Community Based Solutions to Address Our Rural Health Issues

Mountrail County Health Center
Stanley, ND
August 2, 2012

Presented by: Brad Gibbens, Deputy Director and Assistant Professor

• Established in 1980, at The University of North Dakota (UND) School of Medicine and Health Sciences in Grand Forks, ND

• One of the country’s most experienced state rural health offices

• UND Center of Excellence in Research, Scholarship, and Creative Activity

Focus on
– Educating and Informing
– Policy
– Research and Evaluation
– Working with Communities
– American Indians
– Health Workforce
– Hospitals and Facilities

ruralhealth.und.edu
What is Rural Health?

- Rural health focuses on population health and improving health status
  - Quality of care, access to care and services, availability of care and services, cost of care, ability to afford care, health promotion and disease prevention, disease management, financing, health system viability – “drivers”

- Rural health relies on infrastructure: facilities, providers, services, and programs available to the public (all with quality, access, and cost implications)
  - Some are for-profit and some private or public non-profit entities
  - More and more health networks – independence with collaboration
    - Examples include: Community hospitals, clinics, public health, EMS, nursing homes/aging services, home health, mental health, dental, pharmacy, and others

- Rural health is not urban health in a rural or frontier area

What is Rural Health?

- Philosophy: rural people have the *same right* to expect healthy lives and access to care as do urban people – fairness frame
  - Access essential services locally or regionally
  - Access to specialty services through network arrangements
  - Quality of care on par with urban
  - Availability of technology

- Rural health is very *community oriented* – interdependence frame
  - Integral part of what a community is and how people see themselves
  - Community engagement
  - Sectors: Economic/business, public/government, education, faith/church, and health/human services
  - Direct services provided to the public and secondary impact for other sectors
  - Major employer
So Why Is Community Important to Rural Health?

*Rural culture* – more interdependence, connectedness, cohesiveness, collaborative, and people identify with institutions and each other

*Relationships* – things get done because of people, and sometimes don’t get done because of people – are the right people at the table?

*Rural health contributes to the community* – provision of health services (access), improvement of health, economic contributions, community development, health facilities are a sense of community identity

*Communities contribute to the rural health system* – employees, purchase of health services, financing, fund raising, volunteers, ideas and vision
What are Some Important Rural Health Issues?

- Access to and availability of care
- Financial concerns facing rural hospitals and health systems
- Health workforce
- Quality of Care
- Health Information Technology
- Networks — rural hospitals, urban hospitals, clinics, others
- Emergency Medical Services – EMS, ambulance, quick response units
- Community and Economic Development
- Health System Reform

*Sources: 2008 Flex Rural Health Plan, 2009 Environmental Scan, and community presentation feedback surveys*
Access to and availability of care
Access to and availability of care

- 38 rural hospitals over 70,000 square miles (36 are CAH) and there are 6 tertiary PPS hospitals
- 75 rural primary care clinics
- 59 RHC
- 4 Community Health Centers (CHC) serving 10 clinic sites/communities
- 9 other primary care but non-RHC or non-CHC
- 83 LTC with 68 being rural
- 29 home health care agencies with 16 rural, 4 serve ND but located in MN and SD
- 29 Public Health Units
- EMS (2012 CAH Fact Sheet on EMS)
  - 134 ground ambulances
  - 7 air medical (5%)
  - 4 industrial (3%)
  - 78% of ambulances are BLS (N=105) and 14% are ALS (N=19)
  - ALS advanced life support have an EMT-Paramedic
  - In addition to the air and ground ambulances, ND has 81 non-transporting Quick Response units
  - 5,627 EMS personnel
  - 54% are First Responders and/or Drivers
  - 34% are EMT-Basic
  - 5% are EMT-Intermediate
  - 7% are EMT-Paramedic
Access to and availability of care

- Closure of facilities or services (Source is CRH)
  - 1 hospital closed in 2009; since 1991 about 7 hospitals have closed
  - About 30 clinics closed in last 15 years
  - 26 rural pharmacies closed in last 20 years
  - 7 ambulance units closed in last 6 years (2005-2011)
  - Home health closures

Access to and Availability of Care

- CAHs are hub of rural health services – increasing access to quality care
  - Most CAHs own and operate a primary care clinic and/or a nursing home
    - 27 CAHs (75%) operate 60 primary care clinics – 47 are RHC
    - 14 CAHs (39%) operate nursing homes - 700 nursing home beds
      - 11 CAHs (31%) operate both a PC clinic and a nursing home
  - 9 CAHs (25%) operate ambulances
  - 9 CAHs (25%) own apartments that are operated to meet elderly and/or disabled needs
  - 7 CAHs (19%) operate assisted living units
  - 6 CAHs (17%) offer basic care.
  - 5 CAHs (14%) provided home care
  - Only 5 CAHs (14%) are traditional stand-alone organizations
CAHs and Rural Health Issues

- Overall, CAH administrators in 2011 found issues associated with finance (reimbursement and factors that impact finance including the ability of patients to pay for services) and health professional workforce were the two most pressing rural health issues.

