

Minnesota Flex Program Evaluation 2005

Critical Access Hospital Administrator Survey

June 2005

Sixty-three CAH administrators¹ were surveyed as part of Minnesota's Medicare Rural Hospital Flexibility Program. The data was collected to determine strengths and weaknesses in Flex Program activities targeted at designating and supporting CAHs and to identify current and anticipated rural hospital issues and needs. The Minnesota Department of Health, Office of Rural Health and Primary Care administers the Flex Program in Minnesota and was the sponsor of the survey. The survey was developed and conducted by Rural Health Solutions, St. Paul, Minnesota. The survey response rate was 91 percent.

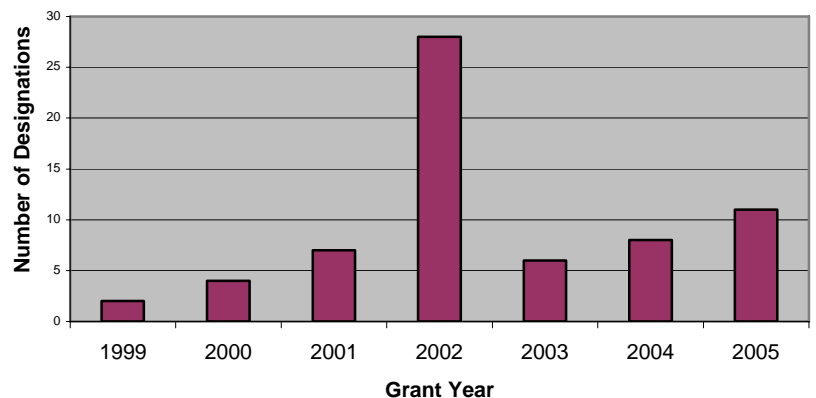
A. MEDICARE RURAL HOSPITAL FLEXIBILITY PROGRAM

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

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

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

Chart 1: CAH Designations By Program Year



There are 69 CAHs in Minnesota, 3rd highest of all states (the national average is 24 per state).² In addition, six Minnesota hospitals are awaiting survey and certification for CAH status and six additional hospitals are considering conversion to CAH status. An average of nine hospital

¹ One hospital administrator is CEO of three CAHs.

² Flex Program Monitoring Team, <http://www.flexmonitoring.org/>, March 2005.

conversions to CAH status have occurred in Minnesota over the past seven Flex Program years, the majority occurring in the 2002 grant year as displayed in Chart 1.³ Although this report focuses on Minnesota Flex Program activities targeted at designating and supporting CAHs, Minnesota’s Flex Program addresses all national program priority areas.

Survey Overview

Sixty-three administrators responsible for 66 CAHs were surveyed. Fifty-six responded via the primary Web-based survey, two provided responses via fax, and two provided responses via follow-up telephone surveys giving a survey response rate of 91 percent. Most survey respondents (88 percent) were hospital administrators while Chief Financial and Operating Officers, Directors of Nursing, and other administrative staff also completed the survey. The intent of the survey was to measure CAH perceptions and satisfaction with the Minnesota Flex Program; identify and measure satisfaction with the technical and financial support that has been provided; determine technical assistance needs; and identify hospital trends, changes to hospital based ambulance services, and emerging concerns and issues. Survey findings will be used for program reporting and as a planning tool for the state’s Flex Program. Survey topics included:

- General satisfaction with CAH conversion assistance
- Use of and satisfaction with the technical assistance, tools, and resources provided by the Minnesota Department of Health, Office of Rural Health and Primary Care
- Grant funding
- EMS, networking, and quality improvement activities
- Planned capital improvement projects
- Post-CAH conversion issues and concerns

B. CAH ADMINISTRATOR SURVEY RESPONSES

CAH administrators were asked about their tenure in the CAH. On average, CAH administrators have worked 9.7 years in their hospital. Most hospital administrators (79 percent) managed and participated in their CAH conversion process, including working with physicians and delegating conversion activities to hospital staff. Twelve hospital administrators indicated they were not involved in the CAH conversion process.

