

# Minnesota Flex Program

October 2009

## 2009 Flex Program Evaluation: CAH Satisfaction, Challenges, and Next Steps

Over the past 12 years, the Minnesota Office of Rural Health and Primary Care has been implementing the Medicare Rural Hospital Flexibility (Flex) Program. The Flex Program conducted a web-based survey of 78 CAH administrators<sup>1</sup> as part of its program evaluation activities. The data were collected to determine the strengths and weaknesses of activities supporting CAHs as well as to identify and prioritize current and anticipated challenges and needs. Survey findings indicate that CAHs are satisfied with the Minnesota Flex Program and all CAHs are participating in Flex Program funded activities. Although many CAHs report positive outcomes due to their involvement in the Flex Program, they are increasingly challenged by hospital finances and the recruitment and retention of physicians.

The Minnesota Department of Health, Office of Rural Health and Primary Care administers the Flex Program in Minnesota and sponsored the study. Rural Health Solutions, Woodbury, Minnesota, developed the survey and prepared this report.

### MEDICARE RURAL HOSPITAL FLEXIBILITY PROGRAM

The 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: 1) federal grants to states to assist them with implementing state specific program activities that advance the goals of the national Flex Program and 2) a CAH-based operating program, which provides cost-based Medicare reimbursement and unique operational requirements for hospitals that convert to CAH status. The U.S. Department of Health and Human Services (DHHS), Health Resources and Services Administration (HRSA), Office of Rural Health Policy administers the grant program. The Centers for Medicare and Medicaid Services (CMS), also located in DHHS, administers the operating program.

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 and sustaining 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.

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<sup>1</sup> One hospital administrator is CEO of two CAHs.

As of 2009, all states participating in the Flex Program are required, at a minimum, to support activities addressing rural health quality improvement, CAH support, EMS integration and enhancement, and Flex Program evaluation.

There are 79 CAHs in Minnesota; this is the third highest number of all states (the national average is 29 per state).<sup>2</sup> Minnesota's Flex Program has averaged \$677,604 from the federal Office of Rural Health Policy to support its program, the highest average annual level of funding of all states. Although this report focuses on Minnesota Flex Program activities targeted at supporting and sustaining CAHs, Minnesota's Flex Program addresses all national program goals.

## **METHODS**

A web-based survey of all Minnesota CAHs was conducted from August 9 through August 19, 2009, with e-mail and telephone follow-up for non-respondents. All CAH hospital administrators/chief executive officers (CEOs) received an email outlining the survey, how the survey data would be used, and requesting that the survey be completed online via the identified link. In addition, Flex Program staff from ORHPC emailed all CAH CEOs requesting their participation in the survey. All CAH survey responses were made online except two via fax and one via telephone. Seventy-three of 79 CAHs responded resulting in a 92 percent survey response rate.

Considering the 90 questions on the survey:

- 67 CAHs responded to all but a very limited and random list of questions
- 6 CAHs responded to a limited but somewhat random list of questions
- For most of the analysis, n=67, but ranges from 62 to 72 depending on the question.

Most survey respondents (89 percent) were hospital administrators/CEOs while two were chief financial officers (CFOs), four were directors of nursing (DON)/chief nursing officers (CNO), and two were listed as "other." Survey respondents report working an average of 11 years at the CAH.

The intent of the survey was to: 1) measure CAH perceptions and satisfaction with the Minnesota Flex Program; 2) identify and measure satisfaction with the technical, programmatic, and financial support that has been provided; 3) identify any program outcomes; 4) identify trends and changes in CAH satisfaction; 5) determine CAH technical assistance needs; and 6) identify CAHs emerging and ongoing challenges and concerns. Survey topics included:

- Background information about the hospital and its telemedicine use and capacity
- Use of and satisfaction with the technical assistance, tools, programs, and resources provided by the Flex Program through the ORHPC
- Use of and satisfaction with the Comprehensive Advanced Life Support (CALs) training made available to CAH staff
- Participation in, satisfaction with, and outcomes of Flex Program supported quality and performance improvement and patient safety activities
- EMS needs and priorities based on the federally defined Flex Program guidance
- Capital improvement activities and planned next steps
- CAH issues, concerns and priorities.

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<sup>2</sup> Flex Program Monitoring Team, <http://www.flexmonitoring.org> reporting July 30, 2009 figures, [obtained August 15, 2009].

Survey questions related to telemedicine were taken from a 2007 ORHPC sponsored survey of Minnesota providers conducted by the University of Minnesota. This survey asked questions about the status, use of, and connectivity issues of telemedicine.<sup>3</sup>

For comparison and analysis purposes, CAH grant funding, CAH participation, as well as past CAH survey data were also obtained and used for the report. These data include:

- 2005 CAH Survey data, a survey conducted by Rural Health Solutions in August 2005
- CALS health care provider course participation data, 1999 – 2008
- ORHPC grants data for grants program administered between 1999-2009
- CAH Survey of Meaningful Use of Health Information Technology (HIT) data, a survey conducted by the ORHPC in June 2009
- Course participation data from Stratis Health, the state quality improvement organization (QIO)
- University of Minnesota, Minnesota Telehealth Inventory.<sup>4</sup>

## **2009 SURVEY RESPONSES AND DATA COMPARISONS**

Seventy-three CAHs (92 percent) participated in web-based survey conducted in August 2009. The survey asked about the Minnesota Flex Program and other ORHPC programs and services, CAH activities, and CAH needs and challenges. Below is a summary of findings, comparisons and analysis.

### **ORHPC FLEX PROGRAM ACTIVITIES**

As part of the 2009 survey, CAHs were asked to report their overall satisfaction with the Minnesota Flex Program. Of the 64 CAHs that responded to this question, 41 percent report they are “very satisfied,” 50 percent report they are “satisfied,” 5 percent report they are “somewhat satisfied” and 5 percent report they are “not aware of the Flex Program.” To better understand their overall satisfaction, CAHs were asked questions about their awareness, use of, and satisfaction with specific technical and financial assistance made available to their hospital through the Flex Program and the ORHPC, including:

- General program information
- Survey and certification preparation and assistance
- Flex Grant funding
- Rural Health/CAH Conference
- Quality and patient safety support
- CAH technical and financial assistance from the ORHPC.

Considering CAHs’ awareness of Flex Program funded activities, the majority of CAHs (at least 72 percent) are aware of the technical and financial assistance available as reported in Table 1. In addition, all CAHs report being “very satisfied” or “satisfied” with the technical and financial assistance (“somewhat satisfied” and “not satisfied” were other measures but were not selected). CAHs also report they are most aware of the Minnesota Rural Health Conference (98 percent of CAHs), they are most likely using the Minnesota Flex Grant program (82 percent), and they are most satisfied with the Minnesota Rural Health Conference (66 percent “very satisfied”).

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<sup>3</sup> Source: University of Minnesota, Minnesota Telehealth Registry, <http://www.mti.umn.edu/>, retrieved July 21, 2009.

<sup>4</sup> Source: University of Minnesota, Minnesota Telehealth Registry, <http://www.mti.umn.edu/>, retrieved July 21, 2009.

Looking at the survey responses of CAHs (7 CAHs) that report using all of the identified CAH technical and financial services available through the Flex Program, these CAHs are more likely to be “very satisfied” (71 percent) with the Flex Program when compared to CAHs as a whole (41 percent). Hospitals reporting they are “not aware of the Flex Program” or are “somewhat satisfied” with the Flex Program were significantly less likely to report using Flex Program assistance.

Overall satisfaction with the Flex Program seems to be higher by use of components of the program by CAHs. For example, those who report they are “very satisfied” with the general program information are also “very satisfied” with the Minnesota Flex Program overall. Many respondents were aware of the survey and certification assistance through ORHPC and they were also “very satisfied” with the Flex Program. Very few respondents left this question blank. It appears that Survey and Certification assistance activities were highly related to satisfaction with the Flex Program. This may be an indication of CAHs’ preference for on-site and/or direct technical assistance. Those CAHs who report using support for quality and patient safety also report being “very satisfied” with the Flex Program. Those not using it are either not aware of the Flex Program or report they are only somewhat satisfied with the Program.

