As a premier system of quality, the Michigan Critical Access Hospital Quality Network (MICAH QN) will be a model in developing processes that demonstrate the high quality service provided by CAHs. MICAH QN will identify opportunities for change that lead to continued improvement in the health status of the population we serve.
The Hybrid Hospital-Wide Readmission (CMS529) and Hybrid Hospital-Wide Mortality (CMS844) measures are scheduled for use in the Inpatient Quality Reporting (IQR) program. CAHs are not required to participate in the Hospital IQR Program but are encouraged to voluntarily report quality data, such as hybrid measure data, for the Hospital IQR Program.

Given this, CAHs may voluntarily participate in reporting for the CMS529 and CMS844 measures, but reporting is not mandatory for CAHs (even after the measure becomes mandatorily reported under the IQR program).

“If it is helpful, please also note that the Hybrid measures are not eCQMs”

However, this is how they are named online:
## eCQM Hybrid Measures


<table>
<thead>
<tr>
<th>Measure Name</th>
<th>Short Name</th>
<th>CMS eCQM ID</th>
<th>NQF #</th>
<th>Meaningful Measure Area</th>
<th>Notes</th>
</tr>
</thead>
<tbody>
<tr>
<td>Core Clinical Data Elements for the Hybrid Hospital-Wide (All-Condition, All-Procedures) Risk-Standardized Mortality Measure (HWM)</td>
<td>Hybrid HWM</td>
<td>CMS844v2</td>
<td>Not Applicable</td>
<td>Risk Adjusted Mortality</td>
<td>• This measure is not in the Data Element Repository at this time and is expected to be included in the Spring of 2022.</td>
</tr>
</tbody>
</table>

| Core Clinical Data Elements for the Hybrid Hospital-Wide Readmission (HWR) Measure with Claims and Electronic Health Record Data | Hybrid HWR | CMS529v2    | Not Applicable | Admissions and Readmissions to Hospitals                               |
Hybrid Measures Basics

• Administrative Data to be included: CMS Certification Number, HICN, Date of Birth, Gender, Admission Date and Discharge Date

• CMS will link with administrative claims with submitted data to develop a risk adjusted outcome measure

• Data may be submitted by your vendor or to QualityNet
Hybrid Measures Basics

CMS 592 V2 HYBRID HOSPITAL-WIDE READMISSIONS

Population: Ages 65 and older

Clinic Data: earliest vital signs, weight and basic lab results (adjusted base on preadmission location, E.g. ED > 24 hours)

Administrative Data: CMS Certification Number, HICN, Date of Birth, Gender, Admission Date and Discharge Date

CMS 844 V2 HYBRID HOSPITAL-WIDE MORTALITY

Population: age 65 – 94

Clinic Data: earliest vital signs and basic lab results (adjusted based on preadmission location, E.g. ED > 24 hours)

Administrative Data: CMS Certification Number, HICN, Date of Birth, Gender, Admission Date and Discharge Date

As a Premier System of Quality, the Michigan Critical Access Hospital Quality Network (MICAH QN) will be a model in developing processes that demonstrate the high quality service provided by CAHS. MICAH QN will identify opportunities for change that lead to continued improvement in the health status of the population we
Organizational Scorecard Showcase

Nicholson, RN
Quality and Accreditation Manager
Helen Newberry Joy Hospital & Healthcare Center
Proposed Metrics for Critical Access Hospital Report
Celebrating the Michigan Critical Access Hospital Quality Network!

TOP 10 PERFORMING STATE!!!!!
Top 10 Performing State – CAH Quality!

Recognized by HRSA for the 6th Year in a row!
Methodology

Analysis is based on Inpatient, outpatient, HCAHPS, and EDTC data are from Q1 2020 through Q4 2020

Measures used for calculating reporting and performance included:

- Three MBQIP Core inpatient measures (HCP/IMM-3, ED-2b; Antibiotic Stewardship);
- Four MBQIP Core outpatient measures (OP-2, OP-3b, OP-18b, OP-22);
- 10 HCAHPS measures
- Seven EDTC measures.

Reporting was defined as reporting data on at least one measure with a denominator of 1 or more for inpatient and outpatient; reporting data with at least one completed survey for HCAHPS; and reporting data on at least one case for EDTC. For all four categories, reporting is calculated out of all CAHs in a state (not just those with signed MOUs).
Methodology

1. For each state, FMT calculated:
   - An inpatient reporting percentage (the percent of CAHs in the state reporting data on at least one core inpatient measure)
   - An outpatient reporting percentage (the percent of CAHs in the state reporting data on at least one core outpatient measure)
   - An HCAHPS reporting percentage (the percent of CAHs in the state reporting HCAHPS data for at least one completed HCAHPS survey)
   - An EDTC reporting percentage (the percent of CAHs in the state reporting EDTC data for at least one patient)
   - An inpatient better performance measure (the number of inpatient measures on which CAHs in the state performed significantly better than CAHs in all other states)
   - An outpatient better performance measure score (the number of outpatient measures on which CAHs in the state performed significantly better than CAHs in all other states)
   - An HCAHPS better performance measure score (the number of HCAHPS measures on which CAHs in each state performed significantly better than CAHs in all other states)
   - An EDTC better performance measure score (the number of EDTC sub-measures on which CAHs in each state performed significantly better than CAHs in all other states)
Methodology

2. FMT then ranked the 45 Flex states on each of the eight measures above to create four reporting ranks (inpatient, outpatient, HCAHPS, and EDTC) and four performance ranks (inpatient, outpatient, HCAHPS, and EDTC). When multiple states had the same score, they each received the same rank (e.g., several states had 100% of their CAHs reporting inpatient measures and each received a rank of one).

3. Each state’s four reporting ranks were summed and states were re-ranked to create a total reporting rank for each state. Similarly, each state’s four performance ranks were summed and states were re-ranked to create a total performance rank for each state.

4. Each state’s total reporting rank and total performance rank were then summed, and states were ranked one last time on this combined reporting and performance sum.

5. This method gives equal weight to reporting and performance across the four types of measures (inpatient, outpatient, HCAHPS, and EDTC).
YOU are why MI is a Top Performing State!

Your ability to prioritize quality during unprecedented times.

Your ability to lead your organization through emotional distress, and immense barriers.

Your ability to continue to support your peers in a new ways, and via a virtual format.
YOU are why MI is a Top Performing State!

- Sharing Best Practices
- Learning from each other
- Networking/connecting with peers
- Learning about program requirements
- Keeping compliant with measures
- Collaboration opportunities
- Idea generation
- Sounding board
- Advance notice/up-to-date on required changes
- Support

- Advocating for rural/vehicle to have a voice
- Have a supportive community
- Focus of improving patient care
- Learn about state, national changes
- Benchmark with like facilities
- Patient safety and quality is focus
Special Kudos

Strategy Group #2 Data Management and Analysis

Jenifer Monzo, RN, BAS, CPHRM, Director of Quality and Risk Management, McKenzie Health System