

RURAL HOSPITAL FLEXIBILITY PROGRAM ADVISORY COMMITTEE

January 20, 2010

10 a.m. - 2 p.m.

Stratis Health - Bloomington, Minnesota

Members: Brian Carlson, Mike Hagen, Mike Hedrix, Joe Herbst, Susan Klabo, Ben Koppelman, Peggy Lien, Kathy Burke Moore, Lori Sisk, Bethany Snyder, Mick Stokes, Karla Weng, Tara Westby, Gary Wingrove.

Staff: Doug Benson, Cindy LaMere, Anne Schloegel, Mark Schoenbaum, Kristen Tharaldson.

Guests: Anne Dobbins (MN HIE), Michael Ubl (MN HIE), Gary Sabart (TSP Architecture Engineering).

Roundtable Reports from Advisory Committee Members

- **Brian Carlson (Lakeview Memorial Hospital, Two Harbors)**
 - The transition to being a fully owned subsidiary of St. Lukes, along with the 2009 closing of the attached nursing home, has been challenging for employees. There are a lot of lessons to be learned, including how to assist both staff who lost jobs, and staff who remain, in dealing with the changes.
 - **Mark Schoenbaum** – The current trend is for hospitals to close or sell attached nursing homes. Given the focus of the Flex program, how do we maintain the quality and continuity of care for patients moving from one setting to another when the nursing home is no longer within the same organization? Mark asked the group to consider new Flex activities in this area.
 - The current physicians in Two Harbors are in their mid-50s. It is hard to recruit people to the area. Medical students have significant debt and cannot afford to go into family practice. There will be problems in the near future if we don't provide incentives to keep students in family practice.
- **Mike Hedrix (Essentia Community Hospitals)**
 - Fosston and Graceville have joined Essentia and are utilizing training and clinical tools to bring about local health system integration.
 - The Institute of Rural Health was recently created within Essentia to address broad national work in education, research and clinical quality. The Institute is developing intersections with other rural health agencies.
- **Joe Herbst (MAPA)** – CAH staff experience frustration providing care for patients with behavioral health issues. Issues arise around cost and legal/ethical ramifications for the provider. One solution is tort reform to relax requirements for providers with limited staff. Medical costs are significant.
 - **Susan Klabo** – Five years ago Mahanomen Health Center applied for and received a HRSA grant to integrate mental health services

with primary care. At the start, the no-show rate was high, so work started on that. Now we have a psychologist for one full day, a social worker (LICSW) for two full days, and we are using telemental health consults.

➤ **Susan Klabo (Mahnomen Health Center)**

- In response to the high incidence of chronic diseases in the area, Mahnomen Health Center convened 20 parishes and eight clergy to get aid for the parish nurse program. Activities include partnering with the Susan G. Komen Race for the Cure Foundation and becoming a diabetes certified center.
- Health Boards in Northwestern and Southwestern Minnesota have expressed concern about economic changes. Health care organizations are having trouble with provider coverage and are losing providers because of the payment system. Providers collect a base salary and have potential for more money with more patients, but pay is not tied to quality. It would be preferable to shift to a value-based system for higher quality.
- CAHs and Stratis Health will need grant funding to address quality measures in rural hospitals. Stratis Health site visits had a positive impact in the past.
- The National Health Service Corp (NHSC) creates incentives for people to work in underserved areas. Since it was created before CAHs were designated, there's been no adjustment for unique CAH circumstances. Mahnomen had several providers fail to show because NHSC requires 32 clinical hours and there is no time for hospital experience. NHSC requirements should be adjusted to allow for unique needs of health campuses. The NHSC was designed for physicians who work in free-standing clinics only.
- Mahnomen area residents have expressed concern about lack of continuity of provider care.
- Currently Mahnomen's ER is seeing 28 percent uninsured (compared to 3 percent in 2000).

➤ **Ben Koppelman (St. Joseph's Area Health Services, Park Rapids)**

- St. Joseph's is a part of Catholic Health Initiatives. This involves 13 facilities working together on strategies around a regional home care model. A goal is that a new model will bring efficiencies and continued access to home care programs.
- The e-ICU Project keeps patients local and helps to retain specialists. This project provides a good opportunity for family physicians to be more involved in around the clock care. St. Joseph's is also trying to tie this in with a hospitalist program to for nights and weekends. An intensivist, who is available through St. Joseph's sister facility in Iowa, monitors up to 120 patients at one time (typically 75-80). The system often picks up issues before they are recognized by in-room providers. It provides reassurance for nursing staff, especially during shifts with low staffing ratios.

