



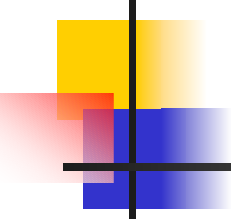
The Rural Hospital Flexibility Program - Strengthening Rural Health Care Infrastructure

The Maturation of CAH Quality Improvement Strategies

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CAH/FLEX NATIONAL TRACKING PROJECT CONSORTIUM



Initial CAH Quality Improvement (QI) Activities

- Majority of CAHs Involved in QI Activities
 - Beyond Expectations
- Most Significant Post-Conversion Activity
 - Redefining QI Process
 - Improving Staffing
- Biggest Barriers
 - Scale of Operations
 - Limited Resources to Make Needed Changes



Flex Program Establishes a Quality Context for CAHs

- Collaborative Orientation for Planning and Delivery System Problem Solving
 - Hospital and Community Involvement
 - State-level stakeholders (SORH, SHA, QIO)
- Framing External Linkage Options to Strengthen QI Efforts in CAHs
 - Support Hospital Relationship
 - Rural Health Network Involvement (QI/PR/Credentials)
- General Groundswell Reframing QA/QI



What Are CAHs Doing in QI and Is It Replicable?

METHODS

- Ranked Most Recently Surveyed CAHs on Composite Quality Item Scores (n=388)
- Top 20% Selected for In-depth Phone Survey on QI Activities (n=73, 100% response rate)



Most Significant Activity to Improve Patient Care

- Patient Safety 24%
- Condition/Service Specific 23%
- Program-wide Efforts 15%
- Oversight/Measurement 11%



Factors Supporting the Most Significant CAH QI Activity

■ Funding

- Hospital Budget 63%
- Grants 22%
- Combination 13%

■ Staffing

- Reallocation 81%
- New 11%
- Contracted 8%



Factors Supporting the Most Significant CAH QI Activity

- Collaboration with Other Providers
 - Support Hospital 59%
 - Groups of CAHs 49%
 - Hospital System 19%
 - Network Partners 16%

- State Infrastructure
 - State Office of Rural Health 37%
 - State Hospital Association 32%
 - QIO 27%
 - JCAHO 16%



Staffing Additions Since CAH Conversion

- Nursing Staff 20%
- Ancillary Staff 20%
- Medical Staff 18%
- QI Staff 7%



Changes in QI Training Since CAH Conversion

- Upgrade or Increase In-Service 44%
- Training w/Support Hospital 15%
- Process Changes, Root Cause 13%
- Target Specific Areas (ALS) 12%
- Computer/Web-based Training 10%
- QIO/SHA/Regional Conferences 10%



Changes in QI Feedback to Staff Since CAH Conversion

- Number/Quality of QI Meetings 24%
- Improved Communications 21%
- Use of Peer Review/Chart Audits 18%



Changes in Equipment Since CAH Conversion

- CT Scanners 30%
- Cardiac (Monitoring, Rehabilitation, ED.) 27%
- Diagnosis/Screening (Mammography) 27%
- Radiology/Telemedicine 25%
- Laboratory 25%



Use of Clinical Protocols Since CAH Conversion

80% Implemented One or More Clinical
Guidelines/Protocols

- Congestive Heart Failure 42%
- Pneumonia 38%
- Acute Myocardial Infarction 18%
- Diabetes 12%
- Chest Pain 10%



Main Source of Protocols Since CAH Conversion

- Quality Improvement Org. 26%
- Affiliate/Support Hospital 21%
- CAH or CAH Group 12%
- State Hospital Association 9%



The Role of a Stronger Rural Health Infrastructure for QI

- Corporate Culture Supportive of QI Efforts in Small Hospitals
- Organizational Partners That Foster a Supportive QI Environment
- Federal and State Policy Options to Enhance Participation in QI Efforts