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.

St. Luke's Hospital, NC

St. Luke's Hospital (SLH), a member of the Carolinas HealthCare system, is a critical access hospital located in Columbus, NC, a small town nestled in the Carolina foothills region. One of 21 CAHs in North Carolina, SLH serves Polk County in North Carolina and a portion of upper South Carolina and has an average daily census of 17-18. The nearest tertiary hospitals are located in upstate North Carolina and are approximately a 25-35 minute drive from SLH.

SLH is a high-performing hospital, as evidenced by their above average HCAHPS response rate (37%), with all HCAHPS scores consistently above state and national averages. Their EDTC scores are consistently at or near 90 percent at both state and national levels, with five-star HCAHPS ratings for both "Overall Rating of Hospital" and "Willingness to Recommend this Hospital".

SLH Chief Nursing Officer Cathy Moore was asked to pinpoint the reasons for their success with the MBQIP measures, HCAHPS scores in particular. Moore stated that all success starts with leadership, including physicians. It requires staff and stakeholder buy-in, ownership and accountability; making sure everyone is at the table, everyone is heard, and that all roles in the process are acknowledged and understood. Additionally, transparency is crucial, whether it be honest discussions regarding opportunities for improvement, or public posting of metrics. A few examples of how these concepts play out at SLH include the hospitalist program, the morning huddle, the interdisciplinary treatment rounds, and discharge planning and care transition activities.

Hospitalist program and morning huddle

SLH has used hospitalists for several years. Beginning two years ago, SLH implemented a virtual hospitalist program to augment existing coverage and perceived gaps in care. SLH now has 24-hour hospitalist coverage with in-house from 7 a.m.-7 p.m. and virtual coverage from 7 p.m.-7 a.m. The virtual hospitalists work remotely – a mobile cart with a camera-equipped computer can be brought directly to the patient bedside – and can admit patients, respond to codes, provide consults and otherwise facilitate care for patients. Ms. Moore noted that this added support has helped improve physician communication at end-of-shift handoffs, which in turn has led to improved teamwork scores, responsiveness of staff to care concerns, and improved patient flow.

Each day at 8 a.m., after shift handoff takes place, SLH holds a daily hospitalist huddle. The huddle is led by the hospitalist; other participants include discharge planner and/or case manager, nursing supervisor, unit clerk, and nurse navigator. Huddle focus areas include discharges to home or other level of care and any

associated needs, a review of all foley catheters in use, patients on telemetry, review of care plans moving remaining patients, and any other urgent needs that have been identified. The huddle lasts 15-20 minutes and helps to set the tone for the day. SLH has seen significant improvements in patient throughput since inception of the morning huddle.

Interdisciplinary treatment rounds
The physician-led, daily interdisciplinary treatment rounds take place Monday – Friday at 10:30 a.m. with all disciplines reporting out following a standardized process. Focus areas include patient progress including nutritional status and goals for patient, expected day of discharge, discharge needs, medication reviews, antibiotic reviews (hospital has an antibiotic time-out during this meeting), and rehab status. On the weekends, the hospitalist, supervisor, and pharmacist on duty hold a mini-meeting to address needs.

Discharge planning and care transitions
Discharge planning is done to help ensure the patients are the recipients of the best handoffs and transitions in care. The discharge planning nurse participates in the daily morning huddle and interdisciplinary treatment rounds, assists with follow-up with external agencies and post-acute care providers, and facilitates care transitions workgroup with the North Carolina Hospital Association. Because clinics are closed on weekends making it impossible to schedule follow-up appointments, weekend discharges are covered by following a standardized process to ensure that all patient needs are met regardless of which day of the week they are discharged. Success is measured by the percent of discharged patients having a follow-up appointment within seven days.

In May of 2017, with funds obtained through a HRSA grant, a new process was implemented with the addition of a transitional care manager. The transitional care manager follows up on weekend discharges, follows up personally with more complex patients and high ED utilizers to help identify potential issues, including attending follow-up appointments if needed, and conducts group visits intended to address needs of underinsured, high ED utilizers. Although it's very early in the process, initial results indicate that the group visits are already helping reduce ED utilization among participants; longer terms results will be monitored to determine the impact on readmissions.

The hard work outlined above has had an enormous impact on St. Luke's Hospital's HCAHPS scores and is reflected particularly in the categories of discharge information, responsiveness of staff, communication with nurses, communication with doctors and care transitions.

