



Quality Improvement Implementation Guide and Toolkit for Critical Access Hospitals

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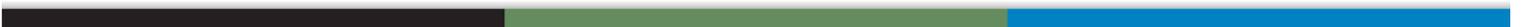


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Overview

About MBQIP

The Medicare Beneficiary Quality Improvement Project (MBQIP) is a quality improvement activity under the Federal Office of Rural Health Policy's (FORHP) Medicare Rural Hospital Flexibility (Flex) grant program. Implemented in 2011, **the goal of MBQIP is to improve the quality of care provided in critical access hospitals (CAHs)** by increasing voluntary quality data reporting by CAHs and then driving quality improvement activities based on the data.

Critical access hospitals have historically been exempt from national quality improvement reporting programs due to challenges related to measuring improvement in low volume settings and limited resources. It is clear, however, that some CAHs are not only participating in national quality improvement reporting programs, but are excelling across multiple rural relevant topic areas. Small rural hospitals that participate in Hospital Consumer Assessment of Healthcare Providers and Systems (HCAHPS) often outperform prospective payment system (PPS) hospitals on survey scores. MBQIP provides an opportunity for individual hospitals to look at their own data, compare their results against other CAHs and partner with other hospitals around quality improvement initiatives to improve outcomes and provide the highest quality care to each and every one of their patients.

As the US moves rapidly toward a health care system that pays for value versus volume of care provided, it is crucial for CAHs to participate in federal public quality reporting programs to demonstrate the quality of the care they are providing. Low numbers are not a valid reason for CAHs to not report quality data. It is important to provide evidence-based care for every patient, 100 percent of the time. MBQIP takes a proactive approach to ensure CAHs are well-prepared to meet future quality requirements.

For more information about MBQIP, please see the FORHP infographic in [Appendix A](#).

Purpose of This Guide

This guide is intended to help CAH staff structure and support quality improvement efforts, as well as identify best practices and strategies for improvement of MBQIP measures.

Measures included in the MBQIP Quality Guide

This guide focuses on measures reported for MBQIP as part of the fiscal year (FY) 2015 Flex grant cycle, which ends August 31, 2016. Recognizing the evolving nature of health care quality measures, this guide will be updated on a routine basis to align with changes made to MBQIP. A current list of MBQIP measures is posted [here](#).

How to Use This Guide

This guide provides basic directions and resources for conducting and streamlining quality improvement projects in rural hospitals, with a particular focus on MBQIP. This guide and toolkit includes:

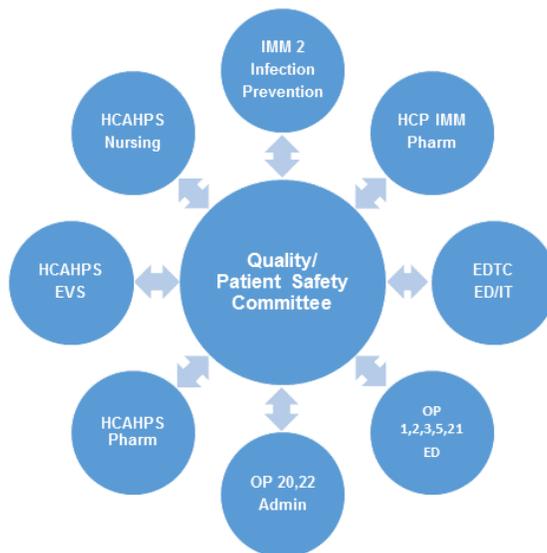
- A quality improvement implementation model focused on small, rural hospital settings
- Suggestions and considerations for identifying and prioritizing areas for improvement

- A table detailing key national quality initiatives that align with MBQIP priorities, including links to external websites for further information ([Appendix B](#))
- A ten step guide to leading quality improvement topics
- An internal monitoring tool to assist with tracking and displaying MBQIP and other quality and patient safety measures
- A list of acronyms related to MBQIP measures ([Appendix C](#))
- Summaries of current MBQIP measures by domain including best practices for improvement ([Appendix D](#))
- A glossary of key words with definitions. Throughout the document key words are hyperlinked so the reader is able to click on the word and go directly to the glossary

Rural Hospital Quality Improvement – A Model for Implementation

When structured in a way that leverages the advantages of smaller scales such as easier access to key people, and less cumbersome decision-making hierarchies, rural hospital quality improvement can be achieved efficiently and effectively. A hub and spoke model can be used as an illustration. Rather than initiating full teams for every topic area or initiative, one core quality and patient safety committee (hub), led by a designated chair, might initiate and oversee multiple topics or projects, active and sustained, by designating a leader or “owner” (spokes) for each of them. Individual project leaders might be chosen based on topic expertise, enthusiasm, or proximity to the process being improved. Active project implementation can be conducted in ad hoc working sessions, with the leader attending quality and patient safety meetings only upon special request, if the leader is not a standing member of the quality and safety committee. The flow of information from the quality and safety chair to each project or topic leader is critical to the success of the hub and spoke model. Below is an illustration of the model, suggesting possible MBQIP topic area designations.

Hub and Spoke Quality Improvement Model



Some key factors to the success of the hub and spoke model of quality improvement in critical access hospitals are creativity, administrative buy in and support, a documentation system that tracks progress on various quality and patient safety topics, and a general expectation that all staff involved in quality improvement projects will complete assignments on time.

- **Flexible Structure:** In rural hospitals, where topic specific project leaders often balance quality improvement work with patient care assignments, it is challenging to attend standing meetings and creative approaches are needed to get the work done. The quality and safety committee chair might communicate with each leader prior to and after meetings, or extend a one time invitation for a project representative to discuss the project with the committee. This arrangement works particularly well with physicians, whose involvement is critical to quality improvement success, but are often unable to leave their clinic practices during the day.
- **Leadership Engagement:** Administrative buy in and support is necessary to ensure that staff involved in quality improvement activities are given enough time to complete project assignments and not routinely reassigned for patient care. It is helpful to agree upon guidelines that specify the “level of crisis” warranting such reassignments, in order to preserve and support the progress of quality improvement efforts. The Switch¹ change model offers many suggestions for gaining leadership buy in, such as the compelling use of data and stories to enhance the sense of urgency around quality improvement efforts.
- **Systematic Process:** It has been said that a plan without a timeline is only a dream, and this idea underlines the importance of a systematic, but concise documentation system to streamline and direct multifaceted quality improvement efforts. A standing quality and patient safety committee meeting agenda/minute template can effectively organize and propel multiple active projects, while monitoring the sustaining power of completed projects. **An adaptable [quality and patient safety agenda/minute template](#) that includes current MBQIP and other common quality and patient safety topics is included in the accompanying CAH QI Toolkit.** Each “spoke” project should also be documented consistently, and tools and templates are also included in the toolkit.
- **Expectations that Prioritize QI:** Finally, without a general expectation that assignments related to quality improvement projects be completed on time, it is difficult to gain and sustain momentum toward goal attainment. The temptation to allow a shift in patient census to trump quality improvement work sends a clear message to staff that quality improvement work is optional. “Patient care comes first” can become a reflexive and acceptable excuse for quality improvement work avoidance, and hospital departments, especially nursing departments, find themselves chronically too busy to improve, like an exhausted wood cutter, too busy cutting wood to sharpen his axe. The delicate balance between healthcare professional shortages and consistent accountability standards is possibly one of the most daunting barriers to moving quality and patient safety metrics in rural hospitals. This is a critical area where top leadership must consistently define, drive, and model the culture of the organization if excellence is to be attained.

