MBQIP Monthly

Medicare Beneficiary Quality Improvement Project

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

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: Jefferson Healthcare Medical Center, WA

Jefferson Healthcare Medical Center in Port Townsend, Washington has grown significantly in recent years from a staff of 500, to around 800, supporting a broad range of services including home health, hospice, palliative care, inpatient and outpatient surgery, imaging and radiology, and an active family birth center. The organization has adopted the Institute for Healthcare Improvement framework, with a goal that every member of the care team recognizes their role in maintaining high quality and keeping patients safe. The care team at Jefferson encompasses not only physicians and nursing staff, but also volunteers, ancillary staff, patients, and their family members.

Jefferson Healthcare's Patient and Family Advisory Council (PFAC) includes five community members and five staff representatives. Through the PFAC, Jefferson makes the most of the strong desire from patients and families to engage in the facility. In some cases, those who express interest in the PFAC end up focusing on a specific initiative. They also have tapped into the wealth of knowledge and expertise patients and families offer. The community has the oldest demographic in the state of Washington, including retired professionals looking for opportunities to volunteer their time and services. Recently, a PFAC member who is a retired nurse and bio-ethicist helped relaunch the hospital's ethics committee at no cost to the facility.

Jefferson engaged their PFAC as they tackled the discharge process, which included improving their performance for the related HCAHPS patient satisfaction survey composite. With PFAC help, they redesigned an un-utilized patient notebook, to incorporate a discharge planning checklist and other tools intended for patient and family use during the hospital stay. The PFAC also assisted in reviewing a vendor-developed discharge folder. Together the team identified what was most important for the patient, noting items that should be reviewed during the stay and what to discuss at the time of discharge. Both the patient notebook and the discharge folder are now actively utilized tools, and Jefferson performs at a 5-star level, with 93 percent of patients responding positively in the most recent HCAHPS data.

Emphasis on community partnerships extends beyond the PFAC and community volunteers. Working closely with the county-based emergency medical service (EMS) has been integral to improving process times for the high rate of AMI and chest pain patients seen in the emergency department

(ED). Jefferson partnered with EMS on coordinated community messaging focusing on the importance of seeking care when one experiences symptoms of chest pain or a stroke. Part of that message includes calling for help and not driving yourself to the hospital. This ensures safe passage and earlier intervention for the patient, while also allowing EMS to give the ED information on the patient before arrival. In the case of chest pain patients, Jefferson's STEMI activation team is immediately paged and waiting in the ED to launch into their chest pain protocol.

The Jefferson Healthcare Medical Center Surgical Services Team huddle up for patient safety.

The ED identified opportunities for improvement related to throughput times for patients admitted to the facility. The team recently received grant funding to address the issue further, but they have an idea of contributing factors based on preliminary analysis. Patients seen in the ED can't be admitted until there is a bed ready for them, and often patients in the hospital are kept later in the day due to social factors, such as not having a ride or wanting to ensure the patient gets a hot meal before leaving the facility. The team has launched a process improvement (PI) project to address these related workflow issues.

Jefferson's antibiotic stewardship team is another PI project with promising results. The team's initial focus was on reducing days of therapy (DOT). Jefferson Healthc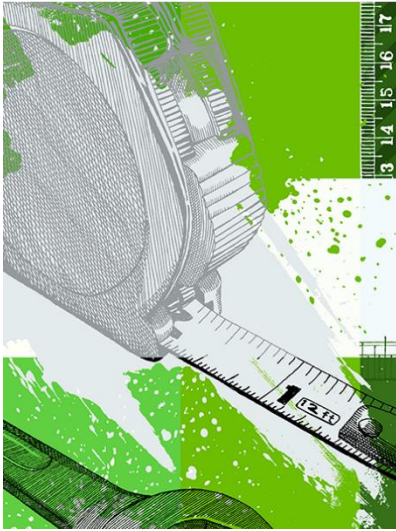are actively participated in the Washington Hospital Association's Hospital Improvement Innovation Network (HIIN), tracking and reporting on DOT. The pharmacist was integrated into the daily huddle to address opportunities for de-escalation, and the team is planning a more focused study looking at antibiotic use by individual providers based on different diagnoses in comparison to the antibiogram.