CAH Conversion Technical Assistance

Hospitals were asked to identify key Flex Program stakeholders that provided technical assistance to their hospital during the CAH conversion process and to rate the assistance provided. CAHs reported receiving assistance from many state program stakeholders Table 1. Survey respondents most frequently identified the Minnesota Department of Health (MDH), Office of Rural Health and Primary Care (86percent) and the hospital’s accounting firm (84 percent) as providing assistance during conversion. The respondents were most satisfied with the assistance provided by the Office of Rural Health and Primary Care. Although hospitals converted to CAH status at different times during the past seven program years, satisfaction with services did not change over time. Hospitals that converted to CAH status in 2002 or later were more likely to have obtained conversion assistance from other CAHs.

“The Office of Rural Health and Primary Care was outstanding – we couldn’t have done it without them.”
- CAH Administrator

CAHs were asked to identify specific technical assistance offered and used and to rate the technical assistance provided by the Office of Rural Health and Primary Care. Table 2 shows that CAH administrators were

³ Flex Program grant years run from September 1 – August 31.

most likely offered, most likely used, and were most satisfied with general program information and they were least likely offered and least likely used services related to hospital board awareness/education. Little dissatisfaction was reported in terms of technical assistance that was provided. Levels of satisfaction were consistent across all program years when comparing satisfaction with CAH conversion technical assistance and CAH conversion dates. For hospitals reporting assistance used, they reported using an average of four services, ranging from one service in two CAHs to seven services in four CAHs as displayed in Chart 3. Hospitals converting to CAH status in earlier program years reported using more conversion assistance as compared to those in subsequent years.

Table 1 Entities Providing CAH Conversion Technical Assistance (TA) to hospitals and Satisfaction with Services Provided

	Provided TA			Satisfaction			
	Yes	No	Unknown	Very Helpful	Helpful	Somewhat Helpful	Not Helpful
Office of Rural Health and Primary Care, MDH	86 %	5 %	9 %	82 %	14 %	4 %	0 %
Accounting Firm	84 %	13 %	4 %	73 %	27 %	0 %	0 %
Other Rural Hospitals/CAHs	66 %	22 %	12 %	61 %	27 %	9 %	3 %
Network Tertiary Hospital	60 %	34 %	6 %	38 %	34 %	25 %	3 %
Facility and Provider Compliance Division, MDH	57 %	26 %	17 %	45 %	32 %	19 %	3 %
Minnesota Hospital Association	51 %	33 %	16 %	53 %	40 %	7 %	0 %
Fiscal Intermediary	42 %	34 %	25 %	16 %	44 %	32 %	8 %
Consultant	25 %	63 %	13 %	70 %	20 %	10 %	0 %
Other	3 %	76 %	21 %	50 %	0 %	50 %	0 %

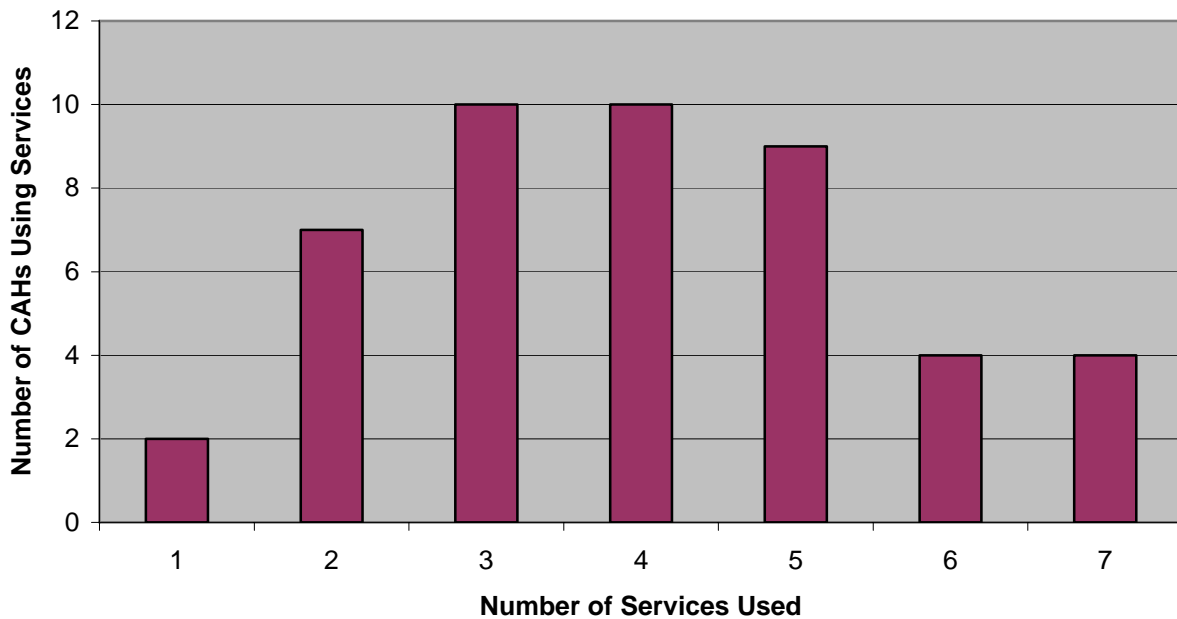
Note: Not all totals equal 100 percent due to rounding.

