



IDAHO

IDAHO FLEX PROGRAM



2006 PROGRAM PLANNING REPORT



2006 program planning report

INTRODUCTION

The Idaho Department of Health and Welfare, Office of Rural Health and Primary Care, conducted a Medicare Rural Hospital Flexibility (Flex) Program planning session with state Flex Program stakeholders. The one-day session included an overview of national and state Flex Program activities, discussions related to Idaho's rural health issues and potential solutions, as well as a solution prioritization process. The intent of the program planning session was to develop participants' understanding of the Flex Program and to identify program priorities, activities, and next steps. Program planning participants included representatives of: networks,



Qualis Health (the state Quality Improvement Organization), Office of Rural Health and Primary Care, Emergency Medical Services (EMS) Bureau, Critical Access Hospitals (CAHs), Idaho



Hospital Association (IHA), and Area Health Education Center. Rural Health Solutions, a rural health and health workforce research and program development firm located in St. Paul, Minnesota, facilitated the discussion.

MEDICARE RURAL HOSPITAL FLEXIBILITY (FLEX) PROGRAM

The Medicare Rural Hospital Flexibility (Flex) Program was established through the Balanced Budget Act of 1997. It is a national program that includes 45 states, including Idaho. In essence, the Flex Program is comprised of two components – grants to assist states in implementing state specific program activities and an operating program that provides cost-based Medicare reimbursement to hospitals that convert to CAH status. The U.S. Department of Health and Human Services (DHHS), Health Resources and Services Administration, federal Office of Rural Health Policy, administers the grant program, while the operating component of the program is administered by the Centers for Medicare and Medicaid Services (CMS), also located within DHHS.

Six Flex Program priority areas have been established for states implementing the program, they are:

1 Creating and implementing
a state Rural Health Plan

2 Designating and supporting CAHs

3 Fostering and developing
rural health networks

4 Enhancing and integrating
Emergency Medical Services (EMS)

5 Improving the quality of healthcare

6 Evaluating Flex Program
activities and related outcomes

IDAHO FLEX PROGRAM

The Idaho Flex Program is managed by the Idaho Department of Health and Welfare (IDHW), Office of Rural Health and Primary Care. During the past eight years, the Idaho Flex Program obtained **\$4,082,605** or an average of **\$510,325 per year** from the Health Resources and Services Administration, Office of Rural Health Policy, to implement the Flex Program in Idaho. There are **26** CAHs in Idaho, which make up **70%** of hospitals in the state. All CAHs receive technical assistance and/or financial support through Idaho's Flex Program.

mission:

The Idaho Flex Program supports collaboration among healthcare entities to capitalize on resources, avoid duplication of activities, and enhance the integration of services. Program stakeholders work as partners to develop and incubate best practices to assure viability and access to high quality healthcare services.

As a part of the current Flex Program grant year (2006-2007), funding is being directed to:

- OFFICE OF RURAL HEALTH AND PRIMARY CARE (54%)
 - Grants to CAHs
 - CAH conferences and workshops
 - Grants to networks for health information technology activities
 - Program administration/planning costs
- IDAHO HOSPITAL ASSOCIATION (30%)
 - Conduct quality improvement in-services, credentialing and quality assurance reviews, and network meetings
 - Support the Quality Improvement Subcommittee
 - Subsidize CAH participation in Databank and the CAH peer review network
 - Reimburse CAHs for Flex Program related travel costs
- STATE EMS BUREAU (12%)
 - Assess the need to expand or change EMT scope of practice based on community health needs and available resources
- OTHER (4%)
 - Program evaluation and planning activities

goals:

- Foster collaboration among CAHs, EMS, and other community healthcare providers.
- Support initiatives that improve quality across the continuum of care.
- Work toward a sustainable and financially viable rural healthcare services infrastructure.
- Promote the sharing of resources, expertise, and best practices.
- Establish grant programs that support the implementation of electronic medical records, new programs, and best practices.
- Eliminate the redundancy of services/programs available throughout the Flex Program, networks, and IHA.
- Eliminate redundancy and unnecessary data collection and reporting activities.
- Support the integration of health services across the continuum of care with a focus on pre-hospital and hospital care.

Note: These goals were developed as part of the 2005 Idaho Flex Program's strategic planning process.