RNs Lee Sperry and Andrea Golden in the Jefferson Healthcare Medical Center emergency department.

A reduction in DOT was accompanied by an increase in rates of *C. difficile*, leading to the implementation of a *C. difficile* task force. The task force worked with the lab, hospitalist team, providers, and infection preventionists to ensure that proper testing protocols were being utilized. This included adopting changes to the testing algorithm and instituting a hard stop in the lab if a sample is received that doesn't meet the criteria for *C. difficile* testing. In the first half of 2018, Jefferson has had zero *C. difficile* infections, while maintaining their gains related to DOT for antibiotics.

Jefferson Healthcare Medical Center is a model of how a small hospital can use engagement and commitment to continuous improvement to provide the best care to their community.
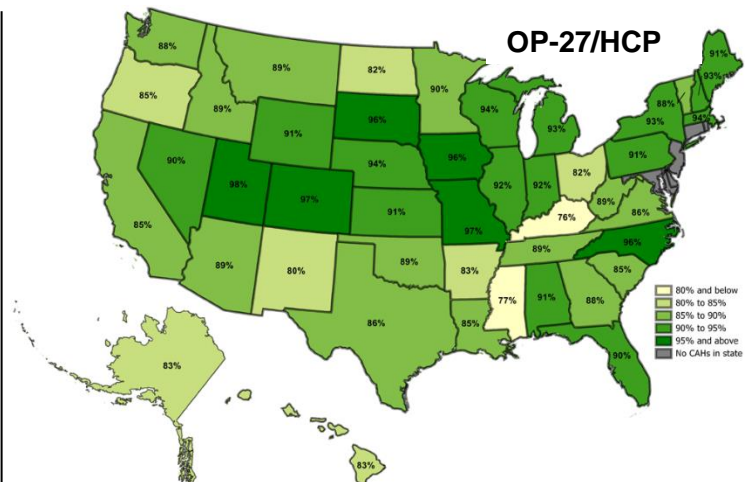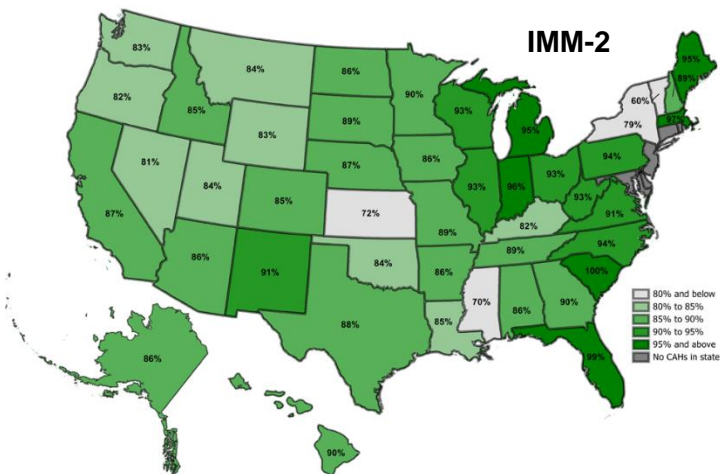
Data

Measuring the Influenza Season

The 2018-2019 influenza season is upon us. CAHs participating in MBQIP report two influenza-related measures for the program:

- The most current data available for IMM-2, or influenza immunization for patients, is for vaccines given during the 2017-2018 influenza season. These IMM-2 rates are on the second pages of your Q4 2017 and Q1 2018 MBQIP Patient Safety and Outpatient Data Reports.
- OP-27/HCP, or influenza vaccination coverage among healthcare personnel, is reported once a year via NHSN—the Centers for Disease Control and Prevention's National Healthcare Safety Network. The most current OP-27/HCP rate is on the third page of your Q1 2018 MBQIP Patient Safety and Outpatient Data Report. The numbers represent vaccinations given during the 2017-2018 influenza season.

