Flex Monitoring Team

University of Minnesota
University of North Carolina at Chapel Hill
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MBQIP Activities 2015-17: Relevant Data and Resources

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June 23, 2015 | Flex Reverse Site Visit | Bethesda MD

Required MBQIP Activities

- **HCAHPS** survey
- **Emergency Department Transfer Communication (EDTC)** measures
- **Emergency Department** measures
- **Influenza vaccinations** for all health care personnel and eligible patients

HCAHPS Reporting 2013-14

- **65.1% of CAHs** reported HCAHPS data
- **48.7%** of reporting CAHs had **<100** completed surveys
- **12.7%** of reporting CAHs had **survey response rate** of **less than 25%**
- **Variation across states** in reporting and response rates

HCAHPS Performance 2013-14

- **CAHs (n=867) and All U.S. Hospitals (n=4143) Reporting Data**

	CAHs	All Hospitals
They gave an overall hospital rating of 9 or 10 (high) on 1-10 scale	74.1	71.0
They would definitely recommend the hospital to friends and family	73.1	71.0
Yes, staff gave patient information about what to do during recovery at home	87.0	86.0
Doctors always communicated well	85.3	82.0
Nurses always communicated well	82.5	79.0
Patient room and bathroom were always clean	79.7	74.0
Patient always received help as soon as s/he wanted	75.0	68.0
Pain was always well-controlled	73.3	71.0
Staff always explained about medications before giving them to patient	68.7	65.0
Area around patient room was always quiet at night	65.9	62.0
Patients who "strongly agree" they understood their care when they left the hospital	55.0	52.0

HCAHPS Takeaway Points

- Number of CAHs reporting HCAHPS data has increased BUT completed surveys per CAH & response rates have decreased
- CAHs continue to perform better than other hospitals on all HCAHPS measures
- Lowest scores for CAHs and all hospitals are on new transition of care composite measure

What Can State Flex Programs Do?

- Encourage 1/3 of CAHs not reporting HCAHPS to report
- Examine reasons for low survey response rates
- TA to improve performance, especially care transitions
  - University of Colorado Care Transitions Program http://www.caretransitions.org/
- Learn from states doing well on HCAHPS:
  - Reporting: Maine, Massachusetts, Vermont, Alabama, Indiana, Pennsylvania, Ohio
  - Response rates: Illinois, Michigan, Wisconsin
  - Performance: Louisiana, Maine, Nebraska, Alabama, Tennessee

Emergency Department Transfer Communications (EDTC)

- Reporting:
  - 28.8% of CAHs reported EDTC data to MBQIP in Q4 2014
  - State reporting rates ranged from 0% (10 states) to 100% of CAHs

EDTC Performance Q4 2014

EDTC Measure Component	% of Cases with Required Data
Administrative Communication	86.2
Patient Information	85.8
Vital Signs	86.6
Medication Information	84.2
Physician or Practitioner-Generated Information	83.7
Nurse-Generated Information	76.1
Procedures Done / Test Results	87.8

