

State Flex Programs: Most Significant Achievements and Success Stories, 2009

A Compilation of the State Flex Programs' Most Significant Achievements and Success Stories

Technical Assistance and Services Center (TASC)

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The information contained in this document was compiled from the Flex State Program Profiles available on the TASC web site at: <http://www.ruralcenter.org/tasc/profiles.php>. In order for the State Flex programs to network together, TASC contacted the Flex programs and the State Offices of Rural Health to collect information on their staff members, major program areas, and successful activities. The information can be used to facilitate communication among other State Flex programs with similar interests

State	Most Significant Achievements (MSA) and Success Stories (SS): Quality/Performance Improvement
Alabama	MSA: Establishment of a Rural Hospital Quality Network.
Alabama	SS: The Alabama Flex Program worked with the Alabama Hospital Association's Quality Taskforce to develop and implement a Statewide Color Coded Wristband Initiative. The development of the program provided color coded wristbands to critical access hospitals and now is a statewide initiative with many hospitals participating in the project. Standardized wristbands improve the quality of care as healthcare providers work in different facilities in Alabama and across state lines.
Alaska	MSA: Providing Alaska's CAHs with the opportunity to work on quality and performance issues that they select as major focus areas has been the single most significant achievement for the Alaska Flex Program. With the isolated nature of Alaskan hospitals, the Flex program has had a significant impact on financial sustainability.
Arkansas	MSA: Arkansas developed a Quality Improvement program in 1999 in conjunction with its Quality Improvement Organization (QIO). All CAHs submitted, and continue to submit, data regarding CAH quality indicators in the areas of heart failure, pneumonia, and acute myocardial infarction. Onsite technical assistance provided support in these designated areas. Through this program, the QIO created a patient safety website - http://www.arpatientsafety.com - to share success stories and best practices.
Colorado	MSA: Development of our Peer Review Network, and the Quality Improvement Peer Network.
Hawaii	MSA: Establishment of the Hawaii Performance Improvement Collaborative, a performance improvement network that meets regularly to identify and address needs of the Critical Access Hospitals.
Iowa	SS: One of many success stories include providing funding that increases access to services that saves lives at the local critical access hospital. Van Buren County Hospital, located in Keosauqua, Iowa, recently used Flex grant funding to increase access to health services and improve patient safety and the quality of care by purchasing and implementing the use of a Bi-Pap (Bi-Level Positive Airway Pressure) machine. The machine helps people get more air into their lungs. In many cases, having access to this machine allows patients to remain at their local hospital instead of being transferred to a larger facility. It has allowed immediate intervention and use of a noninvasive procedure to treat patients who enter the emergency room in acute respiratory distress, especially those with chronic obstruction pulmonary disease or congestive heart failure. Since utilizing the Bi-Pap, the hospital has noticed a decrease in the number of transfers and length of patient stays. Jim Richmond, PA, who staffs the hospital's emergency room, states, "I have seen firsthand that Bi-Pap can be life saving. It is important in a rural hospital to have the equipment to meet our patients' needs."
Kansas	SS: The Multi-state Health Quality in Rural America project (HQRA) currently involves six

	<p>states in addition to Kansas. Four more states will join the project in 2009. HQRA is a highly successful quality/performance improvement project developed and utilized in nearly all of the 83 Kansas critical access hospitals.</p>
Michigan	<p>MSA and SS: The Michigan Critical Access Quality Network (MICAQH QN) was formed in 2001 with fourteen CAHs. The Network formalized in 2003 and received 501(c)3 status in 2007. Today, 35 CAHs and one rural hospital actively participate in the Network. All projects and decisions are driven by the Network via consensus.</p> <p>All hospitals use MHA Core Options™ for data collection and benchmarking. In addition to the MICAQH QN comparative data, individual hospitals have the capability to create their own custom measures. Common areas of local measurement among MICAQH QN measures are review to determine the feasibility of general relevance to all hospitals.</p> <p>The Network meets in-person and via video conference, quarterly. Members readily share best practices and hold education sessions at meetings.</p> <p>The MICAQH QN effort provides a means to include small and low volume hospitals in an effective way to report performance and identify areas for improvement. At the same time, MICAQH QN is developing measures that reflect the more important roles such hospitals play, for example, aspects of care related to stabilization and transfer of patients.</p>
Minnesota	<p>SS: Minnesota's Flex program contracted with Stratis Health QIO to work with a group of CAHs to re-administer the Agency for Health Research and Quality Rural Organization Safety Culture survey, analyze the data, and assist in planning and deploying meaningful interventions.</p> <p>The survey was administered to five hospitals. Four hospitals continued beyond the survey process, with teams attending workshops on "Implementing a Just Culture;" holding conference calls; participating in re-surveys; attending a workshop on implementing Team STEPPS in their hospitals; attending WebEX sessions to discuss survey results and measurements.</p> <p>Among the results: one hospital reported identification and resolution of staffing issues, freeing up RNs to spend more time with patients and increasing staff satisfaction; another showed improvement in their error reporting process and increased comfort level among staff in reporting near misses. All participating hospitals indicated they appreciated the educational opportunities and, even in cases where improvement was not dramatic, they reported they had implemented changes that they anticipated would ultimately yield positive results.</p>
Montana	<p>MSA: The Performance Improvement Network is a well-established, mature network that provides assistance to member facilities ensuring compliance with the Medicare Conditions of Participation quality assurance tags and supports other CAH quality improvement efforts.</p>

