

Center for
Rural Health

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North Dakota State Rural Health Plan ~ A Tool to Guide Decision Making

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March 31, 2009
Dakota Conference on Rural and Public Health

*Connecting resources and knowledge to strengthen
the health of people in rural communities.*

Center for Rural Health

- Established in 1980, at the University of North Dakota School of Medicine and Health Sciences in Grand Forks, ND
- Focuses on:
 - Education, Training, & Resource Awareness
 - Community Development & Technical Assistance
 - Native American Health
 - Rural Health Workforce
 - Rural Health Research
 - Rural Health Policy
- Web site: <http://ruralhealth.und.edu>

Background

- Requirement of national Flex program
- Original SRHP completed in 1999, beginning of Flex program
- Purpose: identify and assess pressing current conditions of rural health services and systems, with a focus on critical access hospitals
- Serve as a functional planning tool and guide for state Flex program – how can Flex address issues identified?
- Study conducted during 2008
- Mechanism for yearly input from community members – forums, focus groups, and other sources



Information Sources

- 2008 CAH and Flex Program survey – CAH administrators
- Key informant interviews with representatives from urban referral centers
- Two rural community forums
- Statewide Flex Program Planning meeting – Flex Advisory Committee and Flex Steering Committee



Report Sections

- ND Medicare Rural Hospital Flexibility Program
 - ND program objectives and national program objectives
- ND Conditions
 - General population characteristics and economic factors
 - Population health, minority health indicators, and children health
- ND Health Care Delivery System
 - Finance, Personnel, Utilization, CAHs, and others
 - RHC, FQHC, LTC, large referral centers, EMS, home care, public health, and others
- Issues Affecting CAH and Rural Delivery
 - Access, finance, HIT, quality, networking, workforce, and system reform
- Summary
- Appendices



Nine Primary Themes

1. Access
2. Community and Economic Development
3. EMS and Trauma
4. Finance
5. HIT
6. Networking
7. Quality
8. System Reform
9. Workforce



Access



- Stakeholder's Perspective (consumers, CAH's, statewide groups, advisory and steering committee members) [the following are representative examples but are not the entire list]
 - Proximity to health facilities
 - Cost of health care
 - Mental health services (identified by 25 CAHs)
 - Impact of the uninsured (identified by 24 CAHs)
 - Access to primary care (identified by 22 CAHs)
- Suggested Solutions from Stakeholders
 - Look at other models of care
 - Define a reasonable distance to primary care
 - Foster leadership
 - Increase involvement of younger people in decision making and community activity
 - Recognition from larger facilities of the importance of rural health in patient outcomes

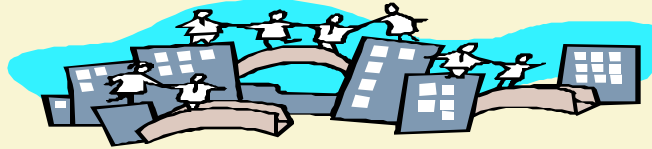
Access (Continued)



- Flex program's role – 2008-2010
 - Increase awareness and use by CAHs of specific federal grant programs that can improve access to care (e.g. Rural Health Outreach grants, Network Development Planning grants, Network Development grants, HIT, and other sources)
 - Explore alternative models such as the Frontier Extended Stay Clinic – demonstration grant in AK
 - Continue to provide technical assistance to CAHs and CAH networks (e.g. community needs assessments, specialty assessments, strategic planning, grant development, community forums and facilitated meetings)
 - Continue to provide subcontract awards to CAHs though the Flex program to address hospital, EMS, quality, HIT staff and community education program development, and network development
 - Work with the newly created AHEC on community based solutions to health workforce issues

Community and Economic Development

- Stakeholder Perspective
 - 14 CAHs believe their community members are aware of hospital financial conditions
 - 9 CAHs receive county mill levy and/or city sales tax contributions
 - 15 CAHs operate hospital foundations
 - Consumers indicated concern over lack of jobs for spouses working in health care
 - Consumers also recognized limited or at times lack of support for the local hospital



Community and Economic Development (Continued)

- Suggested Solutions
 - Assist with economic development by educating hospital CEOs on how to inform their communities on the impact of the hospital and health care on community and economic development
 - Educate hospitals on how to encourage people to leave “legacy” for the hospital – leaving dollars in will or estate planning
 - Foster community support – communities need action plans that include a health focus
 - Create an understanding of how different sectors link together to strengthen the community



