



Center for
Rural Health

University of North Dakota
School of Medicine & Health Sciences

**North Dakota Medicare Rural Hospital
Flexibility (Flex) Program**

Annual Report

Year 9: September 2007 - August 2008

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*Connecting resources and knowledge to strengthen
the health of people in rural communities.*

I. Program Overview

The ND Flex Program is administered by the UND's Center for Rural Health, School of Medicine and Health Sciences. Program partners include the ND Healthcare Review (the state's quality improvement organization), the ND Healthcare (hospital) Association, and the ND Department of Health (Division of Emergency Medical Services and Trauma).

The ND Flex Program was developed in 1998 and has received between \$450,000 and \$630,000 each year. The beginning years of the Flex Program focused on assisting small rural hospitals convert to CAH status. Since 2004 the focus has shifted to providing technical assistance around planning, finance, performance improvement and emergency medical services. The program has always provided funding directly to CAHs for the purposes of program development, network development, financial viability, community engagement, emergency medical services and trauma designation.

Overall, the **ND Flex program has provided over \$3.5 million in direct funding** by way of grants to ND's rural communities. There have been 123 CAH grants, 47 EMS Network grants (impacting 72 additional partners in 30 counties), 40 CAH Network Enhancement grants (impacting 56 additional partners in 26 counties) and 4 Making a Difference grants. Approximately 110 communities have benefited from the four types of Flex Program grants representing almost one-third of all communities in the state.

In addition to administering direct funding to the state's CAHs, the ND Flex Program provides direct technical assistance to small rural hospital, all of which is designed to help plan for the provision of health care in the future. To date the Flex Program has provided or facilitated the following: 19 community needs assessments, 44 community forums/hospital meetings, 10 internal personnel audits, 20 board meetings, 9 grant writing workshops, 6 performance improvement plans, 12 strategic planning sessions, 33 CAH profiles, and developed the statewide ND CAH Quality Network.

North Dakota had two hospitals designated as CAHs in 2008, bringing the state total to 35 of the 39 rural hospitals (90%) that are eligible.

The ND Flex Program is guided by a steering committee comprised of members with expertise in each of the program focus areas including quality, networking, planning, emergency medical services, trauma and hospital finance. Committee members are as follows:

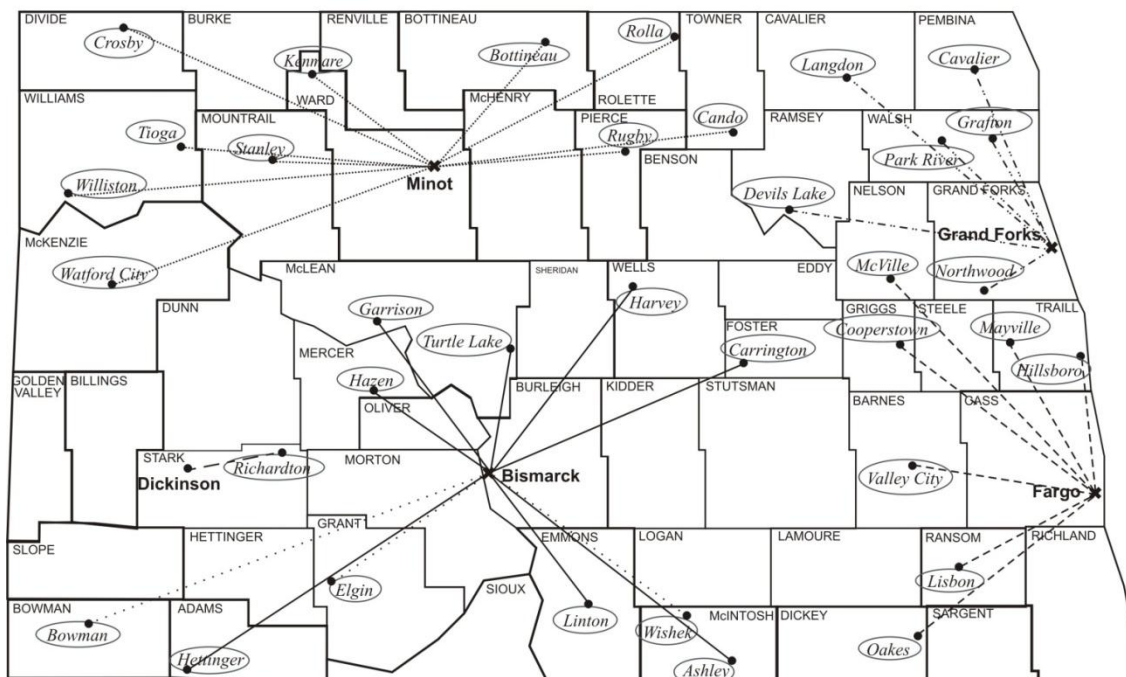
- Marlene Miller, Chair, Center for Rural Health
- Brad Gibbens, Center for Rural Health
- Barb Groutt, CEO, ND Healthcare Review, Inc.
- Tim Meyer, Director, Division of EMS and Trauma, ND Department of Health
- Tim Blasl, Vice President, ND Healthcare Association

An advisory committee works with the steering committee and represents critical access hospitals from the state's eight human service regions. Committee members are as follows:

<p><i>Representing Regions I and II: Crosby, Tioga, Watford City, Williston, Kenmare, Stanley, Bottineau, Rugby</i></p>	<p>Mitch Leupp, Administrator Mountrail County Medical Center (701) 628-2424 Randy Pederson, CEO Tioga Medical Center (701) 664-3305</p>
<p><i>Representing Regions III and IV: Rolla, Langdon, Cando, Devils Lake, Cavalier, Grafton, Park River, McVile, Northwood</i></p>	<p>Pete Antonson, Administrator Northwood Deaconess Health Center (701) 587-6060 Kimber Wraalstad, President/CEO Presentation Medical Center (701) 477-3161</p>
<p><i>Representing Regions V and VI: Mayville, Hillsboro, Lisbon, Harvey, Carrington, Cooperstown, Valley City, Oakes, Ashley, Wishek</i></p>	<p>Kathy Hoeft, Administrator Ashley Medical Center (701) 288-3433 Vacancy</p>
<p><i>Representing Regions VII and VIII: Garrison, Turtle Lake, Hazen, Elgin, Linton, Richardton, Bowman, Hettinger</i></p>	<p>Darrold Bertsch, CEO SW Healthcare Services (701) 523-2314 Roger Unger, Administrator Linton Hospital and Medical Center (701) 254-4511</p>

The following map identifies ND CAHs and their primary referral patterns with the four large urban centers.

North Dakota Critical Access Hospitals & Referral Centers



Critical Access Hospitals

Referral Centers
 Trinity Hospital
 St. Joseph's Hospital & Health Center - - -
 Med Center One
 St. Alexius Medical Center
 Altru Hospital - - -
 MeritCare Hospital - - -

II. ND Flex Program Objectives (2007-2008)

The ND Flex Program addressed seven objectives over the 2007-2008 funding cycle. The following is a summary of accomplishments by objective.

