Building Sustainable Capacity for Quality and Organizational Excellence

Critical Access Hospital Quality Infrastructure Summit

March 2023

Flex Monitoring Team
University of Minnesota
University of North Carolina at Chapel Hill
University of Southern Maine

National Rural Health Resource Center

StratisHealth

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Introduction

Nearly 20 percent of Americans live in rural areas, with local hospitals providing an anchor to community well-being. Rural hospitals face unique challenges in a health care landscape that is dramatically different than that of their urban counterparts. Barriers to provide care in rural America are many, including geographic isolation, limited resources, low patient volume, increased regulatory burdens, and financial vulnerability.[1] Specially designated health care facilities serving rural communities – such as critical access hospitals (CAHs) – are generally not included in federal programs focusing on publicly reported quality measures to the same degree as urban and suburban health care organizations. This variance results from a combination of factors. Incentives and policy mandates are often not applicable to rural providers as those program structures are typically based on traditional fee-for-service reimbursement systems, which do not apply to CAHs. Available measures are often not as relevant to a rural scope of services and small patient volumes prevent reliable calculation of measures.

The federal Health Resources and Services Administration (HRSA) Federal Office of Rural health Policy (FORHP) created the Medicare Beneficiary Quality Improvement Project (MBQIP) to improve the quality of care patients receive in CAHs. These efforts focus on the 45 states that participate in the Medicare Rural Hospital Flexibility (Flex) Program, funded by the FORHP. To date, much of the federal and state Flex Program support in MBQIP has been focused on developing CAH capacity to report quality performance data. These data are used to identify opportunities for improvement on specific measures, leveraging quality improvement (QI) strategies with the goal of building CAH capacity for QI. However, there is currently no means for assessing a CAH's capacity for QI and state Flex Programs have largely focused on individual quality measures rather than QI capacity as a whole.

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[1] American Hospital Association. (2019). *Rural report: Challenges facing rural communities and the roadmap to ensure local access to high-quality, affordable care.* rural-report-2019.pdf (aha.org)

The education, technical assistance, and data reporting on the performance of CAHs participating in MBQIP to the state Flex Programs is completed by three national Flex partners:

- The Rural Quality Improvement Technical Assistance (RQITA) team, a program of Stratis Health;
- The Technical Assistance and Services Center (TASC), a program of the National Rural Health Resource Center (The Center);
- The Flex Monitoring Team (FMT), a consortium of researchers from the University of Minnesota, the University of North Carolina at Chapel Hill, and the University of Southern Maine;

In March 2023, the national Flex partners convened a summit of national subject matter experts to identify the core elements of CAH quality infrastructure and criteria necessary for successful quality efforts in CAHs. The summit's outcomes detailed in this report serve as a framework to inform quality in CAHs. This report has been developed to assist rural hospital leaders in creating sustainable quality infrastructure, moving beyond mere measures and toward organizational excellence. The report defines the elements of sustainable quality infrastructure. For each element, it provides key criteria for evaluating and measuring success in that area. These findings provide practical insight into rural-relevant strategies for elevating quality improvement to organization-wide culture and responsibility. The report findings can serve as a framework for all levels of leadership to implement a culture and practice of quality patient care.

The information presented in this paper is intended to provide general guidance. The materials do not constitute, and should not be treated as, professional advice regarding the use of any technique or the consequences associated with any technique. Every effort has been made to ensure the accuracy of these materials. The National Rural Health Resource Center (The Center) and the authors do not assume responsibility for any individual's reliance upon the information provided in this guide. Readers and users should independently verify all statements made before applying them to a particular fact situation and should independently determine the correctness of any planning technique before recommending the technique to a client or implementing it on a client's behalf.

Purpose and Process

The national Flex partners (RQITA, TASC, and the FMT) convened a summit of national subject matter experts to identify the core elements of infrastructure necessary for successful quality efforts in CAHs. The two-day, in-person summit was held in Bloomington, Minnesota on March 7–8, 2023.

