

# MBQIP Monthly

Medicare Beneficiary Quality Improvement Project



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

## In This Issue

**1 CAHs Can! Rural Success:** Hampshire Memorial Hospital, WV

---

**3 Data: CAHs Measure Up:** Variation and Improvement

---

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

---

**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.

## Hampshire Memorial Hospital, WV



[Hampshire Memorial Hospital](#) (HMH) in Romney, West Virginia, has a small footprint but a significant impact. A 14-bed critical access hospital with an average daily census of roughly six, HMH has been part of Valley Health System since 2008 and moved into a new facility (pictured above) in 2011. In addition to inpatient care, HMH hosts a six-bed emergency department (ED) that cared for more than 10,000 patients in 2017, and an attached 30-bed long-term care unit and multi-specialty clinic. The closest hospital, a partner in the Valley Health System, is 45 minutes away, making HMH a critical point of care for the largely aging population it serves in the rural Eastern Panhandle of West Virginia.

Recognizing there was room for improvement in their HCAHPS scores related to care transitions, HMH implemented a project through which discharge and post-acute care have become a focal point from the time a patient is admitted to the facility. Upon admission, the social worker completes an initial discharge planning assessment, including considering such things as access to transportation and medications, and patients are provided a binder for their keeping as a repository for capturing information throughout their stay. By the time they are discharged, the binder will include information about their diagnosis, diet, care provided, medications, and other education the patient received during the hospital stay. The binder is a living resource that goes with the patient, so they can share it with other providers in follow up and maintain a resource for their reference.

Daily rounds at HMH are also focused on discharge – what needs to happen for the patient to go home? And what needs to happen at home for

the patient to stay well? The interdisciplinary rounding team includes the hospitalist and primary nurse caring for the patient, social worker, case manager, CNA, pharmacist, and appropriate therapy services (e.g., respiratory, PT, OT). Once a discharge plan is set, the nurse initiates a discharge time out, at which time a checklist of all required steps is reviewed to ensure all the pieces are in place for a successful care transition, including scheduling of any follow-up appointments. After



*Some of the HMH staff that participate in Daily Discharge Rounds. From left, R. Ramey, CAN, R. Blacka, CAN, S. Francis, Physical Therapy, H. Hanlin, CAN, C. Yaider, Respiratory Therapy, C. Middleton, House Supervisor/Case Manager, M. Alt, RN, B. Whetzel, RN, J. Martin, Social Worker, S. Basnet, MD, K. Roudybush, CNA*

discharge, a nurse completes a follow-up call to see if the patient has any questions or concerns, and to provide reminders about upcoming appointments or prescription fills.

HMH has built aspects of their infection control and antibiotic stewardship initiatives into the discharge process as well. Assessing patient need for the influenza vaccine is a topic covered in daily rounding as well as on the discharge time-out checklist. The full-time pharmacist is involved in daily rounding and able to provide patient education about antibiotic use when they leave the hospital. While the incidence of healthcare-

associated infections at HMH is quite low, a recent uptick in community-acquired *C. difficile* has led to the automatic inclusion of antibiotic-specific discharge instructions for patients who have received hard-hitting antibiotics, including what to do in case of symptoms.

The discharge project provides a great example of how HMH utilizes a multi-disciplinary team approach to care and quality improvement. Frontline staff was engaged throughout in assisting with the development of the binders, checklists, and other templates. The buy-in of the team and their competitive nature has been instrumental in driving HMH's high performance across MBQIP measures.

Moving from the floor to the ED, this trend continues. The facility recently switched ED physician groups and is now working with a group based out of the Valley Health System, offering a definite shift towards higher provider buy-in with regards to quality performance and improvement initiatives. Triage is completed bedside whenever possible to address patient flow, and several protocols have been implemented, including those to treat chest pain such as providing aspirin and completing an ECG as quickly as possible. HMH boasts a high performance on EDTC, which they struggled with at first, but were able to address by seeking input from staff and making necessary tweaks to their EMTALA form. Beyond their performance on outpatient and inpatient MBQIP ED measures, HMH has recently seen their ED patient satisfaction scores skyrocket.

Hampshire Memorial Health is an excellent example of the great work a small but dedicated team can accomplish with drive and commitment to the community.

