



Center for
Rural Health

University of North Dakota
School of Medicine & Health Sciences

**North Dakota Medicare Rural Hospital
Flexibility (Flex) Program**

Annual Report

Year 10: September 2008 - August 2009

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

I. Program Overview

The ND Flex Program is administered by the UND's Center for Rural Health, School of Medicine and Health Sciences. Program partners include the ND Healthcare Review (the state's quality improvement organization), the ND Healthcare (hospital) Association, and the ND Department of Health (Division of Emergency Medical Services and Trauma).

The ND Flex Program was developed in 1998 and has received between \$450,000 and \$636,000 each year. The beginning years of the Flex Program focused on assisting small rural hospitals convert to CAH status. Since 2004 the focus has shifted to providing technical assistance around planning, finance, quality, performance improvement and emergency medical services. The program has always provided funding directly to CAHs for the purposes of program development, network development, financial viability, community engagement, emergency medical services, trauma designation and other.

Since it began the **ND Flex program has provided over \$3.7 million in direct funding** by way of grants to ND's rural communities. There have been 149 CAH grants, 49 EMS Network grants (impacting 72 additional partners in 30 counties), 54 CAH Network Enhancement grants (impacting 56 additional partners in 26 counties), 4 Trauma Designation grants, 5 Board Boot Camp grants, and 5 Making a Difference grants. Approximately 120 communities have benefited from the varying types of Flex Program grants representing almost one-third of all communities in the state.

In addition to administering direct funding to the state's CAHs, the ND Flex Program provides direct technical assistance to small rural hospitals, all of which is designed to help plan for the provision of health care in the future. To date the Flex Program has provided or facilitated the following: 24 community needs assessments, 45 community forums/hospital meetings, 11 internal personnel audits, 32 board meetings, 9 grant writing workshops, 6 performance improvement plans, 14 strategic planning sessions, 32 CAH profiles, and developed the statewide ND CAH Quality Network.

North Dakota had one CAH reorganize itself which resulted in one less CAH in the state for a total of 38 rural hospitals. Three larger rural hospitals received CAH designation, bringing the state CAH total to 36 of the 38 rural hospitals (95%) that are eligible. The remaining two rural facilities are IHS hospitals in Belcourt and Ft. Yates.

The ND Flex Program is guided by a steering committee comprised of members with expertise in each of the program focus areas including quality, network development, planning, emergency medical services, trauma and hospital finance. Committee members are as follows:

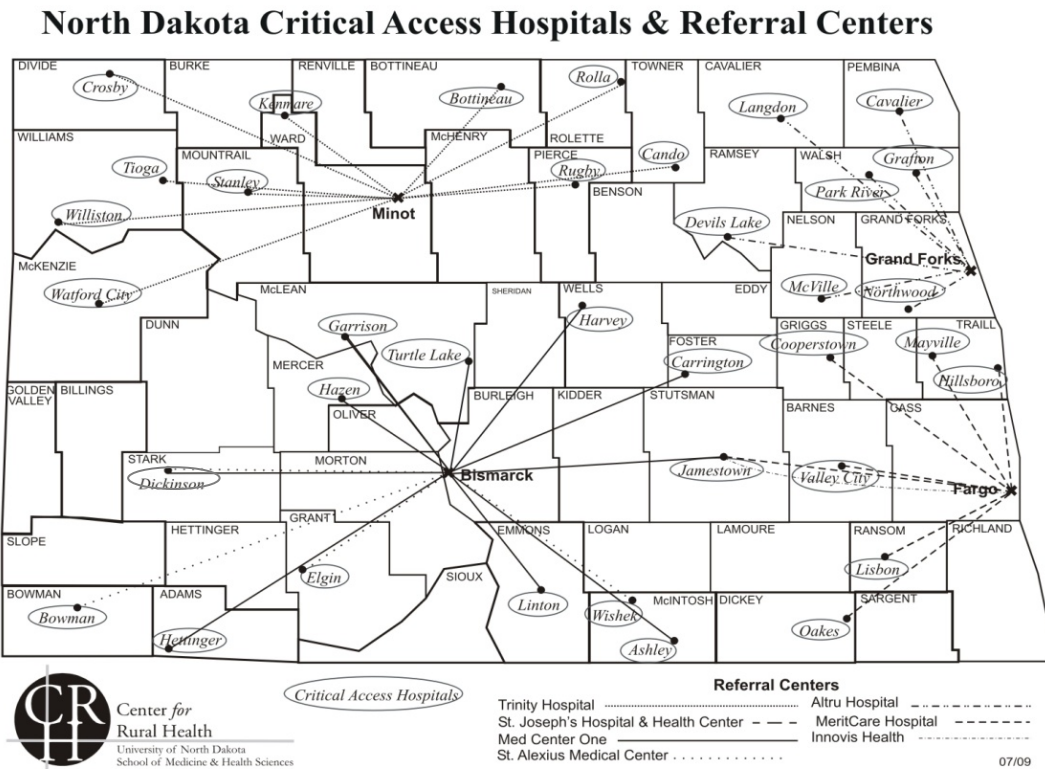
- Marlene Miller, Chair, Center for Rural Health
- Brad Gibbens, Center for Rural Health
- Barb Groutt, CEO, ND Healthcare Review, Inc.
- Tim Meyer, Director, Division of EMS and Trauma, ND Department of Health
- Tim Blasl, Vice President, ND Healthcare Association

An advisory committee works with the steering committee and represents critical access hospitals from the state's eight human service regions.

Committee members are as follows:

<p><i>Representing Regions I and II: Crosby, Tioga, Watford City, Williston, Kenmare, Stanley, Bottineau, Rugby</i></p>	<p>Daniel Kelly, CEO McKenzie County Healthcare Systems (701) 842-3000 Randy Pederson, CEO Tioga Medical Center (701) 664-3305</p>
<p><i>Representing Regions III and IV: Rolla, Langdon, Cando, Devils Lake, Cavalier, Grafton, Park River, McVile, Northwood</i></p>	<p>Pete Antonson, Administrator Northwood Deaconess Health Center (701) 587-6060 Kimber Wraalstad, President/CEO Presentation Medical Center (701) 477-3161</p>
<p><i>Representing Regions V and VI: Mayville, Hillsboro, Lisbon, Harvey, Carrington, Cooperstown, Valley City Jamestown, Oakes, Ashley, Wishek</i></p>	<p>Kathy Hoeft, Administrator Ashley Medical Center (701) 288-3433 Mariann Doeling, CEO Carrington Health Center (701) 652-3141</p>
<p><i>Representing Regions VII and VIII: Garrison, Turtle Lake, Hazen, Elgin, Linton, , Dickinson, Bowman, Hettinger</i></p>	<p>Darrold Bertsch, CEO Sakakawea Medical Center (701) 748-2225 Jim Long West River Regional Medical Center (701) 567-6183</p>

The following map identifies ND CAHs and their primary referral patterns with the four large urban centers.



II. ND Flex Program Objectives (2008-2009)

The ND Flex Program addressed seven objectives over the 2008-2009 funding cycle. The following is a summary of accomplishments by objective.

