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.

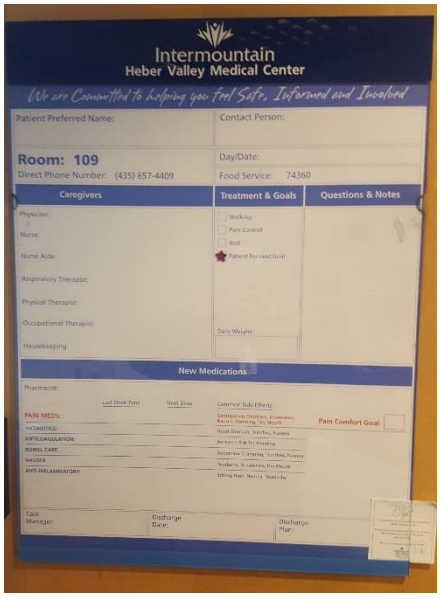
Find past issues of this newsletter and links to other MBQIP resources on TASC's MBQIP Monthly webpage.

Rural Success: Heber Valley Hospital, UT

Heber Valley Hospital in Heber City, Utah, serves a beautiful mountain valley dubbed "Utah's Little Switzerland" around 50 miles southeast of Salt Lake City. The 19-bed critical access hospital, with an average daily census of 10, is a part of the Intermountain Healthcare system. It's another shining example of a CAH that Can. Strong performance across every MBQIP domain is a part of Intermountain's robust quality and patient safety program. The program encompasses topics supported by the Hospital Improvement and Innovation Networks (HIIN) under the CMS Partnership for Patients program.

Brett Bulloch, quality director at Heber Valley Hospital, attributes the overall quality and patient safety success of the hospital to leaders who create an environment where excellence is expected and all staff and providers feel comfortable to contribute ideas and share concerns. Leadership rounding is a foundational practice to create this openness. All leaders round on patient care units to get to know staff. Leaders ask what is going well and not so well with quality improvement topics, and learn about individual department activities. During a recent transition to a new electronic health record (EHR) system, leaders rounded every day to ask how the change was going, and let staff know how to reach out for help. Brett adds that making quality improvement lighthearted and fun for staff is important. He says this helps soften the tenacious approach required to drive and sustain improvement.

Heber Valley Hospital's dedication to continuously improve the health of the community has translated into HCAHPS success. The primary contributing practices are consistent use of whiteboards to improve communication with patients, daily huddles around huddle boards to keep staff abreast of what is happening on the unit, and the practice of managing up—consciously working for the mutual benefit of yourself and your boss, the patient. Nurses are required to update whiteboards at the beginning of each shift to let patients know who their nurse and CNA are, when their next pain med is due, and other information relevant to their care. Huddle boards are tailored to each unit and guide information sharing at the beginning of each shift to optimize staff situational



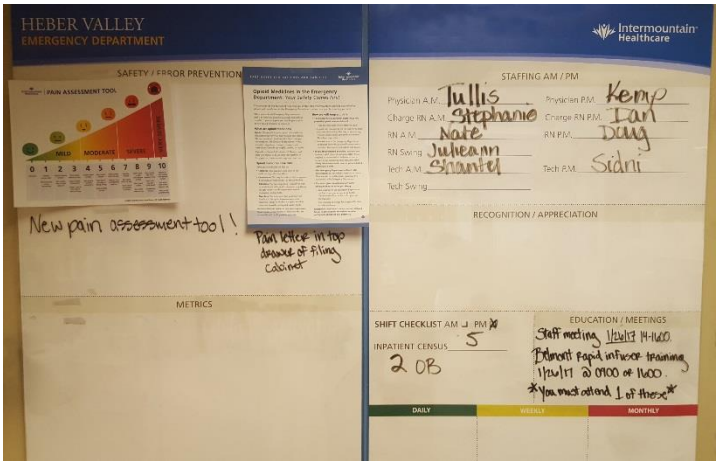
Whiteboard in the inpatient units

awareness and problem solving. As part of managing up, verbal assurance is given to every patient at every handoff regarding the high quality and compassionate care they can expect at the next level of care.

