

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.

Antibiotic Stewardship Profile Series: Greene County General Hospital

[Antibiotic Awareness Week](#) is November 18-24. In light of the recent [final rule from the Centers for Medicare & Medicaid Services \(CMS\)](#) mandating that all hospitals implement an antibiotic stewardship program by March 30, 2020, we're bringing you assets to support implementing and enhancing antibiotic stewardship at your critical access hospital.

Last month we highlighted a new resource, [Antibiotic Stewardship Implementation: Suggested Strategies from High Performing CAHs](#), which shares implementation and enhancement strategies for antibiotic stewardship based on the Centers for Disease Control and Prevention's (CDC's) seven core elements of antibiotic stewardship for hospitals. Insights were collected from high performing critical access hospitals (CAHs) across the U.S. during focus group interviews conducted in Spring 2019.

In the first of a series of profiles below, Melissa Toon, director of pharmacy and infusion services for focus group participant [Greene County General Hospital](#) in Linton, Indiana, outlines what antibiotic stewardship looks like at her facility.

Antibiotic Stewardship (AS) Profile: Greene County General Hospital

Background

Greene County General Hospital (GCGH) is a 25-bed CAH, 9-bed emergency department (ED), independent county hospital, located approximately one hour from larger hospitals and health systems. Its services include: labor and delivery, surgery, swing beds, lab, radiology, cardiac rehab, infusion center, four rural health clinics (RHCs), two physician clinics, orthopedic and sports medicine clinic, contracted specialty clinics (surgery, cardiology, pulmonology, oncology), telehealth clinics at local schools, and a SNFist (hospital-employed, skilled nursing facility physician). Pharmacists provide antibiotic and dosing recommendations and culture review to hospital and other health care providers.

Our Antibiotic Stewardship Journey

GCGH started in August 2016 by reviewing the CDC core elements checklist but had used some of the other AS standards before this (such as working

with medical staff to optimize antibiotic use and dosing, antibiogram use, etc.) GCGH began monitoring antibiotic use during the fourth quarter of 2016. Administration was part of the interdisciplinary team along with pharmacy, quality, nursing, lab, etc., so they were up to date with Joint Commission requirement as of January 2017. The team obtained a signed letter of support from administration, chief of staff, and the hospital board. The team presented education regarding the program to medical staff and the hospital board. Those who did not attend were sent letters to encourage participation. The physician lead, Dr. Patricia Miller-Canfield was a key stakeholder in the development of the program, and pharmacy staff, along with the rest of the team, have put in many hours on implementation and improvement of the program.

Leadership & Accountability

Physician lead: Dr. Patricia Miller-Canfield; Pharmacist lead: Melissa Toon RPh; Leadership (admin, chief of staff, pharmacy, RHC, quality, department heads, etc.) attend AS meetings. There is no separate salary support for the program, but the team has requested budget funds for continuing education.

Drug Expertise

GCGH uses empiric therapy guidelines and inherent pharmacist knowledge, such as being able to use resources to make appropriate antibiotic choices based on literature and formulary. The AS team participates in the Indiana Hospital Association (IHA) Antimicrobial Stewardship-Central Southwest Patient Safety Coalition and continually seeks educational opportunities, including:

- [CDC Training on Antibiotic Stewardship](#)
- [SIDP Antimicrobial Stewardship Certificate Program for Acute Care](#)
- [MAD-ID Antimicrobial Stewardship Certification Program](#)
- [SHEA Antimicrobial Stewardship Training Course](#)
- [AHRQ's Safety Program for Improving Antibiotic Use](#)

Action

- **Facility-Specific Treatment Recommendations**
GCGH's antibiogram is developed yearly and includes all cultures completed at the facility, including the extended care population, and is available to all staff in various ways (print, SharePoint, Sanford Guide online). The GCGH lab and pharmacy update the antibiogram and medical staff-approved empiric guidelines are also available per CDC core elements.
- **Prospective Audit and Feedback**
Pharmacists review all cultures and antibiotic use. They collaborate with medical staff and will offer consult, if necessary, regarding antibiotic choice and or need for antibiotics. This was one of the easiest actions to implement – teamwork was already established before the AS program.
- **Prior Authorization for Specific Antibiotic Agents**
Currently, daptomycin and linezolid require pharmacist prior authorization.
- **Documentation of Indication for All Antibiotics**
Technology presents a challenge at GCGH, as there are multiple electronic health records (EHRs), and some physicians do not exclusively use an EHR. Pharmacy does a lot of manual data extraction. The team has educated physicians regarding the

importance of listing an indication and developed a special electronic progress note for AS indication with a soft stop in the EHR.

