Center *for* Rural Health

North Dakota Hospital Assessment: 2017 Flex Chartbook

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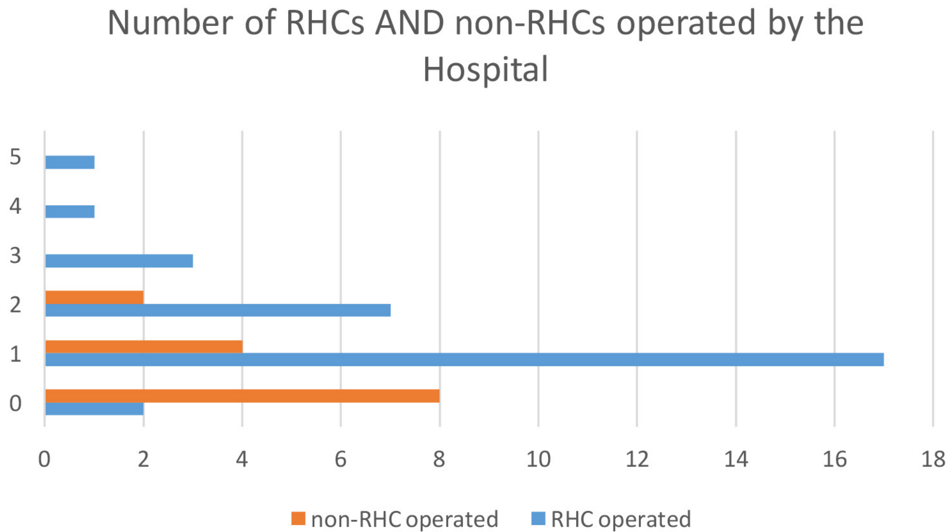
Hospital Characteristics

Hospital Operated Clinics

Each critical access hospital was asked if they operate clinics. If they did, then they were asked to indicate the number of Rural Health Clinics (RHCs) and non-RHCs operated by them. The response rate for this question was 34 of 36 hospitals.

Seventeen of the 34 hospitals operated 1 RHC and one CAH reported to operate 5 RHCs. On the other hand, four CAHs operated 1 non-RHC and two operated 2 non-RHCs. Two CAHs had no clinics operated by them as shown in Figure 1.

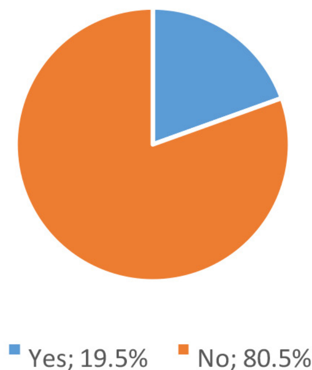
Figure 1. Number of CAHs operating Rural Health Clinics and non-Rural Health Clinics 2017 (n = 34/36)



Accountable Care Organizations

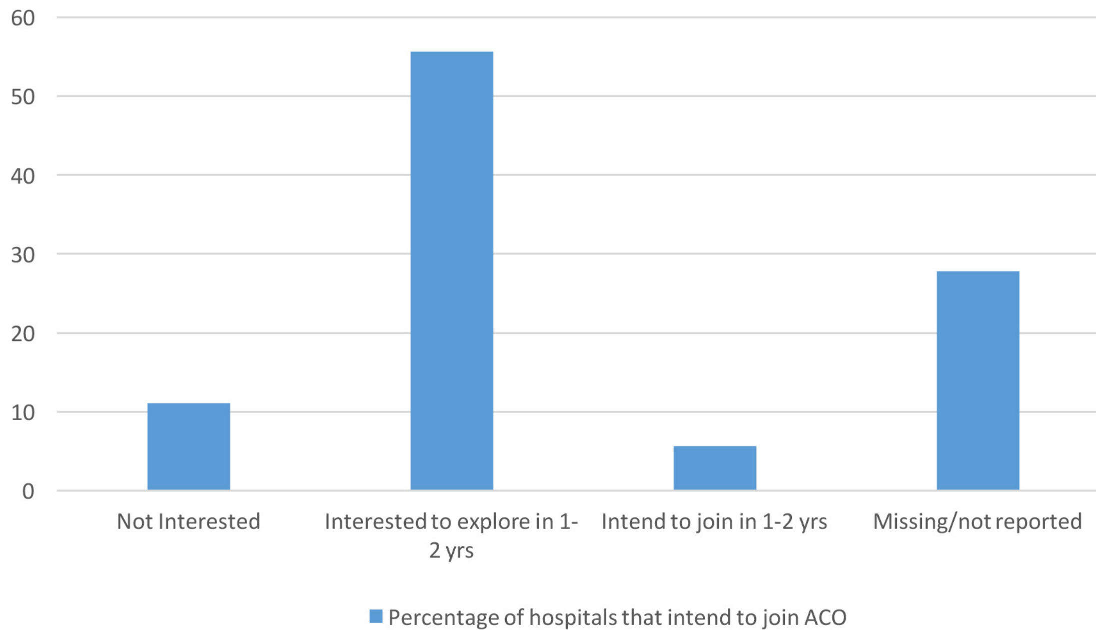
Each critical access hospital was asked if they were a part of an ACO. If they reported yes, then they were asked to provide the name of the ACO or else asked if they intended to join one within the next 1-2 years. The response rate for this question set (five questions) was 36 of 36 hospitals (Figure 2).

Figure 2. Percentage of CAHs that are part of an ACO 2017 (n = 36)



Seven out of 36 CAH reported to be part of an ACO. Out of the 29 who reported no, 22 CAH reported to explore or join within the next 1-2 years. However, 4 hospitals were not interested in joining an ACO (Figure 3).

