

## Medicare Beneficiary Quality Improvement Project



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

### In This Issue

**1 CAHs Can!**  
How Critical Access Hospitals Improved Patient Experience During the Pandemic

**3 Data: CAHs Measure Up:**  
HCAHPS Performance in 2021

**4 Tips: Robyn Quips – tips and frequently asked questions:**  
CART Tool

**5 Tools and Resources:**  
Helping CAHs succeed in quality reporting & improvement

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.

## How Critical Access Hospitals Improved Patient Experience During the COVID-19 Pandemic

The COVID-19 pandemic dramatically changed health care delivery, disrupting the normal flow of daily clinical practices and how patients, their families, loved ones, clinicians, and other health care staff [interact within the health care system](#). Yet, amidst this disruption, critical access hospitals (CAHs) found innovative pathways to improve patient and clinician communication, mitigate the stress and anxiety suffered by patients and their families because of altered visiting policies, and meet the health care needs of their patients while safeguarding best practices for patient experience, during an unprecedented global health care crisis.

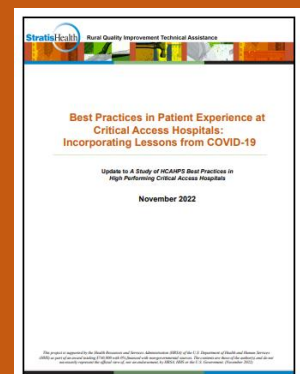
In August 2022, the virtual critical access hospital (CAH) HCAHPS Best Practice Summit was held with 12 high-performing CAHs from 12 states. Participating hospitals were sent a pre-Summit survey before the virtual discussion. They were asked to identify creative approaches implemented during the pandemic to address challenges from changing visitation policies or other COVID-related adaptations.

The following are some of the innovative strategies these high-performing CAHs implemented to improve patient experience based on their lessons learned from the pandemic. Strategies were grouped into these main categories: **technology, visiting policies, physical structure, clear and consistent communication, and cross-staff support.**

### Technology

Most summit hospitals provided patients with hospital-purchased tablet computers to facilitate virtual visiting hours via video chat and/or social media platforms. Care conferences, additional meetings with the care team, and specialty follow-up visits were conducted using virtual meeting platforms to

Read the full report: [Best Practices in Patient Experience at Critical Access Hospitals: Incorporating Lessons from COVID-19.](#)



allow for family presence and engagement, eliminating unnecessary travel and maintaining social distancing practices. Hospitals also leveraged virtual platforms to train family members to provide home-based support post-discharge.

Many hospitals also began using or increased their use of telemedicine (the use of technology that enables remote health care, also called telehealth) as a care delivery platform, expanding access to care.

### Visiting Policies

Varying approaches and strategies were used to accommodate visitation restrictions, such as scheduled visits, placing patients in single rooms to the extent possible, aligning visitation thresholds with positivity rates in the area, and working with families to stagger visitors to allow for a quarantine period after visiting a COVID-positive patient.

Several hospitals created a “support person” or “support partner” program to give a designated individual enhanced access to the care team when regular visitation was either restricted or eliminated.

### Physical Structure

Some hospitals created visiting spaces outside ground-level patient rooms by putting room numbers on the windows and providing canopies to protect visitors from the elements. In addition, hospitals planted flowers, added artwork, and installed bird feeders to make the outdoor space (the “outside hallway” for the patient) more inviting for patients and visitors. This approach made it possible for hospitalized patients to visit with their families, friends, and even pets – an integral part of the healing process – with reduced risk of exposure.

### Clear and Consistent Communication

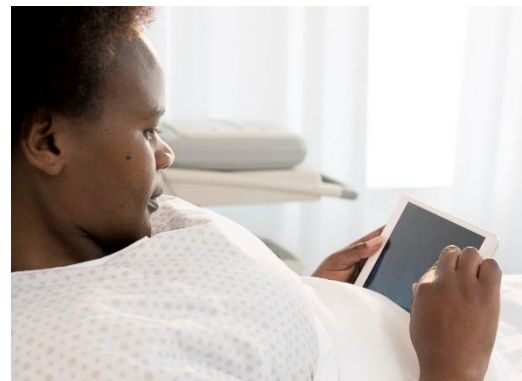
Using a variety of venues, including television, radio, and social media, hospitals made a concerted effort to inform patients, families, and the community what to expect at regular intervals as the pandemic evolved and guidelines were updated or changed.