¹ *Switch: How to Change Things When Change Is Hard*, C. Heath and D. Heath, February, 2010



Key Points:

- The hub and spoke model can be used to guide rural hospital quality improvement to leverage the advantages of smaller scales, easier access to key people, and less cumbersome decision-making hierarchies
- The flow of information from the quality and safety chair to each project or topic leader is critical to the success of the hub and spoke model
- Be creative and flexible to accommodate rural hospital schedules in project planning
- Documentation templates can be very effective tools to organize and propel multiple projects
- Resist the temptation to repeatedly allow a shift in patient census to trump quality improvement work



Tools and Resources:

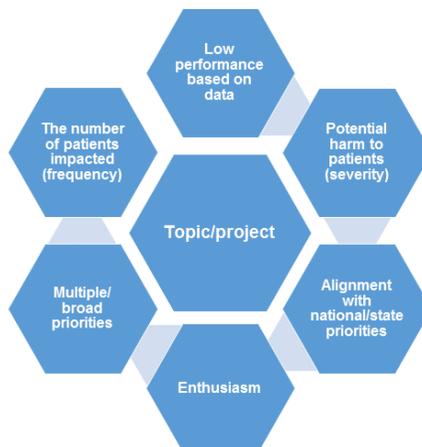
- [Quality and Patient Safety Committee Meeting Agenda/Minute Template](#)

Prioritizing Opportunities for Improvement

With the explosion of quality and patient safety topics, resources and measures the improvement opportunities for hospitals are seemingly endless. A variety of factors should be considered when identifying focus areas for improvement:

- Low performance based on data
- Potential harm to patients (severity)
- The number of patients impacted (frequency)
- Multiple/broad priorities
- Alignment with national, state or regional level quality initiatives
- Enthusiasm in the field for the topic

Quality Improvement Prioritization Factors



Low Performance Based on Data

A foundational step in prioritization is data collection for key patient safety and quality topics, including the MBQIP core improvement activity measures. Objective measurement provides clear direction on which topics have the most opportunity for improvement. Comparisons can be made to state or national [averages](#) or high performing benchmarks (when available). Particular attention should be given to measures/services that align with core services provided by individual CAHs.

Potential Harm to Patients (severity)

Consider the level of risk or patient harm for low performance on measures and prioritize improvement on processes that may have the most impact on individual patients, even if those cases are rare. Quality improvement work that aligns with a recent negative patient safety event will likely be readily embraced by staff and providers.

The number of patients impacted (frequency)

Choose measures that will influence the quality of care on more patients. For example the inpatient influenza immunization measure pertains to a much higher volume of patients than any diagnosis-specific measure.

Multiple/Broad Priorities

Identify measures that align with common priorities. Examples of how multiple MBQIP measures align with different focus areas include:

- Reducing Hospital Readmissions/Improving Care Transitions:
 - HCAHPS Discharge Information and Care Transitions [composites](#)
 - EDTC measure
- Improving Safe Medication Practices
 - HCAHPS Communication about Medicines [composite](#)
 - EDTC - 4 Medication Information
- Time Sensitive Conditions
 - Outpatient measures 1, 2, 3, & 5 (AMI Care)
 - Outpatient measure 20 (Door to diagnostic evaluation by a qualified medical professional)
 - Outpatient measure 21 ([Median](#) time to pain medication for long bone fractures)
- Pain Management
 - HCAHPS Pain Management
 - Outpatient measure 21 ([Median](#) time to pain medication for long bone fractures)

Alignment with National, State or Regional Level Quality Initiatives

A number of federal and national programs and their quality priorities are listed in a table in [Appendix B](#). Frequently there are state or regional level initiatives that align with these programs that can be an opportunity to identify tools, resources, and technical assistance.

Enthusiasm in the Field for the Topic

This should be a secondary consideration, but topics that generate strong interest among staff, physicians and other stakeholders are more likely to realize improvement than areas met with resistance or indifference. Furthermore, allowing staff or practitioner passion to influence resource allocation tends to foster an atmosphere of goodwill that generates buy in for other projects.

Ten Steps to Leading Quality Improvement Topics

Once a decision has been made to focus on a particular topic for quality improvement, or initiate a “spoke” in the hub and spoke model, it is helpful to follow a consistent series of steps to guide the work. Following are suggested steps to conducting a quality improvement project. Depending on the type of quality improvement effort, steps might be combined or eliminated. For example, measure selection is pre-defined for MBQIP, so that step is not necessary. [A template to document completion of project steps can be found in the CAH QI Toolkit.](#)

1) **Research the topic or measure**

It is important to understand the background and rationale behind changes being made to improve patient safety or quality to gain buy in and enthusiasm on the part of the staff and providers being asked to change. For each of the required MBQIP measures, summary information and best practices are provided in the appendices to this document.

For other quality and patient safety topics, a quick google search often will garner a wealth of resources. Keep an eye out for credible national sources such as the Agency for Healthcare Research and Quality (AHRQ), the National Quality Forum (NQF), Institute for Healthcare Improvement (IHI), the Center for Disease Control (CDC), Health Research & Educational Trust (HRET), Technical Assistance Service Center (TASC), and others. Research will also help in developing a list of potential best practice ideas for implementation consideration, and potential measures to track in order to determine whether the work being done is successful.

Consider involving a provider early in the process. If there is a willing and enthusiastic provider that will assist with or review the research, and contribute throughout the project, the effort will be a worthy investment towards ease of implementation.

2) **Set a broad goal and draft a timeline**

Having researched the topic or measure being implemented, it is helpful to articulate a broad goal and come up with a draft timeline to present to the group of people that will participate in the improvement efforts. Don't be afraid to be ambitious in terms of timelines. With creative meeting alternatives, and a commitment to keeping work flowing, it is entirely possible to bring a change to full implementation in two or three months, especially for pre-identified measures such as MBQIP that have readily available research and national alignment in terms of prioritization.

3) **Build the team/ad hoc group**

In deciding who will be needed to bring about a particular change in improvement, it is helpful to start by drawing a rough flowchart of the processes involved and include a representative from every point in the process. As representatives are being invited, it is a good idea to check with them to make sure all stakeholders are represented.

It is important to find a way to obtain input from patients on changes that will impact their care. It may not be realistic to include a patient or family member on every quality improvement activity, but there are other ways to include the patient voice, such as presenting project plans to a patient/family council if one exists, or simply asking several patients for input as projects unfold.

4) Design the strategy

Ask the team or ad hoc group to think through what must be done to achieve the general goal. Drawing a rough flow chart of the process in question with the group, and identifying points in the process where changes need to be made helps structure the discussion. Brainstorming activities to gather implementation ideas are also helpful. Ideas can be categorized into themes and prioritized by the group. A [brainstorming tool](#) has been included in the CAH QI Toolkit. Implementation ideas and best practices identified in this guide, or identified in your research can also be reviewed for applicability to your setting. Encourage participants to gather co-worker input frequently throughout the project so that potential challenges can be detected early. Once an implementation strategy has been identified, a plan of action can be established. A [project action plan template](#) is included in the CAH QI Toolkit.

Policies, order sets, implementation bundles, staff education, and patient education might need to be created, adopted, or adapted. Take time to assess whether your implementation strategies are “weak” or “strong”, and consider the balance between strength of the intervention and the resources needed to support implementation. A sampling of strategies follows:

- EHR templates can be a powerful way to “hardwire” adherence to assessment or practice changes. Such templates make it difficult to do or document the wrong thing, thus, EHR template changes would be qualified as a strong strategy.
- Staff education, although important, might be qualified as a weak strategy if it is the only support for implementation. In rural hospitals, where staff do not typically work in the same area every day, and low volumes are not conducive to repetition, information is likely to be forgotten.
- Checklists are very helpful in driving consistency of care, but are only as strong as the frequency with which they are utilized. Discharge checklists, surgical checklists, shift to shift report templates, and charge nurse duty checklists are examples of situations where checklists can help staff to deliver consistent care.

Strive to keep implementation strategies as simple as possible to help staff navigate changes coming from various simultaneous improvement efforts. Simplicity is the driving force behind bundling, where several key changes to accomplish a goal are promoted, rather than a long list of changes. For example, the Institute for Healthcare Improvement (IHI) Central line associated blood stream infection (CLABSI) bundle is comprised of five best practices projected to be the most impactful in preventing central line associated blood stream infections.

