Minnesota's Medicare Rural Hospital Flexibility Program Evaluation
Executive Summary Of Year 3 Findings
Fall 2001-Fall 2002

The Medicare Rural Hospital Flexibility (Flex) Program continues to have a positive impact on health care and hospital viability in rural communities. This report on the third year of the Flex Program evaluation focuses on quality improvement initiatives, hospital networking, emergency medical services and hospital financial performance at the first ten Critical Access Hospitals (CAHs) focusing especially on follow-up site visits and medical staff surveys with the first two Critical Access Hospitals.

Selected Findings

- All ten Critical Access Hospitals who participated in a 2002 quality improvement collaborative on congestive heart failure and atrial fibrillation noted improvements at the end of the collaborative. They also reported many examples of other quality improvement initiatives undertaken and completed in the past year.
- The ten study CAHs reported no substantive changes in their network relationships in the past year. Overall, the hospitals' network relationships are more formalized than before conversion.
- The first two CAHs reported new dialogues with their network partners, featuring more give and take. One CAH reported their best financial year ever, citing benefits the network relationship brings to patients and to the CAH. The other reported benefits from advanced information technology available through their network partner.
- Medical staff associated with the first two CAHs, while not totally satisfied with the Flex program on all dimensions, rated their satisfaction with the hospital, the primary referral hospital, and their practices in the community higher than on the initial survey two years earlier.
- Emergency room visits in the first two Critical Access Hospitals increased by 17.7% between the conversion year and the follow-up visit.
- All community focus group participants in the first two CAHs to convert rated themselves as "very satisfied" on the questions of access to care and quality of care provided by the CAH.

Follow-Up With Initial Conversion Hospitals

> *"People in the community are no longer by-passing our hospital to use other hospitals for care that could be obtained locally."*
> — Community Focus Group Participant

Considerable progress was achieved by the first two CAHs in Minnesota in the two years following their conversion. Major remodeling of the facilities was accomplished, upgrading their physical plants and making changes such as moving to one level or moving nursing stations, positively impacting patient care and accessibility. One of the CAHs had a physician on staff consistently for the first time in several years, through the J-1 Visa Waiver program. Residents noticed these changes, and in focus group discussions, noted that local residents were no longer bypassing the hospital to seek care in other

communities, based on both the consistency of the physician and on the improvements in the physical plant of the facility. At the other CAH, construction allowed better access by moving departments of the hospital to the same level, and adding assisted living for senior community residents through re-use of the facility that was vacated after the hospital remodeling. At the first two CAHs, medical staff felt that the Flex program met or exceeded their expectations through improving the image of the hospital and the availability of referral physicians and hospitals through network agreements, and by increasing the use of mid-level practitioners to serve the community. They were less satisfied with the Flex program's impact on Medicare reimbursements to the hospital, with quality assurance and performance improvement through network agreements, with the availability of clinical consultants and visiting specialists, and with improving emergency medical transportation. Overall, however, medical staff at the first two CAHs were more satisfied with networking arrangements for quality assurance, credentialing arrangements, and referral and transfer agreements than they had been two years earlier, in the year of CAH conversion. They also rated their satisfaction with the hospital, the primary referral hospital, and their practices in the community higher than they did in the survey two years ago.

Quality of Care

With respect to quality of care, the CAHs experienced a slightly higher number of deficiencies on their second survey by the Minnesota Department of Health than on their initial CAH survey. At the Year 1 CAHs, these deficiencies were satisfactorily corrected and the CAHs were brought into compliance with all applicable regulations. Among the four CAHs that converted in Year 2 and received their second survey, one was cited for 11 deficiencies. This CAH later closed, the only CAH to close in Minnesota.

The first ten CAHs were able to submit numerous examples of quality initiatives implemented during Year 3. Quality improvements were noted in areas such as completeness and timeliness on charts and records, improvements in-patient testing procedures for faster results and enhanced patient comfort, and improved practices based on regular patient satisfaction surveys as well as specialized surveys to address quality improvement in specific areas of care.

Finally, with respect to quality, community residents in the first two CAH communities were asked for their opinions regarding quality of care at the CAHs. All of the residents were "very satisfied" with access to care and quality of care at their CAH. They also expressed their desire for additional services in their communities, such as access to mental health care, and specialty care such as pediatrics, dermatology, and cardiology. Local residents felt that their hospitals brought great value to their communities. In addition to the health care itself, other benefits noted were jobs, benefits to the local economy, community involvement, and the attraction of young families and retirees to the community because of the available health services.