Figure 3. Percentage of CAH that intend to join ACO within next 1-2 years 2017 (n = 36)



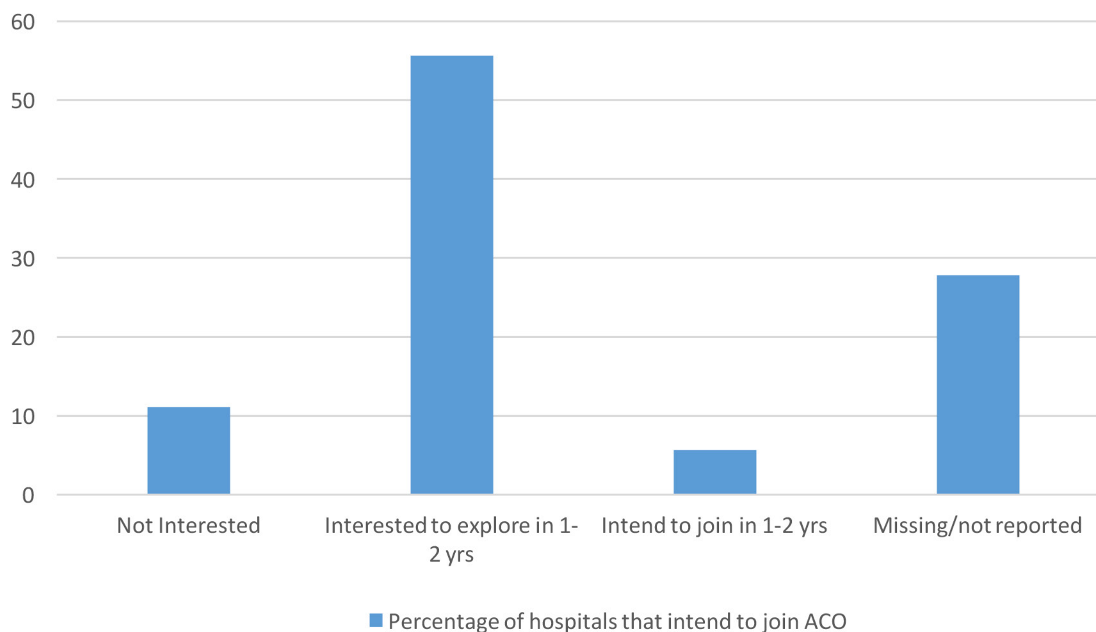
Hospital Tax Support & Foundation Dollars: CAHs

Tax Support

Each critical access hospital was asked if they received county and/or city tax support, as well as whether or not they were currently operating a hospital foundation. The response rate for this question set (five questions) was 36 of 36 hospitals.

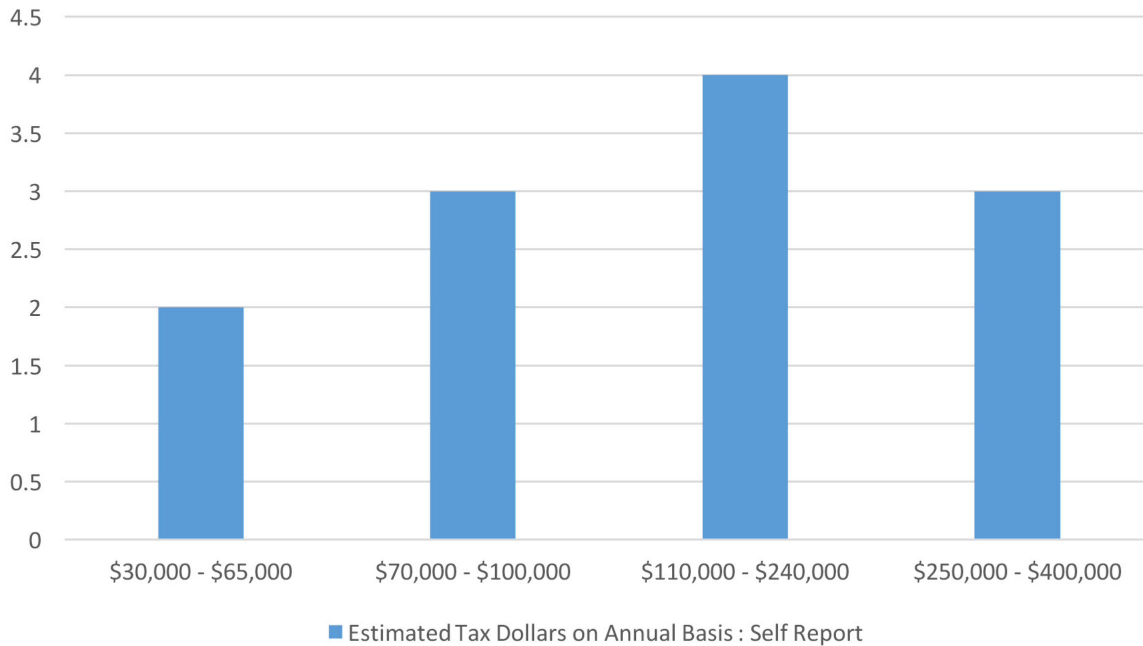
In 2005, only four CAHs had some level of local tax support (e.g., mill levy, sales tax), but by 2014, this had increased to 17, or 47% of all CAHs. The Center for Rural Health's 2017 CAH and PPS Hospital Survey found this had decreased to 14 CAHs (39%). See Figure 4.

Figure 4. Percent of CAHs Receiving County and/or City Tax Support: 2017 (n = 36/36)



Seven CAHs reported receiving $100,000 or more a year from local taxes, with two gaining $300,000 or more a year. The lowest tax yield was $37,000 compared to $30,000 from 2014, and the highest level of local support was $360,000 compared to that of $550,000 from 2014. Only 12 of the 14 CAHs indicating they received tax support provided the estimated annual figure (Figure 5). Over 84% of CAHs receiving county/city tax support receive less than $250,000 on an annual basis.

Figure 5. Estimated Dollars Received on an Annual Basis (2017) by CAHs through County/City Tax Support (n = 12/36)