The summit convenors organized the process using the Baldrige Excellence Framework, a systems improvement approach endorsed by the National Institute of Standards and Technology to assist business entities in growth, problem-solving, and innovation. Essentially, the framework provides a core set of seven categories to help leaders assess needs and growth and to consider approaches in a holistic manner based on systems thinking. The summit facilitators based the experts' pre-work on these categories, asking each individual their top two responses to these questions:

1. **Leadership** —What are key elements of leadership that are important to building sustainable capacity for quality?
2. **Workforce and Culture** —What are key elements of workforce and culture that are important to building sustainable capacity for quality?
3. **Operations and Processes** —What are key elements of operations and processes that are important to building sustainable capacity for quality?
4. **Measurement, Feedback, and Knowledge Management** —What are key elements of measurement, feedback, and knowledge management that are important to building sustainable capacity for quality?
5. **Strategic Planning** —What are key elements of strategic planning that are important to building sustainable capacity for quality?
6. **Impact and Outcomes (Results)** —What are key elements of impact and outcomes (results) that are important to building sustainable capacity for quality?
7. **Patients, Partners, and Communities** —What are key elements of patients, partners, and communities that are important to building sustainable capacity for quality?

Participant responses to the pre-work resulted in more than 200 suggested elements for building sustainable quality infrastructure in CAHs. Pre-work data were used to frame the consensus-based facilitation process at the summit. Discussion focused on two lines of inquiry aimed at identifying the most important rural-specific factors for creating QI culture, processes, and systems:

1. What are the **CORE ELEMENTS** of CAH quality infrastructure?
2. What are the **CRITERIA** for each element?

These pivotal terms are defined as follows:

Core Elements

Those aspects of infrastructure that are necessary to have a successful and robust quality program.

Criteria

The ways in which core elements can be achieved or demonstrated.

Summit Findings and Recommendations

Participants and facilitators worked to provide information that was practical, easily understood, and accessible, with accompanying action steps. Certain themes emerged about what works and what hinders progress when it comes to quality improvement in a CAH:

- ✓ **Quality is not just measures**, but infrastructure. A focus on quality is key to excellence in patient care. If leaders focus only on individual measures, they are bound to miss the mark.

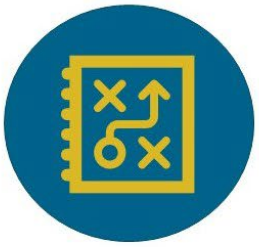
> *"Larger hospitals have a whole quality team. In a rural setting, it's usually one self-taught person. Give them a manual and 'good luck'."* —Summit participant

- ✓ **In CAHs, quality can often be in a silo.** In these instances, quality program responsibility may lie with one individual, who has multiple other roles and potentially little QI training.
- ✓ **To be effective, quality needs to be part of everyone's role.** Quality must include everyone in the hospital, from the ground up. Ideally CAHs can align quality across regulatory and reporting programs while targeting local needs and incorporating a focus on staff development and succession planning. In addition, quality must be deeply embedded in the organizational culture, with clearly defined reporting and coverage processes.
- ✓ Although reporting requirements can be complex, **the quality process itself must be streamlined and simplified,** to the extent possible, and all staff must be aware and well trained.

Summit participants kept these concepts—infrastructure, simplicity, and quality from the ground up—top of mind in discerning the most important **core elements** of quality infrastructure along with clearly defined **criteria** for determining success. Each of the following nine core elements with concurrent criteria can be used as a framework for embedding quality into CAHs.

Nine Core Elements for CAH Quality Infrastructure

Leadership Responsibility and Accountability



Quality Embedded Within the Organization's Strategic Plan

Workforce Engagement and Ownership

Culture of Continuous Improvement Through Behavior

Culture of Continuous Improvement Through Systems

Integrating Equity into Quality Practices

Engagement of Patients, Partners, and Community

Collecting Meaningful and Accurate Data

Using Data to Improve Quality

Leadership Responsibility and Accountability

Leadership ranked high on the priority list for activating hospital-wide engagement in quality improvement and assurance. A robust discussion ensued about the definition of the word "leadership," with the consensus that "leadership at all levels" must drive quality in CAHs. This means everyone from nurse managers, department heads, and the informal leaders on the floor up to the highest level of the C-suite and, importantly, the board itself. Consensus was that the executive team must ignite the movement, reaching every employee, from clinicians to support staff.

"Leadership is so important," one participant noted. "They have a broad view of what's happening in and outside the hospital when thinking about upstream drivers." Since quality ultimately impacts the whole community, upstream drivers, downstream outcomes, and that "broad view" are essential for driving success.

