHY NOW???

Because I was wrong

10 years ago…

…. from recent headlines…

Cuts For Rural Hospitals

"…. as part of debt ceiling negotiations, has proposed $14 billion over 10 years to "reform rural hospital programs."

the President's budget…

…called for $6 billion in cuts over 10 years to rural hospitals, claiming that the proposal eliminates "higher than necessary reimbursement".

WHY NOW???

"Proving Value"

...to patients, payers and policy makers!

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Moving Forward….

What got our CAHs where they are…

…won't get them where they want to go.

The emphasis is changing….

…from "how much" to "how well"

…from " outputs" to "outcomes"

…from "Volume" to "Value"

The Standard for Flex is changing….

…from "process" to "performance"

…from " activities" to "outcomes"

…from "Vision" to "Value"

Simple definition…

Value = Quality / Cost

So how do we increase Value ?

Increase Quality

or

Decrease Cost

By the way...

Patient Protection and Affordable Care Act

"Value – Based Purchasing"

Why FOCUSING our CAHs on "QUALITY" is so important!

"Quality's" evolution... Your challenge!

- *1980's-90's… the "Buzz-word"*

  Series of Programs, initiatives …

  (Monitors, QA, CQI, PI,….)
- *2000's… reporting, transparency, market share…*

  (Hospital Compare, PQRS,)
- *Now… expanding and affecting reimbursement*

So… if CAHs will be accountable for Value…

Value = Quality / Cost

How do CAHs do better while reducing the cost?

Key…

Increasing Quality will decrease Cost.

What will "Quality" look like…

Keeping patients from getting injured or sicker while in our care…

- Adverse Drug Events
- Catheter-Associated Urinary Tract Infections
- Pressure Ulcers
- Injuries from Falls and Immobility
- Central Line Associated Blood Stream Infections
- Obstetrical Adverse Events
- Surgical Site Infections
- Venous Thromboembolism
- Ventilator-Associated Pneumonia

What will "Quality" look like…

Hospitals, communities, patients and families devoting new attention to making sure that transitions out of the hospital are well coordinated….

…helping patients heal without complication...

What will "Quality" look like…

Decreasing inappropriate and duplicative tests and procedures because we are utilizing electronic health records that provide us with the information we need as providers…

What will "Quality" look like…

Increasing patient access to healthcare providers in more cost efficient settings through greater utilization of tele-medicine …

IMPROVING QUALITY
Will
DECREASE COST

MBQIP

(AN OVERVIEW)

Phase 1

(Sept. 2011)

Reporting data…
Finding and using value…
(best practices / best methods)

Pneumonia and Heart Failure Process of Care Measures

Percent Pneumonia Patients:

- Whose Initial Blood Culture Was Performed Prior to the Administration of the First Hospital Dose of Antibiotics
- Given the Most Appropriate Initial Antibiotic(s)

Percent Heart Failure Patients:

- Given Discharge Instructions
- Given an Evaluation of Left Ventricular Systolic Function
- Given ACE Inhibitor or ARB for Left Ventricular Systolic Dysfunction (LVSD)

Phase 2

(Sept. 2012)

Adding Out-Patient Measures

(Benchmarking IP Measures)

HCAHPS

Out-Patient Measures

- **OP-1** Median Time to Fibrinolysis
- **OP-2** Fibrinolytic Therapy Received Within 30 Minutes of ED Arrival
- **OP-3** Median Time to Transfer to Another Facility for Acute Coronary Intervention
- **OP-4** Aspirin at Arrival
- **OP-5** Median Time to ECG
- **OP-6** Timing of Antibiotic Prophylaxis (Prophylactic Antibiotic Initiated Within One Hour Prior to Surgical Incision)
- **OP-7** Prophylactic Antibiotic Selection for Surgical Patients

HCAHPS Survey Topics

- Communication with doctors and nurses
- Responsiveness of hospital staff
- Cleanliness and quietness of hospital environment
- Pain management
- Communication about medications
- Discharge information
- Overall rating of the hospital
- Rating of willingness to recommend hospital

Hospital Consumer Assessment of Healthcare Providers and Systems (HCAHPS)

- 34% of CAHs reported HCAHPS patient assessment of care survey data in 2008.
- On average, CAHs have significantly higher ratings on HCAHPS measures than all US hospitals.