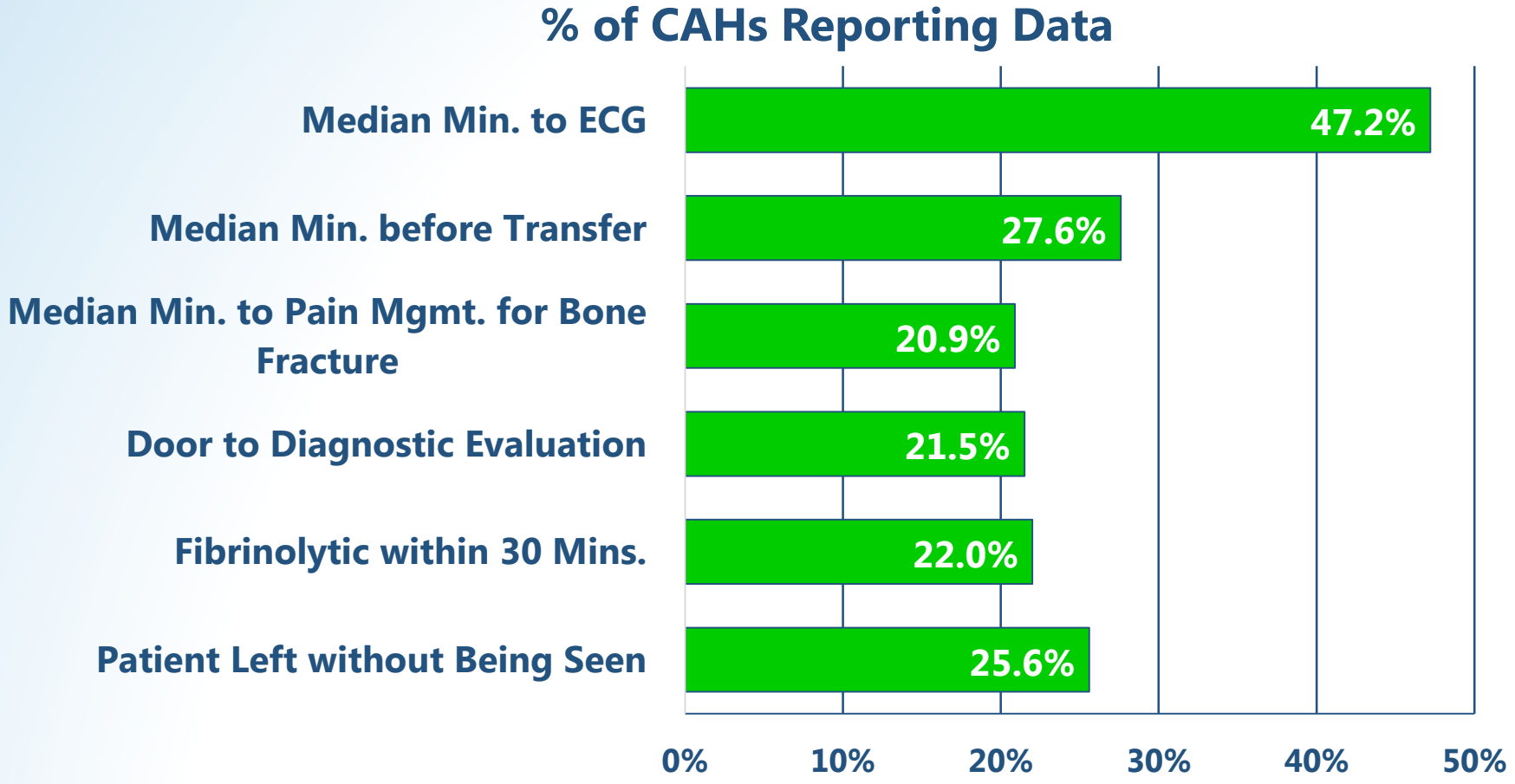
What Can State Flex Programs Do?

- **Encourage CAHs to use EDTC resources**
  - Stratis Health: Rural EDTC Resources

