# New Hampshire Flex Program

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

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**Program Area 1: CAH Quality Improvement:**

The Rural Health Quality Improvement Coordinator creates and provides run charts of each Hospital Consumer Assessment of Healthcare Providers and Systems (HCAHPS) measure for each critical access hospital (CAH) on a quarterly basis. Displaying data over time identifies trends and shifts in these data to assist the CAH staff in identifying significant change.

**Lessons learned during this project include:**

Quality Improvement staff in CAHs may not be familiar with run charts and their use. When a new staff member is hired, this information should be provided at orientation and then noted in the charts provided quarterly.

The Medicare Beneficiary Quality Improvement Project (MBQIP) includes sharing "Promising Practices." New Hampshire CAH quality professionals share promising practices, including those related to patient engagement, in order to promote enhanced performance. The sharing promising practices process is used to make sure that information is shared and may be replicated.

This process works for the New Hampshire Flex Program and is valued by the CAHs. This process is recommended for other programs if needs assessments demonstrate this is an activity the CAHs will find helpful and make use of (not just file it or save it), and it is not duplicated by their vendors. Additionally, adequate staffing must be available for collecting the data, designing and populating the charts, reviewing charts to indicate changes observed, and identifying them for the CAH staff.

## Program Area 2: CAH Operational and Financial Improvement

The New Hampshire Flex Program collaborates with the Maine, Massachusetts, and Vermont Flex Programs to provide the New England performance Improvement (NEPI), a program designed to allow critical access hospital staff in these states to receive reimbursements for professional certifications and Institute for Healthcare Improvement (IHI) virtual learning hours and online courses with coaching.

Current certifications include Certified Professional in Patient Safety (CPPS), Certified Professional in Healthcare Quality (CPHQ), Certified Professional in Health Care Risk Management (CPHRM), and CIC Infection and Disease Control. NEPI States may also provide nursing education such as a Trauma Nurse Core Course (TNCC), a Emergency Nursing Pediatric Course (ENPC), and a Trauma Nurse Core Course (TNCC), ENPC (Emergency Nursing Pediatric Course), and the American Psychiatric Nurses Association Transitions in Practice (ATP), a certificate in psychiatric-mental health nursing practice. In addition, all CAH staffs have access to IHI's Open School, providing them with access to over 35 continuing education credits in quality and safety.

NEPI is funded by a portion of each state's Flex grant. Administrative services are provided by the New England Rural Health Association in collaboration with all four states assuring no duplication of efforts.

In Flex Year 2019, NEPI New Hampshire funded 14 professional certifications and eight online courses. In addition, 260 CAH staff completed IHI Open School courses at no cost. 100% of the allocated funds were spent.

**Lessons learned during this project include:**

For New Hampshire, the key to success was using existing relationships to make sure CAH staff were aware of this program. For example, the coordinator initially relied on the QI Directors to get the word out. Then, they created New Hampshire-specific notices tailored to the individual CAHS to use along with the NEPI fliers and website tools.

As more staff participated over time, they got to know them and were eager to make use of the "free" education. Not every state is as successful as New Hampshire when it comes to taking advantage of this available education; much of the success can be attributed to the direct and trusting relationships the coordinator has created with hospital staff.

A very important lesson learned is that the monthly calls among the four State representatives not only help coordinate NEPI but also lead to conversations and enhanced collaborations in other Flex Program-related areas.

This activity is highly recommended but requires frequent attention, careful tracking, and trusting relationships. In New Hampshire, the staff member responsible for coordinating NEPI is also the Coordinator who trains hospital staff

members on MBQIP. The previous relationships with the staff help engage CAHs to utilize these resources and understand their value.

## Program Area 2: CAH Operational and Financial Improvement

The New Hampshire Flex Program contracts with the Foundation for Healthy Communities (FHC) to provide revenue cycle management initiatives. The FHC is the not-for-profit associated with the New Hampshire Hospital Association and provides programming and quality improvement initiatives for hospitals and community organizations. In 2019, the FHC met with the chief financial officers (CFOs) of the New Hampshire CAHs and determined that denied claims were the primary issue threatening the CAHs' financial health.

The FHC entered into a subcontract with RevSpring, a revenue cycle management company, to complete the Claims Denials Analytics Project (CDAP). New Hampshire's CDAP consisted of a portal on RemitWeb (RevSpring's software for denial analytics) and a dashboard for each hospital where their Health Care Claim Payment and Remittance Advice (hospital form 835s) were submitted and analyzed. Consistently analyzing the 835s can provide important information regarding total dollars denied as well as more detailed denial information such as reasons for denial, payer group, and revenue codes.

