MISSOURI HOSPITAL ASSOCIATION
CRITICAL ACCESS HOSPITALS NETWORK
12 to 4 p.m. Wednesday, March 18, 2015
Missouri Hospital Association
4712 Country Club Drive
Jefferson City, Missouri

AGENDA

I. Welcome and Introductions — Jon Doolittle, Chair

II. DHSS Flex Grant Update — Melissa Van Dyne

III. MBQIP — Dana Downing

IV. Legislative Update — Daniel Landon

V. CAH Network Roundtable

VI. Future Topics

VII. Future Meetings

A. Friday, June 19 — CAH Network and Rural Hospital Council Breakfast Meeting at the Leadership Forum, Branson, 7:30 to 8:30 a.m.

B. Tuesday, September 15 — CAH Network Meeting at MHA, 12 to 4 p.m.

VIII. Adjournment

New FLEX Program Funding Cycle

Melissa VanDyne
Rural Health Manager
MO Department of Health & Senior Services
Office of Primary Care and Rural Health

Purpose of the FLEX Program

Established by Title XVIII (1&2) of the Social Security Act (42 U.S.C. 1395i-4), as amended; Continuing Appropriations Act, 2015 (P.L. 113-235).

Purpose is to assist Critical Access Hospitals (CAHs) by providing funding to state governments to encourage: QUALITY and PERFORMANCE IMPROVEMENT activities; stabilizing rural hospital finance; integrating emergency medical services (EMS) into their health care systems; incorporating population health; and fostering innovative models of health care.

FLEX is Composed of Five Program Areas

1. Quality Improvement - MBQIP (required)
2. Financial and Operational Improvement (required)
3. Population Health Management and Emergency Medical Services* Integration (optional)
4. Designation of CAHs in the State (required if requested)
5. Integration of Innovative Health Care Models (optional)**

*Capped at 25% total budget

** Intended for states with limited needs in other program areas the capacity

FLEX 2015-2018

- Capacity Building (if needed) and/or Implementation in year(s) 1 &/or 2
  Measurement in year(s) 1, 2 &/or 3.
- Focuses on the Collective Needs of CAHs in improvement activities.
- Produce measurable activities benefiting CAH cohorts.
- Activities for individual CAHs are okay but must be justified.

Program Area 1 - Quality Improvement - MBQIP

MBQIP is composed of Four Quality Domains:

- Patient Safety
- Patient Engagement
- Care Transitions
- Outpatient

Each Quality Domain has required QI activities – meaning all CAHs must be reporting or building capacity to report on the listed measures.

Some Quality Domains have additional QI activities – meaning these are optional.

Patient Safety

- HCP/OP-27: Influenza vaccination coverage among healthcare personnel
- Imm-2: Influenza immunization

Patient Engagement

Hospital Consumer Assessment of Healthcare Providers and Systems (HCAHPS)- 32 questions in length

Care Transitions

- Emergency Department Transfer Communication
  - EDTC-1: Administrative communication
  - EDTC-2: Patient information
  - EDTC-3: Vital signs

Care Transitions (cont)

- Emergency Department Transfer Communication
  - EDTC-4: Medication information
  - EDTC-5: Physician or practitioner generated information
  - EDTC-7: Procedures and tests

Outpatient

- 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-5: Median time to ECG

Outpatient (cont)

- OP-20: Door to diagnostic evaluation by a qualified medial professional
- OP-21: Median time to pain management for long bone fracture
- OP-22: Patient left without being seen

“Requirements”

- CAHs must work on all required QI activities in the Quality Domains, or in other words ‘reporting’.
- If a CAH isn’t reporting, then you would need to do a sub-activity (capacity building) to work with them to report on those specific measures.
- CAHs not building capacity toward and/or reporting on all required measures in all Quality Domains are NOT eligible to receive / participate in any FLEX funding.

Program Area 1 – Key Reminders and FAQs

- The idea is not to report for reporting's sake, but to identify where improvements are needed, what might an improvement activity be, and whether improvements in those areas are happening.
- This is part of a larger process focused on quality and the direction health care is going.
- CAHs already doing QI / measurement activities outside of FLEX should maintain those activities in addition to the MBQIP activities. However, FLEX cannot pay for these activities.
- CAHs have a year to work on capacity building if they're not yet ready to report, but they must work on all required areas in order to receive/participate in FLEX funding.

Program Area 1 – Key Reminders and FAQs

What if a CAH decides not to participate in year 1 (thereby not supported by FLEX Funding), but decided to in year 2. Can they?

Yes!

But they must demonstrate capacity building and/or reporting activities for all required areas in all MBQIP Quality domains. They can not pick and choose. All or nothing! Once this is established they can benefit from FLEX Funding again.