Montana	<p>SS: Champions for Quality has become the cornerstone rural healthcare conference in Montana. We bill Champions as Montana’s “premier” rural health care conference and evaluation results indicate we are true to our word. 100% of the participants say the “conference was worth their time” and “they would recommend the conference to others.” What started in 2005 as a small conference with 60 attendees has grown to conference over twice that size with many facilities sending quality improvement teams comprised of providers, quality coordinators, and administrators. It takes a dedicated planning committee, which includes rural providers, a full year to plan and execute this continuing medical education event that also provides great social networking.</p>
Nebraska	<p>MSA: Development and use of the Balanced Scorecard.</p>
Nebraska	<p>SS: The Flex program has collaborated with the University of Nebraska Medical Center (UNMC) to support the TeamSTEPPS project. Over the past two years, more than 30 CAHs in Nebraska have been participating in the program. The goal of TeamSTEPPS is to ensure safe care for patients by improving the communication and teamwork skills of the medical and hospital staff. After an initial readiness assessment, a rural-adapted version of the Agency for Health Research and Quality Hospital Survey on Patient Safety Culture is conducted in each of the participating CAHs. After the survey, a train-the-trainer workshop is held to teach hospital staff about the tools that are available and how to use them effectively. Thus far, a total of 107 master trainers have completed the TeamSTEPPS training and they are now training other CAH staff. Throughout the process, staff from UNMC conduct bi-weekly conference calls, as well as a lessons learned conference. One of the lessons learned is the importance of training all members of the team. When a problem such as disruptive behavior occurs, an action plan is developed with the goal of obtaining buy-in from all team members, and treating every individual on the team so that they feel valued and respected.</p> <p>In March of 2009, the Hospital Survey on Patient Safety Culture was re-administered to all of the CAHs that participated in TeamSTEPPS. The results of the survey will be used to asses the impact of TeamSTEPPS on the patient safety culture in each CAH.</p>
North Carolina	<p>SS: The most exciting new program that we are developing is Lean Management implementation. This is a quality improvement tool based upon the Toyota Production System model that has seen tremendous success in hospitals of all sizes. The Denver Health System is a great large system example of what can be done with Lean implementation. ThedaCare Health System in Wisconsin has also used Lean successfully in its CAHs.</p> <p>In North Carolina we have successfully begun implementation of Lean in three small rural hospitals, two of which are CAHs. Based upon this success we are targeting five small rural hospitals for implementation, four of which are CAHs. This tool for quality improvement has shown significant impacts on improving processes and outcomes as well as a tremendous positive impact on employee engagement and overall morale. We believe that running "lean" hospitals is the way of the future.</p>
North	<p>MSA: Development of a statewide CAH Quality Network.</p>

