

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.

Elizabethtown Community Hospital, NY

University of Vermont Health Network-[Elizabethtown Community Hospital](#) (ECH) is a 25-bed facility with an average daily census of 12.9, located in the heart of Essex County, in upstate New York. ECH serves a 600 square mile section of Essex County, with roughly 39,000 full-time residents and many seasonal visitors. Its emergency department treats 5,500 patients each year, a third of which are trauma patients. The nearest Level 1 trauma center is located across Lake Champlain in Burlington, Vermont, about an hour by ground. Elizabethtown Community Hospital's overriding philosophy is that it is essential for patients to receive care close to where they live and work.

ECH is a consistently high performer across all Hospital Consumer Assessment of Healthcare Providers and Systems (HCAHPS) measures and emergency department transfer communication (EDTC) measures. When asked how ECH can maintain this level of performance, Heather Reynolds, ECH Director of Quality, stated that ECH's high performance stems from their robust culture of safety. For the past several years, ECH has been advancing a cultural evolution including the adoption of relationship-based care concepts targeting three essential relationships:

1. Relationships with patients
2. Relationships with the people who work and volunteer at ECH
3. Relationships with the community that ECH serves

Relationships with Patients

At ECH, the patient is at the center of everything they do. When contemplating a change or making a decision, leadership and staff will always stop to ask the question, "How does this affect the patient?" ECH strives to obtain the patient voice through focus groups and will soon be forming a patient and family advisory council (PFAC). The goals of the PFAC will include active involvement with construction, physical space issues, education materials, and incorporating the patient voice in decisions via participation in hospital committee meetings. "Nothing about us, without us" patient focus groups help illuminate patients' experiences while in the hospital, both positive and negative. Patients reported many positive encounters, such as, "Staff treat us like family." and "It feels different here; they see me as a person, not a room number or condition." Participants felt comfortable enough to discuss staff wording choices in conversations: for example, rather than hearing staff tell her to "take her time", which made her feel she was a burden due to her need to move slowly, one patient said she would rather hear "I'll wait for you."

Relationships with People

At ECH, staff care deeply not just for the patients, but for each other and most importantly themselves. There are several methods that ECH uses to support and enhance relationships between leadership, staff, and employees, including:

1. Hiring for culture fit as well as skill set: It takes a little more effort to find the right people, but it is worth it in the long run. As a result, staff turnover is very low.
2. Including medical and nursing students as team members is important and recognized as “helping grow the next generation of caregivers”.



Another example of helping to grow the next generation of caregivers: ECH's “new visions” students. High school students that are interested in health careers spend clinical time shadowing their interest areas and classroom time learning basics like anatomy and physiology.

3. Establishing shared accountability through TeamSTEPPS training and Just Culture methodology:
 - **TeamSTEPPS training:** employees are given the tools they need to enhance teamwork and communication and address interpersonal issues that may come up. Employees are encouraged to work together to solve problems themselves before turning to management for help. Also Included are the concepts of self-care and self-awareness, along with “having each other’s back”. Staff is expected to take care of themselves and each other, including sharing pertinent information with fellow team members that may impact their ability to provide proper care (e.g., fatigue due to being up all night with a cranky baby.)

- **Just Culture:** when a mistake occurs, the focus is on the process, not the person. Involved employees are not targeted as a cause, rather they become part of the solution and are included in the root cause analysis to help uncover where system failures occurred.
4. Engaging frontline staff in changes by asking, “This change is coming, how do we implement it?”, forming multidisciplinary teams, identifying a champion in the field to help drive each project, even changes that are mandatory due to regulatory requirements.
 5. Recognizing and acknowledging staff members going above and beyond expectations, often with a heartfelt handwritten note or another token of appreciation.

Relationships with the Community

Staff and patients live and work the community; ECH fosters community relationships by offering free health screening events three to four times per year. Each fall, ECH provides a [Hunter’s Health Screening](#) to assess height, weight, vision, blood pressure, glucose, cholesterol, oxygen saturation and an EKG. Many of these patients don’t get to the doctor very often, and this event helps identify health factors that could put hunters at risk when they are in remote areas far from help. Since beginning the screening five years ago, there have been several good catches, including ten emergent

health issues that required immediate attention. ECH has now expanded offerings to include a Women’s Health Screening and a Heart Healthy Screening.

Ms. Reynolds commented that “It’s all about the relationships and having a shared mental model of what success looks like. You can implement protocols and process improvements, but without a supportive culture that willingly embraces change, you won’t see results that stick.”



