

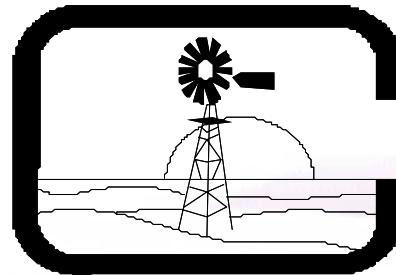
The Road to Quality Improvement in Critical Access Hospitals is Paved by Networks

Presented to the Critical Access Hospital and Rural Health Clinics
Conference

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*October 3-6, 2006
Millennium Hotel
St. Louis, Missouri*



There Once was a Critical Access Hospital...

- 12 inpatient acute care beds
- Average daily census (ADC) of 1
- Community supported
- Active outpatient unit





. . . . That Got a Bad Report Card

- Inadequate procedures to monitor patient care
- Errors resulting in harm to patients
- No adequate quality assurance program



... That led to a Loss of
Community Confidence
and Ultimately Closing



Similar scenarios, not always resulting in closing

- 15 acute care beds, ADC of 10
- 25 acute care beds, ADC of 18



But so unnecessary

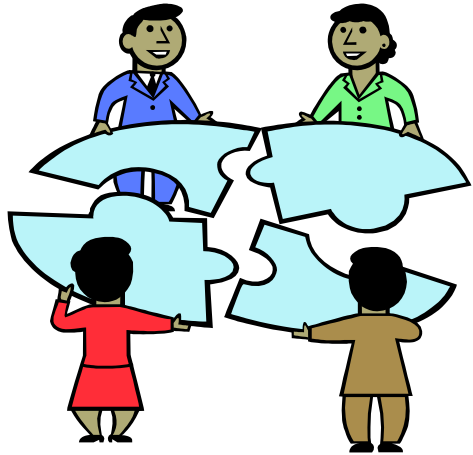
- Using systems of care
- That are patient-centered
- Bringing resources to the point of care
- By pooling and sharing



There once was a Critical Access Hospital...

- 12 acute care beds
- ADC of 1.8
- Outpatient unit active
- Skill nursing care unit





...that participated in
a network of CAH's
and a Hub Hospital

- Regular communication
- For shared ideas
- And mutual support





That supports quality improvement programs...

- Convening
- Infrastructure
- Personnel
- Financial



- . . . Resulting in continuous improvement
- . . . that contributes to sustainable systems of care



In sum, a set of converging factors

- CAHs as community-based providers
- Quality of care as a community effort and benefit
- Flex program to promote quality



The Flex Vision

Vehicle for sustaining access to appropriate healthcare services of high quality in rural America. It will facilitate the development and support of community-based collaborative rural delivery systems



The Flex Mission

- Helping CAHs operate as the hub of a collaborative delivery system in their communities
- Foster the growth of rural collaborative healthcare systems across the continuum of care at the community level with appropriate external relationships for referral and support



Flex Objectives include

- Facilitate the development of all types of effective formal networks and informal collaborations
- Require performance improvement programs (including clinical quality and patient safety) at the hospital and community levels as a State grantee function



The approach to use

- “in the dirt” – same soil
- What are the actions?
- How do we perform them?
- How do we sustain them?

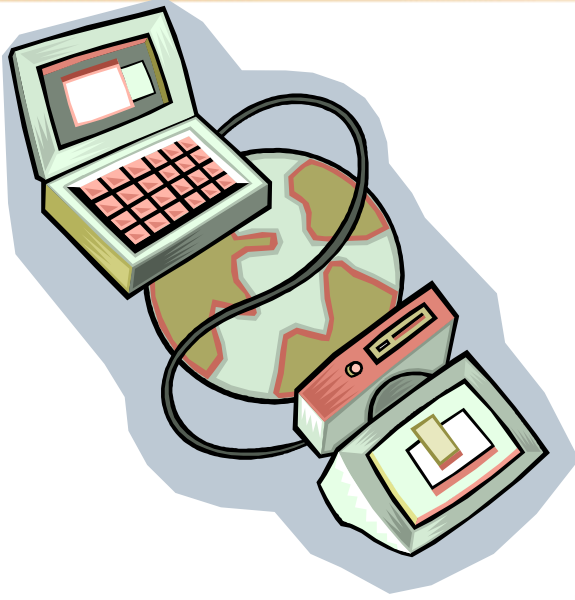


Same soil – the networks

- Beyond the statute
- Serving the patient-centered functional needs of member CAHs
- With leadership from a hub



