SAFER Care for CAH: Structuring for Excellence

Minnesota Rural Health Conference
June 21, 2016

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Objectives

• Understand the connection between quality and patient safety and value based models
• Explore several CAH quality infrastructures that have proven to be successful across multiple patient safety and quality topics
• Hear from representatives of two Minnesota CAH’s that have been recognized by the Minnesota Hospital Association for superior performance in patient safety and have been successful participants in the Medicare Beneficiary Quality Improvement Program (MBQIP)
Minnesota Critical Access Hospital Data
### Minnesota hospital utilization

#### 2014

<p>| | |</p>
<table>
<thead>
<tr>
<th></th>
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</tr>
</thead>
<tbody>
<tr>
<td>Number of hospitals</td>
<td>78</td>
</tr>
<tr>
<td>Acute care admissions</td>
<td>39,306</td>
</tr>
<tr>
<td>Average patient care days</td>
<td>544,371</td>
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<tr>
<td>Average length of stay</td>
<td>3.1</td>
</tr>
<tr>
<td>Swing bed days</td>
<td>44,684</td>
</tr>
<tr>
<td>Swing bed length of stay</td>
<td>9.9</td>
</tr>
<tr>
<td>Births</td>
<td>5,469</td>
</tr>
</tbody>
</table>
Minnesota hospital utilization

Inpatient surgical admissions

![Graph showing inpatient surgical admissions from 2007 to 2014, with data points for each year and a trend line indicating a decrease in admissions over time.]

- 2007: 11,659
- 2008: 11,715
- 2009: 11,102
- 2010: 10,021
- 2011: 10,297
- 2012: 10,171
- 2013: 9,491
- 2014: 9,145

Note: The graph includes a linear trend line superimposed on the data points, showing a consistent decrease in inpatient surgical admissions over the years.
Minnesota hospital utilization

Top 10 DRGs for 2014

<table>
<thead>
<tr>
<th>DRG</th>
<th>Number of Discharges</th>
<th>Average Length of Stay</th>
</tr>
</thead>
<tbody>
<tr>
<td>Normal newborn</td>
<td>3,961</td>
<td>1.9</td>
</tr>
<tr>
<td>Vaginal delivery without complicating diagnosis</td>
<td>3,226</td>
<td>2.0</td>
</tr>
<tr>
<td>Major joint replacement</td>
<td>1,457</td>
<td>3.5</td>
</tr>
<tr>
<td>Esophagitis, gastroenteritis &amp; misc. digestive disorders without major complications/co-morbidities</td>
<td>1,436</td>
<td>2.6</td>
</tr>
<tr>
<td>Simple pneumonia &amp; pleurisy with complications/co-morbidities</td>
<td>1,419</td>
<td>3.9</td>
</tr>
<tr>
<td>Simple pneumonia &amp; pleurisy without major complications/co-morbidities</td>
<td>1,334</td>
<td>3.2</td>
</tr>
<tr>
<td>Misc. disorders of nutrition, metabolism, fluid/electrolytes without major complications/co-morbidities</td>
<td>1,094</td>
<td>2.7</td>
</tr>
<tr>
<td>Cesarean section without major complications/co-morbidities</td>
<td>1,008</td>
<td>2.8</td>
</tr>
<tr>
<td>Kidney &amp; urinary tract infections without major complications/co-morbidities</td>
<td>972</td>
<td>3.1</td>
</tr>
<tr>
<td>Psychoses</td>
<td>847</td>
<td>6.6</td>
</tr>
</tbody>
</table>
Value Based Purchasing 2017 (PPS hospitals)

• Patient and Caregiver-Centered Experience of Care/Care Coordination (25%)
• Safety (20%)
• Clinical Care (30%)
  – Clinical Care – Outcomes (25%)
  – Clinical Care – Process (5%)
• Efficiency and Cost Reduction (25%)
  – Medicare spending per beneficiary
Patient and Caregiver-Centered Experience of Care/Care Coordination
HCAHPS (25%)

