

# 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](#).

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

## Rural Success: St. Elizabeth Healthcare, KY

St. Elizabeth Grant, part of [St. Elizabeth Healthcare](#), is a critical access hospital (CAH) in Grant County, Kentucky. Located 45 miles from the closest Level 1 trauma center, St. Elizabeth Grant operates nine of its licensed 25 beds, three of which are newly designated as swing beds. Originally built in 1964, the hospital and emergency department, which serves an average of 50 patients a day, was renovated in 2018.

St. Elizabeth Grant prides itself on high-quality care, patient engagement, and when appropriate, integration of technological innovations. For example, through numerous interventions, ranging from colored wristbands to patient education to specialized beds with integrated alarms, the facility achieved a zero fall rate in 2016, only one fall in 2017, and zero falls to date in 2018.

Like many other CAHs, St. Elizabeth Grant plays a crucial role in stabilizing and transferring patients that require care at a tertiary facility. To provide the most effective and timely care possible to their high acuity stroke and STEMI patients, the emergency department (ED) has implemented a cloud-based, communication application. Through this system, the various service lines involved in patient care are immediately notified of a stroke or STEMI patient. This ensures everyone from imaging to cardiology to pharmacy and all other teams is at the ready, including team members at the receiving facility and the air ambulance.

The importance of teamwork and communication carries through to St. Elizabeth Grant's focus on ensuring a positive patient experience across all departments. Last year, all staff at the facility went through simulation training through which they demonstrated their ability to implement "[always](#)" behaviors, Acknowledge, Introduce, Duration, Explanation, and Thank You ([AIDET](#)) communication, and bedside reporting and hourly rounding. Managers and senior leaders serve as coaches promoting consistency throughout the organization. The care team utilized whiteboards that were updated with patient feedback, and they "commit to sit" spending five minutes at eye level to help develop a bond between the patient and provider.



The St. Elizabeth Grant team with a “Caregram” basket they received to recognize their work representing St. Elizabeth Healthcare’s I CARE customer service standards (Innovation, Collaboration, Accountability, Respect and Excellence).



Students participating in the St. Elizabeth Grant-hosted and funded leadership summit for youth.

With regards to infection prevention, St. Elizabeth Grant requires flu shots of all staff and contractors, driving high performance on the healthcare personnel influenza vaccination measure. They also review smoking cessation, pneumonia, and influenza vaccination as part of the admission process on every inpatient. Through their shared electronic health record, hospital staff can tell if patients have received their vaccine at a physician’s office within the St. Elizabeth system.

While their commitment to quality can be seen in their MBQIP performance, St. Elizabeth Grant’s obligation to the community is demonstrated in programs and services outside the hospital walls. A recent example was a leadership summit for youth, hosted and funded by the hospital through a donation from a community member. A local, nationally known speaker led the summit, which focused on reducing drug and alcohol use, improving mental health, and suicide prevention. More than 170 middle and high school students representing five school systems across four counties participated in the day-long event. Participants included a mix of students who are leaders in pre-established school groups as well as students at higher risk for some of the behaviors being addressed.

Students were provided with data for their schools collected through the [Kentucky Incentives for Prevention \(KIP\) Survey](#) on student use of alcohol, tobacco, and other drugs, as well as many factors related to potential substance abuse. In the case of one participating school, 50 percent of the youth surveyed said they had thought about or considered suicide. While the purpose of the summit was to address some difficult-to-discuss topics, the environment was positive with the aim of empowering and building up students help develop solutions. The summit presenter will be visiting each school to meet with the students and hear how things are going following the event to help further their plans for interventions. The team at St. Elizabeth Grant is hopeful they will be able to secure funding to continue this offering in the future, recognizing the vital work of engaging youth in prevention to enhance the wellness of the community.

# Data



## Enhanced Hospital Data Reports

You may have noticed in the past few months that your Patient Safety & Inpatient-Outpatient MBQIP Hospital Data reports have been enhanced again! Here's a quick overview of what's changed, starting with reports summarizing Q4 2017 encounter dates, which you likely received sometime in July:

- New measures:** Progress towards implementing the seven [core elements](#) of hospital Antibiotic Stewardship programs, as reported on the NHSN Annual Facility Survey, are now included on page four of your report. This new page contains CAH-specific performance for the current and previous survey year, as well as current performance for CAHs in your state and nationally.

