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: Antibiotic Stewardship in Action

Happy summer! We hope this finds you enjoying the summer months and managing to keep cool wherever you are. This special edition of Rural Success will take a look back at the lessons learned from the 2018 articles to date, specifically as they relate to steps for combatting antibiotic resistance, and share some key resources for assisting facilities in implementing an antibiotic stewardship program.

As announced in Fall 2017, the Federal Office of Rural Health Policy (FORHP) has added antibiotic stewardship as a core measure of the Medicare Beneficiary Quality Improvement Project (MBQIP) under the domain of Patient Safety and Inpatient measures. Data for the measure is collected via the Centers for Disease Control and Prevention (CDC) National Healthcare Safety Network (NHSN) Annual Facility Survey. In addition to a variety of other data, the survey (completed early each calendar year) captures self-assessment information from hospitals regarding activities related to antibiotic stewardship. NHSN then crosswalks answers from those questions to ascertain how many and which of the seven core elements of antibiotic stewardship have been implemented at each facility. It is the goal of FORHP that critical access hospitals (CAHs) have a fully implemented antibiotic stewardship program by August 2022.

State Flex Programs recently received the first quarterly reports containing data for the antibiotic stewardship measure. Hospital reports reflect whether or not the facility has indicated implementation of each of the seven core elements of antibiotic stewardship and allow an opportunity to compare individual hospital performance in this area with state and national averages.

Over the past six months, the hospitals featured in the MBQIP Monthly CAHs Can series have offered some great examples of actions implemented to improve antibiotic stewardship.

- **Integrate pharmacy into team and/or bedside rounding**. This can look different depending on the facility, patient population, and resource availability, but hospitals are recognizing the vital role pharmacy plays in care planning and patient education. Integration might take the form of pharmacy involvement in daily or weekly rounds on patients receiving antibiotics, or explicitly targeting those patients on antibiotics who are set to be discharged.

Leadership commitment
Demonstrate support and commitment to safe and appropriate antibiotic use in your facility

Accountability
Identify physician, nursing and pharmacy leads responsible for promoting and overseeing antibiotic stewardship activities in your facility

Drug expertise
Establish access to consultant pharmacists or other individuals with experience or training in antibiotic stewardship for your facility

Action
Implement **at least one** policy or practice to improve antibiotic use

Tracking
Monitor **at least one process** measure of antibiotic use and **at least one outcome** from antibiotic use in your facility

Reporting
Provide regular feedback on antibiotic use and resistance to prescribing clinicians, nursing staff and other relevant staff

Education
Provide resources to clinicians, nursing staff, residents and families about antibiotic resistance and opportunities for improving antibiotic use

- **Incorporating antibiotic education and follow-up into care transitions**. In addition to meeting patients during care rounds, some pharmacists complete follow-up calls to patients discharged on antibiotics to ensure smooth transitions of care related to medication therapy. Another option is to provide and review specific discharge instructions developed for those patients receiving hard-hitting antibiotics.
- **Pharmacy consult and/or review of orders**. Some hospitals have ensured pharmacist availability for clinician consults regarding the appropriate antibiotic treatment, including dose and duration, while others have triggered an automatic pharmacy review of antibiotic orders, which is followed by a consult with the clinician if there is a better option for treatment or the indication for such treatment is unclear.
- **Appropriate testing and treatment for the patient population**. Knowing when to use antibiotics and which ones will be most effective is key to antibiotic stewardship. Some hospitals can leverage work by larger, nearby facilities in adopting an antibiogram or establishing treatment guidelines. Others have focused on specific infections, such as ensuring appropriate testing for *C. difficile* to avoid unnecessarily treating patients who are merely colonized, or decreasing use of broad-spectrum antibiotics for non-complicated urinary tract infections.

In addition to the examples provided above, below are a few key resources to support hospitals in their antibiotic stewardship work. As with other quality initiatives, implementing an effective antibiotic stewardship program requires time and resources, things we know are at a premium in CAHs. However, as with other quality initiatives, once a CAH has committed to moving forward with an antibiotic stewardship program, there are many benefits to be gained by CAHs regarding their ability to be nimble, focused, and fiercely committed to their patients and community.

Key Resources:
Implementation of Antibiotic Stewardship Core Elements at Small and Critical Access Hospitals
This document provides guidance on practice strategies to implement antibiotic stewardship programs in CAHs and other small hospitals.

Jump Start Stewardship Toolkit: Implementing Antimicrobial Stewardship in a Small, Rural Hospital
This workbook provides small hospitals with guidance and tools, including a framework and strategic plan for implementing a feasible, small-scale stewardship program tailored to its unique characteristics.

National Healthcare Safety Network Annual Survey Resources
This document provides hospitals with step-by-step instructions on how to add the Patient Safety Component and access the NHSN Patient Safety Component Annual Survey, to meet the reporting requirements for antibiotic stewardship.

Quality Improvement Implementation Guide and Toolkit for CAHs
This guide and toolkit offer strategies and resources to help CAH staff organize and support efforts to implement best practices for quality improvement. The Quality Improvement Measure Summaries for MBQIP resource includes suggested strategies and best practices for each of the core MBQIP measures, including antibiotic stewardship.

