



MBQIP OUTPATIENT QUALITY IMPROVEMENT MEASURES TOOLKIT

MEDICARE BENEFICIARY QUALITY IMPROVEMENT PROJECT





Copyright ©2018 by Cynosure Health

This publication was developed for the West Virginia Hospital Association, Critical Access Hospital Network. No part of this publication may be reproduced, distributed, or transmitted in any form or by any means, including photocopying, recording, or other electronic or mechanical methods, without the prior written permission from Cynosure Health. For permission requests, write to Cynosure Health at the address below:

Cynosure@CynosureHealth.org

Cynosure Health
1688 Orvietto Drive
Roseville, CA 95661



The West Virginia Hospital Association CAH Network, with support from the State FLEX program, administrated by the WV State Office of Rural Health, working with Cynosure Health, is pleased to provide a best practice Outpatient Measures toolkit to support your CAH as you move forward with your quality improvement program.

I hope you find this toolkit useful, and I look forward to your feedback.

Dianna Iobst
Executive Director, WVHA CAH Network
diobst@wvha.org
304-353-9715 (o)
304-575-0849 (c)

MBQIP OUTPATIENT QUALITY IMPROVEMENT MEASURES TOOLKIT

BACKGROUND

Critical Access Hospitals (CAH) must be able to identify, treat and/or transfer patients that present to the Emergency Department in the most efficient and timely manner to ensure safety for patients that may require treatment or transfer to a higher level of care at a Regional Receiving Center. Patients that present to critical access hospital emergency departments with symptoms indicative of an acute myocardial infarction must be able to receive reperfusion treatment in a timely manner to prevent mortality or severe morbidity. (McNamara RL, 2007) (DeLuca G, 2004) The Medicare Beneficiary Quality Improvement Project (MBQIP) Outpatient Quality Improvement Measures include data metrics that demonstrate timeliness of treatment for patients that present to Critical Access Hospitals (CAH) with chest pain or symptoms of an acute myocardial infarction (AMI), plus measures to determine timeliness and efficiency of Emergency Department (ED) processes that impact patient flow through the department.

The Outpatient (OP) Quality Improvement Measures originally consisted of 9 separate measures of timeliness, throughput and pain management, but the Centers for Medicare and Medicaid Services has retired 4 of those measures after review for Fiscal Year 2018, starting with discharges after April 1, 2018. The remaining measures consist of three chest pain/AMI measures and two ED throughput measures, although all five measure the efficiency and flow of the ED:

- OP-2 Fibrinolytic Therapy Received Within 30 Minutes
- OP-3 Median Time to Transfer to Another Facility for Acute Coronary Intervention
- OP-5 Median Time to EKG
- OP-18 Median Time from ED Arrival to ED Departure for Discharged ED Patients
- OP-22 Patient Left Without Being Seen

DRIVER DIAGRAM

A driver diagram visually depicts the causal relationship between your overall aim and the primary drivers, secondary drivers and change ideas that “drive” the improvement. This driver diagram is provided to help you and your team identify potential change ideas to implement at your hospital as you work to improve care transition documentation.

AIM	Primary Driver	Secondary Driver	Change Idea
		Secondary Driver	Change Idea

	Primary Driver	Secondary Driver	Change Idea
		Secondary Driver	Change Idea

AIM: A clearly articulated goal describing the desired outcome. It should be specific (What), measurable (How Much), and time limited (By When).

PRIMARY DRIVER: System component for factor that directly contributes to achieving the AIM

SECONDARY DRIVER: Processes and actions that are necessary to achieve the primary driver.

CHANGE IDEAS: Specific interventions and changes that support the secondary driver.

DRIVERS IN OUTPATIENT QUALITY IMPROVEMENT

Drivers for improvement in the Outpatient Quality Improvement Measures include strategies that can effect positive change for all 5 OP metrics. Effective planning, communication and execution of Emergency Department processes and protocols are necessary for improvements in the safe and timely treatment and transfer or discharge of patients that present to Critical Access Hospital Emergency Departments. Situational awareness among the treatment team to identify that an emergency condition exists requires effective communication and collaboration strategies. The ability to efficiently triage and appropriately treat a patient is improved using standardized systems and processes developed by those involved in the care and treatment of emergency department patients. Preparedness for emergencies is enhanced by the availability of equipment and medications, as well as a process for early identification of patients requiring emergency care and/or transfer. Routine analysis of data related to ED processes can help to quickly identify areas for improvement and focus.

