Illinois Flex Program

Fiscal Year (FY) 2019 Significant Accomplishments, Best Practices, and Lessons Learned

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Program Area 1: CAH Quality Improvement

For the past several years, the Illinois Flex program has worked with a laboratory manager from one of their critical access hospitals (CAHs) to manually collect quality and productivity data from laboratory and diagnostic imaging departments. These departments worked together to choose the metrics they would each report on and the benchmarks used to evaluate the reported data. Typically, this type of quality and productivity data is not available to these small departments, which use it to assess staffing plans and compare their quality data to similarly sized and staffed hospitals. The current data collection is manual, which involves a great deal of time on the laboratory manager's part to aggregate the data, input the results into the spreadsheets, and then distribute the monthly report back to the hospitals.

As part of this year's CAH Quality Improvement Program area, the Flex program contracted with a web designer to create a portal that the hospitals could input their data using a standardized form. This data is uploaded into the portal, and charts and graphs would be automatically created for analysis and benchmarking against their Peers. The charts and graphs can be individualized. For example, this flexibility allows the department managers to customize the charts and graphs for inclusion in their reports to the hospital quality committees.

The laboratory manager, Flex program manager, and the website design team met several times to discuss the program's needs and how best to design the graphs to make maximum individualization possible. The website team created a mockup of the website, and the committee was able to explore the website and manipulate the graphs. They did a last walkthrough

at the Summer Virtual Ancillary Meeting. The final website will not be live until the January 2021 data collection window.

This type of quality and productivity data is not readily available to small hospitals. The only information is from large tertiary institutions, making it almost irrelevant to small rural hospital outpatient departments. The Flex program hopes that by streamlining data entry, they can encourage more hospitals to participate. To increase the support for the Outpatient Quality Measures Portal, it has been introduced to each CEO of the CAHs. The website has a design so that anyone can include data from CAHs from other states if other Flex programs are interested in offering this type of data collection and benchmarking abilities to their hospitals.

Lessons learned during this project include:

One of the main lessons that the Illinois Flex Program learned was making sure that they understood the data they wanted to collect and what benchmarks to evaluate it. Flex cannot make this determination without input from the hospital managers involved with the data collection. They will not utilize any data portal if the data collected is not relevant to the collecting departments. Any changes made after the initial build of the website become much more troublesome and time-consuming.

Program Area 2: CAH Operational and Financial Improvement

Leading in health care is a challenge, but holding a small rural hospital leadership position can be more difficult. For many years, the Illinois Flex Program wanted to bring together an academic fellowship program specific to rural health care challenges by providing training and mentorship for individuals who wish to move into executive leadership roles within CAHs.

The Rural Healthcare Fellowship Program is a long-term project for the Illinois Flex Program. The first year of the grant was dedicated to planning and preparation for the following years. They needed input from experts to make this fellowship as robust as possible. The Flex program created a team consisting of educational experts, CAH CEOs, and human resource specialists, and leaders from the Illinois School of Medicine for the initial planning stages. This team met weekly or bi-weekly during the winter and spring. It was determined to focus on four pillars—rural health, operations, finance, and health care leadership. In-person classes and virtual class topics were scheduled with the kickoff class starting in early September. A subcommittee focused on the project completion requirement concept that would be a significant part of the fellowship program. Once approved by the planning committee, this capstone project will culminate the lessons and

project management skills learned during the year. Having been assigned a mentor, the fellows will give periodic updates on their project to their peers to increase networking and collaboration.

They had 16 qualified applicants apply and be accepted into the program. The first cohort of fellows includes a newly appointed chief financial officer, several CNO's, human resource leaders, and ancillary department managers. These applicants provide a vast pool of experience and backgrounds to share and bring different fellowship discussion perspectives.

Lessons learned during this project include:

The primary lesson learned was never to underestimate people's willingness to collaborate on a project such as this. The university personnel that volunteered to be part of the planning committee were invaluable for creating an impressive and challenging curriculum. CAH CEOs were willing to give up valuable time in their schedules to plan the fellowship. In contrast, others volunteered to serve as mentors to the fellows during their year-long training. The leadership teams at the Illinois CAHs were also willing to spend the resources to ensure that their up-and-coming leaders could participate in this fellowship.

Program Area 3: CAH Population Health Improvement

This project aimed to find a clinical site that would create a clinically integrated network in their community that would focus on the community's needs and integrate social determinants of health into meeting those health needs. The site chosen for the pilot project was a county and CAH in southwestern Illinois with a high diabetic prevalence when compared to the state as a whole. Based on this data, the hospital decided to decrease diabetes in their county using a countywide multifactorial approach.

The Illinois Flex Program set up a meeting between the CAH and the Minneapolis Heart Institute Foundation (MHIF). The MHIF was involved with the Hearts Beat Back: The Heart of New Ulm Project. The New Ulm project focused on reducing heart disease by leveraging the information in the hospital's electronic health record (EHR). One of the first steps in the project was to contract with MHIF to provide technical assistance.

The hospital’s clinically integrated network's next step was to bring together community leaders to spearhead the team. They selected an enthusiastic physician champion who started to put together his team. The team consisted of another local healthcare provider, a dietician, the community

health needs assessment coordinator, the county school system leader, local food service providers, and the county's development coalition.

This is a multi-year long-term project, so the Flex program cannot measure the project's impact during the first year. They did gather baseline data, and they can use these benchmarks during the following years to establish progress.

Lessons learned during this project include:

They feel that obtaining the New Ulm Project's technical expertise will be instrumental to this project. The team brought in the technical assistance at the introductory level and will guide the project from its infancy.

Program Area 4: Rural EMS improvement

Based upon input from previous emergency medical services (EMS) interest surveys, the Illinois Flex Program invested in nine active shooter tactical bags given to rural EMS agencies. The project was kicked off by having the CAH emergency departments (EDs) and EMS agencies listen into an in-depth dissection of the active shooter incident in late 2018 in a hospital in Illinois. After that education, the Flex team worked with a representative from state fire, EMS, and police agencies to determine the most valuable items needed in the active shooter bags. They located a subject matter expert to purchase and assemble the bags. This project raised the awareness of the possibility of active shooters and the challenge they provide hospitals.

Lessons learned during this project include:

Both EMS agencies and CAH EDs were on the front lines of handling the COVID pandemic. All of this left extraordinarily little enthusiasm for other projects.

Program Area 5: Innovative Model Development

The Illinois Flex Program put out a call for interested hospitals that wanted to partner with a local nursing home to collaborate to reduce length of stay and reduce readmissions. They chose two CAHs to participate in the two-year project. The hospitals started by gathering the baseline data needed for the program—current Center for Medicare and Medicaid Services (CMS) quality measures, readmission rates, and the number of patients that return to the hospital ED. Action plans were created to implement in the second year of the program. The expansion of existing care coordination teams into the nursing home is part of one of the action plans. Another plan is to use

admission data to better track patients and improve patients' follow-up care as they leave the hospital and go to the nursing home.

The pilot hospitals and their chosen nursing homes will benefit from this project by increasing the collaboration between the two entities. The impact will not be limited to the two pilot projects. As part of their project, each hospital will have to create a presentation, put together a toolkit, and then present on lessons learned and best practices at the Illinois Critical Assess Hospital Network (ICAHN) annual meeting. This will allow the other CAHs to hear about the project from the participants and ask questions about the benefit of implementing it in their areas.

This is a two-year project—with most of the outcomes planned in the second year. COVID, of course, impacted this project also. Illinois had a spike in nursing home COVID infections during spring and summer. This prevented any in-person meetings from happening and delayed the initial implementation for both pilot sites.