MBQIP Reporting Basics

Robyn Carlson, RHIA, CPHQ

Flex Reverse Site Visit
July 20, 2016

Objectives

- Overview of hospital reporting for the Medicare Beneficiary Quality Improvement Program (MBQIP) program
  - Review Domains and Measures
  - Alignment with other Federal programs
  - Review Hospital Reporting Processes

Stratis Health

- Independent, nonprofit, Minnesota-based organization founded in 1971
  - Lead collaboration and innovation in health care quality and safety, and serve as a trusted expert in facilitating improvement for people and communities
- Work at intersection of research, policy, and practice
- Long history of working with rural providers, critical access hospitals (CAHs), and the Flex Program

Rural Quality Improvement Technical Assistance Center (RQITA)

- Three-year cooperative agreement awarded to Stratis Health from Health Services and Resources Administration (HRSA) Federal Office of Rural Policy (FORHP), 2015 – 2018
- Improve quality and health outcomes in rural communities through technical assistance to beneficiaries of FORHP quality initiatives
  - Flex/MBQIP
  - Small Health Care Provider Quality Improvement Grantees (SCHPQI)

MBQIP

- Quality improvement (QI) activity under the Medicare Rural Hospital Flexibility (Flex) grant program through the Federal office of Rural Health Policy (FORHP)
- Improve the quality of care provided in CAHs by increasing quality data reporting and then driving improvement activities based on the data
- Set of rural-relevant hospital metrics, technical assistance, encouragement, and support
- Aligned with other Federal Quality Programs

Goals of MBQIP

- CAHs report common set of rural-relevant measures
- Measure and demonstrate improvement

- ***Help CAHs prepare for value-based reimbursement***

MBQIP Required Measures

- Patient Safety
  - OP-27: Influenza vaccination coverage among health care personnel
  - IMM-2: Influenza immunization
- Patient Engagement
  - Hospital Consumer Assessment of Healthcare Providers & Systems (HCAHPS): Patient Experience Survey
- Care Transitions
  - EDTC: Emergency department transfer communication*

*Not currently a CMS Hospital Measure

MBQIP Required Measures

- Outpatient
  - Acute myocardial infarction (AMI)/Chest Pain
    - OP-1: Median Time to Fibrinolysis
    - OP-2: Fibrinolytic Therapy Received Within 30 Minutes
    - OP-3: Median Time to Transfer to Another Facility for Acute Coronary Intervention
    - OP-4*: Aspirin at Arrival
    - OP-5: Median Time to ECG

*Added to MBQIP for FY2016

MBQIP Required Measures

- ED throughput
  - OP-18*: Median Time from ED Arrival to ED Departure for Discharged ED Patients
  - OP-20: Door to Diagnostic Evaluation by a Qualified Medical Professional
  - OP-22: Left Without Being Seen
- Pain management
  - OP-21: Median Time to Pain Management for Long Bone Fracture

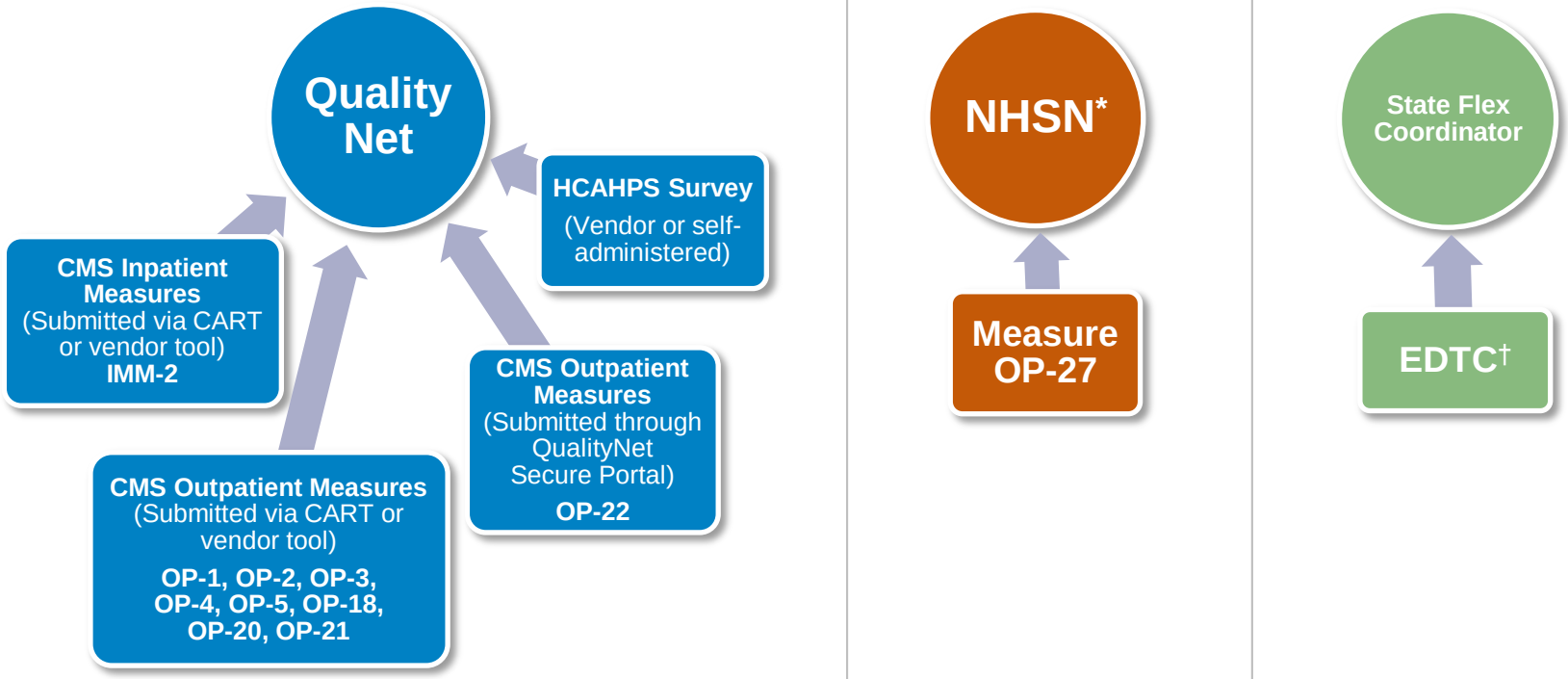
*Added to MBQIP for FY2016

MBQIP Additional Measures

- Patient Safety
  - Healthcare-associated infections (HAIs), stroke care, venous thromboembolism (VTE), perinatal care, surgical care, pneumonia, falls, adverse drug events (ADEs), readmissions, safety culture survey
- Care Transitions
  - Discharge planning, medication reconciliation
- Outpatient
  - ED throughput for admitted patients (CMS ED-1*& ED-2*)

* Although focused on ED care, these two measures are considered part of the CMS Inpatient Measure set.

