

# Quality of Rural Health Care

December, 2003

National Rural Health Association

Excellent quality in healthcare is the goal of all providers. The main objective of quality assessment/quality improvement programs is to ensure that the health care system achieves the goal of optimizing the health of the people for whom it is responsible. As health care can vary significantly between urban and rural areas, there needs to be rural appropriate quality healthcare standards and benchmarks that factor in these differences. Rural America has unique factors that must be acknowledged and analyzed.

In rural areas, the following factors can dominate the effect of traditional curative health-care interactions:

- Transportation
- Unemployment
- Poverty
- Lack of Access
- Community and personal health beliefs and culture
- Lack of health insurance

Additionally, the following factors add to the difficulties in collecting quality data, analysis and improvement tasks:

- Low volume
- Inadequate reimbursement
- Limited investment ability and designated qualified support staff
- Inadequate information technology
- Undersized and overworked medical staff

In rural areas, assuring statistical stability is difficult with low volumes and sample size. Examining systems and process of care, and the decision to provide care based on volume/outcome analysis, can be a better measure of true quality. Perhaps, clustering like facilities for data analysis or comparing compliance with best-defined rural practices or centering on outpatient care would be appropriate. The correct answer is unknown as there is very limited rural quality research available. To design the appropriate standards, rural data collection and research must be strengthened. Each rural population will be different. Thus, it is critical to design standards that apply to the realities of the rural areas and reflect the preferences of the population served. Quality in rural setting assumes the greatest importance across the continuum of care rather than in the inpatient settings.

In the past, standards based on data have been issued by government agencies and private organizations and the specific interpretation as to the limits that exist in the data— specifically when applied to rural— has been lost in the fine print, if there at all. This can be devastating to the rural provider.

For example, a low volume rural hospital with 100 deliveries per year, delivers an infant with a congenital malformation that is incompatible with life. This would leave the hospital with a one percent infant mortality rate while an urban hospital with a 1000 deliveries per

year, delivering the same child, would have a 0.1 percent mortality. This data on the surface would reflect poorly on the rural hospital, but it does not actually give any information on the quality of care. As data sets are becoming nationalized and mined for trends and publications, appropriate safeguards must be put in place.

The rural areas are proportionally at a disadvantage complying with quality assurance tasks and unfunded mandates. For example, having one quality officer to 100 beds, leads the 1,000 bed urban hospital to have 10 staff members to collaborate and task share. This same proportion would have 0.25 quality personnel in a 25 bed rural hospital to comply with the same mandates. Even with this proportional disadvantage, rural health care can be more flexible in its ability to influence change. For example, 100 physicians agreeing to a critical pathway would be proportionately more difficult than just working with three rural physicians. Rural models of change can actually lead in quality innovation.

The National Rural Health Association strongly supports efforts to track and improve the quality of healthcare in rural America. However, toward this goal, the NRHA urges that that these efforts fully recognize that rural America is a different healthcare delivery environment

### **POLICY RECOMMENDATIONS:**

- Use of Quality Improvement Organizations (formerly known as Peer Review Organizations) by the Centers of Medicare and Medicaid Services for the purposes of quality analysis should be properly funded and directed to establish rurally appropriate quality assessment tools and appropriate staff education for the rural health care system and its inherent differences. These tools should also include best practices, trials, struggles, solutions, barriers, and methods.
- National quality accrediting bodies should be encouraged to collaboratively consider and establish rurally appropriate quality assessment tools and appropriate staff education for the rural health care system and its inherent differences.
- Rural practitioners and institutions should be at the table when health care measures, standards and benchmarks of quality are being developed. (In support of this provision, the NRHA should join and become active in the National Quality Forum or similar organizations.
- Any quality benchmark mandates must have appropriately been analyzed for rural differences.
- A rural impact analysis and appropriate modifications to reflect the reality of rural practice must accompany any quality outcomes linked to reimbursement.
- Rural quality measures must recognize the different staffing patterns employed by rural providers compared to urban.
- Emphasis should be placed on the process of care and the systems of care as this will help to address the interpretation of statistics where low volumes and other rural issues are involved.
- Appropriate safeguards to national data sets interpretation should be put into place.

## NRHA Policy Brief

- The Secretary of Health and Human Services should continue to solicit input from rural health care providers in identifying which measures shall be used for any future public reporting systems for all providers.
- Appropriate funding to rural providers to allow building of an information infrastructure.
- Support adequate number of quality rural providers and staff through directed educational programs in and with rural communities, which enhance rural curricular and service learning opportunities in high school, college, health professions schools, and continuing educational programs.
- Support adequate number of quality rural providers and staff through recruitment, retention and reimbursement strategies.
- Support quality programs encouraging urban/rural and rural networking linkages.
- Increase funding and other support for independent rural improvement projects
- Congress should fully fund the Small Health Care Provider Quality Improvement Program authorized in Public Law 17-251.
- The Medicare Rural Hospital Flexibility Grant program should be reauthorized and include strengthening of the program's orientation in promoting quality in Critical Access Hospitals.

Much of the content and many of the concepts and examples have come from the following two papers:

Callico FW, Dillard CD, Moscovice I, Wakefield MK, J Rural Health, *A Framework and Action Agenda for Quality Improvement in Rural Health Care*. 2003;19:226-232.

Moscovice I, Rosenblatt R, *Quality-of-care Challenges for Rural Health*. J Rural Health, 2000;16:168-176

*Questions in regard to this policy brief should be directed to the NRHA Government Affairs Office at 703/519-7910*

**Visit us on-line at [www.NRHArural.org](http://www.NRHArural.org)**



**National Rural Health Association**  
One West Armour Blvd., Suite 203  
Kansas City, MO 64111-2087  
[www.NRHArural.org](http://www.NRHArural.org)