Objective 1 : Update ND's State Rural Health Plan	Outcomes/Impact to Facilities
1. Identify and review the organizational and/or state health plans and/or data sets and other relevant information of key stakeholders groups. Completed	<ul style="list-style-type: none"> • Thirteen state associations and three tertiary hospitals were interviewed regarding their perceptions of North Dakota's health needs and their visions for meeting healthcare needs in the future. • A CAH administrator survey was developed, disseminated, studied, and reported. • Secondary data and information was gathered from a variety of sources. • Preliminary results of the data gathered were presented at the State rural health conference (60 participants)
2. Develop host two community dialogues. Completed	<ul style="list-style-type: none"> • A community dialogue process and formal presentation was developed. • Two community forums were held in Linton and Cooperstown to discuss the future of rural health care (37 participants) • Follow-up newspaper articles were published providing feedback to the communities
3. Expand and enhance focus of Flex advisory committee. Completed	<ul style="list-style-type: none"> • Selection process for Flex Advisory Committee developed. • Committee Guidelines developed and approved. • Potential members identified and invited to participate. All agreed, including 8 CAH administrators representing geographic regions of the state. • Three meetings were been held jointly with the Steering Committee.
4. Develop SRHP Completed	<ul style="list-style-type: none"> • Steering Committee and Advisory Committee met and reviewed the preliminary information and provided vision and strategies for the future of healthcare in North Dakota. • Report completed, distributed to 75 identified stakeholders, federal legislators, ORHP, and posted online
Objective 2: Support Quality Improvement	Outcomes/Impact to Facilities
1. Increase/maintain rural hospitals reporting to Hospital Compare. Technical assistance provided related to reporting, using collection tools. Completed	<ul style="list-style-type: none"> • 29/34 CAHs successfully reported quality measures data into the CMS warehouse. 32/34 CAHs are actively involved in the data collection process. • From 11/1/07 – 2/29/08, the QIO staff provided 402 episodes of technical assistance to CAHs related to clinical topics, the CART tool, Qnet Exchange, public reporting of data IHI 5 Million Lives Campaign, general data collection issues. • From 7/1/07 – 11/30/07, the QIO conducted 30 CAH site visits.
2. Work with Department of Health, ND Healthcare Association, ND Healthcare Review, Inc. and other groups to compare and contrast the measures used to determine the quality of care in Critical Access Hospitals Not Completed.	<ul style="list-style-type: none"> • Support of quality improvement changed focus with development of statewide CAH Network (see no. 3 below).

<p>3. Development of statewide CAH Quality Network. Completed</p>	<ul style="list-style-type: none"> • CAH Quality Development Team was formed and met regularly. • A project work plan; rotation of terms for executive committee and advisory committee; executive committee guidelines; and coordinator position description were created. • The Advisory Committee was established and guidelines were developed and adopted. • Executive Committee formed work groups and held meetings to develop a network structure and to hire a coordinator. • Coordinator position was developed and filled May 2008. • An update was sent via the Flex listserv; another update was featured at the annual CAH workshop in March. • An web- based QI collection tool explored and adopted through a pilot project with 14 CAHs participating (Clarity Group, Inc.)
<p>4. Develop knowledge base related to quality improvement initiatives for CAHs. Completed</p>	<ul style="list-style-type: none"> • Participation sponsored for a Webinar offered to CAH CEOs: “Being Ready for a Medicare CoP Survey”; 13 hospitals participated in the Webinar and 5 participated in video conference discussion following the call. • Annual QIO Conference: “Redesigning Systems” held in October, 2007; 37 participants from 20 CAH hospitals. • QIO staff hosted IHI ‘s Fall Harvest event, on an IHI site visit to West River Regional Health Center. • Flex staff provided rural hospitals with information about applying for Cardinal Health grants to support Campaign intervention implementation. Four ND hospitals received the award • 14 CAHs are currently enrolled in the 5 Million Lives Campaign; North Dakota’s QIO, Hospital Association, and Medical Association serve as the IHI Node • The Node had 296 contacts with rural hospitals between November and February regarding Campaign (average of 9 contacts per hospital) • The Node offered educational activities on: <ul style="list-style-type: none"> ○ “Presenting Pressure Ulcers” (11 CAHs participated) ○ “Preventing Harm from High Alert Meds” (14 CAHs participated) ○ Video conference on MRSA (23 CAHs participated)
<p>5. Assist w/ focus groups & qualitative research project related to CAH patient transfers. Completed</p>	<ul style="list-style-type: none"> • The ND Center for Rural Health, through an AHRQ grant, completed a research study related to transfers between critical access hospitals and tertiary referral center. Flex staff assisted with process. More information available at: http://ruralhealth.und.edu/projects/bric/
<p>Objective 3: Support Hospitals</p>	<p>Outcomes/Impact to ND Rural Hospitals</p>
<p>1. Foster adoption of performance management tools by CAHs. Ongoing</p>	<ul style="list-style-type: none"> • The Flex Director received training from the Rural Health Resource Center (Duluth) by attending a two-day workshop facilitated by TASC. The ND Flex Program has built its capacity to work with critical access hospitals and help them implement the Balanced Scorecard. • Presentations were given to 8 CAHs in ND introducing them to the balanced scorecard. Follow up visits have been provided to 4 of the 8 CAHs with another scheduled for May 2008. • A Balanced Scorecard user-group of CAHs in ND and Montana was formed by the TASC.
<p>2. Coordinate /develop educational opportunities. Completed</p>	<ul style="list-style-type: none"> • CAH Annual Meeting sponsored - “Attributes of Successful CAHs” presented by Eric Shell of Stroudwater – 60 participants • CAH Annual meeting sponsored financial sessions by Stroudwater “CAH Cost Reports to Decision Making” - 20 participants • NDHA sponsored educational opportunities: <ul style="list-style-type: none"> ○ CMS Initiatives (video-conference) - 24 CAHs participated ○ 2008 Chargemaster Update – 26 CAHs participated ○ “Critical Access Hospital Case Management” seminar held – 20 participated ○ CAH MDS seminar ○ Mastering Injections and Infusion Therapy webinar ○ Solutions to Emergency Department Call Coverage Issues webinar ○ Electronic Medical Record Strategies that can Improve Quality, Safety and Employee Morale Seminar • Flex funding sent four CEOs to attend the American Hospital Annual Meeting; information shared back to steering committee and other CAHs via video conference.