1. Communication with Nurses
2. Communication with Doctors
3. Responsiveness of Hospital Staff
4. Pain Management
5. Communication about Medicines
6. Cleanliness and Quietness of Hospital Environment
7. Discharge Information
8. Care Transition (3 new questions starting in FY 2018)
9. Overall Rating of Hospital
Safety (20%)

- **CAUTI** - Catheter-Associated Urinary Tract Infection
- **CLABSI** - Central Line-Associated Blood Stream Infection
- **CDI** - Clostridium difficile Infection (C. difficile)
- **MRSA** Methicillin-Resistant Staphylococcus aureus Bacteremia
- **AHRQ PSI-90 composite** - Complication/Patient Safety for Selected Indicators (composite)
- **PC-01** - Elective Delivery Prior to 39 Completed Weeks Gestation
- **SSI** - Surgical Site Infection: Colon, Abdominal Hysterectomy
Clinical Care Outcomes (25%)

• MORT-30-AMI Acute Myocardial Infarction (AMI) 30-day Mortality Rate
• MORT-30-HF Heart Failure (HF) 30-day Mortality Rate
• MORT-30-PN Pneumonia (PN) 30-day Mortality Rate
Clinical Care Processes (5%)

• AMI-7a - Fibrinolytic Therapy Received Within 30 Minutes of hospital Arrival
• IMM-2 - Influenza Immunization
• PC-01 - Elective Delivery Prior to 39 Completed Weeks Gestation
Efficiency and Cost Reduction (25%)

- MSPB-1 Medicare Spending per Beneficiary (MSPB)
VBP Performance Periods
VBP on the horizon for CAH?

• MBQIP measures – new connection with Flex funded activities and SHIP grants
  – 2015 – reporting one measure in one domain required
  – 2016 - ?

• National reporting
  – NHSN, Quality Net

• HEN topics with NQF endorsement?
  – Falls
  – CAUTI

• Global measures help address volume challenges
  – IMM – 2
  – OP -27 HCP influenza immunizations

• Clinical care outcomes - all cases, all payers readmissions
MBQIP

Medicare Beneficiary Quality Improvement Project (MBQIP) Measures

<table>
<thead>
<tr>
<th>Core Improvement Initiatives</th>
<th>Patient Safety</th>
<th>Patient Engagement</th>
<th>Care Transitions</th>
<th>Outpatient</th>
</tr>
</thead>
<tbody>
<tr>
<td>MBQIP-23: Influenza vaccination coverage among healthcare personnel (HCP) facilities report a single rate for inpatient and outpatient settings</td>
<td>EIP-5: Hospital Consumer Assessment of Healthcare Providers and Systems (HCAHPS)</td>
<td>Hospital Consumer Assessment of Healthcare Providers and Systems (HCAHPS)</td>
<td>Emergency Department Transfer Communication (EDTC)</td>
<td>OP-1: Median time to admission</td>
</tr>
<tr>
<td>IMM-2: Influenza immunization</td>
<td>The HCAHPS survey contains 33 patient perspectives on care and patient rating items that encompass five key topics:</td>
<td>The survey covers four areas of engagement and seven demographic items. The survey is 32 questions in length.</td>
<td>7 sub-measures, 27 data elements, 1 composite</td>
<td>OP-2: Catheter-related therapy received within 30 minutes</td>
</tr>
<tr>
<td></td>
<td>• Communication with doctors</td>
<td></td>
<td>• EDTC-1: Administrative Communication (2 data elements)</td>
<td>OP-3: Median time to transfer to another facility for acute coronary interventions</td>
</tr>
<tr>
<td></td>
<td>• Communication with nurses</td>
<td></td>
<td>• EDTC-2: Patient Information (6 data elements)</td>
<td>OP-4: Explains arrival</td>
</tr>
<tr>
<td></td>
<td>• Responsiveness of hospital staff</td>
<td></td>
<td>• EDTC-3: Vital Signs (6 data elements)</td>
<td>OP-5: Median time to EKG</td>
</tr>
<tr>
<td></td>
<td>• Pain management</td>
<td></td>
<td>• EDTC-4: Medication Information (6 data elements)</td>
<td>OP-5B: Median Time from ED Arrival to ED Departure for Discharged ED Patients</td>
</tr>
<tr>
<td></td>
<td>• Communication about medicines</td>
<td></td>
<td>• EDTC-5: Physician or Practitioner Generated Information (2 data elements)</td>
<td>OP-20: Door to Diagnostic Evaluation by a Qualified Medical Professional</td>
</tr>
<tr>
<td></td>
<td>• Discharge information</td>
<td></td>
<td>• EDTC-6: Nurse Generated Information (6 data elements)</td>
<td>OP-21: Median Time to Pain Management for Long Bone Fracture</td>
</tr>
<tr>
<td></td>
<td>• Cleanliness of the hospital environment</td>
<td></td>
<td>• EDTC-7: Procedures and Tests (2 data elements)</td>
<td>OP-22: Patients left without being seen</td>
</tr>
<tr>
<td></td>
<td>• Quietness of the hospital environment</td>
<td></td>
<td>• All EDTC: Composite of all 27 data elements</td>
<td></td>
</tr>
<tr>
<td></td>
<td>• Transition of care</td>
<td></td>
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</tr>
</tbody>
</table>
MBQIP HCAHPS Measures – 4\textsuperscript{th} Quarter 2014 through 3\textsuperscript{rd} Quarter 2015
MBQIP Emergency Department Transfer Communication – 3rd and 4th Quarter 2015
## MBQIP Outpatient Measures
### 3rd Quarter 2014 through 2nd Quarter 2015