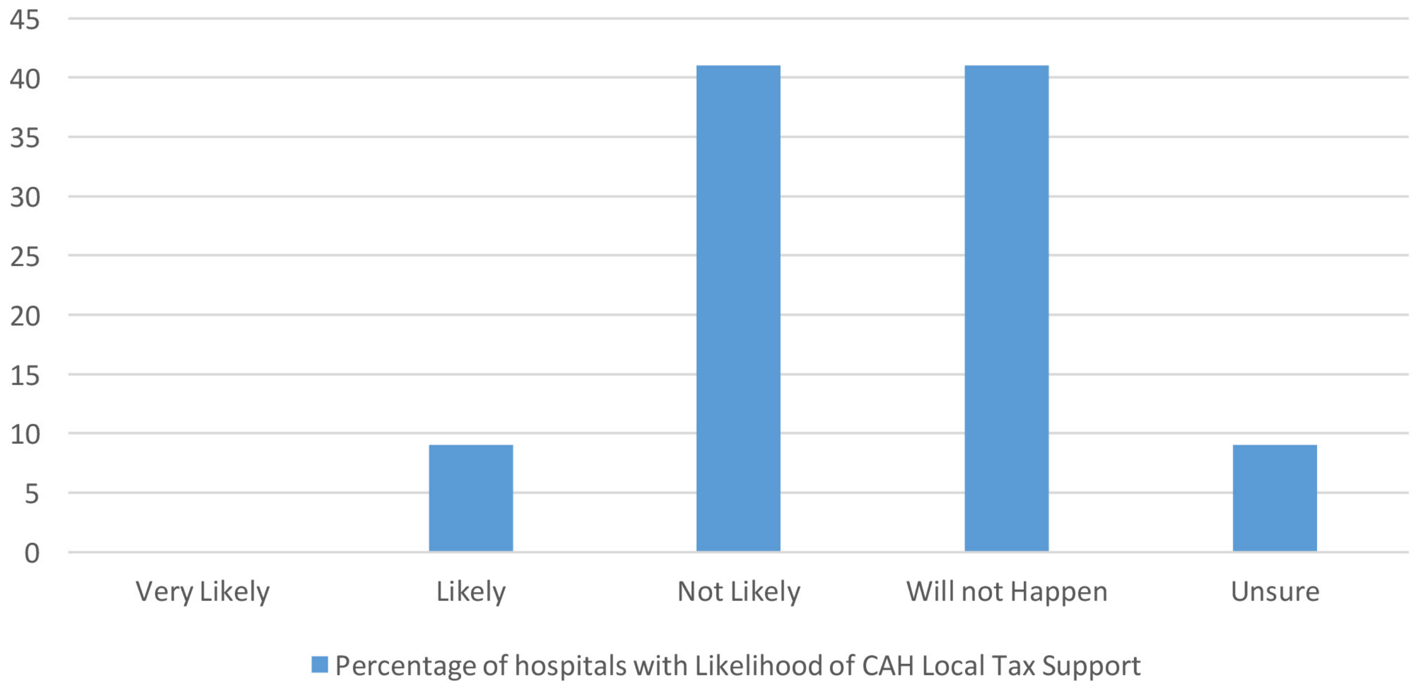
Of those receiving tax support, 11 provided the rate of the tax or mill levy; 82% were receiving City sales tax dollars with 18% receiving mill levy monies. No CAH had a county tax in place (Table 1). Of those with a city sales tax, 89% had a tax rate at or below 1% with no city sales tax greater than 2%. Two CAHs received support from a mill levy at a rate of 5-10; three CAHs did not provide the rate of their mill levy or City tax dollars.

Table 1. Percent of Sales Tax/ Mill Levy for CAHs in 2017

City Sales Tax/ Mill Levy	Number of ND CAHs
0.05% City sales tax	2
1/2% City sales tax	2
1% City sales tax	4
2% City sales tax	1
5 Mills	1

Two of the 22 CAHs not already receiving city/county tax support indicated there was a likelihood of local taxes being initiated in the next five years; nine stated it would not happen (Figure 6).

Figure 6. Likelihood of CAH Local Tax Support in Next Five Years (n = 22/36)

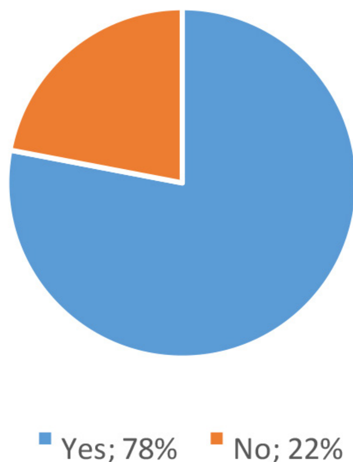


Foundation Dollars

In 2005, 18 CAHs had the support of a local hospital foundation; this increased to 29 CAHs (81%) in 2014. By 2017, 28 CAHs (78%) had a hospital foundation (Figure 7).

Figure 7. Percent of North Dakota CAHs with a Hospital Foundation in 2017 (n = 36)

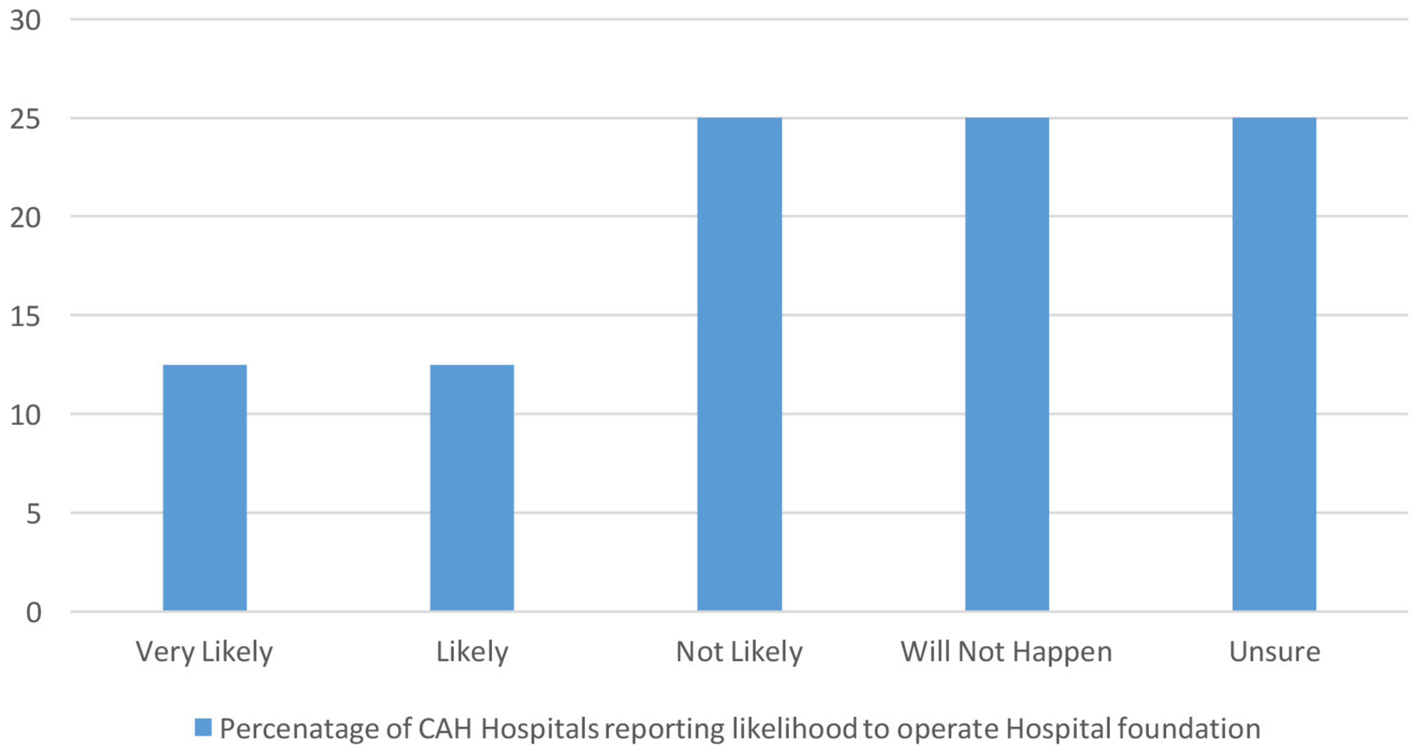
Percentage of North Dakota CAH with Hospital foundation



