

Minnesota Flex Program Evaluation 2008

August 2008

The Financial Status of Minnesota's CAHs: Successes, Challenges, Needs, and Recommendations

Over the past nine years, the Minnesota Department of Health, Office of Rural Health and Primary Care, as part of its Medicare Rural Hospital Flexibility (Flex) Program, has been working to convert small rural hospitals to Critical Access Hospital (CAH) status and support and sustain CAHs. This has been accomplished through providing CAHs with direct technical assistance, workshops and training, contractual arrangements with CAHs, and developing and making available tools and resources as well as through cost-based reimbursement from Medicare and Medicaid. This study was completed to understand the impact of this support, to identify the financial success and challenges of CAHs, and to discuss opportunities to further improve their long-term viability.

To accomplish this, an analysis of the Flex Program Monitoring Team's financial performance indicators for Minnesota CAHs was completed. This included: analyzing data available for all of the indicators, reviewing the overall financial status of Minnesota's CAHs and how this has changed, interviewing CAH administrators to discuss their hospital's financial strengths and weaknesses, and identifying the technical assistance and resource needs of CAHs. Using this approach, the study found that overall CAHs' financial status has improved; however, some CAHs continue to struggle. In addition, although financially challenged hospitals have some unique issues that could be addressed by the Flex Program, all CAHs, regardless of financial status, express concern about health care provider recruitment.

Medicare Rural Hospital Flexibility Program

The Medicare Rural Hospital Flexibility Program (Flex Program) was established through the Balanced Budget Act of 1997. It is a national program that includes Minnesota and 44 other states. The Flex Program comprises two components—grants to assist states in implementing state specific program activities and an operating program, which provides cost-based Medicare reimbursement to hospitals that convert to Critical Access Hospital (CAH) status. The U.S. Department of Health and Human Services (DHHS), Health Resources and Services Administration, Office of Rural Health Policy administers the grant program. The operating component of the program is administered by the Centers for Medicare and Medicaid Services (CMS), also located in DHHS.

Six priority areas have been established for states implementing the Flex Program:

- Creating and implementing a state Rural Health Plan
- Converting hospitals to CAH status and supporting CAHs
- Fostering and developing rural health networks
- Enhancing and integrating rural Emergency Medical Services (EMS)
- Improving the quality of rural health care
- Evaluating Flex Program activities and related outcomes.

There are 79 CAHs in Minnesota, 3rd highest of all states (the national average is 28.6 per state).¹ Minnesota's Flex Program has averaged \$681,682 in funding per year by the federal Office of Rural Health Policy to support its program. This is the highest level of funding of all states.

Methods

This study included three data collection, analysis, and review components: CAH financial data review and analysis, CAH administrator interviews, and CAH administrator report findings review. The intent of this study was to use the national Flex Monitoring Team's Minnesota financial data to identify the financial successes and challenges of CAHs as well as to discuss opportunities to further improve CAHs' long-term viability.² The study was completed between March and August 2008 and included information on 61 CAHs in the state.

CAH Financial Review and Analysis

Data included in the study were obtained from the Flex Monitoring Team through the Minnesota Flex Program. The data are based on 20 indicators that fall under six financial domains: profitability, liquidity, capital structure, revenue, cost, and utilization. Since 2005, the Flex Program Monitoring Team has published an annual *CAH Financial Indicators Report* on all CAHs in the United States, as well as a *Statewide Financial Performance Report* on all CAHs in each state, on a state-by-state basis. Data used by the Flex Monitoring Team for these reports are sent to each state to allow for additional analysis and reporting. This data along with the Flex Monitoring Team's CAH Financial Indicators Report: Summary of Indicator Medians by State, August 2007, served as the basis for this report.

The Flex Monitoring Team uses CAHs' Medicare cost report data for its analysis and reporting. Data used are from CAHs' cost reports from 2001 to 2006 depending on when the hospital converted to CAH status. For example, if a CAH converted in 1999, their financial data dates back to 2001 and five years of financial indicator data are available for that CAH. If the CAH converted in 2004, one year of financial data is available for that CAH. In some instances, Medicare cost report data were not available for some of the CAHs and/or for some of the indicators for all years; however, in Minnesota, the average number of years that data were available per CAH was three.

As stated, Flex Program Monitoring Team data are presented on 20 indicators; however, a survey of CAH administrators and health care experts suggests that some indicators hold greater relevance in predicting the financial health of a CAH.³ Therefore, a weighted ranking process was used to prioritize indicators and to allow for the identification of high and low financially performing CAHs. The weighted ranking used for this analysis was based on a survey of CAHs completed by the Flex Monitoring Team, as well as a survey of CAHs completed by Rural Health Solutions, both of which identified a similar list of ranked indicators: total margin, days cash on hand, days revenue in accounts receivable, cash flow margin, and full-time equivalents per adjusted occupied bed.⁴ All other indicators were ranked equally. Using this approach, the top eight highest performing CAHs as well as the lowest eight performing CAHs, based on financial status, were identified.

¹ Flex Program Monitoring Team, <http://www.flexmonitoring.org> reporting October 5, 2006 figures, [retrieved April 2007].

² The Rural Health Research Centers at the Universities of Minnesota, North Carolina-Chapel Hill, and Southern Maine (the Flex Monitoring Team), are the recipients of a five-year cooperative agreement award from the federal Office of Rural Health Policy to continue to monitor and evaluate the Medicare Rural Hospital Flexibility Grant Program (Flex Program).

³ Financial Indicators for Critical Access Hospitals. Flex Monitoring Team. May 2005.

http://www.flexmonitoring.org/documents/BriefingPaper7_FinancialIndicators.pdf [retrieved online August 2008].

