

Kansas Medicare Rural Hospital Flexibility Program Evaluation Summary Report

January 2005

Introduction

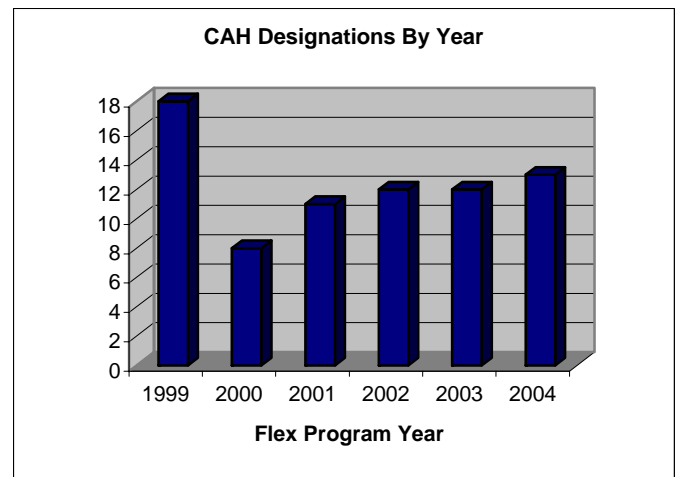
Kansas engaged in a Medicare Rural Hospital Flexibility (Flex) Program evaluation. More than 175 state and local Flex Program stakeholders participated in the evaluation, which was completed January 31, 2005. This report summarizes the evaluation methods, findings, outcomes and recommendations that are described in the Kansas Flex Program Evaluation Report.

Program Overview

During the past six years, the Kansas Flex Program, referred to as the Kansas Rural Health Options Project (KRHOP), has obtained \$4,105,738 from the Health Resources and Services Administration, Office of Rural Health Policy.¹ This is 94.6% of its requested funding (\$4,255,738) and an average of \$684,290 per year. Nationally, Kansas ranks 6th highest of 45 states in Flex Program funding obtained. Kansas has 74 Critical Access Hospitals (CAHs), the highest of all states, and projects it will have at least 80 CAHs – 63% of the state's hospitals - by the time the necessary provider option sunsets January 1, 2006. Chart 1 displays CAH conversions during each of the program years from 1999 – 2004.

The KRHOP has focused on CAH designation and technical assistance, network development, EMS planning, and more recently quality improvement (QI) and performance improvement (PI). It has been consistent in designating Flex Program funds for network related grants: \$1,441,827 (41%) over the past five years. Kansas Flex Program staff includes 1.88 FTE at the Kansas Department of Health and Environment, Office of Local and Rural Health and the Kansas Hospital Association. Complimenting these staff activities are the Flex Program Management Committee, which manages program operations and funding, and Flex Program contracts for network grants administration, Rural Health Works, Critical Illness and Trauma Foundation projects, Web site development, a state EMS conference, as well as several other activities.

Chart 1. CAH Conversions 1999 – 2004



Evaluation Methods

The KRHOP evaluation was a four month project that included a review of: Flex Program documentation (e.g. applications for federal program funding), grants made and follow-up reports (e.g. 50 network grants), surveys (CAH Administrator survey and Community Health Provider Survey), state stakeholder key informant interviews, network interviews, a Director of Nursing (DON) focus group, an EMS focus group, and CAH financial and utilization analysis.

The **CAH Administrator Survey** was conducted via the Internet and included follow-up mailed, faxed, and telephone surveys. Data was collected to identify strengths and weaknesses in the overall implementation of the program and to identify current and anticipated CAH issues and needs. The survey response rate was 93% (69/74).



¹ www.ruralhealth.hrsa.gov

The **Community Health Provider Survey** was a mailed survey conducted in five Kansas CAH communities. Data was collected to determine community provider knowledge of and involvement in the hospitals' conversion to CAH status, changes in practice patterns, and perceptions of the CAH. Seventy-four health care providers not affiliated with the local CAH (e.g. local public health, chiropractors, pharmacists) were surveyed. The survey response rate was 52%.

