



Center for Rural Health
University of North Dakota
School of Medicine & Health Sciences

<http://medicine.nodak.edu/crh>

CAH Quality: Right Place, Right Skills, Right Now!

January 9 & 16, 2007

10-11:30am (same agenda for both meetings)

Bt-wan arranged for registered participants

If you experience technical difficulties call

1.866.809.4014 (toll free) – Passcode: 7776782

ND Medicare Rural Hospital Flexibility Program (Flex)

Partners: Center for Rural Health, ND Department of Health, ND
Healthcare Association, ND Healthcare Review, Inc.

*Connecting resources and knowledge to strengthen
the health of people in rural communities.*



CAH Quality: Right Place, Right Skills, Right Now!

AGENDA

- | | |
|---|--------------------------------|
| I. Welcome – Overview of Meeting's Purpose | Marlene Miller |
| II. Quality, Cost and Access | Mary Wakefield |
| III. CAH Quality Data Update | Barb Groutt |
| IV. CAH Quality Needs Assessment | Marlene Miller
Suzy Beattie |
| V. Creating a Culture of Cooperation & Learning | All participants |
| Current ND Activities | |
| Options to consider | |
| Considerations for creating a supportive infrastructure | |
| IV. Wrap Up/Next Steps | |



CAH Quality: Right Place, Right Skills, Right Now!

CAH Quality: Right Place, Right Skills, Right Now! will be rolled out over the course of the next year, with varying meetings, workshops and opportunities offered to small rural hospitals.

The intent is to foster opportunities for Critical Access Hospitals to come together and share best practices, to learn from one another and others, and to create a supportive network for the purposes of improving quality of care for rural residents.



Interplay of Quality, Access, and Cost





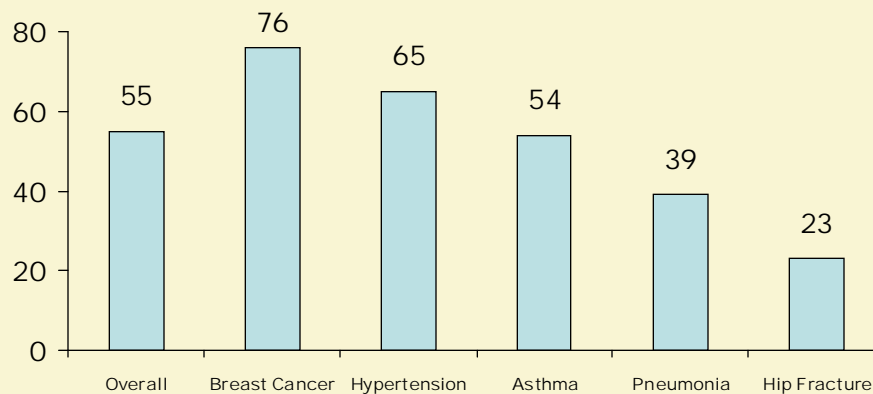
Quality Deficiencies

- ✓ Overuse
- ✓ Under use
- ✓ Errors



Half of U.S. Adults Receive Recommended Care and Quality Varies Significantly By Medical Condition

Percent Receiving Recommended Care



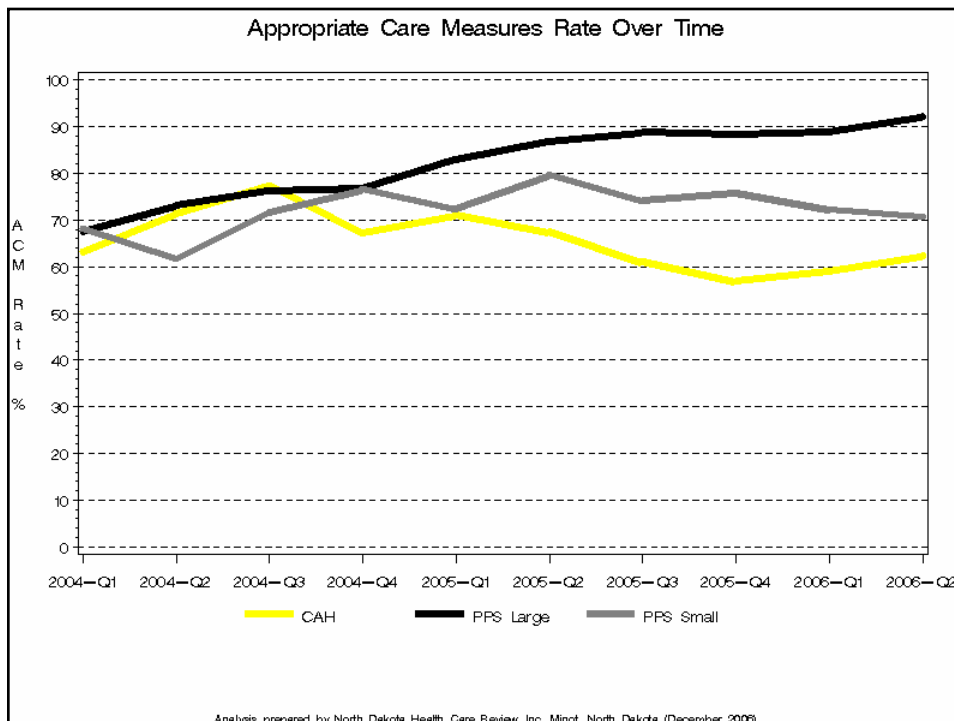
(Source: McGlynn et al., "The Quality of Health Care Delivered to Adults in the United States," The New England Journal of Medicine (June 26, 2003): 2635–2645.)



