MBQIP Monthly

Medicare Beneficiary Quality Improvement Project

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

In This Issue

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.

National Rural Virtual Quality Improvement Mentor Profile Series: Jenifer Monzo

This MBQIP Monthly series highlights each of the 12 critical access hospital (CAH) staff currently serving as national Virtual Quality Improvement Mentors as they share examples and advice to address common CAH quality improvement (QI) challenges.

Jenifer Monzo, RN, BAS, CPRHM

Jenifer Monzo, RN, BAS, CPRHM, director of quality and risk management of McKenzie Health System (MHS), believes, "It takes a team, not one department, to successfully deliver quality health care." When she first started working in quality improvement (QI), one of her main goals was to break down the silos between departments and get people to share QI studies and talk together. "All departments affect each other. For example, what the lab does impacts nursing, and what nursing does impacts respiratory therapy," Jenifer said. "It's a team approach here."

McKenzie Health System, located in Sandusky, Michigan, is an independent health system with a 25-bed critical access hospital, a swing bed program, and six clinics. It is a certified stroke-ready and acute heart attack-ready facility designated as a level IV trauma center.
A significant emergency department (ED) renovation was completed a year ago, allowing state-of-the-art emergency care. MHS was a founding member of Caravan Health's first Accountable Care Organization.

They are currently a member of the Caravan Health ACO 24 and have Patient-Centered Medical Home certifications, which provide for a primary care delivery model. Jenifer shared that they recently joined efforts between the hospital and health care practices to reduce admissions and readmissions of their ACO patients. They successfully reduced admissions by 52% over 12 months. "This effort involved working together from both the inpatient and clinic side, further showing the importance of dissolving barriers and working together," Jenifer said. "There is so much opportunity to share ideas and best practices across different departments showing

McKenzie Health System

that multi-departmental teamwork is effective!" The team consisted of the ACO quality coordinator, community care RNs, hospital utilization review coordinator, and social worker.

Jenifer describes the MHS service area as rural and predominantly agricultural, with sugar beets, corn, soybeans, wheat production, and a big retirement community. Sandusky, in Sanilac County, is the county seat located in the thumb of Michigan, bordering beautiful Lake Huron, where tourists come for boating and fishing. MHS is the largest employer, followed by small factories and schools.

Jenifer was born and raised in the area. She has spent most of her nursing career at MHS. Jenifer has also worked in public health, coordinating a maternal/child health program, at a school system as a case manager for students at risk for developmental delays/medical conditions, and as a state hospital surveyor. In her early years at MHS, she worked medical-surgical, obstetrics, and emergency. She has been in the Quality and Risk Department for almost 15 years.


MHS Readmission Reduction Team

The Performance Improvement Review Committee (PIRC) at MHS consists of multi-department managers and directors who develop department-level QI studies, monitor quality improvement through a comprehensive dashboard and collaborate on improvement efforts. Along with the dashboard, the PIRC receives reports from committees, including Infection Prevention, Environmental Safety, Emergency Department, and Safe Medication Practice. Jenifer brings the quality reports to the Quality Review Committee, the medical staff who oversee the quality program and review hospital and medical staff policies. Recommendations go to the medical executive committee, which makes final decisions regarding policy changes and peer review cases. Finally, the health system board receives summaries of quality data and initiatives.

Jenifer's approach to quality is to dig into the data to look for issues. Then, she said, "take the opportunity to see if there is actually a problem by studying the data through a formal quality study, reporting it to the PIRC, and getting input from others, making it a team approach. The data is your evidence, baseline, target, and improvement."


MHS Fall Reduction Committee

One of the QI projects that Jen is most proud of is the MHS fall prevention program. A diverse committee with representatives from multiple shifts and physical therapy determined areas where they could improve through the data. The committee participated with the Michigan Hospital Association on a fall prevention initiative and significantly reduced their fall rates by implementing multiple interventions, including floor mats, and adopting the Johns Hopkins Fall Risk Assessment Tool.

Jenifer's advice for someone new in the QI leader role is to participate in a QI networking group. She is an active participant and the data strategy group leader in the Michigan Critical Access Hospital Network (MICAH), which includes all 37 Michigan CAHs and is facilitated by the Michigan Center for Rural Health as part of their Flex program. "Along with sharing ideas and results across hospital departments, it's been very worthwhile collaborating with our peer hospitals in Michigan," Jenifer said.

Data

CAHs Measure Up: Antibiotic Stewardship Program Core Elements Met by CAHs

The extent to which an antibiotic stewardship program is implemented is measured using data hospitals submit via the CDC National Healthcare Safety Network (NHSN). An essential first step in this requirement is to complete and submit the **NHSN Patient Safety Component Annual Facility 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 2022, facilities complete the survey based on what occurred in 2021. Although it is recommended to have already completed the 2021 Patient Safety Annual Hospital Survey this year, hospitals that have not already done so are able to submit the survey through December 31, 2022.

