An Exploration of Quality Assurance Activities within the Texas Critical Access Hospital Program

By John H. Picard

An Applied Research Project (Political Science 5397) submitted to
The Department of Political Science
Southwest Texas State University
In partial fulfillment for the Degree of Masters of Public Administration
Fall 2000

Faculty Approval:

Patricia M Shields

Rebecca Scofield

Table of Contents

ABSTRACT

Small rural hospitals across the nation continue struggling to maintain adequate access to quality health care services for their communities. Hundreds of hospitals have closed the past two decades, with Texas leading the nation during the 1980s. The hospitals that have remained in operation often have financial difficulties that make the delivery of quality patient care very difficult.

A majority of small rural hospitals are characterized by old and used equipment, very small medical staffs, poor informational technology and limited services. These hospitals also have a sizeable dependency on Medicare reimbursement since many of their patients are elderly Medicare beneficiaries. Historically, Medicare has not reimbursed these hospitals for their cost of providing services and this has contributed greatly to their financial distress.

Fortunately, the Balanced Budget Act of 1997 has addressed the rural hospital Medicare reimbursement issue through creation of the Critical Access Hospital (CAH) Program. Hospitals that receive the CAH designation are to focus mainly on emergency and out patient services. Inpatient services and the length of stays per patient are to be limited within CAHs. The Medicare reimbursement rate for these hospitals has been raised to a higher "reasonable" cost rate and this gives the CAH a better chance of survival.

In addition to higher reimbursement rates, Medicare grants these facilities lower staffing standards and only requires that basic quality assurance activities take place. The tasks associated with extensive quality assurance activities that are common in urban hospitals will not be found in most CAHs. Given their limited scope of services, special staffing allowances and lack of extensive quality assurance requirements, a legitimate concern exists for the types of activities that do take place to ensure the quality of care within these hospitals.

The purpose of this research is to explore quality assurance activities within the recently created Texas Critical Access Hospital Program. The conceptual framework for the research is derived from an extensive review of rural health care and Critical Access Hospital regulatory and scholarly literature. A triangulation of methodologies consisting of surveys, interviews and document analysis is used to test the working hypotheses within the research. The triangulation method is useful for this research due to the small population of CAHs within Texas at the time of the study.

The research findings indicate that the Texas CAH program is a new program in it's early stage of development. In addition, the findings indicate the need for further development of rural health care networks and peer review organization quality assurance relationships. Fortunately, the leadership at the Texas State Office of Rural Health has identified these areas of needed development and is proactively addressing them.

CHAPTER ONE: INTRODUCTION

Introduction

Rural communities nationwide face a continual struggle to maintain adequate access to quality healthcare services. Hundreds of hospitals have closed over the past decade due to such factors as economic stagnation, shortages of physicians, decreasing reimbursement rates and uncompensated care. The closure of rural hospitals that are the only acute-care provider for miles around results in undue access problems for the residents previously served, especially for elderly or poor residents. Also, the closure of local rural hospitals often leads to the provision of more expensive care in distant urban hospitals away from the support of families and friends. The rural hospitals that remain open often face financial problems that make maintenance of facilities and services difficult.

Texas Rural Healthcare Difficulties

The continuing problem of rural hospital financial difficulty and closure has had a sizeable impact on the State of Texas where it led the nation in hospital closures in the1980's.[1] In August 1998, sixty-two rural Texas counties were without a hospital (CRHI, 1999, p.41) In addition, Texas has 174 whole[2] counties that were classified as Medically Underserved Areas (MUA)[3] and 126 whole counties that were classified as Health Professional Shortage Areas (HPSA).[4] According to the Texas State Health Plan 1999-2004, the population to physician ratio in 1998 for rural areas of the state was

[1] The rural hospital closures continue with including one in 1997 and two in 1998.
[2] 47 counties in Texas are partially designated as HPSAs (CRHI, 1999, p. xxii).
[3] MUA: Areas or populations groups with a quantifiable shortage of personal health services (CRHI, 2000, p.8).

