Research in Quality and Change Management 
Arizona Experience

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Critical Access Hospital Quality Leadership Summit

Arizona Quality Improvement Program Overview
Arizona Flex Quality Improvement Activities

1. Rural Hospital Quality Improvement Trainings
   • QI workshop/seminar and webinar trainings

2. Statewide Rural Quality Network Group

3. Multi-State Performance Improvement Initiatives

4. On-Site Quality Improvement Technical Assistance
   • Stroudwater Visits / Bainbridge Visits / Blair Hospital Mock Surveys

5. EMS Performance Improvement Initiative
   • HealthEMS / ScanHealth

6. Medication Reconciliation Demonstration Project

7. Performance Improvement Summit

8. Health Information Technology Initiative

9. CMS Hospital Compare Performance Summaries
Arizona Small Rural Hospital Quality Improvement Priority Level: 2009

Source: Arizona CAH Quality Improvement Survey: 2009
Arizona Small Rural Hospital Quality Improvement Priority Level Compared to a Year Ago (2008)

Most AZ CAHs provide very little funding support for QI activities

Source: Arizona CAH Quality Improvement Survey: 2009
Sustainable Rural Hospital Quality Factors
Relationship between CAH Leadership and Sustainable Quality Excellence

- **Quality Improvement High Priority of Hospital**
  - CEO / CAH Board / Medical and Nursing Directors

- **Hospital Administration**
  - CEO provides the QI leadership
  - CEO provide needed QI resources (e.g., staffing, training, etc …)

- **Quality Improvement Team**
  - Dedicated and active QI Coordinator (strong leadership)
  - QI team representing key departments (medicine, nursing, etc..)
  - Many QI champions

- **Positive Hospital Quality Improvement Cultural**
  - CEO / Medical Director / Nursing Director / Affected Departments
  - Quality improvement focus on system errors, not people error

- **Low Turn Over Rate of Key QI Personnel (e.g., CEO, QI team)**
  - QI Leadership (e.g., CEO, QI coordinator, medical / nursing / pharmacy directors, and affected department heads)
  - QI Leadership support staff (e.g., data entry)
Education and Business Tools to Support CAH Quality Outcomes

Pneumonia in Small Rural Hospitals
A Collaborative Model for Performance Improvement Seminar and Workshop for Staff of Arizona's Critical Access Hospitals and Other Small Rural Hospitals

June 2003
Phoenix, Arizona
15 Hospitals
7 CAHs / 8 non-CAHs
PDSA Model

Congestive Heart Failure Quality Assurance Training for Rural Hospitals
Phoenix and Tucson
July 8, 2004
A Videoconference Seminar

Phoenix and Tucson
20 Hospitals
8 CAHs / 7 IHS/Tribal / 5 Other
Chronic Care Model

Medication Reconciliation Learning Session for Rural Hospitals
Phoenix, Tucson, and Other Rural Areas
May 17, 2005
A Multi-Site Videoconference Seminar

Phoenix, Tucson, Springerville
19 Hospitals
7 CAHS / 12 non-CAHs
Collaborative Models for Health Care Quality Improvement

Infection Monitoring in Rural Hospitals: System and Practice
Nov. 2, 2009; Nov. 19, 2009; Jan. 21, 2010; Feb. 23, 2010; Apr. 29, 2010

Phoenix and Webinars
10 CAHs
Five Sessions
PDSA Model

Quality Calendars
Create Hospital Culture that Produces Quality / Patient Safety Outcomes

Medication Reconciliation Demonstration Project

1. Patient Admission
   Record current medications

2. Physician Reviews and
   orders Rx medications

3. Pharmacist Reviews and
   fills Rx med orders

4. Nurse Checks and
   administers medications

5. Nurse Checks and
   adds home medications

6. Patient Discharge Review and
   discuss meds
Medication Reconciliation Demonstration Project
Using A Six Step Systematic Approach

2. On-Site Visits to Assess Med. Recon. Process
3. Med. Safety Assessment Survey
5. Med. Recon. Procedure(s) Changed

• Hospital Leader
• Medication Reconciliation Improvement Team
• Including Many Departments
• Meet Needs of Hospital
• Sustainable Changes
Four Year Pneumonia Trend for 2005-08: Oxygenation Assessment Percentages

Source: Center for Medicare and Medicaid Services: Hospital Compare Performance Measures
CAH Quality Reporting and Research

- Quality data collection is not high priority
- Limited staffing available to collect quality data
- Small number of occurrence (e.g., CMS Hospital Compare Performance Measures)
- Usefulness of data collected (Appropriate quality measures for CAHs)
- Data timeliness (time lag – availability of data)
- Multiple data entry for different system requirements
- Not collecting the right quality data
- No financial benefit in quality reporting
Thank You!!
Questions?
Contact Information

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