

# CRITICAL ACCESS HOSPITAL QUALITY IMPROVEMENT PROJECT

*STRATEGIES, TOOLS AND BEST PRACTICES FOR  
MBQIP MEASURE SUCCESS*

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## ***STRATEGIES, TOOLS AND BEST PRACTICES***

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### **INTRODUCTION TO THE TEXAS CRITICAL ACCESS QUALITY TOOLKIT**

This toolkit is designed to support the Medicare Beneficiary Quality Improvement Project (MBQIP) goal to improve the quality of care provided in small, rural critical access hospitals (CAHs) by increasing quality data reporting and using data to drive QI activities. (Stratis Health, 2017)

This toolkit specifically addresses the MBQIP program domains for **Patient Safety, Care Transitions, Outpatient** and **Patient Engagement**. Funds to support this initiative are offered through the Texas Flex Grant through the Texas State Office of Rural Health. Critical Access Hospitals are required to participate in the Medicare Beneficiary Quality Improvement Program (MBQIP) to receive Flex Benefits.

The MBQIP measures are intended to improve the quality, safety and financial stability of participating organizations. This toolkit provides guidance to improve reporting into the state and national databases. By participating in these data resources, the entity is provided with benchmarking and quality data essential to improving the health of the populations they serve. Through timely receipt and acknowledgement of data, organizations can effectively identify and initiate improvement strategies, thereby enhancing the reliability of care and services.

Best practice plans and processes are provided to help organizations incorporate mechanisms to obtain concurrent information necessary to make rapid cycle changes to improve quality and safety.

It is important to stress that each facility work to determine the **root cause** of low performance. Awareness by staff and providers along with intentional efforts toward improvement is essential. Another key and often overlooked component of top performing facilities is full support by Senior Leadership. Evidence of senior leader support involves participation in daily huddles where patient safety and “quality misses” are at the forefront. Additional support must be evident through resources to facilitate quality work.

This document will outline tools and best practices to help you meet the requirements for safe and effective care. In addition to the resources listed here, please visit the Texas Hospital Association Foundation (THAF) website for additional tools, policies and guidelines to help you deliver, record and report safe and effective care.

The format of this document is laid out in sections as such:

**Section One:**

**Overview of the Quality Improvement Process and Key Tools for Success**

**Section Two:**

***Section Two Domain 1 (2.1):* Improving Patient Safety through Influenza Vaccinations for Eligible Patients and Healthcare Workers**

***Section Two Domain 2 (2.2):* Care Transitions – Emergency Department Transitions of Care**

***Section Two – Domain 3 (2.3):* Outpatient Metrics**

***Section Two – Domain 4 (2.4):* HCAHPS**

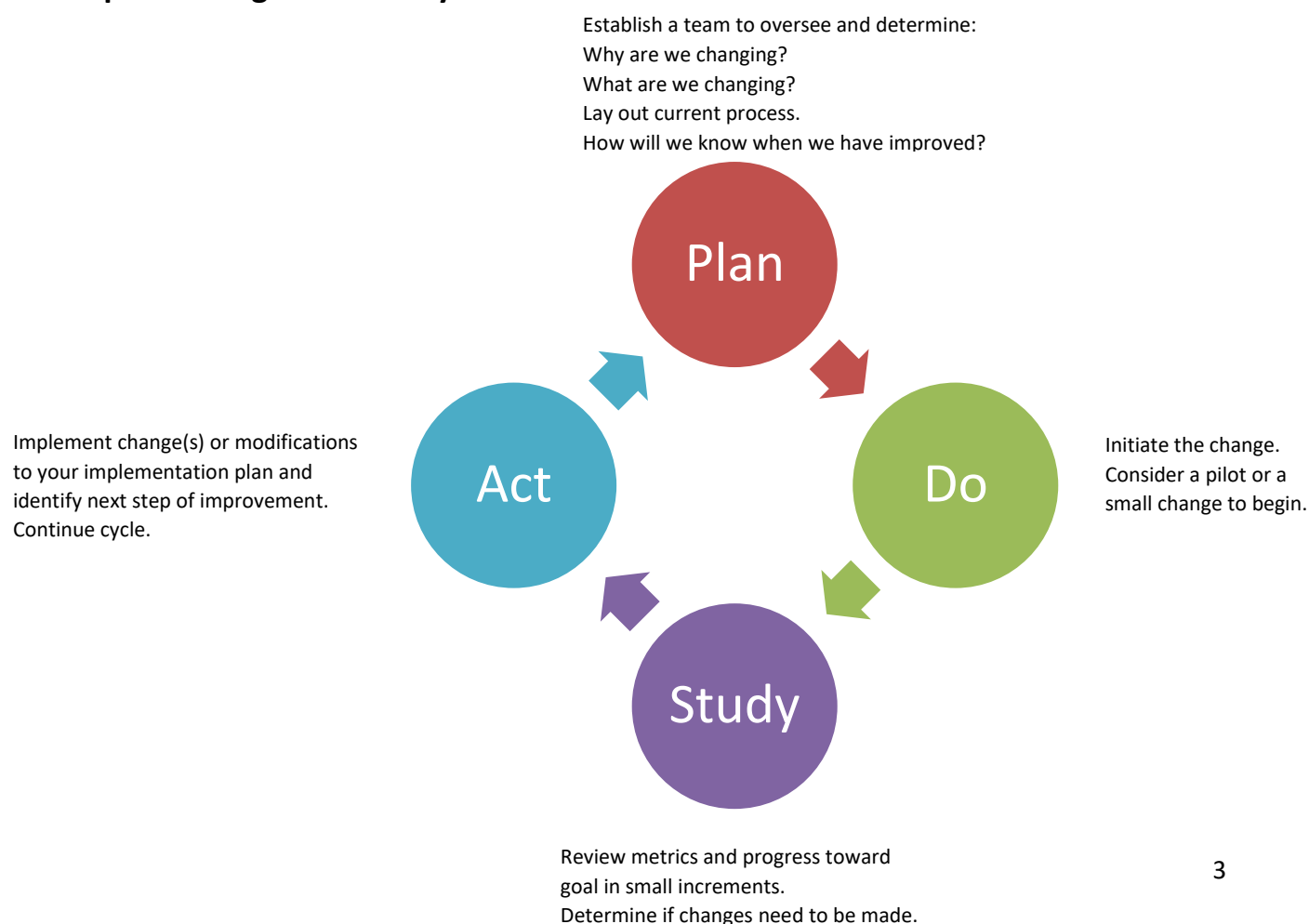
## Successful Strategies for Improvement

### Section One

This toolkit will provide you with examples of ways to improve your quality and patient safety processes and outcomes. As with any improvement method, it is important to define **why** you are initiating the improvement tactics and **what** are you trying to accomplish. Don't be afraid to develop small tests of change. Often small tests of change can be meaningful and prevent staff or those affected by the change from becoming overwhelmed.

The following paragraphs will define each stage of the **Plan, Do, Study, Act (PDSA)\*** cycle of improvement. This cycle is a basic tool that can be used in both simple and complex performance improvement plans.

### Implementing the PDSA Cycle



## The Plan Phase of PDSA

The first step in planning any improvement is determining what you are trying to accomplish. Often, as in the case of the MBQIP measures, you are being guided towards what you are trying to accomplish, e.g., vaccinate 100% of eligible patients for influenza.

## Forming the team

Whether the improvement opportunity is mandated, or an initiative by your facility, gathering a team of key stakeholders and leaders is essential for effective planning and implementation. These *key stakeholders* are often frontline staff and providers.

When forming your team don't forget to include at least one member of senior leadership. Additional team members often consist of people or departments who can impact the success of the desired performance. For example, if you are trying to implement 100% compliance with flu vaccination administration by your nursing staff, it is important to include pharmacy in this effort to ensure access to the vaccine for timely administration.

In critical access or rural hospitals where staff members often assume multiple roles, you may find it best to create process improvement teams using the Hub and Spoke model. This model allows for a central or core quality improvement team where additional members or stakeholders can be added depending upon the subject. For example, a respiratory therapist (RT) may not serve as a member of the core team but when trying to improve ED length of stay for patients with respiratory illness, an RT would be helpful. The diagram from the Stratis Health guide more accurately demonstrates this effort.