- St. Joseph's is involved in a telepharmacy project to provide consultation with nurses and doctors and to verify patient doses.
 - St. Joseph's operates a dental clinic in the CAH, but the state eliminated a large portion of dental reimbursement.
 - The Minnesota Department of Human Services also eliminated some codes that are no longer reimbursable. Half the people who were served in the past are no longer covered and were moved to self-pay. State cuts to GAMC are looming.
 - The county is saying it can no longer legally provide mental health transports. The hospital had relied on it as a resource and currently there is no capacity to replace this service.
- **Peggy Lien (MDH Licensing and Certification)**
- Last year, because of state budget constraints, Licensing and Certification did not do CAH recertification surveys. In 2010 it will survey 26 CAHs. Rural health clinics have been surveyed all along.
- **Cathy Burke Moore (EMS Regulatory Board)**
- Trauma system designation is going well. All hospitals have the information and five specialists are offering help and information.
 - The American Heart Association wants to partner with the EMSRB to survey EMS regions around STEMI guidelines.
- **Lori Sisk (Sanford Canby Medical Center)**
- There is a growing demand for total joint replacement surgery. A year ago, Canby lost its orthopedic surgeon. Now we are working with a firm to create access to specialists within their facility, a model of care that can be replicated in any facility. The specialist, retired from full-time practice, visits one week a month and works Monday through Thursday doing surgery (M-T) and recovery and after-care (W-TH). This schedule kept Canby from losing this business to communities 40 miles away, so the program is seen as a success. Specialists are nearing retirement, but are willing to come out one week a month. Patients don't need to travel and can recover in local hospitals. Now Canby is looking at other specialties (urology) and forming a range of specialty services using this scheduling model within the Sanford network.
- **Bethany Snyder (Senator Franken's office)**
- It's too early to tell what will happen with the national Health Reform bill. Senator Franken has field offices throughout Minnesota for local communication.
- **Mick Stokes (Lakewood Health System, Staples)**
- Lakewood Health System added another obstetrician/gynecologist because of an increased number of births.
 - Lakewood is working with an orthopedic specialist from Brainerd who is

providing hip and knee care. We hired a mid-level orthopedic specialist to do follow-up care. The CAH has not been surveyed, but two clinics were surveyed and those went well.

- Lakewood is moving into a new modern clinic in Browerville.
 - **Mark Schoenbaum** – Details for EHR incentives are troubling (CMS proposal). Provider-based clinics (including rural) are proposed for exclusion for eligibility for incentives. These rules are in the comment periods so now is the time to weigh in. Public comment can be made at <http://www.regulations.gov/search/Regs/home.html#documentDetail?R=0900006480a7c4a8> until March 15, 2010.

➤ **Karla Weng (Stratis Health)**

- Stratis Health is the QIO for Minnesota. About half of the current activity is provided under contracts and grants, including Flex. Activities underway include:
 - Teleconference series for CAHs to prepare for state reform reporting requirements with the first deadline of February 15. Sixty hospitals participated.
 - EHR support for health care organizations, including six CAHs.
 - Education blocks (leadership, quality reporting, clinical decision support, culture change, e-prescribing, health information exchange and communication)
 - Facilitation of end of life nursing education programs in New Ulm and Bemidji, which is part of a palliative care initiative.
 - Outcomes conference April 8 in St. Cloud highlighting 10 communities now providing community-based palliative care services. Registration information coming in February. <http://www.stratishealth.org/palcare>.
- Stratis recently received funding to work on palliative care with six more communities and with UCare.
- Stratis is working with the Rural Health Resource Center and the College of St. Scholastica (Key Health Alliance) on an application to be an HIT regional extension center. We received favorable feedback on the draft proposal. An announcement is expected by January 22. If awarded a contract, the alliance will move quickly to help providers become meaningful users of HIT.
- The CLAS portion of Stratis Health's Web site now has individualized county reports on diverse populations and growth.