# Data



## CAHs Measure Up: Variation and Improvement

Hospitals should strive to reach optimal performance on clinical quality process measures. If your hospital isn't achieving this level of care, review the records for patient stays that did not meet the measures each quarter to understand what might have caused variation – or to understand if you might have abstracted data incorrectly.

Let's look at Measure OP-18b, Median Time from ED Arrival to ED Departure for Discharged ED Patients. While there aren't clinical guidelines for what time to target, CMS' [Achievable Benchmarks of Care](#) consistently show a national 90<sup>th</sup> percentile at about 90 minutes, and a national median between 133 and 140 minutes.

Below are two samples adapted from CAH MBQIP data reports that show variability for the OP-18b measure. One illustrates an example of variability that might reflect an abstraction error, and the other is an example that might warrant some exploration of processes of care.

### Possible abstraction error

This sample report illustrates a possible abstraction error in 1Q17 and 2Q17, which show two significantly longer median times sandwiched by two quarters that are more realistic. The error might be caused by (for example) using the incorrect time field for ED Arrival or ED Departure, or by mistyping times. In this case, a good first step would be to revisit the [Specifications Manual](#) and ensure that abstraction is being done correctly.

		Your Hospital's Performance by Quarter				Sta
MBQIP Quality Measures		4Q16	1Q17	2Q17	3Q17	Median Time/Overall Rate
<b>Immunization</b>						
IMM-2	Influenza Immunization	60% of 20 patients	58% of 30 patients	D/E	D/E	D/E
<b>Emergency Department – Quarterly</b>						
OP-18b	Median Time from ED Arrival to ED Departure for Discharged ED Patients	190 Min. based on 39 patients	760 Min. based on 40 patients	624 Min. based on 35 patients	199 Min. based on 49 patients	100 Min.

### Processes of care

In this sample report, the hospital's performance is more within the realm of what would be expected. However, notice that the median time varies from 115 minutes at the best quarter, to 230 minutes at the worst. This variation might be explainable and possibly acceptable, but it warrants a closer look at ED processes for possible improvement opportunities, particularly for those patients with the longest time between arrival and departure.

		Your Hospital's Performance by Quarter				Sta
MBQIP Quality Measures		4Q16	1Q17	2Q17	3Q17	Median Time/Overall Rate
<b>Immunization</b>						
IMM-2	Influenza Immunization	85% of 32 patients	100% of 30 patients	D/E	D/E	D/E
<b>Emergency Department – Quarterly</b>						
OP-18b	Median Time from ED Arrival to ED Departure for Discharged ED Patients	115 Min. based on 21 patients	201 Min. based on 22 patients	180 Min. based on 24 patients	230 Min. based on 28 patients	93 Min.

For more suggestions on how to interpret MBQIP reports for variation and improvement opportunities, read [Interpreting MBQIP Hospital Data Reports for Quality Improvement](#). For specific clinical guidelines (where available) and suggested strategies for implementing quality improvement activities related to each measure, review the Quality Improvement Measure Summaries for MBQIP that are part of the [Quality Improvement Implementation Guide and Toolkit for CAHs](#).

# Tips



## Robyn Quips - tips and frequently asked questions

### New Discharge/Encounter Year Means New Manuals

With May being the end of submitting 2017 chart-abstracted data, now comes 2018 abstraction, which means new specifications manuals. For those of you who are just starting to abstract Q1 2018 outpatient encounters and inpatient discharges, and hopefully, for those of you who have already started 2018 abstraction, you are using the manuals specified for this time frame.

- Hospital Outpatient Quality Reporting Specifications Manual version 11.0a is for use with encounter dates 1/1/2018 – 12/31/2018.
- The Specifications Manual for National Hospital Inpatient Quality Measures version 5.3a is for use with discharges 1/1/2018 – 6/30/2018.

The only way to know if instructions/specifications for the measures have changed from the prior year is to read the Release Notes that accompany each new version of the manuals. The Release Notes are found on the same pages as the Specifications Manuals in QualityNet. Since manuals come out far in advance of the date they start being used, there can often be more than one set of Release Notes, so be sure to look and see if there are multiple sets of notes.

In addition to being called out in the Release Notes document, additions are highlighted in yellow in the new manual versions. However, just looking to see what is highlighted in yellow isn't going to show you what might have been removed, so don't take the easy way out and only look for yellow highlights!

For those of you that use the paper abstraction tools, they have been updated as well. These can be found by selecting Abstraction Resources on the Data Collection (& CART) pages, which are listed under the Hospital Inpatient and Outpatient tabs on the [QualityNet home page](#).

