

MBQIP Monthly

Medicare Beneficiary Quality Improvement Project

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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.



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

CAHs Can! Year-end Review: What Makes Great CAHs

Over the course of 2017, MBQIP Monthly staff have had the pleasure of speaking with 11 CAHs who have demonstrated consistently high performance on MBQIP measures. Average daily census (ADC) numbers at these CAHs ranged from one to just under 25. Leadership, teamwork, communication, data transparency, and community partnerships were all identified as drivers of MBQIP success. Several CAHs commented that a sense of humor helps, too!

Strong and supportive leadership was the driver most frequently listed. Leaders are visible, accessible, and approachable, and create a culture where staff are willing to communicate concerns and suggestions. Another driver identified is a culture comprised of teamwork, excellence, and continuous learning and improving. To that end, education is ongoing: TeamSTEPPS training, Just Culture, and Lean methodology are some examples of tools used by the CAHs to achieve that vision. Lastly, the analyzing and sharing of data in meaningful ways was identified as a major driver of MBQIP success. It must be timely, relevant, objective, and presented in a way that promotes action.

Below is a summary of best practices from 2017 CAHs Can! articles.

Patient Safety

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

- Easy access to immunizations: infection prevention nurse attends meetings to administer “shots on the spot”
- Implementation of mask policies to protect patients and other care givers from staff who chose to not be immunized.
- Provider incentive policy related to sick pay for influenza-related illnesses
- Staff ID badge stickers reflecting immunization status

IMM 2 (Inpatient Influenza Immunizations)

- Open chart reviews on every acute care patient to ensure all eligible patients have been immunized
- Frequent monitoring of influenza immunization performance and feedback to staff and providers
- Implementing influenza immunization assessments electronic health record (EHR) hard stops in both admission and discharge
- Use of a discharge checklist to improve consistency on influenza immunizations



Care Transitions

Emergency Department Transfer Communication (EDTC)

- Implementation of Emergency Medical Treatment and Labor Act (EMTALA) transfer checklist with regular compliance audits; feedback shared with staff and providers
 - Revision of EDTC transfer sheets for hospitals and nursing homes to accommodate data elements included in the EDTC data specifications manual
 - Sharing hospital EHR with the local nursing home
 - Separation of ED patient registration from other outpatients
 - Hardwiring EDTC measures monitoring in the EHR, with misses reviewed to identify how to strengthen performance

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

Communication with Doctors

- Hospitalist program allowing for better continuity of care and improved provider access
 - Use of virtual providers at the bedside to begin treatment and guide care when hospitalists are not in-house

Communication with Nurses

- Bedside reporting at shift change
 - Focused initiatives around use of white boards and medication education
 - Use of whiteboards and teach-back patient education on medications
Audits of white board utilization correlated with HCAHPS scores for the same timeframe and shared with staff
 - Use of patient focus groups to improve communication, including reducing the use of jargon and wording choices in conversations

Responsiveness of Hospital Staff

- Leadership rounding with all inpatients to assess satisfaction with their hospital experience
 - Use of virtual staff (hospitalists, specialists, pharmacists) to bridge gaps – from admits to responding to codes – when providers are not available on-site
 - Daily huddles to address patient needs and concerns
 - Huddle boards tailored to each unit and guide information sharing to optimize staff situational awareness and problem solving
 - Regular staff and leadership rounding that encourage patients to ask questions and speak up with concerns
 - Hourly nursing rounds, guided by the 4 Ps: pain, potty, positioning and personal space, are documented in the EHR

Pain Management

- Pain checks included in hourly rounding
 - Pain assessment information included in daily huddles
 - Use of white boards to address pain medication educational needs

Discharge Information

- Addition of a dedicated discharge planning nurse
 - Use of a hospital discharge checklist
 - Including discharge planning in daily huddles and multidisciplinary rounds
 - Hospital binders or packets: used throughout hospital stay with information including patient rights, education, medications, discharge appointments and follow-up
 - Social workers meeting with all patients to discuss needs and preferences

