FLEX Medicare Beneficiary Quality Improvement Project (MBQIP)

Background

The Federal Office of Rural Health Policy (FORHP) created the Medicare Beneficiary Quality Improvement Project (MBQIP) as a Flex Grant Program activity within the core area of quality improvement. The primary goal of this project is for critical access hospitals (CAHs) to implement quality improvement initiatives to improve their patient care and operations. MBQIP uses Flex funding to support CAHs with technical assistance and national benchmarks to improve health care outcomes. CAHs opting to participate are requested to report a specific set of annual measures determined by FORHP (see page 2 for timeline and measures) and engage in quality improvement projects to benefit patient care.

Benefits of Participating in MBQIP

- Engage in quality improvement initiatives
- Improves patient care across a broad population
- Improves hospital services, administration and operations
- Allows for clear benchmarking and the identification of best practice CAHs
- Receive technical assistance regarding cutting edge quality improvement tools and models
- Prepare CAHs for the future where CAHs will likely have to report measures
- Fulfills the Quality Improvement portion of the Flex Grant
- Allows CAHs to remain eligible to receive grant funds under the Small Rural Hospital Improvement Program (SHIP)

The passage of meaningful use and the Patient Protection and Affordable Care Act heightened national attention on quality activities and reporting. In the environment of meaningful use, pay for performance, bundled payments, and accountable care organizations (ACO), CAHs are increasingly likely to be compared with their urban counterparts to ensure public confidence in their quality of health services. This initiative takes a proactive and visionary approach to ensure CAHs are well-equipped and prepared to meet future quality legislation. Additionally, MBQIP fulfills the Flex grant Quality Improvement (QI) objectives regarding Hospital Compare reporting, and supporting participation in various multi-hospital QI initiatives. The main emphasis of this project is putting patients first by focusing on improving health care services, processes and administration.

To advance MBQIP, Flex funds may be used to support efforts around quality improvement activities related to select rural-relevant measures. Flex funds can be used to provide technical assistance for hospitals in reporting to Hospital Compare or support organizations or vendors who report hospital data.

Goals and Expectations

FORHP and its partners are charged with increasing current CAH Hospital Compare participation rates and CAH dedication to QI initiatives. While participation in the project is currently voluntary under the Flex program, MBQIP seeks to increase attention on quality health care to all CAH Medicare beneficiaries, both inpatient and outpatient. The following goals were developed to achieve this broader focus via MBQIP*:

- Increase CAH Hospital Compare participation for Phase 1 measures (Pneumonia and Congestive Heart Failure) to 100% by FY2012 to improve publicly available data and motivate CAHs to implement related quality improvement initiatives.
- Achieve CAH Hospital Compare participation for Phase 2 measures (Outpatient and Hospital Consumer Assessment of Healthcare Providers and Systems (HCHAPS)) and non-Hospital Compare Phase 3 measures (Pharmacy Review of Orders and Outpatient Emergency Department Transfer Communication) of 100% by FY2013 to motivate CAHs to implement quality improvement initiatives.
- Achieve a CAH participation rate of 75% by FY2013 and 100% by FY2014 in a quality improvement initiative to be reported to respective states.

*These goals are ambitious but the tangible benefits to CAHs should influence participation. We realize CAHs have individual priorities and staffing challenges that may preclude participation. Flex Coordinators should work with hospitals to understand their needs and challenges, and determine available resources.
Progress as of January 2014

- FORHP has received memorandums of understanding (MOUs) pledging participation in MBQIP from 93% of CAHs nationwide (1,239 of 1,332 CAHs)
- All 45 Flex states are participating in MBQIP; 25 states have 100% CAH participation
- Two years of Phase 1 inpatient data and one year of Phase 2 Outpatient and HCAHPS data has been reported back to each state and participating CAH
- To learn more about the data reports and to find resources on how to use the data as well as a variety of other important MBQIP resources, please visit: [http://www.ruralcenter.org/tasc/resources/medicare-beneficiary-quality-improvement-project-mbqip](http://www.ruralcenter.org/tasc/resources/medicare-beneficiary-quality-improvement-project-mbqip)

Measures*

Please remember that MBQIP is a Flex program quality improvement grant activity and not a separate quality improvement reporting entity, such as the Centers for Medicare and Medicaid Services (CMS). Hospital Compare. Many of the measures, particularly Phases 1 and 2, are simply asking CAHs to report on already existing measures (using the existing data submission processes already in place), and is not meant to create data submission requirements in addition to or in lieu of these existing measures and processes.