Data



CAHs Measure Up: Measuring the Influenza Season

The 2017-2018 influenza season is upon us. CAHs participating in MBQIP report two influenza-related measures for the program:

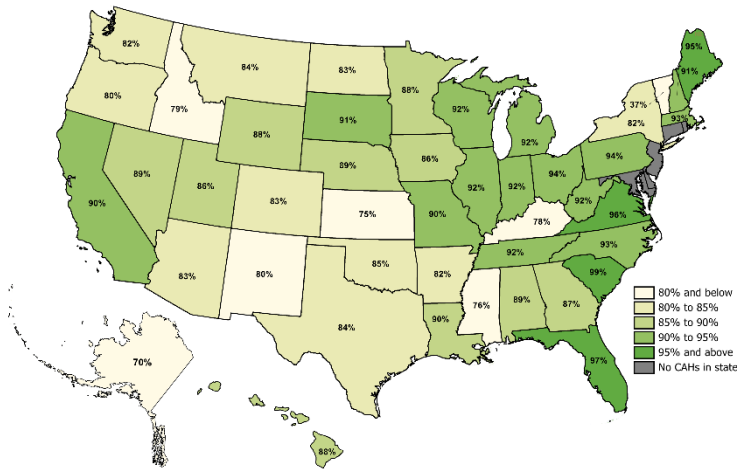
- The most current data available for IMM-2, or influenza immunization for patients, is for vaccines given during the 2016-2017 influenza season. These IMM-2 rates are on the second pages of your Q4 2016 and Q1 2017 MBQIP Patient Safety and Outpatient Data Reports.
- OP-27, or influenza vaccination coverage among healthcare personnel, is reported once a year via NHSN—the Centers for Disease Control and Prevention's National Healthcare Safety Network. The most current OP-27 rate is on the second page of your Q1 2017 MBQIP Patient Safety and Outpatient Data Report. The numbers represent vaccinations given during the 2016-2017 influenza season.

The two maps below show 2016-2017 influenza season state rates for IMM-2 (both quarters) and OP-27. CAHs that didn't report don't contribute to the state rates.

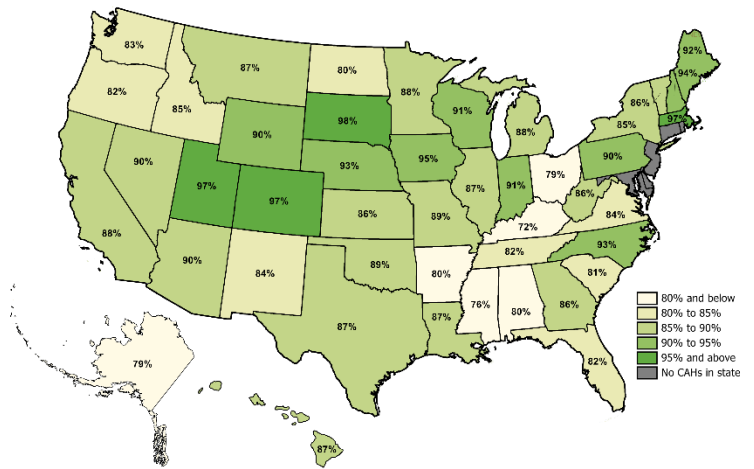
For the measures covering the last influenza season (2016-2017):

- IMM-2 had a 87% national average immunization rate; 968 CAHs reported [immunization data](#) for at least one of two quarters (up from 858 CAHs for the previous season)
- OP-27 had a 88% national average immunization rate; 953 CAHs reported (up from 840 CAHs for the previous season)
- Though the national averages were similar, some states had great variability between rates. Among the CAHs that reported, patient immunization rates ranged from 49% lower to 18% higher than the immunization rates for CAH healthcare personnel
 - 21 states had CAH patient populations with lower rates than health care workers
 - 21 states had CAH patient populations with higher rates than health care workers
 - 3 state had the same immunization rates across patients and health care workers

2016-2017 Influenza Season State Rates for IMM-2



2016-2017 Influenza Season State Rates for OP-27



How did your state perform during the 2016-2017 flu season? How did your hospital compare to the state? Did you improve compared to the 2015-2016 flu season? Check your MBQIP data reports to see. Contact your state Flex program with questions about the reports.

Where do you want to be this influenza season?

Tips



Robyn Quips - tips and frequently asked questions

Inpatient ED Measures (ED-1, ED-2)

Now that the inpatient ED Measures will be required for the MBQIP program, here's some information on how to determine your population, along with some abstraction tips.