- Use of a standardized process for weekend discharges to ensure follow-up with appointments and any other patient needs

Cleanliness of the Hospital Environment

- Cleanliness checks included in hourly rounding
- Workflow redesign allowing staff to work in pairs or teams improved morale, resulting in increased hospital cleanliness

Quietness of the Hospital Environment

- Carpeting and door closers to dampen and prevent noise
- Discourage overhead paging
- Nursing leadership audits of noise level around nursing station
- Visitor guideline brochures and posters that stress the importance of a quiet environment

Care Transitions

- Daily physician-led interdisciplinary treatment rounds following a standardized process: includes nutritional status and goals for patient, expected day of discharge, discharge needs, medication reviews, antibiotic reviews, and rehab status
- Addition of a transitional care manager to follow up on weekend discharges, communicate personally with more complex patients and high ED utilizers, and attend follow-up appointments with patients
- Verbal assurance given to every patient at every handoff regarding the high quality and compassionate care they can expect at the next level of care

Outpatient

OP 1-5 (AMI Care)

- Implementation of a case review committee addressing STEMI, stroke, sepsis, codes and ED throughput
- Ongoing and consistent practice of case reviews when ED quality measures are missed
- Use of process flow maps to help identify barriers to getting EKGs done in a timely fashion
- Real-time reviews on OP measures with timely feedback to staff
- Heart-shaped lapel pins awarded to physicians and nurses involved in each transfer of AMI patients completed within 30 minutes
- Use of overhead paging to alert staff that a patient with chest pain is on the way
- Triage of chest pain patients by EMS personnel who can initiate their STEMI protocol
- Creation of a “STEMI box” with everything in one place for chest pain and AMI patients – protocols, documentation forms, and supplies.

OP 18 – 22 (ED Throughput)

- Workflow redesign:
 - patients are greeted upon arrival by a physician and given a brief preliminary assessment
 - registrar visits patient
 - nursing assessment takes place
 - in-depth physician assessment is then conducted to finalize treatment plan
- Use of nearby post anesthesia care unit (PACU) for ED overflow during busy tourist seasons
- Installation of computers in each triage room

Data



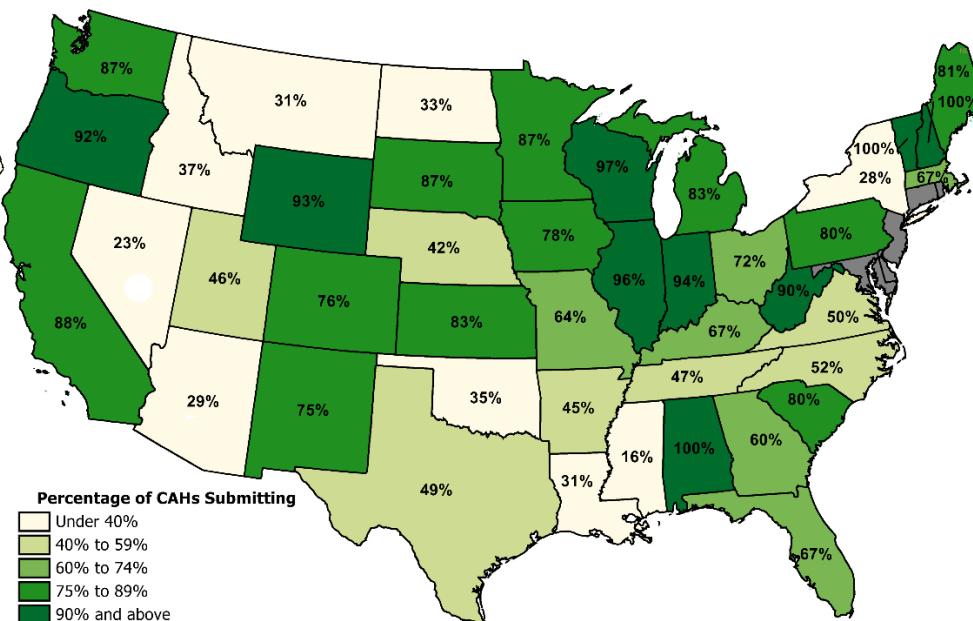
CAHs Measure Up: Antibiotic Stewardship Reporting & Improvement

Fully implementing an antibiotic stewardship program is now a requirement for CAHs participating in MBQIP. With regards to MBQIP, the goal is for all CAHs to fully implement an antibiotic stewardship program (defined by meeting all seven of the CDC's ["Core Elements of Hospital Antibiotic Stewardship Programs"](#)) by August of 2022.