	<ul style="list-style-type: none"> • 2008 Annual Flex Meeting – ND team to participate will include tertiary hospital, CAH CEO, New QI Network Coordinator, Flex director
<p>3. Promote visibility of CAH contribution to healthcare. Partially Completed (Ongoing)</p>	<ul style="list-style-type: none"> • 19 Press releases regarding Flex grants completed. • 18 CAH profiles now visible on the CRH/Flex website. All hospitals have partially completed questionnaires of profiles. Available: http://ruralhealth.und.edu/projects/flex/hospitals.php
<p>4. Provide technical assistance to CAHs. Ongoing</p>	<ul style="list-style-type: none"> • Flex webpage enhanced and updated regularly (visit http://ruralhealth.und.edu/projects/flex/); 9,813 views of the ND Flex webpages between 2007 and 2008. • Two community needs assessment completed. • One internal personnel audit completed. • Flex Monitoring Team CAH Financial indicator reports received and reviewed; hospitals received individual report access and were encouraged to use the information. • Stroudwater Consulting provided detailed analysis of 10 CAH financial reports (based on Flex Monitoring Team information). Disseminated to all CAHS and presented to Blue Cross Blue Shield of ND by CAHs. • Flex Program overview including technical assistance presented at annual conference – 60 participants. • Steering Committee participated in an Eide Bailey Conference Call to gain a better understanding of fiscal issues facing CAHs and opportunities for technical assistance. • NDHA Surveys <ul style="list-style-type: none"> ○ Survey of CAHs regarding mid-levels taking primary call for ER completed. 14 CAHs responded with the mid-level pay received for taking call. 12 CAHs responded with dollars paid to physicians for taking call. Information was shared with all CAHs. ○ Survey of CAHs regarding impact of current rule regarding payments of CRNAs ○ Survey for swing bed charges shared with all CAHs ○ Survey of CAHs regarding payer mix completed. • Facilitate CAH Clearinghouse Role (provided through the hospital association subcontract) <ul style="list-style-type: none"> ○ Continue to work with CAHs regarding payment and reimbursement. ○ Work with ND Insurance Commissioner’s office on payment concerns with insurance companies. Gathered information from hospitals on Medicare Advantage and from Insurance Commissioner’s office on complaints from providers and beneficiaries. ○ Flex Updates (Center for Rural Health) are sent via list-serv approximately 2 times each month. ○ “Informer” electronic newsletter (hospital association) sent out on weekly basis, including articles on: <ul style="list-style-type: none"> ▪ AHRQ Patient Safety tool ▪ Rural ▪ CMS regulations applicable to CAHs ▪ Funding opportunities ▪ School of Medicine Grant Rounds notifications ▪ Regulatory Reminders
<p>5. Strengthen linkages to economic development. Ongoing through 2009</p>	<ul style="list-style-type: none"> • Met with North Dakota economic development association regarding state health plan. • Conference call with members of ND Economic Development Board about conducting a presentation on rural health and economic development. Flex representative presented at annual economic development meeting. • Discussion about collaboration with the Rural Development Council on a community forum. • Video conference held with small workgroup representative of CAHs and rural economic/job develop authorities. Recommendations for next Flex cycle recommended and are being explored. • Meeting with one community and the ND Chamber of Commerce regarding loan repayment options and the J-1 Visa Waiver process for recruiting health professionals.

Objective 4: Support Networking	Outcomes/Impact to Facilities:
<p>1. Support /promote networking activities. Completed</p>	<ul style="list-style-type: none"> • 4 of 22 Flex grants awarded were network enhancement grants which will impact 9 CAH hospitals, the Catholic Health Initiative, and the Northland Healthcare Alliance. The Making a Difference award was also given to a HIT network project (3 CAHs). 17 additional subcontracts were funded directly to hospitals for use with projects related to community engagement, financial analysis, trauma designation, and program development. • CEO Orientation to the Flex Program held. • Each rural liaison from ND's 5 tertiary facilities was contacted to explain the SRHP process and invite their input; the Flex program maintains contact with tertiaries to facilitate networks with CAHs. • NDHA coordinated monthly calls for CAHs. Sample topics include: <ul style="list-style-type: none"> ○ Meth Patients Presenting to ER (25 participants) ○ Focus on state survey, preparedness, hazard planning ○ Session on NDC Codes (19 participants) • QIO met with Trinity Medical Center (regional tertiary) and its 9 network CAHs to discuss data collection, public reporting, quality improvement • Flex participates in a statewide HRSA conference call for the purpose of information exchange and awareness. • Participation in "Upper Midwest Rural Health Policy Summit" – (SORH Initiative) 125 in attendance (MT, MN, ND) • Flex Steering Committee members participated in a statewide CDC-sponsored community forum to ensure that CAH/CHC perspectives and needs were included.
<p>2. Integration w/other grant & program opportunities. Complete</p>	<ul style="list-style-type: none"> • 29 CAHs received SHIP grants • 8 CAHs received funding from ND Blue Cross Blue Shield from Rural HIT Grant Program. • 2 rural North Dakota networks received HRSA network grants for 2008 (impacts 18 CAHs total) • 1CAH received a \$10,000 Incentive Award fundraising for the Giving Hearts Day match program
<p>3. Develop CAH HIT networks. Completed</p>	<ul style="list-style-type: none"> • See Activity 1 (above) for Flex grant support of IT networks. • ND Flex program applied and received 1 of 16 state CAH HIT grants for 1.6 million. This project impacts 3 CAHs, 1 LTC, 1 RHC, 1 CHC, and 1 tertiary. • Health Financial Manager's Association member and CAH HIT coordinator attended national IT conference; information will be shared at statewide meetings • Supported the development of a regional CAH IT network involving 9 CAHs and 1 tertiary.
<p>4. Promote the development of Federally Qualified Health Centers and the relationship of the Centers to CAHs. Partially completed</p>	<ul style="list-style-type: none"> • Numerous meetings attended by Flex partner where group of health systems (including 5 CAHs and tribal health) worked to develop plans for FQHC-look-alive model. Collaborative has successfully obtained HRSA network development planning grant for 2008. • Flex director wrote a technical assistance request of HRSA and obtained expert visit to ND and hosted meeting of interested CAHs in working on CAH/CHC collaborative models. One ND CAH is co-located with a CHC and provides a good example of how the two can collaboratively provide services to rural communities. This network presented along with national experts sponsored by HRSA; 10 CAHs and other stakeholders including the department of health, the PCO and the PCA participated.
Objective 5: Strengthen EMS	Outcomes/Impact to Facilities
<p>1. Assist CAHs with trauma designation. Ongoing through 2010</p>	<ul style="list-style-type: none"> • Subcommittee of Flex program developed Request for Proposal and applications to award funding (\$9,000 each) to support CAHs in obtaining ND trauma designation. • Information disseminated to 7 eligible ND CAHs; three applications were received and approved. Subcontracts were initiated.
<p>2. Support educational opportunities related to financial viability of local EMS units. Completed</p>	<ul style="list-style-type: none"> • Flex sponsored EMT Budget Model Training from EMS expert Gary Wingrove (18 participants) . Session coordinated through the state's Division Director of EMS and the EMS Association of ND. Training held as a pre-conference for EMT directors to the annual EMS Association's meeting (Minot, April 2008). Evaluations very positive.