➤ **Gary Wingrove (Gold Cross Ambulance)**

- Both Aaron Reinert and I from Minnesota are on the National EMS Advisory Council and we will serve for the next two years.
- A recent publication "EMS Making a Difference," shows EMS impact on patients' lives. One of the highlighted areas in the report is STEMI.
- The **next national EMS** conference will be in St. Louis in February.

- Minnesota supported the community paramedic program with a Flex grant for curriculum development. A curriculum was created and piloted in Prior Lake. The instructor was diverted to the H1N1 response, but now the program is finishing and there will be eight graduates. The next step is to update to curriculum 2.0 to include oral health. Funding sources have been secured to continue the program. Community paramedic students will work with local public health to update work plans by surveying communities. Paramedics are now part of the community public health plan.

Behavioral transport issues discussion

Transport of behavioral health patients has been a major problem since state mental health hospitals closed. Some ambulance personnel will drive eight hours on one transport. Issues arise when there are combined behavioral health/medical concerns (e.g., a behavioral health patient having a heart attack), coverage during the absence of the transporting vehicle/team, and the appropriateness of using squad cars or ambulances for transporting the mentally ill. The problem is chronic and growing. There is confusion about counties' legal interpretations of this issue, including who has legal responsibility for transport in these cases. An EMSRB report focuses on prevention. See http://www.emsrb.state.mn.us/docs/EMS_Behavioral_Health_Report.pdf (PDF: 17KB/55pgs).

Flex program funds have supported some training for crisis response teams (CRT) to replicate the Itasca County model. In this model, the sheriff dispatches the crisis response team along with law enforcement officers, enabling crises to be diffused in the field and thus preventing the need for transport. Teams also know inpatient resources in the region and where beds are open. They can call hospitals in the region where they know the staff, so they are more likely to arrange placements closer to home and avoid long transports. Mahnommen had a crisis response team, but lost its grant funding source. Requirements do not allow for getting people help through State Operated Services (SOS), so reevaluation of the whole system is still needed. ERs are not equipped to offer mental health care. Citizens know the ER is open 24 hours, so that's what comes to mind when they are in crisis.

Update from MN HIE (Minnesota Health Information Exchange)

Anne Dobbins and Michael Ubl

MN HIE provides a secure network for exchange of clinical information (end providers, public health, hospitals, clinics, specialty care, etc). It was founded by six entities in the state including health plans, providers and state government. The network can be used with existing EHRs and supports true interoperability. Organizations can track patient eligibility (administrative view) and clinical services (clinical view). MN HIE does not use a central data repository, but instead accesses internal organizational data sources. The system is focused on real time patient care. Provider-based clinics are excluded.

ORHPC report

Mark Schoenbaum

- Rural Health Conference planning is underway and breakout proposals are due January 22.
- The NRHA Policy Institute will be in Washington, D.C., January 25-27. I will be attending along with nine others from Minnesota. A highlight will be visits to congressional offices to communicate the rural health perspective, including successes and challenges.
- Applications for the Small Rural Hospital Improvement Program will be available soon.
- The state budget is affecting state agencies. ORHPC is not filling job vacancies.
- Ambulances are working on their plans for transport within the trauma system. Every hospital in the state plans to obtain trauma designation. Regional Trauma Committees will be created during the next phase of Trauma System development. ORHPC continues to be interested in and available for trauma system development site visits.

Minnesota Flex Program Evaluation

Rochelle Spinarski, Rural Health Solutions

The ORHPC contracted with Rural Health Solutions to conduct a survey of Minnesota's CAH administrators to evaluate the effectiveness and usefulness of the Flex Program and other services ORHPC provides. The survey received a good response rate (92 percent). The survey data will contribute to planning for the federal Flex application and other ORHPC activities in the near future.

The survey objectives were to:

- 1) Measure CAH perceptions of and satisfaction with the Minnesota Flex program
- 2) Identify and measure satisfaction with technical, programmatic and financial support ORHPC provides
- 3) Identify program concerns
- 4) Identify trends and changes in CAH satisfaction
- 5) Determine CAH technical assistance needs
- 6) Identify urgent and ongoing concerns.