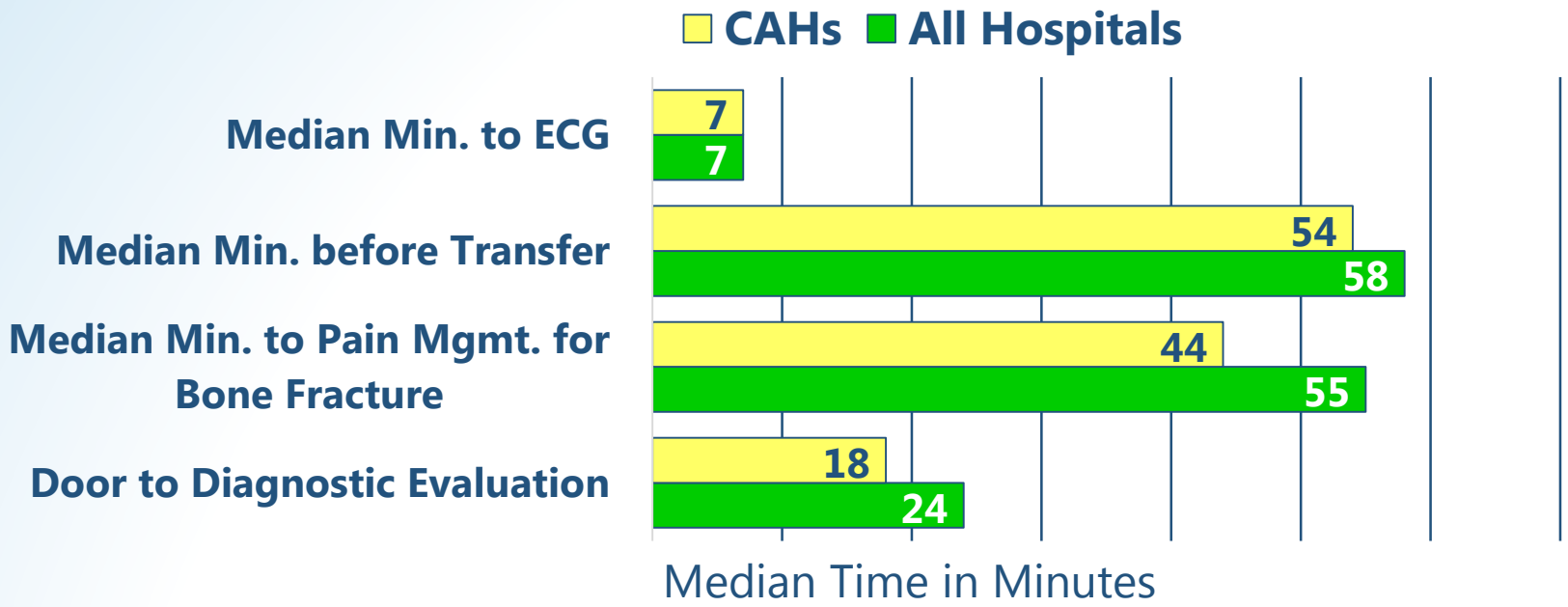
    http://www.stratishealth.org/providers/ED_Transfer.html
  - MBQIP Quality Guide

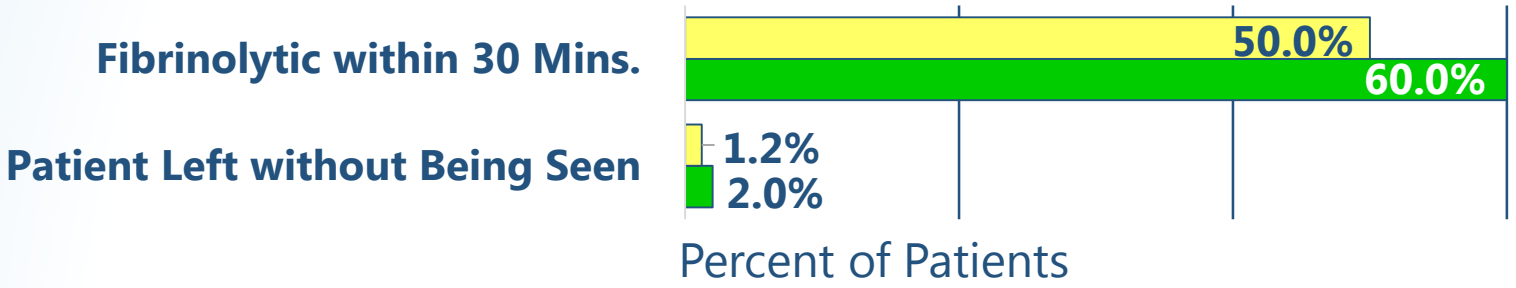
    https://www.ruralcenter.org/tasc/resources/medicare-beneficiary-quality-improvement-project-mbqip-quality-guide
- **Learn from states doing well:**
  - Reporting: Alabama, New Mexico, Oklahoma, Pennsylvania, Utah
  - Performance: New Mexico, Florida, Colorado, North Carolina, Arizona

ED Measures: Reporting



ED Measures: Performance





ED Measure Takeaway Points

- Only about one-quarter or fewer CAHs are reporting data on most ED measures
- Among reporting CAHs, performance on ED measures is comparable or better than other hospitals, except for fibrinolytic measure

What Can State Flex Programs Do?

