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Center for
Rural Health
University of North Dakota
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North Dakota Critical Access Hospital and Flex Program

2008 Survey Results

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NORTH DAKOTA
CRITICAL ACCESS HOSPITAL AND FLEX PROGRAM

EXECUTIVE SUMMARY

In February 2008 North Dakota's critical access hospitals (CAHs) were asked to complete a survey by the ND Medicare Rural Hospital Flexibility Program (Flex). A similar survey was administered by the Flex Program in 2005; its results are reflected in this report to provide comparative information of CAHs as a whole. There were 30 CAHs in ND in 2005 and 34 in 2008; 26 CAHs (87%) completed the survey in 2005 and 25 (73.5%) in 2008. Surveys were e-mailed to each of North Dakota's CAH administrators as an attachment along with a link to complete the survey electronically.

The ND Critical Access Hospital and Flex Program Survey was designed to obtain updated information including current operating status and network activity, anticipated changes over the next two years, and the prioritization of issues. Hospitals were further asked to rate the impact of CAH conversion and to evaluate their use and awareness of Flex Program services. Given the Flex Program's significant focus on networking and its current planning for the future, a number of questions related to current network relationships and suggestions for future Flex support in this area.

As was the case in 2005, all of North Dakota's CAHs are non-profit/non-governmental entities with 36% operating a hospital, clinic(s) and long term care facility; 32% operating a hospital and clinic(s); 24% operating a stand-alone hospital; and 8% operating a hospital and long term care facility. The majority of CAHs (84%) plan to maintain current operations (same response as 2005). Over the past three years, an additional 20% of CAHs reported receiving county and/or city tax support; however, 30% of hospitals feel there is less citizen awareness of the hospital's financial situation.

Reports of staffing levels have remained fairly stable over the past 3 years with the average number of total FTE employees varying only slightly; an average of 78 staff employed by CAHs in 2005 and 80 in 2008. Across specific positions there has been a slight decrease in the average FTE for occupational therapy, pharmacy personnel, LPNs, and information technology staff. CAHs report having an average of 2.21 physicians (compared to 2.9 in 2005); 1 nurse practitioner (compared to 1.54 in 2005); and 1.88 physician assistants (compared to 1.87 in 2005).

From a lengthy list of potential issues, CAHs responded clearly with 100% of CAHs identifying nursing workforce supply and third party reimbursement as the most significant problems they are facing in 2008. Following closely to these issues were maintaining access to mental health services (96%), physician workforce supply, ancillary workforce and the impact of uninsured (92% for each). In 2005, CAHs identified third party reimbursement, rural community economy, impact of uninsured/under-insured as their most significant issues.

Critical access hospital designation was made available in 1999 and the majority of ND CAHs converted prior to 2003. In general, conversion to CAH designation has had a positive impact; however, a significant number of hospital responses reflected a neutral position. The impact of Flex available services varied; responses indicate a need for increased awareness of the communication toolkit, availability of presentations, and balanced scorecard training. In both 2005 and 2008, Flex grants were rated as having the most significant impact, followed by educational opportunities, QI network development, CAH profiles and technical assistance such as community needs assessments. Communication efforts, such as Flex Updates and the Flex website, are viewed positively.

Responses indicate that network relationships with tertiary referral centers has improved substantially over the past three years. In 2008 CAHs viewed this relationship as:

- **strong – 66%** (*an increase of 12%* from 2005);
- **flexible - 66%** (*an increase of 13%* from 2005);
- **comprehensive – 50%** (*an increase of 4%* from 2005);
- **fostering a sense of trust between providers – 62%** (*an increase of 28%* from 2005)

The majority of CAHs (**75%) are optimistic that this network will grow** and positively impact their hospitals (an increase of 17% from 2005). Quality improvement and staff education are identified as the two most common areas of focus for the CAH/tertiary networks.

