

# Rural Hospital *Award Program*

**Awards Presentation  
April 19, 2005**



Arizona Hospital and  
Healthcare Association

**HSAG**  
HEALTH SERVICES  
ADVISORY GROUP

The University of Arizona  
Mel and Enid Zuckerman  
Arizona College of Public Health  
**Rural Health Office**



April 19, 2005

Dear Participants,

Rural communities have often been relegated to the margins of the health care quality movement. A common perception, among health care professionals and the public alike, has been that rural hospitals just do not have the staff, resources, or technology to compete with the “big boys.” As a result, rural hospitals frequently suffer a “bypass” problem, in which potential patients from their own service areas opt to go to larger, urban hospitals in the pursuit of quality health care. Until recently, there has been no objective information with which to counteract this perception.

The Rural Hospital Award Program (RHAP), announced last year by Health Services Advisory Group (HSAG), uses publicly reported Medicare data for established health care quality measures to recognize those hospitals that provide care that is equal to or better than their urban counterparts. It is our hope that the RHAP will help motivate rural hospitals to continue their quality improvement efforts and, in the process, improve the public’s perception of rural hospital quality.

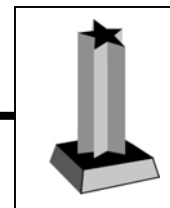
The RHAP is a project that was conceived and championed by Carter Marshall, MD, MPH, who, until he passed away in February, was HSAG’s Vice President of Clinical Quality Assessment. We also honor his memory and life-long commitment to health care quality today as we give the **Carter L. Marshall, MD, MPH, 2005 Rural Hospital Quality Award** to three rural hospitals that provide outstanding care to their communities.

In partnership with the Rural Health Office and the Arizona Hospital and Healthcare Association, HSAG welcomes you to the very first RHAP awards presentation. Enjoy today’s program, congratulate the winners, and celebrate health care quality success in the rural hospital setting.

Sincerely,

A handwritten signature in black ink, appearing to read "Herb Rigberg", is written over a light blue horizontal line.

Herb Rigberg, MD  
Chief Executive Officer  
Health Services Advisory Group



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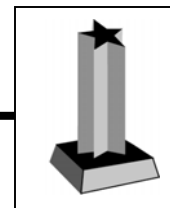
### **RHAP Sponsors**

Health Services Advisory Group

Arizona Hospital and Healthcare Association

Rural Health Office

This material was prepared by Health Services Advisory Group, Inc., the Medicare Quality Improvement Organization for Arizona, under contract with the Centers for Medicare & Medicaid Services (CMS), an agency of the U.S. Department of Health and Human Services. The contents presented do not necessarily reflect CMS policy. Publication No. AZ-7SOW-1C-041605-01



## Carter L. Marshall, MD, MPH

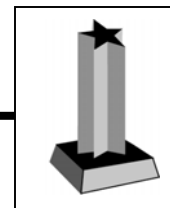


Health Services Advisory Group (HSAG) was fortunate to have Carter L. Marshall, MD, MPH, join its staff in 1990. During his time at HSAG he served in many capacities—most recently as the Vice President of Clinical Quality Assessment. During his 15 years of service, Dr. Marshall improved the quality of care provided to Medicare beneficiaries and other patients through his involvement with many HSAG projects. These projects included:

- Improving Diabetes Management in Managed Care.
- Investigating and Improving Coronary Artery Bypass Graft Surgery and Survival.
- Reducing Radical Prostatectomy in Elderly Males.
- Identifying and Studying the Top Performing Hospitals in the United States.

One of the last projects Dr. Marshall directed, prior to his death on February 18, 2005, was the Three-State Pilot. This pilot project from the Centers for Medicare & Medicaid Services (CMS) was designed to provide direction about the public reporting of hospital quality measures. Dr. Marshall met with representatives from rural hospitals to hear their thoughts about public reporting. He was motivated by the concerns they voiced during those discussions. The design of the Rural Hospital Award Program (RHAP) began to evolve as Dr. Marshall shared the concerns of the rural hospitals with CMS, the Hospital Quality Alliance (HQA), and other stakeholders. The award program held today, April 19, 2005, is not the culmination of RHAP. It is a stepping stone to future rural award programs.

The Rural Hospital Quality Award has been named in honor of Dr. Marshall and his efforts to call attention to the quality of care provided by rural hospitals in Arizona. Dr. Marshall was proud of the hospitals in Arizona and never missed an opportunity to discuss their accomplishments. He recognized the work and effort that resulted in providing quality care. HSAG was both fortunate and privileged to have had such a humanitarian on its team.



# The Rural Hospital Award Program (RHAP)

## **RHAP Overview**

The Rural Hospital Award Program (RHAP) is an annual recognition program for rural hospitals sponsored by Health Services Advisory Group (HSAG). The RHAP recognizes performance on the Centers for Medicare & Medicaid Services (CMS) 7th Scope of Work (SoW) quality indicators for community-acquired pneumonia (PN). There are eight clinical data elements collected for PN. The award, known as the Carter L. Marshall, MD, MPH, Rural Hospital Quality Award, recognizes the rural hospitals with the highest performance in PN care. There is no limit to the number of rural hospitals that may win an award.

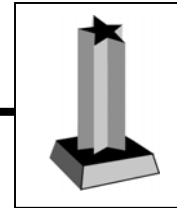
The RHAP promotes quality improvement efforts by encouraging cooperation and collaboration among rural hospitals. Performance feedback and recognition will motivate hospitals to continuously improve the quality of health care they provide. The RHAP will foster the sharing of successful quality improvement strategies.

An additional purpose of the RHAP is to stimulate quality improvement in rural hospitals by assisting them with one of their biggest problems—that of patients bypassing the local hospital in favor of care in Phoenix or Tucson. Bypasses, which have a significant financial impact on rural hospitals, occur because of the perception that rural hospitals do not have the staff, resources, or technology to provide quality health care for serious illnesses. The RHAP provides public recognition for rural hospitals that provide care that is as good or better than that provided by urban hospitals, helping to improve public perception of these rural hospitals in their marketplaces.

## **Eligibility for a RHAP Award**

RHAP eligibility requires that a rural hospital must routinely submit data to the CMS clinical warehouse in conjunction with the Hospital Quality Alliance (HQA). The majority of Arizona hospitals are participants in HQA.

RHAP hospitals must meet geographic criteria for classification as a rural hospital. For the purpose of this project, rural hospitals were defined as all hospitals that reside outside of Maricopa County or Pima County, with the exception of rural hospitals that reside within those two counties.



