

# MBQIP Monthly

Medicare Beneficiary Quality Improvement Project



A publication for Flex Coordinators to share with their critical access hospitals

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Contact your Flex  
Coordinator if you have  
questions about MBQIP.

Find your state Flex  
Coordinator on the  
[Technical Assistance and  
Services Center \(TASC\)  
website.](#)

Find past issues of this  
newsletter and links to  
other MBQIP resources  
on TASC’s [MBQIP  
Monthly](#) webpage.

## Rural Success: Riverview Regional Medical Center, TN

[Riverview Regional Medical Center](#) (RRMC), located sixty miles east of Nashville and 45 minutes from the closest tertiary hospital, serves the community of Carthage, Tennessee and the surrounding counties. The bustling 25-bed critical access hospital (CAH) has an average daily census of 12 inpatient and swing-bed patients. RRMC also houses a 10-bed geriatric-psych unit with an average daily census of six, an eight-bed emergency department (ED) averaging 25 visits a day, and provides a variety of other services, including labor and delivery, inpatient and outpatient surgery, and an array of imaging and laboratory services.

RRMC was the second hospital to achieve [LifePoint National Quality Program](#) designation status, recognizing success in transforming their culture of safety and achieving high standards of quality care, performance improvement, and patient engagement. For that purpose, RRMC has adopted five foundational behavioral tools: briefs, debriefs, huddles, executive patient safety rounds, and learning boards. RRMC uses these tools to address any patient safety concerns within the organization, including communication from frontline staff to leadership and from leadership to frontline staff. Identified issues are tracked on learning boards using a red, yellow, green system. During executive patient safety rounds, leadership talk face-to-face with frontline staff about issues and interventions on at least a weekly basis. This intentional engagement results in a culture of mutual accountability and support between leadership and frontline staff, which is confirmed by RRMC’s strong performance on the annual employee satisfaction survey where staff answer positively regarding the ability to speak up, the response by the entire hospital to address patient safety concerns, joy in work and teams, and overall satisfaction.

RRMC’s team-based approach is reflected in their five-star HCAHPS hospital status, with top-box scores exceeding the national average in every composite. Leadership points to a variety of bedside and rounding initiatives that have assisted in achieving such high performance. Twice a day at shift change the incoming and outgoing nurse conduct bedside shift reporting, engaging the patient and family in the discussion about plans for the day and goals for care. Interdepartmental team-based rounding is completed daily, including the nurse, case manager, physician, and additional staff as available and appropriate such as physical therapy and pharmacy. After rounding on the

patient, the team meets to determine appropriate next steps ensuring everyone is on the same page. In addition to participating in team rounding, pharmacy rounds on patients to provide education regarding new medications, and the team works to ensure patients can afford prescribed medications upon discharge. Department directors, with nurse manager backup, are assigned one or two rooms to round on daily to assess if patients are receiving the care they need, learn how their experience has been, and identify opportunities to make things better while the patient is still in their care.

RRMC has a particularly impressive score related to transitions of care, a composite that hospitals struggle with nationally. In addition to the team-based approaches described above, which engage patients and families in care throughout the stay, discussions around discharge and patient planning start upon admission. Case managers or social workers round on patients to complete an assessment of what resources are available in the home and what services might be need upon discharge. Post-discharge follow-up calls confirm if patients have filled medications and a thank you

card to every patient for choosing RRMC for their care is a friendly touch.

The ED at RRMC is chest pain accredited. In working through that process, the team identified a delay in administering fibrinolytic therapy driven by slow lab turnaround times. Using data to support their request, they were able to secure a new centrifuge and cut that time by 20 minutes. Working with staff to streamline triage and initiative chest pain protocols, RRMC has been able to achieve an average median time to ECG of five minutes or less.

RRMC leverages the electronic health record (EHR) to support high

performance on the ED Transfer Communication (EDTC) measure. There are triggers built into the system to notify the nurse when a patient is getting ready to leave the ED to ensure the appropriate information is passed along to the receiving facility. The EHR also supports high levels of performance relative to the inpatient influenza immunizations, including prompts and a standing order for administration.

