Reducing the Burden of MBQIP Participation: A Pilot and Case Study with Nebraska CAHs

Amber Kavan - Saunders Medical Center
Kari Majors - NEHII
Renee Towne - KPI Ninja

Presenters

Amber Kavan
Performance Improvement Coordinator and Hospital Health Coach, Saunders Medical Center

Kari Majors
Director of Grants and Contract Management, NEHII

Renee Towne
Director of Quality Programs, KPI Ninja
Objectives

**DEFINE**
...the Medicare Beneficiary Quality Improvement Program (MBQIP) and partnership drivers for program participation improvement

**EXPLAIN**
...the process of discovery, documentation and resources used to identify, aggregate, report and analyze quality results

**DISCUSS**
...emerging capabilities that leverage disparate data sources into a single view to produce insights into quality programs and initiatives while reducing the burden of participation

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**MBQIP Overview**

• MBQIP is a quality improvement activity under the Medicare Rural Hospital Flexibility (Flex) grant program of the Health Resources and Services Administration’s Federal Office of Rural Health Policy
• Goal is to improve the quality of care provided in critical access hospitals (CAHs) by increasing quality data reporting by CAHs and then driving quality improvement activities based on the data
MBQIP Overview

Provides an opportunity for individual CAHs to:

1. Look at their own data with other hospitals in the state around quality improvement initiatives to improve outcomes
2. Provide the highest quality care to each and every one of their patients
3. Measure their outcomes against other CAHs

Project Overview

Pilot with three Nebraska CAHs in 2019, including Saunders Medical Center

Participating agencies included Nebraska State Office of Rural Health, NEHII and KPI Ninja

Goal: Improve MBQIP reporting and efficiency through data and report automation to reduce the burden
PILOT PARTNERS

Nebraska State Office of Rural Health
NEHII
KPI Ninja
Saunders Medical Center

• Mission is to define and promote the development of a health care system that assures the availability and accessibility of quality health care services to meet the needs of people living in rural Nebraska.

• Programs and activities are designed to assist rural Nebraskans in receiving high-quality health care through: recruitment and retention, hospital maintenance, community planning, health care networks and cooperative ventures, identifying community leaders, developing leadership skills and having an information clearinghouse.

Nebraska State Office of Rural Health
Medicare Rural Hospital Flexibility Program (FLEX) is one of Nebraska SORH’s programs. SORH’s previous recruitment of CAHs for MBQIP participation has been challenging as the program is voluntary and has traditionally taken extensive amounts of resources to report.

Nebraska State Office of Rural Health

Mission: Provide Nebraska and the region with a platform for the aggregation of health information to facilitate quality, safety and value in healthcare delivery. Vision: Enable a healthier Nebraska and region through the availability of health information needed to facilitate quality, safety and value in the population’s health. Non-profit, neutral collaborator, convener of the healthcare ecosystem. Designated statewide information exchange, integrator and HISP. Population Health Utility.
Quality value-adds:

- MBQIP
- CPC+
- QCDR for MIPS
- Chronic disease management
- Readmission dashboards
- HEDIS care gap reporting (NCQA-certified measures)

Nebraska Health Information Initiative

KPI Ninja

- Healthcare technology company primarily focused on data analytics
- Analytics as a service
  - Ninja Universe (tech platform) + Ninja Advisors (analytics advisors)
- Passionate toward improving the outcomes that matter to organizations and patients
- Big data-driven; one-stop solution for analytics needs
• Mission: To improve the health of the people of Saunders County and beyond by providing convenient and timely access to high-quality comprehensive care with exceptional service and compassion
• 16-bed CAH located in Wahoo
• Served as one of three pilot sites for this project

Saunders Medical Center

PILOT PHASES

Discovery
Design
Implementation
Discovery Phase

IDENTIFY
• MBQIP measures reported
• Electronic Health Record (EHR) used by the pilot site and understand its capabilities for data extraction

UNDERSTAND
• Pattern of work completed by care team members and the degree of variability within documentation processes
• Team members’ roles and level of proficiency with reporting tasks

