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.

CAHs Can. Absolutely, CAHs Can.

In the past year, MBQIP Monthly staff have had the privilege of talking with 11 of the many CAHs in our country that are fully participating in MBQIP and achieving top notch scores across every domain. From an Alaskan CAH with an average daily census (ADC) of less than one to a California CAH with an ADC more than 20. These CAHs have not let low volumes, limited resources, or frequent hat changes get in the way of providing nationally recognized excellence in patient care to their communities.

The most frequent drivers of MBQIP success relate to will and leadership. A decision made by leaders to pursue excellence is followed up by an unwavering commitment to expect nothing less than full participation and engagement by all disciplines of the health care team at all levels. Their pursuit of excellence is standardized, objective, and measureable.

Styles of leadership described involve blends of accountability, respect, visibility, service, and a forward-thinking attitude of readiness for potential changes in CAH payment structures. Leadership rounding is often identified as a practice that keeps non-clinical leaders in touch with what is happening at the bedside and accelerates performance improvement. The notions of teamwork and staff engagement also emerge often, recognizing that the best work happens when the people closest to it are actively involved in performance improvement, in an environment where every member is valued, respected, and challenged to continuously raise the bar. Finally, timely collection, analysis, and feedback of quality improvement data to the people influencing performance is included as a critical component of success across all MBQIP domains.

Compare your hospital against the summary of best practices from 2016 MBQIP Monthly CAHs Can articles. They are organized by MBQIP measure domain on the next page.

Patient Safety

OP 27 (Influenza Vaccination Coverage Among Healthcare Personnel (HCP)

- Easy access to influenza immunizations on all shifts
- Require staff that decline immunizations to wear mask within six feet of patients
- Mandatory health care personnel influenza immunization policies that allow waivers only with physician verified medical exceptions
- Color coded name badge stickers that communicate staff influenza vaccination status

IMM 2 (Inpatient Influenza Immunizations)

- Hardwire influenza immunization assessments into electronic health record (EHR)
- Influenza vaccination assessments completed for patients admitted in late September and discharged in October
- Administer influenza immunizations as soon as immunizations arrive
- Status of patient influenza immunization on agenda of a daily interdisciplinary meeting or safety huddle
- Real time monitoring by nursing leader
- Influenza vaccination order programmed as default in EHR; physician must cancel order if patient has already received the vaccine

Patient Engagement: Hospital Consumer Assessment of Healthcare Providers and Systems (HCAHPS)

Communication with Doctors

- Hospitalist program, which offers greater physician access
- Stools provided for physicians to sit on during rounds

Communication with Nurses

- Bedside shift report by nurses
- Bedside shift report by certified nursing assistants (CNAs)
- Checklists to guide bedside shift report
- Communication education to nursing staff
- Teach back method
- White boards in patient rooms
- Patient and family advisory council reviews written patient education materials for literacy standards
- Nursing leadership audits of nursing communication with feedback

Responsiveness of Hospital Staff

- Documented hourly rounding by nurses or CNAs for pain, positioning, restroom needs, and personal items
- CNAs accommodate reliable hourly rounding and timely response to call lights
- Daily patient rounding by nursing leaders to assess and respond to patient satisfaction
- Bedside shift report by CNAs

Pain Management

- Manage patient expectations related to pain
- Mutual goal setting related to pain
- Checks on pain during hourly rounding

Discharge Information

- Discharge folder or binder, with tabs for medications, follow-up care, and other topics provided on admission
- Follow up phone call to make sure patients understand their post hospital plan of care

Cleanliness of the Hospital Environment

- Note cards in patient rooms indicate room has just been cleaned
- White bags placed over equipment when rooms are cleaned between patients
- Housekeeping supervisors or consistently monitor and provide feedback on cleaning practices
- High-touch surface cleanliness audits
- Nursing staff checks rooms for cleanliness
- Housekeeping supervisor rounds to ask patients about the cleanliness of their environment and address concerns
- Cleanliness added to performance standards for all staff
- Expectations that all staff, providers, and administrators are involved in keeping the facility tidy
- Housekeeping staff scans for environmental issues and communicate to maintenance department

Quietness of the Hospital Environment

- Quiet packs for patients that include ear plugs and eye masks
- Discourage overhead paging
- Carpeting and door closers to dampen and prevent noise
- Visitor guideline brochures and posters that stress the importance of a quiet environment
- Nursing leadership audits of noise level around nursing station

Care Transitions

Emergency Department Transfer Communication (EDTC)

- EMTALA and nursing home transfer forms tailored to EDTC
- EDTC checklists
- Real time monitoring by ED, nursing, or quality leader
- Missed cases reviewed in daily safety huddles

Outpatient

OP 1-5 (AMI Care)

- All nurses and EMTs in ED taught to do ECGs
- EMS and nursing education on atypical presentation AMI
- Chart review and feedback on every case that does not meet goals
- Partnerships with EMS, rural hospital and tertiary hospital to coordinate AMI efforts
- Stop watch necklaces to allow caregivers to track time for time critical diagnoses