2006 PROGRAM STRATEGIC PLANNING PROCESS & OUTCOMES

The Idaho Flex Program planning session was held November 9, 2006 in Boise, Idaho. Thirty-three Flex Program stakeholders participated in this process. The day consisted of reviewing Idaho's Flex Program, the program nationally, and other state programs; identifying on-going rural health issues related to EMS, networking, quality improvement, CAHs, and health information technology; and discussing activities that may contribute to solving the identified rural health issues. The group identified a list of 34 rural health issues and a list of 39 potential solutions/activities. After the list of solutions/activities was developed, participants voted (10 votes per participant) for the activities they believe should be the highest priority for inclusion in Idaho's Flex Program. Following this, activities that received six or more votes were added to the list of current Flex Program activities and participants were again asked to vote (5 votes per participant), using the combined list, for the activities they believe should be the highest priority for inclusion in Idaho's Flex Program. Below is the initial list of rural health issues as well as the corresponding solutions. This is followed by the final prioritized list of solutions/activities for inclusion in Idaho's Flex Program.

ems

ISSUES:

- Lack of coordination and poor working relations between local EMS and hospitals that don't own their ambulances
- Lack of knowledge regarding the legal issues when EMTs enter the hospital and the EMTs' privileges
- Fragile EMS system in particular as it relates to EMS reimbursement and staff
- Difficulty meeting EMS staffs' training requirements
- Lack of quality improvement activities



- Lack of/inability to recruit and retain volunteer EMS providers
- Increase in National Registry initial certification test fees; counties that typically pay for these fees did not budget for this year's increases
- Lack of access to medical direction and/or inability to compensate medical directors for their services
- All rural areas don't have enhanced 911
- Some rural areas do not have radio coverage ("dead areas")
- Difficulties with transports from CAH emergency rooms to tertiary centers (lack of nursing staff and other healthcare providers to ride in the ambulance during transports, the receiving hospital's hospitality towards the EMS and CAH staff transporting patients, radio communication incompatibility between the ambulance, CAH, and tertiary center, and costs when patients are uninsured)

SOLUTIONS/ACTIVITIES:

- Build community awareness regarding EMS (e.g., create samples and templates for communities, CAHs, and local EMS to use for public relations) focusing on recruitment and retention
- CAHs could train ancillary staff as EMTs
- Create and support a pilot project for a CAH community that does not own an ambulance
- Create and support a pilot project that is a CAH-EMS quality/performance improvement project
- Provide funds to offset the National Registry fee increase for initial certification of EMT-Basic and EMT-Advanced for one year
- Develop a pre-screening tool for potential EMS provider candidates to assist with retention of staff
- Conduct an assessment of the inter-facility issues that exist for each EMS agency in the state
- Conduct EMS medical director training

network DEVELOPMENT

ISSUES:

- There may be duplication of efforts occurring between the networks and other state rural health stakeholders
- Lack of coordination/not leveraging resources of rural health organizations in the state



SOLUTIONS/ACTIVITIES:

- Continue to support the “network of networks” meeting that is being hosted by the Office of Rural Health and Primary Care as part of the Idaho Flex Program
- Create an inventory of clinical competencies
- Establish a “grow-your-own” health services recruitment program through the networks
- Develop a formula for CAH community benefit reporting that could be used by all CAHs
- Create a matrix of what the state rural health organizations are doing/ supporting (e.g., work related to QI, health information technology, recruitment and retention, and CAH operations/business planning/performance improvement) so Flex Program stakeholders are better able to plan, identify resources, and coordinate

quality IMPROVEMENT (QI)

ISSUES:

- Formal QI process is needed for EMS, in particular those EMS agencies that are not hospital-based
- Lack of support and funding for EMS QI
- Language barriers between patients and providers (including EMS)
- Lack of coordination between QI programs in the state and nationally
- Survey and licensing and the peer review process
- CAH peer review network is growing, however, there is no data related to resulting outcomes
- Lapses and changes in services available to CAHs due to staff departure (this primarily relates to the departure of the QI Coordinator at the Idaho Hospital Association)

- Continuity of care (e.g., seasonal residents, multiple medications from different providers) and the ability to measure quality across providers
- Patient education needs
- Pharmacy and electronic pharmacy issues
- Pharmacy and lack of/inadequate medication errors program
- Hospital boards' lack of understanding of the QI process



SOLUTIONS/ACTIVITIES:

- Create resource listings for hospitals (e.g., language translation services)
- Use the “network of networks” meetings to coordinate on QI activities that are being supported throughout the state
- Identify patient education successful practices occurring in CAHs and share the information with other CAHs
- Evaluate the use and impact of the CAH peer review network that has been supported by the Flex Program
- Create EMS peer review/QI pilot project that is modeled after the Flex Program supported CAH peer review network and the CAH QI Collaborative
- Request that the Idaho Hospital Association provide a status report on the development of Idaho’s MedMarx system that is being designed to assist with addressing medication errors issues

cah SUPPORT

ISSUES:

- Lack of access to needed continuing medical education for physicians and other staff
- Lack of resources and other barriers to implement health information technology - HIT (e.g., bar coding, information technology staff to support and maintain system, patient portal, the need to create efficiencies in the business through HIT, internal communications and planning, product driving functionality vs. needs driving product)
- Physician and nurse recruitment and training
- Need for foundation development and trained grant writers (e.g., some CAHs have full-time or part-time grant writers while others do not have grant writers)
- Need for capacity building and outreach development support (e.g., it’s difficult to do one training to meet the needs of all CAHs in the state and grant writing is competitive so most don’t feel compelled to share their best practices)
- Limited rural voice on government taskforces
- Lack of pricing transparency
- Lack of a consistent means for community benefit reporting