Based on their patient population and service lines, RRMC tracks on other important quality measures such as healthcare-associated infections (HAIs), falls, and labor and delivery. They've taken infection control precautions such as implementing two-person urinary catheter insertion to reduce the rate of catheter-associated urinary tract infections (CAUTI), chlorhexidine baths for surgical patients, and standard protocols for staff gowning and gloving. They track closely on early elective deliveries and are in the process of completing training on electronic fetal monitoring for all nurses and physicians. As it relates to falls, they measure the rates of falls and falls with injuries, place high-risk fall patients closer to the nursing stations, and utilize bed alarms.

It's evident in talking to the quality leaders at RRMC that the organization is working hard towards achieving its vision of creating places where people choose to come for health care, physicians want to practice, and employees want to work, with the ultimate goal of making communities healthier.



RRMC Leadership: Back Row (L to R): Tim Maynard, Maintenance/Security Director; Jamie Green, MedSurg/OB Director; Leslie Kittrell, Diagnostic Services Director; Tony Britt, PT Director; Kevin Replogle, Material Director; Liz Carver, RT Director. Front Row (L to R): Patty Anderson, CNO; Nicole Harpe, HIM Director; Annasue Collins, Renewal Center Director; Mike Herman, CEO; Joanna Vaden, Surgery Director; Joey Donoho, Pharmacy Director, Melody Oldham, Lab Director; Gina Anderson, HR Director.

# Data



## CAHs Measure Up: Core Elements of Antibiotic Stewardship

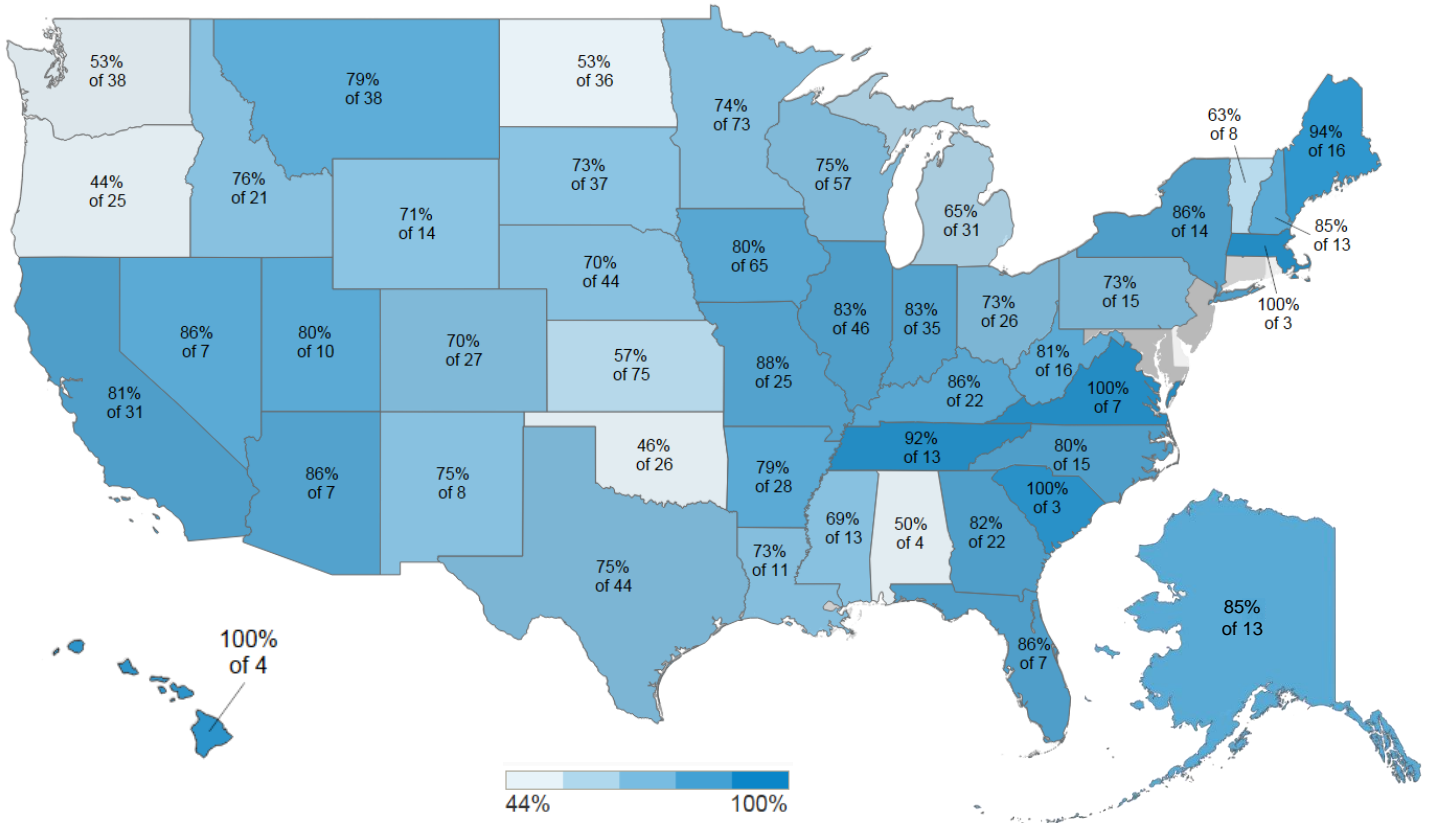
As part of MBQIP, each CAH is expected to implement an antibiotic stewardship program by August 2022. To be considered fully implemented, hospitals must indicate that they have met all seven of the Centers for Disease Control and Prevention (CDC) [Core Elements of Hospital Antibiotic Stewardship Programs](#): leadership commitment, accountability, drug expertise, action, tracking, reporting, and education.