2,296:1. In contrast, the physician to population ratio for Texas urban areas was 40% lower with a ratio of 1,160:1 (CRHI, 1999, p.20). These physician shortages in combination with the lack of hospitals make accessibility to health care in rural Texas a major concern, especially for the elderly.

The elderly population within rural Texas comprises 30% of all Texans age 65 and older (Provost, 2000, p.1). The elderly face more chronic and acute illnesses and therefore require increased accessibility to healthcare services. Rural Texas elderly also have higher poverty levels than in urban areas and are more likely to have inadequate housing and no transportation that results in inadequate access to health care (CRHI, 1999,p.58). If a rural elderly person does have transportation, the access problem remains because as the elderly continue to age they become less mobile and cannot travel to distant medical facilities by themselves. Fortunately, the State of Texas is attempting to address several of the rural accessibility and hospital closure issues through the recent enactment of the Texas Critical Access Hospital Program.

Texas Critical Access Hospital Program

The Texas Critical Access Hospital Program, as part of the federal Medicare Rural Hospital Flexibility Program, began in January 1999 and as of July 2000 there were eight certified Critical Access Hospitals within the State of Texas (see ***Appendix C***). Critical Access Hospitals (CAHs) are alternative model hospitals that operate as limited-service healthcare facilities. These hospitals operate under the authority of Medicare Program,

[4] HPSA: An area, facility, or population group with a demonstrated shortage of primary care, dental or mental health providers (CRHI, 2000, p.8).

the Health Care Financing Administration (HCFA) and under the direction of the Texas State Rural Health Plan and State Office of Rural Health.[5]

CAHs were created primarily to ensure an adequate healthcare delivery system for Medicare beneficiaries in the rural sectors of the United States. These hospitals focus predominantly on emergency and outpatient services. These hospitals also receive higher reimbursement rates from Medicare that assist them in avoiding closure due to financial insolvency. In addition, special provisions are made for CAHs that allow for lower staffing requirements and basic (non-sophisticated) quality assurance activities. These provisions take into consideration the shortage of medical personnel and the overall lack of infrastructure and resources available to most small rural hospitals.

Statement of Research Purpose

Given CAHs limited scope of services, lack of infrastructure and overall lack of resources available to conduct quality assurance activities, there is a concern among various stakeholders about the quality of care that is to be given within these facilities. The purpose of this research project is to explore the quality assurance activities within the State of Texas's Critical Access Hospital Program. The concern for the quality of care provided by CAHs gives legitimacy to this research project. The research is intended to provide an early meaningful assessment of the levels and specific types of quality assurance activities that are present within the CAH Program and individual hospitals within the program.

[5] The Texas State Office of Rural Health is also known as the Center for Rural Health Initiatives.

Chapter Summaries

Chapter Two provides the legal setting for the Critical Access Hospital Program. In addition, discussions of Texas CAH development and specific requirements are provided. Finally, an overview of federal and state quality-based requirements is included.

Chapter Three provides further context for the rural health care quality literature, which is used to formulate the conceptual framework for the research. The literature addresses the unique circumstances and development of rural health care quality assurance. In addition, this chapter establishes the linkage between the literature and the conceptual framework. Finally, the conceptual framework for the research study is also contained within this chapter.

Chapter Four discusses the specific research methodologies employed for this research study. Discussions of interview, survey, and document analysis methodologies and their limitations take place within this chapter. The data collection instruments used in conjunction with the methodologies are linked to the conceptual framework.

Chapter Five reports the results of the research and provides a description of related analysis. Finally, Chapter Six provides conclusions and recommendations that can be used by the Texas CAH program for policy development and future research.

CHAPTER TWO: CRITICAL ACCESS HOSPITAL PROGRAM DEVELOPMENT

Introduction

This chapter provides an overview of the Critical Access Hospital (CAH) Program in the state of Texas. The chapter describes how federal legislation has designed and influenced the CAH Program in Texas. A discussion of the state CAH legislation further describes the benefits of specific mandates and the roles of state agencies. Finally, this chapter describes legislative quality initiatives aimed towards ensuring a high level of care within the CAH Program.

