The Critical Access Hospital Board's Role in Quality Improvement Projects

Texas Healthcare Trustees

Surviving health care reform is a significant challenge for critical access hospitals in Texas. Several CAHs nationwide have had to close their doors in recent years due to the changing health care environment, and the survival of these facilities will depend highly on their ability to improve quality outcomes.

Critical access hospital boards play an important and critical role in the hospital's quality improvement program. This white paper explores the responsibilities of critical access hospital boards in pursuing higher quality outcomes.

WHAT IS A CRITICAL ACCESS HOSPITAL?

The Critical Access Hospital Program was created through the Balanced Budget Act of 1997. Its intent is to help small, rural hospitals provide limited inpatient and outpatient services to residents in rural areas.

To be designated as a critical access hospital or CAH, the hospital must meet certain regulatory requirements including, but not limited to:

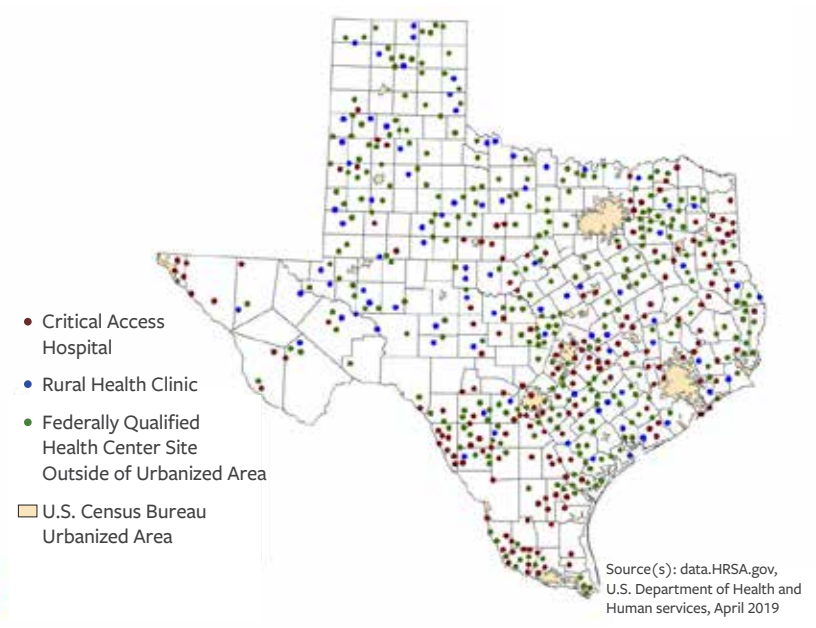
- Is located in a rural area or is treated as rural;
- Is located more than 35 miles from any other hospital (15 miles in mountainous terrain or in areas with only secondary roads available);
- Has no more than 25 inpatient beds;
- Maintains an annual average length of stay of 96 hours per patient for acute inpatient care; and
- Complies with all CAH Conditions of Participation (COPs), including the requirement to make available 24-hour emergency care services 7 days per week.

Critical access hospitals are exempt from the DRG-based payment system. Instead, they are paid based on the actual cost of providing services. While CAHs are provided some level of protection in how they are reimbursed, they still must meet Medicare Conditions of Participation (CoPs) as do other Medicare-participating hospitals.

WHAT IS THE MEDICARE BENEFICIARY QUALITY IMPROVEMENT PROGRAM (MBQIP)?

The Medicare Beneficiary Quality Improvement Program (MBQIP) is a voluntary quality improvement program intended to help critical access hospitals improve their quality of care.

SELECTED RURAL HEALTHCARE FACILITIES IN TEXAS



Source(s): data.HRSA.gov, U.S. Department of Health and Human services, April 2019

CAHs that participate in the program monitor and share their own data, and measure their quality performance against other CAHs. Participants use the data to collaborate to implement best practices that improve outcomes and help their hospitals deliver the highest quality care to their patients.

