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## **The Role of State Flex Programs in Supporting Quality Improvement in CAHs (Policy Brief #16)**

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# The Role of State Flex Programs in Supporting Quality Improvement in Critical Access Hospitals

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## Introduction

A central goal of the Medicare Rural Hospital Flexibility (Flex) Program, as defined in the original and reauthorizing legislation, is to help Critical Access Hospitals (CAHs) develop and sustain effective quality improvement (QI) programs. In support of this goal, the Flex Grant Guidance prioritizes the development of QI and multi-CAH QI programs. Consistent with these priorities, State Flex Programs have supported a wide range of QI and patient safety initiatives including the development of statewide or regional multi-CAH QI collaboratives to promote sharing of knowledge, expertise, resources, and benchmarking data. This study examined QI activities supported by the Flex Program in nine states, assessed the role of the State Flex Programs in developing and supporting QI activities, and explored the effect of these initiatives on CAH QI efforts.

## Methods

Nine states—Alaska, Arizona, Georgia, Idaho, Kansas, Montana, Nebraska, Nevada, and Washington—participated in this study based on a selection process designed to ensure a diversity of State Flex Programs defined in terms of program size, the stage of QI program development (i.e., developing/emerging or mature), and participation in a multi-CAH QI initiative. Information on the states' QI programs and activities was obtained from the 2008 Flex Grant applications and 34 semi-structured interviews with Flex Program Coordinators, hospital QI staff, and other stakeholders.

## Key Findings

There is considerable consistency in state strategies for supporting hospital quality improvement. Table 1 shows the distribution of states' QI programs and activities in two main categories: (1) *Support for CAH participation in quality measurement, reporting and benchmarking* and (2) *Building quality and patient safety improvement systems and capacity*. The first category includes support and programs to encourage hospital participation in *Hospital Compare* and/or other state-level or multi-state reporting and benchmarking initiatives. The second category includes support and programs to help CAHs build QI systems and capacity including, for example, patient safety team training, QI education and training programs, and physician peer review programs.

## Key Lessons from the Field

- The Flex Program has been instrumental in funding and providing leadership for the development of CAH quality improvement initiatives.
- Collaborative shared learning strategies have been central to the success of Flex Program QI programs.
- Scaling QI program activities to the capacity and resources of CAHs is critical to success.
- Administrative, clinical, and board leadership and buy-in are also critical to the success of CAH QI initiatives.
- Despite widespread support for these QI initiatives, there is limited hard evidence on their impact.
- Overlap between the quality measures in *Hospital Compare* and those used by state and multi-state QI reporting and benchmarking programs offers the opportunity for developing a common set of “rural relevant” hospital quality measures.

**Table 1. Summary of the State Flex Program QI Initiatives**

Support for CAH participation in Quality Measurement, Reporting, and Benchmarking	Building Quality and Patient Safety Improvement Systems and Capacity
Support for CAH participation in <i>Hospital Compare</i> : <ul style="list-style-type: none"> <li>- Georgia</li> <li>- Washington</li> </ul>	Quality improvement education and training programs: <ul style="list-style-type: none"> <li>- Alaska</li> <li>- Arizona</li> <li>- Montana</li> <li>- Nebraska</li> </ul>
Support for CAH participation in other individual or multi-state performance and quality reporting and benchmarking initiatives: <ul style="list-style-type: none"> <li>- Alaska</li> <li>- Idaho</li> <li>- Kansas</li> <li>- Nebraska</li> <li>- Nevada</li> </ul>	Multi-hospital patient safety and quality improvement programs: <ul style="list-style-type: none"> <li>- Arizona</li> <li>- Georgia</li> <li>- Idaho</li> <li>- Kansas</li> <li>- Montana</li> <li>- Nebraska</li> <li>- Nevada</li> <li>- Washington</li> </ul>

a Level 1 AMI Protocol to ensure the rapid transfer of patients with chest pain (Washington).

- Georgia developed a QI program using inpatient and outpatient CMS-based measures and a statewide QI collaborative.

- Montana funded a statewide performance improvement network to address the QI knowledge and resources needs of its CAHs.