The ND Flex Program has played a role in network development as well as enhancing network activity over its nine year history. This form of assistance is well regarded by North Dakota critical access hospitals who indicated interest in further assistance centered around organizational development, recruitment and retention efforts, exposure of children to health careers, CAH finance and more.

The ND Flex Program is committed to supporting critical access hospitals and is grateful for the relationships that have been established in North Dakota. There are those who feel the rural health care system is facing a "perfect storm" due to the many challenges it faces: limited resources, aging buildings, community expectations, volunteer emergency medical services, aging workforce, reimbursement issues and ongoing recruitment efforts echo throughout the plains and over the hills of North Dakota. However, there are many success stories evident through this state. No matter the direction one travels, one will find dedicated leaders, competent and caring healthcare providers and staff, and rural citizens in need of care. The Flex Program is proud to work hand-in-hand with our hospitals, partners and communities to make a difference in achieving our vision for the future – access to quality health care for all. The results from this survey will be used for future planning of Flex related support and shared with others interested in making a difference. ***Thank you*** to our critical access hospitals and their partners for your efforts!

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NORTH DAKOTA
CRITICAL ACCESS HOSPITAL AND FLEX PROGRAM
2008 SURVEY RESULTS

Response rate: 25 critical access hospitals (73.5%)

Hospital Characteristics

1. What is the ownership status of the hospital?

100%	Non-government, non-profit	0%	Government, non-federal
0%	Investor owned (for profit)	0%	Government, federal

2. How would you characterize your organization?

24%	Stand alone acute care
8%	Acute care with long-term facility
32%	Acute care with a primary care clinic
36%	Acute care, primary care clinic, and Long-term care

3. Over the next 12 months, which of the following would you expect?

84%	Stay the way we are
4%	Stop providing some services (e.g., home health, OB, cardiac rehab)
0%	Formally join a network
0%	Acquire additional facilities (e.g. LTC, clinic, other)
0%	Close the facility
0%	Explore feasibility of de-certifying as CAH (move back to PPS)
12%	Add services (e.g., home health, OB, cardiac rehab, other)
0%	Be managed by external organization

4. Local citizens are aware of our financial situation.

56%	Agree
16%	Disagree
24%	Unsure

5. Does your hospital receive county and/or city tax support?

36%	Yes
60%	No
4%	Unsure

6. If yes, how much money is received on an annual basis?

- $60,000 (City sales tax)
- $100,000
- $75,000
- $45,000
- $75,000
- $27,000 (County to help support our Hospital EMS costs)
- $180,000
- $115,000
- Lots

7. If you do not receive local tax support, how likely is this to occur in the next five years?

12.5% Very likely
12.5% Likely
31% Not likely
31% Will not happen
12% Unsure

8. Does your hospital operate a hospital foundation to provide additional support to the facility?

61% Yes
39% No
0% Unsure

9. If you do not operate a hospital foundation, how likely are you to create one in the next two years?

60% Very likely
0% Likely
20% Not likely
10% Will not happen
10% Unsure

10. Which of the following tertiary centers does your facility have agreements with?

16% Altru Health System
4% MedCenter One
28% MeritCare
28% Trinity
20% St. Alexius

11. What is the number of FTEs for the following either employed or associated with your facility (associated means physicians or others may conduct health care in facility but are not employees)?

	Mean	**Median**
RN	12.68	10
LPN	6.06	6
Certified Nurse Midwives	0	0
Certified Nurse Anesthetists	1.03	1
Lab services	3.58	3.31
Radiology	2.88	2.75
OT	1.10	.8
PT	1.95	1.78
Other Therapy	1.58	1.25
Pharmacy	1.04	1
Social work/designee	1	1
Information technology	.75	.5
Paramedic	1.71	2
EMT	3.53	2.53
EMT-intermediates	1.38	1
Certified Nurse Aide	6.29	5
Administration	4.4	4
Physicians	2.21	2
Physician Assistants	1.88	1.25
Nurse practitioners	1	1
Visiting specialists	4.8	3.5
TOTAL NUMBER of FTE EMPLOYEES	80	64
TOTAL NUMBER NON-EMPLOYED but ASSOCIATED	11	5