The CDC measures the number of elements each hospital meets via its National Healthcare Safety Network (NHSN) [Annual Facility Survey](#), which should be submitted via NHSN each year between when the survey is released in January and March 1 to reflect your hospital status for the previous calendar year (for example, the 2017 survey should be submitted between the survey's release in January 2018 and March 1, 2018).

Many CAHs are already enrolled in the CDC's NHSN, and are submitting the CDC NHSN Annual Facility Survey, which are the first steps needed to help you meet this new MBQIP requirement. In 2016, 881 CAHs submitted the Annual Facility Survey, up from 848 in 2015, and 692 in 2014.

The map below shows the percentage of CAHs submitting the Annual Facility Survey, by state (2016). How does your state compare? Is your hospital already submitting the Annual Facility Survey?



If you are among the 881 CAHs that submitted the Annual Facility Survey for 2016, how do you compare to other CAHs on the journey to meeting all seven Core Elements?

Number of Core Elements Met (2016)	# of CAHs	% of CAHs (out of 881 submitting)
0	25	2.8%
1	18	2%
2	36	4.1%
3	59	6.7%
4	66	7.5%
5	117	13.3%
6	181	20.5%
7	379	43%

Finally, check out how your state is doing overall in meeting all seven Core Elements of Hospital Antibiotic Stewardship Programs – [this map from the CDC](#) shows the percentage of all hospitals (not just CAHs) meeting all elements by state. The national goal, as set by the CDC, is for 100% of all hospitals to meet all seven Core Elements by 2020. Is your hospital on track to help us meet that goal?

Tips



Robyn Quips - tips and frequently asked questions

Outpatient Measures Being Removed

CMS has announced that four of the Outpatient Measures currently required for MBQIP will be removed **following Q1 2018 data submissions:**

- OP-1: Median Time to Fibrinolysis
- OP-4: Aspirin at Arrival
- OP-20: Door to Diagnosis Evaluation by a Qualified Medical Professional
- OP-21: Median Time to Pain Management for Long Bone Fracture

So what does that mean for abstraction? **CAH's should continue to collect these measures through Q1 2018 (January 1, 2018 - March 31, 2018) encounters, with the due date of August 1, 2018.** Starting with April 1, 2018 encounters, the measures do not need to be collected and the QualityNet warehouse will no longer accept submission of data for those measures.

If you are submitting on the web-based measure OP-25, Safe Surgery Checklist, data for 2017 should be submitted by May 15, 2018 to the QualityNet Secure Portal. Data will no longer need to be collected for that measure after that time.

Year-end Review

Population and Sampling

Outpatient population and sampling data can once again be entered into the grid in the QualityNet Secure Portal. You no longer have to submit this via an .xml file. *A reminder of why we encourage you submit this data:* If you report a zero to show you had no cases that meet a measure's requirements, this will show as a zero on your MBQIP reports. If there is nothing submitted for the population and sampling, and no data for the measures in the QualityNet warehouse, the report will show as not available (N/A). No data in the warehouse means you are a non-submitting CAH on that measure for that quarter. A zero shows you would have reported if you had cases that met the population requirements. Why look like a non-submitter when you aren't? Zeros should only be recorded if you have no cases for the quarter that meet the measure population requirements.

ED-1 and ED-2

ED-1 and ED-2 are new to the MBQIP measures requirements, and abstraction should begin with Q3 2017 submissions, due Feb 15, 2018.