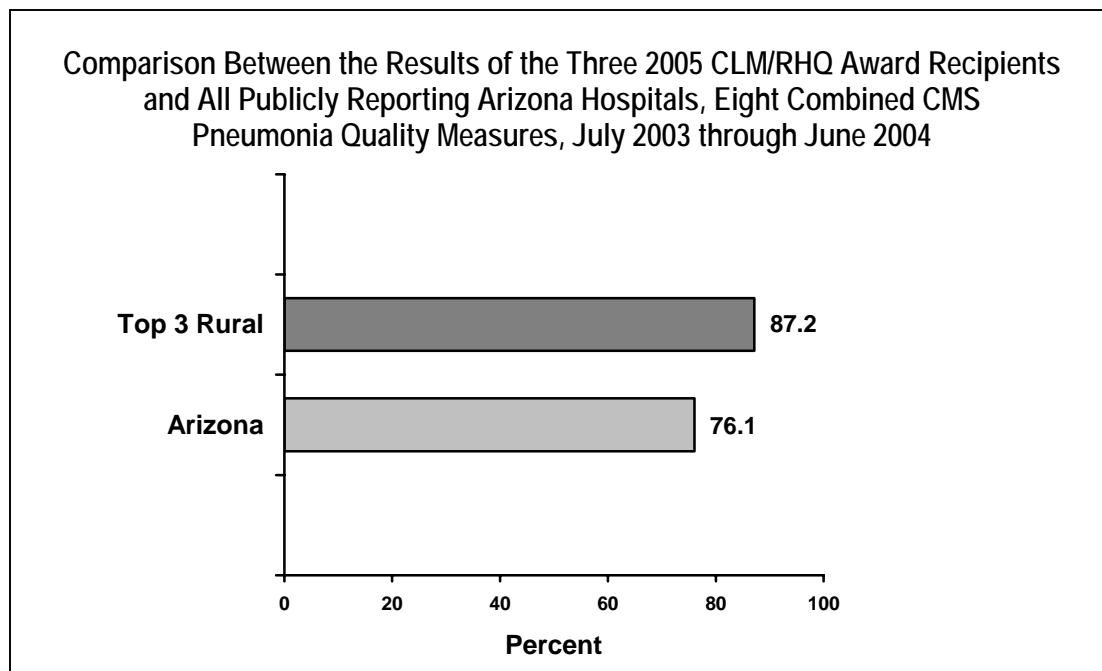
## RHAP Methodology

To be eligible for the 2005 Rural Hospital Award Program (RHAP), hospitals submitted at least two quarters of data in the RHAP reporting period (July 2003 through June 2004) and began participating in the national Hospital Quality Alliance prior to the end of the RHAP data submission period (November 15, 2004).

HSAG used the Achievable Benchmark of Care (ABC) Methodology, developed by the University of Alabama—Birmingham, to rate all Arizona hospitals on the care provided to their pneumonia patients from July 2003 through June 2004. Pneumonia care was defined as the combined performance achieved across all eight national CMS quality indicators. A total of five hospitals (three rural and two urban) exceeded the established ABC criteria (at the 25 percent level) for the 2005 award.

Award winners have achieved results that rank the hospitals among the top performers in Arizona, regardless of size or location. The Carter L. Marshall Rural Hospital Quality (CLM/RHQ) Award recipients for 2005 are:

- **Northern Cochise Community Hospital**
- **Page Hospital**
- **Tuba City Regional Health Care Corporation**



# Pneumonia

## National Project Overview

Pneumonia and influenza cause substantial morbidity and mortality for Medicare patients. This project focuses on changing processes of care to improve outcomes for Medicare beneficiaries admitted to the hospital with pneumonia. An additional objective is to increase rates of inpatient vaccination against influenza and pneumococcal disease.

### Public Health Importance

Pneumonia and influenza are the fifth leading causes of death in the United States in patients age 65 years and older.<sup>1</sup> Pneumonia accounts for nearly 600,000 Medicare patient hospitalizations utilizing more than 4.5 million inpatient days each year.<sup>1,2</sup> In 1993, more than \$3.5 billion was spent on inpatient care of Medicare patients with pneumonia.<sup>3</sup> Pneumonia also is the principal reason for more than 500,000 emergency department visits by Medicare patients each year.<sup>2</sup> The incidence of pneumonia increases with age, and more than 90 percent of deaths due to this condition are in the population aged 65 and older.<sup>1,4,5</sup>

- Initial antibiotic therapy consistent with current guidelines
- Collection of blood cultures within 24 hours of hospital arrival
- Collection of blood cultures prior to the initial antibiotic dose
- Screening for influenza and pneumococcal immunization status and vaccination prior to discharge, if indicated
- Smoking cessation counseling during hospitalization
- Arterial oxygenation assessment within 24 hours of hospital arrival

### Main Objective

To decrease the morbidity and mortality associated with pneumonia in Medicare beneficiaries.

### Process Objectives

To increase the use of the following care processes for patients hospitalized with pneumonia:

- Timely antibiotic administration

### Clinical Background

The quality measures for pneumonia are based on extensive scientific evidence demonstrating their efficacy in improving quality of care for patients hospitalized with pneumonia and for reducing the incidence of pneumonia and influenza.

Based on a review of medical evidence by an expert panel and lessons learned during the 6th Scope of Work (SOW) National Pneumonia project, the following considerations guided the development of the revised quality measures:

*Continued next page*

## CMS Measure Specifications for Pneumonia

| <i>Quality Measures</i>   | <i>Criterion Met or Acceptable Alternative</i>   |
|---|--|
| 1. Number of pneumonia patients who received their first dose of antibiotics within 4 hours after arrival at the hospital   | Time from initial presentation to any antibiotic administration within 4 hours   |
| 2. Number of immunocompetent pneumonia patients who received an initial antibiotic regimen consistent with current guidelines during the first 24 hours of their hospitalization                | See the Antibiotic Recommendations on page 27 for non-ICU and ICU patients   |
| 3a. Number of pneumonia patients who had blood cultures performed within 24 hours prior to or after arrival at the hospital   | Documentation that blood culture collected before admission or within 24 hours of arrival time   |
| 3b. Number of pneumonia patients whose initial blood culture was performed prior to the administration of the first hospital dose of antibiotics  | Documentation that blood culture collected before the date and time of administration of the initial antibiotic dose in patients for whom blood cultures are ordered   |
| 4. Number of pneumonia patients, age 50 years and older, discharged during October-February who were screened for influenza vaccine status and were vaccinated prior to discharge, if indicated | Documentation of screening and administration of influenza vaccine for hospital discharge during the months of October-February. Exceptions include previous immunization during this influenza season, patient refusal, and documented allergy/sensitivity to the vaccine or its components |
| 5. Pneumonia patients, age 65 and older, who were screened for pneumococcal vaccine status and vaccinated prior to discharge, if indicated  | Documentation of screening and administration of pneumococcal vaccine. Exceptions include previous immunization, patient refusal, and documented allergy/sensitivity to the vaccine or its components  |
| 6. Number of pneumonia patients (cigarette smokers) who received smoking cessation advice or counseling during the hospital stay  | Documentation of smoking cessation advice or counseling for all pneumonia patients who are current smokers (this includes any patient who has smoked within 1 year prior to admission)   |
| 7. Number of pneumonia patients whose arterial oxygenation was assessed by arterial blood gas or pulse oximetry within 24 hours prior to or after hospital arrival                              | Documentation of arterial oxygenation assessment by either ABG collections or pulse oximetry within 24 hours of hospital arrival   |

## **Clinical Background** (continued)

### ***The relationship between early antibiotic administration and lower 30-day mortality rate***

Previous studies evaluating the impact of changing processes of care including the administration of antibiotics within 4 hours of hospital admission for patients with pneumonia have demonstrated this relationship.<sup>6,7</sup> Data from the Medicare Quality Indicator System (MQIS) pneumonia module revealed a 15 percent lower odds of 30-day mortality when antibiotics were administered within 8 hours of hospital arrival.<sup>8</sup>

### ***Modification of the time from initial hospital arrival to the first dose of antibiotics (decrease from 8 to 4 hours)***

There is growing clinical evidence of an association between timely inpatient administration of antibiotics and improved outcome among pneumonia patients.

The 8-hour target in the 6th SOW measure is based on published guidelines. Those guidelines are based on Medicare data from the 5th SOW. Recent data from the 6th SOW indicate that several thousand deaths could be prevented each year among hospitalized Medicare pneumonia patients if the initial dose of antibiotic was administered within 4 hours after arrival.

