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: Avera Marshall Regional Medical Center, MN

Located in far Southwest Minnesota is Avera Marshall Regional Medical Center. Part of the larger South Dakota-based Avera Health System, Avera Marshall is like a mini health system itself, with a critical access hospital, including a birth center, several inpatient and outpatient surgical services, a cancer center, a nursing home, behavioral health unit, primary care clinics, and more. The service area of Avera Marshall reaches beyond the confines of the town in roughly a 100-mile radius including into Iowa.

Some hospitals struggle to identify what's driving their quality efforts, but Avera Marshall is on a clear path. They recently wrapped up a five-year journey with the Studer Group focused on leadership development and improving patient experience. The lessons learned from that initiative continue to be essential to how they carry out their work. More recently they have shifted focus to implementing strategies to support the culture of Lean daily management. This has involved formalizing a mentorship with another health system in the state as they aim to standardize use of visual management boards, agile problem-solving processes, and a three-tiered huddle process that serves as a means to elevate issues that can't be resolved at the unit level through the chain of command.

These three Lean daily management concepts work together to support quality improvement at the organization. All huddles convene around a visual management board, where teams track on metrics central to their work. During huddles, teams use standard problem-solving processes to identify potential solutions.

A specific example of a tier one huddle, which happen first thing each day in each unit, can help illustrate the process and highlight some promising practices adopted from Avera Marshall's time as a Studer hospital. The environmental services (EVS) team works hard to improve the HCAHPS cleanliness score, focusing not only on cleaning patient rooms, but also ensuring patients are engaged in the process. EVS staff are expected to either directly engage with patients during the cleaning process, or, if the patient isn't in the room at the time of the cleaning, leave a card letting them know the room was cleaned. Tracking on this engagement is a key performance indicator captured on the team's visual management board and

linked to the overall goal of improving the HCAHPS cleanliness score. Daily review ensures accountability and allows the team to troubleshoot issues, elevating them to a tier two huddle if needed.

Avera Marshall EVS team and their tier 1 huddle board.

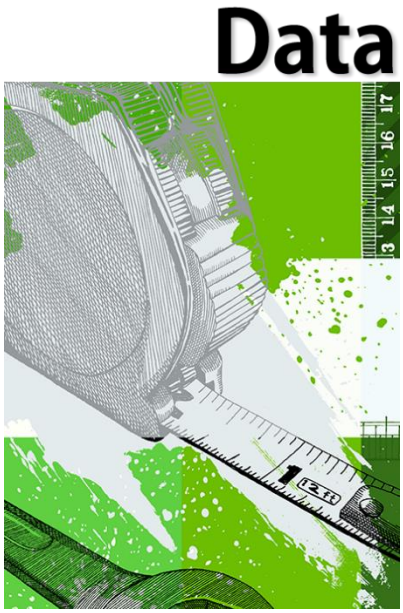
Another focus area for HCAHPS found on visual management boards is related to the discharge process. Like many hospitals, Avera Marshall has found that despite being confident all patients received discharge information, patients are not reflecting that experience when completing their HCAHPS survey. Furthermore, the organization is committed to improving care transitions, reducing readmissions, and has set a goal to complete discharges by 1:00 p.m. each day. To this end, discharge planning begins when a patient is admitted to the facility and patients are engaged in the process from the start. Follow-up appointments are scheduled before the day of discharge, and a team meets daily each morning to talk about discharge planning, including the physician, social worker, long-term care manager if appropriate, and the pharmacist, who can prioritize completing timely medication reconciliation. Ensuring these items are addressed early not only helps to keep things on schedule, but also allows ample time to talk to patients about what to expect next regarding follow-up, any changes to medication, and the discharge plan, which is provided in writing in a folder clearly labeled Discharge Folder. All patients receive a follow-up call from the facility the next day, offering an opportunity for further education, and ensuring the process is as seamless as possible.

Beyond the core MBQIP measures, Avera Marshall is tracking on a myriad of other quality metrics, including those related to their busy birthing center, which delivered 570 babies in 2018, and multiple surgical services, including: orthopedics, ophthalmology, podiatry, and a newly launched bariatric service. The birth center has successfully maintained a zero elective early delivery rate after implementing a policy requiring the Chief Nursing Officer to review any requests for early delivery that don't meet the exception criteria as laid out in the PC-01 measure. Also, Avera Marshall is an active participant in the Hospital Improvement and Innovation Network (HIIN), in part focusing on reducing healthcare-associated infections, including surgical site infections.

Avera Marshall Regional Medical Center.