Table 2 CAH Conversion Technical Assistance (TA) Provided by ORHPC and Satisfaction with Assistance Provided

		TA Offered	If TA Offered, TA Used	Level of Satisfaction	Percent of Respondents
General Program Information	Yes	82 %	85 %	Very Satisfied	85 %
	No	2 %	4 %	Satisfied	15 %
	Unknown	16 %	11 %	Somewhat Satisfied	0 %
				Not Satisfied	0 %
Telephone Consultation	Yes	74 %	80 %	Very Satisfied	74 %
	No	9 %	6 %	Satisfied	23 %
	Unknown	18 %	14 %	Somewhat Satisfied	0 %
				Not Satisfied	3 %
CAH Application Development	Yes	73 %	70 %	Very Satisfied	79 %
	No	9 %	18 %	Satisfied	16 %
	Unknown	17 %	12 %	Somewhat Satisfied	3 %
				Not Satisfied	3 %
Survey and Certification Preparation	Yes	65 %	66 %	Very Satisfied	66 %
	No	16 %	21 %	Satisfied	31 %
	Unknown	20 %	13 %	Somewhat Satisfied	0 %
				Not Satisfied	3 %
Facility/Staff Education and Training	Yes	50 %	38 %	Very Satisfied	71 %
	No	30 %	49 %	Satisfied	29 %
	Unknown	20 %	13 %	Somewhat Satisfied	0 %
				Not Satisfied	0 %
Network Planning and Development	Yes	46 %	33 %	Very Satisfied	67 %
	No	28 %	48 %	Satisfied	27 %
	Unknown	26 %	19 %	Somewhat Satisfied	7 %
				Not Satisfied	0 %
Hospital Board Awareness/ Education	Yes	36 %	17 %	Very Satisfied	88 %
	No	38 %	64 %	Satisfied	0 %
	Unknown	26 %	19 %	Somewhat Satisfied	13 %
				Not Satisfied	0 %

Note: Not all totals equal 100 percent due to rounding.

Chart 1: CAHs and Use of Services



Thirty-five CAHs made comments related to the technical assistance provided by Flex Program staff. Examples of comments included:

- “The staff were very professional and responsive to all my questions.”
- “Simply an outstanding crew – we couldn’t have done it without them.”
- “We did not pursue assistance as we used a consultant and asked a few area hospitals that had already gone through the process.”
- “The staff at the Office of Rural Health were absolutely the best. We worked together, and learned together. As a result, our transition was very successful and I might add painless.”