### Cross-Staff Support

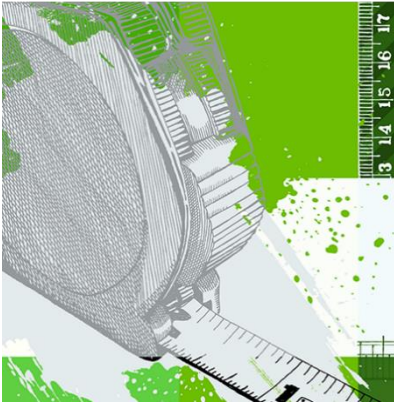
Hospitals cultivated a spirit of teamwork and cross-trained staff, making it easier to allocate staff to the areas of highest need. For example, several hospitals increased their housekeeping staff and cleaning schedules to enhance cleaning in high-patient areas; some purchased expensive ultraviolet (UV) cleaning machines to promote cleanliness and strengthen infection prevention practices; and some hired more nurses to provide one-to-one care for COVID patients and stationed COVID screeners at entry points to help manage the flow of people into the hospitals.

In addition to the strategies above, several CAHs formed multidisciplinary incident command teams to make decisions and address challenges due to changing visitation policies and other COVID-related adaptations.

Best Practice Summit hospitals indicated they plan to continue many of these strategies as they adapt to the still-evolving care-delivery landscape.



# Data



## CAHs Measure Up: HCAHPS Performance in 2021

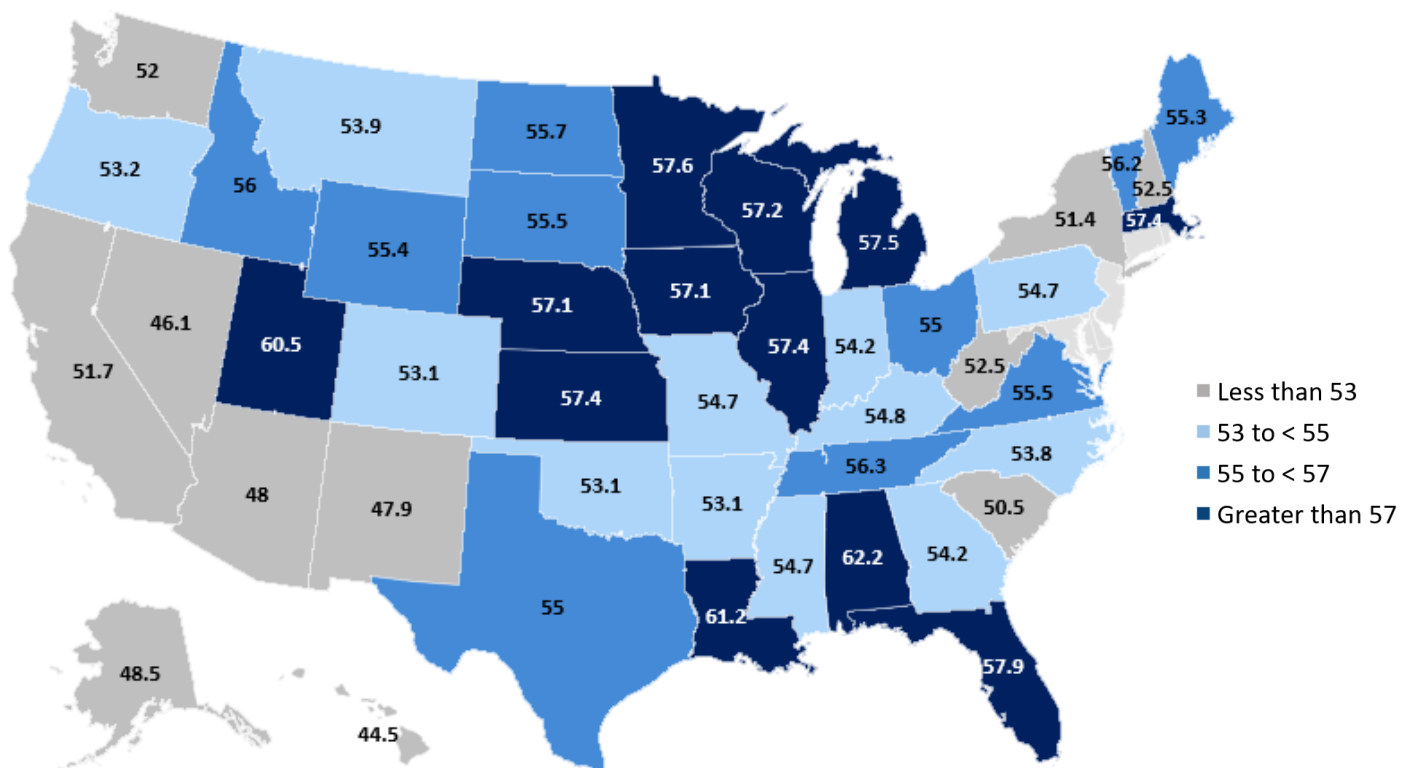
HCAHPS (Hospital Consumer Assessment of Healthcare Providers and Systems) is a national survey that provides a standardized way to measure patients’ perspectives on hospital quality of care. Each year, the Flex Monitoring Team (FMT) releases a set of reports summarizing HCAHPS reporting rates and performance for all CAHs across the nation and by state. The most recent [report](#), published in December 2022, summarizes CAH HCAHPS reporting and performance for discharges during calendar year 2021.