Dakota	
North Dakota	<p>SS: The Flex Program has supported a pilot involving fourteen CAHs and Clarity Group Inc. over a six month time period (ended March 31, 2009). Clarity Group has a product called the Healthcare Safety Zone Portal with over 7,000 users. This tool has yet to be used from a network perspective. The UND Center for Rural Health and Clarity group are working together to develop templates that all CAH participants use to collect event information. Currently the groups collect information on falls, infections, and medication errors by severity, time of day, location, type (patient, resident, employee) and more.</p> <p>First quarter information has been aggregated and CAHs are looking to benchmark and identify best practices within the group. Flex has paid for half of the subscription fee and the CAHs have paid for the other half; an evaluation is currently underway and findings will be presented at our annual Dakota Conference to all CAHs. It is anticipated that there will be continued interest by the pilot participants and there will be efforts to engage others through the ND CAH Quality Network.</p> <p>In addition to tracking and reporting, the Safety Zone has developed a Network page that includes a library for quality related information (specific to CAHs), list of members, resources, events, and more.</p>
Ohio	<p>MSA: The QI CAH Flex/SHIP Network was developed in 2004, and includes representatives from 33 CAHs, SORH staff, and Ohio Hospital Association staff. The group has continued to expand with other quality improvement interests such as patient safety, Balanced Scorecard, health information technology, HIPAA compliance, reduction of medical errors, and quality improvement staff education and performance. The Network is responsible for encouraging Ohio CAHs to report their core measures to the Centers for Medicare and Medicaid (CMS) Hospital Compare. The number of CAHs reporting data to the CMS Hospital Compare web site increased from 26 CAHs to 28 CAHs, totaling 82.4% reporting, compared to the national 69.1% reporting.</p> <p>In 2008, the Network experienced some changes with the decrease in focus on rural hospitals of the State's Quality Improvement Organization and CMS Statement of Work. In response this challenge, the Ohio Department of Health's Flex Program released a request for proposal to solicit a consultant to provide project and group facilitation, technical assistance, and training for the quality improvement staff at the CAHs through the Network. In September 2009, the consultant was identified and began work in October 2009. The successful consultant is Performance Management Institute (PMI) and a CPHQ consultant with Stratis Health.</p> <p>The Flex Program Coordinator and PMI will conduct quarterly meetings that will be data driven, utilize PMI's web based platform, RPM, and "Message Board" with PMI consultants, analysts, and CPHQ from Stratis Health to monitor and respond to all questions in a timely manner. RPM technology will also serve as a central database through the incumbent "CORE Manage" module for data mining, research, and presentation of findings around CMS Core Measures for statewide benchmarking to the CAHs. "Initiative Tracker" will be used as a method to document, record and share best practice policies and procedures among the participating CAHs. Training will also be</p>

	<p>provided by PMI consultants and Stratis Health CPHQ consultants in person, via webinar, and via teleconference to support the evolutionary and expanding nature of Centers for Medicare and Medicaid public reporting through Hospital Compare.</p> <p>The Ohio Flex Program is looking forward to future successes regarding quality improvement and the other program goals.</p>
Pennsylvania	<p>MSA: The Pennsylvania Critical Access Hospital Consortium has brought together twelve rural hospitals to support performance improvement initiatives through the use of Rural Performance Management (RPM), an on-line performance management system which uses a Balanced Scorecard framework. The Pennsylvania critical access hospitals can manage individual hospital strategy, compare performance among peers, and share best practices through the use of this performance management system.</p>
Tennessee	<p>SS: Tennessee's critical access hospitals have had the opportunity to participate in a quality improvement project focusing on improving hospital clinical care to patients with heart attacks, heart failure, and pneumonia. These clinical measures are part of the measurement set proposed by both the Centers for Medicare and Medicaid Services (CMS) and Joint Commission on Accreditation of Healthcare Organizations (JCAHO) for national comparison reports. Participation also allows Critical Access Hospitals to benchmark their performance against state, regional, and national averages in addition to peer group comparisons. The project includes quarterly abstraction of clinical data submitted electronically for data analysis and comparative bench marking. Educational workshops and conference calls are also conducted throughout the year.</p> <ul style="list-style-type: none"> • For the CAHs that have been abstracting and submitting clinical measure data to the Quality Improvement Organization (QIO) Warehouse, the goal was to improve care on one clinical measure. • CMS performance goal: as a group, the CAHs must achieve a 10% reduction in the failure rate (RFR) on at least one clinical measure. There is the potential to earn extra "credit" for a 20% RFR. • Additional goals: <ul style="list-style-type: none"> ○ Encourage all CAHs to not only abstract and submit data, but also to act on the data with a common-measure quality improvement project, and to agree to publicly report their data ○ Collaborative sharing of quality improvement "journey" and best practices ○ Engage leadership, front line staff, and physicians <p>Key Results</p> <ul style="list-style-type: none"> • All sixteen CAHs now report their data to the Clinical Warehouse • Twelve CAHs publicly report their data on Hospital Compare • efforts to increase participation are enhanced through encouraged participation in the Quality Collaborative, a networking approach of sharing quality improvement best practices • The six CAHs that were part of the CMS quality improvement group achieved a

