

Medicare Beneficiary Quality Improvement Project



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

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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.

## CAHs Can! Year-end Review: What Makes Great CAHs

Over the past three years, MBQIP Monthly staff have had the great privilege of interviewing 32 critical access hospitals to learn about the factors that drive success in their quality programs. To date, three summary articles have highlighted best practices for a variety of measures. In [December 2016](#) and again in [December 2017](#), the summary articles included suggested strategies for improving performance on influenza immunizations for patients and healthcare personnel, patient experience as measured by HCAHPS, Emergency Department Transfer Communication (EDTC), and outpatient care including AMI/Chest Pain and emergency department throughput. More recently, the [July 2018](#) CAHs Can article focused on examples of actions implemented to improve antibiotic stewardship, the newest of the MBQIP core measures.

To kick off 2019, we wanted to build on these summaries, sharing some additional promising practices for MBQIP measures, including the inpatient emergency department measures, ED-1 and ED-2 which were added as core MBQIP measures in late 2017, as well as reflect on some of the more general quality improvement themes that have emerged over the past year.

### ED-1 and ED-2: Median Time from ED Arrival to ED Departure for Admitted ED Patients and Admit Decision Time to ED Departure Time for Admitted Patients

- Develop a cross-unit team focused on improving transition workflows
- Move from a process in which the ED is “pushing” the patient to one in which the inpatient unit is “pulling” the patient from the ED
- Reframe and rename the measure to focus on where the patient ends up - “hospital throughput” - vs. where the patient originated - “emergency department throughput”
- Implement bedside transfer in the ED

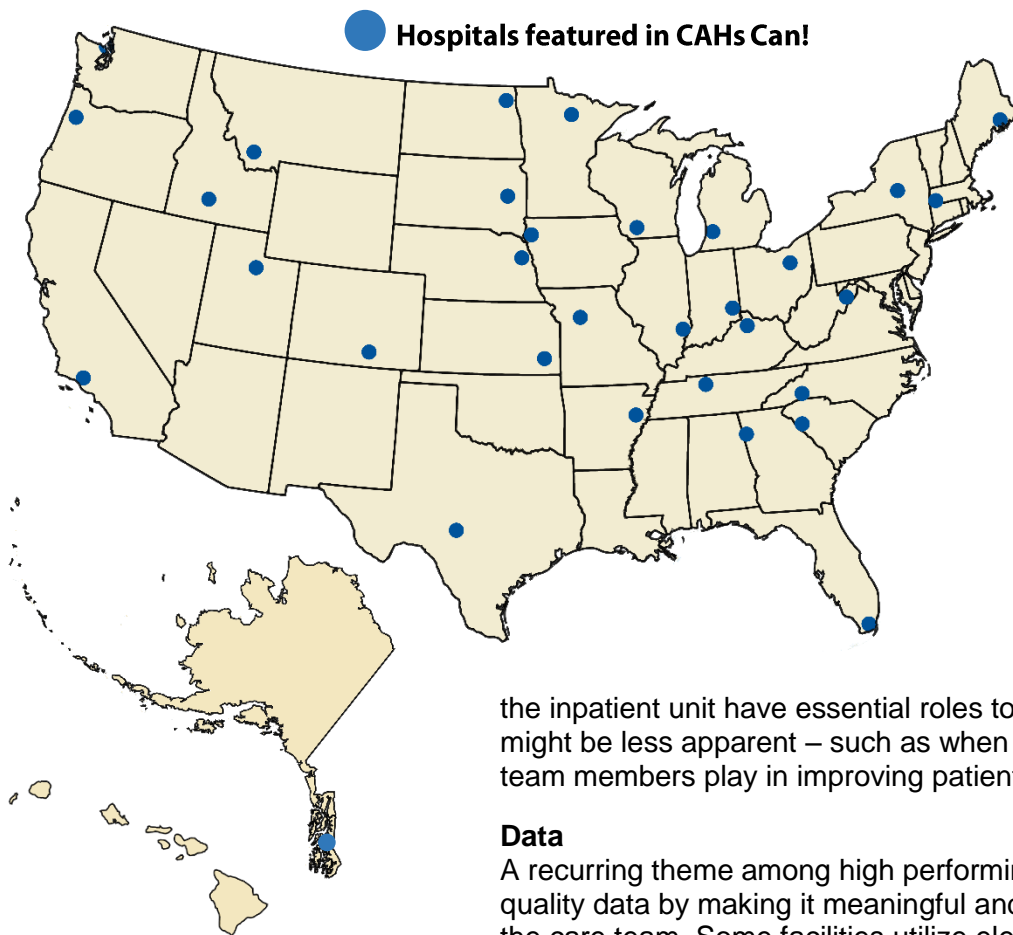
### Rounding

Rounding has been a hot topic in hospital quality for quite some time now and the MBQIP CAHs Can hospitals are all incorporating some combination of these strategies into their work:

- Team/bedside rounding – Daily rounds for inpatients involving multidisciplinary team members responsible for various aspects of

patient care. Depending on the facility the team can vary, but examples from this year included: physician, nursing, pharmacy, scribe, social work, case managers, infection control, quality leadership, dietician, respiratory therapists, physical therapists, environmental services staff, nursing assistants, etc. The key is identifying the appropriate team for each patient and having a consistent time and process to follow for rounds. A majority of facilities have moved this daily process to the bedside, incorporating the patient and family into the team.

- Intentional/purposeful rounding – A practice used by nursing and care teams in which routine rounds on patients are conducted routinely (often hourly), employing an intentional approach with the goal of improving patient care, safety and experience.
- Leadership rounding – A practice used by hospital leaders to connect with patients and/or hospital staff. Many hospitals incorporate leadership rounding on patients, either as part of the team rounding described above or as a separate activity, as an opportunity for patients to provide leaders feedback about their experience. It’s an opportunity for real-time quality improvement. With regards to rounding on staff, leaders from the organization take time to visit with frontline staff, ensuring they have the resources and support they need to do their work.



**Cross-Unit Teams**

Beyond team rounding, there were numerous examples from hospitals interviewed this year regarding the importance of pulling together cross-unit teams. Sometimes it can be cumbersome in the short term to bring together people from across departments, but often there is significant value in the perspectives folks with different roles bring to a given issue, and the long-term gains are worth the investment. In some cases, the need for a cross-unit team might be obvious, for example, when addressing throughput times for patients admitted to inpatient from the emergency department.

In those cases, both the ED and the inpatient unit have essential roles to play. In other cases, the relevance might be less apparent – such as when considering the role non-clinical care team members play in improving patient experience.

**Data**

A recurring theme among high performing hospitals is making good use of quality data by making it meaningful and easily accessible to all members of the care team. Some facilities utilize electronic portals or dashboards, while some use paper and bulletin boards. Some facilities incorporate quality data review into daily morning huddles and others invite frontline staff to participate in their quality committees. Regardless of the methods, the focus

is on calling attention to the data to help staff understand their role in improvement and making their work meaningful.

### Measures that Matter

Hospitals are selected for CAHs Can interviews because of their high performance on the MBQIP Core measures. These facilities appreciate the relevance of the MBQIP core measures to their work and the outcomes and experience of the patients they serve. They also recognize the importance of identifying other quality measures that have significance for their patient populations and their organizational strategies. Such measures varied across the facilities highlighted in 2018, including reducing readmissions, stroke, STEMI, perinatal care, healthcare-associated infections, and care coordination for patients with co-morbidities. Focusing quality data and improvement efforts on measures that matter helps ensure staff engagement

### Other Approaches

There are many similarities among high performing CAHs, but also unique and individualized approaches to consider. Examples from this past year include:

- Margaret Mary Health's focus on improving their patient safety culture ([January 2018](#))
- Lean methodology and rapid cycle improvement at Polk Medical Center ([February 2018](#))
- Morning huddles at Carroll County Memorial ([March 2018](#))
- The focus on creating a High-Reliability Organization at Aultman Orrville Hospital ([April 2018](#))
- Workflow redesign at Hampshire Memorial Hospital focused on improving care transitions ([May 2018](#))
- Development of the Patient Satisfaction Committee at First Care Health Center ([June 2018](#))
- Data transparency at Fairview Hospital ([August 2018](#))
- Mission control boards in Abbeville Area Medical Center ([September 2018](#))
- Use of the Institute for Healthcare Improvement framework at Jefferson Healthcare Medical Center ([October 2018](#))
- The Leadership Summit for Youth convened by St. Elizabeth Healthcare focused on reducing drug and alcohol use, improving mental health, and preventing suicide ([November 2018](#))

We're excited to continue learning about the great work critical access hospitals are doing around the country to improve quality of care and patient outcomes. We hope you'll explore with us through the CAHs Can highlights in 2019.

