Critical Access and Rural Hospitals

A Quality and Safety Story

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Critical access and rural hospitals face unique challenges in maintaining both quality and safety, and the Michigan Critical Access Hospital Quality Network (MICAH) has proven a highly effective consortium to address both issues.

The synergy and camaraderie are very apparent as critical access hospital (CAH) and rural hospital quality and safety leaders arrive for the annual Michigan Critical Access and Rural Hospital Conference. The networking begins instantly as old acquaintances meet in the hotel lobby and talk about the latest challenges facing them. Because it is clear that everyone is experiencing similar issues, they begin to share resources and solutions with each other. In fact, the definition of success for this tight networking group is in supporting and developing the collective knowledge on "how to" meet criteria for a new quality measure or getting updates on new quality requirements such as a pay for performance initiative for CAHs.

I began my journey with this phenomenal quality and safety group in 2005 when Angie Emge, the director of performance improvement with the Michigan Center for Rural Health, contacted me after our hospital achieved critical access status. She came to our facility, provided an orientation to the Michigan Center for Rural Health, and informed me I was now a member of MICAH. She emphasized I would need to attend the quarterly meetings to help support our quality program. It was many years later that I realized it really was an option to join, but with Angie's passion for the group it was impossible not to attend.

By all measures, this group set the benchmark for all CAHs across the country on how to implement and sustain successful quality and safety programs in small hospitals. Three meetings take place in a fabulous education center at Kalkaska Memorial Hospital and the fourth meeting, a joint rural health conference for both quality and finance leaders, is typically held elsewhere in Northern Michigan.

This conference hosts the quality network meeting where best practices, new quality and safety initiatives, concerns, barriers, successes, process improvement, and education are provided, as well as mentoring for new quality leaders. There are 36 Michigan hospitals that belong to this network, headed by a remarkable group of quality leaders who typically wear multiple hats in their organizations, who are truly dedicated to improving the health of their communities and who provide appropriate, safe care to their patients.

I had an opportunity to discuss MICAH with John Barnas, executive director of the Michigan Center for Rural Health (State Office of Rural Health) about the journey Michigan and these exceptional hospitals shared. He provided a history of the group. Originally there were 45 eligible states that qualified for the Medicare Rural Hospital Flexibility Program; five states did not as they did not have rural areas. The

Balanced Budget Act of 1997 created an option for rural prospective payment system (PPS) hospitals to convert to critical access hospital (CAH) status and be reimbursed at 100% for reasonable cost from the Centers for Medicare and Medicaid Services (CMS); the PPS option was based on diagnostic related groups. The criteria for CAH status included a certain distance between hospitals (35 miles) as well as a limited number of beds (15), including swing beds. These provisions were revised in 2005 to increase the number of beds to 25, including swing beds.

Barnas also described the Flex grant program managed by the federal Office of Rural Health which began in 1997. He notes that Congress appropriates $25 million per year to help assist CAHs with clinical and financial improvement, operational improvement, and health system development (emergency medical services). There is a competitive grant process through the federal office and they provide program guidance to receive funds. In 2000, these funds supported quality leaders to come to Mt. Pleasant, Michigan, to discuss what they wanted to do to support quality of care in the state. The Flex program continues to evolve and currently supports this quality network by covering the cost of travel and lodging for the quarterly meetings.

The MICAH network continued to grow and soon Ed Gamache joined the group and was instrumental in developing the structure to make this a nonprofit network with bylaws and elected officers. Their goal was to mobilize a self-selected group of individuals who wanted to improve care in rural communities. They identified quality measures and created a dashboard to share quality data from the group to identify quality improvement opportunities.

This networking continues to support these goals as the Michigan Health & Hospital Association (MHA), Blue Cross Blue Shield of Michigan (BCBSM) and Michigan Peer Review Organization (MPRO) are active supporters of MICAH. They collaborate on how best to serve these small hospitals when addressing quality concerns specific to small inpatient volumes. Comparing data from CAHs to larger hospitals is like comparing apples to oranges. In fact, many hospital measures have very little value for small rural hospitals with minimal inpatient stays.

