Results from the 2011 ND CAH Administrator Survey

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Center for Rural Health

• 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

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

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Background

• Surveys completed in 2005, 2008, and 2011 – standardization but flexibility – compare years
• 2011 – greater emphasis on EMS
• 2011 – less organizational, financial, and staff information – other sources such as NDRHA
• Data used:
  o Fact Sheets – 5 completed http://ruralhealth.und.edu/projects/flex/publications.php
  o Reports – Flex program reports, CRH annual, UNDSMHS
  o Health Policy – congressional delegation and state legislature
  o Explain to others CAH issues, perspectives, functions
• RESPONSE RATE HIGHEST of the 3 Surveys – 34 of 36 CAHs completed

• THANK YOU
Organizational Conditions

- CAHs are hub of rural health services – increasing access to quality care
  - Most CAHs own and operate a primary care clinic and/or a nursing home
    - 27 CAHs (75%) operate 60 primary care clinics – 47 are RHC
    - 14 CAHs (39%) operate nursing homes - 700 nursing home beds
      - 11 CAHs (31%) operate both a PC clinic and a nursing home
  - 9 CAHs (25%) operate ambulances
  - 9 CAHs (25%) own apartments that are operated to meet elderly and/or disabled needs
  - 7 CAHs (19%) operate assisted living units
  - 6 CAHs (17%) offer basic care.
  - 5 CAHs (14%) provided home care
  - Only 5 CAHs (14%) are traditional stand-alone organizations

Looking forward

- Asked about structural changes (add/delete services, ownership, etc.)
  - 28 CAHs (82%) said stay the same
  - 9 (26%) said add a service and only 1 said eliminate a service (home care)
  - 2 CAHs thought hospital may be acquired by another entity
  - No one indicated that closure was anticipated

- 2011 and 2005 surveys similar - CAH would stay the same
- 2011 much more confident about adding services than 2005 and 2008
- Conclusion – significant issues in rural health care delivery, but CAHs appear confident, even adding services, can weather the storm
Figure 1. CAH Organizational Structure

**Financial Conditions**

- ND CAHs higher financial constraints in comparison to national data
  - ND CAH Operating Margins (2009) -2.66
    - National CAH Operating Margins +0.66
    - MN +3.57, SD +1.72, MT -3.53
    - Nationally about 52% of CAHS have negative operating margins; in ND 63%
  - ND CAH Total Margins (2009) -2.14
    - National CAH Total Margins +1.89
    - MN +2.93, SD +1.61, and MT +1.60
    - In every year since 2004, ND CAHs averaged negative total margins but nationally, positive
    - Nationally about 40% of CAHS have negative total margins; in ND 53%
  - Some improvement in ND over last year for both total and operating margins
  - Cash on hand – nationally (about 66 days); ND (about 37 days) – recommended is 60 days

[Image of CAH Organizational Structure]
Figure 2. North Dakota and US CAH Total Margins 2004-2009

Financial Conditions

- Local Community Support is Critical
  - 13 CAHs (2011) had local tax support – 10 CAHs (2008), 4 CAHs (2005)
  - A few thousand dollars to 3 CAHs receiving $100,000/year and 2 CAHs $200,000
  - 26 CAHs (2011) had a hospital foundation – 18 (2005)

- Communities are willing to support their local hospital with their money – willing to tax themselves and target donated funds

- Message conveyed to congressional delegation – need some level of federal funding for rural health but communities also willing to support their health systems
CAH and EMS Collaboration

- EMS Challenges in Rural North Dakota
  - Recruitment and retention of volunteers
  - For 40 years more than 75% of the cost of providing EMS in rural ND has been subsidized by donated labor
  - Over 90% of EMTs are volunteer
  - 35% of ambulance services have difficulty filling squad schedules (46% of volunteers on service rosters are actually inactive)
  - Need to provide financial incentives for volunteers is increasing
  - Some EMS workers are taking more than 120 hours of call time per week
  - Some services reported expecting to close within the next 5 years