CMS anticipates that the time goal in the published guidelines will be revised downward. In recognition that an opportunity to prevent thousands of deaths will be lost if CMS waits for guideline revision to occur, the QIO (Quality Improvement Organization) initial antibiotic administration measure was revised. In the 7th SOW, the QIO community will strive to improve outcomes via a decreased door-to-drug time frame of 4 hours instead of the previous 8-hour threshold.

### ***The association between blood cultures and a lower 30-day mortality rate***

Data from the MQIS pneumonia module demonstrated the association between blood cultures within 24 hours of arrival and a lower 30-day mortality rate.<sup>8</sup> Routine blood cultures are recommended in the guidelines for the management of community-acquired pneumonia from the American Thoracic Society (ATS)<sup>9</sup> and the Infectious Diseases Society of America (IDSA).<sup>10</sup> The emergence of

antibiotic-resistant strains of *Streptococcus pneumoniae* and the need for pathogen-directed antimicrobial therapy emphasize the need for routine cultures.<sup>10</sup>

### ***Delineation of the blood culture measure to include both blood cultures collected prior to the first antibiotic dose and blood cultures collected during the hospitalization***

Collection of blood cultures for all inpatients optimizes therapy, and the yield of clinically useful information is greater if the culture specimen is collected before antibiotics are administered. The actual performance of a culture collection has been added to the measure because restricting measurement to culture collection prior to antibiotics provides an incentive for a hospital not to perform a culture in any patient who had already received antibiotics.

### ***Empiric antibiotic selection to provide appropriate coverage for *Streptococcus pneumoniae* and to cover atypical organisms in patients who require admission to the intensive care unit (ICU)***

*Streptococcus pneumoniae* represents the most common cause of pneumonia and accounts for approximately two-thirds of cases of bacteremic pneumonia.<sup>11</sup> Both *Streptococcus pneumoniae* and *Legionella* species are important causes of lethal pneumonia in seriously ill patients.<sup>12, 13</sup>

Analysis of outcomes for patients in the MQIS pneumonia module demonstrated significant reductions in mortality for patients treated with antibiotic combinations that were effective against both pneumococcus and atypical organisms.<sup>14</sup>

In addition, the incidence of penicillin-resistant strains of pneumococcus has increased during the past decade.<sup>15,16</sup> Empiric antibiotic therapy to cover potentially resistant strains of *Streptococcus pneumoniae* and atypical organisms for patients admitted to the ICU is recommended.<sup>10</sup>

### ***Prevention of Influenza and Pneumococcal Disease***

Despite the fact that influenza and pneumococcal vaccines are effective<sup>17-20</sup> and are Medicare Part B covered benefits, they remain underutilized.<sup>21</sup> Strategies for immunization that include the recommendation for vaccination of outpatients and of inpatients prior to discharge have been suggested.<sup>21-25</sup>

*Continued next page*

## **Clinical Background** (continued)

Guidelines for the management of pneumonia were published in 1983 by the British Thoracic Society<sup>26</sup> and the Canadian Infectious Disease Society.<sup>27</sup> In 2000, the Infectious Diseases Society of America (IDSA) published evidence-based guidelines for the management of community-acquired pneumonia in immunocompetent adults.<sup>10</sup> In 2001, the ATS revised the 1983 guidelines for the management of community-acquired pneumonia.<sup>9</sup>

Recommendations for adult immunization with influenza and pneumococcal vaccines have been published by the Advisory Committee on Immunization Practices (ACIP).<sup>21-23</sup>

### **Addition of measures addressing arterial oxygenation assessment within 24 hours of hospital arrival and smoking cessation advice/counseling**

Inadequate oxygenation of the arterial blood (hypoxemia) is common in severe pneumonia and is a known mortality risk factor.<sup>30</sup> Giving supplemental oxygen, when necessary, has been shown to decrease mortality among pneumonia patients.<sup>6</sup> Since cigarette smoking accounts for 1 out of 5 deaths in the United States, hospitalization can be an ideal opportunity for a patient to stop smoking. Smoking cessation may promote the patient's medical recovery and patients who received even brief smoking cessation advice from their physician are more likely to quit than those who received no counseling.<sup>28-29</sup>

## **Opportunity for Improvement**

Baseline data from the 7th SOW National Pneumonia Project demonstrated that 38.5 percent of Medicare pneumonia patients did not receive initial antibiotics within 4 hours of hospital arrival, and 41.1 percent did not receive the appropriate empiric antibiotic therapy. Collection of blood cultures within 24 hours of hospital arrival occurred in 63.7 percent of pneumonia cases. Of those patients who had blood cultures collected, 81 percent were collected prior to initial antibiotic therapy.

Influenza and pneumococcal vaccines remain underused in the inpatient setting with 13.8 percent of Medicare pneumonia patients receiving an influenza immunization and 16.5 percent receiving pneumococcal immunization before discharge. Analysis of both Medicare claims and survey

data have demonstrated underuse of influenza and pneumococcal vaccines.<sup>19</sup>

## **References**

1. Minimo AM, Smith BL. Preliminary data for 2000. National vital statistics reports; vol. 49 no 12. Hyattsville, Maryland: National Center for Health Statistics. 2001
2. Dicker RC, Han LF, Macone JJ. Quality of care surveillance using administrative data, 1996. Quality resume, no. 2. Baltimore, Maryland: Health Care Financing Administration, 1998.
3. Health Care Financing Administration. 1995 Data Compendium. Baltimore, MD: US Department of Health and Human Services, Health Care Financing Administration; 1995:75. HCFA No. 03364.
4. Marston BJ, Plouffe JF, File TM, et al. Incidence of community-acquired pneumonia requiring hospitalizations: Results of a population-based active surveillance study in Ohio. *Arch Intern Med*. 1997;157:1709-18.
5. Centers for Disease Control. Pneumonia and influenza mortality—United States, 1988-1989 Season. *MMWR Morb Mortal Wkly Rep*. 1989;38:97.
6. Kahn KL, Rogers WH, Rubenstein LV, et al. Measuring quality of care with explicit process criteria before and after implementation of the DRG-based Prospective Payment System. *JAMA*. 1990;264:1969-73.
7. McGarvey RN, Harper JJ. Pneumonia mortality reduction and quality improvement in a community hospital. *Qual Rev Bull*. 1993;19:124-130.
8. Meehan TP, Fine MJ, Krumholz HM, et al. Quality of care, process, and outcomes in elderly patients with pneumonia. *JAMA*. 1997;278:2080-84.
9. Niederman MS, Mandell LA, Anzueto A, Bass JB, Broughton WA, et al. Guidelines for the Management of adults with community-acquired pneumonia. Official statement of the American thoracic society. *Am J Respir Crit Care Med*. 2001;163:1730-54.
10. Bartlett JG, Dowell SF, Mandell LA, File Jr TM, Musher DM, Fine MJ. Practice guidelines for the management of community-acquired pneumonia in adults. *Clin Infect Dis*. 2000; 31:347- 82.