Therefore, it would be more advantageous for CAHs not ready to report to spend the first year building capacity so they can still benefit from FLEX. Building Capacity in Year 3 could be considered if it can lead to participation in the future.

Program Area 2 – F&O Improvement

- Annual Needs Assessment **required**
- In-depth Assessment and targeted initiatives are optional activities. Perhaps a CAH or Cohort of CAHs requires more assessment work done and focus to better understand their need(s)
- Revenue Cycle Management and Operational Improvements activities

Program Area 3 – Population Health Management and/or EMS Integration

- Annual Needs Assessment required only if sub-activities (optional) selected in this program area
- These optional activities include
  - In-depth needs assessment activities related to pop. health and EMS
  - Improving population health
  - Improving EMS areas:
    - TCD (Stroke; STEMI, Trauma) Capacity
    - Operations and Capacity

Program Area 4 – CAH Designation Required If a Rural Hospital Wants Assistance in Evaluating Conversion to CAH Status

- This may include assisting with financial feasibility studies for hospitals considering conversion to CAH status as well as feasibility studies for reopening closed rural hospitals or converting CAHs to other types of facilities.
- The application needs assessment should help identify whether your state will need to conduct activities in Program Area 4.
- You can set aside resources or identify a sub-activity under the program area if you see this as a need.

Program Area 5 – Integration of Innovative Health Care Models

- States with limited needs in other priority areas are encouraged to consider applying if they have the capacity.
- Intended to give states an ability to meet unique needs with activities that could become best practices for the FLEX Program.
- Focused on developing and integrating innovative health care models around the areas of:
  - quality improvement
  - financial/operations
  - population health and/or system delivery

Final Thoughts

- Change is hard, but necessary to align the FLEX program with Federal Priorities and the Health Care landscape.
- Quality Improvement demonstrated via measurement, reporting, and improvement is here to stay – hence the strong focus on MBQIP
- Value and improvement are shown via measureable activities and outcomes – this is how we can demonstrate program integrity.
- FLEX dollars can have a larger reach and impact when tailored to CAH cohorts rather than individual CAHs.

MISSOURI HOSPITAL ASSOCIATION

Medicare Beneficiary Quality Improvement Project

March 18, 2015

Quality Reporting in Critical Access Hospitals

Why report?

- *Hospital Compare* is a tool that all other types of hospitals are required to report into and is, therefore, a source of information that lawmakers use when making funding decisions.

