Rural Hospital Flexibility Program: Moving Forward

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Focused on Access, Financing and Quality Through:
- Health services research
- Health policy
- Education
- State and community health services development
- Information Resource

How: Through partnerships

Where: Grand Forks, ND
When: Established over 20 years ago
Outline

• National Conditions

• MN, ND, SD Conditions

• Critical Access Hospitals (CAH)

• Rural Hospital Flexibility Program (FLEX)

National Conditions

A glance at rural and urban America

<table>
<thead>
<tr>
<th></th>
<th>Rural</th>
<th>Urban</th>
</tr>
</thead>
<tbody>
<tr>
<td>Percentage of U.S. population</td>
<td>20%</td>
<td>80%</td>
</tr>
<tr>
<td>Population aged 65 and older</td>
<td>18%</td>
<td>15%</td>
</tr>
<tr>
<td>Population that is white</td>
<td>83%</td>
<td>69%</td>
</tr>
<tr>
<td>Private insurance</td>
<td>64%</td>
<td>69%</td>
</tr>
<tr>
<td>Medicare beneficiaries</td>
<td>23%</td>
<td>20%</td>
</tr>
<tr>
<td>Medicare hospital payment to cost ratio</td>
<td>90%</td>
<td>100%</td>
</tr>
</tbody>
</table>

Source: NRHA web page
National Conditions

Rural is not the same as agriculture.

- Only 0.39% of the U.S. population is engaged in farming as a primary occupation.
- Only 1.78% of the U.S. rural population is engaged in farming as a primary occupation.
- Farming accounts for 7.6% of rural employment.
- In 1999, 90% of all farm operators' household income came from off-farm sources.

Source: Charles Fluharty - RUPRI

National Conditions

The rural economy has strengthened but remains fragile.

- Over 2 million more Americans are employed today than at the start of the last decade.
- Rural workers are nearly twice as likely to earn the minimum wage (12% - rural; 7% - urban).
- Rural workers are more likely to be underemployed and less likely to improve their employment situation over time.
- Rural/urban earnings gap persisted and widened in the 1990's (from 73.8% to 70%).

Source: Charles Fluharty - RUPRI
National Conditions

- Rural income remain lower than urban ($39,000 – urban; $30,000 – rural; median income 1997).
- Poverty rates are higher in rural areas than urban (14.2% - rural; 11.2% - urban)  
- Rural poverty is working poverty as 2/3 of rural poor live in a family with at least one working member.
- 382 persistent poverty counties – poverty rates 20% or higher in 1959, 1969, 1979, 1989, 1999
  - 6 ND
  - 13 SD
  - 0 MN

Source: Charles Fluharty - RUPRI

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National Conditions

The 1990’s witnessed certain population shifts.

- From 1990-2000, 70% of rural counties increased population.
- About 87% of these counties derived some or all of their increase from in-migration of metro residents.
- From 1990-2000, 2.2 million more people moved from the city to the county, than the reverse.
- Significant rural decline continues in the Great Plains and other disadvantaged rural areas (mining and agriculture counties had the greatest relative declines in the pace of growth).

Source: Charles Fluharty - RUPRI
MN, ND, SD Conditions

• During the 1990’s 70% of rural counties gained population

  - MN  71% of Counties (62/87)
  - SD  52% of Counties (34/66)
  - ND  12% of Counties (6/53)

*Source: US Census*

**Change in Total Population for North Dakota and Minnesota**

*Percentage Change between 1990 and 2000*

- Loss: -25.32% to -11.87%
- Loss: -11.86% to 0%
- Gain: 0% to 13.39%
- Gain: 13.4% to 30.96%
- Gain: 30.97% to 54.72%
Change in Persons Age 0 to 18 for North Dakota and Minnesota

Percentage Change between 1990 and 2000

All States In The Region Grew Faster In The 90s Than 80s
MN, ND, SD Conditions

General population changes

- U.S. population grew by 13.2% from 1990-2000
- MN grew by 12.4% (21st)
- SD grew by 8.5% (36th)
- ND grew by 0.5% (50th)

