MBQIP Monthly

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.

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

Rural Success: Ellenville Regional Hospital

Located ninety miles northwest of New York City and ninety miles southwest of Albany is the town of Ellenville, New York. Ellenville Regional Hospital (ERH), a 25-bed critical access hospital, provides health care to the town and surrounding area and serves as the second-largest employer. As the only hospital in a 30-mile radius, ERH has an average daily census of 12 between inpatient and swing bed patients, sees more than 14,000 patients in the emergency department (ED) annually, and provides a robust line of outpatient services.

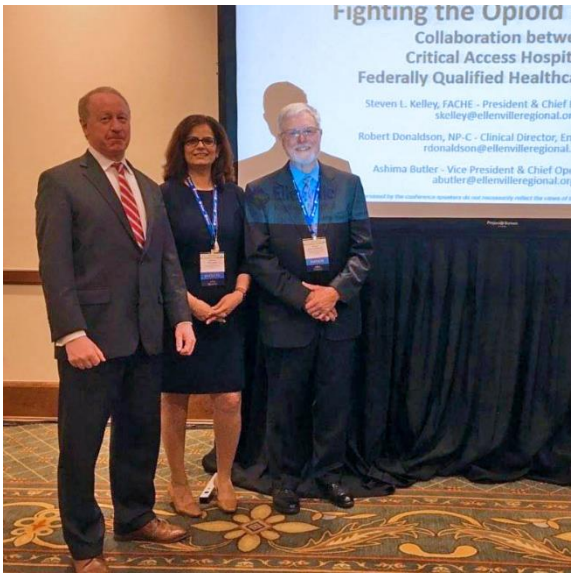
Leaders at ERH credit the hospital's quality success to the organization's collaborative team culture. Vice President and Chief Operating Officer Ashima Butler shared that ERH can leverage its small size, noting, "We are small enough that we don't have silos." This means that staff feels comfortable asking one another for support and bouncing ideas off each other. Leadership also recognizes that buy-in from all staff is crucial when trying to implement new initiatives and improve quality. The team at ERH is local and wants to do what's best for the community. Getting them on board is essential, but also relatively easy if they understand the why behind initiatives. Daily huddles offer an opportunity for teams to review current performance data, reminding everyone of what they are working on and why, while ensuring transparency. Routine audits of processes allow managers to identify opportunities, provide targeted education, and promote accountability. Through it all, ERH leadership is intentional about celebrating successes, making it a point to ensure staff is acknowledged for wins to encourage sustainability and future engagement.

One example of celebrating successes is that ERH instituted an employee of the month recognition program as part of their previous Studer engagement, the focus of which is identifying people who stand out because of the care delivered. The recipient receives a small financial award and peer recognition, including having their photo on the wall along with past recipients. A variety of rounding initiatives have helped ERH drive up their patient experience (HCAHPS) survey scores, including:

- Intentional hourly rounding – whereby nursing staff round on the patients at least once an hour, offering an to address any issues proactively

- Warm bedside hand-offs – during nursing shift change, huddling at the bedside with the patient and family to introduce them to the nurse coming on and talk through the patient care plan
- Patient family advisory council (PFAC) rounding – a volunteer PFAC member routinely visits with patients and families to learn more about their experiences and inform future improvement initiatives
- Team rounding – nurses join physician rounds to ensure the entire care team, including the patient and family, are on the same page
- Pharmacy rounding – the pharmacist rounds on patients to provide education to patients and families about medication changes, including antibiotics and pain management; ERH has identified an opportunity they are working towards of having the pharmacist round with the physician

The pharmacist is also responsible for overseeing the antibiotic stewardship program. ERH has a policy that antibiotics must be admitted within 30 minutes of order and implemented a probiotic protocol. They also monitor certain classes of antibiotics based on internal data monitoring and have developed a committee focused on educating staff and patients regarding appropriate antibiotic use.

