

# MBQIP Monthly

Medicare Beneficiary Quality Improvement Project



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

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Contact your Flex Coordinator if you have questions about MBQIP.

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

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

## Welcome to MBQIP Monthly!

This publication has been developed to highlight current information about the Medicare Beneficiary Quality Improvement Project (MBQIP), and provides critical access hospitals (CAHs) with information and support for quality reporting and improvement. MBQIP is a part of the Medicare Rural Hospital Flexibility (Flex) grant program of the Health Resources and Services Administration's Federal Office of Rural Health Policy (FORHP).

Most are aware that significant efforts are underway to fundamentally change the way health care is provided and paid for in the United States. A critical component of this reform is to accelerate adoption of reimbursement models that reward high value care.

Value-based reimbursement models nearly all include incentives related to performance on quality metrics. Avoiding active participation in quality reporting and improvement programs leaves CAHs at risk of being left behind. Payers, and consumers will, and should, demand evidence that the quality of care provided in a small rural hospital is equivalent, if not better than those same services in an urban setting.

The goal of MBQIP is to support quality data reporting and quality improvement activities in CAHs, not only to improve care for the rural communities they serve, but also to help CAHs prepare for value-based reimbursement models. Despite the challenges, nearly 90 percent of CAHs nationwide participate in public reporting of at least some quality metrics.

MBQIP Monthly is a tool to help support those efforts, and each month will provide tips, ideas, and resources for quality reporting and improvement, as well as showcase high performing CAHs from across the country. We hope it will be a useful resource in your quality improvement journey!

**Yvonne Chow**, MBQIP Coordinator, HRSA, FORHP

**Karla Weng**, Rural Quality Improvement Technical Assistance Program Lead, Stratis Health

# CAHs Can!



## Rural Success: Bigfork Valley Hospital practices servant leadership, nursing department ownership

Bigfork Valley Hospital, a 20-bed CAH in the heart of northeastern Minnesota lake country, has been recognized nationally for its high HCAHPS (Hospital Consumer Assessment of Healthcare Providers and Systems) performance. With response rates consistently over 50% and overall performance rated at over 90% — well above state and national averages — one cannot help but be intrigued as to what makes Bigfork different. Especially when a longer look reveals Emergency Department Transfer Communication performance at 100%, patient influenza vaccinations at near 100%, and high performance in other outpatient measures.

Bigfork hasn't used packaged customer satisfaction programs. When asked about her hospital's high HCAHPS performance, Nancy Probst, CNO, says, "It's just our culture. Patients are delighted enough about the great care to respond to satisfaction surveys and give the hospital outstanding ratings."

After some great conversation with the notably humble leadership team at Bigfork Valley Hospital, several success themes emerge. Servant leadership comes through clearly as we talk. Leaders at Bigfork Valley know their jobs are to make sure the people caring for patients are well taken care of.

According to Aaron Saude, CEO, "Nancy encourages her staff to grow professionally, which in turn encourages them to care and be personally invested in what goes on." Nurses also are empowered to call in extra help when they feel it is warranted by an increased patient care load.

As CNO, Nancy also is responsible for hospital quality performance, as opposed to quality being overseen by a separate department. This lands quality ownership in the lap of the most powerful drivers of HCAHPS and other quality measures – nurses. This arrangement also allows for increased flexibility in responding to census changes – when patient volume is low, a nurse can be assigned to quality data entry.

High standards of patient care have been a tradition handed down at Bigfork long before HCAHPS surveys. Hiring for attitude, positive role modeling, and an environment where staff routinely coach each other on customer service slips are characteristics that leaders attribute to the high patient satisfaction.

"There is no simple solution," Aaron asserts. "The experience starts when a patient walks through the door, and follows through the entire facility, every department, every area. People saying 'hi' to others in the hall is a great gauge of hospital culture and HCAHPS performance."

### Measuring Up

#### Bigfork HCAHPS Performance

- > 50% Response rate
- > 90% Overall performance rating



# Tips



## Go to Guides

### Hospital Quality Measure Guides

- [Emergency Transfer Communications](#)
- [Inpatient Specifications Manual](#)
- [Outpatient Specifications Manual](#)

## Robyn Quips - tips and frequently asked questions

### EDTC Measure Updated for Nurse to Nurse Communication

Since the start of data collection for the Emergency Department Transfer Communication (EDTC) measure, the data element “Nurse to Nurse Communication” has raised many questions and concerns. Hospitals were unsure what the communication needed to contain, was it a report on the patient’s status? If so, many times this was done after the patient left the facility, as nurses were too busy taking care of the patient to make this call prior to transfer. Was it a check to see if the intended receiving hospital had staff and services available to accept the patient? If so, this was often done by hospital staff other than nurses. What about patients transferred to health care facilities that may not always have nurses on staff at all hours?