- Highest rated issue in all 3 surveys was hospital reimbursement from non-Medicare 3rd Party Payers.
  - About 95% in all 3 years (only issue to do this) – Problem, Moderate Problem, and Severe problem.

- Medicare is a concern but not to the same degree – mid to high 80% (88% in 2011).

- Impacting the financial picture – insurance
  - Impact of the uninsured – 91%
  - Impact of the underinsured – 91%
  - Increased from about 80% in 2008.

- Workforce
  - Physician workforce supply -91%, increased from 2008 and 2005.
  - Nursing workforce supply – 85%, down slightly from 2008 and up from 2005.
  - Ancillary workforce supply (lab, X-ray, PT, OT, RT) – 73% and down from 2008 and 2005.

Financial concerns facing rural hospitals and health systems
Financial Conditions

- ND CAHs higher financial constraints in comparison to national data
  - ND CAH Operating Margins (2009) -2.66
    - National CAH Operating Margins +0.66
    - MN +2.93, SD +1.72, MT -3.53
    - Nationally about 52% of CAHs have negative operating margins; in ND 63%
  - ND CAH Total Margins (2009) -2.14
    - National CAH Total Margins +1.89
    - MN +2.93, SD +1.61, and MT +1.60
    - In every year since 2004, ND CAHs averaged negative total margins but nationally, positive
    - Nationally about 40% of CAHs have negative total margins; in ND 53%
  - Some improvement in ND over last year for both total and operating margins
  - Cash on hand – nationally (about 66 days); ND (about 37 days) – recommended is 60 days

Figure 2. North Dakota and US CAH Total Margins 2004-2009
Financial Conditions

• Local Community Support is Critical
  o 13 CAHs (2011) had local tax support – 10 CAHs (2008), 4 CAHs (2005)
  o A few thousand dollars to 3 CAHs receiving $100,000/year and 2 CAHs $200,000
  o 26 CAHs (2011) had a hospital foundation – 18 (2005)

• Communities are willing to support their local hospital with their money – willing to tax themselves and target donated funds

• Message conveyed to congressional delegation – need some level of federal funding for rural health but communities also willing to support their health systems

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Health Workforce
Health Workforce

• National Overview
  o Research has shown that having access to Primary Care is associated with positive patient outcomes (overall outcomes and specific conditions such as chronic disease)
  o Provider shortages are greater in rural areas, nationally, than in urban
  o Nationally, over ten year period Family Medicine residency participation declined from 17.6% to 6.9% (Source: UNDSMHS, First Biennial Report, 2011)
  o A recent residency match (2010) had ND with 16% for Family Medicine, with a national fill rate of only 8% (Source: First Biennial Report, 2011)
  o Less than half as many nurses per capita in isolated rural as found in urban
  o 68% of underserved communities in the country are rural (Source: HRSA)
  o Nationally, the average vacancy rate for physicians in hospitals is 11 percent; however, the vacancy rate found in North Dakota was over 16 percent. (Source: Center for Rural Health, Workforce Program Data, 2010)
  o 2012, nationally, 7 of top 10 fastest growing professions will be in health care (Center for Rural Health, Environmental Scan, 2009)

• North Dakota
  o Issues
    ➢ Supply – are we producing enough? But the first question is, what is our need?
    ➢ Demand – where is the demand located and for what types of disciplines?
    ➢ Mal-distribution – maybe enough but again, where are they going?
    ➢ Solutions – what do we do? And, who is “we”?
Figure 1. Rate of Physicians Associated with Rurality of North Dakota Population

- Urban: 3.25
- Large Rural: 1.89
- Small Rural: 1.38
- Isolated Rural: 0.50

Figure 2. Location of Medical School and Residency for Physicians Currently Practicing in North Dakota