Federal Critical Access Hospital Development

Balanced Budget Act of 1997

An omnibus legislative package, known as the Balanced Budget Act of 1997 (BBA '97), contained legislation that altered the way that health care is provided and financed in rural areas. A major piece of the legislation (section 4201, Pub. L. 105-33) authorized the Medicare Rural Hospital Flexibility Program (MFCHFP). The MRHFP is a grant[6] program that provides funding to states for the creation of a rural-based limited service hospital program known as the Critical Access Hospital (CAH) Program. Under the MRHFP/CAH Program, hospitals that are certified by the Secretary of the Department of Health and Human Services (DHHS) as Critical Access Hospitals can receive reasonable cost-based reimbursement from the Medicare Program.

Congress initially appropriated $25 million in FY 1999 for the MRHFP/CAH Program to be implemented by the Office of Rural Health Policy (ORHP, 1999, p.1), Health Resources and

[6] The program is a categorical grant program with certain restrictions and requirements for eligibility and spending.

Services Administration (HRSA) and DHHS. A total of $125 million was to be given to designated state offices of rural health for the CAH Program (ORHP, 1999, p.1).

The MRHFP gives states the ability to designate rural health facilities as Critical Access Hospitals if they meet Medicare's Conditions of Participation. Certification for the facilities as Critical Access Hospitals is also based on a survey conducted on behalf of the Health Care Financing Administration Agency (HCFA)[7] (Wynn and Cade/HCFA, 1997, p.4). These surveys are usually conducted by a state agency[8] on behalf of HCFA. Critical Access Hospitals are classified as limited-service hospitals (Wynn and Cade/HCFA, 1997,p.1).

The Balanced Budget Act of 1997 initial eligibility requirements, as interpreted by the Health Care Financing Administration (Wynn and Cade/HCFA,1997, p.1) for becoming a Critical Access Hospital were as follows:

- Must be a non-profit facility
- Be located in a state that has developed a state rural health plan that provides assistance in the creation of one or more rural health networks, promotes regionalization of rural health services and improves access to health care for rural residents.
- A rural health network is defined as consisting of one CAH and at least one full-service hospital. The members of the network are to enter into agreements for patient referral and transfer, communications, patient transportation, credentialing and quality assurance.
- A CAH must have agreements for credentialing and quality assurance with a Peer Review Organization (PRO) or another qualified entity as identified by the state rural health plan.

[7] The Health Care Financing Administration is a division of DHHS that is responsible for the Medicare Program and the CAH Program.
[8] The Texas Department of Health conducts these surveys on behalf of HCFA for Texas CAHs.

Be located more than a 35 mile drive from any other hospital or CAH except in mountainous terrain or areas where only secondary roads are available, the mileage criteria is 15 miles, or if the facility is certified by the state as being a necessary provider.

The bed limit for CAHs is 15. The maximum length of stay is 96 hours, unless emergency or bad weather conditions exist or a Peer Review Organization or equivalent entity, by request waives the 96 our restriction.

Exception to the bed limit requirement is made for swing-bed facilities, which may have up to 25 inpatient beds that can be used interchangeably for acute or skilled nursing facility types of care, provided that not more than 15 beds are used at any one time for acute level care.

After the passage of the Balanced Budget Act of 1997, pressure was put on Congress by rural health advocacy groups and stakeholders to restore some of the reductions in payments that were part of the legislation. As a result, Congress passed the Balanced Budget Refinement Act of 1999 which provides $1.3 billion over five years and restores $900 million in additional funding for small or rural hospitals (AHA, 1997 p.1).