AIM: Improve the timeliness, treatment, and final disposition for patients that present to the Emergency Department (ED) in Critical Access Hospitals

<p>PRIMARY DRIVER: Situational Awareness</p>	<p>SECONDARY DRIVER: Chest Pain / AMI (OP-2, OP-3, OP-5) - Communication by ED staff with pre-hospital care providers (EMS), as well as receiving centers and emergency transport agencies (i.e., helicopter transport) while patient en route to ED</p> <p>CHANGE IDEAS:</p> <ul style="list-style-type: none"> • Activation of AMI treatment protocol upon communication with EMS, or upon EKG for walk-in patients • Communication with regional receiving center while AMI patient en route to ED • Communication with emergency transport helicopter service while patient en route to ED
---	--

	<ul style="list-style-type: none"> Standardized notification to all ED staff of timeliness goals for treatment and/or transfer
PRIMARY DRIVER: Efficiency	SECONDARY DRIVER: Chest Pain / AMI (OP-2, OP-3, OP-5) ED Throughput (OP-18, OP-22) Standardized process for rapid evaluation of patient needs and condition, and appropriate care CHANGE IDEAS: Chest Pain/AMI (OP-2, OP-3, OP-5) <ul style="list-style-type: none"> Work with EMS providers to develop a protocol for EKG results in the field to be communicated to the ED prior to arrival. Work with regional receiving center and emergency transport/helicopter transport agencies to develop standardized alert systems while patient en route to CAH ED. Develop a single call system for notification to CAH staff, receiving center and transport agency. Chest Pain/AMI and ED Throughput (OP-2, OP-3, OP-5, OP-18) <ul style="list-style-type: none"> Develop a process for RN/Provider interview of patients upon arrival to ED to fast track ordering of labs or tests. Instead of waiting for patients to be registered prior to treatment in the ED, provide bedside registration after triage. ED Throughput (OP-22) <ul style="list-style-type: none"> Gather contact information for each patient upon arrival to ED.
PRIMARY DRIVER: Preparedness for Emergencies	SECONDARY DRIVER: Chest Pain/AMI (OP-2, OP-3, OP-5) Standardized processes for treatment of AMI patients presenting to the ED CHANGE IDEAS: Chest Pain/AMI (OP-2, OP-3, OP-5) <ul style="list-style-type: none"> Develop standardized process for identification of AMI patients prior to arrival or at arrival for walk-in patients Develop standardized processes for communication with pre-hospital and transfer providers Synchronization of all clocks in Emergency treatment and evaluation areas, including laboratory

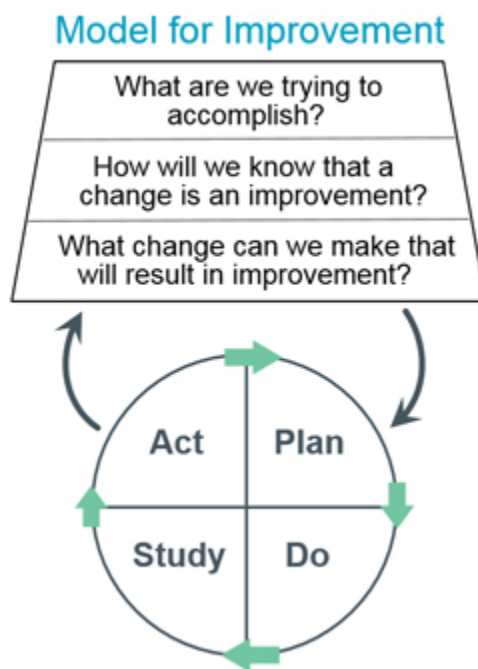
	<ul style="list-style-type: none"> • Store emergency equipment and medications such as EKG and fibrinolytics in the ED
<p>PRIMARY DRIVER: Data Analysis</p>	<p>SECONDARY DRIVER:</p> <p>Chest Pain/AMI (OP-2, OP-3, OP-5)</p> <p>ED Throughput (OP-18, OP-22)</p> <p>Routine review of data related to ED processes to identify areas for improvement and focus.</p> <p>CHANGE IDEAS:</p> <p>Chest Pain/AMI (OP-2, OP-3, OP-5)</p> <ul style="list-style-type: none"> • Implement a process to capture the timeliness of interventions for AMI patients on each shift <p>ED Throughput (OP-22)</p> <ul style="list-style-type: none"> • Implement a process to capture data on each shift for patients that left the ED prior to being seen by a qualified medical professional. • Gather data related to reasons for leaving by calling patients that leave without being seen and analyze that data with a multi-disciplinary team. <p>Chest Pain/AMI (OP-2, OP-3, OP-5)</p> <p>ED Throughput (OP-18, OP-22)</p> <ul style="list-style-type: none"> • Review those data on at least a weekly basis to identify trends and opportunities to improve. • Incorporate review of those data at monthly quality improvement meetings to gather input from staff about trends and potential causes. • Implement a multi-disciplinary team to improve processes related to Emergency Department timeliness and efficiency