- 61% No Medical School or Residency in ND
- 18% Med school in ND
- 13% Med school & Residency in ND
- 8% Residency in ND
Health Workforce

- What Can “We” Do? Solutions
  - ACA (national level) has 18 direct focal areas on health workforce – NHSC, AHEC, residency training changes, Accountable Care Orgs to rely on PC, etc.
  - AHEC – national funds with state level matching funds
  - CRH Workforce Development Program – state supported to UNDSMHS
    - Workforce specialist – R/R assistance, residency fairs, “sourcing” candidates, work with your recruiter/recruitment firm
    - R –COOL-Health – Scrub Camps and Scrub Academy
    - Workforce research, data analysis, projections, and planning
  - GOOD – Grow our own Doctors – state supported to UNDSMHS
    - Increase number of residency slots, medical students, and health sciences, MPH, Geriatrics
  - Rural Medicine Program – state supported tuition waivers to UNDSMHS
  - ROME – rural medical training at 6 sites (3rd yr med. students)
  - Inter-professional Training – UND 1 of only 30 MS out of 126 with this focus
  - Community Level
    - R/R committees
    - Community Awareness and Involvement – Economic Development
    - Networks – hospitals working with other hospitals and systems collaboratively
    - Workforce specialist

Table 1: Demographics of Physicians Practicing in North Dakota by Rurality

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<thead>
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<th>Rurality</th>
<th>ALL</th>
<th>F</th>
<th>M</th>
<th>Mean</th>
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<tr>
<td>N</td>
<td>%</td>
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<tr>
<td>Urban</td>
<td>1,030</td>
<td>73%</td>
<td>262</td>
<td>75%</td>
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<tr>
<td>Large Rural</td>
<td>241</td>
<td>17%</td>
<td>53</td>
<td>78%</td>
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<tr>
<td>Small Rural</td>
<td>62</td>
<td>4%</td>
<td>14</td>
<td>77%</td>
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<tr>
<td>Isolated Rural</td>
<td>90</td>
<td>6%</td>
<td>25</td>
<td>72%</td>
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<tr>
<td>All</td>
<td>1,432</td>
<td>100%</td>
<td>354</td>
<td>75%</td>
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The report finds that several states in the Upper Midwest—Iowa, Minnesota, Nebraska, North Dakota, and South Dakota—were all providing high quality care at lower cost. Their examples suggest that better coordinated care and more efficient use of resources could improve the quality of care people receive while keeping cost in check.

Source: Commonwealth Fund Commission on a High Performance Health System’s second state scorecard report, October 2009
Quality of Care – 2010 Data Year

North Dakota Dashboard on Health Care Quality Compared to All States

Overall Health Care Quality
Average
Weak
Strong
Very Weak
Very Strong

Performance Meter: All Measures

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<th>Measure</th>
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<th>Weak</th>
<th>Average</th>
<th>Strong</th>
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<td>Preventive Care</td>
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<td>Acute Care</td>
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<td>Chronic Care</td>
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<td>Home Health</td>
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<td>Hospital</td>
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<td>Nursing Home</td>
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<td>Ambulatory</td>
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<td>Cancer</td>
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<td>Diabetes</td>
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<td>Heart Disease</td>
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<td>MCH</td>
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<tr>
<td>Respiratory</td>
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Commonwealth Fund
(2009 data, most recent, updated this document July 11, 2012)

• 9th overall ranking in health system performance (13th in previous report)
• 4th avoidable hospital use and costs (9th in previous report)
• 10th healthy lives
• 14th prevention and treatment
• 13th equity
• 10th for children health system performance (access and affordability ranked 16th, prevention and treatment 23rd, potential to lead healthy lives 11th, and equity 17th

Source:

Health Care Quality
Hospital Compare

• 2009 DATA
  o 11% of all U.S. CAHs reported inpatient, outpatient, and HCAHPS
  o 24% of all U.S. CAHs reported inpatient and HCAHPS
  o 32% inpatient only
  o 5% inpatient and outpatient
  o 1% outpatient only
  o 1% HCAHPS
  o Of the 1,312 CAHs that were certified in 2009, 952 (72.6%) submitted data on at least one measure, including inpatient, outpatient and/or HCAHPS data.
  o ND in comparison to MT, SD, and MN
    ➢ ND 53% inpatient (MT – 60%; SD – 58%, and MN – 94%)
    ➢ ND 6% outpatient (MT – 11%, SD – 11%, and MN – 19%)
    ➢ ND 11% HCAHPS (MT – 26%, SD – 42%, and MN – 54%)

• 2012 ND Flex Program report ND 100% for Inpatient and 100% for Outpatient
Health Information Technology (HIT)

HITECH: Catalyst for Transformation

Pre 2009
A system plagued by inefficiencies. 2004-Exec. Order Calling for everyone to have an EHR by 2014.

