



# Quality Measures Under Consideration for MBQIP

**January 12, 2023**


**HEALTHWORKS**  
KANSAS HOSPITAL ASSOCIATION


 Kansas  
 Department of Health  
 and Environment




# Upcoming Webinars and Educational Offerings

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## 2023 Upcoming Webinars

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- SHIP Informational Webinars
  - March 14
  - June 14
  - September 14
  - December 14
- Quality Corner Calls
  - February 9 – Best Practices in Utilization Review, Discharge Planning, Swing Bed Coordination, and Activities Coordination
  - May 3 – FMT Report Review and Resources

## Upcoming Offerings

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- Turning Data Into Improvement
  - January 27 – Wichita
  - February 28 – Garden City
- PSLC Informational Webinar
  - January 24
- QAPI Networking Group
  - January 31, March 1, April 5

## Site Visits (In-person or Zoom)

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### MBQIP Reporting Reviews (5/quarter)

- Current requirements to continue receiving the SHIP grant
- Flex Monitoring Team reports reviewed
- Discussion of who reports what elements at your facility
- Clearing up any questions your facility may have about reporting of this data to meet the deadlines



**MBQIP**

# MBQIP's Tie to SHIP

Kansas SHIP Grant eligible PPS hospitals and CAHs must actively participate in the Medicare Beneficiary Quality Improvement Project [MBQIP] to qualify for full SHIP funding.



### Medicare Beneficiary Quality Improvement Project (MBQIP) Hospital Data Submission Deadlines Reporting Quarters Applicable to SHIP 2022-2023 Grants


Measure ID	Measure Name	Reported To	Submission Deadline by Encounter Period			
			Q4 / 2021 Oct 1 - Dec 31	Q1 / 2022 Jan 1 - Mar 31	Q2 / 2022 Apr 1 - Jun 30	Q3 / 2022 Jul 1 - Sep 30
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OP-2	Fibrinolytic therapy received within 30 minutes	QualityNet via Outpatient CART/Vendor	May 2, 2022	August 1, 2022	November 1, 2022	February 1, 2023
OP-3	Median time to transfer to another facility for acute coronary intervention	QualityNet via Outpatient CART/Vendor	May 2, 2022	August 1, 2022	November 1, 2022	February 1, 2023
OP-18	Median time from ED Arrival to ED Departure for Discharged ED Patients	QualityNet via Outpatient CART/Vendor	May 2, 2022	August 1, 2022	November 1, 2022	February 1, 2023
OP-22	Patient left without being seen	QualityNet via Secure Log In	May 16, 2022 (Aggregate based on full calendar year 2021)			
HCP/IMM-3	Influenza vaccination coverage among health care personnel	National Healthcare Safety Network	May 16, 2022 (Aggregate based on Q4 2021/Q1 2022)			
EDTC	Emergency Department Transfer Communication	QHi	Submit each month by the end of the following month			
HCAHPS	Hospital Consumer Assessments of Healthcare Providers and Systems	QualityNet via Vendor	April 6, 2022	July 6, 2022	October 5, 2022	January 4, 2023
Antibiotic Stewardship	CDC NHSN Annual Facility Survey	National Healthcare Safety Network	March 1, 2023 (Survey year 2022)			

\* Based on currently available information. Submission dates are subject to change.

\* Data submission deadlines on a federal holiday or weekend (Saturday or Sunday) will default to the first business day thereafter and are reflected in this document where applicable.

\*Please note: CMS is considering adding the COVID-19 Vaccination Among Health Care Personnel (HCP) to MBQIP requirements. We will share more information as it becomes available.






# FORHP

## MBQIP Measures Under Consideration

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## Measures Under Consideration

- Antimicrobial Use and Resistance (AUR) Surveillance
- Electronic Clinical Quality Measure (eCQM) – Outpatient
  - ST-Segment Elevation Myocardial Infarction (STEMI) (OP-40)
- Electronic Clinical Quality Measure (eCQM) – Inpatient
  - Venous Thromboembolism Prophylaxis (VTE-1)
  - Global Malnutrition Composite Score (GMCS)
  - Safe Use of Opioids – Concurrent Prescribing (Safe Use of Opioids)
- Hospital Commitment to Health Equity
- Hybrid Hospital-Wide All Cause Readmission
- Screening for Social Drivers of Health
- Screen Positive for Social Drivers of Health
- Sepsis (SEP-1)

## FORHP Feedback Request

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- General feedback regarding measures under consideration
- General feedback regarding potential addition of eCQMs to MBQIP
- Input regarding each of the individual measures under consideration

## Antimicrobial Use and Resistance (AUR) Surveillance

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**Measure Description:**  
The Antimicrobial Use and Resistance (AUR) module provides a mechanism for facilities to report and to analyze antimicrobial use and/or resistance data to inform benchmarking, reduce antimicrobial resistant infections through antimicrobial stewardship, and interrupt transmission of resistant pathogens at facilities.