	38% RFR on the pneumonia immunization measure working collaboratively with the other CAHs
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State	Most Significant Achievements (MSA) and Success Stories (SS): Networking/Collaboration
Alabama	MSA: Establishment of a Rural Hospital Quality Network.
Arkansas	SS: In 2008, five CAHs and one PPS hospital united to form a six-hospital network covering four counties in southeast Arkansas to focus on preventive health and outreach through the use of a mobile health van to conduct screenings and prescription assistance. They have developed a workable sustainability plan and are pursuing additional partnerships to further enhance outreach in their counties.
Colorado	MSA: Development of our Peer Review Network, and the Quality Improvement Peer Network.
Idaho	MSA: Establishing effective and supportive partnerships among stakeholders.
Illinois	MSA: The development of twelve department level user CAH groups where information can be shared and best practices identified through the Illinois Critical Access Hospital Network. These user groups meet at least quarterly throughout the year. The CAHs at all levels now have easy access to peers and resources.
Kansas	MSA: The Kansas Rural Health Options Program (KRHOP) is a highly effective collaboration between the Kansas Department of Health & Environment Office of Local and Rural Health, Kansas Hospital Association, Kansas Board of Emergency Medical Services, and the Kansas Medical Society. This partnership allows for a multitude of constituents and stakeholders to work together progressing program goals in a flexible and successful manner.
Michigan	<p>SS: The Michigan Critical Access Quality Network (MICAH QN) was formed in 2001 with fourteen CAHs. The Network formalized in 2003 and received 501(c)3 status in 2007. Today, 35 CAHs and one rural hospital actively participate in the Network. All projects and decisions are driven by the Network via consensus.</p> <p>All hospitals use MHA Core Options™ for data collection and benchmarking. In addition to the MICAH QN comparative data, individual hospitals have the capability to create their own custom measures. Common areas of local measurement among MICAH QN measures are review to determine the feasibility of general relevance to all hospitals.</p> <p>The Network meets in-person and via video conference, quarterly. Members readily share best practices and hold education sessions at meetings.</p> <p>The MICAH QN effort provides a means to include small and low volume hospitals in an effective way to report performance and identify areas for improvement. At the same time, MICAH QN is developing measures that reflect the more important roles such</p>

	hospitals play, for example, aspects of care related to stabilization and transfer of patients.
Montana	MSA: The Performance Improvement Network is a well-established, mature network that provides assistance to member facilities ensuring compliance with the Medicare Conditions of Participation quality assurance tags and supports other CAH quality improvement efforts.
North Dakota	MSA: Development of a statewide CAH Quality Network.
Ohio	<p>MSA: The QI CAH Flex/SHIP Network was developed in 2004, and includes representatives from 33 CAHs, SORH staff, and Ohio Hospital Association staff. The group has continued to expand with other quality improvement interests such as patient safety, Balanced Scorecard, HIT, HIPAA compliance, reduction of medical errors, and quality improvement staff education and performance. The Network is responsible for encouraging Ohio CAHs to report their core measures to the CMS Hospital Compare. The number of CAHs reporting data to the CMS Hospital Compare website increased from 26 CAHs to 28 CAHs, totaling 82.4% reporting, compared to the national 69.1% reporting.</p> <p>In 2008, the Network experienced some changes with the decrease in focus on rural hospitals of the State's Quality Improvement Organization and CMS Statement of Work. In response this challenge, the Ohio Department of Health's Flex Program released a request for proposal to solicit a consultant to provide project and group facilitation, technical assistance, and training for the quality improvement staff at the CAHs through the Network. In September 2009, the consultant was identified and began work in October 2009. The successful consultant is Performance Management Institute (PMI) and a CPHQ consultant with Stratis Health.</p> <p>The Flex Program Coordinator and PMI will conduct quarterly meetings that will be data driven, utilize PMI's web based platform, RPM, and "Message Board" with PMI consultants, analysts, and CPHQ from Stratis Health to monitor and respond to all questions in a timely manner. RPM technology will also serve as a central database through the incumbent "CORE Manage" module for data mining, research, and presentation of findings around CMS Core Measures for statewide benchmarking to the CAHs. "Initiative Tracker" will be used as a method to document, record and share best practice policies and procedures among the participating CAHs. Training will also be provided by PMI consultants and Stratis Health CPHQ consultants in person, via webinar and via teleconference to support the evolutionary and expanding nature of Centers for Medicare and Medicaid public reporting through Hospital Compare.</p> <p>The Ohio Flex Program is looking forward to future successes regarding quality improvement and the other program goals.</p>
West Virginia	MSA: The expansion of the CAH Network has met with great success. They have spread their wings and really flew. Many states around us have sought participation in the network and have provided real stability to our CAH Network.