The survey included data from past Minnesota CAH surveys, ORHPC grant information and other sources (e.g., CALS) to supplement the survey results. Overall, satisfaction with the Flex program is high. Some specific findings include:

- Those who are reading the ORHPC communication materials are most informed about overall Flex program activities.
- Most CAHs are aware of ORHPC grant programs. Some CAHs consistently apply for ORHPC grants while others rarely apply. We do not know why some CAHs do not apply for any grant programs.
- There are gaps between awareness and use of ORHPC programs, especially related to workforce programs.
- A Flex subsidy for the CALS program has allowed more rural clinical staff to

- obtain training. It's clear that CAHs have high satisfaction with and see value in the CALS program.
- Most CAHs reported that quality improvement initiatives are helpful, but they may or may not know what impact QI initiatives have on their facilities. In this area, response may depend on who filled out the survey (e.g., CEO versus a quality coordinator).
 - The top concerns for CAH administrators are physician recruitment, finances and electronic health records.

The evaluation report concludes with a summary of recommendations for ORHPC staff to consider as the office plans for future activity and response to rural Minnesota needs.

Federal Flex Grant Planning for 2010-11

The Flex application guidance is expected to come out soon. The application will be due at end of March or April. Funding starts September 1, 2010. The Flex committee will have a chance to comment on the application before it is submitted. This year is a competitive grant cycle. For the past three years, Minnesota was awarded the maximum available: \$650,000 per year.

Mark Schoenbaum distributed the Framework for the Flex Program Guidance to help guide discussion. There is concern about future support for the Flex program now that the hospitals are designated. The Office of Rural Health Policy (the federal office from which the funding comes) is focusing on new evaluative measures to show the impact of Flex Program nationwide.

Multistate CAH benchmarking activity – ORHPC has been working with the Minnesota Hospital Association (MHA) on this. There has been a small pilot group. The next step is to become formal participants in a multistate peer group benchmarking service operated out of the Kansas Flex program called QHI. The cost is consistent with what the ORHPC has previously granted to MHA from Flex funds. Right now it costs \$10,000 per state, but they are revisiting this issue at the NRHA Policy Institute next week. This is the tracking phase and there may also be expectations around hospitals making improvements in quality due to tracking results.

Financial improvement – The guidance for 2010 is expected to have a significant focus on assisting CAHs with financial improvement. The ORHPC will meet with MHA and Stratis to discuss specific projects, taking into account the recommendations from the evaluation reports from 2008 (on financial stability of Minnesota CAHs) and 2009 (the report discussed earlier in this meeting). It was suggested that a statewide CFO roundtable on how to absorb bad debt would be useful. MHA currently conducts these.

Quality Improvement – One concern ORHPC identified relative to quality is the phenomenon of CAHs spinning off nursing homes. The driver is inadequate reimbursement. CAHs receive cost-based reimbursement, but costs attributed to nursing homes have to be supported by nursing homes. The most challenging transition when

losing a nursing home is for communities with no alternative facilities. Observations and ideas from the discussion include:

- Some colleagues in northwest Minnesota are looking at co-ops, selling or other options.
- If we accept that this is a trend and we look at quality care related to that trend, a new Flex initiative could be to work with Stratis Health to provide training on maintaining continuity of care in communities where the hospital and nursing home are separating. For example, we could look at EHRs and see if they can exchange information.
- There could be additional problems for ambulance services around billing.
- The nursing home industry is closely regulated. It should not be assumed that quality will necessarily slip because CAHs spin off their nursing homes.
- Discharge planning overall will be more complicated. Discharge planning is another option for LEAN training. Could target communities and bring in neutral facilitators to discuss community solutions to discharge planning.

Another quality issue to consider is OB life support for hospitals that don't deliver babies or are getting out of the business. Also, larger hospitals are looking at stroke prevention projects.

Community Impact and Engagement – Some thoughts regarding this topic included:

- Conducting community assessments is challenging
- Identify trends for collaborative projects to address unmet health and health services needs.
- Provide a connection to local State Health Improvement Projects (MDH-SHIP).
- Develop a toolkit to help EMS report community benefit.
- Look for obvious multistate opportunities
- Use state Planning and Transition Grant Program to fund community assessments or market studies.

Improvement and Integration of EMS Services – See earlier discussion on behavioral health transport issues.

Nomination of New Members

There are two Flex vacancies. Judy will ask the previous committee (Mike Hagen, Mike Hedrix, Gary Wingrove) to nominate candidates.