Even though they are called Emergency Department measures, these are CMS inpatient measures. The ED measures are part of the Global Initial Patient Population, the same population as the IMM-2 measure. The population requirement is all patients discharged from acute inpatient care with a length of stay less than or equal to 120 days. All cases that meet that requirement are abstracted for the measures. So your population and sampling for the ED and IMM measures would never be a zero, unless you had no acute inpatient care discharges for a quarter.

Outpatient ED Cases

If a patient is seen in your hospital's ED department and subsequently admitted, they should not be in your outpatient ED measure set. The outpatient ED measures OP-18 and OP-20 should only include patients who are seen in your ED and discharged/transferred elsewhere.

EDTC

Hospitals need to submit a minimum of 45 cases per quarter. CAHs that see less than 45 cases per quarter should abstract data on all cases. CAHs that see more than 45 cases per quarter can do a sample of 45 or more, they are not limited to 45 cases.

CMS ListServes

Be sure to sign up for the CMS ListServes. CMS uses this method to let us know about issues with QualityNet, new releases or updates to the Specifications Manuals and CART, data deadline submission changes, and other application or initiative alerts. Information on where and how to sign up can be found in the [March 2017 MBQIP Monthly](#).

Case Status Summary Report

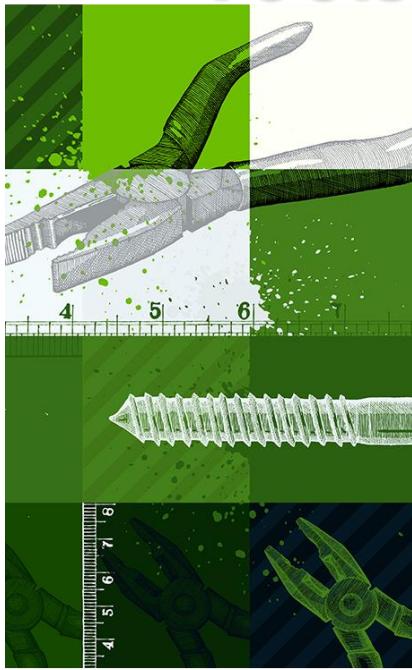
Make sure the data that has been submitted to the QualityNet warehouse has been accepted! Run the Case Status Summary Report, one of the reports that can be run from the Secure Site in QualityNet. This report tells you how many cases were submitted and the number accepted and rejected. That's all that's on this report, that's why it is the best one to check for this information. It doesn't matter if you have a vendor who submits your data or you do it yourself, check to make sure it was done and accepted. The steps on how to run this report can be found in the MBQIP Resource Library [here](#).

Go to Guides**Hospital Quality Measure Guides**

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



Tools



Tools and Resources

Updated! [MBQIP Data Submission Deadlines Chart](#).

Single page document contains a chart showing the MBQIP data submission deadlines.

Updated! [MBQIP Measures Fact Sheets](#) provide an overview of the data collection and reporting processes for the MBQIP measures in a basic, one-measure-per-page overview.

Updated! [MBQIP Reporting Guide](#). Intended to help critical access hospital staff and others involved with MBQIP understand the measure reporting process. For each reporting channel, information is included on how to register for the site, which measures are reported to the site and how to submit those measures to the site.

Ask Robyn – Quarterly Open Office Hour Calls for Data Abstractors

Wednesday, January 10, 2018, 2:00-3:00 p.m. CT [Register here](#)

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).

NHSN Annual Facility Survey for Critical Access Hospitals

Tuesday, January 23, 2018, 1:00-2:00 p.m. CT [Register here](#)

FORHP and CDC are offering this webinar to provide additional information about completion of the NHSN Annual Facility Survey and its use in monitoring implementation of antibiotic stewardship programs.

[Institute for Healthcare Improvement \(IHI\) Framework for Improving Joy in Work](#)

There are proven methods for creating a positive work environment that creates conditions and helps ensure the commitment to deliver high-quality care to patients, even in stressful times. With burnout and staff turnover in health care continuing to rise at alarming rates, this white paper describes four steps leaders can take and nine critical components for ensuring a joyful, engaged workforce. (Free log-in required)



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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