2009
EHR Incentive Program, State HIEs developed, Regional Extension Centers, HIT Workforce Education and Training

2014
Widespread adoption and meaningful use of EHRs
Electronic Health Record Adoption
Significant Changes in North Dakota
(2008 to 2012)

Adoption and Use of Electronic Health Record (EHR)
- 20 hospitals have gone ‘live’ with a certified EHR
- 17 hospitals have gone ‘live’ with EHR between 2008 and 2012
- 12 anticipate they will go ‘live’ within the next year.
- Drivers ‘most significant’ to EHR implementation different from 2008 – Medicare/Medicaid incentives and availability of state loan funds
- Barriers to EHR implementation identified in 2012 - difficulty in justifying expense or return on investment, development of a sustainable business model and difficulty changing workflow patterns.

Infrastructure, Hardware, Software
- Increase in the number of computers in the rural and urban hospitals with access to the internet.
- Overall access to high-speed/broadband internet remains high
- Increase of rural hospital respondents, by 20%, that indicated wireless internet is in place
- Number of facilities sharing data servers with another rural or tertiary increased.

Workforce
- Decrease in number of rural facilities with no FTE designated to oversee the IT (13 in 2008) by nearly half (7) in 2012.
- Increase in number of facilities that have adequate IT staff

North Dakota HIT Efforts
- 2006 – First State HIT Summit held
- 2006-2009 – ND HIT Steering Committee created
- 2009-Senate Bill 2332
  - Established, Governor appointed, Health Information Technology Advisory Committee (HITAC)
  - Hired ND HIT Director - Sheldon Wolf
  - Establish state HIT Office (within ND Information Technology Dept.)
  - Established HIT ($5M) Loan Program
  - $8 million for required federal match and operating the HIE
- 2010 - State received $5.4 M (five years) federal funds to plan and implement a state Health Information Exchange
- 2011 – State funding to expand HIT Office by 3 FTE
  - Renew – ($5 million) State Loan Program
  - Continue – ($8 million) for required federal match and operating the HIE
- 2012 – HITAC continues work to implement state Health Information Exchange
MISSION
Advance the adoption and use of technology to exchange health information and improve healthcare quality, patient safety and overall efficiency of healthcare and public health services in North Dakota.

VISION
Quality Healthcare for all North Dakotans – Anywhere, Anytime.

Website: www.healthit.nd.gov
CAHs and Networks

- CAHs work within network arrangements to better address common issues

- Use networks to gain greater efficiency and effectiveness, provide cost savings, build capacity, and achieve a higher level of organizational performance

- CAH survey found that the areas that ND CAHs network around tend to correspond with the areas they expressed concern – cost factors, greater efficiency, sharing services, and staff

- CAHs are responding to key federal health policy focus through networks

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CAHs and Networks

- CAHs belong to multiple networks – 36 CAHs work with 9 hospital networks – total of 65 CAH arrangements

- Network with: Altru, CHI, Essentia, MedCenter One, Northland Healthcare Alliance, North Region Health Alliance, Sanford, St. Alexius, and Trinity

- 2 most common functions that CAHs address through networks are quality improvement (38 CAH arrangements) and HIT (37 CAHs).

- Average size of a CAH-based network is 7 CAHs (St. Alexius – 11 CAHs, and smallest is Essentia – 1 CAH)

- How Flex could assist:
  - Building and facilitating collaboration
  - Addressing staffing, education, and specialty care
  - Supporting technology
  - Emphasizing quality issues as they relate to credentialing and peer review
  - Supporting primary care
  - Addressing EMS transport and education
Common Types of CAH Networks

- Quality improvement: 38 CAHs*
- Health Information Technology (HIT): 37 CAHs
- Staff education: 34 CAHs
- Staff or board development: 23 CAHs
- Medical education: 22 CAHs
- Medical coverage or support: 21 CAHs
- Recruitment/retention: 18 CAHs
- Supply management: 16 CAHs
- EMS: 9 CAHs