**Table 1 Technical and Financial Assistance Made Available to CAHs through the Flex Program and the ORHPC**

| Types of Technical and Financial Assistance Made Available | Percent that are aware of support/assistance | Percent that are using the support/assistance | Satisfaction with support/assistance* |           |
|--|--|---|---------------------------------------|-----------|
|  |  |   | Very Satisfied                        | Satisfied |
| General Program Information                                | 84%  | 41%   | 50%                                   | 50%       |
| Survey and Certification Preparation Assistance            | 72%  | 20%   | 65%                                   | 35%       |
| Minnesota Flex Grant – Grant Funding                       | 97%  | 82%   | 63%                                   | 37%       |
| Minnesota Rural Health/CAH Conference (held in Duluth)     | 98%  | 77%   | 66%                                   | 34%       |
| Support for Quality and Patient Safety Activities          | 79%  | 47%   | 50%                                   | 50%       |

*\*Note: No CAHs report being “somewhat” or “not satisfied” with these services provided through the ORHPC*

Minimal comparative information is available to look at changes in CAHs’ Flex Program satisfaction and program use over time. The previous CAH Survey (2005) focused on Flex Program assistance/support related to hospitals’ conversion to CAH status (a program priority at that time) compared to current services, which focus on supporting and sustaining CAHs. However, both the 2005 and 2009 surveys asked questions about CAHs’ awareness and use of Flex Program services available and use and satisfaction with general program information and survey and certification support. Table 2 compares the two years. These findings suggest that CAH CEOs’ knowledge of the Flex Program and the services available has increased or remained the same, except for survey and licensing services, while the percentage of CAHs using services has not. The decline in use of survey and licensing support is to be expected as all CAHs now have CAH survey and licensing experience.

**Table 2 Changes in CAH Satisfaction and Use of the Flex Program**

| 2005 CAH Survey Data   | 2009 CAH Survey Data   |
|--|--|
| 61% offered CAH conversion technical assistance                        | 86% aware of the CAH support/assistance available                      |
| 56% use the identified CAH services available through the Flex Program | 53% use the identified CAH services available through the Flex Program |
| 82% offered general program information                                | 84% aware general program information is available                     |
| 85% use the general program information                                | 41% use the general program information                                |
| 57% use survey and certification assistance                            | 20% use survey and certification assistance                            |
| 68% “very satisfied” with survey and certification assistance          | 65% very satisfied with survey and certification assistance            |

**OTHER ORHPC SERVICES**

Another section of the CAH survey focused on CAHs’ awareness, use of, and satisfaction with other non-Flex Program funded assistance available to CAHs through the ORHPC. These include: reimbursement and practice management technical assistance, grants, health care provider recruitment, communications, health workforce research, and health systems planning activities.

**Grants, Technical and Financial Assistance and Health Care Provider Recruitment**

- Reimbursement and practice management technical assistance, often made available to CAHs through their rural health clinics
- J-1 Visa Program, a federal program that supports and allows foreign trained physicians to work in underserved rural areas
- National Health Service Corps, a federal program that supports physicians who practice in rural primary care settings
- Minnesota Loan Forgiveness, state programs that pay student loans for health care providers who agree to work in rural and underserved areas
- Rural Hospital Planning and Transition Grant Program, a state-funded program that provides grants to small rural hospitals for projects that expand and/or maintain access to services
- Capital Improvement Grant Program, a state-funded grants program that provides grants to small rural hospitals for physical plant, equipment and HIT related purchases
- Small Rural Hospital Improvement Program, a federal program that makes grant funding available to small rural hospitals for Health Insurance Portability and Accountability Act, quality improvement/patient safety, and HIT related activities

Considering the programs listed above and as indicated in Table 3, CAH survey respondents are most aware of the grant programs. One hundred percent of CAHs are aware of the Small Rural Hospital Improvement Program, followed by the Hospital Planning and Transition Grant Program (92 percent) and the Capital Improvement Grant Program (89 percent). Additionally, 95 percent report using the Small Rural Hospital Improvement Program and more than 70 percent of CAHs are “very satisfied” with the Small Rural Hospital Improvement Program and Capital Improvement Grant Program.

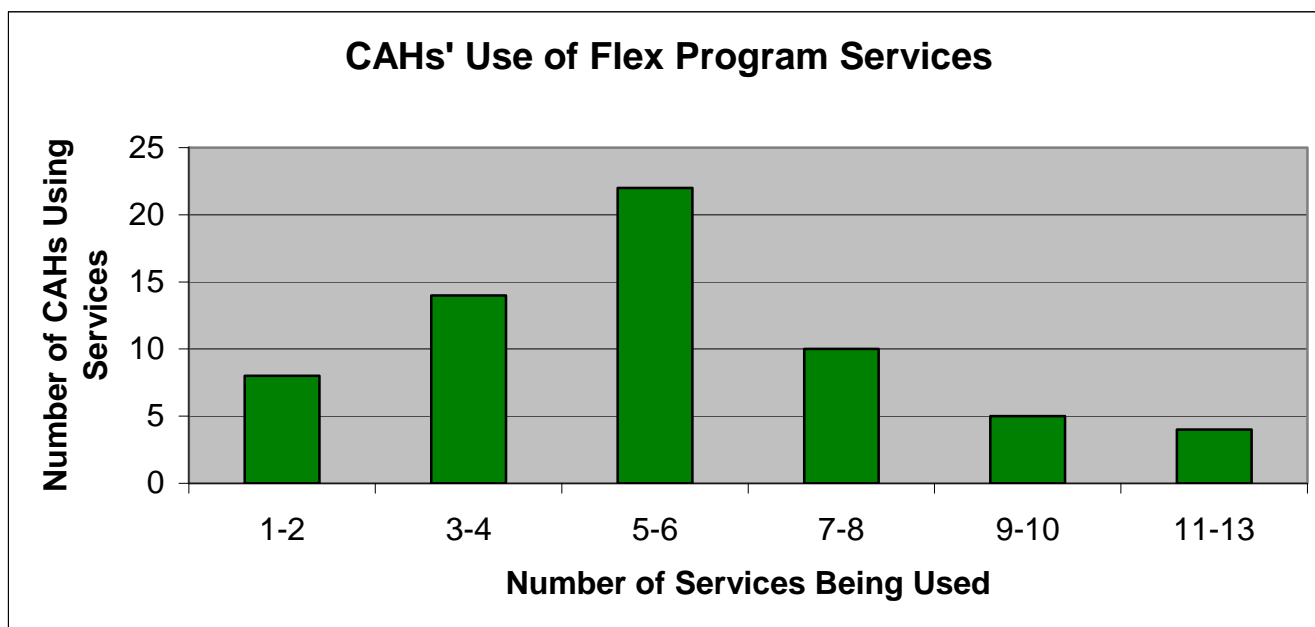
To better understand these results, additional survey analysis examined the relationship between the survey respondents’ expressed level of satisfaction and several other dimensions related to Flex Program use and grant history. Utilization of ORHPC-provided Flex services is one such measure. CAHs are using an average of 5.5 services per hospital. As indicated in Chart 1, this ranges from one

or two services/programs as reported by eight CAHs to 13 services/programs, as reported by two CAHs.

