

# 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.

## Aultman Orrville Hospital, OH

[Aultman Orrville Hospital](#) (AOH) is a 25-bed critical access hospital in Orrville, Ohio. After a long-standing independent relationship with [Aultman Health Foundation](#), the hospital integrated with the system in 2012.

Serving as one of two hospitals in Wayne County, AOH has more than 230 employees and a medical staff of 140 providers. The average daily census at AOH, including inpatient, swing, and observation patients, was 8.5. They consistently see around 12,000 patients in the emergency department (ED) each year and have delivered more than 1,000 babies over the past two years.

AOH started on what they call their High Reliability Journey in 2013. While the initial focus was patient safety, it quickly became about much more than that. By aiming to become a [high reliability organization](#), AOH seeks to hardwire behaviors so that all processes are completed as intended, consistently, over time. The motto for this work, supported by a concrete set of tools (actions) and tones (the way actions are carried out) is “You can count on me every time.” To ensure staff does not perceive this concept as a flavor of the month, AOH has trained 22 high reliability coaches, with representation spread across almost every department and shift. These super users of the high reliability tools are engaged in real-time peer checking and peer coaching, helping their colleagues identify opportunities for improvement and, just as importantly, recognizing successes.

In addition to having high reliability coaches in every department, AOH also has representation across all departments on the Practice and Quality Council. This group routinely meets to review quality data and is responsible for taking the data back to their respective units for other staff to see. Through this cross-departmental approach, the Council can review processes while taking into account how perceptions are different across units. AOH also has taken steps to get input from community volunteers participating in their new Patient Voice Council, which feeds information back to the Practice and Quality Council.

The first focus on the Practice and Quality Council was patient experience. AOH has incorporated leadership rounding, which has made a significant difference in their HCAHPS scores. Leaders not only round on patients to



AOH High Reliability coaches and Practice and Quality Council members, from left, Nick Elser, Nuclear Med tech, Joseph Ault, Admissions Supervisor, Bharati Patel, Med tech, Tiffany Durstine, Phlebotomist(CPT), Mary McClish, Surgery RN, Aimee Smith, PTA, Jennifer Moine, Cardiac Rehab RN, Carol Haines- Emergency Department RN, Jami Mausolf, Surgery RN.

inquire as to how things are going and address any concerns or needs they have, but also to round on staff to ensure they have the resources they need to make the hospital experience as positive as possible for their patients. AOH has continued to see an upward trend in their HCAHPS performance.

The intensive work of the High Reliability Journey and the Practice and Quality Council is evident in other areas of AOH's quality data. While it's not a Core MBQIP measure, PC-01 (elective deliveries) is an essential metric for AOH given their high volume of births. The rationale for this measure is to drive down elective

deliveries between 37 and 39 weeks of gestation due to links to neonatal morbidity. AOH has maintained zero percent for this measure over many years. When they saw a rise in the PC-02 (Cesarean births), the team shared individualized data with each provider to break down the scores and through engagement were able to bring the score back down to goal and below benchmark within a few months.

In their bustling ED, AOH prides itself on their door to discharge time (OP-18), for which [Becker's Hospital Review](#) recognized them on more than one occasion. As importantly, ED patient satisfaction has been high as they've worked to improve discharge time. For those patients that are admitted, an engaged hospitalist group working collaboratively with the ED providers helps ensure patients can easily transition to inpatient status. A robust referring relationship with the tertiary Aultman facility allows for consistent feedback regarding patients that are transferred, contributing to high performance with the Emergency Department Transfer Communication (EDTC) measure.

Example of Aultman Orrville Hospital's "Tools and Tones" communication.

AOH is also able to leverage their relationship with Aultman to support the implementation of antibiotic stewardship. The in-house team, including

two full time and one part-time pharmacist as well as pharmacy technicians, support all areas of the hospital, but if they need additional support, they can reach out to their colleagues at the health system.