QUALITY IMPROVEMENT PRINCIPLES

All improvement requires change. Unfortunately, not all change results in improvement. System changes intended to improve quality must be tested and assessed to determine whether they produce successful outcomes. This process of identifying needed change, planning for and making change, and then testing the outcomes of that change to evaluate effectiveness is fundamental to performance improvement in healthcare. Effective change requires an understanding not only of how one part of a system functions, but of how all the system parts are linked together and coordinated. For example, education and training for staff to enhance their knowledge and skills will only improve a system if the lack of such knowledge

and skills was the major cause of deficient performance in that system. If the system has other unaddressed problems, such as lack of resources, inadequate staffing, or ineffective management or communication structures, even well-trained staff will not be able to accomplish their duties to the best of their abilities. Changes in one specific area may not lead to quality improvements if they do not significantly affect the overall quality of care the system provides.

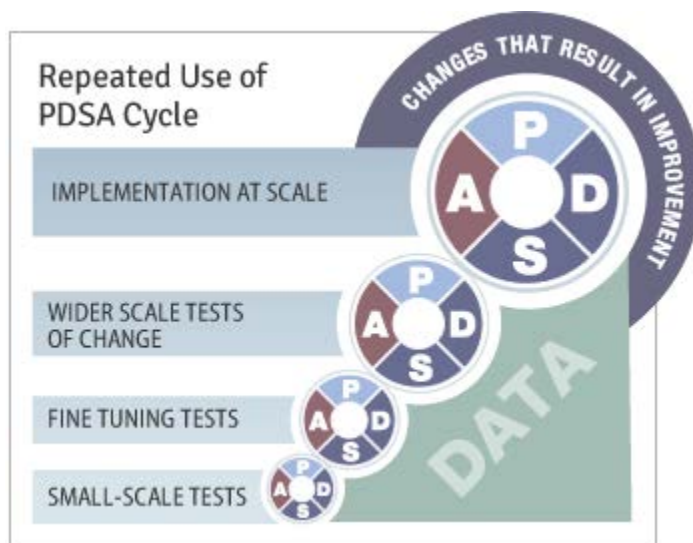
The first step in the quality improvement process is the identification and prioritization of improvement needs, identification of an AIM statement, or improvement goal, followed by the identification of team members tasked with leading the improvement process. Key to success in team identification is the inclusion of team members involved with the system being analyzed, organizational leadership with the ability to provide resources and direction, as well as team members with expertise in quality improvement principles. Once the team is formed, the quality improvement process starts with a series of questions, followed by short, rapid cycle tests of change called the “PDSA Cycle”, as demonstrated with the graphics below.



Source: The Institute for Improvement, *How to Improve*, retrieved at: <http://www.ihl.org/resources/Pages/HowtoImprove/default.aspx>

It is important that the team tasked with leading improvement be willing to test multiple ideas on a small scale, while searching for the changes that result in improved care at the local level. In quality improvement models, these multiple small tests of change are referred to as the PDSA, or Plan Do Study Act cycle. The PDSA cycle is an improvement tool which promotes improvement via the implementation of rapid-cycle tests among an increasingly larger population and a wider range of conditions. The “Plan” step in the cycle involves identifying and planning the change to be tested. The “Do” portion of the cycle

is the actual act of carrying out the test on a small scale. The “Study” phase of the PDSA cycle involves rapid data collection that is done during testing through a “huddle” or “debrief” with the staff or patients involved in the newly designed process. Finally, the “Act” portion of the cycle occurs when the decision to Adapt, Abandon or Adopt is made, based on the analysis of rapidly-collected information. If revisions and changes are indicated, the process is revised or “adapted,” and a new testing cycle is instituted. If the trials have been unsuccessful, the change idea may be “abandoned.” The decision to “adopt” a new process occurs after it has been tested broadly under various circumstances and settings. PDSA cycles should be run among smaller groups (for example, one nurse, one physician, and during one shift to start) before gradually expanding to a larger population within the system or organization if the change is determined to be successful.



