

MBQIP Monthly

Medicare Beneficiary Quality Improvement Project

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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.



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

Margaret Mary Health, IN

Located in Batesville, Indiana, [Margaret Mary Health](#) (MMH) is a not-for-profit, critical access hospital providing both inpatient and outpatient services. Employing nearly 750, the hospital serves a population of more than 65,000 and has an average daily census of around 14 patients.

Named a Top 100 Critical Access Hospital at the National Rural Health Association Annual Conference in 2017, MMH promotes patient safety as their number one priority, a claim supported by their outstanding quality scores. They credit much of their success to their dedicated patient safety team, made up of representatives from all clinical areas. The team monitors outcomes and continuously improves processes to ensure patients are as safe as possible during their stay, with an emphasis on communication between caregivers, patients, and families.

While the patient safety team is a vital part of their success, MMH recognizes the role all staff play in maintaining a safe environment. Over the past ten years the hospital has focused heavily on improving their patient safety culture, utilizing the Agency for Healthcare Research and Quality (AHRQ) [Patient Safety Culture Survey](#) as a metric and guide.

Staff and new team members receive training regarding reporting of adverse events, and assurance that incident reports are not placed in their HR files. Department meetings routinely include discussion of incidents with a focus on process improvement rather than individual blame. Care conferences involving front line staff and physicians are held for sentinel events and medication errors. Recognizing the stress and self-blame that such incidents can cause, the focus is not only on how to improve, but how people feel about the event. The outcomes of these efforts can be seen in the results of the annual AHRQ survey, which place MMH in the top quartile of hospitals for all dimensions, and the top decile for non-punitive response to errors.

Other patient safety successes at MMH include reduced healthcare-associated infection rates, particularly in facility onset *C. difficile* infection (CDI). Much of the improvement related to CDI rates is tied to updating and training on testing protocols. Current protocols help ensure patients are not unnecessarily treated with antibiotics if they are merely colonized, as opposed to truly having an infection. This connects directly with the launch

of antibiotic stewardship at MMH. Their antibiotic stewardship team meets quarterly, with pharmacists included for bedside rounding, at which time they complete an antibiotic review. The team also is using molecular testing to scale back antibiotic usage.

Beyond safety, MMH recently was recognized as being in the top 10 percent of rural providers nationally for patient satisfaction. To help achieve this, the hospital implemented tactics like a bedside rounding process including the hospitalist, pharmacist, scribe, and nursing staff. This standardized approach to reviewing goals, medications, and daily care plan with the entire care team, including the patient and family members, has contributed to their success in high patient experience scores.



Members of the MMA team from left to right, Sharon Kreuzman, Emergency Room Nurse Manager, Herb Hunter, Pharmacy Manager, Deanna Youngman, Infection Prevention Coordinator, Trina Brandon, Quality Data Specialist, Lisa Banks, Quality Services Manager, Bonnie Ploeger, Director of Quality and Risk Management

As a member of an accountable care organization (ACO), MMH also has focused on care coordination within and outside the hospital. Key lessons learned from this experience have included recognition of the various comorbidities of many patients and the multiple medications needed to manage them. Ensuring there are open lines of communication across the care team, including primary care and social services, has been integral in this effort.

Improving flow in the emergency department (ED) has been another priority for MMH. They started reporting on the newly required MBQIP measures ED-1 and ED-2 in 2015 and relied on that data to drive their improvement efforts. To tackle this recurring challenge, they established a

cross-unit team comprised of representatives from the inpatient and emergency departments. The group set the expectation for patients to be transferred to the floor within 15 minutes of the decision to admit. Some of the strategies they employed to make this happen included changing from a phone report between departments to having the ED nurse take the patient to the unit and provide a bedside report following a quick call to let the unit know they are on their way. While this process proved a bit painful at first, having a cross-unit team with champions helped pave the way to quick adoption.

Other approaches that have proved successful in improving ED flow include expectations regarding turnaround time for diagnostic testing to help inform admit and transfer decisions, and establishing a second track of care within the ED for patients presenting with less serious issues. MMH has a goal of keeping the ED waiting room as empty as possible, and the community has come to expect the shorter wait times.