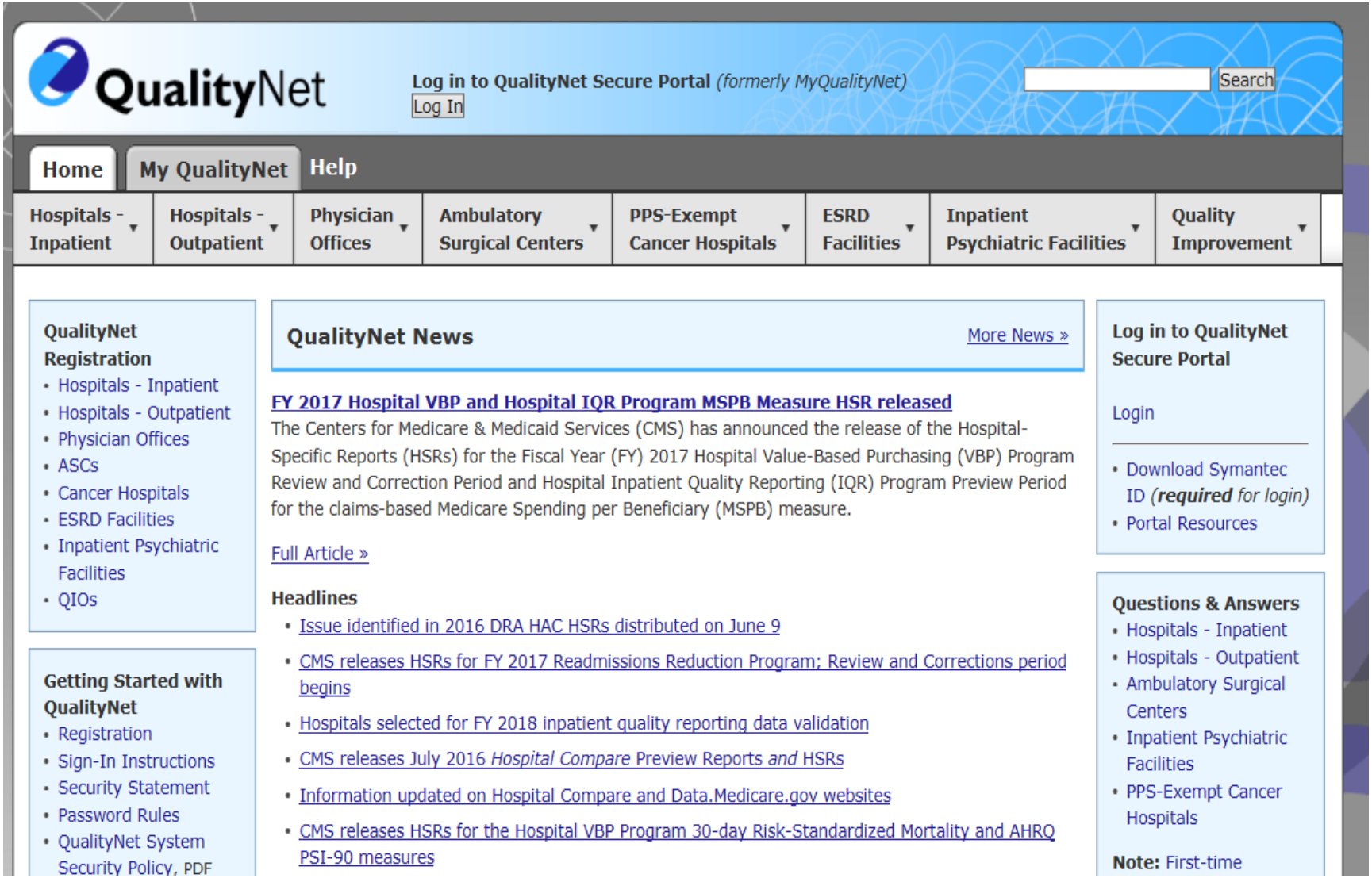
Reporting Channels



*National Healthcare Safety Network †Emergency Department Transfer Communication

Hospital Reporting Basics

- Resources on www.QualityNet.org and how hospitals can use them to collect data:
  - Specification Manuals
  - CART (Centers for Medicare and Medicaid Services Abstraction and Reporting Tool)/data collection tool
  - Secure Log-in
- As time allows:
  - CDC NHSN (National Healthcare Safety Network) (OP-27)
  - EDTC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FY 2017 Hospital VBP and Hospital IQR Program MSPB Measure HSR released
The Centers for Medicare & Medicaid Services (CMS) has announced the release of the Hospital-Specific Reports (HSRs) for the Fiscal Year (FY) 2017 Hospital Value-Based Purchasing (VBP) Program Review and Correction Period and Hospital Inpatient Quality Reporting (IQR) Program Preview Period for the claims-based Medicare Spending per Beneficiary (MSPB) measure.
Full Article »
Headlines
• Issue identified in 2016 DRA HAC HSRs distributed on June 9
• CMS releases HSRs for FY 2017 Readmissions Reduction Program; Review and Corrections period begins
• Hospitals selected for FY 2018 inpatient quality reporting data validation
• CMS releases July 2016 Hospital Compare Preview Reports and HSRs
• Information updated on Hospital Compare and Data.Medicare.gov websites
• CMS releases HSRs for the Hospital VBP Program 30-day Risk-Standardized Mortality and AHRQ PSI-90 measures
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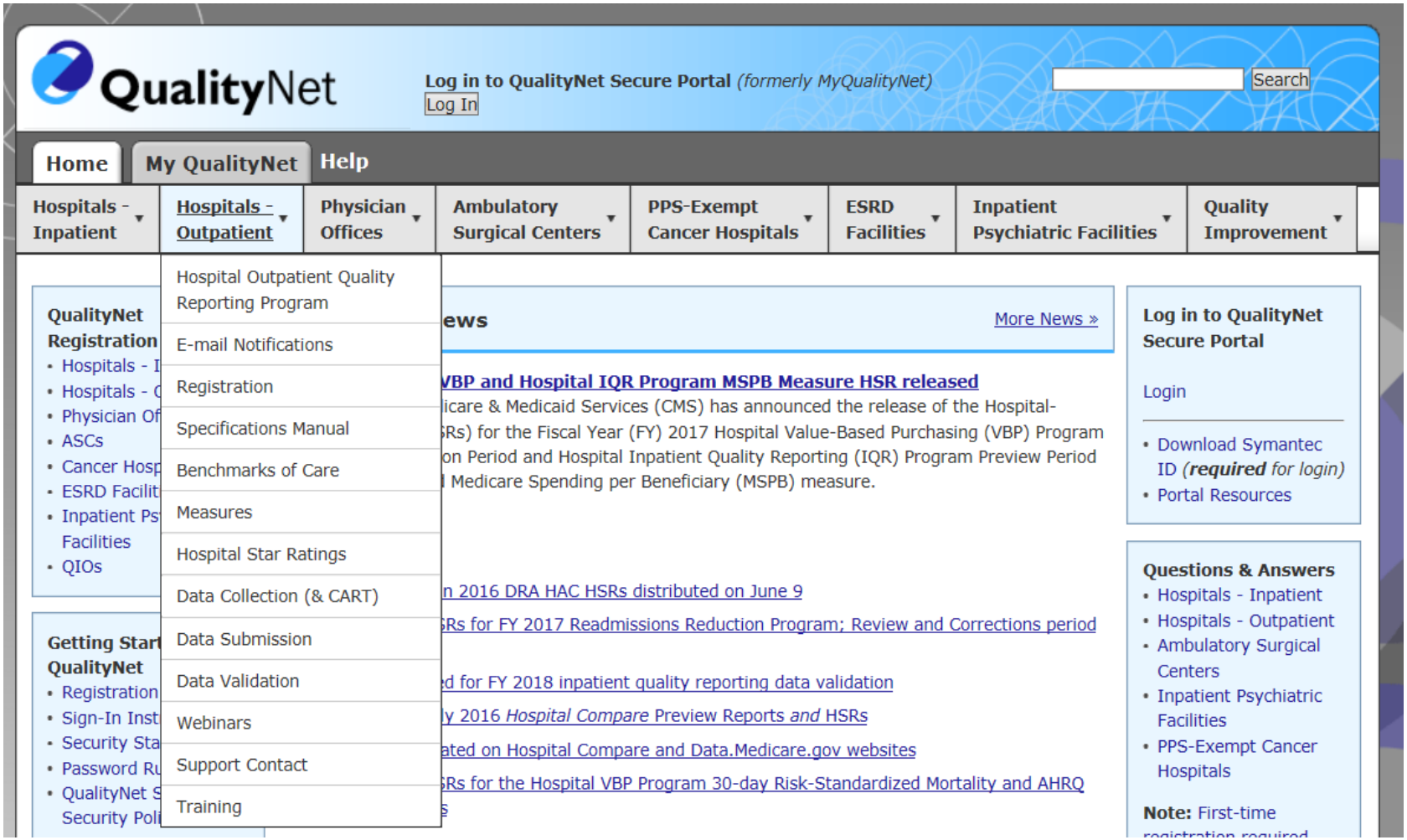
• Portal Resources
Questions & Answers
• Hospitals - Inpatient
• Hospitals - Outpatient
• Ambulatory Surgical Centers
• Inpatient Psychiatric Facilities
• PPS-Exempt Cancer Hospitals
Note: First-time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Hospital Outpatient Quality Reporting Program
E-mail Notifications