Future Payment Approach

“The current no margin-no mission era in health care is ... giving way to a new no outcome-no income era. Revenue will no longer be automatic, it will increasingly be linked to verifiable performance.”

(Denham, NPSF, 2004)

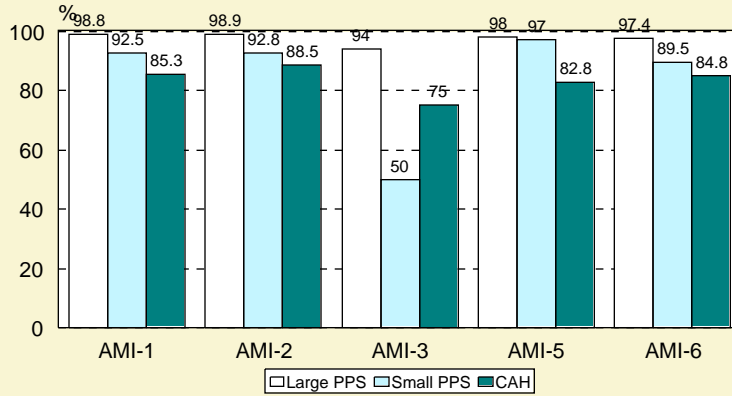




Large PPS, Small PPS, and CAH

AMI Measures

All Payer Data: 01/01/06 - 06/30/06



AMI-1: Aspirin at arrival
AMI-2: Aspirin prescribed at discharge
AMI-3: ACEI or ARB for LVSD
AMI-5: Beta blocker prescribed at discharge
AMI-6: Beta blocker at arrival

Analysis provided by North Dakota Health Care Review, Inc., Minot, North Dakota

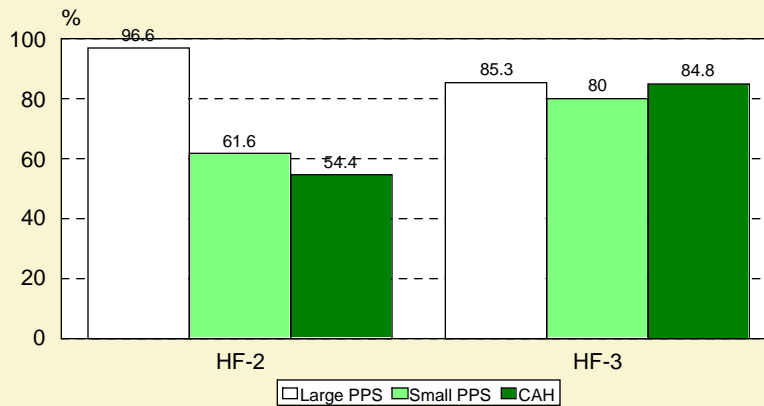
January 2007



Large PPS, Small PPS, and CAH

Heart Failure Measures

All Payer Data: 01/01/06 - 06/30/06



HF-2: Evaluation of LVS function
HF-3: ACEI or ARB for LVSD

Analysis provided by North Dakota Health Care Review, Inc., Minot, North Dakota

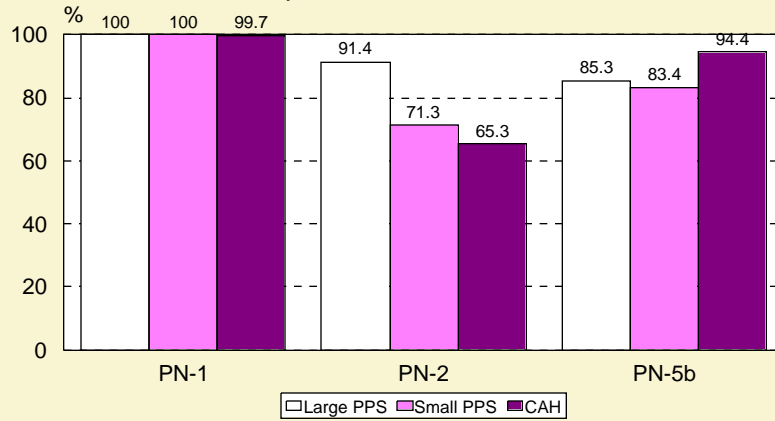
January 2007



Large PPS, Small PPS, and CAH

Pneumonia Measures

All Payer Data: 01/01/06 - 06/30/06



PN-1: Oxygenation assessment
PN-2: Pneumococcal vaccination
PN-5b: Antibiotic timing