It was evident that John Barnas was very proud of all of the work this group has accomplished. While he wouldn't say they set the bar for other states, he did note, "Michigan is highly respected by other states and Montana and Minnesota have quality networks that equal MICAH." For further information on the Michigan Center for Rural Health program, visit the website http://mcrh.msu.edu/.

When I heard MICAH President Ed Gamache present at the first meeting I attended, I was impressed with his relaxed but confident manner, not to mention the fact that he sounds just like Kevin Costner! Not only was he the president of MICAH but he was a CEO of not one, but two, CAHs. Gamache seemed to be informed of healthcare changes that would impact us well before the quality leaders were aware. His quest for knowledge and his genuine passion to positively influence all the community hospitals the committee members served was evident. He is truly a respected healthcare leader.

I had the privilege of interviewing Gamache as well and he noted he began his career in the VA Health System as an engineer, which explained a great deal. He approached quality

improvement from a different perspective. He had ten years' experience as a CEO with a 200-bed VA hospital with a large psychiatric unit outside of New York City prior to coming to Ann Arbor, Michigan. He worked for a University of Michigan tertiary care associate prior to being recruited as administrator for Deckerville Community Hospital, which was one of the first CAHs in Michigan. In 2006 he also became the CEO at Harbor Beach Community Hospital, another CAH. He recalls the MICAH network had 14 CAHs as original members when John Barnas approached them about what to do about quality from a rural health perspective. This began the journey of developing and implementing guidelines to include quality.

Gamache quickly realized the challenges in choosing quality measures that would be statistically significant for the smaller volumes which CAHs typically support in the inpatient setting – sometimes zero or one inpatient. He initiated an annual survey to understand the types of services and the volumes these hospitals experienced. That survey continues to be distributed annually and provides direction to the group to continue to evolve as needs change. The data continues to support the need for funding that provides assistance to this program.

This group identified relevant quality measures and worked with MPRO to participate with the state's Governor's award process. This award identifies those hospitals that demonstrate commitment to quality of care as supported by data that demonstrate improved patient outcomes.

As CAHs, the focus shifted to the quality of transfers for patients being sent to tertiary care centers where multidisciplinary care can be provided appropriately. A safe transfer, including an appropriate hand-off, became a major quality measure and an opportunity to demonstrate the value of CAHs. Once patients were past the critical care needs, they could easily be transferred back to their communities into a swing bed while they recovered to home, nursing home, home care, etc. This system opens acute care beds in the larger hospitals and provides a closer-to-home approach to care for community members.

Being an engineer, it was natural for Gamache to use control charts and graphs, develop strategies, and work with consultants to help form this network. He provided education straight from Edward Deming, a known leader in continual quality improvement techniques, by utilizing data points to shift performance to improve. The network was able to secure a group rate and worked with a data validation vendor to help collect and publicly report data to Centers for Medicare and Medicaid Services (CMS) on behalf of the group. This work continues as the majority of the Michigan CAHs continue to publicly report quality measures as well as participate with the MHA Patient Safety Organization (PSO) reporting and sharing lessons learned. Gamache continued his leadership to MICAH for at least 14 years prior to his recent retirement, continuing to mentor the incoming president and to support the group as they transition into new leadership and challenges facing small hospitals.

MICAH helps address many challenges specific to small rural hospitals which have limited resources, funding, staff, and tools needed for quality and safety. They strive to support change among themselves to improve patient outcomes. This was clearly evident to me as I was elected the second president to this group and I challenged them to restructure our teams

by doing a Rapid Improvement Event (RIE) and created three A3 systematic problem solving strategies to continue to influence and support our hospitals' quality and safety programs.

The group selected three topics they were passionate about after a brainstorming session which led to three strategic groups. The topic goals were identified as

1. **Safe care by reducing harm in care delivery** by identifying opportunities for improvement within the MICAH group

2. **Promoting effective communication and coordination of care** by increasing Medicare Beneficiary Quality Improvement Project (MBQIP) bundle compliance from 60% to 90%; this committee achieved their goal and has now moved on to supporting the quality measures, metrics, and best practice which is truly the core of the MICAH network.

