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Center *for* Rural Health
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Fact Sheet

Hospital Networks

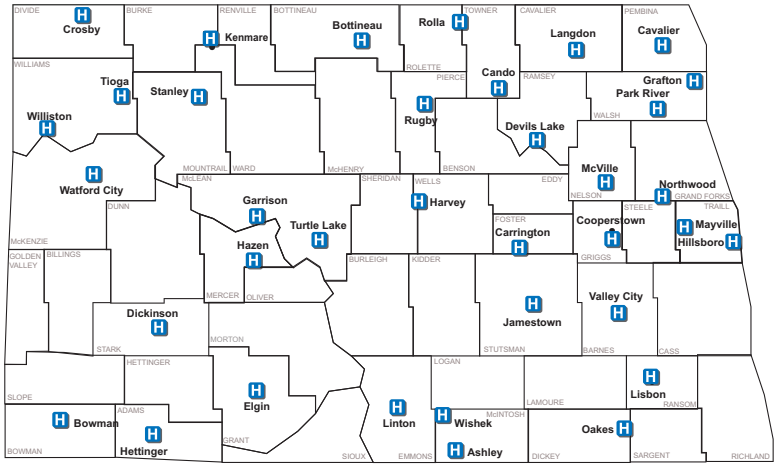
Part of a series of fact sheets on Critical Access Hospitals and the North Dakota Medicare Rural Hospital Flexibility (Flex) program.

In three time periods, (2011, 2008, and 2005), the Center for Rural Health surveyed North Dakota Critical Access Hospital (CAH) administrators on a wide range of subjects. This fact sheet discusses hospital networks. It looks at the types of functions that CAHs address through collaborative arrangements and it discusses CAH administrators' attitudes toward their networks.

Background

- North Dakota has 36 Critical Access Hospitals (CAHs) (See Figure 1). All rural hospitals, with the exception of the two Indian Health Service hospitals, have been designated as CAHs. The CAH designation by the Centers for Medicare and Medicaid Services (CMS) started in 1999 as part of the Balanced Budget Act (BBA) of 1997. The Medicare Rural Hospital Flexibility (Flex) program, also in the BBA, was developed to provide technical assistance to CAHs and to improve the overall rural health delivery system.

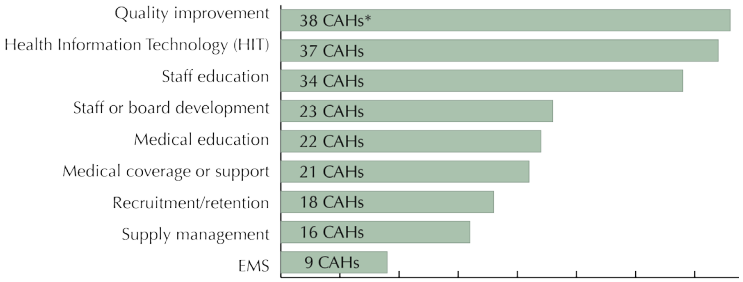
Figure 1. North Dakota CAHs



Common Network Functions

- North Dakota CAHs are involved with nine hospital networks – Altru, Catholic Health Initiatives, Essentia, MedCenter One, Northland Healthcare Alliance, North Region Health Alliance, Sanford, St. Alexius, and Trinity.
- A CAH can belong to multiple networks to accomplish different functions; thus, the nine hospital networks have 65 CAHs associated with them.
- The two most common functions that CAHs address through network arrangements are quality improvement activities (38 CAHs belonged to quality networks) and health information technology (HIT) such as electronic medical records and telemedicine (37 CAHs) (See Figure 2).

