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.

Barrett Hospital & Healthcare, MT

Barrett Hospital & Healthcare (BHH) is an 18 bed critical access hospital (CAH) located in the southwest Montana town of Dillon, with an average daily census of about six. The primary service area is Beaverhead County, an area of over 5,500 square miles, and parts of western Madison County, serving a total population of approximately 10,000. The nearest community hospital with 75 beds is over 60 miles to the north in Butte. In addition to being a high performer on MBQIP measures and maintaining a HCAHPS 5-star rating on Hospital Compare, BHH has been named a top CAH by The National Rural Health Association (NRHA), and iVantage Health Analytics.

"Failure is not an option"

When talking about BHH's MBQIP performance with BHH CEO Ken Westman, Quality-Risk Director/ Compliance-Privacy Officer Maria Koslosky, RN, and Quality Coordinator Ben Power, a recurring theme in the conversation was "failure is not an option." The goal at BHH is zero harm: No harm is acceptable, and no excuse is acceptable. According to Westman, "This is not a flavor of the month for us – we live and breathe it. When an event occurs, we work relentlessly to understand why it happened and make sure it never happens again." Koslosky states BHH has a strong, focused leadership team that works well with dedicated medical and hospital staff, and a highly engaged board whose members place patient safety and quality as the number one priority. Starting with the organizational strategic plan, they subscribe to a rigorous process of understanding why failures occurred, involving front line staff in designing process-oriented solutions to prevent recurrent failures. BHH senior leadership council meets weekly and discusses all harm and near-miss events down to the root cause. An important element in these discussions is personalization – putting names and faces to events, rather than diagnoses or room numbers, and inviting patients and families to board and other meetings to tell their stories.

Organization-wide lean methodology

One improvement strategy BHH has embraced is lean management principles – driving out waste to ensure that all work adds value. BHH has in-house lean trainers working towards the goal of educating all staff in lean methodology, and requires that every department at BHH work on an annual lean project. Power states, "This changes the role of the quality department – we are not the experts on how people do their work – they are – and they lead the work.

Our role is to coach, facilitate and mentor our experts in their quality improvement efforts. We help them make their own jobs better."

Another strategy is data education and transparency. Data are viewed as the backbone for all safety and performance improvement (PI) projects, and are extracted from various sources and shared widely. Mentoring includes helping staff understand data, measurement, and what improvement actually means. Power notes, "It's not just tracking data. We are committed to continuously improving our culture of improvement." The hard work is paying off – more and more staff members speak in terms of data and lean methodology when describing their projects and how they will evaluate success. Power states, "The richness of PI projects our staff is now designing is nothing short of amazing."

Barrett Hospital Leadership Council reviewing Help Chain Harm, Near Harm, and Near Miss events

MBQIP Success stories

BHH began HCAHPS participation in 2007. In addition to the HCAHPS 5-star rating, BHH also received the Hurst Analytics Gold Standard of Nursing Award for top tier performance of nursing-specific HCAHPS scores. Success is attributed to many factors: team building work; strong and supportive nursing and provider leadership; the addition of a hospitalist program that understands the importance of direct communication with patients; regular staff and leadership rounding that encourage patients to ask questions and speak up with concerns; bedside reporting at shift change; focused initiatives around use of white boards and medication education; and sharing HCAHPS data in meaningful ways. For example, if a patient starts a new medication, regular white board audits will reveal whether the discussion was reflected on the white board in the patient's room. Completed audits are correlated with HCAHPS scores for the same timeframe and shared with staff, with feedback like "We noticed that you were diligent about capturing medication education on white boards – HCAHPS scores for medication improved during that time."

Healthcare worker vaccination

For the 2016/2017 flu season, BHH launched an all-out campaign to improve upon the previous year's performance. They employed several tactics, including a focus on fun. They encouraged participation by using board members, leadership, medical staff, department managers in weekly newsletter testimonials, demonstrated campaign measurement using a prominently placed large red thermometer, provided easy access to immunizations by having the infection prevention nurse attend meetings to administer shots on the spot, and implemented a mask policy to protect patients and other care givers from staff who chose to not be immunized. When the campaign was complete, BHH had a 98 percent employee vaccination rate and 95 percent overall (volunteers, etc.). One resource BHH used when designing the campaign was the Association for Professionals in Infection Control – strategies for improving HCW immunization rates.

