# Medicare Beneficiary Quality Improvement Project (MBQIP) Webinar Series

## Session 1: MBQIP Overview and Current State

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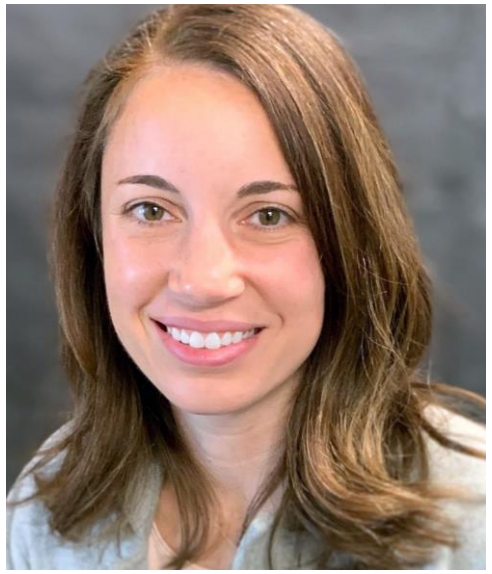
## Sarah Brinkman



## Janelle Shearer

## Sophia Brasil

# Stratis Health

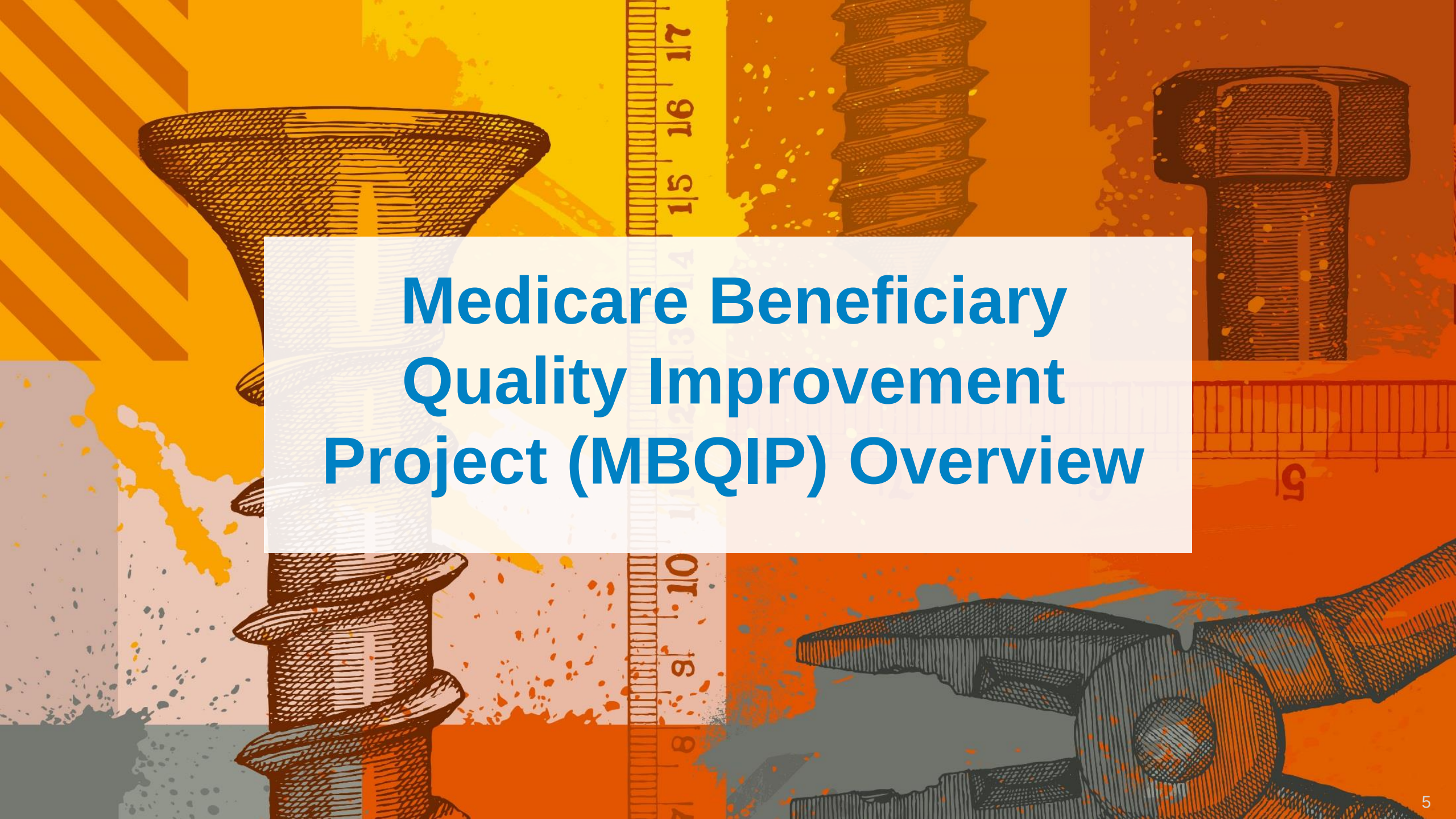
- Independent, nonprofit, Minnesota-based organization founded in 1971
  - Lead collaboration and innovation in health care quality and safety, and serve as a trusted expert in facilitating improvement for people and communities
- Work at intersection of research, policy, and practice
- Long history of working with rural providers, CAHs, and the Flex Program
- Rural Quality Improvement Technical Assistance (RQITA) is a FORHP-funded program of Stratis Health

# Rural Quality Improvement Technical Assistance Center (RQITA)

- Cooperative agreement awarded to Stratis Health starting September 2015 from the Health Resources and Services Administration Federal Office of Rural Health Policy (HRSA FORHP).
- Improve quality and health outcomes in rural communities through TA for FORHP quality initiatives
  - Flex/MBQIP
  - Small Health Care Provider Quality Improvement Grantees (SCHPQI)
- Focus on quality reporting and improvement

# Objectives

- Articulate the purpose of the Medicare Beneficiary Quality Improvement Program (MBQIP) and its position in the national quality reporting landscape
- Understand requirements of MBQIP and how data is reported, and current national performance trends
- Identify ways to utilize MBQIP data and suggested strategies to drive improvement



# Medicare Beneficiary Quality Improvement Project (MBQIP) Overview

# MBQIP Overview

- Quality improvement (QI) activity under the Medicare Rural Hospital Flexibility (Flex) grant program through the Federal office of Rural Health Policy (FORHP)
- Improve the quality of care in CAHs by increasing quality data reporting and driving improvement activities based on the data
- Common set of rural-relevant hospital metrics, technical assistance, encouragement, and support
- Ability for FORHP to demonstrate impact of hospital and state-based efforts on a national scale

# Goals of MBQIP

- CAHs report common set of rural-relevant measures
- Measure and demonstrate improvement


- Prepare CAHs for participation in value-based payment programs

# Benefits of MBQIP Participation

- Improved patient care and quality outcomes
- Increased capacity for participation in Federal reporting programs
- Access to full scope of Flex resources

# Move to Value: Rural Context

- Value-Based Purchasing (VBP) programs have typically launched with ‘reporting’ efforts:
  - Progression to CMS Hospital VBP
- Continued rollout across health care sectors:
  - Hospitals, ESRD, Home Health, Long Term Care, Physicians…
  - Most programs include metrics related to cost/efficiency, including hospital readmissions or admissions
- Increasing engagement by rural providers in alternative models
- Broad movement across payers
- Continued theme spanning numerous administrations

# Health Care Payment Learning & Action Network

## Our Goal Statement

Accelerate the percentage of US health care payments tied to quality and value in each market segment through the adoption of two-sided risk alternative payment models (Categories 3B and 4 of the LAN APM Framework).

| | Medicaid | Commercial | Medicare Advantage | Traditional Medicare |
|---|---|---|---|---|
| 2024 | 25% | 25% | 55% | 50% |
| 2025 | 30% | 30% | 65% | 60% |
| 2030 | 50% | 50% | 100% | 100% |

https://hcp-lan.org/

# MBQIP Current State Assessment

- Significant increases in CAH quality reporting (consistency still a challenge)
- To date, improvement on individual metrics is mixed
- Seeing a shift in conversations – from a reporting to an improvement focus
- Growing set of resources to support reporting and improvement