CAH/Tertiary Networks Assessment of Characteristics

- CAH/Tertiary network is strong: 2011: 15%, 2008: 5%, 2005: 2%
- CAH/Tertiary network is comprehensive services: 2011: 27%, 2008: 6%, 2005: 1%
- I am optimistic that this network will grow and positively impact my hospital: 2011: 38%, 2008: 5%, 2005: 1%
Community and Economic Development

Community Perspectives on ND Issues – Rural Health Issues

- Financial issues facing rural hospitals 4.17
- Health system reform 4.12
- Health workforce (physician, nurse, and other health professionals) 4.00
- Access and availability of care (Keeping hospitals and clinics open) 3.96
- EMS 3.90
- Community and economic development 3.85
- Quality of care 3.55
- HIT 3.39
- Networks 3.36

Likert Scale of 1-5 with 1 = no concern and 5 = severe concern
Surveys at 7 events
Community and Economic Development

• Community Perspectives on ND Issues – Community Factors
  o Retaining and/or recruiting youth 4.11
  o Community growth 3.87
  o Local population 3.75
  o Local economics 3.71
  o Available/affordable housing 3.53
  o Community leadership 3.50
  o Maintaining quality school system 3.47
  o Confidence for the town 3.38
  o Responsive local government 3.36
  o Transportation services 3.27
  o Active faith community 3.12

Likert Scale of 1-5 with 1 = no concern and 5 = severe concern
Surveys at 7 events

What is the Relationship Between Rural Health and Economic Development?

• Employment
  • 10 percent of direct employment and 5 percent indirect (15%)
  • Rural hospital first or second largest employer
  • 36 CAHs payroll impact
    ➢ About $215 million impact on rural ND economy
    ➢ About $4-10 million for each CAH, (direct and indirect)
  • CAH average about 220 jobs (about 150 direct and 75 indirect)
  • Statewide CAH’s contribute about 8,000 jobs to the rural economy
  • About 40% of CAHs have local tax support and 75% have hospital foundation – community support
  • One rural physician can have an impact of $1-1.5 million in a year and generate over 20 additional jobs
  • Statewide 8 of top 10 private employers are health related
  • Statewide health care is 8.5%-9% of GSP
  • ND ranks 6th for percentage of workers in health care jobs
  • Health jobs rank 2nd only to business jobs for growth in ND (2000-2010)
Health System Reform
Center for Rural Health

Center for Rural Health

8/7/12
Health Reform Impact in North Dakota

- Overall, for hospitals decrease uninsured decreases bad debt and uncompensated care – AHA and AMA both supported the ACA
- Health Workforce Improvements (more detail in later slide)
- Focus on payment reform – outcome based
- Focus on prevention, disease management, individual responsibility
- Smaller and more focused areas, yet important to rural health
  - 340 B Drug Pricing Program – CAH but not RHC (yet)
  - Frontier Amendment – “Big 6” hospitals – benefits rural hospitals through outreach services provided by tertiary hospitals
  - Community Health Needs Assessment to retain non-profit status – stay connected to the community – learn what community thinks/wants from the local system
  - Community Transformation Grants – focus on evidenced-based health prevention, community engagement – physical activity and nutrition, chronic disease
  - Extension of the Medicare Rural Hospital Flexibility Program (Flex)
  - Strengthening of the Indian Health Services – protection for cost sharing in state exchanges – income level

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Health Reform Impact in North Dakota

- 340,000 ND residents protected against ceiling on annual insurance coverage limits
- 2,630 North Dakotans covered under parents insurance
- 17,700 small ND businesses eligible for tax credits

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1The Affordable Care Act: Immediate Benefits for North Dakota. HealthReform.gov
http://www.healthreform.gov/reports/statehealthreform/northdakota.html
Health Reform Impact in North Dakota

- 9,050 Medicare recipients helped with “closing the donut hole” – totally closed by 2020

- 28,864 North Dakotans covered under increased Medicaid expansion from 100% of FPL to 133% of the federal level (cuts ND uninsured by 45.1%)

- 132,000 North Dakotans with pre-existing conditions protected from insurance denial

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   http://www.healthreform.gov/reports/statehealthreform/northdakota.html

2. Medicaid Coverage and Spending in Health Reform: National and State-by-State Results for Adults at or Below 133% FPL.

   http://www.familiesusa.org/assets/pdfs/health-reform/pre-existing-conditions/north-dakota.pdf

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Health Reform Impact in North Dakota