If you haven't done so already, make sure you update to the latest version of CART, Outpatient version 1.16 and Inpatient version 4.20.2.

### Open Office Hours Call

The next Open Office Hours Call for Data Abstractors is June 20. These calls are for abstractors to be able to ask questions specifically pertaining to abstraction, such as how to determine the ED-1 and ED-2 measure population or what is acceptable documentation for determining transfer for acute coronary intervention? It's also a time when you can reach out to other abstractors and them for advice or suggestions. It's time set aside for you to ask about abstraction, so your questions drive the call. There are no stupid questions, and you can bet if you are wondering about something, someone else probably is, too. It's nice to hear what others are asking, but remember, if no one talks there is no discussion! We ask you to register for the call because that is the only way we can get a count on the number participating. Information on registering is listed in the Tools and Resources section of this issue of MBQIP Monthly.

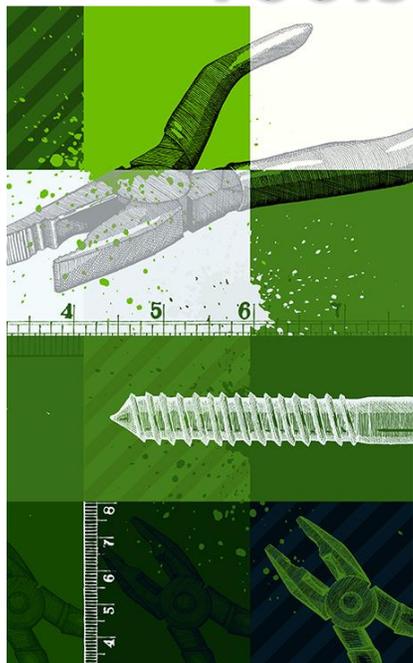
## Go to Guides

### Hospital Quality Measure Guides

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



# Tools



## Tools and Resources

### Ask Robyn – Quarterly Open Office Hours Calls for Data Abstractors June 20, 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](mailto:rcarlson@stratishealth.org))

### Also Available! [Online MBQIP Data Abstraction Training Series](#)

This recorded training series is for CAH staff with responsibility for data collection of CMS Inpatient and Outpatient quality measures.

### [CAPTURE Falls Toolkit](#)

Developed by the University of Nebraska Medical Center as part of a research project with Nebraska CAHs, the Collaboration And Proactive Teamwork Used to Reduce (CAPTURE) Falls toolkit provides a wealth of tools and resources supporting implementation of a system-based interdisciplinary team-based approach to address the complex challenge of reducing patient falls.

### [National Healthcare Safety Network Annual Survey Resources](#)

This document provides step-by-step instructions on how to add the Patient Safety Component and access the National Healthcare Safety Network (NHSN) Patient Safety Component Annual Survey, the results of which are used to determine performance on the MBQIP Antibiotic Stewardship measure.

### [QualityNet Request for Feedback](#)

CMS is investing in changes to [QualityNet.org](http://QualityNet.org) and the team is interested in feedback from people who use the QualityNet Secure Portal. As the team begins to work on the QualityNet Secure Portal, they want to hear about what works and what's challenging.

If you're interested in participating or have any questions, please fill out this form: [2018 HQR Sign Up Form](#). If you have any trouble accessing the form, please email the research team at [HQRResearch@bellese.hcgis.org](mailto:HQRResearch@bellese.hcgis.org)

### [Quiet at Night HCAHPS Improvement Brief](#)

You've instituted quiet hours, installed cushions on cabinet doors, greased squeaky wheels, monitored noise levels with a yacker tracker, distributed white noise machines, headphones and guided imagery videos to patients, and STILL your hospital struggles to move the needle on the HCAHPS question "How often was the area around your room quiet at night?" This brief from [Planetree](#) introduces five approaches for improving Quiet at Night that, interestingly enough, have little to do with reducing noise.



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.

This project is supported by the Health Resources and Services Administration (HRSA) of the U.S. Department of Health and Human Services (HHS) under grant number U1RRH29052, Rural Quality Improvement Technical Assistance Cooperative Agreement, \$500,000 (0% financed with nongovernmental sources). This information or content and conclusions are those of the author and should not be construed as the official position or policy of, nor should any endorsements be inferred by HRSA, HHS, or the U.S. Government.