Summit participants described the **core element** and **criteria** relating leadership to creating sustainable and effective quality infrastructure this way:

Core Element: Leadership Responsibility and Accountability

Actively demonstrate governance and administrative leadership support for improving quality.

Criteria:

- The organization's board engages in and supports quality improvement.
- Organizational resources are adequately allocated to support quality improvement.
- Executive leadership oversees design and functionality of the quality improvement program.

Quality leadership and department managers demonstrate support for quality initiatives and improvement at the highest levels when they provide targeted functional management for quality improvement. Leadership must also demonstrate the relevance of quality by continuing support for quality education; for instance, a leader's presence in trainings speaks volumes to staff about its importance. Regarding demonstrated board support, quality issues should routinely be on the board's agenda and a board member can serve on the hospital quality committee. Additionally, quality metrics can be included on the board dashboard, putting information front and center for decision-makers. Ideally, the board should come to see quality as a foremost element of its responsibility, ranking equally with financial stability and improvement.

"Resources" refers to both time and money; committing to hospital-wide quality initiatives and understanding requires training and whatever else the staff needs to effectively implement quality improvement and measure reporting. This may include information technology upgrades, investment in clinical supplies, and other supports to grow the quality program. Several staff members should be trained in quality systems and processes, promoting shared knowledge and responsibility.

As with any health care initiative, all levels of leadership must communicate a clear vision and message regarding quality and be consistent and transparent with staff in those communications, always embracing a facility-wide expectation of quality participation. Executive leaders can build strong relationships with nursing leadership and hold managers accountable for quality. Quality should become a part of all staff and leadership performance evaluations, and effective leaders will integrate quality, finance, and performance improvement.

Experts attending the summit organically wove the concept of informed and active leadership in quality into every other core element of sustainable quality infrastructure. First and foremost, quality is tied to excellence in patient care, but more frequently it can also be tied to reimbursement. Integral to a hospital's success, CAH executives should understand quality at every level.

Quality Embedded Within the Organization's Strategic Plan

As the bedrock of an organization's values and its road map to the future, leadership should infuse a CAH's strategic plan with quality considerations, reflecting both the systems and strategies previously noted. A strategic plan reflects a hospital's intentions to provide high-quality, accessible patient care, holding the organization, its leadership, and its workforce accountable for all outcomes. Some CAHs still see quality as "checking the boxes" on metrics and measures developed by external requirements; there is not always an investment in QI across the board. Critical access hospitals should always have a strategic plan that embeds quality to point the way and support them in spreading ownership of quality outcomes to the entire workforce.

Summit participants described this **core element** and **criteria** for creating sustainable and effective quality infrastructure this way:

Core Element: Quality Embedded Within the Organization's Strategic Plan

Ensure quality is an intentional component of the strategic plan process and strategic plan.

Criteria:

- Quality leaders participate in organizational strategic planning.
- Quality is a core component of the organization's strategic plan.
- Quality is reflected in all core components of the organization's strategic plan.

Embedding quality into the strategic plan assumes that QI is not the sole responsibility of one individual, but a core building block of all staff throughout the facility. There should be a direct connection between quality and each area of the CAH's strategy. Quality-related strategic goals should align with organizational measures. When a CAH is in the process of reviewing the organizational mission, vision, and values, this is a prime opportunity to embed quality into the

words that drive the work, creating an aligned focus on quality from the very top. Finally, the nature of this process—integrating quality into every area of a strategic plan —will help break down the silos within organizations that can undermine consistent high-quality patient care. Quality is integral in finance, operations, culture, partnerships, and many other potential components of a CAH's strategic plan, and therefore should be reflected in those other strategic goals as well.

Workforce Engagement and Ownership

One of the notable characteristics of rural CAHs, reflecting the communities they serve, is the resourcefulness of their staff. With increasing regulatory burdens and limited resources, rural hospitals may designate just one employee (or a portion of one FTE) to manage something as crucial as quality, and if that person leaves, another individual is expected to fill that vacuum, often with little guidance or previous training. This is why workforce engagement and across-the-board ownership of quality initiatives is so crucial to building quality infrastructure.

From teaching quality at new hire orientation to building strong mentoring programs, summit participants made it clear that, in a CAH, quality should be everyone's business.

Summit participants described the **core element** and **criteria** related to workforce in creating sustainable and effective quality infrastructure this way:

Core Element: Workforce Engagement and Ownership

Develop and support a workforce that embeds quality in everyday work.