- **Encourage CAHs to report data**
  - Reporting on ED measures needs to improve
- **TA to improve performance**
  - Particular attention to fibrinolytic measure
- **Learn from states doing well:**
  - Reporting: Alabama, North Dakota, Pennsylvania, Michigan, Ohio
  - Performance: Maine, New Hampshire, Ohio, Wisconsin, Iowa

Influenza Vaccination Measures

- **For patients**
  - Reporting: **32.6% of CAHs** nationwide
  - Performance: **90.1% of CAH patients** received influenza vaccination
- **For health care personnel**
  - Reporting: **25% of CAHs** nationwide
  - Performance: **86.3% of HCPs** received influenza vaccination

What can State Flex Programs do?

Encourage CAH reporting & use of resources to improve influenza vaccination rates

- Health care personnel (CDC NHSN Manual)
  - Educate HCPs re: benefits of HCP vaccination
  - Convenient access to free influenza vaccinations for all HCPs at work site
  - Signed declinations for non-medical refusals
- Patients (FMT Policy Brief on Pneumonia QI)
  - Baseline data on hospital performance, data feedback, and benchmarking
  - Provider reminders to check vaccination status at admission; automatic reminders when due
  - Standing orders to immunize patients

What can State Flex Programs do?

- **Learn from states doing well:**
  - Influenza Vaccination Reporting
    - Health Care Personnel: Massachusetts, Pennsylvania, South Carolina, Wisconsin, Oregon
    - Patients: Minnesota, Alabama, Indiana, Virginia, Kansas
  - Influenza Vaccination Performance
    - Health Care Personnel: Arizona, New York, Utah, Georgia, Colorado
    - Patients: Minnesota, Kansas, Texas, Colorado, Georgia

Additional MBQIP Activities

- **New to MBQIP, but Hospital Compare data & resources are available in FMT State Quality Reports and Policy Briefs**
  - Healthcare Associated Infections
  - Readmissions
  - Falls, Patient Safety Culture Survey, Medication Safety
  - Stroke, VTE, ED Throughput, Safe Surgery Checklist

Healthcare-Associated Infections

- Optional new MBQIP measures: CLABSI, CAUTI, CDI, MRSA
- CMS requires PPS hospitals to report these along with two SSI HAIs to Hospital Compare
- 34 Flex states require hospitals to report one or more of these HAIs to state and/or NHSN
  - About 2/3 of state requirements include CAHs
  - Some Flex Coordinators and State HAI contacts unclear about whether requirements apply to CAHs

Healthcare-Associated Infections

- Percent of CAHs reporting HAI data to Hospital Compare via NHSN
  - CDI (21%)
  - MRSA (17%)
  - SSIs (14% colon surgery, 11% hysterectomy)
  - CLABSI and CAUTI (11% each)
- State requirements: related to higher CAH reporting in some but not all states

Healthcare-Associated Infections

- Many CAHs do not have minimum number of cases to calculate facility-level risk-standardized infection ratios
- Analysis of pooled data
  - help states track infection trends, identify potential targets for HAI prevention and quality improvement initiatives
- NHSN training, protocols, resources
  - http://www.cdc.gov/nhsn/acute-care-hospital/index.html

Readmission Rates, 2010-13

CMS 30-Day Risk-Adjusted Unplanned Readmission Rates for CAHs with 25 or More Reported Cases, 2010-2013

	CAHs with ≥ 25 Cases	Readmission Rate	
		CAHs	All U.S. Hospitals
Hospital-Wide All-Cause	1,127	15.6	15.6
Pneumonia	1,039	17.1	17.3
Heart Failure	769	22.5	22.7
COPD	736	20.8	20.7
Hip/Knee Replacement	228	5.1	5.2
Stroke	174	12.9	13.3
AMI	27	17.6	17.8