Why MBQIP Participation Matters

- Your hospital gets **access to education, resources and data** insights not accessible otherwise.
- Your hospital's performance is being compared to urban hospitals that are required to report outcomes data. Having data **instills public confidence** in your hospital's services.
- CAHs are **not immune to value-based reimbursement** measures; partners and affiliated providers likely have reimbursement tied to quality.
- Demonstrating your commitment to quality improvement and quality reporting makes your hospital **more attractive to recruiting** health care professionals.
- Voluntary reporting **likely will become mandatory** over time, giving hospitals in MBQIP an advantage by having processes and outcomes metrics well established already.
- You are **joining nearly 90 percent of CAHs** nationwide that publicly report at least some quality metrics.

86 critical access hospitals in Texas

1,380 critical access hospitals in the U.S.

367 CAHs accredited by The Joint Commission

What Does MBQIP Measure?

MBQIP measures quality outcomes that are relevant to a critical access hospital's services and volume. Essentially they are a subset of and align closely with the broader Centers for Medicare & Medicaid Services (CMS) quality measures for other hospitals. They are grouped in four categories measuring these core outcomes:

- **Inpatient/Patient Safety:** includes influenza vaccination of personnel, antibiotic stewardship, and inpatient emergency department measures.
- **Patient Satisfaction:** covers Hospital Consumer Assessment of Healthcare Providers and Systems (HCAHPS) ratings.
- **Care Transitions:** seven measures related to emergency department care transitions.
- **Outpatient:** includes chest pain/ acute myocardial infarction and emergency department throughput measures.

THE BOARD'S ROLE IN QUALITY IMPROVEMENT

CMS Conditions of Participation make it clear that the board has oversight responsibility for the hospital's quality improvement. It is the board's duty to ensure there is a data-driven quality improvement program that covers every service line within the organization. MBQIP is a critical tool in helping the board to meet its oversight responsibility. There are three significant components of board oversight:

1. The Board Must Demonstrate a Top-Down Commitment to High Quality Care and Quality Improvement.

Numerous studies have found that hospitals whose boards devote more time and attention to quality have better quality outcomes. Boards must understand that quality improvement is not simply under the purview of the physician. While the medical staff is one component to achieving quality care, improving quality is the responsibility of everyone — from housekeeping and dietary to clinicians, the CEO and the board. Ultimately, it is the board's job to set an expectation for a quality program that effectively evaluates the quality of care and that implements correction when needed. Creating a "culture of safety" begins with the board.

The board can demonstrate that quality improvement is a priority in several key ways:

1. Include a statement in the hospital bylaws documenting that the board maintains oversight for quality and patient safety.
2. Make quality improvement reports and discussion a regular part of meeting agendas and meeting minutes. Set an example to the entire hospital that quality is a priority.
3. Develop an annual quality plan, and receive at least quarterly updates on it.
4. Demonstrate visible engagement and support of quality initiatives, such as a quality committee or a patient and family engagement committee.
5. Ensure the CEO's job description and the performance evaluation both include a quality component.

What is Quality?

"Quality is the degree to which health services for individuals and populations increase the likelihood of desired health outcomes and are consistent with current professional knowledge."

Institute of Medicine (IOM)

6. Become familiar with quality improvement terms and acronyms.
7. Participate in rounds and attend education programs with clinical team leaders.
8. Benchmark against other hospitals.
9. Create a partnership of mutual trust and respect between the board, CEO and medical staff, with a shared goal of quality performance excellence.

2. The Board Must Require Objective Quality Measures that Gauge the Hospital's Quality of Care.

For an effective quality improvement program, data integrity is required and transparency must be evident. The board should expect and receive regular reporting of the hospital's quality metrics. Many hospitals use a dashboard or scorecard format to compare performance and improvement over time. For critical access hospitals, scorecards should encompass data for the measures within each of the MBQIP's four focus areas.