Objective 6: Conversion of Hospitals to CAH status	Outcomes/Impact to Facilities
1. Facilitate conversion of suitable eligible facilities to CAH status. Completed	<ul style="list-style-type: none"> • 2 eligible hospitals have received CAH designation: Mercy Hospital (Devils Lake), Mercy Hospital (Williston). • Provided technical assistance to one CAH around de-certification issues (Richardton Memorial Hospital, Richardton). Hospital has received federal funding to assist with process through 2009.
Objective 7: Development and Management of ND Flex Program	Outcomes/Impact to Facilities
1. Develop, implement & evaluate 2007-2008 Work Plan for partners. Completed	<ul style="list-style-type: none"> • Work plan developed , reviewed and finalized upon notification of Flex award. • Work plan used as communication tool between Flex partners and updated every two months. • Used to inform final report for upcoming Flex grant cycle. • Flex calendar developed and online as additional communication tool for partners and CAHs. • Flex Steering Committee received educational of CAH financial studies available through ND consulting firm Eide Bailey. This enhanced understanding related to how often CAHs should have certain studies completed and to what extent Flex might fund these. • Information of the Flex Program’s work and impact was disseminated in an annual report to CAHs and stakeholders and made available online.
2. Conduct sub-grantee evaluations. Completed	<ul style="list-style-type: none"> • Flex Outcome Reports from all CAH subcontracts awarded between 2007 and 2008 completed and summarized within this report. • ND Flex Director present at annual Flex meeting in July 2008 and discussed how to optimize the Flex Program.
3. Evaluation of technical assistance provided. On going through 2010	<ul style="list-style-type: none"> • The Flex Program completed a CAH statewide survey in Feb 2008 which measured the impact and knowledge of Flex assistance available/provided. Results included in this report. • The Flex Steering and Advisory Committee members reviewed the results; decision to continue with currently available assistance.
4. Explore the development of a Flex Program Balanced Scorecard. Ongoing through 2009	<ul style="list-style-type: none"> • Joint Planning session held on April 17th 2008 was to include balanced scorecard presentation; this was indirectly achieved, however, additional efforts will provide for this focus in the next fiscal year. Steering Committee members are aware of the balanced scorecard as a performance improvement model being used by some CAHs, but the intent is to work on a balanced scorecard that complements the work of the Flex Program.
5. Statewide hospital survey. Completed	<ul style="list-style-type: none"> • CAH survey developed, administered and analyzed. The results have been shared with the Flex Steering and Advisory Committees and will be used to inform the next year’s work plan and Flex application.

III. Critical Access Hospital Accomplishments

The ND Medicare Rural Hospital Flexibility (Flex) Program awarded a total of 25 Flex subcontract grants, totaling \$296,849 to critical access hospitals in 2007-2008.

25 Grants Awarded

Grant Type	Number Completed	Amount Awarded
Financial Analysis	6	\$53,800
Program Development	7	\$120,500
Network Enhancement	4	\$54,495
Community Engagement	2	\$20,000
Making a Difference	1	\$20,000
Trauma Designation	3	\$27,000
Rural Healthcare Exchange	2	\$1,054

Grant recipients are required to submit a final report upon completion of the grant cycle and the following is a summary of CAH activity funded by the ND Flex Program. The results of those reports are shared by type of grant and reported using the following categories: accomplishments, hospital and community benefits, and lessons learned.

OVERALL IMPACT

- **100%** of respondents indicated that the grant provided by the ND Flex Program **helped their organization reach project goals.**
- An average of 3,700 individuals and 6 communities were positively impacted per grant (average grant award: \$14,794, range: \$2,500 to \$30,000)

Communities Impacted (Average: 6 communities per grant)

Range	1-5	6-10	11-20
Number of Communities Impacted	8	9	3

Individuals Impacted (Average: 3,700 individuals per grant)

Range	1-1000	1001-7500	7501 +
Number of Individuals Impacted	2	17	1

FINANCIAL ANALYSIS PROJECTS

Accomplishments: Flex funds (\$53,800) were used to support six CAHs with financial studies including the impact of third party reimbursement, chart to payment reviews, viability of CAH conversion, and chargemaster reviews. Ways to improve business office operations, improve cash flow, reduce bad debt and increase efficiencies were identified. Information was shared with staff.

Hospital and Community Benefits: Through the varying financial analyses that were completed critical access hospitals benefited from:

- **Improved understanding** of the costs and benefits of participating with third party payer.
- **Improved accuracy** of billing and compliance.
- Enhanced documentation and charging that allowed the hospital to **receive appropriate payment** for services.
- Identified charges that should not be made and various coding and billing changes to **ensure compliance** with coding and billing regulations.
- **Education** to staff on how facility is reimbursed on charges.
- Quality improvements on building and patient satisfaction with bills.
- Charge master changes to **enhance reimbursement**.
- **Work flow changes** were made to improve billing efficiencies. (E.g. did away with low cost, low revenue charge items that only served as busy work, and not productive or revenue enhancing.)
- **Patients** see their bills processed quicker and are able to track more closely their deductibles and co-payments
- Patient records will be directly available to our providers via the Electronic Medical Record.

Lessons Learned: Hospitals are asked to reflect on lessons learned as a result of the initiatives undertaken in order to inform others involved in similar activities. The following was shared from critical access hospitals that completed financial analysis through the use of consultants.

- Hospital learned that it was missing charges related to chemotherapy due to coding and billing processes.
- The billing of CRNA charges will be changed. We will be using a solely time based method rather than using a base plus procedure method. This will actually result in less charges but will result in more accurate billing and less contractual adjustments. This review resulted in several other changes that will be made to documentation, coding and billing processes.
- IV hydration billing charges, review documentation with nursing, and in general an excellent teaching method - will allow us to build upon the process internally. We will make changes within the system that will impact the number of the billing departments. We also noted that we have

some areas that are very effective and will recognize that as well.

- Charge Master should be reviewed often.
- Continued education is valuable.
- Charge master review eliminated duplicative items, taking out very small items, and

increasing prices on other more tangible, significant items. This speeded up billing services and reduced errors.

- Billing code modifiers were added to better reflect services provided and improve the subsequent payment for such services.

PROGRAM DEVELOPMENT

Accomplishments: Seven CAHs received Flex funding (\$120,500) to support program development.

Programming included the following:

- A new lab information system to build on an electronic medical record
- Implementation of an EHR and PACs system (two similar awards to two CAHs)
- Financial software package to begin EMR implementation
- Intensive blood pressure intervention program including presentations, information booths and screenings
- Blood pressure cuffs were distributed at eight nutrition program sites in the county and the site coordinators participated in training of the usage of automated blood pressure cuffs.

Hospital and Community Benefit:

- Lab reports are directly faxed/printed to the proper departments directly from the Lab Information System and will be available in an Electronic Medical Record when installed.
- **Increased efficiency and communication**
- Our hospital benefited because part of its **Mission to promote healthy communities.** The promotion of blood pressure awareness and healthier lifestyles is a benefit not only to the hospital but also to the people it serves in the various communities. People perceive that the hospital cares about their health.
- It will **eliminate critical issues of lost** or available **films**, and guarantee timely readings by a radiologist, greatly assisting practitioners in diagnosing and treating a patient's condition. It will also allow us to move to a filmless system **reducing costs over time.**
- **Patient reports will be directly available to our providers** via the Electronic Medical Record.
- **Increased quality of care**, better access the records.
- Compliance, accuracy, HIPAA; **identify theft protection.**
- Five businesses benefited because the program provided information for their employees on how to decrease risk factors for hypertension; education for employees on the importance of controlling blood pressure; and screened employees for high blood pressure. **Community businesses were very willing to participate in the worksite program.** In addition the hypertension display at the Go Red event and the County Fair provided education and the opportunity to have blood pressure checked for 500 individuals. Eight County Nutrition Program sites and the Ultimate Gym received blood pressure monitors and training which offers a continued benefit for blood pressure monitoring by the individuals who use the sites.
- Patients will be able to receive more timely and appropriate treatment improving consumer satisfaction with a rapid

turnaround time in reading of studies by the radiologists.

Lessons Learned: Hospitals are asked to reflect on lessons learned as a result of the initiatives undertaken in order to inform others involved in similar activities. The following was shared from critical access hospitals involved in program development activities.