Yes; 78% No; 22%

Two of the eight CAHs not already receiving additional support through a hospital foundation indicated that it was not likely they would create a foundation in the next two years (Figure 8).

Figure 8. Likelihood of CAH Hospital Foundation (n = 8/36)



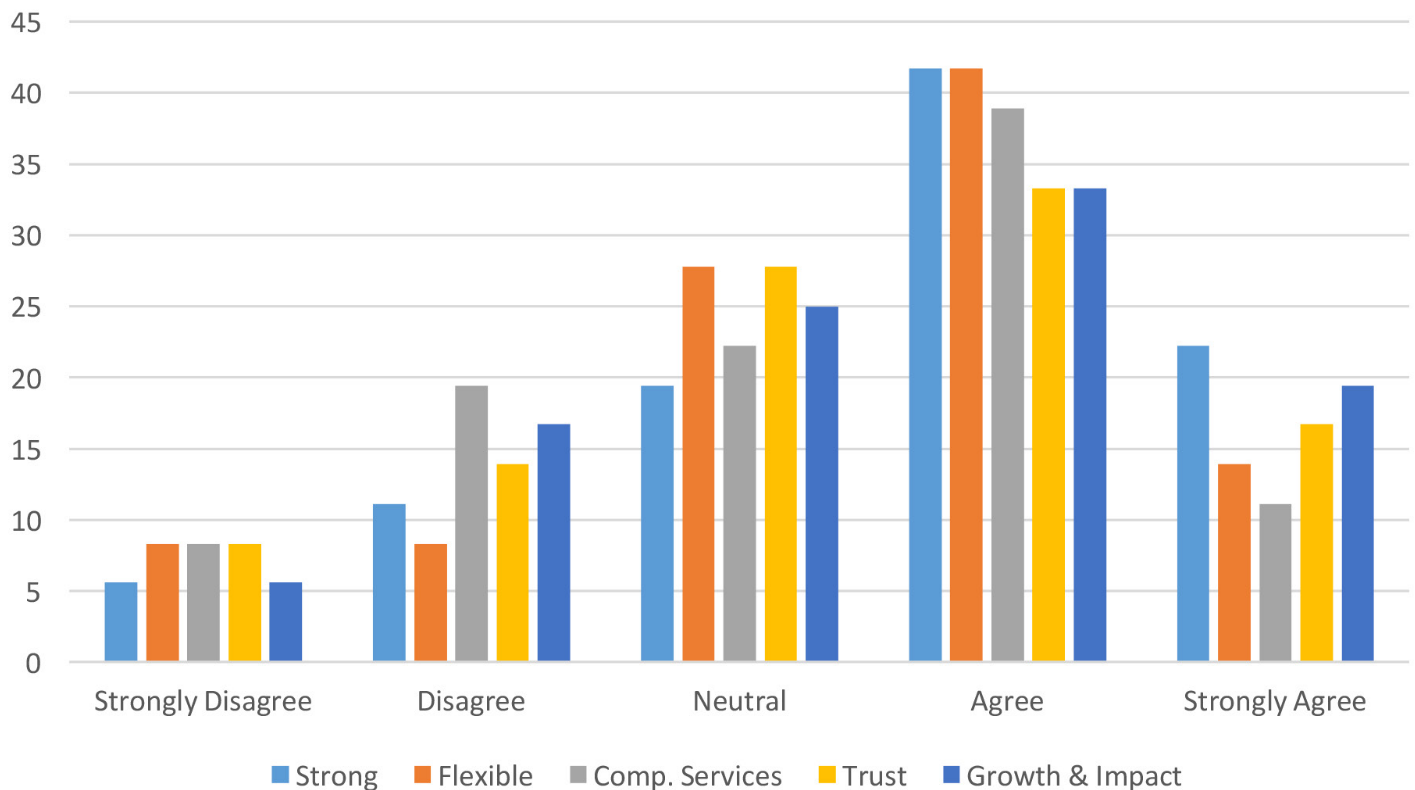
Hospital Relationships & Networks: CAH Reporting

As mentioned, each of the 36 critical access hospitals has at least one agreement with one of the six tertiary facilities. To assess the relationship between the CAHs and their primary tertiary center, each rural hospital was asked to identify their primary tertiary facility, and rate the CAH- tertiary relationship with regard to five variables (Figures 9).

The five variables included:

- The CAH/Tertiary Network is Strong (n = 36)
- The CAH/Tertiary Network is Flexible (n = 36/36)
- The CAH/Tertiary Network Provides Comprehensive Services (n= 36)
- The CAH/Tertiary Network Fosters Trust between Providers (n = 36)
- The CAH/Tertiary Network Will Grow & Positively Impact CAH (n = 36)

Figure 9. ND CAH/PPS Hospital Relationship Variables by Level of CAH Agreement



Nearly 64% of the North Dakota CAHs agreed or strongly agreed that the current network was strong; 56% indicated they agreed or strongly agreed that the network was flexible; 50% agreed or strongly agreed the network provided comprehensive services; 50% felt the network fostered a sense of trust between providers; and 53% agreed or strongly agreed that they were optimistic the network would grow and positively impact the hospital (Figures 9).