**Table 3 Other Technical and Financial Assistance Made Available to CAHs through the ORHPC**

| Types of Technical and Financial Assistance Made Available by ORHPC | Percent that are aware of support/assistance | Percent that are using the support/assistance | Satisfaction with support/assistance |           |                    |               |
|---|--|---|--------------------------------------|-----------|--------------------|---------------|
|   |  |   | Very Satisfied                       | Satisfied | Somewhat Satisfied | Not Satisfied |
| Reimbursement and Practice Management Technical Assistance          | 45%  | 14%   | 42%                                  | 58%       | 0%                 | 0%            |
| J-1 Visa Program  | 66%  | 18%   | 43%                                  | 57%       | 0%                 | 0%            |
| National Health Service Corps                                       | 58%  | 16%   | 33%                                  | 67%       | 0%                 | 0%            |
| Loan Forgiveness Programs   | 78%  | 24%   | 32%                                  | 68%       | 0%                 | 0%            |
| Rural Hospital Planning and Transition Grant Program                | 92%  | 55%   | 63%                                  | 34%       | 3%                 | 0%            |
| Capital Improvement Grant Program                                   | 89%  | 59%   | 76%                                  | 18%       | 3%                 | 3%            |
| Small Rural Hospital Improvement Program                            | 100%   | 95%   | 70%                                  | 28%       | 2%                 | 0%            |

**Chart 1 CAHs and Use of Flex Program Services Made Available by ORHPC**



Analysis of CAHs' grant history (grants received through ORHPC from 1999 through 2008) and its relationship to survey respondents' satisfaction with services included types of grants received, total

grant amounts, and number of grants received. There is some support for the idea that those hospitals that had more contact and involvement with the Minnesota Flex Program (e.g., grant application process, hospitals that were successful in receiving grants) would have a more favorable view of the program than those that were not as involved in seeking and receiving grants. Of the several survey respondents who reported a lack of awareness of the Flex program, their grant history reflects either no grants received or a relatively small amount of grant funding received. Table 4 shows the relationship between total grant amounts and level of satisfaction with the Flex Program.

**TABLE 4: Total ORHPC Grants and Level of Administrator Satisfaction with the Minnesota Flex Program**

| Total Grants         | Degree of Satisfaction*       |                    |           |                | Blank/NA |
|----------------------|-------------------------------|--------------------|-----------|----------------|----------|
|                      | Not Aware of the Flex Program | Somewhat Satisfied | Satisfied | Very Satisfied |          |
| \$ 0                 | 1                             | 0                  | 1         | 1              | 0        |
| \$1 to \$9,999       | 1                             | 1                  | 5         | 6              | 2        |
| \$10,000 to \$19,999 | 0                             | 0                  | 10        | 6              | 0        |
| \$20,000 to \$29,999 | 0                             | 0                  | 6         | 4              | 3        |
| \$30,000 to \$39,999 | 0                             | 2                  | 1         | 5              | 3        |
| \$40,000 and greater | 1                             | 0                  | 9         | 4              | 1        |
| <b>TOTAL</b>         | <b>3</b>                      | <b>3</b>           | <b>32</b> | <b>26</b>      | <b>9</b> |

\*Note: No CAH reports they are “not satisfied” with the Flex Program.

Survey respondents at hospitals that received \$10,000 to \$30,000 or \$40,000 or more in total grants were “satisfied” or “very satisfied” with the Flex Program, with the exception of one administrator who reports a lack of awareness of the Flex Program.

### Data and Publications

In addition to grants, financial and technical assistance, and workforce recruitment programs, ORHPC also offers CAHs support through its health professions workforce data collection and reporting, publications, and rural health research/planning. As part of the CAH survey, CAHs were asked to report their knowledge and use of these programs and services. The survey questions focused on the Minnesota Rural Health Plan, health professions data collection and reporting, and communications.

### Minnesota Rural Health Plan

The Minnesota Rural Health Plan was completed in 2008 using both Flex Program and other ORHPC resources and was a 2007/2008 Flex Program required activity. The intent of Minnesota’s plan was to “build on the work done over the past several years and address the need to ensure a strong integrated rural health care system, a sound professional workforce, improvements to health care access and high quality health care, and support use of health information technology and telehealth delivery”.<sup>5</sup> To understand if and how CAHs are using the plan, the 2009 CAH Survey asked questions about the plan and its use. Approximately half of the survey respondents (52 percent) report they are not aware of the Minnesota

**“The plan [Rural Health Plan] is incorporated into our hospital's strategic plan for the type of services that should continue, should be altered to meet demographic changes, and those that should be scaled back or referred to a higher level of service.”**  
*CAH Administrator*

<sup>5</sup> Minnesota’s Rural Health Plan, Minnesota Department of Health, Office of Rural Health and Primary Care, November 2008, <http://www.health.state.mn.us/divs/orhpc/flex/studies/rhplan.pdf>, retrieved June 2009.

Rural Health Plan but 19 percent (13 CAHs) report they have used the plan for reference information, as a framework for workforce and professional development, strategic planning, community planning, and board education.

### **Health Professions Data**

ORHPC collects and reports data on 13 health professions in the state (e.g., physicians and nurses). The intent is to track the availability of and changes in health workforce in the state. When asked, 51 percent of CAHs report they are aware ORHPC collects and reports data on 13 health professions. Thirty-five percent report they receive email releases of the new workforce publications, and 27 percent report they use the health professions data/reports and they find the data useful. The survey respondents' tenure at the CAH was not an indicator of their awareness of the availability of health professions data. However, further exploration of the data show that of those respondents who are aware of the J-1 Visa Program, 55 percent are aware of the ORHPC health professions data. This may indicate that those CAHs looking at staffing resources might be the most inclined to use this data as a resource.

### **Communications**

ORHPC uses a number of communications tools as part of its programs and operations; its ORHPC *Monthly Update*, *ORHPC Quarterly*, and Web site are its three primary vehicles. To better understand CAHs' use of these tools, CAHs were asked to identify the tools they are using, areas of most interest, and topic areas that may be missing. Over half of all CAHs report using all of the communication vehicles: the *ORPHC Monthly* being the most used. Most CAH survey respondents report reading *Monthly Update* articles on ORHPC grants and loans, MDH/ORHPC news, and other grants and loans while 25 percent or less report reading the other articles. Most CAHs report reading *Quarterly* articles on specific subjects as well as the Director's Column, some (18 percent) report reading the profiles of Rural Health Advisory Committee Members. Sixty-seven percent report they are using the ORHPC Web site. CAHs report most frequently they are aware of the grants and loans, Flex Program, statewide trauma, and shortage designations information. No CAHs report they follow ORHPC on Twitter but 17 percent report they would like to be included. All but one survey respondent reports there are no additional topic areas they would like included in the communication tools. One survey respondent reports an interest in CAH-specific articles.

Use of ORHPC communication tools seems to influence CAHs' overall view of the Flex program. An analysis of the readership patterns of the monthly and quarterly newsletters shows that respondents who read the *Monthly Update* are also most satisfied with the MN Flex Program. A similar pattern was found with the quarterly newsletter. Survey respondents who read these publications "quarterly" rather than "occasionally," were most likely to be "very satisfied" with the Flex Program. This may be a reflection of these CAH staff having more familiarity with the Flex program and other ORHPC activities through what they learn in these publications.

### **OTHER FLEX PROGRAM ACTIVITIES**

In addition to support made to CAHs directly by the ORHPC, the Flex Program also funds CAH activities/programs that are made available through other Flex Program partners, including the Comprehensive Advanced Life Support (CALs) program, Stratis Health, the Minnesota Hospital Association and the Rural Health Resource Center. Therefore, the 2009 CAH survey asked respondents to report their use of, satisfaction with, and future needs for this support.