Stratis Health, 2017 available at [Hub and Spoke Model](#)

### **Asking What?**

The “what” is often referred to as your overall goal or outcome metric. During the planning phase of the PDSA cycle you will establish the metrics for success. You will evaluate the data from these metrics in the study phase and then determine if changes or adjustments in any process metrics will help you more easily attain your outcome goal. You will need to determine your overall outcome goal and metric and then determine the process or steps to successful implementation and measurement. The example of outcome and process metrics are further defined in the following paragraph.

1. Outcome
  - a. Provide flu vaccinations to 100% of eligible patients.
2. Process
  - a. Screen 100% of patients for flu vaccination within 4 hours of admission.
  - b. Flu vaccination is available on the unit 100% of the time.

### **Asking Why?**

The reasons to improve processes and outcomes are many, but here are a few to consider:

1. Better patient care
2. Better reimbursement
3. Increased efficiency
4. Monetary savings

### **Asking How?**

To gauge success of your efforts towards improvement, you will want to establish process metrics. Process metrics are ways we can track smaller components or “how” you will improve to attain your desired outcome.

By tracking process metrics, you and your team can more accurately identify where in the improvement cycle an error is most often occurring. This information will help you identify where in the process the error or breakdown is occurring.

Remember, your initial educational roll-out may only be directed toward a pilot unit or an area of minor change. When the improvement team moves into the Study phase of the PDSA cycle they can evaluate the effectiveness of the education and make any necessary changes.

## The Do Phase of PDSA

Once you have developed a plan, the next phase is to implement or “do” the plan. This phase can be small increments (small tests of change) of the overall improvement plan or goal. You may also choose to implement the plan on one unit or department to test the outcome. Staff education and effective communication is crucial for improvement even when implementing in one unit or department. Education for physicians and staff must contain (Please see following section):

- a) which patients need screening through established criteria
- b) how to follow up or respond to patients who refuse the vaccination

It is also important to make sure you include the process metrics in this phase. One of the most frequent errors in measuring the effects or results of change, is failure to link the implementation to the plan. When the linkage is not clear, you will not know which change is impacting your outcome.

### *Figure 2 Linking the Implementation to the Plan*

Outcome: Provide flu vaccinations to 100% of eligible patients for “X” nursing unit



Process Metric #1: Screen 100% of patients for need of vaccination for “X” nursing unit

Without development of a process metric to measure screening of patients, it would be difficult to attain your goal of 100% vaccination. Education on patient screening is key to success.

### **Staff Education**

An important part of the planning phase is educating staff and even physicians when necessary and appropriate. As you develop your education plan, determine critical elements to relay to staff and/or physicians. Change is often difficult. Including informal leaders as change agents is a helpful strategy.

You should never rely on education alone when implementing change. Organizing your education plan and communicating the plan to staff, is vital to its success. Providing staff with the *situation*, background, current *assessment* or metrics and the planned change or *recommendation*, is essential to gain the greatest buy-in. As you read this section of the tool you may have noticed the use of the terms associated with the acronym SBAR.

Your facility may already be using SBAR for nurse to physician communication, but using SBAR to communicate improvement efforts or other pertinent information to staff is an excellent way

to organize thoughts and promote educational awareness. The SBAR communication can be as detailed as you'd like. The following example provides you with a simple outline on how to communicate the changes and the rationale for the changes. This form can be posted on the unit or for increased ownership. Leaders can ask each staff member to read and sign as a method of education. (See Sample SBAR-Appendix A)

The use of this form can be used when conducting a small test of change within one unit or department, or when implementing a new process across the hospital.

*Table 2 SBAR Communication Example*

<b>S</b> ituation	On September 1 <sup>st</sup> , we will begin our annual process for screening and immunizing our patients for influenza.
<b>B</b> ackground	This screening and subsequent immunization of qualified patients is a quality measure mandated by the federal government.
<b>A</b> ssessment	The purpose of this measure is to help eliminate the number of hospitalizations and often death associated with flu. During last year's flu season, we screened only 75% of our patients and immunized 50% of those screened. We have formed a team of your peers and leaders to examine our data and develop a plan for improvement.
<b>R</b> ecommendation	Begin the new process for screening and vaccinating eligible patients on September 1 <sup>st</sup> . <ol style="list-style-type: none"> <li>1. Use the form to assess each patient at each shift. (See Appendix A – IMM-2 Quality Audit Checklist)</li> <li>2. Be prepared to report any deficiencies in daily huddles.</li> </ol>



## The Study Phase of PDSA

During this phase of the PDSA cycle, the team should evaluate the data and determine if changes in process steps or education are necessary to more effectively reach the outcome.

The Study phase of the cycle helps the team make timely decisions. It is always helpful to look at process data concurrently. Process data can be measured or monitored in several ways. Some of the most common ways are through use of checklists, direct observations, or audits. Concurrent data is discussed in more depth throughout the following paragraphs.

Collecting, reporting and analyzing data concurrently can provide significant improvements to quality performance. Other benefits are:

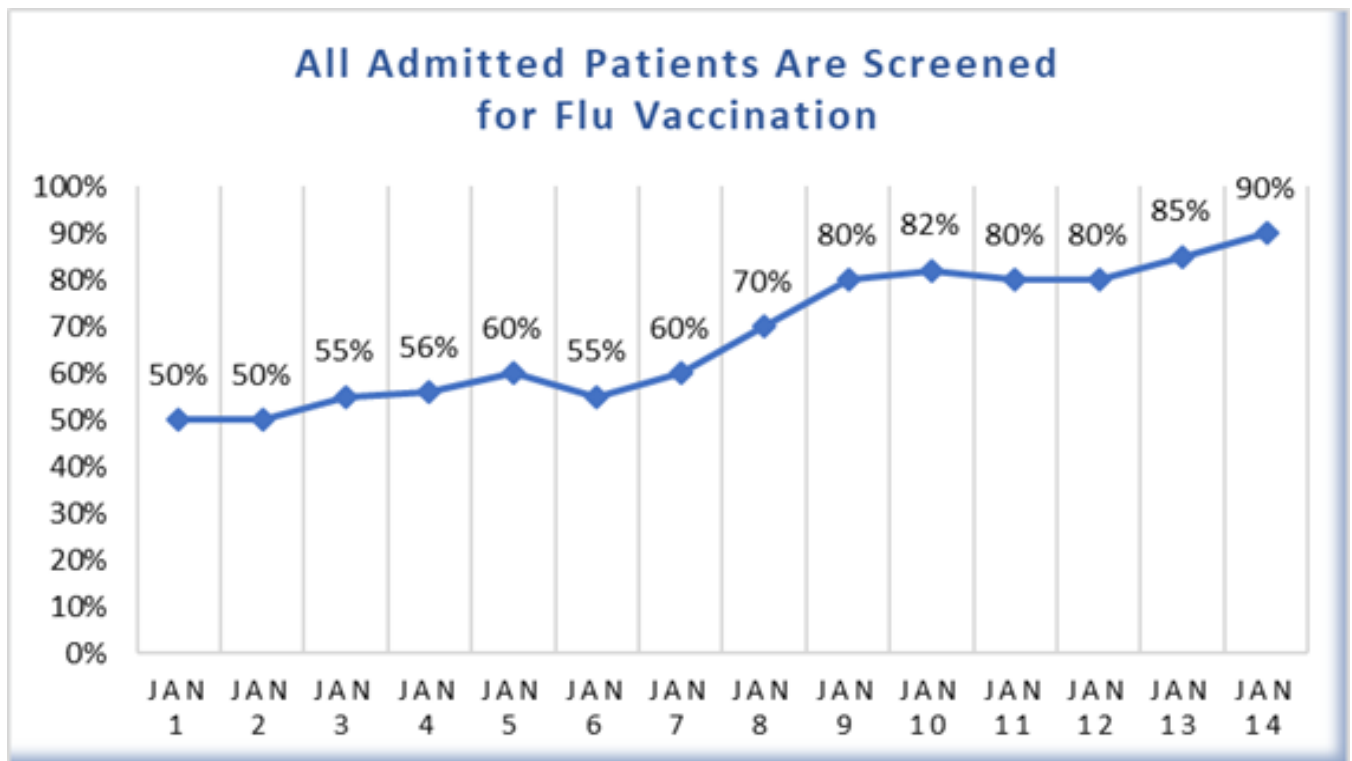
1. Preventing an error from “reaching the patient”.
2. Preventing delays in CART data entry.
3. More quickly identifying gaps in structures and processes.