In 2021, 91.5 percent of CAHs reported HCAHPS survey data nationally – up from 89.8 percent of CAHs the year before and just 41.3 percent of CAHs 10 years earlier in 2011. Additionally, 112 states had 100 percent of their CAHs reporting HCAHPS data in 2021. Of the 1,243 CAHs reporting, only seven states had less than 80 percent of CAHs reporting HCAHPS.

The national performance rates for CAHs show that the highest rating of 88.4% was regarding staff giving patients information about recovery at home. This contrasts with the lowest rating for patients strongly agreeing that they understood their care upon leaving the hospital at 55.2%. This discrepancy may provide an opportunity for staff to evaluate the quality, quantity, and dissemination method of patient information and resources to improve their satisfaction and at-home recovery.

The map below shows an area of improvement for CAHs: Top-box performance for the Care Transition composite by state (the percentage of patients who said they “Strongly agree” that they understood care when they left the hospital). HCAHPS rankings by state can be found on page eight of the [FMT report](#).

**Care Transitions Composite Map:**  
Percent of patients who “Strongly agree” care understood when left hospital.





# Tips

## Go to Guides

### Hospital Quality Measure Guides

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

## Robyn Quips - tips and frequently asked questions

### CART Tool

CART, the CMS Abstraction & Reporting Tool, is an application for the collection and analysis of quality improvement data. Through data collection, retrospective analyses, and real-time reporting, CART enables hospitals to comprehensively evaluate and manage quality improvement efforts. CART assists hospitals in meeting the CMS measurement specifications for performance monitoring and data collection with a single application. It also maintains the security of patient data to comply with the Health Information Portability and Accountability Act (HIPAA).

The [CART Outpatient application](#) is available at no charge to hospitals seeking to improve the quality of care in the following clinical areas:

- **Acute Myocardial Infarction**
- **Emergency Department (ED) – Throughput**
- **Stroke**

The [CART Inpatient application](#) is available at no charge to hospitals seeking to improve the quality of care in the following clinical area:

- **Severe Sepsis and Septic Shock (SEP)**

Both CART versions are available for use on a stand-alone, Windows-based computer, in a computer network, or environments without computing resources ([paper tools](#)).