Margaret Mary Health prides itself on providing top-notch, quality care; it's clear they have a lot to be proud of.



CAHs Measure Up: Data Quality & Accuracy

CAHs Measure Up: Data Quality & Accuracy

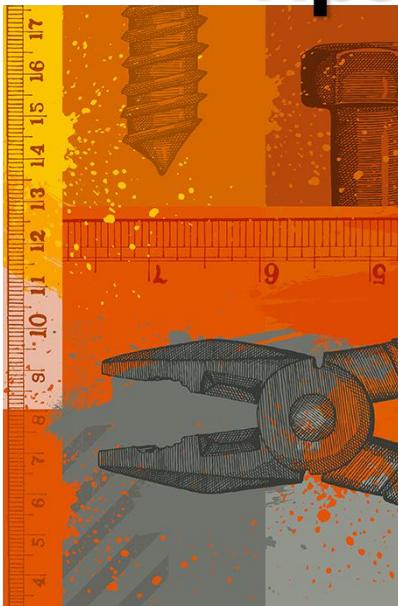
Reporting your quality data is important, but so is using your quality data for improvement efforts. And if you are using your quality data to identify areas for improvement, it's also important to know that your data is accurate so that you aren't implementing a potentially time-consuming change when it might not be necessary, or might have unintended consequences! It's also important to submit accurate data so that others in your state and at the federal level have adequate information to support program decisions.

Here are a couple of data accuracy issues to watch out for:

- **Numerator is larger than denominator.** This should never happen, and is most likely caused by mistyping. The denominator should always be larger than the numerator. Most commonly, we notice this in the EDTC data submitted to your state Flex Coordinator each quarter. EDTC measures are calculated by taking the total number of records meeting each EDTC measure (EDTC-1, EDTC-2, etc. – this is the numerator) divided by the total number of records reviewed (this is the denominator), multiplied by 100% to create a percentage. For example, if your hospital has reviewed 45 records for the quarter then it is never possible for the number of records meeting each EDTC measure to be larger than 45. The number of records meeting each EDTC measure can be any number up to 45, but never greater than 45.
- **Incorrect use of '0' in population & sampling.** Incorrect use of '0' happens in two situations:
 - In the first, we see some hospitals reporting a '0' for their ED-1 & ED-2 population which is unlikely for the majority of facilities, since the only way this would happen is if a hospital had no inpatient acute care discharges for that quarter. (See Robyn Quips in [November 2017 MBQIP Monthly](#) for more specifics)
 - In the second, some hospitals share that they have no patients for some measures (particularly the AMI metrics). If this is truly accurate, it's important to submit a '0' in population and sampling to indicate your facility has no cases that meet the measure population requirements.

It is also possible to abstract records inaccurately, perhaps by interpreting the instructions in various Specifications Manuals incorrectly. This in turn can cause your calculated quality measures to be inaccurate. For example, it's possible to use an incorrect time when abstracting a record that contributes to a timing-based emergency department measure, and this might make it appear that your hospital has longer (or shorter) emergency department wait times than is actually the case. If you are curious to learn more about how you are abstracting data, RQITA is offering a new Abstracting for Accuracy opportunity. Check out the next sections of MBQIP Monthly: *Robyn Quips* and *Tools and Resources* for information on how to participate.

Tips



Go to Guides

Hospital Quality Measure Guides

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



Robyn Quips - tips and frequently asked questions

Population and Sampling

February is the next data submission time period, and as I still get questions about this, I'd like to again mention some steps regarding the process, and why we encourage submission of population and sampling information:

- If you have cases that meet the measure population requirements and you are submitting data to the QualityNet warehouse, entering population and sampling data is a step in the process that confirms how many cases you will report.
- If you do not have any cases for one or more of the measure population requirements, submitting a zero for the population and sampling data meets the requirements of reporting for MBQIP. It also allows for a more accurate understanding of how many CAHs have data to report and are included in comparison data for the MBQIP reports.
- If your facility does not have any cases that meet the measure population requirements for a particular quarter, and no population and sampling data is entered, an N/A will appear on the MBQIP report for that measure. An N/A means the hospital submitted no data; that they did not report. If you have no data to submit because you have no cases for the quarter that meet population requirements, then record a zero (0) for the population. Then you will see a 0 on the MBQIP report. The 0 means you had no cases that met the population requirements for the measure.
- It is *not correct* to record zero or fill out the population and sampling grid for measures you are choosing not to report on. In this instance an N/A is what *should* appear on your MBQIP report.