⁴ A description of the weighted ranking used is included as Appendix B.

Given that financial data were not available on all CAHs, for all indicators, for all years, a number of data issues existed during this analysis; however, since the intent of this study was not to identify and report on CAHs' financial status and/or the ranking of CAHs' by their financial status but rather to identify financial trends, successes, challenges, and recommended next steps for the Minnesota Flex Program, the data available met those purposes.

CAH Administrator Interviews

Interviews with CAH administrators were used as part of this CAH financial study to better understand the current financial status, successes, challenges, and needs of Minnesota's CAHs. Although interviews were attempted with 16 CAH administrators (top eight and bottom eight financially performing hospitals), interviews were conducted with CAH administrators in the top seven and bottom five financially performing CAHs. The CAH administrators were asked to: 1) confirm the financial data used in the analysis, 2) report any changes in their financial status dating back to the last year that financial data were available, 3) identify challenges that have contributed to their hospital's financial status and/or factors that have led to their success, and 4) identify steps the Flex Program should take to best address CAHs' long-term financial viability. In addition, for hospitals identified as one of the top eight performing CAHs, they were also asked to identify their top three "best practices" for any CAH that continues to struggle financially. For those hospitals identified as one of the bottom performing CAHs but reporting a positive trend in their financial indicators over the past two years, they were also asked to report the activities/factors that they believe are/have contributed to this change. Each CAH administrator interview was conducted by telephone in July and August 2008. The interviews were 30 minutes to 1.25 hours in duration, depending on the CAH.

Additional Input

To ensure the findings of this study reflect the intent, needs, concerns, and recommendations of the high and low performing CAHs, this report was emailed to all 16 CAH administrators for additional input and comments. Therefore, their input, recommendations, and feedback are included as part of this report.

Financial Status of CAHs in Minnesota

The financial health of any organization, including CAHs, is measured by a number of indicators over time. To better understand the financial well-being of CAHs in Minnesota and how this may or may not be changing, an analysis of 20 financial indicators was completed, focusing on five key indicators: total margin, cash flow margin, days revenue in accounts receivable, days cash on hand, and FTEs per adjusted occupied bed. The analysis considered state versus national trends and trends among Minnesota's CAHs related to the highest performing CAHs, lowest performing CAHs, averages for all CAHs, and the percentage of CAHs performing below average for each year. Below is a summary of each of the five key financial indicators as well as charts depicting CAHs' financial trends over the past six years.

Chart Key:

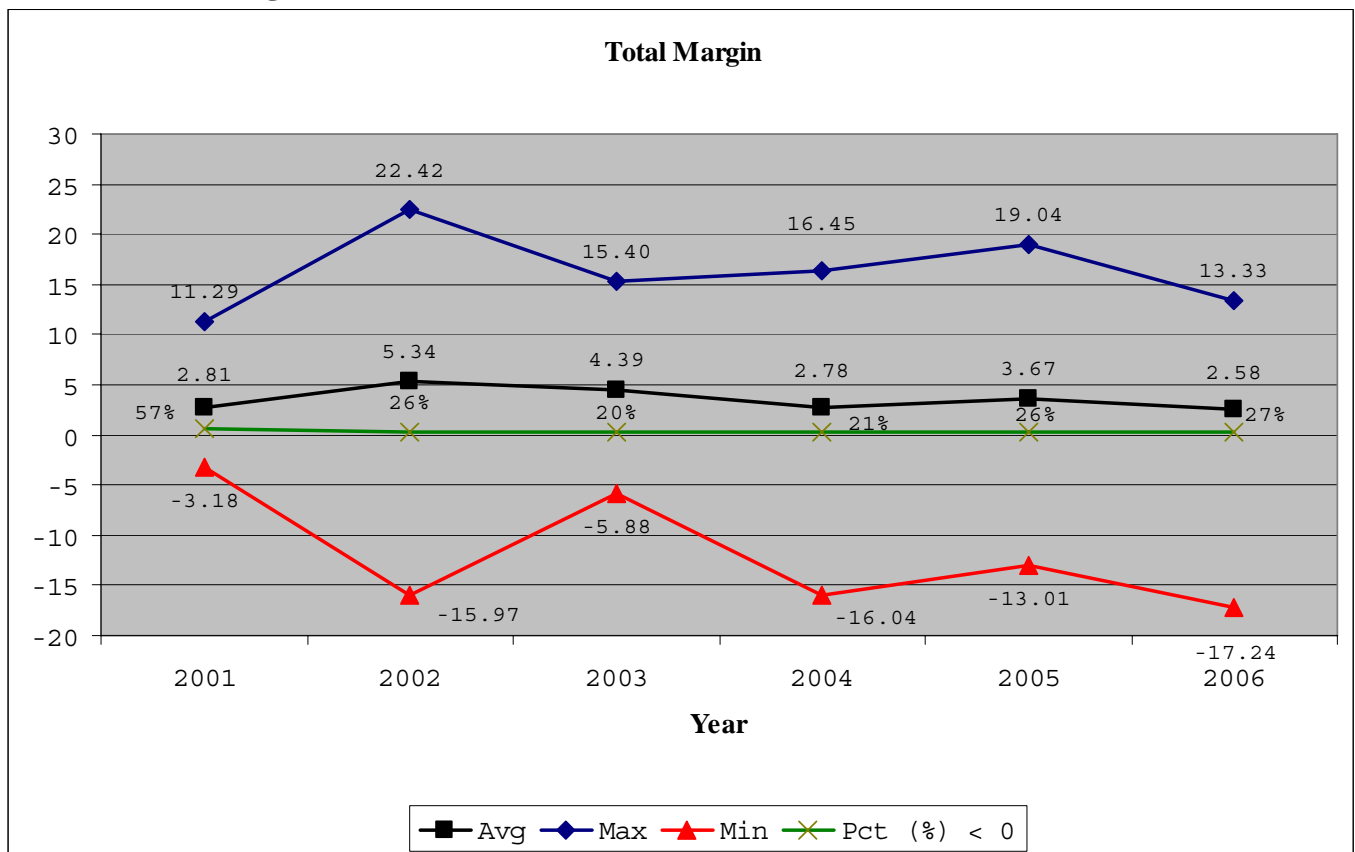
- Avg = Average rate for all CAHs reporting for that year.
- Max = The highest rated CAH of all CAHs reporting for that year and for that indicator.
- Min = The lowest rated CAH of all CAHs reporting for that year and for that indicator.
- Pct (%) < 0 = The percent of CAHs reporting for that year whose rating falls below 0.
- Pct (%) < Avg = The percent of CAHs reporting for that year whose rating falls below the average rating for all CAHs, for that indicator, for that year.
- CAHs Included in Analysis: 2001 n= 7, 2002 n=19, 2003 n=42, 2004 n=43, 2005 n=57, 2006 n=26.

