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: West Valley Hospital, Dallas, OR

The West Valley Hospital in Dallas, Oregon, is a six-bed critical access hospital with an average daily census of about two. The hospital defies any presumed connection between low patient volume and inferior quality performance. Located in the northwest corner of the state, the hospital is highly successful across all MBQIP measures, including Hospital Consumer Assessment of Healthcare Providers and Systems (HCAHPS). But, the low patient volume does not allow them to receive an HCAHPS star rating—in spite of a higher than average response rate at 36 percent.

Marketing the best of both worlds, West Valley Hospital is close to home and can provide specialty services such as cardiology through a partnership with sister hospital, Salem Hospital. The hospital offers services such as lab work, imaging with CT and mobile MRI, ambulatory surgery, ED, rehab therapy, infusion therapy including anticoagulation, and wound care clinics.

With strong leadership support and a healthy dose of teamwork across departments, the quality coordinator keeps a robust quality improvement program in motion. Quality and patient safety are reviewed quarterly at the leadership meeting. The quality coordinator, who is also responsible for risk management, infection control, and employee health, routinely uses the IHI trigger tool to guide chart audits that reveal patient safety events and help identify areas of weakness and harm potential.

Staff engagement is identified as a critical factor in maintaining a lively quality and patient safety program. Staff are eager to participate in quality improvement activities and want their voices heard. Specialty practice teams, which vary in degrees of formality, identify and lead improvement opportunities. A practice council with representatives from every department meets monthly to talk about current quality improvement activities.

The planning work of the these teams is kept dynamic through a 10 to 15 minute interdisciplinary quality and patient safety huddle that includes administration held every weekday morning. Three bulletin boards structure the agenda. The "regeneration and improvement" board covers active

quality improvement topics, while the "sustain and operate" board includes topics that have been worked and have sustained momentum. The "safety huddle" board guides a report-out from every department on patient safety. A similar patient safety huddle is coordinated by the Emergency Department charge staff on weekends.

When West Valley Hospital first participated in HCAHPS, the surveys were printed and shared with nurses so they understood what would be asked of patients, and general HCAHPS improvement education was provided. The hospital maintains an overall satisfaction rating of 92 percent, and scores well above the national averages on most HCAHPS composites. Hourly rounding for pain, repositioning, and restroom needs, documented on magnetic signs on patient doors, was initiated around one year ago upon the request of staff and managers. Physicians from the community, who participate in the hospitalist program, visit patients up to twice a day, ensuring nurses know when next to expect them in order to keep patients and families well informed. Pharmacists also recently began rounding and reviewing medications with patients to support better communication and patient understanding.

West Valley Hospital quality board with data to Regenerate and Improve, as well as Sustain and Operate.

ED manager and staff implemented the Emergency Department Transfer Communication (EDTC) measures before they became MBQIP measures, when they researched ways to improve patient outcomes. A checklist was developed to guide EDTC practices and documentation. Missed cases are reviewed in daily safety huddle meetings to identify and address barriers. Charge nurses check to make sure the requirements are met before patients are transferred, and the ED manager checks charts to audit compliance. The intense scrutiny and frequent feedback has paid off with all EDTC performance at 95 percent.

As far as the new MBQIP measures, West Valley staff and managers are well on their way to success. Patient influenza immunization assessments are hardwired into the EHR, and IMM 2 compliance is reported during daily safety huddles. Every October, health care personnel influenza immunizations and fit testing are provided during four clinics, and nurses on evening and night shifts give vaccinations to staff unable to attend. Physicians and board members can receive immunizations before regular meetings. The immunizations are not mandatory, but staff that decline must wear a mask when within six feet of patients. The hospital staff and leaders have achieved a 97 percent immunization rate, and enter the data into NHSN yearly. "NHSN is not easy, and it's time consuming, but it's important!" declares Penny Edwards, West Valley Quality Coordinator.

ED throughput is being monitored closely by the ED manager, and lean principles are being used to improve performance.

The West Valley Hospital has proven to be "the little CAH that could" by engaging and empowering staff, looking ahead, and working as a team to achieve goals.

Data

CAHs Measure Up: Comparison Data

Quality improvement doesn't happen in a vacuum. When looking at your quality measures, it's useful to know how you stack up against others to help understand where to set goals and prioritize areas of greatest need. You might want to make comparisons and set goals relative to all CAHs in your state or across the nation, or (ideally) to high-performers within a group.

To use comparison data against a measure, first identify potential comparison data sources for that measure. State and national measure averages for CAHs are in the quarterly hospital MBQIP reports available from your state Flex program. In particular, you might start there for HCAHPS and EDTC measures. Or for EDTC, consider using the data highlight in the April MBQIP Monthly, which gives an average of national performance among consistently reporting hospitals. For OP measures and IMM-2, you can use averages on Hospital Compare. These measures, new to MBQIP, will be available MBQIP reports later this year.

Ideally, you'll want to do better than average. If you can, find a source that provides the rate of top performers, such as the top 10%. For example, quarterly OP benchmarks for the top 10% of hospitals are available through QualityNet's Benchmarks of Care.

Use the most recent data available for the measure. If the only data available is not from the same timeframe as your hospital's data, that comparison data should still be OK to use, as long as the specifications were the same during the time periods the data was collected.

Once you've identified a comparison data source, line it up against your own hospital's data. You might print hard copies of the data or enter the data into Excel to help visualize it. Better yet, consider using the Excel Internal Quality Monitoring Tool to enter your own measure data on a real-time basis, then enter the state or national comparison data points into the "Your Goal" column. This will automatically create Excel charts for your measure to help visualize your hospital's performance and compare it to the goal.