Source: U.S. Census

MN, ND, SD Conditions

<table>
<thead>
<tr>
<th></th>
<th>MN</th>
<th>ND</th>
<th>SD</th>
<th>U.S.</th>
</tr>
</thead>
<tbody>
<tr>
<td>Median age</td>
<td>35.4</td>
<td>36.2</td>
<td>35.6</td>
<td>35.3</td>
</tr>
<tr>
<td>&lt; 19 years</td>
<td>29.1%</td>
<td>28.5%</td>
<td>30.2%</td>
<td>28.6%</td>
</tr>
<tr>
<td>&gt; 65 years</td>
<td>12.1%</td>
<td>14.7%</td>
<td>14.3%</td>
<td>12.4%</td>
</tr>
<tr>
<td>&gt; 85 years</td>
<td>1.7%</td>
<td>2.3%</td>
<td>2.1%</td>
<td>1.5%</td>
</tr>
<tr>
<td>White</td>
<td>89.4%</td>
<td>92.4%</td>
<td>88.7%</td>
<td>75.1%</td>
</tr>
<tr>
<td>African American</td>
<td>3.5%</td>
<td>0.6%</td>
<td>0.6%</td>
<td>12.3%</td>
</tr>
<tr>
<td>American Indian</td>
<td>1.1%</td>
<td>4.9%</td>
<td>8.3%</td>
<td>0.9%</td>
</tr>
</tbody>
</table>

Source: U.S. Census
MN, ND, SD Conditions

• Frontier Counties
  • MN 7% (6/87)
  • SD 52% (34/66)
  • ND 66% (35/53)

Source: US Census

MN, ND, SD Conditions

• Economy/Occupations
  • Mg/Professional 36% 33% 33% 34%
  • Sales and Office 27% 26% 27% 27%
  • Productive, Transportation 15% 12% 14% 15%
  • Services 14% 17% 16% 15%
  • Farming, Fishing, Forestry 1% 2% 2% 1%

Source: US Census
National and State

Why the focus on national and state level condition's?

- Impact: Individual, Community, Health
  - Individual and health status
  - Ability for individual to access health services
  - Ability of individual and business to pay for health services
  - Economic and community development
  - Health sector, including the rural hospital, to services

Change in the Rural Environment

Environmental Impacts
- Demographics
- Economic Conditions
- Political Process
- Workforce
- Finance
- Health Organizations
- Culture and Attitude

Action
- Planning and Assessment
- Education
- Community Forums
- Task Force Development
- Collaboration
- Advocacy
- Program Development
- Integration of Health Care with Community and Economic Development
- Hospital Diversification

Community and Hospital
- Take Action
- No Action
What is a CAH?

- History of Alternative Hospital Arrangements
  - Experimental Projects 1947-1980:
    - California - Kentucky
    - Colorado - North Carolina
    - Florida - Washington
    - Wyoming
  - Special Medicare Waivers
    - MAF (1987)
    - EACH/PCH (1989)
    - BBA 1997 (CAH)

Critical Access Hospital Criteria

- Rural Location
- 25 beds (15 acute)
- 35 miles from another hospital
  - 15 by secondary roads
  - Necessary provider
- 24-hour emergency services
- 96-hour average LOS
- Network member
  - Referral and transfer
  - Communication and telemedicine
  - Transportation
  - Credentialing and quality assurance
- MDs, PAs, NPs, etc., subject to state and federal laws re: duties
- Medicare participation
The Purpose

- Local access through administrative flexibility
  - Staffing
  - Services

- Cost-based Medicare payments

Why Become a Critical Access Hospital?

- Local economic stability
- Local access through networks
- 100 percent access; zero health disparities
- Foundation for related personnel and services
National CAH/FLEX

• Growth in Number of CAHs
  ➢ 1998 - 38
  ➢ 1999 - 66
  ➢ 2000 - 232
  ➢ 2001 - 458
  ➢ 2002 - 661
  ➢ 2003 - 722 (Jan.)
  ➢ 2003 - 762 (April)
CAH

Top 10 States

- Nebraska 58
- Kansas 54
- Iowa 49
- Minnesota 46
- Texas 35
- Georgia 28
- North Dakota 28
- South Dakota 28
- Wisconsin 28
- Illinois 26

Total 380

Account for 49.86% of all CAHs

CAH

As of April, 2003

- 762 CAH
- 69 Certifications Pending
- 311 Hospitals Actively Considering Conversion
- 786 Hospital Eligible for Conversion
  (eligible but not counted in above)
### National CAH/FLEX Data
#### Hospital Characteristics