Total Margin

Total Margin is used to measure the control of expenses relative to revenues. It is calculated by net income divided by total revenue. A higher total margin is preferable. Considering changes in Minnesota CAHs' total margins over the past six years by using data as reported by the Flex Monitoring Team and as indicated in Chart 1, the following findings were identified:

- Minnesota's 2006 median total margin was greater than that of CAHs nationally.
- The average annual total margin for CAHs in Minnesota has ranged from a high of 5.34 in 2002 to a low of 2.5 in 2006.
- The percent of CAHs with a total margin of less than 0 has not gone below 20 percent of CAHs over the past six years.
- Three CAHs have had a negative total margin for all years that financial data are available.
- 25 CAHs have had a negative total margin over the past six years.
- While CAHs' total margins can vary greatly from year-to-year (e.g., 22.42 one year and 8.94 the next), one CAH has had three years where their total margin was above 10.0.
- The gap between the lowest performing CAH and highest performing CAH has changed little over the past six years, with the gap being the least in 2003.
- Hospital size was not a determinant of having a higher or lower total margin.

Chart 1: Total Margin

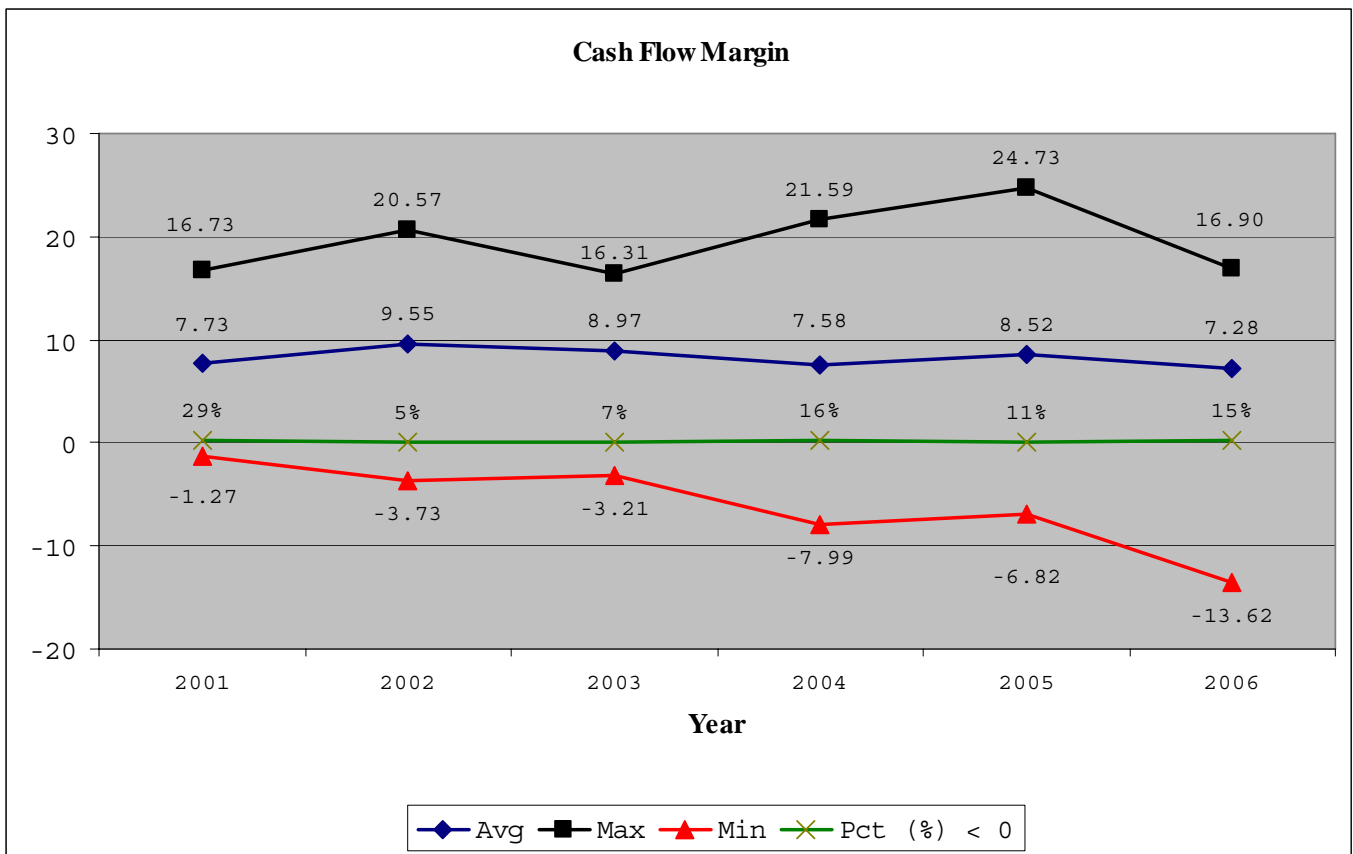


Cash Flow Margin

Cash flow margin measures the ability to generate cash flow from providing patient services. A higher cash flow margin is preferable. Considering changes in CAHs' cash flow margins over the past six years, by using data as reported by the Flex Monitoring Team and as indicated in Chart 2, the following findings were identified:

- Minnesota's median cash flow margin (8.10) is significantly higher than the national median (4.73).
- The average annual cash flow margin for CAHs in Minnesota has ranged from a high of 9.55 in 2002 to a low of 7.28 in 2006.
- The percent of CAHs with cash flow margins below zero has fluctuated but appears to be increasing.
- Seventeen CAHs in Minnesota have had at least three consecutive years where their cash flow margin was above 8.0.
- Three CAHs in Minnesota have had at least three consecutive years where they were unable to obtain a positive cash flow margin.

Chart 2: Cash Flow Margin

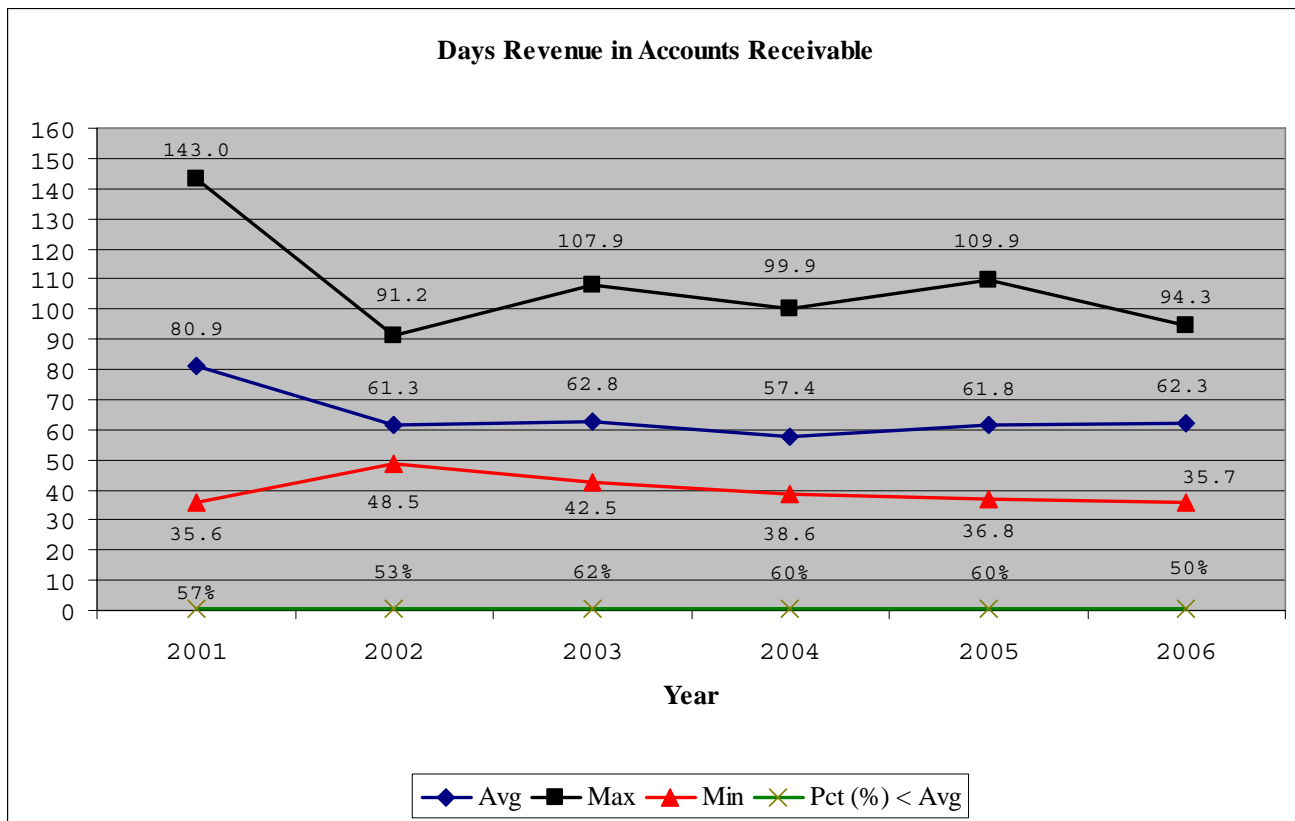


Days Revenue in Accounts Receivable

Days revenue in accounts receivable (days in A/R) measures the number of days that it takes an organization to collect its receivables. The less time it takes to collect receivables the better the financial status of an organization. Considering changes in CAHs' days in A/R over the past six years, by using data as reported by the Flex Monitoring Team and as indicated in Chart 3, the following findings were identified:

- Minnesota's median days in A/R (57.22) is just slightly below the national median (57.4).
- The average annual days in A/R for CAHs in Minnesota has ranged from a high of 80.9 in 2001 to a low of 57.4 in 2004.
- The percent of CAHs with days in A/R above the state's annual average has been fairly stable and declined significantly in 2006.
- Three CAHs in Minnesota have had at least three consecutive years where their days in A/R were below 50 days.
- Four CAHs in Minnesota consistently have issues with days in A/R.

