

**Annual ND Flex Program Planning Meeting**  
Steering and Advisory Committees  
April 17, 2008 Grand Forks, ND (8:30am-5pm)

**Present:** Pete Antonson, Darrold Bertsch, Randy Pederson, Rick Failing, Kathy Hoeft, Mitch Leupp, Gary Garland, Brad Gibbens, Barb Groutt, Karen Haskins, Fred Larson, Chris Lennon, Marlene Miller.

**Absent:** Tim Meyer, Roger Unger, Kimber Wraalstad

**Facilitator:** Tami Lichtenberg, Program Director, Technical Assistance and Services Center (TASC)

### **FLEX PROGRAM OVERVIEW – MARLENE MILLER**

The 5 (federal) Flex Program Goals are:

1. Designation of CAHs in the State
2. Development and Implementation of Rural Health Networks
3. Support of existing CAHs and Eligible Hospitals
4. Improvement and Integration of EMS Services
5. Improving Quality of Care

The North Dakota Flex Program aligns with the 5 federal Flex Program Goals and also includes the mandatory program evaluation component and the goal of updating the State Rural Health Plan.

### **PURPOSE OF THE DAY**

- Inform Flex Activities for Upcoming Year (September '08 – August '09)
- Discussion of Proposed Activities
- Planning for the Future of CAHs
- Aligning Flex Activities to Needs
- Evaluative Feedback
- Informing State Rural Health Plan Report

### **ENVISIONING THE FUTURE OF RURAL HEALTH in North Dakota**

**Facilitated by Tami Lichtenberg**

#### **Acceptable level of service means:**

Reasonable primary care available

Responsive EMS Services

Expectation is not for specialty services – Need coordinated care, emergency services, clinic care

Extended access for lifespan – including assisted living and long term care

#### **Healthcare hubs/regions across the state**

Leverage assets, maximize benefits

Coordinate service delivery (Example – Trinity Health serves as a hub for ambulance services)

Need infrastructure – cell phone towers

Manager/Hub of Services (i.e., EMS/ambulance – improve access to services)

Optimize tele-health – for everything to help maintain access to care

## **Leader in Quality**

- North Dakota is a leader in technology (i.e., btwan)
- Want to be the leader in quality healthcare
- Provide highest quality product
- High quality, skilled

## **Economic Development Partnerships**

- Economic Development needs to see healthcare as a partner
- More community/civic involvement and interest
- Building/growing rural population
- Without healthcare – communities go away – elderly need access
- Hospitals/healthcare providers are the leaders in the community
- Creation of other jobs in communities – motivating economic development
- We are the largest employer
  - System needs to recognize/support/accommodate
  - hub role so we can keep people

## **Workforce**

- Ready supply of nurse practitioners – way of the future
- Expand the nurse practitioner program @ colleges to plan for need
- Flexibility of workforce model to maintain care
- Adequate coverage for practitioners – RNs, pharmacists, physicians

## **Community Education about Healthcare Models**

- Need to educate community about model for service and why
  - They are aware of issues and they are practical
- Need to plan for continued loss of geographical access
  - There are pockets without services
  - What is our moral obligation? Response as a state?

## **Responsive Healthcare**

- Primary care, wellness, ED, observation, swing beds
- Link/collaborate with other agencies to share resources – School, park board, and wellness/fitness
- Move away from illness focus – turn to prevention; cautionary note in terms of how this will be funded
- Be open to looking at other models of care (e.g. urgent care center, expanded use of paramedics)

## **Reimbursement**

- Changes are required in reimbursement – policy change
  - Finance healthcare differently
  - Provide funding equitably for rural
- Need to remove disincentives for providing necessary services

## **Demonstration/Pilot Project**

- Demonstration projects – Experimental strategy
  - Involve congressional leadership – demonstration project
  - Don't want to lose infrastructure in the process of change

Regulatory flexibility critical to make healthcare responsive  
Ability to provide services without penalty  
Recognition that coordinated services are essential  
Healthcare is beyond walls of hospital  
Wellness, schools, employer assisted  
Fundamental changes are needed to allow service delivery – need ability to provide a full spectrum to meet needs  
Need positive legislation – not executed under a waiver which can be taken away.

### **STATE RURAL HEALTH PLAN (SRHP) – Brad Gibbens**

The SRHP is a requirement of each state Flex program and is intended to provide a current analysis and a blueprint for the future of rural health, specifically focused on CAHs. Key informant interviews were held with 13 statewide organizations. In addition, two community forums were facilitated. A CAH Administrator Survey was completed in February and March. Secondary data is being collected and analyzed regarding North Dakota demographics and economic information, the rural health care environment, quality, EMS, workforce, and a number of other areas.