Continued page 28

## Antibiotic Selection

### Acceptable Antibiotics

| <i>Non-ICU</i>  | <i>ICU</i>  | <i>ICU<br/>with Pseudomonal Risk*</i>   |
|---|---|---|
| <p><b>â-lactam (IV or IM) + macrolide (IV or Oral)</b></p> <p style="text-align: center;"><b>or</b></p> <p><b>Quinolone monotherapy (IV or Oral)</b></p> <p style="text-align: center;"><b>or</b></p> <p><b>â-lactam (IV or IM) + doxycycline (IV or Oral)</b></p> <p><i>â-lactam =</i><br/>ampicillin-sulbactam, cefotaxime, ceftriaxone</p> <p><i>Macrolide =</i><br/>azithromycin, clarithromycin (oral), erythromycin</p> <p><i>Quinolones =</i><br/>gatifloxacin, levofloxacin, moxifloxacin</p> | <p><b>â-lactam (IV) + macrolide (IV)</b></p> <p style="text-align: center;"><b>or</b></p> <p><b>â-lactam (IV) + quinolone (IV)</b></p> <p><i>If documented â-lactam allergy:</i><br/><b>Quinolone (IV) + Clindamycin (IV)</b></p> <p style="text-align: center;"><b>or</b></p> <p><b>Quinolone (IV) + Vancomycin (IV)</b></p> <p><i>â-lactam =</i><br/>ampicillin-sulbactam, cefotaxime, ceftriaxone</p> <p><i>Macrolide =</i><br/>azithromycin, erythromycin</p> <p><i>Quinolones =</i><br/>gatifloxacin, levofloxacin, moxifloxacin</p> | <p>*In addition to the antibiotics listed under ICU, if the patient had a secondary ICD-9 code of bronchiectasis, or a positive response to the bronchiectasis question, malnutrition [as reflected by a serum albumin below 3], or documentation of malnutrition, these antibiotics would also be considered acceptable:</p> <p><b>Antipseudomonal â-lactam (IV) + Antipseudomonal quinolone (IV)</b></p> <p style="text-align: center;"><b>or</b></p> <p><b>Antipseudomonal â-lactam (IV) + Aminoglycoside (IV) + either a [Macrolide (IV) or Antipneumococcal quinolone (IV)]</b></p> <p><i>If documented â-lactam allergy:</i><br/><b>Aztreonam (IV) + Aminoglycoside (IV) + Antipneumococcal quinolone (IV)</b></p> <p><i>Antipseudomonal â-lactam =</i><br/>cefepime, imipenem, meropenem, piperacillin-tazobactam</p> <p><i>Macrolide =</i><br/>azithromycin, erythromycin</p> <p><i>Aminoglycosides =</i><br/>amikacin, gentamicin, tobramycin</p> <p><i>Antipseudomonal quinolone =</i><br/>ciprofloxacin</p> <p><i>Antipneumococcal quinolones =</i><br/>gatifloxacin, levofloxacin, moxifloxacin</p> |

## References (continued)

11. Fine MJ, Smith MA, Carson CA, et al. Prognosis and outcomes of patients with community-acquired pneumonia. *JAMA*. 1996;275:134-41.
12. Marston BJ, Lipman HB, Breiman RG. Surveillance for Legionnaires' disease: Risk factors for morbidity and mortality. *Arch Intern Med*. 1994;154:2417-22.
13. Stout JE, Yu VL. Legionellosis. *N Engl J Med*. 1997;337:682-87.
14. Gleason PP, Meehan, TP, Fine JM, et al. Associations between initial antimicrobial regimens and medical outcomes for elderly patients with pneumonia. *Arch Intern Med*. 1999; 159:2562-72.
15. Butler JC, Hofmann J, Cetron MS, et al. The continued emergence of drug-resistant *Streptococcus pneumoniae* in the United States: An update from the Centers for Disease Control and Prevention's Pneumococcal Sentinel Surveillance System. *J Infect Dis*. 1996;174:986-93.
16. Doern GV, Brueggemann A, Holley HP Jr, Rauch AM. Antimicrobial resistance of *Streptococcus pneumoniae* recovered from outpatients in the United States during the winter months of 1994 to 1995: Results of a 30-Center National Surveillance Study. *Antimicrob Agents Chemother*. 1996;40:1208-13.
17. Foster DA, Talsma A, Furumoto-Dawson A, et al. Influenza vaccine effectiveness in preventing hospitalizations for pneumonia in the elderly. *Am J Epidemiol*. 1992;136:296-307.
18. Nichol KL, Margolix KL, Wouremna J, et al. Effectiveness of influenza vaccine in the elderly. *Gerontology*. 1996;42:274-79.
19. Mullooly JP, Bennett MD, Hornbrook MC, et al. Influenza vaccination programs for elderly persons: Cost-effectiveness in a health maintenance organization. *Ann Intern Med*. 1994;121:947-52.
20. Centers for Disease Control and Prevention. Influenza and pneumococcal vaccination levels among adults aged > 65 Years – United States, 1997. *MMWR Morb Mortal Wkly Rep*. 1998;47:797-802.
21. Centers for Disease Control and Prevention. Prevention of pneumococcal disease: Recommendations of the Advisory Committee on Immunization Practice (ACIP). *MMWR Morb Mortal Wkly Rep*. 1997;46:1-24.
22. Centers for Disease Control and Prevention. Prevention and control of influenza: Recommendations of the Advisory Committee on Immunizations Practices (ACIP). *MMWR Morb Mortal Wkly Rep*. 2000;49(RR03):1-38.
23. Centers for Disease Control and Prevention. Prevention and control of influenza: Recommendations of the Advisory Committee on Immunization Practices (ACIP). *MMWR Morb Mortal Wkly Rep*. 2003;52(RR08):1-36.
24. Centers for Disease Control and Prevention. Use of standing orders programs to increase adult vaccination rates: Recommendations of the Advisory Committee on Immunization Practices (ACIP). *MMWR Morb Mortal Wkly Rep*. 2000;49(RR01):15-26.
25. American Hospital Association. Management advisory-health care delivery: immunization. American Hospital Association Technical Panel on Infections within Hospitals. *Am J Infect Control*. 1994;22:42-46.
26. The British Thoracic Society. Guidelines for the management of community-acquired pneumonia in adults admitted to hospital. *Br J Hosp Med*. 1993;49:346-50.
27. Mandell LA, Niederman M. The Canadian Community-Acquired Pneumonia Consensus Conference. Antimicrobial treatment of community-acquired pneumonia in adults: a conference report. *Can J Infect Dis*. 1993;4:25.
28. Fine MJ, Auble TE, Yealy DM, et al. A prediction rule to identify low-risk patients with community-acquired pneumonia. *N Engl J Med*. 1997;336:243-250.
29. Fiore MC, Bailey WC, Cohen SJ, et al. Treating tobacco use and dependence. Clinical Practice Guideline. Rockville, MD: U.S. Department of Health and Human Services. Public Health Service. June 2000.
30. Kikano GE, et al. The value of brief, targeted smoking cessation advice. *Fam Prac Management*. January 2000, 7(1):50.

**FOR IMMEDIATE RELEASE:**

November 18, 2004

**Press Release**

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## **HSAG Announces Rural Hospital Award Program**

PHOENIX, ARIZONA—Health Services Advisory Group Inc. (HSAG), Medicare’s Quality Improvement Organization (QIO) in Arizona, will begin giving quality improvement awards to deserving rural Arizona hospitals in 2005. The Rural Hospital Award Program (RHAP) will recognize excellence in the clinical management of pneumonia among rural hospitals. Award criteria will be based on hospital results for the Centers for Medicare & Medicaid Services (CMS) pneumonia quality measures.

