

EXECUTIVE SUMMARY OF YEAR 2 FINDINGS

This report summarizes the experiences of the Minnesota Rural Hospital Flexibility Program during Year 2. It is divided into eight chapters. The first chapter gives an overview of the program and the evaluation plan. Chapter 2 focuses on the activities of the Office of Rural Health and Primary Care (ORHPC) in continuing the implementation of the program in Minnesota. The remaining chapters each focus on a specific aspect of the Flex Program, for example, networking, quality assurance, and financial performance of Critical Access Hospital (CAHs).

In the first year of the program, two facilities converted to Critical Access Hospital (CAH) licensing status. In Year 2, the ORHPC designated seven additional CAHs for certification and one more was ready for designation at the end of the program year. All eight Year 2 facilities were certified by the Health Care Financing Administration (HCFA, renamed the Centers for Medicaid and Medicare Services or CMS) during or shortly after the end of Year 2. The first ten CAHs comprise the CAH study, which is a multi-year evaluation. Quantitative and qualitative data were gathered from these facilities involving both primary and secondary data. Data were collected for the year before conversion, the year following conversion, and during annual follow-ups. For some evaluation components, the performance of the CAHs was compared to a control group of similar hospitals (i.e., CAH eligible hospitals). The evaluation is designed to gather the relevant information needed to assess and monitor progress in implementation of the Flex program in Minnesota, while minimizing the time that local hospital staff must spend in completing evaluation documents and interviews. In addition, the community focus groups conducted as part of the evaluation involve the community in the evaluation process and allow community members to share their experiences concerning the local health care system in a structured setting.

Findings for Year 2 are summarized below.

IMPLEMENTATION OF THE FLEX PROGRAM (Chapter 2)

- The ORHPC has continued to target hospitals that would most likely benefit from the Flex Program. In partnership with the Minnesota Hospital and Healthcare Partnership (MHHP), the office has engaged in numerous activities to make target hospitals aware of the program and its possible benefits. This is demonstrated by the increase in the number of hospitals that sought information about CAH designation, grants for assistance in the conversion decision-making process, and the increase in the number of hospitals that converted to CAH during Year 2 than in Year 1.
- The ORHPC effectively organized staff and other resources to implement the Flex Program in Minnesota, focusing on program management, awarding grants, and providing direct technical assistance to hospitals and communities.
- The ORHPC awarded 44 grants to 38 CAH-eligible hospitals, two EMS consortia, one hospital network, two hospital and clinic consortia, one nursing home, and one local public health agency, financing 67 distinct projects. This work built on the foundation of the 37 grants to 30 hospitals that were awarded in Year 1. Eight of the hospitals receiving grants in Year 2 were certified as CAHs before the end of the year. In addition, a number of hospitals receiving Year 2 grants had applied for conversion before the end of Year 2 or shortly thereafter. The grants appear to have played a key role in the decision to convert and planning for conversion. Interviews with administrators from the Year 2 CAHs confirmed this, with descriptions of the role of the grants as “critical” and “extremely critical” in establishing decision criteria, gathering relevant data, and making the conversion decision.

- Grants made to hospitals and communities in Year 2 focused primarily on conversion assessment and planning, community needs assessment, development and enhancement of rural health networks, staff and community education, and a number of specific projects in the areas of EMS, telemedicine, wellness, and trauma system development.
- The ORHPC provided a wide variety of communication and technical assistance services to eligible hospitals. There appears to be a relationship between conversion and the amount of technical assistance provided by the ORHPC. This relationship suggests that support from the ORHPC increases immediately before and after conversion. Administrators from the hospitals that converted during Year 2 all rated the assistance provided by the ORHPC as 9-10 (on a scale of 1 to 10, with 10 being very helpful). Assistance included clarification of regulations, survey guidelines, immediate information and resources, and information such as that provided in the ORHPC *Critical Access News* publication. One administrator said the staff of “ORHPC were the teachers and we were the students out here who wanted to learn.” Another administrator noted that he regretted not using the available services because he felt that the process would have gone “a lot more smoothly.”

PHYSICIAN INTEGRATION AND SATISFACTION (Chapter 3)

- Of the Year 2 CAHs, more than one-third employed their medical staff and two-thirds had offices on land owned by or adjacent to the hospital. This is a much higher proportion of employment of medical staff members by the CAH and a higher proportion with offices adjacent to the hospital leading to staff integration into the CAH than Year 1 CAHs.
- Over two-thirds of the medical staff at Year 2 CAHs felt fully informed about conversion, 19% felt informed but would have liked more information, and 7% felt that information was not adequately shared. Given the much higher number of practitioners in the Year 2 CAHs than Year 1, the number of staff who felt fully informed about CAH conversion continues to remain high. Similarly, a high proportion of CAH staff fully supported conversion, with only 2.3% being opposed.
- As in Year 1 CAHs, Year 2 CAH medical staff members expected that the conversion would benefit the hospital and community more than their own practices. However, unlike staff at Year 1 CAHs, more of the staff at Year 2 CAHs expected some benefit to their practices, and 9.3% reported an increase in their practices.
- Overall, the vast majority of CAH medical staff was satisfied with the hospital, the primary referral hospital, and their practices in the community. There was less satisfaction with the quality assurance networking arrangements with other facilities (about 50%) and somewhat less satisfaction (about 40%) for credentialing and patient referral and transfer.

