



Writing the Grant: Linking Data Needs and Activities in Rural MA

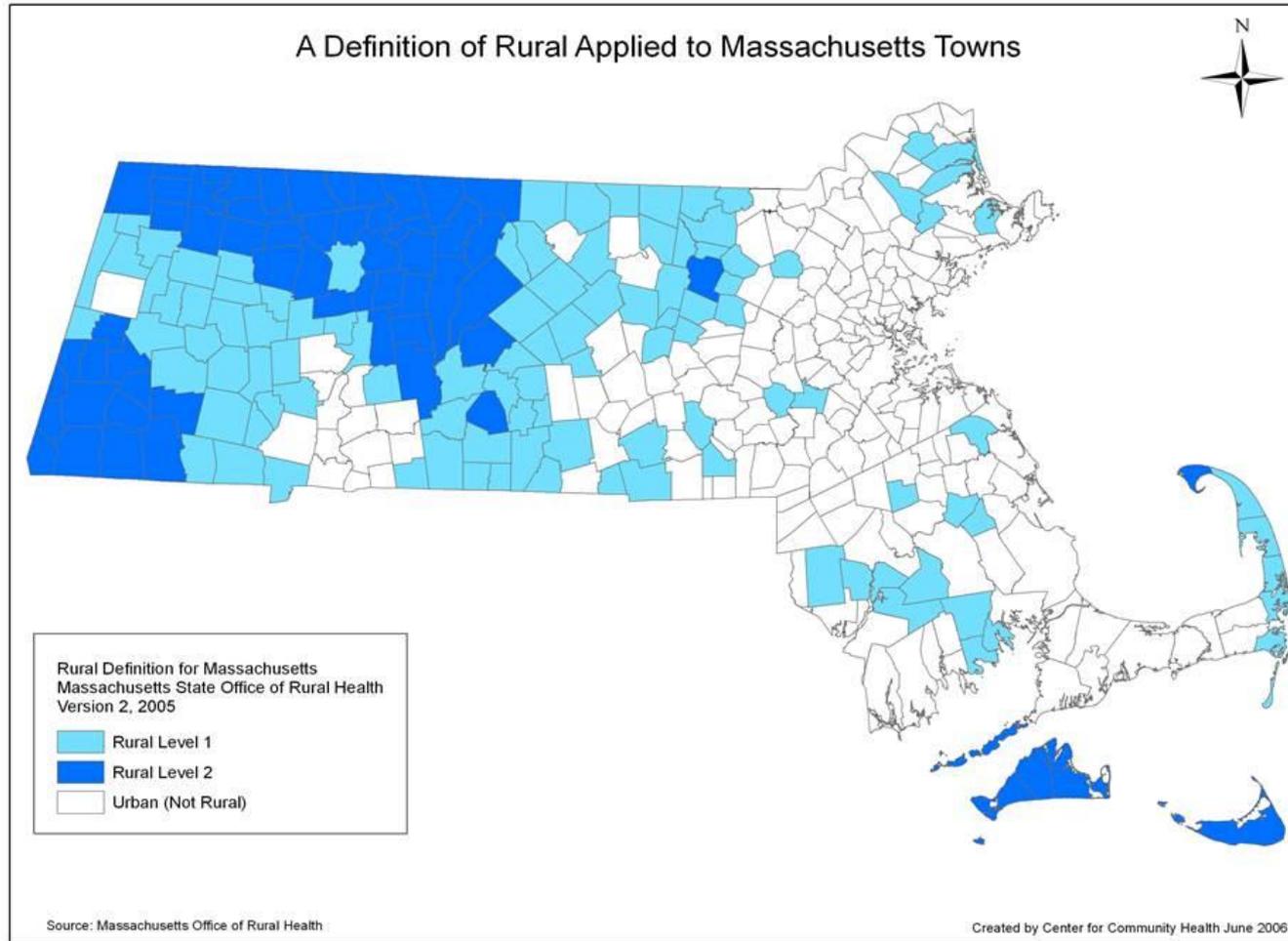
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Outline: Data, Needs, Activities

- ▶ Brief background on MA Rural
- ▶ Examples of data sources used to identify needs
- ▶ Examples of non-data context
- ▶ Examples of 3 projects using data to identify need, track progress: Quality, Finance, Health Systems Development/Community Engagement
- ▶ Tying data with need - Lessons Learned



Brief Background on MA Rural



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- ▶ MA Rural Map – shows cluster of rural areas (West, Central, SE, Islands)
- ▶ New England Map – MA hospitals on periphery of MA, adjacent to rural communities in other NE states
- ▶ 3 CAHs, 8 SHIP Hospitals, 2 Community Hospitals, 7 Rural-area FQHCs/CHCs
- ▶ 2/3 non-urban land mass ; roughly 700,000 (@11% of MA pop) live in small and rural towns