The RHAP has three objectives:

- To stimulate quality improvement efforts and encourage cooperation and collaboration among rural hospitals. Performance feedback and recognition will motivate hospitals to continuously improve the quality of the health care they provide. RHAP activities will foster the sharing of successful quality improvement strategies.
- To assist rural hospitals in coping with the “bypass” problem, which occurs when potential patients bypass the local hospital in favor of larger institutions. It is anticipated that patients will give stronger consideration to their local hospital if that hospital is publicly recognized for providing high-quality care.
- To achieve these objectives without adding to the workload of rural hospitals. The award criteria are based on data that hospitals are already collecting and submitting to CMS; participating in the RHAP does not require hospitals to expend any additional financial or administrative resources.

The RHAP awards banquet will be held on April 19, 2005. Guests will include the award recipients, rural hospital administrators, and representatives of the media, the Governor’s office, the Arizona Hospital and Healthcare Association, and other state agencies. The banquet will feature a nationally known hospital quality improvement speaker and a panel discussion of issues common to rural hospitals. The panel will be comprised of RHAP award recipients.

To be eligible for the RHAP, hospitals must:

- Demonstrate ongoing data collection and participation with the Hospital Quality Alliance (HQA).
- Meet geographical criteria for classification as a rural hospital.
- Achieve results on the eight pneumonia quality measures that rank the hospital among the top performers in Arizona, regardless of size or location.

The eight CMS pneumonia quality measures used as the basis for RHAP evaluation and awards are:

- Oxygenation assessment within 24 hours of hospital arrival
- Pneumococcal immunization
- Blood culture performed within 24 hours prior to or after hospital arrival
- Blood cultures performed before first antibiotic received in the hospital
- Adult smoking cessation advice/counseling
- Initial antibiotic received within four hours of hospital arrival
- Administration of antibiotics consistent with current guidelines
- Influenza immunization

Additional information regarding the CMS pneumonia quality measures is available at:  
<http://www.medqic.org/content/nationalpriorities/topics/projectdes.jsp?topicID=445>

# # #

### **About Health Services Advisory Group (HSAG)**

For over 25 years, HSAG has provided innovative leadership on health care quality improvement projects for federal, state, and private sector clients. Founded by a group of medical professionals in 1979, HSAG is one of most experienced quality improvement organizations in the nation. HSAG is recognized as an agent of change in the health care industry because of the company's successful collaboration with providers across the continuum of care. For more information about HSAG, go to [www.hsag.com](http://www.hsag.com).

Publication No. AZ-7SOW-1C-111804-01

*This material was prepared by Health Services Advisory Group Inc., the Medicare Quality Improvement Organization for Arizona, under contract with the Centers for Medicare & Medicaid Services (CMS), an agency of the U.S. Department of Health and Human Services. The contents presented do not necessarily reflect CMS policy.*

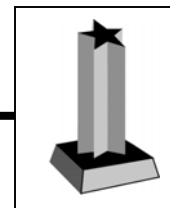
# Rural Hospital Award Program

**Tuesday, April 19, 2005**  
11 a.m. to 2 p.m.

HSAG Carter Marshall Conference Center

## AGENDA

- Welcome .....Lawrence Shapiro, MD  
*President, Chairman of the Board of Directors, HSAG*
- Rural Hospital Quality Improvement Through Collaboration.....Howard J. Eng, MS, DrPH, RPh  
*Associate Director, Education and Research, Rural Health Office*  
*Director, Southwest Border Rural Health Research Center*  
*Assistant Professor, Mel and Enid Zuckerman College of Public Health, University of Arizona*
- A Statewide Perspective on Rural Health Care ..... John Rivers, FACHE  
*President and CEO, Arizona Hospital and Healthcare Association*
- Carter L. Marshall Rural Hospital Quality Award Presentations .....Dr. Shapiro
- Lunch*
- Rural Health Care: What Are the Challenges? .....Phil Lopes, MA  
*Minority Leader, Arizona House of Representatives*
- Methods of Their Success.....Northern Cochise Community Hospital  
Page Hospital  
Tuba City Regional Health Care Corporation
- RHAP Participation Awards ..... Suzanne Powell, RN, MBA  
*Director, Acute Care/QI Program, HSAG*
- Closing Remarks ..... Ms. Powell



## Speaker Bios

### **Howard J. Eng, MS, DrPH, RPh**

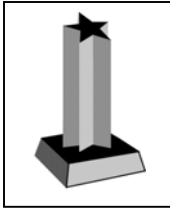
Dr. Eng is the Associate Director for Education and Research of the Rural Health Office, Director of the Southwest Border Rural Health Research Center, and Assistant Professor in the Mel and Enid Zuckerman College of Public Health, University of Arizona. He has 30 years of experience in health care. Dr. Eng's training includes health services and policy research, health economics, epidemiology, public health, and pharmacy. He has 20 years of teaching experience and has been a faculty member in the Colleges of Pharmacy, Medicine, and Public Health. His research interests include issues related to access to health services, especially for the socioeconomically disadvantaged and underserved; minority population and health disparities; border and tribal health; health care financing (e.g., managed care, Medicare, Medicaid, and Children's Health Insurance Program); barriers to health care utilization; health care delivery systems; health care quality improvement; and pharmaceutical usage patterns.

### **Phil Lopes, MA**

Mr. Lopes is the Minority Leader of the Arizona House of Representatives. He is also an independent consultant specializing in improving access to health services for uninsured persons. He is a founder and member of the board of the Arizona Health Care Campaign and, as the interim Executive Director of El Pueblo Clinic (2000–2001), he is credited with saving the financially ailing Southside health institution that serves poor and uninsured area residents. During his tenure as a senior manager at the Arizona Department of Health Services, he was responsible for the distribution of the Tobacco Tax funds earmarked for services to uninsured people. Before joining the Department of Health, he was Senior Lecturer in Community Medicine and Assistant Director of the Rural Health Office of the UA College of Medicine. He is a founding faculty member of the UA College of Public Health and has taught at the University of Phoenix since 1981. Other community activities have included membership on the Independent Citizens Committee, responsible for review of the TUSD court-ordered desegregation, Board member of the Arizona Public Health Association, and chair of the District 11 Democrats.

### **Suzanne Powell, RN, BSN, MBA, CPHQ, CCM**

Ms. Powell is the Director of Acute Care Quality Improvement at HSAG. She is responsible for leadership and direction of the acute care team regarding strategic planning and initiation of quality improvement activities in hospital settings. Ms.



## Rural Hospital Award Program

Powell has over 17 years of health care experience in critical care nursing, case management, utilization management, and quality improvement. She is also a Certified Case Manager and a Certified Professional in Healthcare Quality. She has published three case management books in affiliation with Lippincott, Williams, & Wilkens, has been a Senior Editor for the *National Core Curriculum for Case Management*, and is currently editor of *Lippincott's Case Management*.

### **John R. Rivers, FACHE**

John R. Rivers is president and chief executive officer of the Arizona Hospital and Healthcare Association (AzHHA). In this capacity, Mr. Rivers serves as a member of the AzHHA Board of Directors, a member of the AzHHA Executive Committee, and as president of the AzHHA Education Foundation and Service Corporation. He served as chairman of the American Hospital Association Committee on Allied Hospital Associations, one of six specialty committees of the AHA Board of Trustees, from 1992 to 1995. He is a Fellow in the American College of Healthcare Executives, served as Arizona's Regent to the College from 1992–1997, and also served as a member of the National Steering Committee for the Robert Wood Johnson Foundation's SmokeLess States Project. He is a member of the Phoenix 100 Rotary Club, a member of the Gift of Life Board of Directors, an adjunct professor in the School of Health Administration and Policy at Arizona State University, a member of the campaign cabinet for the Valley of the Sun United Way, a member of the Arizona Town Hall Board of Directors, and an active participant in numerous other civic and community activities.