# Data

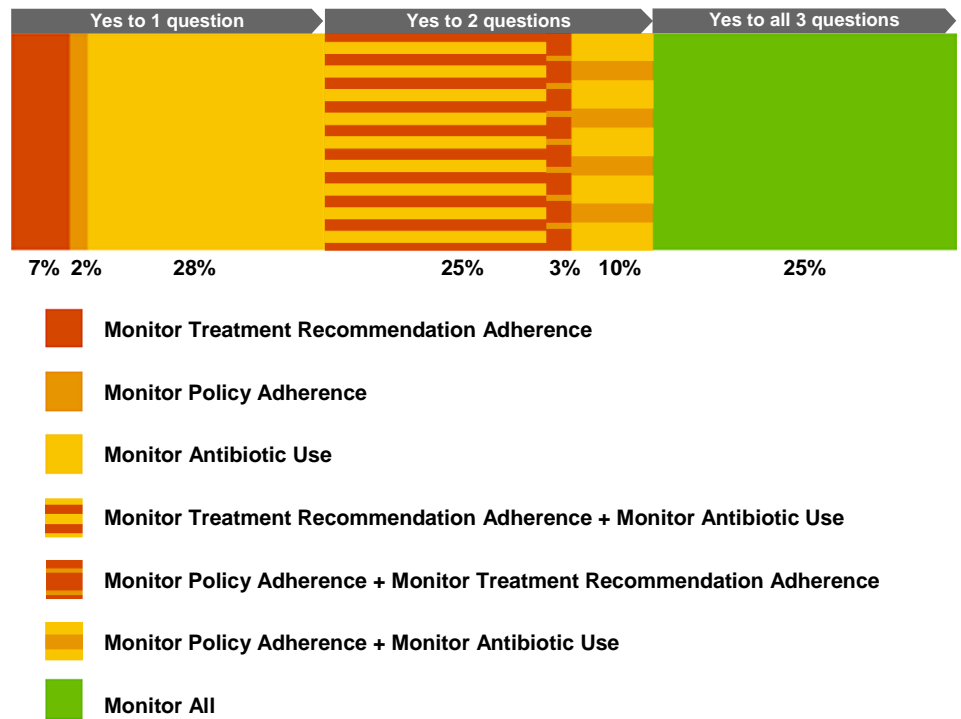


## Antibiotic Stewardship Tracking

As of August 2018, 1,080 CAHs submitted the 2017 Annual Facility Survey. A total of 877, or 81%, have indicated that they are meeting the Core Element of *Tracking* for [antibiotic stewardship programs](#) as collected through the National Healthcare Safety Network’s Annual Facility Survey. CAHs can meet the Core Element of *Tracking* by answering ‘Yes’ to at least one of the following three questions:

- If your facility has facility-specific treatment recommendations based on national guidelines and local susceptibility to assist with antibiotic selection for common clinical conditions, has adherence to **facility-specific treatment recommendations** been **monitored**?
- If your facility has a policy that requires prescribers to document an indication for all antibiotics in the medical record or during order entry, has **adherence to the policy** been **monitored**?
- Does your facility **monitor antibiotic use** (consumption) at the unit, service, and/or facility wide?

### 100% of CAHs Meeting Core Element of *Tracking* (877)



Among these 877 CAHs, 533 have indicated monitoring adherence to treatment recommendations, 354 have indicated monitoring adherence to policy, and 767 have indicated monitoring antibiotic use. However, as highlighted above, many CAHs are meeting the Core Element of *Tracking* by indicating that they are monitoring not just one, but two or even all three of these tracking items – an admirable goal!

Compare your hospital’s Annual Facility Survey to the data above. How do you compare? Where do you want to improve?

# Tips



## Robyn Quips - tips and frequently asked questions

### Year-end and New Year Abstraction Reminders

The end of 2018 is behind us – except for your abstraction and data submission! Data submission for Q3 2018 isn't until February so make sure you still abstract the measures that aren't slated for removal until 2019. You still have two more quarters, Q3 2018 and Q4 2018 to abstract the inpatient measures:

- IMM-2: Immunization for Influenza
- ED-1: Median Time from ED Arrival to ED Departure for Admitted ED Patients

The Outpatient measure OP-5: Median time to ECG continues to be abstracted thru Q1 2019. CMS is removing that measure starting with Q2 2019 data submissions.