The extent to which an antibiotic stewardship program is implemented is measured using data hospitals submit via the CDC National Healthcare Safety Network (NHSN) Annual Facility Survey, so an essential first step in this requirement is to complete and submit that survey. The survey becomes available in January of each year and hospitals are encouraged to complete the survey by March 1, with answers reflecting what happened in the previous calendar year. For example, in 2019, facilities would complete the survey based on what occurred in 2018. Although it is recommended to have already completed the Annual Facility Survey, hospitals who have not already done so are able to submit the survey through December 31, 2019.

Eighty-two percent of CAHs participating in MBQIP have already submitted the Annual Facility Survey in 2019. The map below shows how many hospitals in your particular state have submitted the survey and the percent of those hospitals indicating that they are meeting all seven core elements.

Is your hospital among the CAHs in your state that have already submitted the Annual Facility Survey in 2019? How many core elements of hospital antibiotic stewardship programs has your CAH implemented?

### CAHs Meeting All Seven CDC Core Elements Hospital Antibiotic Stewardship Programs





# Tips



## Robyn Quips - tips and frequently asked questions

### MBQIP Chart-abstracted Measures – What’s Been Removed and What’s Staying

CMS has been removing some of the chart-abstracted measures, and it appears some are confused about how that affects the MBQIP measures and what data they need to be submitting. When CMS removes a measure from their reporting programs, it means the QualityNet warehouse will no longer accept data for that measure. Since that is the submission route by which the MBQIP program gets the inpatient and outpatient data, the measures have to be removed for MBQIP as well. There is currently no other way for MBQIP to receive data on those measures.

### Outpatient Measures

Starting Q2 2019, CMS removed OP-5: Median Time to ECG. Since that was the only measure remaining in the Chest Pain measure set, there are no longer any Chest Pain measures available for chart abstraction and data submission.