Criteria:

- The organization has formal onboarding and orientation that embed quality as a priority.
- The organization has regular and ongoing professional development opportunities for staff related to quality.
- Quality improvement is incorporated into standard work.
- The organization embeds diversity, equity, and inclusion in workforce development.

These actionable steps to engaging a CAH workforce start with the new hire (and ideally even before that, in the job description and posting) and continue during the employee's tenure

through regular communication and discussion about quality. Essential means of supporting workforce engagement and ownership include recruitment and retention, training and development, and consistent messaging and communication around quality. At meetings, huddles, and in the normal course of everyday work in all departments, management teams must get staff involved in quality.

> *"Do you rent your job, or do you OWN it?"*
> *—Summit participant*

No one individual can or should be required to bear the burden of quality for a CAH. Distributed ownership with strong mentoring can build a quality team that is supported by leadership at all levels, continuing all-staff education, and integration of quality discussions into daily clinical practice. Critical access hospitals should focus on cross-training and redundancies in creating quality infrastructure. Redundancies will ensure that the organization has systems in place to ensure continuity in the instances of staff absences or changes, whether abrupt or planned.

QI initiatives positively impact patient safety and care. This should not be a one-person job but an entity-wide, shared responsibility. With a well-trained quality team, and sound systems in place, every CAH can proceed with confidence knowing that quality measures, initiatives, data, and improvements will not abruptly stop if one person is absent.

Culture of Continuous Improvement Through Systems

A clear intent of summit experts was to articulate the building blocks of a "culture of continuous improvement," a phrase used often in health care and other enterprises. Participants deconstructed this concept into several subcategories. For example, a culture of continuous QI would include things like overall organizational culture, transparency within the organization, embedded just culture, and employee well-being and safety. These and other concepts fell into two broader categories: 1) systems and processes, and 2) behavior. This element related to continuous improvement addresses systems and processes, while the following addresses behavior.

Summit participants described the **core element** and **criteria** relating to systemic continuous improvement in creating sustainable and effective quality infrastructure in this way:

Core Element: Culture of Continuous Improvement Through Systems

Design and manage systems and processes in a manner that supports continuous quality improvement.

Criteria:

- The organization uses standardized methods for improving processes.
- Leadership incorporates expectations for quality improvement into job descriptions and department and committee charters.
- The organization has processes in place for continuous reporting and monitoring of quality improvement data.

Summit participants provided a variety of practical examples to illustrate the criteria above such as:

- "Standardized methods" that include closed-loop processes where staff see the results of their reporting and suggestions.
- Critical access hospitals can implement the Plan-Do-Study-Act (PDSA) method to implement changes in quality processes and evaluate the effectiveness of proposed initiatives supporting these changes.
- Use of standardized forms for documenting and reporting QI projects was also encouraged.
- Each unit or department can have a representative on the hospital Quality Committee so that information is shared across work groups and problem-solving quality issues becomes a collaborative effort.
- Leadership should embed quality in all communication processes as well as job descriptions and evaluations.
- Organizations need to embrace a just culture that recognizes the majority of mistakes and near misses in health care are a result of faulty systems rather than the fault of individuals. A just culture employs a non-punitive reporting process and allows the organization to learn from mistakes.

Culture of Continuous Improvement Through Behavior

The qualities of human behavior necessary to sustain processes are more nuanced but just as important as standardized systems. In this, as in every core element, leadership at all levels is key. If, for example, there is an overall lack of trust in the organization, standardized systems can become meaningless. A flexible, innovative workforce is required to meet the substantial challenges of delivering high quality care in rural communities. Leaders must ignite an energy and mindset shift that guides employee behavior, from the lab to the bedside and from radiology to environmental services.

Summit participants described the **core element** and **criteria** for creating sustainable and effective quality infrastructure through continuous improvement in workplace behavior in this way:

Core Element: Culture of Continuous Improvement Through Behavior

Support quality improvement behaviors in an adaptable organization that embraces innovation, motivation, and accountability.

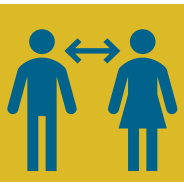
Criteria:

- The organization monitors adherence to best practices such as evidence-based protocols/order sets in all areas.
- The organization intentionally develops strong peer relationships with internal and external partners including those at the local, state, and federal levels.
- Employees demonstrate initiative to achieve goals and strive for excellence.
- Managers and leaders regularly evaluate behaviors to ensure they align with organizational values.

