

MBQIP Monthly

Medicare Beneficiary Quality Improvement Project



A publication for Flex Coordinators to share with their critical access hospitals

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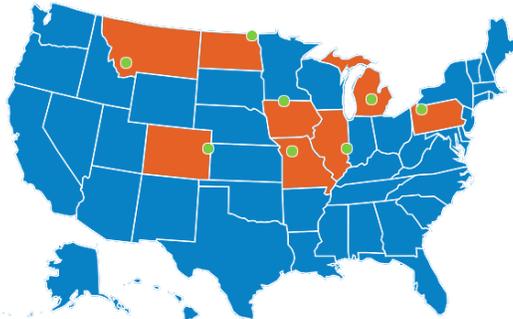
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Contact your Flex Coordinator if you have questions about MBQIP.

Find your state Flex Coordinator on the [Technical Assistance and Services Center \(TASC\) website](#).

Find past issues of this newsletter and links to other MBQIP resources on TASC's [MBQIP Monthly](#) webpage.

Virtual Quality Improvement Mentor Program



Eight experienced critical access hospital (CAH) quality improvement (QI) staff from across the country will serve as [national virtual quality improvement mentors](#) through a new initiative that aims to broadly transfer knowledge from leading CAH quality improvement staff to others. The eight outstanding mentors

below were selected from a pool of candidates across the country who were nominated by their respective state Flex programs as quality improvement leaders. They represent the diversity of CAHs nationally, with varying rural locations, service lines, and patient volumes, which average 2.5 to 16 patients per day and 1,300 to 13,000 emergency room visits annually.

Meet the QI mentors



Amy Arnett, Horizon Health – Paris Community Hospital, Paris, IL,



Cindy Gilman, Carroll County Memorial Hospital, Carrollton, MO



Mariah Hesse, Sparrow Clinton Hospital, St. Johns, MI



Karen Hooker, Kit Carson County Health Service District, Burlington, CO



Christy Mintah, Avera Holy Family Hospital, Estherville, IA,



Ben Power, Barrett Hospital & Healthcare, Dillon, MT



ArvaDell Sharp, Pembina County Memorial Hospital, Cavalier, ND



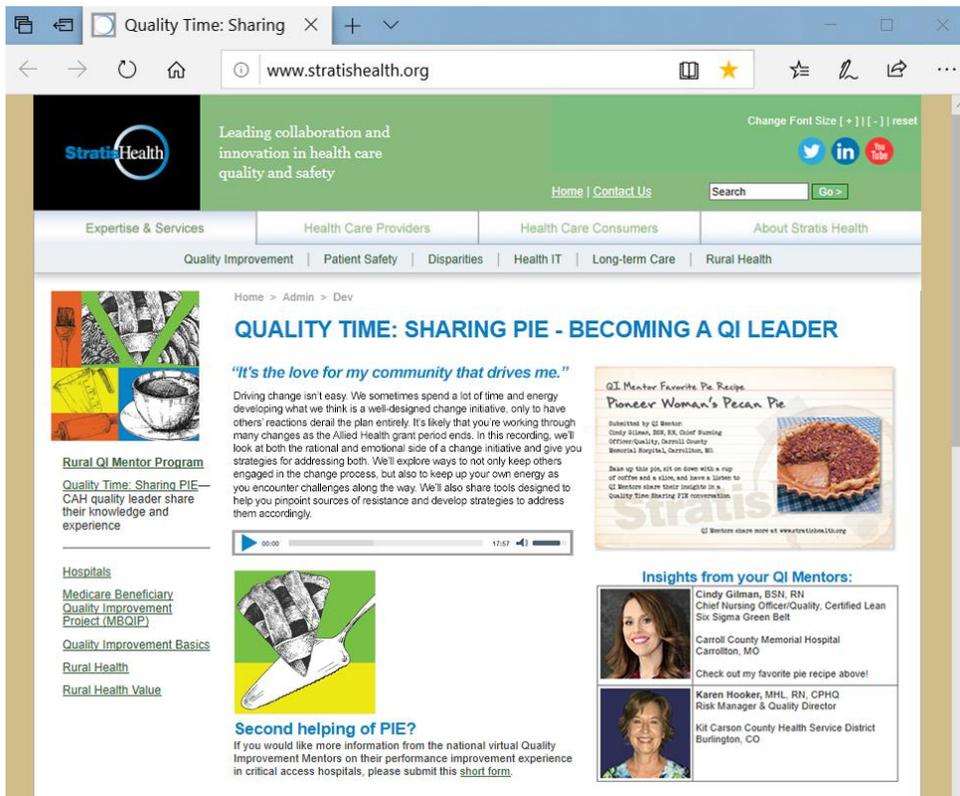
Brenda Stevenson, Titusville Area Hospital, Titusville, PA

Coming Soon! Quality Time: Sharing PIE (performance improvement experience) Conversations

Listen and learn from the lived experience of the virtual QI mentors. Select mentors will come together periodically for quality time to share PIE—their performance improvement experience. They discuss key

topics that help drive quality improvement in their rural hospitals. Listen to their lessons learned, strategies, tips, and ideas. Find valued supportive resources for each of their topics, along with their real favorite pie recipes!