<table>
<thead>
<tr>
<th>Measure ID</th>
<th>Measure Name</th>
<th>State</th>
<th>National</th>
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<tbody>
<tr>
<td>OP-1</td>
<td>Median Time to Fibrinolysis (Minutes)</td>
<td>39</td>
<td>39</td>
</tr>
<tr>
<td>OP-2</td>
<td>Fibrinolytic Therapy Received Within 30 Minutes of ED Arrival (%)</td>
<td>13%</td>
<td>40%</td>
</tr>
<tr>
<td>OP-3b</td>
<td>Median Time to Transfer to Another Facility for Acute Coronary Intervention (Minutes)</td>
<td>55</td>
<td>65</td>
</tr>
<tr>
<td>OP-4</td>
<td>Aspirin at Arrival (%)</td>
<td>96%</td>
<td>96%</td>
</tr>
<tr>
<td>OP-5</td>
<td>Median Time to ECG (Minutes)</td>
<td>9</td>
<td>8</td>
</tr>
</tbody>
</table>
National Quality Forum Rural Provider Recommendations

After discussion of many of the rural health and setting-specific challenges related to performance measurement of rural providers, the Committee agreed that their recommendations should, at minimum, address four key issues:

• Low case volume
• Need for measures that are most meaningful to rural providers and their patients and families
• Alignment of measurement efforts
• Mandatory versus voluntary participation in CMS quality improvement programs

SAFER Care for Critical Access Hospitals

Minnesota Hospital Association (MHA), Stratis Health, and the Office of Rural Health and Primary Care are collaborating to assist participants with improvement through implementation of the SAFER Care road map. MHA’s SAFER Care road map for Minnesota critical access hospitals (CAH) combines all the quality and patient safety priorities required by both federal and state programs.
SAFER Care for Critical Access Hospitals

- Quality Improvement Specialist site visits to MN CAH’s - 60 completed so far
- Continued phone consultation
- SAFER Care webinars, regional meetings
- CAH quality advisory group
Resources available

- SAFER Care CAH Roadmap
- SAFER Care data inventory
  - Measures, specifications,
- SAFER Care topic resource sheet
TRI-COUNTY HEALTH CARE
A CRITICAL ACCESS HOSPITAL’S
TEAMWORK APPROACH TO QUALITY REPORTING

Tammy Suchy, MLS  Director of Quality and Risk
Who Is Tri–County Health Care (TCHC)?