The summit participants emphasized creating an organizational culture of safety and well-being, coupled with a commitment to just culture as described above. For the systems to work, there must be strong follow-through and hospital-wide accountability for policies, procedures, and measures. Quality champions who are self-motivated leaders can collaborate to create this supportive culture. As a team, leaders can create strategies to motivate the workforce to implement and meet goals and continue striving even when goals are met. Overall, a motivated and nimble staff can embrace innovation, adapt to change, and embody strong follow through and accountability.

These behaviors and mindsets (adaptability, follow through, willingness to pivot and adapt) can become the fertile ground of a culture where quality is a top-of-mind priority for everyone, including clinicians, leadership, and staff. Leaders again lay the groundwork for behavior change through thoughtful initiatives, engaging strategies and trainings, and evidence of personal commitment.

Managers can identify and develop self-motivated individuals to assist with necessary changes and innovations that build sustainable quality infrastructure. While each CAH has a unique community and culture, leaders need to model and reward a hospital-wide commitment to constant striving for improvement. This can help build a culture where employees organically act in ways that support a focus on the highest quality care.



Integrating Equity into Quality Practices

The Health Resources and Services Administration (HRSA) defines health equity as "the absence of disparities or avoidable differences among socioeconomic and demographic groups or geographic areas in health status and health outcomes such as disease, disability, or mortality."[2]

Many health outcomes for rural residents are markedly worse than for those who live in urban areas.[3] In addition to disparate outcomes based on geography, people living in rural areas can also experience health care inequities based on individual characteristics such as age, race, gender, sexual identity, and disability status, as well as social drivers of health (SDOH) such as economic stability, education access, discrimination, access to housing and transportation, and many others.

Furthermore, individuals may face stigma that precludes or discourages access to health care. So, even though an individual is a member of a community and lives in the service area of a health care facility, they may not be a patient. This means that CAHs cannot solely rely on patient-collected data to inform their approach to eliminating disparities and achieving health equity.

Summit participants described the **core element** and **criteria** related to equity in creating sustainable and effective quality infrastructure this way:

[2] HRSA Office of Health Equity
[3] Gavidia, M. (2021, July 1). *underscoring disparities in rural health: challenges, solutions for a long-standing and growing national issue*. AJMC. https://www.ajmc.com/view/underscoring-disparities-in-rural-health-challenges-solutions-for-a-long-standing-and-growing-national-issue

Core Element: Integrating Equity into Quality Practices

Undertake intentional improvement activities to ensure a fair and just opportunity to be as healthy as possible for all community members.

Criteria:

- Managers use collected data and other available resources to identify inequities.
- Leaders routinely assess quality interventions and processes to address identified inequities.
- Units and departments implement specific health equity projects to improve care and lessen inequities.

In health care, inequities arise on a wide spectrum from access to care to treatment. Consistently collecting data that allow organizations to stratify information by a variety of characteristics is a key first step, however it is essential that data collection options and processes are inclusive and patient led. For example, when documenting patient gender, more than two identifiers need to be available in the electronic health record (EHR), and the patient must self-identify their gender rather than any member of the hospital team assuming and documenting on their behalf. Accurate and inclusive data allow for stratified analysis to identify inequities so the team can develop targeted QI projects to close equity gaps along the continuum of care.

"Rural relevant needs to be more than measures; it is also about systems. How do we teach quality from the ground up?" —Summit participant

During informal discussions, some summit participants noted the difficulties in shepherding a rural hospital board or CAH leadership into considering potential inequities in care or in "finding" all members of the community and targeting outreach appropriately. Hospitals and clinics can be centers of the community, creating connection and involvement that supports care coordination and equity. Health care organizations need to know their communities, which means they must do care coordination that is incentivized or reimbursed. This process organically enhances both health equity and positive outcomes for population health. Leadership committed to equity can

use a focus on quality to broaden access and implement processes to reach and help historically marginalized and underserved members of the rural community.

Engagement of Patients, Partners, and Community

Critical access hospitals are often anchors of their communities, providing not just health care but jobs, making them natural conveners of community partners. While patient engagement is a long-standing pillar of quality care, engagement with partners and the wider community also helps to maximize the efficacy of scarce resources, generate broader support for the hospital, and ignite collaboration and innovation. These factors make this kind of engagement particularly valuable when advancing QI and building a long-term infrastructure.