Phase 1 Measures
- Pneumonia: Hospital Compare CMS Core Measure (participate in all sub-measures); AND
- Congestive Heart Failure: Hospital Compare CMS Core Measure (participate in all sub-measures)

Phase 2 Measures
- Outpatient 1-7: Hospital Compare CMS Measure (all sub-measures that apply); AND
- Hospital Consumer Assessment of Healthcare Providers and Systems (HCAHPS)

Phase 3 Measures
- Pharmacist CPOE/Verification of Medication Orders Within 24 Hours; AND
- Outpatient Emergency Department Transfer Communication

*Please see the appendix for additional information on measure definitions

Timeline

<table>
<thead>
<tr>
<th>Project Period Years (September – August)</th>
<th>Measures</th>
<th>Activities</th>
</tr>
</thead>
<tbody>
<tr>
<td>Year 1: 2010-2011</td>
<td></td>
<td>Planning for the project (work with hospitals, determine technical assistance needs for data collection)</td>
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<tr>
<td></td>
<td>By September 1, hospitals have begun reporting on Phase 1 measures</td>
<td>Plan for QI activities and assist with technical assistance (TA) around data collection and analysis. Review first quarterly report data and plan QI activities, available Summer 2012. Hospitals register for Outpatient Reporting by March 31, 2012</td>
</tr>
<tr>
<td>Year 3: 2012-2013</td>
<td>By September 1, hospitals have added Phase 2 measures to their reporting</td>
<td>Review Phase 1 and Phase 2 quarterly report outcomes and plan QI activities and TA for Phases 1 and 2.</td>
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</tbody>
</table>
Expectations of Flex Coordinators

By participating in this project, Flex Coordinators are expected to coordinate five key activities:

1. Outreach to hospitals to enroll them in to MBQIP
2. Assist hospitals in accessing needed technical assistance around data collection and reporting
3. Assist hospitals in analyzing their own and comparative data via Hospital Compare and the Flex Monitoring Team reports and any other tools in place at the state level
4. Determine funding allocation and appropriate partners to execute quality improvement activities
5. Provide support for technical assistance around quality improvement activities

Flex coordinators should seek other state partners (Quality Improvement Organizations (QIOs), State Hospital Associations) already engaged in similar activities to establish partnerships or contracts related to QI activities.

Note: FORHP does not endorse any specific vendor, organization, firm or association for the purposes of any portion of this project other than the Flex Monitoring Team (FMT) and Technical Assistance and Services Center (TASC), who are federally funded through cooperative agreements.

Flex Coordinator Activities:
1. Watch the two brief YouTube videos on MBQIP:
   (MBQIP overview: http://www.youtube.com/watch?v=hYbgvZUbTlg)
   (Phase 3 Pharmacist measure: http://www.youtube.com/watch?v=CqwqlqS38w0&feature=youtu.be)
2. Continue to work with the CAHs in your state to achieve 100% participation in MBQIP
3. Collect MOUs or consent forms and submit to your Project Officer in FORHP
4. Use the quality data results provided to you quarterly to assist your CAHs with targeted quality improvement activities; this includes redistributing the data reports to your CAHs
5. Continue to work with your CAHs to ensure that they are reporting Hospital Compare and Phase 3 measure data each quarter (reporting deadlines are provided below)
6. Participate in MBQIP-related learning sessions