EXAMINE
• Inputs needed, steps performed and timing of resources in the reporting process

PROVIDE
• The VPN access and data integration form to the pilot site IT team

Design Phase

• Collect current MBQIP quality specifications
• Build measures in reports and scorecard
• Creation of quarterly reports and scorecard highlighting:
  • Numerator/denominator
  • Benchmarking
  • Categories
• Quarterly trends for ease of interpretation and use for reporting and to drive improvements
Implementation Phase

- Extract preliminary data
- Identify data gaps
- Improve documentation gaps
- Validate data accuracy
- Conduct ongoing monitoring and validation as gaps close
- Review and validate reports

MBQIP SCORE CARD

Reports module
Score card example
Reports Module

Welcome to Ninja Universe
KPI Ninja (Testing)

Admin

Users

S.M.A.R.T

Strategic

Patient Experience

Audit

HIE 360

Market Share

Reports

Score Card Example

2016Q1

Active

Patient Safety/Inpatient

Metric Name | 2016Q1 | State Benchmark (2015) | National Benchmark | Status | Action
--- | --- | --- | --- | --- | ---
ED-1: Median Time from ED Arrival to ED Discharge for Admitted ED Patients (min) | 120 | 120 | 120 | Complete | ![Action Icon]
ED-2: Median Time from ED to ED Departure for Admitted Patients (min) | 30 | 30 | 30 | Complete | ![Action Icon]

Output

Metric Name | 2016Q1 | Benchmark Rate (%) | National Rate (%) | Status | Action
--- | --- | --- | --- | --- | ---
CP-2: Physician: Therapist Received within 30 minutes | 95% | 95% | 95% | Complete | ![Action Icon]
CP-3: Median Time to Transfer to another Facility for Acute Coronary Intervention (hrs.) | 30 | 30 | 30 | Complete | ![Action Icon]

ED Throughput

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CP-1: Median Time from ED Arrival to ED Departure for Discharged ED/Patients | 60 | 60 | 60 | Complete | ![Action Icon]
CP-2: Patient Left Without Being Served | 5% | 5% | 5% | Complete | ![Action Icon]

Case Transitions

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EDTC-1: Administration Communication | 95% | 95% | 95% | Complete | ![Action Icon]
EDTC-2: Patient Information | 95% | 95% | 95% | Complete | ![Action Icon]
EDTC-3: Admitting Information | 95% | 95% | 95% | Complete | ![Action Icon]
EDTC-4: Medication Information | 95% | 95% | 95% | Complete | ![Action Icon]
EDTC-5: Physician or Practitioner Generated Information | 95% | 95% | 95% | Complete | ![Action Icon]
EDTC-6: Other Services and Tests | 95% | 95% | 95% | Complete | ![Action Icon]
EDTC-7: Admitting and Discharge Information | 95% | 95% | 95% | Complete | ![Action Icon]
EDTC-8: Hospital and General Information | 95% | 95% | 95% | Complete | ![Action Icon]
EDTC-9: Diagnoses and Treatments | 95% | 95% | 95% | Complete | ![Action Icon]
Score Card Example

SAUNDERS CASE STUDY

Pre-intervention state
Current state
Next steps
Pre-intervention state

Barriers

- Large patient data extraction by multiple team members (limited consistency); 120 hours of manual data extraction annually
- 3+ month lagging performance data
- Limited ability to "see" trend performance
- Quality staff validating all tools prior to data entry

Pre-intervention state

- Manually having to identify if a patient was a direct admit, SNF or came from the ED (to be aligned with measure specs)
- Delay in performance monitoring/reporting secondary to the need for coding process to be completed at the end of each month
- Higher risk for manual entry error
- Increased delay due to billing department having to run necessary reports
Current state

- 100% extraction automation success
- Currently receiving quarterly reports for submission
- Provisioning for dashboard scorecard underway
- Integration of real-time information into standard management and improvement processes
- Leveraging increased to use time for other value-add work

NEXT STEPS

Exploring and seeking funding for scaling to other CAHs
Q&A