- Health Information Technology related activities:

- New high tech equipment allows nursing staff to meet the needs of our patients.
- Staff able to be more efficient
- We need better information systems.
- It is a challenge getting all computers and printers talking to each other.
- We needed 2 weeks of training from the software company instead of 2 days.
- We learned that this process would be impossible without an IT staffer on site.
- We learned that we have a lot of change that we can still make to become more efficient and have better communication.
- Need to continue to implement IT in our facility.
- When dealing with upgrading technology, always expect unforeseen increases in overall costs due to compatibility of combining various systems.
- Practitioners and patient satisfaction can be greatly increased with upgrades in technology such as the PACS and CR systems. We are providing faster service between the clinics and hospital for lab reports.
- It has modified all our imaging diagnostic procedures in improving

the process of reading and storage of all studies. It has improved the practitioners' ability in diagnosing and treating of a patient's condition. It has improved consumer satisfaction through the rapid turnaround time of reading studies.

- Currently the only increase in service has been the digital x-ray system. However, with a more stable financial picture, services will continue to be provided and increased as needed.
- The Respiratory Therapy Department was developed. The addition of the Vision Bi-Pap system greatly expanded the emergency and hospital services we could offer.
- We were utilizing tapes and Dictaphones which failed frequently. We no longer have to deal with those issues. We redesigned our entire workflow.
- Due to the increase of referrals for transportation needs and a need for consistent communication, a transportation policy was written.
- Added additional security measures into our IT network.
- Our biggest challenge was finding a qualified IT in a timely manner; it took months.

- Community Programming related activities:
 - E-mail was a good way to have weekly contact with the participants to pass on information and encourage compliance. Phone calls were better at increasing compliance. We needed to have more than one person making phone calls.
 - We found that it was difficult to have sessions during the summer. The participants wanted the sessions but vacations interfered with their ability to log their blood pressure daily and have access to the phone or computer.
 - We found that the business owners were very interested in the program and very supportive of their employee's participation. We believe that shows that businesses and employees are interested in worksite wellness activities.
 - We can expand in a lot more ways in outpatient services through our clinic and we should concentrate there.
 - The program had been piloted with hospital employees as part of a wellness effort and the program for the community businesses was patterned after that program. The program was modified at the County Nutrition sites and the Ultimate Gym to include training for the staff at those places rather than having the screenings and presentations because all of the people who use those places would not have been able to attend a screening.

NETWORK ENHANCEMENT

Accomplishments: Four network initiatives were supported (\$54,495).

- Board education for 10 CAHs and Long term care board members.
- A central dictation system was implemented for three facilities networking with one tertiary.
- CAH worked with Faith in Action Program to promote health services. The number of persons receiving access to health-promoting services was increased and the strength and financial sustainability of the Faith in Action program was heightened; 17 new volunteers joined the program, and an additional 44 individuals were added to the list of those receiving services. Hundreds of people were introduced to the services that Faith in Action offers.
- CAH networked with local ambulance to improve patient care and reporting.

Hospital and Community Benefits: The Benefits of Networking....

- Hospital **partnered** with the Co. Health District for smoking cessation resources for the business presentations. The hospital also was a partner with County Health District for the Go Red event for the county with its emphasis on heart health which also includes B/P monitoring and healthy lifestyle promotion.
- The PACS system will improve the tertiary radiologist's ability to read the studies. It will allow the capability to send the studies to other radiologist across the country if needed.
- By networking with the tertiary we have **improved turnaround time and reduced duplication between the facilities.**
- Two hospitals were able to coordinate dates with the consultant from IHC to so we were able to **share in travel expenses.**
- Utilization of staff and resources in a more efficient manner, elimination of duplication,

significantly improved turn-around-time, and cost savings.

- Discussed financial hurdles CAHs face; discussed how ND CAH are working together to gain better reimbursement from Blue Cross/ Blue Shield.
- *Faith in Action* is an extension of our hospital's caring ministry by providing assistance with basic essential services. Because of volunteers providing rides, **individuals have been able to access medical services provided by the hospital and other medical facilities.** The improved networking allows a broader base of support and caring.
- **Timely and unified reporting**
- The patients of the communities who utilize services at these facilities will have dictation available sooner and improved communication to the staff providing hands on care.
- **Improved patient care**
- Due to the increased visibility and awareness of the *Faith in Action* program and the services offered, more people found the help they needed for themselves or for friends and family members. The opportunities to volunteer were known by more people as well and this **resulted in increased numbers of volunteer applicants.** Those that volunteer benefit in ways that cannot be obtained through paid services – they receive an opportunity to make a difference in another person's life. Most volunteers claim that they experience

higher levels of joy and contentment as an added benefit to their volunteer service.

- **Working relationships are much stronger** and we are dependent on each other as we share staff. We found very knowledgeable staff to work with at St. Alexius. We will continue to function as a network on this project and any future feasible projects.
- Sharing experiences and ideas **helps make us feel united and stronger** – “we are all going through the same difficulties.” We may feel like we can call each other to share ideas and thoughts now that we know each other better.
- Our network with community organizations, our Advisory Board, Catholic Health Initiatives, three CAHs, *Faith in Action* – Northern Plains, area faith communities, public health, social services, and human services was strengthened through making intentional contacts and connections with these partners. The additional staff hours that were provided through this grant allowed our office to be staffed full time and allowed a **greater outreach and impact in the community.** These partners became more aware of the value of the *Faith in Action* program and the services we provided and we learned more of the services and strengths of our networking partners.
- Our network was strengthened in the fact that all reports coming into the hospital on patients transferred by ambulance are now unified, which allows for easy understanding by nurses and doctors.

Lessons Learned:

- Advantages of working with other partners to decrease purchase price for each facility.
- We have a limited number of educated and trained staff in a rural setting. We were able to work together and implement a system and truly share staff.
- Technology is expensive and at times unavailable in a rural setting. By partnering with a larger facility, we were able to implement a superior system. The magnitude of this project was made possible by networking.

- We learned the necessity of having 20-30 additional staff hours working to support and expand the services *Faith in Action* can provide. We now know how additional personnel and time contributes to the success of serving more people and increasing volunteer involvement. We have a better understanding of the hours and types of support needed.
- We learned that other communities would very likely benefit from a *Faith in Action* or similar program and that more exploration of this type of service in these communities would be beneficial.
- It is very difficult to get outside entities to understand the importance of different measures we must follow in a hospital setting.
- The installation of the clinical scanning module was different from the installation of the Laboratory Information Software and other clinical software that have been installed. It did not need the intense level of preplanning that has been experienced with past installations. We found however, that detailed information at the time of installation is preferred by our staff. The module was installed and then we spent a great deal of time developing policies and processes on what, how and when to scan. Because this information could not be decided upon at the time of installation, there were many questions by staff that are used to more extensive preplanning processes during software installations. The results were the same but the anxiety was increased.

COMMUNITY ENGAGEMENT

Accomplishments: Two community engagement initiatives were supported (\$20,000).

- County residents were educated on the importance of Critical Access Hospitals. Topics ranging from economics to personal impacts of the local CAH were presented. Residents received flyers in the mail, articles and ads in the local newspaper, as well as opportunities to attend public meetings to become educated about Critical Access Hospitals. The final result was the residents approved a county-wide Hospital District hospital.
- A CAH worked with consultants to prepare a facility master plan and community partner involved to network health, economic development and others.