Summit participants described the **core element** and **criteria** related to engagement for creating sustainable and effective quality infrastructure this way:

Core Element: Engagement of Patients, Partners, and Community

The CAH intentionally builds external relationships with patients, partners, and the community to enhance access and improve the care experience.

Criteria:

- The organization collects feedback from patients and families beyond patient experience surveys.
- The organization collaborates with other care providers using closed-loop referral processes to help ensure quality of care.
- The organization uses a variety of mechanisms to share quality data with patients, families, and the community.
- Leaders synthesize and develop action plans in response to patient, family, and community feedback.

Since CAHs cannot flourish in isolation from the community, there are multiple methods for CAHs to successfully engage patients, partners, and its community in pursuit of quality excellence, including:

- An active feedback processes such as a Patient and Family Advisory Council (PFAC), focus groups on discharge instructions, or bedside shift reports.
- Opportunities for collaboration and referrals to community partners such as emergency medical services, mental health providers, specialists, community-based services, and other social supports.
- Sharing data on quality boards throughout the hospital, the hospital website, social media channels, and the local newspaper.

Participants stressed the value of patient and community voices in quality initiatives. Leaders should actively seek, analyze, and share findings collected through patient surveys, focus groups, or a PFAC. They should seek out other intentional methods of involving the whole community and partners in quality improvement. Patients and partners should have a clear understanding of quality and defined lines of communication with the hospital related to quality of care. In rural communities where neighbors look out for each other, community investment in the CAH's quality infrastructure is vital to growing and sustaining high-quality health care.

Collecting Meaningful and Accurate Data

The final two elements for building quality infrastructure involve data collection and use of data to drive improvement. These pillars are paramount to supporting the entire quality effort in a CAH, affecting all other aspects, from workforce engagement to patient care and reimbursement. Summit participants intentionally created two discrete areas of focus:

1. Collecting meaningful and accurate data; and
2. Using these data to inform quality efforts and improve outcomes.

Even if CAH leaders understand the importance of data and quality, they may fail to recognize the ongoing training and resources needed to ensure adequate and accurate data collection. The summit findings urge CAH leadership and engaged team members to widen the net to capture relevant and equitable data while distributing the responsibility for quality to the whole organization.

Summit participants described the **core element** and **criteria** involving data collection and accuracy for creating sustainable and effective quality infrastructure this way:

Core Element: Collecting Meaningful and Accurate Data

Apply a multidisciplinary approach to identify key quality metrics, prioritizing complete and accurate data collection.

Criteria:

- The organization has a multidisciplinary process for identifying key quality metrics.
- Leaders identify risks and opportunities based on analyses of key quality metrics.
- The organization leverages health information technology (HIT) to support complete and accurate data collection.
- The organization collects and documents race, ethnicity, and language (REL), sexual orientation and gender identity (SOGI), and health related social needs (HRSN) data.

In embracing a comprehensive approach to quality infrastructure, all parts of the system are related to each other and, ideally, data collection mirrors this perspective, engaging the entire organization in feedback about meaningful and accurate data. The data strategy can and should reflect rural-relevant measurement and provide an equitable view of the community served, while aligning with relevant national programs and requirements. Data also need to be shared across the organization in meaningful ways. This could include qualitative outcomes (such as patient stories) that help make the data findings accessible and relevant to all staff. Standardized, meaningful metrics shared with clarity and transparency can transform the compliance process from a solitary effort to a hospital-wide touchstone of achievement and identified challenges.

Using Data to Improve Quality

Well-analyzed meaningful and accurate data can drive a CAH's strategy to achieve good health outcomes and advance health equity. Rather than simply a compulsory compliance effort, using high-quality data can create insights, identify populations that could benefit from services, find the root causes of poor outcomes and inequities, and craft interventions to improve patient and community health.

In connecting equity to quality measures and infrastructure, CAHs can leverage available data, such as internal claims, data from state networks, community health needs assessments (CHNA) and county health rankings, for instance, to discern quality needs for the entire community. Additionally, education for all staff and leadership should address the importance of collecting patient-reported demographics and offering regular opportunities for review and updating. Demographic data should include information on race, ethnicity, and primary language (REL) and sexual orientation and gender identity (SOGI) in addition to assessing and identifying health-related social needs (HRSNs).

