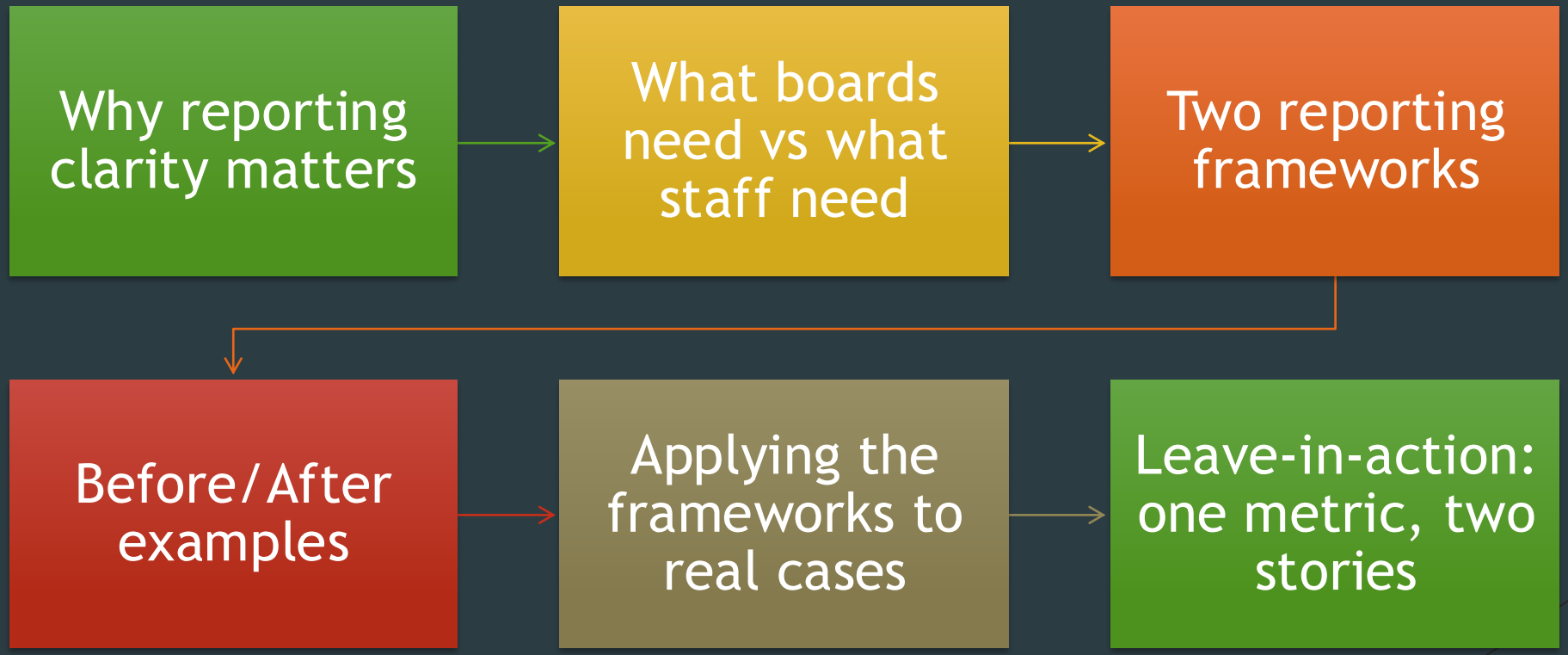
2026 Oregon Rural Health Conference Presentation Slides

Quality in Focus: Reporting That Matters to the Board and Staff

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Today's Roadmap



Why Reporting Matters



Reporting is how leaders understand risk, reliability, and where the system is drifting.



When reporting is unclear, signals get missed — and preventable harm can follow.



Clear reporting turns data into a story leaders can act on.



It protects patients, strengthens trust, and keeps the organization focused on what matters.



The quality story you tell determines whether leaders see a number or a risk signal.

Why This Session Matters for Us as Quality Leaders

- Boards rely on us to translate complex data into clear, meaningful stories.
- Staff rely on us to make metrics relevant to daily work.
- We sit at the intersection of strategy, operations, and culture.
- Strong reporting builds trust, alignment, and momentum for improvement.
- When we get reporting right, everyone — patients, staff, leaders, trustees — benefits.