Chart 3: Days Revenue in Accounts Receivable

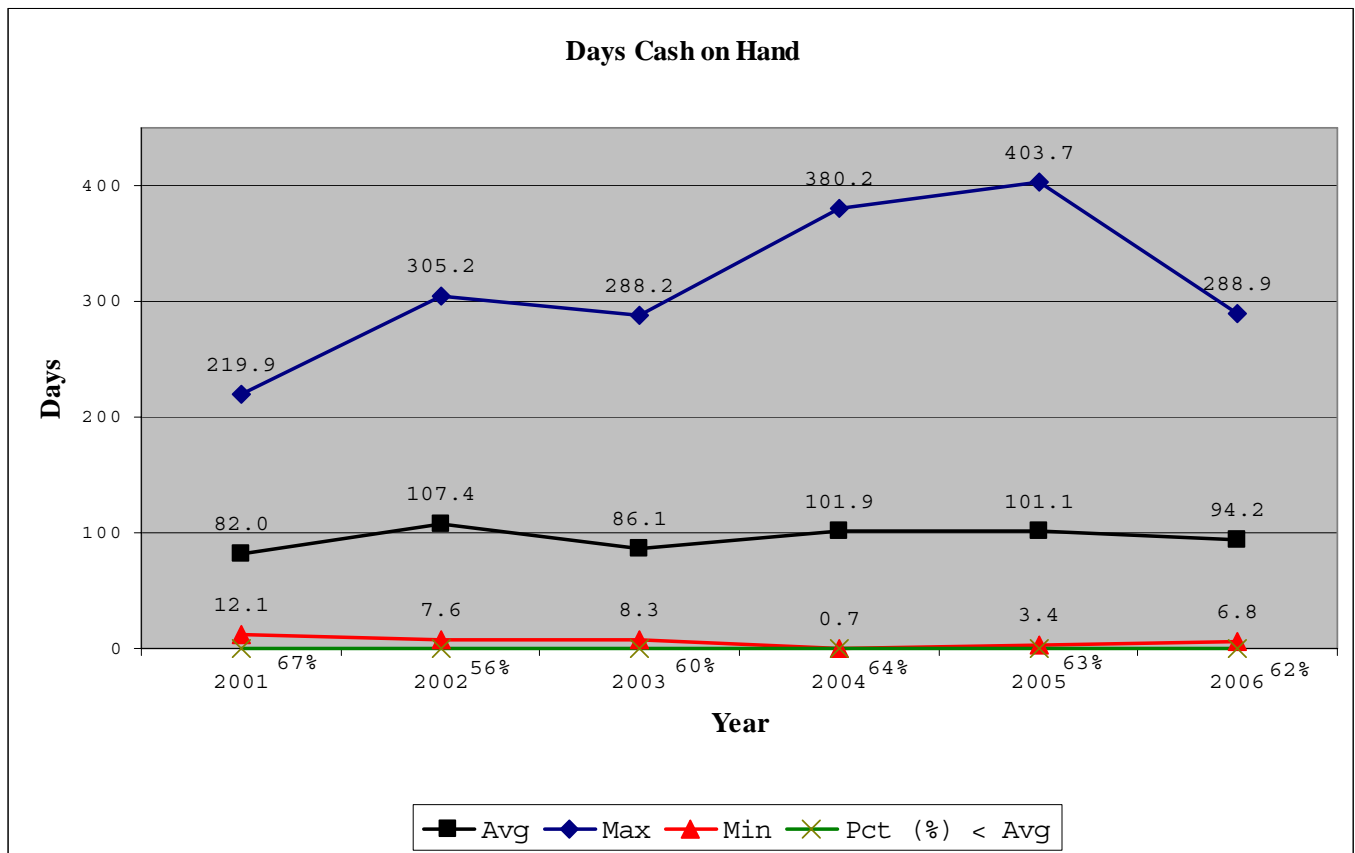


Days Cash on Hand

Days cash on hand measures the number of days an organization can operate if no cash was collected or received. The higher the number of days cash on hand, the better the financial status of an organization. Considering changes in CAHs' days cash on hand over the past six years, by using data from the Flex Monitoring Team and as indicated in Chart 4, the following findings were identified:

- Minnesota's median days cash on hand (69.41) is higher than the national median (53.42).
- The average annual days of cash on hand for CAHs in Minnesota has ranged from a high of 107.4 in 2002 to a low of 82.0 in 2001.
- The percent of CAHs with days cash on hand below the state annual average has been fairly stable.
- Although some CAHs report a significant number of days cash on hand (e.g., 300 plus days), for most this is a result of preparations for large hospital capital improvement projects.
- Fourteen CAHs in Minnesota have had at least three consecutive years where their days cash on hand was below 50 days.
- Two CAHs in Minnesota consistently have issues with days cash on hand (less than 15 days).