### ***What is Concurrent Data?***

For the purposes of this toolkit, concurrent data collection and its benefit to improvement is defined as data collected within 3 timeframes categorized as listed below. The value of the data for improvement opportunities are further categorized within these timeframes. However, it must be stressed that concurrent data allows an organization to “catch” the opportunity to address or fix a problem in real time. Through the collection of concurrent data, one can even address the issue before the patient gets discharged.

### ***Concurrent Data and Timeframe Categorization***

Good	Better	Best
Data collected and reviewed within 2 weeks of care provided. This type of data review/collection is usually done by the quality department or department manager. The results of this data review permit the hospital to address the issue for future patients.	Data reviewed within 3 days of care provided. This data is typically collected or reviewed by quality department representative or a unit staff member.	Data reviewed and monitored while care is provided. This type of concurrent data produces the greatest chance for success and is done by using prompts in the electronic health record or checklists or “care-maps” that guide the care delivery. Care to address the metric is performed before discharge.



Outcome data can be examined less frequently than process data. In other words, on a weekly basis with outcome data, you may look at whether 100% of your eligible patients are receiving flu vaccinations, while with process data, leaders may want to examine if patients are being screened on each shift.

## The **Act** Phase of PDSA

This phase of the PDSA cycle is where the team implements any changes to the initial plan. Following the Act phase, the PDSA cycle starts over until the outcome has been met. Your team may decide to change some of the process steps to better measure or track performance. Additions to staff education or other methods to promote staff ownership and accountability of the new process could be implemented.

### Keeping Track of Progress

In every improvement plan, it is important to track progress, assign responsibility and identify barriers to success. Please see the **Sample Performance Team Agenda and Minutes** worksheet your team may find useful. (See Appendix B)

## **Additional Tools and Resources for Performance Improvement, Teamwork and Staff Engagement**

Below are descriptions of tools for use in more complex situations or when you feel you must “dig deeper” into actual or potential problem. Use of these tools in performance improvement can be help to more accurately determine which issues are causing poor compliance in a quality measure.

Another useful source for learning more about performance improvement tools is the Centers for Medicare and Medicaid Services (CMS). Lastly, Stratis Health ([stratishealth.org](http://stratishealth.org)) is a non-profit organization with a mission to support quality and performance improvement. Stratis offers a team of experts and several on-line resources to help you further develop your organization’s plan for quality and ongoing performance improvement.

### **Huddles**

Huddles are an excellent way to engage staff in performance measures, provide immediate feedback and instill a sense of comradery for success. Huddles are a structured “stand-up” meeting with a central focus, usually around quality, patient safety and/or discharge planning.

Huddles should be daily, brief (no more than 15 minutes), have a set agenda, and be held with core members of the team who are empowered to solve problems. Typically, huddles are led by the manager or senior leader. The leader can remind the group of the main topics and then proceed around the table for issues/problems. The key to a successful huddle is for each issue identified to be assigned an owner responsible for follow-up. Huddles should provide an opportunity to “look back” to solve any issues from the previous day and “look forward” to help prevent any failures. The roundtable reporting should be done by exemption only with each participant in the roundtable responding with a report or either with “no concerns” or “nothing to report”.

Just as with any other plan, you can establish metrics around your huddles to determine if the process is helping you with the overall improvement plan. (For example, your team might decide that huddles would be a helpful process in reaching the outcome goal of 100% flu vaccination on 100% eligible patients. To help measure the effect of this intervention your team sets process goals around the huddle.)

1. “We will have daily huddles before 10am 90% of the time by January 15.<sup>th</sup>”
2. “All clinical departments will be represented at the huddle.”
3. “The huddle will last no more than 15 minutes.”

*Table 2 Sample Huddle Agenda*

<b>Daily Huddle for Quality, Safety and Discharge Planning</b>	
<b>Agenda</b>	
<b>1. “Look-back” Issues</b>	
a.	Any issues to report or f/u from previous day. (These issues are often referred to as “Start the Clock” issues.) When identified they should have an owner assigned with the expectation that the issue or problem is resolved during a specific time frame.
<b>2. Discharge Planning Concerns</b>	
a.	Are there any known reasons for delays in discharges?
b.	Is transfer paperwork complete? (modify question according to facility need)
<b>3. Patient Safety</b>	
a.	Are there any known or potential threats to patient or employee safety?
<b>4. Quality</b>	
a.	Are there any known quality issues?
b.	Have all patients received appropriate vaccinations? (this could be modified or broadened depending on the patient population or the facilities improvement needs)
<b>5. Look Forward</b>	
a.	Concerns for next shift/tomorrow?

### ***Staff Incentive Program***

Many facilities have decided to link quality performance to the staff member’s individual job evaluation. Examples of linking quality performance with employee performance are:

- incentives for staff when performance is met; or
- evaluating the employee on the number of successful screens or evaluations.

### **Understanding Errors and Near Misses**

It is essential that errors or near misses are included in data collection and reviews. Errors are typically those incidences that reach the patient and near misses are events that are caught and corrected prior to reaching the patient. Your facility may decide to track errors and near misses through your event or incident reporting system and a Root Cause Analysis may be performed. Near misses should be carefully reviewed since these types of mistakes can often provide great insight into problem-prone errors and when reviewed, can help to prevent an actual error from occurring.

### ***Root Cause Analysis (RCA)***

A root cause analysis (RCA) is simply a process to help caregivers, quality leaders and physicians determine how an error occurred. We often think most about doing an RCA when a major or serious safety event occurs but, an RCA can be done for any error. It may be especially important to perform an RCA on an error or near miss that has occurred more than once to prevent recurrence.

If you have been performing RCAs at your facility, you may be performing these by gathering a group of individuals around the table to discuss what happened. Interviews conducted by a quality leader prior to the team coming together to discuss and develop an action plan can be a more time efficient method of performing an RCA.

### ***Failure Modes Effect Analysis (FMEA)***

A Failure Modes Effects Analysis (FMEA) is an excellent tool for evaluating potential problems when a new or revised process is being implemented. A FMEA process determines occurrences and helps a team assign levels of risk or impact to the success or desired outcome of process. The Institute of Healthcare Improvement (IHI), has numerous resources in its QI Essentials toolkit. This toolkit is available for free at [www.ihl.org](http://www.ihl.org) by creating a log-in identification.

### ***Fishbone Diagram***

The Fishbone Diagram, (Appendix C), demonstrates a clear explanation of the advantages of considering people, processes or equipment impacting the team's ability to meet defined goals.

#### **Toolkit Appendices:**

Appendix A – [SBAR Sample](#)

Appendix B – [Sample Performance Team Agenda and Minutes](#)

Appendix C – [Fishbone Diagram](#)

#### **Additional Resources:**

[Little River, QA, PI Loop Enclosure](#)

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## SECTION 2

### MBQIP Measures

This section of the toolkit will focus on best practices and processes to improve performance with each of the MBQIP measures. The measures are divided into four domains: **Patient Safety** (Flu vaccinations), **Care Transitions** (EDTC), **Outpatient Measures**, and **HCAHPS**.

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## **Section Two Domain 1 (2.1): Patient Safety**

### **Influenza Vaccinations for Healthcare Workers**

#### **OP-27**

#### **HEALTHCARE WORKER IMMUNIZATION**

Healthcare worker immunization is an essential component of disease prevention. Missed work due to illness creates a hardship for employees and facilities. The following best practices can help your facility more fully comply with this standard. An important aspect of this measure is preparation. Begin early in the year to evaluate last year's performance and put in place measures to improve the upcoming immunization cycle.

#### **BEST PRACTICES:**

##### **EMPLOYEE MANAGEMENT/HUMAN RESOURCES**

- Vaccinate current employees at Annual Health or Skills Fair
- Immunize upon hire (during season)
- "Rounding" by Employee Health/Infection Prevention Nurse to vaccinate
- Perform all employee evaluations during September-December, tying presence of vaccination to annual performance review
- Provide incentives to employees for getting vaccinated during October (may include September with appropriate flu vaccination for that season)
- Require physician letter supporting declination for health concerns
- Organize campaign to provide vaccinations on all shifts/weekends
- Target attempts to reach PRN staff

##### **POLICY**

- Establish and implement a policy requiring all healthcare personnel be immunized as defined by MBQIP measure.  
This policy should contain:
  - a. Requirement of face to face counseling for employees who decline the vaccine
  - b. Requirement of a signed declination from staff without medical contraindication
  - c. Requirement of the use of face mask for unvaccinated employees

## INFORMATICS

- If using EHR, engage IT requiring up-to-date vaccination prior to log-in

## PHYSICIANS

- Include compliance for provider vaccination through medical staff by-laws, use of provider peer review and through granting hospital privileges

## USE OF DATA/CONCURRENT REVIEW

### Tactics:

- Consider use of THAF/ARCHI flu tracking spreadsheets (Appendix B)
- Coordinate Human Resources to provide Employee Health/Infection Prevention with lists of current employees, monthly, beginning on October 1<sup>st</sup> through March 31<sup>st</sup>. It is permissible for staff receiving vaccinations in September to be included in the count beginning October if they have received the flu vaccination for that season. Staff not receiving vaccinations are scheduled for face to face follow-up with EHR/IP for vaccination or reason for declination, as appropriate.
- Provide Data reports (daily, weekly) to staff and C-Suite
- Review in Huddles the data for the measures and ways to capture employees for immunization.