CAHs Measure Up: Charting MBQIP Reporting Rates

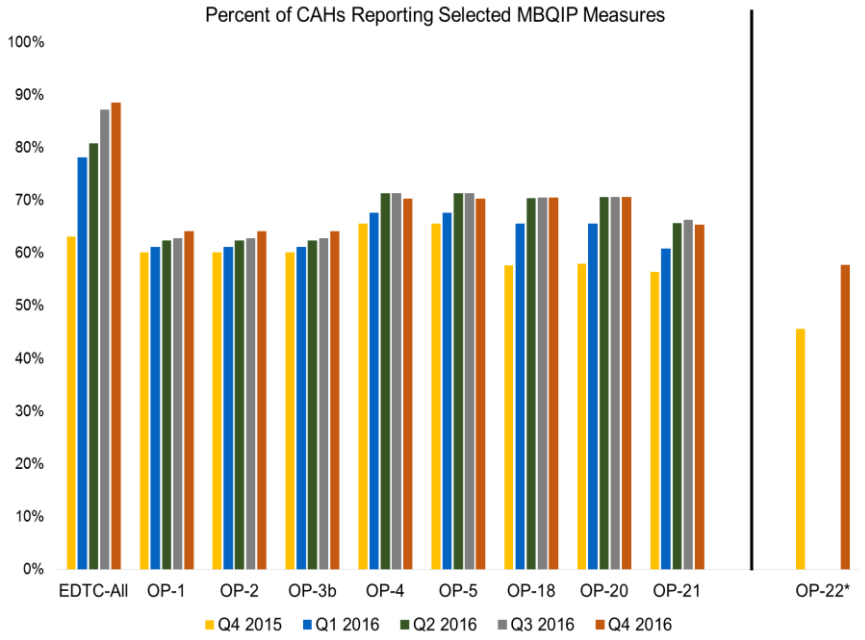
More than 1,320 CAHs (out of a total of 1,341 CAHs in the United States) were participating in MBQIP as of Q4 2016 reporting. The goal of MBQIP is to improve the quality of care provided in CAHs, which includes increasing quality data reporting by CAHs, and then implementing quality improvement activities based on that data. Both of these activities go hand-in-hand. Increased reporting can result in better benchmarking tools, and consistent reporting lends more meaning to trends – which can better inform quality improvement projects.

Quality data reporting rates by CAHs participating in MBQIP has generally increased steadily over the past several quarters:

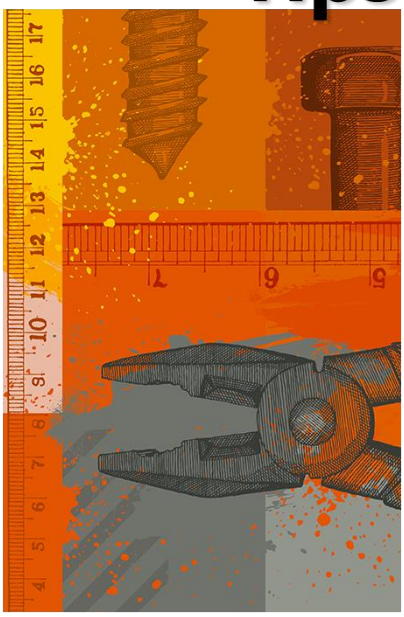
- For Q4 2015 transfers, about 63% of CAHs reported EDTC-All. By Q4 2016, nearly 90% of CAHs were reporting that measure.
- For outpatient (OP) measures reported on a quarterly basis, for patient encounter dates in Q4 2015, the number of CAHs reporting each of the OP measures was generally about 60%. By Q4 2016 patient encounter dates, between 65% and 71% of CAHs were reporting those measures.
- *OP-22 is reported once per year (for OP-22 in the chart below, the bar associated with Q4 2015 represents the percent of CAHs that reported for CY 2015 dates, and the bar associated with Q4 2016 represents the percent reporting for CY 2016 dates). Only 45% of CAHs reported OP-22 for 2015 encounter dates – for 2016 encounter dates, that rate rose to 58%.

While rates have increased over the past several quarters, they haven't been increasing as quickly as in the past. Is your hospital reporting these measures yet? If so, are you reporting them consistently? Check your MBQIP hospital data reports to be sure, and join in if your hospital is not!