Using the quality data to inform QI Activities
- Use the first few quarters as benchmarks to show future improvement. The first few quarters of data should also be used to determine which of your CAHs may require additional assistance regarding data submission.
- Use the data to determine the QI needs of your CAHs and target your Flex QI activities.
- Remember that data may not be statistically significant at the individual CAH level, but it is still important for improving patient care. Measuring quality of care, no matter the volume of patients, and then using the data to implement quality improvement initiatives is also an important step in developing and/or enhancing a “culture of quality,” even among the smallest rural hospitals.
- Discuss outcomes and share ideas/best practices/success stories with other Flex Coordinators. Encourage CAHs to discuss and share their outcomes and learn from one another as well.
• Post your best practices and success stories on the Flex Program Forum. You can also pose questions to other Flex Coordinators on the Forum.
• Please use the data appropriately:
  • As there may be considerable fluctuation with the data from one quarter to another, it is important to pay attention to trends in quality outcomes over time rather than focusing solely on any one outlier report (good or bad) in a single quarter.
  • MBQIP allows for the aggregation of quality data at the state and national level, however, individual CAHs will likely still have a small volume of cases for any one particular measure. As such, that data is not intended to be used for marketing purposes.

There are multiple ways to show improvement regarding your MBQIP activities
We understand that states may not be able to implement QI interventions immediately and that you may need a few more quarters of data to start seeing trends and identifying the CAHs most in need of specific QI interventions. Also, because some hospitals have never before reported quality data, there is still a lot of room for improvement in the data submission process itself. As such, FORHP recognizes that an improvement in your quality data outcomes is not the only way to show improvement in your state. Improvement can be shown in the following ways:
• Increase in the number of CAHs participating in MBQIP your state
• Improvement in the data submission process by your CAHs (which includes increasing the number of CAHs who actually submit data each quarter)
• Improvement in the quality outcomes through the use of MBQIP data and implementation of QI interventions

Considerations when looking over MBQIP data outcomes and determining quality improvement needs
• Which, if any, of your measures are lagging behind national CAH performance?
• Which, if any, of your CAHs are lagging behind the state CAH average performance?
• Which, if any, of your CAHs are high-performers on specific (or all) measures? Could they serve as best practice models for other CAHs in the state? Discuss any potential national models with your FORHP project officer.
• What interventions may be appropriate to implement to assist with improving quality outcomes? Resources: TASC, FMT, state quality partners such as QIO, other Flex Coordinators, high-performing CAHs
• Are changes to your Flex work plan required in order to implement QI activities to address the needs identified by the data in your MBQIP reports? Discuss with your FORHP project officer.

The importance of building a relationship with the quality partners in your state
We cannot stress enough the importance of building and maintaining a strong working relationship with the quality partners in your state. Of particular importance is the QIO in your state, but other partners, such as your State Hospital Association, can be significant partners as well. It is your role as the Flex Coordinator to know who the essential quality partners are in your state and to build a working relationship with them and see where you can collaborate around similar goals. Additionally, FORHP recognizes that each Flex Coordinator may not have the quality improvement background or expertise necessary to provide the appropriate assistance to CAHs regarding quality data and quality improvement needs, so partnerships with other organizations or subcontracts with quality improvement experts will be necessary for implementing the QI component of MBQIP. Through these partnerships, you will be able to ensure your CAHs receive the quality improvement technical assistance they need in order to continuously improve quality outcomes.
• If you have already established a relationship with your QIO, please continue to maintain that relationship, and please share best practices on the Flex Program Forum. If you do not currently partner with your state’s QIO, a directory is below. We urge you to reach out to build that relationship.
  • QIO Directory: www.qualitynet.org/dcs/ContentServer?c=Page&pagename=QnetPublic%2FPage%2FQnetTier2&cid=1144767874793
• Continue to identify other important quality partners in your state, and build and maintain a relationship with them as well.

