

I D A H O F L E X P R O G R A M

# strategic plan

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IDAHO FLEX PROGRAM

# strategic plan

December 2009

## INTRODUCTION

*The Idaho Department of Health and Welfare, Office of Rural Health and Primary Care, conducted a multi-year Medicare Rural Hospital Flexibility (Flex) Program strategic planning process. This included: **1)** facilitating local, regional, and statewide rural health stakeholder discussions related to Critical Access Hospitals (CAHs) and quality and performance improvement; **2)** surveying local emergency medical services (EMS) agencies to identify their challenges and needs, **3)** conducting CAH case studies to identify CAH accomplishments and on-going challenges, and **4)** facilitating a strategic planning discussion with Flex Program stakeholders. The intent of the planning process was to develop a framework to guide Flex Program priorities and activities for the coming five years.*

*The Idaho Department of Health and Welfare, Office of Rural Health and Primary Care, administers and manages the Flex Program in Idaho. Rural Health Solutions, Woodbury, Minnesota, prepared this report.*



## RURAL IDAHO AND IDAHO RURAL HEALTH SERVICES

Located in the Pacific Northwest, Idaho is predominantly a rural state. Nationally, it is ranked 14th in terms of its geographic area (83,642 square miles) and 39th in terms of its population size (1,523,816 estimated population in 2008) (Source: US Census Bureau). Between 2007 and 2008 it was the 6th fastest growing state in the nation based on percentage change in total population (1.8 percent) and 28th when considering population growth (27,671). Idaho has vast mountain, desert, and agricultural areas that are sparsely populated with heavily traveled two-lane highways. It also has many recreation areas that experience large population increases during winter and summer months with newly emerging recreation areas, no medical school, an EMS system that has few hospital-based providers, two time zones, and a predominantly rural remote hospital infrastructure.

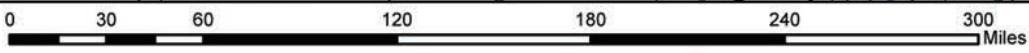
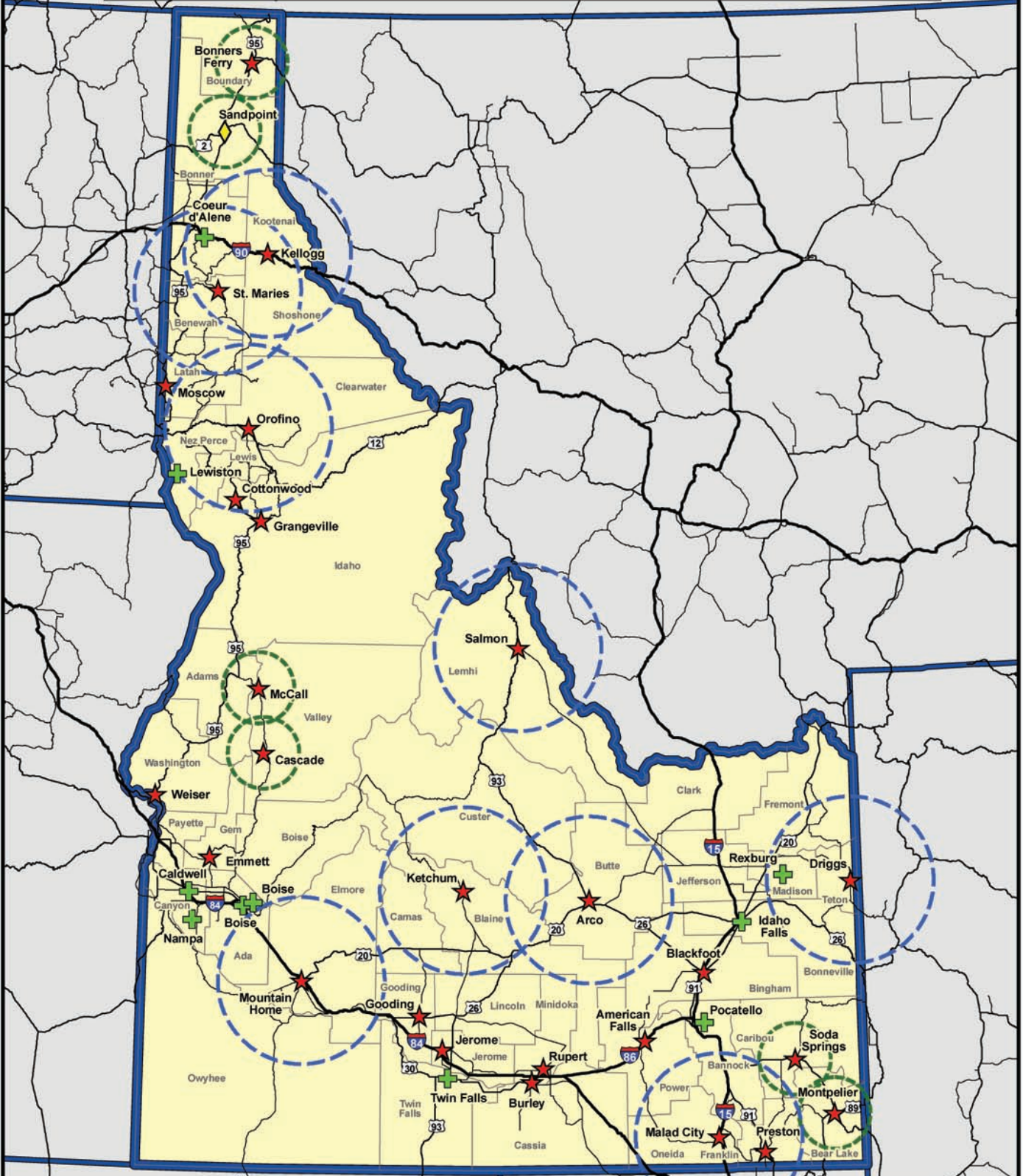