Community and Economic Development (Continued)

- Flex program role – 2008-2010
 - Promote visibility of CAH contributions to community and economic development
 - Strengthen linkages to economic development and job development authorities
 - Further educate the economic development community on health cares' contribution
 - Enhance media relations at the community level
 - Explore opportunities in legacy planning e.g. meet with Impact Foundation and the North Dakota Community Foundation
 - Develop contact and linkage with the statewide Young Professional Association



EMS and Trauma



- Stakeholder Prospective
 - Heavy reliance on a volunteer system
 - Funding
 - Leadership and management
- Suggested Solutions
 - Measure EMS outcomes and link with other data
 - Rural payment system to reflect quality measures
 - Explore greater regionalization
 - Explore a paid model vs. volunteer model
 - Support training
 - Leadership training and development

EMS and Trauma (Continued)

- Flex program role 2008-2010
 - Support educational opportunities related to financial viability
 - Explore offering technical assistance to EMS units – e.g. strategic planning and assessment
 - Continue to financially assist CAHs in trauma designation
 - Continue to support EMS networks with Flex grants



Finance

- Stakeholder Perspective
 - Lack of adequate 3rd party reimbursement
 - Concerns over Medicare and Medicaid reimbursement
 - Consumers expressed concerns over reimbursement for preventive services and home care
 - Consumers perceived difference in reimbursement for rural vs. urban providers
- Suggested Solutions
 - Streamline health systems
 - Reduce paper work
 - Increase 3rd party reimbursement
 - Fair reimbursement from Medicare and Medicaid
 - Need flexible policy options on insurance and financing



Finance (continued)

- Flex program role 2008-2010
 - Provide CAH finance information to state and national policy makers for policy development
 - Continue to provide performance improvement technical assistance
 - Fund additional financial analysis of CAHs
 - Continue to collaborate with NDHA to provide finance related technical assistance and education
 - Continue to provide Flex grants to support CAH financial feasibility studies



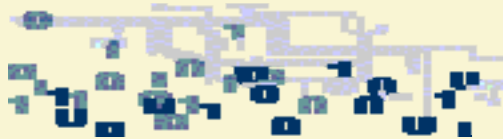
Health Information Technology (HIT)

- Stakeholder Perspective
 - Funding of HIT
 - Access to technology
 - Compatibility of disparate systems
- Suggested Solutions
 - Funding telemedicine
 - Need information technology support
 - Look for different funding for technology
 - In-home video to connect patients and providers



HIT (continued)

- Flex program role 2008-2010
 - Continue to support HIT development through Flex subcontracts to CAHs and networks
 - Continue to work with state HIT committee
 - Continue to explore other funding sources
 - Encourage CAHs and CAH networks to share information and experiences at statewide meetings such as Dakota Conference



Networking



- Stakeholder Perspective
 - Not identified as a problem, but as an area needing support through enhancement and sustainability
 - Networking seen as method to address systemic issues such as workforce, HIT, and quality
 - Consumers did identify the need for networking in general
 - Evidence of provider support of networking; 2008 CAH survey found substantial improvement from 2005 survey regarding CAH-tertiary providers' relationship (22 CAHs stated that their network was strong; 22 CAHs found their network to be flexible; and 17 CAHs identified their network as comprehensive)

Networking (continued)



- Suggested Solutions
 - Share “best practices” with tertiary providers in ND and encourage their involvement with CAHs
 - Foster seamless service provision with long term care, small rural hospitals, tertiary hospitals and clinics (coordinated services are essential e.g., hospital, wellness, schools, employers)
 - Explore the “lean philosophy” as application to CAHs
 - Flex program must be selective in use of dollars – encourage and mandate connectedness with others (networking)
 - Support networks for staff development and training
 - Support network approach to hospital board training (regional approach)
 - Support increasing and enhancing network activities among CAHs

Networking (continued)



- Flex program role 2008-2010
 - Support the sharing of “best practices” for CAH/tertiary networks by encouraging proposal submissions to Dakota Conference
 - Promote the development of FQHC and the relationship between FQHC and CAHs
 - Work collaboratively with other statewide organizations including the ND Rural Health Association
 - Continue to fund network activities through Flex grants
 - Continue to provide technical assistance and support to the statewide Quality Network and regionally based networks
 - Continue to coordinate orientation for new CAH administrators and their staff