Quality Improvement Collaborative

> *"As hard as it is to get away from my facility, I know that one day spent in this workshop saves me three days back on the job."*
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> *"It's nice to know we are not alone – we face similar problems. I thought it was just us."*
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> — Participants in the Stratis/ORHPC Quality Collaborative

The first ten CAHs participated in a quality collaborative developed through a partnership of Stratis Health (the state Quality Improvement Organization) and the Office of Rural Health and Primary Care. The collaborative focused on congestive heart failure and atrial fibrillation. Baseline and end of collaborative measures in five areas including patient assessment, use of ACE inhibitors in appropriate

patients, patient education, Warfarin planning, and follow-up planning all showed improvements from baseline to end of project. In addition, participants from these rural hospitals discovered that they were "not alone" in some of the problems they faced in dealing with quality improvement activities. At the end of the collaborative, they knew staff from other CAHs and from Stratis Health who they could contact after the collaborative ended, as they were working to maintain these improvements at their rural hospitals. Several staff from the first quality collaborative volunteered to act as mentors for a new quality collaborative taking place during Year 4 of the Flex Program.

Network Relationships

With respect to CAHs and networking, the overall picture is one of more formalized network arrangements than existed prior to CAH conversion. In the previous two years, while the formal arrangements hadn't changed, the CAHs were working on more activities with their network partners. They have taken on new projects such as a joint clinic project, increased disaster planning activities, and infection control activities. Both CAHs noted the importance of the network relationships in their success. One administrator pointed out that their network hospital is one of the 100 most wired hospitals in the United States. This means that when a patient is transferred, all of the information is on-line; there is no need to repeat labs, for example. In addition, all radiology is read by the doctors at the network hospital. The administrator feels this results in increased quality of care for the patient. The administrator at the other CAH reported that the positive network relationship results in better customer service, which in turn has "ultimately changed revenues." Network relationships have enhanced patient care and helped rural hospitals strengthen their positions in providing care as well as financially.

Emergency Medical Services

> *"The physical plant is a big change. The visibility in the community—people have taken more ownership of the hospital through the pledge drive. People are more aware of all the services offered. I think we're keeping people in town more. We hear about problems from other ambulance services that aren't CAH—we don't have those issues. They've done a wonderful job of making us feel like we are a part of the hospital."*
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> — EMT at a local ambulance service transporting to a CAH in response to a question about the impact of the hospital's conversion to CAH

In the area of emergency medical services, the Year 1 CAHs saw an increase in the number of emergency room visits at their facilities in the previous two years. Relationships between the CAHs and the ambulance services remain strong and have been enhanced through activities such as Comprehensive Advanced Life Support (CALS) training and cross training of hospital and ambulance staff. These steps are seen as enhancing to professional relationships as well as patient care.

Financial Performance

The financial performance of the Year 1 CAHs has improved. One of the CAHs reported their strongest financial year ever. These hospitals were smaller, with lower patient census, lower revenues, and lower expenses than other rural hospitals in Minnesota at the time of conversion to CAH. Since conversion, the average daily census at the Year 1 CAHs has grown at a faster rate than that of comparable hospitals. Their revenues grew at a rate comparable to other rural hospitals, but the rate of growth of their expenses was lower. Overall, while uneven, there has been growth in revenue at the Year 1 CAHs in the years since they converted to CAH designation.

Summary

The Flex Program has brought benefits to many of Minnesota's rural hospitals. Network relationships have brought more resources in areas such as credentialing, specialist visits, and technology. Conversion to CAH has meant that rural hospitals are beginning to see improvements in their bottom lines. While the progress has been somewhat uneven, the hospitals are generally in a stronger financial position in the years following conversion than previously. Communities have been involved with their hospitals through sharing of information about the Flex Program and as hospitals have undertaken fund drives and information campaigns to assist in upgrading facilities and adding new services. Residents report "hearing around town" that more people are staying in the community to seek their medical care rather than traveling to larger population centers. Emergency room visits are up, contrary to fears that there might be ER closings at CAHs. Relationships with local ambulance services are positive, with EMS personnel reporting respect and acceptance by CAH emergency department personnel. CAHs are reporting many quality improvement initiatives, designed to improve everything from external signage to help people find the emergency room, to taste and temperature of the food, to measures to enhance patient comfort during procedures. Through the quality collaborative developed by the Office of Rural Health and Primary Care and Stratis Health, rural hospital personnel are working with personnel in other communities and with medical experts to enhance patient care. Local medical staff is more positive about the conversion of their local hospital to CAH now than two years ago. This picture is one of stronger rural hospitals, benefiting from relationships with other health providers, to improve patient care and enhance financial stability.