**Toolkit Appendices:**

Appendix A: Sample Policies from CAHs on Immunizing Health Care Workers (OP-27)

[Coon Memorial, Influenza Vaccination Program for Healthcare Personnel](#)  
[Parmer Medical Center, Influenza Immunization Vaccination Policy](#)  
[Influenza Vaccine Policy, Lynn County Hospital District](#)  
[Vaccinations and Immunization Requirements for Employees and Volunteers, Medina Healthcare System](#)  
[Flu and Pneumonia Policy, Ward Memorial Hospital](#)

Appendix B: THAF/ARCHI Healthcare Worker Immunization Tracking Forms (OP-27)

[OP-27 Flu Oct2017 to Mar2018.xlsx](#)  
[OP-27 Healthcare Personnel Immunization Status Form - 2017 Oct.docx](#)  
[OP-27 Monthly Summary Form - 2017 Oct.docx](#)

**Resources:**

[OP-27, Q&A Sheet, Telligen, QIO for CMS](#)  
[MBQIP Measures Fact Sheets, Stratis Health](#)  
[Influenza Vaccination for Health Care Workers CDC](#)  
[Outline from Workshop, Take a Stand, Immunization Action Coalition](#)  
[Community Acquired Pneumonia, Memorial Medical Center](#)

## **Section Two Domain 1 (2.1): Patient Safety**

### **Influenza Vaccinations for Eligible Patients**

#### **IMM-2**

##### **PATIENTS RECEIVING IMMUNIZATION FOR INFLUENZA**

Over 3 million people get infected with the flu each year. Nosocomial infections from community acquired infections can increase hospital lengths of stay and even result in death. The Centers for Disease Control (CDC) and the Center for Medicare and Medicaid Services strongly recommend facilities develop a process for screening, educating and immunizing patients entering facilities seeking care and treatment.

This measure evaluates the facility's effectiveness in screening and offering influenza vaccinations to their patients. Below is a list of best practices for implementation and reinforcement of this measure which is evaluated with discharges beginning October 1<sup>st</sup> and running through March 31<sup>st</sup>.

##### **BEST PRACTICES:**

##### **PRACTICE**

- Make plans with Nursing, Pharmacy and Physicians on upcoming immunization campaign for eligible patients.
- Begin educating the staff on the Immunization Campaign for patients in the summer with a major communication the week before October 1 to assure readiness on October 1<sup>st</sup> for appropriate screening and vaccination.
- Establish a nurse-driven standing order or protocol which allows for screening and administration of vaccine to all eligible patients without a physician's order (See Section on Physician Orders).
- Collaborate with pharmacy to have vaccine available in ED and Inpatient units.
- Identify strategy to address patients who decline.
- Consider use of THAF/ARCHI flu tracking spreadsheets (Appendix A)
- Conduct daily review of patients' administration status (see form below) (See printable form in Appendix B - IMM-2 Quality Audit Checklist)
- Review status at discharge for completeness (see form below) (See printable form in Appendix B - IMM-2 Quality Audit Checklist)

## PHYSICIAN ORDERS/STANDING ORDER SETS

Develop Standing Delegated Medical Orders for Immunizations on all patients seen in ED or Inpatient (See Appendix C)

- Another resource <https://www.thecommunityguide.org/findings/vaccination-programs-standing-orders>
- Add order for “Immunize on Admission” to all Admission order sets

## INFORMATICS

- For those hospitals on an electronic health record, work with your IT department/vendor to develop a Best Practice Alert to fire on admission, every 12 hours and upon discharge.
- Embed assessment or prompt in EHR/paper medical record

## CONCURRENT DATA

This measure is best managed for concurrent review while the patient is hospitalized. Daily review of the patient’s status during huddles and nursing shift to shift reporting will best facilitate monitoring and action for each eligible patient.

**Appendix A provides tracking forms (manual or electronic) to collect and analyze your performance in immunizing patients in real time.**

- Consider use of THAF/ARCHI flu tracking spreadsheets (Appendix A)

### **Quality Audit Form for Concurrent Review of Patient’s Immunization Status**

Another alternative to collect quality data in real time is the use of the audit form. The goal for any improvement effort is for the necessary processes to be hard-wired into the daily regimen. To assist in hard-wiring the process for screening and vaccination, develop a plan to ensure all patients are screened at each shift until the measure has been fulfilled.

Knowing that hospitals are complex environments, forms are often helpful to drive compliance. The sample form (Appendix A IMM-2 Quality Audit Checklist), could become part of the admission paperwork and attached to the front of the chart during ED Visits and on admissions to the facility. This form should not become a part of the patient’s medical record but should be forwarded to the quality department upon discharge of the patient to help the quality department monitor concurrent compliance and reporting. (See Appendix B IMM-2 Quality Audit Checklist)

## IMM-2 Quality Audit Checklist

Patient Name: \_\_\_\_\_ Room # \_\_\_\_\_ Primary Diagnosis: \_\_\_\_\_ Primary Physician: \_\_\_\_\_

Quality Process Domain: Patient Safety	Day 1 Date _____			Day 2 Date _____	Day 3 Date _____	Day 4 Date _____	Day 5 Date _____
IMM-2 Assessed for Flu Vaccine (September-March)	Rec'd previous Adm/Clinic Y <input type="checkbox"/> N <input type="checkbox"/>	Given Y <input type="checkbox"/> N <input type="checkbox"/>	Action/FU  Initials	Action/FU  Initials	Action/FU  Initials	Action/FU  Initials	Action/FU  Initials
Assessed for Pneumonia Vaccine	Rec'd previous Adm/Clinic Y <input type="checkbox"/> N <input type="checkbox"/>	Given Y <input type="checkbox"/> N <input type="checkbox"/>	Action/FU  Initials	Action/FU  Initials	Action/FU  Initials	Action/FU  Initials	Action/FU  Initials

Initials \_\_\_\_\_ Signature \_\_\_\_\_ Date \_\_\_\_\_

Initials \_\_\_\_\_ Signature \_\_\_\_\_ Date \_\_\_\_\_

Initials \_\_\_\_\_ Signature \_\_\_\_\_ Date \_\_\_\_\_

Initials \_\_\_\_\_ Signature \_\_\_\_\_ Date \_\_\_\_\_

Evaluated By \_\_\_\_\_ Date \_\_\_\_\_

Plan of Action \_\_\_\_\_

### COMMUNITY INVOLVEMENT

- Partner with local voting precincts to give flu vaccinations to those arriving to vote.
- Provide each participant with a card indicating they have received the immunization
- Partner with local physician offices, long-term care facilities, home health agencies and community health clinics to host an immunization fair and to develop methods to receive patient immunization records when patient is admitted.