- **Antibiotic Time-Out**

The GCGH EHR has a 48-hour soft stop for renewal of antibiotics. Pharmacists monitor culture and sensitivity reports and report out to the ordering physician at interdisciplinary rounds or contact them directly as needed.

Tracking & Reporting

Data tracking and sharing at GCGH is at least quarterly (and as needed) to the medical staff, administration, and board. The team monitors culture collections, carbapenem usage, fluoroquinolone usage, compliance with empiric guidelines, indication documentation, duration documentation, IV to PO conversion-target meds, dose adjustments/optimization, RHC antibiotic prescribing and indications, and outpatient clinic antibiotic prescribing and indications. GCGH has been successful in using data to drive improvement. In implementing the requirement to document indication, the AS team sent out an approved list of indications of use of Rocephin and followed up with individual providers as needed. Through this effort, they saw a decreased use of that medication in the ED. In another example, the team saw intravenous (IV) to oral (PO) antibiotic conversion numbers drop when they changed from a pharmacy-driven protocol to a provider-driven protocol. When the metrics indicated that the IV to PO conversion goal was not being met, the information was presented to medical staff, and the protocol was changed back to pharmacy-driven. Goals are now being met.

Education

Initially, information on the Joint Commission standard for AS was presented to medical staff, administration, and the board. The AS team explained what they were going to do and why. The team uses data to identify areas that need education, such as antibiotics for gastrointestinal infections, quinolone use, RHC antibiotic prescribing practices, treatment for urinary tract infections, and documentation of indication. Providers (including in the RHC, ED, and SNF) are invited to all educational opportunities. Emails and or written information are distributed. All hospital staff was educated on AS during GCGH's annual "Quality Fair." Face-to-face meetings and or direct interaction seem to be most effective. There is a custom educational document in EHR to distribute to patients and families. Some of the providers also use "viral prescription pads" in the ED or offices to acknowledge illness and provide symptomatic relief but not an antibiotic. GCGH participates in [Antibiotic Awareness Week](#) during which the team sets up an information table in the cafeteria and shares information on social media. Informational signs regarding AS and antibiotic use are posted in the clinics and hospital. Education for medical staff has been one of the easiest actions to implement. They are very receptive to information the AS team has to share.

Collaboration

GCGH participates in continuum of care meetings with area nursing homes, providing AS information, including antibiograms. The physician's outpatient clinic and RHC clinic quality representative, medical director, and administration attend the AS meeting, where they report out on antibiotic prescribing. GCGH participates in the IHA Patient Safety Coalition AS group, on which the pharmacy director serves as the lead representative for Central

Southwest Region. As a coalition, this group co-branded an educational document for patients and meets via telephone conference quarterly and as needed.

Words of Wisdom and Advice

- Make sure you have a great interdisciplinary team that works together and actively participate. GCGH's physician lead, Dr. Canfield, has played a big part in the success of the team.
- Take advantage of educational opportunities and groups that support AMS activities.
- Build relationships and trust with providers, so they are willing to consult with pharmacy staff.
- Involve IT/informatics early on to help collect data – one of the biggest challenges. This will help get staff from behind the desk to in front of the patient.

Learn More During Antibiotic Awareness Week

The CDC-hosted webinar [Improving Antibiotic Stewardship in Critical Access Hospitals: Strategies and Success Stories](#) on Wednesday, November 20, will explore the above resources, including the antibiotic stewardship program at Greene County General Hospital and another focus group participating facility.

Data



CAHs Measure Up: Benchmarking with CAHMPAS

By Flex Monitoring Team Staff

The Flex Monitoring Team (FMT) is a partnership of rural health researchers at three Universities funded by the Federal Office of Rural Health Policy (FORHP) to monitor the Flex Program and the CAHs the program serves. As part of the FMT’s work to evaluate the Flex Program, FMT maintains the Critical Access Hospital Measurement and Performance Assessment System (CAHMPAS), an online data tool with CAH data in the areas of finance, community impact, and quality improvement.