Preliminary reviews indicate that Workforce, EMS, Community/Economic Development, Payment Policy System Reform, Transportation, Collaboration, and Technology are critical issues to be addressed for the future of rural health in ND.

### **QUALITY IMPROVEMENT - Barb Groutt**

CAHs are not required to collect and report data on the quality measures at this time. Outpatient measures fit nicely for rural hospitals – CAHs will have the option to collect and report data to CMS. The QIO has not been allowed to continue to offer resources or support for the outpatient data collection objective, but will be able to support inpatient data collection activities. Support services for outpatient data collection have been outsourced to Florida.

PPS hospitals are being required to collect/report Mortality, Patient Safety (“Never Events”), and Patient Satisfaction for HCAHPS survey. There are 43 additional measures that the PPS hospitals will be reporting as well as 9 more hospital acquired conditions that Medicare will not pay for.

At the same time quality measures are being ramped up, CMS is removing the infrastructure to help support the activities. The goal is to increase the number of hospitals reporting. There are understandable limitations in staffing, resources, and patient volume. It is hard to put strategy systems in place for such a small number of cases.

The Federal Flex program wants to increase the number of CAHs reporting. 31 of 34 ND CAHs are reporting at this time.

### **CAH SURVEY HIGHLIGHTS**

Tami Lichtenberg reviewed the CAH Administrator Survey results. Some of the top issues that were identified from her perspective included: maintaining access, workforce, reimbursement (3<sup>rd</sup> party payer, CAH reimbursement rates), access to capital and technology, impact of uninsured, maintenance of quality care, physical plant, technology, pharmacy coverage model needed, and network activities.

## **Priorities Indicated by CAH Survey:**

Quality Improvement (31%)

Strengthening Rural EMS (31%)

State Rural Health Planning (27%)

Networking (8%) *Advisory Committee comments: Flex assistance with network development is not needed as most networks have been formed and are functioning; support of those networks or use of networking as avenue for QI, EMS, and other areas is helpful and needed.*

*Advisory Committee Question: If there is turnover in CEOs and DONs, they may not be aware of Flex programs available. How much of the feedback in the CAH Administrator's Survey was from new CEOs? Answer: Most feedback was from "veteran" CEOs – a few of the new CEOs did not complete and return the survey.*

## **DISCUSSION: ALIGNING THE FLEX PROGRAM TO CAH NEEDS**

### **CEO Orientation**

This may need to be done face-to-face rather than over btwan. Trying to do it over btwan didn't work well because the intended audience members occasionally were called away from the session for other business within their facilities. One person from Flex could go to the facility and the rest of the Steering Committee could be available over btwan. CEOs could be encouraged to bring their management team to the CEO orientation to make sure others within their organization (CFO, administrative assistant, DON, etc.) are familiar with Flex.

### **Leadership**

There is a high turnover rate of CAH hospital leadership. Succession planning is needed; recognizing that turf issues can be very problematic within an organization.

Leaders need to communicate the future to people ("change leadership"). True value is not just what you do while you're there but also how seamless the transition is if/when you leave. However, sometimes there is no one from within the staff who can take over.

"Succession" or "Leadership" training could be offered to 2-3 key managers so that others can be ready if needed in case of turnover. Staff time is difficult to release due to numerous commitments.

Leadership can entail coaching the staff within organizations to help them realize they are not *the* job – they are *doing the* job. Cross training leadership teams can help maintain organizations during interim periods. We need to provide staff development to plan for succession through the organization.

We can create communities across facilities to strengthen one another. A Flex program peer exchange program was implemented this year. This program has not been utilized yet – may need more publicity. Best practices sharing can occur at all levels. People have difficulty taking the time away from their organizations.

### **CFO – Shared learning between CAH CFOs?**

HFMA is already facilitating CFO discussions. Flex could become more involved with HFMA.

### **Pharmacy Needs for Future**

Pharmacists and pharmacy techs may be used differently in the future; they are no longer mixing chemicals, but are dispensing pills so the level of education needed may be changing. Nationally, the trend is to use pharmacists in an increased role and as a primary point of contact for patients.

Karen Haskins noted that the **btwan** cannot be used if there is a charge for the program. Webinars can be offered to other hospitals over btwan.