An insightful and rewarding application of the practice of exit interviews came up in conversation around hospital cleanliness. Exit interviews performed during a higher than usual turnover period for housekeeping staff revealed that staff felt isolated. The Environmental Services manager redesigned the workflow so that staff work in pairs or teams, which has improved morale as well as the cleanliness of the hospital.

Against the backdrop of solid MBQIP performance across the board for Heber Valley Hospital, ED Throughput—the timeliness of care in the emergency department—stands out as a particularly shiny star. The hospital has an average of two minutes from time of arrival until patients are seen by a physician. The national average is 17 minutes. Outstanding timeliness follows through to pain management for long bone fracture, which averages 20 minutes, less than half the national average of 45 minutes. These accomplishments have been achieved through innovative changes in workflow design.

The moment patients walk into the department, a physician generally greets and escorts them to a room for a preliminary assessment. Shortly thereafter, a registrar visits the patient to collect registration information and a nurse completes a nursing assessment. A more in depth physician assessment is then conducted to finalize the treatment plan.



Huddle board in emergency department

During busy tourist seasons, the nearby post anesthesia care unit (PACU) can be utilized as an overflow ED point of care. And, as a last resort, some patients can be seen in private hallway areas until a room is available to preserve a timely preliminary physician assessment. Stroke and trauma certification levels in the Heber Valley Hospital ED require the presence of a physician in-house at all times, which is accomplished in 12 hour shifts and through partnerships with nearby Intermountain hospitals.

In the midst of this current influenza season, Brett offers a timely and effective strategy to boost rates of influenza immunization screening and administration for inpatients (IMM 2). Seven days a week throughout the season, open chart reviews are performed on every acute care patient to make sure that the influenza immunization screening has been done, and to provide reminders to administer the immunizations for eligible patients. A concrete example of the tenacious approach required to drive and sustain improvement.

CAHs Measure Up: MBQIP Hospital Data Reports

You may have noticed that the MBQIP Hospital Data reports you've begun receiving from your Flex Coordinator (first in October, and most recently in December) look a bit different than they have in the past. Here's a quick overview of what's changed.

Changes in the MBQIP Patient Safety & Outpatient Quality Report:

- The Patient Safety and Outpatient measures are now integrated into a single report—the MBQIP Patient Safety and Outpatient Quality Report.
- Starting with the reports summarizing through Q2 2016 discharges, all MBQIP Core Measures are included, which means that you can now find OP-18b, OP-20, OP-21, OP-22, OP-27, and IMM-2 in addition to the measures that were included previously.

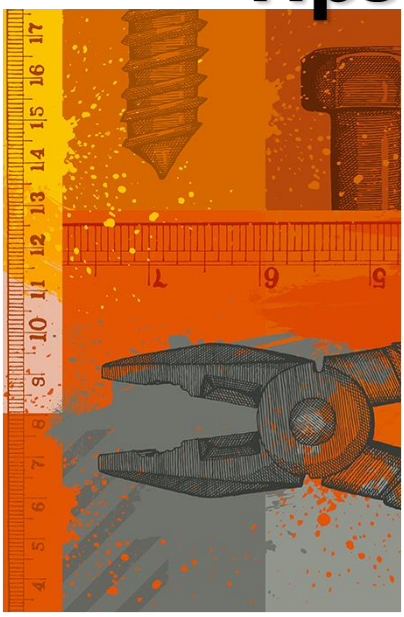
Changes in both the MBQIP Care Transitions Quality Report for Emergency Department Transfer Communication (aka EDTC Report) and the MBQIP Patient Safety & Outpatient Quality Report:

- In addition to the overall averages, state and national comparisons now include a 90th percentile benchmark for each measure so that you can compare your hospital against the top 10%, the highest performing hospitals.
- These state and national comparisons include the number of CAHs that are submitting for each measure.
- More specific data labels are now included for measures where your hospital has no data. This makes it easier to know if your hospital:
    - Had no eligible cases (either a 0 or a D/E will be shown)
    - Did not submit (an N/A will be shown).