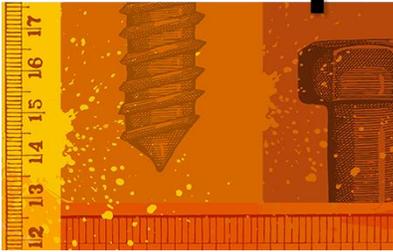
One way CAHs can utilize CAHMPAS is as a benchmarking tool for quality improvement measures. State and national level quality improvement data are publicly available in CAHMPAS by year starting in 2016. CAHs can compare their quality improvement data from MBQIP Hospital Data Reports to the performance data of all CAHs in their state or the rest of the nation in CAHMPAS.

To assess how your CAH is performing in comparison to your state, first navigate to CAHMPAS’ quality data page (<https://cahmpas.flexmonitoring.org/topics/quality/>). From there, select your state and a data year. Quality improvement data are available in the areas of patient safety/inpatient, outpatient, and patient engagement. You have the option to select specific quality improvement measures or view all data. Next, the Data Summary page will load and display data for each selected measure. These results can be used as a benchmark to see how your CAH’s performance (taken from MBQIP Hospital Data Reports) compares to the average performance of all CAHs in your state (shown in the red box below). For some measures, a lower number means better performance, so it is important to check the footnotes of each table. The same steps can be taken to compare your CAH’s performance to the national CAH performance. Access CAHMPAS any time at <https://cahmpas.flexmonitoring.org/>, and feel free to reach out to the FMT with any questions by emailing monitoring@flexmonitoring.org.

Example of a CAHMPAS table for inpatient and outpatient quality improvement measures

Patient Group	Measure	Description	Wisconsin CAHs (n = 58)		All Other CAHs (n = 1,290)	
			CAHs reporting	% of patients ¹	CAHs reporting	% of patients ¹
Inpatient	IMM-2†	Immunization for influenza	56	93.2	955	88.0
Inpatient	OP-27/IMM-3†	Healthcare workers given influenza vaccination	55	91.7	973	88.0
Inpatient	PC-01‡	Early elective delivery	19	5.6	172	2.6
Inpatient	VTE-6	Incidence of potentially-preventable VTE	10	*	112	*
Outpatient	OP-2†	Fibrinolytic therapy received within 30 minutes	12	65.9	349	51.3
Outpatient	OP-4‡	Aspirin at arrival	48	96.6	770	95.1
Outpatient	OP-22†	Patient left without being seen	44	0.4	583	1.0
Outpatient	OP-23	Received head CT scan interpretation within 45 minutes	31	70.1	495	62.4
Outpatient	OP-29	Appropriate follow-up interval, colonoscopy, average-risk patients	9	93.2	168	83.6
Outpatient	OP-30	Appropriate follow-up interval, colonoscopy, patients with polyps	9	96.4	167	91.0

Tips



Go to Guides

Hospital Quality Measure Guides

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



Abstracting 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.

Robyn Quips - tips and frequently asked questions

MBQIP Reports – Is Your HCP Data Showing?

Since flu season is here, it's a good time to check on your Influenza Vaccination Coverage Among Healthcare Personnel (HCP) measure. (The measure formerly known as OP-27.) Data submission for the current flu season isn't due until May 2020, but check out your latest MBQIP report, have you been submitting this measure? If your CAH has been submitting the HCP measure to NHSN, but your MBQIP report isn't showing any data, check the following:

- This data must be submitted to NHSN by the CMS inpatient measure due date, which this year is May 18, 2020. It would normally be the May 15, but CMS is adding an extension if the due date falls on a weekend, and they are considering Friday as part of the weekend. NHSN will let you enter your HCP data any time, but since the data is provided to CMS, which then, in turn, provides it to FORHP for the MBQIP reports, their deadline must be followed.
- If you had submitted by the May due date but still show no data for HCP, check to see if you have submitted an Inpatient Notice of Participation (NoP). CAHs should have done this as part of participating in MBQIP, but we are seeing not all have. If you haven't submitted an NoP, the Center for Disease Control (CDC)/NHSN, does not submit your HCP data to FORHP for the MBQIP reports.