Objective 1 Update ND Flex Rural Health Plan	Outcomes/Impact to Facilities
1. Finalize ND State Rural Health Plan (SRHP) <ul style="list-style-type: none"> - Development of environmental scan - Complete final report of state rural health plan 	<ul style="list-style-type: none"> • Final version was completed fall 2008 and distributed. The plan was submitted to ORHP, steering and advisory committees, stakeholders, state associations, CAHs, and tertiary hospitals. It was also packaged for distribution (as appropriate) to legislators and posted to the web site. State associations were invited to participate in individual follow up calls to walk through the document. • PowerPoint of the Plan was developed and shared broadly spring of 2009. Report distribution list includes 68 organizations. • The Plan was used to inform a North Dakota Environmental Scan on Health and Healthcare. (Published February 2009).
2. Implementation of SRHP Workplan <ul style="list-style-type: none"> - Develop committee structure (comprised of Steering and Advisory Comm. with others) to implement recommendations developed in 07-08 - Collaborate with existing initiatives and structures addressing identified themes <i>Ongoing</i> 	<ul style="list-style-type: none"> • The Plan was used to inform the 2009-2010 Flex application with focus on each of the major themes. A small workgroup was formed to discuss economic development suggestions. It includes 3 CAH CEOs and 3 representatives from rural economic development authorities. (<i>See objective 3: Supporting Hospitals, Task 4</i>) • The Flex program is collaborating with the North Dakota AHEC on workforce. Flex director worked with AHEC and SORH in submitting NIH grant application (\$300,000) to support local workforce initiatives. Grant was submitted May 2009; denied fall 2009. • State appropriations approved (\$500,000/biennium) to support rural workforce. The majority of this will be used to address workforce issues including recruitment/retention (including strategic planning), workforce data analysis (supply and demand), and exposing youth to health careers.
3. Develop and host three community dialogues <ul style="list-style-type: none"> - Develop dialogue process for two types of events <ol style="list-style-type: none"> a. one as a facilitated community forum b. one as a focus group to secure input from broader constituencies, one as meeting with a civic group combined with short survey 	<ul style="list-style-type: none"> • Focus groups were held at St. Andrews Health Center in Bottineau in February 2009. 4 groups were held and 40 participants attended. Analysis and a final report was completed and distributed in April 2009. Input from the focus groups was used within the framework for the community dialogues. • In March 2009, focus groups were performed for Jacobson Memorial Hospital. Sessions were held in Elgin, Carson, New Leipzig, and Glen Ullin. A total of 8 groups were held and 14 people attended. 8 key informant interviews were also conducted in April. A final report was completed and delivered in May 2009.

Objective 2 Support Quality Improvement	Outcomes/Impact to Facilities
<p>1. Maintain CAHs reporting to Hospital Compare.</p> <ul style="list-style-type: none"> - Technical assistance provided related to reporting, using collection tools. 	<ul style="list-style-type: none"> • Increased number of CAHs reporting data to the CMS warehouse from 26/35 to 33/36. (Reporting on at least one quality measure). About one half of these CAHs are submitting their data to Hospital Compare. • To increase reporting from CAHs, a significant level of assistance has been provided including support materials being sent and a request for assistance form. • A significant level of assistance was offered including sending out support materials and request for assistance forms to CAHs. NDHCRI provided at least 48 episodes of technical assistance to 36 CAHs relative to quality data collection and reporting. • NDHCRI presented on CMS quality measures for the NDHA CAH Quality Initiative on March 17, 2009. Also presented at the CAH Quality Network conference in June 2009 and their strategic planning meeting in October 2009. • 4 CAHs utilized NDHCRI's rural peer review process from 4/1/09-7/15/09.
<p>2. Support statewide CAH Quality Network.</p> <ul style="list-style-type: none"> - Formalize QI Network workplan - Network and learn from Montana PI Network - Priority areas: sharing information and resources, developing network and mentoring program, education, conditions of participation, CMS indicators. - Explore usefulness and interest in subscribing to a patient safety internet-based portal. - Participation in national training to build capacity - NDHA Quality Initiative to work in conjunction with the ND CAH Quality Network 	<ul style="list-style-type: none"> • Developed ND CAH Quality Network. Participation from all 36 CAHs as well as 2 IHS facilities. <ul style="list-style-type: none"> - Network Coordinator, Jody Ward was hired to support the Network in May 2008. - Webpage launched Oct 2008. www.ruralhealth.und.edu/projects/cahquality - Network listserv went live Sept 2008. Participation from over 100 CAH staff. - Network brochure developed in June 2009. Disseminated quarterly. • Partnership call was held with MT PI Network in December 2008 to discuss abstraction tools used for patient safety, ER trauma, CoP, etc. • Health Care Safety Zone Software Portal – live demonstration project with 14 ND CAHs developing mechanism for collecting, reporting and benchmarking events (medication errors, falls, employee incidents, and more). <p>On February 4th a survey was sent to 14 CAHs participating in the pilot project. Results were used to inform future Flex funding and recommendations for other CAHs. Evaluation of results was also performed with Clarity on Feb 20th. HCSZ New User Packets were mailed out to potential new users. This included a support letter from Nelson County Health System, a letter from Clarity, a software survey, and a ND Fact sheet. A discussion and demo call was held on April 24th for potential new users; many current users were also included.</p> <p>13 CAHS have extended their membership for next year (2 new hospitals joined and 2 from pilot dropped off). Flex is assisting with membership fees by funding \$1,500 of the \$5000 fee for each hospital.</p> • The Network developed a policies and procedures document to assist with CoP compliance (April 2009). This was distributed to members, posted to website, and sent to the Flex Committee. • CAH Quality Network Conference was held in June 2009 in Mandan. 45 people attended with 25 CAHs represented. Presentations were given on latest quality data and Peer Review (NDHCRI); CoP, survey process and common deficiencies (NDDoH); EMR (First Care Health Center); and the Quality Network. • In April 2009 the Network was awarded a one year HRSA Network Planning grant for \$85,000. This application was submitted through Nelson County Health System on behalf of the Network. Only 18 of approximately 200 were awarded. <p>A HRSA grant work call was held to discuss the creation of a workplan, communications and deliverables. A strategic planning meeting was held in October 2009 for all Network members.</p> • Jody Ward has participated in a number of training opportunities and has been making contacts with all hospitals in North Dakota, other statewide networks, IHI on behalf of the Network members. She has provided direct technical assistance

	<p>to CAHs as requested, manages the list serve, meets monthly the Network's Executive Committee, participates in regional quality meetings as requested and more. She has been very well received having made several site visits to date.</p>
<p>3. Assist small group of CAHs to reduce incidence of hospital-acquired pressure ulcers.</p>	<ul style="list-style-type: none"> • 1 CAH, 1 PPS, and 5 Nursing homes participating in this project (through NDHCRI). • IHI Node hosted educational offering in April regarding pressure ulcers. • NDHCRI provided ongoing support to the CAH participating in their initiative to reduce the incidence of hospital-acquired pressure ulcers. They also facilitated an AHRQ Patient Safety Culture Survey.
<p>4. Provide technical assistance with IHI campaign.</p> <ul style="list-style-type: none"> - Provide technical assistance about IHI's campaign - Coordinate educational sessions 	<ul style="list-style-type: none"> • The ND IHI Node is made up of representatives from NDHCRI, NDMA and NDHA. In July 2009 a call was held with the IHI field officer to discuss future plans. ND node partners scheduled to meet after August 2009 to discuss future activities to support IHI's current initiatives. • From September through November 2008, NDHCRI provided technical support for data collection and reporting activities to approximately 17 CAHs. Additionally, have provided information via group e-mails to all CAHs concerning the dry run for posting of heart failure readmission rates, as well as HCAHPs data submission deadlines. • Supported 15 CAHs participating in the 5 Million Lives Campaign. In January 2009 the IHI node hosted a BTWAN broadcast for all ND hospitals. The broadcast featured IHI faculty from Boston, MA who provided education on MRSA, Pressure Ulcers, and Surgical Care Improvement for ND hospitals only. All CAHs invited to participate in this series. • NDHCRI provided all hospitals (including CAHs) with the Surgical Safety Checklist, asking them for implementation. Collaboration with BCBSND.
<p>5. Coordinate CAH training of TeamSTEPPS training</p> <ul style="list-style-type: none"> - Work with Lewin Group consultants (subcontracted through AHRQ) to provide CAH trainings 	<ul style="list-style-type: none"> • Master Trainer Workshop held in August 2008. This was a co-sponsored training for CAHs and other hospitals and a total of 15 participated (12 CAHs). All CAHs who participated in the August training were invited to join monthly calls with NDHCRI to discuss best practices. Calls were held through April 2009. On average, 8 hospitals participated and shared their TeamSTEPPS efforts. • The Quality Network assisted with a one day regional training sponsored by Altru Health for their annual ethics conference. TeamSTEPPS was presented and 54 people attended. • In January 2009 an electronic survey was sent to CAHs to gauge interest in 2009 TeamSTEPPS training. • A TeamSTEPPS fundamental training was scheduled for March 2009 but was cancelled due to flooding. (70 participants were registered to attend). This training was rescheduled for June in Mandan. It was a collaboration between Flex, NDHCRI and the CAH Quality Network. The Flex program covered meals, mileage and lodging. 31 people were in attendance made up of 11 CAHs, 2 IHS, MeritCare, Dept. of Health, CRH and Eastern Area Health Education Center. • Correspondence with 5 Flex programs (OR, WY, WA, ID, NE) regarding TeamSTEPPS initiatives across states. Shared information on ND approach and anticipated continuation. (Request from Oregon and Idaho to share TeamSTEPPS process during Region E meetings). - April 2009. • A second Master Training was held in June 2009 in Minot (QIO sponsored). 1 IHS and 2 CAHs were present. • Marlene and Jody presented on TeamSTEPPS to the UND faculty of inter-professional courses in spring of 2009. The faculty is considering ways of integrating TeamSTEPPS with their curriculum.