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Specifications Manual
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Data Submission
Data Validation
Webinars
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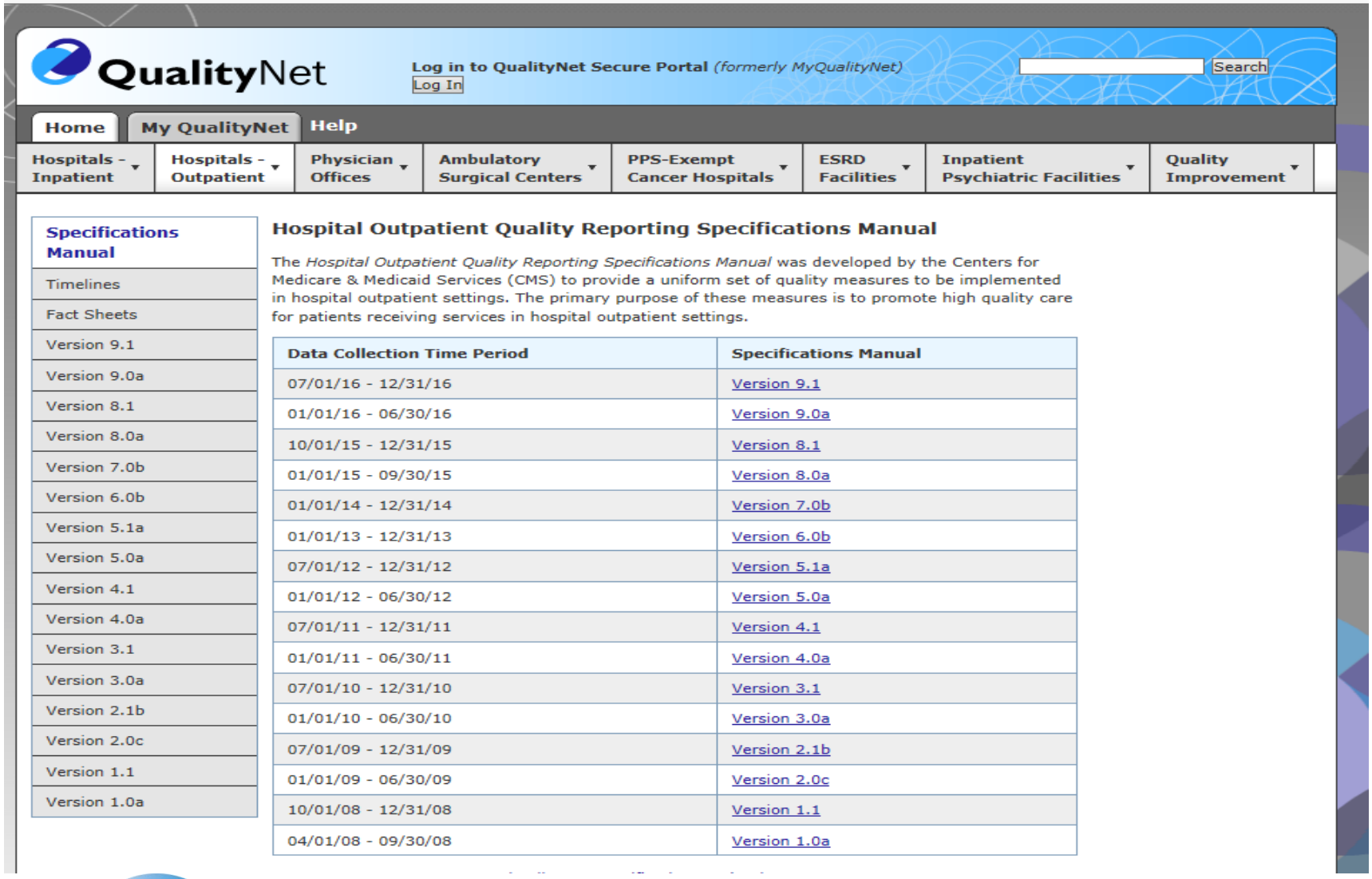
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Fact Sheets
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Version 9.0a
Version 8.1
Version 8.0a
Version 7.0b
Version 6.0b
Version 5.1a
Version 5.0a
Version 4.1
Version 4.0a
Version 3.1
Version 3.0a
Version 2.1b
Version 2.0c
Version 1.1
Version 1.0a
Hospital Outpatient Quality Reporting Specifications Manual
The Hospital Outpatient Quality Reporting Specifications Manual was developed by the Centers for Medicare & Medicaid Services (CMS) to provide a uniform set of quality measures to be implemented in hospital outpatient settings. The primary purpose of these measures is to promote high quality care for patients receiving services in hospital outpatient settings.
Data Collection Time Period
Specifications Manual
07/01/16 - 12/31/16
Version 9.1
01/01/16 - 06/30/16
Version 9.0a
10/01/15 - 12/31/15
Version 8.1
01/01/15 - 09/30/15
Version 8.0a
01/01/14 - 12/31/14
Version 7.0b
01/01/13 - 12/31/13
Version 6.0b
07/01/12 - 12/31/12
Version 5.1a
01/01/12 - 06/30/12
Version 5.0a
07/01/11 - 12/31/11
Version 4.1
01/01/11 - 06/30/11
Version 4.0a
07/01/10 - 12/31/10
Version 3.1
01/01/10 - 06/30/10
Version 3.0a
07/01/09 - 12/31/09
Version 2.1b
01/01/09 - 06/30/09
Version 2.0c
10/01/08 - 12/31/08
Version 1.1
04/01/08 - 09/30/08
Version 1.0a

- Fact Sheets
- Version 9.1
- Version 9.0a
- Version 8.1
- Version 8.0a
- Version 7.0b
- Version 6.0b
- Version 5.1a
- Version 5.0a
- Version 4.1
- Version 4.0a
- Version 3.1
- Version 3.0a
- Version 2.1b
- Version 2.0c
- Version 1.1
- Version 1.0a

View and/or download individual sections of the Specifications Manual, (PDF documents, unless noted), listed below.