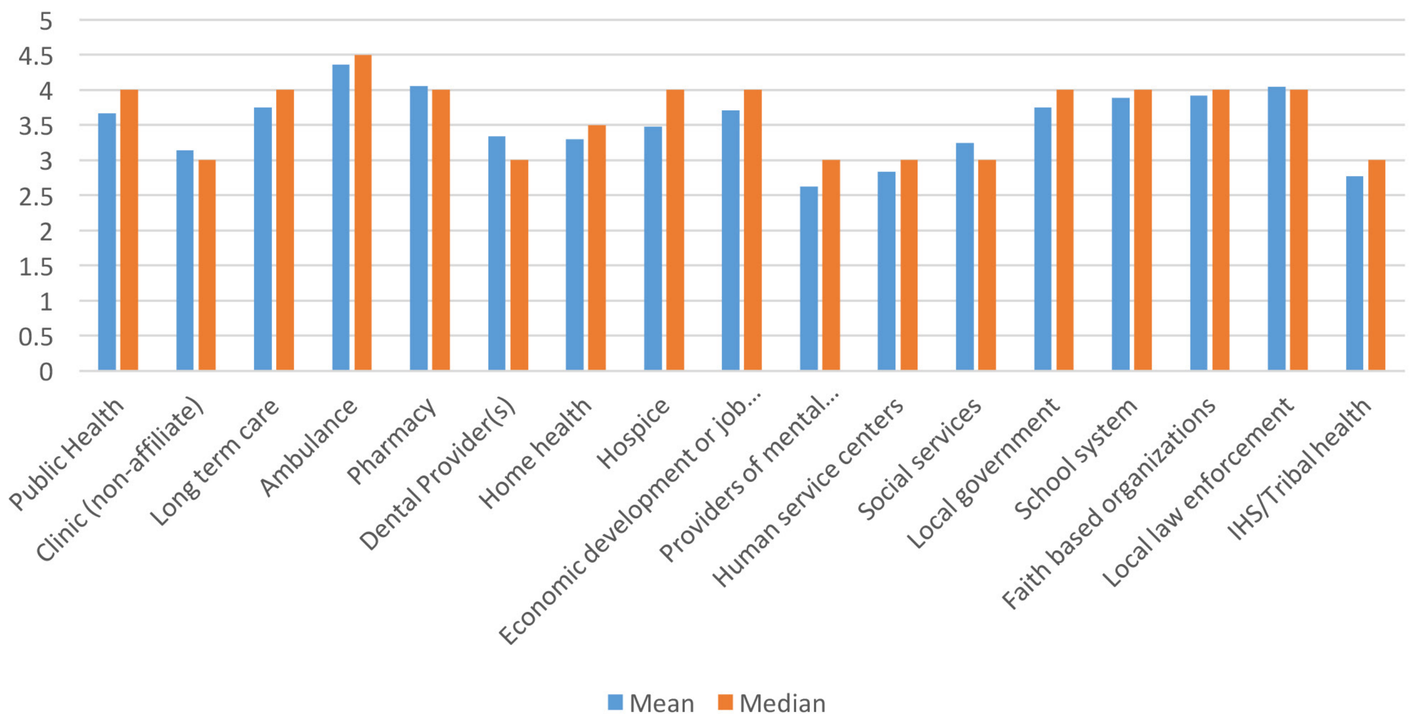
Outside of hospital agreements/networks, the 36 CAHs participate and engage in health activities with community organizations. The participating rural hospitals were asked to indicate the quality of their relationship (poor [1]; below average; average [3]; above average; excellent [5]) with 11 community organizations, to include:

- Public health
- Local clinic
- Long-term care
- Ambulance

- Pharmacy
- Dental
- Economic development
- Behavioral/mental health
- Local government
- Other health organizations
- Other community organizations

On average, the participating hospitals indicated the strongest quality relationship with ambulance (average score of 4.36, median score of 4.5), and the lowest quality relationship with mental/behavioral health (mean 2.63, median of 3). Average scores presented below do not include response values for those who responded with "we operate this organization," illustrated in Figure 10.

Figure 10. North Dakota CAH's Average Scores & Most Common Responses for Quality of Relationship with Community Organizations



Issues Facts North Dakota CAHs

Through work with the critical access hospitals in North Dakota, the Center for Rural Health was able to provide a list of issues that CAHs have identified as significant problems in recent years. From this list of 22 issues, each CAH rated how significant of a problem each has been for their facility (not a problem [1]; minor problem; problem [3]; moderate problem; severe problem [5]).

Table 2 lists each of the issues in descending value based on the average rating. The most severe problem facing North Dakota CAHs is listed first. The categories of "access to substance use disorder- inpatient/outpatient treatment services" was averaged at 4.28 and 4.20, respectively and "access to mental/behavioral health inpatient services" was averaged at 4.36, and had "severe problem" identified by the greatest number of participants (mode value of 5). Following "transport of patients with mental health/substance use disorders to treatment services" and "care for the under and un-insured" were rated as moderate or severe problems for North Dakota CAHs.

Table 2. Rank Listing of Problems CAHs are Facing & their Rated Severity

Variable	Mean	Median	Valid (N)	Missing (N)
Hospital reimbursement (Medicare)	2.81	2.5	36	0
Hospital reimbursement (Medicaid)	3.11	3	36	0
Hospital reimbursement (third party payer)	3.08	3	36	0
Meeting Medicare Conditions of participation	2.19	2	36	0
Access to substance use disorder inpatient treatment services	4.28	5	36	0
Access to substance use disorder outpatient treatment services	4.20	5	35	1
Access to mental health inpatient services	4.36	5	36	0
Access to mental health outpatient services	4.03	4	36	0
Impact of uninsured	3.29	3	35	1
Impact of under-insured	3.28	3	36	0
Providing 24/7 pharmacy coverage	2.08	2	36	0
Community support for the hospital	1.83	2	36	0
Providing 24 hour emergency coverage	2.14	2	36	0
Service area economic change	2.78	3	36	0
Service area population change	2.81	3	36	0
Maintaining Updated HER	2.69	2	36	0
Optimizing the capacity of the HER	3.00	3	36	0
Addressing community health and wellness	2.72	3	36	0
Understanding and addressing population health	2.50	2	36	0
Understanding and transitioning to value based care	2.78	3	36	0
Transport of patients with mental health/substance use disorders to treatment services	3.89	4	36	0
Transport of patients from tertiary facility back to CAH	2.72	2	36	0

Following identification of problem severity, CAHs were given the opportunity to list the one issue they were most concerned about, either from the list above or a new struggle. All of the self-identified issues could be described as a financial/ reimbursement concern, or a concern for current workforce (see Table 3).