# MBQIP Measures

# MBQIP Core Measures

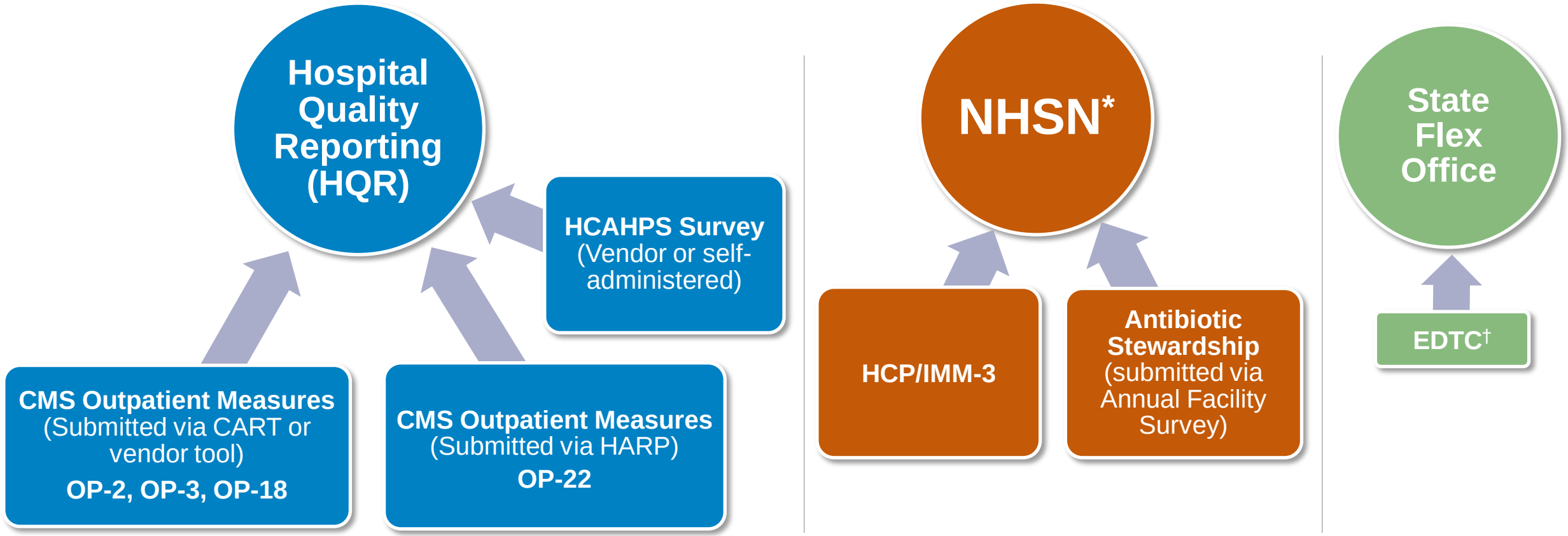
| Patient Safety/ Inpatient | Patient Engagement | Care Transitions | Outpatient |
|---|---|---|---|
| • HCP/IMM-3 – Healthcare personnel influenza vaccination<br><br>• Antibiotic Stewardship – Implementation of core elements | • Hospital Consumer Assessment of Healthcare Providers & Systems (HCAHPS) | • Emergency Department Transfer Communication (EDTC) § | AMI:<br>• OP-2 – Fibrinolytic therapy w/in 30<br>• OP-3 – Time to transfer<br><br>ED Throughput:<br>• OP-18 – Time from arrival to departure<br>• OP-22 – Left w/o being seen |

§ EDTC – Only measure not collected through CMS or NHSN

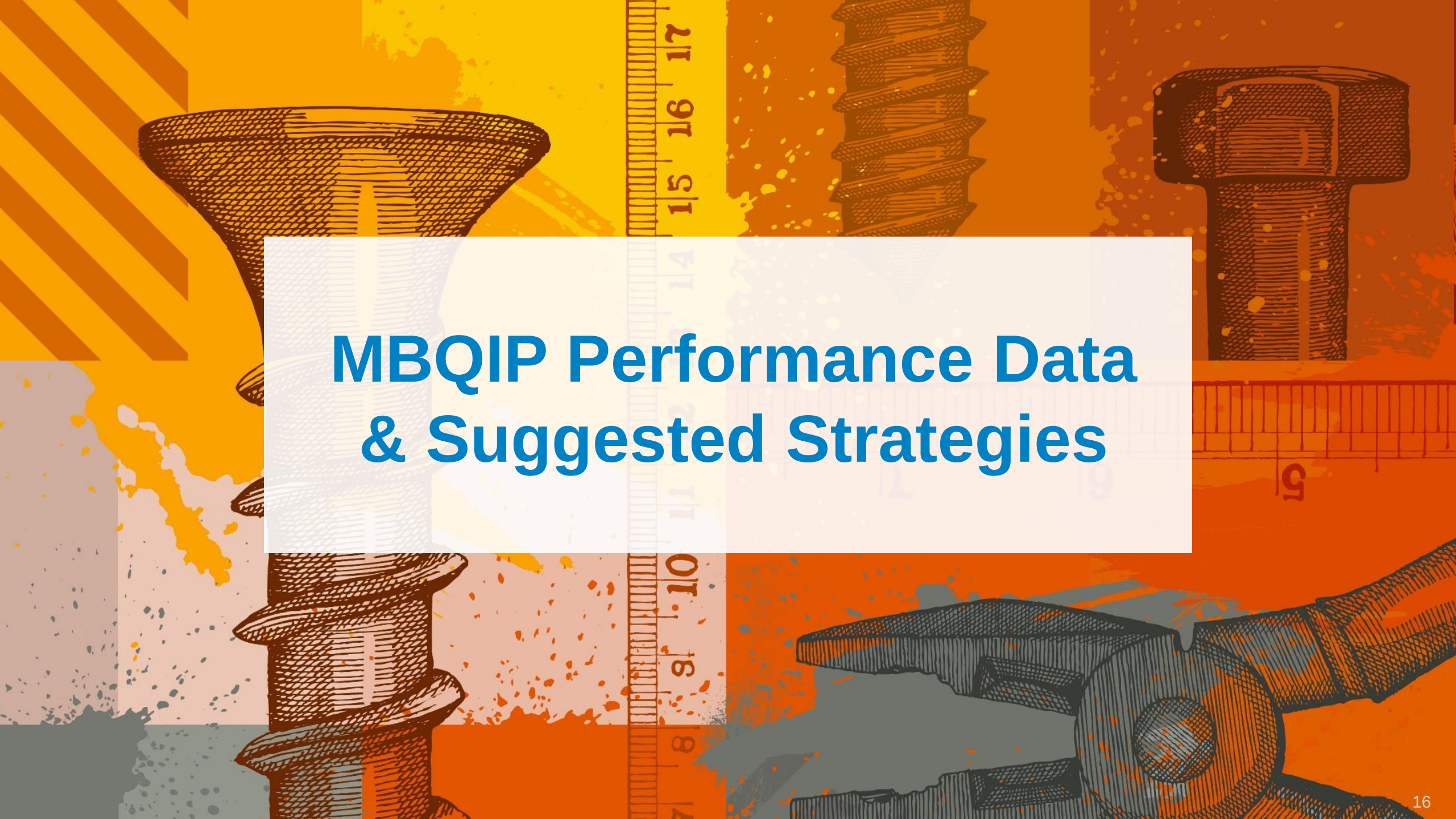
# Question

**Which measure(s) does your organization find most challenging with regards to performance?**

# Reporting Channels for Core MBQIP Measures




*National Healthcare Safety Network †Emergency Department Transfer Communication



# MBQIP Performance Data & Suggested Strategies

# MBQIP Core Measures – Patient Safety/Inpatient

| Patient Safety/ Inpatient | Patient Experience | Care Transitions | Outpatient |
|---|---|---|---|
| • HCP/IMM-3 – Healthcare personnel influenza vaccination<br><br>• Antibiotic Stewardship – Implementation of core elements | • Hospital Consumer Assessment of Healthcare Providers & Systems (HCAHPS) | • Emergency Department Transfer Communication (EDTC) § | AMI:<br>• OP-2 – Fibrinolytic therapy w/in 30<br>• OP-3 – Time to transfer<br><br>ED Throughput:<br>• OP-18 – Time from arrival to departure<br>• OP-22 – Left w/o being seen |

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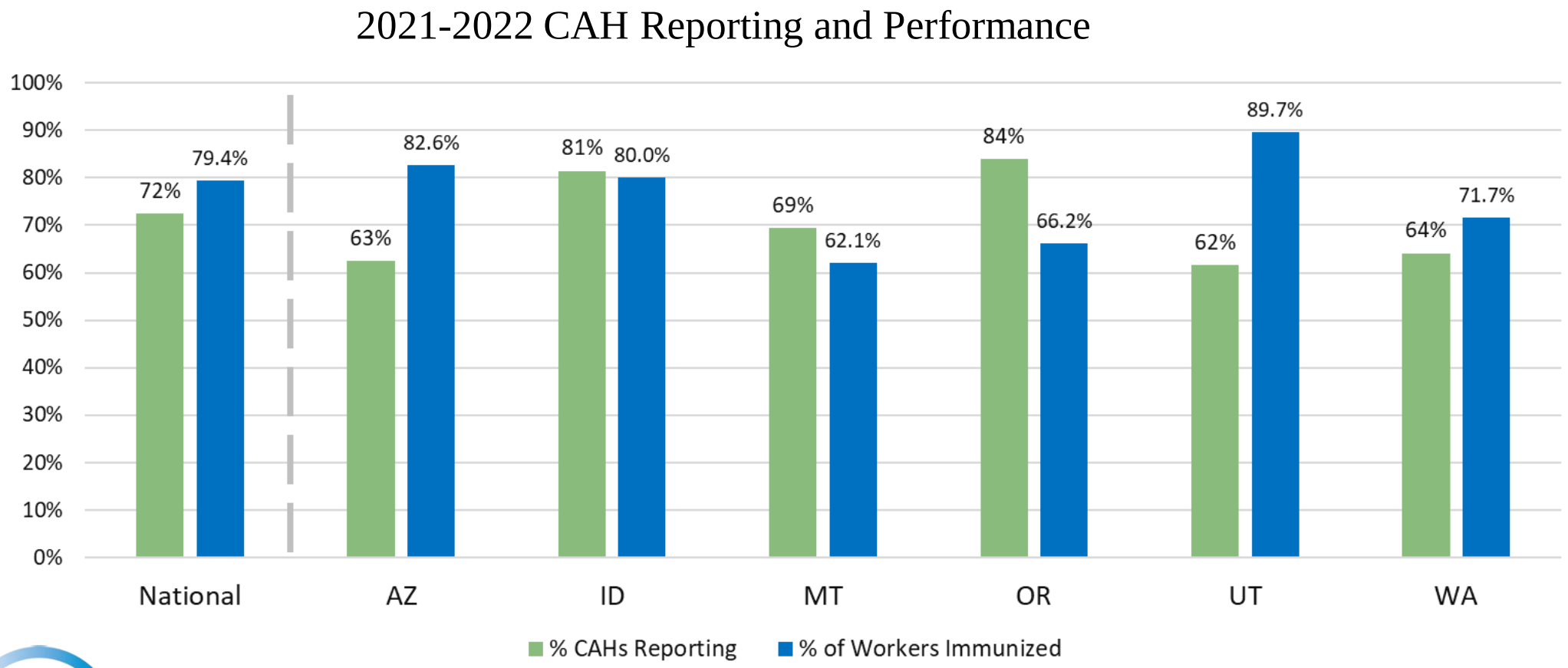
# HCP/IMM-3: Healthcare Personnel Influenza Vaccination

