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.

Rural Success: Abbeville Area Medical Center, SC

Located in the town and county of Abbeville, South Carolina, Abbeville Area Medical Center (AAMC) is a critical access hospital that prides itself on high-quality service and patient outcomes. Most of the population served by AAMC is located within the county, which is seeing significant growth in the community of residents 65 and older. The hospital, which has several surgery services lines, including urology, general surgery, and plastics, is affiliated with two large family practice clinics and three specialty clinics. The family physicians serve as the hospitalist group, which allows for high levels of engagement through care transitions and hospital-based initiatives. Despite low volumes in many areas (their average daily census is 8.4 patients), AAMC reports on all inpatient and outpatient measures, demonstrating their commitment to quality reporting.

In 2013 through funding from the Duke Endowment, AAMC undertook a three-year project focused on implementing a Lean methodology. Training beyond the quality department to include frontline staff and senior leaders led to Lean becoming an ingrained, organization-wide structure for addressing quality improvement. Mission control boards can now be found throughout the hospital, and staff gathers daily to review and talk about what happened yesterday, what's going well, and what needs improvement. This review is done in the context of the unit overall and to individual patients. For example, if in the previous day a patient were diagnosed with pneumonia, part of the review would include asking if that patient got a pneumonia vaccine. The routine nature of the Lean approach is adopted by leadership as well, with the Executive Steering Committee meeting bi-weekly to review financial, quality, and staff measures. Using the Studer Group and Just Culture framework, the goal is to push the entire staff to a high level of performance by looking at improving processes and not blaming individuals.

For example, AAMC identified a desire to improve their emergency department (ED) throughput times for those patients admitted to the facility. The team engaged in a Lean process and met daily at the mission control board to review previous day performance for each patient. Through a comprehensive root cause analysis, the team decided to move to a pull environment, rather than a push. In other words, once the ED

clinician has determined the patient will be admitted, the patient becomes the responsibility of the inpatient unit. The receiving unit is notified, and a nurse comes to the ED where they complete a bedside handoff before taking the patient back to the floor. This process helps to account for limited resources in an ED that sees over 13,000 patients a year and keeps the patient at the center of the process.

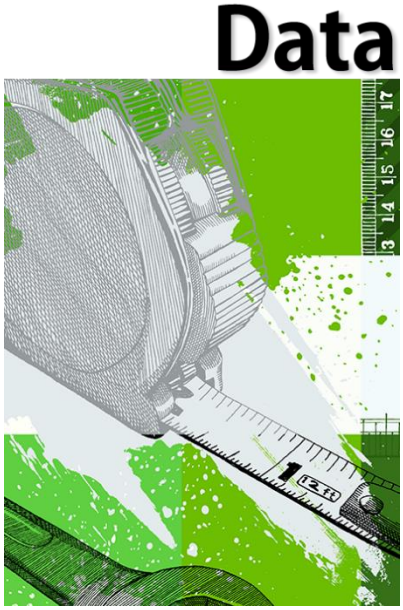
In another example of patient-centered care, AAMC has adopted a unique approach to reducing readmissions. They created guidelines for the top three readmission areas: pneumonia, chronic obstructive pulmonary disease, and chronic heart failure. Patients with any of these three diagnoses are automatically discharged to receive home health. At discharge, patients are sent home with a diagnosis-specific kit that contains much of the equipment they will need when receiving home health.

AAMC's ED Mission Control Board, which emphasizes A3 thinking and creates awareness through visual management.

Patients are seen at home three days in a row immediately following discharge. On day one they are visited by the home health admission nurse. Day two, a nurse visits to start the protocol. On day three, when appropriate as determined by diagnosis, patients are visited by the respiratory therapist who saw them in the hospital. AAMC's commitment to this strategy means they will pay for all patients to receive these services even if they don't qualify for home health based on reimbursement requirements. Through this initiative and other related efforts, AAMC has been able to drop their readmission rates substantially, reaching zero readmissions for some chronic illnesses for as many as three months and hovering at six to seven percent for all-cause readmissions based on current internal data monitoring using standard industry definitions. Also, the fact that family doctors are seeing patients in the hospital and the clinic assists in care planning and continuity of care.