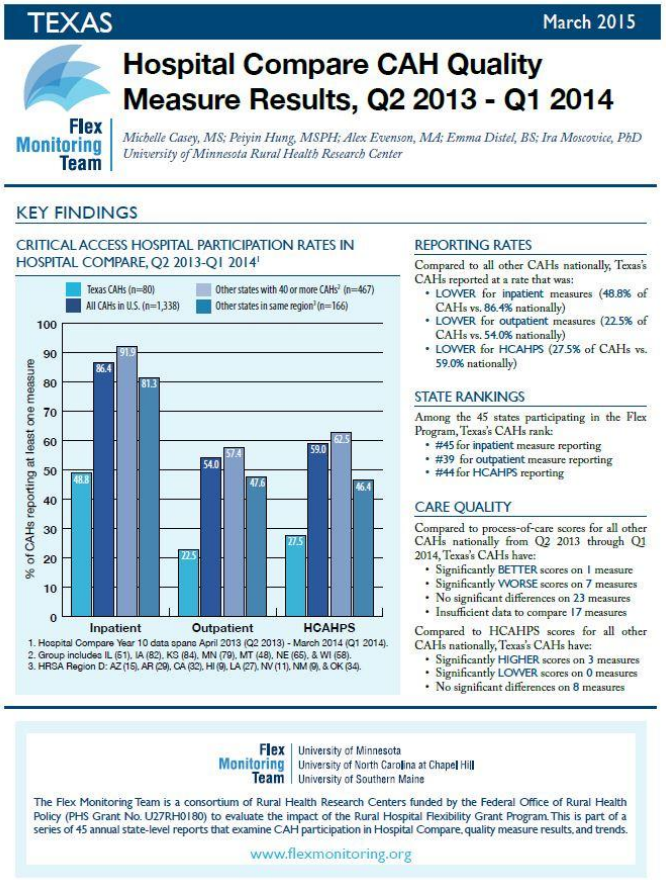
Hospital rates calculated by CMS using Medicare claims data: Hospital-Wide All-Cause from Q3 2012 – Q2 2013; all other rates from Q3 2010 – Q2 2013.

Readmission Takeaway Points

- Most CAHs have minimum number of cases for CMS to calculate all-cause hospital-wide and pneumonia readmission rates using Medicare claims
- Risk-adjusted readmission rates for all CAHs are similar to all U.S. hospitals
- Multiple efforts to reduce readmission rates; current FMT project focusing on efforts involving CAHs

FMT State CAH Quality Reports

- Available on www.flexmonitoring.org
- Use Hospital Compare data for all reporting CAHs
- Includes data CMS suppresses from Hospital Compare website due to small volume



TEXAS March 2015

Flex Monitoring Team

Hospital Compare CAH Quality Measure Results, Q2 2013 - Q1 2014

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KEY FINDINGS

CRITICAL ACCESS HOSPITAL PARTICIPATION RATES IN HOSPITAL COMPARE, Q2 2013-Q1 2014[1]

1. Hospital Compare Year 10 data span: April 2013 (Q2 2013) - March 2014 (Q1 2014).
2. Group includes IL (51), IA (82), KS (84), MN (79), MT (48), NE (65), & WI (58).
3. HRSA Region D: AZ (15), AR (29), CA (32), HI (9), LA (27), NV (11), NM (9), & OK (34).

REPORTING RATES

Compared to all other CAHs nationally, Texas's CAHs reported at a rate that was:

- LOWER for inpatient measures (48.8% of CAHs vs. 86.4% nationally)
- LOWER for outpatient measures (22.5% of CAHs vs. 54.0% nationally)
- LOWER for HCAHPS (27.5% of CAHs vs. 59.0% nationally)

STATE RANKINGS

Among the 45 states participating in the Flex Program, Texas's CAHs rank:

- #45 for inpatient measure reporting
- #39 for outpatient measure reporting
- #44 for HCAHPS reporting

CARE QUALITY

Compared to process-of-care scores for all other CAHs nationally from Q2 2013 through Q1 2014, Texas's CAHs have:

- Significantly BETTER scores on 1 measure
- Significantly WORSE scores on 7 measures
- No significant differences on 23 measures
- Insufficient data to compare 17 measures

Compared to HCAHPS scores for all other CAHs nationally, Texas's CAHs have:

- Significantly HIGHER scores on 3 measures
- Significantly LOWER scores on 0 measures
- No significant differences on 8 measures

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The Flex Monitoring Team is a consortium of Rural Health Research Centers funded by the Federal Office of Rural Health Policy (PHS Grant No. U27RH0180) to evaluate the impact of the Rural Hospital Flexibility Grant Program. This is part of a series of 45 annual state-level reports that examine CAH participation in Hospital Compare, quality measure results, and trends.

www.flexmonitoring.org

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Quality Measurement Challenges for Low-Volume Rural Providers

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June 23, 2015 | Flex Reverse Site Visit | Bethesda MD