- **Health Workforce**
  - Improved education and training efforts with either additional or new funds for medical students and residents, nursing, public health, nurse practitioners, physician assistants, allied health, and dentistry – support of NHSC
  - Renewed emphasis on rural-based training options and resources
  - Development of a national vision for health workforce with enhanced coordination, collaboration, and evaluation
  - Renewed emphasis on information, data analysis, and projections to support workforce planning at the national and state levels
Health Reform Impact in North Dakota

• Health Workforce
  
  o Increased support to state government, academic programs, and overall state efforts to address health workforce needs – 2 year grants to states $150,000

  o Recognition and support of efforts to improve medical and health science education relative to chronic disease, care coordination and management, disease prevention and wellness

  o Recognition and support to projects that emphasize rural and/or underserved communities efforts to “grow-your-own” local health professionals

  o Strengthened opportunities for pilot or demonstration efforts intended to develop and test models that can be responsive to rural health needs and inclusive of rural health participation

• Health Workforce
  
  o Improved incentives (at a state, community, health system, and academic levels) to increase the number of health professionals for a restructured health care system built around primary care

  o Inclusion of a broader array of health disciplines recognizing their contribution to building a stronger rural health system

  o Increased bonus payments to rural providers (physicians, physician assistants, and nurse practitioners) in underserved areas and some equity adjustments for rural physicians relative to urban.

  o Creation of ACO’s

  o Medicaid fees paid equal to Medicare for primary care services

  o Expansion and support to Area Health Education Centers
Still on the Table following Reform - What Else?

- RHC and 340 B drug program
- Increase Medicare payments to RHC – increase cap
- CAH and 340 B for inpatient
- Allow CAHs more flexibility in bed count – flexible 20 beds not hard 25
- Eliminate the CAH isolation test for ambulance reimbursement
- CAH Medicare Outpatient co-payments based on interim payment rates
- Increase access for rural veterans to mental health and behavioral health services through contracts with local rural health providers
- Direct physician supervision based on clear clinical evidence of need

Medicare Rural Hospital Flexibility Program (Flex)
Flex Program - 2012

• Focus Areas
  Quality Improvement
  Financial and Operational Improvement
  Health System Development/Community Engagement

• UND Center for Rural Health Partners
  Providers – CAHs, EMS, Tertiary Centers
  North Dakota Hospital Association
  North Dakota Healthcare Review, Inc.
  North Dakota EMS Association
  North Dakota Department of Health

Flex Grant Awards Received To Date Mountrail County Health Center

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<th>Year Awarded</th>
<th>Award Amount</th>
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<td>1999</td>
<td>$26,440</td>
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<td>2002</td>
<td>$40,195</td>
<td>Equipment: teleradiology, spirometer, colposcope, traction table</td>
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<td>2003</td>
<td>$6,115</td>
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<td>2004</td>
<td>$35,651</td>
<td>Cardiac rehab services: equipment, materials, resources, staff time</td>
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<td>2004</td>
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<td>2006</td>
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<td>Training, program development, equipment</td>
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<td>2009</td>
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<td>Application server - financial scanning software</td>
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<td>2010</td>
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SHIP Grant Awards Received To Date

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<td>2007-08</td>
<td>$9,237 QI activities, equipment, computers, printers</td>
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<td>2008-09</td>
<td>$8,282 HIPAA server and software, computers</td>
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<td>2009-10</td>
<td>$7,750 Chargemaster review, billing and coding training</td>
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<td>2010-11</td>
<td>$7,549 Clinical documentation software</td>
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<td>2011-12</td>
<td>$7,503 ICD-10 training, medication barcoding software and hardware</td>
</tr>
<tr>
<td>Total</td>
<td>$40,321</td>
</tr>
</tbody>
</table>

ND Flex Technical Assistance

- **Peer Exchange** - MCMC has been approved for (but has not yet completed) a 2011-2012 Flex Peer Exchange activity – MCMC staff to visit Watford City to observe utilization of various Healthland EMR software utilization. (Physician Practice Documentation, Transcription module, etc.)

- **Economic Impact Study** – completed July 2011.

- **ND CAH Quality Network Virtual Library** user.