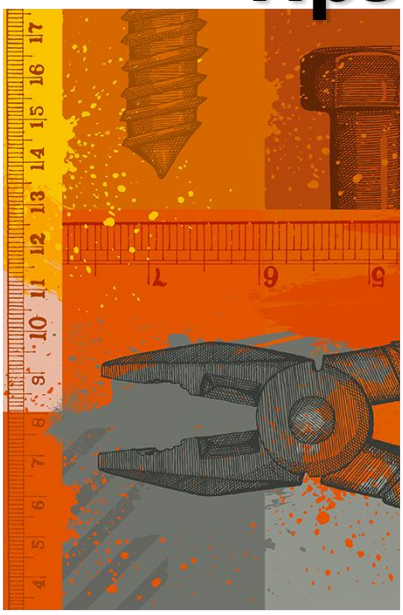
Currently, antibiotic stewardship program summary data from the 2021 Patient Safety Annual Hospital Survey are available in your MBQIP Hospital Data Reports. As of May 2022, 1,160 of 1,357 CAHs (85%) completed the 2021 annual facility survey. The following tables provide a summary of Core Elements met by CAHs.

# of Core Elements Met	# of CAHs (%; n=1,160)
0	1 (<1%)
1	4 (<1%)
2	2 (<1%)
3	2 (<1%)
4	10 (1%)
5	28 (2%)
6	82 (7%)
7	1,031 (89%)

Core Elements Met	# of CAHs (%; n=1,160)
Leadership	1,135 (98%)
Accountability	1,121 (97%)
Drug Expertise	1,123 (97%)
Action	1,131 (98%)
Tracking	1,115 (96%)
Reporting	1,134 (98%)
Educate	1,144 (99%)

Of note: while the overall seven Core Elements remain the same, the 2021 survey itself and the questions mapping to each of the Core Elements underwent some changes relative to 2020. Check out the CDC's Crosswalk of Antibiotic Stewardship Practices items from 2021 Patient Safety Annual Surveys to the 2019-2020 Annual Survey for details. Minor edits were made to existing questions, additional required questions were added to help demonstrate achievement of Core Elements, and some new optional questions were included as well. The question changes were unlikely to make it harder for your hospital to meet the same Core Elements as in the previous year. Rather, the intention was to help CDC and others better assess components of hospital antibiotic stewardship practices.

Tips



Go to Guides

Hospital Quality Measure Guides

- MBQIP Quality Reporting Guide
- Emergency Department Transfer Communications
- Inpatient Specifications Manual
- Outpatient Specifications Manual

Robyn Quips - tips and frequently asked questions

Outpatient Measure Abstraction Quiz Answers
Time to see how you did on the Outpatient Abstraction Quiz! The answers are below in red. If you have any questions, you can contact me at rcarlson@stratishealth.org.

1. Where do you find the CMS Hospital Outpatient Quality Reporting Manuals?
   a. The Quality Reporting Center site.
   b. The Stratis Health website.
   c. The QualityNet home page.
   d. Why would we need a manual?

   Go to the QualityNet home page, https://qualitynet.cms.gov/, and click on the Hospitals-Outpatient box. On the left-hand side of the screen, you will find the Specification Manual options.

2. To be included in the AMI measure population, the patient must be/have
   a. 18 years of age or older.
   b. Discharged/transferred to another healthcare facility.
   c. An ICD-10-CM Principal Diagnosis Code for AMI defined in Appendix. A, OP Table 1.1.
   d. All of the above.

   Answer D is not correct. The patient must be Discharged/Transferred to a short-term general hospital for inpatient care or a federal healthcare facility, not to any other healthcare facility.

3. If we have less than 5 cases that meet the AMI measure population requirements for a quarter, we aren't required to submit them for MBQIP.
   a. True
   b. False

   For MBQIP, you submit all cases that meet the AMI population requirements, even if there is only one.

4. Which are true statements regarding OP-22?
   a. The next due date will be in May of 2023.
   b. You will be submitting data for the year 2022.
   c. You will need to know the total number of patients that presented to the ED and the total number that left without being evaluated by a physician/APN/PA.
   d. All of the above.
   e. None of the above.

   The due date for the next submission of OP-22 is May 2023, with data from 2022. The data you need to submit is the total number of patients that presented to the ED and the total number that left without being evaluated by a physician/APN/PA.

5. To be in the OP-18 measure population, the patient must have a principal ICD-10 CM code listed in Appendix A Table OP Table 1.0.
   a. True
   b. False

   There is no principal diagnosis code requirement to be in the population for OP-18. The only requirement is that the patient has an E/M code.