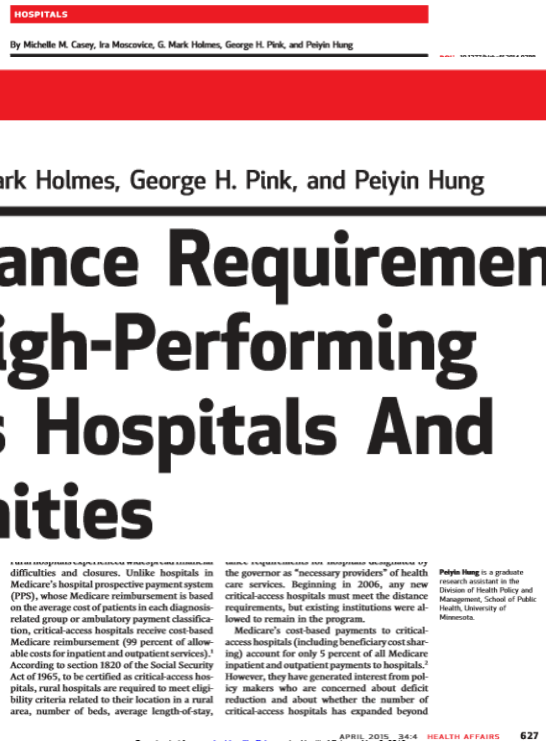
CAHs Under Siege

- Numerous proposed changes to CAH program:
  - End CAH program entirely (CBO, 2011)
  - Eliminate enhanced payments for CAHs (MedPAC, 2012)
  - Remove "necessary provider" permanent exemption from CAH distance requirement (OIG, 2013)
  - Prohibit CAH designation for facilities that are less than 10 miles from the nearest hospital (OMB, 2014)

Effects of Proposals

- Reduced number of hospitals eligible for CAH program
- Hospitals losing CAH status forced back on PPS reimbursement, reducing Medicare revenue
- Reduced access to care for rural populations

HealthAffairs



HOSPITALS

By Michelle M. Casey, Ira Moscovice, G. Mark Holmes, George H. Pink, and Peiyin Hung

Minimum-Distance Requirements Could Harm High-Performing Critical-Access Hospitals And Rural Communities

difficulties and closures. Unlike hospitals in Medicare's hospital prospective payment system (PPS), whose Medicare reimbursement is based on the average cost of patients in each diagnosis-related group or ambulatory payment classification, critical-access hospitals receive cost-based Medicare reimbursement (99 percent of allowable costs for inpatient and outpatient services).[1] According to section 1820 of the Social Security Act of 1965, to be certified as critical-access hospitals, rural hospitals are required to meet eligibility criteria related to their location in a rural area, number of beds, average length-of-stay,

the governor as "necessary providers" of health care services. Beginning in 2006, any new critical-access hospitals must meet the distance requirements, but existing institutions were allowed to remain in the program.

Medicare's cost-based payments to critical-access hospitals (including beneficiary cost sharing) account for only 5 percent of all Medicare inpatient and outpatient payments to hospitals.[2] However, they have generated interest from policy makers who are concerned about deficit reduction and about whether the number of critical-access hospitals has expanded beyond

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Conclusions

- None of the proposals to change the CAH program recognize the potential harm on the rural health system and access to care for rural residents.
- Even with close proximity to another hospital, many CAHs could be considered safety-net facilities if they provide certain services, have a large proportion of Medicaid patients, etc.

…The Rhetoric Continues

Health Affairs

ACCESS TO CARE

By Karen E. Joynt, Paula Chatterjee, E. John Orav, and Ashish K. Jha

Hospital Closures Had No Measurable Impact On Local Hospitalization Rates Or Mortality Rates, 2003–11

On the Other Hand…

- The article declares that "these findings may offer reassurance to policy makers and clinical leaders who are concerned about the potential acceleration of hospital closures as a result of health care reform."
- Only 44 of the 195 hospitals that closed (22 percent) were rural.
- The 44 rural hospital closures in the study occurred from FY 2003-11. The pace of rural hospital closures has increased considerably since that time.

Furthermore…

- The implications of closing a hospital in a rural community with no other hospital are very different from a closure in an urban area with multiple other hospitals very nearby (e.g., potential loss of physicians as well as other health care services besides inpatient care).
- Many rural hospitals are now the proud owners and operators of their associated clinics. If the hospital closes, the primary care practitioners are now left unemployed.