Avera Marshall is a high performer in another area of infection control with regards to influenza immunizations both among healthcare personnel, who are oriented to the expectation upon hire and among inpatients. They recently implemented a bi-directional flow of information with the state immunization record system and track closely on immunization rates as a metric tied to their accountable care organization.

A comprehensive and standardized approach to engaging all staff in quality measurement and improvement enables Avera Marshall to achieve high performance now and into the future.



Internally Monitoring OP-22

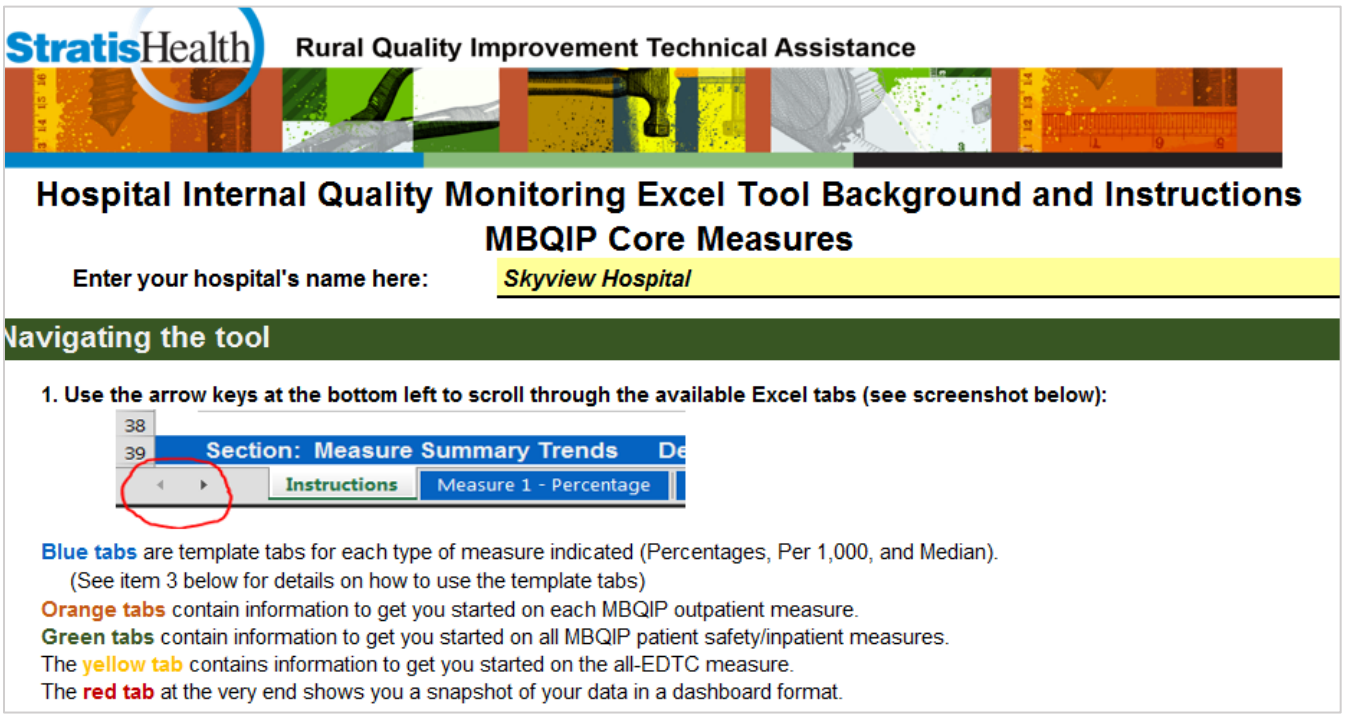
In this month's Robyn Quips, Robyn reminds us that submissions for the measure OP-22 (percentage of patients who leave the emergency department (ED) without being seen) are due soon! The encounter period for OP-22 is a full calendar year. In CAHs Measure Up, we'll discuss some ways you could track on this measure more frequently than just once a year when you submit it. This way, your hospital can more quickly adjust practices when it sees unexpected results in its data. RQITA's Internal Quality Monitoring Tool (part of the Quality Improvement Implementation Guide and Toolkit for Critical Access Hospitals) can help you do just that.

This Excel-based tool is for internal use at your hospital. It does not replace any reporting requirements. However, the tool can help you track progress and have all your data ready for state and national reporting. You might consider entering data into this tool monthly to track progress. And if it's an option, a good place to start is to enter past data to provide you a picture of where hospital's performance.

Getting started with the Internal Quality Monitoring Tool

Here are step-by-step instructions on how to start using the Internal Monitoring Tool for tracking OP-22 monthly within your CAH. We've created the fictitious "Skyview Hospital" to illustrate.