# HCP/IMM-3:
# Healthcare Personnel Influenza Vaccination

| State | 2021-2022 Flu Season HCP/IMM-3 Measure | | | |
|---|---|---|---|---|
| | # of CAHs | # of CAHs Reporting | % CAHs Reporting | % of Workers Immunized |
| **National** | **1359** | **984** | **72%** | **79.4%** |
| Arizona | 16 | 10 | 63% | 82.6% |
| Idaho | 27 | 22 | 81% | 80.0% |
| Montana | 49 | 34 | 69% | 62.1% |
| Oregon | 25 | 21 | 84% | 66.2% |
| Utah | 13 | 8 | 62% | 89.7% |
| Washington | 39 | 25 | 64% | 71.7% |

# Healthcare Personnel Influenza Vaccination



# HCP/IMM-3: Suggested Strategies Promote Uptake

- Organize an influenza immunization campaign to improve HCP acceptance of vaccination
- Provide easy access to free influenza vaccinations to all HCP on all shifts as soon as vaccinations arrive (October)
- Highlight the level of vaccination coverage among HCP to be one measure of a patient safety quality program that is measured and reported to facility administrators and staff

# HCP/IMM-3 – Suggested Strategies Address Declinations

- Obtain signed declinations from personnel who decline influenza vaccination and document reasons for non-receipt
- Take steps to minimize/reduce potential for spread of vaccine preventable disease by unvaccinated employees such as the use of facemasks
- Consider policy for a follow-up conversation with anyone who declines or refuses vaccine to provide resources to counter misinformation (if indicated) and advise employee on post-exposure protocols and any need to restrict or modify work

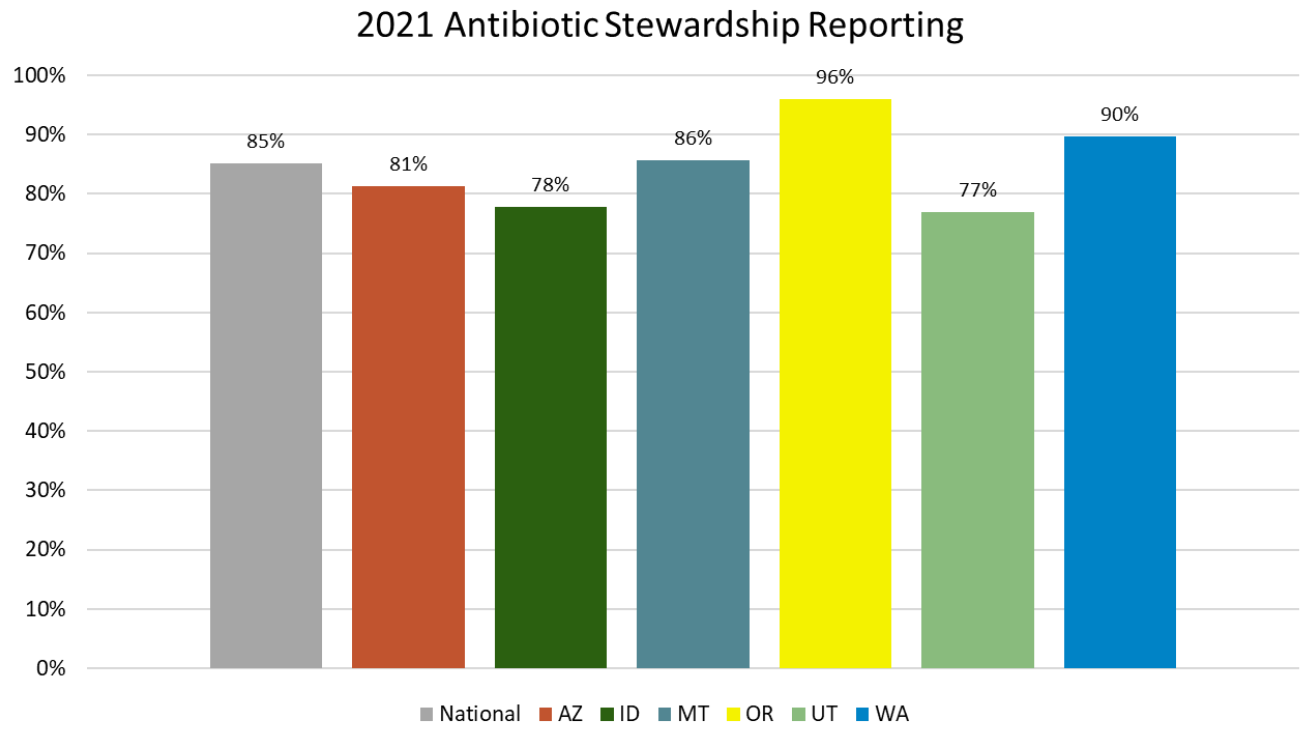
# Antibiotic Stewardship

# Core Elements of Hospital Antibiotic Stewardship

- Leadership Commitment
- Accountability
- Drug Expertise
- Action
- Tracking
- Reporting
- Education

# Antibiotic Stewardship

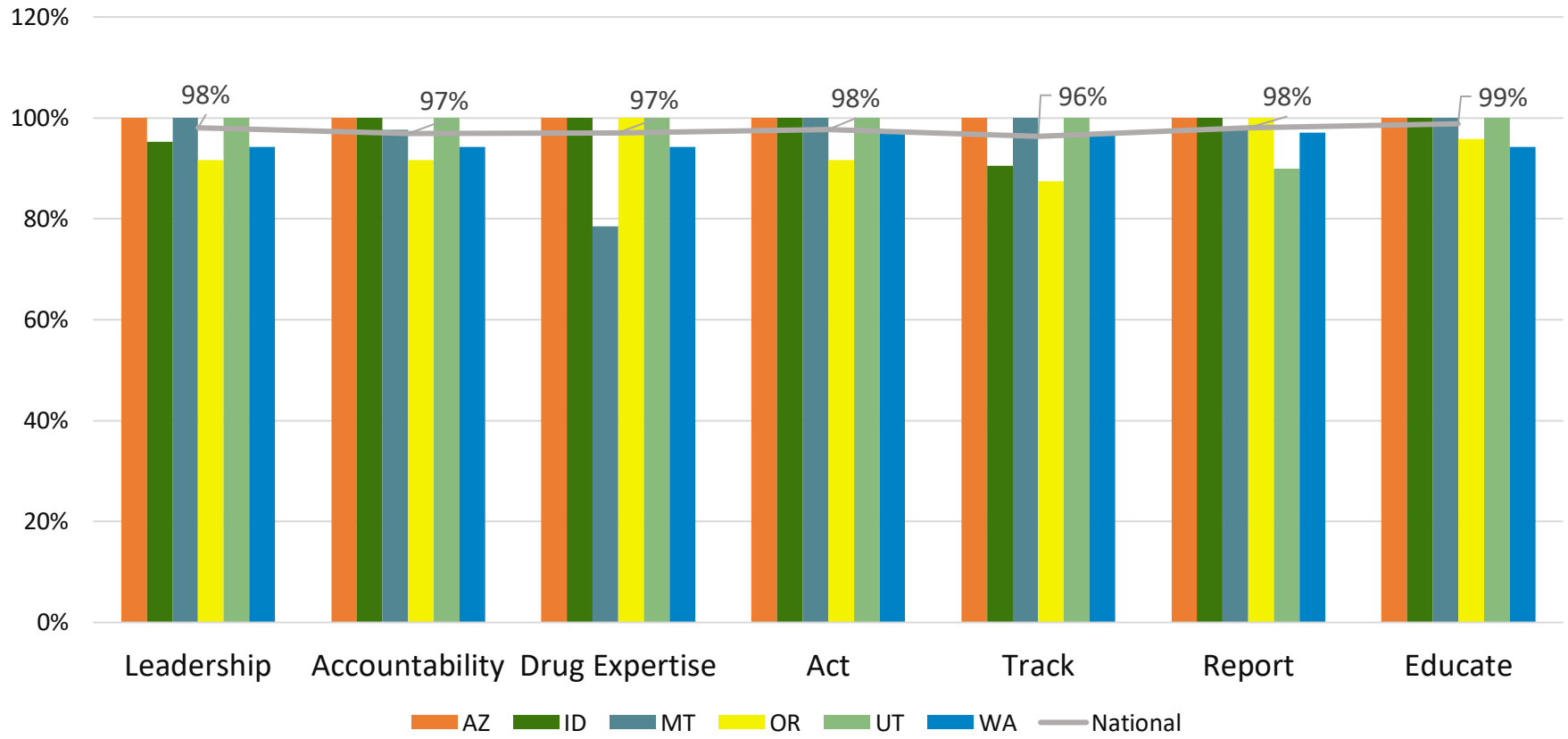
| State | 2021 Survey Reporting | |
|---|---|---|
| | # of CAHs | # CAHs Reporting |
| **National** | **1359** | **1157** |
| Arizona | 16 | 13 |
| Idaho | 27 | 21 |
| Montana | 49 | 42 |
| Oregon | 25 | 24 |
| Utah | 13 | 10 |
| Washington | 39 | 35 |



