



TASC 90 Highlights

Date: April 13, 2004
Facilitator: Karen Madden

Karen Madden stated the reason for the call was that the Flex Committee of NOSORH thought it would be good for other states to hear what states are doing that is new and innovative. Calls were put out to states to describe some of the things they are doing in their states.

Tami Lichtenberg briefly talked about innovation in regard to the Flex applications. Innovation is largely a matter of perception. You need to make a case for whatever you're doing. It is a fresh way of looking at things in your particular state in your case. Tami noted for Forrest that he wanted to emphasize that people look in the direction of what they can do in quality and collaboration. Innovation has worried a lot of people but the key is making the strong case for why this is innovative or why this is fresh in your state in your particular case.

EMS Examples: Arizona

Alison Hughes reported that Arizona has a pilot program going on in Cochise County which is where most of the Critical Access Hospitals are clustered. In that pilot program, laptops were given to the ambulance services with matching money from the flex grants. All ambulances are equipped so that they can start to enter the agreed upon NHTSA Data sets so that transport data could be analyzed. They want to be able to prevent some of the unnecessary transport because the CAH's want to keep the patients they can. Some preliminary data is being obtained from the pilot in addition some training of emergency room nurses in trauma care; how to care for trauma patients has been arranged.

Arizona also supported bringing 2 people from all of the CAH's EMS Systems, those systems serving their geographic area in which there are CAH's to a statewide conference on EMS training last year. From that they developed an EMS working group that developed an Arizona vision paper of EMS for the future modeling, on the national paper.

Finally, in planning for next year's Flex Program, there was a meeting to discuss another pilot for next year because Arizona wants to do one with Native Americans. They discovered that one tribe has no EMT's and that there were 3 broken necks near the bottom of the Grand Canyon where the tribe lives. Negotiations are in the works for an EMT training program and some basic Public Health 101 training step on preparedness.

Minnesota

Pam Hayes reported on EMS in Minnesota. Minnesota was anticipating expanding CALS training for EMT's. The EMS ambulance services with paramedics are involved in the training, but Minnesota thought they would work with several other states to develop a course for EMT's that could hook up with the CALS course on a higher level.

Missouri

Barry Backer contacted Dr. Carter and is trying to get on his list to see if MO can be the first CALS site out of Minnesota.

QI/PI Examples:

Arizona

Joyce Hospodar has 6 hospitals doing the Balance Scorecard, 4 of which are tribal. It is going well and about to kick off the data collection. There is a quality group that was started again in Cochise County. They have a quality group already organized and the flex staff is using that to try to develop a statewide quality group. This quality group found out when going to training in Phoenix with the QIO the programs in the seventh scope of work really did not apply to them very well in the rural area. They decided to attend those meetings and come back and focus in on how it could be modeled to their rural needs. The first statewide teleconference will be on April 20th and invite all the directors of nursing and the quality managers from all of the CAH's to see what kind of topics they want to talk about.

TASC

Terry Hill mentioned that we have been advocating that in the eighth scope of QIO work. In other words, the QIO's would be budgeting money specifically for support for rural hospitals. The preliminary word out of the American Quality Health Association (CAQUA) is that those recommendations have been taken seriously. It appears that the eighth scope of work will contain a specific focus on rural health. It should bring significant new resources to the CAH's and resources for the Flex program as well. In the past there has not been any incentives built in, in terms of funding. The eighth scope of work will have that incentive. Also in our experience, the QIO's are much more active this year than we have seen in the past.

Arizona

Joyce Hospodar mentioned that last year the QIO did a session for their CAH's and other small rural hospitals (SHIP) on pneumonia and that was very successful. On July 8th, the QIO is doing one on congestive heart failure patients.

Washington

Kris Sparks talked about exciting networks being developed for quality purposes. There are two in Washington state; one dealing with all CAH's in the eastern and one with the western part of the state.

They have been struggling with getting; creating a separate legal organization. They now have their 501c3 in place and will begin doing business. Kris has a list of things she would like them to look at: 1) medical errors, 2) quality improvement for rural health clinics. Some funding was provided through Washington's state office. They also received a network development grant.

Massachusetts

Cathleen McElligott mentioned that they are working on a stroke initiative. When you look at the stroke data in MA, particularly only in rural areas, it really jumps off the page. MA office is involved in setting up a statewide training, an onsite training at the MA Medical Society and video conference it to 4 locations across the state. MA has a CAH that is 30 miles from another hospital and they are networking them with a primary stroke center program out of Partners Telemedicine in Boston, provide stroke consultation, sub-acute and acute stroke consultation for patients.

TASC

Terry Hill mentioned that TASC is working on a contract with the FORHP to develop both workshops and manuals on Balanced Scorecard implementation. The goal is to produce two workshops this summer. The tentative dates are July 12, 13 and August 17, 18; starting at noon on day one and ending at 2:30 on day two. Curriculum is well underway. These workshops are intended for the Mississippi Delta participants; but the second workshop will be opened up for people from other state flex programs as well. The intention is to not only provide an overview of the Balanced Scorecard itself but to focus on national experience using Balanced Scorecard in a small hospital setting. A manual is in the process of being developed on the use of balanced scorecard in rural hospitals.

Pennsylvania

Larry Barroner mentioned that they have been working on the Balanced Scorecard for some time and this year the hospitals are now getting quarterly reports. One of the things found from the data was that dedication to medication error reporting was all over the board. They have identified a group in PA called the Institute for Safe Medication Practices and they are putting together a quality collaborative for not only CAH's but have invited some other small rural hospitals. There are nine hospitals coming together as a consortium and they have put in to their SHIP grant for this year. They are trying to take some of the data from the BSC and create initiatives that are useful for hospitals.