- **Community/Staff Board Meeting facilitation.**
  - 2 Board meetings
  - 1 community and/or staff meeting
ND Flex Impact Statewide

- Since 1999, ND Flex has provided over $4.3 million in grants to ND CAHs through over 160 separate grants to all 36 CAHs
- Network development grants, CAH grants to individual CAHs, and EMS network grants
- Cardiac rehab care, pulmonary rehab care, surgery, chronic disease management, staff training, HIT (hardware and software), PT/RT/OT, community engagement, program development studies, financial assessment, and other
- Technical Assistance – 160 community/hospital meetings, 25 community needs assessments, 25 strategic planning assessments, 13 economic impact assessments, 11 staff surveys, 24 statewide workshops

Flex Program Website Analytics

- The Flex project had a total of 22,744 visits in 2011
- The CAH Quality project had a total of 11,176 visits – this includes the password protected folder for the Virtual Library of Shared Tools.
- The SHIP project had a total of 2,040 visits
Core Area 1: Quality Improvement

• ND CAH Quality Network Support
  • Listserve (130 CAH personnel use on average 3x/week)
  • CAH Virtual Quality Library – 56 new resources posted
  • 10 tools developed (e.g. conditions of participation checklist, falls protocol, PDSA worksheet)
  • MBQIP outreach (100% CAHs signed MOUs)
  • CAHs rated highest based on all available Flex outreach
  • Statewide credentialing process continues
  • 8 regional meetings

Core Area 1: Quality Improvement

• Event Reporting
  • 18 ND CAHs participating (increase of 5 since last year)
  • Monthly user group calls/participation in national benchmarking project/presentation at NRHA in April 2012
  • Focus on falls prevention
  • Vendor visit/evaluation; 3 new reporting tools developed to streamline CAH efforts and reduce duplication (safety rounds, employee illness, root cause analysis)

• Collaboration
  • NDHCR (QIO) – MBQIP/other
  • NDHA – HEN/HCAHPS/other
  • AHA – STEMI
  • NDDoH – Stroke/Injury Prevention/Trauma/EMS
Core Area 2: Financial Improvement

- **CAH Subcontract Awards**
  - $214,395 awarded (23 subcontracts to 20 CAHs; 11 involved local EMS).
  - 15 awards related to program development, 3 related to financial analysis, 3 related to network enhancement, and one to community engagement.

- **CAH Finance Study**
  - In progress by LarsonAllen
  - Findings/recommendations will be presented at NDHA Annual Convention in October 2012

Core Area 2: Financial Improvement

- **Information Dissemination**
  - 12 Flex Updates
  - Weekly NDHA Informer
  - CAH Profiles – 15 updated

- **Peer Exchange Program**
  - Travel expenses to learn from peers (EMR, surgical procedures, ER transfer protocols, pulmonary rehabilitation)
  - Supported attendance for 20 CAHs to Dakota Conf
  - Supported 3 nurse leaders to attend national quality and clinical conference
Core Area 2: Financial Improvement

- Apgar Study
  - Community assessment of recruitment strategies
  - 16 completed for ND CAH communities
- Technical Assistance
  - 5 CAHs assisted with strategic planning
  - 11 CAHs assisted with grant writing
  - NDHA Attorney
  - NDHA policy/reimbursement assistance
- Educational
  - NDHA offering
  - CAH Pre-Conference
  - CAH CEO to National AHA Convention

Core Area 3: Health System Dev.

- ND Trauma System support
  - 36 CAHs remain designated
  - Quarterly regional meetings/discuss performance
  - Site visits conducted and patient charts reviewed/recommendations made
- EMS Leadership Development
  - Two leadership trainings supported
  - JCREC meeting/committee
  - EMS Video for annual conference
  - A Vision for the Future of EMS in ND
  - Speaker support/exhibit – ND EMSA Convention
Core Area 3: Health System Dev.

• Community Health Needs Assessment
  • 6 completed – themes/priority needs:
    (1) recruiting and retaining an adequate number of providers;
    (2) addressing mental health and substance abuse issues;
    (3) ensuring that emergency medical services will be available 24/7 in the future, especially where the EMS personnel are entirely (or mostly) volunteers; and
    (4) dealing with the demands placed on health systems by increased energy (especially oil)

Core Area 3: Health System Dev.

