What do North Dakota CAH Administrators Really Think about Rural Health?—Findings and Implications from the 2014 CAH CEO Survey

Presented by:
Brad Gibbens, MPA, Acting Director and Assistant Professor

Presented to:
CAH Pre-Conference Workshop
2015 Dakota Conference on Rural and Public Health (30th Anniversary)
Minot, ND

June 3, 2015

• Established in 1980, at The University of North Dakota (UND) School of Medicine and Health Sciences in Grand Forks, ND
• One of the country’s most experienced state rural health offices
• UND Center of Excellence in Research, Scholarship, and Creative Activity
• Home to seven national programs
• Recipient of the UND Award for Departmental Excellence in Research

Focus on
– Educating and Informing
– Policy
– Research and Evaluation
– Working with Communities
– American Indians
– Health Workforce
– Hospitals and Facilities
ruralhealth.und.edu

Today’s Objectives:
• Gain useful knowledge on the environment impacting ND CAHs and rural health
  o Finance
  o Rural health issues
  o Networking/collaboration
  o Health Workforce
• Discuss how we use this information or how can we use it
Background

- 2011 – greater emphasis on EMS
- 2014 – de-emphasized EMS; emphasized number of issues facing CAHs, and new workforce section
- How findings being used:
  - North Dakota Hospital Assessment: 2014 Chartbook
  - Fact Sheets – developing fact sheets on issues
  - Health Policy – congressional delegation and state legislature
  - UNDSMH Advisory Committee – brief overview
  - Explain to others CAH issues, perspectives, functions
- RESPONSE RATE HIGHEST of the 3 Surveys – 36 of 36 (2011, 34/36)
- THANK YOU
Financial Conditions

- Local Community Support is Critical – Local Tax Support
  - Local Tax Support – Steady Increase over the years
    - 17 (47%) (2014)
    - 13 (36%) (2011)
    - 10 (28%) (2008)
    - 4 (2005)
  - Amount per year – 17 CAHs
    - 7 less than $100,000
    - 9 $100,000-$500,000 (i.e. at $300,000 or more)
    - 1 over $500,000
    - Lowest tax yield, $30,000 - Highest tax yield, $550,000
  - Over 80% of CAHs with mill levy/sales tax support received $250,000 or less
  - 14 CAHs identified type of tax – 64% city sales tax; 35% mill levy
  - City sales tax – 56% at 1% or below; none more than 5%
  - 4 CAHs without tax support indicated there was a likelihood of tax in next 5 years; 7 said it would not happen

Table 1. Percent of Sales Tax/ Mill Levy for CAHs in 2014

<table>
<thead>
<tr>
<th>City Sales Tax/ Mill Levy</th>
<th>Number of mill CAHs</th>
</tr>
</thead>
<tbody>
<tr>
<td>1/2% City sales tax</td>
<td>2</td>
</tr>
<tr>
<td>1% City sales tax</td>
<td>5</td>
</tr>
<tr>
<td>2% City sales tax</td>
<td>1</td>
</tr>
<tr>
<td>5% City sales tax</td>
<td>1</td>
</tr>
<tr>
<td>3% Mills</td>
<td>1</td>
</tr>
<tr>
<td>4% Mills</td>
<td>1</td>
</tr>
<tr>
<td>5% Mills</td>
<td>1</td>
</tr>
<tr>
<td>10% Mills</td>
<td>1</td>
</tr>
<tr>
<td>Mill levy</td>
<td>2</td>
</tr>
</tbody>
</table>

Likelihood of CAH Local Tax Support in Next Five Years (17/36 CAHs)

- Very Likely
- Likely
- Not Likely
- Will Not Happen
- Unsure
Financial Conditions

- Local Community Support is Critical – Hospital Foundations
  - Hospital Foundations have Increased Steadily
    - 29 (81%) (2014) 26 (72%) (2011) 18 (50%) (2005)

- Why local financial support is important?
  - ND CAHs have financial issues – ND Total Margin (-0.02), National (+2.23); ND Operating Margin (-1.67), National (+0.68); ND days cash on hand (48 days), National (69 days) – 2014 Flex Monitoring Team Data Summary
  - ND more reliant on Medicare (both inpatient and outpatient)
  - ND Average Daily Census much lower than CAHs nationally – U.S. 3.74 acute beds occupied per day; ND 1.50 (only AK, HI, and MT are lower)
  - CAH survey results (later) shows CEO’s identify reimbursement as a serious problem
  - POLICY argument – data shows strong commitment from rural citizens to their hospitals