One of those metrics is HCAHPS scores. Due to the small numbers of CAH patients completing HCAHPS surveys, relying on HCAHPS data can be a challenge for CAHs. Instead, many are choosing to gather patient satisfaction ratings themselves from patients before discharge to ensure the highest number of data points possible. Another alternative is to monitor patient complaints and grievances through focus groups, adding a patient/family representative to the board, and/or establishing a patient/family council for feedback on quality of care.

How to Use a Quality Scorecard

Scorecards present large amounts of complex information in an easy-to-read, visual format. No two scorecards will be identical, as each hospital board must set goals and determine the metrics to track. The scorecard should show key indicators of areas on track to meet goal, and areas that need improvement. This typically is done in a color-coded format – green, yellow, red – along with benchmarks or targets for each quality measure. The board should receive regular scorecard updates, and routinely allocate meeting time for discussion of trends and areas of concern.

Key Takeaways for Hospital Scorecards:

- Choose metrics that are meaningful and actionable.
- Include metrics for MBQIP's four focus areas.
- Use data that is as real-time as possible.
- Display data in color-coded format. For example:
  - Green – meeting target, positive or stable trend
  - Yellow – potentially at risk (declining), or within 5% of achieving goal
  - Red – not meeting target, flat or negative trend
- Require process owners to provide action plans for all RED metrics, as well as mitigating steps in progress to address YELLOW metrics.

SAMPLE OF SCORECARD 1

Service Indicators	Last Quarter 7/1/17-9/30/17	Last Month 10/1/17-10/31/17	This Month 11/1/17-11/30/17	Last Fiscal Year 1/1/16-12/31/16	Bench	Monthly Trend
Inpatient Satisfaction						
Overall Satisfaction with Inpatient Services.						
Month of Patient Discharge for Inpatient Surveys						
Outpatient Satisfaction						
Overall Satisfaction with ER / Outpatient Services.						
Home Health Satisfaction						
Overall Satisfaction with Home Health.						
Quality Indicators						
Internal Hospital 30 day readmission rate						
Overall percentile 30 day readmit FRMC to FRMC						
CMS Project - Global Immunizations						
Overall percent of compliance with CMS' standards for Influenza needs						
CMS Project - Sepsis/Septic Shock						
Overall percent of compliance with CMS' standards for inpatient Sepsis care.						
CMS Project - OP Quality Measures						
Overall percent of compliance with CMS' standards for Outpatient care.						
CMS Project - VTE Quality Measures						

SAMPLE OF SCORECARD 2

Organizational Scorecard														
Covenant	**Key Measure**	**2014**	**2015**	**2016**	**4/17-6/17**	**7/17-9/17**	**Sep-17**	**Oct-17**	**Nov-17**	**Target - Goal - Budget**	**Stretch Goal**	**Benchmark**	**Comment**	**Current Result**
Workforce Engagement	Staff Turnover-Includes voluntary & involuntary turnover on a 12 month rolling calendar									≤ 16.9% Median ASHHRA (2016)	≤14.1% Top Quartile ASHHRA (2016)	≤12.7% ASHHRA Top Decile (2016)	↓ is better - updated benchmark in June 2017	
	DART-Days Away/Restricted or Transfer									OSHA 2015 National Average - 2.4%			Goal: 0%; ↓ is better	
Quality	Falls with injury/rate per 1000 pt days. Includes ICU, Post-Surg, Medical, BHS, CHSS, OB, Peds, IRC									x	x	0 NDNQI Top Decile from Q1 2017	↓ is better	
	Readmission Rate/All Cause (excluding IRC & SCC)									2015 Performance	6% reduction from 2015; ≤5.41%	12% reduction from 2015; Partnership for Pts--≤5.07%	↓ is better	
	Readmission Rate/All cause AMI									2015 Performance	6% from 2015; ≤8.36%	12% reduction from 2015; Partnership for Pts --≤7.82%	↓ is better	
	Readmission Rate/All cause HF									2015 Performance	6% from 2015; ≤14.29%	12% reduction from 2015; Partnership for Pts; ≤13.38%	↓ is better	
	Readmission Rate/All cause PN									2015 Performance	6% from 2015; ≤10.13%	12% reduction from 2015; Partnership for Pts; ≤9.49%	↓ is better	
	Readmission Rate/All cause COPD									2015 Performance	6% from 2015; ≤11.32%	12% reduction from 2015; Partnership for Pts; ≤10.6%	↓ is better	
	Readmission Rate/All cause THA/TKR									2015 Performance	6% from 2015; ≤3.45%	12% reduction from2015; Partnership for Pts; ≤3.23%	↓ is better	
	Hand Hygiene Compliance									100%--internal goal; there is no national benchmark			Goal: 100% all the time	