	<ul style="list-style-type: none"> • QIO presented TeamSTEPPS at the UND School of Medicine for Senior Colloquium. • Jody, Marlene and Barb attended a national TeamSTEPPS meeting in Omaha June 2009.
<p>6. Participate in HRSA Patient Safety Collaborative</p> <ul style="list-style-type: none"> - Attend May 1st national meeting - Coordinate ND efforts and work with other stakeholders - Work to inform and solicit CAH interest of the program 	<ul style="list-style-type: none"> • Marlene and Barb attended a national introductory meeting in May 2008. • Recruitment efforts were conducted but no CAHs applied. In June 2009 discussions were held with one facility regarding the interest to submit an application for the 9/2010 series for collaboration with long term care, hospital, clinic and pharmacy. Application will be submitted July 2009.
<p>Objective 3 Support Hospitals</p>	<p>Outcomes/Impact to ND Rural Hospitals</p>
<p>1. Foster adoption of performance management tools by CAHs.</p>	<ul style="list-style-type: none"> • Balanced Scorecard presentations given to 4 CAHs: McVile, Linton, Langdon, and Watford City. Linton implemented a Balances Scorecard for their Quality program. Others not ready at this time. • BSC implementation is now part of the Flex program’s TA offerings. Relevant documents have been updated to include this type of assistance. BSC was featured in June 09 Flex Update.
<p>2. Coordinate /develop educational opportunities</p> <ul style="list-style-type: none"> - CAH Pre-Conference at annual Dakota conference. - Explore leadership training opportunities, succession planning, other. - NDHA offerings that address coding, reimbursement or quality. - Support Administrators to attend national meetings. 	<ul style="list-style-type: none"> • 12 CRH staff members attended a CAH finance presentation by Darrold Bertsch (SW Healthcare) and Pete Antonson (Northwood Deaconess) at the UND School of Medicine and Health Sciences in November 2008. • Dakota Conference 2009 was cancelled due to flooding. Preconference had 45 attendees registered. CAH meeting was rescheduled in conjunction with the NDHA Annual Conference in Sept 2009. • NDHA supported costs for Dan Kelly (Watford City) to attend annual AHA convention. • NDHCRI presented “Quality Matters” at the Public Health Evaluation in Dickinson in May 2009. • A Board Boot Camps were hosted in Bowman on May 2009 by Southwest Healthcare System. Another was hosted in Grand Forks by Nelson County Healthcare Systems (McVile) in July 2009. <i>(See Objective 4: Networking, Task 1)</i> • Eric Shell, Stroudwater Associates, presented a CAH Fiscal Management seminar to the ND CAH facilities on June 16 2009 through NDHA and Flex. There were 71 in attendance, representing 24 CAH facilities. This was an all day presentation geared towards CAH department managers and supervisors, accompanied by senior management, to help managers better understand rural hospital financial performance and the linkage between finances and service delivery. A composite of the evaluation form is on file. • Brad Gibbens, Co-Interim Director, presented "North Dakota Rural Hospital Flexibility Program: Grant and Technical Assistance for ND CAHs" to the board of directors of the Towner County Medical Center (Cando) in July 2009. The presentation also included discussions on other federal grants such as the Rural Health Outreach, Network Development, and Network Development Planning grants. • Barb Groutt, NDHCRI CEO, presented “Quality Update 2009” to the North Dakota Risk Manager’s Association in September 2009.

<p>3. Promote visibility of CAH contribution to healthcare.</p> <ul style="list-style-type: none"> - Coordinate press releases for all Flex funded activities at the local level - CAH profile dissemination plan continued and profiles updated as needed. - Research and provide CAHs with options for planned giving programs. 	<ul style="list-style-type: none"> • Flex collaborated with the PCO and SORH to host a “Meet and Greet” in November at the UND School of Medicine and Health Sciences for 14 hospitals to visit with medical students (including PT, OT, and CLS students) for the purpose of workforce recruitment. “Meet and Greet” was cancelled due to poor weather conditions. • Press releases submitted to all local newspapers regarding 2008-2009 Flex awards. Also published by The Office of Public Affairs at the UND SMHS. • Press releases submitted to all local newspapers regarding 2008-2009 SHIP awards (December 2008). • April 2009 issues of CRH-U informed that SW QI regional network received the Making a Difference Award. This was also featured in June 2009 issue of SMHS “<i>Medicine.</i>” • CAH Quality Network featured in various publications: Grand Forks Herald, <i>ND Hospitals Focus on Teamwork to Ensure Safe Care for Patients</i>, Minot Daily News, <i>Hospitals ‘Step’ it up</i>, North Dakota Medicine, <i>Improving the Quality of Hospital Care in North Dakota</i>, and PRWEB, <i>North Dakota Critical Access Hospital Quality Network Selects Clarity Group in Pilot Project to Improve Patient Safety in the State</i> • Continuing to update CAH profiles: 30 of 36 completed. Can be viewed on the Flex website. Updates made as needed and upon request. • Planned giving programs: TASC fundraising manuals featured in December Flex Update (Issue 161). Also posted to Flex website (resources page). <i>See task 4.</i>
<p>4. Provide technical assistance to CAHs.</p> <ul style="list-style-type: none"> - Community needs assessments, internal audits, financial, strategic planning, grant writing workshops. - Develop template for planned giving programs - Information dissemination through Informer /other NDHA publications and Flex updates - Clearinghouse (NDHA) - Access to consultants and NDHA attorney 	<ul style="list-style-type: none"> • A Community Needs Assessment was developed for Bottineau (St. Andrew’s Healthcare); however, the return rate for the surveys was not sufficient to form recommendations. A final report including written comments was sent to St. Andrew’s in November 2009. The decision was made to host a number of focus groups to inform the hospital of the community needs. A final report was completed and distributed in April 2009. • In March 2009, focus groups were performed for Jacobson Memorial Hospital. Sessions were held in Elgin, Carson, New Leipzig, and Glen Ullin. A total of 8 groups were held and 14 people attended. 8 key informant interviews were also conducted in April. A final report was completed and delivered in May 2009. • In October, Marlene connected with TASC regarding a Toolkit for CAHs which is designed to provide guidance to administrators in collecting and reporting community benefit data to comply with federal and state community benefit reporting requirements. <p>The toolkit was posted to the website in December. It contains information about capital campaigns, fundraising, and estate planning. The Flex Program decided to use this available toolkit, rather than recreating a new one for ourselves.</p> <ul style="list-style-type: none"> • Highlighted TASC’s “Raising Funds for Rural Health Care” manual in the December Flex Update (issue 161) along with posting to the website. This manual lays out the basics for establishing a structured process of ongoing philanthropic resource development. The information provided in this manual is targeted at small, rural health care entities with limited resources and staff for fund raising. It addresses the main components of a well-structured resource development program. The goal of this manual is for the reader to develop a better understanding of the core areas of resource development: Annual Fund, Capital Campaigns, and Endowment. • Each Flex Update features a single form of technical assistance offered by the Flex Program (started in June 2009). This is to raise awareness to CAHs and others.

