

Minnesota Flex Program Evaluation 2005

Critical Access Hospital Administrator Survey

SUMMARY REPORT June 2005

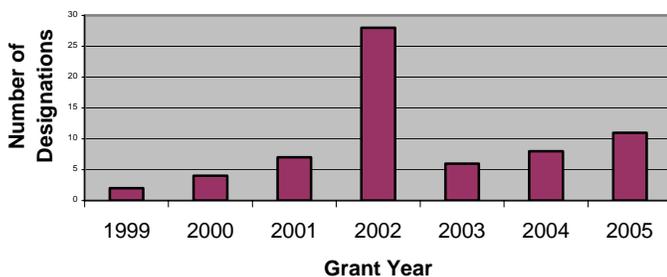
An Internet-based survey of 63 CAH administrators¹ was conducted as part of Minnesota's Medicare Rural Hospital Flexibility (Flex) Program and its program evaluation activities. The data was collected to determine strengths and weaknesses in Flex Program activities targeted at designating and supporting CAHs and to identify current and anticipated rural hospital issues and needs. Survey findings will be used for program reporting and as a planning tool for the state's Flex Program. The Minnesota Department of Health, Office of Rural Health and Primary Care (ORHPC) 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%.

A full survey report can be found on the ORHPC Website at <http://www.health.state.mn.us/divs/chs/rhpcrpts.htm>

A. MINNESOTA'S CAHS

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

Chart 1: CAH Designations By Program Year



¹ One hospital administrator is CEO of three CAHs.

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

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

B. CAH ADMINISTRATOR SURVEY RESPONSES

The CAH Administrator Survey was administered in April 2005. Eighty-eight percent of hospital administrators have worked an average 9.7 years in their hospital. Twelve hospital administrators were not involved in the CAH conversion process.

CAH Conversion Technical Assistance

Hospitals were asked to identify Flex Program stakeholders that provided technical assistance to their hospital during the CAH conversion process and to rate the assistance. Survey respondents most frequently cited the ORHPC (86 percent) and the hospitals' accounting firm (84 percent) as providing assistance. The respondents were most satisfied with the assistance provided by the ORHPC.

“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.”

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.

CAHs were asked to identify specific technical assistance offered and used and to rate the technical assistance provided by the ORHPC. CAH administrators were 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. Table 1 highlights satisfaction with services.

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 2. Hospitals converting to CAH status in earlier

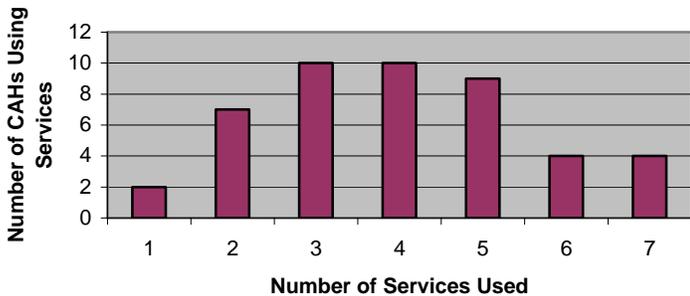
program years reported using more conversion assistance as compared to those in subsequent years.

Table 1: CAH Conversion Technical Assistance Provided by ORHPC and Satisfaction with Assistance Provided

	TA Offered	If TA Offered, TA Used	Very Satisfied *	Satisfied *
General Program Information	82%	85%	85%	15%
CAH Application Development	73%	70%	79%	16%
Telephone Consultation	74%	80%	74%	23%
Hospital Board Awareness/Education	36%	17%	88%	0%
Facility/Staff Education & Training	50%	38%	71%	29%
Survey & Certification Preparation	65%	66%	66%	31%
Network Planning & Development	46%	33%	67%	27%

* Remaining respondents were either "somewhat satisfied" or "not satisfied" with the assistance provided.

Chart 2: CAHs and Use of Services



CAH Conversion Support Materials

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. CAHs most often used the CAH conversion information materials (72 percent) and least often used survey support (57 percent) and the Website (57 percent). CAHs were most satisfied with the E-mail messages and other written

communication (82 percent) and least satisfied with the Website.

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 (62) were very satisfied with the grants administration process.

“The materials were really helpful and easy to use.”