Table 3. Self-Reported CAH Primary Concerns

Behavioral health
Behavioral health - treatment services very difficult to find/access
Changes to the Affordable Care Act
Continued political pressure to restrict rural healthcare is making it increasingly difficult to recruit and retain qualified individuals. Decisions like the most recent from the Board of Radiology about licensing of technicians, will in the end lead to decreased services in rural facilities.
Decreased reimbursement, potential loss of 340b revenues, increase in self pay/bad debt
Ensuring Medicaid Expansion stays and pays at commercial rates.
Expense of maintaining updated supplies, equipment and services.
Health insurance coverage. Large deductibles with large premiums are forcing people to not seek preventive healthcare services
Hospital reimbursement from all payers
Hospital reimbursement; the need for the hospital to have so much non-operating revenue to sustain financially
Increasing patient care services. Growing revenue to offset oil boom revenue decrease.
Inpatient Mental Health and Substance Abuse bed availability.
Keeping expenses in line with decreasing reimbursement will eventually result in unsafe care. At some point many communities are going to have to evaluate their ability to maintain a full service hospital
Lack of Mental Health Services in state
Main concern is not receiving our patients back after procedures/surgeries. Larger facilities are now admitting to local TCU's and our Swing Bed numbers are being affected. Patients are being told we "can't provide services when we CAN indeed provide those services. Larger HealthCare systems tell patients they can't have labs etc. done locally.
Maintaining updated EHR - IT issues - Mental Health
Mental Health Care - lack of it
Mental Health Service Availability
Mental health support
Nursing Shortage
Our difficulty in maintaining/sustaining financial stability. As a hospital, RHC, and SNF, the cost-based care really drives the severe highs and lows of our reimbursement. It has been a challenge for my CFO to adequately forecast the changes in order to stay ahead of expenses.
Overall reimbursement issues and battles with legislatures both national and state to stop reduction in payments. 340b continuing push back by BIG Pharma
Personnel time to work through the volume to value and implementing the CHNA plans.
Recruitment. Growing population in a Health Professional Shortage Area.
Reduced reimbursement

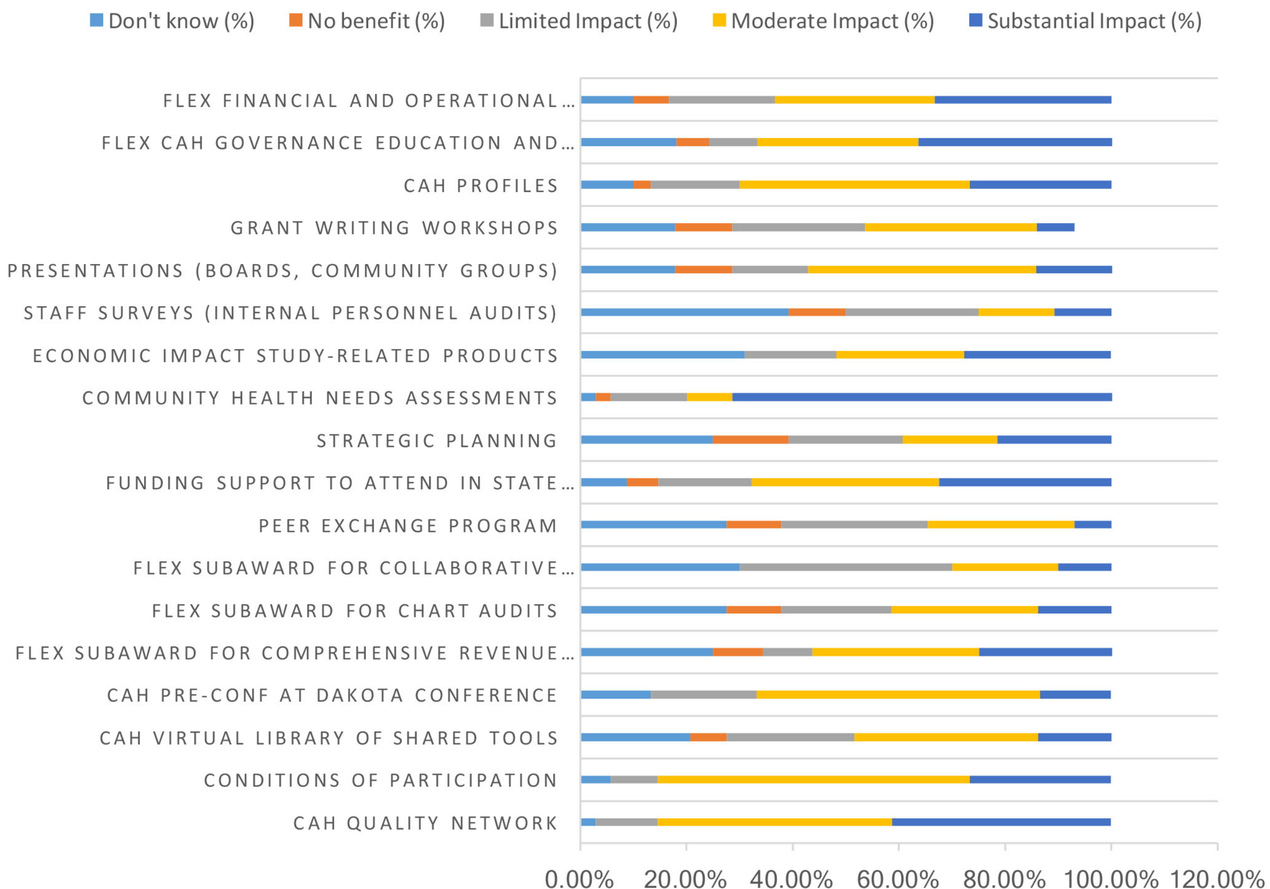
Reimbursement - continues to be decreased as well as certain things are no longer billable
Reimbursement, CAH regulations, professional staffing and physician recruitment and system encroachment and competition
Support of Tertiary hospital is also competition. Hospitals in rural communities cannot survive if the Altru's & Sanford's steal the money-making studies and do not perform procedures in the CAHs. We need their out-reach physicians, but it comes at the cost of them capturing the patient for everything as soon as they travel to those hospitals.
The ability to address behavior/mental health issues in our service area
The ability to obtain and retain professional staff, such as physicians, APRN's and RN's. Generally they will come to a rural area for experience and loan repayment incentives and then leave once they have met their obligation.
There are multiple issues that CAH hospitals are facing.
Access to capital