## **Comprehensive Advanced Life Support (CALs)**

CALS is an educational program in advanced life support training for rural health care providers. It is designed for teams of physicians, mid-level practitioners, nurses and allied health care professionals (e.g., nurse anesthetists and paramedics) working in rural settings. Map 1 shows that 1,961<sup>6</sup> health care providers, representing 75 CAH communities have been trained in CALS over the past 12 years or 2,828 course participants.<sup>7</sup> Since 2003, the CALS program has received funding through the Flex Program to offset the cost of CALS and encourage CAH providers to participate in the course. The number of CALS course participants working in CAH communities has been increasing, with one of the largest increases occurring when the Flex Program funding was established (Chart 2). It is unclear whether this funding had a direct impact on CAH health care providers taking the course.<sup>8</sup>

In order to better understand CAHs' support and satisfaction with the CALS program, CAHs were asked:

- If there are health care providers trained in CALS in their hospital
- Whether they have staff that need to be CALS trained
- To rate the value of CALS training to the hospitals' emergency department.

Ninety percent of CAH survey respondents report they have health care providers in their facility trained in CALS. Seventy-eight percent report they have providers who need to be trained or re-trained in CALS. Of those reporting they have staff trained in CALS, 69 percent report they are "very satisfied" and 21 percent report they are "satisfied" with the CALS training and 10 percent are "somewhat satisfied" or "not satisfied" with the training.

To further understand these survey findings, in particular those related to satisfaction, course participation data were obtained from the CALS program and were compared to 2009 CAH Survey responses. Using both data sets, it appears that some CAHs have health care providers trained in CALS but they are not aware of it. In addition, a cross tabulation was performed to examine how administrators rate the value of CALS training for their hospital. Table 5 shows that 50 administrators who had CALS trained providers are "satisfied" or "very satisfied" with the value of CALS training for their emergency departments. Five administrators who report having CALS-trained providers in their hospitals express they were "somewhat satisfied" or "not satisfied" with the value of CALS training for their emergency departments.

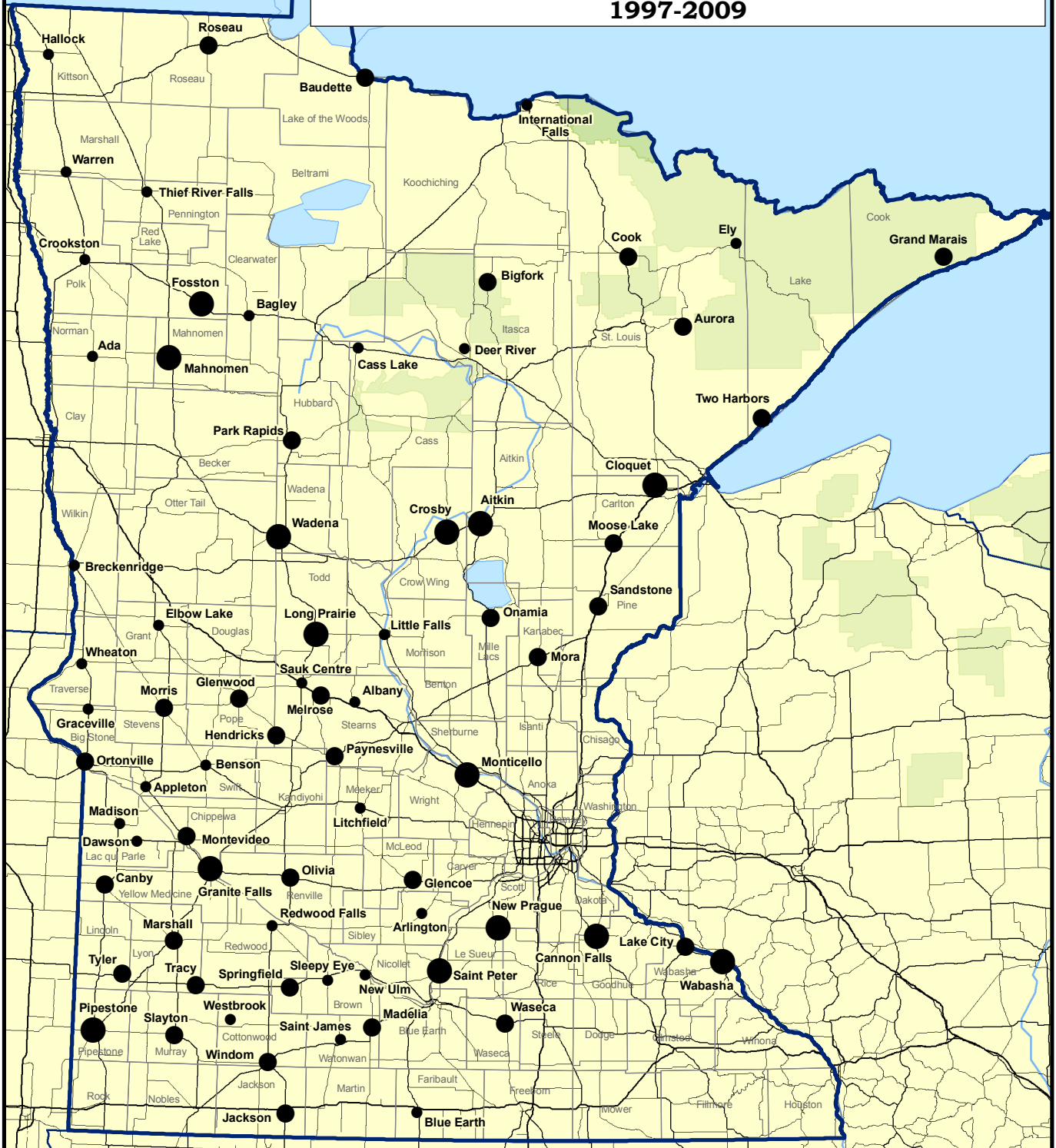
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<sup>6</sup> Some providers may have received training more than once; however, this figure reflects the number of providers and not the number of courses taken.

<sup>7</sup> Some providers may have received training more than once as this figure represents the number of courses taken.

<sup>8</sup> Some providers may have received training more than once as this figure represents the number of courses taken.