Chart 4: Days Cash on Hand

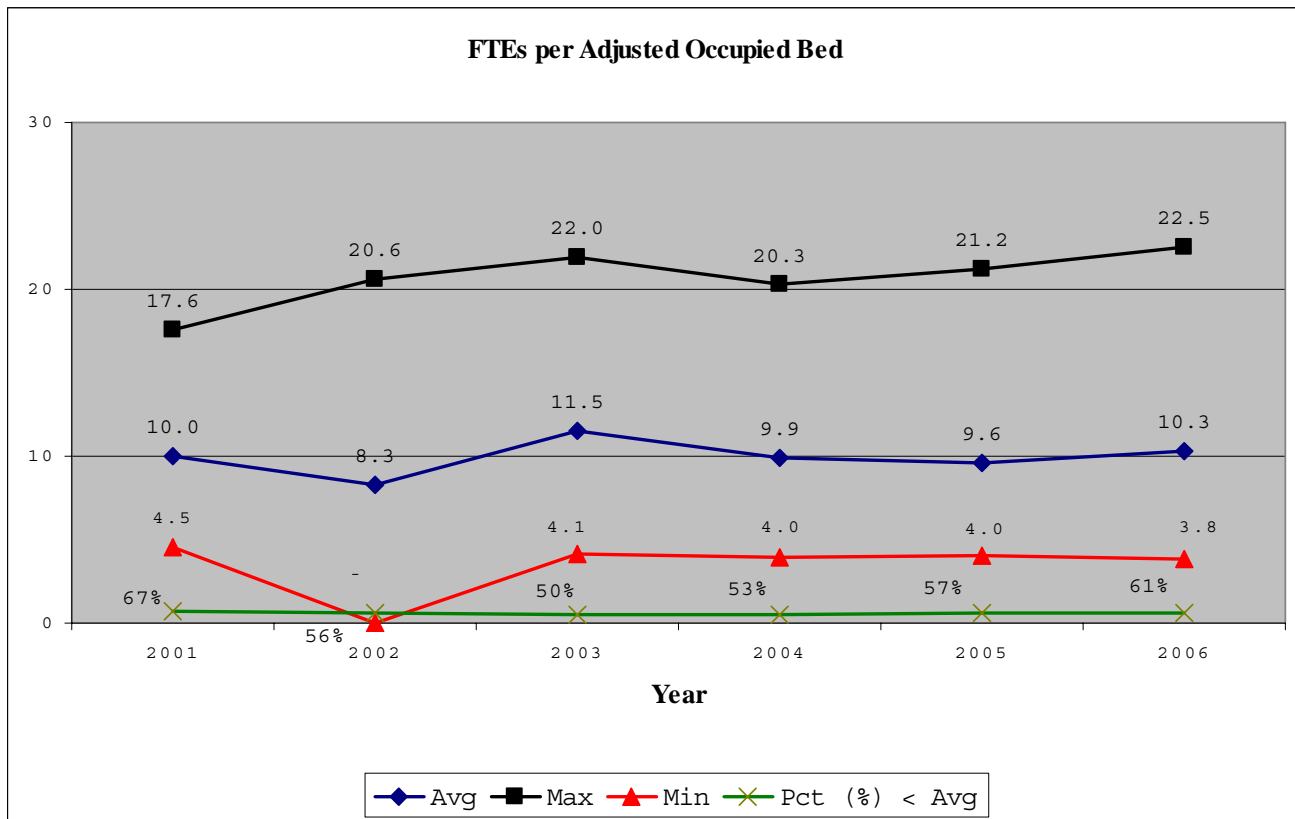


FTEs Per Adjusted Occupied Bed (AOB)

FTEs (full time equivalents) per adjusted occupied bed (AOB) measures the number of FTEs per each occupied bed. Lower FTEs per AOB are considered preferable; however, no national benchmark was identified through this study’s research. Considering changes in FTEs per AOB over the past six years, by using data from the Flex Monitoring Team and as indicated in Chart 5, the following findings were identified:

- Minnesota’s median FTEs per AOB (8.62) is higher than the national median (5.92).
- The average annual FTEs per AOB for CAHs in Minnesota has ranged from a high of 11.5 in 2003 to a low of 8.3 in 2002.
- The percent of CAHs with FTEs per AOB below the state annual average has been increasing since 2003.
- In general, Minnesota’s smallest CAHs had lower FTEs per AOB as compared to its larger CAHs.
- Five of the “top performing” CAHs had an average FTE per AOB of 4.80 or less over the six-year period.
- CAHs without attached long-term care facilities had significantly lower FTEs per AOB when compared to CAHs with an attached long-term care facility.

Chart 5: FTEs Per Adjusted Occupied Bed



High and Low Performing Minnesota CAHs

Using information from the data analysis as stated above and interviews conducted with 12 CAH administrators, CAHs' financial challenges, concerns, successes, and opportunities were identified. Below is a synopsis of financial data and CAH interview findings from both the high performing CAHs and low performing CAHs. Also included are CAH administrators' recommendations for improving the financial viability of CAHs in Minnesota, in particular, CAHs that continue to struggle financially.

Low Financial Performers

As noted earlier, eight CAHs were identified as low performing CAHs by analyzing data made available through the Flex Monitoring Team. While examining the financial data for these hospitals (2001 – 2006), it was determined that for all years:

- They had an average total margin of -1.56
- They had an average of 39.39 days cash on hand
- Their days revenue in A/R averaged 59.85 days
- Their cash flow margin averaged 2.47
- Their FTEs per AOB averaged 11.9.

Considering the characteristics of the low performing CAHs included as part of this analysis, they had a few things in common, such as:

- Most own and operate a nursing home
- Most are smaller CAHs.

Characteristics unique to each hospital include: CEO tenure, hospital location (throughout the state), and service mix.

To better understand this data and the challenges and opportunities of these CAHs, five CAH administrators working in these CAHs were interviewed and asked to respond to the following questions:

- 1) What is your hospital's current financial status?
- 2) Given your hospital's financial status, what challenges are of most concern to your hospital? And which ones are you currently trying to address/resolve?
- 3) What support, resources, tools, and/or assistance are needed by your hospital to improve its financial viability?

Considering these questions, low performing CAHs report:

Current Financial Status:

- Three CAHs report that although their hospital's financial status continues to be poor and fragile, they have seen improvements in some financial indicators.
- One CAH reports the hospital is doing well financially; however, their long-term care facility is having a significant and negative impact on the hospital's financial indicators.
- One CAH reports the hospital's financial status has improved significantly as reflected by an increase in hospital utilization, a decrease in days revenue in A/R from 70 to 45 days, and an improved total margin (based 2008 financial data to date).
- Three CAHs report their long term care facilities are having a negative impact on the hospitals' financial status (e.g., annual losses of \$2.5 million or reports of \$2.00 to \$2.50 per day/resident financial loss in long term care facilities).
- Two CAHs report they closed or sold a long term care facility due to financial issues.