Source: Coaching and Leading <https://coachingandleading.wordpress.com/presentation1/pdsa-and-types-of-change/>

Quality improvement initiatives are best implemented by designated improvement teams composed of representatives from the relevant departments, units, or groups involved in the process or system to be addressed. Project management includes identification of team leadership and membership; creation of AIM statements; development of a Project Plan; selection of Tests of Change and tools for implementation, measurement, and analysis of change efforts; and communication with relevant stakeholders including senior management, medical staff, front-line staff, and patients and families about the progress and success of the improvement project. In the small hospital setting, large improvement groups may not be possible. In this setting a “hub and spoke” model for improvement work can be effective. Instead of convening large teams for every improvement initiative, one core quality and patient safety committee (the “hub”), led by a chairperson, initiates and oversees multiple improvement activities by designating a leader (or “spoke”) for each initiative. Individual project leaders can be selected 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 request, if the leader is not a standing member of the quality and safety committee. This allows for improvement work to commence without interruption of duties for large groups of staff members.

BARRIERS AND CHALLENGES TO IMPROVEMENT

Partnering together to improve quality and safety is challenging work. In addition to what feels like a regular onslaught of new and competing priorities, getting on board with meaningful improvement requires a culture that supports the work, and eliminates barriers. A safety culture that supports this work requires an understanding of change management at all levels of the organization, because improvement requires change. One group that plays a significant role in the success or failure of an improvement initiative is middle managers. Without buy-in and effective leadership by middle managers to operationalize culture change, healthcare organizations will face many barriers to improvement. Few people relish the idea of changes to the comfortable status quo.

To exact positive change in the work that we do to keep patients and staff safe and improve outcomes, it takes small, incremental changes by all individuals in our organization that will build up to the large cultural shift that is needed for reliable improvement. Our frontline staff members are the eyes and ears of our organizations. Organizational leadership and middle managers can help to make this work safer and processes more reliable by listening to the frontline workforce when barriers and challenges are brought up and acting on the suggestions made. Organizational leadership input, encouragement and follow up can be the key to successful change.

A few keys to successful change management, and eventual cultural shifts includes the following:

- Create a sense of urgency: you are part of something big, we must make a difference now – reference not only what we know from research about the vast number of errors we are missing, but stories from actual events in your organization and your own department.
- Build a guiding coalition: organize opinion leaders and those in authority to help spread the message. Work with the willing before trying to engage those who are opposed to anything new. Let those who are enthusiastic about the new processes become the unit champions and help to spread the message.
- Form a strategic vision to help steer the change initiative: do you have a unit-specific strategic vision that is built by staff? Create that vision together at the outset.
- Enlist a volunteer army: Work with the willing. The others will come as they see enthusiasm grow.
- Enable action by removing barriers: what can you do to leverage work that is already being done? How can you help staff create time to make this a priority? Can you include a discussion about the new process in daily shift huddles and department meetings?
- Generate short term wins: Publicly celebrate the small, individual steps being made. Together they make a significant impact.
- Sustain acceleration: Keep the attention on the cultural shift by celebrating near misses that are caught and safety issues that are identified.
- Institute change: Hardwire new processes by showing how the new way of doing things has made a positive impact. Use the power of storytelling.

RESOURCES

- National Rural Health Resource Center / Flex Monitoring Team. Evidence-Based Acute Myocardial Infarction (AMI) Quality Improvement Programs/Strategies for CAHs. <https://www.ruralcenter.org/resource-library/evidence-based-acute-myocardial-infarction-ami-quality-improvement-programs>
- AHRQ Emergency Severity Index (ESI): A Triage Tool for ED Care. <https://www.ruralcenter.org/resource-library/emergency-severity-index-esi-a-triage-tool-for-ed-care>
- National Rural Health Resource Center / Flex Monitoring Team. Developing Regional STEMI Systems of Care: A Review of the Evidence and the Role of the Flex Program. <https://www.ruralcenter.org/resource-library/developing-regional-stemi-systems-of-care-a-review-of-the-evidence-and-the-role-of>
- AHRQ Guide to Improving Patient Flow and Reducing Emergency Department Crowding. <https://www.ahrq.gov/research/findings/final-reports/ptflow/index.html>
- National Rural Health Resource Center. CAH Quality Improvement Implementation Guide and Toolkit. <https://www.ruralcenter.org/resource-library/quality-improvement-implementation-guide-and-toolkit-for-cahs>

REFERENCES

- DeLuca G, S. H. (2004). Time Delay to treatment and mortality in primary angioplasty for acute myocardial infarction: Every minute of delay counts. *Circulation*, *109*, 1223-1225.
- McNamara RL, H. J. (2007). Impact of Delay in Door to Needle Time on Mortality in Patients with ST-Segment Elevation Myocardial Infarction. *American Journal of Cardiology*, *100*, 1227-1232.