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

Presented by:
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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

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  – Policy
  – Research and Evaluation
  – Working with Communities
  – American Indians
  – Health Workforce
  – Hospitals and Facilities

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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
  - UNDSMHS 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
North Dakota CAHs and Referral Hospitals
Financial Conditions

• Local Community Support is Critical – Local Tax Support
  o Local Tax Support – Steady Increase over the years
  o Amount per year – 17 CAHs
    ➢ 7 less than $100,000
    ➢ 9 $100,000-$500,000 (3 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
  o 14 CAHs identified type of tax – 64% city sales tax; 35% mill levy
  o City sales tax – 56% at 1% or below; none more than 5%
  o 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 ND 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>9 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)
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
(combined problem, moderate problem, and severe problem scores)

- 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
- 79% 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
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
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”
  o 62% access to medical library – remote access
  o 57% relationship with designated tertiary hospital
  o 51% community support for hospital
  o 47% maintaining trauma designation
  o 40% providing pharmacy coverage
  o 38% access to medical library – on site
  o 35% adequate patient transport services (EMS)
  o 34% access to dental care
  o 31% providing 24 hour emergency coverage
  o 28% non-primary care physician workforce supply
## Survey Results Over Time

<table>
<thead>
<tr>
<th>Issue</th>
<th>2014</th>
<th>2011</th>
<th>2008</th>
<th>2005</th>
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<tbody>
<tr>
<td>Impact on Uninsured</td>
<td><strong>94%</strong></td>
<td>91%</td>
<td>79%</td>
<td><strong>96%</strong></td>
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<tr>
<td>Impact of Underinsured</td>
<td><strong>94%</strong></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><strong>96%</strong></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 asked as readiness)</td>
<td>75%</td>
<td><strong>94%</strong></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>
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</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.
ND CAH and Tertiary (PPS) Hospital Relationship
## Number of CAHs Participating in Health Related Activities within a Network

<table>
<thead>
<tr>
<th>Name of Network</th>
<th>Not a Member</th>
<th>Quality</th>
<th>Recruit/Retention</th>
<th>Health IT</th>
<th>Staff Ed.</th>
<th>Medical Ed.</th>
<th>EMS</th>
<th>Medical Coverage/Support</th>
<th>Board Develop.&amp; Ed.</th>
<th>Supply Mgmt.</th>
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<tbody>
<tr>
<td>Altru Health System</td>
<td>21</td>
<td>7</td>
<td>_</td>
<td>9</td>
<td>5</td>
<td>7</td>
<td>_</td>
<td>4</td>
<td>6</td>
<td>1</td>
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<tr>
<td>Catholic Health Initiatives</td>
<td>25</td>
<td>6</td>
<td>6</td>
<td>6</td>
<td>5</td>
<td>3</td>
<td>4</td>
<td>6</td>
<td>5</td>
<td></td>
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<tr>
<td>Essentia Health System</td>
<td>30</td>
<td>_</td>
<td>_</td>
<td>1</td>
<td>_</td>
<td>_</td>
<td>_</td>
<td>_</td>
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<tr>
<td>Northland Healthcare Alliance</td>
<td>22</td>
<td>3</td>
<td>2</td>
<td>7</td>
<td>5</td>
<td>2</td>
<td>_</td>
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<td>2</td>
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<tr>
<td>North Region Health Alliance</td>
<td>21</td>
<td>_</td>
<td>_</td>
<td>4</td>
<td>2</td>
<td>1</td>
<td>_</td>
<td>_</td>
<td>5</td>
<td>2</td>
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<tr>
<td>Sanford Bismarck</td>
<td>26</td>
<td>_</td>
<td>1</td>
<td>_</td>
<td>_</td>
<td>_</td>
<td>_</td>
<td>2</td>
<td>1</td>
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<tr>
<td>Sanford Fargo</td>
<td>19</td>
<td>8</td>
<td>3</td>
<td>6</td>
<td>3</td>
<td>3</td>
<td>5</td>
<td>4</td>
<td>4</td>
<td></td>
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<tr>
<td>St. Alexius Medical Center</td>
<td>19</td>
<td>7</td>
<td>7</td>
<td>8</td>
<td>6</td>
<td>7</td>
<td>2</td>
<td>7</td>
<td>5</td>
<td>5</td>
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<tr>
<td>Trinity Hospital</td>
<td>22</td>
<td>4</td>
<td>1</td>
<td>1</td>
<td>1</td>
<td>1</td>
<td>1</td>
<td>2</td>
<td>1</td>
<td>1</td>
</tr>
<tr>
<td>CAH Quality Network</td>
<td>7</td>
<td>25</td>
<td>2</td>
<td>3</td>
<td>17</td>
<td>5</td>
<td>2</td>
<td>2</td>
<td>3</td>
<td>1</td>
</tr>
</tbody>
</table>
ND CAHs and Average Scores and Most Common Responses for Quality of Relationship with Community Organizations
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**
### CAH & PPS Hospitals’ Total Entry-Level & Nursing Staff FTEs