• State Stroke Program
  • 28 of 36 CAHs participating
  • Staff logged 374 activities to support
  • Regions working on discharge and transfer protocols
Flex – Future Focus 2012-2015

Program Changes

- Leadership
- Technical Assistance
  - Community Health Needs Assessments will no longer be provided. Will provide Flex grants to support effort.
- Flex Grants
  - Funds set aside for specific purposes and those most in need will be invited to apply.
  - Use of funds:
    1) Charge Master Reviews (10 per year)
    2) Revenue Cycle Management Studies (10 per year)
    3) Community Health Needs Assessments (5 per year)

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Flex – Future Focus 2012-2015

- Quality improvement activities
- Financial assistance – studies
- Health system development
  - Flex grants for assessments
  - Strategic planning
  - Community forum (can be a form of community assessment)
  - Key informant interviews with local health providers and community leaders
  - Grant development assistance (e.g., grant writing workshops in your hospital for the area, research funding options)
Additional Background Material

Population Projection to 2040 for Metropolitan, Micropolitan, and Rural Areas
Change in Population by Metropolitan Status

Change in Population 2000-2010
Comparative Rural and Urban Strengths and Weaknesses

**Rural**

**Strengths:**
- Strong informal support network
- Fundraising availability of resources
- Cohesive availability of professionals
- Established interdependence growing and diverse population
- Collaboration change is natural

**Weaknesses:**
- Skewed population demographics lack of cohesiveness
- Fluctuating economy limited informal support
- Resistance to change competition among providers
- Shortage of professionals competition for fundraising
- Lack of resources more contentious-fractions

**Implications of strengths and weaknesses on rural health systems**

**Urban**

**Strengths:**
- More stable economy
- Availability of resources
- Availability of professionals
- Growing and diverse population
- Change is natural

**Weaknesses:**
- Skewed population demographics lack of cohesiveness
- Fluctuating economy limited informal support
- Resistance to change competition among providers
- Shortage of professionals competition for fundraising
- Lack of resources more contentious-fractions

**Implications of strengths and weaknesses on rural health systems**
Access to and Availability of Care

- Looking forward
  - Asked about structural changes (add/delete services, ownership, etc.)
    - 28 CAHs (82%) said stay the same
    - 9 (26%) said add a service and only 1 said eliminate a service (home care)
    - 2 CAHs thought hospital may be acquired by another entity
    - No one indicated that closure was anticipated
  
  - 2011 and 2005 surveys similar - CAH would stay the same
  
  - 2011 much more confident about adding services than 2005 and 2008
  
  - Conclusion – significant issues in rural health care delivery, but CAHs appear confident, even adding services, can weather the storm

Health Workforce

- 2011 CAH Administrator Survey found:
  - Physician workforce supply -91%, increased from 2008 and 2005
  - Nursing workforce supply – 85%, down slightly from 2008 and up from 2005
  - Ancillary workforce supply (lab, X-ray, PT, OT, RT) – 73% and down from 2008 and 2005
  - Physician workforce rated 3rd highest issue, nursing was 7th, and ancillary was 10th
  - Fully 62% of administrators rated physician workforce as a severe problem – highest rated
Health Care Quality
Hospital Compare

- Public reporting data base for hospital quality measures (inpatient and outpatient)
- Inpatient: heart attack, heart failure, pneumonia, surgical care improvement, and children’s asthma
- Outpatient: AMI/chest pain, surgical process of care measures
- Hospital Consumer Assessment of Healthcare Providers and Systems (HCAHPS) survey results
- Risk-adjusted mortality and readmission rates for AMI, heart failure, and pneumonia (Medicare claims data)
- PPS financial incentives to provide data; no financial incentives for CAHs

HITECH Vision

Regional Extension Centers
Workforce Training
Medicare and Medicaid Incentives and Penalties
State Grants for Health Information Exchange
Standards and Certification Framework
Privacy and Security Framework
Adoption of EHR’s
Meaningful Use of EHR’s
Exchange of Health Information
Research to Enhance HIT

Improved Individual and Population Health Outcomes
Increased Transparency and Efficiency
Improved Ability to Study and Improved Care Delivery

Source: Celebrating the First Anniversary of the HITECH Act and Looking to the Future (Feb 2010)
CAHs and Networks

- Evaluation of CAH Networks: Primary tertiary hospital
  - 2011 CAH administrators less likely to rate their network as strong in comparison to other years
  - CAHs see their networks as flexible – 80%
  - About half (47%) see their network as comprehensive – services provided
  - 2011 CAH administrators were much less inclined to say that their network fosters a sense of trust between providers (35% in 2011 and 62% in 2008, but 34% in 2005)
  - 2011 CAH administrators were much less inclined to say that they were optimistic that their network would grow and positively impact their hospital (38% - 2011 and 75% - 2008)
Center for Rural Health

Contact us for more information!

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