Medicare Rural Hospital Flexibility Program Impact

To measure the impact of Medicare Rural Hospital Flexibility Program, each of the 36 CAHs were asked to report the impact that each FLEX program service has on their hospital. As reported by the hospitals, the table below indicates if the hospitals had No Impact, Limited, Moderate or Substantial Impact.

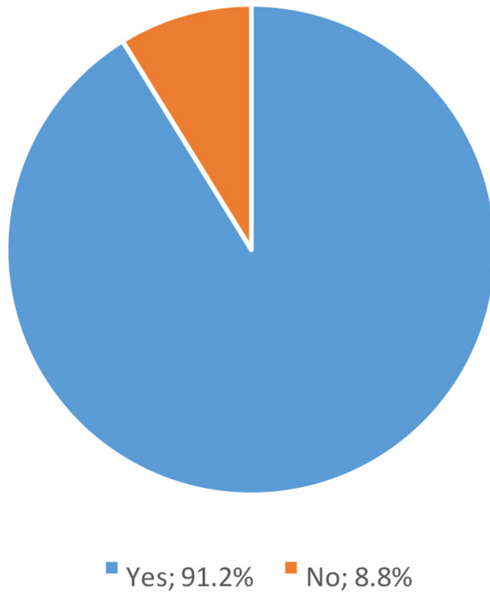
Almost 71% of the hospitals reported substantial impact from the Community Health Needs Assessment program whereas 7% reported substantial impact from the Grant Writing workshops. 40% hospitals reported limited impact from the Flex Sub award for collaborative population health activities. Nearly 59% hospitals reported moderate impact from the Conditions of Participation program (Figure 11).

Figure 11. Percentage of hospitals that were impacted by FLEX program



Each CAH were asked if they are willing to use mutually agreed upon Credentialing Verification Organization (CVO) for provider credentialing applications in order to reduce the credentialing burden on providers. Out of a total of 36 CAHs, 3 were missing (Figure 12).

Figure 12. Use of mutually agreed upon CVO by CAH



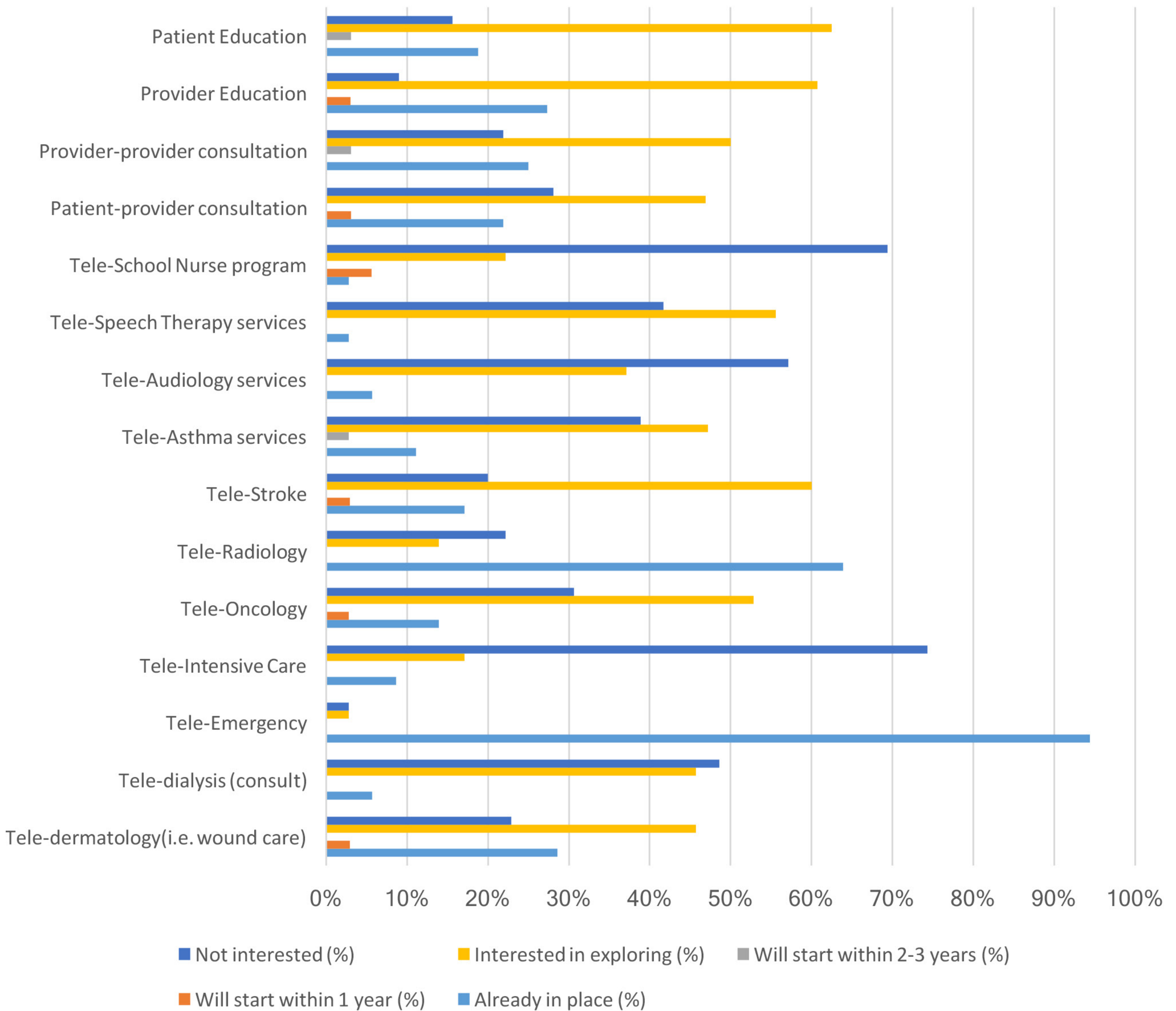
Telehealth Services

All of 36 CAHs were asked to report the status of various telehealth services in their hospitals. Hospitals reported if a particular telehealth service was already in place, will start within 1 year, within 2-3 years, interested in exploring or not interested.