   MBQIP is a quality improvement activity under the Medicare Rural Hospital Flexibility (Flex) grant program of the Health Resources and Services Administration's Federal Office of Rural Health Policy (FORHP). The goal of MBQIP is to improve the quality of care provided in critical access hospitals (CAHs), by increasing quality data reporting by CAHs and then driving quality improvement activities based on the data. This project provides an opportunity for individual hospitals to look at their own data, measure their outcomes against other CAHs and partner with other hospitals in the state on quality improvement initiatives to improve outcomes and provide the highest quality care to each and every one of their patients. (https://www.ruralcenter.org/tasc/mbqip)

3. **Promote healthy communities** by working with our populace to promote wide use of best practices to enable healthy living.

Numerous leaders of this group have dedicated many years of support by their leadership and knowledge. One such is Anne Barton, who was affectionately known as the data guru. She noted the group was always problem solving and she always left a meeting with a valuable piece of information or a "take away." She became a member in 2005 and remained until her move into a new role in 2015. The most important component of the MICAH network to her was the willingness to share knowledge with others. The network developed an email list so effective that on any given day a question may be posed to the group and within minutes there are several responses with policies or clarifications provided. Other members like Mariah Hesse from Sparrow Clinton Hospital appreciates the opportunity to build relationships with those who also wear multiple hats in their organizations and the ability to relate to similar barriers faced by quality peers.

The director of performance improvement at MCRH, Crystal Barter, really "gets it" and her support to this network is invaluable. Her leadership in helping the members connect the dots or resources among this group are seen over and over, and she feels that the MICAH network has become a national leader in establishing benchmarks for quality for more than ten years. She states the group is very progressive and always looking at the future state to determine how CAHs will transition into value-based purchasing and become highly

reliable organizations. She is impressed and inspired by the team's ability to accept additional responsibility outside of their normal jobs to improve care provided to all CAHs and rural hospitals in Michigan. She notes the group has the respect of the Rural Health program as natural mentors for all quality and safety leaders in the healthcare industry as they continue to provide succession planning and support for future leaders.

Identifying and improving safety and quality of care for small rural and critical access hospitals is vital to Mary Kay VanDriel, president at Spectrum Health Big Rapids (rural) and Spectrum Health Reed City (CAH) Hospitals. She noted issues such as helping people understand the different measures for CAHs and rural hospitals as compared to larger hospitals within a system: how do you compare the two to focus on needs that may be independent based on size? Smaller hospitals may think errors "can't happen here." The key to success, she notes, is in standardization and supporting critical thinking. The volume of quality inpatient measures can be so small that one missed opportunity can mean failing to meet a quality metric associated value based purchasing measure or missing a pay for performance incentive measure. While CAHs are very nimble and can often times drive change much quicker than larger hospitals, there are challenges.

When asked what she saw as a positive factor in driving change as it relates to safe care, VanDriel noted that it is a long journey, and you have to make it safe for staff to speak up without fear of punishment. Having the support of management is essential and acknowledging staff along the way is very important. At Spectrum Health, she utilizes the hospital's Facebook page to acknowledge staff who have demonstrated their commitment to quality and safety for patients, as well as providing an exceptional experience. Having experience as a leader with Value Health Partners, a conglomerate of health systems in West Michigan, she understands the importance of providing the appropriate tools and training to help create a safe culture and that leading by example is paramount to success. Sharing successes with the medical staff and the hospital board help generate discussion and support on the journey to becoming highly reliable hospitals. The hospital celebrates each 100 days without harm, recognizing staff along the way and sharing concerns with leaders who report out at a daily check in. Merging two small hospitals and creating one culture of success has led to sharing best practices in rural community hospitals, which has led to successful implementation of quality and safety practices.