Quality



- Stakeholder Perspective
 - CAHs continued to identify compliance with Medicare Conditions of Participation as a concern
 - Consumers expressed concerns if workforce shortages would impact quality of care; availability of “good doctors”
 - Large referral centers identified a need for increases transparency within the quality arena
 - CAHs and large hospitals found that working through the statewide quality network was a positive step
- Suggested Solutions
 - Adequate funding to address areas such as evidenced based practices, responding to regulations, new initiatives
 - Newly formed ND CAH Quality Network will play a strong role
 - Engage physicians to drive the quality agenda further

Quality (continued)



- Flex program role 2008-2010
 - Continue to partner with the ND Healthcare Review, Inc. to support the CAH Quality Network, Hospital Compare, and the Institute of Healthcare Improvement initiatives
 - Continue to work collaboratively with the NDHA quality related initiatives
 - Financially support the ND CAH Quality Network
 - Explore connections with NDMA to engage physicians in quality improvement efforts
 - Encourage increased involvement of board members and improve understanding of the board’s role with quality improvement

System Reform

- Stakeholder Perspective
 - Consumers, providers (rural and urban), and statewide organizations saw need for more consensus and less competition
 - Additional support for rural health facilities and providers
 - Defining essential access to care while taking into consideration distance, finance, equity, and patient needs
 - Concern over ability of communities to initiate change and accept change



System Reform (Continued)

- Suggested Solutions
 - Continue to develop and work with ND Rural Health Association
 - One stop shop approach for consumers on health issues
 - Insurance options that mix private and public subsidies
 - Blue Ribbon panel to address affordability
 - Look at setting up different levels of care, different provider arrangements
 - Need younger community people involved in decision making
 - Change attitudes to be less parochial and more global
 - More education of public on rural health issues
 - Document access problems



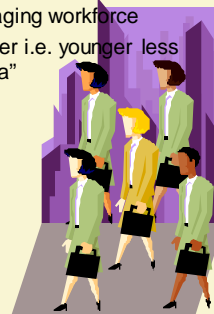
System Reform (Continued)

- Flex program role 2008-2010
 - Consult with NDRHA and other stakeholder groups on SRHP findings and results – look at additional role with other groups
 - Continue to seek input for SRHP particularly from consumers on a yearly basis
 - Promote leadership opportunities for rural health managers, board members, and providers
 - Flex program will continue to provide data and information to state and national policy makers on rural health and rural hospital issues
 - Continue to monitor the implementation of new models such as the Frontier Extended Stay Clinic (FESC)



Workforce

- Stakeholder Perspective
 - Statewide associations identified need for increased collaboration on workforce issues
 - Refinement of the traditional medical model
 - Examine different provider roles
 - Regulatory requirements that constrain current practice models
 - Network of providers for interdisciplinary training, disease management, and other service provision
 - All stakeholders identified workforce shortages and an aging workforce
 - Larger hospitals concern that generational attitudes differ i.e. younger less willing to “go on the road to provide services in rural area”
 - Physician availability
 - System reform
 - Recruitment and retention
 - Education and training
 - Rural health delivery system and workforce
 - HIT
 - Regulations
 - Reimbursement



Workforce (continued)

- Suggested Solutions
 - Flexibility of the workforce model to maintain care
 - Career awareness of school-agers
 - Focus on retention – develop a recognition program for exemplary staff
 - Offer succession/leadership cross-training to 2-3 key managers at each hospital
 - Incentives (e.g., money, housing, other)
 - Increase nurse faculty
 - Develop an ambassador program to interest children in long term care and other areas
 - Look at developing provider networks to be shared by communities



Workforce (continued)

- Flex program role 2008-2009
 - Continue to provide technical assistance in the form of 1) performance improvement planning inclusive of recruitment and retention strategies and 2) internal personnel audits inclusive of strengths and weaknesses related to staff retention
 - Continue to fund Peer Mentor program
 - Continue to fund Flex grants which can be used to create network based approaches to workforce issues
 - Continue to support leadership development
 - Partner with AHEC, SORH, NDDH, and Department of Career and Technical Education to expand Health Occupations for Today and Tomorrow (HOTT) which works to create awareness of health careers in school aged children





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