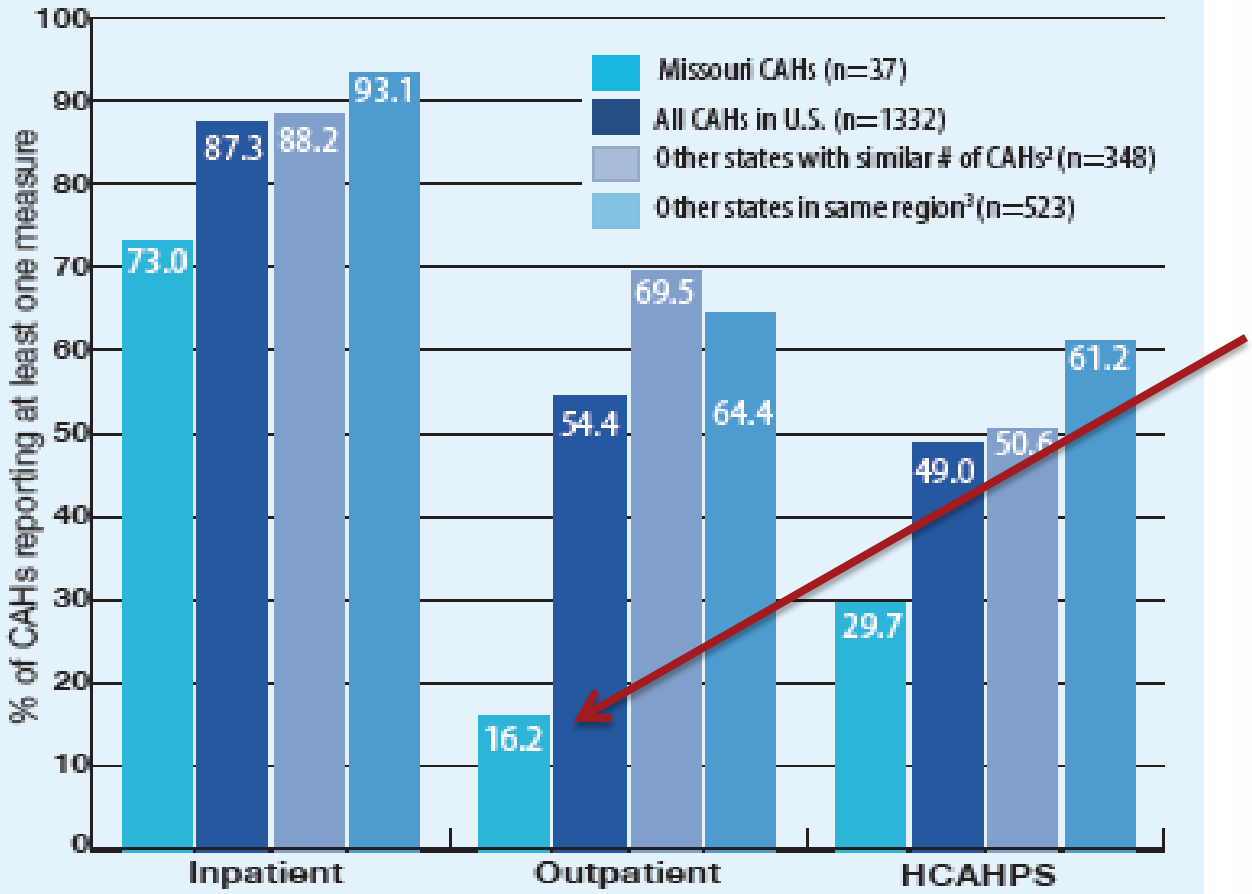
CAH Reporting

- Compared to all other CAHs nationally, **Missouri's** reporting rates were:
  - LOWER for inpatient measures
  - LOWER for outpatient measures
  - LOWER for HCAHPS

State Rankings

- Among the 45 states participating in the FLEX program, **Missouri's** CAHs rank
  - 39th for inpatient measure reporting
  - 41st in outpatient measure reporting
  - 35th for HCAHPS reporting

CRITICAL ACCESS HOSPITAL PARTICIPATION RATES IN HOSPITAL COMPARE, Q2 2012-Q1 2013[1]



1. Hospital Compare Year 9 data spans April 2012 (Q2 2012) - March 2013 (Q1 2013).
2. Group includes CA (32) GA (33) IN (35) MI (36) MS (32) ND (36) OH (34) OK (34) SD (38) WA (38).
3. HRSA Region C: IL, IN, IA, KS, MI, MN, NE, OH, WI.

How Can I Use My Data?

- Strategic Planning
  - How are measures trending?
  - What is consistent and what is not?
  - What is the root cause of the process failure?
  - How can the clinical team and the quality team work together to improve?

Stakeholders

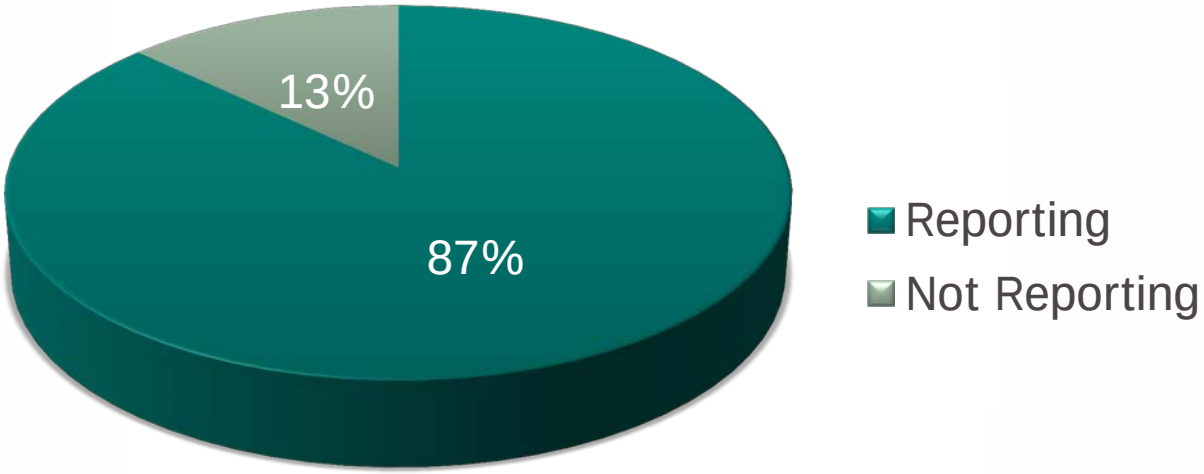
- Communication
  - Board of Governors
  - senior leadership
  - management
  - front line staff
  - patient safety teams
  - core measure teams
  - process improvement teams

Celebrate Wins!