Summit participants described this data-related **core element** and **criteria** in creating sustainable and effective quality infrastructure this way:

Core Element: Using Data to Improve Quality

Use internal and external data comprehensively, meaningfully, and transparently to inform quality improvement.

Criteria:

- The organization shares data transparently both internally and externally.
- The organization incorporates external data sources to inform quality improvement efforts.
- Leaders act on and clearly communicate the data results from quality initiatives.
- The organization uses benchmarking to identify where quality can be improved.

The recommended use of data fall into two broad subcategories: transparent and widespread communication of results, and timely targeted follow-up. Summit experts emphasized the importance of data transparency throughout the organization, with care partners, and with the community—even on social media and CAH websites. Staff must be completely informed and clear regarding quality goals, which should remain visible on dashboards, scorecards, huddle boards, employee forums and provider meetings, and, of course, in board meetings.

Some examples of external data sources to inform quality include Children's Health Insurance Program (CHIP), CNHAs, and data regarding SDOH. CAHs can incorporate relevant SDOH assessment tools, such as PRAPARE (Protocol for Responding to and Assessing Patient Assets, Risks, and Experience), into their health information systems to ensure that they are gathering relevant information for the entirety of the region they serve.

"We need to use storytelling when connecting the dots from process to outcome (data). 'Left without being seen' always has a relevant backstory."

—Summit participant

Leaders receive data results from various sources, and they can act on and communicate this hospital wide. For example, managers can use results of patient experience surveys such as

Consumer Assessment of Healthcare Providers and Systems (CAHPS) in creating a Performance Improvement (PI) plan.

Concurrent with visibility is the concept of timely and targeted feedback. Quality leaders should develop and establish practices to evaluate poor results, direct follow-up, make action plans, and enact a process to close the loop on input. Follow-up can include specific education on the root cause of poor results and outcomes, which will increase awareness as well as positive results.

Conclusion

Sustainable quality infrastructure for CAHs requires an "all hands-on deck" effort supported by commitment from all levels of leadership—board to C-suite, department heads, unit leaders, and employees. With vision and commitment, a CAH's organizational culture can shift from measures to systems, processes, and behaviors that are rooted in a thorough understanding of the inextricable connection between quality and patient outcomes and satisfaction.

Summit participants—who are all leaders in the field of rural-relevant quality—identified nine core elements essential to building that sustainable quality infrastructure, along with specific criteria to assess movement in the right direction to ensure positive outcomes. Data loom large in this picture, providing both the evidence and the motivation to set goals and improve in a hospital-wide effort to embed quality as a core strategy. Fueled by fidelity to transparency and equity in the creation and use of data, CAHs can use this opportunity to move from "checking boxes" to identifying opportunities to provide better patient care.

FORHP and state Flex Programs aim to support CAHs' efforts in improving quality of care. In addition to this summit, the National CAH Quality Assessment will gather an inventory of service lines and related quality measures that hospitals are tracking to identify trends and help inform Flex initiatives at the state and national levels. The summit and this report hopefully provide a solid starting point for CAHs wanting to move from beyond measure reporting to organizational excellence.

Appendix A: CAH Quality Infrastructure Core Elements and Criteria

Leadership Responsibility and Accountability **Element:** Actively demonstrate governance and administrative leadership support for improving quality. **Criteria:** • The organization's board engages in and supports quality improvement. • Organizational resources are adequately allocated to support quality improvement. • Executive leadership oversees design and functionality of the quality improvement program.
Quality Embedded Within the Organization's Strategic Plan **Element:** Ensure quality is an intentional component of the strategic plan process and strategic plan. **Criteria:** • Quality leaders participate in organizational strategic planning. • Quality is a core component of the organization's strategic plan. • Quality is reflected in all core components of the organization's strategic plan.
Workforce Engagement and Ownership **Element:** Develop and support a workforce that embeds quality in everyday work. **Criteria:** • The organization has formal onboarding and orientation that embed quality as a priority. • The organization has regular and ongoing professional development opportunities for staff related to quality. • Quality improvement is incorporated into standard work. • The organization embeds diversity, equity, and inclusion in workforce development.
Culture of Continuous Improvement Through Systems **Element:** Design and manage systems and processes in a manner that supports continuous quality improvement. **Criteria:** • The organization uses standardized methods for improving processes. • Leadership incorporates expectations for quality improvement into job descriptions and department and committee charters.