**Measure Submission and Reporting Channel:**

Monthly, pharmacy and/or laboratory information software derived data submitted via HL7 Clinical Document Architecture to NHSN. The CDC maintains a list of validated AU vendors and AR vendors

- Currently available to report

## Antimicrobial Use and Resistance (AUR) Surveillance

Things to consider:

- Vendor – do you have one? How easy will it be to connect them to your EHR?
- Cost – how much and who covers it?
- Microbiology Lab – do you have one? Can you even report this measure set?
- NHSN Access – who has it and how easily can you grant access to your vendor?

## ST-Segment Elevation Myocardial Infarction (STEMI) (OP-40)

Electronic Clinical Quality Measure (eCQM) – Outpatient

Measure Description:

Percentage of emergency department (ED) encounters for patients 18 and older with diagnosis of STEMI that received appropriate treatment:

- Fibrinolytic therapy within 30 minutes of ED arrival OR
- Percutaneous coronary intervention (PCI) within 90 minutes of ED arrival OR
- Transfer within 45 minutes of arrival

Measure Submission and Reporting Channel:

Annual, QRDA Category 1 File via Hospital Quality Reporting (HQR) platform.

- Clinically similar to current chart abstracted OP-2 and OP-3, which retire after 1Q23
- First available reporting period is CY2023, with data due May 15, 2024

## ST-Segment Elevation Myocardial Infarction (STEMI) (OP-40)

Things to consider:

- Rural relevant?
- How many OP-2 & OP-3 cases do you have?
- What do you do with your OP-2 & OP-3 data currently?
- Does your vendor support this eCQM?

## Venous Thromboembolism Prophylaxis (VTE-1)

Electronic Clinical Quality Measure (eCQM) – Inpatient

**Measure Description:**  
This measure assesses the number of patients who received VTE prophylaxis or have documentation why no VTE prophylaxis was given the day of or the day after hospital admission or surgery end date for surgeries that start the day of or the day after hospital admission

**Measure Submission and Reporting Channel:**  
Annual, QRDA Category 1 File via Hospital Quality Reporting (HQR) platform.



## Venous Thromboembolism Prophylaxis (VTE-1)

Thoughts to consider:

- Is this one of your current self-selected eCQMs?
- Rural relevant?
- Does your vendor support this eCQM?

## Malnutrition Composite Score (GMCS) Global

### Electronic Clinical Quality Measure (eCQM) – Inpatient

Measure Description:

The malnutrition composite measure for those 65 or older includes four component measures, which are first scored separately, and then integrated into an overall composite score. The overall composite score is derived from averaging the individual performance scores of the following four component measures:

- Screening for malnutrition risk at admission
- Completing a nutrition assessment for patients who screened for risk of malnutrition
- Appropriate documentation of malnutrition diagnosis in the patient's medical record if indicated by the assessment findings
- Development of a nutrition care plan for malnourished patients including the recommended treatment plan.

Measure Submission and Reporting Channel:

Annual, QRDA Category 1 File via Hospital Quality Reporting (HQR) platform.

- The first year GMCS will be available for reporting is CY 2024
- This could be one of your three self-selected measures/quarter

## Malnutrition Composite Score (GMCS) Global

Thoughts to consider:

- Will this be one of your self-selected eCQMs for CY 2024 reporting?
- Does your vendor support this eCQM?

## Safe Use of Opioids – Concurrent Prescribing (Safe Use of Opioids)

### Electronic Clinical Quality Measure (eCQM) – Inpatient

#### Measure Description:

Denominator: Inpatient hospitalizations that end during the measurement period, where the patient is 18 years of age and older at the start of the encounter and prescribed one or more new or continuing opioid or benzodiazepine at discharge. Exclusions include patients with cancer that begins prior to or during the encounter or are receiving palliative or hospice care during the encounter, patients discharged to another inpatient care facility, and patients who expire during the inpatient stay

Numerator: Inpatient hospitalizations where the patient is prescribed or continuing to take two or more opioids or an opioid and benzodiazepine at discharge

#### Measure Submission and Reporting Channel:

Annual, QRDA Category 1 File via Hospital Quality Reporting (HQR) platform.