Available resources
• Flex Monitoring Team (FMT): www.flexmonitoring.org
  • Search the numerous quality improvement publications on the FMT website


- **Technical Assistance and Services Center (TASC):** [www.ruralcenter.org/tasc](http://www.ruralcenter.org/tasc)
  - Search for a variety of resources on the TASC website, or go to the search function and type “MBQIP” or “Quality Improvement”
  - General MBQIP resources are located at: [www.ruralcenter.org/tasc/resources/medicare-beneficiary-quality-improvement-project-mbqip](http://www.ruralcenter.org/tasc/resources/medicare-beneficiary-quality-improvement-project-mbqip)
  - There are a variety of other resources such as:
    - [www.ruralcenter.org/tasc/pharm-review](http://www.ruralcenter.org/tasc/pharm-review)
    - [www.ruralcenter.org/tasc/resources/quality-reporting-matrix](http://www.ruralcenter.org/tasc/resources/quality-reporting-matrix)

- **QualityNet:** [www.qualitynet.org](http://www.qualitynet.org)
  - Established by CMS, QualityNet provides healthcare quality improvement news, resources and data reporting tools and applications used by healthcare providers and others.
  - Hospital Inpatient Q&A: [https://cms-ip.custhelp.com/](https://cms-ip.custhelp.com/)
  - Hospital Outpatient Q&A: [https://cms-ocsq.custhelp.com/](https://cms-ocsq.custhelp.com/)

**Concerns and Solutions**

*With a small case load, does it make sense to have CAHs publicly report?*
Yes. Public reporting will expand in the future based on the Patient Protection and Affordable Care Act. In time, reimbursement across all hospitals will be tied to performance so it is to the advantage of CAHs to begin the process of publicly reporting to ensure preparedness for future federal requirements. Mindful of small case load, FORHP will roll the data up to ensure that small patient numbers is not an issue. Hospitals with small numbers should report all of their cases, no matter how large or small their volume may be (but it will not be listed publicly unless the numbers meet the threshold as set by CMS). Because the data will be aggregated at the state and national level, FORHP will have the ability to show a more robust picture of the quality of care being provided in rural. The aggregation will also address the small case load issues faced by individual CAHs; you will notice that the small numbers in each CAH add up to a lot of patients for each state and the nation as a whole.

*Why are we using Hospital Compare when my state already has an existing data collection and reporting system?*
By reporting to Hospital Compare or another single entity nation-wide, you will have access to benchmark data and comparative analysis to all participating organizations to enable the identification of key opportunity areas. It is anticipated that future CMS reimbursement will be tied to participation in Hospital Compare. You are not required to replace or duplicate existing data collection systems. You should design your current system to support data transmission in to Hospital Compare. We will work with existing network partners to adjust their indicator sets to conform to Hospital Compare specifications and minimize the administrative burden of publicly reporting.

*How will MBQIP be funded?*
This project will be funded out of existing Flex program dollars within your state. These activities meet the Core Area of Quality Improvement requirements. Given that Flex funds are limited, we know that states will need to prioritize the needs of CAHs and fund activities to target those specific needs, and encourage states to set aside funds for MBQIP activities.

*How will data be submitted or reported?*
Measures such as Congestive Heart Failure, Pneumonia and HCAHPS, currently collected in Hospital Compare via the CMS Abstraction and Reporting Tool (CART) or other mechanism, will be reported via that route. Additional information will be provided regarding data submission for the non-Hospital Compare Phase 3 measures.
Do CAHs have to register in order to submit and report their data?

Yes, CAHs will have to register with QualityNet. Most CAHs have already been reporting Inpatient Measures to Hospital Compare and a lesser number have been reporting Outpatient Measures and HCAHPS. CAHs that will be reporting measures for the first time as a result of MBQIP participation will need to register with QualityNet in order to submit data into the CMS data warehouse. This registration is very important, because if they are not registered, they will not be able to submit their data.

In order to ensure CAHs are registered with QualityNet and ready to submit their quality data by the submission deadlines, we ask the Flex Coordinators to follow up with each of the CAHs in their state and encourage all CAHs to register by the March 31 deadline. Again, this is particularly important for those CAHs that will be reporting quality for the first time as a result of participation in MBQIP.

Below are links to more information on reporting inpatient, outpatient, and HCAHPS measures.