- Located in Wadena MN at the cross roads of State Highways 71 and 10
- CAH with one attached clinic and five outlying clinics—all Rural Health Clinics
- Average daily inpatient census of 9
- 3,000 patient days a year with Med Surge, ICU, OB/NSY, Outpatient (including OP surgical), Swing Bed and Observation Care
- Ambulatory Care department with over 2,000 visits annually
- Emergency Department that sees over 6,000 cases a year
- Ambulance/Community Paramedic with over 2,500 visits annually
- Clinics with a total of 54,000 patient visits a year
Quality and Improvement for All!

- What do we collect data on and who do we report to?
  - Out Patient Measures for Emergency Care (nine measures)
  - Transfer Communication for patient transferred from the Emergency room (7 measures that roll up to a composite score)
  - Stroke Registry
  - Trauma Registry
  - Physician Quality Reporting Systems Data (PQRS–Data across all areas of the CAH)
  - Inpatient Data
    - Immunization and Emergency through put for admitted patients
    - Perinatal Care–Early Elective Delivery
    - VTE
    - Heart Failure
    - Pneumonia
Quality and Improvement for All!

- Minnesota Community Measures for Clinics (MNCM) – Appropriate care for Diabetes, Vascular Disease, Asthma, Depression, Pediatric Care, Colorectal Cancer Screening and Cesarean Section Rates

- Patient Experience data

- NHSN Data – CAUTI and Vaccination data

- Other performance/process Improvement data such as
  - Verbal Orders
  - Unsupervised Entry to Pharmacy
  - Critical Values
  - Rapid Response/Code Blue data
  - Medication Administration Barcoding
  - Mental Health Measures

- MHA Road Map Data
  - Falls, Pressure Ulcers, HAIs, ADEs, Perinatal Safety, Sepsis
How Do we meet all the Reporting and Data Deadlines?

TEAMWORK
  Nurses as Data abstractors and reviewers from the departments Low Volume time

STAFF AND PROVIDER ENGAGEMENT
  Owning and improving with TCAT (Transforming Care at Tri–County)

STRUCTURE AND COMMITTEE REPORTING
  Score Cards for reporting data at Committees and to the board

ACCOUNTABILITY
  Data is sent quarterly to Quality for reporting on scorecards
What has made the greatest impact...

TEAMWORK of the staff – Desire to make a difference

- Falls prevention progress – Many great TCAB projects with great success

- TCAT – Transforming Care at Tri-County
  - A process improvement initiative based on TCAB philosophies – Organization wide
Our Organization made it a strategic initiative to develop a process and performance improvement program based on the original TCAB concepts that were started by the Robert Wood Johnson Foundation (RWJF) and the Institute for Healthcare Improvement (IHI).
TCAT—Transforming Care at Tri–County

- Engage Front Line Staff
- Projects that increase Quality and Safety
- Now when we recognize room for improvement—Let’s do a TCAT Project is the response
A Structure for Collaboration

- Quality and Safety Committee and Medical Staff Committees are oversight to other service committees that funnel the data up and assign sub groups to work on improvement
  - Acute Care
  - Pharmacy and Therapeutics
  - Emergency Department
  - Clinic Services
  - Surgery Committee
  - Diagnostic Services
A Structure for Collaboration

- Quality Department
  - Accreditation, Patient safety, Patient Experience, Quality Reporting and Abstracting, Infection prevention, HIPAA/Privacy and Compliance
You cannot do this alone!