Table 1 Other Evaluation Methods

What	How Many	Why
State Stakeholder Interviews	13 In person	Measure satisfaction with KRHOP operations, management, and implementation; discuss their involvement in program development; and identify program planning, development, and implementation needs and next steps.
Network Coordinator Interviews	11 Via telephone	Measure satisfaction with KRHOP operations, management, and implementation; identify the networks' perceived roles, responsibilities, and goals; and determine next steps.
CAH Director of Nursing Focus Group	7 Tele-Conference	Identify KRHOP strengths and weaknesses related to the CAH conversion process, community involvement, QI and PI, and networking; identify program outcomes, recommendations, and community needs and issues.
EMS Focus Group	4 Tele-Conference	Identify EMS concerns, needs and future planning activities, and measure satisfaction with Flex Program assistance, the integration of EMS, collaborative efforts, and program related outcomes.
Documentation Review	112	Gain a historical perspective regarding the program and determine the relationship between program implementation activities and program activities. Conduct a grants review.
CAH Data Analysis	4	Identify changes in CAH services, financial status, and utilization.**

*Interviews were conducted in-person when possible. ** Flex Program Monitoring Team Reports, the American Hospital Association Annual Survey of Hospitals, and the Kansas Hospital Association follow-up survey of hospitals data was used for this portion of the evaluation.

Summary of Findings

The evaluation resulted in many findings. Key findings related to program implementations, CAHs, network development, and EMS are noted below.

Program Implementation

"We've done a very good job at maintaining a very fragile system."

"No one is isolated, we do a lot of group-think."

Stakeholders are satisfied with the implementation of the Kansas Flex Program and have used the technical assistance (TA) and tools made available through the KRHOP. Key areas for improvement are program communications, Web site, meeting coordination, updating the CAH Toolbox, and program strategic planning.

- CAHs reported being "very satisfied" (63%) or "satisfied" (29%) with the technical assistance provided by the KRHOP. Program stakeholders reported they are satisfied with the KRHOP.
- CAHs identified the supporting hospital most frequently of those providing assistance during conversion. They were most satisfied with the assistance provided by the Kansas Hospital Association.

- Regarding technical assistance available during the conversion process, CAHs were least aware of the availability of hospital board awareness/education training (30%) and most aware of the availability of general program information (83%).
- CAHs were most likely to use the survey preparation materials and least likely to use the KRHOP Website. They were most satisfied with the CAH Toolbox and least satisfied with the KRHOP Website.
- 66% of CAHs reported receiving survey certification preparation TA through the KRHOP.
- All but two CAHs have had staff participate in at least one State Network Council (SNC) meeting, while 17 CAHs have been represented at 50% or more of the meetings.
- On a scale of 1 (very low) – 5, 23% of CAHs rated the SNC meetings a five, 38.5% rated them a four, and 38.5% rated them a three or lower. Network coordinators reported being satisfied with the SNC meetings.
- CAHs have been satisfied with KRHOP activities related to Rural Health Works, the Kansas Recruitment Center, and patient satisfaction

surveys; however, they have been most satisfied with Rural Health Works.

- CAHs most commonly get updates on CAH issues and changes from the KHA (96%); KDH, OLRH (84%); and other CAHs (74%).
- Flex Program stakeholders reported they are ready to re-engage in a state Flex Program strategic planning process.

Critical Access Hospitals

“Our hospital may not be here if we hadn’t converted.”

“We have some of the most diagnostically advanced hospitals as CAHs.”

Changes in utilization and service mix have occurred in CAHs; however, the change to CAH status has had a limited impact on communities. Although CAHs’ financial status has improved and they are addressing issues related to QI, PI and other areas, they continue to have on-going issues and concerns.