Description of NQF Rural Health Project

To provide performance measurement guidance to rural, low-volume providers, including:

- Critical Access Hospitals (CAHs)
- Rural Health Clinics (RHCs)
- Community Health Centers (CHCs)
- Small rural hospitals
- Small rural clinical practices
- Clinicians who serve in these settings

Key Issues Regarding Rural Provider Measurement

- **Geographic isolation-** Limited availability of healthcare providers, difficulties with transportation, and lack of information technology capabilities
- **Small practice size**- Limited time, staff, and/or finances available for quality improvement activities
- **Heterogeneity**- Heterogeneity in setting and patient population (e.g., disproportionate number of vulnerable residents)
- **Low case-volume-** Insufficient number of patients to achieve reliable and valid measurement results

Key Issues Regarding Rural Provider Measurement

- **Meaningful measures** for rural providers and their patients and families
- **Alignment of measurement efforts** – across public and private sector programs
- **Mandatory versus voluntary participation** – in CMS quality improvement programs

Recommendations of NQF Rural Health Committee

- Make participation in CMS quality improvement programs mandatory for all rural providers
  - Utilize a phased approach for full participation across program types
  - A lack of data denies rural residents the ability to choose providers based on performance and may suggest that rural providers cannot provide high-quality care

Recommendations of NQF Rural Health Committee

- Use measures for rural providers that are:
  - Broadly applicable across rural providers
  - Reflect community wellness
- Reconsider exclusions for existing measures

Guiding Principles for Selecting Quality Measures

- Address the low case-volume challenge
- Facilitate fair comparisons for rural providers
- Address areas of high risk for patients
- Support local access to care
- Address actionable activities for rural providers
- Be evidence-based
- Address opportunities for improvement

Guiding Principles for Selecting Quality Measures

- Suitable for use in internal quality improvement efforts
- Require feasibility for data collection by rural providers
- Exclude measures that have unintended consequences for rural patients
- Suitable for use in particular programs
- Align with other programs
- Support the triple aim

Recommendations of NQF Rural Health Committee

- Use a core set of measures, along with a menu of optional measures for rural providers
  - A core set (no more than 10-20 in areas such as screening, immunization, or medication reconciliation) should include cross-cutting measures and the optional set should allow flexibility to tailor to various types of patients and services

Recommendations of NQF Rural Health Committee

- Consider measures that are used in Patient-Centered Medical Home models
  - Many such measures are currently used by rural providers, thus reducing the data collection burden
  - Examples include breast, cervical, and colorectal cancer screening; poor control of A1c, blood pressure control, pneumonia vaccination

Recommendations of NQF Rural Health Committee

- **Consider rural-relevant socio-demographic factors in risk adjustment**
  - Facilitate more valid comparisons among rural providers
  - Socio-demographic factors to consider
    - Distance to referral hospital
    - Time travel to referral hospital or physician
    - Availability of other healthcare resources in the area
    - Shortage area designations defined by HRSA
    - Frontier area designations

Recommendations of NQF Rural Health Committee

- Continue to align measurement efforts for rural providers
  - Use across HHS programs and multiple health care settings
  - Collect data only once
  - Align technical assistance

Recommendations of NQF Rural Health Committee

- **Fund development of rural-relevant measures**
  - Patient hand-offs and transitions
  - Alcohol/drug treatment
  - Telehealth/telemedicine
  - Access to care and timeliness of care
  - Population health at geographic level
  - Advance directives/end-of-life

Recommendations of NQF Rural Health Committee

- Create payment programs that include incentive payments, but not penalties
  - Do not compromise safety net

Recommendations of NQF Rural Health Committee

- Offer rewards for rural providers based on achievement or improvement
  - Due to socio-demographic factors, low case-volume, distance from providers

Conclusions

- We are approaching a tipping point for health care reform.
- It is still unclear how rural providers and populations will be affected by health care reform.
- It is clear that the successful implementation of health care reform requires reliable and valid quality measurement.
- The challenge is to ensure that quality measurement is relevant for rural providers and populations (particularly in low-volume environments).

Thank You!

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