



Rural Hospital Flexibility Program

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Historical Perspective

- From 1980 to 1991 over 350 rural hospitals were closed.
- The Inpatient Prospective Payment System (PPS) led to the decline in the numbers of rural hospitals.



Critical Access Hospitals Program

- **Critical Access Hospitals (CAHs) are based on the experience of the Medical Assistance Facility (MAF) Demonstration Project in Montana and the EACH/RPCH Demonstration Project.**



The Rural Hospital Flexibility Program

- The Balanced Budget Act of 1997 (BBA) established the Medicare Rural Hospital Flexibility Program (Flex Program).



The Rural Hospital Flexibility Program

- **The Flex Program consists of two separate but complementary components:**
 - **A State grant program administered by ORHP to support the development of community-based, rural, organized systems of care in the participating States.**
 - **Cost-based reimbursement for certified Critical Access Hospitals (CAH)**



The Rural Hospital Flexibility Program

- Grants to States
- \$25 Million a Year Focus on CAH Conversion, Quality, EMS Integration and Networking
- Supports the Technical Assistance Services Center (TASC)
- Supports the Flex Monitoring Project



Original Flex Program Goals

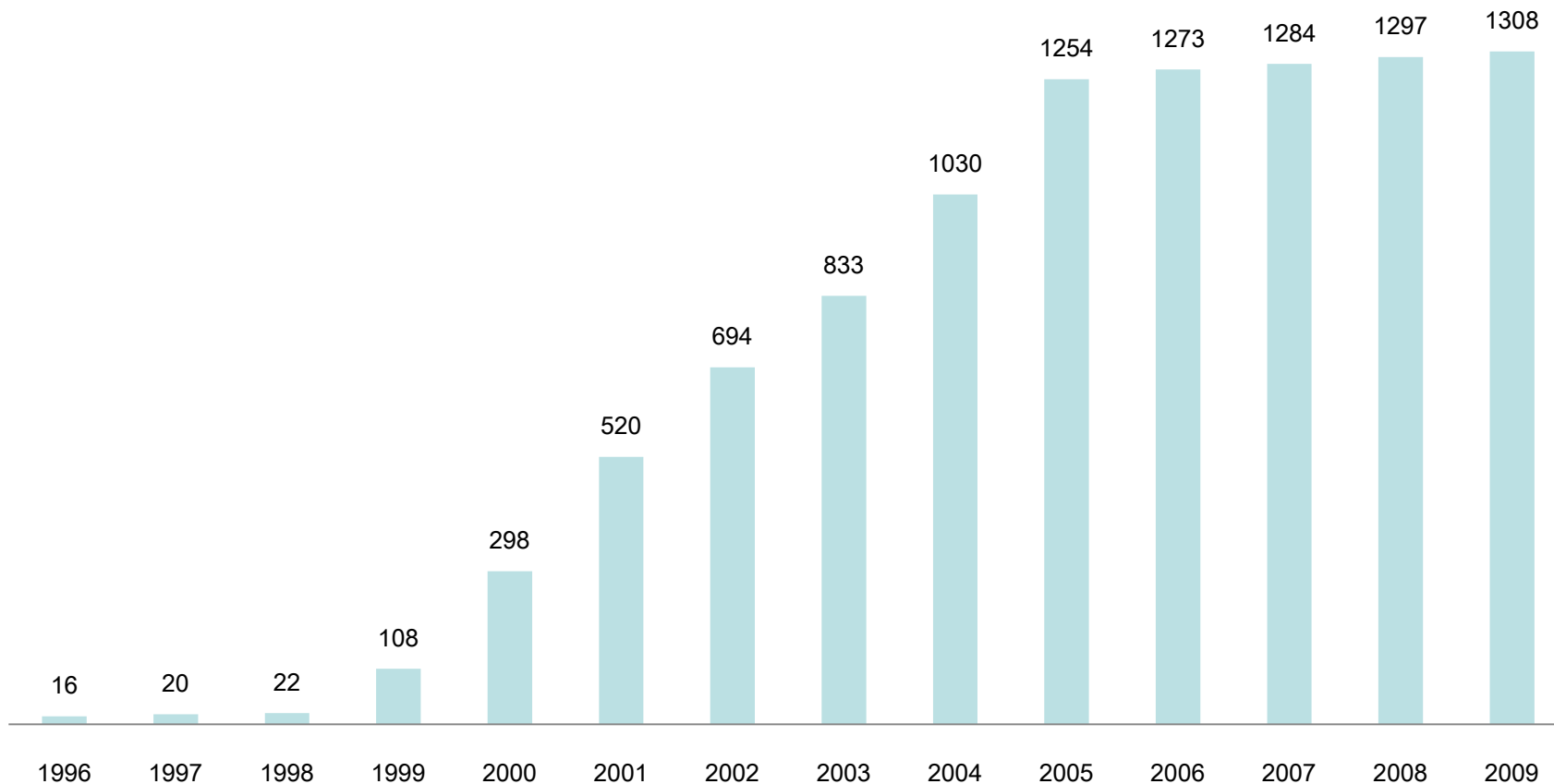
- Development of State Rural Health Plan (SRHP)
- Designation of CAHs in the State
- Development and Implementation of Rural Health Networks
- Improvement and Integration of EMS Services
- Improving Quality of Care