Wyoming	MSA: Wyoming is the ninth largest state geographically, yet the least populated. The Flex program has provided a need and a means to bring the CAHs together in an organized manner through the development of the Wyoming Critical Access Hospital Network. Leadership at the WCAHN level (CAH CEOs), the Wyoming Hospital Association (which provides day to day leadership to the WCAHN), and the Wyoming Office of Rural Health has made it difficult for the WCAHN to grow. There has been stability within these three organizations for about a year and a half, and the WCAHN is now in a position to pursue meaningful initiatives that provide benefit to its members.
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State	Most Significant Achievements (MSA) and Success Stories (SS): CAH Designation
Kentucky	MSA: The conversion of 32 hospitals to Critical Access status.
Kentucky	SS: Marcum and Wallace Memorial Hospital was a small rural hospital in the red struggling to make payroll each month. They were the first Kentucky hospital to convert to CAH status. CAH conversion helped stabilize the financial situation for this hospital and even allowed them to erase a substantial outstanding debt. After conversion, the hospital partnered in and received a HRSA outreach grant that brought key community leaders and health providers together to address unmet health needs throughout the service area. As a result, many solid collaborative relationships were developed that continue to exist today. Marcum and Wallace Memorial Hospital has undergone a complete renovation and has taken the lead in Trauma Team Development for CAHs. They were the first hospital to receive Rural Trauma Team Development Training through the Flex program and are slated to become the first Level IV Trauma Center in Kentucky. The hospital has agreed to mentor other CAHs in readiness for Trauma Team Development. In partnership with the Flex Program, the hospital recently invited other CAH representatives to the facility for an educational demonstration of what it means to be a Trauma Center. Marcum and Wallace Memorial Hospital has gone from being a struggling hospital on the verge of closure to a strong viable critical access hospital leading the state in collaborative health care management.
Minnesota	MSA: Designating 79 CAHs in Minnesota and supporting them as they become stabilized as hubs of care in their rural communities.
North Carolina	MSA: The single most significant achievement of our Flex program has been the conversion of the now 22 CAHs and the related stabilization of necessary revenue streams required to keep these facilities viable. There have been many other achievements of the Flex program but this is most notable, showing huge return on investment of Flex dollars and sustaining the anchor hospital of many rural North Carolina communities.
New Mexico	MSA: Designation of six critical access hospitals has led to the stabilization of their operation.
Texas	MSA: Designation of 76 hospitals to Critical Access Hospital status.

Utah	MSA: Financial support provided to rural hospital in order for them to convert to critical access hospitals.
Utah	SS: Conversion of all eligible and interested rural hospitals to Critical Access Hospital status.

State	Most Significant Achievements (MSA) and Success Stories (SS): Emergency Medical Services (EMS)
Wisconsin	<p>SS: In September 2007, the Wisconsin Office of Rural Health Flex Program awarded a Rural Community Grant to Upland Hills Health in Dodgeville for the "Iowa County AutoPulse Project." Upland Hills Health formed a Coalition, which included Dodgeville and Mineral Point EMS and the Iowa County Sheriff's Department. As a justification for their request, the Coalition noted that Iowa County ranked in the top four counties in the state for deaths due to coronary heart disease.</p> <p>The coalition used grant funds to purchase two AutoPulse units. These devices perform hands-free chest compressions on cardiac patients; an improvement over manual chest compressions. The devices provide regular compressions at the appropriate rate and free an EMT to work on other patients or provide additional care. The AutoPulse unit can continue compressions during transport, when EMTs are required to wear seat belts, restricting their ability to perform compressions. Grant funds were also used to train Sheriff's Deputies and EMS volunteers throughout the County on using the AutoPulse device. (The units are housed with Dodgeville and Mineral Point services but transferred to other services, such as Avoca and Arena, as requested for emergencies.) In total, the units in these communities been placed on approximately 20 patients resulting in approximately five saves. One of these units was placed on a patient who had brain damage, but it extended life long enough to allow the family time to say goodbye to their loved one and make the important decision to harvest the organs. Additional EMS agencies in the County have purchased their own devices after their positive experiences.</p>

State	Most Significant Achievements (MSA) or Success Stories (SS): Health Information Technology (HIT) and Telehealth
Florida	MSA: The Pharmacy HIT grant has enabled the eleven CAHs in Florida to purchase excellent, up-to-date equipment, such as medication distribution cabinets and Pharmacy Information Management Systems.
Florida	SS: The Patient Safety Initiative in combination with the Pharmacy HIT grant equipment has had a significant improvement in quality, reduction of medication errors and education of practitioners.