Hospital and Community Benefit:

- A **hospital district was formed** supporting our CAH with 10 mills of property tax per year. The hospital district will help support the hospital financially to bridge the gap between revenue and expenses.
- This served as a **future plan for healthcare delivery** in our community.
- The residents of our county have chosen to help put the CAH on more stable financial footing. With a more financially stable future, the Medical Center can look to update equipment and expand services to better care for the community members. One service already expanded without even seeing any of the tax money - updating of the x-ray equipment to a digital system which will **reduce duplication** by allowing x-rays to be read by providers at other hospitals.

Lessons Learned:

- Our county residents view local health care as a vital part of their community.
- Many people had misconceptions about how a Critical Access Hospital is run, and although health care is a very complex business, people wanted to understand the basics to ensure survival of their local facility.

MAKING A DIFFERENCE

Accomplishments: One Making a Difference Award (\$20,000) is made each year (since 2004). Two hospitals have been working to build a health information technology in their region. They have slowly worked to build EMRs, sharing services, negotiating with vendors and more. A once small network involving two hospitals has since expanded to include 10 facilities. Funds were used to purchase clinical scanning modules to enhance their EMRs.

Hospital and Community Benefit:

- The hospitals purchased and installed clinical scanning. ER records, radiology reports, EKGs, acute care discharge instructions, have been scanned. This information is now readily available to clinic staff. Staff no longer need to leave the patient's bedside to retrieve records. The addition of clinical scanning has allowed our hospitals to move toward the goal of a fully functional electronic medical record.
- **Information needed for patient care is readily accessible** to the clinic staff without having to go search for the patient's recent records. With the information being easily available, decisions concerning care and thus treatment are able to begin in a **timelier manner** and that ultimately benefits the patient.
- The hospital has many radiology tests that are ordered by outside physicians, however, often these patients also see one of the providers at the local clinic as well. Now it is very easy for the clinic nursing staff and providers to view the reports ordered by other physicians to allow for **continuity of care**. Because staff members are using scanned documents as reference, they are finding fewer errors regarding the spelling of patient's names and date of birth. The billing area is also finding that they are more efficient because they have access to diagnosis and documentation needed to submit claims rather than having to wait for paper copies to be routed.

Lessons Learned:

- We are finding that the more patient information that we make available electronically, the more that the Clinical Staff and Providers want available.
- The installation of the clinical scanning module was different from the installation of the Laboratory Information Software and other clinical software that have been installed. It did not need the intense level of preplanning that has been experienced with past installations. We found, however, that detailed information at the time of installation is preferred by our staff. The module was installed and then we spent a great deal of time developing policies and processes on what, how, and when to scan.

TRAUMA DESIGNATION

Accomplishments: Three awards of \$9,000 each were available in 2007, all of which were awarded (\$27,000). One hospital received trauma designation from the ND Department of Health (Level V); two hospitals submitted application to the ND Department of Health for Level V trauma designation which were pending at the time of this report.

Impact to Relationship with local EMS:

- We have a close working relationship with local EMS and application for trauma center designation has not affected our relationship.
- Our main ambulance service is a part of our facility. Obtaining trauma level designation was a joint venture. **Nursing service and the ambulance service worked together** to make a process which would work for both entities. But it went beyond our local ambulance service as well. It required education to the ambulance services in the surrounding communities as well.
- On June 18th, we experienced unplanned community engagement. The American Crystal Sugar plant had an SO2 spill resulting in an MCI for our hospital and ambulance service. The reaction to the incident was positive with very good patient outcomes. All the agencies worked well together and learned many lessons from the experience. **The community also learned how fortunate they are to have a great community hospital that took the time and effort to become Level V designated.**

Technical Assistance Received:

- Amy Eberle – ND State Trauma Coordinator – was a key resource for us as we worked through this process. Assisting us with the policies necessary, with data collection and submission, with the quality assurance components and the application process.
- The other important person for us was Vicki Black – Trauma Program Coordinator at Altru Health System. She was also a fabulous resource for us and assisted to answer many of our questions.
- We also established rapport with the surrounding rural hospitals as we visited with them to determine how they managed their programs and made them work
- Amy Eberle and Deb Syverson from MeritCare were invaluable resources. Their patience and assistance with our numerous questions were greatly appreciated.

HEALTHCARE EXCHANGE

The ND Flex Program offers support to critical access hospitals who assist each other through peer support. The Rural Healthcare Exchange Program provides travel and stipend support for individuals or small groups to meet with similar entities from other areas of the state and share information, ideas, and successful approaches to improving quality and access to healthcare services.

Accomplishments: This program began in 2007 and received two requests which were funded (\$1,054). One CAH community hosted EMS providers with trauma expertise to share with their staff. Another CAH sent a small team to their tertiary provider to observe the emergency room to better understand processes and develop peer relationships.

Hospital Benefits:

- Will implement some changes in our facility appropriate for rural setting.
- Increased understanding of when LS backup should be called to expedite extra help when needed; and better able to handle trauma calls of unusual nature.
- Information will be used to train our squad members and to provide better patient care for those needing our services. Better education and practice lead to better patient care. Patient assessment pages shared to reinforce the steps needed to complete.

Lessons Learned:

- Able to observe how things are done in a larger facility
- The continuing need for training & education to provide for the best in patient care; practice & continuing education are imperative for the best in patient care.
- Safety first, learned about trauma
- Trauma assessment/management
- How to better assess trauma patients and calling a trauma code
- A lot of different medical patient possibilities
- Reminding all the steps we need to use
- Reviewed medical assessment/management
- Refreshed on the basics of medical assessment and management
- Refresh on patient assessment /medicine sometimes we don't get to see certain calls, it is nice to practice these as a team like we would on a call

Consultant Ratings

Nine of the above-referenced Flex subcontracts involved the use of consultants. Hospitals are asked to rate the consultants used; the results were combined and are reflected in the table below. All respondents said that they would recommend the consultant used by their facility. A list of the consultants used follow.

<i>Area</i>	<i>Mean Rating</i>	<i>Range</i>
Expertise, knowledge, skill level	4.78	4-5
Effective communication of ideas and concepts	4.67	3-5
Responsiveness/availability	4.56	4-5
Utilization of your time and money	4.11	2-5
Overall rating of consultant services	4.67	4-5

Consultants

- Eide Bailley of Fargo, ND (varying staff)
- Independent Healthcare Consultants (Mark Hollan)
- Northern X-ray and St. Alexius Medical Center
- CPI Groups
- Pam Nathan

IV. Evaluation of the ND Flex Program

An important objective of the Flex Program is to evaluate its impact and effectiveness in meeting its goal to support critical access hospitals in their delivery of health care to rural residents. The ND Flex Program approaches this objective in different ways:

- Each year critical access hospitals are asked for suggestions to improve the Flex Program and for general comments of their experience with staff, subcontracts, and technical assistance.
- A semi-annual survey has been administered every other year over the past six years to solicit information from CAH administrators. Twenty-five CAHs (73.5%) responded to the 2008 survey.
 - The Survey is designed to obtain updated information including current operating status and network activity, anticipated changes over the next two years, and the prioritization of issues.