Sunset of Necessary Provider Waiver



A State may designate a facility as a critical access hospital if the facility... is certified before January 1, 2006, by the State as being a necessary provider of health care services to residents in the area.

Total CAHs Certified by Year





The Future of Flex

- Virtual end of conversions.
- Where are we now?
- What comes next?

Where are CAHs?

- There are 1,316 CAHs currently certified as of July 2010
- The number of CAHs per State ranges from 3 to 83
- Five States (CT, DE, MD, NJ and RI) do not have certified CAHs



How Big a Part of the Health Care System?

- Total Community Hospitals = 5,010
- Number of Rural Community Hospitals = 1,998
- Total CAHs (July 2010) = 1,316
 - 26% of all Community Hospitals
 - 65% of all Rural Hospitals

Source: ***Fast Facts on US Hospitals, American Hospital Assoc.***
Updated November 11, 2009



MEDPAC Report

- “Medicare’s cost-based payments to CAHs were roughly \$7 billion in 2007, representing 5 percent of all Medicare inpatient and outpatient payments to hospitals.”
- Roughly \$1.5 billion more than PPS payments would have been.
- Total Medicare Expenditures in 2007=\$432.2 billion



**DEPARTMENT
of HEALTH
and HUMAN
SERVICES**

Fiscal Year
2011

Health Resources and
Services Administration

*Justification of
Estimates for
Appropriations Committees*

“Within the total amount requested for Rural Health activities, the Budget includes \$79 million to continue the President’s initiative to improve rural health. The goal for of this initiative is to improve the access to and quality of health care in rural areas.

The Improving Rural Health Initiative: Key Elements

■ Health Workforce Recruitment and Retention



■ Building a Programmatic “Evidence-Base”



■ Telehealth/HIT Coordination



■ Cross Governmental Collaboration



Flex Program Guidance

1. Support for Quality Improvement
 - Flex Programs are required to support efforts to improve and sustain the quality of care provided by CAHs
 - Health information technology (HIT) can be used as a tool to help improve the quality of care provided by CAHs.

Flex Program Guidance

2. Support for Operational and Financial Improvement
 - Flex Programs are required to support efforts to improve CAH financial and operational performance improvement.

Flex Program Guidance

3. Support for Health System Development and Community Engagement
 - Flex Programs are required to support efforts to assist CAHs in developing collaborative regional or local systems of care, addressing community needs, and integrating EMS in those regional and local systems of care.

Flex Program Guidance

4. Facilitate Conversion of Small Rural Hospitals to CAH status
 - In accordance with current statute, State Flex Programs are expected to facilitate appropriate conversion of small rural hospitals to critical access status. Flex programs must assist hospitals in evaluating the effects of conversion to critical access status.



Summary of Flex Program Quality Improvement Activity in the Study States*

SUPPORT FOR CAH PARTICIPATION IN QUALITY MEASUREMENT, REPORTING, AND BENCHMARKING

- 1) Support for CAH participation in *Hospital Compare States* : *Georgia, Washington*
- 2) Support for CAH participation in other individual or multi-state performance and quality reporting and benchmarking initiatives
States: Alaska, Nevada, Kansas, Idaho & Nebraska

* *Flex Monitoring Team Briefing Paper No. 25*

Models For Quality Improvement In Critical Access Hospitals: The Role Of State Flex Programs
March 2010



BUILDING QUALITY AND PATIENT SAFETY IMPROVEMENT SYSTEMS AND CAPACITY

Multi-Hospital Patient Safety And Quality Improvement Programs

Support for Patient Safety Initiatives
Inpatient and Outpatient Quality Improvement
EMS Quality Improvement
Performance Improvement Networks
Peer Review Programs
Hospital Surveys

States

Idaho, Nebraska

Georgia

Arizona, Washington

Montana

Washington, Georgia

Kansas, Nevada



Quality Improvement Education and Training Programs

1) Quality Improvement Training

States: *Alaska, Arizona, Montana*

2) Executive Fellowship Program

States: *Nebraska*

CMS Quality Efforts

- Hospital Compare is a consumer-oriented website that provides information on how well hospitals provide recommended care to their patients. On this site, the consumer can see the recommended care that an adult should get if being treated for a heart attack, heart failure, or pneumonia or having surgery.