- Nobody can be the subject matter expert across all of the disciplines
  - Working Closely with all Managers, Supervisors and staff
  - Roadmap owners
  - Department specific data collection and abstraction
  - Committee ownership and work groups
  - Supportive Administration and Board
Avera Marshall Regional Medical Center

Safety, Quality, Reliability

Vickie Abel, LSW, MS
VP, Organizational Excellence
Avera Marshall Regional Medical Center

- 25 bed Critical Access Hospital
- 10 bed Behavior Health Unit
- 76 bed long term care center
- Avera Cancer Institute Marshall
- Clinic Operations
  - Primary Care
  - Surgical Services
  - Orthopedics
  - Podiatry
  - OB/GYN
  - Ophthalmology
  - Optometry
  - Behavior Health
Quality/Safety Journey

- Restructure of Organizational Excellence department 4 years ago
- Consultant to provide education on microsystems, FMEA, measuring quality, etc. 4 years ago
- Contract with Studer 3 years ago
- Change to internal safety and quality meetings and quality reporting 2 years ago
Quality and Safety:

- Quality Committees
  - Acute Care
  - Long term care
  - Clinic
  - MSQIC – Medical Staff Quality Committee
  - Nursing Peer Review
  - Quality Board

- Safety Committees
  - Clinical Readiness
  - Facility Readiness
  - Employee/Workplace
  - Fall Prevention – acute and LTC

- Reporting of data
  - Quality Board
  - Operations Council
  - Quality committee meetings
  - Department meetings

- Involvement of patients/family members
Initiatives:

- LDI – Leadership Development Institutes
- LEM – Leader Evaluation Manager
- Leader rounding with staff
  - Senior leader rounding with departments
- AIDET – Acknowledge, Introduce, Duration, Explanation, Thank You
  - 5 and 10 rule
- Leader rounding with patients
- Leader to leader rounding
- Retaining staff – 30/90 day review with new staff
Initiatives (cont.)

- Discharge phone calls
- Hourly rounding
- Bedside shift report
- New Leader Intensive
- Communication boards – acute care and Transitions Unit in LTC
- Med/Surg patient room design change
Tools and Accountability:

- Organizational and departmental goals
- Quality Scorecards
  - Variance report for the “reds”
- Process map
- Post Event Analysis and/or RCA
- Action plans and task lists
- Test of change
- Measuring for change
- Stoplight Reports
- 90 day action plans by leaders to address department and organizational goals
Tools and Accountability (cont.)

- Values discussions: High-Middle-Low
- Missed core measures to MSQIC
- Linkage Grid
<table>
<thead>
<tr>
<th>Issue/Task</th>
<th>RESPONSIBLE</th>
<th>Status</th>
<th>Start Date</th>
<th>End Date</th>
<th>NOTES</th>
</tr>
</thead>
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<tr>
<td>FY 2016 Med/Surg/CCU</td>
<td>Jul</td>
<td>Aug</td>
<td>Sep</td>
<td>1st Qtr</td>
<td>Oct</td>
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<td>-----</td>
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<tr>
<td># pts evaluated for LVS function</td>
<td>1</td>
<td>3</td>
<td>1</td>
<td>5</td>
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<td># HF patients</td>
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<td>3</td>
<td>1</td>
<td>5</td>
<td>1</td>
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<tr>
<td>% Heart Failure-Eval for LVS Function</td>
<td>100%</td>
<td>100%</td>
<td>100%</td>
<td>100%</td>
<td>100%</td>
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<tr>
<td># pts received appropriate antibiotic selection</td>
<td>0</td>
<td>2</td>
<td>4</td>
<td>6</td>
<td>2</td>
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<tr>
<td>% Pneumonia patients</td>
<td>0</td>
<td>2</td>
<td>4</td>
<td>6</td>
<td>2</td>
</tr>
<tr>
<td>% Pneumonia-Abx selection-Non ICU patient</td>
<td>NA</td>
<td>100%</td>
<td>100%</td>
<td>100%</td>
<td>100%</td>
</tr>
</tbody>
</table>