# Antibiotic Stewardship cont.

| State | 2021 Survey - Core Element Overall Score | | | | | | |
|---|---|---|---|---|---|---|---|
| | Leadership | Accountability | Drug Expertise | Act | Track | Report | Educate |
| **National** | **98%** | **97%** | **97%** | **98%** | **96%** | **98%** | **99%** |
| Arizona | 100% | 100% | 100% | 100% | 100% | 100% | 100% |
| Idaho | 95% | 100% | 100% | 100% | 90% | 100% | 100% |
| Montana | 100% | 98% | 79% | 100% | 100% | 98% | 100% |
| Oregon | 92% | 92% | 100% | 92% | 88% | 100% | 96% |
| Utah | 100% | 100% | 100% | 100% | 100% | 90% | 100% |
| Washington | 94% | 94% | 94% | 97% | 97% | 97% | 94% |

# Antibiotic Stewardship 2021 Core Element Performance Score



| Leadership | Nat'l | AZ | ID | MT | OR | UT | WA |
|---|---|---|---|---|---|---|---|
| Our facility has a formal statement of support for antibiotic stewardship (e.g., a written policy or statement approved by the board). | **71%** | 69% | 86% | 74% | 58% | 80% | 80% |
| Leadership communicates to staff about stewardship activities, via email, newsletters, events, or other avenues | **72%** | 69% | 76% | 69% | 54% | 80% | 57% |
| Leadership provides opportunities for hospital staff training and development on antibiotic stewardship | **69%** | 62% | 76% | 64% | 71% | 80% | 60% |
| Leadership allocates resources (e.g., IT support, training for stewardship team) to support antibiotic stewardship efforts. | **69%** | 69% | 76% | 64% | 63% | 80% | 60% |
| Information on stewardship activities and outcomes are presented to facility leadership and/or board at least annually | **70%** | 92% | 90% | 64% | 63% | 80% | 66% |
| Leadership ensures that staff from key support departments and groups (e.g., IT and hospital medicine) are contributing to stewardship activities. | **59%** | 62% | 67% | 60% | 50% | 10% | 49% |
| Leadership:<br>• Provides stewardship program leader(s) dedicated time to manage the program and conduct daily stewardship interventions OR<br>• Has a senior executive that serves as a point of contact or "champion" to help ensure the program has resources and support to accomplish its mission OR<br>• Ensures the stewardship program has an opportunity to discuss resource needs with facility leadership and/or board at least annually | **64%** | 69% | 67% | 62% | 67% | 90% | 57% |
| If a physician and/or pharmacist are leading antibiotic stewardship activities, antibiotic stewardship responsibilities are in their contract or job description | **37%** | 62% | 29% | 17% | 38% | 60% | 37% |

| Accountability | Nat'l | AZ | ID | MT | OR | UT | WA |
|---|---|---|---|---|---|---|---|
| Our facility has a leader or co-leaders responsible for antibiotic stewardship program management and outcomes. | **97%** | 100% | 100% | 98% | 92% | 100% | 94% |

| Drug Expertise | Nat'l | AZ | ID | MT | OR | UT | WA |
|---|---|---|---|---|---|---|---|
| Our facility has a pharmacist lead or co-lead responsible for antibiotic stewardship outcomes | **79%** | 100% | 81% | 60% | 79% | 90% | 77% |
| Our facility has a physician or "other" leader responsible for antibiotic stewardship outcomes but there is at least one pharmacist responsible for improving antibiotic use at our facility | **16%** | 0% | 19% | 19% | 13% | 10% | 17% |
| Total | **95%** | 100% | 100% | 79% | 92% | 100% | 94% |

# Action

| Our facility has a policy or formal procedure for: | Nat'l | AZ | ID | MT | OR | UT | WA |
|---|---|---|---|---|---|---|---|
| Early administration of effective antibiotics to optimize the treatment of sepsis | **71%** | 77% | 52% | 62% | 67% | 60% | 74% |
| Treatment protocols for Staphylococcus aureus bloodstream infection | **32%** | 38% | 14% | 21% | 17% | 10% | 37% |
| Stopping unnecessary antibiotic(s) in new cases of Clostridioides difficile infection (CDI) | **48%** | 38% | 29% | 43% | 46% | 30% | 43% |
| Review of culture-proven invasive (e.g., bloodstream) infections | **55%** | 54% | 57% | 40% | 58% | 60% | 49% |
| Review of planned outpatient parenteral antibiotic therapy (OPAT) | **22%** | 23% | 14% | 21% | 21% | 50% | 14% |
| Assess and clarify documented penicillin allergy | **43%** | 31% | 33% | 45% | 33% | 10% | 37% |
| The treating team to review antibiotics 48-72 hours after initial order (i.e., antibiotic time-out). | **61%** | 46% | 62% | 69% | 46% | 50% | 69% |
| Using the shortest effective duration of antibiotics at discharge for common clinical conditions (e.g., community-acquired pneumonia, urinary tract infections, skin and soft tissue infections) | **45%** | 38% | 48% | 40% | 42% | 20% | 51% |

# Action cont.

| Our facility has the following priority antibiotic stewardship interventions: | Nat'l | AZ | ID | MT | OR | UT | WA |
|---|---|---|---|---|---|---|---|
| Prospective audit and feedback for specific antibiotic agents. | **61%** | 54% | 62% | 67% | 50% | 80% | 57% |
| Preauthorization for specific antibiotic agents. | **28%** | 31% | 19% | 19% | 33% | 40% | 23% |
| Facility-specific treatment recommendations, based on national guidelines and local pathogen susceptibilities, to assist with antibiotic selection for common clinical conditions (e.g., CAP, UTI, skin and soft tissue infection). | **73%** | 85% | 67% | 71% | 63% | 90% | 71% |

| Our facility has the following specific "pharmacy-based" interventions: | Nat'l | AZ | ID | MT | OR | UT | WA |
|---|---|---|---|---|---|---|---|
| Pharmacy-driven changes from intravenous to oral antibiotics without a physician's order (e.g., hospital-approved protocol) | **45%** | 62% | 43% | 26% | 54% | 60% | 43% |
| Alerts to providers about potentially duplicative antibiotic spectra (e.g., multiple antibiotics to treat anaerobes) | **68%** | 85% | 71% | 40% | 67% | 40% | 69% |
| Automatic antibiotic stop orders in specific situations (e.g., surgical prophylaxis) | **55%** | 54% | 57% | 29% | 50% | 70% | 43% |

| Our facility has the following specific "nurse-based" interventions: | Nat'l | AZ | ID | MT | OR | UT | WA |
|---|---|---|---|---|---|---|---|
| Nurses initiate discussions with the treating team on switching from intravenous to oral antibiotics | **24%** | 23% | 10% | 21% | 4% | 10% | 29% |
| Nurses initiate antibiotic time-out discussions with the treating team | **12%** | 8% | 5% | 14% | 4% | 0% | 3% |
| Nurses track duration of therapy | **11%** | 23% | 5% | 14% | 0% | 0% | 6% |

| Tracking | Nat'l | AZ | ID | MT | OR | UT | WA |
|---|---|---|---|---|---|---|---|
| Our stewardship program monitors adherence to our facility's treatment recommendations for antibiotic selection for common clinical conditions (e.g., community acquired pneumonia, urinary tract infection, skin and soft tissue infection). | **64%** | 85% | 38% | 64% | 50% | 80% | 54% |
| Our antibiotic stewardship program monitors prospective audit and feedback interventions (e.g., by tracking antibiotic use, types of interventions, acceptance of recommendations). | **55%** | 46% | 52% | 62% | 46% | 80% | 43% |
| Our antibiotic stewardship program monitors preauthorization interventions (e.g., by tracking which agents are requested for which conditions). | **22%** | 23% | 19% | 17% | 13% | 40% | 11% |
| Our stewardship program monitors adherence to use of shortest effective duration of antibiotics at discharge for common clinical conditions (e.g., CAP, UTIs, skin and soft tissue infections), at least annually. | **32%** | 31% | 24% | 33% | 21% | 20% | 31% |
| Our stewardship team monitors antibiotic resistance patterns | **83%** | 100% | 81% | 71% | 75% | 80% | 86% |
| Our stewardship team monitors antibiotic use in days of therapy (DOT) per 1000 patient days or days present, at least quarterly | **63%** | 54% | 62% | 88% | 54% | 50% | 89% |
| Our stewardship team monitors antibiotic use in defined daily doses (DDD) per 1000 patient days, at least quarterly | **21%** | 23% | 10% | 19% | 4% | 0% | 23% |
| Our stewardship team monitors antibiotic expenditures (i.e., purchasing costs), at least quarterly | **31%** | 46% | 33% | 24% | 21% | 0% | 26% |

| Reporting | Nat'l | AZ | ID | MT | OR | UT | WA |
|---|---|---|---|---|---|---|---|
| Facility leadership has demonstrated a commitment to antibiotic stewardship efforts by presenting information on stewardship activities and outcomes to facility leadership and/or board at least annually | **70%** | 92% | 90% | 64% | 63% | 80% | 66% |
| Our facility has the following priority antibiotic stewardship interventions: prospective audit and feedback for specific antibiotic agents | **61%** | 54% | 62% | 67% | 50% | 80% | 57% |
| Our stewardship team provides individual, prescriber-level reports on antibiotic use to prescribers at least annually | **24%** | 23% | 24% | 33% | 13% | 0% | 20% |
| Our stewardship team provides unit- or service-specific reports on antibiotic use to prescribers at least annually | **35%** | 23% | 33% | 40% | 17% | 50% | 29% |
| Our facility distributes an antibiogram to prescribers, at least annually | **87%** | 100% | 95% | 76% | 100% | 80% | 83% |
| Information on antibiotic use, antibiotic resistance, and stewardship efforts is reported to hospital staff, at least annually. | **82%** | 92% | 95% | 86% | 54% | 90% | 74% |

| Education | Nat'l | AZ | ID | MT | OR | UT | WA |
|---|---|---|---|---|---|---|---|
| Our facility has the following priority antibiotic stewardship interventions: preauthorization for specific antibiotic agents. | **61%** | 54% | 62% | 67% | 50% | 80% | 57% |
| Our facility has the following priority antibiotic stewardship interventions: prospective audit and feedback for specific antibiotic agents | **28%** | 31% | 19% | 19% | 33% | 40% | 23% |
| Prescribers receive education on optimal prescribing, adverse reactions from antibiotics, and antibiotic resistance at least annually. | **76%** | 85% | 52% | 86% | 67% | 80% | 71% |
| Nursing staff receive education on optimal prescribing, adverse reactions from antibiotics, and antibiotic resistance at least annually. | **40%** | 54% | 29% | 48% | 29% | 70% | 29% |
| Pharmacists receive education on optimal prescribing, adverse reactions from antibiotics, and antibiotic resistance at least annually. | **73%** | 77% | 62% | 52% | 63% | 100% | 69% |
| If 'Individual, prescriber-level reports' or 'Unit- or service-specific reports' are provided, stewardship program uses reports to target feedback to prescribers about how they can improve their antibiotic prescribing, at least annually | **42%** | 38% | 33% | 52% | 8% | 50% | 29% |
| Are patients provided education on important side effects of prescribed antibiotics? | **92%** | 100% | 100% | 90% | 75% | 100% | 86% |