<https://www.thecommunityguide.org/stories/good-shot-reaching-immunization-targets-duval-county>

## **Toolkit Appendices:**

Appendix A: THAF/ARCHI IMM-2 Tracking Forms (Manual or Electronic)

[IMM-2 Inpatient Flu Oct2017 To Mar2018.xlsx](#)

[IMM-2 Inpatient Immunization Status Form - 2017 Oct.docx](#)

[IMM-2 Monthly Summary Form - 2017 Oct.docx](#)

Appendix B: [Quality Audit Checklist \(IMM-2\)](#)

Appendix C: Sample Policies from CAHs/Other Sources on Medical Staff Standing Orders

[Implementing Standing Orders in Medical Practices, Immunization Action Coalition](#)

[Administering Influenza Vaccination, Immunization Action Coalition](#)

[Inpatient Influenza Immunization, Memorial Medical Center](#)

[Inpatient Pneumococcal, Influenza Immunization, Ward Memorial Hospital](#)

[Administering Influenza and Pneumococcal Vaccine, Medina Healthcare System](#)

## **Resources:**

Templates, Policies, Processes

[Consent for Influenza Vaccination, Palacios Community Medical Center](#)

[Healthcare Personnel Safety Flu Vaccine Protocol, CDC NHSN](#)

[Hospital Policy & Protocols for Influenza & Pneumococcal Vaccination, Sample, Immunization Action Coalition](#)

[Influenza Consent Form, DSHS](#)

## **Best Practices:**

[Flu Activity and Surveillance, CDC](#)

[Influenza Vaccination Information for Health Care Workers, CDC](#)

[Immunization Record Card, DSHS](#)

[Immunization Record Cards, Immunization Action Coalition](#)

[Immunization, information sheet, TMF Quality Innovation Network](#)

[Implementing Standing Orders in Medical Practices, Immunization Action Coalition](#)

[Improving Influenza Vaccination Rates among Health Care Workers, TMF Quality Innovation Network](#)

[Influenza Vaccination Information for Health Care Workers, Influenza, CDC](#)

[Influenza Vaccine Information Statement, CDC](#)

[Literature and Forms Online Order Form, DSHS](#)

[Recommended Immunization Schedule, 0-18yrs, CDC](#)

[Recommended Immunization Schedule for Persons Aged 0 through 18 Years, CDC](#)

[Strategies to Increase Staff Immunization, TMF Quality Innovation Network](#)

[Surveillance for Healthcare Personnel Vaccination, CDC](#)

[Vaccine Information for Adults, CDC](#)

## **Section Two Domain 2 (2.2): CARE TRANSITIONS**

### **Emergency Department Transitions of Care**

The greatest risk of variances in Patient Safety occur during times of transfer. The Emergency Department Transfer Communication measures were put in place to promote adequate communication among entity caregivers. For each patient transferring to another acute care facility, the transferring facility is required to have a mechanism to report essential communication to the receiving facility. A Memorandum of Transfer (MOT) contains many of these essential elements but additional elements should be added to the MOT to further advance patient safety and meet the intent of the MBQIP EDTC Measures.

#### **BEST PRACTICES**

##### **PRACTICE**

- Memorandum of Transfer document with all measures defined (See Appendix A for MOT)
- Use of checklist or Stop in Transfer process as an alternative (See Appendix B, Emergency Department Care Transition Checklist)
- Include 2 signatures on all forms to promote teamwork in helping to ensure compliance
- Develop process for daily review of completed forms

##### **INFORMATICS**

- EHR prompts with all elements documented

## Memorandum of Understanding Revisited

This example shows the MOT containing all the required elements of EDTC. It is helpful when using this tool to have a second person verify all the information is complete. The report should then be given to the receiving department.

<b>MEMORANDUM OF TRANSFER</b> ***** <b>SECTION A (To Be Filled Out at Transferring Hospital)</b> *****	
1. Name of Transferring Hospital: _____ Address: _____ Phone #: _____	9. Transferring physician's signature or signature of hospital staff acting under physician's orders: _____ Printed Name of transferring physician: _____ Phone Number: (____) _____ Address: _____
2. Patient Information (If Known): Patient's Full Name: _____ Address: _____ Phone Number: _____ Sex: <input type="checkbox"/> Male <input type="checkbox"/> Female Age: _____ DOB: _____ National Origin: _____ <input type="checkbox"/> Physical Disability <input type="checkbox"/> Demographic/Face Sheet/Insurance Info Attached	10. Accepting hospital secured by transferring hospital: Date: ____/____/____ Time: _____ Name of receiving hospital administration person: _____
3. Next of Kin (If Known): _____ Address: _____ Phone Number: _____ Next of Kin notified? (____) Yes (____) No	11. Report given by transferring hospital nurse: Signature: _____ Title: _____ Time: _____
4. Date of Arrival: ____/____/____ Time: _____ 5. Diagnosis: _____ Isolation status: _____	12. Pertinent Nursing Findings: V/S: B/P ____ P ____ R ____ Temp ____ O2 Sat ____ Lines: <input type="checkbox"/> O2 per ____ <input type="checkbox"/> IV Fluids ____ Rate: ____ <input type="checkbox"/> Intubated/Vent <input type="checkbox"/> Urinary Cath Other: _____ LOC/Sensory Status: <input type="checkbox"/> None <input type="checkbox"/> Mental <input type="checkbox"/> Vision <input type="checkbox"/> Hearing <input type="checkbox"/> Speech <input type="checkbox"/> Sensation <input type="checkbox"/> Immobilizer  Oral Restrictions: <input type="checkbox"/> None <input type="checkbox"/> NPO <input type="checkbox"/> Other: _____ Allergies <input type="checkbox"/> No <input type="checkbox"/> Yes Immobilization: <input type="checkbox"/> None <input type="checkbox"/> Cast <input type="checkbox"/> Splint <input type="checkbox"/> Traction <input type="checkbox"/> Other: _____
6. Initial contact with the receiving hospital administration: Date: ____/____/____ Time: _____ Name of contact person at receiving hospital: _____	13. Type of transfer vehicle and company used: _____ Equipment/Personnel needed: _____
7. Receiving physician secured by transferring physician: Date: ____/____/____ Time: _____ Name of receiving physician: _____	14. Facility transported to: _____ City _____ Date: _____ Time: _____
8. Reason for Transfer: <input type="checkbox"/> Higher Level of Care <input type="checkbox"/> Other _____	15. Other Attachments for Care/Results from Transferring Facility: <input type="checkbox"/> Radiology <input type="checkbox"/> Nursing Notes <input type="checkbox"/> Lab Reports <input type="checkbox"/> H&P <input type="checkbox"/> Progress Notes <input type="checkbox"/> MAR (meds in ED) <input type="checkbox"/> List of Home Meds
***** <b>SECTION B (To Be Filled Out at Receiving Hospital)</b> *****	
1. Name of Receiving Hospital: _____ Address: _____ Phone Number: (____) _____	Receiving Physician's signature: _____ Name: _____ Address: _____ Phone Number: (____) _____
2. Date of Arrival: ____/____/____ Time: _____	5. If response to the transfer request was delayed beyond thirty (30) minutes, document the reason for the delay, including any agreed time extensions. Use additional sheet, if necessary: _____ _____ _____ _____ _____
3. Receiving Hospital Administration Signature: Title: _____ Date: ____/____/____	
4. Receiving physician who assumed responsibility for the patient: Date: ____/____/____ Time: _____	

*If you choose not to use the MOT with EDTC elements imbedded you may opt to use this sample **Care Transition Checklist**. This sample checklist should be used by frontline, direct-care nursing to track inclusion of the essential elements of EDTC to help ensure safe and effective communication.*

## Appendix B

### Emergency Department Care Transitions Checklist

(To be completed prior to patient's transfer to another facility)

Date: \_\_\_\_\_
Patient Name: \_\_\_\_\_
MR # \_\_\_\_\_

Measure	Action	Reviewed by:
Time Discharge Order Written _____ (This time "starts the clock for the 60-minute reporting requirement)		
D/C Report Given to Receiving Facility Physician? <input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> Transfer Agreement in place	Time _____ <div style="text-align: center;"></div> If no, Secure physician to physician hand-off.	
D/C Report Given to Receiving Facility Nurse? <input type="checkbox"/> Y <input type="checkbox"/> N	Time _____ <div style="text-align: center;"></div> In no, Secure nurse to nurse hand-off	
D/C Documentation (copy sent with patient) contains essential Information? <input type="checkbox"/> Y <input type="checkbox"/> N If any of the elements are not checked then answer "N" and notify discharging nurse and/or physician to address missing data elements prior to transfer.	<input type="checkbox"/> Name of Patient <input type="checkbox"/> Address <input type="checkbox"/> Age <input type="checkbox"/> Gender <input type="checkbox"/> Next of Kin/Contact <input type="checkbox"/> Insurance <input type="checkbox"/> D/C Status Code present (may be preliminary) <input type="checkbox"/> Pulse <input type="checkbox"/> Respiratory <input type="checkbox"/> Blood Pressure <input type="checkbox"/> Temperature <input type="checkbox"/> Glasgow Coma and/or other essential findings for level of consciousness <input type="checkbox"/> List of Home Meds <input type="checkbox"/> List of Meds Rec'd in ED <input type="checkbox"/> Presence/absence of Allergies/Reactions <input type="checkbox"/> Current/relevant findings by physician <input type="checkbox"/> History and Physical <input type="checkbox"/> Reason for Transfer/Plan of Care <input type="checkbox"/> Current/relevant findings by nursing <input type="checkbox"/> Assessment <input type="checkbox"/> Interventions/Treatment <input type="checkbox"/> Catheter/IV <input type="checkbox"/> Immobilizer <input type="checkbox"/> Respiratory Support Needs <input type="checkbox"/> Verbal/Oral limitations <input type="checkbox"/> List of Tests/Procedures done <input type="checkbox"/> Results of Tests/Procedures on chart	
Date/Time of Discharge: _____	This time completes 60-minute interval.	