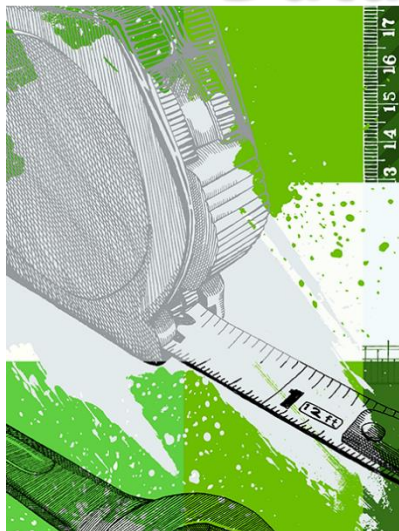
It's clear that AOH has a strong quality framework supported by a dedicated staff that seeks to serve the community. As explained by Angela Caldwell, Vice President of Patient Services, "Everyone knows everyone. There is a sense of family here, and communication is key. Our staff truly understands the contributions they make to all aspects patient care."



AOH Clinical Directors, from left, Teresa Rowe, Director of Surgery, Lori Josefczyk, Director of Emergency Department, Stacey DiGiulio, Director of Rehab, Tieryn Cotterman, Quality Coordinator, Beth Chenevey, Director of Quality and Infection Prevention, Julie Girton- Team Lead Laboratory, Angela Caldwell, VP of Patient Services, CNO, Patty Vanegas, Director of Medical Surgical/ICU, Tara Snyder, Director of Obstetrics.



# Data



## CAHs Measure Up: ED-1 and ED-2 Measures Now in MBQIP Hospital Data Reports

With the addition of ED-1 and ED-2 to the MBQIP Core Measures, the MBQIP Hospital Data reports you receive from your Flex Coordinator each quarter have also been updated to reflect those new measures and also to incorporate some additional enhancements. Here's a quick overview of what's changed, starting with reports summarizing Q4 2016 encounter dates, which you likely received in late December:



- **New measures:** ED-1 (median time from ED arrival to ED departure for admitted ED patients) and ED-2 (admit decision time to ED departure time for admitted patients) were incorporated into reports.
- **Reordering the pages:** All ED measures are now grouped together on the second page of the report, and the third page of the report now includes all measures reported yearly.
- **Yearly measure comparisons:** Full year comparisons for those measures that are only reported yearly (OP-22 and OP-27) have been added to the report.

RQITA has also updated a handful of existing resources to reflect these measure additions and updated reports:

- **CAH Quality Prioritization Tool** (part of [Quality Improvement Implementation Guide and Toolkit for CAHs](#)) – an Excel-based tool to help CAH quality and patient safety leaders prioritize and make decisions related to patient safety and quality planning.
- **Internal Quality Monitoring Tool** (part of [Quality Improvement Implementation Guide and Toolkit for CAHs](#)) – 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.
- **[Interpreting MBQIP Hospital Data Reports for Quality Improvement](#)** – contains detailed tips on interpreting your reports, including some example reports that outline different opportunities for quality improvement.

# Tips



## Robyn Quips - tips and frequently asked questions

### Measures OP-22 and OP-27

May 15 is the once-yearly submission date for measures OP-22: Left without Being Seen, and OP-27: Influenza Vaccination Coverage among Healthcare Personnel. If you need a refresher or are new to these measures, here are some resources to assist you in submitting them.

#### OP-22 – Left Without Being Seen

This measure consists of the percent of patients who leave the Emergency Department without being evaluated by a physician, advanced practice nurse (APN), or physician assistant (PA).

Because this is an administrative measure and not chart-abstracted, CMS does not specify how to collect data. However, the CMS [Hospital Outpatient Quality Reporting Specifications Manual](#) does include definitions of the two values hospitals need to submit:

- What was the total number of patients who left without being evaluated by a physician/APN/PA?
- What was the total number of patients who presented to the ED?

Definition for patients who presented to the ED:

- Patients that signed in to be evaluated for emergency services.

Definition for Physician/APN/PA:

- Patients who are seen by a resident or intern are to be considered as seen by a physician.
- An institutionally credentialed provider, acting under the direct supervision of a physician for healthcare services in the emergency department (e.g., an obstetric nurse providing assessment of an obstetric patient) are to be considered as seen by a physician.
- Advanced Practice Nurse (APN, APRN) titles may vary between state and clinical specialties. Some common titles that represent the advanced practice nurse role are: Nurse Practitioner (NP), Certified Registered Nurse Anesthetist (CRNA), Clinical Nurse Specialist (CNS), and Certified Nurse Midwife (CNM).