CAHs were also asked to identify any CAH related assistance that they anticipate needing in the future. They identified anticipated need for:

- In-services on CAH guidelines and the survey process,
- Mock surveys and survey preparedness,
- Guidance on cost reports, cost allocation, and fiscal preparedness,
- Information materials to inform the community of the program and provide program updates,
- Information related to program updates and changes,
- Rules and regulations information related to JCAHO certification,
- Assistance with developing a Minnesota CAH consortium for policy, procedure, and process standardization among members,
- Information on building a new hospital,
- Program advocacy to assure current CAHs are able to maintain their CAH designation, and
- Assistance with converting back from CAH status and the closure of one CAH.

CAH Conversion Support Materials

As part of the Flex Program, the Office of Rural Health and Primary Care has supported CAH conversion by providing information materials (e.g. newsletter), survey support (e.g. mock surveys), and conversion templates (e.g. network agreement templates). When asked about the CAH conversion and support materials that have been made available to CAHs and other stakeholders, the majority of survey respondents reported using the materials. CAHs reported using an average of 3.5 forms of support materials per hospital for CAH conversion activities. As indicated in Table 3 CAHs most often used the CAH conversion information materials and least often used survey support and the Website and CAHs were most satisfied with emails and other written communication and least satisfied with the Website.

Table 3 Flex Program CAH Conversion Support Materials

	Program Materials Used			If Used, Level of Satisfaction			
	Yes	No	Unknown	Very Satisfied	Satisfied	Somewhat Satisfied	Not Satisfied
CAH Conversion Information Materials	72%	9%	19%	76%	24%	0%	0%
E-mail messages and other written communication	62%	11%	26%	82%	18%	0%	0%
Network Agreement Templates	58%	18%	25%	76%	21%	3%	0%
Survey Support	57%	20%	23%	68%	26%	6%	0
Web site	57%	22%	20%	47%	50%	3%	0%
Other	11%	39%	50%	67%	33%	0%	0%

Twenty-one CAHs made comments related to the Flex Program materials made available by the Office of Rural Health and Primary Care. Examples of comments included:

- “The materials were really helpful and easy to use.”
- “Excellent examples and templates for meeting the CAH guidelines.”
- “Very helpful.”

CAH administrators were asked to identify materials that they anticipate needing in the near future to support CAH activities. Although most requests for information related to survey guidelines, CAHs indicated needing the following:

- E-mail alerts and information regarding survey issues, changes in CAH guidelines and policies and resource materials/tools to show how other CAHs are meeting the new regulations and guidelines
- Assistance with fostering national interpretation of the new Conditions of Participation (COP) standards between surveyors and the Centers for Medicare and Medicaid Services (CMS) regional office in Chicago
- Regular updates related to changes in reimbursement, MedPac, EMS reimbursement, national quality improvement changes and activities
- Information related to cost relief for prescription drugs
- Information and tools related to converting back from CAH status

CAH Post-Conversion Activities and Concerns

CAH administrators were asked questions about post-conversion activities and concerns and Flex Program support related to quality improvement (QI), performance improvement (PI), community health collaboratives and networking, EMS, and capital improvement planning and implementation. Approximately one third of CAH survey respondents reported receiving Flex Program support related to these activities and most of those who used the support reported the support as being “very helpful”. In addition, most CAHs stated that they obtained grant funding through the Flex Program and almost all were “very satisfied” with the grants administration process.

Quality Improvement and Performance Improvement: Supporting QI in CAHs is a required national Flex Program component. As a result, Minnesota’s Flex Program has provided QI and PI grants, workshops, training, as well as support for QI collaboratives as part of a partnership with the state Quality Improvement Organization, Stratis Health. To better understand CAHs’ use of and satisfaction with Flex Program QI support, CAH administrators were asked questions related to their quality improvement and performance improvement activities and the assistance provided by the Office of Rural Health and Primary Care. All CAHs reported being engaged in QI (71 percent) and/or PI (65 percent) activities. They also reported that the Office of Rural Health and Primary Care assisted with QI activities (33 percent) and PI activities (29 percent). Those that reported receiving assistance stated that the QI assistance was very helpful (69 percent), helpful (23 percent), or somewhat helpful (8 percent) while the PI assistance was very helpful (58 percent), helpful (33 percent), or somewhat helpful (8 percent). When asked about their future (next two years) QI and PI needs, hospitals reported needing grant funding (45), information technology (42), training and education (39), and infrastructure assistance (18).