Another area where continuity can be seen is with regards to antibiotic stewardship. AAMC's contracted pharmacy is fully immersed in a statewide project on antibiotic stewardship. They've worked to create protocols in the ED regarding treatment of diagnoses including urinary tract infections, upper respiratory infections, and otitis media, tightening up the medications given in the ED and prescribed at discharge. The physician office practices have adopted these protocols as well, communicating a consistent message with patients about when antibiotics are and are not appropriate for use.

AAMC is an excellent example of a small hospital using innovation and a patient-centered approach to improve the care they provide to their community.

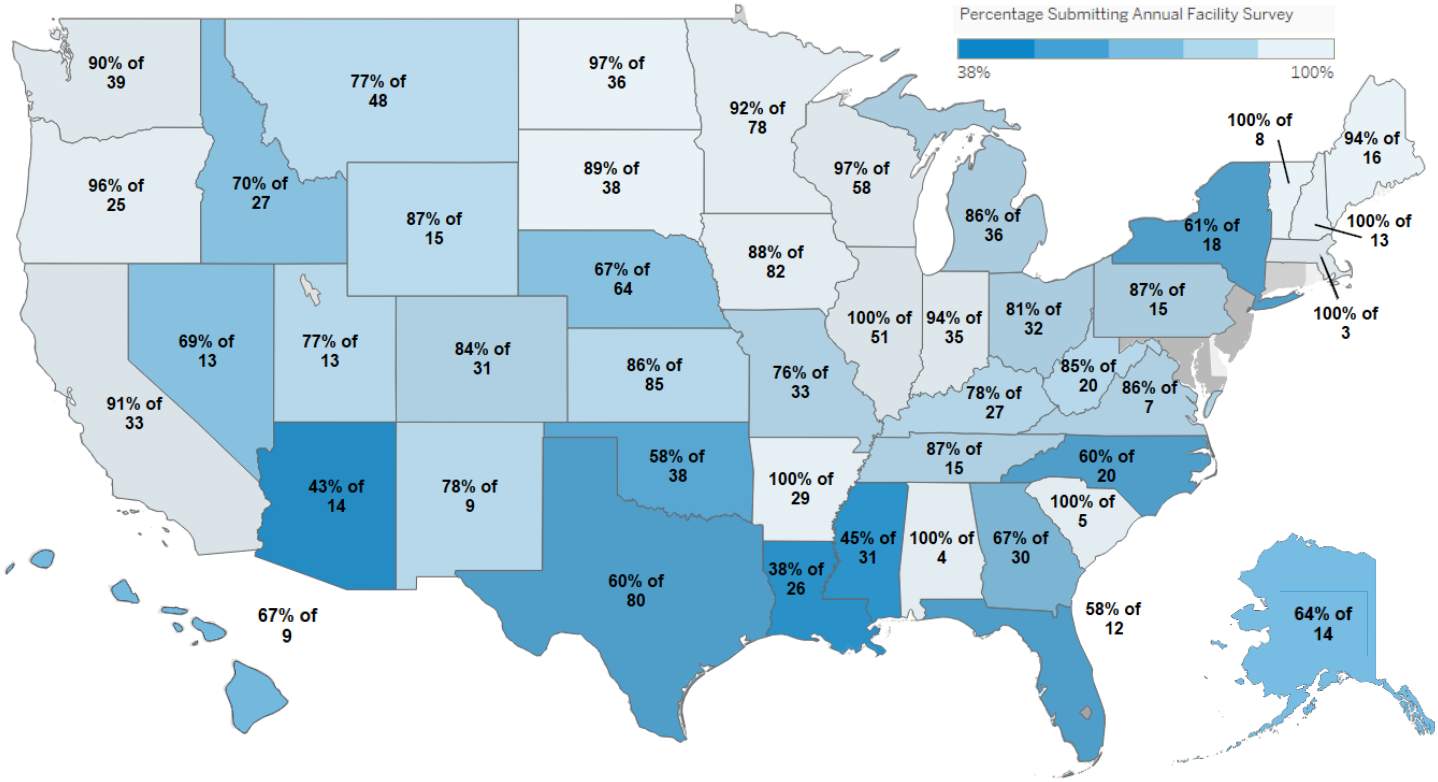


CAHs Measure Up: Annual Facility Survey

As part of MBQIP, each CAH is expected to begin implementing an antibiotic stewardship program – with the Centers for Disease Control and Prevention Antibiotic Stewardship core elements fully implemented by August 2022. The extent to which an antibiotic stewardship program is implemented is measured using data hospitals submit via the CDC NHSN Annual Facility Survey, so an essential first step in this requirement is to complete and submit that survey.