Phase two of the project continued the access to the portals and priority customer service but did not include license transfers or orientations. Monthly phone calls were not conducted with hospital staff members during this phase. In the last phase of the project, hospital staff continued to have access to the portal and dashboards but were not given priority customer service or the ability to transfer licenses.

The first quarter of 2020 was the last data examined due to the effects of the COVID-19 pandemic on patient volumes and revenue. Only eight hospitals were able to sustain their efforts through to that time. While utilization of the RemitWeb software was variable across participating CAHs, several hospitals stated that the revenue savings was significant enough to consider contracting with the vendor directly after the conclusion of the project.

### Lessons learned during this project include:

The first lesson is to have a deep bench of people trained for anything that requires an orientation. Revenue cycle positions in the New Hampshire CAHs have a relatively high turnover rate; while CAHs were encouraged to utilize the five available licenses, staff turnover challenged the survival of the project. One hospital had three different CFOs during the project period, so their utilization of the software ceased by the first quarter of 2020. Staff turnover and expectations around succession planning should be part of any project taking place within the CAHs.

Three hospitals converted to an electronic medical record (EMR) with integrated

denials analytics capabilities during the project period. As a result, their utilization of the RemitWeb software ceased as well. EMR transitions are bound to happen with any project of significant length, so having discussions with CAHs considering an EMR transition is helpful prior to begin any new initiative. System transitions take significant time and energy away from staff so that certain hospitals may decline participation due to necessary changes in priorities or time commitments. On the encouraging side, the choice of a new EMR with data analytics may have been influenced by the success of this project.

The CDAP was a beneficial financial improvement project for New Hampshire CAHs that was able to sustain their attention and efforts. Similar projects would be beneficial for other states if they are able to engage and sustain the efforts of the hospitals. Due to the current environment with the pandemic and case counts throughout the country rising exponentially, investment in a project like this would be difficult to manage in the near future. Especially for financial managers that are attempting to track so many other aspects of the pandemic effects on hospital budgets and funding applications, it may quickly be put aside for other priorities.

**Program Area 4: Rural Emergency Medical Services (EMS)**

The Division of Fire Standards and Training & Emergency Medical Services (FSTEMS) is working with the New Hampshire Flex Program to create a workforce survey that will assess current workforce capacity and future workforce needs of EMS statewide. Three versions of the survey have been drafted at this point; new licensees in the field of EMS, retiring licensees in the field of EMS, and current licensees who are renewing their license. The Flex program manager was able to pilot test the questions for the first drafts of the survey, so the next step is to put the survey into Qualtrics, the online survey tool.

The intended impact of this project is yet to be realized, but the Division of FSTEMS will be launching a new user management system in spring 2021, and having the survey ready for the new software launch will help streamline the new process. The goal of this project is to be able to analyze the current EMS workforce capacity and future workforce needs by investigating what drives people to serve in the EMS community and what influences people to stay.

**Lessons learned during this project include:**

The Flex manager has been able to implement previous educational experience with survey research methods to draft and refine these surveys. An epidemiologist in the New Hampshire State Office of Rural Health specializing in workforce surveys has collaborated with the Flex Manager to ensure the necessity and validity of the questions. Working with someone who can put a pair of fresh eyes on a survey is extremely helpful as they can show you what questions appear to ask and the potential information that may be gathered. During the development of the surveys, the Flex manager helped translate the needs of the Bureau Chief of EMS to the epidemiologist to help justify questions.

There have been some significant delays in putting the final surveys into the web-based tool. It is helpful to set deadlines for all involved, but also to be flexible as situations change (which occurred when the pandemic hit, hiring freezes affected priorities, and roles shifted for everyone involved). Pilot-testing the surveys with members of the EMS community was an essential step in survey development since it helped contextualize each question to the roles of EMS professionals. As implementation occurs, additional best practices will be developed.

The New Hampshire Flex Program based its survey on two other states' models that had previously launched. It was very helpful to see an example of something that had been done, so the New Hampshire Flex Program wasn't recreating the wheel.

This activity may be very helpful for other states to implement, but New Hampshire is aware that many have already done so. Any state beginning the design of their own EMS workforce survey would likely benefit from discussing with another state who has already implemented their own so the designers can save time—discussing the possibility of survey creation with the Joint Committee on Rural Emergency Care (JCREC) and looking into a partnership with the National Registry of Emergency Medical Technicians (NREMT) for analysis of the results.