Quality Reporting as Strategy

Clear reporting informs strategic priorities.

Leaders make resource decisions based on the signals we surface.

When reporting is clear, quality becomes part of organizational strategy, not a side project.

Alignment happens when boards and leaders understand the *story* behind the data.

What Boards Need vs What Staff Need



How Leaders Use Quality Reporting

To understand organizational risk

To set strategic priorities

To allocate resources

To monitor reliability

To align teams around improvement

To protect community trust

What Boards Need From Us When We Report Data

- A curated, mission-aligned view
- Interpretation: “What does this mean?”
- Signals about variation, reliability, and risk
- Trends, not single points
- Clear learning and implications
- Context for small numbers

What Boards Do Not Need from Us

- Large packets of operational detail
- Single-point data without context
- Metrics without meaning
- Lists of activities
- Reactive explanations

What Staff Need From Us When We Report Data

- Clear expectations: “What does good look like?”
- Connection to daily work
- Simple, meaningful stories
- Visibility into progress
- A sense of contribution
- Psychological safety to ask and learn

What Staff Do Not Need from Us

- Complex dashboards
- Statistical language
- Metrics they can’t influence
- Blame, shame, or fear
- Reports that feel disconnected from their reality



Tools for Clear, Actionable Reporting

The Board Story Framework

What are we seeing?
Trend • Variation • Reliability • Risk

Why is it happening?
Drivers • Constraints • Context

What's the plan?
Actions • Timelines • Accountability

How will we know?
Milestones • Expected trajectory

Before – What the Board Actually Saw

Falls per 1,000 patient days increased from 3.2 to 4.1

Benchmark comparison buried in a table

No explanation of why falls increased

No indication of risk level or contributing factors

No plan, no timeline, no leading indicators

One line in a long quality report packet

After – Board-Ready Story

What are we seeing?

- We had 2 patient falls last month, both occurring during transfers.
- This represents a 25% increase over our baseline and puts us above the state average.

Why is it happening?

- Inconsistent use of gait belts during morning care.
- Staffing patterns on early shifts create variability in support during transfers.

After – Board-Ready Story

What's the plan?

- Reinforce gait belt use during all transfers.
- Add a second-checker process for high-risk patients during morning care.
- Conduct weekly audits with real-time feedback.

How will we know?

- Leading indicators: % of transfers with documented gait belt use; audit compliance.
- Target: return to baseline within 60 days and sustain for 6 months.

After – Board-Ready Story

Why this matters to the board:

- Falls are a patient safety risk and a reliability signal.
- A pattern of transfer-related falls indicates a system issue, not isolated events.
- Early action prevents harm and protects community trust.

The Staff Story Framework

What are we focusing on?
One metric • One behavior • One goal

Why does it matter?
Patient impact • Safety • Trust

What are we learning?
Barriers • Bright spots • Patterns

What's our next step?
Clear • Doable • Team-level action

Before – What the Staff Actually Saw

Falls per 1,000 patient days increased from 3.2 to 4.1

We need to reduce variation

Staff should follow the protocol

After — Staff-Ready Story

What are we focusing on?

- We had 2 falls last month, and both happened during patient transfers.

Why does it matter?

- When a gait belt isn’t used, even strong, steady patients can lose balance during transfers.
- A fall can change a patient’s entire recovery — and it’s preventable.

After — Staff-Ready Story

What are we learning?

- The biggest variation is during morning care.
- When staff consistently use the gait belt, falls drop to zero.
- Teams that pause and plan the transfer have fewer close calls.

What's our next step?

- This week, we're focusing on one behavior: Use the gait belt for every transfer during morning care.

After — Staff-Ready Story

How we'll know it's working?

- Fewer near-misses reported.
- More consistent documentation of gait belt use.
- A return to zero transfer-related falls.