The May 15 due date is for encounters in the previous calendar year, January 2017 – December 2017, and entered through the QualityNet Secure Portal. After logging in, on the *MyTasks* page, look for *Manage Measures*.

Page seven of the [MBQIP Quality Reporting Guide](#) has a link to a CMS webinar showing how to find and submit the OP-22 measure.

#### OP-27 – Influenza Vaccination Coverage among Healthcare Personnel

The May 15 due date is for the flu season October 2017 – March 2018. Data is submitted to the National Healthcare Safety Network (NHSN) and your facility must be enrolled in NHSN to report the measure.

Definition for Healthcare Personnel (HCP):

Facilities must report vaccination data for three categories of HCP: employees on payroll; licensed independent practitioners (who are physicians, advanced practice nurses, and physician assistants affiliated with the hospital and not on payroll); and students, trainees, and volunteers aged 18 or older. [Reporting data on the optional, other contract personnel category is not required at this

time.] Only HCP physically working in the facility for at least one day or more between October 1 and March 31 should be counted. Data on vaccinations received at the facility, vaccinations received outside of the facility, medical contraindications, and declinations are reported for the three categories of HCP.

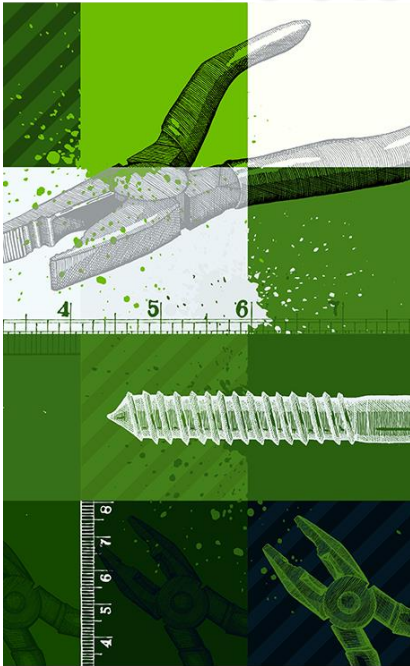
For information on how to enroll in NHSN, and links to resources on how to gather and submit data see page 12 of the [MBQIP Quality Reporting Guide](#).

## Go to Guides

### Hospital Quality Measure Guides

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

# Tools



## Tools and Resources

### [Antibiotic Stewardship Program \(ASP\) Case Study: Critical Access Hospital - Southwest Health System](#)

Outlines the governance structure, implementation strategies, key milestones, and outcomes from Cortez, Colorado-based Southwest Health System's antimicrobial stewardship program.

### [Eliminating Harm, Improving Patient Care: A Trustee Guide](#)

These resources illustrate the important role that trustees play in the journey to improve patient care. They serve as a tool for all trustees to use as they work towards the goals of improving quality within their organizations and improving the health of their patients and communities they serve. Resources include four video modules and a discussion guide, as well as a self-assessment tool for boards.

### [HCAHPS Podcast: Improving Response Rates of HCAHPS Hospitals](#)

This 11-minute podcast, with accompanying slides, provides an overview of how the HCAHPS response rate is calculated, why it is important, what can affect response rates, and suggestions for improving them.

### [Seven Popular Improvement Tools: How \(and When\) to Use Them](#)

In this Institute for Healthcare Improvement video, David M. Williams, PhD, executive director & improvement advisor, talks about what tools improvers need to do their work, including:

- PDSA
- Time Series Charts: Run Chart and Control Chart
- Process Map
- Scatter Diagram
- Driver Diagram
- Pareto Chart
- Cause and Effect Diagram

### [Strategies for Superbugs: Antibiotic Stewardship for Rural Hospitals](#)

This Rural Health Information Hub *Rural Monitor* article details how rural and critical access hospitals are activating their stewardship programs to combat the spread of antibiotic-resistant bacteria.



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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