While the recommendation is to complete the survey for the previous calendar year by March 1, hospitals can submit the survey at any point during the year – meaning that although it is recommended for hospitals to have already completed the 2017 Annual Facility Survey, hospitals are able to submit the 2017 Annual Facility Survey through December 31, 2018.

80 percent of CAHs participating in MBQIP have already submitted the 2017 Annual Facility Survey as of August 2018. Where does your state stand? Has your hospital submitted the survey?



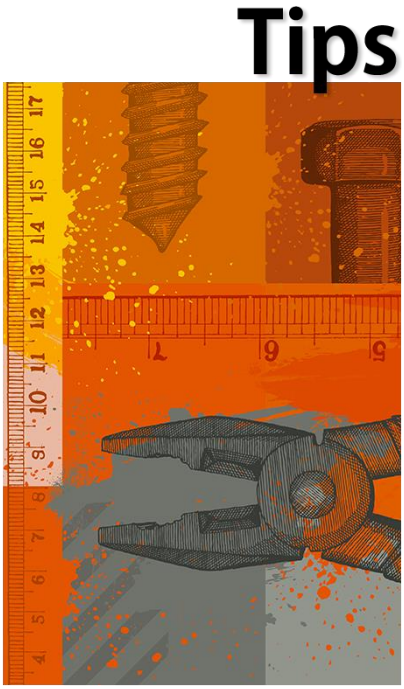
Not sure if your hospital has submitted the Annual Facility Survey? Check page four of your most recent MBQIP Patient Safety and Inpatient/Outpatient Quality Report to see if your hospital has data included. Instructions for enrolling in NHSN and completing the survey can be found on page 12 of the MBQIP Quality Reporting Guide.

Measure Updates

CMS Announces Upcoming Removal of Inpatient Measures
CMS has announced that three chart-abstracted inpatient measures that are currently required for MBQIP will be removed:

- Two of the measures will be removed following Q4 2018 data submission (anticipated deadline May 15, 2019):
  - IMM-2: Influenza Immunization
  - ED-1: Median Time from Emergency Department (ED) Arrival to ED Departure for Admitted ED Patients
- One of the measures will be removed following Q4 2019 data submission (anticipated deadline May 15, 2020):
  - ED-2: Admit Decision Time to ED Departure Time for Admitted Patients

Reporting on these chart-abstracted measures should continue until they are no longer available for submission.



Robyn Quips - tips and frequently asked questions

Abstracting for Accuracy Findings
In upcoming issues of MBQIP Monthly, I'll be reviewing some of the topics that came to light from the Abstraction for Accuracy Pilot project. Abstraction for Accuracy offers CAHs an opportunity to validate their abstraction with an RQITA abstraction professional – which in this case was me. One common issue found in the pilot project was that abstractors were not always sure of the population (which records should be abstracted) for each measure set. In this column, I'll review the Emergency Department Transfer Communication (EDTC) and Outpatient ED Throughput (OP-18 & OP-20) measure set populations.

EDTC Population
The population of the EDTC measure consists of those patients seen in your hospital's ED who were then discharged/transferred to these facilities:

- Hospice Health Care Facility
- Another Acute Care Facility which includes:
  - PPS Hospitals, CAHs, Cancer Hospitals
  - Children's Hospitals
  - Department of Defense or VA Hospitals.
    (This does include the emergency department of these hospitals.)
- Other Healthcare Facilities such as:
  - Extended or Intermediate Care Facility (ECF/ICF)
  - Long Term Acute Care Hospital (LTACH)
  - Long Term Care Facility
  - Nursing Home (including VA Nursing Facility)
  - Psychiatric Hospital or Psychiatric Unit of a Hospital, Rehabilitation Facility (including Inpatient Rehab Facility/Hospital or Rehab Unit of a Hospital)
  - Skilled Nursing Facility (SNF)
  - Sub-Acute Care or Swing Bed
  - Transitional Care Unit.