Policy Brief #15 March 2010

Critical Access Hospital Year 5 Hospital Compare Participation and Quality Measure Results

Michelle Casey, MS, Michele Burlew, MS, Ira Moscovice, PhD
University of Minnesota Rural Health Research Center

Phase 3

(Sept. 2013)

ED Patient Transfer Communication Measure

- **NQF Endorsed…**
- **Potential Special QIO Project**
- **Hopefully CMS Approved Measure by then!**

ED Patient Transfer Communication*

- Pre-Transfer Communication Information (0-2)
- Patient Identification (0-6)
- Vital Signs (0-6)
- Medication-Related Information (0-3)
- Physician or Practitioner Generated Information (0-2)
- Nurse Generated Information (0-6)
- Procedures and Tests (0-2)

* NFQ Endorsed

Phase 3

(Sept. 2013)

Pharmacist CPOE or Verification of Medication Orders within 24 hours

- *Readiness of your CAHs?*
- *Resources available to them?*
- *Networking opportunities?*

Because…

"Approximately one in five of the nation's smallest hospitals have… (1) a pharmacist review of orders within 24 hours…"

Prevalence of Evidenced-Based Safe Medication Practices in Small Rural Hospitals
RUPRI Center for Rural Health Policy Analysis
April 2008

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- Across all our states…
- Involving over 1,000 CAHs
- Aggregating the data – national benchmarking.
- Rural Appropriate Measures & Processes

  - Heart Failure, Pneumonia, (30 Day Re-admissions)
  - OP Measures , HCAHPS
  - Ed OP Transfer Measure, Med Orders Reviewed within 24 hours

http://www.hrsa.gov/ruralhealth/about/video/index.html

MBQIP is about…

Leveraging Resources and Relationships….

Measuring and Reporting data…

Finding and using value…
(best practices / best methods)

Your role….

- *Engage your CAHs in the Medicare Beneficiary Quality Improvement Project*
  http://www.hrsa.gov/ruralhealth/about/video/index.html
- *Engage their Hospital Engagement Network to assure CAH participation in reducing harm.*
- *Work with the CAHs and the QIO in improving care transitions.* **(Integrating Care for Populations and Communities)**
- *Help them enlist Community Partners in the work.*
- *Help them put forth their own quality story….*

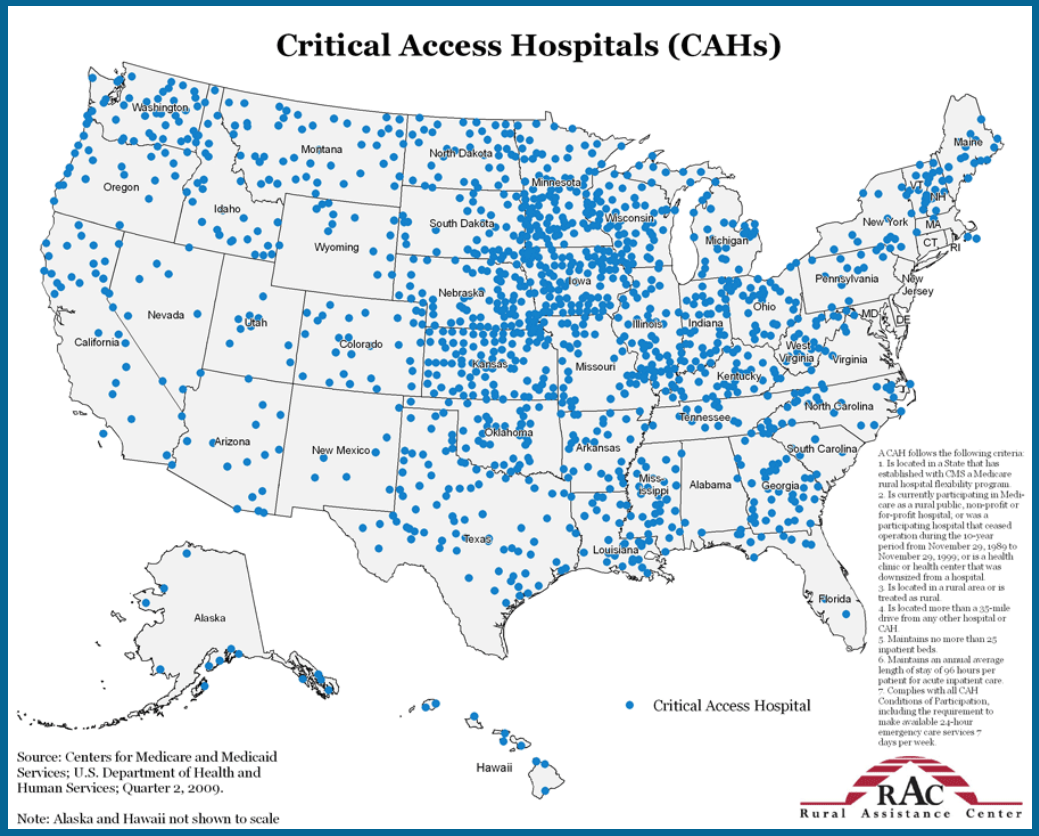
One final word… (for all of us)

The time has come to *prove* Value…

… for our CAHs…

…for our programs that support them.

At the end of the day…



This is why we are here.

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