Koslosky notes success isn't always easy. "It takes a lot of team effort to attain high performance, and just as much or more to stay there. But we're not afraid to work hard!"

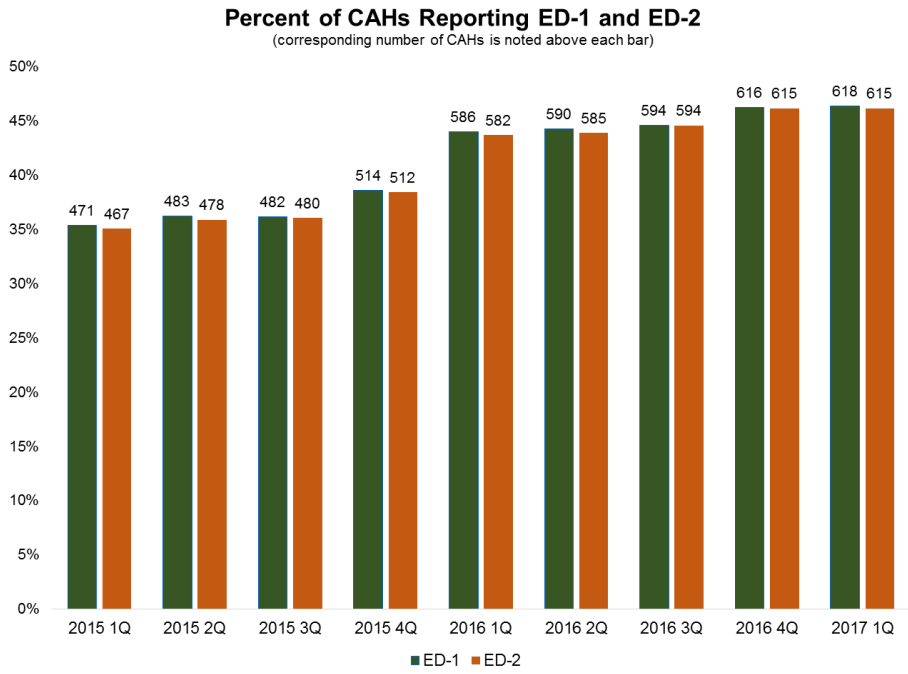
CAHs Measure Up: New ED Measures Equal New Improvement Opportunities

Several new inpatient emergency department measures have been added for MBQIP reporting:

- ED-1 (Median Time from ED Arrival to ED Departure for Admitted ED Patients)
- ED-2 (Admit Decision Time to ED Departure Time for Admitted Patients)

ED-1 and ED-2 are corollary to the Outpatient Throughput measures (OP-18, OP-20). The Outpatient ED Throughput measures include patients who are discharged or transferred from the ED. Patients included in the ED-1 and ED-2 measures are admitted for an inpatient stay from the ED. (CMS considers ED-1 and ED-2 to be Inpatient measures, since the population for the measures is patients with an inpatient stay.)

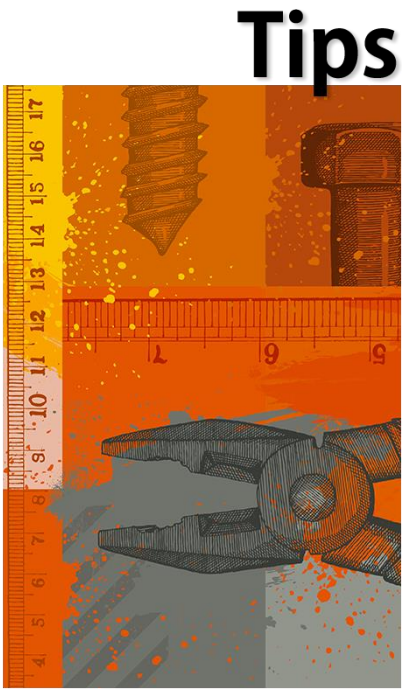
The first quarter of required MBQIP reporting for CAHs is Q3 2017 (submission deadline February 1, 2018). However, you will begin to see these measures on your hospital-level MBQIP Patient Safety and Outpatient reports starting Q2 2017, and several quarters of data will be available via those reports. The percentages (and corresponding number) of the 1,332 CAHs participating in MBQIP that are reporting each measure are shown in the chart below.