ED patients who have been put in observation status and then transferred to another hospital or healthcare facility should be included.

Patients excluded from the population include those discharged/transferred:

- Home – which includes Assisted Living Facilities, Court/Law Enforcement (detention facilities, jails, prisons)
- Board and Care (foster or residential care, group or personal care homes, homeless shelters)
- Home with Home Health Services
- Outpatient Services (including outpatient procedures at another hospital, Outpatient Chemical Dependency Programs, Partial Hospitalization)
- Hospice-Home
- Expired
- AMA (left Against Medical Advice)

It's important to note that it does not matter where a patient resides before admission to the ED, the population is determined by where they are discharged/transferred. For example, even though a patient may live in a nursing home, if they are discharged/transferred back to the nursing home that is considered an "Other Healthcare Facility" and those patients should be included in the EDTC population. It does not matter if your facility codes these patients as discharged to "home", for the EDTC abstraction these patients are going to an "Other Healthcare Facility".

OP-18 and OP-20 Hospital Outpatient Emergency Department Throughput Population

The population of the OP-18 and OP-20 measures is identified by only one requirement: they need to have an E/M code. The table below can also be found in the Hospital Outpatient Quality Reporting Specifications Manual, in Appendix A, OP Table 1.0.

OP Table 1.0: E/M Codes for Emergency Department Encounters

Code	Shortened Description
99281	Emergency department visit, new or established patient
99282	Emergency department visit, new or established patient
99283	Emergency department visit, new or established patient
99284	Emergency department visit, new or established patient
99285	Emergency department visit, new or established patient
99291	Critical care, evaluation and management

It is important to note that for patients who are seen in your ED and then directly admitted to your hospital as an acute care inpatient, these ED encounters should not be included in the Outpatient ED Throughput measures. Even though your hospital may bill these ED visits separately from the inpatient stay and they have E/M codes, for this abstraction those visits are considered to be part of the inpatient record. That ED visit will be abstracted as part of the Inpatient ED measures.

Since there is no discharge diagnosis code or specific age requirement for OP-18 and OP-20, everyone who is discharged/transferred outside your hospital is part of that population. The only time you would have no cases to abstract for these measures is if you had no patients that were seen in your ED for the quarter, or all of them were directly admitted as inpatients. Both situations seem unlikely so if you are claiming a population of zero for your OP-18 and OP-20 you are probably not following the population requirement instructions.

Next month I'll go over the population requirements for the Outpatient AMI and Chest Pain measures and the Inpatient ED and IMM measures.

Thank you to the CAHs that participated in the Abstraction for Accuracy Pilot Project; I hope it was as great of a learning experience for you as it was for me. We are going to continue to offer this service, look for information in the tools and resources section.

Go to Guides

Hospital Quality Measure Guides

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

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
October 10, 2018 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)

MBQIP Data Submission Deadlines - Updated
Chart showing MBQIP data submission deadlines through Quarter 4 2018.

New Report: National Quality Forum (NQF) Measures Application Partnership (MAP): A Core Set of Rural-Relevant Measures and Improving Access to Care. This report describes the selection criteria and processes used by the MAP Rural Health Workgroup to generate the core set of the best available rural-relevant measures to address the needs of the rural population, catalogs the core set of measures along with the rationale for inclusion for each measure, summarizes measurement gap areas identified by the Workgroup, and presents the Workgroup's recommendations on access to care from a rural perspective.

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

- **Healthcare Professional Flu Measure (OP-27) Webinar**. This recorded webinar provides an overview of the Healthcare Professional Flu Measure (OP-27) including how to sign up for an account through the National Safety Healthcare Network (NHSN), the measure submission process, and available quality improvement support.
- **A Toolkit for Long-Term Care Employers: Increasing Influenza Vaccination among Health Care Personnel in Long-term Care Settings**. Although focused on long-term care settings, this new resource from the Centers for Disease Control and Prevention (CDC) provides strategies and resources to support vaccination among health care personnel that also may be applicable in hospital settings.

StratisHealth

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