The two maps below show 2017-2018 influenza season state rates for IMM-2 (both quarters) and OP-27/HCP. (CAHs that didn't report don't contribute to the state rates.)

For the measures covering the last influenza season (2017-2018):

- IMM-2 had an 88.1% national average immunization rate; 1,027 CAHs reported immunization data for at least one of two quarters (up from 968 CAHs in the prior season)
- OP-27/HCP had an 89.9% national average immunization rate; 1,030 CAHs reported (up from 953 CAHs for the previous season)
- Though the national averages were similar, some states had great variability between rates. Among the CAHs that reported, patient immunization rates ranged from 28 percentage points lower to 15 percentage points higher than the immunization rates for CAH healthcare personnel
  - 22 states had CAH patient populations with lower rates than health care workers
  - 20 states had CAH patient populations with higher rates than health care workers
  - Three states had the same immunization rates across patients and health care workers

How did your state perform during the 2017-2018 flu season? How did your hospital compare to the state? Did you improve compared to the 2016-2017 flu season? Check your MBQIP data reports to see. Contact your state Flex program with questions about the reports.

Where do you want to be this influenza season?

Tips

Robyn Quips - tips and frequently asked questions

Abstraction for Accuracy Findings: Determining Measure Populations, Part Two

Continuing to focus on findings from the Abstraction for Accuracy project, I'll again talk about measure populations. This month's column will describe the measure population requirements for the Outpatient AMI, Chest Pain, and Inpatient IMM and ED measure sets.

AMI Measure Set
The criteria for determining the AMI population is patients:
- Seen in a hospital emergency department, with 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
- With an 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 emergency department (ED) and are transferred to 1) another acute care hospital (this doesn't 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 date element for abstracting, these are patients who have a value of 4a Acute Care Facility-General Inpatient Care or 4d Acute Care Facility-Department of Defense of Veteran's Administration. These are discharge codes from the Specifications Manual; they may not match your billing discharge status codes.

For determining the code, use the principal diagnosis code at *discharge*. Do not use a code that might be given on admission.

Even though a couple of the AMI measures have been removed from abstraction, that doesn't matter when pulling your population. You are pulling cases for the AMI measure set, not any one particular AMI measure. Cases that meet the above requirements make up your AMI population and should be abstracted.

Chest Pain Measure Set
The criteria for determining the Chest Pain population is patients:
- Seen in a hospital emergency department and with 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
- With an age on the Outpatient Encounter Date of greater than or equal to 18 years
- With an ICD-10-CM Principal or Other Diagnosis Code for AMI listed in Appendix A, OP Table 1.1a of the Hospital Outpatient Quality Reporting Specifications Manual

The population for the Chest Pain measure is very similar to the AMI except for the diagnosis code requirement. The code on discharge can be either the principal diagnosis code or other diagnosis code (sometimes referred to as a secondary code) for the case to fit in the Chest Pain measure set. However, any patient who has an ICD-10-CM Principal Diagnosis Code for AMI is not eligible for the Chest Pain measure set, even if they have a secondary chest

pain code. Those patients will fall into your AMI population, and they shouldn't be abstracted in both measure sets.

The population for Chest Pain remains the same as it has been, even though one of the measures was removed for abstraction.

The things to remember are these populations do not include patients who are seen in your ED and then admitted to your facility, and use the ICD-10 diagnosis codes given upon discharge, not admission.

Inpatient IMM-2 and ED Measures
These two measures sets are part of CMS's Global Hospital Inpatient Quality Measures, and the population requirements can be found in that section of the Specifications Manual for National Hospital Inpatient Quality Measures.