6. "Population" in measure abstraction refers to the number of cases that meet the initial measure set inclusion requirements.
   a. True
   b. False

7. Where do you find the information on how to determine sample sizes for the Outpatient Measures?
   a. On the Quality Reporting Center site.
   b. In the specific measure section of the CMS Hospital Outpatient Quality Reporting Manual.
   c. In the Population and Sampling section of the CMS Hospital Outpatient Quality Reporting Manual.
   d. Doesn't matter, we can do however many we want.

   The Population and Sampling section of the manual contains the sample size requirements for the outpatient measures included in the MBQIP program, AMI (OP-2, OP-3), and ED-Throughput (OP-18).

8. Instructions on how to answer the measure data element questions are found in the Data Dictionary section of the CMS Hospital Outpatient Quality Reporting Manual.
   a. True
   b. False

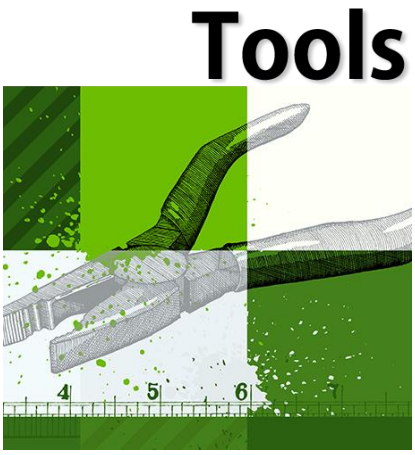
   Instructions on what is/isn't acceptable documentation, where you should be looking for that information in the record, and more are found in the Data Dictionary.

9. If a patient is going to a nursing home after leaving the hospital, what should the discharge code for abstraction be?
   a. 1 – home.
   b. 5 – other healthcare facility.
   c. Depends on whether the patient resides in the nursing home prior to the outpatient encounter.

   It doesn't matter where the patient lives prior to the outpatient encounter. This is about where they are going when leaving the ED. If they are going to a nursing home, that is listed as an inclusion under the allowable value 5 – Other Healthcare Facility.

10. Chart documentation states that the patient was transferred to cardiology at General Hospital because our hospital doesn't provide that level of care. How would you answer the "Transfer for Acute Coronary Intervention" data element?
    a. There was documentation that the patient was transferred from this facility's emergency department to another facility specifically for acute coronary intervention.
    b. There was documentation that the patient was transferred from this facility's emergency department to another facility for reasons other than acute coronary intervention, or the specific reason for transfer was unable to be determined from medical record documentation.

    Answer a. is incorrect. There needs to be documentation in the chart that the patient is being transferred specifically for an acute coronary intervention, such as a cardiac cath or other cardiac procedure or test. Just being transferred to a cardiac floor or unit is not considered an acute intervention per the Specifications Manual.



COVID-19 Information

Resources to support health care providers in responding to coronavirus disease 2019 (COVID-19) are continually updated. The Rural Health Information Hub and National Rural Health Association are regularly updating and adding links for Rural Response to COVID-19:

- Federal and National Response Resources
- State Response Resources
- Rural Healthcare Surge Readiness
- COVID-19 Vaccine Rural Resources

One-Stop Online COVID Prevention and Treatment in Every County. Enter your county to find local COVID-19 guidance and resources.

MBQIP and Rural Health Resources

Ask Robyn – Quarterly Open Office Hours Calls for Data Abstractors
Tuesday, October 25, 2022, 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.

Applications Open! Rural Healthcare Provider Transition Project
The Rural Health Care Provider Transition Project (RHPTP) is designed to help strengthen your organization's foundation in the key elements of value-based care, including efficiency, quality, patient experience, and safety of care. Small rural hospitals and certified rural health clinics are encouraged to apply. Applications are accepted on a rolling basis with a deadline of Sept. 30, 2022, with technical assistance beginning January 2023. Watch this short video for more info, and see the eligibility and application process, benefits of participation, and FAQs.

Get Ahead of Sepsis
Educational materials and resources from the Centers for Disease Control and Prevention (CDC) focused on early recognition and timely treatment of sepsis.

Influenza vaccination season is around the corner! These resources from the CDC can assist your hospital in improving vaccination rates and reporting data:

- Frequently Asked Influenza (Flu) Questions: 2023-2023 Season.
- Surveillance for Healthcare Personnel Vaccination. (Info on data collection and reporting for the National Healthcare Safety Network (NHSN) Influenza Vaccination Coverage Among Healthcare Personnel (HCP).
- Increase Influenza Vaccination Coverage among your Health Care Personnel. Although focused on long-term care, this resource provides vaccination strategies and resources that also may be applicable in hospital settings.

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