North Dakota Flex Program

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

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Program Area 1: CAH Quality Improvement

The North Dakota Flex Program collaborate with their quality improvement organization (QIO) to promote data collection for Medicare Beneficiary Quality Improvement Project (MBQIP) Emergency Department Transfer Communication (EDTC). The QIO, as part of a past Health Resources and Services Administration Rural Health Network Development grant, has developed a web-based portal for North Dakota critical access hospitals (CAHs) to enter their data on the EDTC measure. All 36 ND CAHs have reported data for at least twelve consecutive quarters.

A new development of the portal is a report feature. The feature allows CAHs to run real-time reports specific to their hospital in Excel format (summary data and detail report). North Dakota CAHs receive quarterly technical assistance three times a year with one face-to-face meeting. At each meeting, CAHs who are top performers are identified and they discuss measure elements and highlight most frequently missed measures. To ensure CAHs are meeting measure requirements, CAHs share strategies that are working for them. The QIO and network together track data reporting and provide individual technical assistance to the North Dakota CAHs who are close to the reporting deadline and have not submitted data.

Lessons learned during this project include:

The results of this activity are consistent reporting and review of data. This is a measure that has impacted transfer communication between CAHs and CAH to Tertiary. The impact on the participating hospitals has been positive.

The CAHs have shared emergency room (ER) communication forms with one another and built the transfer questions into their electronic health records (EHRs). The North Dakota Flex Program has collaborated closely with the state QIO to identify high and low performers and discuss the overall and individual data results with participants. This is the first quality project they have participated in as a Flex program with this many quarters of data submitted consistently by all 36 ND CAHs.

A lesson learned was the development of a portal for all North Dakota CAHs to enter their data. They use a program called REDCap and collaborate with their QIO to support the technical assistance of the portal. This portal development was a best practice for their state and was leveraged to develop other arms off it for other projects such as infection prevention reporting, Age-Friendly Health Systems (4Ms Model reporting), and other topics.

The North Dakota Flex Program recommends this portal REDCap for other state Flex programs. It would be wonderful for each state to have this portal to submit MBQIP data into and from the REDCap everyone all could send to the Federal Office of Rural Health Policy (FORHP). This would allow real-time data, using a single password instead of multiple websites and passwords as MBQIP is set up currently.

Program Area 2: CAH Operational and Financial Improvement

Yearly, CAH financial data analysis is supported by the North Dakota Flex Program, completed by Darrold Bertsch, CEO of the Sakakawea Medical Center, Hazen, ND. Mr. Bertsch contacts each of the 36 CAHs to have them provide him with specific financial data (2020 is Year 13). This data includes organizational structure, the number of CAHs that own primary care clinics including rural health clinics (RHCs), those that own or operate nursing homes, basic care, assisted living and ambulance services, inpatient vs. outpatient data, occupancy rates, a time comparison of the number of licensed beds, acute patients, skilled swing beds, non-skilled swing beds operating and net margins, bad debt/charity care, sources of revenue, and revenue and expense comparison.

Lessons learned during this project include:

They completed a comparative analysis of the original 27 CAHs that participated in the first review in 2007 to compare with time periods and cumulative analysis and an analysis of the western CAHs, primarily in "Oil country," to isolate differences of impact. The Flex program leverages this information in working with North Dakota CAHs.

The data is vital in developing an understanding of the organizational and financial structure of their CAHs. Data is shared within policy discussions with the North Dakota Congressional delegation, state legislators and is used in fact sheets and legislative testimony. It is incorporated into other formats and documents, such as the UND School of Medicine and Health Sciences Biennial Report on the Status of Health in North Dakota, which is widely disseminated. The data is reliable, coming straight from each North Dakota CAHs, and has the advantage of allowing for multiple-year comparisons.

The North Dakota Flex Program does recommend this activity for other Flex programs as it allows for multiple-year comparison and is leveraged as an education piece for legislators.

Program Area 3: CAH Population Health Improvement

The North Dakota Flex Program continues to facilitate community health needs assessments (CHNAs) and provide TA and build local capacity of CAHs. A CHNA eToolkit developed in-house is used to manage the process. CRH works with hospitals and local public health units conducting the assessments and also works with them on their implementation plans. All CHNA reports and the implementation plans are posted on the Flex program website).

The expected outcome is that all CHNAs scheduled to be conducted will be completed by the deadline so as not to miss any Affordable Care Act (ACA) mandates. In a typical year, this requires North Dakota Flex Program staff to travel to the communities on two occasions as part of the process. The first is to collect data through a focus group and conduct in-person key informant interviews. The second meeting out in the communities is to bring together the focus group participants and key informants and report out the findings from the data they collected at the first focus group meeting, through the key informant interviews, via the community survey that they administered, and through a collection of secondary sources and prioritize the needs based on those findings.

Due to COVID-19's impacts, they had to modify their process while still ensuring that they were able to collect the necessary information in order for otheir findings to be reflective of the community's needs. Instead of being in-person interviews, all of them were conducted via telephone or Zoom. For the second meeting, when they would typically gather all of the focus group and key informant interviewees together to report out the findings and have them prioritize the needs of the community, they had to do that virtually too. Instead of conducting a live virtual meeting, the North Dakota Flex

Program recorded their presentation and email it out to all of the people who were interviewed. After viewing the recording, they are asked to complete a survey where they rank their top three community health needs based on the findings. From the results of the first survey, they are then sent a second survey to complete. In this survey, they select their number one most important concern for the community. The results and all findings are then incorporated into the report and given to the CAH to have approved by their board.

Lessons learned during this project include:

The results of this activity are continued meeting of ACA requirements for nonprofit hospitals to conduct a CHNA every three years. The impact on the participating hospitals has been positive. The CAHs have met their ACA requirements while making needed improvements to address the community's needs. The CRH conducted 32 of 36 CAH CHNAs in the last 3-year cycle and is scheduled to conduct 33 of 36 in the current/upcoming cycle.

A lesson learned is that when facing a pandemic, there are modifications that need to be made. Not only to protect public health (not gathering large groups, etc.), but also considerations need to be made in the time that it takes to do the necessary activities that are part of a CHNA. Conducting all key informant interviews instead of gathering some of that information through a focus group adds an additional 10+ hours of time required to collect the data. The CAHs and public health units are also extremely taxed for time because of the pandemic, which doesn't always allow them to be able to think about things other than patient care. It is important to make modifications to the process, give the communities advanced notice of what is going to be needed, make them templates to make everything as easy as possible for them, and let them know that you recognize that they are overly busy at this time and are open to suggestions from them regarding ways that you can help them move the process along. The eToolkit that they use to facilitate communications between the community liaison and the Flex Program is the best practice because it allows both the people working on this in the community and the Flex Program on it to know, at all times, where the community is at in regards to the process. It has become inevitable that people have to take time off because they have become sick or have issues that have to be addressed. The eToolkit allows others to pick right up where they left off.

The North Dakota Flex Program assists communities with their CHNAs and implementation plans are necessary to aid them in meeting ACA

requirements, building community repour, and improving the community’s health outcomes.