12. Is your local ambulance service a part of the hospital?

24% Yes
56% No

13. If yes to #12, how do you have the ambulance staff? (18 answered this question)

12.5% Paid employees
12.5% Volunteer only
75% Some paid and some volunteer

14. If no to #12, do you financially support its operation in any way?

31% Yes, we annually donate:

- $3,000; minimal, with support of storage of ambulance and laundry; laundry services, medical supervision; pharmacy; it varies; two paramedics: $90K; $2,100;

15. If you have paid ambulance employees, which other duties are they responsible for in the hospital?

4% Inpatient care (Nursing)
0% X-ray
0% Lab
4% Cardiac rehab
0% ER
4% Building maintenance/janitorial

16. Do you include your local ambulance personnel in quality improvement activities?

60% Yes
40% No

17. Do you feel that your local EMS agency is adequately staffed?

28% Yes
72% No

Hospital Issues

18. Rural hospitals face many pressures and issues. Please review each issue below and on a scale of one to five with one being "no problem" and five being "severe problem" assess the degree of significance you feel is associated with that issue for your hospital.

	No problem	Minor problem	Problem	Moderate problem	Severe problem
Physician workforce supply	4%	4%	17%	25%	50%
Nursing workforce supply	0	0	12.5%	46%	42%
Ancillary workforce supply	4%	8%	8%	58%	21%
Maintaining access to primary care services	4%	17%	42%	29%	8%
Hospital reimbursement (Medicare)	0	12.5%	37.5%	25%	25%
Hospital reimbursement (3rd party)	0	0	21%	12.5%	67%
HIPAA compliance	29%	50%	12.5%	8.5%	0
Access to capital	4.5%	37.5%	33%	12.5%	12.5%
Hospital staff training	12.5%	54%	17%	17%	0
Hospital staff morale	12.5%	50%	29%	4%	4.5%
Life/Safety Code	17%	58%	8.5%	17%	0
Rural community demographics	17.5%	9%	13%	26%	35%
Rural community economy	4%	26%	26%	35%	9%
Geographic limitations to creating effective & efficient networks	0	46%	8.5%	33%	12.5%
Medicare conditions of participation survey readiness	0	62.5%	29%	8.5%	0
Maintaining access to mental health services	0	4%	29%	21%	46%
Impact of uninsured	0	8%	33%	38%	21%
Impact of under-insured	0	12%	21%	42%	25%
Maintaining quality of care	12.5%	29%	46%	12.5%	0
Physical plant/building issues	8%	25%	17%	29%	21%
Access to telemedicine	17%	33%	37.5%	4%	8%
Access to technology	8%	17%	42%	25%	8%
Relationship w/designated support hospital	37.5%	29%	21%	12.5%	0
Providing pharmacy coverage	25%	29%	29%	13%	4%
Relationship w/other rural hospitals	58%	29%	8%	4%	0

	No problem	Minor problem	Problem	Moderate problem	Severe problem
Relationship with local clinic	75%	4%	0	17%	4%
Relationship with local/area public health	54%	33%	12%	0	0
Relationship with local/area nursing home	62%	29%	8%	0	0
Community support for the hospital	33%	25%	37%	4%	0
Providing 24 hour emergency coverage	25%	21%	21%	29%	4%
Providing diagnostic services	25%	21%	37.5%	12.5%	4%
Maintain average length of stay requirements	79%	8%	12%	0	0
Receiving technical assistance when necessary from agencies such as the ND Flex Program	79%	12.5%	8.5%	0	0
Adequate patient transport services (EMS and trauma)	41.7%	33%	12.5%	12.5%	0