Balanced Budget Refinement Act of 1999

In addition to restoring some of the reductions in payments, the Balanced Budget Refinement Act of 1999 also made a few changes and additions to the Medicare Rural Hospital Flexibility Program/Critical Access Hospital Program (Mueller, 1999,p.1). The Balanced Budget Refinement Act of 1999 made the following revisions for the Critical Access Hospital Program:

- The 96-hour length of stay provision enacted by the BBA of 1997 was changed to an annual per patient average of 96 hours.

- For-profit hospitals may now be designated as CAHs by the state.
- The conversion of facilities that closed or downsized within 10 years of this legislation and meet the criteria for becoming a CAH may be designated as a CAH by the state. A clinic or health center that had previously been a hospital and subsequently downsized and meets the criteria may now be designated as a CAH by the state.
- CAHs will be paid a reasonable cost rate for outpatient services[9].
- Elimination of coinsurance for clinical diagnostic laboratory tests.
- Urban hospitals can now be designated as CAHs if they meet certain criteria.

Other provisions contained within the Refinement Act address problems from the BBA that affected rural health clinics, federally qualified health clinics, programs in training health care professionals and other services such as therapy and hospice (Mueller, 1999, p.21). The legislation also attempts to attract more managed care to rural areas by lowering the quality assurance requirements for the Medicare+Choice managed care program. In addition, the Refinement Act funds several health care personnel licensing studies meant to assist states in their attempts to address health care personnel shortages in rural areas.

Texas Critical Access Hospital Development

The State of Texas was approved by the Health Care Financing Administration (HCFA) to participate in the Critical Access Hospital (CAH) Program in January 1999 (CRHI, 1999, p.85). This program provides flexibility, improved Medicare reimbursement and relief from full-service Medicare regulations for small rural hospitals that meet program qualifications. The Center for

[9] CAHs within several states, such as Texas, also receive "reasonable" cost-based reimbursement from Medicaid.

Rural Health Initiatives (State Office of Rural Health for the State of Texas) administers the CAH Program in conjunction with the Texas Department of Health.

Center for Rural Health Initiatives

In 1989, the 71st Legislature passed the Omnibus Health Care Rescue Act (HB 18) in response to a Governor's rural health task force findings.[10] This bill encouraged the growth of rural health care clinics, the development of emergency medical care networks and created the Center for Rural Health Initiatives (CRHI). The primary mission of CRHI is to be the main resource for the state of Texas for facilitation of planning, coordination and advocacy of statewide rural health services. The legislation directs CRHI to perform the following[11]:

- Integrate health care services and programs;
- Research and implement innovative models to maximize area resources;
- Provide leadership to consult with rural communities regarding current needs, analysis and access to government-funded initiatives; and
- Lead interagency efforts on rural health care initiatives that include state agencies, universities, medical schools, and private entities.

The Center for Rural Health Initiatives is the primary administrative agency for the Critical Access Hospital program in the State of Texas.

---

[10] The task force found that hospital closures produced a shortage of physicians and other health professionals serving rural communities. It also identified the need for a state level entity to address the rural health care delivery system.

[11] From Texas Sunset Advisory Commission Report "Center For Rural Health Initiatives" 1998, www.sunset.state.tx.us/sunset/reports.

Texas Critical Access Hospital Program

As part of the Federal CAH legislation, each state that desired to participate in the CAH Program was directed to develop a State Rural Health Plan[12] that will guide state rural health and CAH development. The state plan development for Texas was a collaborative committee effort that included members from the following organizations/agencies[13]:

- Center for Rural Health Initiatives
- Texas Hospital Association
- Texas Organization of Rural and Community Hospitals
- Texas Medical Foundation
- Texas Department of Health
    * Bureau of Emergency Management[14]
    * Bureau of State Health Data and Policy Analysis
    * Health Facility Licensing Division
    * Health Facility Compliance Division
    * Bureau of Reimbursement Analysis and Contract Compliance
    * State Medicaid Office

The multi-agency committee also developed the application process and comprehensive application package (see ***Appendix*** D) for the Texas CAH Program. Before a facility applies to

---

Also, CRHI Rural Health Work Plan available at: http://crhi.state.tx.us/strat_plan.pdf. Also, see ***Appendix*** *F*.