Brief Background on MA Rural

- ▶ Our state has –
 - ▶ Urban-rural disparity
 - ▶ Advanced health reform/payment reform (<3% of MA are uninsured)
 - ▶ Advanced HIT – eHealth Institute, Hlway,
 - ▶ High healthcare profile - Boston-area Academic Med Ctrs
 - ▶ The Institute for Healthcare Improvement (IHI) – visionaries of “The Triple Aim”
 - ▶ Long-standing reputation as pioneers and innovators in healthcare - # of early ACOs
 - ▶ Diverse rural communities – seasonal destinations w/ income extremes; economically-depressed former mill towns



Examples of MA Data Sources:

- ▶ Selected Data Available to all Flex Programs
 - ▶ MBQIP
 - ▶ Flex Monitoring Team
 - ▶ QIN- QIO – Care Transition/Avoidable Readmissions data/ADE Data
 - ▶ Hospital Engagement Network
 - ▶ Robert Wood Johnson Foundation County Health Rankings
- ▶ State-specific available data
 - ▶ Center for Health Information and Analysis (CHIA); MA CHIP
 - ▶ Homegrown Surveys; Community Health Needs Assessments
 - ▶ Consultant Data –assessments, benchmarking -Stroudwater, BNN, Institute for Safe Med Practices(ISMP), iVantage Hlth Analytics
 - ▶ Data from key collaborators – Hospital Association, Pharmacy school, MA Tech Collaborative /REC, New England Rural Health RT
 - ▶ New England Rural Hospital Performance Improvement Network (NEPI) – IHI, Quality Professional Certifications
 - ▶ EMS - MA Ambulance Trip Record Information System (MATRIS) data

Examples of Non-Data Context

- ▶ Scanning local, state and federal environment for:
 - ▶ New/Emerging healthcare legislation, regulations
 - ▶ Reports/Action Plans from Health-related Agencies and Institutes (DHHS, Institute of Med, AHRQ)
 - ▶ Changing industry standards (Joint Commission, Provider Professional Associations)
 - ▶ Recent healthcare issues in the press, lawsuits



Examples of MA Data/Need/Activities: Quality

- ▶ MA Rural Hospital Pharmacy Network and Medication Safety Activities:
 - ▶ Quality Goal - To Reduce Adverse Drug Events (ADEs)
Mentoring Hospital suggests Anticoagulation Safety Focus (DHHS just identified as 1 of 3 top categories of drugs for ADEs)
 - ▶ Data Review:
Are hospitals on track to meet Joint Commission Guidelines for Anticoagulation Medication Safety by Deadline? (Grid)
 - ▶ Established Need:
Only 2 of 12 hospitals meet criteria; Deadline w/in 12 months
 - ▶ Resulting Activities: & Outcomes:
 - ▶ Mentor hospital designs focused, small hospital training with CEU credits
 - ▶ Identified and purchased at group discount Patient Education videos, brochures in English and Spanish, appropriate to meet guidelines
 - ▶ Followed up at each meeting – 3, 6, 9 month progress until all hospitals met goal



Examples of MA Data/Need/Activities: Financial

- ▶ MA CEO/CFO Forum:
 - ▶ Financial Goal – To Improve Financial Stability of CAHs, SRHs
 - ▶ Data Review: Profitability, Liquidity, Solvency (Chart)
 - ▶ Established Need:
 - ▶ Hospitals struggling with profitability, most with liquidity
 - ▶ Resulting Activities:
 - ▶ On-site Revenue Cycle Management Assessments
 - ▶ Opportunity for Group Trainings Based on Results