▸**Release Notes**

▸**Introductory Materials**

▾ **Section 1 – Measure Information**

Introduction

1.1 - Outpatient Acute Myocardial Infarction (AMI)

AMI Measure Set
AMI General Data Element List
AMI Specific Data Element List
AMI Population Algorithms
Measurement Information Form (MIF) and Flowchart (Algorithms)
(OP-1, OP-2, OP-3, OP-4, OP-5)

Note: Measurement Information Forms (MIFs) OP-4 and OP-5 are used for both AMI and Chest Pain.

1.2 - Chest Pain (CP)

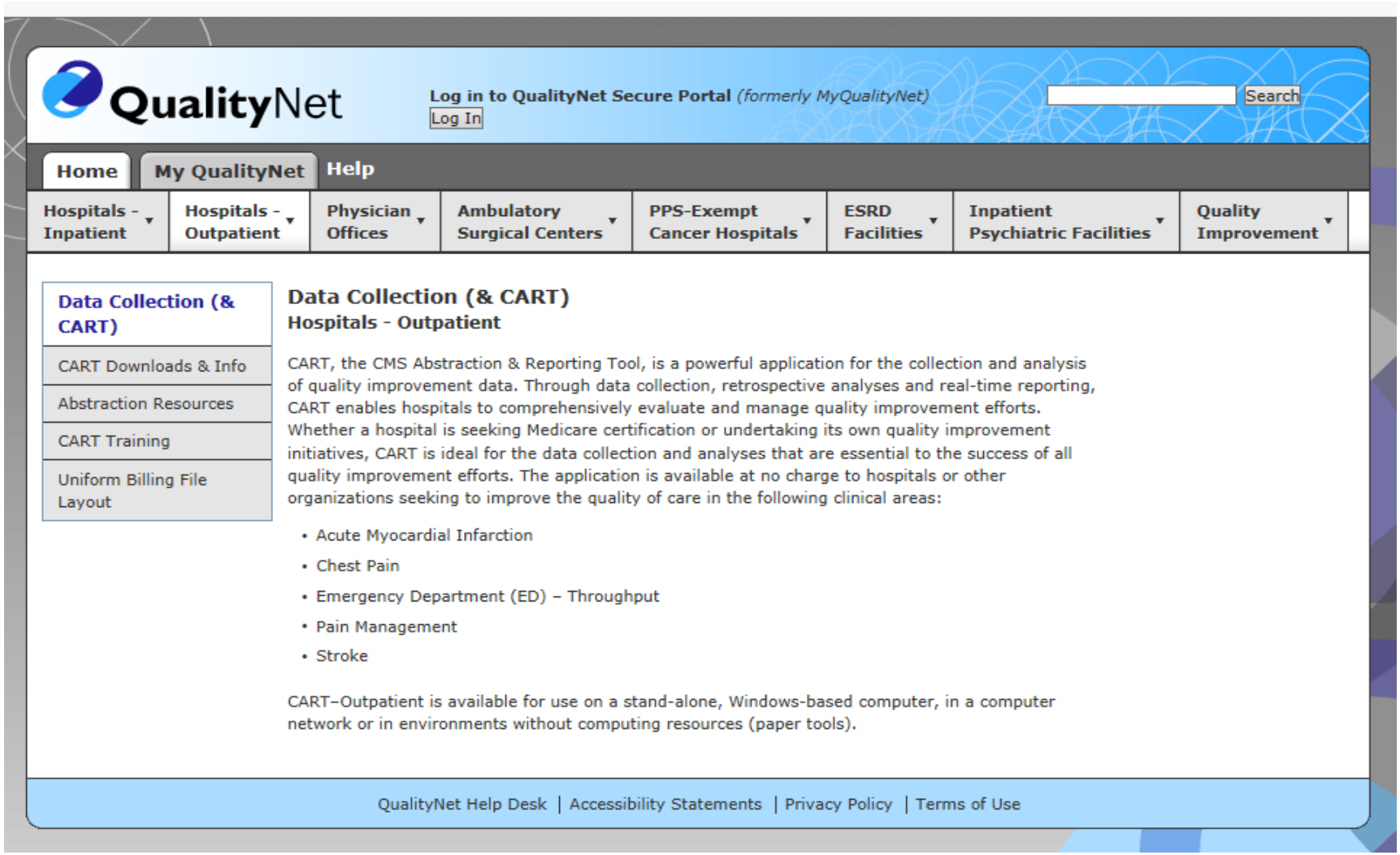
CP Measure Set
CP General Data Element List
CP Data Element List
CP Population Algorithm
Measurement Information Form (MIF) and Flowchart (Algorithms)
(OP-4, OP-5)

1.3 - Emergency Department (ED)-Throughput

ED-Throughput Measure Set
ED-Throughput General Data Element List
ED-Throughput Specific Data Element List
ED-Throughput Population Algorithm
Measurement Information Form (MIF) and Flowchart (Algorithms)
(OP-18, OP-20, OP-22)

