

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: Petersburg Medical Center, Petersburg, AK

With an average daily census of 0.75, leaders and staff at Petersburg Medical Center are to be commended for strong participation and excellent scores across all Medicare Beneficiary Quality Improvement Project (MBQIP) domains. This critical access hospital serves a small, vibrant fishing community of around 3,100 along southeast Alaska's Inside Passage on the northern tip of Mitkof Island, in Petersburg.

According to Jennifer Bryner, director of nursing and chief nursing officer, "Participation in MBQIP is not easy, but we can do it." She cites the association between MBQIP participation and access to Flex funding and support as a key driver. Jennifer relates that the most helpful attribute of national hospital quality improvement programs is the comparative data. "We know that not all of the measures perfectly reflect the quality of our hospital because of low volumes, but the data helps us know how we do". With a very matter of fact resolve to participate in the [required MBQIP measures](#), Jennifer and her team have figured out how to overcome the challenges associated with very low volumes. They've put in place an effective, no-frills approach to quality improvement.

Jennifer works closely with Nicole Rowley, quality specialist at Petersburg Medical Center, on all quality improvement topics. Nicole checks every day to see if there are patients that fit the various inpatient, outpatient, and Emergency Department Transfer Communications (EDTC) measures. She tracks the data in real time, and is able to respond to the data quickly with the small number of nursing staff. She provides them with timely feedback and helps brainstorm quality improvement solutions. Low patient volumes make manual chart abstraction manageable. Evident, a CPSI electronic health record product, allows for immediate monitoring of charts, and guides nursing documentation that supports MBQIP measures, such as inpatient influenza immunization assessments and EDTC components, with prompting questions hardwired into the system.

When leaders at Petersburg Medical Center began participating in the Hospital Consumer Assessment of Healthcare Providers and Systems (HCAHPS) about three years ago, they started with community education to introduce the surveys. Their patients complained about too many

Impressive HCAHPS Scores – Percentage of patients who chose most positive responses

Overall hospital rating	100%
Cleanliness of hospital environment	100%
Discharge information	100%
Responsiveness of nursing staff	97%
Communication with nurses	92%
Communication about medications	88%

surveys, so all satisfaction surveys other than HCAHPS surveys were eliminated. This strategy has garnered a respectable HCAHPS response rate of 28 percent.

Jennifer and Nicole find value in the consistency of national HCAHPS surveys for comparison, and are proud of their scores, even though their number of completed surveys is low. For first quarter 2014 to second quarter 2015, the hospital had some exceptionally high HCAHPS composite scores. The percentage of patients choosing positive responses (the “top box” scores reported in Hospital Compare) was 100 percent for “Overall hospital rating,” “Cleanliness of hospital environment,” and “Discharge information.” An overwhelming majority of patients also rated the hospital highly for “Responsiveness of nursing staff” 97 percent, “Communication with nurses” 92 percent, and “Communication about medications” 88 percent. Nicole and Jennifer attribute this success to what is often considered a barrier to HCAHPS participation: low census.

Jennifer elaborates, “Low volumes allow staff to spend more time with patients. They form relationships, anticipate the needs of patients, and strive to take care of their needs before they have them.”

Two nurses and a nursing assistant are routinely staffed at the hospital during the day and one nurse and a nursing assistant at night. The hospital has a contract arrangement with the local retail pharmacist, who reviews medications, sits on committees, and is a resource for nurses, who perform many of the functions of a hospital pharmacist. The staff at

Petersburg Medical Center start planning for every patient’s discharge at the time of their admission, anticipating where the patient will go and what they will need. Jennifer adds that hospital housekeepers consistently monitor and sustain excellent cleaning practices. They also spend time with and form relationships with patients.

Petersburg Medical Center has achieved reporting of all EDTC measures, with consistent use of a medivac checklist that was created to ensure that all the necessary information is communicated. The facility successfully reported OP-27: Influenza Vaccination Coverage Among Healthcare Personnel (HCP) to the National Healthcare Safety Network (NHSN) this spring with a score in the mid-90s, and is presently working on improving patient

influenza screening and administration. This trend of excellence spreads into outpatient AMI measures and is the foundation on which the MBQIP ED throughput reporting and improvement work is beginning. Petersburg Medical Center also participates in the [CMS Partnership for Patients program](#), reporting and improving on data for all topics that are relevant to their patient population.

The small fishing community ought to be proud of this small and outstanding hospital, whose leaders and staff, with a very matter of fact and simple resolve, knock national critical access hospitals measures out of the park.



Data



CAHs Measure Up: All About HCAHPS

Within the last month, you've probably received your latest MBQIP reports for Hospital Consumer Assessment of Healthcare Providers and Systems (HCAHPS) data covering 4Q2014-3Q2015 from your state Flex coordinator. Those reports have raised some questions. Below we address those and other questions we've heard about HCAHPS data.