QUALITY OF CARE (Chapter 4)

- The eight CAHS seeking certification in Year 2 passed their initial surveys with no difficulties. Seven of the CAHs made use of the mock surveys conducted by the ORHPC.
- Of the eight Year 2 CAHs, only three received their re-certification survey after one year. This was primarily due to budget constraints in the survey office. One of the 3 CAHs was cited for deficiencies, which were related to the role of mid-level practitioners and inclusiveness in the policy development process.
- Most of the Year 2 CAHs submitted examples illustrating the facility’s quality assurance program and its ability to identify problems, develop and implement interventions, and measure results.
- The CAHs’ communities are vaguely aware of the change in licensing status of the CAHs, and the communities highly rate the care provided by the CAHs. These opinions may be considered indicators of quality.

- As with Year 1 CAHs, no significant problems with quality of care were identified at the Year 2 CAHs in the year following conversion.

RESIDENT ACCESS AND SATISFACTION (Chapter 5)

- Year 2 CAH communities continue to be supportive of the conversion to a CAH. As was the case with Year 1 CAHs, the actual “limitations” of the model (e.g., bed size, average length of stay) are little noted by community residents. Instead, they view the program as an expansion of the previously existing services, through networking arrangements, greater availability of diagnostic testing and specialist appointments, enhanced EMS, and improved reimbursement.
- Overall, the residents of the Year 2 communities had highly favorable opinions of the quality of care provided and the access to services.
- Access was particularly important in communities such as Community E, who frequently lose access to services due to annual spring flooding. Access was especially important to Community I, which is just starting to see a stable physician base after nearly 15 years of physician turnover (see Appendix B for Community Focus Group summaries).
- Of the Year 2 CAHs for which data were available, the market share declined slightly in the year of conversion, though an increase in the number of patients was seen. There was not a pronounced use of urban hospitals as was seen in Year 1 CAHs, but an increase in the use of other rural hospitals was noted. It is unclear at this time if this change was related to the CAH network affiliations.

NETWORK DEVELOPMENT (Chapter 6)

- The Year 2 CAHs continued existing relationships with their primary referral hospitals and in some cases these relationship were written into formal agreements.
- CAHs are involved in a number of agreements for patient transfer and referral, clinical services, credentialing, quality assurance, purchasing, and emergency transportation. Some CAHs are involved in multiple agreements in one or more of these areas.
- The CAH administrators are primarily satisfied with the networking relationships. Many of them expected few changes in these relationships after CAH designation. Most of the changes were for additional enhancements. There were some additional costs reported related to peer review.
- No changes were made in networking relationships in the first year after CAH designation, suggesting that fundamental aspects of the relationship did not change.
- All eight Year 2 CAHs are integrated substantially by virtue of their diverse networking relationships. This integration with full-service, acute care hospitals, as well as other networking partners, helps to insure the local availability of services and the quality and efficiency of such services.
- Based on the additional observations from the Year 2 CAHs, the Flex Program appears to have resulted in little substantive change in networking behavior of rural hospitals. The network relationships are more formalized than before CAH designation and some additional services have been added, but these seem to be a continuation of networking activities that were in process prior to conversion.

EMS DEVELOPMENT AND INTEGRATION (Chapter 7)

- The EMS plans of all eight Year 2 CAHs satisfy the requirements of designation. None of the CAHs made significant amendments to their EMS Plans in the first year of operation.
- In the year of conversion, the number of emergency room (ER) visits to the CAHs grew by eleven percent (controlling for one CAH that added urgent care services). This is consistent with ER changes seen in Year 1 CAHs. Emergency room transfers remained almost

unchanged, with less than a one percent reduction. Finally, acute care transfers dropped by almost six percent; at this time it is unclear what role the 96 hour annual average length-of-stay may play in this drop.

- Year 2 CAHs remain strongly integrated with EMS and report good relationships with EMS providers. One CAH reported an improved relationship with the EMS provider following conversion.

FINANCIAL PERFORMANCE (Chapter 8)

- Before conversion, the Year 2 CAHs were larger than the comparison hospitals but showed lower average daily census and total patients days than a group of comparison hospitals. Even though they were larger, they had lower revenues and expenses than those of the comparison group.
- In the year of conversion, the average daily census increased in the Year 2 CAHs, while it remained relatively flat at comparison hospitals.
- During the year of conversion, Year 2 CAHs increased their net patient revenues by 2% over the comparable hospitals.
- Based on the information available, conversion to CAH appears to have increased revenues for the Year 2 CAHs.