Challenges that are of Greatest Concern:

- Merging/upgrading/reconfiguring HIT being used by the hospital, long term care facility, home health agency, and/or other distinct part units.
- Prior to CAH status, many of the hospitals brought a number of non-hospital services in-house; however, given the current financial drain of some of these services, the CAHs are trying to determine the best service mix to meet the health care needs of the community while maintaining the financial viability of the hospital.
- Inability to successfully recruit staff, which is resulting in high staff overtime costs and/or non-employee/interim staff costs (e.g., locums and travelling nurses).
- Overcoming a history of politics and health care provider issues in the community.
- Turnover in hospital leadership.

Support and Resources Needed

- Models to meet communities' long term care needs
- Access to physician assistants and nurse practitioners with emergency room experience
- Tools and resources to restructure debt
- Shared IT staff persons
- Regular access to grant writing training and other resources
- Access to budgeting and operations experts
- HIT assessments to look at what their hospital currently has in place, what is worth keeping, and what is needed to move forward
- Information and resources on telemedicine opportunities
- Marketing tools that best showcase key services (e.g., swing bed program)
- Information on the tools, resources, and technical assistance available through the Flex Program
- A means to prioritize the quality improvement projects (state and national) available to CAHs so they can prioritize and select projects that they should be involved and/or would most effectively meet their hospitals' quality improvement needs
- Assistance with developing partnerships with other CAHs to establish a regional system, with each having niche services to meet the regional market needs (e.g., creating economies of scale)
- Create opportunities for CAHs to collaborate with Indian Health Services
- Create community wellness program models and support their replication throughout the state

High Financial Performers

As noted earlier, eight CAHs were identified as high performing CAHs based on the set of financial indicators used by the Flex Monitoring Team. While examining the financial data for these hospitals (2001 – 2006), it was determined that:

- They had an average total margin of 10.11
- They had an average of 212 days cash on hand
- Their days revenue in A/R averaged 53.27 days
- Their cash flow margin averaged 14.52
- Their FTEs per AOB averaged 6.9.

Considering the characteristics of the high performing CAHs interviewed as part of this analysis, they too had a few things in common, such as:

- Most do not own and operate a nursing home,
- Most are somewhat larger small rural hospitals, and
- None were located on the eastern side of the state.

Characteristics unique to each hospital included: CEO tenure, hospital location (north, south, remote, less remote) and service mix.

Seven CAH administrators working in these high performing hospitals were interviewed and asked to respond to the following questions:

- 1) What is your hospital's current financial status?
- 2) Given your hospital's financial status, what do you believe has contributed to your hospital's financial well-being?
- 3) For CAHs that continue to struggle financially, what three things do you think they should focus on to improve their financial performance?

Considering these questions, high performing CAHs report:

Current Financial Status

- Overall, they continue to do well financially
- Two CAHs have experienced a decline in revenue over the past two years, primarily due to physician recruitment/retention issues
- One CAH reports its financial success has resulted in other local organizations and stakeholders wanting to share in the success.

Contributors to Hospitals' Financial Well-Being

CAHs reported a number of factors that they believe have contributed to their hospitals' financial success. Many of the factors were reported by a number of CAHs (as indicated by an * below) while some were reported by one or two CAHs. Factors contributing to their success include:

- Establishing internal staff accountability toward meeting hospital goals*
- Accessing all of the services available through management contracts, system contracts/relations, and/or networks they are involved (e.g., if your hospital is part of a system, fully utilize its recruitment, marketing, legal, and/or contracts negotiations staff)*
- Investing in/stabilizing the hospitals' workforce*
 - Limited staff turnover
 - Staff recognition programs
 - Ongoing and high level of training/staff education opportunities
 - Increasing salaries/making salaries more competitive
 - Improving benefit options (including retirement plans)
- Improving negotiations/skills/knowledge about negotiations with third party payers
- Better understanding service areas and where to target resources to increase market share and/or expand service mix*
- Establishing a work environment that includes pride in ownership in the organization*
- Focusing on process excellence*
- Making regular updates/modernizing the hospitals' physical plants
- Initiating "big projects" (e.g., capital improvements and equipment purchases) when the hospital can afford them
- Controlling expenses*
- Using a Lean Philosophy when operating and managing their hospital*
- Paying attention to key factors impacting expenses, such as square footage allocations
- Providing CAH financing 101 courses to all hospital staff

- Setting realistic financial expectations, which supports staff morale
- Being selective when hiring a physician
- Strong and educated hospital board (NIFO – nose in, fingers out).

Areas to Focus for Improved Financial Performance

When the hospital administrators were asked to report what they believe are the three things financially challenged CAHs should focus on to improve their financial viability, CAH administrators report:

- Address hospital management training needs
- Establish internal staff accountability
 - Engage all staff in the budgeting process
- Improve the hospital's image
 - Market hospital services
 - “Work to make sure people feel that you want them at your hospital”
 - Get involved in the community
 - Work with other community organizations to market all local services, “keep it local,” reduce duplication of services, and enhance available local services through partnerships
 - Update the hospital's physical plant
- Obtain and use management support (consultants, networks, system, others)
- Examine services being provided locally to make sure the hospital is providing the correct mix of services
- Manage expenses
- Evaluate and improve the billing, coding, and collections processes
 - Obtain professional consultants to review system
 - Establish an electronic health record
 - Ensure charges are entered on time
 - Ensure coding is accurate
- Engage physicians in the activities of the hospital
 - Use a strategic approach to medical staff leadership
 - Create incentives for physicians
 - Professional
 - Personal
 - Financial
- Increase the hospital's volume of surgical procedures.