### **Workforce Initiatives**

Workforce initiatives to address today's **healthcare model** will not work for the future. We need to understand and develop the model for the future so that it is not developed for us. The model will drive the workforce and other needs. It doesn't make sense to assume our needs of today (based on the model of today) will continue to be the needs of the future – a different model would change the needs. We need both short term and long term (sustainable) models and solutions.

Resources must be provided to train **nursing educators**; each clinical advisor must be master's level so there are not enough **clinical sites** available. It is very costly to provide training onsite. The Northwood/Rugby – Lake Region nursing program via btwan is an example of a way to meet the clinical site issue.

An **AHEC Grant** has been submitted. If it is funded, it will take the Medical School into 3 regions in the State: Eastern/Central/Western. The focus will be on training/education of healthcare professionals.

Fundamental change is needed regarding **reimbursement issues**. We need to be careful about asking for change without having a plan for what we want. If ND Flex/Healthcare can partner with 3-4 other rural states to address reimbursement issues we could have more leverage. We need to bring ideas to legislators; they know other states to partner with and how to move ideas forward, perhaps for a **“demonstration” or pilot project** to address reimbursement issues.

### **Leverage Economic Development Funds**

There is very little money available from the state for economic development, and there has not been adequate assistance for healthcare institutions (i.e., tax incentives). Sometimes the local economic development offices are more helpful; they understand the local issues, but don't have the financial resources needed. We need to take advantage of development efforts. There are economic development alternatives (i.e., church sponsored) that are not part of the organized, political structure.

The Flex program can assist with economic development issues by connecting and educating about the needs and the economic impact. More UND collaboration is needed from across departments and divisions to understand and communicate the need.

We could build capacity by training someone in the **Rural Health Works model (Dr. Gerald Doeksoen)**. This model might be too time consuming; would need to further explore.

We need to find a way to effectively communicate the economic impact of CAHs. **NDHA is updating information. We need a way to disseminate that information – to show how hospitals impact their communities.** This information is better coming from an outside agency rather than individual hospitals – otherwise it is “suspect.” We need to have accurate information to explain the information.

### **Economic Impact Questions to Explore:**

- If hospital closes, in addition to the payroll impact, how many people would leave the community because of issues related to healthcare access?
- The Flex program could study referral patterns and admissions from North Dakota communities and CAH hospitals to demonstrate the impact of CAHs and rural communities to tertiary hospitals.

- How many hospitals are receiving tax support? How much? (see recent CAH Survey)

### **Planned Giving/Estate Financial Planning**

Hospitals can encourage people to leave “legacy of healthcare” for their communities through estate planning to keep wealth in the community. An idea is to sponsor dinners with financial planners, tax experts, and leaders from nonprofits to help people consider their estate planning. Without planned giving, when people die, the money in their estates leave the community, hurting the schools, hospitals, banks, churches, and businesses because often their families are no longer in the area.

The CAH Administrator Survey showed that 41% of CAHs do not have a foundation supporting them. However, 50% said they are likely to develop one.

### **Network Support**

Flex can distribute network “best practices” to tertiaries throughout the state to encourage their involvement with CAHs. Flex funding can help the tertiaries if they are helping CAHs meet something in the scope of work, but the money has to be funded through a CAH.

### **Specialty Coverage**

It is very difficult to find specialists to come to CAHs. It may not be realistic to try to hire them, because the tertiaries can’t even get enough specialists. Specialty medicine for rural communities may be possible only through telemedicine. Flex can help by **funding telemedicine**.

### **Support EMS**

Flex can assist by providing training for EMS staff. The EMS recertification requirements may need to be addressed. They may be unrealistic and discouraging for volunteers.

The CAH Administrator Surveyed showed that 43% of hospitals have the ambulance service as part of the hospital. 71% reported that their ambulance service is not adequately staffed.

### **Board Training**

The Board Training that Southwest Healthcare facilitated has been opened up to nursing home boards as well. Board members could be empowered to train their own boards upon return from the training – at least recap to their own board members. The model has worked well on the western side of the state – could work on the eastern side as well. Board training participants should be given tours of the local hospitals when they are at trainings to help them learn about other hospitals.

The North Region Health Alliance hosts an annual board mini session including a dinner and a topic that helps reinforce messages.

### **Reimbursements**

Flex should continue to bring in experts like Eric Shell, Stroudwater. He provides information and national cost comparisons from an independent view. The legislature needs to know what the reality is. The Center for Rural Health can continue to acquire information to use by hospitals to advocate for change.