Hawaii	<p>SS: The Hawaii Flex Program works with the University of Hawaii on the development and implementation of an open source electronic health record for use by small rural hospitals and clinics. As the project develops, more CAHs show interest in the project and are asking for demonstrations and to be included in future expansions. Another interesting aspect of the project is the inclusion of public health nurses so that the electronic health record will meet their needs also.</p>
Nevada	<p>SS: The Nevada Flex Program has played a lead role in the development of a coordinated response by rural hospitals, communities, and stakeholders to Nevada’s worsening rural mental health crisis. The centerpiece of programmatic efforts has been the development of a well-established, effective telehealth application for telepsychiatry. The telepsychiatry application has expanded the mental health services currently available to residents served by CAH and CAH-eligible hospitals in Nevada.</p> <p>The vision of the project is to expand the specialty medical services delivered via the state’s telehealth network resulting in an enhanced system of care for rural Nevada residents. The project builds on the extensive telemedicine network linking:</p> <ul style="list-style-type: none"> • Urban and rural clinical and teaching sites developed by the University of Nevada School of Medicine • The existing formal network of rural and frontier hospitals managed by Nevada Rural Hospital Partners (the principal Flex subcontractor in Nevada) • A wide range of ongoing, network-oriented technical assistance to rural hospitals provided by the Nevada Office of Rural Health and Nevada Rural Hospital Partners through Flex and SHIP funding for the past eight years.

State	Most Significant Achievements (MSA) or Success Stories (SS): Trauma Designation
Arizona	<p>SS: The Arizona Flex Program introduced the state’s critical access hospitals to the benefits of acquiring Level IV trauma designation. As a result, six CAHs have applied, or are in the process of applying, for Flex funds to support their efforts. Three received the designation early in 2009. The Flex program is currently supporting Rural Trauma Team Development training opportunities for CAHs.</p>
New Mexico	<p>SS: The New Mexico Flex Program has coordinated with the Department of Health’s EMS Bureau and the independent regional EMS agencies to develop Level IV trauma centers in three Critical Access Hospitals. Two additional Critical Access Hospitals are also in the process of trauma center designation. These developments have come about largely because of the coordination of the Flex Program with the New Mexico Trauma System Fund, a state-funded special appropriation designed for trauma system improvement in both urban and rural areas.</p>
South Dakota	<p>MSA: Since the FY2004 Application, the South Dakota Flex Program has been working towards the development of a statewide trauma system. In preparation for this, a</p>

	Steering Committee with broad membership was convened. Trauma nurse training for CAH nurses was developed and reviews of CAHs were funded so the facilities could prepare to become trauma receiving facilities. A bill was passed to establish a statewide trauma system during the January-February 2008 South Dakota Legislative Session.
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State	Most Significant Achievements (MSA) or Success Stories (SS): Training/Education
Alaska	<p>SS: An innovative program in Alaska is the Rural Hospital Administrative Internships (RHAI) - Active Learning for Graduate Students in Professional Settings. RHAI is a collaborative among three Alaskan universities, the Alaska State Hospital and Nursing Home Association, and the Alaska Department of Health and Social Services, with program financial support provided by the State. The program provides experiential learning opportunities for graduate students interested in the business of healthcare with a focus on rural areas.</p> <p>Alaska Pacific University, University of Alaska, and Wayland Baptist University graduate students interested in health administration may apply for RHAI in rural Alaskan hospitals. Rural hospitals are considered as those outside the catchment areas of the major population centers of Anchorage, Fairbanks, and Palmer-Wasilla. The RHAI experience is anticipated to consist of a visit or two to a rural hospital site to provide the student with an opportunity to work on a real administrative issue, while being introduced to life in the community. Travel, per diem, and other associated academic costs will be provided for the student. Academic credit may be secured for the work.</p>
Colorado	<p>SS: In response to interest from Colorado's CAHs, the Colorado Rural Health Center partnered with the Colorado Center for Nursing Excellence to offer a Nurse Leader Development Course. The training targeted frontline nurse leaders interested in effectively leading and managing care delivery within healthcare facilities. The course focused on improving leadership through skill-building in change management, effective communication and dealing with personnel problems. Nurse Leaders who attended the course learned ways to create a culture which encourages the development of each staff nurse while assuring patient safety, satisfaction, quality of care, and increasing staff nurse retention.</p>
Nebraska	<p>SS: The FLeX program has collaborated with the University of Nebraska Medical Center (UNMC) to support the TeamSTEPPS project. Over the past two years, more than 30 CAHs in Nebraska have been participating in the program. The goal of TeamSTEPPS is to ensure safe care for patients by improving the communication and teamwork skills of the medical and hospital staff. After an initial readiness assessment, a rural-adapted version of the AHRQ Hospital Survey on Patient Safety Culture is conducted in each of the participating CAHs. After the survey, a train-the-trainer workshop is held to teach hospital staff about the tools that are available and how to use them effectively. Thus far, a total of 107 master trainers have completed the TeamSTEPPS training and they are now training other CAH staff. Throughout the process, staff from UNMC conduct bi-weekly conference calls, as well as a lessons learned conference. One of the lessons</p>