[13] Information from Center for Rural Health Initiatives.

[14] The improvement of Emergency Medical Service delivery and infrastructure is a primary concern of the CAH Program.

the Texas CAH Program they must assess whether they can meet the following general requirements for CAHs (see *appendix* D):

- Classified as a rural[15] or eligible Metropolitan Statistical Area (urban) general or special hospital.
- Must be located 35+ miles from another hospital or CAH or state certified as a "necessary provider".
- Must be a member of a network with at least one other hospital.
- Must maintain a 96-hour annual average length of stay per-patient.
- Must be limited to 15 beds, with the option of an additional 10 swing beds.[16]

Once a facility determines that it can meet the CAH requirements, they can contact CRHI to obtain an application packet. The CRHI directly assists hospitals and communities throughout the application process and provides consultation for specific CAH requirements.

Texas Critical Access Hospital Requirements

In addition to the federal and Texas CAH program rules and application requirements, CAHs must meet state licensing and Medicare quality-based procedural guidelines. These requirements are geared toward ensuring the delivery of quality healthcare services.

---

[15] According to the U.S. Bureau of the Census: Territory, population and housing units not classified as "urban" constitute "rural" areas. For the 1990 census, "urban" was defined as comprising all territory, population, and housing units in places of 2,500 persons incorporated as cities, villages, boroughs and towns, but excluding the rural portions of "extended cities," in census designated places of 2.500 or more, or in other territory, incorporated or unincorporated, including urbanized areas.

[16] "Swing beds" can be used as either acute care beds or long term care beds.

Medicare Quality Requirements

Minimal quality assurance requirements within Critical Access Hospitals must meet the guidelines cited by the Medicare/Medicaid interpretive guidelines for Critical Access Hospitals. Under tag number 336 regulation (b) and requirement 485.641 of Part III of the Medicare Interpretive guidelines for Critical Access Hospitals (see ***Appendix E***) quality assurance programs are to include:

Data collection and monitoring.

- Data analysis, problem prevention and identification.
- The identification, implementation and evaluation, of corrective actions.

Quality improvement measures.

Medicare will conduct a survey to verify that all of the above quality assurance activities are being performed. Documentation from quality assurance (QA) committees and meetings will also be reviewed in order to assess the scope, methodology and organization of the QA program (Wynn and Cade/ HCFA,1997, p.5). Medicare gives authority for hospital surveys within Texas to be conducted by the Texas Department of Health.

Texas Department of Health Licensing Requirements

The State of Texas requires that any hospital providing services must be licensed as either a General or Special Hospital and meets the Hospital Licensing rules, 25 Texas Administrative Code, Chapter 133 requirements. Facilities classified as a General Hospital offer services, facilities and beds for two or more unrelated individuals requiring diagnosis, treatment, or care for injury, illness, deformity, abnormality or pregnancy beyond 24 hours.[17] A General Hospital must also maintain clinical laboratory services, x-ray services and treatment facilities related to

either surgical or obstetrical services or both. A facility classified as a Special Hospital has requirements similar to a General Hospital, but does not provide surgical or obstetrical services.

Peer Review Organization Agreement

In addition to meeting Texas Department of Health requirements, Critical Access Hospitals are required to have an agreement with a Peer Review Organization (PRO).[17] The Health Care Financing Administration (HCFA) requires that patient care evaluations and utilization reviews of healthcare facilities that receive federally funded patients be performed by PROs. The HCFA has contracted with independent PRO organizations to perform the following functions[19]:

- Perform review for case-by-case waivers of the 96-hour average length of stay for Critical Access Hospitals.
- Determine whether services provided or proposed are reasonable and medically necessary for the diagnoses and treatment of illness, injury, or to improve functioning of a malformed body member, or for the prevention of an illness, or for the palliation and management of terminal illness.
- Determine whether those services furnished or proposed to be furnished on and inpatient basis could be furnished on an outpatient basis, or in an inpatient health care facility of a different type.
- Determine the medical necessity, reasonableness, and appropriateness of inpatient hospital care for which additional payment is sought under the outlier provisions of the prospective payment system.