Due to these questions and concerns, the University of Minnesota (National Quality Forum measure owner) reviewed the feedback from CAHs and Flex programs, which led to two changes to the Nurse to Nurse Communication data element. The data specifications were revised to better reflect the intent of the measure—ensuring availability of bed and staffing at the receiving facility—and it was renamed “Healthcare Facility to Healthcare Facility Communication,” to recognize that the communication is not always done by nurses.

The abstraction instructions still indicate that the communication needs to occur prior to the patient’s transfer but can now be done by ED staff other than nursing. The notes for abstraction clarify that assuring availability of appropriate bed and services for the patient is considered acceptable communication.

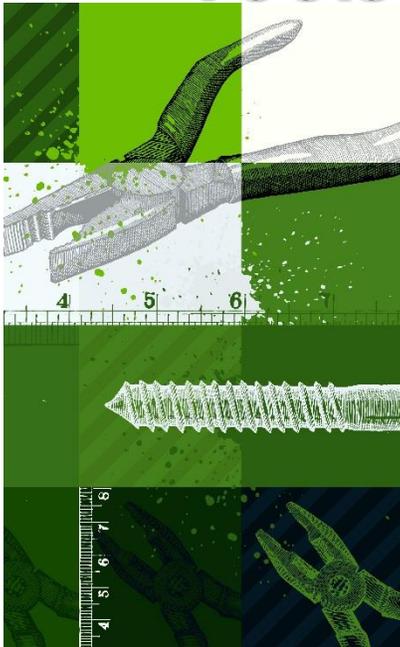
The [EDTC Data Specifications Manual dated January 2016](#) includes these changes. This manual should be used for data collection starting with Quarter 1, 2016 transfers. [Current data specifications](#) should be used to complete Q4 2015 (October-December) data collection due for MBQIP by January 31, 2016.

### Common Question: EDTC measure

A question often comes up regarding patients who reside in nursing homes, get sent to the ED and are then transferred back to the nursing home, should they be included in the EDTC population? These are sometimes coded as the patients being discharged to home, since they live in the nursing home. For EDTC abstraction, these patients should be included in the measure population, as they are being transferred to a nursing home, which fits under the discharge code category of 5—other health care facility.

**Robyn Carlson**, Stratis Health quality reporting specialist, provides Flex Coordinators with technical assistance related to MBQIP.

# Tools



## Tools and Resources

**[MBQIP Measures Fact Sheets.](#)** These fact sheets provide an overview of data collection and reporting processes for the Medicare Beneficiary Quality Improvement Project (MBQIP) required measures. The goal of this resource is to capture details regarding the MBQIP measures them in a basic, one-measure-per-page overview.

**[Maneuvering MBQIP Measures 101.](#)** This recorded webinar provides a review of the required measures for MBQIP, and includes an overview of their significance in improving health, data reporting processes, and additional resources available to support data collection and improvement. (58-minute webinar)

**[Data Specifications Manual - Emergency Department Transfer Communication Measure \(January 2016\).](#)** Use this updated data specifications manual for data collection starting with Quarter 1, 2016 transfers.

**[Data Collection Tool - Emergency Department Transfer Communication Measure \(January 2016\).](#)** Use this updated Excel tool for transfers starting Quarter 1, 2016.

**[EDTC Online Recorded Trainings.](#)** Two recorded trainings are now available to help support data collection for the EDTC Measure.

- **EDTC Data Specifications Overview.** A guided overview of all the data elements in the EDTC Measure Data Specifications Manual. We recommend having the manual open to follow along. (22-minute audio file)
- **EDTC Data Collection Tool Training Video.** A step-by-step guide on how to download the Excel-based data collection tool, enter data, and run reports to calculate your measures. (18-minute video)

### Coming Soon!

**MBQIP CAH Quality Improvement Implementation Guide and Toolkit.** This guide and toolkit will offer strategies and resources to help CAH staff organize and support efforts to implement best practices for quality improvement. Anticipated release is February 2016.

**MBQIP Data Collection Checklist.** Step-by-step overview of MBQIP data reporting processes including links to resources to support data collection and reporting. Anticipated release is March 2016.



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. (01/20)

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