CMS Quality Efforts

- Never events are 28 occurrences on a list of inexcusable outcomes in a health care setting. The list was compiled by the National Quality Forum. They are defined as "adverse events that are serious, largely preventable, and of concern to both the public and health care providers for the purpose of public accountability.

What Happens to CAHs?

- CAHs may soon be compared with their urban counterparts to ensure public confidence in their quality of health services



Multi-State Quality Improvement Project (MSQIP)

- Grantees can also elect to use Flex funding to take part in a special multi-grantee project focused on Medicare Beneficiary Health Status improvement. The Flex program and the CAH designation were created in 1997 to ensure access to appropriate inpatient, outpatient, skilled nursing and emergency services in isolated communities. By taking part in this special initiative, grantees can help demonstrate how the Flex program improves access to quality care for Medicare beneficiaries served by CAHs.



Benefits of Participating in MSQIP

- Engage in quality improvement initiatives
- Improves patient care across a broad population
- Improves hospital services, administration and operations
- Allows for clear benchmarking and the identification of best practices
- Receive technical assistance regarding cutting edge quality improvement tools and models
- Prepare CAHs for the where CAHs will likely have to report measures
- Fulfills the QI portion of the Flex Grant



CMS Hospital Compare

~Process Measures

Outcome Measures



Questions....

Are these rural-appropriate measures?

Do they represent the quality provided in CAHs?

Will they “drive” quality improvement in rural hospitals?



Phase 1

(Sept. 2011)

Reporting data...
Finding and using value...
(best practices / best methods)

Pneumonia Process of Care Measures

Percent Pneumonia Patients:

- Assessed and Given Pneumococcal Vaccination
- Whose Initial Blood Culture Was Performed Prior to the Administration of the First Hospital Dose of Antibiotics
- Given Smoking Cessation Advice / Counseling
- Given Initial Antibiotic(s) within 6 Hours After Arrival
- Given the Most Appropriate Initial Antibiotic(s)
- Assessed and Given Influenza Vaccination

Heart Failure Process of Care Measures

Percent Heart Failure Patients:

- Given Discharge Instructions
- Given an Evaluation of Left Ventricular Systolic Function
- Given ACE Inhibitor or ARB for Left Ventricular Systolic Dysfunction (LVSD)
- Given Smoking Cessation Advice / Counseling



Hospital Outcome of Care Measures

- **30 Day Readmissions:**

(Shows how often patients are readmitted within 30 days of discharge from a previous hospital stay for heart failure, or pneumonia.)



Phase 2

(Sept. 2012)

Adding Out-Patient Measures (Benchmarking IP Measures)

HCAHPS

Out-Patient Measures

- **OP-1** Median Time to Fibrinolysis
- **OP-2** Fibrinolytic Therapy Received Within 30 Minutes of ED Arrival
- **OP-3** Median Time to Transfer to Another Facility for Acute Coronary Intervention
- **OP-4** Aspirin at Arrival
- **OP-5** Median Time to ECG
- **OP-6** Timing of Antibiotic Prophylaxis (Prophylactic Antibiotic Initiated Within One Hour Prior to Surgical Incision)
- **OP-7** Prophylactic Antibiotic Selection for Surgical Patients

Out Patient Chest Pain Measure

- Principal diagnosis or other diagnoses of chest pain
- Eligible for 2 OP Measures
 - OP-4: Aspirin on Arrival
 - OP-5: Median time to ECG





Hospital Consumer Assessment of Healthcare Providers and Systems (HCAHPS)

- 34% of CAHs reported HCAHPS patient assessment of care survey data in 2008.
- On average, CAHs have significantly higher ratings on HCAHPS measures than all US hospitals.

Policy Brief #15 March 2010

Critical Access Hospital Year 5 Hospital Compare Participation and Quality Measure Results

Michelle Casey, MS, Michele Burlew, MS, Ira Moscovice, PhD

University of Minnesota Rural Health Research Center



Phase 3

(Sept. 2013)

ED Patient Transfer Communication Measure

- NQF Endorsed...
- FR Notice for Public Comment
- Hopefully CMS Approved Measure by then!

ED Patient Transfer Communication*

- Pre-Transfer Communication Information (0-2)
- Patient Identification (0-6)
- Vital Signs (0-6)
- Medication-Related Information (0-3)
- Physician or Practitioner Generated Information (0-2)
- Nurse Generated Information (0-6)
- Procedures and Tests (0-2)

* NFQ Endorsed



Are these rural-appropriate measures?