Signature of Attending Physician: \_\_\_\_\_

Signature of Attending Nurse: \_\_\_\_\_

Signature of Unit Clerk/Secretary: \_\_\_\_\_

\*\*\*\*This form is for Quality Improvement Purposes and is not part of the official Medical Record\*\*\*\*



## Toolkit Appendices:

- Appendix A: Memorandum of Transfer (MOT) with all measures defined ([MOT](#)).pdf
- Appendix B: [Emergency Department Transfer Communication Checklist with Guidelines](#) (*Collingsworth General Hospital*)
- Appendix C: [Emergency Department Care Transition Checklist](#)

## Resources:

[Data Collection Tool, MBQIP EDTC](#)

## Best Practices:

[Care Transitions Measure Summary](#), Stratis Health  
[QI Toolkit, Emergency Department Transfer Communication Measures](#), Stratis Health  
[Regional Stroke Plan](#), East Texas Gulf Coast RAC-R

## Section Two Domain 3 (2.3): OUTPATIENT METRICS

### START THE CLOCK!



The MBQIP quality measures discussed in the next section are time sensitive. To provide the highest standard of quality care for your patients, the care staff must formulate processes that allow for timely and appropriate responses to patient's needs. Evaluating your ED practices before making changes is helpful and can prove to be less disruptive to staff. The Studer Group ([www.studergroup.com](http://www.studergroup.com)) has created a document to help you diagnose areas for improvement. Multiple resources and tools are available in the appendices of this document and on the Stratis Health website ([www.stratishealth.org](http://www.stratishealth.org))

The document below is divided into three distinct segments relevant to the phases of ED throughput. The questions listed for process evaluation in each area can help you and your ED Performance Improvement team focus on the key areas where improvement is needed. When initiating improvement, it is often useful to divide areas into: people, processes, environment and equipment. The team can examine how each of these areas impact the improvement effort as well as divide opportunities or best practices into these 3 areas. This focus may help you diagnose issues related to time-sensitive patient care.

## Taking Your ED to Next Level-Understanding Flow Issues

The next time-sensitive measures will have their focus in the ED. To perform well on these measures, it is essential to examine the processes impacting your ED. Remember, when evaluating areas of opportunity, it is always helpful to examine areas impacting your ED: types of patients received, ambulance service contracts, ED physician/provider contracts, admission offices, and inpatient units. Broken or dysfunctional processes in any of these areas can impact your ED services. You will see in the table below that by dividing up your ED throughput into 3 categories or distinct functions, you can develop insight into flow issues.

Area of Flow	Questions to Ask	Performance Improvement Activities
<b>Front-end issues</b>	Is the triage process efficient? Is a patient immediately bedded if a bed is open? Does the provider see the patient quickly after the patient is bedded? Is there a sufficient number of beds to manage volume (on average)?	Evaluate various times and seek ways to increase efficiency. Consider fast-track of non-emergent cases by putting an RN in triage. Evaluate days or hours with ED holds.
<b>Middle Issues</b>	Is the staff able to enter orders quickly? If using physician order entry is it efficient and easy to use? Is nursing able to execute orders in a timely manner? Is the physician able to execute a disposition in a timely manner? Does the ED physician admit or do they rely on another physician? If another physician is involved do they respond in a timely manner?	Consider standard order sets Consider placing mini-lab in ED Consider allowing ED physicians to admit to floor with minimal orders placed. Assess policy for physician response time. Are appropriate protocols or standing delegated medical orders in place, e.g., ASA on arrival?
<b>Back-end Issues</b>	If admitted, is a bed assignment made in a timely manner? Does bed control have an easy ability to know what beds are available? Does a report to the admitting floor/nurse happen in a timely manner? Is the patient transferred in a timely manner? Can the ED admit a patient? (Hall bed or inpatient unit)? Is there a transfer policy/agreement in place for increased level of care center?	Track time to bed availability? Consider a tracer or failure modes effect analysis on patients admitted to ED.

## **DOMAIN 3 OUTPATIENT**

### **OP- 18, 20, and 22**

ED throughput can be a complex and complicated process to improve. Detecting the time from arrival to departure can have an indirect impact on the number of patients leaving without being seen and patient satisfaction scores in the ED population. Evaluating metrics in this measure may help you to determine staffing levels and/or needs for throughput improvement. Below are some examples of best practices.

These measures are best managed when concurrent review (closest to the point of delivery) is used. The best way to build in concurrent review in these processes is to use checklists, prompts in the EHR, and/or teamwork. Having these redundant barriers in place can help prevent an error or omission in care from reaching the patient.

#### **OP-18 MEDIAN TIME FROM ED ARRIVAL TO ED DEPARTURE FOR DISCHARGED PATIENTS**

#### **OP-20 DOOR TO DIAGNOSTIC EVALUATION BY QUALIFIED MEDICAL PROFESSIONAL**

#### **OP-22 PATIENTS LEFT WITHOUT BEING SEEN**

### **OVERALL BEST PRACTICE TACTICS**

#### **EQUIPMENT**

- Synchronize all clocks and equipment in the ED
- Develop a process for plant operations and/or ED leadership for ongoing “clock checks”

#### **PROCESSES**

- Work with a team to track a patient from arrival to discharge. Track incremental time and look for delays and bottlenecks in processes.
- Consider Open Bed Policy-allowing patients to advance to open bed upon after initial triage screening (AHRQ Improving Patient Flow and Reducing Department Overcrowding) <https://www.ahrq.gov/research/findings/final-reports/ptflow/index.html>
- Have low acuity patients evaluated by provider upon arrival and discharged as soon as full registration is completed

## PEOPLE

- Consider RN triage and preliminary registration
- Provider/RN team evaluations or “provider in triage” to assess patients immediately upon arrival
- Bedside registration can be especially effective for EDs with low-acuity patients
- Build prompts in the EHR or paper forms to track timeframes.

## DATA

- Partner with your registration staff and IT departments on data collection. Many software packages that capture patient entry into the ED also have mechanisms to capture several of these data points. At the end of the week or month, reports can be run to establish the data points.
- Share data on time before physician evaluation and total time in ED
  - Set realistic goals to reduce times

## **OP-22**

### **PATIENTS LEFT WITHOUT BEING SEEN (LWBS)**

Detecting the number of patients who are leaving your ED without being seen can be beneficial on several levels. Primarily, it can be harmful not only to patients returning to the community or home without receiving care, but also to the health of the patient’s family and significant others. Secondly, knowing the number and types of patients (diagnoses, age) who are leaving the ED without being seen can provide information needed to drive the QI process.

### **BEST PRACTICE TACTICS**

## PEOPLE

- Establish and implement staff education about improving patient experiences, e.g., frequent updates on wait time (see Resource Section below for a variety of tactics)
- Use trained volunteers/staff in the ED to provide updates to patients
- Use nurse or mid-level practitioner in the ED triage

## EQUIPMENT

- Provide electronic boards with wait times
- Improved time-tracking in the EHR, e.g., seen by provider time

## PROCESSES

- Develop detailed tracking of arrival time
- Reduce door to evaluation time
- Use nurse or mid-level practitioner in ED triage
- Capture and visit with patients before they leave without being seen
- Conduct regular patient analyses for trends
- Utilize the knowledge that literature supports the key reason for LWBS is wait times and that communication about wait times is a key driver to prevent LWBS
- [AHRQ Patient Flow Guide](#)

## DATA

- Work with registration, IT or data vendor as data may be easily collected from electronic or manual registration logs
- Conduct regular patient record analyses to identify and understand trends, such as a diagnosis-related delays
- The best practices to reduce door to evaluation by qualified medical provider (OP-20) are likely to reduce the number of patients who leave without being seen

## **AMI AND CHEST PAIN MEASURE SETS**

**OP-1: Median Time to Fibrinolysis**

**OP-2: Fibrinolytic Therapy received within 30 minutes**

**OP-3: Median Time to transfer to another facility for Acute Coronary Intervention**

**OP-4: Aspirin at Arrival**

**OP-5: Median Time to ECG**

When dealing with patients with known or suspected cardiac arrest, effective time management is essential. Time is muscle! Once again, the best practice tactics identified below have been divided into areas for processes, people and equipment.