Analysis provided by North Dakota Health Care Review, Inc., Minot, North Dakota

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CAH Quality Needs Assessment

ND Rural Hospitals interested in:

- Patient safety (100%)
- Creating an organizational culture of quality (100%)
- Guidelines for rural hospitals (100%)
- Meeting state survey requirements (96%)
- Using data to improve quality (96%)
- Medication reconciliation (96%)
- Methods and models (92%)
- Medication error reporting (92%)
- Falls (92%)

<http://www.med.und.nodak.edu/depts/rural/pdf/QISurveyHospitalReport6-06.pdf>



CAH Quality Needs Assessment

Wide variation in delivery of medications in rural hospitals in ND

- *pharmacy
- *mediation administration, documentation storage
- *variance reporting
- *unit dose only 20% of the time
- *Best Practice Acts

Who sets the benchmark or bar for patient safety in CAH's?

- *JCAHO
- *CMS-Medicare and Medicaid Conditions of Participation

Best Practice Acts come from a variety of areas

- *Hospital Quality Initiatives (2001)
- *IOM Report
- *AHRQ (Agency for Healthcare Research and Quality)
- *ISMP (Institute for Safe Medication Practices)
- *IHI-100,000 Lives Campaign-5 Million Lives Campaign Biggest

Barrier - lack of conduit for this information



CAH Quality Needs Assessment

BARRIERS to implementing quality initiatives

- Finances (75%)
- Staff time (92%)
- Technology (80%)
- Physician participation (70%)
- (Note: 65% of CAHs report that they are not preparing for 3rd party reimbursement)

STRENGTHS for implementing quality initiatives

- Statewide organizations willing to provide assistance
- Leadership buy-in including board participation

▪**88% of CAHs would be willing to participate in statewide rural quality committee** (86% PPS would also).



Creating a Culture of Cooperation & Learning

Current ND Activities:

- ND Rural Peer Review
- QI Networks
- Clinical Standard Compliance Project (NDHA)
- Medication Safety Project (CRH)
- Creating a Culture of Safety (QIO and CRH)
- IHI's Saving 100,000 Lives Campaign & latest 5 Million Lives Campaign
- 32% of CAHs reporting to Hospital Compare
- 24 of 31 CAHs collecting & reporting data on at least one quality measure
- ND QIO Quality Improvement Projects



Creating a Culture of Cooperation & Learning

Options to Consider:

- CAH Quality Network --- Montana (www.mtpin.org)
 - Montana: Started in 2001 with 14 CAHs (now have statewide - 45 hospitals) working together on quality. Funding: Hospital Association, Flex, QIO, ORHP Network Grant, AHRQ Grant
 - Focus on:
 - 1st focused on quality assurance needs, then other initiatives:
 - Peer Review
 - Data collection, analysis, benchmarking (CAH Peer Groups)
 - Technical Assistance (onsite with all CAHs)
 - Education (physicians, quality coordinators, etc.)
 - Help each other --- share information and tools



Creating a Culture of Cooperation & Learning

Options to Consider:

- Tertiary connections – Mayville/Meritcare Network
 - Meritcare and 11 CAHs (ND and MN) have worked to develop a QI network over the past 4 years.

Recent Activities:

- Strategic planning with the network
- QI coordinator works with all sites
- Information and policy exchanges
- Implementation of SBAR communication, rapid response, medication reconciliation (participation varies within network)
- Transfer protocol evaluation and follow up
- Coordinated educational sessions



Creating a Culture of Cooperation & Learning

Multitude of Other Options to Consider:

- Many states have benchmarking programs for the purposes of clinical, operational and financial improvement
- Data collection programs
- Management of chronic conditions
- Transfer protocols, Balanced Scorecard, Technical assistance programs
- Educational programming

Source:

http://www.flexmonitoring.org/documents/BriefingPaper12_QIactivities.pdf



Creating a Culture of Cooperation & Learning

Considerations for creating a supportive infrastructure:

- Commitment ...
 - to participate
 - to allocating resources
 - to sharing information
- Creating a structure (statewide, regional, topic specific, information sharing)
- Statewide meeting: February 27, 2007 – Bismarck (Tentative)
- Identifying priorities/goals/next steps
- Lessons learned from other rural hospital administrators ... page 25 of http://www.uppermidwestrhrc.org/pdf/pay_for_performance.pdf
- Resources: Flex, SHIP, NDHA, other



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Next Steps?

How can Critical Access Hospitals come together to share best practices, learn from one another, and create a supportive network to improve quality of care for rural residents?

Roundrobin of participants

Questions:

1. Are your needs adequately reflected? If not, please add.
2. Do you currently receive adequate information related to quality?
3. Please share any ideas not already mentioned that would be helpful to ND's CAHs.
4. Please comment on your facility's interest in next steps – Feb meeting? Regional calls? Other ideas mentioned?



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