<table>
<thead>
<tr>
<th></th>
<th>CAHS (N = 721)</th>
<th>Small Rural Hospitals (ADC ≤ 15) (N = 439)</th>
<th>Other Rural Hospitals (ADC ≤ 15) (N = 939)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Average Number of Beds</td>
<td>30.2</td>
<td>34.5</td>
<td>95.9</td>
</tr>
<tr>
<td>Median Daily Census (acute only)</td>
<td>3.7</td>
<td>7.3</td>
<td>30.1</td>
</tr>
<tr>
<td>Average Length of Stay (acute only)</td>
<td>3.3</td>
<td>3.7</td>
<td>3.9</td>
</tr>
<tr>
<td>Average Proportion of Discharges Paid for by Medicare</td>
<td>59.3%</td>
<td>54.3%</td>
<td>47.8%</td>
</tr>
<tr>
<td>Average Operating Margin</td>
<td>-16.2%</td>
<td>-19.2%</td>
<td>-1.1%</td>
</tr>
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</table>

### National CAH/FLEX Data
#### County Characteristics and Health Care Resources

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<tr>
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<th>Small Rural Hospitals (ADC ≤ 15) (N = 439)</th>
<th>Other Rural Hospitals (ADC ≤ 15) (N = 939)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Hospitals in a Health Professional Shortage Area (HPSA)</td>
<td>73.7%</td>
<td>76.1%</td>
<td>64.9%</td>
</tr>
<tr>
<td>Hospitals in Frontier Counties</td>
<td>36.5%</td>
<td>17.5%</td>
<td>2.2%</td>
</tr>
<tr>
<td>Hospitals in County with a “Rural Health Clinic”</td>
<td>66.3%</td>
<td>60.1%</td>
<td>50.8%</td>
</tr>
<tr>
<td>Hospitals in Counties with a Federally-Qualified Health Center</td>
<td>19.1%</td>
<td>29.2%</td>
<td>23.0%</td>
</tr>
</tbody>
</table>
FLEX Networks

- CAHs in Systems 24%
- CAHs in formal network 61% relationships
  - Hospital member only networks 31%
  - Broad membership networks 69%

Source: Walter Gregg – UMN Rural Health Research Center

FLEX
Benefits of Network Participation

<table>
<thead>
<tr>
<th>Benefit</th>
<th>Very/Extremely Beneficial</th>
</tr>
</thead>
<tbody>
<tr>
<td>Strengthen Existing Services</td>
<td>58%</td>
</tr>
<tr>
<td>Obtain Technical Assistance</td>
<td>53%</td>
</tr>
<tr>
<td>QA/QI Processes</td>
<td>49%</td>
</tr>
<tr>
<td>Financial Performance</td>
<td>37%</td>
</tr>
<tr>
<td>Diversify into New Services</td>
<td>35%</td>
</tr>
<tr>
<td>Obtain New Technologies</td>
<td>32%</td>
</tr>
<tr>
<td>Obtain Capital</td>
<td>19%</td>
</tr>
</tbody>
</table>

Source: Walter Gregg – UMN Rural Health Research Center
Networking

Scope of Services

• “Contrary to initial expectation, most participating hospitals experienced a general increase in this scope of services” (page 6)

• 5 Most Commonly expanded services
  ➢ Swing beds
  ➢ Specialty Clinics
  ➢ Outpatient rehabilitation
  ➢ Radiological Services
  ➢ RHC

Source: Third Year Findings, February, 2003

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**Figure 1**: Percentage of States Reporting Various Activities Shared Between CAHs & Network Partners

<table>
<thead>
<tr>
<th>Type of Activity</th>
<th>Percentage of States</th>
</tr>
</thead>
<tbody>
<tr>
<td>Transitions/Referrals</td>
<td>89%</td>
</tr>
<tr>
<td>CA/OI issues</td>
<td>64%</td>
</tr>
<tr>
<td>Provider Support</td>
<td>51%</td>
</tr>
<tr>
<td>Telemedicine</td>
<td>49%</td>
</tr>
<tr>
<td>Business Support</td>
<td>38%</td>
</tr>
<tr>
<td>Clinic Support</td>
<td>32%</td>
</tr>
</tbody>
</table>

Source: RUPRI Findings From the Field
Initial CAH Quality Improvement (QI) Activities

- Majority of CAHs Involved in QI Activities
  - Beyond Expectations
- Most Significant Pos-Conversion Activity
  - Redefining QI Process
  - Improving Staffing
- Biggest Barriers
  - Scale of Operations
  - Limited Resources to Make Needed Changes

Source: Moscovice, Casey, and Gregg – UMN Rural Health Research Center

Flex Program Establishes a Quality Context for CAHs

- Collaborative Orientation for Planning and Delivery System Problem Solving
  - Hospital and Community Involvement
  - State-level stakeholders (SORH, SHA, QIO)
- Framing External Linkage Options to Strengthen QI Efforts in CAHs
  - Support Hospital Relationship
  - Rural Health Network Involvement (QI/PR/Credentials)
  - General Groundswell Reframing QA/QI

