EQIC
EASTERN US QUALITY IMPROVEMENT COLLABORATIVE

News
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In This Issue

Workgroup updates

Thank you for participating in EQIC's monthly affinity workgroup meetings.

This issue of *EQIC News* covers the most recent workgroup meetings for health equity, falls, readmissions and patient and family engagement. Summaries for the sepsis, pressure injuries, infections and adverse drug events/opioid prescribing workgroups are shared in alternating issues.

Health equity

At the Sept. 19 meeting, the workgroup discussed organizational leadership and key components of implementing systematic organizational change to advance health equity. Members also reviewed the workgroup content discussed thus far, including the importance of making equity a key strategic priority, building an organizational response to disparities, the power of qualitative data and storytelling, and data collection and use.

Members reviewed the EQIC Health Equity Gap Analysis elements and shared how they are integrating equity into their overall operations. Examples include:

- collaborating with key leaders to identify priority populations for disparities reduction;
- reviewing data with an equity lens at quality committee meetings;
- developing disparities dashboards and written action plans with measurable goals and interventions;
- partnering with community-based organizations to address health-related social needs; and
- strengthening capacity/infrastructure needs (i.e., staff training, health literacy, survey readiness).

Members discussed engaging patients and staff to reduce all-cause harm and eliminate disparities through diversity, equity and inclusion and patient and family advisory council-focused committees, employee training, patient information/materials, social needs and provision of culturally and linguistically appropriate services. Strategies for applying an equity lens in clinical practice have focused on patient screening across harm areas to tailor care plans and interventions including readmission reduction, expanding language access/services, occurrence reporting and stratifying infection data to address identified disparities.

Teams reviewed approaches to embedding equity into adverse event analysis and unit-based small tests of change (i.e., PDSA) to address equitable care opportunities at the bedside. A set of questions to proactively apply an equity lens to performance improvement was shared. Teams will consider what organizational leadership topic to bring back to their executive leadership teams in preparation for the Oct. 17 meeting, which will focus on health literacy.

Falls

Happy belated falls week! At the Sept. 21 meeting, the falls workgroup reviewed prevention strategies previously presented by falls subject matter expert Pat Quigley for behavioral health patients. The group spent the rest of the time recognizing their fall prevention successes thus far, including instituting:

- “no pass” zones;
- red leaves on patient doors;
- safety device rounding;
- physical therapy evaluations and partnership;
- toileting schedules/purposeful rounding;
- low beds;
- bedside interdisciplinary reporting; and
- post-fall huddle standardization.

EQIC applauds all the incredible improvements our falls workgroup has implemented!

Readmissions

At the Sept. 26 meeting, workgroup members shared the challenges of implementing the Care Partner Program and ideas for addressing them, including creating workflows, EMR modifications and staff and community understanding and buy in. Suggested solutions include marketing to the community, primary care and community-based organization education, and just-in-time re-education and bedside reinforcement of the positive influence of the care partner on the staff and patients. Additionally, workgroup participants discussed available data reports and reviewed the trends identified by the EQIC MAP Data report and disease-specific interventions to prevent readmission, including enhanced education efforts and additional transition team interventions. For the next meeting, the workgroup was tasked to come prepared to discuss root cause analysis findings from the recent readmission RCA exercise.

Patient and family engagement

At the Sept. 28 meeting, the workgroup discussed the findings of the hospital readiness and leadership assessments that hospitals were asked to perform. The team members discussed challenges, the likeliness of starting a PFAC and timelines for implementation. Workgroup leads introduced the three phases of the PFAC implementation process and discussed steps to implement “Phase I - assessment and planning” by getting leadership support and launching a PFAC team. Members were asked to implement strategies and examples discussed during the meeting and come prepared next time to dive into Phase II.

Announcements

Join us today for EQIC's fall conference!

Thursday, Oct. 12
Advancing healthcare excellence: The power of high reliability and just culture to improve patient safety
9 a.m. - 3 p.m.

While you may be familiar with high-reliability organizing and just culture concepts, EQIC challenges you to consider, what do these words really mean?

Speakers at today's event will enhance your knowledge of HRO tactics to positively impact patient safety, staff satisfaction and clinical and operational outcomes.

All hospital staff are encouraged to attend, including executive leadership, clinical leaders, managers, quality improvement team members and bedside staff.

October is Health Literacy Month!

During Health Literacy Month, EQIC urges you to put health literacy awareness into action! According to the Agency for Healthcare Research and Quality, 88% of U.S. adults do not have the health literacy skills needed to manage all the demands of the current healthcare system and only 36% have limited health literacy.

Healthy People 2030 defines health literacy as the degree to which individuals can find, understand and use information and services to inform health-related decisions and actions for themselves and others. The new definitions are in alignment with the Health Literate Care Model and HHS' National Action Plan to Improve Health Literacy, which calls for healthcare providers to:

- approach all patients as if they are at risk of not understanding health information;
- employ a range of strategies for clear communication; and
- confirm that patients understand what providers are saying.

Join our monthly health equity workgroup meeting on Oct. 17 to discuss how we can accelerate action and spread awareness (contact your PM for a registration link). Together, we can equitably address health literacy to improve outcomes, safety and quality while reducing disparities and costs for all. To learn more, visit EQIC's website for health equity resources.