3. The Board Must Understand How Clinical Quality and Outcomes Relate to Medical Staff Credentialing.

In the past, many hospital boards have delegated quality oversight to the medical staff for a variety of reasons. They may feel uncomfortable questioning medical decisions, or don't want to appear as micromanaging. They may fear impacting physician relations or causing physician turnover.

But given the CMS' clear expectation that quality oversight is the board's responsibility, boards must become comfortable in asserting clear quality performance expectations for its physicians. While the physicians' job is to deliver the highest quality care possible, it is the board's job to define and establish a culture of quality.

The board, CEO and medical staff work must together as a team to ensure that quality is hardwired into the hospital.

Bringing Quality into the Credentialing Process

While credentialing is often an area that creates discomfort for boards, particularly in small communities like those served by CAHs, the board is legally obligated to ensure medical care is safe and quality standards are met. One of the board's most significant duties is approving appointments to the medical staff, and physician credentialing is an important step in the approval process.

While it may be tempting to abdicate that role to physicians themselves, the ultimate accountability for credentialing cannot be delegated to management. Through its credentialing responsibility, the board ensures that only qualified physicians are admitted and allowed to remain, and it defines the scope of practice and adherence to privileging standards.

Board members need to fully understand the process the medical staff uses to make final recommendations for clinical privileges and should ensure appropriate physician information is collected, validated and evaluated.

Ways to Hardwire Regulatory Quality into Medical Staff Credentialing

- Establish a strategic quality plan with goals and objectives
- Identify the quality outcomes aligned with MBQIP that will drive your strategic plan.
- Ensure that quality metrics are included in medical staff credentialing and are the basis for recredentialing approvals.
- Establish a relationship of mutual respect, communication and trust between the medical staff leadership and board.
- Have a physician on the board to help answer medical-related questions of the board. Create an environment in which board members feel comfortable asking questions of medical staff.
- Have medical staff leadership share quarterly quality reports, addressing yellow or red metrics.
- Define how quality errors or issues will be addressed, including within the credentialing process.

BEST PRACTICES

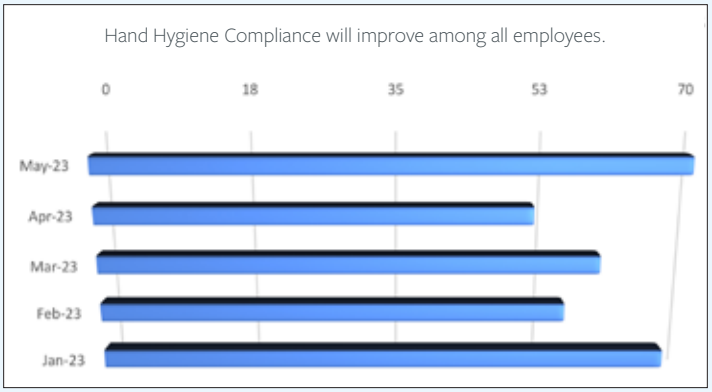
Building a Quality Program from the Ground Up

When Pam Ezzell, RN, was asked to take on the role of quality improvement at 16-bed Parkview Hospital in Wheeler, Texas, it was an opportunity to learn and build from the ground up. Although Ezzell was an experienced charge nurse, she had no training in quality improvement but quickly began self-training. She found that, at the time, the hospital's quality improvement program consisted solely of scorecards documenting specific data points. She turned to online resources to research what a comprehensive quality program should encompass. "What I learned was that a quality improvement program should be driven toward patient satisfaction and patient safety," she said.