Inpatient: http://www.qualitynet.org/dcs/ContentServer?c=Page&pagename=QnetPublic%2FPage%2FQnetTier3&cid=1138900291659

Outpatient: http://www.qualitynet.org/dcs/ContentServer?c=Page&pagename=QnetPublic%2FPage%2FQnetTier3&cid=1192804530878

HCAHPS: http://www.qualitynet.org/dcs/ContentServer?c=Page&pagename=QnetPublic%2FPage%2FQnetTier2&cid=1140537251096

What are the reporting deadlines for Hospital Compare Measures?

Please see the appendix for a matrix of reporting deadlines for inpatient, outpatient, and HCAHPS.

The deadline to register with QualityNet to submit outpatient data is March 31, 2014. What happens if a hospital does not register by the deadline, but decides they want to submit outpatient data?

If a hospital does not register to report outpatient data by the March 31, 2014, deadline, the hospital may still decide to register after the deadline has passed; however the registration will be for the following year of outpatient data reporting (2015). For inpatient data, the hospital may register at any time, and they can begin submitting data immediately.

Does MBQIP replace the CMS Core Measure program?

No, MBQIP does not replace the Core Measure program. If you are currently submitting Core Measures, continue this process. For Phases 1 and 2 of MBQIP, no additional reporting is required if you are currently submitting your Core Measures.

How were these measures selected?

FORHP with the input of rural experts who have worked with or within CAHs (CAH quality administrators, Flex Monitoring Team, State Flex Coordinators and rural clinical experts) selected these measures.

Who will have access to the data? How will it be used?

The data that is submitted by the hospital into Hospital Compare will be provided to FORHP through a contract with Telligen, the CMS QualityNet inpatient data warehouse contractor. Telligen will create individual hospital and aggregated state level reports that will be distributed to each State Flex Program to be shared with their CAHs and key MBQIP partners in the state. Flex Coordinators should use the data to determine the types of quality improvement activities to support through the Flex grant. Individual hospitals should be analyzing their data as they report it and using the data to determine which processes should be improved to ensure that every patient receives the highest quality care. Additionally, State Flex Coordinators are encouraged to work with hospitals to share the data among the CAHs in the state for benchmarking and for tying quality improvement activities based on the more current data. MBQIP data will also be shared with the Flex Monitoring Team to allow for additional data analysis. Data will be aggregated and no individual hospital data will be reported out in this analysis.

Note: FORHP anticipates that QIOs will collaborate with states to provide technical assistance, training, and/or data reports regarding results of Hospital Compare measures specified in this strategic plan. According to Title 42 Public Health Part 480.140 provision (Disclosure of quality review study information), parts (d) and (e): A QIO may disclose quality review study information with identifiers of particular practitioners or institutions, or both at the written consent of, the identified practitioner(s) or institution(s);
and An institution or group of practitioners may redisclose quality review study information, if the information is limited to health care services they provided.

**How should states incorporate MBQIP into existing activities?**
With nationwide participation in MBQIP, FORHP hopes to leverage what is already working in rural hospitals across the country regarding quality improvement. Appropriate activities will differ from state to state. FORHP would like to hear from states on the innovative ways the MBQIP data is being used to fit your situation. From there, we can all begin sharing successes, lessons learned, challenges, and addressing additional questions as they arise.

***For more information about MBQIP, please contact Megan Meacham (mmeacham@hrsa.gov).

**Appendix: Measure Definitions**

**Phase 1 Measures**
- **Pneumonia:** CMS Hospital Compare Core Measure (participate in all sub-measures);
  - **PN-3b:** Blood Cultures Performed in the Emergency Department Prior to Initial Antibiotic Received in Hospital
  - **PN-6:** Initial Antibiotic Selection for CAP in Immunocompetent Patient
- **Congestive Heart Failure:** CMS Hospital Compare Core Measure (participate in all sub-measures)
  - **HF-1:** Discharge Instructions
  - **HF-2:** Evaluation of LVS Function
  - **HF-3:** ACEI or ARB for LVSD

*Note:* Three of the Phase 1 inpatient measures (indicated above with *** selected for MBQIP inclusion have been retired by CMS as of January 1, 2014. However, CMS has informed FORHP that these measures will remain available for voluntary data submission, likely through Fall of 2014. We ask that all CAHs continue to report on these measures until they are formally removed. Many CAHs have begun quality improvement activities around these measures, and continued reporting for an additional year will allow us to measure and track any improvements made.