Nebraska

Dave Palm mentioned that Nebraska is going to the BSC. They are thinking about doing a quality project with Rural Health Clinics who are now required to have some kind of quality improvement initiative around the area of diabetes and tie that back with CAH's. Dave asked if anyone else working with Rural Health Clinics or doing a quality project? Kris Sparks mentioned that they did a big study with a Rural Health Clinic that was both financial and qualitative. One of the things that came out of that is that clinics clearly don't have the resources to deal with some of the quality initiatives. A large number of their CAH's have Rural Health Clinics as part of their service mix. Dave stated that there will be a meeting in a month or so to have someone from the QIO talk with them. John Gale suggested

that Dave talk with Joellen Edwards in East Tennessee State as she has a project underway looking at quality issues in Rural Health Clinics and she might have some resources/materials.

Networking Examples:

Nebraska

Dave Palm stated that they are not doing a lot of new and innovative things this year although they are going to focus on several different areas. What they have done for a number of years is given grant money to CAH networks; giving about \$5,000 per CAH. They are also trying to get the larger supporting hospital to work more closely with CAH's and also to get CAH's to work more closely together. What a lot of the networks have done is focus on workforce training of various kinds and they have quality improvement projects using benchmarking. The networks range from two to seventeen hospitals. There are many quality improvement initiatives underway. A couple of networks will focus on the BSC. Also, the University of Nebraska Medical Center with the Center for Rural Health Research has done a medication errors project that a few CAH's have gotten into. By providing an incentive to work together, they have developed a variety of networks, many around quality but some around other things such as EMS. Nebraska has a long way to go to regionalize their EMS systems. Nebraska also notes that the supporting hospitals are willing to give a lot of in-kind contributions.

TASC

Terry Hill commented that Dave just presented an example of using the network as a tool rather than as a formal entity itself and providing an incentive for providers to come together to solve common problems or deal with common issues. Pam Hayes echoed Terry's using networking as a tool, not necessarily a thing in itself. Minnesota's group of 22 CAH's has participated in a quality improvement collaborative with Stratis Health, the QIO. There was improved collaboration between hospitals, getting information and sharing projects with others. Based on that, they are taking the quality improvement project and piloting a discharge planning project and expanding it to the nursing homes, ambulance services, durable goods, and public health organizations.

ORHP

Forrest commented that networking is a preventative, whether talking about quality, EMS, or networking. Collaboration is a key issue. Also, back to Tami's early comments, all of the things presented today were excellent examples of innovation. That certainly met what he had in mind, innovation which is basically using flex funding and knowledge to build rural healthcare systems in new and improved ways.

Iowa

Kate Payne in Iowa mentioned that they offer \$5,000 per CAH for the network hospital that applies through the competitive process. Right now one of the larger networks that have six or seven CAH's in it developed a diabetes education program for all the small rural hospitals in the network, funded through the network. One of the smaller networks that have two hospitals, has developed a leadership training program for all department supervisors.

South Carolina

Graham Adams stated that SC has also gone down a new network development track, putting out an RFP geared to building linkages among hospitals and other partners. Two new efforts that are doing some interesting things involving FQHC's and health departments. One involves a private foundation, a family practice residency, and a school of medicine based clinic. Out of all the efforts that SC has done, this has probably been the most successful on getting folks to start to brainstorm.

Pennsylvania

Larry Barroner stated that what they have been doing is having a technology focus with CAH's and a larger referral hospital that has advanced information systems. The larger hospital has leased a part of their information system to these small rural hospitals. In the case of one hospital, they lost their radiologist and would have had to go out and recruit one, but through technology linkages created with this network, now the referral hospital can send a radiologist out to the smaller hospital and access film archived at the referral hospital.

ORHP

Evan Mayfield stated he liked the emphasis on quality improvement. He asked whether states had looked at quality in pre-hospital environment.

South Carolina

In SC, they are also hosting a rural EMS leadership conference. Part of the emphasize there is really on the quality of pre-hospital efforts and one of the things that they are focusing on medical direction for EMS and trying to provide education and link them to other providers in the system.

Washington

Kris Sparks said that one of the CAH's administrators was asking for some quality measures for EMS. There are so many different organizational entities like fire districts, public hospital district, etc. It is hard to know if they are doing a good job since they don't have anyone to compare themselves to in terms of benchmarks. Some of their EMS staff were also at this conference and thought that might be something to look at. They sometimes have trouble engaging CAH's and EMS in any kind of activity. Both sides seem to get excited about the potential.

Nebraska

Denny didn't know if folks were aware of the EMS agenda for the future for rural and frontier areas. If you are interested, there is a web site with the second edition of this agenda to look at: www.nrharural.org\emsagenda. He said to check it out if you are interested in the May 26th EMS Summit for Rural and Frontier.

Illinois

Pat Schou - The interesting things that have happened is the creation of their new CAH network called ICAHN; it administers both the SHIP and Flex Grant for the Department of Public Health. Pat has been hired as the Executive Director and they are looking at a number of business opportunities for these hospitals. There is a Board of Directors of nine CAH members. They have their own scorecard that they are working on as well as other projects. Pat noted that each hospital that joined agreed to put in \$5,000 as an initial assessment and then set up dues of \$5,000 per year. 80% of CAH's are in the network. Denny asked what the relationship is between this organization and the larger hospitals. Pat said very positive. They had a nursing user group meeting recently and St. John's Hospital, a 400 bed facility, hosted the event. There was no charge.

The meeting was adjourned at 3:30 p.m. CST. The next TASC 90 conference call is July 14, 2004. For further information, please contact TASC at 218-727-9390 or tasc@ruralresource.com