5) Select specific measures, and define the goal

Measure selection

Measures for quality improvement projects such as those related to MBQIP are predetermined, eliminating the need for this step. Standardized measures have been established for many quality and patient safety topics, and it is wise to align with them to be consistent with state and national efforts, and allow for comparison with other hospitals. [The National Quality Forum \(NQF\)](#) maintains an inventory of current measures and is a great place to start looking for established measures on various hospital quality and patient safety topics.

It is also important to consider what type of measure(s) to utilize to support implementation and measure improvement:

- Process measures are measures that reflect consistency in staff adherence to tasks, assessments, or treatments associated with providing care. Process measures are often more effective as a feedback tool for staff because improvements will be reflected sooner than in outcome measures, especially in low volume settings. All required MBQIP measures other than HCAHPS survey scores are process measures.
- Outcome measures reflect patient outcomes, such as morbidity, mortality, or readmission rates. In rural hospitals, low volumes can diminish the usefulness of outcome measures, since the occurrences measured, such as death or readmissions, can be rare in any specific subset of the population.
- HCAHPS surveys are a measure of patient perception, which do not tidily fit into either the process or outcome measure category, but provide a valuable view of quality from the patient perspective.

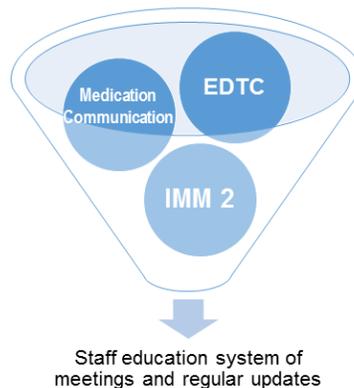
Setting Goals

Broadly speaking, goals should ultimately be “the right care for every patient, every time”, which for process measures translates into 100% or below benchmark time [medians](#) for every measure. It is helpful to have this in mind for a general long term goal, but to initially focus on measureable improvement. Any improvement translates into one more patient that received high quality care, and that is an encouraging message for staff.

6) Educate widely and creatively

Staff education is a challenge given the pace of change and the amount of information that must be shared to keep staff current in terms of quality and patient safety.

To support the mindset and expectation of “continuous improvement”, it is a fruitful investment to develop a consistent system of staff education that combines periodic in-person education sessions that are recorded for those unable to attend, with monthly electronic updates (written or short video recordings) that include a feedback mechanism to communicate receipt and review. All quality improvement education can be funneled into this ongoing education system.



Determine whether there are other groups that can influence the success of the project or topic implementation as education is being planned. Other departments, healthcare

settings, hospital leadership and boards, and community members are potential considerations, as well as patients and family members.

However staff education is delivered, there are some concepts that are important to keep in mind:

- Enthusiasm is an insightful prediction of change success, and can be generated early in the quality improvement process by soliciting stakeholder input formally or informally, and continued throughout the course of the project.
- The inclusion of pertinent compelling patient stories or sharing goals and progress using real numbers of lives saved or harm averted helps to generate enthusiasm.
- Sharing baseline hospital performance metrics with national and state comparisons and benchmarks provides a sense of direction for the project.
- Simplicity in the design and delivery of staff education will help them to learn and remember the information. Consider what staff absolutely need to know to support the change, and design education around that core.
- Critical project implementation steps should be hardwired into paper or electronic documentation systems to provide “just in time” guidance.

7) **The kick off**

Timelines should be arranged so that the launch of the project, sometimes termed “kick off” or “go-live” begins shortly after staff education has been completed, when the information and inclination are fresh. Project leaders should review the new process beforehand to make sure that staff have everything they need to ensure success. A fun kick off mini-event, such as a treat in the cafeteria or a name draw for a gift basket or tickets to a sports event can be an inexpensive and positive way to bring attention to the project.

8) **Rapid tests of change**

It is important to evaluate the changes being made using a rapid tests of change tool, which aids in guiding the documentation, communication, and correction of unforeseen technical or process errors. **A [sample rapid tests of change tool](#) is included in the CAH QI Toolkit.**

It is helpful for members of the project team or ad hoc group to be available to answer questions, document issues, and communicate frequently to respond to complications during initial implementation. Daily or weekly huddles can be held to communicate with staff about the new processes. Rapid tests of change continue until it appears that the new process is running smoothly and implementation can be considered complete.

9) **Evaluation**

The best way to build momentum on quality improvement efforts is to actively monitor staff adherence to process measures as close to real time as possible, and provide feedback to staff and providers individually or during regular communications. As audits or observations are being done, “catching people doing right” and thanking them personally and/or publicly builds morale and encourages a continuation of the behavior. When interventions are missed, a timely and friendly conversation to learn more about potential barriers and elicit suggestions can lend valuable insight into process improvement. Staff and provider performance feedback at least monthly is extremely

important in the beginning stages of project implementation. Once improvement has plateaued, a decision has to be made whether to move the project into sustain mode and monitor less frequently, or to reconvene the group for a discussion on how to improve further.

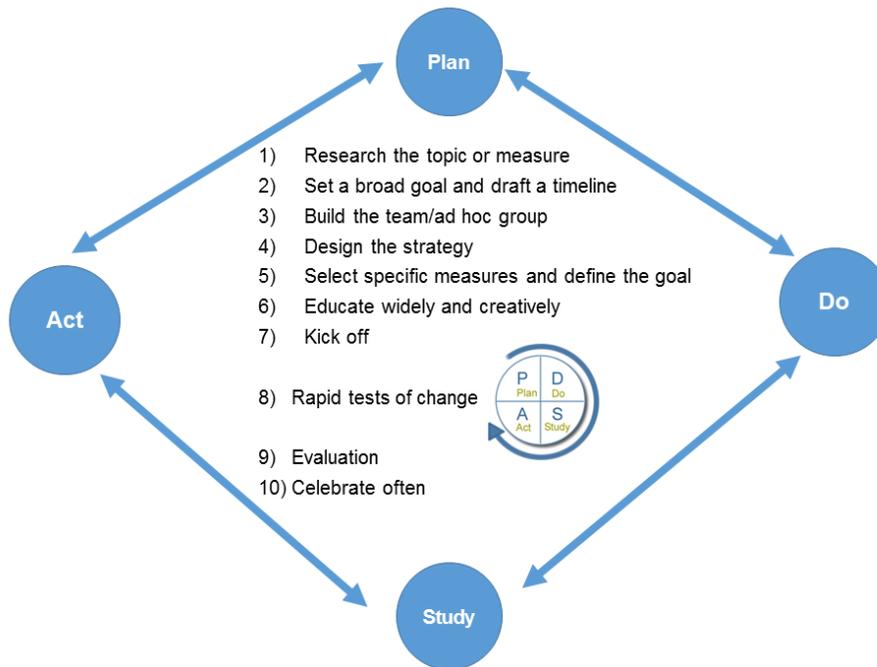
The MBQIP reports distributed by state Flex Programs can provide valuable state and national comparison data. However these reports are generated months after the delivery of the patient care they reflect, which is not helpful in providing frequent feedback during active quality improvement efforts.

A user friendly [internal quality monitoring tool](#) included in the CAH QI Toolkit has been developed to assist in tracking and reporting more frequent progress on MBQIP and other quality and patient safety measures. The tool generates run charts that can be shared with staff and leadership.

10) Celebrate often

It is very exciting when quality improvement efforts pay off and run charts begin to show an improvement in process and outcome measures! Frequent and prominent displays of run charts or graphs that acknowledge and celebrate great work foster pride and encourage staff to continue to improve. Administrative involvement in celebratory communications, staff meetings, and events reinforces the message that quality improvement is a high organizational priority.