# MBQIP Core Measures – Patient Experience

| Patient Safety/ Inpatient | Patient Experience | Care Transitions | Outpatient |
|---|---|---|---|
| • HCP/IMM-3 – Healthcare personnel influenza vaccination<br>• Antibiotic Stewardship – Implementation of core elements | • Hospital Consumer Assessment of Healthcare Providers & Systems (HCAHPS) | • Emergency Department Transfer Communication (EDTC) § | AMI:<br>• OP-2 – Fibrinolytic therapy w/in 30<br>• OP-3 – Time to transfer<br><br>ED Throughput:<br>• OP-18 – Time from arrival to departure<br>• OP-22 – Left w/o being seen |

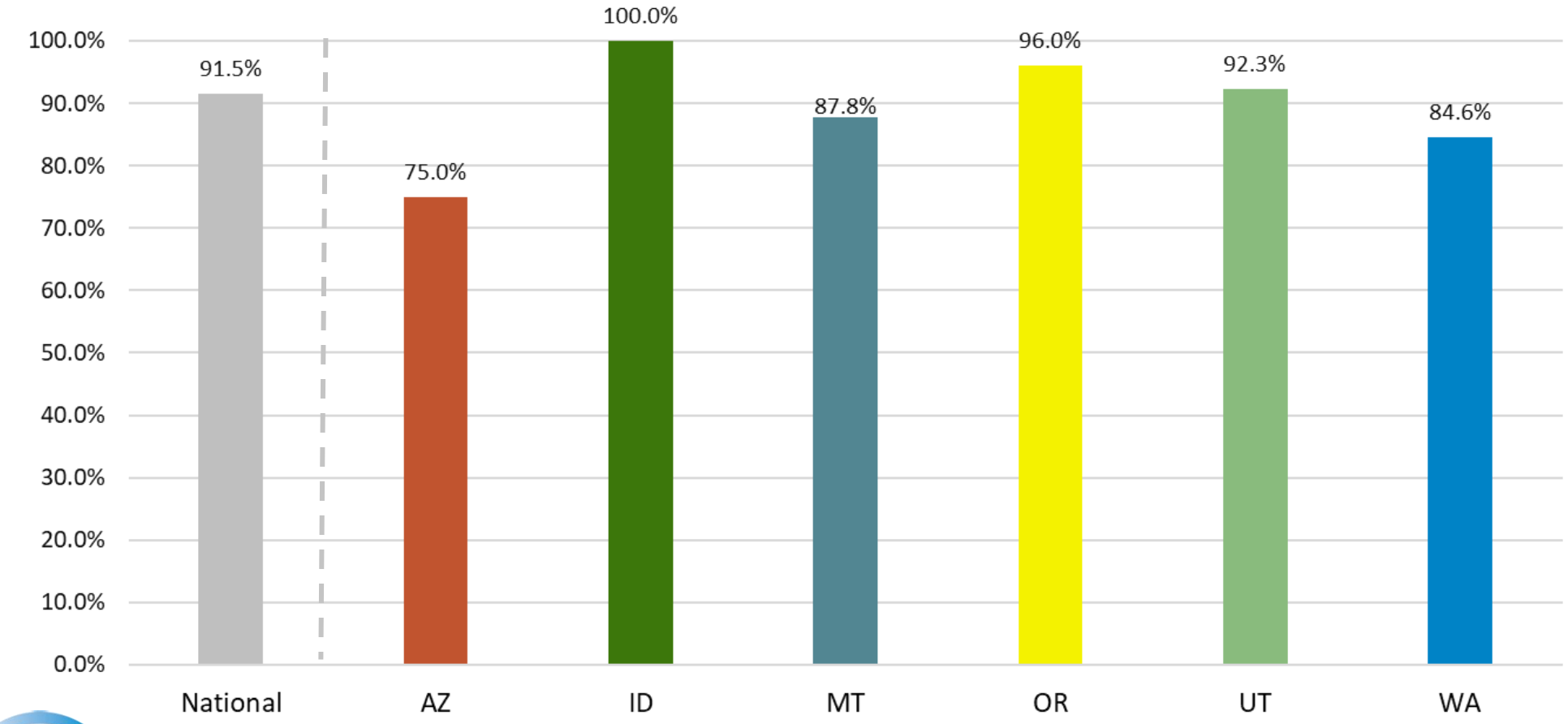
§ EDTC – Only measure not collected through CMS or NHSN

# HCAHPS: Hospital Consumer Assessment of Healthcare Providers and Systems

# HCAHPS: Consumer Assessment of Healthcare Providers and Systems

| State | 2021 HCAHPS Measures Reporting | | |
|---|---|---|---|
| | # of CAHs | CAHs Reporting # (%) | Reporting Rank |
| **National** | **1359** | **1243 (91.5%)** | **-** |
| Arizona | 16 | 12 (75%) | 39 |
| Idaho | 27 | 27 (100%) | 1 |
| Montana | 49 | 43 (87.8%) | 32 |
| Oregon | 25 | 24 (96%) | 20 |
| Utah | 13 | 12 (92.3%) | 27 |
| Washington | 39 | 33 (84.6%) | 37 |

# 2021 HCAHPS % of CAHs Reporting



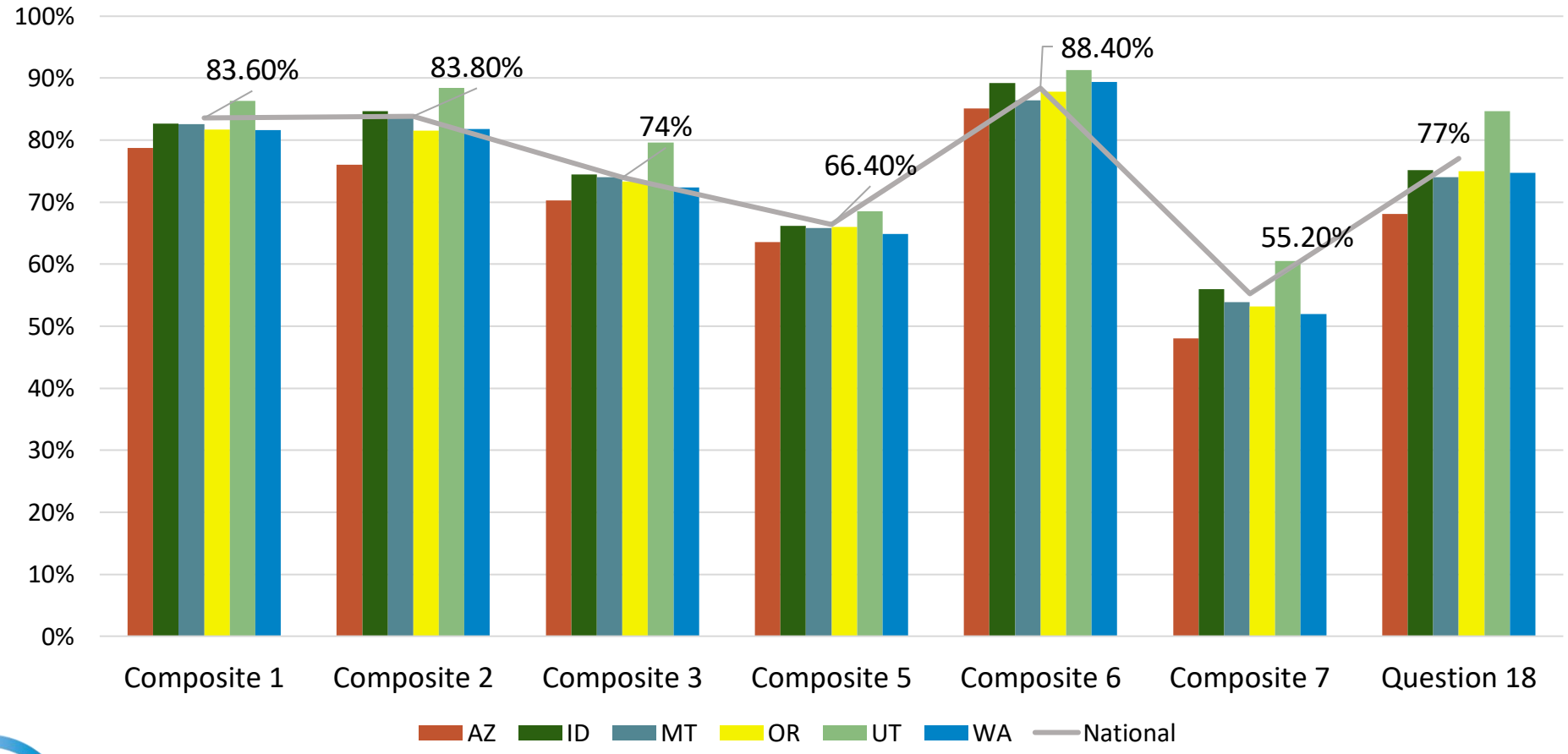
# HCAHPS: Consumer Assessment of Healthcare Providers and Systems