	<p>learned is the importance of training all members of the team. When a problem such as disruptive behavior occurs, an action plan is developed with the goal of obtaining buy-in from all team members, and treating every individual on the team so that they feel valued and respected.</p> <p>In March of 2009, the Hospital Survey on Patient Safety Culture was re-administered to all of the CAHs that participated in TeamSTEPPS. The results of the survey will be used to assess the impact of TeamSTEPPS on the patient safety culture in each CAH.</p>
Missouri	<p>MSA: Legislation was enacted on August 28, 2008, that created the Time Critical Diagnosis System, through which emergency medical care is provided for patients who experience trauma, stroke, or ST-segment elevation myocardial infarction (STEMI) to develop treatment policy and procedure requirements. To assist critical access and rural hospitals in having the latest training prior to the requirements being formalized, the Office established a contract with a trainer to provide stroke, STEMI, and EKG training to rural hospitals and their community partners. Participants are eligible for six continuing education units upon completion of each training. The trainer received requests to provide trainings across the state. Another contract is being established for the current grant year to continue these trainings.</p>
Montana	<p>SS: Champions for Quality has become the cornerstone rural healthcare conference in Montana. We bill Champions as Montana’s “premier” rural health care conference and evaluation results indicate we are true to our word. 100% of the participants say the “conference was worth their time” and “they would recommend the conference to others.” What started in 2005 as a small conference with 60 attendees has grown to conference over twice that size with many facilities sending quality improvement teams comprised of providers, quality coordinators and administrators. It takes a dedicated planning committee, which includes rural providers, a full year to plan and execute this continuing medical education event that also provides great social networking.</p>
Pennsylvania	<p>SS: Through a partnership of the Pennsylvania Flex Program, Penn State Management Development and Penn State's Office of Economic and Workforce Development, the Rural Health Care Managers Academy was developed. Over the past two years, the Academy has trained over 130 new and prospective rural hospital staff and EMS and other providers in management and supervisory skills. For the program's capstone project, each hospital or provider team is responsible for completing a project and presenting it to their peers at the annual Pennsylvania Rural Health Conference. The goal of that project is for the participants to put to practical use the skills learned in the Academy and to provide a tangible benefit to their organization.</p>
Texas	<p>SS: With the support of Flex funding, Texas Tech University Health Sciences Center (HealthNet) provides accredited continuing health education and training to healthcare personnel at 76 Texas CAHs. As part of this service, each CAH receives an extensive video tape/CD ROM package and unlimited on-line access to over 440 educational courses in over 20 health disciplines monthly. Based on the current utilization rate, more than 35,000 educational courses are completed each year, making this an extremely cost-effective and essential continuing health education program for the Texas CAHs.</p>

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State	Most Significant Achievements (MSA) and Success Stories (SS): Workforce
Idaho	SS: The Idaho State Office of Rural Health partnered with Family Medicine Residency of Idaho and Boise State University to develop and implement the Community Apgar Questionnaire in CAHs. The project is designed to improve physician recruitment and retention in CAH communities by identifying community-specific challenges and advantages. Information is shared with CAH senior leaders and boards to help them develop an action plan to address their specific barriers to physician recruitment and retention.
Pennsylvania	SS: Through a partnership of the Pennsylvania Flex Program, Penn State Management Development and Penn State's Office of Economic and Workforce Development, the Rural Health Care Managers Academy was developed. Over the past two years, the Academy has trained over 130 new and prospective rural hospital staff and EMS and other providers in management and supervisory skills. For the program's capstone project, each hospital or provider team is responsible for completing a project and presenting it to their peers at the annual Pennsylvania Rural Health Conference. The goal of that project is for the participants to put to practical use the skills learned in the Academy and to provide a tangible benefit to their organization.
South Dakota	SS: The South Dakota State Flex Program has developed the Health Occupations for Today and Tomorrow (HOTT) program. The HOTT Program is part of the state's Healthcare Workforce Initiative. This program is a partnership of the South Dakota Departments of Health, Education, and Labor and is designed to attract K-12 students into health careers.