Other QI system and capacity building efforts included the following: the development

Specific *quality measurement, reporting and benchmarking activities* included:

- To encourage participation in *Hospital Compare*, Washington and Georgia funded the development of tools to assist CAHs to improve performance on relevant *Hospital Compare* measures (Washington) and to support data entry and export to minimize the reporting burden for CAHs (Georgia).
- Alaska and Kansas supported CAH participation in the multi-state *Healthcare Quality for Rural America* (HQRA) benchmarking initiative. Kansas supported the development of QHi, the web-based quality reporting tool, used by HQRA. Alaska provided technical assistance to CAHs participating in HQRA and works with its QIO to identify opportunities for improvement.
- Idaho and Nevada developed their own state-specific QI reporting initiatives using web-based data entry and reporting systems. Nevada’s Rural Hospital Benchmarking Initiative included financial and operational performance measures.

The states engaged in a variety of *QI systems and capacity building initiatives*, including:

- Idaho and Nebraska supported the implementation of TeamSTEPS, an evidence-based teamwork training system to improve communication and teamwork skills.
- Arizona and Washington concentrated on improving EMS systems of care by helping CAHs achieve Level IV Trauma Center designation (Arizona) and developing

of peer review services in Washington and Georgia; a program to conduct mock facility surveys in Kansas; the development of patient and employee satisfaction survey tools in Nevada; network-based QI education and training programs in Alaska, Arizona, and Montana; and an executive fellowship program in Nebraska.

**Discussion and Conclusions**

The Flex Program has been an important source of funding and expertise supporting the QI activities of CAHs. States and their CAH partners have developed an impressive array of sophisticated quality reporting, benchmarking, and QI systems and capacity development programs that provide a solid foundation on which to work toward the Flex Program goal of assuring that all CAH’s are engaged in assuring the quality and safety of the care they provide.

Although many of the states’ QI programs have been in place for many years and could be considered “models” for other states, none have been formally evaluated. As a result, demonstrating what works and best practices among the states’ QI programs and activities remains a challenge. For states that are not as far along in the development of their QI programs and for the Flex Program more generally, more evidence on program efficacy is needed to focus and deploy limited Flex Program resources and to document overall program performance. In addition, recent changes to the Flex Grant Guidance and interest in the development of Flex Program outcome measures suggest the need for more formal evaluation of the states’ QI programs and activities.

To this end, it is appropriate to consider ways in which

State Flex Programs can support the development of performance data and measures that would allow individual states and the Flex Program to monitor and assess the impact of their QI programs and activities. The following are among the key needs identified in this study:

1. The Flex Program needs a system for documenting program impact through the collection of outcome measures for Flex QI initiatives. Outcome data enables State Flex Programs to better target their activities, choose among successful QI strategies and models, and/or refine existing initiatives.
2. A core set of CAH quality measures and a system to collect and report data on the core measures are needed. QI reporting and benchmarking systems have their own “rural relevant” quality measures. A preliminary comparison of these measures and those used by *Hospital Compare* shows considerably more overlap than many stakeholders indicated. This suggests that identifying a core set of quality measures reflecting the service mix and common conditions treated by CAHs is an achievable goal. A common set of core measures and a coordinated reporting system would provide important data on the quality of care provided by CAHs, allow for comparison across benchmarking systems, and provide evidence of Flex Program impact.
3. The 30% of CAHs that do not publicly report quality data need explicit incentives to encourage them to do so.<sup>1</sup> Although some CAH stakeholders we interviewed do not support public reporting due to concerns with the relevance of the *Hospital Compare* measures and problems with the reporting of data based on small patient volumes, interest in publicly reporting of hospital quality data remains high. Furthermore, many believe that public reporting of quality data will benefit CAHs, especially on certain measures (e.g. patient satisfaction).

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## Endnotes

1. Casey, M, Burlew, M, & Moscovice, I. Critical Access Hospital Year 5 Hospital Compare Participation and Quality Measure Results (Briefing Paper No. 26). University of Minnesota: Flex Monitoring Team; March 2010.

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