CAHs and EMS

- 9 CAHs own and operate ambulance systems
- Pay per shift ranges dependent on licensure level (paramedic -$42, EMT-I -$25, EMT-B -$12, and driver with CPR - $10)
- CAHs estimated annual costs to run an ambulance ranged from $88,500 to $285,000 with an average of $166,000
- 5 CAHs reported reoccurring annual loses that ranged from $10,000 to $60,000
- CAH paid ambulance employees do other duties:

<table>
<thead>
<tr>
<th>Emergency department</th>
<th>Provide education – CPR</th>
</tr>
</thead>
<tbody>
<tr>
<td>Inpatient care</td>
<td>Cardiac rehabilitation</td>
</tr>
<tr>
<td>Building maintenance</td>
<td>Community Relations</td>
</tr>
<tr>
<td>Public health</td>
<td>Stress lab</td>
</tr>
<tr>
<td>Same day surgery</td>
<td>Disaster planning</td>
</tr>
<tr>
<td>Transport LTC residents</td>
<td>Human resources</td>
</tr>
</tbody>
</table>
CAHs and EMS

- CAH administrators rated the quality of the relationship with a non-CAH ambulance highly
  - Excellent (8 CAHs) Above average (9) Average (8) Below average (1)
  - The 8 CAHs rating this as excellent was the highest recorded, higher than clinic, public health, LTC, pharmacy, dental, economic development, and other health organizations

- 15 CAHs include ambulance personnel in quality improvement activities and 12 do not

- 62% of CAHs gave a positive review to “adequate patient transport services” and 38% said it was a problem (in 2005 54% of CAHs said this was a problem)

- CAHs gave positive marks to ambulance response times, timeliness of patient care reports, and ambulance delivery of appropriate care

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**Figure 3. EMS Issues - CAH Perspective of Significance of Each as a Problem**

- Lack of legislation recognizing EMS as an essential service: 82%
- Staffing: 82%
- Community understanding of true cost of providing EMS: 79%
- Funding: 76%
- Community view that EMS should be a “free service”: 53%
- EMS Leadership: 35%
- Medical director involvement: 32%
- Useable data & outcome information: 32%
- Integration & communication between hospital & ambulance: 12%
CAHs and Networks

- CAHs work within network arrangements to better address common issues

- Use networks to gain greater efficiency and effectiveness, provide cost savings, build capacity, and achieve a higher level of organizational performance

- CAH survey found that the areas that ND CAHs network around tend to correspond with the areas they expressed concern – cost factors, greater efficiency, sharing services, and staff

- CAHs are responding to key federal health policy focus through networks

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CAHs and Networks

- CAHs belong to multiple networks – 36 CAHs work with 9 hospital networks – total of 65 CAH arrangements

- Network with: Altru, CHI, Essentia, MedCenter One, Northland Healthcare Alliance, North Region Health Alliance, Sanford, St. Alexius, and Trinity

- 2 most common functions that CAHs address through networks are quality improvement (38 CAH arrangements) and HIT (37 CAHs).

- Average size of a CAH-based network is 7 CAHs (St. Alexius – 11 CAHs, and smallest is Essentia – 1 CAH)

- How Flex could assist:
  - Building and facilitating collaboration
  - Addressing staffing, education, and specialty care
  - Supporting technology
  - Emphasizing quality issues as they relate to credentialing and peer review
  - Supporting primary care
  - Addressing EMS transport and education
Figure 4. Common Types of CAH Networks

- Quality improvement: 38 CAHs
- Health Information Technology (HIT): 37 CAHs
- Staff education: 34 CAHs
- Staff or board development: 21 CAHs
- Medical education: 22 CAHs
- Medical coverage or support: 21 CAHs
- Recruitment/retenion: 18 CAHs
- Supply management: 16 CAHs
- EMS: 9 CAHs