Community Collaboratives and Networking: Network development is another goal of the national Flex Program and an area that Minnesota’s Flex Program has assisted CAHs. CAH administrators were asked about their engagement in networking activities and satisfaction with the assistance provided by the Office of Rural Health and Primary Care. CAHs reported networking with other hospitals (91 percent), being involved in community collaboratives (77 percent) and continuum of care activities (74 percent). Of those reporting networking with another hospital, 20 percent reported having obtained networking assistance from the Office of Rural Health and Primary Care, 14 percent reported using community collaborative assistance, and 5 percent continuum of care related assistance. Hospitals found the community collaborative assistance to be the most helpful (80 percent reported “very helpful” and 20 percent “helpful”) while they rated the networking assistance as either “very helpful” (64 percent) or “helpful” (36 percent) and the continuum of care assistance as “very helpful” (66 percent) or “somewhat helpful” (33 percent).

When asked to identify future community health and collaborative assistance needs, hospitals reported the following:

- Increasing grant funding
- Identifying unmet community health needs, prioritizing public health concerns, creating plans and strategies to address public health issues (example: obesity)
- Discussing community health facilities issues and needs
- Establishing rural health clinics or community health centers
- Identifying and expanding needed specialty services
- Standardizing policies and procedures in CAHs
- Enhancing the use of technology (e.g. electronic medical records)
- Integrating Rural Health Clinics and Federally Qualified Health Centers
- Establishing better relations and programs with local public health
- Creating a local health collaborative or committee

CAHs were also asked to identify the hospital that they have their required CAH network agreement. Table 4 reports the number of CAHs that have network agreements with the identified network hospitals.

Table 4 CAHs and Network Hospitals

Network Hospital	City	# of CAHs
Abbott Northwestern	Minneapolis, MN	1
Altru Health System	Grand Forks, ND	4
Avera McKennan Hospital	Sioux Falls, SD	4
CentraCare Health System	St. Cloud, MN	7
Douglas County Hospital	Alexandria, MN	2
Fairview Health – Northland	Princeton, MN	1
Immanuel-St. Joseph's	Mankato, MN	5
Innovis	Fargo, ND	1
MeritCare Health System	Fargo, ND	2
Methodist Hospital - Park Nicollet Health Services	St. Louis Park, MN	1
New Ulm Medical Center	New Ulm, MN	1
North Country Regional Hospital	Bemidji, MN	2
North Memorial Hospital	Robinsdale, MN	1
Prairie Lakes	Watertown, SD	1
Regions Hospital	Saint Paul, MN	1
Rice Memorial Hospital	Willmar, MN	5
Sioux Valley Hospital and Health System	Sioux Falls, SD	6
St. Luke's Hospital	Duluth, MN	5
St. Mary's Hospital	Duluth, MN	4
St. Mary's Hospital	Rochester, MN	2

Emergency Medical Services (EMS): Enhancing EMS is yet another goal of the national Flex Program supported by Minnesota’s Flex Program. Minnesota’s EMS Flex Program supports EMS QI at the state level, as well as at the local level. To understand the impact of CAH designation at the local level, CAHs were asked about ambulance ownership and changes that may have occurred to the ambulance service due to converting to CAH status. They reported that:

- 47percent own and operate their local ambulance service
- CAH status creates a disincentive to own and operate ambulance services and nursing homes so they are searching for ways to remove these services from hospital operations
- Reimbursement and workforce issues continue to be a struggle
- Networking with a larger tertiary hospital allowed one hospital access to an emergency room specialist. This specialist meets with EMS staff to develop EMS protocols and to provide advanced life support training (e.g. ACLS, PALS, ATLS) on-site to reduce staff time and training costs. This change was supported through Flex Program grant funding.