In a nutshell, here's how the HCAHPS data process works. Check out [HCAHPS Online](#) if you want to learn more detail.

- HCAHPS surveys are administered (by phone, mail, or both) to a random sample of eligible patients who are discharged by your hospital. A vendor usually administers the surveys, but some hospitals may choose to do this with CMS approval.
- HCAHPS survey data are submitted to QualityNet at least quarterly.
- CMS contractors process and analyze HCAHPS data.
- Once the data is ready:
 - Your hospital receives an MBQIP report showing your HCAHPS performance compared to other hospitals.
 - Your hospital's HCAHPS results also may be published on Hospital Compare. If this is the case, you will be able to review a Preview Report in QualityNet before the results are made public.

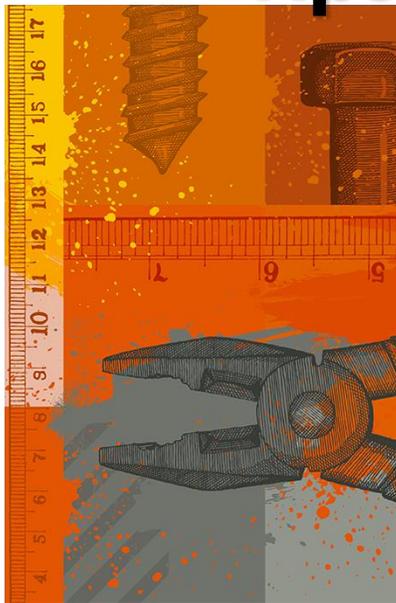
If something doesn't look quite right in your report and you think your CAH is following the HCAHPS data submission process, check these out:

- If you see an "N/A" in your MBQIP report:
 - If you have a vendor, confirm with them that they are submitting your HCAHPS data to QualityNet on your hospital's behalf.
 - Does your hospital have a very small number of patients eligible to be surveyed (or no patients eligible to be surveyed)? If so, this can still be recorded in QualityNet so you can get credit. If you have a vendor, ask them if this is happening.
 - Your hospital needs to submit four consecutive quarters of HCAHPS data to QualityNet in order to have data appear. Is this the case?
- If your data isn't appearing on Hospital Compare, check all of the things above, as well as:
 - Did your hospital sign the pledge (Notice of Participation) to have data appear?
 - Did your hospital specifically request to have data suppressed?

Finally, here are some of the main differences between HCAHPS data on Hospital Compare and the MBQIP reports:

- Hospital Compare gives only the "top box" scores from HCAHPS (this is the most positive response, such as "Always" or "Strongly Agree"), whereas MBQIP reports provide results for all of the response categories.
- Hospital Compare data is adjusted according to a hospital's patient mix and the way they administer HCAHPS surveys, while MBQIP data is simply the raw survey data.

Tips



Robyn Quips - tips and frequently asked questions

Outpatient AMI and Chest Pain Measures

We've received several questions about the AMI and Chest Pain population and data elements, so I'll try and clear them up here.

AMI Measures

Let's start with the outpatient AMI measure set which consists of these measures:

- OP-1 Median Time to Fibrinolysis
- OP-2 Fibrinolytic Therapy Received Within 30 Minutes
- OP-3 Median Time to Transfer to Another Facility for Acute Coronary Intervention
- OP-4 Aspirin at Arrival
- OP-5 Median Time to ECG

The criteria for determining the OP-1 thru OP-5 AMI population is patients:

- Seen in a hospital emergency department and have an E/M code listed in Appendix A OP Table 1.0 of the Hospital Outpatient Quality Reporting Specifications Manual
- Discharged/transferred to a short-term general hospital for inpatient care or to a federal health care facility (Discharge Code)
- With age on the Outpatient Encounter Date of greater than or equal to 18 years
- With an ICD-10-CM Principal Diagnosis Code for AMI listed in Appendix A, OP Table 1.1 of the Hospital Outpatient Quality Reporting Specifications Manual

When looking at the discharge/transfer status of the patient, these are patients who leave your hospital's ED and are transferred to 1) another acute care hospital (this does not include another CAH or transfer to a cancer hospital) or 2) a federal health care facility such as a VA or Department of Defense facility. If you look at the discharge code data element for abstracting, these are the patients who have a value of 4a Acute Care Facility - General Inpatient Care and 4d Acute Care Facility – Department of Defense or Veteran's Administration.

Use the criteria above to determine the cases you abstract for the AMI Outpatient Measures OP-1 thru OP-5. You pull the patients that meet the criteria and you abstract them for all the measures. Don't abstract some cases for one AMI measure and some for another AMI measure—all the cases in the population are abstracted for OP-1 thru OP-5. The one set of questions apply to all the AMI cases.