Report Run Date: 09/18/2018

MBQIP Patient Safety and Inpatient/Outpatient Care Quality Report:  
Improving Care Through Patient Safety and Inpatient/Outpatient Measures

Reporting Period: Second Quarter 2017 through First Quarter 2018 Discharges

NHSN Patient Safety Component: Annual Facility Survey							
NHSN Annual Facility Survey	Your Hospital's Performance for Previous and Current Survey Years		CAH State Percentage for Current Survey Year		CAH National Percentage for Current Survey Year		ALL National Current Survey Year
	Previous Survey Year: 2016	Current Survey Year: 2017	Percentage of CAHs Meeting Element	# CAHs with MBQIP MOU Submitting Data	Percentage of CAHs Meeting Element	# CAHs with MBQIP MOU Submitting Data	Percentage of ALL National Meeting Element
Element 1: Leadership	Y	Y	64%	73	82%	1076	N/A
Element 2: Accountability	Y	Y	85%	73	93%	1076	N/A
Element 3: Drug Expertise	Y	Y	82%	73	94%	1076	N/A
Element 4: Action	Y	Y	90%	73	95%	1076	N/A
Element 5: Tracking	N	Y	74%	73	81%	1076	N/A
Element 6: Reporting	Y	Y	70%	73	85%	1076	N/A
Element 7: Education	Y	Y	71%	73	83%	1076	N/A
All Elements Met	6	7	33%	73	58%	1076	N/A

- Additional benchmarking:** Except for Antibiotic Stewardship, each measure now includes an overall performance benchmark for all reporting hospitals nationally (Prospective Payment System hospitals and CAHs combined), in addition to overall and 90<sup>th</sup> percentile benchmarks for all reporting CAHs by state and nationally.

MBQIP Quality Measures	Your Hospital's Performance by Quarter				CAH State Current Quarter			CAH National Current Quarter			ALL National Current Quarter	
	2Q17	3Q17	4Q17	1Q18	Median Time/Overall Rate	# CAHs with MBQIP MOU Submitting Data	90th Percentile**	Median Time/Overall Rate	# CAHs with MBQIP MOU Submitting Data	90th Percentile**	Median Time/Overall Rate	
<b>Immunization</b>												
IMM-2 Influenza Immunization	D/E	D/E	100% of 68 patients	100% of 81 patients	92%	74	100%	90%	997	100%	94%	
<b>Emergency Department – Quarterly Measures</b>												
OP-18b Median Time from ED Arrival to ED Departure for Discharged ED Patients	100 Min. based on 105 patients	92 Min. based on 105 patients	94 Min. based on 95 patients	104 Min. based on 87 patients	106 Min.	77	82 Min.	108 Min.	1011	79 Min.	140 Min.	
OP-20 Median Time from ED Arrival to Provider Contact for ED patients	15 Min. based on 105 patients	14 Min. based on 102 patients	14 Min. based on 88 patients	15 Min. based on 92 patients	17 Min.	77	8 Min.	16 Min.	1012	8 Min.	20 Min.	
ED-1b Median Time from ED Arrival to ED Departure for Admitted ED Patients	160 Min. based on 44 patients	166 Min. based on 49 patients	143 Min. based on 39 patients	146 Min. based on 37 patients	167 Min.	73	108 Min.	196 Min.	932	110 Min.	270 Min.	
ED-2b Admit Decision Time to ED Departure Time for Admitted Patients	13 Min. based on 43 patients	16 Min. based on 49 patients	13 Min. based on 39 patients	8 Min. based on 37 patients	32 Min.	73	6 Min.	46 Min.	932	8 Min.	94 Min.	

RQITA has also updated [Interpreting MBQIP Hospital Data Reports for Quality Improvement](#) with some tips on how to utilize your hospital's Annual Facility Survey data and the national rates.