- **Composite 1:** Communication with nurses
- **Composite 2:** Communication with doctors
- **Composite 3:** Responsiveness of hospital staff
- **Composite 5:** Communication about medicines
- **Composite 6:** Discharge information
- **Composite 7:** Care Transition
- **Question 18:** Overall hospital rating

# HCAHPS: Consumer Assessment of Healthcare Providers and Systems

| State | 2021 HCAHPS Composite Scores | | | | | | |
|---|---|---|---|---|---|---|---|
| | Composite 1 (Comm w/RNs) | Composite 2 (Comm w/Docs) | Composite 3 (Responsiveness) | Composite 5 (Comm re: Meds) | Composite 6 (Discharge Info) | Composite 7 (Transitions) | Question 18 (Overall Rating) |
| **National** | **83.6%** | **83.8%** | **74.0%** | **66.4%** | **88.4%** | **55.2%** | **77%** |
| Arizona | 78.7% | 76.0% | 70.3% | 63.6% | 85.1% | 48.0% | 68.1% |
| Idaho | 82.7% | 84.7% | 74.5% | 66.2% | 89.2% | 56.0% | 75.2% |
| Montana | 82.6% | 83.6% | 74.0% | 65.8% | 86.4% | 53.9% | 74% |
| Oregon | 81.7% | 81.5% | 73.3% | 66% | 87.8% | 53.2% | 75% |
| Utah | 86.3% | 88.4% | 79.6% | 68.5% | 91.3% | 60.5% | 84.7% |
| Washington | 81.6% | 81.8% | 74.0% | 64.9% | 89.4% | 52.0% | 74.7% |

# HCAHPS 2021 Scores



# Communication

## Whiteboards

- Communication tool
- Must be used faithfully
- Users design

## Bedside Shift Report

- Template/checklist
- Natural leaders
- Observational auditing

## Team Huddles

- Multidisciplinary – leaders involved
- In care units
- Different structures

Source: Improving Patient Flow and Reducing ED Crowding

# Responsiveness of Hospital Staff

## Hourly Rounding

- Communication tool
- Must be used faithfully
- Users design

## No Pass Zone

- Template/checklist
- Natural leaders
- Observational auditing

## Technological Devices

- Multidisciplinary – leaders involved
- In care units
- Different structures

Source: Improving Patient Flow and Reducing ED Crowding

# Communication about Medications

## Pharmacist Visits

- Trigger and process verified
- Medication reconciliation
- Interdisciplinary huddles and rounds

## Patient Education

- Written and easy to read
- When: time of new meds, daily, discharge
- Teach back
- EHR reminders and hard stops

## Key Words

- “Education on your medications”
- “Side effects of your medications”
- “This medication is for…”

Source: Improving Patient Flow and Reducing ED Crowding

# Cleanliness of Hospital Environment

## Cleaning Schedules

- Morning cleaning
- Afternoon or evening tidy up
- PM by nurse, CNA, volunteer or environmental services staff

## Notices of Cleaning

- Tent cards, calling cards, white board notes
- Name, time, contact information

## Cleanliness Auditing

- Adenosine triphosphate (ATP) monitoring
- Glow gel monitoring
- Rounding inspections

Source: Improving Patient Flow and Reducing ED Crowding

# Quietness of Hospital Environment

**Awareness**

- Noise monitors
- Reminders – verbal, written, scheduled, in real time
- “SHHH” campaigns

**Structural Changes**

- Enclosed nursing stations
- Decentralized nursing stations
- Carpets or floor padding

**Environmental Noise**

- Doors, carts
- Cleaning or maintenance schedules
- Communication devices

Source: Improving Patient Flow and Reducing ED Crowding

# Discharge & Care Transitions

## Discharge Planning

- Start at admission
- Social worker, care manager, discharge RN
- Rounds or huddles
- Interdisciplinary involvement

## Discharge Education

- Discharge packet, folder, binder
- Written discharge instructions/care plan/AVS
- Simple language
- Teach back

## Discharge Calls or Home Visits

- Phone calls in 2-3 days
- Discharge planner, nurse, pharmacist
- Selected patients by risk or diagnosis vs. all
- Home visits effective but less common

Source: Improving Patient Flow and Reducing ED Crowding

# Global Improvement

## Leader Behaviors

- Leader visibility
- Leadership Development
- Leader rounding with staff

## Culture

- Standards of behavior
- Teamwork
- Accountability

## Data

- Share data with staff and providers often
- Opportunities for discussion and suggestions
- Friendly competition and momentum

Source: Improving Patient Flow and Reducing ED Crowding

# MBQIP Core Measures – Care Transitions

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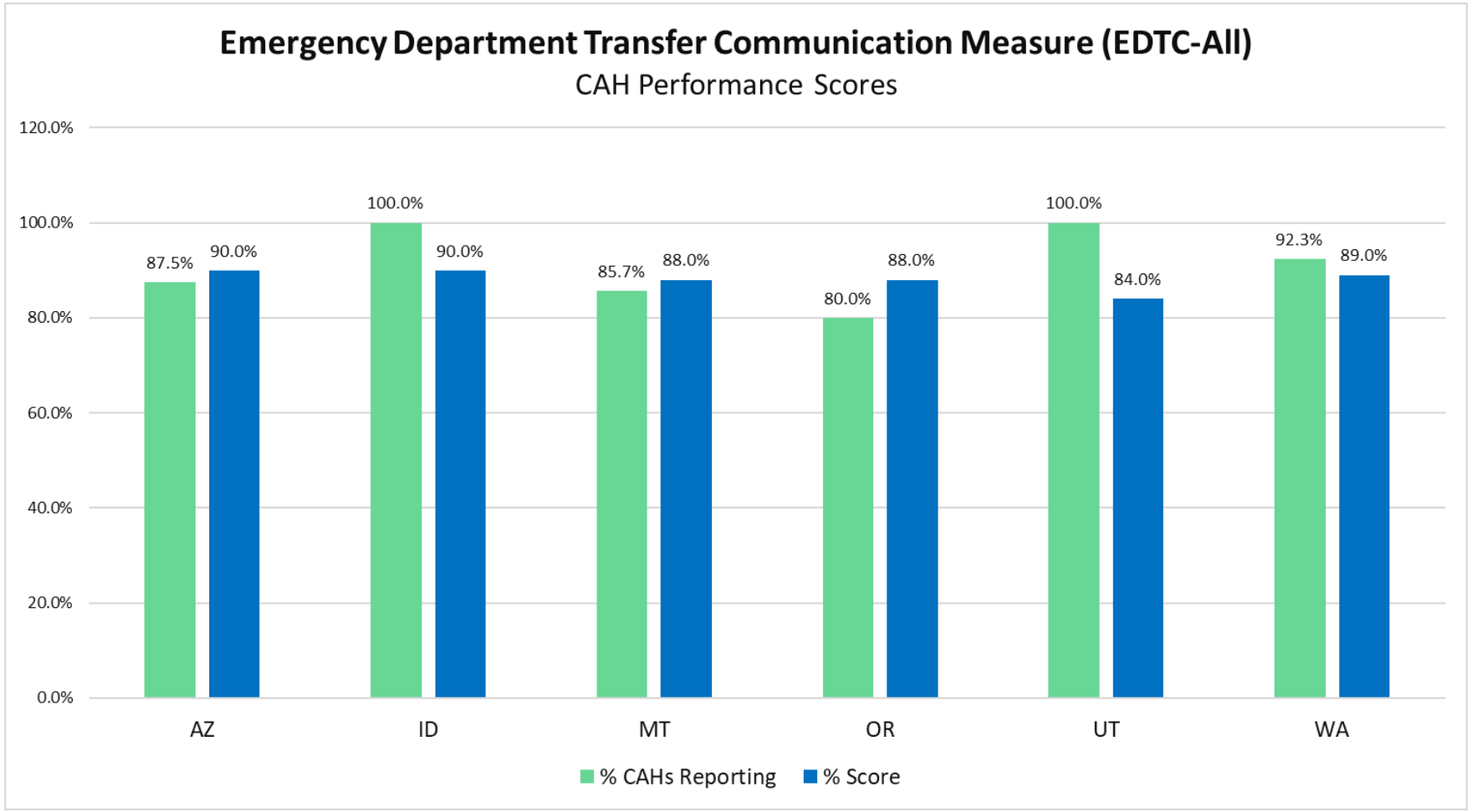
# EDTC: Emergency Department Transfer Communication

# EDTC-All: Emergency Department Transfer Communication Composite

| State | Q3 2022 EDTC Measures | | |
|---|---|---|---|
| | # of CAHs | CAHs Reporting # (%) | % Score |
| Arizona | 16 | 14 (87.5%) | 90% |
| Idaho | 27 | 27 (100%) | 90% |
| Montana | 49 | 42 (85.7%) | 88% |
| Oregon | 25 | 20 (80%) | 88% |
| Utah | 13 | 13 (100%) | 84% |
| Washington | 39 | 36 (92.3%) | 89% |

# EDTC-All Q3 2022 CAH Performance Scores



# EDTC Suggested Strategies

- Initiate discussions with organizations, both hospitals and long-term care centers that frequently receive patients from the ED, regarding opportunities for improved transfer communication and care for patients
- Implement prompts and documentation in the EHR to ensure elements are captured and communicated to the receiving facility, whether electronically or via a printed paper form