# Minnesota's Critical Access Hospital (CAH) Communities Health Care Providers Trained in CALS 1997-2009



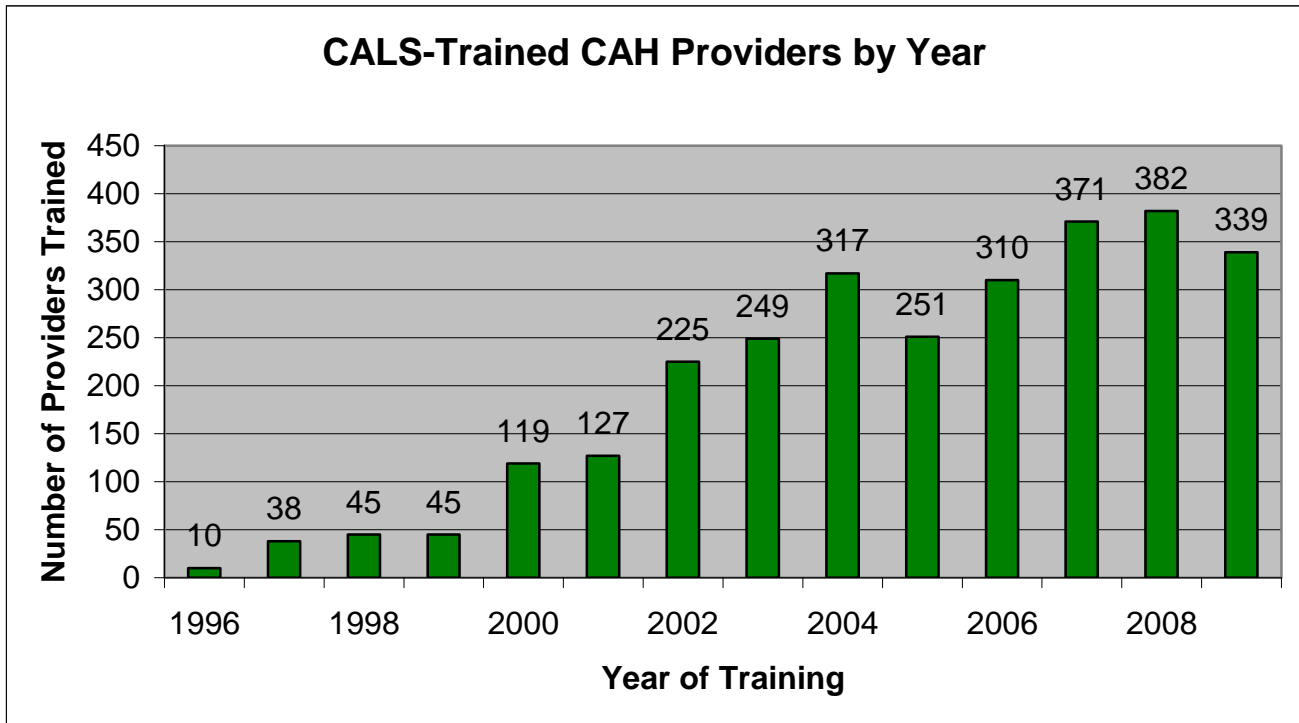
0 25 50 100 150 200 250 Miles

**CALS Trained Health Care Providers by Practice Location**

- 40 - 77
- 20 - 39
- 1 - 19

Data Source:  
Comprehensive Advanced  
Life Support Program,  
September 2009

**Chart 2 Health Care Providers Trained in CALS and Working in CAH Communities by Training Year: 1996-2009**



**Table 5 CAHs with CALS-Trained Providers and the Value of the CALS Program**

| Rate the Value of CALS in the Hospital Emergency Department | CALS-trained providers in your hospital? |           |
|---|--|-----------|
|   | No                                       | Yes       |
| Not Satisfied   | 0  | 2         |
| Somewhat Satisfied  | 1  | 3         |
| Satisfied   | 0  | 12        |
| Very Satisfied  | 1  | 38        |
| <b>TOTAL</b>  | <b>6</b>                                 | <b>56</b> |

Data tracking the number of unique CALS providers in a community were matched with the 2009 CAH Administrator survey data to examine if there are any differences in survey respondent’s satisfaction with CALS based on the number/prevalence of CALS providers in their community. Table 6 shows that in communities with at least 20 CALS providers, survey respondents were most likely to say they are “very satisfied” with the value of CALS training in their hospital emergency department. Only 1 respondent with more than 40 CALS providers present in their community was other than “very satisfied” with the value of CALS in their emergency department.

**Table 6 Number of CALS Providers in CAH Communities and CAH Satisfaction with the CALS Program**

| Satisfaction With CALS in their E.D. | Number of CALS Providers in CAH Community |      |       |     |
|--------------------------------------|---|------|-------|-----|
|                                      | None                                      | 1-19 | 20-39 | 40+ |
| Blank                                | 3   | 6    | 3     | 3   |
| Not Satisfied                        | 0   | 1    | 0     | 1   |
| Somewhat Satisfied                   | 1   | 1    | 2     | 0   |
| Satisfied                            | 0   | 7    | 5     | 0   |
| Very Satisfied                       | 0   | 11   | 19    | 10  |
| TOTAL                                | 4   | 26   | 29    | 14  |

**Quality and Performance Improvement Initiatives**

A portion of Flex Program quality and performance improvement support to CAHs is provided through ORHPC’s contractual relations and partnerships with the Minnesota Hospital Association (MHA), Stratis Health (the state’s Quality Improvement Organization) and the Rural Health Resource Center. This support has been in many forms but most recently through a pressure ulcer initiative, foreign objects initiative, performance improvement project, rural measures project, and patient safety culture project. The 2009 CAH Survey asked about participation in these activities, whether their participation has improved hospital performance and/or quality, and to rate the impact of the activities on hospital performance/quality.

As indicated in Table 7, most CAHs report participating in the quality/performance improvement projects. For those that are aware of their hospital’s participation, most report the projects are impacting their hospital and all but two of these report all of the projects as “very helpful” or “helpful.” Although use and satisfaction with these projects are evident, over a quarter of all survey respondents report no impact or an unknown impact of these projects, which suggests a lack of awareness of project activities and outcomes.

Survey respondents were asked to describe any outcomes resulting because of their involvement in the quality and patient safety projects. They report:

- Receiving awards of quality excellence
- Incorporating the quality/performance improvement project activities into the hospital strategic plan
- Improving patient care across the continuum of services provided (e.g., long term care and home care)
- Standardizing patient protocols and processes to improve patient care/safety
- Improving quality indicators, in particular those related to falls
- Developing and using strategy maps and balanced scorecards
- Engaging employees more in patient safety and quality improvement

Survey respondents were also asked to identify their quality and performance improvement needs for the next two years. They report needing assistance to address the following items:

- Diabetes care
- Minnesota quality measurement mandate
- Stratis Health pressure ulcer initiative and the state quality measures initiative
- Interdepartmental communications
- Pay-for-performance

- Hospital challenges associated with disruptive behavior, congestive heart failure readmissions, and cardiovascular ambulatory care, readmissions in general, and infection rates
- Re-measure for the patient safety culture (AHRQ) survey using electronic sources
- Comprehensive approach to stroke care
- Patient medication education
- EHR use to reduce errors and improve outcomes
- Health care homes education
- Physician-patient relations
- Hospital-specific, evidenced-based practice goals (e.g., health care associated infections)
- Level IV trauma designation.

**Table 7 CAH Quality and Performance Improvement Projects**

| CAH Quality and Performance Improvement Initiatives Supported through the Flex Program | Percent reporting participation in the project |     |         | Percent reporting project impacting hospital performance/quality |     |         | Project impact on performance/quality |         |                  |             |
|--|--|-----|---------|--|-----|---------|---------------------------------------|---------|------------------|-------------|
|  | Yes  | No  | Unknown | Yes  | No  | Unknown | Very helpful                          | Helpful | Somewhat Helpful | Not Helpful |
|  | MHA - Pressure Ulcer Initiative                | 65% | 16%     | 19%  | 64% | 6%      | 30%                                   | 54%     | 43%              | 3%          |
| MHA - Retained Foreign Objects Initiative  | 70%  | 30% | 0%      | 65%  | 14% | 21%     | 41%                                   | 56%     | 3%               | 0%          |
| RHRC - Rural Performance Improvement Initiative  | 69%  | 31% | 0%      | 45%  | 10% | 45%     | 48%                                   | 52%     | 0%               | 0%          |
| Stratis – Rural Measures   | 73%  | 3%  | 24%     | 74%  | 2%  | 24%     | 41%                                   | 59%     | 0%               | 0%          |
| Stratis – Patient Safety Culture   | 85%  | 15% | 0%      | 64%  | 8%  | 28%     | 44%                                   | 56%     | 0%               | 0%          |

## CAH ACTIVITIES AND NEEDS

### CAH Networks

CAHs rely on a number of larger hospitals for the referral and transfer of patients. In fact, this is one of the requirements for CAH designations. All CAHs are required to have at least one network agreement in place with a tertiary center. In order to understand the referral and transfer patterns of hospitals and how this may be changing over time, CAHs were asked to report where they are most frequently referring and transferring patients. As stated in Table 8, CAHs most frequently refer and transfer patients to CentraCare Health System in St. Cloud, St. Mary’s Hospital in Duluth, and Sanford Health, USD Medical Center in Sioux Falls, South Dakota.