### **Lawrence J. Shapiro, MD**

Dr. Shapiro is President and Chairman of the Board of Directors of Health Services Advisory Group. He has been a leader in health care for over 35 years, serving the medical community as well as maintaining a private gastroenterology practice in Phoenix. He has been active in a variety of health-care-related efforts, including serving as a Board Member and President of the Maricopa Foundation for Medical Care, the state's oldest and largest PPO. Dr. Shapiro was a member of the Arizona Medical Association's Board of Directors, the Board of Directors of Arizona Blue Shield, and the Executive Committee of St. Joseph's Hospital in Phoenix, Arizona. He has received two distinguished-service medals from the Maricopa County Medical Society. In October 2004 the Arizona Chapter of the American College of Physicians (ACP) presented its Laureate Award to Dr. Shapiro at its annual scientific meeting.

# 2005 Winner of the *Carter L. Marshall Rural Hospital Quality Award*

## **Northern Cochise Community Hospital**



**The *Carter L. Marshall Rural Hospital Quality Award* is given by Health Services Advisory Group (Medicare's Quality Improvement Organization for the state of Arizona) to rural hospitals that provide the highest quality of care to patients with pneumonia.**

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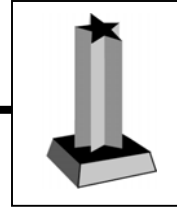
Northern Cochise Community Hospital (NCCH) is a full-service health care facility located in Willcox, Arizona, at Exit 340 on Interstate 10. NCCH offers a 24-hour-a-day emergency department, a physical therapy department, a respiratory department, a radiology department (x-ray, mammography, sonography, MRI, and CT), and a full-service laboratory. Life Net is based on the hospital campus and provides emergency medical transportation by helicopter.

NCCH was organized in 1968 as a not-for-profit corporation to serve the rural community, providing basic medical and emergency services. The Northern Cochise Nursing Home was added in 1972 with 24 beds and is a model long-term care facility.

The governing board consists of five elected community members of the Northern Cochise Hospital District, who also serve as the Corporate Board of Directors; the Medical Chief of Staff also serves on the Corporate Board. NCCH was designated as a Critical Access Hospital on February 1, 2002.

Specialty clinics host physicians from neighboring communities to serve local patients. Examples are allergy, cardiology, dermatology, ear-nose-throat, gastroenterology, gynecology, orthopedic, podiatry, pulmonology, and urology—plus prenatal care.

NCCH opened the Sulphur Springs Medical Center in 1995 with two physicians and moved into a new building in 2002 with three physicians and a certified physician's assistant; the facility currently has three physicians, a certified physician's assistant, and a certified nurse practitioner. NCCH assumed the Sunsites Medical Clinic in 1998 and moved into a new space in 2002; it serves patients in the Pearce/Sunsites area with a part-time physician, a certified physician's assistant, and a certified family nurse practitioner. Both clinics were designated Rural Health Clinics in 2004.



## Methods of Success

### Northern Cochise Community Hospital

Philosophy of Quality Services:

1. Primary Influence
  - a. Purpose and Vision
  - b. Culture
2. Quality Improvement, Performance Improvement
  - a. Partners in Quality
3. Staff, Staff Development
  - a. Training
  - b. Communications
  - c. Best Practices
    - i. Networking with other rural providers
  - d. Buy-in
4. Physician Involvement
  - a. Protocols
  - b. Best Practices
    - i. Networking with secondary providers
  - c. Training
  - d. Buy-in
5. Board of Directors Involvement
  - a. Monitoring
6. Conclusion

# 2005 Winner of the *Carter L. Marshall Rural Hospital Quality Award*

## Page Hospital



**The *Carter L. Marshall Rural Hospital Quality Award*** is given by Health Services Advisory Group (Medicare's Quality Improvement Organization for the state of Arizona) to rural hospitals that provide the highest quality of care to patients with pneumonia.

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Page Hospital is a 25 bed, JCAHO-accredited acute care hospital. It is located in Northern Arizona on the Utah/Arizona border, next to Lake Powell. Page, Arizona, has a local population of 6,500 people, but the hospital treats a much larger service area, including patients from the bordering Navajo Nation. Page Hospital's CEO is Sandy Haryasz and the CNO is Anne Haley.

Page Hospital's primary admitting diagnosis is normal vaginal delivery with healthy newborn infants. The next most frequent diagnoses are pneumonia and respiratory disease. Page Hospital is designated as a Critical Access Hospital, with five OB beds and 20 acute-care beds—all of which can be used as swing beds.

Page Hospital is managed/leased by Banner Health but owned and supported (provides capital) by the Page Hospital District.

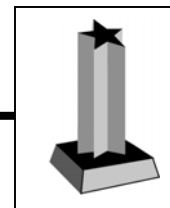
Page Hospital's Mission Statement:

*Page Hospital will lead and act as a catalyst in improving the health of the people we serve.*

*Page Hospital is committed to integrity, respect, and compassion, both to the people we serve and to each other.*

*Page Hospital will provide quality health care in a financially responsible manner.*

Page Hospital follows the Planetree Philosophy by providing Patient-Centered Care in all we do. We have many different committees functioning under Planetree, including: Healing Gardens, First Impressions, Native American Cultural Committee, Service Excellence, Integrative Therapies, Fitness/Wellness, Chaplaincy, and Personnel Appreciation Committee.



## Methods of Success

### Page Hospital

Due to our small size, we have three medical staff committees who are responsible for the oversight of quality at Page Hospital.

We have a CQI/UR Committee that is made up of the chief of staff and physician representatives from QI, ED, Surgery, Radiology and Family Practice. Our UR Advisor also sits on this committee along with the CEO, Quality Coordinator/UR Nurse, and Medical Staff Coordinator.

Page Hospital has 13 full-time physicians on staff and 34 physicians with courtesy privileges. Medical Staff membership primarily consists of family practice physicians with OB privileges. We have one internal medicine physician, one pediatrician, one surgeon, one radiologist, and three ED physicians.

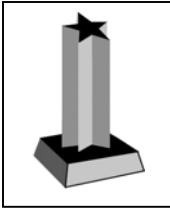
Nursing leadership consists of the CNO and supervisors of OR, ED, Med/Surg, Education, and CQI/UR.

Page Hospital has participated in the HSAG quality improvement program for many years—with pneumonia being one of our first programs. In the early 1990s we started creating clinical pathways, and pneumonia was one of the first pathways completed. This was accomplished by a special committee of two physicians, two nurses, and the CQI/UR Coordinator.

With the guidance of the Quality Coordinator, the Pneumonia Pathway was created and approved through the Nursing and CQI/UR committees. Then, with their support, the pathway was forwarded to the Medical Staff Executive Committee for approval. As new recommendations were made for the Pneumonia Pathway from either HSAG or Banner Health, reviews of the guidelines were completed by the committees and adjustments communicated.

If problems arose and variances occurred we would investigate and adjust the guidelines as needed (e.g., the ED staff was noted as not using the standing orders for pneumonia and, after special meetings and education by the Quality Coordinator, this was resolved).

The job of the UR/CQI Nurse is to ensure all new physicians are educated and oriented to the processes of Page Hospital and how the CQI department works. All patients are reviewed at the beginning of the workday, Monday through Friday, and, as the



## Rural Hospital Award Program

physicians round on their patients, the CQI/UR nurse is present to have discussion with them on the care and needs of the patient.