1. Download and save the tool to your computer network.
2. Open the tool and review the instructions tab. Enter your hospital's name in the yellow box:



3. Click on the "OP-22 Percentage" tab at the bottom of your screen. You will need to scroll several tabs to the right to see it. The "Instructions" tab explains how to scroll.
4. Complete the missing information in the yellow boxes under Background Information. The months and years are automatically updated in the Monthly Measure Summary Trends for OP-22 table and the graph to the right, based on the Frequency of Monitoring and Start Date of Monitoring that you enter.

5. If it's available, enter six months to one year of past data in the yellow boxes of the table Monthly Measure Summary Trends for OP-22. This will help you establish a past monthly baseline for OP-22 at your hospital, which will be useful to compare against your real-time data going forward. The percentage column will calculate automatically.

We've entered hypothetical data in the table below to illustrate, along with a potential goal (what the Skyview Hospital hopes to achieve) and some comments. The chart to the right of the table will automatically be populated with data (blue line) and the goal (horizontal orange line) using what is entered in the table.

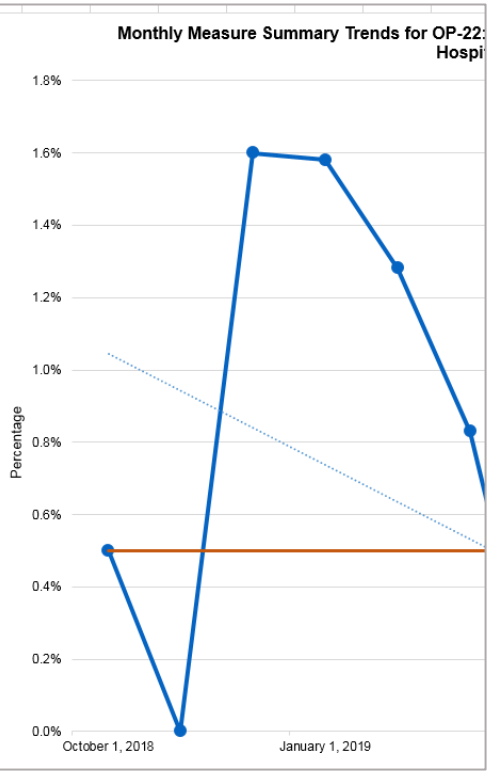
Background Information	
Name of Hospital or Unit:	Skyview Hospital
Name of Measure:	OP-22: Patient Left Without Being Seen
Frequency of Monitoring:	Monthly
Start Date of Monitoring:	10/1/2018
Data Source:	Hospital tracking
What is the numerator?	# of pts. who left w/o eval
What is the denominator?	# of pts. who presented to ED
Notes:	Outpatient MBQIP Domain, ED throughput measure set, goal is a decrease in the rate (percent)

Only update/enter data in the yellow-highlighted cells. All others will automatically update.

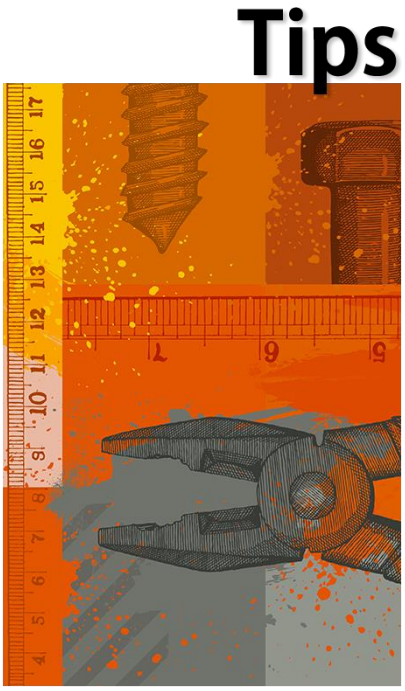
Once you've chosen a frequency and start date for monitoring and started entering data, don't change the frequency or start date for monitoring in this tool without also updating the data or your data will no longer match up to the dates.