**Table 8 CAH Network Hospitals**

| Network Hospital                                     | City, State        | # of CAHs reporting this as their most frequent referral hospital |
|--|--------------------|---|
| CentraCare Health System                             | St. Cloud, MN      | 10  |
| St. Mary's Medical Center, Duluth                    | Duluth, MN         | 8   |
| Sanford Health, USD Medical Center                   | Sioux Falls, SD    | 7   |
| Abbott Northwestern Hospital                         | Minneapolis, MN    | 6   |
| MeritCare Health System                              | Fargo, ND          | 6   |
| Immanuel St. Joseph's Hospital                       | Mankato, MN        | 5   |
| Altru Health System                                  | Grand Forks, ND    | 4   |
| Rice Memorial Hospital                               | Wilmar, MN         | 4   |
| St. Mary's Hospital/Mayo Clinic                      | Rochester, MN      | 3   |
| Avera McKennan Hospital and University Health Center | Sioux Falls, SD    | 2   |
| St. Luke's Hospital                                  | Duluth, MN         | 2   |
| Park Nicollet Methodist Hospital                     | St. Louis Park, MN | 2   |
| Hennepin County Medical Center                       | Minneapolis, MN    | 1   |
| Innovis Health, Fargo                                | Fargo, ND          | 1   |
| Methodist Hospital                                   | St. Louis Park, MN | 1   |
| North Country Health Services                        | Bemidji, MN        | 1   |
| Sanford Regional Hospital                            | Worthington, MN    | 1   |

To look at changes in referral and transfer patterns, 2005 CAH Survey data was examined and it was determined that little has changed over the past five years with all but three CAHs reporting the same patterns.<sup>9</sup>

### Telemedicine Use

The 2009 CAH survey asked about telemedicine status, use, and connectivity issues in CAHs.<sup>10 11</sup> Fifty-five percent of CAHs are using telemedicine to provide services. The most frequently identified uses are: telemedicine, radiology, staff training, behavioral health, dermatology, and home care. Sixty-six percent of CAHs reporting their physicians use telemedicine as part of their practice report they use two or fewer types of telemedicine services; three CAHs report using telemedicine for five to eight services.

<sup>9</sup> Some CAHs included in the 2009 survey did not participate in the 2005 survey so changes in their referral and transfer patterns are unknown.

<sup>10</sup> Minnesota Telehealth Inventory 2007 Report, University of Minnesota, [http://www.mti.umn.edu/download\\_report.php](http://www.mti.umn.edu/download_report.php), retrieved July 2009.

<sup>11</sup> 2009 CAH survey questions on telemedicine were taken from the 2007 ORHPC-sponsored survey of health services statewide, conducted by the University of Minnesota.

When asked about the types of connections that CAHs are using for their telemedicine and other HIT needs, the majority (56 percent) report using T1 lines, followed by DSL (17 percent), T3 lines (10 percent), dial-up modem (7 percent), cable modem (5 percent), other (4 percent), and ISDN (1 percent). Twenty-four percent of survey respondents report having connectivity issues, including those related to:

- Long lapses in time before responsiveness
- Connection speed
- Occasional down time
- Need for expanded bandwidth
- Cost
- Loss of connection
- Power surges.

### **Emergency Medical Services (EMS)**

EMS integration is a goal of the national Flex Program and an area supported through Minnesota's Flex Program. Most of Minnesota's support has been targeted to Flex Program grants to EMS stakeholders, CALS training, and trauma system development activities. To better understand CAHs' role and needs associated with EMS, the 2009 CAH Survey asked CAHs to report if their hospital owns an ambulance, the needs they have associated with this service, and how they would like the Flex Program to support EMS in the state. Forty-five percent of CAHs report they own an ambulance service, compared to 47 percent that reported owning an ambulance service in 2005. For those owning an ambulance service, they report needing assistance with:

- High cost of long transfers
- Ongoing training for emergency medical technicians (EMTs)
- Equipment costs (e.g., hydraulic cots to handle heavier patients)
- Ongoing access to CALS training
- Technical assistance with moving from a basic life support service to an advanced life support service
- Enhanced reimbursement
- HIT to bridge the data collection between EMS and the local CAH
- Boundary/service area alignment to best meet patient care needs
- Assistance with grants/identify grants available to fund local EMS' needs.

When asked how the CAHs would like the Flex Program to support EMS in the state, they report their priorities in order as: grants to EMS agencies, EMS provider training, trauma system development support, and EMS quality improvement initiatives. As indicated above, these priorities reflect current Flex Program EMS activities in the state.

### **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, staff recruitment and retention, and hospital operations. The age of a hospital's physical plant is considered an indicator of a hospital's financial status. CAHs were asked about completed (2005-2009) and planned (2010-2012) capital improvement projects. Eighty-one percent of CAH survey respondents report completing a project in the past five years, including:

- Equipment purchases (74 percent)
- Hospital renovations projects (62 percent)
- HIT/EHR purchases (62 percent)
- Hospital expansion projects (34 percent)
- Construction of a new hospital (1 percent).

This can be compared to the 2005 CAH survey data that reported 82 percent of respondents having completed a capital improvement project in the past five years (1999-2004), including:

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

During this earlier time period, it is clear that more CAHs were taking on larger physical plant related projects.

When asked about projects planned to begin in the next two years, 71 percent report they have projects planned. Of the planned projects, 60 percent will include equipment, 60 percent HIT/EHR purchases, 42 percent hospital renovations, 20 percent hospital expansions, and 20 percent construction of a new hospital.

Comparing 2005 and 2009 CAH survey responses, of those CAHs that reported in 2005 that they planned a capital improvement project in the next two years, 25 report in 2009 that they completed a capital improvement project in the past five years. Four hospitals that planned such a project in 2005 had not completed a project, according to their 2009 responses. In addition, 11 hospitals that reported not having a project planned in 2005, report having completed a project in 2009.

### **Flex Program Grant Funding**

Flex Program grants have been made available to CAHs in Minnesota for CAH conversion needs (e.g., financial feasibility studies, developing network agreements, updating policies and procedures) as well as to advance other Flex Program goals (e.g., EMS integration, CAH support, quality improvement). Since nearly all eligible hospitals have converted to CAH status, grant funding over the past eight years has focused on the other Flex Program goals. To further understand current grant funding needs, CAHs were asked to report how they would spend a \$25,000 grant. No guidance or direction was given on how the funding could be used; however, thirty-two percent of survey respondents report they would direct the funding to an HIT/EHR related need. Considering all responses, CAHs report they would use grant funding for the following:

- HIT/EHR capabilities
  - EHR purchase/additional components
  - Document imaging
  - Staff training
  - Automated pharmacy
- Equipment purchases
  - C-arm
  - Bathtubs
  - Digital radiology and mammography equipment
  - Defibrillator
  - Ultrasound
  - In-wall oxygen equipment
  - Patient lift
  - Surgical and lab equipment
  - CT
- Master facility planning
- Hospital expansion planning
- Facility renovation
- Heliport and parking lot upgrade

- Interdisciplinary palliative program
- Improvement in access to services
  - Cardiology
  - Oncology
- Telemedicine
  - Equipment
  - Staff training
- Staff training
- EMS
  - New ambulance
  - Staff training
- New ambulance
- Process improvement
- Structured strategic analysis with both staff and community involvement
- Community needs assessment
- Chronic disease management program
- Physician recruitment.

### **Other CAH Needs**

Although the Minnesota Flex Program supports CAH financial and performance improvement needs through various program activities, it does not have an initiative in place directed specifically at CAH chief financial officers (CFOs). ORHPC has a technical assistance program for rural health clinics. CAHs were asked whether their CFO would be interested in participating in a similar technical assistance group that would be statewide with other CAH CFOs. Fifty-three percent of survey respondents report their CFO would like to participate, 2 percent report they would not like to participate, and 45 percent report they do not know if they would like to participate.

### **CAH CHALLENGES AND CONCERNS**

Each year, the Office of Rural Health and Primary Care applies for federal grant funding to implement the Flex Program in Minnesota. For Flex Program planning purposes, the 2009 Survey asked CAHs to identify and rank common hospital issues and concerns related to staffing, services, finances and administration. Survey respondents most frequently report finances, reimbursement (Medicaid and Medicare), and physician recruitment and retention as issues at their hospital (Table 9). When asked to rate their level of concern for each of the identified issues, CAHs most frequently report being “very concerned” about reimbursement, finances, and recruitment and retention of physicians, which is consistent with the 2005 CAH Survey findings. Survey respondents consistently report they are most concerned about issues that relate directly back to finances/reimbursement, including the recruitment and retention of physicians and specialty care providers.