Through their recorded PIE conversations, virtual QI mentors will share their examples and advice on how to address common quality improvement challenges that occur in CAHs as well as their desire and passion for doing better, improving outcomes, preventing harm. As mentor Mariah Hesse put it, “The people that we serve and the people that walk through our doors are our friends, our neighbors, our relatives. We want to ensure that we treat



every single one of our patients as if it's someone that we love in that bed, and to ensure that we have the best evidence-based practices to help them.”

RQITA will capture the strategies, tips, and ideas in these recorded conversations to disseminate them broadly to others serving in CAH quality roles.

Resources will be shared starting in Spring 2020. In the meantime, enjoy this [Recipe for a successful PIE](#).

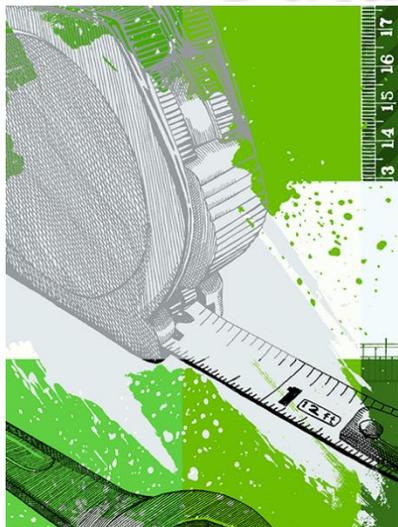


Burning QI Question? Ask the Mentors.

The virtual QI mentors want to share their performance improvement experience in critical access hospitals with you. Have a burning question? Want to suggest a PIE conversation topic? Just submit this [short form](#).

The national rural Virtual Quality Improvement Mentor Program is led by [Stratis Health](#). Contact [Sarah Brinkman](#) for more information.

Data



CAHs Measure Up: Data Quality and Accuracy

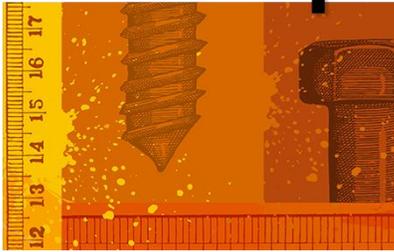
Reporting your quality data is essential, but so is using your quality data for improvement efforts. If you are using your quality data to identify areas for improvement, it's also important to know that your data is accurate. That way, you aren't implementing a potentially time-consuming change when it might not be necessary or might have unintended consequences. Submitting accurate data also helps ensure that others in your state and at the federal level have adequate information to support program decisions.

Here are a couple of common data accuracy issues to watch out for:

- **Numerator is larger than denominator.** This should never happen and is most likely caused by mistyping. The denominator should always be larger than the numerator. Most commonly, we notice this in the EDTC data submitted to your state Flex Coordinator each quarter. For example, if your hospital has reviewed 45 records for the quarter, then it is never possible for the number of records meeting each EDTC measure to be larger than 45. The number of records meeting each EDTC measure can be any number up to 45, but never greater than 45.
- **Incorrect use of '0' in population & sampling.** Some hospitals share that they have no patients for some measures (particularly the AMI metrics). If this is truly accurate, it's important to submit a '0' in population and sampling to indicate your facility has no cases that meet the measure population requirements.

It is also possible to abstract records inaccurately, perhaps by interpreting the instructions in various Specifications Manuals incorrectly. This, in turn, can cause your calculated quality measures to be inaccurate. For example, it's possible to use an incorrect time when abstracting a record that contributes to a timing-based emergency department measure, and this might make it appear that your hospital has longer (or shorter) emergency department wait times than is actually the case. If you are curious to learn more about how you are abstracting data, consider participating in RQITA's Abstracting for Accuracy opportunity. Check out the [project description and guidelines](#) for information on how to sign up.

Tips



Go to Guides

Hospital Quality Measure Guides

- [MBQIP Quality Reporting Guide](#)
- [Emergency Department Transfer Communication](#)
- [Inpatient Specifications Manual](#)
- [Outpatient Specifications Manual](#)



Abstracting Resources

[Abstracting for Accuracy Consultation](#)

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

Robyn Quips - tips and frequently asked questions

Comments and Observations on the EDTC Training Sessions

I hope you were able to attend one of the three training sessions held on the revised Emergency Department Transfer Communication (EDTC) Specifications Manual for use starting with Jan 1, 2020 encounters. For those that want to hear me review the EDTC Specifications Manual, we will have a recording up in January. The link will be on the [EDTC Resource page](#) along with a Q&A document, containing questions that came out of the webinar training sessions. If you asked a question during a session but feel like it wasn't addressed when you check out the Q&A, please [contact me](#). We'll send out additional information when these resources are posted.

