IOWA FLEX PROGRAM

Strategic Planning Report

February 2005

Introduction

The Iowa Department of Public Health, Bureau of Health Care Access, Medicare Rural Hospital Flexibility Program (FLEX Program) began a program strategic planning process that included presenting and discussing the findings of the 2004 Iowa FLEX Program Evaluation with FLEX Program stakeholders, discussing program activities with Critical Access Hospitals (CAHs) at CAH Peer User Group meetings, and conducting a one-day strategic planning session with program stakeholders. The intent of the strategic planning session was to identify key issues that should be addressed as part of the FLEX Program and to establish a program mission, goals, and next steps. Participants included representatives of: networks, Iowa Foundation for Medical Care (IFMC – the state Quality Improvement Organization), Iowa Department of Public Health, Iowa Bureau of Emergency Medical Services (EMS), local EMS, Critical Access Hospitals (CAHs), Iowa Hospital Association (IHA), and Iowa Department of Inspection and Appeals (DIA). Rural Health Solutions, a rural health and health workforce research and program development firm located in St. Paul, Minnesota facilitated the discussion.

FLEX Program Background

The Medicare Rural Hospital Flexibility Program (FLEX Program) was established through the Balanced Budget Act of 1997. It is a national program that includes 45 states, including Iowa. In essence, the FLEX Program is comprised of two components – grants to assist states in implementing state specific program activities and an operating program that provides cost-based Medicare reimbursement to hospitals that convert to Critical Access Hospital (CAH) status. The federal Office of Rural Health Policy, Health Resources and Services Administration, U.S. Department of Health and Human Services (DHHS) administers the grant program, while the operating component of the program is administered by the Centers for Medicare and Medicaid Services (CMS), also located within DHHS.

Six FLEX Program priority areas have been established for states implementing the program, they are:

- Creating and implementing a state Rural Health Plan;
- Designating facilities as CAHs;
- Fostering and developing rural health networks;
- Enhancing Emergency Medical Services (EMS);
- Improving the quality of health care; and
- Evaluating FLEX Program activities and related outcomes.

The Iowa Department of Public Health, Bureau of Health Care Access, FLEX Program administers the program in Iowa. Iowa has 69 CAHs and has obtained approximately $428,275 per year to administer the FLEX Program in Iowa. To date, Iowa's FLEX Program has addressed CAH designation related activities, regionalization of EMS services, hospital quality improvement and performance improvement, rural health planning, networking, and evaluation. Iowa's FLEX Program will continue to address each program area.

Strategic Planning Outcomes

The strategic planning session was conducted on January 11, 2005. The day consisted of discussing Iowa's FLEX Program, the program nationally and in other states, on-going rural health issues related to EMS, networking, quality improvement, CAHs, and program communications. This work resulted in the creation of a FLEX Program mission, goals, and activity action steps to meet the mission and goals. Iowa FLEX Program staff identified the action step completion dates.

Mission: To work as partners in fostering an integrated, dynamic, yet sustainable rural health care system that provides access to the highest quality of care.

Goals:

1) Engage communities, providers, networks, EMS, and quality improvement organizations in the rural health planning and FLEX Program implementation process.
2) Support initiatives that foster high quality care.
3) Create a seamless, responsive, accessible health care system.
4) Make, assist with, and facilitate connections (resources, technology, education, purchasing, negotiating, and representation, etc.) between communities, health care providers, hospitals and other care providers (EMS and long-term care), and networks.
5) Effectively and efficiently communicate FLEX Program information and outcomes to all stakeholders.
6) Seek collaboration to understand system changes within EMS.
7) Assist networks with performance/quality (PI/QI) improvement in CAHs and other hospitals.

Action Steps:

Emergency Medical Services (EMS)

- Host a short-term hospital-EMS work group to discuss opportunities for system development, purchasing alliances, and workforce sharing and to identify rules and regulations that impede these opportunities. (2005 – 2006)
- Provide educational opportunities for CAHs and EMS regarding rules and regulations discussed as part of the hospital-EMS work group. (2005)
- Establish a pilot project in south-central Iowa that supports resource sharing (staff, equipment, materials). (2005 – 2006)
- Investigate opportunities related to "Pilot Response Teams" a concept identified by the IFMC. (2005 – 2006)
- Explore models that are working (e.g. Sumner and Iowa County EMS). (2005 – 2006)

Critical Access Hospitals (CAHs)