Comparing 2009 CAH Survey findings with 2005 CAH Survey findings, few changes have occurred except in the areas of health workforce. In 2005, 44 percent of survey respondents reported they were “very concerned” about physician recruitment and retention as compared to 65 percent in 2009 indicating a significant increase in concern. In addition, in 2005, 41 percent of survey respondents reported they were “very concerned” with nurse recruitment and retention as compared to 17 percent in 2009, indicating a significant decline in concern. These comparative changes likely suggest that recent market changes in the United States continue to have an impact on the supply and demand for nurses. However, given the extreme shortage of rural physicians (primary and specialty care), the gap between their supply and demand will continue to be an issue for Minnesota’s CAHs.

Considering CAHs' increasing concern related to EHRs, other data comparisons can also be made. This includes conducting cross tabulations between 2009 CAH Survey data and the ORHPC's June 6, 2009, CAH HIT Meaningful Use Survey data. Completing this analysis, there is no correlation between a CAH's reported HIT readiness and concern about their hospital's EHR. In addition, there is no correlation between those CAHs not responding to the CAH HIT Meaningful Use Survey and CAHs reporting being "very concerned" or "concerned" about their hospital's EHR.

Given the large number of challenges, CAHs were given the same list of issues and concerns identified in Table 9 and asked to rank their top three concerns. Table 10 displays the issues/concerns in order using a weighted ranking<sup>12</sup> of respondent hospital's top three concerns. Using this method, CAHs identified their greatest concern as recruiting and retaining physicians followed by financial performance. Comparing 2009 to 2005 survey results and consistent with the findings reported in Table 9, it is clear that CAHs continue to be most concerned about physician recruitment and hospital finance. However, unlike 2005, CAHs are now expressing more concern about EHRs and quality improvement. It is interesting to note that although almost all CAHs report Medicaid reimbursement as an issue at their hospital and 72 percent are "very concerned" about it, Medicaid reimbursement was rated as a top three concern by only nine hospitals.

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<sup>12</sup> 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.

**Table 9 CAH Issues and Level of Concern with Each Issue**

| Issue   | Issue at the CAH |     |         | Level of Concern |           |                    |               |
|---|------------------|-----|---------|------------------|-----------|--------------------|---------------|
|   | Yes              | No  | Unknown | Very Concerned   | Concerned | Somewhat Concerned | Not Concerned |
| Medicaid reimbursement  | 93%              | 5%  | 2%      | 72%              | 25%       | 4%                 | 0%            |
| Financial performance   | 87%              | 13% | 0%      | 53%              | 28%       | 19%                | 0%            |
| Medicare reimbursement  | 86%              | 11% | 3%      | 58%              | 33%       | 9%                 | 0%            |
| Physician recruitment and retention                               | 83%              | 17% | 0%      | 65%              | 19%       | 15%                | 2%            |
| Rules and regulations   | 84%              | 16% | 0%      | 33%              | 55%       | 11%                | 2%            |
| Market share  | 82%              | 16% | 2%      | 38%              | 42%       | 15%                | 5%            |
| Expansion/enhancement of services                                 | 79%              | 18% | 3%      | 28%              | 49%       | 21%                | 2%            |
| Quality improvement   | 79%              | 21% | 0%      | 21%              | 44%       | 31%                | 4%            |
| Patient satisfaction  | 76%              | 24% | 0%      | 31%              | 38%       | 23%                | 8%            |
| Electronic health record  | 76%              | 22% | 2%      | 41%              | 21%       | 16%                | 12%           |
| Patient safety  | 73%              | 27% | 0%      | 27%              | 39%       | 27%                | 6%            |
| Specialty care provider recruitment and retention                 | 71%              | 29% | 0%      | 54%              | 29%       | 13%                | 4%            |
| Planning and strategic planning                                   | 61%              | 37% | 2%      | 9%               | 52%       | 18%                | 20%           |
| Other reimbursement   | 65%              | 25% | 10%     | 51%              | 31%       | 11%                | 6%            |
| Relations with other health care providers                        | 60%              | 40% | 0%      | 9%               | 23%       | 51%                | 16%           |
| Other staff recruitment and retention                             | 58%              | 39% | 3%      | 33%              | 38%       | 18%                | 10%           |
| Nurse recruitment and retention                                   | 58%              | 41% | 1%      | 17%              | 28%       | 51%                | 4%            |
| System/Network relationships                                      | 51%              | 48% | 1%      | 10%              | 35%       | 28%                | 28%           |
| Telemedicine  | 44%              | 51% | 5%      | 11%              | 39%       | 32%                | 18%           |
| Licensing and certification                                       | 41%              | 55% | 4%      | 8%               | 31%       | 31%                | 31%           |
| Recruiting and retaining nurse practitioners/physician assistants | 35%              | 63% | 2%      | 24%              | 22%       | 30%                | 24%           |
| Recruiting and retaining management staff                         | 34%              | 64% | 2%      | 10%              | 33%       | 36%                | 21%           |

**Table 10 Weighted Ranking of CAH Issues and Concerns: 2009**

| Issue / Concern                      | Score | Issue / Concern                            | Score |
|--------------------------------------|-------|--|-------|
| Physician recruitment and retention  | 102   | Recruiting and retaining mid-levels        | 8     |
| Financial performance                | 71    | Other reimbursement                        | 8     |
| Electronic health record             | 32    | Patient satisfaction                       | 8     |
| Medicare reimbursement               | 29    | Other staff recruitment and retention      | 7     |
| Expansion/enhancement of services    | 19    | Rules and regulations                      | 6     |
| Quality improvement                  | 19    | System/Network relationships               | 3     |
| Medicaid reimbursement               | 13    | Planning and strategic planning            | 1     |
| Specialist Recruitment and Retention | 12    | Telemedicine                               | 0     |
| Patient safety                       | 10    | Relations with other health care providers | 0     |
| Nurse recruitment and retention      | 9     | Management staff recruitment and retention | 0     |
| Market share                         | 9     | Relations with state agencies              | NA    |

**Table 11 Ranking of Top Five CAH Issues and Concerns: 2009 and 2005 Comparisons**

| Issue / Concern                     | Ranking | Issue / Concern                     | Ranking |
|-------------------------------------|---------|-------------------------------------|---------|
|                                     | 2009    |                                     | 2005    |
| Physician recruitment and retention | 1       | Physician recruitment and retention | 1       |
| Financial performance               | 2       | Financial performance               | 2       |
| Electronic health record            | 3       | Expansion/enhancement of services   | 3       |
| Medicare reimbursement              | 4       | Medicare reimbursement              | 4       |
| Expansion/enhancement of services   | 5       | Rules and regulations               | 5       |

## SUMMARY OF FINDINGS

The 2009 CAH Survey set out to: 1) measure CAH perceptions and satisfaction with the Minnesota Flex Program; 2) identify and measure satisfaction with the technical, programmatic and financial support; 3) identify any program outcomes; 4) identify trends and changes in CAH satisfaction; 5) determine CAH technical assistance needs; and 6) identify CAHs emerging and ongoing challenges and concerns. It accomplished this by asking CAHs questions, including those related to:

- Background information about the hospital and its telemedicine use and capacity
- Use of and satisfaction with the technical assistance, tools, programs, and resources ORHPC provided, including but not limited to those supported by the Flex Program
- Use of and satisfaction with the CALS training made available to CAH staff
- Participation in, impact of and satisfaction with Flex Program supported quality and performance improvement and patient safety activities
- EMS needs and priorities based on the federally defined Flex Program guidance
- Capital improvement activities and planned next steps.