# Tips



## Robyn Quips - tips and frequently asked questions

### The Current MBQIP Core Measures

Continuing with the findings that came out of the Abstraction for Accuracy pilot, it seems like there is some confusion out there on what measures should be abstracted. So here is a list of the measures that currently make up MBQIP. **These measures should be abstracted for Q3 (due February 2019) and Q4 (due May 2019) 2018.** (See the [MBQIP Measures page](#) for more detail on current measures)

### Outpatient Measures

#### AMI Measure Set

- OP-2: Fibrinolytic Therapy Received within 30 Minutes
- OP-3: Median Time to Transfer to Another Facility for Acute Coronary Intervention
- OP-5: Median Time to ECG

Maybe you aren't doing the AMI measures because your hospital doesn't administer fibrinolytic therapy. That is not correct. You're not following the abstraction instructions. There is nothing in the AMI population requirements that say "Only include cases that had been given fibrinolytic therapy".

#### Chest Pain Measure Set

- OP-5: Median Time to ECG  
This is the same measure as the one in the AMI measure set, but use the chest pain population requirements to determine the cases to abstract.

#### ED Throughput Measure Set

(I like to just refer to them as the Outpatient ED measures so not to confuse them with the Inpatient ED measures)

- OP-18: Median Time from ED Arrival to ED Discharge for Discharged ED Patients

Remember these are patients who are seen in your ED and then discharged or transferred to another location, not patients seen in the ED and then admitted as an inpatient to your hospital.

- OP-22: Patient Left Without Being Seen

### Inpatient Measures

#### IMM Measure -2: Influenza Immunization

#### ED Measure Set

- ED-1: Median Time from ED Arrival to ED Departure for Admitted ED Patients
- ED-2: Admit Decision Time to ED Departure Time for Admitted Patients

These are considered inpatients because they are patients admitted from your ED to acute care inpatient at your hospital.

### Emergency Department Transfer Communication (EDTC)

#### OP-27: Influenza Vaccination Coverage Among Healthcare Personnel

Something to note, for those of you that have heard CMS is retiring OP-27, it's really just undergoing a name change. It's going to be referred to as HCP, which is how the CMS Inpatient program refers to the measures. It will continue to be an MBQIP measure reported via NHSN.

**Antibiotic Stewardship**

- This is currently measured by completing the Annual Facility Survey in NHSN.

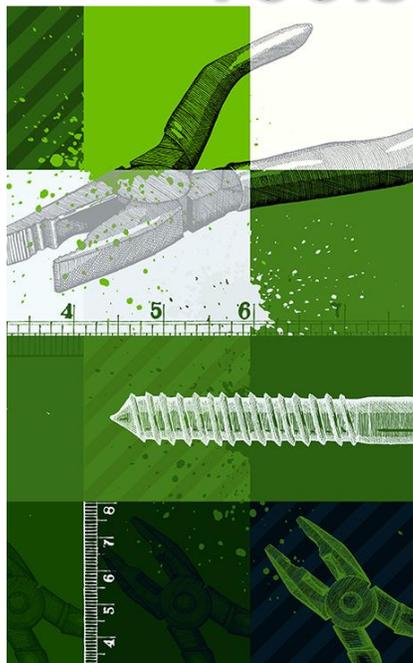
**Hospital Consumer Assessment of Healthcare Providers and Systems (HCAHPS)**

Even if you have just one case that meets the measure population requirements for the quarter it should be abstracted. If you have zero cases that meet the population requirement, record a zero in the population and sampling grid. That will consider you to be reporting on the measure set; you just have no cases this quarter. If you are not sure how to determine which cases fall in a measure set, you can refer to the [MBQIP Quality Reporting Guide](#) for links to the CMS and EDTC Specification Manuals and YouTube abstraction videos.

**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](#)

This project offers CAHs an opportunity to participate in an abstracting review process to help 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, January 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))

### **Updated! [Critical Access Hospital eCQM Resource List](#)**

This list of resources related to electronic clinical quality measure (eCQM) reporting, is intended to aid critical access hospitals seeking to meet the quality measure reporting requirements for the Promoting Interoperability Program (formerly known as the Medicare EHR Incentive Program).

### [Preventing Falls in Hospitals: A Toolkit for Improving Quality of Care](#)

Fall prevention involves managing a patient's underlying fall risk factors and optimizing the hospital's physical design and environment. This comprehensive toolkit, available from AHRQ (Agency for Health Care Research and Quality), focuses on overcoming the challenges associated with developing, implementing, and sustaining a fall prevention program.



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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