Selected Measures	
EDTC-All	7 sub-measures; 27 data elements; 1 composite
OP-1	Median Time to Fibrinolysis
OP-2	Fibrinolytic Therapy Received within 30 minutes
OP-3	Median Time to Transfer to another Facility for Acute Coronary Intervention
OP-4	Aspirin at Arrival
OP-5	Median Time to ECG
OP-18	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



Tips



Robyn Quips - tips and frequently asked questions

Should patients directly admitted to your hospital from the ED be included in the Outpatient Measure sets?

Patients seen in your hospital's Emergency Department (ED) and then admitted as an inpatient should not be included in your outpatient abstractions. The outpatient population should not contain patients who are admitted to your hospital, they should be patients who are discharged or transferred elsewhere.

This question came up recently, since the population requirement of OP-18 and OP-20 is patients seen in the ED and have an E/M code. Some billing requirements allow the patients to be discharged from the ED and then admitted as an inpatient, thus they get an E/M code. These patients should not be included in the outpatient ED population. These patients are discharged for billing purposes only, they are not actually discharged from the hospital. According to CMS, patients that are admitted rather than discharged should not fall within the outpatient measure set. CMS has given direction that the data submitted for the outpatient program should not include inpatients, as they may be abstracted twice. Patients who are seen in the hospital ED and then directly admitted to inpatients should be part of the Inpatient ED measures, ED-1 and ED-2, not the Outpatient ED measures OP-18 and 20.

However you determine your outpatient measure populations, patients who are seen in the ED and then admitted as an inpatient should be removed. This applies to all the outpatient measures, AMI (OP 1-5), Chest Pain (OP 4-5), and Pain Management (OP 21) as well as OP 18 and OP 20.

NEW HCAHPS Pain Management Questions Have Been Posted

Beginning with patients discharged in January 2018, CMS replaced the current HCAHPS Pain Management questions (items 12, 13 and 14 on the HCAHPS Survey) with three new questions that will comprise a new composite measure, "Communication About Pain."

Previous Pain Questions	Newly Finalized Pain Questions
• During this hospital stay, did you need medicine for pain? ☐ Yes ☐ No	• During this hospital stay, did you have any pain? ☐ Yes ☐ No
• During this hospital stay, how often was your pain well controlled? ☐ Never ☐ Sometimes ☐ Usually ☐ Always	• During this hospital stay, how often did hospital staff talk with you about how much pain you had? ☐ Never ☐ Sometimes ☐ Usually ☐ Always
• During this hospital stay, how often did the hospital staff do everything they could to help you with your pain? ☐ Never ☐ Sometimes ☐ Usually ☐ Always	• During this hospital stay, how often did hospital staff talk with you about how to treat your pain? ☐ Never ☐ Sometimes ☐ Usually ☐ Always

The new pain items will be required on all surveys administered to patients discharged from January 1, 2018 and forward. This change will affect all survey translations and all survey modes. The official versions of the new Pain Management items for all survey modes and in all language translations have been posted.

Please click here to access a copy of the updated survey.

Go to Guides

Hospital Quality Measure Guides

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

Tools and Resources

Re-Engineered Discharge (RED) Toolkit: In this month's CAHs Can! article, Saint Luke's Hospital in North Carolina identified having a standardized process for discharge planning as one of their strategies to improve HCAHPS scores, and reduce readmissions. The RED Toolkit provides a wealth of resources and implementation process for this evidence-based improvement strategy.

Influenza vaccination season is around the corner! These resources can assist your hospital in improving vaccination rates and reporting data:

Healthcare Professional Flu Measure (OP-27) Webinar. This recorded webinar provides an overview of the Healthcare Professional Flu Measure (OP-27) including how to sign up for an account through the National Safety Healthcare Network (NHSN), the measure submission process, and available quality improvement support.

A Toolkit for Long-Term Care Employers: Increasing Influenza Vaccination among Health Care Personnel in Long-term Care Settings. Although focused on long-term care settings, this new resource from the Centers for Disease Control and Prevention (CDC) provides strategies and resources to support vaccination among health care personnel that also may be applicable in hospital settings.

Influenza Immunization Strategies. Implementation of standing orders to support influenza vaccination of hospitalized patients is a proven strategy for increasing vaccination rates. Resources supporting implementation of a standing order strategy are highlighted.

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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