1.4 - Pain Management

Pain Management Measure Set
Pain Management General Data Element List
Pain Management Specific Data Element List
Pain Management Population Algorithm
Measurement Information Form (MIF) and Flowchart (Algorithms)
(OP-21)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CART Downloads & Info
Abstraction Resources
CART Training
Uniform Billing File Layout
Data Collection (& CART)
Hospitals - Outpatient
CART, the CMS Abstraction & Reporting Tool, is a powerful application for the collection and analysis of quality improvement data. Through data collection, retrospective analyses and real-time reporting, CART enables hospitals to comprehensively evaluate and manage quality improvement efforts. Whether a hospital is seeking Medicare certification or undertaking its own quality improvement initiatives, CART is ideal for the data collection and analyses that are essential to the success of all quality improvement efforts. The application is available at no charge to hospitals or other organizations seeking to improve the quality of care in the following clinical areas:
• Acute Myocardial Infarction
• Chest Pain
• Emergency Department (ED) – Throughput
• Pain Management
• Stroke
CART–Outpatient is available for use on a stand-alone, Windows-based computer, in a computer network or in environments without computing resources (paper tools).
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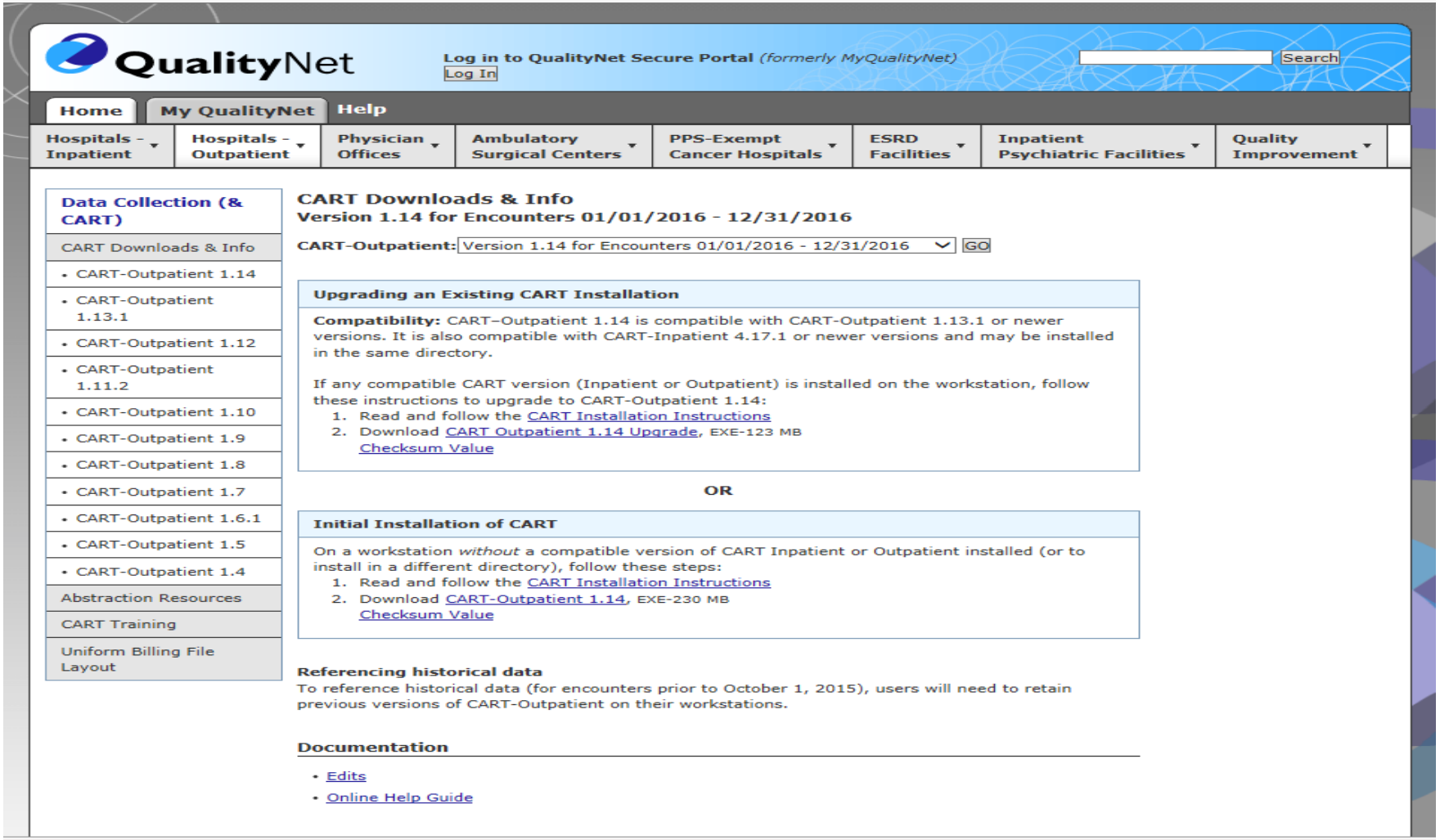
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• CART-Outpatient 1.13.1
• CART-Outpatient 1.12
• CART-Outpatient 1.11.2
• CART-Outpatient 1.10
• CART-Outpatient 1.9
• CART-Outpatient 1.8
• CART-Outpatient 1.7
• CART-Outpatient 1.6.1
• CART-Outpatient 1.5
• CART-Outpatient 1.4
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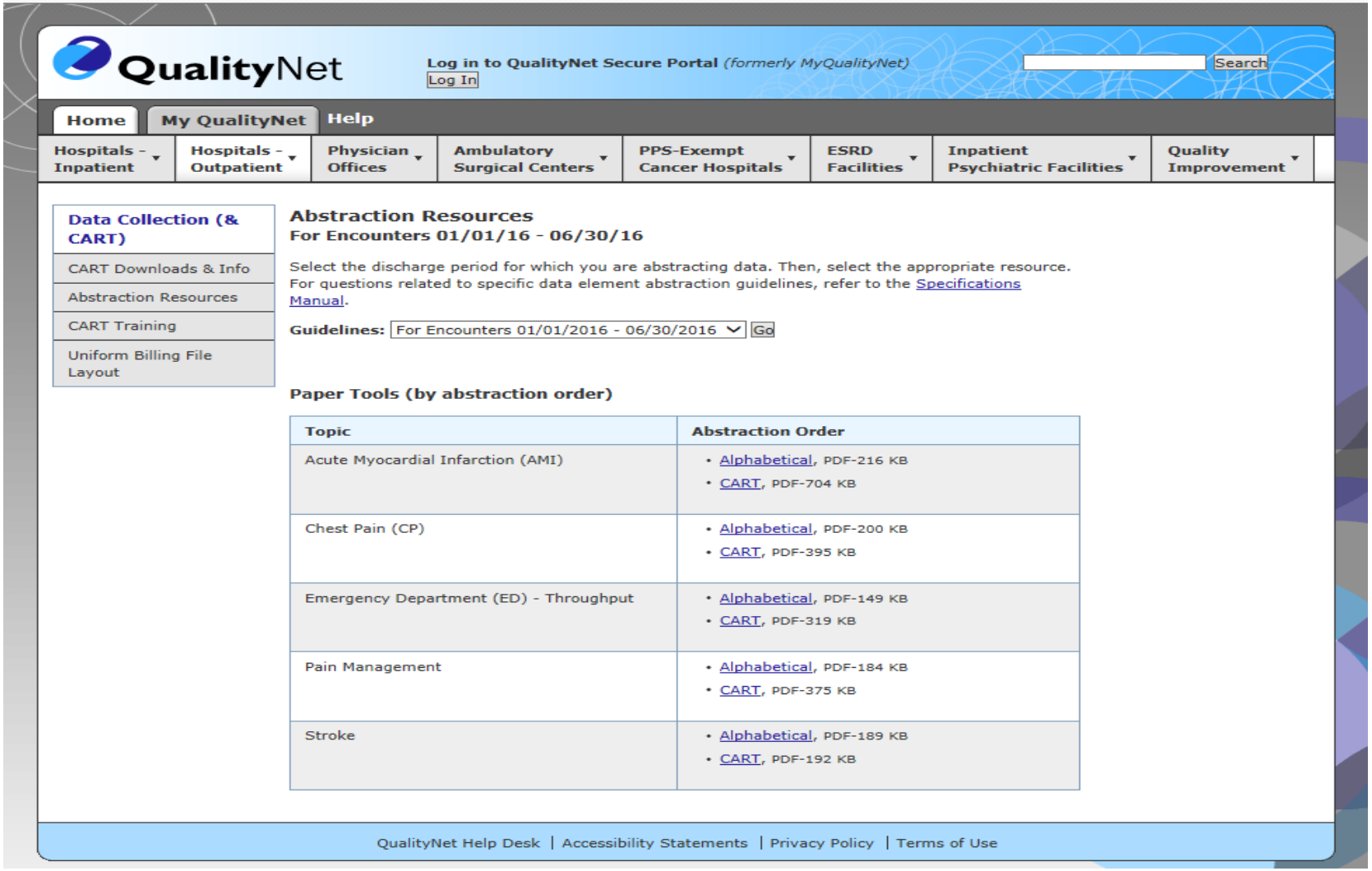
Uniform Billing File Layout
CART Downloads & Info
Version 1.14 for Encounters 01/01/2016 - 12/31/2016
CART-Outpatient: Version 1.14 for Encounters 01/01/2016 - 12/31/2016
GO
Upgrading an Existing CART Installation
Compatibility: CART–Outpatient 1.14 is compatible with CART-Outpatient 1.13.1 or newer versions. It is also compatible with CART-Inpatient 4.17.1 or newer versions and may be installed in the same directory.
If any compatible CART version (Inpatient or Outpatient) is installed on the workstation, follow these instructions to upgrade to CART-Outpatient 1.14:
1. Read and follow the CART Installation Instructions
2. Download CART Outpatient 1.14 Upgrade, EXE-123 MB
Checksum Value
OR
Initial Installation of CART
On a workstation without a compatible version of CART Inpatient or Outpatient installed (or to install in a different directory), follow these steps:
1. Read and follow the CART Installation Instructions
2. Download CART-Outpatient 1.14, EXE-230 MB
Checksum Value
Referencing historical data
To reference historical data (for encounters prior to October 1, 2015), users will need to retain previous versions of CART-Outpatient on their workstations.
Documentation
• Edits
• Online Help Guide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Abstraction Resources
For Encounters 01/01/16 - 06/30/16
Select the discharge period for which you are abstracting data. Then, select the appropriate resource.
For questions related to specific data element abstraction guidelines, refer to the Specifications Manual.
Guidelines: For Encounters 01/01/2016 - 06/30/2016
Go
Paper Tools (by abstraction order)
Topic
Abstraction Order
Acute Myocardial Infarction (AMI)
• Alphabetical, PDF-216 KB
• CART, PDF-704 KB
Chest Pain (CP)
• Alphabetical, PDF-200 KB
• CART, PDF-395 KB
Emergency Department (ED) - Throughput
• Alphabetical, PDF-149 KB
• CART, PDF-319 KB
Pain Management
• Alphabetical, PDF-184 KB
• CART, PDF-375 KB
Stroke
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• CART, PDF-192 KB
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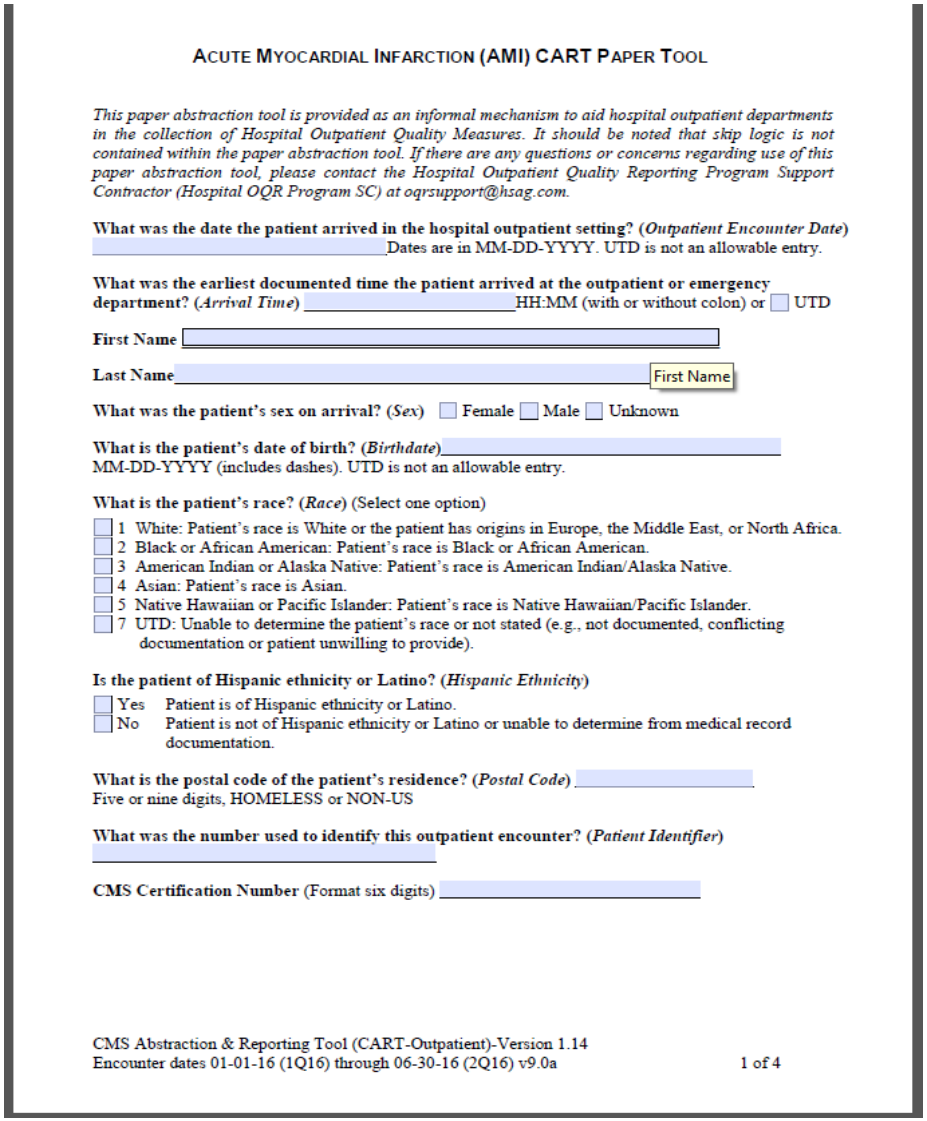