Capital Improvement: Although hospital capital improvements are not a goal of the national Flex Program, they impact a hospital's performance, its ability to provide access to high quality health care services, and are considered an indicator of a hospital's financial status. Therefore, CAHs were asked about completed and planned capital improvement projects. Eighty-two percent of respondents reported having completed a capital improvement project in the past five years (1999 – 2004), including:

- Hospital renovation projects (87 percent)
- Hospital expansion projects (51 percent)
- Construction of a new hospital (9 percent)

When asked about projects planned to begin in the next two years, 63 percent reported that they have planned projects. Of the planned projects, 81 percent will include hospital renovations, 42 percent hospital expansions, and 6 percent new construction of a hospital.

Flex Program Grant Funding: Flex Program grants have been made available to CAHs in Minnesota through the CAH Planning and Conversion Grant Program (e.g. financial feasibility studies, developing network agreements, updating policies and procedures). The grants were administered on a first-come, first-serve, non-competitive basis for a set level of funding. Seventy-four percent of CAH respondents reported that their hospital received a CAH Planning and Conversion Grant and 95 percent reported that the grant making process met their needs in a timely and responsive manner. Twenty-four hospitals made comments related to the grants and grant making process and of those, all agreed that the grants were easy to apply for and helped pay for consulting fees. Two hospitals indicated that they were not aware that the grants were available. CAHs were also asked to identify the person responsible for searching for and preparing their grant applications in the hospital. Sixty percent of respondents reported that the hospital administrator/CEO is responsible while others reported foundation, marketing, support services, and financial staff as those responsible for grants.

When asked to identify future grant funding needs, CAHs reported the following:

- Capital improvements and equipment
- Technology (e.g. tele-pharmacy, electronic medical records)
- Ambulance
- Long range and strategic planning
- Self-pay discounts
- Patient safety and quality improvement initiatives

Several hospitals stated that they support continuation of Flex Program related grants as well as the Minnesota funded Capital Improvement Grants Program.

Information and Updates: CAHs have access to a variety of hospital, state, regional, and national resources to obtain Flex Program information. To better understand the resources being used and not used, CAHs were asked about where they get updates on CAH issues and changes. The most common resources identified included: the Office of Rural Health and Primary Care (88 percent); the Minnesota Hospital Association (82 percent); other CAHs (73 percent); and the hospitals' accounting firm (70 percent). When asked, "Who do you contact first with questions?" CAHs identified staff in the Office of Rural Health and Primary Care (42 percent), accounting firm staff (30 percent), network staff (19 percent), and Minnesota Hospital Association staff (9 percent).

Post-Conversion Issues and Concerns: Each year, the Office of Rural Health and Primary Care applies for federal grant funding to support the Flex Program in Minnesota, including the needs of CAHs. For Flex

Program planning purposes, CAHs were asked to identify and rank issues and concerns related to staffing, hospital services, finances, and administration. Table 5 displays the level of concern for all issues and indicates the percentage of hospitals that have initiatives in place or plan to address each issue. The issues CAHs identified most as being "Very Concerned" about were Medicare reimbursement (82 percent) and Medicaid reimbursement (77 percent). The issues CAHs identified most as being "Not Concerned" about Recruiting and retaining nurse practitioners and physician assistants (37 percent) and system/network relationships (28 percent). The most often noted current/future initiatives were financial performance (92 percent), patient satisfaction (91 percent), patient safety (90 percent) and expansion/enhancement of services (90 percent).