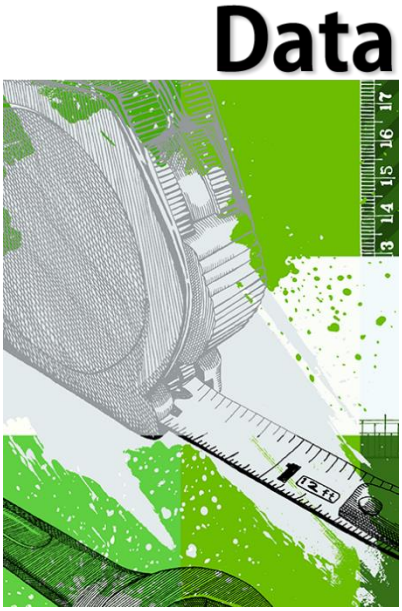


Presenting on ERH's opioid work at the AHA Rural Health Care Leadership Conference: President and CEO Steven Kelly, VP and COO Ashima Butler, and Clinical Director Robert Donaldson.

Beyond the core MBQIP measures, ERH is doing some exciting things in the realms of swing bed utilization and addressing the opioid epidemic. With regards to their swing bed program, ERH has worked to ensure that physical therapy, occupational therapy, and speech-language pathology services are available seven days a week and established processes to support transport for appointments outside of the facility. Learn more about the ERH swing bed program, including how they have worked on marketing the services and coordinating with local hospitals.

The opioid epidemic has hit the Ellenville community hard, and ERH has stepped up to be part of the solution, establishing a medication-assisted recovery (MAR) program. They utilize an audit tool to ensure that ED staff has the information they need to act quickly and effectively to address overdoses and have sought funding to support a substance use coordinator position. Beyond addressing overdose cases, ERH supports recovery by assigning patients peer navigators to support their transition to outpatient services or inpatient treatment. Learn more about the ERH opioid program.

Ellenville Regional Hospital is an excellent example of the ways a critical access hospital can leverage its small size to its advantage. Through a truly collaborative approach, staff works together to ensure quality services are available to the community – their families and friends.



CAHs Measure Up: Improving HCAHPS Scores

Patient experience is a central component of hospital care, and the HCAHPS survey is one way to explore how patients perceive the care they receive in your hospital. Two key areas of patient experience are captured in the Discharge Information composite (Composite 6) and Care Transitions composite (Composite 7), which are each calculated using patient responses from a handful of questions:

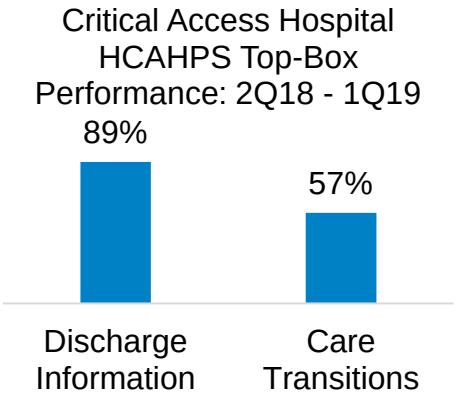
Discharge Information:

- "During this hospital stay, did doctors, nurses or other hospital staff talk with you about whether you would have the help you needed when you left the hospital?" (Yes, No)
- "During this hospital stay, did you get information in writing about what symptoms or health problems to look out for after you left the hospital?" (Yes, No)

Care Transition:

- "During this hospital stay, staff took my preferences and those of my family or caregiver into account in deciding what my health care needs would be when I left" (Strongly Disagree, Disagree, Agree, Strongly Agree)
- "When I left the hospital, I had a good understanding of the things I was responsible for in managing my health" (Strongly Disagree, Disagree, Agree, Strongly Agree)
- "When I left the hospital, I clearly understood the purpose for taking each of my medications" (Strongly Disagree, Disagree, Agree, Strongly Agree)

Interestingly, because these composites seem quite related, it may be assumed that performance should be similar, but typically this is not the case. For Discharge Information, the top-box[1] average among CAHs (2Q18-1Q19) was 89 percent. However, for Care Transition, this average was only 57 percent. Why could this be?