*Do they represent the quality provided in
CAHs?*

*Will they “drive” quality improvement in rural
hospitals?*



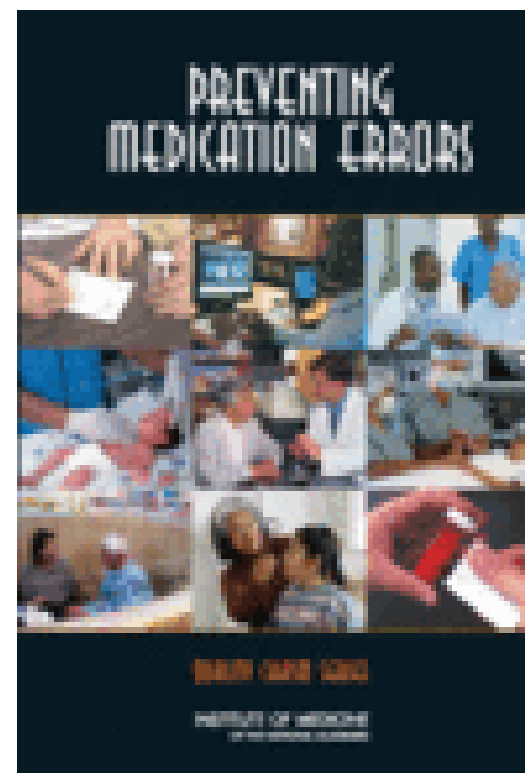
Measuring Quality VS Driving Quality

**Where can the most improvement
actually be made....**

...then measured and reported?

“...a hospital patient can expect on average to be subjected to more than one medication error each day.”

July 20, 2006



Medication Errors

(the most common medical error)

The human cost....

- *Harm at least 1.5 million people/year*
- *Average of 7% of all hospital patients suffer an adverse drug event (ADE)*
- *Over 7,000 ADE deaths/year*

Medication Errors

(the most common medical error)

The economic cost...

- *US spends \$3.5 billion/year to treat drug related injuries.*
- *Increased length of stay (“never pay” rules)*
- *Possible litigation;*
- *Affects the “bottom line” of the hospital.*

Medication Errors

(the most common medical error)

The public relation cost...

- *“Word of mouth” – the “by-pass” factor*
- *The “6 O’Clock NEWS”*
- *The deleterious impact on staff;*

Also...

- *Affects the “bottom line” of the hospital.*



Phase 3

(Sept. 2013)

***Pharmacist CPOE or Verification of
Medication Orders within 24 hours***

(meets HER “Meaningful Use” criteria)

Pharmacist Review of Orders

- **Potential Drug-Drug Interactions**
- **Patient Allergies / Sensitivities**
- **Appropriate Drug / Dose / Frequency**
- **Accuracy of order entry / transcription**
- **Therapeutic monitoring / recommendations**
- **Formulary substitution**

??? The Project ???

- **Across Multiple States**
- **Involving significant number of CAHs**
- **Aggregating the data – national benchmarking.**
- **Rural Appropriate Measures & Processes**
 - Heart Failure, Pneumonia, (30 Day Re-admissions)
 - OP Measures , HCAHPS
 - Ed OP Transfer Measure, Med Orders Reviewed within 24 hours



Rural Community Hospital Demonstration Program

- CMS will extend the Rural Community Hospital Demonstration for 5 years to include up to 30 hospitals. A hospital must meet the eligibility requirements and be located in one of the designated rural States. Applications are due to CMS by October 14, 2010.



Eligibility for the Rural Community Hospital Demonstration Program

- Hospitals must be located in one of the 20 states with the lowest population density. These States are: Alaska, Arizona, Arkansas, Colorado, Idaho, Iowa, Kansas, Maine, Minnesota, Mississippi, Montana, Nebraska, Nevada, New Mexico, North Dakota, Oklahoma, Oregon, South Dakota, Utah, and Wyoming.
- Is located in a rural area (as defined in section 1886(d)(2)(D) of the Social Security Act (42 U.S.C. 1395ww(d)(2)(D)) or treated as being so located pursuant to section 1886(d)(8)(E) of the Act (42 U.S.C. 1395ww(d)(8)(E)));
- Has fewer than 51 acute care beds, as reported in its most recent cost report
- Makes available 24-hour emergency care services; and
- Is not eligible for CAH designation, or has not been designated a CAH under section 1820 of the Social Security Act.

What is a Rural Community Hospital?

- A Hospital that is NOT located in a Metropolitan Statistical Area.

OR

- An official document that shows that your *hospital* is reimbursed by Medicare on the basis of a *rural* designation
- A Hospital that IS located in a Rural Census Tract inside a Metropolitan Statistical Area.
- <http://datawarehouse.hrsa.gov/RuralAdvisor/>



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