OP 18 – 22 (ED Throughput)

- Nurses triage upon arrival with bedside registration taking place after triage
- Process maps to understand work flow and opportunities for improvement

CAHs Measure Up: New MBQIP Measures

Starting in September 2015, several new outpatient emergency department measures were added for MBQIP reporting:

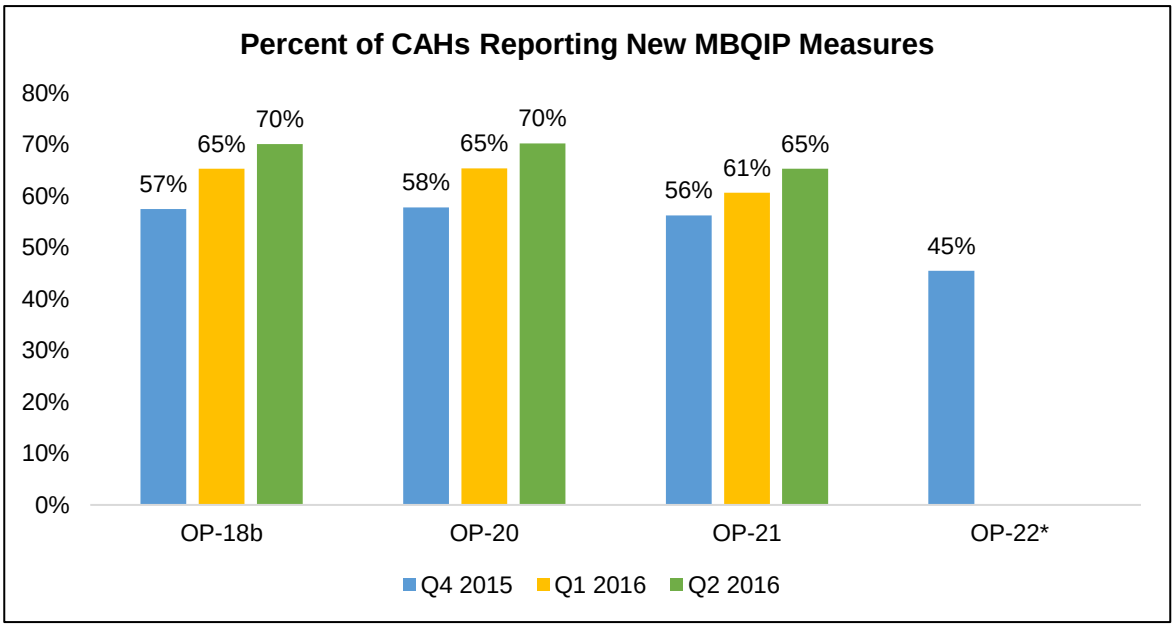
- OP-18b (Median Time from ED Arrival to ED Departure for Discharged ED Patients)
- OP-20 (Door to Diagnostic Evaluation by a Qualified Medical Professional)
- OP-21 (Median Time to Pain Management for Long Bone Fracture)
- OP-22 (Patient Left Without Being Seen).

Hospital-level MBQIP Patient Safety and Outpatient reports have been updated to include these outpatient measures, and several quarters of data are now available via those reports. The percentages of CAHs participating in MBQIP that are reporting each measure are shown in the chart below.

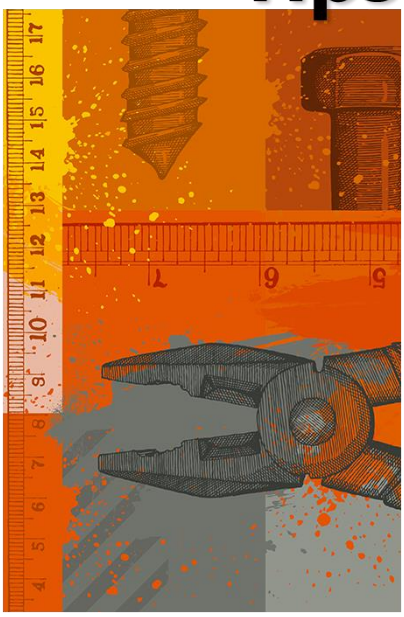
OP-22 is reported once per year (in the chart below, OP-22 represents the percent of CAHs that reported for CY 2015 dates). Only 45% of CAHs reported OP-22 for 2015 encounter dates. Make sure your hospital submits OP-22 for 2016 encounter dates, which are due by May 15, 2017.

For patient encounter dates in Q4 2015, between 56% and 58% of the 1,310 CAHs participating in MBQIP reported OP-18b, OP-20, and OP-21. The number of CAHs participating in MBQIP increased to 1,320 for Q2 2016 encounter dates, and reporting rates for all three measures rose as well.

Is your hospital reporting these measures? Check your MBQIP Patient Safety and Outpatient reports to be sure, and join in if your hospital is not.