CAHs and Networks

- Evaluation of CAH Networks: Primary tertiary hospital
  - 2011 CAH administrators less likely to rate their network as strong in comparison to other years
  - CAHs see their networks as flexible – 80%
  - About half (47%) see their network as comprehensive – services provided
  - 2011 CAH administrators were much less inclined to say that their network fosters a sense of trust between providers (35% in 2011 and 62% in 2008, but 34% in 2005)
  - 2011 CAH administrators were much less inclined to say that they were optimistic that their network would grow and positively impact their hospital (38% - 2011 and 75% - 2008)
Figure 5. CAH/Tertiary Networks Assessment of Characteristics

- Overall, issues associated with finance (reimbursement and factors that impact finance including the ability of patients to pay for services) and health professional workforce were the two most pressing rural health issues.
- Highest rated issue in all 3 surveys was hospital reimbursement from non-Medicare 3rd Party Payers.
- About 95% in all 3 years (only issue to do this) – Problem, Moderate Problem, and Severe problem.
- Medicare is a concern but not to the same degree – mid to high 80% (88% in 2011).
- Impacting the financial picture – insurance:
  - Impact of the uninsured – 91%.
  - Impact of the underinsured – 91%.
  - Increased from about 80% in 2008.
- Workforce:
  - Physician workforce supply -91%, increased from 2008 and 2005.
  - Nursing workforce supply – 85%, down slightly from 2008 and up from 2005.
  - Ancillary workforce supply (lab, X-ray, PT, OT, RT) – 73% and down from 2008 and 2005.

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CAHs and Rural Health Issues

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### Figure 2. Rural Hospital Issues Comparison of CAH Administrator Surveys 2011, 2008, 2005

<table>
<thead>
<tr>
<th>Issue</th>
<th>2011*</th>
<th>2008</th>
<th>2005*</th>
</tr>
</thead>
<tbody>
<tr>
<td>Hospital Reimbursement (non-Medicare 3rd Party Payer)</td>
<td>94%</td>
<td>96%</td>
<td>95%</td>
</tr>
<tr>
<td>Health Care Reform Readiness</td>
<td>94%</td>
<td>Not Asked</td>
<td>Not Asked</td>
</tr>
<tr>
<td>Physician Workforce Supply</td>
<td>91%</td>
<td>82%</td>
<td>72%</td>
</tr>
<tr>
<td>Impact of Uninsured</td>
<td>91%</td>
<td>79%</td>
<td>96%</td>
</tr>
<tr>
<td>Impact of Underinsured</td>
<td>91%</td>
<td>75%</td>
<td>95%</td>
</tr>
<tr>
<td>Hospital Reimbursement - Medicare</td>
<td>88%</td>
<td>86%</td>
<td>84%</td>
</tr>
<tr>
<td>Nursing Workforce Supply</td>
<td>85%</td>
<td>89%</td>
<td>81%</td>
</tr>
<tr>
<td>Physical Plant Building Issues</td>
<td>79%</td>
<td>64%</td>
<td>88%</td>
</tr>
<tr>
<td>Access to Mental Health Services</td>
<td>79%</td>
<td>79%</td>
<td>73%</td>
</tr>
<tr>
<td>Ancillary Workforce Supply (lab, x-ray, PT, etc.)</td>
<td>73%</td>
<td>86%</td>
<td>88%</td>
</tr>
</tbody>
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*Totals represent the combination of problem, moderate problem, and severe problem

### Figure 7. Issues Rated a Severe Problem, 2011 Survey

- Physician Workforce Supply: 62%
- Hospital Reimbursement (Third Party Payer): 56%
- Access to Mental Health Services: 44%
- Impact of the Uninsured: 38%
- Hospital Reimbursement (Medicare): 38%
Conclusion

- CAHs are critically important providers of essential quality health services
- Serve as health hubs for communities
- Each survey indicates more willingness on part of rural citizens to target money to stabilize and support the CAH
- Part of our health policy message – federal and local support, partnership
- Twin health policy goals that CAHs can address – Access and improved health status
- ND CAHs, relative to national numbers, are more financial vulnerable
- CAHs not anticipating much significant change but many are looking to add services – sense of optimism
- CAHs see finance and workforce as the big issues they face
- CAHs use networks extensively and network focus match policy drivers such as quality improvement and HIT
- CAHs have mixed feelings about their networks

Contact us for more information!

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