Several possibilities:

- Simply the way the questions are asked. Questions that roll up into Discharge Information ask just "Yes/No" whereas those that roll up into Care Transition are a broader scale.
  Discharge information questions are simply about process (did staff talk to you; did you receive information) whereas Care Transition asks that patients think about their own experience and preferences.

What to do?

- Take a look at the breakdown of how patients who don't answer top box for the Care Transitions questions respond to get a better sense of whether you might need to completely rethink your approach (for example, if most patients disagree or strongly disagree to those questions) or if you can make some tweaks to the way you do things to improve the score (for example, if most patients agree, but don't yet strongly agree).
- For more suggestions about how you can improve your Discharge Information, Care Transitions, and other areas of HCAHPS, check out our Study of HCAHPS Best Practices in High Performing Critical Access Hospitals.

[1] HCAHPS performance by topic is often communicated using the percentage of patients choosing the "top box", which is the most positive response to HCAHPS survey items. For Discharge Information, top-box means patients responding "Yes" and for Care Transitions top-box means patients responding "Strongly Agree."

Go to Guides

Hospital Quality Measure Guides

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

Abstracting Resources

Abstracting for Accuracy Consultation

Sign up for this customized abstraction review process and phone consultation that will provide your hospital the opportunity to receive one-on-one education and assistance on how to abstract the MBQIP core measures. Abstracting for Accuracy can help CAHs increase the validity of data collection and identify opportunities for additional training and clarification as it relates to chart abstraction.

Robyn Quips - tips and frequently asked questions

Test Your Knowledge: EDTC Abstraction Quiz

Time to see how you did on the Emergency Department Transfer Communication (EDTC) Data Specifications Manual for 2020 encounters quiz! Answers are below in red.

1. Since this measure is the Emergency Department *Transfer* Communication Measure, we only include patients that we transfer to another hospital for a higher level of care.
   a. True b. **False**

   The population includes anyone seen in your ED and then discharged, transferred, or returned to any of the facilities listed under "Inclusions" in the Data Specifications Manual. It does not include only those going elsewhere for a higher level of care.

2. How many EDTC cases should be submitted each quarter?
   a. 15
   b. **A minimum of 45.**
   c. **All ED cases for the quarter if we have less than 45.**
   d. Whatever number of cases we feel like doing.

   Either B or C is correct depending upon the number of cases you have for the quarter. If you have less than 45 cases per quarter, you must do all of them. If you have more than 45 cases, you must do at least 45 but can do as many as you would like.

3. Picking ED cases from just one day a month and choosing those for your EDTC abstraction submission is a good method of random sampling.
   a. True b. **False**

   You want to make sure you select cases from different days with different ED staff. Cases need to be randomly selected in such a way that the individual cases in the population have an equal chance of being selected. You need to make sure that all staff is correctly documenting and sending data to receiving facilities.

4. For purposes of EDTC measure abstraction, discharges/transfers/returns to which of the following facility types are not considered to be "Home" and should, therefore, be included in the abstraction population?
   a. Assisted Living c. Jails/Prisons
   b. **Nursing Homes** d. Group Homes

   Nursing homes are listed in Inclusions, under 'Other health care facility'. It does not matter if the patient lives in a nursing home. For this EDTC abstraction, the patient is being transferred to another health care facility. Information on what occurred during the ED visit needs to be sent back to the nursing home so the patient can be correctly cared for by the nursing home staff.

5. Patients seen in the hospital's ED and directly admitted as an acute care inpatient should be included in the EDTC measure population.
   a. True b. **False**

   The EDTC measure is for patients who are seen in your hospital ED and then discharged, transferred, or returned to another health care facility. Patients who are directly admitted from the ED to acute inpatient care at your facility are not included in the population.