19. From the above list (question 12), which issues are you most concerned about? Please explain why.

- **Reimbursement:**
  - Payment from third-party payors; especially from BCBS and for rural health clinic services
  - Reimbursement and recruitment because reimbursement drives our ability to recruit, retain, and provide new equipment.
  - Non governmental reimbursement is inadequate.
  - The third level party payments i.e. NDBCBS is not keeping pace with our costs, lastly by law church sponsored hospitals can not receive tax support even if the majority of local citizens vote to levy on themselves.
  - Reimbursement - who survives on a one percent operating margin for your Medicare business. Medicaid lacks funding. Staffing - if you lose one professional you have a crisis. Physician recruitment is SCARY!
  - 3rd party reimbursement
  - Reimbursement for services.
  - Reimbursement: in order to maintain/recruit staff and have a functional cash flow; Facility update/structure: in order to update/maintain compliance, improve efficiencies; Reimbursement: to be able to at least be reimbursed for actual costs....be on equitable terms with other states re: reimbursement; and enable rural facilities to continue to be efficient without being penalized for it by decreasing reimbursement due to the efficiencies enacted by rural facilities.

- **Workforce:**
  - Professional staff in the future - many professional staff are approaching retirement age - workforce needs will increase and I don't see much movement in the academic world to address this.
  - Physician workforce, nurse workforce, non-competitive healthcare provider relationships
  - Shrinking demographics are very concerning, as well the related problem of attracting health professionals and techs along with the ever present problem of recruiting and retaining physicians and now beginning to see this with mid-levels too.
  - Physician/professional staffing uninsured/underinsured
  - Physician services, ability to recruit physician to work in rural area.
  - Physician workforce supply - we have been recruiting for 19 months and only 3 interviews; none signed; need 2 doctors - 100% of physicians. This is not a salary or benefit issue but no one wants to come to rural ND, or they don't want to work in a certain area, i.e. hospital, ER, nursing home.
  - Physician recruitment, every hospital in North Dakota is attempting to recruit providers. We are competing with each, bigger facilities in the state and other areas of the country. No provider - no facilities and services.
  - Available workforce
  - Staffing : In order to provide care

- **Other:**
  - Uninsured & underinsured - our hospital is seeing an upward trend of providing more and more uncompensated care. Where will it end?
  - Local competition from a competing facility
  - HIT/EHR: High cost of purchasing same and then its implementation; Being able to afford all of the required/specific programs which would improve quality of care through the documentation, accessibility to medical information, sharing of information, as well as the technology which is provided for services (digital radiography, etc.)

CAH and Flex Impact

20. Conversion to Critical Access Hospital status can bring forth a number of changes. Some of these changes are associated with being a CAH and some are more closely associated with the Flex Program. Below are a series of impacts, **one for CAH and a second for Flex**. Please select a response that most closely represents your viewpoint.

CAH Conversion Impacts	**Very Negative (1)**	**(2)**	**Neutral (3)**	**(4)**	**Very Positive (5)**
Financial reimbursement	0	4%	21%	42%	33%
Flexibility in staffing mid-levels in the ER	0	0	37%	29%	34%
Flexibility in staffing nurses in the hospital	0	4%	54%	33%	8%
Relationship with physicians	0	0	58%	33%	9%
Relationship with clinics	0	0	58%	33%	9%
Physician Peer Review Process	0	8%	63%	29%	0
Local fund raising	0	5%	85%	10%	0

CAH Conversion Impacts	**Very Negative (1)**	**(2)**	**Neutral (3)**	**(4)**	**Very Positive (5)**
Access to capital	0	8%	67%	25%	0
Recruitment/retention of physicians	0	8%	75%	17%	0
Recruitment/retention of nurses	0	12%	84%	4%	0
Recruitment/retention of ancillary staff	0	8%	88%	4%	0
Public support for the hospital	0	0	75%	25%	0
Inpatient services	0	0	46%	50%	4%
Outpatient services	0	0	38%	58%	4%
Network relationship w/tertiary referral center	0	9%	17%	65%	9%
Network relationship w/other CAHs and rural hospitals	0	4%	29%	63%	4%
Staff morale	0	4%	71%	25%	0
Diversifying services	4%	0	71%	25%	0
Addressing local/area EMS issues	0	9%	70%	17%	4%
Telemedicine/telehealth and HIT	0	9%	56%	30%	4%
Addressing quality of care efforts	0	4%	42%	54%	0
Overall hospital stability	0	13%	17%	63%	8%