ACUTE MYOCARDIAL INFARCTION (AMI) CART PAPER TOOL

This paper abstraction tool is provided as an informal mechanism to aid hospital outpatient departments in the collection of Hospital Outpatient Quality Measures. It should be noted that skip logic is not contained within the paper abstraction tool. If there are any questions or concerns regarding use of this paper abstraction tool, please contact the Hospital Outpatient Quality Reporting Program Support Contractor (Hospital OQR Program SC) at oqrsupport@hsag.com.

What was the date the patient arrived in the hospital outpatient setting? (*Outpatient Encounter Date*)
_____ Dates are in MM-DD-YYYY. UTD is not an allowable entry.

What was the earliest documented time the patient arrived at the outpatient or emergency department? (*Arrival Time*) _____ HH:MM (with or without colon) or ☐ UTD

First Name _____

Last Name _____ First Name

What was the patient's sex on arrival? (*Sex*) ☐ Female ☐ Male ☐ Unknown

What is the patient's date of birth? (*Birthdate*) _____
MM-DD-YYYY (includes dashes). UTD is not an allowable entry.

What is the patient's race? (*Race*) (Select one option)

☐ 1 White: Patient's race is White or the patient has origins in Europe, the Middle East, or North Africa.
☐ 2 Black or African American: Patient's race is Black or African American.
☐ 3 American Indian or Alaska Native: Patient's race is American Indian/Alaska Native.
☐ 4 Asian: Patient's race is Asian.
☐ 5 Native Hawaiian or Pacific Islander: Patient's race is Native Hawaiian/Pacific Islander.
☐ 7 UTD: Unable to determine the patient's race or not stated (e.g., not documented, conflicting documentation or patient unwilling to provide).