Quality Improvement and Performance

Improvement: Supporting quality improvement in CAHs is a required national Flex Program component. Minnesota’s Flex Program has provided quality improvement and performance improvement grants, workshops, training, as well as support for quality improvement collaboratives as part of a partnership with the state Quality Improvement Organization, Stratis Health. CAH administrators were asked questions related to their quality improvement and performance improvement activities and the assistance provided by the ORHPC. All CAHs reported being engaged in quality improvement (71 percent) and/or performance improvement (65 percent) activities. They also reported that the ORHPC assisted with quality improvement activities (33 percent) and performance improvement activities (29 percent). Those that reported receiving assistance stated that the quality improvement assistance was “very helpful” (69 percent), “helpful” (23 percent), or “somewhat helpful” (8 percent) while the performance improvement assistance was “very helpful” (58 percent), “helpful” (33 percent), or “somewhat helpful” (8 percent).

Community Collaboratives and Networking:

CAH administrators were asked about their engagement in networking activities and satisfaction with the assistance provided by the ORHPC. 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 ORHPC, 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).

CAHs were also asked to identify the hospital that they have their required CAH network agreement. Twenty network hospitals were identified. Hospitals that are networked with five or more CAHs include: CentraCare Health System, St. Cloud, MN; Immanuel-St. Joseph’s Hospital, Mankato, MN; Rice Memorial Hospital, Willmar, MN; Sioux Valley Hospital and Health System, Sioux Falls, SD; and St. Lukes Hospital, Duluth, MN.

Emergency Medical Services (EMS): 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:

- 47 percent 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: 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). When asked about projects planned to begin in the next two years, 63 percent reported that they have planned projects.

Flex Program Grant 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.

Information and Updates: CAHs were asked about where they get updates on CAH issues and changes. The

most common resources identified included: the ORHPC (88 percent); the Minnesota Hospital Association (82 percent); other CAHs (73 percent); and the hospitals’ accounting firm (70%). When asked, "Who do you contact first with questions?" CAHs identified staff in the ORHPC (42 percent), accounting firm staff (30 percent), network staff (19 percent), and Minnesota Hospital Association staff (9 percent).

Post-Conversion Issues and Concerns: CAHs were asked to identify and rank issues and concerns related to staffing, hospital services, finances, and administration. 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 were 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) and patient satisfaction (91 percent).

CAHs were also asked to rank their top three concerns. Table 2 displays issues/concerns reported by CAHs’ using a weighted ranking⁴ of respondent hospitals’ top three concerns. Using this method, CAHs identified their greatest concern as recruiting and retaining physicians.

Table 2: Weighted Ranking of CAH Issues and Concerns – Top 10

Issue / Concern	Score
Recruiting and retaining physicians	56
Financial performance	49
Expansion/enhancement of services	43
Medicare reimbursement	38
Rules and regulations	26
Recruiting and retaining nurses	25
Patient safety	20
CAH utilization	17
Planning and strategic planning	10
Information Technology	9

CAH Administrators’ Anticipated Needs

CAH administrators were asked to identify materials that they anticipate needing in the near future to support CAH activities. CAHs indicated needing the following:

- E-mail alerts, information, and in-services regarding survey concerns, changes in CAH guidelines and

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.

policies and JCAHO certification policies and procedures

- Resource materials/tools to show how other CAHs are meeting the new regulations and guidelines
- Mock surveys
- Assistance with fostering national interpretation of the new Conditions of Participation 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 QI/PI changes and activities
- Information related to cost relief for prescription drugs
- Information, tools, and assistance with converting back from CAH status
- Guidance on cost reports, cost allocation, and fiscal preparedness
- Information materials to inform the community of the program and provide program updates
- 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
- Information and assistance with closing a CAH
- Support to establish better relations and programs with local public health
- Assistance with identifying unmet community health needs, prioritizing public health concerns, creating plans and strategies to address public health issues (example: obesity), and creating a local health collaborative or committee
- Assistance with community health facilities issues and needs, establishing rural health clinics or community health centers, identifying and expanding needed specialty services, and integrating Rural Health Clinics and Federally Qualified Health Centers
- Standardizing policies and procedures in CAHs
- Support to enhancing the use of technology (e.g. electronic medical records)
- Grant funding for capital improvements and equipment, technology (e.g. tele-pharmacy, electronic medical records), ambulances, long range and strategic planning, self-pay discounts, and patient safety and quality improvement initiatives

C. CONCLUSIONS

All of Minnesota CAHs have used Flex Program CAH conversion technical assistance and/or support materials available through the ORHPC. 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 ORHPC.
- 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 ORHPC as their primary resource for program information and updates.
- EMS, quality improvement, and performance improvement assistance has been made available to CAHs and approximately one third of facilities report using these services.
- CAH-based EMS have seen little to no Flex program impact since hospitals converted to CAH status.
- CAHs were most frequently “Very Concerned” about reimbursement (Medicare and Medicaid).
- CAHs are most concerned about recruiting and retaining physician staff.
- 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



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