SOLUTIONS/ACTIVITIES:

- Offer site-specific solutions to CAHs through grants and/or technical assistance
- Create or make available QI training for CAH boards
- Support tele-pharmacy activities in rural areas
- Develop patient education packets that can be adapted and used by all CAHs
- Conduct QI case reviews (EMS, nurses, physicians)
- Use the regional networks to create workforce float pools throughout the state (float pool staff would be hired to work solely on the float pool)
- Create statewide workforce float pools where the staff are employees of the pool
- Support a project that identifies the community benefit of CAHs (through Boise State University or using the VHA model)
- Identify financial success stories (e.g., steps that were taken in CAHs that resulted in improved financial performance) and share the success stories among CAHs
- Make grants available to CAHs to purchase software for community benefit reporting
- Support foundation, board, and hospital staff training related to strategic planning
- Conduct basic and advanced grant writing workshops
- Identify and share CAH success stories/best practices within Idaho
- Create a state health care provider loan repayment program
- Support CAH information technology staff training
- Make grants available to CAHs to purchase information technology hardware
- Host a statewide health information technology summit
- Develop an inventory of successful methods to assure clinical competencies
- Create a statewide “grow-your-own” workforce recruitment and retention program that may include a loan pool, stipends, health careers information, and/or scholarships that does not just focus on nursing careers

PRIORITIZED SOLUTIONS/ACTIVITIES:

**Activities are ranked according to stakeholder support, () indicates the number of votes each solution/activity received from stakeholder participants, and bolded items indicate 8 or more votes.*

ems

- **DEVELOP AND SUPPORT AN EMS PEER REVIEW/QI PROJECT (13)**

This is intended as a pilot project consisting of a small number of CAHs with hospital-based and independent ambulance services that would engage in planning, EMS indicator identification, training, and information technology development. This pilot project would have elements of, and be modeled after, the CAH Quality Improvement Collaborative and the CAH peer review network

- Fund initial certifications of EMTs at high need locations (6)
- Support and conduct EMS medical director training (4)
- Support the statewide EMS assessment/planning process and related activities (1)

network DEVELOPMENT

- Create a network that enables a shared Picture Archiving and Communication System (PACS) (5)
- Support the on-going CAH peer review network (5)
- Support health information technology grants to three CAH regional networks (0)

quality IMPROVEMENT (QI)

- **DEVELOP AN INVENTORY OF SUCCESSFUL METHODS TO ASSURE CLINICAL COMPETENCIES (9)**
- **SUPPORT THE ON-GOING WORK OF THE QUALITY COMMITTEE/DATA TRACKING AND MEDICATION ERRORS PROJECTS (11)**
- **SUPPORT A QI COLLABORATIVE TO DEVELOP AND IMPLEMENT CAH PATIENT SAFETY BEST PRACTICES/SUCCESSES COLLABORATIVE (9)**
- Support on-going, on-site, CAH quality assurance/credentialing review activities (5)
- Support on-going CAH memberships in Databank (4)
- Support on-going, on-site, CAH QI in-services activities (3)

cah SUPPORT

- **HOST A STATEWIDE HEALTH INFORMATION TECHNOLOGY STAFF TRAINING SUMMIT (12)**
- **SUPPORT THE ON-GOING CAH MINI-GRANTS PROGRAM THAT MAKES APPROXIMATELY \$5,000 IN GRANTS AVAILABLE TO EACH CAH ANNUALLY USING A NON-COMPETITIVE GRANT MAKING PROCESS (12)**
- **SUPPORT THE CURRENT IDAHO FLEX GRANTS PROGRAM THAT MAKES FOUR GRANTS OF UP TO \$30,000 AVAILABLE USING A COMPETITIVE GRANT MAKING PROCESS (12)**
- Create a “grow-your own” recruitment and retention program that can be replicated at multiple sites (EMS and CAH) (6)
- Support CAH foundation education and development (2)
- Support on-going statewide, regional, and local CAH financial training (0)
- Support on-going CAH business office training (0)



next steps:

Flex Program staff in the Office of Rural Health and Primary Care will obtain additional program planning input from CAH administrators and other stakeholders to complete the program strategic planning process. Discussions with stakeholders will occur from November 2006 – February 2007. This input will further assist the Office of Rural Health and Primary Care with determining Idaho’s Flex Program plans for the 2007-2008 grant year.

PROGRAM PLANNING PARTICIPANTS:

Facilitator:

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ADDITIONAL INFORMATION:

If you have questions about the Idaho Flex Program or the Office of Rural Health and Primary Care, please contact Mary Sheridan, Director at **208/334-0669** or via e-mail at ruralhealth@dhw.idaho.gov.

You can find the Office of Rural Health and Primary Care on the Web at

<http://www.healthandwelfare.idaho.gov/site/3459/default.aspx>.



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