State	Most Significant Achievements (MSA) or Success Stories (SS): Other
Arizona	MSA: The Arizona Flex Program was instrumental in getting the state legislature to allocate funding for Arizona's critical access hospitals through the state's Medicaid program (Arizona Healthcare Cost Containment System). Funding is distributed to the CAHs from a \$1.7million pool, based on Medicaid volume reported by the CAHs.
Illinois	SS: Illinois provides over \$400,000 to its hospitals through a variety of small grant projects (\$3,000-\$5,000/each). These projects have stimulated new programs and services within the CAHs. CAHs did not have funds prior to do these community and education programs. The hospitals are appreciative of this mini grant program. Current mini grant categories are: board education; recruitment and retention; EMS education and equipment; information technology; men's health; community development and

	special innovative programs (\$20,000 each x3).
Ohio	<p>SS: The SORH and Flex Program had collaborated to coordinate efforts to provide funding for five Federally Qualified Health Center (FQHC) and CAH projects in Ohio. In April 2009, the Ohio Department of Health provided an additional \$95,000 to the Foundation for Healthy Communities (through an existing eighteen month grant award of over \$1.4 million to provide funding to 33 of 34 of Ohio's CAHs for quality improvement, EMS training, patient safety, networking, and hardware and software purchases). The Foundation for Healthy Communities made another Request For Proposal available to all CAHs to respond to an opportunity to receive a total of \$114,320 (including the \$95,000). The five FQHC and CAH collaborative projects are briefly described below:</p> <ol style="list-style-type: none"> 1. Hardin Memorial Hospital and Allen County Health Partners applied for project planning funds to support the development of a Public Health Section 330(e) application. Hardin is committed to evaluating the feasibility of locating a health center in a hospital building creating a health services campus in downtown Kenton, Ohio, and will provide support services such as laboratory and radiology to the health center. Hardin and Allen County Health Partners have been working together with the Hardin County Department of Jobs and Family Services, local medical providers, schools, and the Mental Health Recovery Services for the past two years. Allen County Health Partners operate a PHS 330(e) community health center in Lima, Ohio, and a PHS 330(g) migrant health center in Tipp City, Ohio. 2. Highland District Hospital and Health Source of Ohio applied to provide diabetes testing supplies for patients with financial need (guidelines for qualification include federal poverty guidelines, qualifying catastrophic events, or recent change of debt to income ratio) in Highland, Adams, and Brown Counties. In 2001, three area hospitals, including two CAHs, and a FQHC came together to establish a Rural Health Collaborative of Southern Ohio with one of its guiding principles to identify health care needs, which can be addressed most effectively and efficiently in a collective manner. The members of the Collaborative are Adams County Regional Medical Center (CAH), Brown County General Hospital, Highland District Hospital (CAH), and Health Source of Ohio (FQHC). 3. Galion Community Hospital and Third Street Family Health Services applied to prepare a Health Needs Assessment for Crawford County. While using published data, the research study would include the basics of general population data, health information, oral health need information, analysis of payer mix in the community, insurance, Medicare and Medicaid enrollment and utilization vs. the uninsured, unemployment rates and trends, and socioeconomic indicators. A presentation of the key findings to Galion Community Hospital as well as a written and electronic final report suitable for peer distribution would also be provided. The findings will provide guidance for future direction and development on a community level and results will be shared. The goal is to provide the necessary basic information to identify how Third Street Family Health Services can tailor their services to match current needs, and to efficiently help solve current health problems in Crawford County. 4. Bucyrus Community Hospital and Third Street Family Health Services applied to improve the quality of life and address the unmet need of primary care dental

	<p>services for low-socio economic status (low-SES) tobacco users in a five county area, as a part of the Crawford Health & Wellness Coalition. The five counties include Crawford, Marion, Morrow, Richland, and Wyandot. The low-SES patients will receive free dental care when they normally would not seek expensive dental services to reduce the number of patients seen in the much more costly hospital ER for dental related pain and swelling.</p> <p>5. Barnesville Hospital and Ohio Hills Health Services applied to support the recruiting and retention of a family practice physician to the Freeport Family Health Center.</p>
Tennessee	<p>MSA: The Centers for Medicare and Medicaid Services (CMS) notified the state of Tennessee's Medicaid Program (TennCare) in late 2003, that it had approved a critical access hospital (CAH) supplemental pool of up to \$10 million dollars. Tennessee submitted amendments to the operational pool incorporating the methodology and describing the operating provisions applicable to making special payments to CAHs and also distributed approximately \$5,000,000 to seven CAHs during FY 05. These payments increased to approximately \$10,000,000 during 2006 and an additional \$15,000,000 during 2007-08.</p>
Missouri	<p>SS: During regional meetings with CAH Administrators, it was requested that a resource directory be developed to assist rural hospitals. An online Resource Directory, http://www.ruralspotlight.com, was developed that contains links to funding opportunities, regulations, and associations; the latest research articles and publications; and a calendar of events. There is an option to subscribe to the website, which provides the person with an e-mail update when something is added.</p>
Wyoming	<p>SS: "Maximizing Opportunities in CAHs", presented by Mike Bell, CPA and revenue/reimbursement expert. As a result of this training, two Wyoming CAHs have sent their CFO to Mike's on-site "Boot Camp" for CAH finance and reimbursement.</p>