The following are services provided by the State Flex Steering Committee partners (Center for Rural Health, North Dakota Healthcare Association, North Dakota Department of Health, and the North Dakota Healthcare Review, Inc.). Please indicate for each service your assessment of the impact to your hospital.

Flex Program Impacts	**Don't know**	**N/A**	**No benefit**	**Limited**	**Moderate**	**Substantial**
Assistance with CMS CART Tool	26%	0	16%	21%	32%	5%
Monthly CAH Calls	9%	4%	48%	26%	13%	0
Educational opportunities (workshops, trainings)	0	0	9%	52%	22%	17%
CAH Pre-Conf. at Dakota Conference	17%	4%	13%	39%	9%	17%
Balanced Scorecard Training	23%	46%	0	9%	18%	5%
CAH profiles	18%	8%	0	32%	23%	14%
CAH Quality Network development	17%	8%	0	43%	9%	22%
Flex grants	0	0	0	17%	50%	33%
Access to other federal or private foundation grants	4%	20%	0	46%	17%	12%
Communication toolkit	23%	27%	0	27%	14%	9%
Flex Updates	9%	0	9%	39%	22%	22%
Flex Website	8%	4%	0	44%	30%	13%
Presentations (boards, community groups)	23%	9%	0	32%	18%	18%
Network support	14%	28%	0	24%	19%	14%
Practice site assessments	27%	9%	0	41%	23%	0
CAH designation – rules and regulations	22%	13%	4%	22%	30%	9%
CAH clearinghouse	13%	9%	13%	30%	26%	9%
Technical assistance (e.g. strategic planning, community needs assessments, staff surveys)	9%	9%	0	36%	27%	18%

Networks - Acute and/or Tertiary Networks

21. One of the national goals of the Flex program is to develop and strengthen hospital networks. All CAHs participate in at least one network with an acute care hospital which is typically a tertiary partner. Please review each statement below and on a scale of one to five with one being "strongly disagree" and five being "strongly agree" assess the experience your facility has had within its primary network by answering with one of the descriptors.

	Strongly Disagree (1)	**(2)**	**Neutral (3)**	**(4)**	**Strongly Agree (5)**
The CAH/tertiary network is **strong**	4%	17%	13%	54%	12%
The CAH/tertiary network is **flexible**	4%	17%	13%	62%	4%
The CAH/tertiary network is **comprehensive** in terms of services provided	13%	8%	29%	50%	0
The CAH/tertiary network **fosters a sense of trust between providers**	4%	13%	21%	58%	4%
I am **optimistic that this network will grow** and positively impact my hospital	4%	4%	17%	58%	17%

22. In thinking about your acute care or tertiary network, what areas does the network address?

68% Quality improvement
48% Quality assurance
56% Staff education
52% Medical education
40% HIT
28% Medical coverage or support
24% Provider recruitment/retention
5% Other
8% EMS

23. In thinking about your acute care or tertiary network, what issues or subjects would you like to see the network work to address?