Tools and/or resources that were identified as highly valued by the high performing CAHs included:

- Studer Group concepts, <http://www.studergroup.com/home/index.dot>
- QHR (Quorum Health Resources), <http://www.qhr.com/>
- Balanced Scorecard (hospital and department specific)
- Lean
- Strategy maps
- Hospital specific accounting firms
- Minnesota Rural Health Cooperative.

Other Factors to Consider:

- Several of the high performing hospitals report they have employed physicians and some are working to employ more of their physicians, including specialists
- Some of the high performing hospitals indicate they are exploring new joint ventures to increase services and/or improve service delivery.

Although these high performing CAHs are currently doing well financially, they also identified challenges they are anticipating will impact their hospitals' long term financial viability, including:

- 1) Physician recruitment and retention
- 2) Maintaining and/or improving their market share
- 3) Meeting patient needs through the appropriate service mix
- 4) Maintaining HIT
- 5) Ongoing issues with long term care reimbursement rates as they reportedly have not kept pace with costs.

Recommendations to Improve the Financial Viability of Minnesota Critical Access Hospitals

The CAH financial data analysis and interviews with CAH administrators identified a number of challenges and needs that threaten the long-term viability of Minnesota's CAHs. Below is a list of recommendations, derived from the CAH staff interviews, that Minnesota's Flex Program should consider to continue to support and sustain its CAHs.

- 1) The Flex Program should continue providing financial education opportunities to all CAHs. All CAHs seem to agree that they will never receive enough financial education, particularly given the ongoing changes in rules and regulations, including those related to reimbursement. Ongoing financial education can be incorporated into the state's annual rural health conference but could also be supported as part of other state and regional meetings that CAHs attend.
- 2) The Flex Program should consider working with CAHs and other organizations in the state (e.g., accounting firms that provide services to CAHs) to develop some requested, web-based, CAH, performance-based tools. Examples of tools to develop include a CAH finances 101 educational program, successful negotiations, and a Balanced Scorecard how-to program and template. The intent of this training would be to: a) create easily accessible, cost-effective, training tools for all CAH staff and hospital board members, b) to increase CAHs' financial/performance improvement knowledge, and c) to support CAH staff accountability and process improvement initiatives.
- 3) Based on the financial data available, four CAHs have ongoing and significant financial issues that seriously threaten the future viability of these hospitals. Some of these hospital's challenges could be addressed with some targeted technical assistance and support. These CAHs should be contacted directly by the Flex Program to discuss their financial strengths, weaknesses, and challenges and to determine the best strategic approach to meet their hospital-specific needs.
- 4) Flex Program contractual arrangements with CAHs have been a cornerstone of Minnesota's Flex Program. Continuing with this approach, the Flex Program could consider building incentives into the contracting process by encouraging CAHs to complete "best practices" as identified by CAHs in this analysis (e.g., conducting service specific needs assessments, management training, supporting activities to increase CAHs' market share, process improvement approaches and/or training).
- 5) Given the number of CAHs that own and operate nursing homes in Minnesota and the reported financial issues associated with this line of business, this appears to be an increasingly important issue that could affect the future financial viability of many CAHs. The Office of Rural Health and

Primary Care, through its Rural Health Advisory Committee and Flex Program Advisory Committee, should consider exploring the use and development of financially viable, rural, long term care models. This work would need to have a strong community impact/input component to ensure community needs, concerns, and issues can be addressed.

- 6) Through this study, it was evident that many highly experienced CAH administrators and chief financial officers) are interested in supporting other CAHs in improving their financial viability. While some CAH administrators may be experts at CAH billing and coding, others may have developed expertise in marketing and public relations, and others may be new to the job. One-on-one CAH mentoring opportunities should be considered and made available to CAHs through a CAH mentoring program. The program could be managed by the Flex Program with additional support for CAH administrator travel costs.
- 7) A number of CAHs expressed a need to have an internal analysis of processes related to their hospital's performance, including that related to billing and coding, health information technology, and quality. The Flex Program should consider either establishing a contractual arrangement with a few firms to provide a set amount of support to a pre-established number of CAHs or establishing teams of CAH administrators, supported through the Flex Program, to serve in this capacity.
- 8) Recruitment of health care providers was the most significant financial issue identified by all CAHs during the CAH administrator interviews. Not only is health care provider recruitment impacting financially fragile CAHs but it threatens and is impacting hospitals that have a history of success. All CAHs agree that health care provider recruitment needs to be a focus of rural health related programs, including the Flex Program.
- 9) Supporting the educational needs of rural health care providers should be considered another role of the Flex Program. As noted in the study, CAHs are increasingly recruiting nurse practitioners and physician assistants to work in rural areas; however, they need to have broad, rural, emergency room training experience, to ensure they are ready and able to work within the rural context of care.
- 10) Given the health care provider recruitment and retention needs of CAHs, and some CAHs move toward employing physician, the Flex Program should consider monitoring and tracking the impact of this approach to identify and report any outcomes that may result.
- 11) It is evident that many CAHs struggle with having the might to negotiate with health care stakeholders toward resolving issues, including those related to reimbursement. There may be a role for the Flex Program to support coaching training for key CAH staff.

ADDITIONAL INFORMATION

For additional information about the Minnesota Flex Program contact Judith Bergh, Minnesota Department of Health, Office of Rural Health and Primary Care, Flex Program Coordinator, at 651-201-3843 or email at judith.bergh@state.mn.us.



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