You want your report to accurately show you had no cases to submit rather than inaccurately showing you chose not to report. Why have to explain an N/A if that isn't the case?

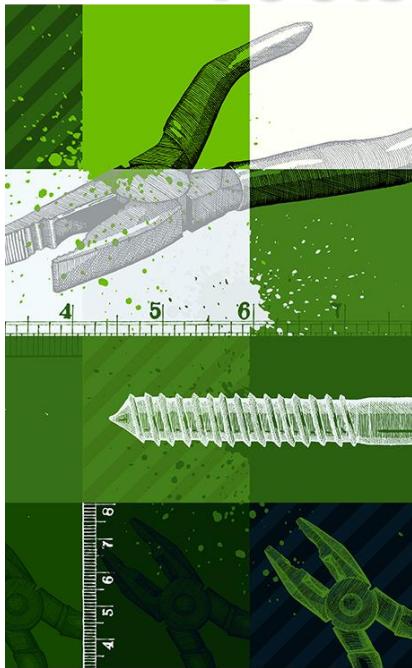
Also, as the preceding *CAHs Measure Up* article mentions, letting your state Flex program and FORHP know that you had no patients that met population requirements helps them when they are evaluating which measures may be relevant for reporting.

NEW! Abstracting for Accuracy Review and Consultation

We are offering a new opportunity for CAHs to assist them in ensuring the accuracy of their abstracted data. Often, if you are the only person in your hospital doing abstraction, there is no one to bounce questions off, or check to see if you are interpreting the instructions in the Specifications Manual correctly. This is an opportunity to validate your data collection process and identify opportunities for additional training and clarification as it relates to chart abstraction by comparing notes with an abstraction professional.

A sample of inpatient, outpatient, and EDTC abstractions done by the hospital will be re-abstracted by me, Robyn Carlson. After my abstraction a phone consultation will be set up to discuss the results. Hospitals will need to send hard copies of the entire inpatient stay or outpatient encounter along with a hard copy of their abstraction tool. More information about this abstraction review process [can be found here](#).

Tools



Tools and Resources

New Opportunity! [Abstracting for Accuracy Consultation](#).

Stratis Health is offering a customized consultation that will provide hospitals with the opportunity to receive one-on-one education and assistance on how to abstract MBQIP core measures. This is a chance to validate your abstraction process with Stratis Health Quality Reporting Specialist Robyn Carlson, RHIA, CPHQ, using an inter-rater reliability process that compares abstraction results between two abstractors to assess the comparability of findings. Space is limited! Visit the [project page](#) for more information or to submit your interest in participating.

Updated! [Quality Improvement Implementation Guide and Toolkit for CAHs](#).

Offers strategies and resources to help critical access hospital (CAH) staff organize and support efforts to implement best practices for quality improvement. Updated to include additional strategies and best practices for MBQIP measures.

[Hospital Survey on Patient Safety Culture](#). For more than a decade, hospitals have been using this staff survey developed by the Agency for Healthcare Research and Quality (AHRQ) to help assess and improve the culture of safety in their organizations. Resources include an annual comparison database, an extensive resource list that provides links to a wide variety of strategies and tools for improvement, and a newly released [supplemental set of survey questions](#) focused on helping hospital assess opinions about the culture of value and efficiency in their organizations.

[Quality Improvement Basics: A Collection of Helpful Resources for Rural Health Care Organizations](#). This collection of resources for rural health care organizations points health care quality professionals to the most helpful introductory resources and provides awareness of the more prominent health care quality organizations, programs and terms.



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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