The population for these measures is: All patients discharged from your hospital's acute inpatient care with a length of stay less than or equal to 120 days. So assuming that no one in your hospital was there for 120+ days, your population would be all your inpatients that were discharged for the quarter. Unless you had no inpatient discharges for a quarter, your population would never be zero.

The population doesn't say only include certain months of the year, or only if the patient was seen in the ED. It's ALL patients discharged from acute inpatient care. If you had 20 inpatients discharged for the quarter, you would have 20 IMM chart abstractions and 20 ED abstractions. Each of those 20 patients would be abstracted for the IMM measure and the ED measure. Maybe they weren't seen in the ED, or maybe they were discharged outside of what is considered to be the flu season, it doesn't matter; if they fit the population requirement – all patients discharged from acute inpatient care with a length of stay less than or equal to 120 days – they must be abstracted.

So why are these ED measures part of the Inpatient Quality Measures when it's about what's happening in the ED? These measures look at patients who are seen in your ED and then admitted to your hospital. Patients who are seen in your ED and transferred elsewhere are part of the Outpatient Quality Measures. For this measure abstraction, what happens during the ED encounter becomes part of the inpatient stay. Even though your hospital might bill this ED encounter separately, the population is based on acute care inpatient discharges, so you must include the ED documentation in your abstraction for these measures. This seems to be causing problems in abstraction.

For example, say you have Jane Doe, who was admitted as an acute care inpatient on 6/10/18 and was discharged on 6/15/18. Is she part of the IMM and ED population? Yes, because she was discharged from acute inpatient care with a length of stay of fewer than 120 days. Was she admitted during the flu shot season? No. Was she seen in the ED and then admitted? No. Well, then why would she be abstracted for the IMM and ED measure? Because there is nothing in the population requirements about needing either of those to occur. She was discharged from acute care with a length of stay less than 120 days, period. That makes the case part of the population.
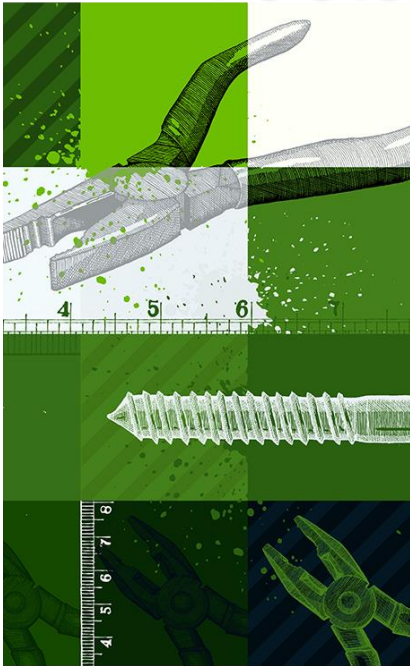
Try to remember that the measure population requirements are separate from the actual individual measure requirements. First, you pull your measure set population. You abstract all the cases that meet the population requirements. How you answer the data element questions will determine if the case is included or excluded and then whether it passes or fails the individual measures.

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.

Updated! ### HCAHPS Overview: Vendor Directory
This guide, from the National Rural Health Resource Center, updated August 2018, provides information on the Hospital Consumer Assessment of Healthcare Providers and Systems (HCAHPS) including vendors, to guide small rural hospital and CAH vendor selection of this important, patient-centered survey process.

Updated! ### Interpreting MBQIP Hospital Data Reports for Quality Improvement
This guide assists CAH staff in using MBQIP data reports to support quality improvement efforts and improve patient care, and has been updated to reflect recent additions to the MBQIP Patient Safety and Inpatient/Outpatient Hospital Data Reports.

Huddles as a Strategy for Quality and Safety
From the Institute for Healthcare Improvement. Daily huddles can give teams a way to actively manage quality and safety, including a review of important standard work such as checklists.

- Information on implementing daily huddles
- Recorded webinar: Sustaining and Strengthening Safety Huddles

Get Ahead of Sepsis
Educational materials and resources from the Centers for Disease Prevention and Control focused on early recognition and timely treatment of sepsis.