ED-1 *Median Time from ED Arrival to ED Departure for Admitted Patients*, and ED-2 *Admit Decision Time to ED Departure Time for Admitted Patients*, are part of the CMS inpatient reporting measures. They are inpatient measures since these measures apply to those patients who were seen in your hospitals emergency department and directly admitted to inpatient acute care.

As always, it's important to pay attention to how you determine the population for these inpatient ED measures. The ED measures are part of the Global Hospital Inpatient Quality Measures. If this sounds familiar, it's because the IMM-2 Measure is also a Global Measure. These Global Measures all have the same population requirements. The population requirement for the ED measures is "All patients discharged from acute inpatient care with a length of stay less than or equal to 120 days." This population should be familiar to anyone doing IMM-2, it is the exact same population. That means every case you pull to do the IMM-2 measure on, you will do the ED 1&2 measures on as well. You don't have to pull any additional cases – it's the same population – so you would have the same number of IMM cases as ED cases.

Go back to that population requirement again: notice that there is nothing in it that says the patient must be seen in the ED. Being seen in the ED is NOT a requirement for the population, so do NOT pull cases out of your population if they were not seen in the ED. When you start abstraction, there is one data element question that asks "Was the patient an ED patient at the facility"? If the patient was, you go on to answer the other questions. If not, then you are done with abstraction and the case is excluded from the ED measures. How you answer the data element questions determines how the case does on the measure, you do not exclude cases prior to abstraction.

CMS does allow sampling of the Global Inpatient Measures but you need to have over 153 discharges from acute care per quarter, or over 51 discharges from acute care a month to sample so most CAH's will not meet the sampling requirements. No matter how few acute care discharges you have for the quarter, they should all be abstracted for the inpatient ED measures.

If you have any questions on the ED measure population, look in the [Specifications Manual for National Hospital Inpatient Quality Measures](#), Section 2 – Measurement Information, subsection 2.4 – Global Initial Patient Population.

We recommend starting abstraction of the ED-1 and ED-2 measures beginning with your Q3 2017 abstraction, as we have heard from some that the admit decision time is not always easy to locate in your electronic health record, or it hasn't been captured in your records. Now is the time to look at that process and make the needed changes to be able to collect this data.

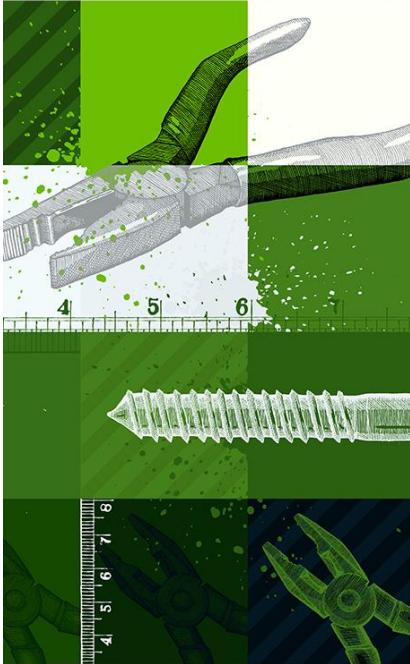
Go to Guides

Hospital Quality Measure Guides

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



Tools



Tools and Resources

Updated! [Hospital Consumer Assessment of Healthcare Providers and Systems \(HCAHPS\) Overview: Vendor Directory](#). Provides information on HCAHPS including the benefits and challenges to implementing a HCAHPS survey process with small rural hospitals, specifically critical access hospitals (CAHs). The resource identifies certified HCAHPS vendors that have opted in to be listed in the directory for your review of their available services.

[Institute for Safe Medication Practices \(ISMP\) Medication Safety Self Assessment for High-Alert Medications](#). This tool offers hospitals, long-term care facilities, and outpatient facilities a unique opportunity to assess the safety of systems and practices associated with up to 11 categories of high-alert medications. Not all targeted high-alert medications may be used in every facility; thus, each facility can choose one or more of these high-alert medications upon which to focus its assessment.

Tips to Improve Handoff Communication

A new resource was released recently by the Joint Commission, in the form of a Sentinel Event Alert that prioritizes the importance of high quality communication between the sender and receiver during transitions of care. This [Inadequate Handoff Communication report](#) specifies common underlying causes, an [infographic diagram](#) with the top eight tips, and reference to the Joint Commission Provision of Care standard in practice.



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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