	<ul style="list-style-type: none"> • Developed EMR Get Ready Project which provided specific assistance to 13 ND CAHs to prepare for EMR implementation. Opportunity for the CAHs to participate in the EMR Get Ready was sent out with a deadline for the end of June 2009. Excess Flex dollars were reallocated to help this process (CAHs provide \$2000; Flex contributed approximately \$3,500 per CAH). The purpose was to assist CAHs in a step-by-step process to implement EMRs. Ex: Skills inventory of staff, equipment inventory and workflow process. Assistance includes group webinars and individual assistance.
<p>5. Strengthen linkages to economic development</p> <ul style="list-style-type: none"> - Develop CAH-Economic Development work group - Identify 3-4 CAH administrators with interest in rural economic development and/or active participation in local/area economic development 	<ul style="list-style-type: none"> • In January 2009 the Flex Economic Development Committee met to discuss health as a part of rural economic development and to identify five next steps that can be reviewed for possible action. • Elizabeth Huso attended a workshop held by the National Center for Rural Health Works in April 2009. The workshop covered technical assistance and training on measuring the economic impact of the health sector. IMPLAN data was purchased May 2009. The current goal is to complete an impact study for each hospital over the next 2 years. The first report was completed September for McKenzie Co. Health - Watford City. • Brad Gibbens presented on the economic development aspect of healthcare in May 11 at Board Boot Camp in Dickinson. A survey was administered to get input on how people see local healthcare and community issues. This survey was again administered at the July Boot Camp. • Brad Gibbens presented "What Does My Hospital Have to do With My Town's Economic Development" at the AgriWellness, Inc. "The Clock is Ticking for Rural America" conference in Sioux Falls, SD (August 2009). AgriWellness is a national network of organizations working to address the behavioral health care needs of agricultural populations and communities and to provide education about those needs. • Brad Gibbens presented "Community Development Tools for Decision Making" to community representatives in a multi-community forum hosted by the MHCH Foundation in Chamberlain, SD on April 24, 2009. Representatives attended from health and community organizations from five rural and tribal communities to learn the importance of community development and how they could apply development techniques to improve their communities.
<p>Objective 4 Support Networking</p>	<p>Outcomes/Impact to Facilities</p>
<p>1. Support /promote networking activities</p> <ul style="list-style-type: none"> - Maintain listservs as requested for CAHs and their networks - Coordinate new CAH CEO orientations as needed - Meet with tertiary facilities - Support mentoring program - Administer subaward grant process to CAHs - Support two regional (eastern and western ND) board trainings by providing grants to CAHs for coordination 	<ul style="list-style-type: none"> • Flex listserv continues to be maintained. CAH Quality Network listserv went live September 2008 and has over 100 CAH staff participants. • CAH CEO Orientation was scheduled for March 2009, but it was cancelled due to statewide flooding. Rescheduled for NDHA Annual Convention in September 2009. • Brad and Marlene attending the 2009 Annual NDHA Conference in Bismarck (Sept 2009). Marlene and Tim Blasl, NDHA presenting on 2009-2010 Flex Program Goals. [39 people attended the presentation, representing 30 different organizations. Flex program hosted supper for attendants (\$632)]. • Regional tertiary/CAH meetings (quarterly). • Funds of \$10,000 available for Peer Mentoring program. Mentoring funds may be requested throughout the grant year until the available funds are used. Activity for 2008-2009 included the following: funding for staff from a ND CAH to gain a better understanding of how the EMR process will affect their environment and to prepare for the EMR implementation. Three CAHs participated in program where two helped another with its plan of correction in response to a state survey.

	<ul style="list-style-type: none"> • Flex Subcontracts: \$196,000 were funded to support CAH subcontracts. RFPs were developed and distributed to all CAHs. They were also made available on the Flex website. 18 applications for Flex grants and one application for the Making a Difference grant were received for a total request of \$519,479. • No applications for Trauma Designation were submitted. A follow up call was made to each of the five hospitals eligible for the Trauma Designation Awards encouraging them to apply. One application was received and awarded for \$8,390. The Flex Steering Committee chose releasing the remaining funding for other uses. Before this was done, each remaining eligible hospital was addressed a final time. No other hospitals requested the money. (<i>See Objective: Strengthen EMS Services, Task 1</i>). • In total, 16 applications were awarded totaling \$240,390. • Funds of \$18,000 were set aside for two board trainings (\$9,000 each). RFPs were released December 1, 2008 and awarded January 19, 2009. Two awards were made to Bowman (Southwest Healthcare System) and McVille (Nelson County Healthcare System). Bowman hosted their Boot Camp in May 2009 in Bowman and McVille hosted theirs in July in Grand Forks. • Flex calendar of events was created through Google and posted on website. Calendar is updated monthly showing upcoming events from a variety of organizations that are relevant to CAHs.
<p>2. Integration with other grant & program opportunities</p>	<ul style="list-style-type: none"> • SHIP grants were awarded to all 35 CAHs (about \$290,000) to support HIT and quality. • CAH HIT Project completed (\$1.6M) and 3 CAHs implemented EMRs. Monthly Steering Committee meetings held. Evaluations completed through national consultants (Altarum) and John Snow Inc. • BCBSND awards made to 11 CAHs (\$375,000) – HIT focus. • NW CAH region (NWAIT) submission for USDA teledistance learning grant. (Feb 09). • Flex Program worked with Altru region to submit AHRQ grant. • NIH supplemental funding awarded to support Workforce initiative (\$300,000). • Marlene presented at semi-annual Flex orientation for new coordinators and other staff in October 2008. • TASC: Marlene Miller gave National Flex Presentation in April 2009. Presentation made available on CRH website. • ND Flex featured at NRHA annual conference (May 09). • Marlene attended the TASC annual advisory committee meeting in Duluth, Minn. She has served on the committee for the past two years and has been re-elected to serve another two-year term. TASC is the national program that assists all of the nation's 45 Flex Programs, and the advisory committee assists with planning for and feedback on this federally funded program's efforts. • Brad attended the Impact Institute's capacity-building seminar “Nonprofit Executive Leadership: Leading and Managing for Success” held in August 2009 in Grand Forks, ND. The Impact Institute is a creation of the joint efforts of the Dakota Medical Foundation and The Alex Stern Family Foundation. The Institute aims to help nonprofits improve their ability to produce results. • Marlene attended ORHP All Program’s meeting Aug 31-Sept 2 in Washington, DC. (Grant requirement.)