Figure 2. Common Types of CAH Networks



**CAHs can belong to multiple networks therefore the number of CAHs involved in network activities may exceed the actual number of North Dakota CAHs which is 36.*

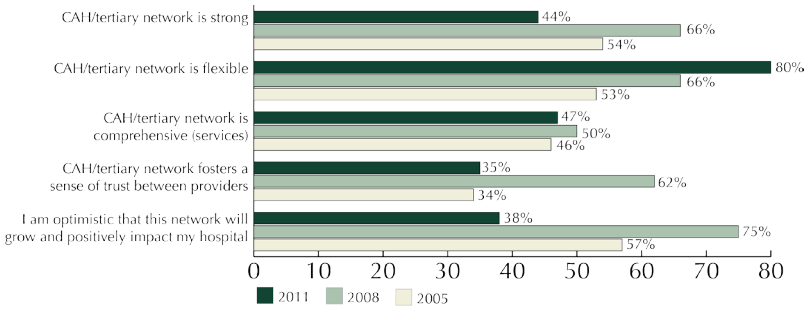
- The average size of a CAH network involves seven CAHs. The largest was St. Alexius with 11 CAHs and the smallest was Essentia involving only one CAH.
- CAH administrators were also asked to identify ways that the Flex program could assist CAHs with network activities. Areas identified included the following: building/facilitating collaboration; addressing staffing, education, and specialty care; supporting technology; emphasizing quality issues as they relate to credentialing and peer review; supporting primary care; and addressing EMS transport and education.

Attitudes Toward CAH Networks

- In comparison to 2008 and 2005, there was a significant shift away in 2011 from respondents stating that their

network was strong to those being neutral on the question. In 2008 and 2005 majorities agreed/strongly agreed (66% and 54%, respectively) that their network was strong (See Figure 3).

Figure 3. CAH/Tertiary Networks Assessment of Characteristics



*Percentages represent agree and strongly agree.

- CAH administrators viewed their networks as flexible. In all three years, strong majorities found that they agreed/strongly agreed that their network was flexible (2005, 53%; 2008, 66%; and 2011, 80%). This was also the only measure where there was continuous positive growth over the three time periods.
- About half of respondents found their networks to be comprehensive with regard to the services provided by the network. This stayed roughly the same in all three years (2005, 46%; 2008, 50%; and 2011, 47%).
- An important element in any network is the level of trust between partners. In 2011, more respondents agreed than disagreed that their network fostered a sense of trust; however, those agreeing accounted for only 35% of the respondents. This was well below the 62% that agreed with the statement in 2008.
- A final measure was that of optimism for the growth of the network and its ability to positively impact the CAH. Similar to the measure of trust, more respondents agreed than disagreed that they were optimistic toward their network. The 38% agreeing to this was significantly below the 75% who agreed with the statement in 2008.

Conclusions

- CAHs work within network arrangements to better address common issues through some level of shared resources and activities. They typically seek greater efficiency and effectiveness, cost savings, and higher organizational performance that can be achieved through group activities.
- The CAH Administrator Survey found the issues that CAHs had higher levels of concern for (reimbursement and overall financial factors along with health workforce) correspond to the focus of the CAH networks. Cost factors, achieving greater efficiency, and sharing services and/or staff are all considerations in networks. Thus, CAHs seek organizational arrangements and structures – such as networks – as a means to address the systemic issues they face.
- Over the last decade federal policy, including payment structure, have increasingly emphasized changes in the health delivery system that relate to the need to address and improve the quality of care and patient safety and developing HIT as a means to facilitate a system-wide focus on quality improvement and organizational performance. The 2011 CAH Administrator survey found that the two most common CAH networks addressed these twin concerns of quality and HIT. CAHs use network arrangements to address not only the issues they face, but as a means to respond to health policy.
- North Dakota CAHs tend to associate with multiple networks. The average CAH belongs to two different networks.
- By-in-large, CAHs were satisfied or at least expressed neutral views with regard to their networks.
- Of the five conditions used to measure satisfaction, CAHs were most likely to view their networks as being flexible. Accommodating the interests and needs of the CAHs was important as it likely allowed for more CAH direction and/or input within the networks.
- In 2011, CAHs were least likely to view their network as fostering trust. This had a precipitous decline from 2008.
- There was an even steeper erosion with regard to their optimism that the network would grow and positively impact their hospital.
- For both the trust measure and the optimism measure the neutral viewpoint was the most common.

References

2011 Flex CAH Administrator Survey, Center for Rural Health, UND School of Medicine and Health Sciences, August 2011.

2008 Flex CAH Administrator Survey, Center for Rural Health, UND School of Medicine and Health Sciences, 2008.

2005 Flex CAH Administrator Survey, Center for Rural Health, UND School of Medicine and Health Sciences, 2005.

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