Monthly Measure Summary Trends for OP-22: Patient Left Without Being Seen (Skyview Hospital)

Monthly Encounters for Month Starting:	Numerator	Denominator	Percentage	Your Goal	Notes or comments	Date Data Entered
October 1, 2018	1	200	0.5%	0.5%	Looked back at data	3/10/2019
November 1, 2018	0	231	0.0%	0.5%	Looked back at data	3/10/2019
December 1, 2018	4	250	1.6%	0.5%	Looked back at data	3/10/2019
January 1, 2019	4	253	1.6%	0.5%	Looked back at data	3/10/2019
February 1, 2019	3	234	1.3%	0.5%	Looked back at data	3/10/2019
March 1, 2019		241	0.8%	0.5%	Entered after end of month	4/2/2019
April 1, 2019			N/A	0.5%		
May 1, 2019			N/A	0.5%		
June 1, 2019			N/A	0.5%		
July 1, 2019			N/A	0.5%		
August 1, 2019			N/A	0.5%		
September 1, 2019			N/A	0.5%		
October 1, 2019			N/A	0.5%		
November 1, 2019			N/A	0.5%		
December 1, 2019			N/A	0.5%		
January 1, 2020			N/A	0.5%		
February 1, 2020			N/A	0.5%		
March 1, 2020			N/A	0.5%		



6. As each month passes, you can update the tool with that month's data. Consider using the data table or the graph as a conversation starter with key staff at your hospital. Based on what you see, you might bring together a few people from the ED or your administration.
   a. If you notice a trend in the wrong direction or if it's taking longer to achieve your goal than you planned, talk about best practices or areas for improvement. Consider using other resources within the Quality Improvement Implementation Guide and Toolkit for Critical Access Hospitals (including the Quality Improvement Measure Summaries) to help plan your next steps.
   b. If you see progress, celebrate the success!



Robyn Quips - tips and frequently asked questions

Measures OP-22 and HCP/IMM-3 (formerly OP-27)
May 15 is the once-yearly submission due date for measures OP-22: Left Without Being Seen and HCP/IMM-3 – Influenza Vaccination Coverage Among Healthcare Personnel. If you are new to these measures, here are some resources to assist you in submitting them.

OP-22 - Left Without Being Seen
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). The May 15th due date is for encounters in the previous calendar year, January 2018 – December 2018. Because this measure uses administrative data and is not chart-abstracted, CMS does not specify how to collect the data. Instructions on what data needs to be collected and where to submit that data can be found starting on page six of the MBQIP Quality Reporting Guide.

HCP/IMM-3 - Influenza Vaccination Coverage Among Healthcare Personnel
The May 15 due date is for the flu season October 2018-March 2019. Data is submitted to the National Healthcare Safety Network (NHSN), and your facility must be enrolled in NHSN to report the measure. If you're confused about what happened to OP-27, refer to my column in the March MBQIP Monthly. Training materials and FAQs on how to submit this data are available on the NHSN website and page 12 of the MBQIP Quality Reporting Guide.

Open Office Hours Call for Data Abstractors
The next open office hours call for your MBQIP data abstraction questions will be Wednesday, April 17, 2019.
I usually don't have an agenda, this is your opportunity to ask abstraction questions, but this time I will start the call talking about the Emergency Department Transfer Communication (EDTC) measure. In doing the Abstracting for Accuracy project and while answering abstraction questions, it has come to my attention that many CAH's are not pulling the correct population for the measure. You aren't at 100 percent on the measure if you're not abstracting all the cases that should be in the population! Flex Coordinator's, if your CAH's are always at 100 percent, that's great, but are they really? Maybe not if they're pulling the incorrect population.
The call is free, but registration is required. The link to register is on the Tools and Resources page of this issue.

Go to Guides

Hospital Quality Measure Guides

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

Tools and Resources

Ask Robyn – Quarterly Open Office Hours Calls for Data Abstractors
Wednesday, April 17, 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.

Updated! MBQIP Quality Reporting Guide
Intended to help Flex Coordinators, critical access hospital staff and others involved with the Medicare Beneficiary Quality Improvement Project (MBQIP) understand the measure reporting process. 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 those measures to the site.

Antibiotic Stewardship Core Elements Report and Crosswalk
Instructions for how to run a report of answers submitted in the survey as they relate to implementation of the Core Elements of Antibiotic Stewardship and a mapping of survey questions to Core Elements.

National Healthcare Decisions Day (NHDD) is April 16
NHDD can be an opportunity highlight the importance of advance care planning as part of high quality care delivery. Resources listed below may be helpful to inspire, educate and empower the public and providers about the value of advance care planning.

- National Healthcare Decisions Day. Organizations can pledge to participate, identify other partners or organizations that are engaged and find tools, ideas, and suggestions to highlight advance care planning in your community
- The Conversation Project. Tools and resources for individuals, families, and communities to help people talk about their wishes for end-of-life care.
- "Conversation Ready": A Framework for Improving End-of-Life Care. A newly updated version this IHI white paper is now available to help health care organizations and clinicians provide respectful end-of-life care.

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) 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)