- Support local community planning initiatives. (On-going)
- Focus on information technology (IT) as a means of addressing some workforce issues. (On-going)
- Coordinate workforce-planning initiatives with SHIP grants. (TBD)
- Identify IT best practices and worst practices through national and state queries of hospitals and networks. This includes, but it not limited to, IT related to electronic medical records and tele-pharmacy. (2005 - 2006)
- Encourage all CAHs to participate in Databank (108 of 116 hospitals participate). (On-going)
- Support and develop comparative data opportunities to work towards performance and quality (PI/QI) improvement. For example, establish definitions for financial, utilization, and quality improvement measurement. (In-process)
- Address issues related to access to mental health, in particular those related to referral and transfers. Do this in coordination with the IHA Behavioral Health Taskforce. (2005)

- Encourage CAH participation in FLEX Program activities; including reaching out to those that do not/have not participated. (On-going)
- FLEX Program staff participate in hospital district meetings on an as-needed basis. (2005 – On-going)

Networks

- Assist networks in their work of supporting CAHs with survey and licensing compliance. (2005)
- Encourage networks to use Databank to assess PI/QI across their network. (On-going)
- Host a network of networks meeting. (2005)
- Create templates to standardize the mock survey process. (TBD)
- Support networks in established network-wide protocols. (On-going as part of the Medicare Rural Hospital Flexibility Network Grant Program).

Communications

- Post CAH Peer User Group Meeting Minutes on the FLEX Program website. (In-process - 2005)
- Physicians, nurse practitioners, physician assistants, other local health providers, and communities need to be notified that the 96-hour length of stay limit has changed. (TBD)
- Establish a statewide FLEX Program image and message to assure all stakeholders are aware of FLEX Program accomplishments. (On-going and 2005 IA FLEX Program Annual Report and website)
- Create a user-friendly and effective website that not only includes key program information and tools but also links to other programs and services and education information. (In-process – On-going)
- Support new CAH administrators by providing them with CAH orientation opportunities and information. (In-process, as part of the scheduled CAH site visits)

Other

- Support the elimination of the 35-mile rule for cost-based reimbursement for rural CAH-based ambulance services. (On-going)
- Support initiatives that encourage specialty care providers to practice in rural area. (2005 – 2006)
- Making changes to the CAH Peer User Group meetings to allow for both in-person meeting opportunities and tele-meeting opportunities was a finding of the 2004 FLEX Program Evaluation; however, CAH Peer User Group evaluations have reported conflicting information. Therefore, this issue will be monitored. (TBD)

Strategic Planning Participants

Facilitator: Rochelle Schultz Spinarski, Rural Health Solutions, St. Paul, Minnesota

FLEX Program Stakeholders:

- Allen Pohren, Administrator, Montgomery County Memorial Hospital, Red Oak, IA
- Art Spies, Senior Vice President/Membership Services, Iowa Hospital Association, Des Moines, IA
- Brian Evans, Rural Development Director, Iowa Health System, Des Moines, IA
- Erran Miller, Paramedic/Volunteer, Hampton County/Franklin General Hospital, Hampton, IA
- Jim Striepe, Executive Vice President/Regional Health Services, Sioux Valley Health System, Sioux Falls, SD
- Kate Payne, Program Planner/Contract Manager, Iowa Department of Public Health, Bureau of Health Care Access, Medicare Rural Hospital Flexibility Program, Des Moines, IA
- Kathy Williams, Coordinator, Iowa Department of Public Health, Bureau of Health Care Access, State Office of Rural Health, Des Moines, IA
- Larry Frazier, Program Coordinator, Iowa Department of Inspection and Appeals, Des Moines, IA
- Marvin Firch, Coordinator, Iowa Department of Public Health, Bureau of Health Care Access, Medicare Rural Hospital Flexibility Program, Des Moines, IA
- Mary Anderson, Network Manager, Alegent NPG Health Link, Lincoln, NE
- Peggy Wilkinson, CAH Network Liaison, University of Iowa Hospitals and Clinics, Iowa City, IA
- Ray Jones, Bureau Chief, Iowa Department of Public Health, Bureau of Emergency Medical Services, Des Moines, IA
- Sandra Petersen, RN/Manager, Iowa Foundation for Medical Care, West Des Moines, IA
- Steve Simonin, Administrator, Wright Medical Center, Clarion, IA (via phone during the morning)
- Tom Creighton, EMS Manager/Respiratory Care Manager, Franklin General Hospital, Hampton, IA

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