Eric Shell could present to a legislative forum of key legislative leaders, BC/BS leaders, and other interested stakeholders. It is anticipated that Blue Cross would claim that they have increased reimbursements, but the reality is that they cut funding for procedures done daily, but increase rates for procedures that are rarely done; resulting in a net loss for hospitals. Additionally, BC/BS will claim that due to CAH reimbursement increases, insurance rates will increase and tertiary reimbursements will be

negatively affected. Charlie Hundley of BC/BS said utilization is way up; but operating losses are increasing.

We need to verify the data to show the reality. The general public knows that Medicare is a problem – but they don't understand that BC/BS reimbursements are a problem. Eide Bailly is going to take 6 CAH hospitals from Minnesota and ND and do a comparative analysis on outpatient charges. They will show what the charges and reimbursements are.

### ***OBJECTIVE 1. State Rural Health Planning***

- Community Dialogues – plan to go to 3 communities and target various audiences. Will tie in to business/community economic development groups.
- May need to offer community meetings in the evening or go to their already-scheduled meeting times (i.e., noon hour meetings).
- Give immediate feedback to the local newspaper when community forum is complete; tie the feedback into the process.
- Utilize civic groups for surveying the local community (i.e., Lions Club brought fliers with surveys around to community and collected surveys to increase participation).
- Consider other uses for the SRHP.
- Flex Steering Committee should have the voice of the NDRHA. It is an expectation of the Flex program. This may cause a conflict of interest when discussing Flex grants that would need to be addressed.

### ***OBJECTIVE 2. QUALITY IMPROVEMENT***

- Three CAHs don't collect or report at this time. They are not required to do so. Goal is to maintain reporting.
- The CAH QI Network will be supported with Flex funding. Executive committee is moving forward with hiring a coordinator through the CRH infrastructure, although they may be physically housed somewhere else. There is a draft work plan and executive committee/advisory committee guidelines. Flex has budgeted 60% of the position's costs for next year. 20 hospitals released some SHIP funds to cover these costs, Flex will cover the rest. The Network will be open to all CAHs.
- Information portal will be available to help CAHs understand regulations.
- NDHA also has a quality initiative committee. It is hoped that the quality committee and the CAH quality network can be coordinated. These can be complimentary and not duplicative. If the CAH Network coordinator can be a liaison to the NDHA committee, (i.e., through quarterly reports) communication will improve. Transparency on quality and patient safety priorities is needed for improvement.
- Gary will be writing a report under this year's work plan.
- It would be helpful to have fewer and more coordinated surveys. There are too many and some have been very similar in scope. This is confusing and time consuming for CAHs.
- Lewin Group – AHRQ – TeamSTEPPS – patient safety tool to help reduce patient safety events. QIO will provide this to PPS hospitals. Lewin Group is providing the training to CAHs. There is no charge for the training. We have been invited because of a relationship we have with Nebraska. Richard Bubach and Barb Groutt have already been trained, but with the model they are proposing, hospital staff would be trained onsite.
- Participate in HRSA Patient Safety Collaborative
- CHI – received funding for telepharmacy.
- Under description of Activity 4: Change wording to say, “The ND Quality Improvement Organization in partnership with NDHA and NDMA has established itself . . .”

### **OBJECTIVE 3 – SUPPORTING HOSPITALS**

#### **Performance Management Tools – Balanced Scorecard**

Usergroup is functioning between MT and ND  
4 new CAHs will begin the BSC process

#### **Coordinate/develop educational opportunities**

Can western North Dakota CAHs work with Montana for some training?

**QI Showcase in Montana** – all of their doctors attend. Can Flex funding be used to pay/sponsor medical staff to attend? QIO: “If they will come, we will build it.”  
Physicians need to hear QI information, because they give the orders.

**National and regional conference opportunities** are very important for CEOs to meet peers and get a different perspective. Flex can improve process of CEOs reporting back to other hospitals.

#### **Promoting Visibility – CAH profiles – other partners can add the profiles to their websites**

Hospital quality awards will be given in June. That could be added to Profiles. Profiles can be updated as needed.

#### **Technical Assistance**

Flex offers through the CRH: Internal Personnel Audit, Grant Writing, Community Needs Assessments, Strategic Planning. The question of whether the TA should be reduced or changed was asked, but the decision was to keep it as is.