# EDTC Suggested Strategies

- Identify and implement a standardized process for documentation and transfer of information to the next setting of care
- Update paper transfer forms to ensure capture of all the required data elements and documentation that necessary information was communicated to the next setting of care
- Develop standardized setting of care processes to report outstanding test or lab results to the next setting of care if not available prior to transfer

# MBQIP Core Measures - Outpatient

| Patient Safety/ Inpatient | Patient Engagement | Care Transitions | Outpatient |
|---|---|---|---|
| • HCP/IMM-3 – Healthcare personnel influenza vaccination<br><br>• Antibiotic Stewardship – Implementation of core elements | • Hospital Consumer Assessment of Healthcare Providers & Systems (HCAHPS) | • Emergency Department Transfer Communication (EDTC) § | AMI:<br>• OP-2 – Fibrinolytic therapy w/in 30<br>• OP-3 – Time to transfer<br><br>ED Throughput:<br>• OP-18 – Time from arrival to departure<br>• OP-22 – Left w/o being seen |

§ EDTC – Only measure not collected through CMS or NHSN

# AMI Measures – OP-2 & OP-3

# AMI Measures (OP-2 and OP-3) Suggested Strategies

- Diagnose as early in patient flow as possible
  - Enable EMS to diagnose STEMI and/or notify ED of possible STEMI to initiate appropriate prep
- Synchronize clocks and ED equipment
- Establish local guidelines or care pathways for AMI patients

# Fibrinolytic Therapy (OP-2)

- Ensure physician on duty activates reperfusion plan according to established local guidelines
- Treat registration for patients with AMI in a fashion similar to patients with trauma
  - E.g., Fast-track critical labs
- Store fibrinolytic agent in the ED and/or establish ability to reconstitute and administer fibrinolytic in the ED

# Median Time to Transfer (OP-3)

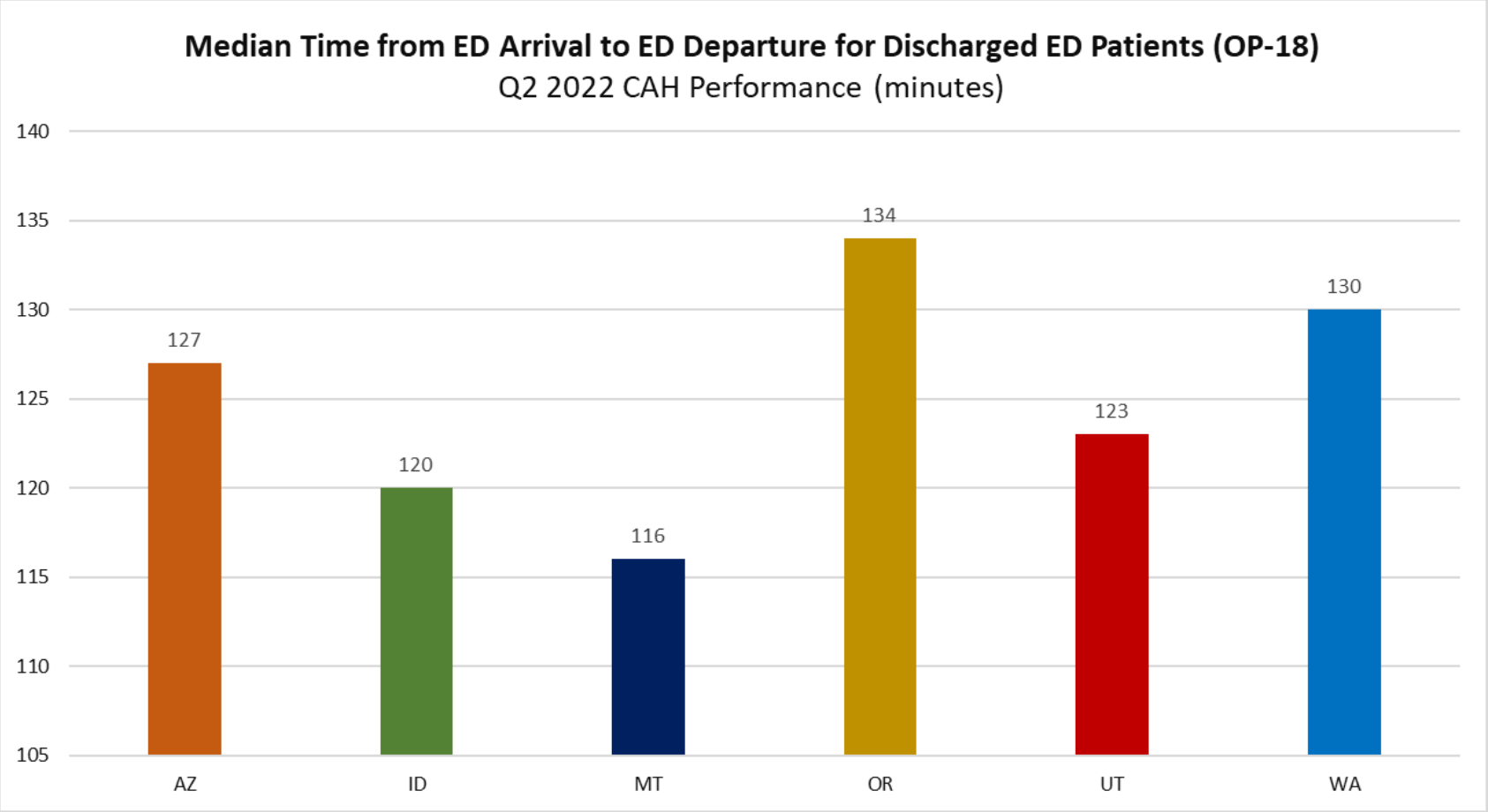
- Work with EMS and regional centers to establish processes and protocols to expedite communication and transfer
- Establish initial and backup plan for transfer or transport to a STEMI-receiving hospital
- For helicopter transfer, immediately activate transport during initial communication between referring and receiving hospital regarding need for reperfusion

# OP:18 – Median Time from ED Arrival to Departure

# OP-18: Median Time from ED Arrival to Departure (in minutes)

| State | Q2 2022 OP-18 Performance | | |
|---|---|---|---|
| | # of CAHs | Median Minutes | 90th Percentile (minutes) |
| Arizona | 16 | 127 | 94 |
| Idaho | 27 | 120 | 98 |
| Montana | 49 | 116 | 67 |
| Oregon | 25 | 134 | 111 |
| Utah | 13 | 123 | 96 |
| Washington | 39 | 130 | 99 |

# OP-18: Median Time from ED Arrival to Departure



# AHRQ Resource: Improving Patient Flow & Reducing ED Crowding

**Form a Patient Flow Team**

- Multi-disciplinary/departmental representation
- Day to day, senior, and technical leaders
- Identify champions

**Measure Performance**

- Regulatory/accreditation data
- Mission driven data
- Rapid cycle change data

**Identify & Test Strategies**

- Process mapping
- Change management
- Share results

Source: Improving Patient Flow and Reducing ED Crowding

# Alternative Patient Flows

- Nurse triage and registration at bedside
- Provider/RN team evaluations upon arrival
- Low acuity patients evaluated upon arrival and discharged as soon as registration is complete

Source: Improving Patient Flow and Reducing ED Crowding

# Patient Experience

## Form a Patient Flow Team

- Set expectations
- Under promise and over deliver
- Provide updates

## Measure Performance

- Arrange the space
- Remove the term “waiting”
- Occupy time

## Identify & Test Strategies

- Engage your patient & family advisory council
- Review ED CAHPS or other survey feedback
- Follow-up calls post-discharge and to patients who LWBS

Source: Improving Patient Flow and Reducing ED Crowding

# Data Collection and Monitoring

- Share median patient time spent in ED data with ED managers, staff and providers daily
- Implement a process to collect measure and contact data for patients that left without being seen
- Conduct regular patient record analyses to identify and understand trends, such as diagnosis or timeframe