The ten steps to leading quality improvement topics can be viewed as a project-specific Plan – Do – Study – Act (PDSA) cycle, within which intervention-specific PDSA cycles are implemented in Step 8 - “Rapid Tests of Change”. The following table illustrates the connection between the Ten Steps to Quality Improvement Projects and Plan – Do – Study – Act cycles.



**Key Points:**

- With creative meeting alternatives, and a commitment to keeping work flowing, it is entirely possible to bring a change to full implementation in two or three months
- It is important to find a way to obtain input from patients on changes that will impact their care
- Gather staff input frequently so that potential challenges can be detected early
- Strive to keep implementation strategies as simple as possible
- Develop a consistent system of staff education that combines periodic in-person, recorded education sessions with monthly electronic updates that include a feedback mechanism to communicate receipt and review
- The best way to build momentum on quality improvement efforts is to actively monitor staff and provider adherence to process measures and provide timely feedback

**Tools and Resources:**

- [Brainstorming Tool](#)
- [Internal Quality Monitoring Tool](#)
- [Project Action Plan Template](#)
- [Quality and Patient Safety Committee Meeting Agenda/Minute Template](#)
- [Rapid Tests of Change Tool](#)
- [Ten Step Quality Improvement Project Documentation Template](#)

MBQIP Quality Improvement Focus Areas

Individual measures for MBQIP continue to evolve to stay aligned with other federal quality reporting programs while keeping a focus on CAH relevant services. The table in [Appendix D](#) provides a quick reference guide for all required measures reported for MBQIP as part of the FY 2015 Flex grant cycle and [Appendix C](#) provides a list of acronyms.

Currently, focus areas for MBQIP improvement fall into four quality domains:

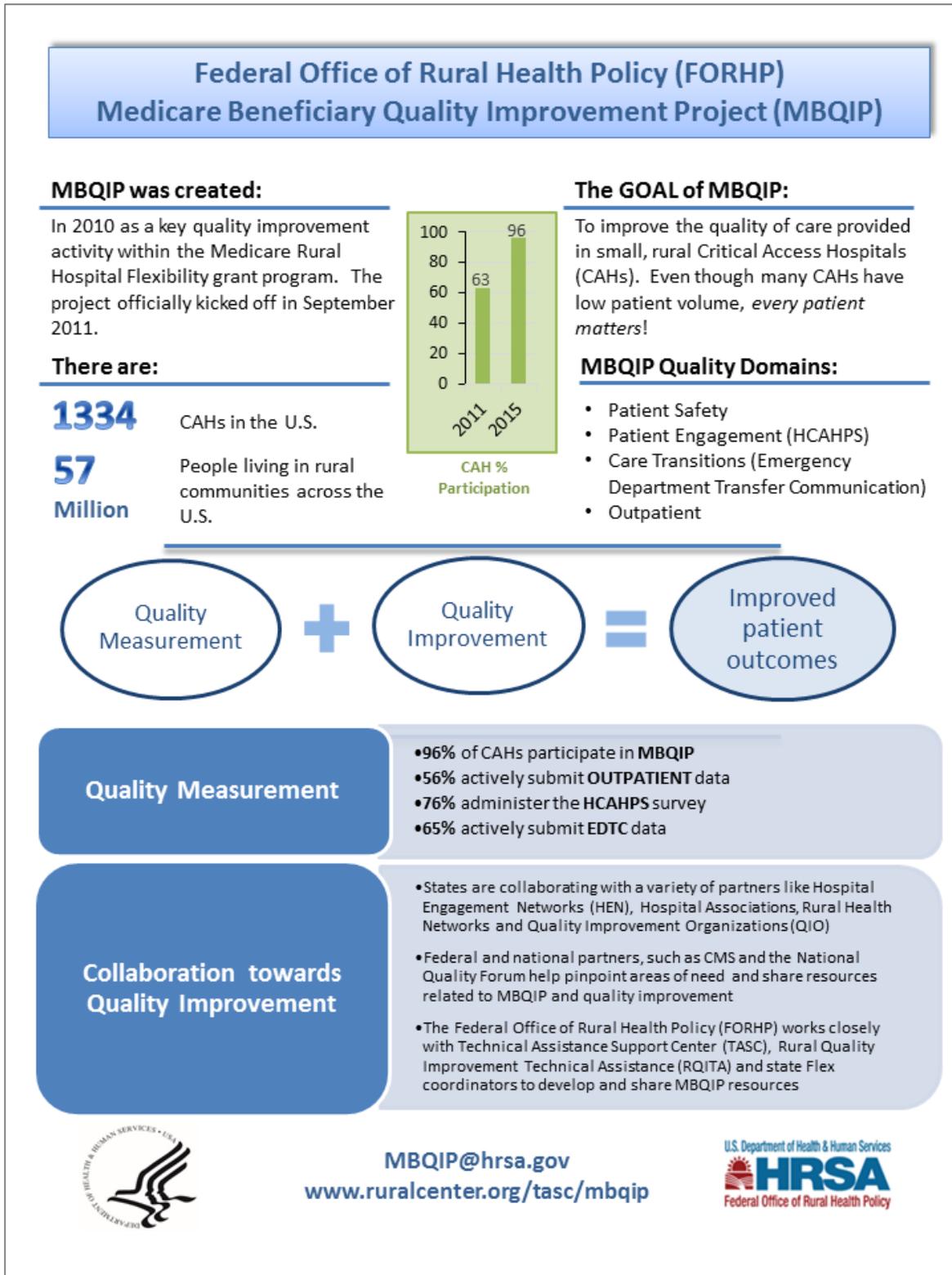
- Patient Safety ([Appendix E](#))
- Outpatient Care ([Appendix F](#))
- Patient Engagement ([Appendix G](#))
- Care Transitions ([Appendix H](#))

The tables in Appendices E through H summarize the measures by focus area and include best practices for improvement for each area. Although for reporting purposes HCAHPS is considered a patient engagement measure, many of the individual questions and domains in the HCAHPS survey can be relevant to improvement efforts related to patient safety and care transitions and can be found in the related quality domains.

Additional Resources

- A wide variety of resources related to MBQIP can be found on the TASC [MBQIP page](http://www.ruralcenter.org/tasc/mbqip) (<http://www.ruralcenter.org/tasc/mbqip>). Categories of these resources include:
 - [Care Transitions](#)
 - [Data Reporting and Use](#)
 - [Outpatient](#)
 - [Patient Engagement/HCAHPS](#)
 - [Patient Safety](#)
 - [MBQIP Monthly](#)
 - [MBQIP Measures Fact Sheets](#)

Appendix A – FORHP MBQIP Infographic



Appendix B – Federal and National Quality Programs

Supporting Organization	Initiative/Program	Focus Area(s) & Initiative/Program Website
Centers for Medicare & Medicaid Services (CMS)	Partnership for Patients (P4P) Hospital Engagement Networks (HENs)	Reduce all cause-preventable inpatient harm by 40 percent and readmissions by 20 percent. Topics include: <ul style="list-style-type: none"> • Adverse drug events • Healthcare-associated infections (HAI) • Early elective delivery • Falls • Pressure ulcers • Venous thromboembolism (VTE) • Ventilator-associated events (VAE) • Hospital readmissions • Perinatal safety • Delirium • Sepsis Partnership for Patients website
CMS	Quality Innovation Network – Quality Improvement Organizations (QIN-QIOs)	Hospital focused priorities include: <ul style="list-style-type: none"> • HAI • Hospital readmissions • Reporting and using clinical quality data/value based purchasing QIO website CDC Healthcare Acquired Infections website
Office of the National Coordinator for Health Information Technology (ONC)	Meaningful Use of Electronic Health Records Clinical Quality Measures (MU)	Electronic medical record capability relating to processes, experience and/or outcomes of patient care, relative to one or more quality aims Eligible Hospital & CAH Meaningful Use Table of Contents Core & Menu Set Objectives
American Heart Association	Get with the Guidelines (GWTG)	Reporting, improvement and recognitions programs related to cardiac conditions including AMI, heart failure, stroke and atrial fibrillation American Heart Association – Get With the Guidelines website