Hospitals were further asked to rate the impact of CAH conversion and to evaluate their use and awareness of Flex Program services.

- Following all Flex supported educational offering, attendees are asked for their feedback of presenters and logistics related to the workshop.
- Lastly, in 2007 the Center for Rural Health, home to the ND Flex Program, developed an activity tracking system. This system allows for program activity tracking across many variables such as hospital, county, grant objective, staff, date, level of support provided and more. This system has proved valuable to the Flex team in identifying its outreach and tracking its efforts.

The following are the results from the aforementioned evaluation efforts.

Suggestions and Comments from CAHs (Annual Inquiry through Subcontract Process)

Flex Grant Program

- Allow funding to be used for physician recruitment and building maintenance cost.
- Thank you for the educational opportunity provided by the grant. This will allow us to put operation improvements in place both for quality and financial!
- I am thankful for the Flex program is available to help us small hospitals pay for the software and etc to move toward an EMR. The Flex Program is an excellent way to pilot programs that have the potential to help communities with wellness activities. For our program, another six months would have helped for us to be able to process the data after we were given additional funding.
- We feel very fortunate that we are able to participate in this project. It has significantly improved working condition and morale in a rural setting.
- More funds available - it's a great program and helps with projects greatly.
- I appreciate the opportunities that the Flex grant has allowed our Center.
- We are grateful for the grant monies. We were able to give all ambulance personnel attending four hours of continuing education. Thank you for helping rural EMS.
- Again, we were grateful for the funds to bring in the best educators to improve our squad's knowledge.
- The Flex grant allowed us to do community outreach that we otherwise did not have funding to do.

Flex Program in General

- This is a great resource for North Dakota hospitals.
- Great program!
- We are appreciative of all it does for rural health care and depend on it. Thanks.
- You do a great job.
- You were all great to work with and we appreciate your support very much. I don't have any suggestions for improvements.

Overall Impact of CAH Conversion (2008 CAH Survey)

- CAH administrators were given a list of 20 ways that conversion may or may not have impacted their organizations; the most positive impact was financial reimbursement as indicated by 19 of the responding CAHs.
- 18 CAHs report their network relationship with the tertiary referral center as having a positive impact since CAH conversion.

- Overall hospital stability was positively impacted as a result of CAH conversion (reported by 18 CAHs) followed by network relationships with other CAHs/hospitals (N=17, flexibility in staffing mid-levels in the emergency department (N=16), and outpatient services (N=15).
- Three CAHs believe their overall hospital stability has been negatively impacted.
- Other areas of potential impact were rated as neutral (e.g. public support for the hospital (N=19), addressing local EMS issues (N=17)).

ND Flex Program Services (2008 CAH Survey)

Eighteen services of the Flex Program were rated by CAHs in order to evaluate the impact and awareness of available resources. As expected, newly offered resources (i.e. communication toolkit, balanced scorecard implementation) ranked highest for “don’t know”. Monthly CAH calls, offered through NDHA, were ranked as least beneficial (12 said they provided “no benefit”).

The most positively ranked feature of the Flex program (N=21) were the grants awarded to CAHs each year. Eleven CAHs view technical assistance such as community needs assessments, staff surveys, and other as having moderate to substantial impact as well as the Flex Program’s main method of communication (Flex Updates and the Flex Webpage).

Receiving technical assistance from the Flex Program was not a problem, as indicated by 23 CAHs.

A complete list of 2007 Flex Program services follow along with CAH rankings of impact for each. Note: Services were provided by one of the Flex Program partners: hospital association, department of health, quality improvement organization, Center for Rural Health.

<i>Flex Program Impacts</i>	Don’t know	N/A	No benefit	Limited	Moderate	Substantial
Assistance with CMS CART Tool	26%	0	16%	21%	32%	5%
Monthly CAH Calls	9%	4%	48%	26%	13%	0
Educational opportunities (workshops, trainings)	0	0	9%	52%	22%	17%
CAH Pre-Conf. at Dakota Conference	17%	4%	13%	39%	9%	17%
Balanced Scorecard Training	23%	46%	0	9%	18%	5%
CAH profiles	18%	8%	0	32%	23%	14%
CAH Quality Network development	17%	8%	0	43%	9%	22%
Flex grants	0	0	0	17%	50%	33%
Access to other federal or private foundation grants	4%	20%	0	46%	17%	12%
Communication toolkit	23%	27%	0	27%	14%	9%
Flex Updates	9%	0	9%	39%	22%	22%
Flex Website	8%	4%	0	44%	30%	13%
Presentations (boards, community groups)	23%	9%	0	32%	18%	18%
Network support	14%	28%	0	24%	19%	14%
Practice site assessments	27%	9%	0	41%	23%	0
CAH designation – rules and regulations	22%	13%	4%	22%	30%	9%
CAH clearinghouse	13%	9%	13%	30%	26%	9%
Technical assistance (e.g. strategic planning, community needs assessments, staff surveys)	9%	9%	0	36%	27%	18%

Network Development and Support

The ND Flex Program has played a role in network development as well as enhancing network activity over its nine year history. This form of assistance is well regarded by North Dakota critical access hospitals who indicated interest in further assistance with organizational development, recruitment and retention efforts, exposure of children to health careers, CAH finance and more.

Responses from the 2008 CAH Administrator survey¹ indicate that network relationships with tertiary referral centers has improved substantially over the past three years. In 2008 CAHs viewed this relationship as:

- **strong** – **66%** (an increase of 12% from 2005);
- **flexible** - **66%** (an increase of 13% from 2005);
- **comprehensive** – **50%** (an increase of 4% from 2005);
- **fostering a sense of trust between providers** – **62%** (an increase of 28% from 2005)

The majority of CAHs (N=19) **are optimistic that this network will grow** and positively impact their hospitals (an increase of 17% from 2005). Quality improvement and staff education are identified as the two most common areas of focus for the CAH/tertiary networks.

Workshop Feedback

Two workshops were supported through the Flex Program funding cycle in 2007-2008. Following are the results and impact for each.

1. Annual CAH Pre-Conference to statewide Dakota Conference on Rural and Public Health

Speaker:	Eric Shell, Stroudwater Associates
Topic:	CAH Finance – “Attributes of Successful Rural Hospitals”
Time:	3 hour intensive
Participants:	63
Cost:	\$5,000 (presenter fees/travel, room, food, materials)

Workshop evaluation results:

- **The workshop achieved the stated educational objectives**
(36% rated this category as excellent, 28% very good, 36% good)
- **The information presented was valuable in increasing participant knowledge and competence in the area**
(45% rated this category as excellent, 28% very good, 28% good)
- **The presentation was organized and provided clarity**
(36% rated this category as excellent, 28% very good, 36% good)
- **The speaker was knowledgeable.**
(45% ranked this category as excellent, 45% very good, 10% good)
- **Overall, the presentation was excellent** (36%), very good (45%), good (19%).

¹ Miller, M. ND CAH and Flex Program Survey Results. July 2008. Available:
http://ruralhealth.und.edu/projects/flex/pdf/2008_survey_results.pdf

Participants were asked to rank their level of knowledge before and after the workshop; the results were favorable with 19% shifting from “novice” to an increased level of understanding.