**STROKE**

| STK 1 - VTE prophylaxis | 100.0% | 100.0% | 100.0% | 100.0% | 100.0% | 100.0% | 100.0% | 100.0% | 100.0% | 100.0% | NA | 100.0% | 100.0% | 99%  |
| STK 2 - Ischemic stroke patients prescribed antithrombotic therapy at discharge | 100.0% | 100.0% | 100.0% | 100.0% | 100.0% | 100.0% | 100.0% | 100.0% | 100.0% | 100.0% | NA | 100.0% | 100.0% | 99%  |
| STK 3 - Ischemic stroke patients with atrial fibrillation who are discharged on anticoagulation therapy | NA | 100.0% | NA | 100.0% | 100.0% | 100.0% | 100.0% | NA | 100.0% | 100.0% | NA | 100.0% | 100.0% | 99%  |
| STK 5 - Ischemic stroke patients administered antithrombotic therapy by the end of hospital day 2 | 100.0% | 100.0% | 100.0% | 100.0% | 100.0% | 100.0% | 100.0% | 100.0% | 100.0% | 100.0% | NA | 100.0% | 100.0% | 99%  |
| STK 6 - Ischemic stroke patients w/ LDL >100 mg/dL or LDL not measured, or who were on lipid-lowering medication prior to hospital arrival are prescribed statin medication at hospital discharge | 100.0% | 100.0% | 100.0% | 100.0% | 100.0% | 50.0% | 100.0% | NA | 100.0% | 100.0% | NA | 100.0% | 100.0% | 99%  |
| STK 8 - Stroke patients who were given appropriate discharge instructions | 0.0% | 0.0% | 0.0% | 0.0% | 0.0% | 0.0% | 0.0% | 0.0% | 0.0% | 0.0% | NA | 100.0% | 100.0% | 99%  |
| STK 9 - Smoking cessation education | NA | NA | 100.0% | NA | NA | NA | NA | NA | NA | NA | NA | NA | 100.0% | 99%  |
| STK 10 - Stroke patients who were assessed for rehabilitation services | 100.0% | 100.0% | 100.0% | 100.0% | 100.0% | 100.0% | 100.0% | 100.0% | 100.0% | 100.0% | NA | 100.0% | 100.0% | 99%  |

**Sepsis 3-hour bundle**

| Event within 3 hours | 25% | 100% | 100% | 82% | 100% | 100% | 100% | 100% | 100% | 100% | 100% | 100% | 100% | 100% | 100% | 100% | 100% | 94% | 70%  |
| Blood culture within 3 hours | 75% | 100% | 100% | 100% | 100% | 100% | 100% | 100% | 100% | 100% | 100% | 100% | 100% | 100% | 100% | 100% | 100% | 94% | 70%  |
| Antibiotic within 3 hours | 50% | 100% | 78% | 78% | 100% | 100% | 100% | 100% | 100% | 100% | 100% | 100% | 100% | 100% | 100% | 100% | 100% | 94% | 70%  |
| Antibiotic after blood culture | 75% | 100% | 100% | 100% | 100% | 100% | 100% | 100% | 100% | 100% | 100% | 100% | 100% | 100% | 100% | 100% | 100% | 94% | 70%  |
| IV volume | 0% | 50% | 95% | 17% | 6% | 6% | 6% | 6% | 6% | 6% | 6% | 6% | 6% | 6% | 6% | 6% | 6% | 6% | 41% | 40%  |
POST EVENT ANALYSIS

(Type of Event), (Date)

Review of Event:

Date of Review:

After Action Review Team:

Response Agencies:

Summary of Event

Observed Strengths

Note: Strengths and areas for improvement can be grouped by the following critical areas: communication, safety and security, resource allocation, leadership, staff responsibilities, and patient care.

1. Communication/Education:

2. Safety and Security:

3. Resource Allocation/Mobilization/Equipment:

4. Leadership/Policy/Procedure:

5. Staff Responsibilities/Roles:

6. Patient Care:

7. Other:
Patient Room Communication Boards
Room Design Change
Questions ?
Stratis Health is a nonprofit organization that leads collaboration and innovation in health care quality and safety, and serves as a trusted expert in facilitating improvement for people and communities.

Prepared by Stratis Health, with funding from Minnesota Department of Health Office of Rural Health & Primary Care.