Source: Moscovice, Casey, and Gregg – UMN Rural Health Research Center
Factors Supporting the Most Significant CAH QI Activity

- **Funding**
  - Hospital Budget: 63%
  - Grants: 22%
  - Combination: 13%

- **Staffing**
  - Reallocation: 81%
  - New: 11%
  - Contracted: 8%

Source: Moscovice, Casey, and Gregg – UMN Rural Health Research Center

Factors Supporting the Most Significant CAH QI Activity

- **Collaboration with Other Providers**
  - Support Hospital: 59%
  - Groups of CAHs: 49%
  - Hospitals System: 19%
  - Network Partners: 16%

- **State Infrastructure**
  - State Office of Rural Health: 37%
  - State Hospital Association: 32%
  - QIO: 27%
  - JCAHO: 16%

Source: Moscovice, Casey, and Gregg – UMN Rural Health Research Center
About 17% ($4.3 million) of the $24.8 million FLEX program is targeted to EMS. State focus on training, needs assessments, data collection system improvements, computerized billing systems, and equipment purchases. Large number of states use “mini-grants” to strengthen rural EMS (ND EMS Network, MN EMS recruitment and retention).

Rural EMS Issues:
- Adequate staffing – volunteers
- Training
- Finance
- Equipment

<table>
<thead>
<tr>
<th>Type of Activity</th>
<th>Percentage</th>
</tr>
</thead>
<tbody>
<tr>
<td>Staff development</td>
<td>31.9%</td>
</tr>
<tr>
<td>Benchmarking</td>
<td>27.7%</td>
</tr>
<tr>
<td>Peer review</td>
<td>21.3%</td>
</tr>
<tr>
<td>Guideline/protocol development</td>
<td>21.3%</td>
</tr>
<tr>
<td>Disease management programs</td>
<td>21.3%</td>
</tr>
<tr>
<td>Outcomes measurement systems</td>
<td>19.1%</td>
</tr>
<tr>
<td>Accreditation changes</td>
<td>17.0%</td>
</tr>
<tr>
<td>Health status indicators</td>
<td>14.5%</td>
</tr>
<tr>
<td>Detection/Resolution of medical errors</td>
<td>14.9%</td>
</tr>
<tr>
<td>Disciplinary practices</td>
<td>5.4%</td>
</tr>
<tr>
<td>New information systems</td>
<td>0.0%</td>
</tr>
</tbody>
</table>

Source: RUPRI Findings From the Field
FLEX

• Financial Resources
  ➢ State FLEX Grants
  ➢ Federal Rural Health Outreach Grants
  ➢ Federal Network Development Grants
  ➢ Private Foundation Grants
    ❗ BCBS of ND Rural Health Grant Program
    ❗ BCBS of MN Foundation
    ❗ Wellmark BCBS of SD Foundation
    ❗ Otto Bremer Foundation
    ❗ Blandin Foundation
    ❗ Northwest Area Foundation
  ➢ USOA Community Facilities Grant, Loan, and Loan Guarantee
  ➢ HUD 242
• Resources
  - SORH
  - RAC (www.raconline.org)

FLEX

• Future
  ➢ Building rural organized systems of care
    (Forrest Calico)
  ➢ Networks – Collaboration
  ➢ Quality of Care Efforts
  ➢ EMS
    ❗ Inclusive
    ❗ System
    ❗ Resources
  ➢ Collaboration between SORH, SHA, SHD
“The question is not what you look at, but what you see”

~ Henry David Thoreau

“Why not go out on a limb? That’s where the fruit is.”

~ Will Rogers
Flex

• Resources
  ➢ TASC (Technical Assistance and Services Center)  www.ruralcenter.org
  ➢ RAC (Rural Assistance Center)  www.raonline.org
  ➢ North Dakota – UND Center for Rural Health
    Brad Gibbens (bgibbens@medicine.nodak.edu)
    www.medicine.nodak.edu/crh
  ➢ North Dakota Healthcare Association
    www.ndha.org

Flex

• Resources
  ➢ North Dakota Health Department
    www.health.state.nd.us
  ➢ South Dakota Office of Rural Health
    www.state.sd.us
  ➢ South Dakota Association of Healthcare Organizations
    www.sdaho.org
Flex

• Resources
  ➢ Minnesota Office of Rural Health and Primary Care
    www.health.state.mn.us/divs/chs/orh_home.htm
  ➢ Minnesota Hospital Association
    www.mnhospitals.org