She began identifying the key quality indicators to include in a hospital quality assurance and performance improvement (QAPI) program. "I ask each department manager what they were most worried about for their department when it came to patient safety and satisfaction," she said. From their input, she created a QAPI plan that included goals and metrics for each department. "For instance in emergency medical services, we look at turnaround times, restocking of the units after each call, being successful with IV attempts, anything measurable that they can improve upon."

Understanding that the board ultimately is accountable for the hospital's quality of care and patient safety, she and administrator Monica Kidd involved the board in the QAPI plan from the outset. "When we created our strategic plan in 2018, we made QAPI a part of it," said Kidd. "We got board approval of the plan before sharing it with department managers. Having them on board was very important.

"Our policy statement and plan for quality improvement includes board involvement, so I asked Pam to make a



Parkview Hospital uses graphs like this one to track performance on quality metrics in each hospital department. Graphs and discussion of the data are shared with the board as a regular part of board meetings.

presentation to the board on QAPI, so they would be aware of what we will be monitoring and sharing with them," said Kidd. "As CEO, it is my job to make quality a part of every board meeting– exposing them a little bit at a time helps them to understand more. It is a regular part of the agenda now and every month the board sees at least four to five department indicators."

Board education is a key part of Parkview's quality improvement strategy as well. Early on, board members viewed a video on how hospital reimbursement based on quality and safety is going to affect future revenue. Members also receive newsletters and attend continuing education through Texas Healthcare Trustees to further their hospital knowledge.

"A hospital board isn't necessarily made up of medical people, so it's important to use terminology that a business owner or

a rancher or banker would understand in layman's terms, not medical jargon," she said.

Ezzell created two forms to support the types of data being reported. One is a data collection form for managers to collect their data; the other is a data reporting form, essentially a set of graphs that she uses to report to the board. "I began putting QAPI reports in the board packets, so that at a glance they could see the progress we were making toward each goal," said Ezzell, who also gives the board a QAPI update quarterly.

A QAPI Council, which includes not only Ezzell and the director of nursing, but the CEO, a physician advisor, and several other department managers, meets monthly to review specific departments' indicators and how they are performing. "If there is a negative indication or if we fall below the threshold of the national reporting, our committee members and I come up with a plan to bring that number up," she said. "As a result of having our QAPI program, what we are seeing is the ability to catch something in its infancy and work on it before it becomes a problem."

BEST PRACTICES

Making Quality Everyone's Job – Including the Board

One of the first things Janice Simons recognized when she became CEO at Medina Regional Hospital in 2011 was the need for a quality improvement program. She recruited a director and started building the program. When now-Chief Nursing Officer Billie Bell took on the quality manager role in 2014, the hospital had a strong quality foundation that was ready to grow to the next level.

"We wanted quality to not just be a department, but have it integrated into the whole culture, so that everyone from the staff to the medical staff to the board could see quality as a part of all our jobs," Bell says.

She admits that getting everyone on board at first created a little bewilderment. "It was new, there was lots of data and it was a little foreign to people," she recalls. But that soon turned to excitement as individuals and teams began working together in a more formalized way to improve quality.

"We established baselines, and started putting out dashboards to see our progress and track trends. We also began integrating quality into all our board meetings, with annual quality education," she says.

The 25-bed critical access hospital in Hondo, Texas, serves patients across Medina County. Among numerous other services, the Level 4 trauma center's 10-bed emergency department serves about 1,000 patients a month. With such a busy emergency department, throughput time was a high priority.

At the time, ED physicians spent most of their non-patient time in a small office set up for charting. The downside: physicians couldn't see when patients came in for triage, and nurses couldn't see which doctors were available. To improve visibility and communication, the team decided to close that space and relocate computer monitors. A new tracking board installed across from the ED station lets clinicians see which rooms are occupied, and who needs attention next.