Supporting Organization	Initiative/Program	Focus Area(s) & Initiative/Program Website
<p>Agency for Healthcare Research & Quality (AHRQ)</p>	<p>Hospital Survey on Patient Safety Culture</p> <p>Team Strategies and Tools to Enhance Performance and Patient Safety (TeamSTEPPS)</p> <p>Comprehensive Unit Based Safety Program (CUSP)</p>	<p>Wide variety of tools and resources that focus on evaluating and improving hospital patient safety culture through teamwork and communication. CUSP has a particular emphasis on HAIs</p> <p>AHRQ Hospital Survey on Patient Safety Culture website</p> <p>Action Planning Tool for the AHRQ Surveys on Patient Safety Culture Agency for Healthcare Research & Quality</p> <p>AHRQ TeamSTEPPS website</p> <p>AHRQ CUSP website</p>
<p>Robert Wood Johnson Foundation (RWJF) and Institute for Healthcare Improvement (IHI)</p>	<p>Transforming Care at the Bedside (TCAB)</p>	<p>Improvement initiative that focuses on nursing staff. Priorities include:</p> <ul style="list-style-type: none"> • Improve the reliability and safety of patient care on medical and surgical units • Increase the vitality and retention of nurses • Engage and improve the patients' and family members' experience of care • Improve the effectiveness of the entire care team <p>RWJF TCAB website</p>
<p>Centers for Disease Control and Prevention (CDC)</p>	<p>National Healthcare Safety Network (NHSN)</p>	<p>System for tracking a variety of measures related to health care associated infections</p> <p>NHSN website</p>

Appendix C – MBQIP Acronym Guide

The following is a list of acronyms used throughout the MBQIP measure summaries in Appendices D through G.

AMI	Acute Myocardial Infarction
ECG	Electrocardiogram
ED	Emergency Department
EDTC	Emergency Department Transfer Communication
EHR	Electronic Health Record
EMS	Emergency Medical Service
ESI	Emergency Severity Index
HCAHPS	Hospital Consumer Assessment of Healthcare Providers and Systems
HCP	Health Care Provider
IMM	Immunization
LBF	Long Bone Fracture
MBQIP	Medicare Beneficiary Quality Improvement Project
NHSN	National Healthcare Safety Network
OP	Outpatient
QMP	Qualified Medical Professional
STEMI	ST Segment Elevation Myocardial Infarction

Appendix D – Measure Quick Reference Guide

The following table displays all current MBQIP measures, including the measure abbreviation, measure name and the focus area in which the measure is included within this guide. Clicking the measure abbreviation will take you to the measure in its corresponding measure summary table.

Measure Abbreviation	Measure Name	Focus Area
EDTC	Emergency Department Transfer Communication	Care Transitions
HCAHPS Composite 1	Communication with Nurses	Patient Engagement
HCAHPS Composite 2	Communication with Doctors	Patient Engagement
HCAHPS Composite 3	Responsiveness of hospital staff	Patient Safety
HCAHPS Composite 4	Pain Management	Patient Safety
HCAHPS Composite 5	Communication about Medicines	Patient Safety
HCAHPS Composite 6	Discharge Information	Care Transitions
HCAHPS Composite 7	Care Transition	Care Transitions
HCAHPS Q8	Cleanliness of Hospital Environment	Patient Engagement
HCAHPS Q9	Quietness of Hospital Environment	Patient Engagement
HCAHPS Q21	Overall Rating of This Hospital	Patient Engagement
HCAHPS Q22	Willingness to Recommend This Hospital	Patient Engagement
OP-1	Median Time to Fibrinolysis	Outpatient Care
OP-2	Fibrinolytic Therapy Received Within 30 Minutes of ED Arrival	Outpatient Care
OP-3	Median Time to Transfer to Another Facility for Acute Coronary Intervention	Outpatient Care
OP-5	Median Time to ECG	Outpatient Care
OP-20	Door to Diagnostic Evaluation by a Qualified Medical Professional	Outpatient Care
OP-21	Median Time to Pain Management for Long Bone Fracture	Outpatient Care
OP-22	Patient Left Without Being Seen	Outpatient Care
OP-27	Influenza Vaccination Coverage Among Healthcare Personnel	Patient Safety
IMM-2	Influenza Immunization (inpatient)	Patient Safety

Appendix E – Patient Safety Measure Summary

Patient safety measures are used to gauge how well a hospital provides care to its patients. MBQIP Measures are based on scientific evidence and can reflect guidelines, standards of care, practice parameters, and patient perceptions. Medical information from patient records and/or HCAHPS survey responses are converted into rates or percentages that allow facilities to assess their performance.

Note: In the tables below, unless otherwise noted, the provided “Technical Description” is taken from the Inpatient [CMS Measures Specification Manual](#); the “HCAHPS Survey Question” descriptions are taken from the [HCAHPS website](#); and the “Description for Consumer” is taken from [Hospital Compare](#).

Measure Abbreviation, Name	Data Submission or Origin	Technical Description/ HCAHPS Survey Question	Description for Consumer	Best Practices/Resources
HCAHPS Composite 3 Responsiveness of hospital staff	HCAHPS Surveys	During this hospital stay... <ul style="list-style-type: none"> • After you pressed the call button, how often did you get help as soon as you wanted it? (Q4) • How often did you get help in getting to the bathroom or in using a bedpan as soon as you wanted? (Q11) 	Patients who reported that they "Always" received help as soon as they wanted	<ul style="list-style-type: none"> • Establish protocols and identify accountability for responding to inpatient calls • Track the type and timing of inpatient call requests to target support and response processes • Implement intentional hourly rounding • Establish processes and expectations regarding communication for nurses when stepping away from the floor or when assistance is needed
HCAHPS Composite 4 Pain Management	HCAHPS Surveys	During this hospital stay... <ul style="list-style-type: none"> • How often was your pain well controlled? (Q13) • How often did the hospital staff do everything they could to help you with your pain? (Q14) 	Patients who reported that their pain was "Always" well controlled	<ul style="list-style-type: none"> • Consistently use a pain scale to evaluate patient perception of pain • Implement intentional hourly rounding • Use whiteboards for communication regarding timing and dose of pain medication • Offer alternative methods to manage pain and engage family and caregivers in communication about pain management

Measure Abbreviation, Name	Data Submission or Origin	Technical Description/ HCAHPS Survey Question	Description for Consumer	Best Practices/Resources
HCAHPS Composite 5 Communication about Medicines	HCAHPS Surveys	During this hospital stay... <ul style="list-style-type: none"> • Before giving you any new medicine, how often did hospital staff tell you what the medicine was for? (Q16) • Before giving you any new medicine, how often did hospital staff describe possible side effects in a way you could understand? (Q17) 	Patients who reported that staff "Always" explained about medicines before giving it to them	<ul style="list-style-type: none"> • Implement triggers and prompts in care processes to ensure education about medications. • Use teach-back to assess patient understanding • Limit use of jargon and technical terms • Provide nurses ready access to resources and tools regarding information about medications in patient friendly terms • Consider providing a pharmacist bedside visit to review new medications • Share best practices and processes among staff for communicating in difficult situations (e.g., patient doesn't speak English or has difficulty hearing)
OP-27 Influenza Vaccination Among Healthcare Personnel (HCP)	NHSN	Influenza Vaccination Coverage Among Healthcare Personnel	This measure shows the percentage of all healthcare workers in a hospital that received the flu vaccine	<ul style="list-style-type: none"> • Consider an organized 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 regularly measured and reported to facility administrators and staff