---

[17] Emergency Medical Treatment and Active Labor Act (EMTALA).
[18] See *Appendix* D for this and other Texas CAH application requirements.
[19] Source: Health Care Financing Administration's *Peer Review Organization Manual Part 1 Background and Responsibilities.*

- Determine whether a hospital has misrepresented admission or discharge information, or has taken an action that results in the unnecessary admission of an individual entitled to benefits under Medicare part A, unnecessary multiple admissions of an individual, or inappropriate medical, billing or other practices in relation to beneficiaries.
- Determine the validity of diagnostic and procedural information supplied by the provider to the intermediary for payment purposes.
- Determine the completeness and adequacy of hospital care provided.
- Determine whether the quality of services meets professionally recognized standards of health care.
- Review beneficiary complaints, violations of the Emergency Medical Treatment and Active Labor Act (EMTALA), and issued notices of noncoverage, discharge and Medicare appeal rights.
- Perform regional meetings with medical and administrative staff of the hospitals that are served.
- Perform onsite review of activities at provider facilities.
- As part of the Health Care Quality Improvement Program, which HCFA designed to improve the health care related outcomes of all Medicare beneficiaries, PROs are required to implement quality improvement projects on a standardized set of quality indicators in each of the clinical areas: acute myocardial infarction, pneumonia, diabetes, breast cancer, stroke/transient ischemic attack/atrial fibrillation and congestive heart failure.
- Impose sanctions for not meeting standards.

The Texas Medical Foundation (TMF) is contracted with the HCFA to perform the peer review functions within the State of Texas. Approved CAHs are required to sign a memorandum

of agreement with TMF. Also, review procedures for obtaining a waiver for the 96-hour per patient average length of stay requirement must be provided for in the agreement with TMF.

Accreditation

In response to the increasing numbers of small and rural hospitals converting to CAHs, the Joint Commission on Accreditation of Healthcare Organizations[20] (JCAHO) has initiated efforts to establish an accreditation track for CAHs. Accrediting organizations, such as JCAHO, which successfully prove to the HCFA that accredited organizations are meeting requirements comparable to the Medicare Conditions of Participation may be granted "deeming" authority. If JCAHO were successful in achieving deeming authority for CAHs, such hospitals would not be subject to the Medicare survey and certification process. Currently, no accrediting organizations have deeming authority for CAHs. There are many scholarly opinions about the types of accreditation and quality assurance activities that should be present within CAHs. The following chapter presents the scholarly literature as it relates to quality assurance for rural health care and Critical Access Hospitals.

---

[20] **JCAHO accredits nearly 20,000 health care organizations in the U.S. Accreditation by the JCAHO is recognized nationwide as a symbol of quality that indicates an organization meets certain performance standards.** www.jcaho.org/whatwedo_frm.html

CHAPTER THREE: RURAL HEALTH CARE QUALITY ASSURANCE LITERATURE

Introduction

The purpose of this chapter is to explore the issues and programs related to the quality assurance activities of Critical Access Hospitals (CAH) and the rural health care sector of America as outlined in relevant literature. This chapter also builds upon the previous legal settings chapter by offering various opinions within the literature related to CAH and rural health care legislation. In particular, this chapter examines (1) state guidance for CAH quality assurance activities, (2) the effect of rural health networks on quality assurance for CAHs, (3) internal quality assurance activities within CAHs and (4) community input for quality based health care delivery decisions. Finally, this chapter develops the conceptual framework that guides the research process and organizes the empirical portion of the study.

Rural Quality of Life

The quality of life in America's rural sector is being diminished by the lack of health care resources. Although rural residents comprise 20% of the United States population, they lack the same access to basic healthcare as other Americans (Orloff, 1998, p.2). In addition to an increasing elderly population, basic problems such as poverty, unemployment, isolation and the lack of transportation contribute to the growing healthcare crisis[21] in rural American communities[22] (AHRQ, 1996, p.1).