- Improved finances were identified by CAHs as the greatest benefit of converting to CAHs status. 75% of CAHs reported a positive financial impact due to CAH conversion, 4% reported a negative impact, and 7% reported no impact; however, 37% of CAHs ranked financial performance as their top concern and 50% ranked it as one of their top three greatest concerns.
- CAHs averaged 3.1 deficiencies per survey in 2001 and 4.9 deficiencies per survey in 2003. Survey codes 308, 337, and 388 appear to be on-going issues for CAHs.
- 67% of community health providers surveyed are aware their local hospital is a CAH.
- Some ambulance services located in CAH communities are not aware their local hospital is a CAH.
- 12% of the community health providers surveyed were involved in the decision to convert to CAH status. 38% of all survey respondents strongly supported the decision, 54% supported the decision, and 8% were undecided. 14% of community health providers surveyed reported that their community was involved in the hospital’s decision to convert to CAH status.
- 90% of community health providers surveyed indicated they have a working relationship with the CAH: 29% described the relationship as “very strong”, 53% described it as “strong”, 3% stated “weak”, and 15% were “undecided”.
- 97% of community health providers surveyed stated that their referral patterns have not changed since the hospital converted to CAH status. Those who changed their referral patterns

did so because of the 96-hour length-of-stay limit.

- Community health providers reported on their overall opinion of the local CAH and the care they provide: 53% reported “very good”, 37% reported “good”, 8% reported “undecided”, and 3% reported “fair”.
- 40% of CAHs reported they have completed a capital improvement project in the past five years, while 41% are planning a capital improvement project in the next two years. In addition, 57% of CAHs working on capital improvement projects reported they are having difficulty accessing capital to finance the projects.
- Staffing issues was a great concern of CAH survey respondents: 23% reported it as their number one concern while 73% reported it as one of their top three concerns.

EMS

“The Flex Program has changed EMS in Kansas.”

EMS strategic planning has “been a God-send for EMS.”

EMS reports many accomplishments due to the Flex Program and continues to be an area with great program potential.

- One of the greatest accomplishments of the Flex Program in Kansas is supporting the Board of EMS strategic planning process, according to focus group participants.
- EMS strategic planning has increased state legislators’ knowledge of EMS roles and responsibilities within the state, stabilized state funding for EMS programs, changed the image of the state Board of EMS from purely regulatory to also providing technical assistance, reduced non-compliance issues with local EMS, increased involvement by local EMS in the state EMS planning process, and facilitated staffing re-organization at the Board of EMS.
- The Flex Program funded 16 grants totaling \$677,570 that included an EMS component as part of the grant activities.
- The paramedic-RN education-bridging program has given EMS personnel opportunities for advancement while helping to incorporate EMS into the state health care system.

Network Development

“One of the biggest hurdles we needed to overcome was trust: trust that we weren’t trying to take their (CAH) business. We are finally getting over that hurdle.”

“We have great opportunities in quality improvement so we are charting our destiny.”

The Kansas Flex Program provided the impetus for networking in Kansas resulting in improved coordination, projects to address PI, QI, staff training, referral and transfers, and many other activities; however, opportunities for improvement continue to exist.

- CAHs report that compared to prior years, networks are addressing fewer EMS related issues and more quality improvement and chronic illness related issues.
- CAH perceptions of their network have improved slightly over the past four years.
- Average network grant scores improved from 2000 to 2002 but decreased in 2003.
- Network coordinators support on-going Flex grant funding to networks.
- 13 planning grants have supported the development of plans and other network planning projects and 23 implementation grants have supported activities related to QI, PI, education and training, EMS, equipment, and chronic disease prevention.
- For many network coordinators, time dedicated to networking has decreased as other hospital activities have taken priority.
- CAHs selected hospitals as their network because of geographic location, past working relations, grant writing capabilities, mission, and/or networking information shared by other CAHs.

Recommendations

Based on the evaluation findings, Rural Health Solutions recommends the following to enhance an already successful Flex Program in Kansas.

- 1) Re-engage in a formal Flex Program strategic planning process.
- 2) Establish a communication plan to communicate program activities, changes, updates, and best practices to Flex Program stakeholders.
- 3) Consider changing the network grant program from a site-based application process to a project-based focus.
- 4) Incorporate grant outcomes information into the grant-making process.
- 5) Respond to CAH technical assistance needs identified during the evaluation.
- 6) Support program planning activities that are followed by a commitment to supporting the related program implementation activities (next steps).
- 7) Continue to monitor and evaluate program outcomes.



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