Idaho's hospitals consist of 37 acute care hospitals, four specialty care hospitals, six psychiatric hospitals, one rehabilitation hospital, one Veterans Administration hospital, and one Air Force hospital. Rural hospitals are scattered throughout the state while urban hospitals are located in the Boise metropolitan area, Coeur d'Alene, Idaho Falls, Lewiston, and Pocatello. As indicated on the map on the following page, there are 26 CAHs in Idaho: 10 are more than 35 miles from the next nearest hospital, four are more than 15 miles from the next nearest hospital in mountainous terrain or in areas with only a secondary road, and 12 meet the necessary provider criteria in the state. In addition, one is awaiting Medicare certification for its CAH status.

Idaho's EMS system consists of 199 licensed EMS agencies that predominantly provide Basic Life Support Services.<sup>1</sup> Like rural hospitals, they are scattered throughout the state and they serve very remote areas with varying geographic terrain. Some rural EMS squads have service response areas that are up to 7,000 square miles.



# IDAHO HOSPITALS: DISTANCES AND DESIGNATIONS



- ★ Critical Access Hospital
- + Prospective Payment System Hospital
- ◆ Critical Access Hospital Status Pending
- 15 Mile Radius<sup>2</sup>
- 35 Mile Radius

Map Date: December 2009

<sup>2</sup> The map indicates mileage based on aerial distance versus the actual road miles that are used for CAH designation eligibility purposes.



## MEDICARE RURAL HOSPITAL FLEXIBILITY (FLEX) PROGRAM

The Balanced Budget Act of 1997 established the Flex Program. It is a national program that includes 45 states, including Idaho. The Flex Program comprises two components: **1)** federal grants to states to assist them with implementing state specific program activities that advance the goals of the national Flex Program and **2)** a CAH-based operating program, which provides cost-based Medicare reimbursement and unique operational requirements for hospitals that convert to CAH status. The U.S. Department of Health and Human Services (DHHS), Health Resources and Services Administration, 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.