Results relative to compliance with the Pneumonia Pathways and other initiatives are reported to the CQI/UR Committee quarterly then reviewed by the medical staff. Since the 4th Quarter of 2004, information on compliance with pneumonia guidelines is now gathered/trended per physician and nurse, with individual counseling and thank-you notes given to inform them how they are doing.

# 2005 Winner of the *Carter L. Marshall Rural Hospital Quality Award*

## **Tuba City Regional Health Care Corporation**



*The **Carter L. Marshall Rural Hospital Quality Award** is given by Health Services Advisory Group (Medicare's Quality Improvement Organization for the state of Arizona) to rural hospitals that provide the highest quality of care to patients with pneumonia.*

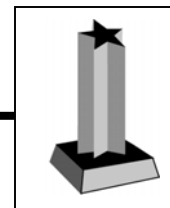
**HSAG**  
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Tuba City Regional Health Care Corporation (TCRHCC) is a 73-bed, acute-care facility on the Navajo Reservation, serving a large geographic area encompassing 3,576 square miles. The current population of the Tuba City service unit is estimated to be 27,590, with a median age of 24. The population is expected to increase at a 9.9 percent growth rate (twice the overall U.S. rate) to 30,343 by 2015. Opportunities for employment are limited on the Reservation, resulting in 43 percent of individuals living below the poverty level. Many families do not have water or electricity in their homes. In Tuba City, we also serve a large number of Hopi people, as well as members of the San Juan Paiute Tribe.

The hospital staff includes nearly 700 employees and volunteers. There are 57 permanent staff physicians, with 28 associate staff members. Nearly 150 registered nurses are also included in the total staffing for the hospital.

TCRHCC provides a full range of outpatient, inpatient, and ICU care. Surgical services include general, orthopedic, and ENT. Women's health services include routine and specialty gynecologic care, mammography, prenatal care, and birthing/breast-feeding classes. Ancillary services include physical, speech, and occupational therapy, as well as nutrition and dietetics. We have on-site laboratory, radiology, CT, and MRI capabilities. The medical center also serves as a communications hub for northern Arizona's Telemedicine Program.

The medical center is proud of its strong community ties. TCRHCC has a tradition of fostering community wellness through its Health Promotion/Disease Prevention programs and activities, the Diabetes Prevention Program, school-based clinics, and via our active Public Health Nursing Department.



## Methods of Success

### Tuba City Regional Health Care Corporation

#### Clinical Excellence in Inpatient and Outpatient Departments

Small staff/community fosters teamwork and collegiality

Medical/nursing staff longevity

Epidemiology of community-acquired pneumonia (CAP) on the reservation  
6th leading cause of death for Native Americans  
Mortality rate of CAP for Native Americans is 1.5 times U.S. rate  
Increased awareness

Patient continuity of care

Multi-disciplinary committees  
Meet regularly to discuss issues/standards of practice  
Pharmacy and Therapeutics Committee 10/02

Hospital standards for CAP

Focus on evidence-based treatment and cost-effectiveness

Standing orders  
Inpatient admission orders assess immunization status  
Outpatient departments for administration of pneumococcal/flu vaccines

#### Clinical Excellence within the Emergency Department

Nursing triage  
Identification of “the sick patient”  
Oxygen saturation as the 5th vital sign  
Rapid IV access/lab work

Average holding time for admissions

Some (not all) ER physicians immunize during a patient visit



## Rural Hospital Award Program

### Performance Improvement Excellence

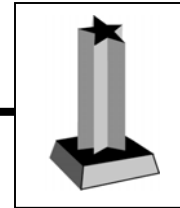
A big key: Manual extraction of data by Renee Paul/PI department

Full-time position

Regular meetings with Medical Executive Committee and the Board

Meetings with clinical staff

PI in both administrative and clinical arenas

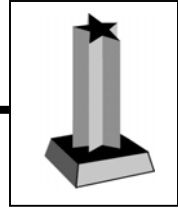


## RHAP Participation Awards

The following 23 hospitals are being given RHAP Participation Awards for meeting the following criteria:

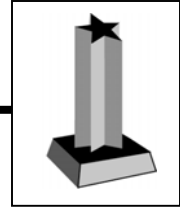
- Were designated as rural hospitals
  - Submitted at least two quarters of data in the RHAP reporting period (July 2003 through June 2004)
  - Began participating in the Hospital Quality Alliance (HQA) prior to the end of the RHAP data submission period (November 15, 2004)
- 
- Benson Hospital
  - Carondelet Holy Cross Hospital
  - Casa Grande Regional Medical Center
  - Cobre Valley Community Hospital
  - Copper Queen Community Hospital
  - Flagstaff Medical Center
  - Havasu Regional Medical Center
  - Kingman Regional Medical Center
  - La Paz Regional Hospital
  - Mt. Graham Regional Medical Center
  - Navapache Regional Medical Center
  - Northern Cochise Community Hospital
  - Page Hospital
  - Payson Regional Medical Center
  - PHS Indian Hospital—San Carlos
  - PHS Indian Hospital—Whiteriver
  - Sage Memorial Hospital
  - Sierra Vista Regional Health Center
  - Tuba City Regional Health Care Corporation
  - Verde Valley Medical Center
  - Western Arizona Regional Medical Center
  - Yavapai Regional Medical Center
  - Yuma Regional Medical Center

**Rural Hospital Award Program**



*Notes*

**Rural Hospital Award Program**



*Notes*

## A LEADER IN HEALTH CARE IMPROVEMENT

For over 25 years HSAG has provided innovative leadership on health care quality improvement projects for federal, state and private sector clients. Founded by a group of medical professionals in 1979, HSAG is one of the most experienced quality improvement organizations (QIOs) in the nation. HSAG is recognized as an agent of change in the health care industry because of the company's successful collaboration with providers across the continuum of care.

### Federal Division

Since 1982, HSAG has served as the Arizona QIO for the Centers for Medicare & Medicaid Services (CMS). The goal of the QIO program is to improve the processes and outcomes of care for Medicare beneficiaries—a goal achieved through close collaboration with community partners, including hospitals, managed care organizations, skilled nursing facilities, health and governmental agencies, community organizations, and Medicare beneficiaries. Under the current CMS contract (7th Scope of Work), HSAG promotes quality health care services for 746,026 Medicare beneficiaries and determines whether services rendered are medically necessary, appropriate, and meet professionally recognized standards of care. HSAG has extensive utilization management experience, having reviewed over 300,000 medical and surgical cases.

As a leader in the health care community in both the Medicare and Medicaid arenas, HSAG frequently convenes and facilitates committees, task forces, and work groups, such as the Arizona Managed Care Quality Enhancement Program (AMCQEP). We provide a forum for Arizona's Medicare+Choice managed care organizations (M+COs) to discuss common concerns and to develop joint strategies for addressing these concerns.