Objective 5 Strengthen EMS Services	Outcomes/Impact to Facilities
1. Assist CAHs with trauma designation <ul style="list-style-type: none"> - Issue RFP for applications - Foster training - Share information 	<ul style="list-style-type: none"> • Trauma Designation RFPs were sent out to all 5 eligible hospitals and follow up calls were made to remind of the application process. No applications were submitted. A second RFP was released and individual calls were made to each of the 5 eligible hospitals encouraging applications. One award was made (8,390). Remaining funds available to support this activity were shifted to cover speaker costs at the ND EMS Association’s annual convention (April 09; \$5,000). This decision was based on the Flex Steering Committee’s recommendations.
2. Support newly developed (federal) online training for medical directors or other training if availability falls outside for the Flex grant cycle	<ul style="list-style-type: none"> • Several calls were made with Tim Meyer to learn more about the EMS director’s training. A call was then placed by Marlene to Teri Sanddal (Montana based program) to set up the training. All ND doctors can participate – not just those who are EMS directors. Participants must complete all of the modules to get the certificate. It usually takes about 6 hours to complete all of it. Tim Meyer completed the “state specific information” which was emailed to the Bozeman office (11/14/2008). Marketing language will be sent to us. When the contract is finished, the program should be available online in about 10 days. The cost is \$4,999. The individual cost for the program is \$300 per person; if 17 people participate, the funding has been effective. • Due to non-responsiveness from the Critical Illness and Trauma Foundation in Bozeman, this task will not be pursued any longer. (April, 2005).
3. Explore regional access to medical direction for CAH EMTs through tertiaries <ul style="list-style-type: none"> - Explore current Trinity model - Share with other tertiaries - Foster like-access to medical direction through tertiary (Altru, MeritCare, St. Alexius, MedCenter One) 	<ul style="list-style-type: none"> • Due to Flex funding reduction for program year 2008-2009, this activity was not completed. <p><u>OTHER ACTIVITY SUPPORTING EMS</u></p> <ul style="list-style-type: none"> • CRH assisted the Walsh County EMS Council with 2009 Strategic Planning. Key informant interviews were held with all Quick Response Units, ambulance services and hospitals. Information gathered will be used to develop a strategic plan in September 2009. Final report was submitted. • NDHA: Healthcare Facility Competitive Awards Program - The North Dakota Emergency Preparedness program completed the Competitive Awards for 2009. This program awarded \$300,314.00 to qualified hospitals that met certain criteria. 17 CAHs received awards. The funding is utilized to acquire physical materials needed to enhance the facility’s capacity or capability to respond to emergency events in one of the following areas: Mass fatality events; evacuation of the facility or receipt of patients from an evacuating facility; shelter in place; critical infrastructure protection; provision of trauma services; and treatment of at risk populations • NDDoH: RFP for the Rural Ambulance Service Improvement Plan was submitted June 2009. The contract will address 4 areas including: management training, quality assurance, site reviews/assessments, and a statewide recruitment drive.
Objective 6 Conversion of Hospitals to CAH status	Outcomes/Impact to Facilities
1. Facilitate conversion of suitable eligible facilities to CAH status.	Current CAH Status = 36 <ul style="list-style-type: none"> • Williston (Mercy Medical Center) received CAH designation 9/2008. (35th CAH) • Jamestown (Jamestown Hospital) received CAH designation 3/1/2009. (36th CAH) • Richardton (Richardton Health Center) relinquished CAH status 5/1/09. The hospital has converted to a long term care facility. (35 CAHs) • Dickinson (St. Joseph’s Hospital and Health Center) received CAH designation 6/30/2009. (36th CAH) .

Objective 7 Development and Management of ND Flex Program	Outcomes/Impact to Facilities
<p>1. Develop, implement & evaluate 2008-2009 ND Flex Work Plan .</p> <ul style="list-style-type: none"> - Create detailed Work Plan. - Data collection and analysis. - Dissemination of results. - Explore reconfiguration of Flex Steering Committee - Attendance at ORHP All programs meetings - Participate in NOSORH - Flex calls, TASC 90 calls, national meeting 	<ul style="list-style-type: none"> • Video conference with Advisory and Steering Committees held August 2009. The agenda reviewed the 2008-2009 accomplishments and also covered the new workplan and ideas for future work. • In March 2009 a draft workplan for the 2009-2010 year was completed and distributed to the Steering Committee for review. A Flex application for 2009-2010 was submitted in April (\$630,000). The ND Flex Program received noticed of funding for 2009-2010 (\$636,000). • Assisted with national Flex orientation (October 2008- April 2009). • Marlene served as mentor to new Colorado Flex coordinator (Fall 2009). • Invitation extended to NDRHA for board members Michael Schwab, Pharmacy Association, and Carol Goodman, Economic Development Authority in Langdon, to join the Flex steering committee (February). Michael declined. Marlene was in touch with NDRHA in July 09 to inquire again - Pete (President) to follow up with Carol and advise. • Participation in monthly NOSORH Flex calls and quarterly TASC 90 calls. • TASC: Marlene gave National Flex Presentation in April 2009. Presentation made available on CRH website. Marlene also serves on the TASC advisory committee (attended annual meeting). • Marlene attended the ORHP All Program’s meeting Aug 31-Sept 2 in Washington, DC. • ND Flex Program participated on a panel of 8 state Flex programs at a national meeting with the ORHP in Washington, DC in July. The ORHP invited the states to join in order to learn and share what makes each of them strong programs. Future planning was discussed and the information gathered will be used to develop a “Flex Success Manual.”
<p>2. Conduct sub-grantee evaluations.</p> <ul style="list-style-type: none"> - Data Collection and analysis (outcome forms and interviews of CAHs) - Develop network profiles including map and description of Flex supported initiatives - Dissemination. Share data with Flex Monitoring team as requested. 	<ul style="list-style-type: none"> • Data collection and analysis completed. Report posted online and distributed. • Map and description of Flex supported initiatives completed and updated appropriately. • All outcome reports from 2008-2009 grant year have been collected. Summary report will be available on the Flex Website. There was a total of \$23k unspent funds from the 08-09 budget. • Flex data submitted to Flex Monitoring team in October 2009.
<p>3. Evaluation of technical assistance provided.</p> <ul style="list-style-type: none"> - Conduct 6 month post technical assistance and workshop surveys - Analysis and use - Track Flex assistance provided using Center’s internal database system 	<ul style="list-style-type: none"> • CRH uses an internal tracking program (CATS) to track all activates related to the Flex workplan. • Technical assistance surveys distributed for focus groups and strategic planning. • Marlene and Elizabeth reviewed all Flex expenses submitted for 2008-2009. This is to review CRH expenses. In addition, an estimate is being pulled together for the cost of the Quality Network.
<p>4. Explore the development of a Flex Program Balanced Scorecard.</p>	<ul style="list-style-type: none"> • Not completed.
<p>5. Use of Flex Advisory Committee.</p> <ul style="list-style-type: none"> - Quarterly meetings (calls) - Maintain committee - Send to national Flex Program 	<ul style="list-style-type: none"> • Advisory committee met Sept 2009. They worked independently on the SRHP over a 3 month period. • Advisory committee intended to meet at Dakota Conference, but the conference was cancelled due to flooding. Brought together via video conference in August 2009.

	<ul style="list-style-type: none"> Steering Committee reviewed the terms of the Advisory Committee. 2-3 vacancies needed to be filled by August 2009. Chose to invite Dan Kelly (Watford City) to represent the NW region (replacing Mitch Leupp); Jim Long (Hettinger) to represent the SW region (replacing Roger Unger) Mariann Doeling (Carrington) to represent the SE region. All have agreed to join. Thank you letters were sent to Mitch and Roger for their work on the committee.
<p>6. 2008 CAH Survey</p> <ul style="list-style-type: none"> - Further analysis of CAH 2008 survey results - Use to inform Flex program initiatives including educational focus areas, subcontract awards, other. 	<ul style="list-style-type: none"> Analysis of CAH 2008 survey results were used to inform Flex program initiatives.

III. Critical Access Hospital Accomplishments

The ND Medicare Rural Hospital Flexibility (Flex) Program awarded a total of 18 Flex subcontract grants, totaling \$241,858 to critical access hospitals in 2008-2009. The following table outlines the type of grant awards made and the total amount funded by type.