- CAHs are required to report this eCQM for CY 2023 for the Medicare Promoting Interoperability Program

## Safe Use of Opioids – Concurrent Prescribing (Safe Use of Opioids)

Thoughts to consider:

- CAHs are required to report this eCQM for CY 2023 for the Medicare Promoting Interoperability Program
- PPS hospitals, eCQM reporting requirements are aligned between the Medicare Promoting Interoperability Program and the Inpatient Quality Reporting Program

## Hospital Commitment to Health Equity

Measure Description:

Hospitals will receive points for responding to questions in five different domains of commitment to advancing health equity:

- Domain 1 – Equity is a Strategic Priority
- Domain 2 – Data Collection
- Domain 3 – Data Analysis
- Domain 4 – Quality Improvement
- Domain 5 – Leadership Engagement

Hospital score can be a total of zero to five points (one point for each domain, must attest “yes” to all sub-questions in each domain, no partial-credit)

Measure Submission and Reporting Channel:

Annual attestation via Hospital Quality Reporting (HQR)

- New CMS IQR program measure
- First available reporting timeline is Spring 2024 (reflecting CY 2023 activity)

## Hospital Commitment to Health Equity

Thoughts to consider:

- Not looking for perfection or to have a total score of 5
- The improvement will be to keep moving your total score up
- Maximum score of 5
- Unlike the 7 domains of an antibiotic stewardship program, you must answer “yes” to each question in a domain to obtain the point

## Hybrid Hospital-Wide All Cause Readmission

Measure Description:

Hybrid measures differ from the claims-only measures in that they merge electronic health record (EHR) data elements with claims-data to calculate the risk-standardized readmission rate. The Hybrid HWR was developed to address complex and critical aspects of care that cannot be derived through claims data alone.

To report, hospitals submit a patient level Quality Reporting Data Architecture (QRDA) Category I file (the same type of file used for eCQM submission) that includes clinical variables and linking elements for each patient:

- Clinical variables (13): Heart Rate, Systolic Blood Pressure, Respiratory Rate, Temperature, Oxygen Saturation, Weight, Hematocrit, White Blood Cell Count, Potassium, Sodium, Bicarbonate, Creatinine, Glucose
- Linking elements (6): CMS Certification Number (CCN), Health Insurance Claims Number or Medicare Beneficiary Identifier, Date of birth, Sex, Admission date, Discharge date

Measure Submission and Reporting Channel:

Annual attestation via Hospital Quality Reporting (HQR)

- CMS IQR program measure
- Next available reporting deadline is October 2, 2023 for July 1, 2022 through June 30, 2023 hospitalizations.

## Hybrid Hospital-Wide All Cause Readmission

Thoughts to consider:

- PPS hospitals required to report to meet the IQR program requirements and avoid a negative payment adjustment for encounters July 1, 2023 – June 30, 2024 with data due October 1, 2024
- Beginning with 2023-2024 data, CAHs that are not reporting Hybrid HWR data elements will no longer have readmissions rate calculated
- Hybrid HWR will be publicly reported starting with the July 2025 refresh of Care Compare (replacing the claims-based HQR measure)

## Screening for Social Drivers of Health

Measure Description:

Percent of patients 18 and older admitted for an inpatient stay that are screened for all of the following health-related social needs (HRSNs):

- Food insecurity
- Housing instability
- Transportation needs
- Utility difficulties
- Interpersonal safety

Measure Submission and Reporting Channel:

Annual numerator and denominator submission through Hospital Quality Reporting (HQR) platform via web-based data form.

- Hospitals are allowed to select their own screening tool, as long as it captures all five required areas
- First available reporting period is May 15, 2024 for calendar year (CY) 2023 data

## Screening for Social Drivers of Health

Thoughts to consider:

- PPS hospitals required to report to meet the IQR program requirements and avoid a negative payment adjustment for CY2024 data which would be due May 15, 2025
- What would you do with this type of data?
- Why gather data if there is little that can be done to improve the numbers from the hospital perspective?

## Screen Positive for Social Drivers of Health

Measure Description:

Denominator: Total number of patients 18 and older screened for an HRSN.

Numerator: Number that screen positive for each of the five HRSNs captured in the Screening for Social Drivers of Health measure.

- Food insecurity
- Housing instability
- Transportation needs
- Utility difficulties
- Interpersonal safety

Measure Submission and Reporting Channel:

Annual numerator and denominator submission through Hospital Quality Reporting (HQR) platform via web-based data form.

- Hospitals are allowed to select their own screening tool, as long as it captures all five required areas
- First available reporting period is May 15, 2024 for calendar year (CY) 2023 data

## Screen Positive for Social Drivers of Health

Thoughts to consider:

- PPS hospitals required to report to meet the IQR program requirements and avoid a negative payment adjustment for CY2024 data which would be due May 15, 2025
- What would you do with this type of data?
- “This measure is not an indication of performance”
- If hospitals are not reimbursed to solve these problems, is there potential to be penalized down the line if the numbers do not decrease?