Data
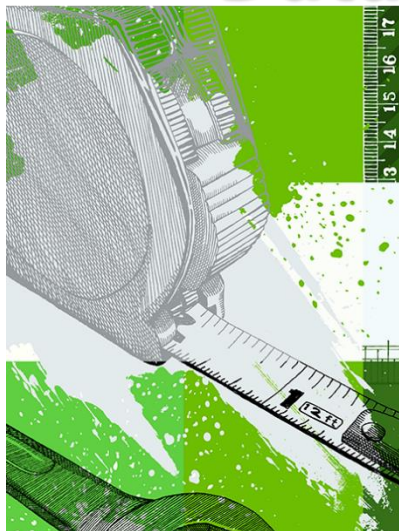
CAHs Measure Up: Preliminary Abstracting for Accuracy Results

This spring, RQITA offered an "Abstracting for Accuracy" opportunity to CAHs to help quality staff ensure the accuracy of their abstracted quality measure data. RQITA Quality Reporting Specialist Robyn Carlson provided individualized abstraction consultation tailored to the needs of hospitals and abstractors. Each participating hospital abstracted a set of records for MBQIP measures, and Robyn independently abstracted the same set of records. The hospitals and Robyn then compared their element-by-element results to help identify areas that may need further explanation or clarification.

Through the next several MBQIP Monthly issues, we will be highlighting lessons learned and key takeaways; we are also compiling them into an abstraction tips summary. An overview of the findings by measure and measure set details is below and highlights areas with the most opportunity for improvement in abstraction accuracy.

Measure Set	Percent of Abstractions Agreeing with Robyn	Total Sets of Abstractions	Sets of Abstractions with Correct Population
AMI	94.4%	32	100%
Chest Pain	73.1%	28	75%
ED Throughput	91.3%	32	97%
EDTC	90.2%	33	NA
IMM	87.8%	34	97%
Inpatient ED	88.5%	34	97%
Pain Management	86.3%	34	94%

Most frequently incorrect data elements, by measure set:
- **AMI**: Earliest Time Arrived
- **Chest Pain**: Earliest Time Arrived
- **ED Throughput**: Provider Contact Time
- **EDTC**: Data elements 23 (Immobilizations) and 7 (Patient Contact Information)
- **IMM**: Discharge Disposition and Flu Vaccine Status
- **Inpatient ED**: ED Departure Time
- **Pain Management**: Pain Medication Time

Stay tuned for more details on common errors or misconceptions, comments by measure set and population, and tips for how to improve your own abstractions!

Tips

Robyn Quips - tips and frequently asked questions

CART Tool Updates

A patch to the CMS Abstraction and Reporting Tool (CART) Outpatient version 1.16 was released on June 9 and is available on the QualityNet website. The patch is version 1.16.1 and can be used for encounter dates January 1, 2018 – March 31, 2018 (Q1 2018) and April 1, 2018 – December 31, 2018 (Q2 2018-Q4 2018).

This patch includes the removal of measures OP-1, OP-4, OP-20 and OP-21 which go into effect beginning with April 1, 2018 encounters.

If you have CART Outpatient version 1.16 already installed, you can enter and submit your Q1 2018 cases before downloading the patch since the above measures must still be reported for this quarter. After you have submitted those cases to the QualityNet warehouse and are ready to start abstracting Q2 2018 cases, install the outpatient patch version 1.16.1. You will need to go in the Provider Information Screen to Provider Preferences and set up CART for the 4/01/2018 – 12/31/2018 time period. This version has been adjusted for that time period and does not contain the data element questions for those removed measures.

If you did not update to CART version 1.16 and still have version 1.15.1, you will need to update CART before you can enter any 2018 encounter data. Version 1.16 is no longer available; you will need to download version 1.16.1. NOTE: Don't follow the patch download instructions, instead use the "Upgrading an existing CART installation" instructions.

Make sure to set your Provider Preferences for Q1 2018 (01/01/2018-03/31/2018) to include all the OP AMI, Chest Pain, ED, and Pain Management measures. After you have submitted and are ready to enter Q2 cases, go back to the Provider Preferences and select the measures for the next time period.
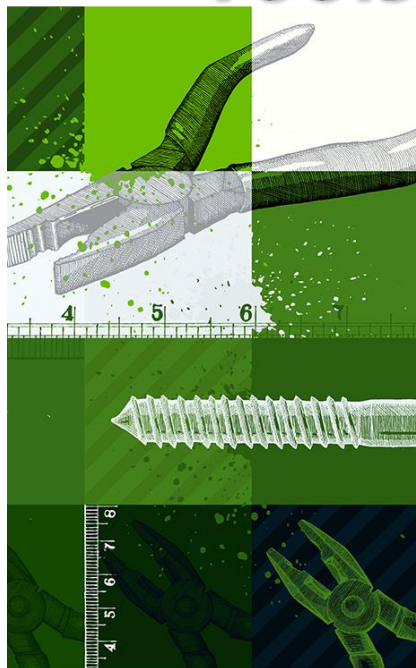
Go to Guides

Hospital Quality Measure Guides

- MBQIP Quality Reporting Guide

- Emergency Department Transfer Communications

- Inpatient Specifications Manual

- Outpatient Specifications Manual

Tools

Tools and Resources

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).

Hospital Quality Institute HCAHPS Resources
HCAHPS Improvers Playbook: Includes a focus on increasing HCAHPS response rates.
Journey to a Quiet Night: Strategies to reduce hospital noise and promote healing.

UDS Crosswalk to Quality Reporting Programs
This table highlights the alignment between Uniform Data Set (UDS) measures and other quality reporting programs. Intended to help health centers identify which UDS measures are being utilized by other programs such as CMS Accountable Care Organizations (ACOs), and CMS Quality Payment Program (QPP).

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.

Stratis Health   www.stratishealth.org