Rural Health Issues

- CEOs asked to review 32 challenges (increased the number in this survey)

- CEO indicated if the challenge was: no problem, minor problem, a problem, moderate problem, severe problem

- Analysis focused on problem, moderate problem, and severe problem combined to indicate a significant concern

- Also isolated severe problem and no problem

- How does data compare over time

Significant 2014 CAH Issues

- 94% Impact of the uninsured
- 94% Impact of the underinsured
- 89% Access to mental/behavioral health services – substance abuse
- 86% Hospital reimbursement (3rd party payer)
- 86% Primary care physician workforce supply
- 85% Access to mental/behavioral health services – inpatient & outpatient
- 84% Hospital reimbursement (Medicaid)
- 80% Nursing workforce supply
- 75% Hospital reimbursement (Medicare)
- 75% Impact of health care reform
- 74% Ancillary workforce supply (lab, x-ray, PT, and others)
- SO…basically we see: insurance coverage, mental/behavioral health, reimbursement, and workforce
Center for Rural Health

Significant 2014 CAH Issues

- Looking at the data from some other angles:
  - Isolate by severe problem
    - 51% Access to mental/behavioral health – inpatient & outpatient
    - 47% Access to mental/behavioral health – substance abuse
    - 44% Hospital reimbursement (3rd party payer)
    - 43% Primary care physician workforce supply
    - 39% Hospital reimbursement (Medicaid)
    - 38% Hospital reimbursement (Medicare)
    - 35% Impact of the uninsured
    - 26% Nursing workforce supply
  - Isolate by Mean score (average)
    - Only 2 with mean over 4 – 2 mental health challenges

Center for Rural Health

Significant 2014 CAH Issues

- Access to mental health is most significant challenge (2 of 3 measures)
- But reimbursement, workforce, and insurance are also high
- Isolate by "no problem"
  - 62% access to medical library – remote access
  - 57% relationship with designated tertiary hospital
  - 51% community support for hospital
  - 47% maintaining trauma designation
  - 40% providing pharmacy coverage
  - 38% access to medical library – on site
  - 35% adequate patient transport services (EMS)
  - 34% access to dental care
  - 31% providing 24 hour emergency coverage
  - 28% non-primary care physician workforce supply

Center for Rural Health

Survey Results Over Time

<table>
<thead>
<tr>
<th>Issue</th>
<th>2014</th>
<th>2011</th>
<th>2008</th>
<th>2005</th>
</tr>
</thead>
<tbody>
<tr>
<td>Impact on Uninsured</td>
<td>96%</td>
<td>91%</td>
<td>79%</td>
<td>96%</td>
</tr>
<tr>
<td>Impact of Underinsured</td>
<td>94%</td>
<td>91%</td>
<td>75%</td>
<td>95%</td>
</tr>
<tr>
<td>Access to Mental/Behavioral Health Services – substance Abuse*</td>
<td>89%</td>
<td>79%</td>
<td>79%</td>
<td>73%</td>
</tr>
<tr>
<td>Hospital Reimbursement – 3rd Party Payer</td>
<td>86%</td>
<td>94%</td>
<td>95%</td>
<td>95%</td>
</tr>
<tr>
<td>Primary Care Physician Workforce Supply*</td>
<td>86%</td>
<td>91%</td>
<td>82%</td>
<td>72%</td>
</tr>
<tr>
<td>Access to Mental/Behavioral Health Services – inpatient/outpatient</td>
<td>85%</td>
<td>79%</td>
<td>79%</td>
<td>73%</td>
</tr>
<tr>
<td>Hospital Reimbursement (Medicaid)</td>
<td>84%</td>
<td>Not asked</td>
<td>Not asked</td>
<td>Not asked</td>
</tr>
<tr>
<td>Nursing Workforce Supply</td>
<td>80%</td>
<td>85%</td>
<td>89%</td>
<td>81%</td>
</tr>
<tr>
<td>Hospital Reimbursement (Medicare)</td>
<td>79%</td>
<td>88%</td>
<td>86%</td>
<td>84%</td>
</tr>
<tr>
<td>Impact of Health Reform (2011 stated as readiness)</td>
<td>75%</td>
<td>Not asked</td>
<td>Not asked</td>
<td>Not asked</td>
</tr>
<tr>
<td>Ancillary workforce supply (lab, x-ray, PT)</td>
<td>74%</td>
<td>73%</td>
<td>86%</td>
<td>88%</td>
</tr>
</tbody>
</table>
Networking and Collaboration

- Rural health relationships with other provider organizations and community groups are critical
- Survey asked about the CAH/Tertiary relationships
- Survey asked about relationship with other community organizations.