### State & Corporate Services Division

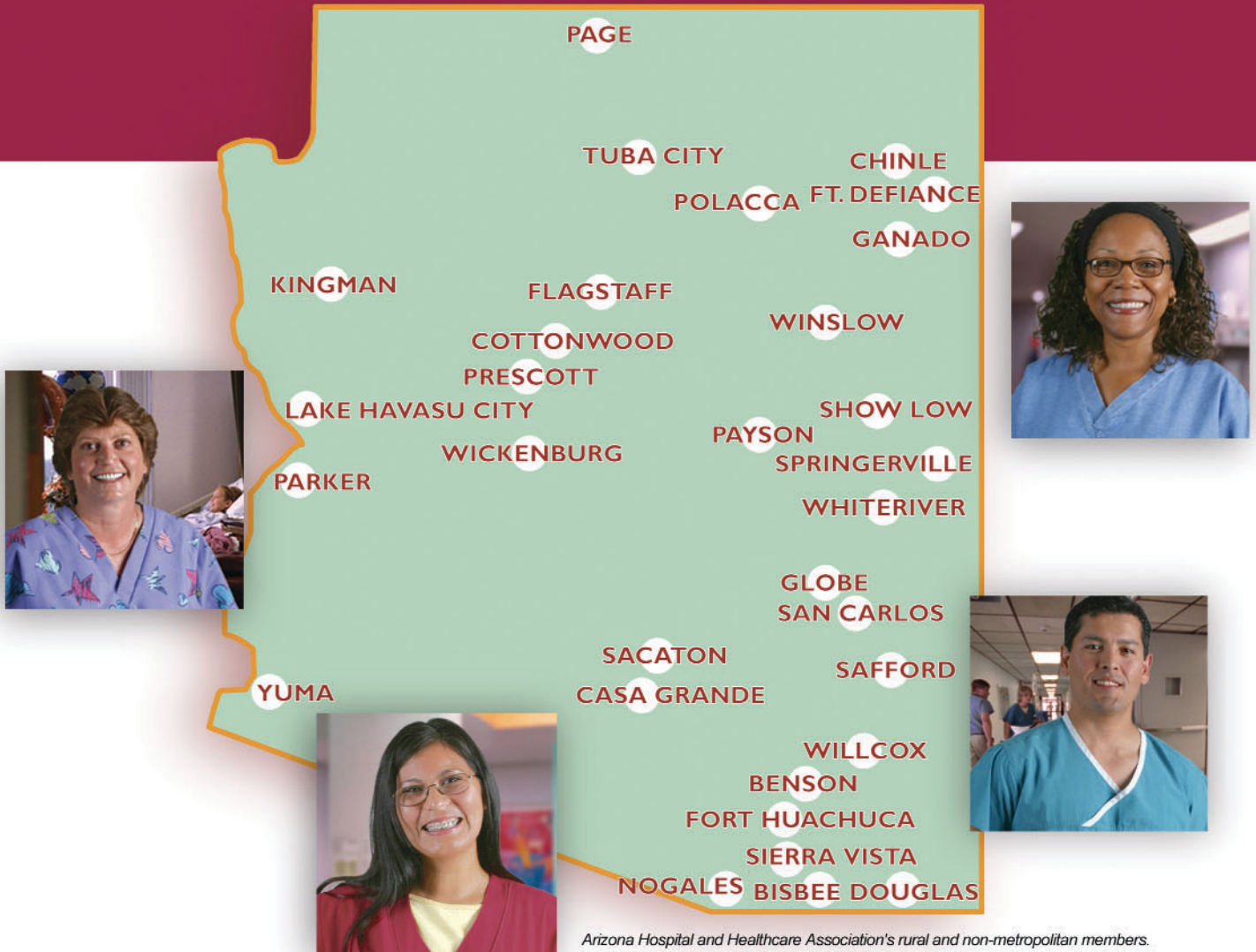
HSAG is a nationally recognized External Quality Review Organization (EQRO). For numerous Medicaid state agencies across the country, HSAG conducts health-plan specific, external quality review (EQR) of the quality of care and access to the services provided to beneficiaries enrolled in managed care organizations, behavioral health organizations, and prepaid inpatient health plans. With over a decade of EQR-related experience, the HSAG team is knowledgeable and highly experienced with Medicaid programs, populations, policies, data systems, and processes; managed care delivery systems, organizations and financing; quality assessment and improvement methods; and research design and methodology, including statistical analysis.

### Surveys, Research & Analysis Division

Surveys, Research & Analysis offers outcomes measurement and quality improvement interventions for a variety of government and private clients, utilizing survey techniques and technologies that yield high response rates and reliable, valid results. HSAG has been certified as a CAHPS® vendor since 1998. HSAG's expertise includes the use of patient reported health status surveys in large, population-based studies and multiple site projects. The Surveys, Research & Analysis team is experienced in survey management and instrument design, as well as data management, analysis, and reporting. Surveys, Research & Analysis is also responsible for the analysis and report dissemination of the Medicare Health Outcomes Survey, CMS's first outcomes measure for managed care.

CAHPS® 3.OH is a registered trademark of the Agency for Healthcare Research and Quality (AHRQ).

# Rural & Non-Metropolitan Healthcare: Delivering Value to Arizona



Arizona Hospital and Healthcare Association's rural and non-metropolitan members.

From Page to Nogales and communities in between, Arizona's rural hospitals deliver value to the people of our state. Value means delivering life-saving healthcare services, caring for the chronically ill, sponsoring needed preventive education programs, providing recession-resistant employment to the people of their communities, and more.

The Arizona Hospital and Healthcare Association (AzHHA) salutes rural hospitals for the essential services they provide to people and the critical role they play in their local economies.

To learn about AzHHA's 2005 rural healthcare legislative agenda, visit [www.azhha.org](http://www.azhha.org) and click on "Advocacy."

*AzHHA's Mission: To provide leadership on issues affecting the delivery, quality, accessibility and cost effectiveness of healthcare in Arizona. AzHHA accepts and shares in the responsibility for improving the health status of the people of Arizona.*

## Arizona Hospital and Healthcare Association

# Rural Health Office

The mission of the Rural Health Office (RHO) is to promote the health of rural and medically underserved individuals, families, and communities through service, education, and research.

The office is located in the Mel and Enid Zuckerman College of Public Health at the University of Arizona. Funding for the RHO comes from a variety of federal, state, and private resources.

One of our major priorities is the reduction of health disparities in rural Arizona. We continually address this priority through our service, education, and research activities.

Following are some examples of our activities that address our mission and priority area:

- Administer the state's Rural Hospital Flexibility Program to strengthen the rural hospital infrastructure through training programs and performance improvement initiatives.
- Recruit youth into health careers programs.
- Provide prevention services through a mobile health program for people without health insurance.
- Serve as an Information Clearinghouse to keep rural health advocates and providers informed about issues pertinent to their work.
- Perform rural health needs assessments in collaboration with local communities.
- Provide participatory program evaluation to support rural grant programs, with emphasis on the U.S.-Mexico border.
- Provide physician recruitment services to rural providers using the National Rural Recruitment and Retention Network (3-R Net).

## Current Activities

- Electronic newsletter disseminated statewide
- Rural Health Resource Directory available on RHO Web site
- Arizona Rural Health Plan available on Web site
- Grant-writing skill development
- Annual rural health conference
- Annual rural health legislative forum
- Northern and southern rural health forums
- Virtual network exchanges on current issues (e.g., Lessons Learned from the Rodeo-Chediski Fire, Influenza Vaccine Shortage, Understanding and Treating West Nile Virus, Diabetes Management and Control Strategies)
- Rural hospital board governance training
- Rural Hospital Flexibility Conference
- Trauma training for ER nurses and first responders
- Balanced Scorecard Performance Improvement Initiative
- Patient Safety Performance Improvement Initiative
- Service and Education activities in collaboration with Arizona Tribes and Nations
- Quality Managers Network
- Diabetes Coordinators Network

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**Alison Hughes**, MPA, Director (Ext. 248)  
**Howard Eng**, DrPH, Associate Director for  
Research and Education (Ext. 237)  
**Lynda Bergsma**, PhD, Associate Director for  
Service (Ext. 235)

## Web Sites

<http://www.rho.arizona.edu/>  
<http://azflexprogram.publichealth.arizona.edu/>