### **BEST PRACTICE TACTICS**

#### **PROCESSES**

- Establish local guidelines or care pathways for AMI patients with EMS
- Ensure the emergency physician on duty activates the reperfusion plan according to established local guidelines and care pathways
- Treat registration for patients with AMI similar to trauma patients with the ability to fast-track critical labs, such as creatinine and Prothrombin Time (PT)/International Normalized Ratio (INR) test
- Nurse Driven Protocol for aspirin upon arrival
- Develop a process with receiving hospitals for feedback on how to improve patient care and transfer processes

A process or care pathway that:

- diagnoses the patient early
- contains a reperfusion plan
- treats registration of these patients like trauma
- identifies patients needing ECG through registration and nurse interview
- works with local EMS, helicopter and regional care center
- contains a transfer plan for these patients

## PEOPLE

- Develop a comprehensive educational program for staff, using the SBAR (format explained earlier in the document)
  - See the AMI CareMap Appendix A for staff education and training
- Reinforce education through daily huddles and routine staff meetings
- Teach the importance of teamwork and the concept of “wingman” to help reinforce team ownership

## DATA

- Present data in increments to detect variation in processes
  - Door to EKG
  - Door to aspirin
  - Door to fibrinolytics
- Display data on units
- Present data in board and leadership meetings

## EQUIPMENT/SUPPLIES

- Provide or arrange for dedicated EKG machine in ED
- Place EKG on auto-read and respond to + for STEMI
- Identify the management of fibrolytic agent in ED. Some hospitals have arranged to transfer fibrolytics near expiration dates to avoid the drugs from expiring.



The **Chest Pain AMI Quality CareMap** can serve as a Care Pathway for the patient presenting to the ED with chest pain or other symptoms that may indicate an AMI. (See Appendix A, Chest Pain AMI Quality Care Map). This form is most useful if it is used concurrently with any patient with chest pain. Tracking times as the patient is progressing through the ED can help keep all staff aware of providing quality evidence-based care and thereby meeting time-sensitive metrics.

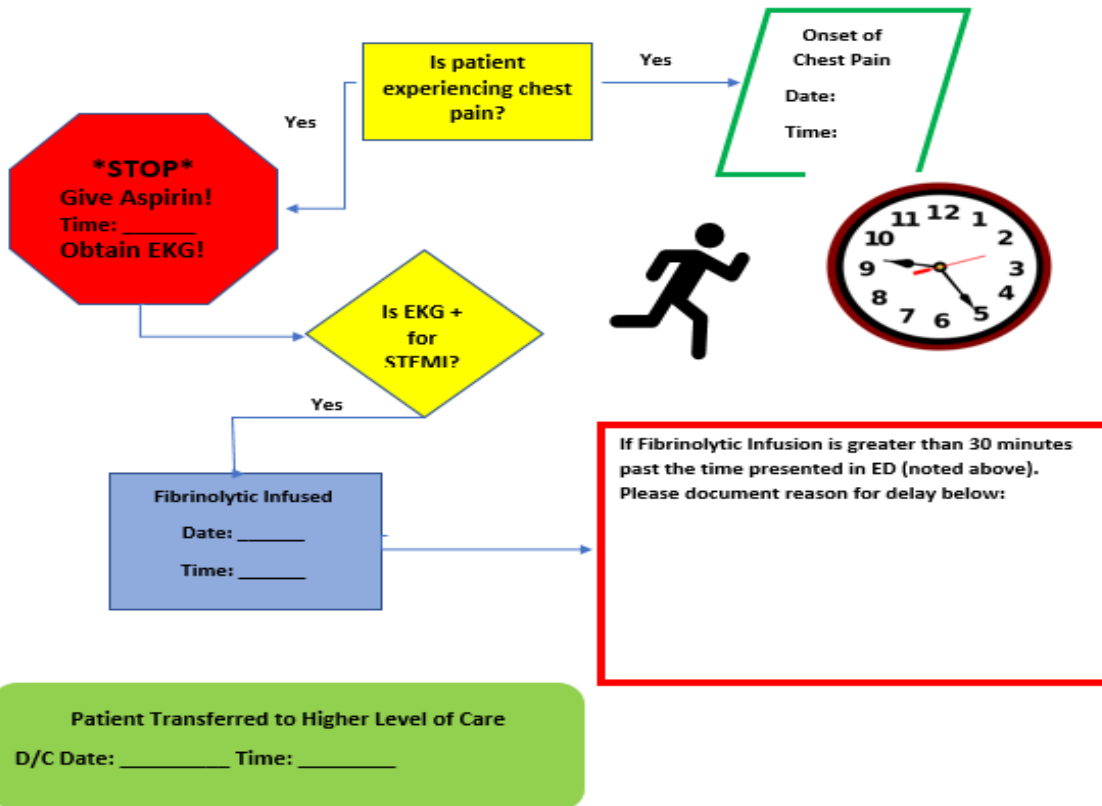
## **Chest Pain AMI Quality CareMap**

(OP-1, 2, 3, 4, and 5)

*This concurrent audit form should be a part of each ED admission packet. The flowchart will assist the care team in tracking quality measures in the ED for patients presenting with chest pain.*

Patient Name: \_\_\_\_\_ DOB: \_\_\_\_\_ MR #: \_\_\_\_\_

ED Arrival Time: \_\_\_\_\_ Seen by Physician: \_\_\_\_\_



Name of Person Completing Form: \_\_\_\_\_ Date: \_\_\_\_\_

*This form is protected as part of the hospital's quality committee. This form is not part of the patient's medical record and should be forwarded to the quality department upon completion.*

## **OP-21**

### **CARE OF THE PATIENT WITH A LONG-BONE FRACTURE (LBF)**

Addressing pain management in the ED can be difficult. Many providers are skeptical about prescribing and often seem to doubt the credibility of a patient's self-assessment of pain. In evaluating and treating pain in the presence of long-bone fractures there should be little doubt to the significance of the pain. Assessment and appropriate medication administered in a timely manner is essential in providing quality care.

#### **BEST PRACTICE TACTICS:**


##### PEOPLE

- Provide ongoing staff education on the requirements for LBF pain management
- Give frequent feedback on performance

##### PROCESSES

- Consider implementing a nurse-driven pain protocol for LBF or suspected LBF
- Triage patients with suspected or known LBF as Emergency Severity Index (ESI) level-2, or equivalent prioritization
- Examine the Emergency Nurses Association Position Statement at [www.ena.org](http://www.ena.org) for best care practices for pain management
- Document time of arrival in ED and time of 1<sup>st</sup> physician assessment


Look for best practices such as the one noted in the diagram below:




## Within Sixty is Nifty:


# Improving Long-Bone Pain Management Outcomes

Nancy M. Robin M.Ed, RN, CEN Denise Brennan MSN, RN, CNL  
Joanne Kane AD, RN, CEN Cheryl Pappas BSN, RN, CEN  
Miriam Hospital, Providence, R. I.