Example Of MA Data/Needs/Activities: Financial

MA CAH and SHIP Hospitals: Profitability, Liquidity, Solvency, FY2013

| Hospital | Dependent Share | Profitability | | | Liquidity | | | Solvency | | | |
|---------------------------------------|-----------------|---------------|-----------|---------------|-----------|------------------|-----------------|--------------------|-----------------|----------|-----------|
| | | Total | Operating | Non-Operating | Current | Days in Accounts | Average Payment | Cash Flow to Total | Debt to Service | Equity | |
| Green indicates positive correlations | | Hospital | Margin | Margin | Margin | Ratio | Receivable | Period | Debt | Coverage | Financing |
| Red indicates negative correlations | | | | | | | | | | | |
| Hospital A | Yes | 0.3% | 0.1% | 0.3% | 0.5% | 40 | 90 | 12.1% | 2.1 | 22.6% | |
| Hospital B | Yes | 10.1% | 5.0% | 5.2% | 1.0% | 45 | 29 | 47.7% | 13.4 | 51.8% | |
| Hospital C | No | 6.6% | 2.5% | 4.0% | 2.2% | 60 | 33 | 98.7% | 30.0 | 88.7% | |
| Hospital D | No | -2.2% | -3.1% | 0.9% | 1.8% | 38 | 42 | 15.4% | 6.2 | 60.8% | |
| Hospital E | Yes | -1.3% | -3.0% | 1.7% | 0.6% | 53 | 276 | 4.3% | N/A | 47.7% | |
| Hospital F | No | 1.4% | -5.9% | 7.2% | 1.0% | 55 | 29 | 41.2% | 8.8 | 89.8% | |
| Hospital G | No | 0.2% | 0.2% | 0.0% | 0.4% | 37 | 116 | N/A | N/A | -19.1% | |
| Hospital H | Yes | 4.1% | 3.6% | 0.5% | 1.8% | 40 | 62 | 11.9% | 1.8 | 1.5% | |
| Hospital I | Yes | 3.0% | 2.0% | 1.0% | 1.5% | 24 | 85 | 18.8% | 4.9 | 58.5% | |

Source: MA Center for Health Information and Analysis (CHIA)

Examples of MA Data/Need/Activities: Health Systems Development & Community

▶ MA EMS:

- ▶ HSD/CE Goal – To Improve EMS PI Reporting, Benchmarking
- ▶ Data Review: Reviewed data on EMS Reporting by rural vs urban squads and towns
- ▶ Established Need:
 - ▶ Too few rural towns reporting; Can help track status or improvement of services. In 2011, 59 rural squads (49%) not reporting
- ▶ Resulting Activities and Outcomes:
 - ▶ Funded two phases of EMS rural outreach, TA, training
 - ▶ Post-Intervention: 81% of rural squads reporting, now covering 79% of MA rural towns – 13% better than expected



MA Data Lessons Learned:

- ▶ **Plan ahead for data - may take time to get/analyze**
- ▶ **Ask your partner organizations for data and sources**
- ▶ **Data more powerful in larger context** – e.g. compared to rest of state, region, nation and/or rural vs. urban
- ▶ **Meaningful Data vs. Ineffective Data**
 - ▶ Paints a picture
 - ▶ Focuses on top priorities - demonstrating intensity, impact
 - ▶ Focuses on what is unique and/or counterintuitive
 - ▶ Needs non-data background context – e.g. impact of health reform/other legislation, regulation, challenges



MA Data Lessons Learned

- ▶ **Data can either define or support need**

- ▶ Can use trend data to identify less obvious issues (3-5 yrs)
- ▶ Can use data to support provider anecdotal experiences

- ▶ **Volunteer to be a grant reviewer – & take note of:**

- ▶ Organized vs. random data presentation
- ▶ Is data used persuasively to support broad statements?
- ▶ Recent data vs. data 5+ years old
- ▶ Is data used to build a larger view of statewide/regional experience?
- ▶ Does data pass the “So what?” test?



MA Data Lessons Learned

- ▶ **Combine Individual On-site or Self-Guided Hospital Assessments with follow-up Group Action**
 - ▶ Gets accurate, timely data to benchmark progress, impact, ROI
 - ▶ Gives group common experience and starting point
 - ▶ Opportunity to create more economies of scale for training and follow up



MA Data Lessons Learned

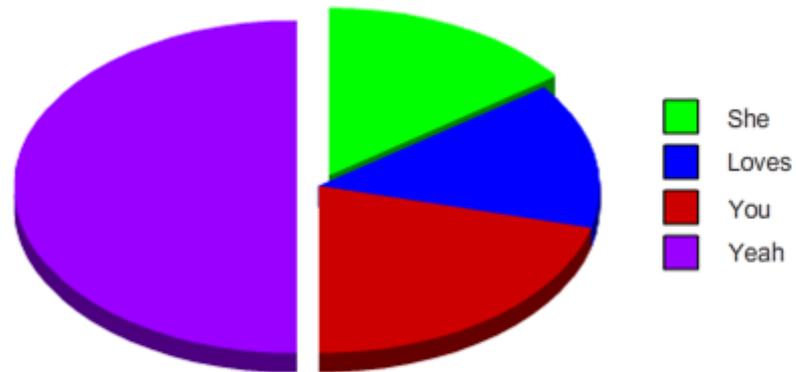
Tying Data/Need/Activities:

- ▶ FOCUS: Using a variety of data, as well as non-data context, identify the most or one of the most significant problems in each core area
- ▶ ADD VALUE: Choose a problem that your program can make a unique and lasting impact on over 3-5 years (bring in otherwise inaccessible expertise, network hospitals on shared concerns, partner with otherwise inaccessible partners)
- ▶ MEASURE OVER TIME: Demonstrate value with data-backed improvements over time



Meaningful Data or Not?

Content of A Beatles Song





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