- Continuity of care
- Telemedicine, QA, staff/medical education
- Providing of MD/Midlevel coverage to the rural areas versus recruiting our staff to their areas.
- Almost any of the above.
- Can't answer, last time I got in to trouble
- Almost any of the above

- How to improve upon referrals of patients back to their local medical community, good example is promoting patients to return to use their local swing bed program if post hospital care is needed.
- Physician recruitment
- IT support
- Assist with physician recruitment for rural communities
- Physician recruitment
- I should probably change our tertiary network.
- Medical Coverage or Support
- They currently do not address any issues, BUT they are finally starting to work on some, and I believe that is very positive. What the results will be are unknown at this time, but it seems they are "shifting" some of their priorities to their rural referral facilities.
- All of them

24. In thinking about your acute care or tertiary network, what **barriers exist** that limit its effectiveness?

- Financial situation facing CAH
- Do we trust each other?
- Distance, knowing the right people, St. A's and MCO working more together on their side and then filtering their efforts to the CAH's they are networked with according to CAH regs. St. Alexius has developed a wonderful role in Kurt Waldbillig to address CAH networking - I have not seen this from MCO.
- Can't answer
- Competition for all levels of staff.
- Time to attend all the meetings that everyone is having. Overlapping. Cost of attending meetings. Sharing of policies and procedures. Ensuring that you get the updates to policies when they are.
- Distance
- HIPAA
- We all have our own different issues and everyone is so busy and focused on their own issue it is difficult to address issues on a network level. Finances at all levels make it difficult for anyone to help others if there is a significant cost either in dollars or staff time.
- They don't make their relationship with CAH's a priority.
- Reimbursement and generally staffing levels.
- Communication and accessibility; understanding of the "rural" facilities and capabilities; priorities placed on "payment" by the patient vs. care; tertiary staff are VERY rude to rural staff and belittle them due to their "rural" location;
- All of them

Future Network Activities

25. Below are a series of subject areas that hospital networks could address (network might include tertiary, rural hospitals, other).
Please indicate the degree of need you associate with addressing the subject through NETWORK ACTIVITIES.

	No Need	Some Need	Moderate Need	High Need
Finance Issues				
Capital access	29%	25%	33%	13%
Economic development	13%	46%	25%	17%
Economic impact	0	58%	21%	21%
CAH finance	4%	21%	38%	37%
Local fundraising/wealth transfer	8%	21%	54%	17%
Performance				
Quality improvement	0	48%	30%	22%
Performance improvement	0	44%	30%	26%
Organizational development	0	43%	44%	13%
Market share analysis	4%	39%	39%	17%
Workforce				
Staff development and training	0	21%	50%	29%
Recruitment	0	17%	38%	46%
Retention	0	25%	42%	33%
K-12 exposure to health careers	4%	25%	50%	21%

26. If you think that the ND Flex Program should assist with any of the above-mentioned network Ideas.

Organizational development – 32%
Recruitment – 32%
K-12 exposure to health careers – 28%
Retention – 24%
CAH finance – 24%
Staff development and training – 20%
Local fundraising/wealth transfer – 20%
Economic development – 20%
Economic impact – 20%
Performance improvement – 16%
Quality improvement – 12%
Market share analysis – 8%

Capital access – 8%

27. All Flex Programs must maintain activities within a nationally directed scope of work. The following lists those activities.

a. Please rank the following 5 Flex focus areas in the **order of importance that you think the ND Flex Program should focus its attention over the next two years**

Quality Improvement (36%)
State Rural Health Plan (32%)
Strengthening Rural Emergency Medical Services (27%)
Network development (5%)
Conversion of hospitals to CAH status (0)

b. Please use this space to elaborate on ideas/suggestions you have related to the above identified priority areas:

- Rural EMS is another avenue of our striving to keep healthcare accessible to those in our areas - some would not survive a MI if they needed to travel to Bismarck which can be as long as 1.5 hours away. I think the tertiary facilities need to step up their accountabilities to the CAHs they are networked with - they need us just as much as we need them. The State Rural Health Plan impacts everything - thus it needs the attention as well. QA is important - however focus needs to be drawn to other areas ND is doing very well in the nation for QA - the problem? We do not get any credit - lower reimbursements, out-migration of workforce, etc. And finally, only a handful of hospitals can go CAH in this day so should not be a high goal of FLEX
- Concerns regarding the continued decline in our rural populations and the impact that is and will have on our rural hospitals to continue over the next ten years to provide services, especially ED services. We need to have some very frank discussions from legislators to local community leaders, to large business employers and BCBS. There is a "perfect storm" developing and without detailed and honest and open discussion now we will be unprepared for the crisis that will occur within our rural areas of our state.
- Concerns about another layer and flex dollars spend to fund a position rather than facilities coming together to share information. A number of associations such as HFMA or MGMA function with volunteers only.