Measure Abbreviation, Name	Data Submission or Origin	Technical Description/ HCAHPS Survey Question	Description for Consumer	Best Practices/Resources
				<ul style="list-style-type: none"> • Consider obtaining signed declinations from personnel who decline influenza vaccination for reasons other than medical contraindications • Document reasons for non-receipt of a recommended vaccine • Consider steps to minimize/reduce potential for spread of vaccine preventable disease by unvaccinated employees such as the use of facemasks • Declination/Refusal: consider policy for a follow-up conversation to provide resources to counter misinformation (if indicated) and advise employee on post-exposure protocols and any need to restrict or modify work
<p>IMM-2 Influenza Immunization (inpatient)</p>	<p>Quality Net via inpatient CART or vendor</p>	<p>Documentation of the patient's vaccination status during this influenza season. If found to be a candidate for the influenza vaccine, documentation that the influenza vaccine was given during this hospitalization.</p>	<p>This measure shows how well the hospital is screening for and providing influenza immunizations.</p>	<ul style="list-style-type: none"> • Offer influenza vaccination by October, if possible. Vaccination should continue to be offered as long as influenza viruses are circulating (generally October – March) • Incorporate influenza vaccination status into initial patient assessment and identify a process for follow-up when needed • Review influenza vaccination status in the discharge process with administration of vaccine if indicated on initial assessment and not already given during hospitalization

Appendix F – Outpatient Measure Summary

Many rural hospitals provide the bulk of their services in an outpatient setting. The CMS outpatient measures evaluate the regularity with which a health care provider administers the outpatient treatment known to provide the best results for most patients with a particular condition. The below measures have been identified as relevant to most critical access hospitals (CAHs) and are included in the Medicare Beneficiary Quality Improvement Project (MBQIP).

Note: In the table below, the provided “Technical Description” is taken from the Outpatient [CMS Measures Specification Manual](#) and the “Description for Consumer” is taken from [Hospital Compare](#).

Measure Abbreviation, Name	Data Entry or Origin	Technical Description	Description for Consumer	Best Practices/Resources
OP-1 Median time to Fibrinolysis (AMI Care)	Quality Net via outpatient CART or vendor	Median time from emergency department (ED) arrival to administration of fibrinolytic therapy in ED patients with ST-segment elevation on the electrocardiogram (ECG) performed closest to ED arrival and prior to transfer	Not reported on Hospital Compare	See OP-2 below
OP-2 Fibrinolytic Therapy Received Within 30 Minutes of ED Arrival (AMI Care)	Quality Net via outpatient CART or vendor	Emergency Department AMI patients with ST-segment elevation on the ECG closest to arrival time receiving fibrinolytic therapy during the ED stay and having a time from ED arrival to fibrinolysis of 30 minutes or less	Outpatients with chest pain or possible heart attack who got drugs to break up blood clots within 30 minutes of arrival	<ul style="list-style-type: none"> • Diagnose the patient as early in the patient flow as possible (e.g., enable EMS to diagnose ST segment elevation myocardial infarction (STEMI) patients and/or notify ED of possible STEMI to initiate preparation processes) • Synchronize clocks and equipment in the ED • Establish local guidelines or care pathways for AMI patients • Ensure the emergency physician on duty activates the reperfusion plan according to established local guidelines and care pathways. • Treat registration for patients with AMI in a fashion similar to trauma patients with the ability to fast-track critical labs, such as

Measure Abbreviation, Name	Data Entry or Origin	Technical Description	Description for Consumer	Best Practices/Resources
				creatinine and Prothrombin Time (PT)/International Normalized Ratio (INR) test <ul style="list-style-type: none"> • Store fibrinolytic agent in the ED and/or establish ability to reconstitute and administer fibrinolytic in the ED
OP-3 Median Time to Transfer to Another Facility for Acute Coronary Intervention (AMI Care)	Quality Net via outpatient CART or vendor	Median time from emergency department arrival to time of transfer to another facility for acute coronary intervention	Average number of minutes before outpatients with chest pain or possible heart attack who needed specialized care were transferred to another hospital	<ul style="list-style-type: none"> • Diagnose the patient as early in the patient flow as possible (e.g., enable emergency medical service (EMS) to diagnose STEMI patients) • Synchronize equipment and clocks in the ED • Work with EMS providers 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 transport, immediately activate transport during initial communication between referring hospital ED and receiving hospital regarding the need for reperfusion

Measure Abbreviation, Name	Data Entry or Origin	Technical Description	Description for Consumer	Best Practices/Resources
OP-5 Median Time to ECG (AMI Care)	Quality Net via outpatient CART or vendor	Median time from emergency department arrival to ECG (performed in the ED prior to transfer) for AMI or Chest Pain patients (with Probable Cardiac Chest Pain)	Average number of minutes before outpatients with chest pain or possible heart attack got an ECG	<ul style="list-style-type: none"> • Diagnose the patient as early in the patient flow as possible (e.g., enable EMS to diagnose STEMI patients and/or notify ED of possible STEMI to initiate preparation/processes) • Synchronize equipment and clocks in the ED • Promptly identify patients requiring ECG through nurse interview prior to registration or provide necessary training to registration personnel • Specify processes and protocol for rapidly acquiring ECG, including having ECG equipment in the ED and specifying a location that affords prompt access and adequate patient privacy
OP-20 Door to Diagnostic Evaluation by a Qualified Medical Professional	Quality Net via outpatient CART or vendor	Median time patients spent in the emergency department before they were seen by a healthcare professional.	Average number of minutes patients spent in the emergency department before being seen by a qualified medical professional (QMP)	<ul style="list-style-type: none"> • Consider implementing alternative patient flow models such as: <ul style="list-style-type: none"> - RN triage and preliminary registration upon arrival, with bedside registration - Provider/RN team evaluations upon arrival with bedside registration - Low acuity patients evaluated by provider upon arrival and discharged as soon as full registration is completed • Share door to qualified medical professional (QMP) evaluation data with ED managers, ED staff, and providers daily • Synchronize all staff and equipment clocks in the ED • Ensure that providers consistently document the time of their first face patient assessment or exam • AHRQ Patient Flow Guide

Measure Abbreviation, Name	Data Entry or Origin	Technical Description	Description for Consumer	Best Practices/Resources
				<ul style="list-style-type: none"> • AHRQ Emergency Severity Index (ESI): A Triage Tool for Emergency Department
OP-21 Median time to Pain Management for Long bone Fracture	Quality Net via outpatient CART or vendor	Median time from emergency department arrival to time of initial oral, intranasal or parenteral pain medication administration for emergency department patients with a principal diagnosis of long bone fracture (LBF).	For all patients 2 years and older who came to the emergency department with a broken arm or leg, this shows the average time they waited before getting pain medication	<ul style="list-style-type: none"> • Provide regular nurse and provider education on the requirements for LBF pain management with frequent feedback on performance • Consider implementing a nurse-driven protocol for LBF or suspected LBF • Triage patients with suspected or known LBF as Emergency Severity Index (ESI) level-2, or equivalent prioritization
OP-22 Patient left without being seen	Quality Net	Percent of patients who leave the Emergency Department (ED) without being evaluated by a physician/advance practice nurse/physician’s assistant (physician/APN/PA).	This measure shows the percentage of all individuals who signed into an emergency department but left before being evaluated by a healthcare professional.	<ul style="list-style-type: none"> • The best practices to reduce door to evaluation by QMP (OP 20) also are likely to reduce the number of patients left without being seen • Implement a process to capture patients that leave without being seen • Conduct regular patient record analyses to identify and understand trends, such as a particular diagnosis or timeframe • Contact patients who leave without being seen before the end of the shift or the next day to encourage them to return to the ED or seek treatment • AHRQ Patient Flow Guide

Appendix G – Patient Engagement Measure Summary

Patients and their families are essential partners in the effort to improve the quality and safety of health care. Their participation as active members of their own health care team is an essential component of making care safer and reducing readmission. Studies have demonstrated measurable benefits to providing patient-centered care with a positive impact on patient satisfaction, length of stay and cost per case. By improving communication with patients, whether via providers at the bedside or institutionally through committees focused on systemic changes in patient care, patient outcomes can and will improve. Broad improvement efforts focusing on patient-centered care, organizational culture, communication strategies, and staff engagement/satisfaction are critical for comprehensive improvement.