Since the MBQIP program currently doesn't include the inpatient chart abstracted measure, it is up to you if you want to install or continue updating inpatient CART.

CART has been designed to allow hospitals to abstract and edit medical record data, allowing for the answering of all questions or the use of skip pattern logic (in other words, skip some questions based on specified criteria). CART reports are available within the tool to preview detailed abstraction information as well as detail and summary measure outcome information for both providers and physicians.

The tool provides the ability to import or export abstractions in uniform billing file layout information. Administrative and demographic data from a Uniform Billing (UB-92) system can be imported into CART and, combined with the clinical data abstracted from medical records, then exported as XML files for submission to the QIO Clinical Warehouse. Uniform Billing File Layout information can be found [here](#).

To meet reporting requirements, once data collection is completed, hospitals must export their data from the tool and submit it to CMS Hospital Quality Reporting (HQR). Users must log in to their HARP account to access HQR and submit their CART data.

### CART Tips

If you use the CART tool for data submission, make sure to check and see that you have installed the most recent version. Don't go by the dates attached to the version. Those are there to let you know when you *must* use that version, not you can *only* use that version. People see the date range and then don't update to the most current version because they aren't entering data for that time frame yet. It doesn't always happen, but on occasion, a new version of CART is timed with changes made in the warehouse, and if you don't submit with that updated version, data can be rejected.

Your CART password does expire. According to the [CART Online Help Guide](#), a password change is required every 60 days. For those who didn't even know there was a guide, take time to look since it is a valuable resource. It is a must if you are downloading CART for the first time because you must follow specific steps for the initial login. You can also read about the different reports that can be run from the tool. Don't be put off by the 2017 date on the Guide. The instructions for using CART haven't changed.

Even if you aren't ready to enter or submit data, logging into your CART and HARP accounts at least once a month is good to keep them active. It might help you to remember your passwords, or at least if you need to change them, you can do so without the added stress of a looming due date! It also helps keep your accounts active, so you aren't locked out due to inactivity.

# Tools



## COVID-19 Information

Resources to support health care providers in responding to coronavirus disease 2019 (COVID-19) are continually updated. The Rural Health Information Hub and National Rural Health Association are regularly updating and adding links for Rural Response to COVID-19:

- [Federal and National Response Resources](#)
- [State Response Resources](#)
- [Rural Healthcare Surge Readiness](#)
- [COVID-19 Vaccine Rural Resources](#)

## [One-Stop Online COVID Prevention and Treatment in Every County.](#)

Enter your county to find local COVID-19 guidance and resources.

## MBQIP and Rural Health Resources

### Ask Robyn – Quarterly Open Office Hours Calls for Data Abstractors

Tuesday, April 25, 2023, 2:00 – 3:00 p.m. CT – [Register](#)

Sometimes it just helps to talk to someone! Quality Reporting Specialist Robyn Carlson will offer open office hours 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).

### [IDEAL Discharge Planning](#)

Resources from AHRQ that focus on key elements of engaging the patient and family in the discharge planning process. Part of the Guide to Patient and Family Engagement in Hospital Quality, IDEAL Discharge Planning resources include checklists, patient and clinician handouts, and other step-by-step guidance to help hospitals implement strategies to address common challenges.

### [Online Modules Available: Service Recovery in Health Care](#)

Designed with rural hospitals in mind, this short four-part recorded training series from Stratis Health is designed to equip health care professionals with the knowledge and tools to support service recovery training at their facilities.

### [Team STEPPS Video Toolkit](#)

Looking for tools and strategies to help you communicate effectively with colleagues, patients, and their families? Team Strategies and Tools to Enhance Performance and Patient Safety (TeamSTEPPS) is evidence-based and can be used by anyone who wants to improve communication and teamwork in health care. Brought to you by American Hospital Association Team Training and CDC's Project Firstline. This toolkit has been designed to help improve teamwork in health care. It highlights nine of the most used TeamSTEPPS tools using relatable scenarios, critical thinking prompts, and best practices examples.



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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