28. Additional Comments:

- Build a better working relationship with NDHA. Expand and work with a number of organizations in the state such as MGMA, HFMA, HIMA. Not enough money to have all organizations working on similar projects. Employees are busy and it is challenging to attend sessions outside the organization. The HFMA group is utilizing btwan more and more to reduce travel and windshield time. As always. thanks.
- The North Dakota Flex Program does a wonderful job working with CAH's and trying to improve the services provided in rural areas. A full array of services are available. I

appreciate everything you do. You have truly had a positive impact on the delivery of healthcare in the rural areas of our state.

Summary of Survey Results by Flex National Goals

Quality Improvement

CAHs were provided with a list of 35 issues and asked to what extent each was a problem.

A. "Medicare Conditions of participation survey readiness" was:
   Not a problem – 0%
   A minor problem – 62.5%
   Problem – 29%
   Moderate problem – 8.5%
   Severe problem – 0%

B. "Maintaining quality of care"
   Not a problem – 12.5%
   A minor problem – 29%
   Problem – 46%
   Moderate problem – 12.5%
   Severe problem – 0%

CAHs were provided with a list of impacts and asked to what degree CAH designation influenced them:

A. Physician peer review process
   - 29% - very positively impacted by CAH designation
   - 29% - positively impacted
   - 63% - neutral
   - 8% - negative impact

B. Addressing quality of care efforts
   - 0% - very positively impacted by CAH designation
   - 54% - positively impacted
   - 42% - neutral
   - 4% - negative impact

CAHs were asked to think about their tertiary network and what they currently work on together – 68% identified QI; 48% identified quality assurance

OVERALL, when offered 5 choices – QI was identified as the 1st priority (36%) that CAHs think should be supported through the Flex Program. [1st priority is Quality Improvement, 2nd is rural health planning, 3rd is EMS, 4th is network development and 5th is CAH conversion .]

Emergency Medical Services

- CAHs employ an ***average of*** ….
  1.71 paramedics (median: 2)
  3.53 EMTs (median: 2.53)
  1.38 EMT-intermediates (median: 1)
- 24% report that local ambulance is part of the hospital (56% No)
  - Of the 24% who employ/own the ambulance services:
    - 12.5% pay EMS personnel
    - 12.5% have volunteer-only EMS personnel
    - 75% have a combination of paid and volunteer EMS personnel
  - Of the 56% of CAHs that do not have the ambulance as part of the hospital:
    - 6 indicated some financial support of the unit (e.g. funding, storage space, laundry services)
- CAHs having paid ambulance staff were asked if they used EMS personnel for other duties:
  - Inpatient nursing care (1 CAH)
  - Cardiac rehab (1 CAH)
  - Building maintenance (1 CAH)
  - X-Ray, lab, ER – none reported
- 60% of CAHs reported including their local ambulance personnel in quality improvement activities.
- 72% reported feeling that their local EMS is **inadequately** staffed

CAHs were provided with a list of 35 issues and asked to what extent each was a problem.