Rural emergency hospital designation

Rural emergency hospital is a new Medicare provider designation established by Congress through the Consolidated Appropriations Act of 2021. REHs are meant to reinforce access to outpatient medical services and reduce health disparities in areas that may not be able to sustain a full-service hospital. Starting in January 2023, critical access hospitals and small rural hospitals with no more than 50 beds may apply for REH designation and receive Medicare payment for providing emergency services.

If an EQIC hospital receives REH designation, its status in EQIC will not change. EQIC has reached out to subject matter expert consultants to ensure that the support provided to REHs meets the hospitals' needs and requirements. To date, no EQIC hospital has been designated as a REH.

Data portal updates

Medicare fee for service data

EQIC is collecting and is pleased to begin reporting hospital-level Medicare Fee for Service data on its secure data portal. EQIC is required to adhere to CMS' current cell-size suppression policy when utilizing MCFFS data, which stipulates that no cell containing a value of 10 or fewer (e.g., admittances, discharges, events, etc.) may be displayed. As such, EQIC calculates a rolling sum of a year's worth of data that moves forward on a quarterly basis. For example, the data point representing 2021/Q4 will contain a sum of data (numerator and denominator) from 2021/Q1 through 2021/Q4. The next data point, which ends 2022/Q1, would contain the period from 2021/Q2 through 2022/Q1. Any rolling sum data point that does not meet the cell-size threshold and contains a value of 10 or fewer will display a "#" to indicate that data has been excluded.

The following MCFFS measures will be displayed on the portal:

- ADE rate per 1,000 discharges
- Hyperglycemic ADE rate per 1,000 discharges
- ADE rate per 1,000 discharges (minus opioids)
- High-risk medication utilization in the elderly population per 10,000 discharges
- Anticoagulant-related ADE rate per 1,000 discharges
- Hypoglycemic ADE rate per 1,000 discharges
- Falls HAC rate per 1,000 patient days
- MRSA Rate per 100 Discharges: Colon Surgery, Hip Prosthesis, and Abdominal Hysterectomy
- Opioid-related ADE rate per 1,000 discharges
- Naloxone Upon Discharge
- Safe Use of Opioids – Concurrent Prescribing
- High-Dose Opioid Prescribing Upon Discharge
- Opioid-related mortality rate per 1,000 discharges
- Percentage of patients prescribed two or more opioids at discharge
- AHRQ PSI 3: Stage III or IV pressure injuries per 1,000 discharges
- Hospital-wide, All cause, unplanned hospital 30-day readmissions (NQF 1789)
- Health equity readmission rate (Asian)
- Health equity readmission rate (Black)
- Health equity readmission rate (Hispanic)
- Health equity readmission rate (Native American)
- Health equity readmission rate (Other)
- Health equity readmission rate (Unknown)
- Health equity readmission rate (White)
- Disease-specific readmission rate: Sepsis
- Disease-specific readmission rate: Diabetes
- Disease-specific readmission rate: Dual Eligible
- AHRQ PSI 13: Post-operative sepsis rate per 1,000 elective surgical discharges
- Mortality rate per 100 sepsis discharges
- AHRQ PSI 12: perioperative pulmonary embolism or deep vein thrombosis (secondary diagnosis) per 1,000 surgical discharges
- VTE rate per 1,000 medical discharges
- VTE rate per 1,000 discharges
- VTE rate per 1,000 surgical discharges

Sepsis measure

EQIC has made an adjustment to its all-payer sepsis measure that may result in changes to your

hospital-level rates displayed on the portal. Effective this month, the Sepsis Mortality Rate will now include patients who have a sepsis diagnosis as either the primary or secondary diagnosis. The change ensures that all septic patients are included, regardless of present on admission status, thus providing more actionable data. All other all-payer measures will continue to capture only secondary diagnoses.

Readmissions rate

The readmissions rate has been updated to more accurately reflect the patient population. Effective immediately, the readmission rate numerator now includes the following patients/diagnosis codes on the second admission:

- deceased patients;
- those who left against medical advice;
- transfers;
- primary psychiatric diagnosis;
- patients admitted for rehabilitation; and
- patients admitted for medical treatment of cancer.

Additionally, to align with recent CMS methodology changes, patients with a COVID-19 diagnosis are now excluded from the numerator and denominator.

Please contact your project manager with any questions about the data updates.

Tools and resources

COVID-19 variants fact sheet

Evolving variants of a virus may allow it to spread more easily or make it resistant to treatments or vaccines. New variants of SARS-CoV-2, the virus that causes COVID-19, will continue to occur. This fact sheet, created by TMF Health Quality Institute, provides fundamental knowledge about COVID-19 variants including how the virus may change, who is at risk and tracking variants in the U.S.

Try CDC's Project Firstline for infection reduction

The CDC's Project Firstline provides innovative and accessible resources for all healthcare workers to learn about infection control. Explore the educational and training content to learn more about where germs live in healthcare settings and how to recognize the risk for them to spread — which is the first step in understanding when to take action to protect yourself and your patients from infections. EQIC encourages hospitals to prioritize this free resource for all frontline staff.

Education

Thursday, Nov. 9
The core elements of antibiotic stewardship: National updates and promising practices
1 - 2 p.m.

Antibiotic stewardship remains a national priority aimed at optimizing antibiotic use to effectively treat infections, protect patients from harm caused by unnecessary use and combat antibiotic resistance.

This CMS Community of Practice call features national trending data from the CDC, strategies and best practices to address AS challenges and a hospital success story of engaging leaders, providers and frontline staff in hospital-wide AS efforts to improve outcomes.

Questions?

Please contact Cathleen Wright or your EQIC project manager with any questions.

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