Is the patient of Hispanic ethnicity or Latino? (*Hispanic Ethnicity*)

☐ Yes Patient is of Hispanic ethnicity or Latino.
☐ No Patient is not of Hispanic ethnicity or Latino or unable to determine from medical record documentation.

What is the postal code of the patient's residence? (*Postal Code*) _____
Five or nine digits, HOMELESS or NON-US

What was the number used to identify this outpatient encounter? (*Patient Identifier*)
_____

CMS Certification Number (Format six digits) _____

CMS Abstraction & Reporting Tool (CART-Outpatient)-Version 1.14
Encounter dates 01-01-16 (1Q16) through 06-30-16 (2Q16) v9.0a 1 of 4

ACUTE MYOCARDIAL INFARCTION (AMI) CART PAPER TOOL

1. **What was the E/M Code documented for this outpatient encounter? (EMCODE)**
   - ☐ 99281 Emergency department visit, new or established patient
   - ☐ 99282 Emergency department visit, new or established patient
   - ☐ 99283 Emergency department visit, new or established patient
   - ☐ 99284 Emergency department visit, new or established patient
   - ☐ 99285 Emergency department visit, new or established patient
   - ☐ 99291 Critical care, evaluation and management

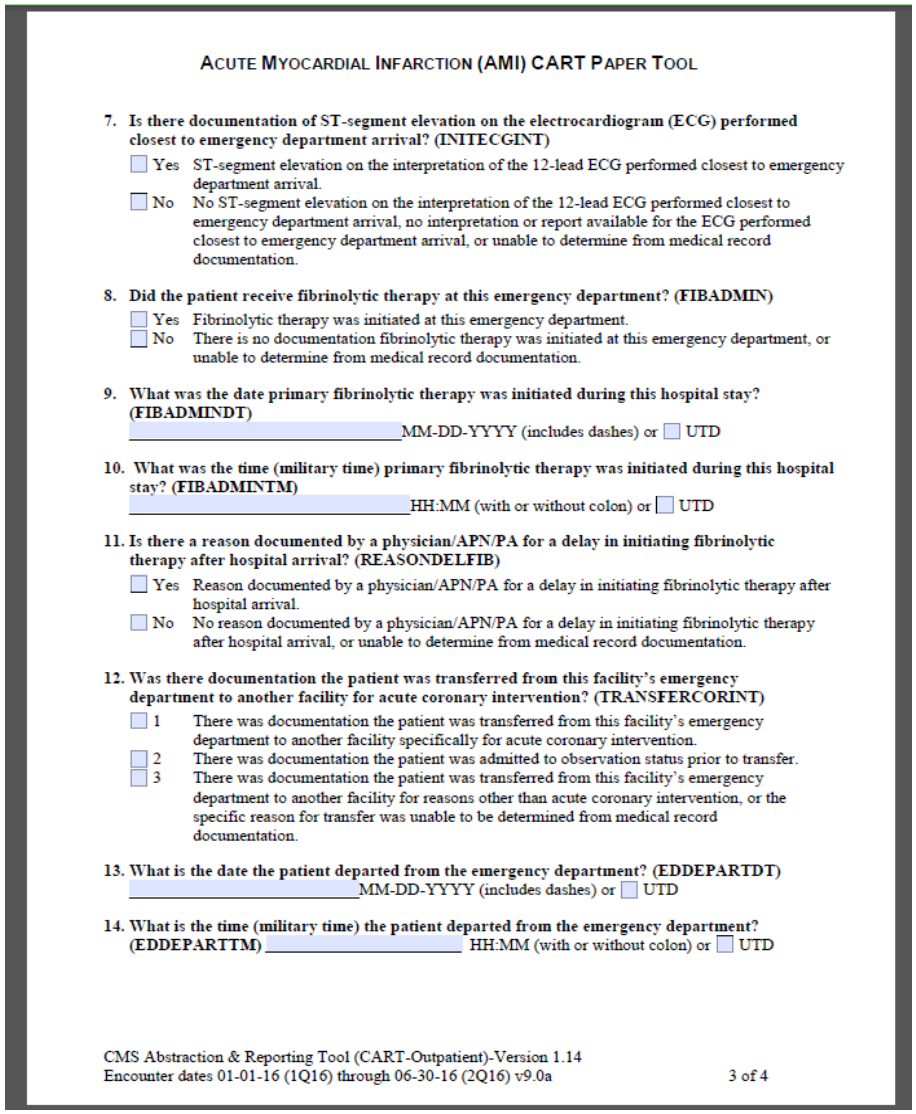
2. **What was the patient's discharge code from the outpatient setting? (DISCHGCODE?)** (Select one option)
   - ☐ 1 Home
   - ☐ 2 Hospice – Home
   - ☐ 3 Hospice – Health Care Facility
   - ☐ 4a Acute Care Facility – General Inpatient Care
   - ☐ 4b Acute Care Facility – Critical Access Hospital
   - ☐ 4c Acute Care Facility – Cancer Hospital or Children's Hospital
   - ☐ 4d Acute Care Facility – Department of Defense or Veteran's Administration
   - ☐ 5 Other Health Care facility
   - ☐ 6 Expired
   - ☐ 7 Left Against Medical Advice/AMA
   - ☐ 8 Not Documented or Unable to Determine (UTD)

3. **What was the ICD-10-CM code selected as the principal diagnosis for this record? (PRINDX)** (Format eight digits, without a decimal point)

4. **What were the ICD-10-CM other diagnoses codes selected for this medical record? (OTHRDX#)** (Format eight digits, without a decimal point)

5. **What is the patient's source of payment for this outpatient encounter? (PMTSRCE)**
   - ☐ 1 Source of payment is Medicare
   - ☐ 2 Source of payment is Non-Medicare

6. **What is the patient's Medicare/HIC number? (PTHIC)** (Required for patients with a Payment Source of Medicare who have a standard HIC#. All alpha characters must be upper case.)



ACUTE MYOCARDIAL INFARCTION (AMI) CART PAPER TOOL

7. **Is there documentation of ST-segment elevation on the electrocardiogram (ECG) performed closest to emergency department arrival? (INITECGINT)**
   - ☐ Yes ST-segment elevation on the interpretation of the 12-lead ECG performed closest to emergency department arrival.
   - ☐ No No ST-segment elevation on the interpretation of the 12-lead ECG performed closest to emergency department arrival, no interpretation or report available for the ECG performed closest to emergency department arrival, or unable to determine from medical record documentation.

8. **Did the patient receive fibrinolytic therapy at this emergency department? (FIBADMIN)**
   - ☐ Yes Fibrinolytic therapy was initiated at this emergency department.
   - ☐ No There is no documentation fibrinolytic therapy was initiated at this emergency department, or unable to determine from medical record documentation.