Depending upon how the data element questions are answered, cases might be excluded from a specific measure. For example, look at OP-2, Fibrinolytic Therapy Received Within 30 Minutes. Maybe your facility never gives fibrinolytic therapy. If that's so, those cases in your population will be excluded from the measure, because they didn't meet the criteria. You will answer "No" to those data element questions regarding fibrinolytic therapy. Your reports won't show cases for that measure, and that's ok because no

cases met the criteria. You keep them in your initial population because they meet the AMI criteria listed above, they just don't meet the criteria for OP-2. Every case might not meet the criteria for every measure.

Chest Pain Measure

The Chest Pain measure set only consists of two measures:

- OP-4 Aspirin at Arrival
- OP-5 Median Time to ECG

Those measures apply to both the AMI population and the Chest Pain population. The difference for abstracting is how you determine your Chest Pain population. The discharge/transfer and age requirements are the same but the coding requirement is:

- An ICD-10-CM Principal or Other Diagnosis Code for Chest Pain as defined in Appendix A, OP Table 1.1a.

When you pull your Chest Pain population, it's not only the principal diagnosis of chest pain you use to select the cases, any secondary or other diagnosis code for chest pain (listed in the table mentioned in the bullet above) also would be included in your population. Any patients with an ICD-10-CM Principal Diagnosis Code for AMI are not eligible for the Chest Pain Hospital Outpatient Population. Those cases are going to fall in your AMI population and you don't want to include them in both populations.

After you determine your Chest Pain population, those cases all get abstracted with the data element questions that make up OP-4 and OP-5. Maybe none of the cases will meet the measure criteria, but you must take all the cases in the population and answer the questions for Chest Pain.

Remember Abstract All Cases

All cases in the initial population for a measure don't always meet the measure criteria, but all those cases in the population must be abstracted. Meeting or not meeting the measure criteria only happens after you answer the data element questions for that measure set.

Robyn Carlson, Stratis Health quality reporting specialist, provides Flex Coordinators with technical assistance related to MBQIP.

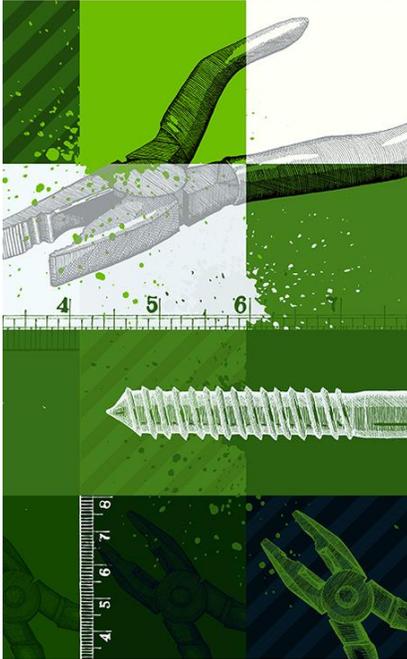
Go to Guides

Hospital Quality Measure Guides

- [Emergency Department Transfer Communications](#)
- [Inpatient Specifications Manual](#)
- [Outpatient Specifications Manual](#)



Tools



Tools and Resources

Updated - [Quality Improvement Implementation Guide and Toolkit for Critical Access Hospitals](#). Offers strategies and resources to help critical access hospital (CAH) staff organize and support efforts to implement best practices for quality improvement.

- Updates include the addition of improvement strategies for OP-4 (Aspirin on arrival) and OP-18 (Median time from arrival to departure for discharged ED patients).

Updated - [Internal Quality Monitoring Tool](#). A simple, Excel-based tool to assist CAHs with tracking and displaying real time data for MBQIP and other quality and patient safety measures to support internal improvement efforts.

- Update includes OP-4 and OP-18. A brief video tutorial on how to use the tool also is available.

[Health Care Leader Action Guide to Effectively Using HCAHPS.](#)

Describes how the Hospital Consumer Assessment of Healthcare Providers and Systems (HCAHPS) data should be used in context with other information about organizational performance. Highlights cultural elements necessary to build a firm foundation for HCAHPS success. Once these foundational elements have been considered, the guide outlines a 5-step approach to using HCAHPS effectively to improve the patient experience, quality and safety.

Due July 31 - Emergency Department Transfer Communication (EDTC) Measure: These tools can help!

[Data Specifications Manual - EDTC \(January 2016\)](#). Use this manual for data collection starting with Quarter 1, 2016 transfers.

[Data Collection Tool - Emergency Department Transfer Communication Measure \(January 2016\)](#). Use this Excel tool for transfers starting Quarter 1, 2016.

[EDTC Online Recorded Trainings](#). Two recorded trainings are now available to help support data collection for the EDTC Measure.

- **EDTC Data Specifications Overview.** A guided overview of all the data elements in the EDTC Measure Data Specifications Manual. Have the manual open to follow along. (22-minute audio file)
- **EDTC Data Collection Tool Training Video.** A step-by-step guide on how to download the Excel-based data collection tool, enter data, and run reports to calculate your measures. (18-minute video)



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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