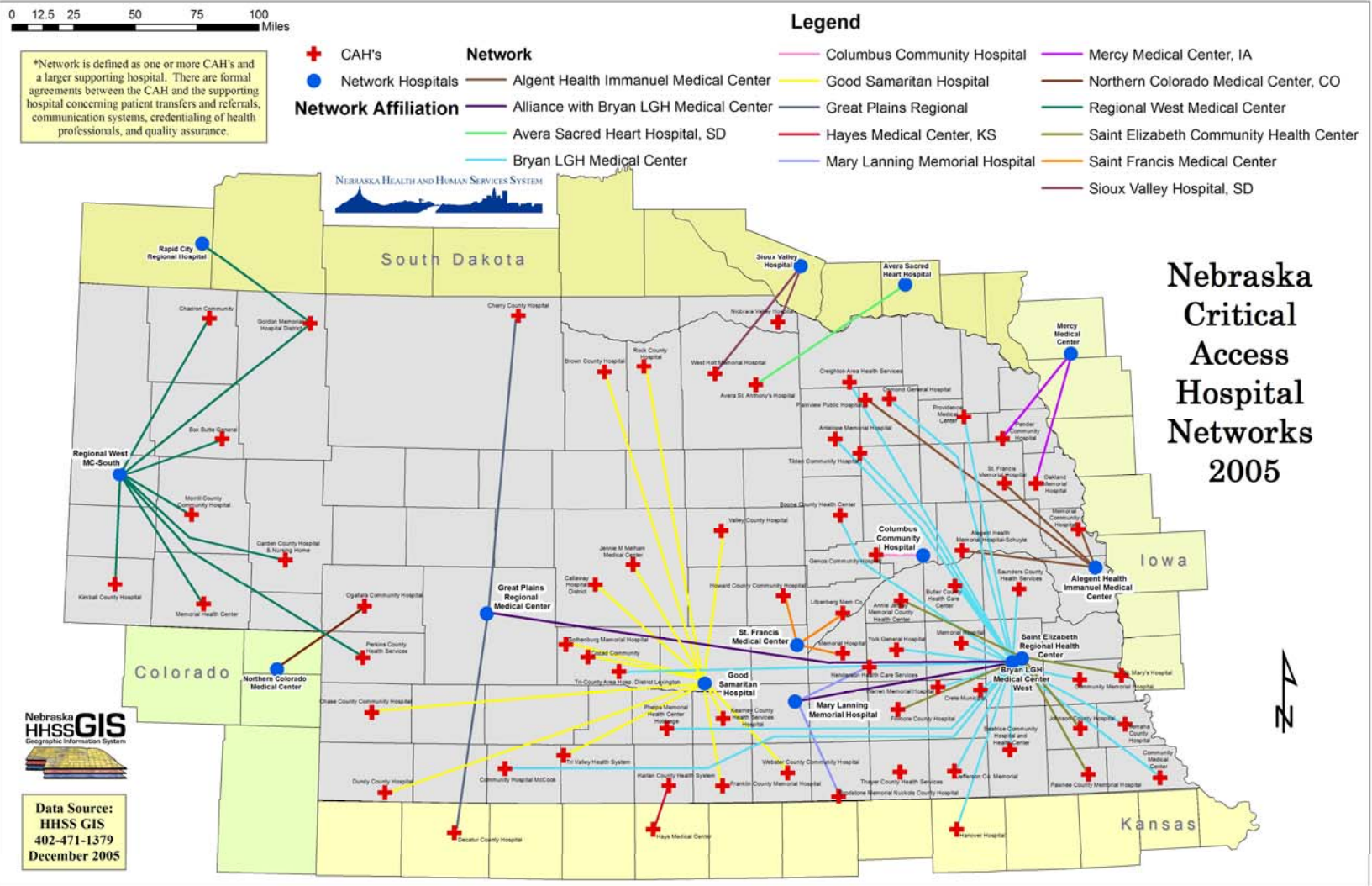
Network linkages



- Could be integrated systems
- But could also be networks of affinity
- Not networks of convenience



Nebraska's networks of affinity



A supportive decision-making structure

- Supported by a “hub” hospital
- In a supportive role
- To facilitate exchange
- To develop programs



Nebraska's Flex environment

- The commitment
- A state program that allows networks to determine their own agendas
- Grants to the networks from the state program
- State facilitation through pursuit of a quality agenda determined based on input from CAHs and networks