Table 5 CAH Ratings of Issues and Concerns and Initiatives in Place or Planned

Issue	Level of Concern				Current or Future Initiative to Address Issue
	Very Concerned	Concerned	Somewhat Concerned	Not Concerned	
Medicare Reimbursement	82%	16%	2%	0%	85%
Medicaid Reimbursement	77%	20%	4%	0%	85%
Information Technology	60%	20%	20%	0%	67%
Other Reimbursement	57%	30%	9%	4%	83%
Financial Performance	56%	30%	12%	2%	90%
Patient Satisfaction	55%	22%	16%	7%	91%
Expansion/Enhancement of Services	54%	25%	13%	9%	90%
Rules and Regulations	48%	38%	18%	0%	83%
Patient Safety	47%	29%	13%	11%	90%
Recruiting and Retaining Physicians	44%	29%	20%	7%	88%
Recruiting and Retaining Nurses	41%	30%	24%	6%	81%
Quality Improvement	38%	29%	24%	9%	87%
CAH Utilization	30%	44%	20%	6%	74%
Planning and Strategic Planning	25%	36%	20%	20%	89%
Recruiting and Retaining Other Staff	20%	36%	38%	7%	75%
Telehealth	20%	35%	25%	20%	58%
Staff Training	17%	26%	46%	11%	82%
Relations With Other Health Care Providers	16%	35%	31%	18%	58%
System/Network Relationships	13%	26%	32%	28%	63%
Relations With State Agencies	12%	37%	29%	22%	59%
Recruiting and Retaining Mid-Levels	10%	22%	32%	37%	46%
Recruiting and Retaining Management Staff	7%	27%	47%	18%	54%

CAHs were also asked to rank their top three concerns. Table 6 shows issues/concerns ordered using a weighted ranking⁴ of respondent hospital's top three concerns. Using this method, CAHs identified their

⁴ Weighted ranking assigns a value of 3 points to a hospital's #1 concern, 2 points to their #2 concern and 1 point to their #3 concern.

greatest concern as recruiting and retaining physicians followed by financial performance. In addition, CAHs identified concerns related to “other” issues not listed as part of the survey including: retaining CAH designation and cost-based reimbursement, the government’s need to stay abreast of rural health access issues, and the importance of health care in a rural setting.

Table 6 Weighted Ranking of CAH Issues and Concerns

Issue / Concern	Score	Issue / Concern	Score
Recruiting and retaining physicians	56	Quality improvement	6
Financial performance	49	Other reimbursement	5
Expansion/enhancement of services	43	Staff training	4
Medicare reimbursement	38	Recruiting and retaining other staff	3
Rules and regulations	26	Patient satisfaction	3
Recruiting and retaining nurses	25	Relations with other health care providers	3
Patient safety	20	Tele-health	1
CAH utilization	17	System/Network relationships	1
Planning and strategic planning	10	Other	0
Information Technology	9	Recruiting and retaining management staff	0
Recruiting and retaining mid-levels	7	Relations with state agencies	0
Medicaid reimbursement	7		

C. CONCLUSIONS

All of Minnesota CAHs have used Flex Program CAH conversion technical assistance and/or support materials available through the Office of Rural Health and Primary Care. Comments and data reported through the Minnesota CAH Administrator Survey indicate the Flex Program has met the needs of small rural hospitals. Highlights from the survey findings include:

- Most CAHs were very satisfied with the CAH conversion and technical assistance support materials provided by the Office of Rural Health and Primary Care.
- CAHs have been most satisfied with general program information and least satisfied with the Flex Program Website.
- CAHs rely on a variety of resources for CAH related information but continue to use the Office of Rural Health and Primary Care as their primary resource for program information and updates;
- EMS, QI, and PI assistance has been made available to CAHs and approximately one third of facilities report using these services.
- CAH-based EMS has seen little to no Flex program impact since converting to CAH status;
- CAHs were most frequently “Very Concerned” about reimbursement (Medicare and Medicaid).
- Applying a weighted average to the ranking of CAH’s top three concerns, respondents identified recruiting and retaining physician staff as their greatest concern.
- CAHs have many current and on-going technical assistance needs, including those related to surveys and regulations compliance, information technology, program updates and information, networking among CAHs, capital improvements, disease prevention and health promotion, and converting back from CAH status.

For additional information about the Flex Program, contact Pamela Hayes, Flex Program Coordinator, Minnesota Department of Health, Office of Rural Health and Primary Care at 651/282-6304 or e-mail at Pamela.Hayes@health.state.mn.us



REAL WORLD. RESULTS.

This project was completed by Rural Health Solutions, St. Paul, Minnesota, www.rhsnow.com, funded by the Minnesota Department of Health, Office of Rural Health and Primary Care, through a grant from the Federal Office of Rural Health Policy, Health Resources and Services Administration, Public Health Service, U.S. Department of Health and Human Services.