The year-end means you can start pulling together your OP-22, Left Without Being Seen data. This measure consists of the percent of patients who leave the emergency department without being evaluated by a physician, advanced practice nurse (APN), or physician assistant (PA). Based on previous years, data for calendar year 2018 is anticipated to be due to the QualityNet warehouse May 15, 2019. CMS will let hospitals know when QualityNet will be open for that data submission.

Your hospital should continue collecting OP-27– Influenza Vaccination Coverage Among Healthcare Personnel (HCP). You may have heard that CMS is removing that measure, but it's really just being removed from the outpatient list and will now be only an inpatient measure. It will start being referred to as HCP rather than OP-27.

EDTC data submission is coming up at the end of the month – a reminder about the population for that measure. It's not only for patients being transferred to another acute care hospital. Patients who are being transferred to skilled nursing facilities, nursing homes, swing beds, and other facilities are to be included in the EDTC population for abstraction. If you are not including these cases, you are not abstracting the measure correctly.

Also, it's incorrect to assume that since you have a shared electronic health record (EHR) with the facility you are transferring the patient to that you can state you meet the data elements 100 percent. Documentation must indicate that the required data elements were entered into the EHR and made available to the receiving facility before patient transfer for the communication data elements and within 60 minutes of discharge for all the others. Please refer to the [EDTC Data Specifications Manual](#) to check on the population and EHR requirements.

### Open Office Hours Call

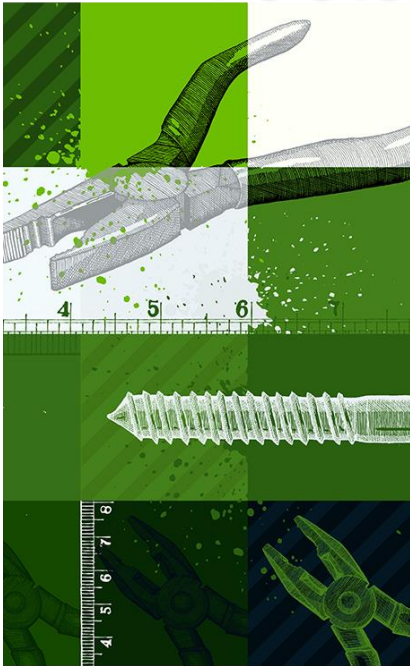
The next Open Office Hours Call for Data Abstractors is January 9, 2019. These calls are for abstractors to be able to ask questions specifically about abstraction, like how to determine the ED-1 and ED-2 measure population, or what documentation is acceptable for determining transfer for acute coronary intervention. Your questions drive the call. There are no dumb 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! 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 Quality 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 Wednesday, January 9, 2019 2:00 – 3:00 p.m. CT [Register](#)

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))

### Updated! [MBQIP Data Submission Deadlines Chart](#)

Single page document contains a chart showing the MBQIP data submission deadlines.

### [Study of HCAHPS Best Practices in High Performing Critical Access Hospitals](#)

Start the New Year with a fresh look at best practices for improving patient experience! Strategies and effective best practices for each component of HCAHPS, were collected from high performing critical access hospitals across the U.S. during a series of focus group interviews.

### [Implementation of Antibiotic Stewardship Core Elements at Small and Critical Access Hospitals](#)

Provides guidance on practical strategies to implement antibiotic stewardship programs in small and critical access hospitals (CAHs). Suggestions provided are based on discussions with staff in small and CAHs, several of which have implemented all of the Centers for Disease Control and Prevention Core Elements.

**Leadership Rounding** is a common strategy for improving quality, patient safety, and employee engagement. Resources on implementation include: [Patient Safety Leadership Walkrounds](#) from the Institute for Healthcare Improvement (IHI).

[Rounding for Outcomes](#) from the Studer Group.

A free registration may be required to access these materials.



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) as part of an award totaling \$625,000 with 0% financed with non-governmental sources. The contents are those of the author(s) and do not necessarily represent the official view of, nor an endorsement, by HRSA, HHS or the U.S. Government. (11/2018)*