Now, assess your data. Some things to look for:

- If you have multiple data points, what general direction is your hospital's data moving? Is it heading in the right direction? Is it moving away from or towards the comparison data?

- How big is the gap between your hospital's data and the comparison data? If you have more than one time point available, is that gap getting smaller if you need to improve or bigger if you're already doing better than the comparison?

- Many measures or measure sets have various components (e.g. HCAHPS has various measures and EDTC measure set has multiple sub-measures). Look at state or national comparison data for all of those components. Are there areas where your hospital is not doing as well as the comparison?

For more tips on using data for comparison, look at the MBQIP Quality Guide. Use comparisons as a way to identify potential areas for focused improvement. When your hospital is doing better than the comparison, celebrate and keep up the good work!

Tips

Robyn Quips - tips and frequently asked questions

Understand a Measure's Population

The first step in abstracting is to determine the population—this identifies the cases that you need to abstract for the measure. Following the population requirements will assure that you are abstracting the correct cases for each measure. All the cases that meet the population should be abstracted. If your hospital has a high number of cases, refer to the sampling guidelines for each measure to see if that is an option. Here are two population examples:

1. **OP-18 and OP-20 Hospital Outpatient Emergency Department Throughput Population ED-Throughput**
Let's look at the population for the Outpatient measures OP-18 and OP-20. To find the population for those measures, refer to the Hospital Outpatient Quality Reporting Specifications Manual. OP-18 and 20 are part of the ED-Throughput set of measures—look in that section of the manual for the population requirement and find:

> The population of the OP-18 and OP-20 measures is identified using 1 data element:
>
> *E/M Code*
>
> Patients seen in a Hospital Emergency Department (E/M Code on Appendix A OP Table 1.0) are included in the OP-18 and OP-20 Hospital Outpatient Population and are eligible to be sampled if they have: An E/M Code on Appendix A, OP Table 1.0

Following the measure requirement, everyone who came into your Emergency Department that received the required E/M code (find the table of E/M codes in the appendix of the Specifications Manual) would be abstracted for OP-18 and 20. There is no age requirement here so age doesn't matter. There is no discharge code requirement, so it doesn't matter where they were discharged/transferred to (excluding those admitted directly to the hospital).

2. **Immunization Initial Patient Population**
Let's look at the inpatient IMM measures. In the CMS Inpatient Specifications Manual, go to the Immunization section, where you will see "Immunization Initial Patient Population."

Refer to the Global Initial Patient Population document and Global List for the Immunization Initial Patient Population definition, which is:

> The Global Initial Patient Population is defined by two data elements:
> - Admission Date
> - Discharge Date
>
> All patients discharged from acute inpatient care with Length of Stay (Discharge Date minus Admission Date) less than or equal to 120 days are included in the Global Initial Population and are eligible for sampling.

Everyone that meets the above requirement should be abstracted for the IMM measure. There is no age requirement. There is no requirement in the population about having had a vaccination. The requirement is that they were

Go to Guides

Hospital Quality Measure Guides

- Emergency Department Transfer Communications
- Inpatient Specifications Manual
- Outpatient Specifications Manual

discharged from your acute care facility with a length of stay of less than or equal to 120 days. Which, I am guessing, is probably all of your acute care discharges.

Remember: Determining your population is your first step for all chart abstracted measures. Your population is all of your hospital's cases before they pass, fail, or get excluded from the measure for various reasons. These decisions happen only <u>after</u> you have your population and start abstracting cases and answering the data element questions. The population does not change and all of the cases should be submitted to the warehouse.

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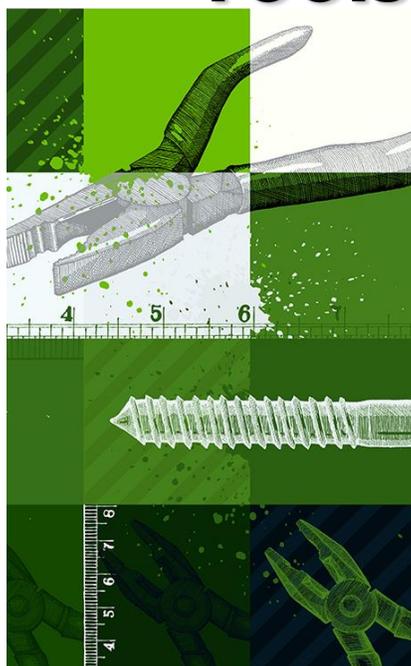
Tools and Resources

IHI Global Trigger Tool for Measuring Adverse Events. Provides an easy-to-use method for accurately identifying adverse events (harm) and measuring the rate of adverse events over time. Tracking adverse events over time is a useful way to tell if changes being made are improving the safety of the care processes. Free login required to download tool.

Are you, or other staff in your hospital, new to quality reporting and MBQIP? Here are some key resources to get you started:
MBQIP Measures Fact Sheets. One-measure-per-page-overview of the data collection and reporting processes for the required MBQIP measures.

MBQIP Data Submission Deadlines Chart. Single-page document contains the data submission deadlines for the required MBQIP measures.

MBQIP Reporting Guide. Intended to help CAH staff and others involved with MBQIP understand measure reporting processes. 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 measures to the site.

Quality Improvement Implementation Guide and Toolkit for Critical Access Hospitals. Strategies and resources to help CAH staff organize and support efforts to implement best practices for quality improvement. Includes: quality improvement implementation model; 10-step guide to leading quality improvement efforts; summaries of key national quality initiatives that align with MBQIP priorities; best practices for improvement for current MBQIP measures; and Excel-based tool to assist CAHs with tracking and displaying real time data for MBQIP and other quality and patient safety measures to support internal improvement efforts

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.