#### **Brad Gibbens - Economic Development**

- Bring together CAH administrators and Economic Development leaders. Note: talk to Don Frye, Mayor of Carrington. He is an economic development consultant for Otter Tail Power Company.
- Rural Electric Cooperatives
- Dakota Medical Association
- Kenton Onstad (Parshall) (North Dakota House of Representatives) – Director, Mountrail County Job Development Authority, Business Development, Mountrail Williams Electric Cooperative
- Develop a Comprehensive list of Foundations and Community Development agencies – they understand the issue even though they may not have much money to work with
- Local foundations and Economic Development foundations
- Help screen types of organizations
- Flex could provide a canned program for foundation giving. CAH hospitals don't need a foundation as a 501C because they are a non-profit.
- Host a community dinner with financial planners and tax preparers to plant a seed for planned giving.
- Department of commerce has very little to provide due to their function

#### **Through NDHA (Karen Haskins):**

- Send out surveys and report back to CAHs
- Work with EideBailley - working with Medicaid on getting cost-based reimbursement on inpatient/outpatient procedures
- Meet with boards (i.e. board of nursing)

- Post most common deficiencies on the website
- Can do on-going site visits, such as when construction is happening, to prevent problems
- Flex funds can not be used for advocacy – only for education

Proposed through NDDoH (Fred Larson/Gary Garland)

- Document Transportation access problems to CAHs through surveys, telephone conversations, email and face to face
- Veterans report difficulty getting to healthcare
- Add department of transportation – Bruce Fuchs is working with transportation problems

### **Workforce/personnel development**

#### **Shortage Designation Implications for CAHs**

- Add back in: Recruit and retain workforce personnel – with no funding

The Primary Care Office grant (HRSA) designates shortage areas – principal objective

The second objective is to improve access to healthcare

Foreign physicians to come in through J1 Visa program. Flex worked with Conrad's staff to connect J1 with H1B. Flex gets the information and the associations do the advocacy

*Question from CAH's: What is the average time it takes to fill a physician position? Is it increasing? Need to quantify how long it is. We don't have a baseline, but it could be useful to show need. One hospital has had a physician opening for 23 months and still has had no candidates – they can't even get an interview.*

*The law needs to be changed to allow church-affiliated hospitals to receive tax funds.*

### **Loan Repayment Repository**

Can loan repayment programs be expanded be used for healthcare faculty (i.e., nursing faculty) or other health practitioners – allied health and/or mental health. The advisory committee could request that legislators expand loan repayment programs.

None of the loan repayment programs have any administrative money attached.

Loan repayment is helpful but is not the answer, because we can't even get the interview.

## **OBJECTIVE 4. NETWORKING**

Priority Needs:

- More IT focused
- Recommendations for IT – common standardized framework for state
- Make sure it is compatible with counterparts – there are patches to make programs work together
- Flex CAH-HIT grants – we will learn a lot about this that we can use/share
- Toolkit – HIT CAHs – “tele-presence” – where you can ignore and forget about the technology
- State funding to push IT – see Utah example

## **OBJECTIVE 5. STRENGTHEN EMS SERVICES**

Getting CAH trauma designation will probably become a mandate. Funding has been set aside for 3 hospitals within the current year; 2 more hospitals will receive funding next year; 2 more the year after. This will cover all CAHs as part of the trauma system.

Critical Illness and Trauma in Montana – Rural Model for online training - Nels Sandal  
24-access to communication with physicians – cell phone problems - infrastructure needs to be strengthened. Trinity Hospital and its CAH network hospitals is a model for other tertiaries to learn about (plan to explore in next Flex year).

EMS initiatives will continue to be considered for funding through Flex network grants.

#### ***OBJECTIVE 6. CAH CONVERSION***

Some hospitals are considering decertification due to increased volume of non-Medicare. There are many changes in the western part of the state due to the oil industry. The population is increasing. This is causing changes for CAHs. If their volumes are high enough, may not be beneficial to remain a CAH. Outpatient volume continues to be much higher than inpatient.

#### ***OBJECTIVE 7. EVALUATION***

We have obligations to meet our work plan objectives and we are required to collect information and evaluate our activities. This is achieved in different ways such as statewide survey of CAH feedback, evaluation of technical assistance, and partners. Flex plans to explore performance improvement strategy using the balanced scorecard at the programmatic level.

#### ***WRAP UP***

Flex is a very broad program, covering many areas of focus. We want to continue to improve, be the best possible, and meet the needs of ND CAHs. The program wishes to remain flexible to the changing healthcare environment and greatly appreciates input from its partners, CAHs and others with a vested interest.