When Reporting Fails, Trust Breaks

Why Reporting Clarity Matters

- A middle-aged patient arrives in the ED with fever and confusion.
- Sepsis is suspected, but critical early sepsis elements were initiated late.
- The patient deteriorates and requires transfer to a regional center.
- Months later, a statewide collaborative publishes data showing the sepsis bundle compliance is **42%**, well below the **state average of 68%**.
- A partner hospital notices the trend and contacts the CEO with concerns.
- The CEO informs the board chair, who is surprised — they didn't realize sepsis reliability was a known risk.
- The CEO explains the metric has been included in routine quality reports.
- The board did not recognize the signal — and external partners saw it before they did.



What signal was missed — and why?

Why This Scenario Matters

The harm was preventable

The signal was visible

The board didn’t see it

External partners did

This is a reporting failure, not a clinical failure

The board missed a strategic risk signal because the reporting lacked clarity

Applying the Frameworks



Before – What the Board Actually Saw



The Board Story Framework

What are we seeing?
Trend • Variation • Reliability • Risk

Why is it happening?
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What's the plan?
Actions • Timelines • Accountability

How will we know?
Milestones • Expected trajectory

After – Board-Ready Story

What are we seeing?

- Our sepsis bundle compliance is 42%, well below the state average of 68%.

Why is it happening?

- Delays in recognizing sepsis during ED triage.
- Inconsistent initiation of the bundle elements.
- Staffing variability during high-volume shifts.

After – Board-Ready Story

What's the plan?

- Implement a rapid sepsis screening tool in triage.
- Standardize bundle initiation with a checklist.
- Add real-time huddles for suspected sepsis cases.

How will we know?

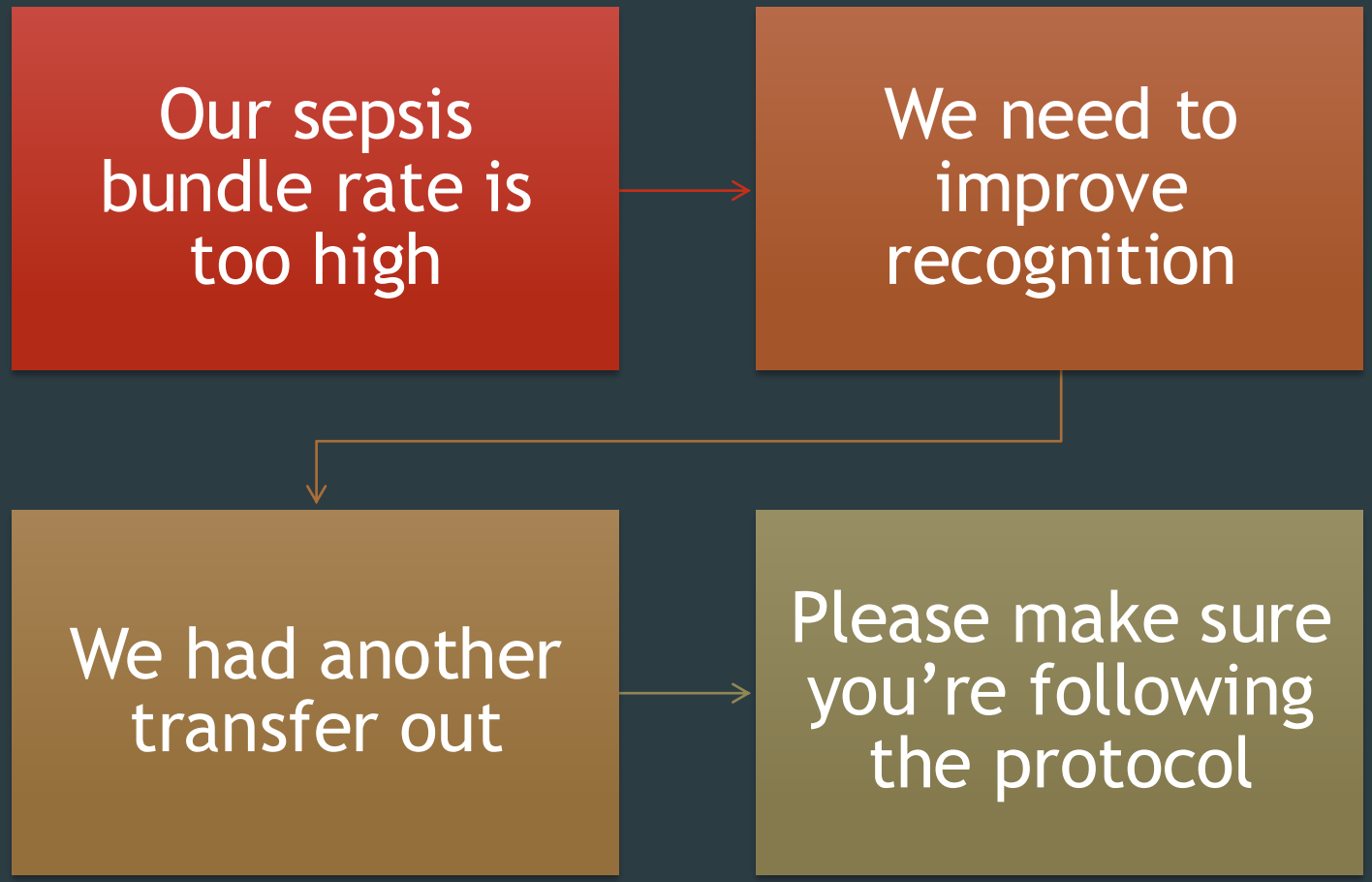
- Leading indicators: % of patients screened in triage; % of bundles started within 60 minutes.
- Target: improve bundle compliance to 60% within 90 days and reach 70% within six months.