## Sepsis (SEP-1)

Measure Description:

Sepsis (SEP-1) measures the percentage of patients that received appropriate care for severe sepsis and/or septic shock.

Denominator: Inpatients age 18 and over with an ICD-10-CM Principal or Other Diagnosis Code of Sepsis, Severe Sepsis, or Septic Shock and not equal to U07.1 (COVID-19).

Numerator Statement: Patients who received ALL of the following:

- Within three hours of presentation of severe sepsis:
  - Initial lactate level measurement
  - Broad spectrum or other antibiotics administered
  - Blood cultures drawn prior to antibiotics
- AND received within six hours of presentation of severe sepsis. ONLY if the initial lactate is elevated:
  - Repeat lactate level measurement
- AND within three hours of initial hypotension:
  - Resuscitation with 30 mL/kg crystalloid fluids
- OR within three hours of septic shock:
  - Resuscitation with 30 mL/kg crystalloid fluids
- AND within six hours of septic shock presentation, ONLY if hypotension persists after fluid administration:
  - Vasopressors are administered
- AND within six hours of septic shock presentation, if hypotension persists after fluid administration or initial lactate  $\geq 4$  mmol/L:
  - Repeat volume status and tissue perfusion assessment is performed

Measure Submission and Reporting Channel:

Chart-abstracted and submitted quarterly via CART (CMS Abstraction Reporting Tool) or a vendor tool via the Hospital Quality Reporting (HQR) platform.

- Current Inpatient Quality Reporting (IQR) program measure
- Clinical guidance is updated regularly – resulting in regular updates to the measure specifications and abstraction guidance
- Many CAHs have been focused on sepsis as part of their work with Hospital Quality Innovation Networks (formerly HIIN/HEN) or as part of statewide initiatives or requirements

## Sepsis (SEP-1)

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Thoughts to consider:

- PPS hospitals are required to report
- Rural relevant?
- Complicated chart abstracted measure
- Should be OP to be rural relevant
- 440 CAHs reported this measure in 1Q22
- Believed alignment w/ HQIN
- Not the same as the 2023 BCBSKS QBRP

## Next Steps



## FORHP Feedback Request

- General feedback regarding measures under consideration
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## Timeline



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Hospital Data Submission Deadlines  
Reporting Quarters Applicable to SHIP 2022-2023 Grants**

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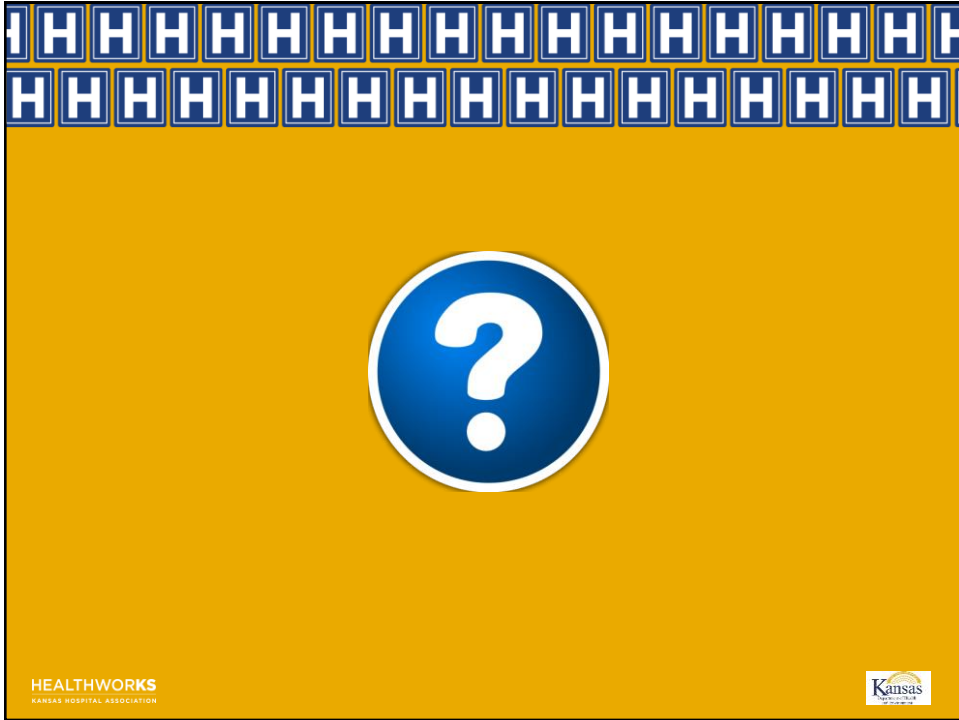


# Survey Monkey

## We need YOU

## Complete one per facility

## Return by January 31



## Contact Us

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