<table>
<thead>
<tr>
<th>Role</th>
<th>CAH</th>
<th>PPS</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>Entry-level</td>
<td>452.0</td>
<td>934.4</td>
<td>1386.4</td>
</tr>
<tr>
<td>Nurse assistants</td>
<td>280.7</td>
<td>680.5</td>
<td>961.2</td>
</tr>
<tr>
<td>LPNs</td>
<td>187.7</td>
<td>740.8</td>
<td>928.5</td>
</tr>
<tr>
<td>NPs</td>
<td>50.5</td>
<td>214.6</td>
<td>265.1</td>
</tr>
<tr>
<td>RNs</td>
<td>605.0</td>
<td></td>
<td>3741.4</td>
</tr>
</tbody>
</table>

**Total Staff FTEs:**
- CAH: 3741.4
- PPS: 4346.4
- Total: 8087.4
CAH and PPS Hospitals’ Total FTEs by Health Profession

- **MLT/CLT**: CAH - 86.3, PPS - 96.8, Total - 183.2
- **Physician assistants**: CAH - 41.6, PPS - 131.2, Total - 172.8
- **Occupational therapists**: CAH - 14.8, PPS - 88.4, Total - 103.2
- **Physical therapists**: CAH - 69.2, PPS - 230.0, Total - 299.2
- **Med. Records Tech.**: CAH - 69.8, PPS - 120.8, Total - 190.6
- **Dieticians**: CAH - 15.7, PPS - 55.5, Total - 71.2
- **Respiratory therapists**: CAH - 37.8, PPS - 212.6, Total - 250.4
Physician Positions in CAHs & PPS Hospitals by Care Type

- Specialist
  - CAH Total: 27
  - PPS Total: 860
  - State Total: 887

- Primary Care
  - CAH Total: 63
  - PPS Total: 337
  - State Total: 400
Total Primary Care Physician Positions by Region and CAH/PPS Designation

- CAH
  - SW: 23
  - SE: 4
  - NE: 12
  - NW: 24

- PPS
  - SW: 72
  - SE: 182
  - NE: 65
  - NW: 18

- Total
  - SW: 95
  - SE: 186
  - NE: 77
  - NW: 42
Importance of Various Barriers to Physician Recruitment in CAHs
(1=not important problem, 4=important problem)

- Lack of continuing education/training opportunities
- Hospital facility condition
- Lack of spousal employment opportunities
- Lack of cultural activities and opportunities
- Difficulty finding good housing
- Poor local elementary and high schools
- Excessive workload and call schedule
- Noncompetitive compensation package
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**
  - 35% CAH Board Training – “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 implication – 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
- 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, LTC, clinic, and pharmacy
Conclusions

- **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 Knauf 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!

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