Using this approach the survey identified the following key findings:

### **Program Satisfaction**

- Ninety-one percent of survey respondents report they are “very satisfied” or “satisfied” with the program.
- Three CAH survey respondents report they are “not aware” of the Flex Program.
- When considering the specific Flex Program services ORHPC provides to CAHs, all CAHs report being “very satisfied” or “satisfied” with these services.
- CAHs are most aware of and satisfied with the CAH/Minnesota Rural Health Conference.
- Data indicate a direct correlation between use of Flex Program services and program satisfaction.
- Compared to 2005 CAH Survey data, 2009 data indicates that CAHs are more aware of the Flex Program services available.
- CAHs report high satisfaction with all of the grants available through the ORHPC, in particular the Small Rural Hospital Improvement Program.
- Survey data suggests there is a direct correlation between CAHs receiving grant funding through the ORHPC and CAHs’ satisfaction with the Flex Program.
- Ninety percent of CAHs report they are “very satisfied” or “satisfied” with CALS.
- Survey respondents working in communities with at least 20 CALS-trained providers were most likely to report they are “very satisfied” with the value of CALS training for their hospital emergency department.
- Although use and satisfaction with quality and performance improvement projects are high, survey respondents are not aware of their impact.

### **Program Services/Use**

- Although over half of CAHs are not aware of or using the Minnesota Rural Health Plan, 13 CAHs have used it for hospital planning and education purposes.
- Most CAHs report they are aware of the health professions data available through the ORHPC. Of those that are aware, approximately one quarter are using the data.
- Over half of CAHs report they are using all of ORHPC’s formal communications tools and they are most interested in information about grants and loans.
- CAHs that read ORHPC communications materials on a regular basis are more satisfied with the Flex Program.
- Most CAH communities have health care providers trained in CALS.

### **CAH Activities, Challenges, and Concerns**

- One CAH is considering changing its CAH status.
- A number of tertiary centers in Minnesota, North Dakota, and South Dakota are networked with Minnesota CAHs for the referral and transfer of patients: CentraCare Health System, St. Cloud, Minnesota, has the largest number of CAHs referring to its facility.
- CAH referral and transfer patterns have changed little since the 2005 CAH survey.
- CAHs are using telemedicine; radiology is the most common service.
- Grants to EMS agencies and EMS provider training are CAHs’ EMS priorities.
- Over 80 percent of CAHs have completed capital improvement projects in the past five years and over 70 percent have projects planned for the coming two years.
- Support for HIT/EHR in CAHs is the most identified grant funding need.

- CAHs are most concerned about hospital finances, including Medicare and Medicaid reimbursement, and physician recruitment and retention.
- Concern for physician recruitment and retention has increased over the past five years while concern for nursing recruitment and retention has declined.

## RECOMMENDATIONS FOR PROGRAM IMPROVEMENT

The information and findings identified in this evaluation indicate there are many opportunities for the Minnesota to advance its Flex Program goals. Therefore, it is recommended that the Minnesota Flex Program consider the following:

- 1) CAHs continue to report their greatest concern as physician recruitment and retention. Not only does this affect hospital performance but also access to health services. Although state and national programs have centered on increasing the supply of physicians, greater opportunities may exist to impact the demand for physicians. A community-based pilot project that would focus on redesigning the use of physicians and other health services providers (e.g., physician assistants, nurse practitioners, nurses and paramedics), the use of technology, and the community's demand for services.
- 2) It is clear that CAHs continue to be concerned about their financial status and reimbursement. Given the lack of timely data about their current financial health it is unclear whether immediate action is needed. Regardless, the Flex Program should take a multi-pronged approach to both better understand this concern and develop program initiatives to meet it.

Action steps may include:

- a. Facilitating a CAH CFO/CEO conference call series that focuses on Medicaid, Medicare and other reimbursement issues and the policy changes needed to resolve the issues.
- b. Establishing an ongoing CAH CFO discussion group as indicated as an action item by over half of the survey respondents.
- c. Monitoring the financial health of CAHs. This may include any of the following:
  - i. Working with the Minnesota Department of Health, Health Economics Program, and the hospital financial data they collect through the Health Care Cost Information System (HCCIS) or the Minnesota Hospital Association to explore the possibility of creating regular and timely CAH financial reports to better monitor CAHs' financial status. This report may be inclusive of all CAHs or limited to historically most vulnerable CAHs. Reports that may be of interest in guiding this work are the Financial Effects of Wisconsin CAH Conversion 2009, Wisconsin Office of Rural Health, <http://www.worh.org/files/FinConv09.pdf> and Critical Access Hospital Financial Analyses – 2008, Georgia State Office of Rural Health, [http://dch.georgia.gov/vgn/images/portal/cit\\_1210/52/36/138800924CAHFiscalAnalysisPhase2.pdf](http://dch.georgia.gov/vgn/images/portal/cit_1210/52/36/138800924CAHFiscalAnalysisPhase2.pdf)
  - ii. Encouraging and supporting CAHs in their participation in QHi, a quality and performance improvement data collection and benchmarking program hosted by the Kansas Rural Health Options Project at the Kansas Hospital Association.
- d. Supporting site-specific CAH revenue cycle review teams/committees to continuously identify key issues in the revenue cycle, identify systemic causes of the problem, evaluate problem indicators, and implement best practices that can eliminate the problems.

- e. Working with CAHs with attached long term care facilities to explore 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.
- 3) Sixty-two percent of CAHs report they are “very concerned” or “concerned” about their EHR. Since most CAHs are in the process of planning, identifying, purchasing, and/or implementing their EHR, there may be value in facilitating regular and ongoing conference calls for CAH CEOs and CAH HIT staff to discuss issues, identify best practices, and foster networking. This would also serve as an opportunity to better understand and address the connectivity issues identified by 25 percent of CAHs.
- 4) Although most CAHs are aware of the Flex Program and its activities, there continue to be some that are not taking advantage of the available programs and services. Flex Program staff should consider making site visits to these organizations, focusing initially on CAHs that have not applied for or received Flex Grant funding in the past five years.
- 5) CAHs continue to be interested in and supportive of CALS training for the health care providers working in their facility. This is evidenced by 90 percent being “very satisfied” or “satisfied with the program and 78 percent reporting they have staff that need to be trained in CALS. In addition, CALS training is included as a national Flex Program priority. Therefore, CALS training continues to be an appropriate use of Flex Program funding. However, since some CAHs have a limited number of health care providers trained in CALS, ongoing information, to CAHs and their emergency department managers, may be needed.
- 6) Given the number of CAHs using telemedicine to improve patient access to specialty services and their concern for recruitment of specialists, consider CAH case studies on the cost-benefits from a patient’s and health system’s perspective. CAHs that have a long history in using telemedicine services as well as those that are a great distance from tertiary centers may be good candidates for this work.
- 7) Seventy-nine percent of CAHs report quality improvement is an issue and 65 percent report being “very concerned” or “concerned.” The Flex Program could look at models and best practices to share and support for implementation in Minnesota.
- 8) Given the large number of CAHs referring and transferring patients to a few tertiary centers, the Flex Program should explore some pilot projects (based on best practices) between these facilities and CAHs to improve quality, physician recruitment, and HIT.
- 9) Considering the status of Minnesota’s Flex Program, program evaluation work should move towards a standardized outcomes-based approach. Outcome measures could be built into program activities and be required of organizations working to support the Flex Program. This would include developing standardized project tracking tools to collect initial project data as well as follow-up data as needed.
- 10) Flex Program outcomes should be reported to all stakeholders on a regular basis. This may include creating a program annual report or reporting project outcomes through the ORHPC’s regular newsletters, Web site, and/or at the annual CAH/Rural Health Conference.

### **Additional Information**

For questions and information about the Minnesota Flex Program, contact Judith Bergh at the Minnesota Department of Health, Office of Rural Health and Primary Care at (651)201-3843 or e-mail at [Judith.Bergh@state.mn.us](mailto:Judith.Bergh@state.mn.us)

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