A. "Adequate patient transport services (EMS and trauma)" was:
   Not a problem for 41.7%
   A minor problem for 33%
   Problem for 12.5%
   Moderate problem for 12.5%
   Severe problem – none

B. "Providing 24 hour emergency coverage"
   Not a problem for 24%
   A minor problem for 21%
   Problem for 21%
   Moderate problem for 29%
   Severe problem – 4%

CAHs were provided with a list of impacts and asked to what degree CAH designation influenced them:

a. Addressing local/area EMS issues
    i. 21% - very positively impacted by CAH designation
    ii. 17% - positively impacted
    iii. 70% - neutral
    iv. 9% - negative impact

CAHs were asked to think about their tertiary network and what they currently work on together – 8% identified EMS

When asked to think about what issues might work through a tertiary network – 0% identified EMS

OVERALL, when offered 5 choices - EMS was identified as the 3rd highest priority (27%) that CAHs think should be supported through the Flex Program. [1st priority is Quality Improvement, 2nd is rural health planning, 4th is network development and 5th is CAH conversion .]

CAHs were provided space to elaborate on any of their responses:

> Rural EMS is another avenue of our striving to keep healthcare accessible to those in our areas – some would not survive a MI if they needed to travel to Bismarck which can be as long as 1.5 hours away. I think the tertiary facilities need to step up their accountabilities to the CAHs they are networked with – they need us just as much as we need them.

Networking

CAHs were asked to rate five questions about their referral hospital relationship:

- 65% agree that their tertiary network is strong
- 66% believe that their network is flexible
- 50% see their network as comprehensive
- 62% believe their tertiary hospital fosters a sense of trust between providers
- 75% are optimistic that this network will grow and positively impact their hospital

CAHs reported the following level of activity with their tertiary hospital:

68% work on quality together
56% staff education
52% medical education
48% quality assurance
40% health information technology
28% medical coverage or support
24% provider recruitment/retention
8% emergency medical services

CAHs were asked to reflect on any existing barriers that limit the tertiary/CAH network's effectiveness. There were 11 responses which identified the following barriers:

- Financial situation facing CAHs
- Trust
- Distance and knowing the right people to contact at the tertiary
- Competition for staff
- Time and costs of attending meetings
- Everyone is focused on their own issues
- CAH relationship is not a priority for the tertiary facility
- Communication

CAHs were asked to identify network areas of focus that should be supported through the ND Flex Program:

Organizational development – 32%
Recruitment – 32%
K-12 exposure to health careers – 28%
Retention – 24%
CAH finance – 24%
Staff development and training – 20%
Local fundraising/wealth transfer – 20%
Economic development – 20%
Economic impact – 20%
Performance improvement – 16%
Quality improvement – 12%
Market share analysis – 8%
Capital access – 8%

CAH Conversion

- Of the 22 areas effecting CAHs (as presented in the CAH Survey 2008), the most positive impact has been financial reimbursement as indicated by 75% of responding CAHs (N=25).
- 74% of CAHs report their network relationship with the tertiary referral center as having a positive impact since CAH conversion.
- Overall hospital stability was the next most positive impact (71%) as a result of CAH conversion followed by network relationship with other CAHs/hospitals (67%), flexibility in staffing mid-levels in the emergency department (63%), and outpatient services (62%).
- 13% of CAHs believe their overall hospital stability has been negatively impacted.
- Other areas of potential impact were rated as neutral (e.g. public support for the hospital (75%), addressing local EMS issues (70%)).

Evaluation

Eighteen services of the Flex Program were rated by CAHs in order to evaluate the impact and awareness of available resources. As expected, newly offered resources (i.e. communication toolkit, balanced scorecard implementation) ranked as highest on "don't know". Monthly CAH calls, offered through NDHA, were ranked as least beneficial (48% said they provided "no benefit").

The most positively ranked feature of the Flex program (83%) were the grants awarded to CAHs each year. 45% of CAHs view technical assistance such as community needs assessments, staff surveys, and other as having moderate to substantial impact as well as the Flex Program's main method of communication, Flex Updates (44%), and the Flex Webpage (43%).

Results indicating the need for performance improvement include educational opportunities, the Flex webpage, and practice site assessments due to scores of 40% of greater for having "limited impact".

Receiving technical assistance from the Flex Program was not a problem, as indicated by 91.5%.