The primary goal of the national Flex Program is the development of collaborative, community-based, rural health delivery systems with CAHs as the hub of those local systems of care. Since its inception, the Flex Program has focused on CAH conversions, CAH support, network development, quality improvement, EMS integration, rural health planning, and program evaluations. However, it is intended that program changes will be made. Therefore, the Office of Rural Health Policy released a preliminary list of core areas and related program activities for state Flex Programs to base their upcoming program plans, including:

- 1** Quality improvement
- 2** Performance and financial improvement
- 3** Community engagement and impact
- 4** Health information technology (HIT)
- 5** Emergency medical services (EMS)

*It is within this new context that the Idaho Flex Program strategic planning occurred.*

## 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 11 years, the Idaho Flex Program obtained **\$5,584,392** or an average of **\$507,672 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** percent of acute care hospitals in the state. All CAHs have access to technical assistance and/or financial support on an annual basis 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 (2009-2010), funding is being directed to:

- **Office of Rural Health and Primary Care**
  - Sub contractual agreements with CAHs, regional networks, and other local and regional stakeholders
  - CAH conferences and workshops
  - HRSA patient safety collaborative
  - Medical interpreter qualification course in 2 CAH communities
  - CAH quality improvement data collection coordination and planning discussions
  - Program administration/planning
  - Program evaluation (CAH case studies)
  - Program planning – Flex Program 5-year strategic plan
- **Idaho Hospital Association**
  - Quality and performance improvement in-services, finance/business office training, and credentialing and quality assurance reviews
  - Quality improvement data collection website
  - CAH Quality Improvement/Performance Improvement Subcommittee
  - CAH participation in the peer review network
  - CAHs transportation to state Flex Program events
- **State EMS Bureau**
  - Plan and process development for transitioning to paramedic level service
  - EMS medical director and agency administrator workshops

## GOALS

- Foster collaboration among CAHs, EMS, and other community health care providers.
- Support initiatives that improve quality across the continuum of care.
- Work toward a sustainable and financially viable rural health care 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 the Idaho Hospital Association.
- 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 rural health planning process and were revisited as part of the rural health planning process in 2007 and 2008. Although the national guidance directing state Flex Programs has changed, the goals of Idaho's Flex Program continue to be aligned with the national goals.*



## 2009 RURAL HEALTH PLANNING PROCESS

A multi-year Flex Program strategic planning process was completed and included the following: **1)** local, regional, and statewide rural health stakeholder discussions related to Critical Access Hospitals (CAHs) and quality and performance improvement; **2)** local EMS questionnaire, **3)** CAH case studies, and **4)** strategic planning event. The intent of the planning process was to gather information to support the development of a 5-year Flex Program strategic plan for Idaho. Below is a summary of each activity contributing to the strategic planning process.

### STAKEHOLDER DISCUSSIONS

Six Idaho Flex Program planning sessions were held in Pocatello **(4)**, Coeur d'Alene **(1)**, and Boise **(1)** from August through November 2008. Sixty-seven Flex Program stakeholders participated in the sessions. Five of the planning sessions were 1.5 hour discussions that focused on CAHs' financial performance improvement and benchmarking, rural health network development, quality improvement and reporting, or supporting and sustaining CAHs. Each included discussions about the strengths, challenges, solutions to address the challenges, and future threats related to the topic. These discussions included CAH foundation, business office, human resources, CEOs, CFOs, and nursing staff. The sixth planning session was a half-day event that included discussions about rural EMS, network development, and quality improvement. A diverse group of rural health stakeholders were involved in this event.

### EMS QUESTIONNAIRE

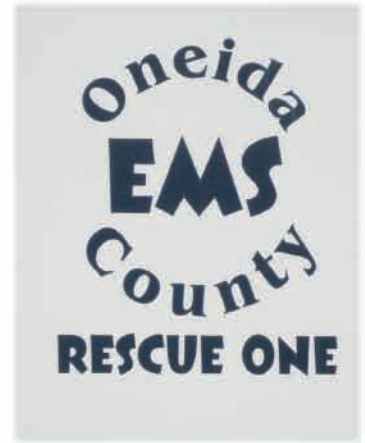
An EMS questionnaire was mailed to all EMS directors in CAH communities in June 2008. Nine of 26 EMS agencies responded. The questionnaire asked EMS agencies to report the following:

- Factors that are contributing to the EMS agency's success
- Challenges and unmet needs affecting the EMS agency
- Solutions/strategies to resolve/address EMS agency challenges and unmet needs
- Priority areas to that the Idaho Flex Program should invest resources based on the national Flex Program EMS topic areas.<sup>3</sup>



<sup>3</sup> Federal Flex Program EMS activities focus on regional or community EMS assessments, Rural Trauma Team Development and Comprehensive Advanced Life Support courses, medical director training courses, recruitment and retention programs, EMS budget training, and rural EMS management leadership training.

This questionnaire determined that EMS agencies have some unique strengths and weaknesses, as well as ideas on how these challenges should be met. However, EMS agencies also had much in common, including:



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**STRENGTHS:**

- Dedicated and professional EMS volunteers
- Strong team work both within the ambulance services community but also between local EMS and other local organizations
- Active training and staff retention programs/activities

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**CHALLENGES:**

- Increased EMS agency certification and staff training requirements
- Lack of access to high quality training throughout the state
- Recruitment and retention of active EMS staff
- Declining reimbursement/sustainable funding, including funding for training and equipment
- Limited to no full-time staff
- Declining volunteerism/community members working longer hours resulting in less time to volunteer
- Lack of grant writers/grant writing skills
- Lack of benefits/recognition for EMS staff
- Aging population

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**SOLUTIONS TO ADDRESS CHALLENGES:**

- Increase Medicaid reimbursement for EMS
- State supported incentives for EMS volunteers (e.g., tax reductions, retirement, health insurance)
- Grant funding to support improved access to training, equipment, and supplies
- Public relations/marketing/media campaign too recognize the importance and role of EMS volunteers

*When asked to rank their EMS Flex Program priority areas, they rated EMS budget training, Rural Trauma Team Development (RTTD) courses, recruitment and retention programs and rural EMS management leadership training (in that order) as their greatest priorities.*

# CASE STUDIES

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Seven CAH communities participated in case studies, including: Malad City (2009), Salmon (2009), Bonners Ferry (2008), McCall (2007), Preston (2007), Kellogg (2006), and Montpelier (2006). Considering all of the case study communities, their average population was 8,955 and the average distance to the nearest hospital was 40.7 miles at the time each case study was completed.

The case studies were completed to identify community, hospital, and other health care related changes and outcomes that have occurred due to each hospital's conversion to CAH status and its involvement in the Flex Program. They were also completed to identify needs and issues for Flex Program planning purposes. Data for each case study were obtained from the Idaho Department of Health and Welfare, Office of Rural Health and Primary Care, State EMS Bureau, and the national Flex Monitoring Team, as well as case study participants. Case study participants were asked questions related to each of the Flex Program goals, focusing on outcomes, accomplishments, needs, and on-going issues. A total of 169 individuals participated.

The case studies determined that CAHs have expanded access to health services, enhanced services, upgraded equipment, provided additional staff training, and have initiatives in place to improve the quality of patient care. In addition, local EMS agencies have made changes to update equipment, implement EMS staff recruitment and retention strategies, and in many cases improve EMS' overall operations. Although much has been accomplished, challenges continue to exist, such as: physician recruitment and retention, lack of fully-implemented electronic health records, ongoing financial issues in some CAHs, on-going staff training needs, and no/limited EMS-hospital integration has occurred.

169 PARTICIPANTS  
7 COMMUNITIES



# STRATEGIC PLANNING SESSION

The Idaho Flex Program planning session was held November 5, 2009, in Boise, Idaho. Twenty Flex Program stakeholders participated as indicated in Table 1. The day consisted of:

- 1) Reviewing Idaho’s Flex Program and national program history and planned changes;
- 2) Discussing challenges related to each Flex Program goal: rural EMS, CAHs’ performance/financial improvement, health information technology (HIT), and quality improvement;
- 3) Identifying objectives for each Flex Program goal;
- 4) Identifying strategies to reach each objective; and
- 5) Prioritizing all of the strategies.