If you are unsure of how to see if you have completed an inpatient NoP go to the Quality Net NoP resource page (<https://qualitynet.org/inpatient/iqr/participation#tab2>) and scroll down for the Inpatient NoP Quick Reference Guide. The information is also listed in the [MBQIP Reporting Guide](#), page 5.

If you have been submitting by the due date and see you have an Inpatient NoP, but your data isn't showing on the MBQIP reports, then email NHSN (nhsn@cdc.gov) to make sure that the data has been submitted correctly.

SAVE THE DATE!

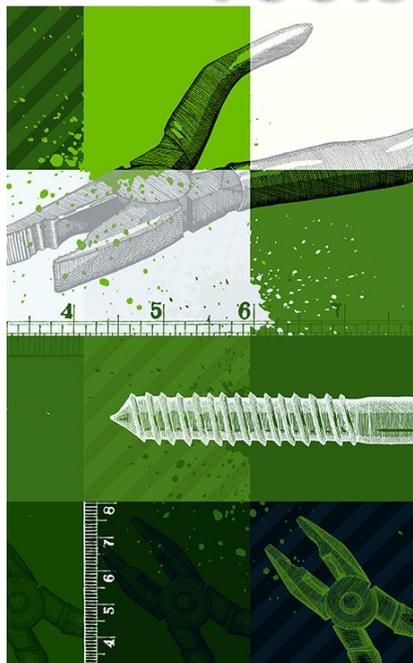
EDTC Training and Updates

The revised emergency department transfer communication (EDTC) measure rolls out January 1, 2020. Below are the dates for upcoming training sessions. The content for each session is the same, so you only need to attend one; we are having three to try to accommodate everyone's busy schedules.

- December 12, 2019, 2:00-3:00 p.m. CT
- December 18, 2019, 11:00-12:00 p.m. CT
- January 8, 2020, 3:00-4:00 p.m. CT

Pick one and save the date on your calendars; registration will be made available the first week in December, timed with the release of the new EDTC Data Specifications Manual.

Tools



Tools and Resources

Webinar: Improving Antibiotic Stewardship in Critical Access Hospitals: Strategies and Success Stories

Wednesday, November 20, 2019, 12:00-1:00 p.m. CT

Co-hosted by CDC and HRSA's Federal Office of Rural Health Policy. Leading experts will discuss evidence-based strategies to improve antibiotic prescribing in rural hospitals and share stewardship success stories in critical access hospitals. [Register](#).

Order Free CDC Materials for U.S. Antibiotic Awareness Week (USAAW)

U.S. Antibiotic Awareness Week (USAAW) is Nov. 18-24. CDC provides free antibiotic stewardship materials for health care facilities, health departments, and individual clinicians. Fact sheets, posters, and educational materials can be ordered and mailed directly to your organization. Go to [CDC-INFO On Demand](#) and then select "Antibiotic Use" under "Programs."

[Rural COPD Resources and Efforts](#)

November is National COPD Awareness Month. The National Rural Health Resource Center has developed and compiled several rural relevant resources related to improving awareness and quality of care for COPD:

- [Rural Hospital Guide to Improving Chronic Obstructive Pulmonary Disease](#)
- [Rural Chronic Obstructive Pulmonary Disease Toolkit](#) from the Rural Health Information Hub
- A six-episode Rural COPD Podcast hosted by Dr. Bill Auxier of [Rural Health Leadership Radio](#)

CMS Final Rules Changing Quality Related CAH Conditions of Participation (CoP)

In late September, CMS released two final rules that impact quality activities including updated CAH Quality Assessment and Performance Improvement (QAPI), antibiotic stewardship, and discharge planning requirements:

- [Omnibus Burden Reduction Final Rule](#). Includes changes to CAH QAPI, Antibiotic Stewardship, Emergency Preparedness, and other requirements.
- [Discharge Planning Requirements for Hospitals, CAHs, and HHAs](#). For CAHs, the final rule adds a new, separate condition of participation (CoP) specific to discharge planning. The new regulatory language outlines the standards for the discharge planning process, beginning with identifying those patients (at an early stage of hospitalization) likely to suffer adverse health consequences upon discharge in the absence of adequate discharge planning.

Additional details can be found at the HRSA Federal Office of Rural Health Policy, [Rural Health Policy page](#).



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.

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