18 Grants Awarded

Grant Type	Number Completed	Amount Awarded
Financial Analysis	2	\$16,200
Program Development	6	\$90,647
Network Enhancement	3	\$92,575
Community Engagement	1	\$1,940
Making a Difference	1	\$12,638
Trauma Designation	1	\$8,390
Rural Healthcare Exchange	2	\$1,468
Board Boot Camp	2	\$18,000

Grant recipients are required to submit a final report upon completion of the grant cycle and the following is a summary of CAH activity funded by the ND Flex Program. The results of those reports are shared by type of grant and reported using the following categories: accomplishments, hospital and community benefits, and lessons learned.

OVERALL IMPACT

- **100%** of respondents indicated that the grant provided by the ND Flex Program **helped their organization reach project goals.**
- An average of 2,500 individuals and 7 communities were positively impacted per grant (average grant award: \$15,024.38, range: \$1,480 to \$62,575)

Communities Impacted (Average: 6 communities per grant)

Range	1-5	6-10	11-20
Number of Communities Impacted	6	5	3

Individuals Impacted (Average: 2,500 individuals per grant)

Range	<1000	1000-6000	>6001
Number of Individuals Impacted	5	3	6

FINANCIAL ANALYSIS PROJECTS

Accomplishments: Flex funds (\$16,200) were used to support 2 CAHs with financial studies including a feasibility study to look at current mix and census/utilization to determine whether it was advantageous to convert from its current provider based clinic to a rural health clinic status; and a charge master review for another facility.

Hospital and Community Benefits: Through the varying financial analyses that were completed critical access hospitals benefited from the following:

- **Increased revenue** related to lab services, radiology and other diagnostic testing as well as patient admissions.
- **Gained understanding** of charge master and how to set up new CPT codes as well as building a relationship with a **go-to resource** for future questions.
- The community benefits from **maintained access** to a rural clinic. Community reliant on economic impact of health care.
- **Patients now experience uniform billing** on their accounts.

PROGRAM DEVELOPMENT

Accomplishments: Six CAHs received Flex funding (\$90,647) to support program development. Programming included the following:

- Clinical documentation software was purchased and installed to build onto an electronic medical record.
- Local diabetes program developed (12 participants completed the program).
- Community health fair coordinated.
- HIT interface purchased and installed to facilitate one registration system between the clinic and hospital.
- Pediatric emergency services reviewed and updated.
- Patient safety project involving urinary tract infections and the swing bed program reviewed and updated.
- Mammography program reviewed and improved through education, notification process and purchase of models.

Hospital and Community Benefit:

- **Reduced errors** caused by human error the result of clinical documentation.
- **Increased response time** in the emergency department by moving crash carts or finding the appropriate items needed for care; equipment has been used three times in code situations; portability of equipment has allowed staff to use it anywhere in the emergency room and have the option to send in the ambulance if needed or for use on the second floor of hospital.
- **Decreased unnecessary** catheter use; staff increased satisfaction.
- **Investment in staff education** necessary to continued quality of care at rural facility.
- Community gained **awareness of services and education** on advanced directives and children's health.
- **Reduction** in patient falls.
- **Peace of mind** for community.
- **Increased networking** with other local providers (community members exposed to public services, **students interacted** through events as well).
- **Promotion of diabetes education and cardiac rehab program available locally.**
- **Coordination of care** with pre-hospital setting – benefit to both EMS and nursing!

Lessons Learned: Hospitals are asked to reflect on lessons learned as a result of the initiatives undertaken in order to inform others involved in similar activities. The following was shared from critical access hospitals involved in program development activities.

- Related to the IT program – facility experienced lots of “down time” due to the system's network. They had to dismissed their IT coordinator and hire a consultant. Their full time IT position is still vacant.
- Quotes for equipment originally obtained to write the grant application had increased; not a significant different but had to use memorial funds to meet the need. Staff was very receptive and excited about new programming and equipment and very willing to be trained.

- Largest difficulty for health fair was finding an appropriate time for student participation. Flooding and blizzard conditions interrupted scheduling which resulted in absence from the keynote speaker and some exhibitors.
- Software interfacing caused many challenges until all of the “bugs” were worked out.
- Some occasional problems with hypoglycemia; having the diabetes class in the mid-afternoon may have been an issue; some forms created did not work as well as planned.
- Nurses learned the new process better and more accepting than anticipated.
- Patients are pleasantly surprised when alternative, less invasive measures are offered to ensure proper voiding. Going above their expectations in providing the best and highest quality of care to speed their recovery and decrease chance of infection instills a confidence they are receiving the best possible care close to home.
- Staff realize the importance of well organized, mobile, and updated equipment. Staff may question if the equipment is really needed or that the old stuff works fine, even though it may not be mobile. We resist change, especially when it comes to equipment we may be unfamiliar with, however once trained and implemented; the staff was excited about the increased response time and quality of care that could be given to the patients.
- Promoting healthy life styles, exercise, and wellness is important at ANY AGE. Exposure of health services available and maintenance of good health practices is essential at every age. The goal to involve the student population was accomplished and well received. The students engaged with the presenters. Superintendent was pleased.
- The conclusion/results of the feasibility study determined that changing the status of the clinic from an independent clinic to a RHC would be advantageous financially, if staffing and services were left unaltered. However, even after thoroughly reviewing the regulations for establishing a RHC prior to the feasibility study it was still determined following the study that there would be some unanticipated changes in order to meet the more stringent RHC guidelines. Therefore, the feasibility study does not reveal ALL costs needed to change status. Changing the status of a facility does not occur quickly. It requires a lot of time, work and collaboration within the facility and community.
- Found that we were better able to demonstrate true CPR on a life size mannequin. A lot of the women were actually surprised on how hard they have to press and are finding out that they need to do their breast exams more thoroughly. They are very happy that we have the breast models for their education.
- Updated technology is very difficult to obtain with the financial restraints. It is critical to take advantage of grant opportunities to increase quality of care the facility can provide.
- Interfacing required patience.
- Did not see the anticipated change in Hgb A1C - many had fairly good diabetic control prior to class.

NETWORK ENHANCEMENT

Accomplishments: Three network initiatives were supported (\$92,575).

- HIT interfaces were purchased, installed and processes implemented (involved a tertiary and CAH)
- Server purchased to support network of 3 CAHs and their EMR implementation.
- Recruitment program developed between 2 CAHs and their respective economic development corporations. Traveled to Michigan to promote rural communities and need for health profession workforce and economic development opportunities.

Hospital and Community Benefits:

- Providers have the ability to view and monitor patients' lab results electronically.
Decreased registration duplication and increased efficiencies. Accuracy of patient information a significant benefit as well.
- Continued networking allows CAHs to continually look for ways to build upon strong initiatives and relationships. Alone we are geographically isolated; we have learned that **we can and should work together in order to survive.**
- Able to provide a broad range of services to our communities and are attempting to **expand those services.**
- Hospitals involved experienced **increased efficiencies; decrease of costs.**
- **Cost of equipment was shared;** worked together to facilitate planning and structural development.

Lessons Learned:

- The unemployed people of Michigan are having a hard time selling houses. A lot of unemployed seemed very interested in relocating to western North Dakota - but when we called them back to interview them - they either did not pass their background check or lost interest in relocating.
- We enhanced our working relationship with our tertiary hospital through completion of this project. We learned that there is a lot of training and a lot of bugs to be worked out when completing a project like this.
- The positive lessons learned would be the continued ability for the members to work together to develop the data center. Because of the need for one CAH to move quickly on the new server, it was important for us to come to a consensus concerning the location of the data center. I also think a lesson learned was having just a little more time to make that decision would have been good but when the need was there, the information was gathered and everyone came together. I also think we reinforced the need to have a systematic plan of the addition of organizations to the data center. The planning process is very important! The decision to proceed with the blade server technology has been reinforced as Healthland has been adding web based modules. The ability to add a SQL Server for all organizations is much more cost effective with the blades versus the other servers.

COMMUNITY ENGAGEMENT

Accomplishments: One community engagement initiative was supported (\$1,940).