This commitment to becoming a highly reliable hospital became apparent as I was rounding to influence patient safety awareness recently at both these Spectrum hospitals. The safety topic of the month was patient identifiers. I asked staff what barriers they have that prevent them from using the two patient identifiers of name and date of birth prior to providing care. I was provided feedback from staff regarding misidentified patients from both hospitals, and as part of our safety culture, sharing a safety story at the beginning of each meeting helps identify opportunities or lessons learned. Having two hospitals with common staff and leadership includes sharing stories across facilities. This has led to obtaining *additional* information surrounding similar events.

While rounding on the CAH inpatient and swing bed unit, I had a staff member share a concern

about two patients on this small unit that had the same last name. She noted that the electronic health system or electronic medication unit did not flag the same name because the swing bed patient name was not listed in the inpatient files. This was a Good Catch but surely the staff knew there were two patients on this small unit that had the same name. However, when interviewed, they were unaware. This could have led to an assumption to provide care to the wrong patient should staff bypass the two patient identifier process of validating name and date of birth. While our clinical informatics nurse went on to correct this system process, I had a great story to share with staff to validate the importance of the two patient identifier process. I shared it at several meetings and continued to round at both facilities.

While rounding in the other hospital I was informed by a diagnostic department registration clerk that they recently registered two patients within a short timeframe and discovered they had the same last name identified in the first event and they also had the same first name. The patients had been registered incorrectly and would have received the wrong test had they not registered in such a close timeframe so the staff recognized the error and made a "Good Catch." No harm was done to the patients, but now I was starting to see a little trend. Not only were we skipping the two patient identifiers, but this was no longer an isolated event.

This was validated once again when a patient safety coach approached me regarding a family member that was about to receive the wrong test when his wife intervened and asked staff to validate the order. They discovered he had been registered incorrectly and he had the same name as the first two Good Catches!

At this point I requested a report from our Health Information Management (HIM) department to determine how many patients in our two hospital service areas had this name and I was not surprised to discover that there are 21 that had the same last name, first name, and middle initial; 15 with the same last name and same first name and different middle initial, and six with the same last and first name. Now I have a powerful story I share when discussing the importance of using the two patient identifiers of name and date of birth.

It is important to note that CAHs and rural hospitals do not want to be exempt from quality and safety measures, and they do want to dedicate the limited resources and staff to address those initiatives that are truly meaningful and impactful to their patient population. Having the flexibility and conversation surrounding what those might be is extremely important to ongoing quality of care for those valuable small hospitals located throughout the nation. Not only do our rural patients rely heavily on these community hospitals to meet their needs, they are typically the largest employer in small towns and serve as the hub for community members and businesses alike. These communities deserve the best quality and safest care available. Networks like the MICAH are essential in the ongoing success to meet these constant challenges faced by these hospitals. I consider myself very fortunate to have worked with this group for the last 12 years.

About the author

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Areas of responsibility: Patient safety, risk management, medical staff, regulatory compliance, and infection prevention

Employment: Barb Coté has been with Spectrum Health for more than 35 years , including managing patient safety and risk in two rural hospitals. Her past experiences in healthcare includes cardiopulmonary and occupational health, medical staff, regulatory compliance and infection prevention. She has been an adjunct professor at Ferris State University teaching the quality class in the healthcare administration bachelor program (2006 – 2010).

Educational Background: She earned an MBA (2013) and a bachelor degree (2000) in healthcare administration from Baker College, and completed the Spectrum Health Executive Leadership Institute (ELI) program, Michigan Ross School of Business (2007).

She is extremely passionate to provide the right care the first time, every time, so patients receive affordable, quality care they expect in a safe and healing environment. She is currently the president of the Michigan Critical Access Hospital (MICAH) quality network and truly enjoys working with all of the Critical Access Hospital (CAH) quality leaders in improving the quality of healthcare provided throughout Michigan. She regards this group as an asset to patients throughout the state and as recognized as a leader in quality for Critical Access Hospitals (CAH) throughout the nation as well. She also represents MICAH as a member of the Rural Quality Advisory Council sharing national perspectives of providing quality care in rural and critical access hospitals.

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