"Now, everyone has a clear line of sight to the triage window, and it creates an environment where the nurses and physicians can sit and talk about a patient together," says Simons. "It was a big improvement from an efficiency standpoint and from a teamwork standpoint, and has really helped the communication. It has been a big help in getting our patients moved through."

The results in quality performance improvement have been nothing short of spectacular. Since implementing the changes five years ago, throughput time has dropped 50 percent. Both lab processing and imaging time have improved as well. The hospital currently far exceeds state and national averages as well as its MBQIP peer group measures.

Board involvement is an integral component of Medina's quality improvement program. Members receive in-depth quality updates in each meeting, where they review quality dashboards and separate MBQIP dashboards. One board member is assigned to review every patient survey, and share feedback in the monthly meetings. Members are invited to sit in on performance improvement committee meetings, where they can get insights into what it takes to achieve the hospital's quality metrics.

In addition, Simons stresses the importance of ongoing board education. Members regularly attend conferences and each board meeting features an education component. "The hospital staff lives and breathes HCAHPS and clinical performance improvement information, but board members don't have that background in healthcare. So we do continual education," says Simons, who encourages board members to become credentialed through Texas Healthcare Trustees.

COMMONLY USED TERMS

Admitting Privileges - Permission granted to a physician (M.D./D.O.), dentist or podiatrist to admit patients to a particular hospital or health care facility for the provision of diagnostic services or treatment.

Adverse Event - An undesirable medical occurrence resulting in unintended physical or psychological harm to the patient caused by an act of commission or omission, rather than by the underlying disease or condition of the patient. This term is associated with the phrase "never events."

Antibiotic Stewardship - A practice that optimizes the dose and duration of antimicrobial therapy with the intent of creating the best clinical outcome while minimizing adverse events associated with antibiotic use and preventing the development of antimicrobial resistance.

Centers for Medicare & Medicaid Services (CMS) - Part of the Department of Health and Human Services.

Clinical Quality Measure (CQM) - A tool that helps to assess and track the quality of health care services and providers. CQMs evaluate various aspects of patient care, including health outcomes, clinical processes, patient safety, efficient use of health care resources, care coordination, patient engagement, population and public health, and clinical guidelines.

Credentialing and Privileging - Process by which a hospital obtains, verifies and assesses the qualifications of a practitioner and determines the scope of practice for him or her to provide services in the hospital. Credentials are documented evidence of licensure, education, relevant training and experience, or other qualifications. The criteria for granting privileges is determined by the hospital, is specific to that facility, and is based on credentials, practice history and performance.

Diagnostic-related groups (DRGs) - A patient classification system that standardizes how Medicare and some insurance companies will pay for charges associated with an inpatient stay from the time of admission to discharge.

Hospital Consumer Assessment of Healthcare Providers and Systems (HCAHPS) Survey - A patient satisfaction survey required by CMS for all hospitals in the United States The survey is for adult inpatients, excluding psychiatric patients, and provides the patient perspective of hospital care given.

Medicare Conditions of Participation (CoPs) – Conditions that health care organizations must meet in order to begin and continue participating in the Medicare and Medicaid programs.

Quality (Health Care) - The degree to which health services for individuals and populations increase the likelihood of desired health outcomes and are consistent with current professional knowledge.

Quality Assurance - The process of providing a desired level of quality care on a consistent basis. Quality assurance includes the continual monitoring and evaluation of current processes to determine consistency or areas of improvement.

Quality Assurance and Performance Improvement (QAPI) - The coordinated application of two mutually-reinforcing aspects of a quality management system: Quality Assurance (QA) and Performance Improvement (PI). QAPI takes a systematic, comprehensive, and data-driven approach to maintaining and improving safety and quality.

Root Cause Analysis - Systematic process used to identify causal factors that underlie variations in performance or adverse events.

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