Note: MBQIP Patient Engagement Quality reports for HCAHPS data have not been updated at this time.

Interested in learning more about how to interpret these updated reports, and how you can use the data for quality improvement? RQITA has just released a new resource, "Interpreting MBQIP Hospital Data Reports for Quality Improvement," that contains more detailed tips on interpreting your reports, including some example reports that outline different opportunities for quality improvement.

Tips



Robyn Quips - tips and frequently asked questions

New Year Reminders

As we say goodbye to the holidays and get back to work, here are some reminders about the upcoming data submission due dates.

Due January 31, 2017
The Emergency Department Transfer Communication Measure 4Q 2016 (October, November, December) data is due to your Flex Coordinator January 31, 2017. Remember that this data is Q4 not Q3 like the other measures.

Due February 1, 2017
Population and Sampling for the Q3 2016 (July, August, September) CMS Outpatient and Inpatient measures are due February 1, 2017. This is the number of cases that meet the population requirements for each measure. The information gets entered through the secure portal on QualityNet. If your population size is such that you chose to sample instead of doing all your cases that number also would be entered here. Information on how to determine your measure population and sampling numbers are found in the CMS Inpatient and Outpatient Hospital Reporting Specifications Manuals, found from the main QualityNet home page.

CMS Outpatient Measures for Q3 2016 (July, August, September) are due to the QualityNet warehouse February 1, 2017. This includes the AMI Measures OP 1-5, Chest Pain Measures OP 4-5, ED Throughput Measures OP 18 and 20 and the Pain Management Measure OP 21. If your facility is doing additional outpatient measures, they also are due on this date.

You may receive an email reminder from CMS Outpatient Support indicating that the Hospital Outpatient Quality Reporting (OQR) clinical data submission deadline is approaching. It will indicate how many records you have submitted to the QualityNet warehouse at the time of the email. Be aware that it lists all the measures in the CMS Outpatient Hospital Reporting Program, which at this time is more than what you might be doing for MBQIP.

Due February 15, 2017
CMS Inpatient Measures for Q3 2016 (July, August, September) are due to the QualityNet warehouse Feb 15, 2017. This includes the IMM-2 measure. If your facility is doing additional inpatient measures, they are also due on this date.

QualityNet sent emails about the release of new versions of CART (Outpatient version 1.15 and Inpatient version 4.19) since the last time data was submitted. The new versions are compatible with the last versions of CART (Outpatient 1.14 and Inpatient 4.18.1), meaning that you can use that version to enter Q3 and Q4 2016 data. So if you haven't started abstracting yet, go ahead and update to the latest version. If you have started, don't change versions until after you have finished abstracting and have submitted data for the quarter.

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

Go to Guides

Hospital Quality Measure Guides

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

Tools and Resources

New from the Rural Quality Improvement Technical Assistance (RQITA) Program
Interpreting MBQIP Hospital Data Reports for Quality Improvement. This guide is intended to help CAH staff use MBQIP Hospital Data Reports to support quality improvement efforts and improve patient care.

Quality Improvement Basics: A Collection of Helpful Resources for Rural Health Care Organizations. This collection of resources points rural health care quality professionals to the most helpful introductory resources and provides awareness of the more prominent health care quality organizations, programs and terms.

Other Resources
Evidence-Based Programs and Strategies for Reducing Healthcare-Associated Infections (HAI) in CAHs. This policy brief focuses on successful evidence-based programs and strategies for measuring, reducing, and preventing HAIs that can be replicated in CAHs. From the Flex Monitoring Team.

Jump Start Stewardship: Implementing Antimicrobial Stewardship in a Small, Rural Hospital. This workbook provides small hospitals with guidance and tools to develop a framework and strategic plan for implementing a feasible, small-scale stewardship program tailored to their own unique characteristics. Developed by the EQuIP Partnership in Washington State.

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.