- The organization has processes in place for continuous reporting and monitoring of quality improvement data.

Culture of Continuous Improvement Through Behavior

Element: Support quality improvement behaviors in an adaptable organization that embraces innovation, motivation, and accountability.

Criteria:

- The organization monitors adherence to best practices such as evidence-based protocols/order sets in all areas.
- The organization intentionally develops strong peer relationships with internal and external partners including those at the local, state, and federal levels.
- Employees demonstrate initiative to achieve goals and strive for excellence.
- Managers and leaders regularly evaluate behaviors to ensure they align with organizational values.

Integrating Equity into Quality Practices

Element: Undertake intentional improvement activities to ensure a fair and just opportunity to be as healthy as possible for all community members.

Criteria:

- Managers use collected data and other available resources to identify inequities.
- Leaders routinely assess quality interventions and processes to address identified inequities.
- Units and departments implement specific health equity projects to improve care and lessen inequities.

Engagement of Patients, Partners, and Community

Element: Intentionally build external relationships with patients, partners, and the community to enhance access and improve the care experience.

Criteria:

- The organization collects feedback from patients and families beyond patient experience surveys.
- The organization collaborates with other care providers using closed-loop referral processes to help ensure quality of care.
- The organization uses a variety of mechanisms to share quality data with patients, families, and the community.
- Leaders synthesize and develop action plans in response to patient, family, and community feedback.

Collecting Meaningful and Accurate Data

Element: Apply a multidisciplinary approach to identify key quality metrics, prioritizing complete and accurate data collection.

Criteria:

- The organization has a multidisciplinary process for identifying key quality metrics.
- Leaders identify risks and opportunities based on analyses of key quality metrics.
- The organization leverages health information technology (HIT) to support complete and accurate data collection.
- The organization collects and documents race, ethnicity, and language (REL), sexual orientation and gender identity (SOGI), and health related social needs (HRSN) data.

Using Data to Improve Quality

Element: Use internal and external data comprehensively, meaningfully, and transparently to inform quality improvement.

Criteria:

- The organization shares data transparently both internally and externally.
- The organization incorporates external data sources to inform quality improvement efforts.
- Leaders act on and clearly communicate the data results from quality initiatives.
- The organization uses benchmarking to identify where quality can be improved.

Appendix B: 2023 CAH Quality Infrastructure Summit Attendees

The Summit participants included representatives from CAHs, state Flex Programs, RQITA, hospital and health care associations, FMT, MBQIP and Health Quality Improvement Contract (HQIC) subcontractors, FORHP, and several quality consultants. Combining decades of experience in rural health care, the 2023 CAH Quality Infrastructure Summit participants include the following field experts.

- Alison Page—Western Wisconsin Health (Retired, WI)
- Becky Royer—Royer Consulting (based in IN)
- Cara Cruz—Carson Valley Medical Center (NV)
- Carla Wilber—Stroudwater Associates (ME)
- Carrie Howard—Stratis Health (Partnership to Advance Tribal Health)
- Greg Ruberg—Lake View Hospital (MN)
- Jen Wagner—Montana Hospital Association (MT)
- Jody Ward—University of North Dakota (ND)
- Karen Hooker—Melissa Memorial Hospital (CO)
- Katherine Bryant—Covington Hospital (MS)
- Linda Webb—Pulaski Memorial Hospital (IN)
- Mariah Hesse—Sparrow Clinton Hospital (MI)
- Shakeerah McCoy—North Carolina Healthcare Association (NC)
- Shondia Evans—Georgia Hospital Association (GA)
- Stacie Rothwell—Oregon Health & Science University (OR)
- Susan Runyan—Runyan Health Care Quality Consulting (based in KS)

Summit Facilitators and Partners

- Debra Lane, National Rural Health Resource Center (The Center)
- Tracy Morton, The Center
- Caroline Bell, The Center
- Karla Weng, RQITA, Stratis Health
- Sarah Brinkman, RQITA, Stratis Health
- Maddy Pick, FMT, University of Minnesota
- Megan Lahr, FMT, University of Minnesota
- Natalia Vargas, Federal Office of Rural Health Policy (FORHP)