---

[21] Rural areas are also characterized by alcoholism and drug use (AHRQ, 1996, p.1).

[22] Almost one in three adults living in rural America describe themselves as being in fair/poor health compared to metropolitan areas where one in five perceive their health status as fair/poor (Braden, 1994 p.4).

Growing Elderly Population

Similar to the aging trend throughout America, the elderly population within the rural sector is also increasing. From 1990 to 1996, the elderly population age 65 and older in the rural sectors of America rose by 7.3 percent, while the population numbers of people age 85 and older rose 20 percent (Orloff, 1998, p.3). Although only 13 percent of United States residents are over 65 years old, they account for about a one third of national health care expenditures (Provost, 1999, p.1). In addition, the elderly have an increased need for accessibility to healthcare due to chronic and acute health problems. The aging population within the rural areas is further encouraged by the lack of job and higher education opportunities for younger people ***(Economist,*** 1999, p.30).

The Rural Poor

Poverty is more widespread in rural areas. The poverty rate for rural areas in 1996 was 15.9 percent, as compared to 13.2 percent in urban areas (Nord, 1999, p.81). Poverty is especially high among rural minorities. In 1996, 35.2 percent of rural blacks were living in poverty, while 26.9 percent of urban blacks lived in poverty (Nord, 1999, p.82). Likewise, the poverty rate for rural Hispanics was 33.4 percent as compared to 28.6 percent in urban areas (Nord, 1999, p.82). In 1996, however, almost two-thirds of the rural poor were non-Hispanic whites (Nord, 1999, p.82).

The income levels in rural America are generally lower than urban areas. In 1996, the real per capita income in rural areas was $18,527 compared to $25,944 in urban areas (Ghelfi, 1999, p.64). Unemployment was not a factor for the discrepancy. In 1997, unemployment in rural areas was only slightly lower at 5.2 percent, as compared to 4.9 percent in urban areas (Kusmin, 1999, p.43).

Inhibiting Factors for Rural Health Care Delivery

Accessibility and availability[23] to adequate healthcare services are the biggest general health policy problems facing rural America. In order to fully assess the scope of these issues, further exploration into their underlying factors are needed. Issues related to health policy such as medical insurance, medical personnel shortages, managed care barriers and rural healthcare infrastructure, all contribute to the accessibility and availability issues of rural healthcare.

Medical Insurance

Rural residents are more likely to lack health insurance than urban residents are. For instance, within the rural sector approximately 46 percent of residents have no health insurance as compared to 37 percent in urban areas (Moscowicz, 1999, p.37). Of the people in rural areas that do have health insurance, 18 percent are Medicare beneficiaries, while in comparison, 15 percent of the people in urban areas are Medicare beneficiaries (Fox, 1999, p.2). The health insurance makeup is particularly important in understanding the financial barriers facing rural healthcare delivery, especially when considering that Medicare[24] payments can comprise up to 80 percent of

[23] Healthcare services might not be accessible due to large distance barriers or available because of the lack of facilities within the community.

[24] Medicare spends more on urban beneficiaries than rural. In 1996, Medicare spent an average of $4,375 per rural

a small rural hospital's inpatient revenue (Fox, 1999, p.2). In contrast, Medicare comprises 35-45 percent of inpatient revenues for urban hospitals (Menninger, 1999, p.1).

Physician Shortages

Shortages of healthcare professionals available in rural areas have a profound effect on the access to basic quality healthcare. The United States Department of Health and Human Services (DHHS) recommends 1 primary care physician for every 2000 people, however, rural areas in the United States have 1 physician for every 3500 people or more (Orloff, 1998, p. 4). Overall, rural areas have a shortage of 2200 physicians, while 243 counties in the U.S. have no physician at all (Moscowicz, 1999, p.37). The U.S. DHHS designates counties that do not meet the physician-staffing ratio as Health Professional Shortage Areas (HPSA). The rural medical practice and lifestyle are less than appealing to most physicians, especially when considering that 20 percent of Americans live in rural areas, while only 10 percent of physicians practice there (Moscowicz, 1999, p.37).