- County residents were educated on the importance of Critical Access Hospitals. Topics ranging from economics to personal impacts of the local CAH were presented. Residents received flyers in the mail, articles and ads in the local newspaper, as well as opportunities to attend public meetings to become educated about Critical Access Hospitals. The final result was the residents approved a county-wide Hospital District hospital.

Hospital and Community Benefit:

- A **hospital district was formed** supporting our CAH with 10 mills of property tax per year. The hospital district will help support the hospital financially to bridge the gap between revenue and expenses.
- This served as a **future plan for healthcare delivery** in our community.
- The residents of our county have chosen to help put the CAH on more stable financial

footing. With a more financially stable future, the medical center can look to update equipment and expand services to better care for the community members. One service already expanded without even seeing any of the tax money - updating of the x-ray equipment to a digital system which will **reduce duplication** by allowing x-rays to be read by providers at other hospitals.

Lessons Learned:

- Our county residents view local health care as a vital part of their community.
- Many people had misconceptions about how a critical access hospital is run, and although health care is a very complex business, people wanted to understand the basics to ensure survival of their local facility.

MAKING A DIFFERENCE

Accomplishments: One Making a Difference Award is made each year (since 2004). The 2008-2009 Making a Difference Award (\$12,638) was made to Union Hospital, Mayville on behalf of a regional quality network that involves CAHs and one tertiary facility (MeritCare). The network began with a Flex grant in 2003 and additional funds were used to coordinate education across all network partners. The focus was on emergency department response to pediatric and obstetric patients as well as transfer protocols.

Hospital and Community Benefit:

- **Increased knowledge and accessibility** of information needed for emergency response (pediatrics & OB)
- Community access and **assurance of quality/safe care** to emergency needs.
- **Strengthened relationship** between CAHs and tertiary.
- **Establishment of a clear referral process.**

Lessons Learned:

- Over the course of the grant period two CAHs discontinued OB services.
- There is a need for continued education of CAHs in this area – lack of confidence by staff in this area before training.
- Out-of-state observation at tertiary was difficult for RN's licensed from out of state.
- Would like to have arranged for CEUs for the educational session.

TRAUMA DESIGNATION

Accomplishments: One award of approximately \$9,000 was made to assist a CAH with achieving trauma designation. Funds were used to support training, education, and the implementation of trauma protocols. The facility has received trauma designation and is the 34th of 36 CAHs to participate in the state's trauma system.

Hospital and Community Benefit:

- **Staff trained** for trauma designation requirements as well as one new physician.
- **Improved skills** of EMS, nursing and physician.
- Community benefits through **coordination of care.**
- **Improved relationship/networking** between tertiary, hospital, and EMS providers.

Lessons Learned:

- Cannot control schedules of locums to accommodate class schedules.
- Technical class (TNCC) is able to be held at a rural facility successfully with 100% class completion/passing.

HEALTHCARE EXCHANGE

The ND Flex Program offers support to critical access hospitals that assist each other through peer support. The Rural Healthcare Exchange Program, introduced in 2007, provides travel and stipend support for individuals or small groups to meet with similar entities from other areas of the state and share information, ideas, and successful approaches to improving quality and access to healthcare services.

Accomplishments: Two applications were received (both funded \$1,543.44) to support peer exchange needs. One hospital used the funding to send a small team to a like-facility which was steps ahead in their implementation of an electronic medical record. A second facility utilized the funds to cover the costs of travel for two peers to visit their facility and assist their new directors of nursing and others with a plan of correction from a recent state survey.

Hospital Benefits:

- Facility was able to see first-hand how the same software they were in the process of implementing was being used and programmed in a like-facility. **Will result in time saved, reduced anxiety/better understanding of what they could expect or be required to do, and they developed networking contacts** to help them through the process.
- **Timely response** from peers who rallied around a common need; **lending their expertise** to developing a plan of correction. Receiving facility was able to learn from their peers, **feel supported** and submit an acceptable plan of correction to the department of health as requested. **Better prepared** for their next survey.

Lessons Learned:

- This was a great opportunity for our staff to experience the software at work in a “real” environment – not just a demo of software.
- Director of nursing and other learned how to walk through the process of developing a plan of correction. A very effective way to deal with such a situation.

BOARD BOOT CAMPS

Accomplishments: Two board boot camps were supported (\$18,000). One of the camps was held for facilities in the western part of the state (north and south regions), the other on the eastern side of the state for those located in the Northeast area including CAHs in western Minnesota. Both completed evaluations of their respective events and the results are included in this section.

- One of the awards was utilized to engage board of directors from CAHs and rural long term care facilities. A total of 18 facilities were represented by 61 participants the first day and 62 on the second day. This was the groups 3rd consecutive year in coordinating this event.
- The second board boot camp, held in the Northeast, was the first Flex supported initiative in this part of the state. Coordinators worked with those in the west to replicate processes to best suit their plans and audience. A total of 5 facilities were represented by 22 participants the first day and 12 on the second day.

Hospital and Community Benefit:

- Focus on important board related topics to **increase knowledge and comfort to serve local facility**. Topics included: cost reports, compliance, risk management, provider relations and reimbursement, roles and responsibility of health care board members, importance of economic development and healthcare, role of the tertiary and collaboration, legislative update, operations, the law of the boardroom, and quality improvement.
- Summary of participant feedback:
 - ✓ I learned a lot, very good information, great variety
 - ✓ Valuable to me as a new board member
 - ✓ Outstanding speakers
 - ✓ I learned more here at this conference than I have in the almost six years of being on my board
 - ✓ I think every board member should attend (even if they are old ones!)
 - ✓ Please do this again
 - ✓ This was very worthwhile – a reinforcement as to proper board etiquette.

Consultant Ratings

Two of the above-referenced Flex subcontracts involved the use of consultants. Hospitals are asked to rate the consultants used; the results were combined and are reflected in the table below. All respondents said that they would recommend the consultant used by their facility. Below is a list of the consultants used.

<i>Area</i>	<i>Mean Rating</i>	<i>Range</i>
Expertise, knowledge, skill level	5	5
Effective communication of ideas and concepts	5	5
Responsiveness/availability	5	5
Utilization of your time and money	5	5
Overall rating of consultant services	5	5

Consultants

- Angenix
- Independent TNCC instructors

IV. Evaluation of the ND Flex Program

An important objective of the Flex Program is to evaluate its impact and effectiveness in meeting its goal to support critical access hospitals in their delivery of health care to rural residents. The ND Flex Program approaches this objective in a variety of ways:

- Each year critical access hospitals are asked for suggestions to improve the Flex Program and for general comments of their experience with staff, subcontracts, and technical assistance.
- All Flex supported educational offerings are evaluated - attendees are asked for their feedback of presenters and logistics related to the workshop.
- The Center for Rural Health, home to the ND Flex Program, uses a comprehensive activity tracking system. This system allows for program activity tracking across many variables such as facility, county, grant objective, staff, date, level of support provided and more. This system has proved invaluable to the Flex team in identifying its outreach and tracking its efforts.

The following are the results from the aforementioned evaluation efforts.

Suggestions and Comments from CAHs (Annual Inquiry through Subcontract Process)

Flex Grant Program

- We think the Flex Program is an excellent opportunity for critical access hospitals.
- The patients and staff have been very satisfied with the programming and equipment that was implemented.
- The Flex grant process was very easy and clear cut. Questions were answered completely and timely by staff at UND's Center for Rural Health. E-mail reminders and ease of sending in requests for reimbursements and reports was greatly appreciated.
- Thank you for your support.
- It's been helpful for our facility and allows us to implement training and changes that I believe would not be done without this funding.
- We would never have been able to try this programming without the grant funds.
- This program has been a great benefit for our facility.

Workshop Feedback

Four workshops were supported through the Flex Program funding cycle in 2008-2009. Following are the results and impact for each.