Note: In the table below, the “HCAHPS Survey Question” descriptions are taken from the [HCAHPS website](#) and the “Description for Consumer” is taken from [Hospital Compare](#).

Measure Abbreviation, Name	Data Entry or Origin	HCAHPS Survey Question	Description for Consumer	Best Practices/Resources
HCAHPS (general)	HCAHPS Surveys	N/A	N/A	<ul style="list-style-type: none"> • Consider exercises where staff and providers complete the HCAHPS survey based on their experience and/or knowledge of the hospital, and discuss strategies to improve patient perception on care. • HCAHPS response rates are positively correlated with high HCAHPS performance. • Work closely with HCAHPS vendors to monitor and improve HCAHPS response rates. • HCAHPS website
HCAHPS Composite 1 Communication with Nurses	HCAHPS surveys	During this hospital stay... <ul style="list-style-type: none"> • How often did nurses treat you with courtesy and respect? (Q1) • How often did nurses listen carefully to you? (Q2) • How often did nurses explain 	Patients who reported that their nurses "Always" communicated well	<ul style="list-style-type: none"> • Provide staff training and promote awareness relating to empathy and effective communication • Use teach-back, limit jargon and employ other health literacy principles • Standardize shift change processes and/or bedside report and use as an opportunity to engage the patient and family in care • Implement intentional hourly rounding • Use scripting for key messages and/or employ a communication frameworks such as AIDET

Measure Abbreviation, Name	Data Entry or Origin	HCAHPS Survey Question	Description for Consumer	Best Practices/Resources
		things in a way you could understand? (Q3)		
HCAHPS Composite 2 Communication with Doctors	HCAHPS Surveys	During this hospital stay... <ul style="list-style-type: none"> • How often did doctors treat you with courtesy and respect? (Q5) • How often did doctors listen carefully to you? (Q6) • How often did doctors explain things in a way you could understand? (Q7) 	Patients who reported that their doctors "Always" communicated well	<ul style="list-style-type: none"> • Provide staff training and promote awareness relating to empathy and effective communication • Implement peer to peer mentoring • Use teach-back, limit jargon and employ other health literacy principles • Engage patients and families in care conferences and/or interdisciplinary rounds • Use scripting for key messages and/or employ a communication frameworks such as AIDET
HCAHPS Q8 Cleanliness of Hospital Environment	HCAHPS Surveys	During this hospital stay... <ul style="list-style-type: none"> • How often were your room and bathroom kept clean? (Q8) 	Patients who reported that their room and bathroom were "Always" clean	<ul style="list-style-type: none"> • Clarify roles and responsibilities in responding to patient or staff concerns regarding cleanliness • Designate a housekeeping quality assurance supervisor and trainer • Inspect an agreed number of patient rooms on a regular basis, and follow up with cleaning staff to correct deficiencies • Provide visible information in the room to let patients and families know who to contact if they have a housekeeping concern or request • Provide training on communication standards and processes to cleaning staff as a part of orientation and ongoing evaluations (e.g., AIDET)

Measure Abbreviation, Name	Data Entry or Origin	HCAHPS Survey Question	Description for Consumer	Best Practices/Resources
				<ul style="list-style-type: none"> • Use logs to identify patients who communicate cleaning concerns. Follow-up with those patients at least daily to ensure that their room and their bathroom is cleaned to their satisfaction • Implement intentional hourly rounding
HCAHPS Q9 Quietness of Hospital Environment	HCAHPS Surveys	During this hospital stay... <ul style="list-style-type: none"> • How often was the area around your room quiet at night? (Q9) 	Patients who reported that the area around their room was "Always" quiet at night	<ul style="list-style-type: none"> • Utilize single patient rooms if feasible • Close doors to patient rooms whenever possible • Use "Quiet Zone" signs and reminders in the corridors • Eliminate use of overhead paging, particularly at night • Designate zones for staff conversation (e.g., nurses station) to help avoid hallway discussions that may be disruptive to nearby rooms • Evaluate transport carts and replace noisy wheels and casters • Turn down the alarm sound level on monitoring equipment if feasible or have telemetry equipment monitoring away from the patient (e.g., in the nurses station) • Request that work involving heavy machinery only be done during the daytime. (e.g., use of battery powered scrubbers, buffers and other loud equipment) • In the evening/nighttime, use a portable lantern or flashlight to illuminate the area in which the employee is working rather than turning on the overhead lights when the patient are resting
HCAHPS Q21 Overall Rating of This Hospital	HCAHPS Surveys	Using any number from 0 to 10, where 0 is the worst hospital possible and 10 is the best hospital possible, what number would you use to rate this hospital during your stay? (Q21)	Patients who gave their hospital a rating of 9 or 10 on a scale from 0 (lowest) to 10 (highest)	The following areas are most strongly correlated with a high overall hospital rating and therefore most likely to support improvement in the overall rating of the hospital: <ul style="list-style-type: none"> • Scores on Nurse Communication (see best practices above) • Pain Management (see best practices in the Patient Safety Measures Summary) • Responsiveness of Hospital Staff (see best practices in the Patient Safety Measures Summary)

Measure Abbreviation, Name	Data Entry or Origin	HCAHPS Survey Question	Description for Consumer	Best Practices/Resources
HCAHPS Q22 Willingness to Recommend This Hospital	HCAHPS Surveys	Would you recommend this hospital to your friends and family? (Q22)	Patients who reported "Yes", they would definitely recommend the hospital	<p>The following areas are most strongly correlated with a high willingness to recommend:</p> <ul style="list-style-type: none"> • Scores on Nurse Communication (see best practices above) • Pain Management (see best practices in the Patient Safety Measures Summary) • Responsiveness of Hospital Staff (see best practices in the Patient Safety Measures Summary)

Appendix H – Care Transitions Measure Summary

Care transitions refer to the movement of patients from one health care provider or setting to another. For people living with serious and complex illnesses, transitions in setting of care are prone to errors. For example, one in five patients discharged from the hospital to home experience an adverse event within three weeks of discharge. The current rate for hospital readmissions among Medicare beneficiaries within 30 days of discharge is nearly 20%, contributing to lower patient satisfaction and rising health care costs².

Note: In the table below, the “Technical Description” of the Emergency Department Transfer Communication (EDTC) measure and sub-measures is taken from the [Stratis Health Data Collection Guide: Emergency Department Transfer Communication Measures](#); the “Hospital Consumer Assessment of Healthcare Providers and Systems (HCAHPS) Survey Question” descriptions are taken from the [HCAHPS website](#); and the “Description for Consumer” is taken from [Hospital Compare](#).

Measure Abbreviation, Name	Data Entry or Origin	Technical Description/ HCAHPS Survey Question	Description for Consumer	Best Practices/Resources
EDTC Emergency Department Transfer Communication	EDTC spreadsheet sent to state Flex Coordinator	<p>Composite of seven sub-measures; 27 data elements.</p> <p>Patients who are transferred from an Emergency Department (ED) to another health care facility have...</p> <ul style="list-style-type: none"> • EDTC-SUB 1: Administrative Communication (two data elements) – Physician to physician communication and health care facility to health care facility communication prior to discharge • EDTC-SUB 2: Patient Information (six data elements) – Patient identification information sent to the receiving facility within 60 minutes of discharge 	Not reported on Hospital Compare	<ul style="list-style-type: none"> • 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 the information was communicated to the next setting of care • Implement prompts and documentation in the electronic health record (EHR) to ensure elements are captured and communicated to the receiving facility, whether electronically or via a printed-paper form

² Geoffrey Gerhardt et al., “Data Shows Reduction in Medicare Hospital Readmission Rates During 2012,” *Medicare & Medicaid Research Review* 3 (2013), accessed April 1, 2015, doi: 10.5600/mmrr.003.02.b01.