Using this framework, the following EMS, CAH performance, CAH HIT, and CAH quality improvement challenges, objectives and strategies were determined:

**TABLE 1:**  
*Strategic Planning Session Participants*  
*Facilitator: Rochelle Spinarski, Rural Health Solutions*

PARTICIPANT	ORGANIZATION
Larry Barker	Clearwater Valley Hospital
Robert Cuoio	The Hospital Cooperative
Gerri Garten	Boundary Community Hospital
Charlene Godec	Bonner General Hospital
Ken Harman	Cassia Regional Medical Center
Gordon Hawkins	City of Kamiah Ambulance Service
Nanette Hiller	Idaho Hospital Association
John Hoopes	Caribou Memorial Hospital
Brent Hutchinson	Emergency Response Ambulance
Gay Johnson	Walter Knox Memorial Hospital
Doreen Krabbenhoft	Elmore Medical Center
Toni Lawson	Idaho Hospital Association
Jennifer Palagi	Qualis Health
Blane Ripplinger	Teton Valley Healthcare Clinic
Mary Sheridan	State Office of Rural Health
Craig Thomas	Bear Lake Memorial Hospital
Kim Vega	Minidoka Memorial Hospital
Todd Winder	Oneida County Hospital
Sharon Wilson	Qualis Health
Diane Wood	Walter Knox Memorial Hospital

## ems



### RURAL EMS CHALLENGES:

- Recruitment and retention of volunteer EMTs
- Responsibility of maintaining access to local EMS services (e.g., payment for services and operations)
- Lack of a statewide trauma system
- Lack of full-time EMS director

## **RURAL EMS CHALLENGES (CONT):**

- Hospital-EMS relations (e.g., operationally, patient care, training, and HIT)
- Patient transfers
- Integration with quick response units (QRUs)
- Limited access to training for EMTs and medical directors
- Lack of funds for equipment
- Lack of formal QI programs
- Perceived move towards a paramedic-based EMS system
- Changes in support from the state EMS Bureau
- Turnover of local EMS leadership



## **RURAL EMS OBJECTIVES AND STRATEGIES:**

### **OBJECTIVE - IMPROVE LOCAL EMS OPERATIONS/PERFORMANCE**

#### **STRATEGIES (in order of priority)**

- 1) Support EMS-CAH provider training that requires collaboration between local health services providers
- 2) Develop a statewide EMS network similar to the regional CAH/hospital networks that exist in the state
- 3) Support EMS director training focusing on EMS performance, billing, management, and budgeting
- 4) Make Rural Trauma Team Development (RTTD) courses and Comprehensive Advanced Life Support (CALs) training available to local EMS providers



## **CAH CHALLENGES:**

- Recruitment/retention of physicians
- Uninsured/underinsured patients
- Emergency room use for primary care
- High management turnover
- Lack of quality/auditor checks by coders
- Lack of insurance pre-authorizations
- Recovery Audit Contractor (RAC) Program
- Hospital renovations, expansions, and rebuilds
- Unfunded mandates
- Billing and coding

## **CAH PERFORMANCE OBJECTIVES AND STRATEGIES:**

### **OBJECTIVE - IMPROVE CAH FINANCES.**

#### **STRATEGIES**

- 1) Support Idaho Hospital Association financial seminars
- 2) Provide mini-grants to CAHs to support hospital-specific performance improvement needs
- 3) Support mock RAC audits in CAHs
- 4) Support CAH charge master reviews
- 5) Conduct a CAH webinar on community benefit data collection and reporting

### **OBJECTIVE - IMPROVE CAH OPERATIONS.**

#### **STRATEGIES**

- 1) Provide larger grants to CAHs to support them in addressing hospital-specific challenges
- 2) Support Lean training for CAH staff
- 3) Support CAH leadership development training
- 4) Develop and support succession planning training for CAHs