**Phase 2 Measures**
- **Outpatient 1-7:** Hospital Compare CMS Measure (all sub-measures that apply):
  - **OP-1:** Median Time to Fibrinolysis in the Emergency Department
  - **OP-2:** Fibrinolytic Therapy Received Within 30 Minutes of ED Arrival in the Emergency Department
  - **OP-3:** Median Time to Transfer to another Facility for Acute Coronary Intervention in the Emergency Department
  - **OP-4:** Aspirin at Arrival in the Emergency Department
  - **OP-5:** Median Time to ECG in the Emergency Department
  - **OP-6:** Timing of Antibiotic Prophylaxis (Prophylactic Antibiotic Initiated Within One Hour Prior to Surgical Incision) in Surgery
  - **OP-7:** Prophylactic Antibiotic Selection for Surgical Patients in Surgery
- **Hospital Consumer Assessment of Healthcare Providers and Systems (HCAHPS)**

**Phase 3 Measures**
- **Pharmacist CPOE/Verification of Medication Orders Within 24 Hours**
  - **Numerator:** Number of electronically entered medication orders for an inpatient admitted to a CAH (acute or swing-bed), verified by a pharmacist or directly entered by a pharmacist within 24 hours
  - **Denominator:** Total number of electronically entered medication orders for an inpatient admitted to CAH (acute or swing-bed) during the reporting period
- **Outpatient Emergency Department Transfer Communication (Seven Elements)**
  - **Pre-Transfer Communication Information**
  - **Patient Identification**
- Vital Signs
- Medication-related Information
- Practitioner generated information
- Nurse generated information
- Procedures and tests

For additional information on the Phase 3 measures, please refer to the TASC MBQIP resource page:
www.ruralcenter.org/tasc/resources/medicare-beneficiary-quality-improvement-project-mbqip
## Appendix: Reporting Deadlines

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<th>MBQIP Phase</th>
<th>CMS Reporting Quarter (Dates)</th>
<th>Inpatient</th>
<th>Outpatient**</th>
<th>HCAHPS*</th>
<th>Pharmacist Order/Verify</th>
<th>ED Transfer Communication</th>
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<td>FY11 Flex Grant Year</td>
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<td>N/A</td>
<td>N/A</td>
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<td>N/A</td>
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<tr>
<td>Phase 1 Continues; Phase 2 Begins</td>
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<td>May 15, 2013</td>
<td>May 1, 2013</td>
<td>April 3, 2013</td>
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<td>February 1, 2016</td>
<td>TBD, 2016</td>
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* Data is submitted for **discharges** occurring during the reporting quarter
** Data is submitted for **patient encounters** occurring during the reporting quarter
Partnership for Patients and MBQIP

The Partnership for Patients: Better Care, Lower Costs, is a new public-private partnership that will help improve the quality, safety, and affordability of health care for all Americans. It brings together leaders of hospitals, employers, physicians, nurses, and patient advocates along with state and federal governments in a shared effort to make hospital care safer, more reliable, and less costly. The key goals of the Partnership for Patients line up with the work critical access hospitals will be engaging in when signed up for the Medicare Beneficiary Quality Improvement Project (MBQIP).

**What does joining the Partnership for Patients commit me to?**

As a hospital it means committing to work to attain the goals of the initiative to achieve safe, high quality care by utilizing tools and processes that improve safety for patients through:

- Making achieving the goals of harm reduction and improved care transitions to reduce readmissions a priority of your Board of Directors, senior leaders, clinicians, and staff;
- Supporting clinicians and staff and engaging patients and families in order to make care safer, improve communication, and increase coordination by implementing proven systems and processes; and
- Learning from and sharing with others your experiences with making care safer and more coordinated.

To find out more about Partnership for Patients and to sign up, visit: [www.healthcare.gov](http://www.healthcare.gov)