1. Annual CAH Pre-Conference to statewide Dakota Conference on Rural and Public Health

The CAH Pre-Conference was planned to be hosted by the CAH Quality Network. 45 attendees were registered to attend; however, the conference was cancelled due to flooding conditions in the state. An agenda was developed to include an update on ND CAH data on quality improvement measures, a presentation on driving quality improvement, CAH specific updates from the NDDoH, and a progress update from the CAH Quality Network.

The conference was rescheduled for June 2009 in Mandan. 45 people attended with 25 CAHs represented. Presentations were given on latest quality data and Peer Review (NDHCRI); CoP, survey process and common deficiencies (NDDoH); EMR (First Care Health Center); and the Quality Network.

Feedback: Results from conference evaluation forms showed much positive feedback. On average, attendants felt that the conference speakers were knowledgeable, organized and effective. They also felt that the objectives of the conference were met. Attendants noted that the topics covered were valuable and there was over a 20% increase in the knowledge level after the conference. There were 24 comments where people identified areas on how information that was learned could be applied to their individual work situations. The evaluation forms also gained insight on how the Network could better assist its members along with determining that 78 percent of attendants would be interested in attending Fall workshops. It was noted that a majority of conference attendants included nurses and DONs.

2. EMR Get Ready

The Flex Program supported 13 CAHs in the EMR Get Ready project. The program is designed to assist CAHs in a step-by-step process to implement electronic medical records. This includes conducting individual surveys of skills, staff and equipment along with technical assistance and education. Evaluative information of this project is pending at the time of this report.

3. Fiscal Management Seminar

NDHA and the Flex Program supported a CAH Fiscal Management Seminar from Stroudwater Associations. This was an all day presentation geared towards CAH department supervisors or senior management to help better understand rural hospital financial performance and the linkage between finances and service delivery. 24 CAHs attended via BTWAN.

Feedback: An evaluation of the seminar showed the following ratings (1 to 10 with 10 being excellent):

Overall rating of the seminar = 8.92

Expectations were met = 8.92

Seminar objectives were met = 9.13

Teaching effectiveness of the presenter = 9.33

Seminar was interesting and enjoyable = 9.02

Seminar was practical and useful = 9.06

Seminar was organized and easy to follow = 8.92

A few of the comments provided on the evaluations included to following:

- ✓ Being new to critical access, understanding the “settlement” process of the cost report was very important to be
- ✓ Let’s do it again – want to send more managers from my facility
- ✓ Totally met my expectations. More on the same topics but go into more detail.
- ✓ Made me aware of what drives profitability up. Key components to making a budget.
- ✓ Overview only – need more time to go into budgeting and how to establish budgets. Good speaker – kept my attention on what could be a boring subject. Loved the ambulance example. Gives me hope. Would like more time on establishing budgets – department specific would be helpful. Do not understand contractual allowances.
- ✓ I’ve learned a lot about the cost report and will now go back and talk with the CFO and controller to help me understand how my department works. It was an interesting seminar and I learned quite a bit of info that I will take back.
- ✓ Presenter was very knowledgeable and has good presentation skills
- ✓ Materials were good; seminar leader was easy to understand and kept me awake
- ✓ I liked the speaker – kept it moving – was aware of his topic/audience – good job. A lot of information but put together well.

- ✓ I was introduced to information I had not seen before which will aid me in managing my units more efficiently. This seminar was very informative. The content was easy to understand.
- ✓ Excellent content - Excellent speaker - Very informative
- ✓ Great presenter with lots of enthusiasm. Good take-home info.
- ✓ Gave me more insight into financial reports
- ✓ Leader had a very good way of keeping crowd involved
- ✓ Excellent speaker. Eric's delivery of a complex matter was great!! - I always learn something new from Eric! - Eric presents difficult material in an easy to understand fashion
- ✓ Content – good. Seminar leader – good. Materials – FAC Spreadsheet discussion helpful. Resources – very good.

4. TeamSTEPPS for CAHs and Tertiary Network Partners

- The Quality Network, Flex and the NDHCRI co-sponsored a TeamSTEPPS master training for all ND hospitals. A total of 15 hospitals participated (12 CAHs). All CAHs who participated were invited to join in monthly calls with NDHCRI to discuss best practices in TeamSTEPPS efforts. These calls were held for 8 months and had an average attendance of 8 hospitals.
- The Quality Network assisted with a one day regional training sponsored by Altru Health for their annual ethics conference. TeamSTEPPS was covered and 54 people were in attendance.
- A TeamSTEPPS fundamental training was scheduled for the spring; however this was postponed due to statewide flooding. 70 participants were registered to attend. The training was rescheduled for the summer. This was collaboration between Flex, NDHCRI and the Quality Network. 31 people attended including 11 CAHs.
- The NDHCRI sponsored a master training in the summer. 2 CAHs and 1 IHS were present. They also presented TeamSTEPPS at the UND School of Medicine senior colloquium.
- The Flex Program and the Quality Network presented TeamSTEPPS to the UND faculty of inter-professional courses who has integrated it into their curriculum.

Feedback: Evaluations of all training sessions were taken. Results from the June master training in Minot showed that 94% agreed that the activity was well organized, using the scheduled time efficiently. 100% agreed that the activity provided practical useful information; the sequence of the activity facilitated learning; and that the activity was up-to-date in terms of current practice and issues.

Evaluation comments included the following:

- ✓ The presenters were excellent.
- ✓ Overall, a really great learning experience.
- ✓ Class was well organized; thank you for keeping it upbeat.
- ✓ AWESOME COURSE!
- ✓ Faculty very committed; very professional and supportive of learners; all gave great, appropriate, positive, helpful, and constructive feedback; I learned a lot; I also appreciated and observed the teamwork between the faculty.
- ✓ I learned additional great ideas when hearing the course taught by our classmates; food for thought . . . we want to engage physicians in this course and empower them to use the tools also; we need to use language that demonstrates the partnership we want/have with physicians and draw them in; we really appreciate this course being offered in ND; well done!

- ✓ Jean did a nice job of keeping it moving in spite of time crunch; she handed out feedback/certificates during session; much appreciated. Thank you; it was great! Everything was presented well and organized; retention of information and long-term goal for objectives will depend on my own follow up.
- ✓ The workshop could be a bit longer so we aren't rushing through some of the material. Wonderful team—thank you—knowledgeable, supportive, fun; loved that the program organizers/presenters are either people actively engaged in clinical work or have history of clinical experience.
- ✓ Excellent workshop; great networking; I really feel we have someone to contact in the future; thanks.
- ✓ I think we should have the option if we want to do public speaking aspect; some people just don't have the comfort zone of speaking in public especially when the material is Greek to us.

Comments from the fundamental training included the following:

- ✓ Speaker is a great communicator and very easy to listen to.
- ✓ Good videos. Short videos were nice.
- ✓ Great use of examples to show shared mental models.
- ✓ Good knowledge of communication strategies. Great videos. Good info! Easy to listen to.
- ✓ The presentations were all great - wonderful presenters!
- ✓ Thank you for training - it was great!
- ✓ Pocket guide very helpful.
- ✓ Enjoyed the day very much.
- ✓ Wish more from our facility were here.

V. Summary

The ND Flex Program has accomplished the majority of its intended objectives throughout the year. Critical access hospitals highly value the grant program and continue to demonstrate the importance of local decision making. Valuable partnerships have been established with key stakeholders throughout the state and elsewhere; and, the program has representative committees involved with informing its activities and processes. Staffing has remained stable with the original program director's continued involvement and current program director having 7 years experience with the Flex Program.

The Flex Program continually seeks to adjust and adapt to the changing needs of the healthcare environment. Evaluation is a continual process, the results of which have shaped the program over the years. Meeting the needs of critical access hospitals is a priority and sharing the Flex program's story, its accomplishments and challenges, is an important component to maintaining this highly valued and needed program.