Source: Improving Patient Flow and Reducing ED Crowding

# OP:22 – Left Without Being Seen

# Left Without Being Seen (OP-22)

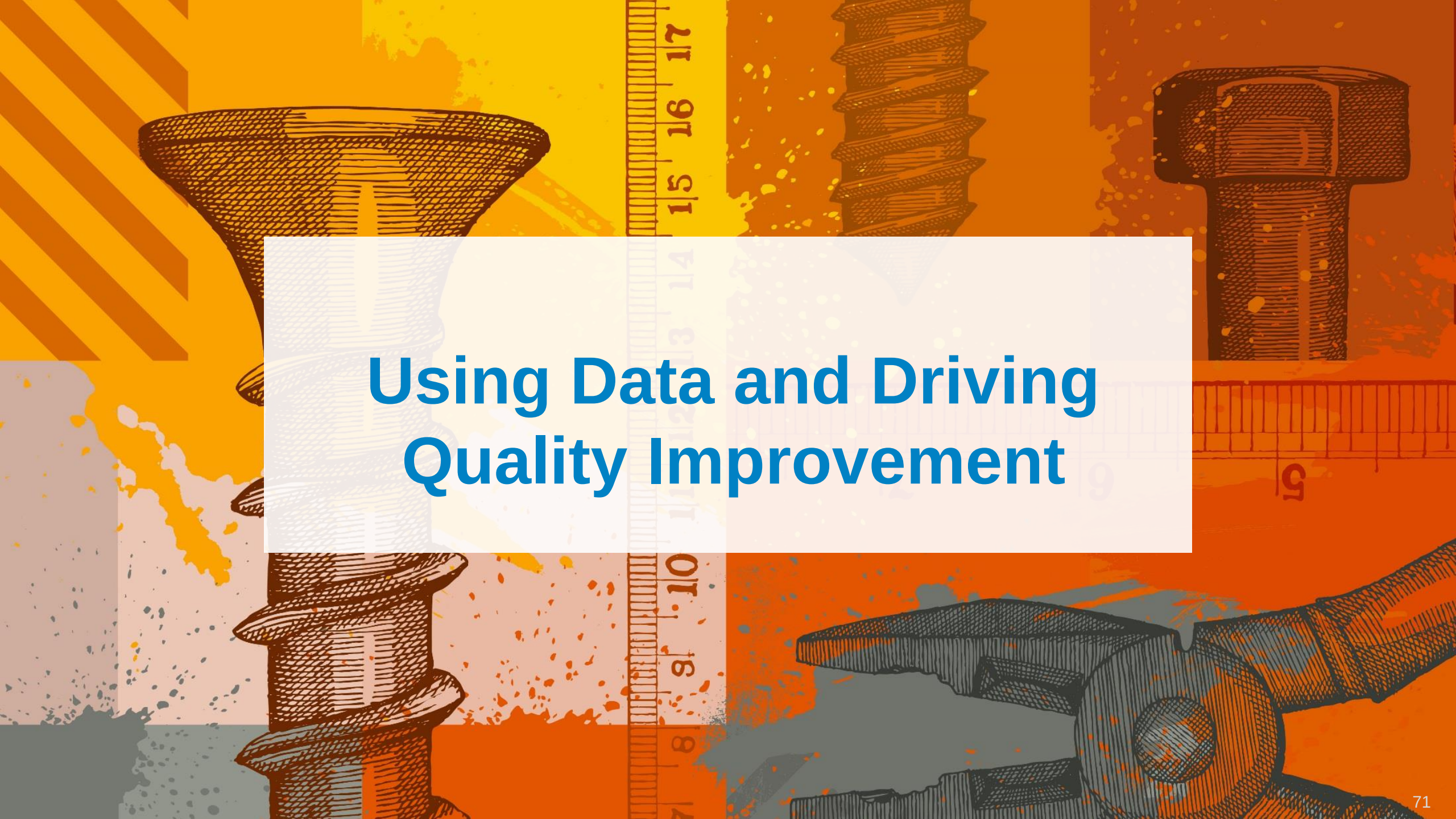
- Implement a process to capture information
- Focus on shortening the time it takes for patients to be evaluated
- Utilize AHRQ resource: Improving Patient Flow and Reducing ED Crowding

# Left Without Being Seen (OP-22) – Follow Up

- Gather contact info at sign-in and reach out to patients that LWBS before the end of the shift or the next day to encourage them to seek care; ask why they LWBS and utilize feedback to improve processes
- Conduct regular patient record analyses to identify and understand trends, such as diagnosis or timeframe

# Discussion

**Thinking back to the measure(s) your organization finds most challenging, what new strategy will you try following today's discussion?**



# Using Data and Driving Quality Improvement

# MBQIP Data Analysis Resources

- **Interpreting MBQIP Hospital Data Reports for Quality Improvement**
  https://www.ruralcenter.org/sites/default/files/2022-11/Interpreting%20MBQIP%20Data%20Reports%20for%20Quality%20Improvement%20%28March%202021%29.pdf
- **How Small is Too Small?**
  https://www.ruralcenter.org/sites/default/files/How%20Small%20is%20too%20Small.pdf
- **Eliminate the Denominator**
  http://www.reinertsengroup.com/publications/Improvement-Ideas/idea-1-eliminate-the-denominator.html

# MBQIP Monthly

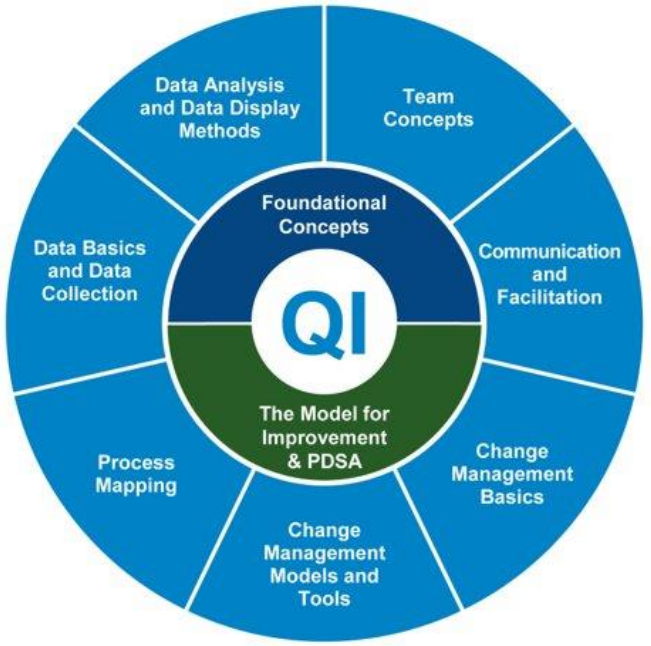
https://www.ruralcenter.org/tasc/mbqip/mbqip-monthly

- CAHs Can!
- Data: CAHs Measure Up
- Tip: Robyn Quips
- Tools and Resources

# Quality Improvement Basics Course

https://stratishealth.org/quality-improvement-basics/

- 11 didactic modules including videos, slides, and transcripts
  - Can be completed in sequence or stand-alone
- Templates and tools
- Facilitator Guide and Sample Syllabus also available



# Quality Improvement Implementation Guide & Toolkit for CAHs

https://www.ruralcenter.org/resource-library/quality-improvement-implementation-guide-and-toolkit-for-cahs

- QI Implementation Guide
- QI Measure Summaries
- Brainstorming Tool
- Internal Quality Monitoring Tool
- Project Action Plan Template
- Meeting Agenda Template
- Rapid Tests of Change Tool
- Prioritization Tool
- Internal Quality Monitoring Tool
- 10-Step QI Project Documentation Template

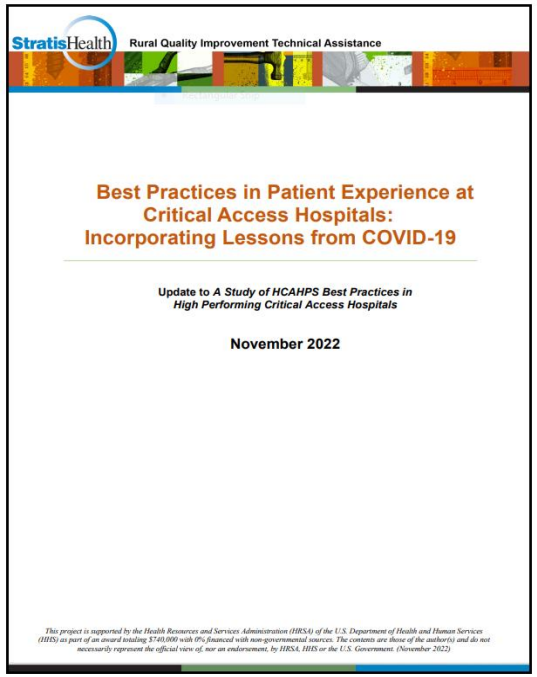
# Suggested Strategies for Improving MBQIP Measures

- Part of the Quality Improvement Implementation Guide and Toolkit for CAHs
- Suggested promising strategies for QI for each of the MBQIP Core Measures

https://www.ruralcenter.org/resource-library/quality-improvement-implementation-guide-and-toolkit-for-cahs

# HCAHPS Best Practices

- Best practices for improving HCAHPS, as collected from high performing CAHs
- Includes strategies for creative approaches during the pandemic, increasing response rates, and performance in each HCAHPS domain

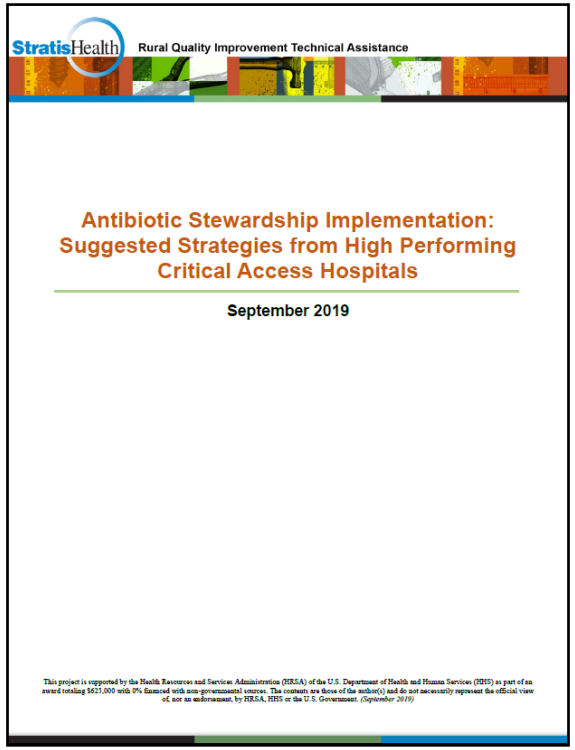



2022 Full report
https://www.ruralcenter.org/sites/default/files/2022-12/HCAHPS-CAHs%20Best%20Practices%20Report_2022.pdf

2022 summary
https://www.ruralcenter.org/sites/default/files/2022-12/Summary-HCAHPS%20CAHs%20Best%20Practices%20Report_2022.pdf

# Antibiotic Stewardship Strategies

- Best practices for improving implementing AS collected from high-performing CAHs
- Aligned with the Centers for Disease Control & Prevention 7 core elements of antibiotic stewardship




https://www.ruralcenter.org/sites/default/files/2022-11/Antibiotic%20Stewardship%20Implementation%20-%20Suggested%20Strategies%20from%20High%20Performing%20CAHs42020.pdf

# Questions?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