As shown in Figure 13, almost 95% of hospitals reported to have Tele-Emergency already in place and around 64% had Tele-Radiology in place. Around 60% of hospitals were interested in exploring Tele-Stroke, Provider Education and Patient Education programs. About 74% of CAHs were not interested in starting Tele-Intensive Care and almost 70% were not interested in Tele- School Nurse Program (See Figure 13).

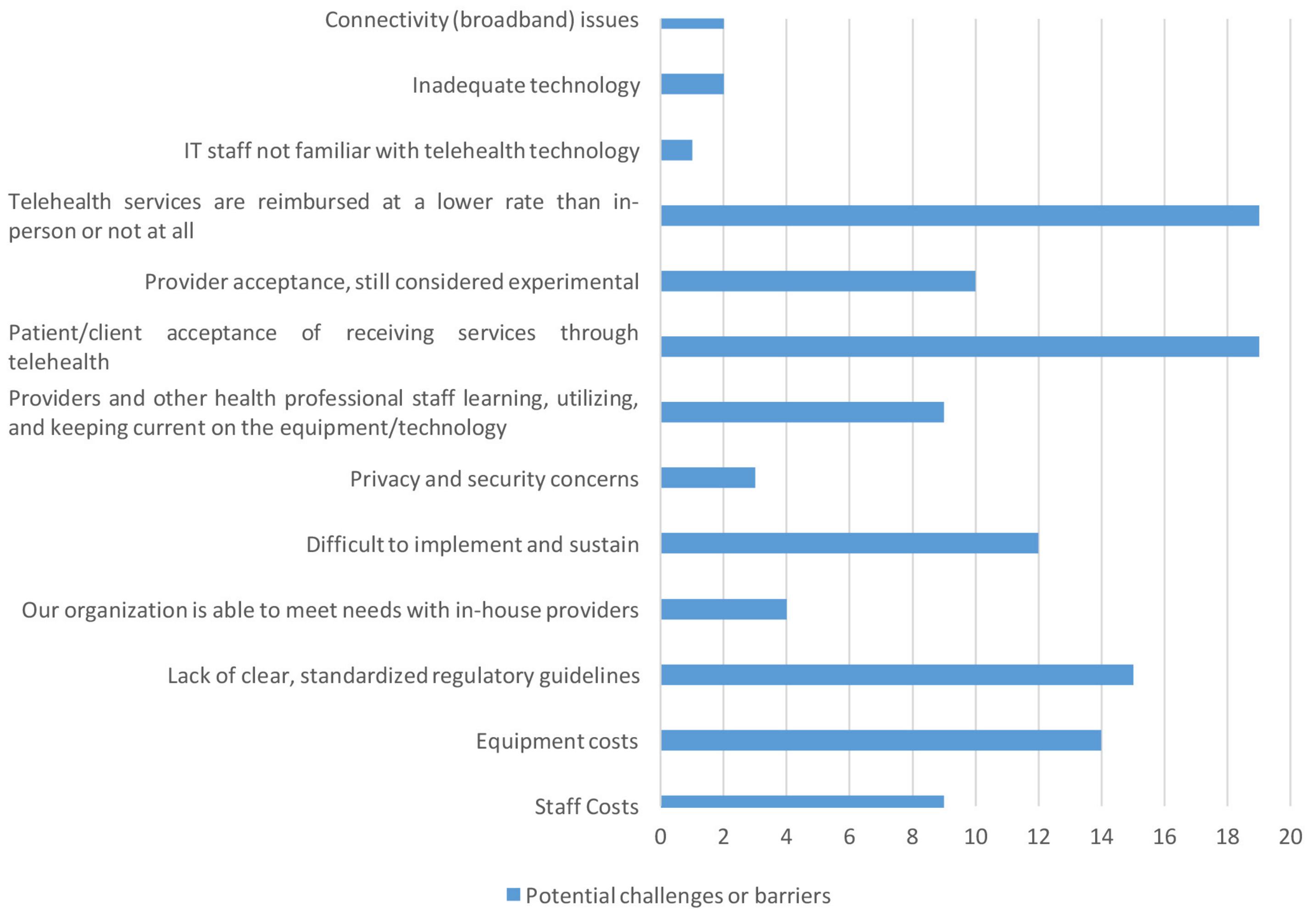
Hospitals were asked to report the name of the provider who is the main provider of each telehealth services. 22 CAHs reported Avera/Altru as the main Tele-Emergency provider and 6 CAHs reported it as the main provider of Provider Education. Altru and CHI were reported as the main provider of Tele-Dermatology and Tele-Radiology by 5 CAHs, respectively.

Figure 13. Current Status of Telehealth Services self-reported by Hospitals



As critical access hospitals in North Dakota are in the process of setting up telehealth services, they were asked to indicate any potential challenges or barriers in utilizing telehealth for services out of a list of challenges provided. Nineteen CAHs indicated patient/client acceptance of receiving services through telehealth and lower rate of reimbursement than in-person as the main challenges. Lack of clear, standardized regulatory guidelines was reported as an issue by fifteen hospitals and equipment cost was an issue reported by fourteen hospitals as shown in Figure 14.

Figure 14. CAH reporting potential challenges or barrier in utilizing telehealth services



Apart from the challenges mentioned above, all critical access hospitals in North Dakota were asked to mention any other issues that they might face in utilizing telehealth services. Table 4 below consists of other challenges or barriers as shown below.

Table 4. Other Challenges or barriers in utilizing telehealth services

Other challenges or barriers
Lack of telehealth providers to offer services
Trinity currently does not provide tele-consulting
PCP willingness, tertiary facility resistance
Network hospital providing services through telemedicine
Remote site reimbursement is not worth it. G-Code barely keeps the lights on.
Obtaining specialists willing to participate in telehealth
Staff are already stretched thin, no one to do the work
Availability of services
Not all providers using the same platforms or the ability to cross those
Peer review