Inpatient Quality Reporting

Percent Missouri CAHs Reporting

As of 1st Quarter 2014



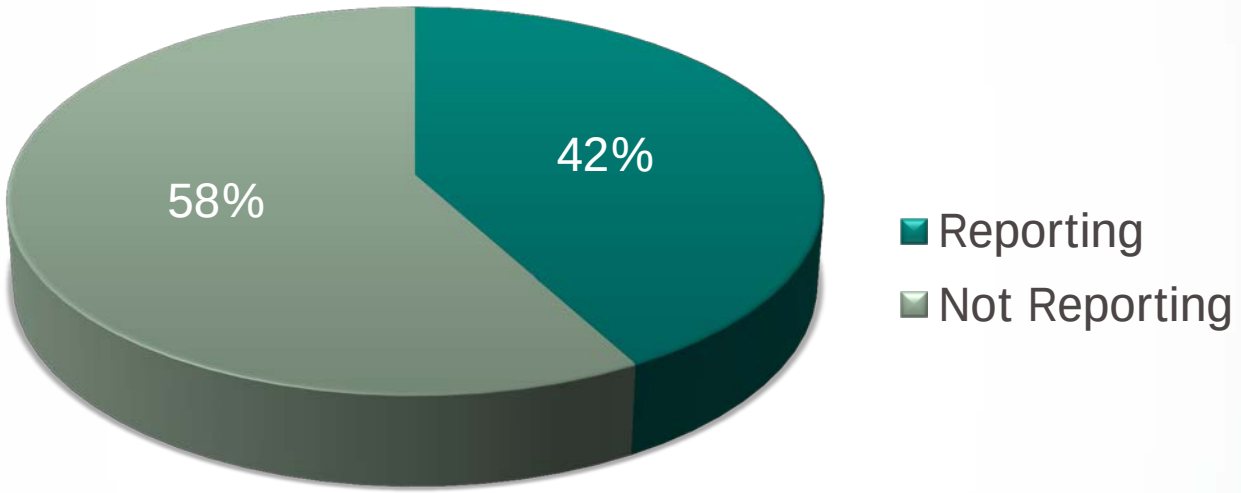
IQR Performance

Measure	Description	MO Average	National Average
~~HF-1~~	Discharge Instructions	77%	82%
HF-2	Evaluation of LVS Function	78%	89%
~~HF-3~~	ACEI or ARB for LVSD	80%	90%
~~PN-3b~~	Blood Cultures in E.D. Prior to Initial Abx	97%	94%
PN-6	Initial Abx Selection	87%	89%

Outpatient Quality Reporting

Percent Missouri CAHs Reporting

As of 1st Quarter 2014



OQR Performance

Measure	Description	MO Average	National Average
OP-1	Median Time to Fibrinolysis	52 Minutes	31 Minutes
OP-2	Fibrinolytic Therapy within 30 Minutes of ED Arrival	33%	50%
OP-3b	Median Time to Transfer for Acute Coronary Intervention	60 Minutes	71 Minutes
OP-4	Aspirin at Arrival	94%	96%
OP-5	Median Time to ECG	8 Minutes	8 Minutes
~~OP-6~~	Timing of Abx Prophylaxis	100%	94%
~~OP-7~~	Prophylactic Abx Selection	96%	94%

Emergency Department Transfer Communications

EDTC Measures

- EDTC-1: Administrative Communication
- EDTC-2: Patient Information
- EDTC-3: Vital Signs
- EDTC-4: Medication Information
- EDTC-5: Physician or Practitioner Generated Information
- EDTC-6: Nurse Generated Information
- EDTC-7: Procedures and Tests

Hospital Consumer Assessment of Healthcare Providers and Systems

Delay In Reporting

- Change in the HCAHPS contractor- working out a new contract

Hospital Compare Release Dates

Hospital Compare Releases for Calendar Year 2015

Release	Anticipated Release Date	Anticipated Preview Dates
April	April 16, 2015	December 31, 2014 through January 29, 2015
July	July 16, 2015	April 3, 2015 through May 2, 2015
October	October 8, 2015	July 2, 2015 through August 2, 2015
December	December 10, 2015	September 15, 2015 through October 14, 2015

Resources

- Missouri Hospital Association website, MBQIP section
- QualityNet website
- National Rural Health Resource Center
- Hospital Compare

MBQIP Activity

- Spring Regional Meetings- 3 locations
- Fall Regional Meetings- 3 locations
- Statewide Meeting
- Site Visits
- Quarterly Reports
- Help Desk
- Communication dissemination

MBQIP Statewide Meeting

Tuesday, July 28

Columbia Hampton Inn & Suites at the University of Missouri

Akin Demehin

Senior Associate Director, Policy

American Hospital Association

Questions?

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