There has been an increase in CAH reporting on these measures in recent years, with 35 percent of CAHs reporting the measures in Q1 2015, increasing to about 46 percent of CAHs reporting the measures in Q1 2017. In terms of performance, for Q1 2015, the average median time for reporting CAHs was about 200 minutes for ED-1, and about 69 minutes for ED-2*. For Q1 2017, the average median time for reporting CAHs was about 202 minutes for ED-1, and about 61 minutes for ED-2*. Shorter times are generally better for these measures.

Is your hospital reporting these measures? Do you have opportunities for improvement?

*Due to the type of data available, calculated by taking the median of all reported median times for CAHs



Robyn Quips - tips and frequently asked questions

Outpatient Population and Sampling Fix

CMS sent out notification on 10/17/2017 that the issue with reporting the outpatient population and sampling had been fixed. Hopefully you saw that email or heard it from the announcement RQITA send out through the Flex Coordinators, and were able to enter your population and sampling data for this Q2 2017 data submission. For an explanation of why the MBQIP program requests you enter this data along with instructions on how to enter, please refer back to the October 2016 MBQIP Monthly.

Inpatient ED Measures Reporting

In last month's issue I talked about how to determine the population for the inpatient ED measures, ED-1 and ED-2. There have been some CAHs already reporting on this data and we've seen what might be a potential problem with a few of the population and sampling numbers. There were a few CAHs reporting a zero for their ED-1 & ED-2 population. The only way this would be accurate is if the CAH had no inpatient acute care discharges for that quarter.

Why is that you might be asking? Because the population requirements for the inpatient ED measure set is "all patients discharged from acute inpatient care with a length of stay less than or equal to 120 days". So as long as you had a patient who was discharged from acute inpatient care in less than 120 days, you would have cases that met the inpatient ED population. Again, the only way your inpatient ED measure set population would be zero is if you had no inpatient discharges for the quarter.

If you are new to abstracting the inpatient ED measure set, or would just like to makes sure you are pulling the correct population, I've recorded a new session to the MBQIP Abstraction Training Series posted on YouTube. Session 8 is on the Inpatient ED measure set, ED-1 and ED-2. Check out the Tools and Resources section in this issue for the link to the sessions.

Go to Guides

Hospital Quality Measure Guides

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

Tools and Resources

Updated! Online MBQIP Abstraction Training – ED-1/ED-2 Video Now Available! This recorded training series is for critical access hospital (CAH) staff with responsibility for data collection of the Centers for Medicare & Medicaid Services (CMS) Inpatient and Outpatient quality measures. These short videos provide a comprehensive overview of the process to identify each measure population and abstract the required data elements.

Ask Robyn – Quarterly Open Office Hour Calls for Data Abstractors
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).

Leading a Culture of Safety: A Blueprint for Success
Patient safety experts and researchers have increasingly pointed to the role of organizational culture in the success of patient and workforce safety initiatives. Yet, creating a culture of safety in healthcare settings has proven to be challenging, and there is a lack of clear actions for organizational leaders to take in developing such a culture.
Developed by an expert roundtable convened by the American College of Healthcare Executives and the Institute for Healthcare Improvement/National Patient Safety Foundation, this resource was designed to bridge this gap in knowledge and resources by providing CEOs and other leaders with a useful tool for assessing and advancing their organization's culture of safety. This guide can be used to help determine the current state of an organization's journey, inform dialogue with the board and leadership team, and help leaders set priorities.

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.

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.