Center for Rural Health

ND CAH and Tertiary (PPS) Hospital Relationship

Number of CAHs Participating in Health Related Activities within a Network
Center for Rural Health

Health Workforce

- Totally new focus – related in part to CRH need to develop more data on the subject for both policy and planning purposes along with the Medical School Biennial Report
- Data on workforce capacity, vacancy rates, barriers to recruitment (have not had this data before – THANK YOU)

Center for Rural Health

CAH & PPS Hospitals’ Total Entry-Level & Nursing Staff FTEs

<table>
<thead>
<tr>
<th>Category</th>
<th>RNs</th>
<th>NPs</th>
<th>LPNs</th>
<th>NAs</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>Entry-level</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Nurse assistants</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>LPNs</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>NAs</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>RNs</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>NPs</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>LPNs</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>NAs</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Total</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

[Graph showing data]
Total Primary Care Physician Positions by Region and CAH/PPS Designation

Importance of Various Barriers to Physician Recruitment in CAHs

Assessment of Flex Program Impact

- Substantial Impact
  - 64% Flex subcontracted funds to CAHs
  - 56% CAH Quality Network
  - 53% Community Health Needs Assessments
  - 26% CAH Pre-Conference at Dakota Conference

- Moderate and Substantial Combined
  - 84% CAH Quality Network
  - 82% Flex subcontracted funds to CAH
  - 78% Community Health Needs Assessments
  - 68% CAH Pre-Conference at Dakota Conference
  - 64% CAH Profiles
  - 52% Economic impact studies

- No Benefit
  - 31% CAH Board Teaching – “Boot Camp”
  - 31% Staff Surveys Internal Personnel Audit
Conclusions

- Steady increase in local financial support to the hospital – taxes and hospital foundation – Policy implications “shows skin in the game”
- Insurance coverage, mental health, reimbursement, and workforce remain primary issues – some evidence that mental health is the most critical
- These issues have history – 2014, 2011, 2008, and 2005 – Policy implications – frame as long standing problems that we need policy partners
- CAHs value their network relationships with tertiary – strong, flexible, comprehensive services, trust, continue to grow and have impact
- These issues have history – 2014, 2011, 2008, and 2005 – Policy implication – frame as long standing problems that we need policy partners
- Most common needs CAHs use networks to address – 1) quality (60 CAHs), 2) staff education (49), and Health IT (44)
- Most used network is the CAH Quality Network – 25 CAHs for quality, 17 for staff education; but St Alexius Network had more breadth, most CAHs on 4 of the 9 subjects
- For community partners, CAHs identified their highest quality relationships to be: ambulance, ITC, clinic, and pharmacy

For the first time we have empirical data on hospital workforce supply and vacancy rates
- CAHs employ slightly more NP than PA, but as a percentage of the disciplines a slightly higher percentage of all PA are in CAHs than that of NPs
- MLT/CLT discipline with highest presence in CAH – 47% of this group are in CAHs
- Vacancy rate data – Vacancy rates higher in CAHs for 13 of 23 disciplines
- Primary care is more prevalent in CAHs; specialty care is more prevalent in PPS – Policy implications – recruitment needs may differ and so may the strategies and incentives; what does it mean for newly designed delivery systems – ACO
- Housing, workload, and cultural opportunities important in recruitment and can be barriers – APGAR also found mental health (again an issue)

Shameless Self-Promotion Slide

- Lynn Barr – Keynote – ACOs Adapting to Healthcare Reform – today, 12:45
- North Dakota Rural Health Association Meeting – Wednesday, 7:00 AM
- Tiffany Knudt and Brad Gibbens – Building a Vision for Health: Community Ownership and Engagement – Wednesday, 9:15 AM
- Jody Ward and Shila Thorson – Status of Stroke/Cardiac Systems of Care in North Dakota – Wednesday, 3:35 PM
Contact us for more information!

501 North Columbia Road, Stop 9037
Grand Forks, North Dakota 58202-9037

701.777.3848 • ruralhealth.und.edu