Tips



Robyn Quips - tips and frequently asked questions

New CMS Specifications Manuals

Starting with Q3 2016 (July, August, and September) both the CMS Inpatient and Outpatient Hospital Reporting Specifications Manuals have changed from the version used the last two quarters. For 7/1/16 -12/31/16, use Inpatient version 5.1 for discharges and Outpatient version 9.1 for encounters. Make sure you are using the instructions from the Specifications Manual for the discharge/encounter timeframe you are abstracting. The release notes, located on the QualityNet homepage along with the manual, indicate what changes were made from the previous version.

Highlights from This Year's Tips

Some abstracting topics seem harder to grasp than others. Here are the topics from the 2016 MBQIP Monthly issues that CAHs had the most questions about.

Discharged to a nursing home. Patients who reside in the nursing home, are seen in the ED and then are transferred back to the nursing home should be included in the EDTC population. For both CMS and EDTC reporting, transfer to a nursing home is considered a discharge disposition/code of 5 – Other Health Care Facility. For these reporting programs, even if the patients reside in the nursing home, they are not considered to be discharged/transferred home. They are considered to be discharged/transferred to another health care facility.

QualityNet warehouse data tips. You must submit data from all measures in a measure set for the data to be accepted in the QualityNet warehouse. You cannot pick and choose measures from within a measure set. For outpatient AMI data submission, you must quarterly submit measures OP-1-5. For outpatient ED you must submit quarterly on OP-18 and OP-20 (OP-22 is only submitted once a year via the portal). Otherwise, the cases will be rejected from the warehouse.

The first step for all chart abstraction is to determine your measure population. Your population is all of your hospital's cases that meet the requirements before they pass, fail or get excluded from the measure for any reason. These decisions happen only after you have determined your population and start abstracting cases (answering the data element questions). The population does not change and all of the cases that fit the initial measure population requirements should be submitted to the QualityNet warehouse. Population requirements can be found in the CMS Specification Manuals and the EDTC Data Specifications Manual.

Enter the hospital's populations and sampling counts. If you meet the sampling requirements and choose to sample, enter the number sampled along with your initial measure population counts in QualityNet via the Secure Portal. Read more about entering Population and Sampling in the October 2016 MBQIP Monthly.

AMI and Chest Pain are two different initial populations. The Outpatient Measures OP 1-5, consists of both AMI measures (OP-

Go to Guides

Hospital Quality Measure Guides

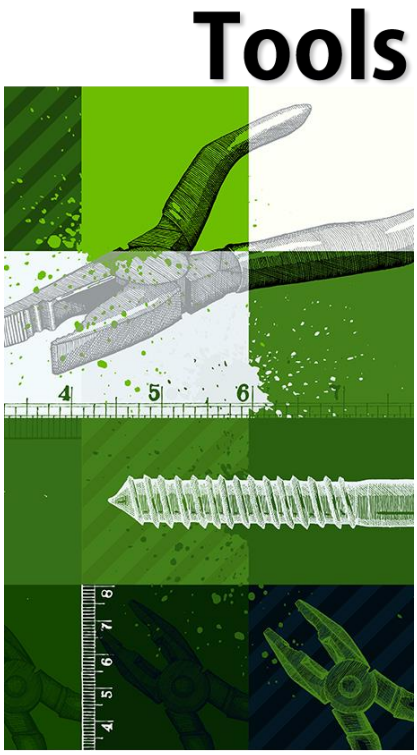
- MBQIP Reporting Guide
- Emergency Department Transfer Communications
- Inpatient Specifications Manual
- Outpatient Specifications Manual

1-5) and Chest Pain measures (OP-4&5). Both measures sets are included in the MBQIP program abstraction.

Keep your version of CART current. If using CART (CMS Abstraction and Reporting Tool) for data submission to the QualityNet warehouse, make sure you have the most current version on your computer before you start abstraction for the quarter. The Inpatient CART tool and Outpatient CART tool each require its own installation. Find the online CART Help Guide on the CART Downloads and Info page under both the Inpatient and Outpatient Hospital tabs on the QualityNet home page.

Always run the Case Status Summary Report from the secure site in QualityNet, after submission of your hospital data to the QualityNet warehouse. This report tells you the number of cases submitted to the warehouse and how many were accepted and/or rejected. Do this even if you have a vendor submitting your data! Find the steps for running the report in the February 2016 MBQIP Monthly.

Robyn Carlson, Stratis Health quality reporting specialist, provides Flex Coordinators with technical assistance related to MBQIP.



Tools and Resources

MBQIP Quick Reference Resource List. Summary list that includes the most frequently utilized key resources for Medicare Beneficiary Quality Improvement Project (MBQIP) data reporting and improvement

HCAHPS Vendor Directory. The National Rural Health Resource Center has updated its Hospital Consumer Assessment of Healthcare Providers and Systems (HCAHPS) Overview: Vendor Directory. It provides information on HCAHPS including the benefits and challenges to implementing a HCAHPS survey process with small rural hospitals, specifically critical access hospitals. The resource identifies certified HCAHPS vendors that have opted to have their services listed in the directory. This resource is beneficial for those working with HCAHPS to support facilities with the Small Rural Hospital Improvement Grant Program (SHIP), as well as work in the Flex Program with MBQIP.

StratisHealth

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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