Measure Abbreviation, Name	Data Entry or Origin	Technical Description/ HCAHPS Survey Question	Description for Consumer	Best Practices/Resources
		<ul style="list-style-type: none"> • EDTC-SUB 3: Vital Signs (six data elements) – Communication with the receiving facility within 60 minutes of discharge for patient’s vital signs • EDTC-SUB 4: Medication Information (three data elements) – Communication with the receiving facility within 60 minutes of discharge for medication information • EDTC-SUB 5: Physician or Practitioner Generated Information (two data elements) – Communication with the receiving facility within 60 minutes of discharge for history and physical and physicians orders and plan • EDTC-SUB 6: Nurse Generated Information (six data elements) – Communication with the receiving facility within 60 minutes of discharge for key nurse documentation elements • EDTC-SUB 7: Procedures and Tests (two data elements) – Communication with the receiving facility within 60 minutes of discharge of tests done and results sent • EDTC-All: Number of patients transferred to another health care facility whose medical record documentation indicated that all of the relevant elements for each 		<ul style="list-style-type: none"> • 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 • 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

Measure Abbreviation, Name	Data Entry or Origin	Technical Description/ HCAHPS Survey Question	Description for Consumer	Best Practices/Resources
		<p>of the seven sub-measures were communicated to the receiving hospital in a timely manner</p>		
<p>HCAHPS Composite 6</p>	<p>Discharge Information</p>	<p>During this hospital stay...</p> <ul style="list-style-type: none"> • Did doctors, nurses or other hospital staff talk with you about whether you would have the help you needed when you left the hospital? (Q19) • Did you get information in writing about what symptoms or health problems to look out for after you left the hospital? (Q20) 	<p>Patients who reported that "Yes", they were given information about what to do during their recovery at home</p>	<ul style="list-style-type: none"> • Conduct pre-discharge assessment of ability of patient and/or family to provide self-care, including: problem solving, decision making, early symptom recognition and taking action, quality of life, depression and other cognitive and functional ability factors • Develop a comprehensive shared care plan using a shared decision making approach. Consider patient values and preferences, social and medical needs • Throughout the patient stay, work with the patient and family to prepare for discharge and follow-up planning, including goals, questions and concerns • Ensure written discharge plan is easy to read and includes only essential education on health condition, using plain language and health literacy principles
<p>HCAHPS Composite 7</p>	<p>Care Transition</p>	<p>During this hospital stay...</p> <ul style="list-style-type: none"> • 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. (Q23) • When I left the hospital, I had a good understanding of the things I 	<p>Patients who "Strongly Agree" they understood their care when they left the hospital</p>	<p>In addition to the above strategies:</p> <ul style="list-style-type: none"> • Use personal health records or patient portals to ensure patients have access to necessary information, including: lab results, radiology results, prescription refills requests and ability to email doctors, nurses and staff with questions • Whenever possible, make follow-up appointments or arrangements

Measure Abbreviation, Name	Data Entry or Origin	Technical Description/ HCAHPS Survey Question	Description for Consumer	Best Practices/Resources
		<p>was responsible for in managing my health. (Q24)</p> <ul style="list-style-type: none"> • When I left the hospital, I clearly understood the purpose for taking each of my medications. (Q25) 		<p>for other services prior to discharge, always with patient and family input regarding availability and preferences</p> <ul style="list-style-type: none"> • Use teach-back and health literacy principles in patient education • Conduct follow-up phone calls within 48 hours post-discharge to clarify patient and family understanding of medications and follow-up services • Provide a written listing of medications to the patient and family including the name of the medication, dose, route, purpose, side effects and special considerations in language that is easy to understand for the patient • For patients with complicated medication regimes, whenever possible, engage pharmacy staff in performing patient education, medication review and follow-up phone calls

Appendix I – Glossary

This glossary includes a list of commonly used terms and their explanations as they apply to the Medicare Beneficiary Quality Improvement Project (MBQIP) and quality data reporting.

Aggregate: Sum; total combined.

Average: State and national averages are calculated by adding up all the numerators and denominators of every reporting critical access hospital then dividing to get the percentage.

CART: The Centers for Medicare & Medicaid Services (CMS) Abstraction & Reporting Tool; a free tool that hospitals can utilize to collect and submit the chart abstracted inpatient and outpatient [Hospital Compare](#) measures.

CMS Measure Specifications Manuals: Manuals created by the Centers for Medicare & Medicaid Services (CMS) to provide definitions for a uniform set of quality measures to be implemented in hospital settings. The inpatient and outpatient manuals can be found on the [QualityNet website](#).

Composite: A composite measure combines more than one item in order to measure a concept that is too complex to be measured with one item. In reference to Hospital Consumer Assessment of Healthcare Providers and Systems (HCAHPS), a composite measure is a grouping of related questions.

Hospital Compare: A website developed by the Centers for Medicare & Medicaid Services (CMS) that compiles information about hospitals and their reported quality measures and allows consumers to compare hospitals to assist in making a decision about where to seek care. For more information visit the [Hospital Compare website](#).

Intentional hourly rounding: A practice used by nursing and care teams in which routine rounds on patients are conducted hourly employing an intentional approach with the goal of improving patient care, safety and experience; also known as purposeful hourly rounding.

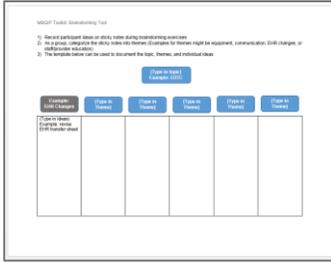
Median: The middle number in a set of values; half the numbers are less and half the numbers are greater.

Teach-back: A communication method for ensuring that a patient understands what a provider has told them. For more information and resources visit the [Always Use Teach-back website](#).

Time-out: A step in a medical process in which all activity stops to allow the team to focus fully on communication with and about the patient. For example, surgical time-outs are a time to confirm which body part is being operated on.

Appendix J – Tools

Brainstorming Tool



The brainstorming tool is designed to help categorize and document ideas elicited during brainstorming sessions.

[Download the tool](#)

Internal Quality Monitoring Tool



This excel spreadsheet assists in tracking and reporting progress on MBQIP and other quality and patient safety measures. The tool generates run charts that can be shared with staff and leadership.

[Download the tool](#)

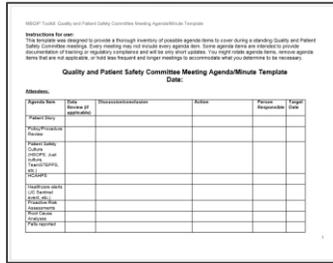
Project Action Plan Template



This template provides a structure for documenting progress on a project action plan.

[Download the template](#)

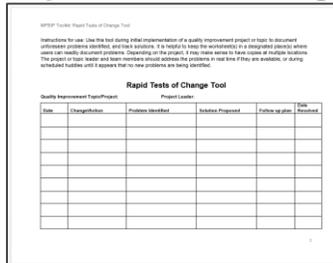
Quality and Patient Safety Committee Meeting Agenda/Minute Template



This template is designed to provide a thorough inventory of possible agenda items to cover during Quality and Patient Safety Committee meetings.

[Download the template](#)

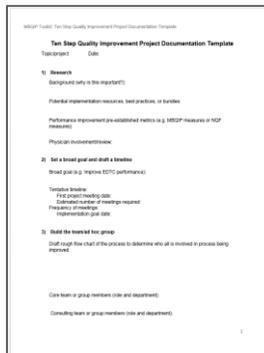
Rapid Tests of Change Tool



Use this tool during initial implementation of a quality improvement project or topic to document unforeseen problems identified, and track solutions.

[Download the tool](#) [Tool example](#)

Ten Step Quality Improvement Project Documentation Template



This template assists with documenting the completion of quality improvement project steps

[Download the template](#)