

CAH/FLEX

National
Tracking
Project

FINDINGS FROM THE FIELD

Volume 1, Number 9
December 11, 2000

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From Kansas and Idaho: Supporting Quality Assurance/ Improvement in Critical Access Hospitals— A Role for Networks and State Agencies

Background

Critical Access Hospital (CAH) administrators realize that operational efficiencies, levels of utilization, and maintaining quality services remain as important as ever. The quality of care requirements for CAHs could be used to address these issues.

What is the Strategy?

By seeking assistance and support from State Office of Rural Health (SORH) and State Hospital Association partnerships, CAHs can take full advantage of the hospital and network opportunities available in the quality-related provisions of the Rural Hospital Flexibility Program (RHFP). Assistance and support can take many forms, including the provision of capital resources for systems development, technical assistance, and the provision of legitimacy through state-level recognition.

Why is Quality Assurance/Improvement Necessary?

Providers, consumers, and external regulatory bodies alike want assurances that CAHs can meet prevailing standards and, at a minimum, provide a level of care comparable to similar rural providers. The ability of CAHs and their networks to provide assurances will vary according to their specific capacity and resources, state support, and their pre-conversion reputation.

Kansas: Quality Assurance/Improvement Through Partnerships and Network Development

As a former EACH/RPCH demonstration state, Kansas has almost a decade of experience in assisting primary care hospitals and CAHs. During this time, the Office of Local and Rural Health and the Kansas Hospital Association have worked as a team. They have long highlighted the importance of quality of care and formal Quality Assurance (QA) programs in CAHs and networks.

Previous Findings from the Field

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Project Website: <http://www.rupri.org/rhfp-track/>

In the Kansas Rural Health Options Project (KRHOP), the local version of the RHFP, network linkages and support are central to assuring a high level of care in small rural facilities such as CAHs. The partners involved in the KRHOP include representatives of the Kansas Department of Health and Environment, the Kansas Hospital Education and Research Foundation, the Kansas Board of Emergency Medical Services, and the Kansas Medical Society.

Kansas has specifically targeted a number of quality-related activities with the federal funds awarded under the RHFP, including: development and use of peer review and clinical pathways and protocols, support for performance measurement and improvement, and continuing medical and nursing education efforts. This support has enabled some networks to develop sophisticated network-wide QA and/or Quality Improvement (QI) programs.

Network membership can...

provide opportunities, especially through the establishment of clinical and administrative linkages, for improved operations and viability that might not otherwise have been available to a freestanding facility.

An example of a network-wide QA program is the Pioneer Health Network. This Network maintains a QA/QI plan that includes the evaluation of:

- transfers between the CAH and the supporting hospital;
- discharges from the supporting hospital and back to the CAH;
- support of hospital physician acceptance of patient transfers; and
- quality of patient care provided via interactive video.

CAHs are also encouraged to participate in the Kansas Hospital Association Patient Satisfaction Project (one half of the cost of participation is covered through the federal grant funding to the state). This annual survey focuses on patient satisfaction with inpatient, outpatient, and emergency services. Participation provides key information useful in continuous quality improvement efforts.

Efforts during the second year of the Kansas program are expected to focus on more broadly targeted activities, including network community health quality improvement projects and the involvement of the Peer Review Organization in quality assessment activities and the development of policy recommendations.

Idaho: Quality Assurance/Improvement Through Partnerships, Credentialing, and Data Collection

Idaho, like Kansas, is a rural state with a large number of hospitals that could potentially benefit from participation in the RHFP. Idaho has a very small SORH (one staff person) with limited resources (federal State Office funds only). With the Idaho Hospital Association (IHA) in a lead role, the SORH and State Health Department formed a workgroup to assist hospitals in their conversion efforts. Central to this approach is a commitment to assist rural hospitals that cannot or do not take advantage of opportunities to join a larger system. The ultimate goal of their effort is to certify CAHs and help them develop into exemplary models for rural hospitals. *A key role of the IHA in this partnership is assisting rural hospitals in the areas of quality assurance and credentialing by focusing particularly on the process of survey and certification and the implementation of RHFP QA requirements for CAHs.*

Although originally expected to be included in most CAH affiliation agreements, the provision of credentialing support has become a major focus of agreements between CAHs and the IHA (over one half of the CAHs have signed a credentialing agreement with the IHA).

The IHA credentialing process includes:

- # an initial site visit by IHA personnel within ninety days of CAH certification;
- # a 100 percent review of the hospital's credentialing files;
- # an exit report by IHA;
- # a report by IHA detailing all credentialing deficiencies for each practitioner who works at the CAH; and
- # a response of CAH to IHA within ninety days detailing how credentialing deficiencies have been or will be corrected.

The credentialing agreement available with the IHA has provided an economical and effective means to complete the process. It provides the CAH with a baseline assessment and identifies deficiencies for correction as well as on-going support to maintain new systems.

As a sponsor of the Maryland Quality Indicator Project (MQIP) the IHA requires rural hospitals that have signed a QA agreement with it to participate in the MQIP. Participating hospitals are given individual quarterly reports generated from a set of pre-selected indicators. The reports can be customized (e.g., stratifying findings by similar facilities in the MQIP). The hospital then forwards the indicator scores to the IHA for review and recommendation. When combined with an agreement for an external physician review of 10% of the hospital's peer review cases, the program meets all RHFP quality provisions.

What are the Benefits?

The obvious benefit from developing quality systems for CAHs and their networks is the improvement in the quality of care provided. Another benefit noted in the Idaho experience is the potential for assisting rural hospitals other than CAHs, contributing to a broader rural impact while at the same time addressing critical issues for CAHs.

Another important benefit for CAHs in particular and small rural hospitals in general is the potential effect of these activities on the reputation of the hospital in the minds of consumers and area providers. Improving a hospital's reputation and image facilitates the ability to generate, maintain, or reclaim the level of community and professional acceptance necessary to enhance appropriate use of the local facility. Structural and organizational changes, such as less fragmentation of services, centralized services to increase volume, quality and efficiencies, and the introduction of services previously unavailable to the community, can be cast in the light of improving services, access, and continuity of care.

Where Can I Get More Information?

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About this project: Check our website: <http://www.rupri.org/rhfp-track/>

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Background

The Rural Hospital Flexibility Program is a federal initiative to strengthen rural health. The Program:

1. Allows small hospitals the flexibility to reconfigure operations and be licensed as Critical Access Hospitals (CAHs).
2. Offers cost-based reimbursement for Medicare acute inpatient and outpatient services.
3. Encourages the development of rural-centric health networks.
4. Offers grants to states to help implement a CAH program in the context of broader initiatives to strengthen the rural health care infrastructure.

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This Issue:
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