6. Which facility is not listed in 'Inclusions' under "Other health care facility" in the EDTC Data Specifications Manual, and therefore discharges/transfers/returns to that facility type should not be part of the abstraction population?
   a. Long Term Care Facility
   b. **Residential Care**
   c. Swing Bed
   d. Psychiatric Hospital

   For this abstraction, the population residential care is listed in 'Exclusions' under 'Home'.

7. A patient was seen in your ED and then transferred to observation status. Are they included in the EDTC abstraction population?
   a. Yes
   b. **No**
   c. Depends on if the observation is in the ED department or on another unit.
   d. Depends on where the patient goes after observation.

   Patients who are seen in the ED and then go to observation status are no longer included in the EDTC population starting with your 1/1/20 encounters. It does not matter where the observation unit is located, or where they go after observation.

8. What chart documentation from the patient's ED encounter can we use to answer the EDTC data element questions?
   a. Only the Transfer Summary/Form/Sheet.
   b. Just the provider notes.
   c. Only the EMTALA Form.
   d. **The patient's entire ED record.**

   The entire ED record is the source document for abstraction. You don't have to have all the data elements in one area or one document in the ED record.

9. The documentation required for the data element "Mental Status/Orientation Assessment" must be done by a physician, advanced practice nurse (APN) or physician assistant (PA).
   a. True
   b. **False**

   This documentation is not required to be done by a physician, APN, or PA. Per the Data Specifications Manual, the only data elements that must be completed by the physician, APN, or PA are the "ED Provider Note" and the "Reason for Transfer and/or Plan of Care"..

10. A patient was transferred to another facility before culture results were back. What documentation in the ED record is acceptable to answer yes for the data element "Tests and/or Procedure Results"?
    a. The culture was negative, and we don't communicate negative results so there doesn't need to be any documentation.
    b. We have a shared electronic health record with the receiving facility, so the test results can be considered sent, no documentation needed.
    c. Culture results will be called to the receiving facility when available.
    d. Transfer Summary sent with the patient.

    If facilities have a shared electronic health record, then tests and procedure results are considered sent since the receiving facility would have access to the results. If the facilities do not share an electronic health record, the documentation must indicate how the results will be made available to the receiving facility. Documentation of calling the facility with results is also acceptable. It does not matter if results are negative, there still needs to be documentation of how that information will get to the receiving facility.

Tools and Resources

New! **Emergency Department Transfer Communication (EDTC) Specifications Manual.** The Specifications Manual for the revised EDTC measure is now available. Hospitals should use the revised specifications manual for data collection starting with January 1, 2020, encounters. Additional resources, including an EDTC Specifications Overview Training video, a Frequently Asked Questions summary, and an updated Excel-based data collection tool, are also available.

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Age Friendly Health Systems.
The John A. Hartford Foundation and the Institute for Healthcare Improvement (IHI), in partnership with the American Hospital Association (AHA) and the Catholic Health Association of the United States (CHA), have set a bold vision to build a social movement so that all care with older adults is age-friendly care. Becoming an Age-Friendly Health System entails reliably providing a set of four evidence-based elements of high-quality care, known as the "4Ms," to all older adults in your system:

- **What Matters** – Know and align care with each older adult's specific health outcome goals and care preferences including, but not limited to, end-of-life-care, and across settings of care.
- **Medication** – If medication is necessary, use Age-Friendly medication that does not interfere with What Matters to the older adult, Mobility, or Mentation across settings of care.
- **Mentation** – Prevent, identify, treat, and manage dementia, depression, and delirium across settings of care.
- **Mobility** – Ensure that older adults move safely every day in order to maintain function and do What Matters.

Ask Robyn – Quarterly Open Office Hours Calls for Data Abstractors
Wednesday, April 22, 2020, 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.

Can't make the call? The Online MBQIP Data Abstraction Training Series is always available as a resource.

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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