Most of the questions were regarding the population for the EDTC measure, and it was made clear that some hospitals may not have been pulling the population for abstraction correctly. The only change made to the population with this revision was that patients who are seen in your ED and then admitted to observation status are no longer included in the population.

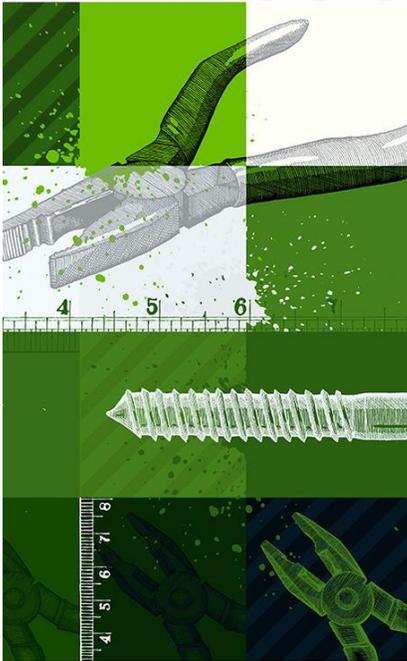
Patients who are seen in your ED and then discharged, transferred, returned to (or whatever term you use to describe it) a nursing home, skilled nursing facility, or swing bed are to be included in the population. They have always been part of the population and are listed in the manual under 'Other Health Care Facility'. We get asked about this frequently, and no, it does not matter if the nursing home or swing bed is part of your hospital. The patient was seen in your acute care ED and is now going to a lesser level of care. It does not matter if the patient resides in the nursing home, for measure abstraction they are not going 'home', they are going to a facility listed under 'Other Health Care Facility' in the Specifications Manual. The nursing home or staff at the 'other' health care facility needs to know what occurred during the ED visit; were meds changed, was there a new diagnosis, etc.

Look for a revised Q&A resource for more addressing these questions coming this month.

Assistance from CMS Outpatient/Inpatient Support or QualityNet

For those of you who ask for assistance from Centers for Medicare & Medicaid Services (CMS) resources such as Outpatient or Inpatient Support and the QualityNet Service Desk (formerly called the help desk), you need to be aware that staff there may not know about the MBQIP program. They know how to answer questions based on the requirements of the CMS programs. At this time, CMS doesn't require any chart abstracted measure data to be submitted by CAHs. That's why when you ask your question or are having problems submitting, you might hear, "Don't worry about it, submission isn't required for CAHs." That is true for the CMS programs, but you are submitting for the MBQIP program! So, tell them that you need to submit and want help for whatever the issue might be. Then be sure to let your Flex Coordinator and or me ([Robyn](#)) know if you get this kind of response when you are looking for assistance. That way, we know we still must continue to get the word across to CMS staff about the MBQIP program.

Tools



Tools and Resources

New! [Emergency Department Transfer Communication \(EDTC\) Specifications Manual](#). The Specifications Manual for the revised EDTC measure is now available. Hospitals should use the revised specifications manual for data collection **starting with January 1, 2020, encounters**. Additional resources, including an updated Excel-based data collection tool and tool training video, are also available. A recorded training on the EDTC measure using the revised Data Specifications Manual will be available in January.

Ask Robyn – Quarterly Open Office Hours Calls for Data Abstractors Wednesday, January 22, 2020, 2:00 – 3:00 p.m. CT – [Register](#)

Sometimes it just helps to talk to someone! Quality Reporting Specialist Robyn Carlson will be offering open office hour calls to discuss your MBQIP abstraction questions. Sessions are free of charge, but registration is required. For more information about the Ask Robyn calls, contact Robyn Carlson, rcarlson@stratishealth.org.

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

[Clinician Wellbeing Knowledge Hub](#)

Clinicians of all kinds, including doctors, nurses, pharmacists, dentists, medical trainees, and others, are experiencing alarming rates of burnout. This poses a significant threat to the sustainability of our health system and the safety of our patients. Supported by the National Academy of Medicine's Action Collaborative on Clinician Well-Being and Resilience, the Hub is intended to provide an easy-to-navigate repository of helpful resources for those seeking information and guidance on how to combat clinician burnout in their organizations and their personal lives.

[QI Basics Online Learning Modules and Resources](#)

The Quality Improvement (QI) Basics course is designed to equip professionals with the knowledge and tools to start quality improvement projects at their facilities. Developed by Stratis Health, with rural audiences in mind, the course may be completed in sequence, or individual modules and tools may be used for stand-alone training and review. A newly released facilitators guide, and sample course syllabus is also available for those that may want to utilize the resource for group training and discussion within their organization.



MBQIP Monthly is produced by Stratis Health to highlight current information about the Medicare Beneficiary Quality Improvement Project (MBQIP). This newsletter is intended for Flex Coordinators to share with their critical access hospitals.

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