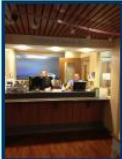






The Miriam Hospital  
*A Lifespan Partner*



The Miriam Hospital  
*A Lifespan Partner*

Purpose	Relevance/Significance	Methods	Results/Outcomes
<p>In July 2013, the median time to pain management for long-bone fractures had increased to 103 minutes exceeding the goal of 60 minutes</p> <div style="display: flex; align-items: center; margin-top: 10px;">  <div style="border: 1px solid black; padding: 5px; background-color: #ffff00;"> <p style="margin: 0;"><b>Median time to pain medication within 60 minutes</b></p> </div> </div>	<p>Timely and effective care supports optimum outcomes and improved patient comfort</p> <div style="text-align: center; margin-top: 10px;">  <p style="margin: 0; color: red; font-weight: bold;">Pain Management Needed</p> </div>	<p>Ideas for change came from the staff</p> <p>Pain protocol policy was revisited with the staff</p> <div style="border: 1px solid black; padding: 5px; margin-top: 10px;"> <p style="font-size: small; margin: 0;">Medication Standing Orders Protocol for Pain</p> <p style="font-size: x-small; margin: 0;">1. Pain Level 1 to 6</p> <p style="font-size: x-small; margin: 0;">a. Acetaminophen 650 mg by mouth. (See Contraindications Below)</p> <p style="font-size: x-small; margin: 0;">b. If Acetaminophen has been taken within 4 hours of presentation to the Emergency Department, then administer Ibuprofen 600 mg by mouth. (See Contraindications Below)</p> <p style="font-size: x-small; margin: 0;">c. If both Ibuprofen and Acetaminophen have been taken within 4 hours of presentation, then patient must await evaluation by LEP.</p> <p style="font-size: x-small; margin: 0;">d. For Abdominal Pain give Morphine Sulfate 2 mg IV and notify LEP of administration.</p> <p style="font-size: x-small; margin: 0;">1. If no IV access available, give Morphine Sulfate 2 mg SC and notify LEP of administration.</p> <p style="font-size: x-small; margin: 0;">ii. Hold for RBP &lt; 90.</p> <p style="font-size: x-small; margin: 0;">iii. Hold for age &gt; 75.</p> <p style="font-size: x-small; margin: 0;">2. Pain Level 7 to 10</p> <p style="font-size: x-small; margin: 0;">a. One set of Tylenol/Codeine/Acetaminophen (Vicodin) 1/300.</p> <p style="font-size: x-small; margin: 0;">b. For abdominal pain, flank pain or worse keep medication on hold for finger distention give Morphine Sulfate 4 mg IV and notify LEP of administration.</p> <p style="font-size: x-small; margin: 0;">c. If no IV access, give Morphine Sulfate 4 mg SC and notify LEP of administration.</p> <p style="font-size: x-small; margin: 0;">1. If no IV access, give Morphine Sulfate 4 mg SC and notify LEP of administration.</p> <p style="font-size: x-small; margin: 0;">ii. Hold for RBP &lt; 90.</p> <p style="font-size: x-small; margin: 0;">iii. Hold for age &gt; 75.</p> </div>	<p>One year later, our median time to pain medication was 25 minutes</p> <div style="text-align: center; margin-top: 10px;">  </div>
<div style="background-color: #ffff00; padding: 5px; text-align: center; font-weight: bold;">Design</div> <p>Quality Improvement project</p>			
<div style="background-color: #ffff00; padding: 5px; text-align: center; font-weight: bold;">Setting</div> <p>Teaching, urban emergency department with 61,000 visits</p> <div style="text-align: center; margin-top: 10px;">  </div>	<div style="background-color: #ffff00; padding: 5px; text-align: center; font-weight: bold;">Methods</div> <p>Identifiable barriers during staff meetings and daily huddles</p> <ul style="list-style-type: none"> <li>Inability to be immediately evaluated by physician</li> <li>Pain protocol orders not being used</li> <li>Visualization of medicated patients</li> </ul>	<p>Better visualization with New ED renovations</p> <div style="display: flex; justify-content: space-around; margin-top: 10px;">   </div> <p>Recognition: Daily Huddles Email Notification, Badge Emblem</p> <div style="text-align: center; margin-top: 10px;">  </div>	<div style="background-color: #ffff00; padding: 5px; text-align: center; font-weight: bold;">Implications</div> <p>Emergency departments need to share collaborative strategies that will assist improving pain management for this population</p> <p>Breaking down barriers, weekly staff recognition, badge recognition, and celebrating accomplishments are important strategies that worked with this initiative</p>
<div style="background-color: #ffff00; padding: 5px; text-align: center; font-weight: bold;">Participants</div> <p>All ED RN's ED Quality Nurse ED Nursing Leadership ED Physicians</p>			<div style="border: 1px solid black; padding: 5px; background-color: #ffff00; margin-top: 10px;"> <p style="font-size: x-small; margin: 0;">Contact Information</p> <p style="font-size: x-small; margin: 0;">dbrennan@lifespan.org</p> <p style="font-size: x-small; margin: 0;">nrobin@lifespan.org</p> </div>

**Appendices:**

Appendix A: [Chest Pain AMI Quality CareMap Tool](#)

**Resources:**

[OP-21 Long Bone Fracture - Pain Management](#)  
[OP-21 Long Bone Fracture - ICD-10 codes](#)  
[Chest Pain \(CP\) CART Paper Abstraction Tool](#)  
[Chest Pain AMI Quality CareMap Tool](#)  
[Regional STEMI Plan, Panhandle RAC](#)  
[STEMI Thrombolytic Checklist, Big County RAC](#)  
[21 Steps for Optimizing your ED, HealthStream](#)  
[A Pragmatic Approach to Improving Patient Efficiency Throughput, IHI](#)  
[Emergency Department Flow and Operations, HealthStream](#)  
[Emergency Department Success, Leave Without Being Seen, Studer Group](#)  
[Emergency Department Hourly Patient Flow Analysis, IHI](#)  
[Emergency Department Operations in Top-Performing Safety-Net Hospitals, Commonwealth Fund](#)  
[Florida Hospital Tampa ED Workflow, diagram](#)  
[7 Tips for Improving ED Patient Flow, Florida Hospital Tampa, HFMA](#)  
[Improving Inpatient and Emergency Department Flow for Veterans, IHI](#)  
[Improving Patient Flow and Reducing Emergency Department Crowding, AHRQ](#)  
[OP 21, Documenting Pain Medication given to Patient, QualityNet](#)  
[Patient-Centered Excellence in the ED, HealthStream](#)  
[TNKase® \(Tenecteplase\) Dosing and Administration](#)

**Templates, Policies, Processes:**

[Little River, QA, PI Loop Enclosure](#)  
[Average Minutes to Milestones Report, Memorial Medical Center](#)  
[Chest Pain Tracking Template, Otto Kaiser Memorial Hospital](#)

## Section Two Domain 4: HCAHPS

Seeking and understanding the experiences of your patients and their families during their hospital stay is crucial for the viability and the reputation of your hospital. Patients with solid and excellent inpatient stays are more likely to recommend your facility to others and return to you for care.

A key resource for your organization to identify and implement best practices within your facility is the “Stratis Health HCAHPS Best Practices in High Performing Critical Access Hospitals Study”. It may be accessed here: [Study - Stratis Health HCAHPS Best Practices in High Performing Critical Access Hospitals](#)

### **Additional Resources:**

[Summary–HCAHPS Best Practices in High Performing CAHs Study](#)  
[HealthStream](#)  
[Press Ganey](#)  
[Quality Improvement Implementation Guide and Toolkit for CAHs, Stratis Health](#)  
[HCAHPS information](#)  
[HCAHPS Star Ratings FAQs](#)  
[Patient Engagement Measure, 1, 2, 8, 9, 21, 22, Stratis Health](#)  
[Patient Engagement Measure, 1, 2, 8, 9, 21, 22, Stratis Health](#)  
[Care Transitions Measure, Composites 6 and 7, Stratis Health](#)  
[Hospital Surveys and Instructions, AHRQ](#)  
[Improving Patient Communication using RELATE, HealthStream](#)  
[Ten Steps to Leading Quality Improvement Topics, Stratis Health](#)  
[Ten Step QI Project Documentation Template, Stratis Health](#)  
[AIDET guidelines, key words, Studer Group](#)  
[RELATE in the ED, HealthStream](#)  
[Bedside Shift Reporting, Studer Group](#)  
[Patient Whiteboards as a Communication Tool in the Hospital, Journal of Hospital Medicine](#)  
[Improving Patient-Staff Communication through White Boards, RWJF](#)  
[Patient Communication Boards Infographic, Standard Register](#)  
[Discharge Call Backs, 4 Questions, Rollins Brook Community Hospital](#)  
[Phone Follow up after Discharge, Little River Healthcare](#)  
[Post Visit Phone Calls, Studer Group](#)  
[Daily, Hourly Rounding Log, Seton Healthcare](#)  
[Hourly Rounding: The Critical HCAHPS Driver at the Frontline of Care, HealthStream](#)  
[Rounding for Outcomes, Studer Group](#)

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We hope you find the contents of the CAHQI Best Practices Toolkit helpful. For questions regarding any of the resources found in the toolkit, please call:

***The Texas Hospital Association Foundation***

**512-465-1003**

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