Nebraska's flex networks

- Created based on choices of CAHs after discussions with regional hospitals
- Decisions to use network resources based on consensus of CAHs and support from the hub hospitals
- Variability in working as network and working as complete autonomous units



Key structural elements

- Affinity networks, allowing CAHs to opt in and out, consistent with culture of the state's delivery system
- Resources provided to networks based on number of CAHs in the network creates expectations of meeting each CAH's needs



Key structural elements, con't

- Network coordinators from hub hospitals develop and staff programming
- CAH staff participating in networking activities



Role of the hub/supporting hospital

- Learning from the CAHs about delivery of services in their environments
- Provide care for the residents of rural communities in the most appropriate setting
- Becoming part of the local system of care
- Facilitating exchange among the CAHs



Challenges to the network hospitals

- Building trust with CAHs
- Staff turnover in any of the hospitals
- Meeting needs of multiple CAHs in large networks



Networks and economies of scale

- Bringing special educational offerings
- Building network system such as electronic medical/health records
- Specific cases aggregated; example of root cause analysis



Action: Network-sponsored Patient safety initiatives

- Patient safety module in a regional electronic health record:
 - Includes network hospital expertise in implementing the HER
 - Collects network-wide information from the EHRs
 - Implementing change in process of care



Action: Network-sponsored Patient safety initiatives

- Participation in a statewide project focused on reporting medication errors for the purpose of identifying and implementing changes in the process
 - Includes collaboration across CAHs
 - Includes direct assistance from AHRQ-funded grant team



Action: Network-sponsored Patient safety initiatives

- Workshops focused on patient safety
- Training in root cause analysis
 - Network hospital assigned experts
 - On-site training
 - Follow up assistance



Action: Network-led efforts in quality improvement

- Training programs tailored to the needs of CAHs
 - Use of telecommunications
 - Use of network staff meetings
 - Workshops
 - EHR as a platform for quality improvement



Action: Network-led efforts in quality improvement

- Assistance with interpreting and applying regulations (e.g., EMTALA)
- Assistance with interpreting and applying new incentive programs (e.g., hospital compare)
- Fostering peer-to-peer interaction



Action: CAH-initiated activity in patient safety

- Promoting culture of patient safety
 - Promote attention to this throughout all departments
 - “anyone walking into a patient room is empowered to notice, report, and act on any observed situation that threatens patient safety”
 - inappropriately placed furniture that blocks line of vision or pathways of movement



Action: CAH-initiated activity in patient safety

- Focus of all personnel: knowing the water temperature in the bath used by patients
- All department heads on patient safety committee
- Use of model safety plans to recognize threats to safety:
yellow shoes to identify patients at risk of falling



Action: CAH-initiated activity in patient safety, Con't.

- Engage board of trustees
- Reports from all departments focused on patient safety
- First item on board agenda after approval of consent agenda, which included the financial reports
- Following and discussing trend data
- Use of patient satisfaction surveys: Doors to ob unit open and closed too often



Focus on quality improvement in CAHs

- Build into reporting and reward structure for department heads
 - 20% of annual evaluation
 - Require a monthly quality study
 - Protected time for QI officer



Action: specific improvements in CAHs

- Use of interchangeable crash carts
- Full risk assessment of every patient which includes medications, age, diagnosis
- Use of a controlled lift program
- Programs to improve infection control
- Use of chart audits and 25 indicators for events in obstetrics, emergency care, other
- Use of NQF and JCAHO standards for patient safety



Summary: Data collection and use reported nationally

- More than 4/5 use standardized protocols or clinical guidelines for a number of conditions
- More than 4/5 collect data on quality measures for patients with pneumonia, acute myocardial infarction, and congestive heart failure
- Majority collect data of use in protocols, risk management, peer review
- Source: Flex Monitoring Team. "Quality improvement activities in critical access hospitals: results of the 2004 national CAH survey."
Briefing Paper No. 2 September, 2004.



Summary: Moving to action

- Cannot be done effectively with national programs
- Difficult to do independently among the CAHs
- Network affiliations a natural source of collective action



Summary: taking action

- Use of grant resources to initiative efforts: Flex and SHIP
- Making this a priority of the state Flex program
- Following the rhetoric of priority with the funds
- Allowing for regional and local variation in programming and spending



Summary: getting results

- Support for specific changes in operating procedures
- Support for adopting changes in process of care
- Supporting the staff engaged in change



Making a difference

- Keeping the eye on the prize: PATIENT CARE
- At the point of care
- Through the persons providing the care



Thank you

For more information, please visit:
<http://www.rupri.org/healthpolicy/>

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