**HIT CHALLENGES:**

- Funds to purchase electronic health records (EHRs)
- Connectivity between pre-hospital, CAH, tertiary, clinics, and long-term care sites
- Physicians/clinics choosing different EHRs
- HIT master planning
- Policy and procedure changes and implementation
- Staff and staffing costs to maintain and update HIT
- Staffing costs (training time) to implement HIT
- Staff frustration/morale related to HIT implementation/use
- Provider buy-in
- Contract staff (medical) may not be familiar with EHR and its use
- Identifying internal champions/super-users for HIT
- System back-up/redundancy/disaster recovery
- Lack of staff trained in EHR software
- On-going training

**HIT OBJECTIVES AND STRATEGIES:**

**OBJECTIVE - CAHS ARE INFORMED OF STATE AND NATIONAL HIT POLICIES AND OPPORTUNITIES.**

**STRATEGIES**

- 1) Establish someone (e.g., within the Idaho Hospital Association, Idaho Office of Rural Health, other state HIT organization) as the CAH HIT liaison/resource to collect and disseminate state and national HIT information
- 2) Create a Web site of resources where CAHs can access HIT resources



**HIT OBJECTIVES AND STRATEGIES (CONT.):**

**OBJECTIVE - CAHS HAVE A FULLY-FUNCTIONAL EHR.  
STRATEGIES**

- 1) Conduct a CAH EHR needs assessment
- 2) Conduct a meaningful use webinar for CAH staff
- 3) Conduct a webinar series for CAH staff that addresses CAH EHR challenges identified in the needs assessment
- 4) Make grants to regional networks to support HIT activities



**QI CHALLENGES:**

- Lack of coordination between QI programs
- Lack of EHRs in CAHs
- High turnover of CAH QI staff (e.g., QI Coordinator)
- Resources for education of staff to implement policies and procedures
- Lack of processes for initial review of medications
- Quality focus is on data collection rather than process/  
policy changes and patient outcomes
- Few CAHs are reporting to Hospital Compare
  - Time required to enter and submit data
  - CAH volumes are low resulting in limited data/indicators that reflect poorly of CAHs
  - Difficult tool to enter data
  - Other reporting mandates exist while Hospital Compare is not required, making it a significantly lower priority

## QI OBJECTIVES AND STRATEGIES:

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### OBJECTIVE - CAHS HAVE THE CAPACITY TO MEASURE AND IMPROVE QUALITY OF CARE.

#### STRATEGIES

- 1) Support multi-hospital, regional, patient safety/QI programs in CAHs. The programs should be based on CAH quality data collected and should include key state stakeholders (e.g., Blue Cross, Blue Shield, Qualis Health, Idaho Hospital Association)
- 2) Create a statewide QI resources Web site with tools, resources, and best practices
- 3) Train CAHs on pneumonia data collection and reporting to Hospital Compare

### OBJECTIVE - CAHS HAVE THE TOOLS TO MEASURE AND IMPROVE QUALITY OF CARE.

#### STRATEGIES

- 1) Develop a common set of quality measures across data collection systems (e.g., Blue Cross, Blue Shield, Qualis Health, Idaho Hospital Association)
- 2) Support a multi-hospital peer review network
- 3) Train CAH staff in the benefits and use of the peer review network

## PROGRAM RURAL HEALTH PLANNING *next steps:*

The Idaho State Office of Rural Health will develop the state's Flex Program over the next five years using these objectives and strategies as a guide. In addition, CAHs and EMS staff will be consulted on an annual basis to assure other new challenges and policy changes are considered as part of the program's development.

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](tel:2083340669) or via e-mail at [ruralhealth@dhw.idaho.gov](mailto:ruralhealth@dhw.idaho.gov).

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

[www.ruralhealth.dhw.idaho.gov](http://www.ruralhealth.dhw.idaho.gov)



This report was created by Rural Health Solutions, Woodbury, Minnesota - [www.rhsnow.com](http://www.rhsnow.com), funded by the Idaho Department of Health and Welfare, Office of Rural Health and Primary Care, through a grant from the U.S. Department of Health and Human Services, Health Resources and Services Administration, Office of Rural Health Policy.