The measure sets that you need to continue to submit on are for AMI (OP-2, OP-3) and ED Throughput (OP-18 quarterly, OP-22 once a year). Remember you pull records for chart abstraction based on measure set, not the individual measure. For example, just because you might not give fibrinolytics at your facility, you can’t decide not to abstract measure OP-2. That measure is part of the AMI measure set, and that set is abstracted for MBQIP. You cannot pick and choose measures to abstract within a measure set. You start by determining the population for the measures set and then pull those records for abstraction. How the data element questions are answered determines whether the case is included or not in the measure.

### Inpatient Measures

IMM-2 and ED-1 measures were removed by CMS, starting with Q1 2019 data submission. The only inpatient chart-abstracted measure currently part of MBQIP is ED-2. Nothing changes in how you pull the charts for abstraction since the IMM and ED measure sets had the same population requirements. There is only the one measure, ED-2, but the population remains the same.

If you are using the CART tool to submit your data to QualityNet, you must make sure that the correct quarter is set up under Provider Preferences in CART. The CART tool is designed to be used for various quarters. If you aren’t abstracting with the right provider preference time frame, you could be submitting data for measures that have been removed. You could have data element questions that should no longer be answered, and if you submit that to QualityNet, your cases could be rejected.

If you use a vendor tool, check with your vendor to make sure the tool is set up for abstracting only the current measures.

## Go to Guides

### Hospital Quality Measure Guides

- [MBQIP Quality Reporting Guide](#)
- [Emergency Department Transfer Communications](#)
- [Inpatient Specifications Manual](#)
- [Outpatient Specifications Manual](#)



# Tools



## Tools and Resources

### [Abstracting for Accuracy Consultation](#)

Sign up for this customized abstraction review process and phone consultation that will provide your hospital the opportunity to receive one-on-one education and assistance on how to abstract the MBQIP core measures. Abstracting for Accuracy can help CAHs increase the validity of data collection and identify opportunities for additional training and clarification as it relates to chart abstraction.

### **Ask Robyn – Quarterly Open Office Hours Calls for Data Abstractors Wednesday, October 9, 2019, 2:00 – 3:00 p.m. CT [Register](#)**

Sometimes it just helps to talk to someone! Quality Reporting Specialist Robyn Carlson will be offering open office hour calls to discuss your MBQIP abstraction questions. Sessions are free of charge, but registration is required. For more information about the Ask Robyn calls, contact Robyn Carlson, [rcarlson@stratishealth.org](mailto:rcarlson@stratishealth.org).

### [A Rural Hospital Guide to Improving Chronic Obstructive Pulmonary Disease](#)

Developed by the National Rural Health Resource Center, this guide is for rural hospital leaders, Rural Health Clinics, and their partners to help them understand rural chronic obstructive pulmonary disease (COPD) services and adopt best practices for COPD diagnosis, treatment, and long-term care. The guide addresses rural COPD prevalence and services, clinical diagnosis and treatment, service models, care management, technologies, and community support services. Includes considerations for implementing a pulmonary rehab program, roles and staffing needed, and basic billing and coding.

### [Comments Requested: Rural Access to Health Care Services](#) – Due October 9

The Health Resources and Services Administration (HRSA) seeks information from the public about measuring access to health care in rural communities. This Request for Information (RFI) supports the ongoing work of the [HHS Rural Health Task Force](#) that is seeking to identify the needs of rural communities, how to meet those needs, and what HHS policy changes can address those needs. Questions for public comment specific to rural communities include: what are the core health care services needed, what types and numbers of health care professionals are needed, what factors are important to identify core health services, and what are the best ways of measuring quality of care in rural communities?



MBQIP Monthly is produced by Stratis Health to highlight current information about the Medicare Beneficiary Quality Improvement Project (MBQIP). This newsletter is intended for Flex Coordinators to share with their critical access hospitals.

*This project is supported by the Health Resources and Services Administration (HRSA) of the U.S. Department of Health and Human Services (HHS) as part of an award totaling \$625,000 with 0% financed with non-governmental sources. The contents are those of the author(s) and do not necessarily represent the official view of, nor an endorsement, by HRSA, HHS or the U.S. Government. (September 2019)*