After – Board-Ready Story

Why this matters to the board:

- Sepsis is a high-mortality condition and a reliability signal.
- Delayed bundle initiation is a preventable harm.
- Regional partners noticed the trend before the board — a reputational risk.
- Clear action now protects patients and strengthens community trust.

Before – What the Staff Actually Saw



The Staff Story Framework

What are we focusing on?
One metric • One behavior • One goal

Why does it matter?
Patient impact • Safety • Trust

What are we learning?
Barriers • Bright spots • Patterns

What's our next step?
Clear • Doable • Team-level action

After – Staff-Ready Story

What are we focusing on?

- Initiating the 3-hour sepsis bundle as soon as sepsis is suspected for every case.

Why does it matter?

- When the bundle is delayed, patients deteriorate quickly — even when they look stable at first.
- A recent patient required transfer because the bundle started late.
- This is preventable.

After – Staff-Ready Story

What are we learning?

- The biggest gap is early recognition in triage.
- When the bundle starts as soon as suspected, patients stabilize faster and avoid transfer.
- Teams that use the checklist consistently have zero delays.

What's our next step?

- This week, we're focusing on one behavior:
  - Use the sepsis screening tool for every patient with fever, confusion, or suspected infection.

After – Staff-Ready Story

How we'll know it's working:

- More bundles started immediately upon suspicion.
- Fewer transfers for sepsis deterioration.
- A steady rise in bundle compliance.



Putting It Into Practice

Leave In Action

1. Differentiate the Story

Boards and staff need different information — and different levels of interpretation.

Use the Board Story Framework and Staff Story Framework every time you report.

Why it matters:

This is how you prevent confusion, overwhelm, and missed signals.

Leave In Action

2. Interpret the Signal

Don’t just report the number.

Explain what it means, why it’s happening, and what comes next.

Why it matters:

Interpretation is what turns data into decisions.

Leave In Action

3. Connect Metrics to Daily Work

Staff engage when they understand the behavior that moves the metric.

Choose one metric, one behavior, one next step.

Why it matters:

Clarity builds confidence — and confidence builds reliability.

Leave In Action

4. Use Real Stories to Make Data Meaningful

Stories — like the sepsis case — turn abstract numbers into shared purpose.

Stories build trust, urgency, and alignment.

Why it matters:

People remember stories long after they forget the data.

Leave In Action

5. You Are the Bridge

Quality leaders translate complexity into clarity.

Your reporting shapes culture, strategy, and community trust.

Why it matters:

When you communicate clearly, everyone — patients, staff, leaders, trustees — benefits.



YOU are the clarity your organization is waiting for!

One Action in the Next 30 Days
Rewrite one metric using both frameworks:

- Board Story Framework:
  - Trend • Variation • Reliability • Risk • Drivers • Plan • Trajectory
- Staff Story Framework:
  - One metric • One behavior • One goal • Why it matters • What we're learning • Next step



QUESTIONS



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