9. **What was the date primary fibrinolytic therapy was initiated during this hospital stay? (FIBADMINDT)**
   _____MM-DD-YYYY (includes dashes) or ☐ UTD

10. **What was the time (military time) primary fibrinolytic therapy was initiated during this hospital stay? (FIBADMINTM)**
    _____HH:MM (with or without colon) or ☐ UTD

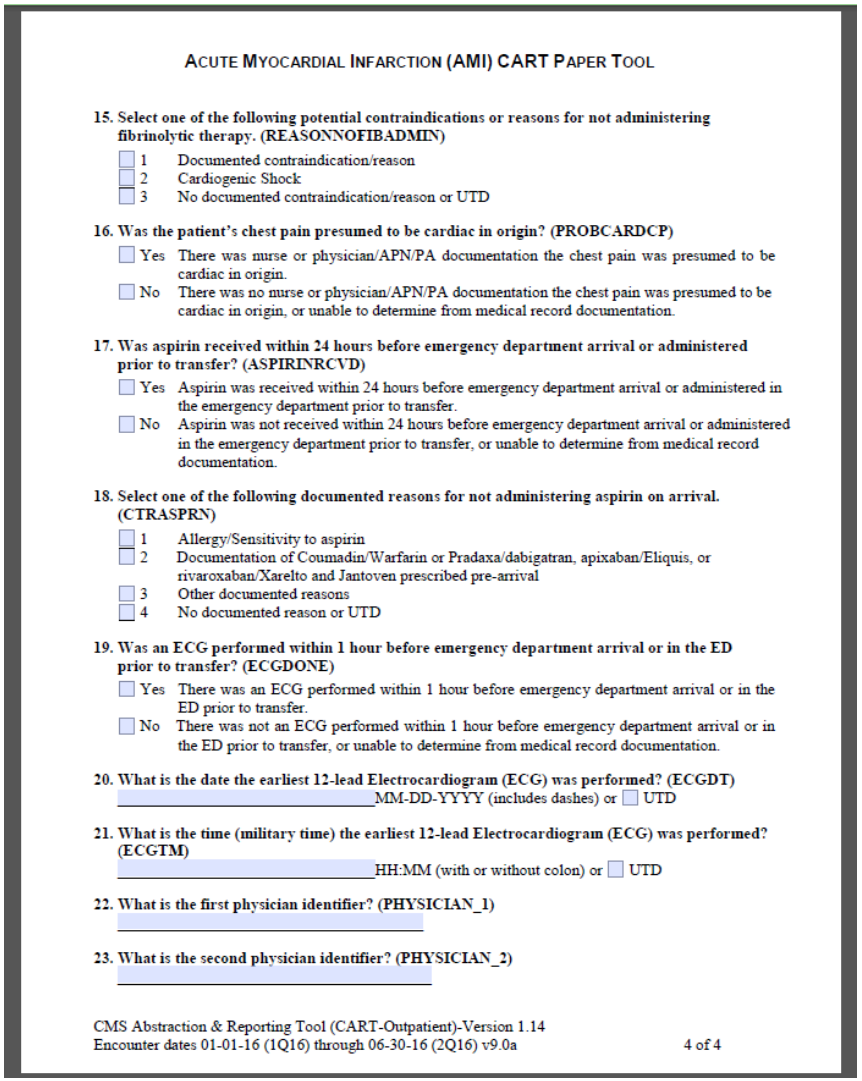
11. **Is there a reason documented by a physician/APN/PA for a delay in initiating fibrinolytic therapy after hospital arrival? (REASONDELFIB)**
    - ☐ Yes Reason documented by a physician/APN/PA for a delay in initiating fibrinolytic therapy after hospital arrival.
    - ☐ No No reason documented by a physician/APN/PA for a delay in initiating fibrinolytic therapy after hospital arrival, or unable to determine from medical record documentation.

12. **Was there documentation the patient was transferred from this facility's emergency department to another facility for acute coronary intervention? (TRANSFERCORINT)**
    - ☐ 1 There was documentation the patient was transferred from this facility's emergency department to another facility specifically for acute coronary intervention.
    - ☐ 2 There was documentation the patient was admitted to observation status prior to transfer.
    - ☐ 3 There was documentation the patient was transferred from this facility's emergency department to another facility for reasons other than acute coronary intervention, or the specific reason for transfer was unable to be determined from medical record documentation.

13. **What is the date the patient departed from the emergency department? (EDDEPARTDT)**
    _____MM-DD-YYYY (includes dashes) or ☐ UTD

14. **What is the time (military time) the patient departed from the emergency department? (EDDEPARTTM)** _____ HH:MM (with or without colon) or ☐ UTD

CMS Abstraction & Reporting Tool (CART-Outpatient)-Version 1.14
Encounter dates 01-01-16 (1Q16) through 06-30-16 (2Q16) v9.0a 3 of 4



ACUTE MYOCARDIAL INFARCTION (AMI) CART PAPER TOOL

15. Select one of the following potential contraindications or reasons for not administering fibrinolytic therapy. (REASONNOFIBADMIN)

- ☐ 1 Documented contraindication/reason
- ☐ 2 Cardiogenic Shock
- ☐ 3 No documented contraindication/reason or UTD

16. Was the patient's chest pain presumed to be cardiac in origin? (PROBCARDCP)

- ☐ Yes There was nurse or physician/APN/PA documentation the chest pain was presumed to be cardiac in origin.
- ☐ No There was no nurse or physician/APN/PA documentation the chest pain was presumed to be cardiac in origin, or unable to determine from medical record documentation.

17. Was aspirin received within 24 hours before emergency department arrival or administered prior to transfer? (ASPIRINRCVD)

- ☐ Yes Aspirin was received within 24 hours before emergency department arrival or administered in the emergency department prior to transfer.
- ☐ No Aspirin was not received within 24 hours before emergency department arrival or administered in the emergency department prior to transfer, or unable to determine from medical record documentation.

18. Select one of the following documented reasons for not administering aspirin on arrival. (CTRASPRN)

- ☐ 1 Allergy/Sensitivity to aspirin
- ☐ 2 Documentation of Coumadin/Warfarin or Pradaxa/dabigatran, apixaban/Eliquis, or rivaroxaban/Xarelto and Jantoven prescribed pre-arrival
- ☐ 3 Other documented reasons
- ☐ 4 No documented reason or UTD

19. Was an ECG performed within 1 hour before emergency department arrival or in the ED prior to transfer? (ECGDONE)

- ☐ Yes There was an ECG performed within 1 hour before emergency department arrival or in the ED prior to transfer.
- ☐ No There was not an ECG performed within 1 hour before emergency department arrival or in the ED prior to transfer, or unable to determine from medical record documentation.

20. What is the date the earliest 12-lead Electrocardiogram (ECG) was performed? (ECGDT)

_____MM-DD-YYYY (includes dashes) or ☐ UTD

21. What is the time (military time) the earliest 12-lead Electrocardiogram (ECG) was performed? (ECGTM)

_____HH:MM (with or without colon) or ☐ UTD

22. What is the first physician identifier? (PHYSICIAN_1)

_____

23. What is the second physician identifier? (PHYSICIAN_2)

_____

CMS Abstraction & Reporting Tool (CART-Outpatient)-Version 1.14
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MBQIP Support: Tools and Resources

- MBQIP Reporting Guide
- CAH Quality Improvement Implementation Guide and Toolkit
- Monthly Reporting Reminders
- MBQIP Measure Fact Sheets
- MBQIP Monthly
- EDTC Data Collection webinars and tips

RQITA & TASC Coordination

Resources posted to TASC website:
www.ruralcenter.org/tasc/mbqip

MBQIP TA Questions should be sent to:
tasc@ruralcenter.org

Questions?

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Stratis Health is a nonprofit organization that leads collaboration and innovation in health care quality and safety, and serves as a trusted expert in facilitating improvement for people and communities.

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