Level of Knowledge	Before the Workshop	After the Workshop
Novice	19%	0
Slightly knowledgeable	36%	10%
Somewhat knowledgeable	28%	45%
Very knowledgeable	10%	36%
Expert	10%	10%

Comments of the presenter included:

- Eric Shell does an excellent job and is very knowledgeable and passionate about his topics.
- Thanks for bringing Eric to ND.
- I wish Eric would have more time. He is someone I would invite back to the state – even if it is a repeat performance all good information. Thanks!
- Stroudwater Associates – where is quality in the “Attributes of Successful Rural Hospitals”?
- 100% of participants felt that the program was free of commercial bias.

2. TeamSTEPPS for CAHs and Tertiary Network Partners

Speakers:	Katherine Jones, Ph.D., University of NE – lead facilitator
Topic:	Team Strategies and Tools to Enhance Performance and Patient Safety
Time:	2.5 days
Participants:	40 (15 hospitals – 12 CAHs, 3 PPS)
Cost:	\$11,500

TeamSTEPPS was developed by the Department of Defense Patient Safety Program in collaboration with the Agency for Healthcare Research and Quality (AHRQ). TeamSTEPPS is an evidence-based comprehensive system to train health care workers in the skills needed to function as a safe, effective team. Go to <http://www.ahrq.gov/qual/teamstepps/> for additional information about TeamSTEPPS.

Through the ND Center for Rural Health’s relationship with the University of Nebraska on a past medical safety project we were contacted to host this AHRQ funded workshop. The Flex Director connected with the ND Healthcare Review Inc. (the state’s QIO) to partner and gauge interest. Hospital interest was also solicited and plans to provide this training were extensive.

Hospitals that had completed the AHRQ Patient Safety Culture survey in the past were encouraged to utilize the results from that survey to inform their facility-wide planning which measures the culture of patient safety in an organization.

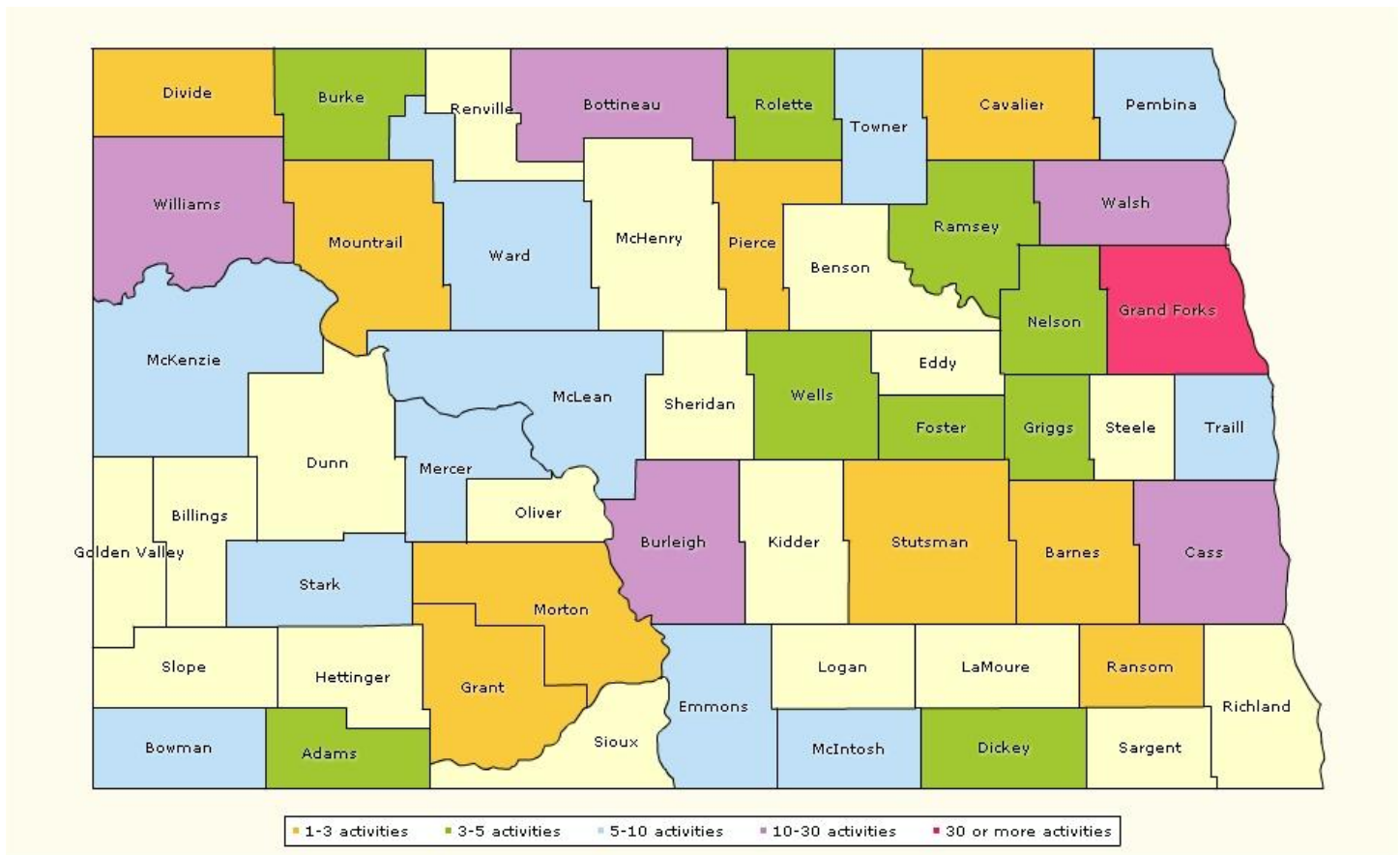
Outcomes of training:

- 40 individuals are Master Trainings of the curriculum in ND; 15 teams prepared to return to their facilities and train others; all curriculum materials and access to on-line videos was provided. Teams completed workplans for next steps prior to finishing the training.
- 15 hospitals working toward implementing varying modules of the evidence-based patient safety curriculum.

- The 15 hospitals that participated continue to share with each other on a monthly call (average of 8-10 hospitals on each month's call); working towards developing a shared community of TeamSTEPPS users.
- 2009 training is underway and master trainers from the 2008 session will assist.

Tracking Program

A query of the Center for Rural Health's Activity Tracking System identified 383 Flex related activities benefiting 35 of the state's 53 counties over this reporting period. The following map reflects those activities by county. Grand Forks County is home to the Flex Program and activities that use teleconference or videoconference are associated with Grand Forks, ND and is the reason for the higher activity level in that county.



V. Summary

The ND Flex Program has accomplished the majority of its intended objectives throughout the year. Critical access hospitals highly value the grant program and continue to demonstrate the importance of local decision making. Valuable partnerships have been established with key stakeholders throughout the state and elsewhere; and, the program has representative committees involved with informing its activities and processes. Staffing has remained stable with the original program director's continued involvement and current program director having 6 years experience with the Flex Program.

The Flex Program continually seeks to adjust and adapt to the changing needs of the healthcare environment. Evaluation is a continual process, the results of which have shaped the program over the years. The next year brings significant focus to strategic planning for the purpose of developing a Flex and CAH state rural health plan. Meeting the needs of critical access hospitals is a priority and sharing the Flex program's story, its accomplishments and challenges, is an important component to maintaining this highly valued and needed program.