***Lower** Wages*

The typical young medical school graduate incurs $80,000 dollars in debt and does not receive the type of salary[25] in a rural setting that would enable repayment of such debt without hardship (Moscowicz, 1999, p.37). For example, Dr. Jack Berry, a family practitioner in Wray, Colorado, estimates the small town physician in Colorado makes $50,000 less than if he or she were to practice in a big city such as Denver (Moscowicz, 1999, p.37).

---

beneficiary versus and average of $5,288 per beneficiary in urban areas (HCFA, 1998 p.44).

[25] In 1996 the mean income for a physician in a rural area was $174,000 as compared to $204,000 for a physician in

Professional Challenges

The rural physician has been described by *The Economist* (1999, p.30) magazine as a "cross between a missionary and a cowboy" and for good reason, because these physicians have to perform numerous other duties that might be totally unrelated to their area of expertise. Rural physicians are forced to perform procedures that they have little training for. For example, rural physicians perform specialist duties such as orthopedics, which would otherwise be referred to an orthopedist. A Hastings Center Report (summer 1999) noted that rural physicians "experience significant bamers in their work as they care for patients whose illness may be beyond their training and expertise and whose suffering is severe" (Moscowicz, 1999, p.37). Physicians for rural areas are also getting hard to recruit because rural hospitals don't have the advanced technology that medical schools teach graduates to rely upon (Moscowicz, 1999, p.37).

In addition to the forced duties and lack of technology that confront a rural physician, there are personal challenges that a rural physician will endure. For example, a physician who is the lone primary care provider for a community may feel increased personal stress because of the lack of other physicians for backup to afford time away from responsibilities or to take a vacation. Likewise, there are little opportunities for a rural physician's spouse and limited amenities for a family (Orloff, 1998, p.4). Continuing education opportunities and professional contact with peers can also be limited (Orloff, 1998, p.4). Hence, the professional and personal hardships that a physician must face in a rural setting can be unappealing. Despite the hardships, concerted governmental efforts are being made to lure physicians and other practitioners into the rural setting.

---

an urban area with a population of **less** than 1 million (AMA, 1998 p.106).

Potential Staffing Solutions

The federal government has taken action in response to the physician shortage in rural areas. The Balanced Budget Act of 1997 requires states to develop a state rural health plan in order to participate in the Medicare Rural Hospital Flexibility Program. The State Office of Rural Health (SORH) enacts the State Rural Health Plan (SRHP) and provides for programs that enhance health care professional recruitment.[26] Innovative programs such as the University of Nebraska Rural Residency Program and the National Rural Recruitment and Retention Network have had some success in physician placement, yet this limited success has far from addressed the provider shortage in rural areas.

Further studies are currently being conducted by DHHS to examine the differences in competency levels between non-certified and certified support personnel such as ultrasonographers and respiratory therapists (Mueller, 1999, p.21). Many might question the rational behind studies that could bring lesser-qualified healthcare workers to rural areas, however, an effective solution for addressing the physician shortage in rural areas has been to use lesser-qualified midlevel providers such as certified physician assistants and nurse practitioners. These healthcare professionals practice under the license of a supervising physician (Moscowicz, 1999 p.37). This midlevel staffing strategy seems to be working (25 percent of all certified physician assistants practice in communities with 10,000 or fewer persons and 24 percent of nurse practitioners work in rural areas) (Moscowicz, 1999, p.37).

[26] **State Offices of Rural Health offer physician and midlevel practitioner loan repayment programs to lure these providers into rural areas** (CRHI, **1999,** p.81).

Managed Care Difficulties

One issue that might raise more attention to inadequate provider staffing is the reluctance of managed care to move into some rural hospital areas.[27] As it stands right now, with the shortage of providers, it is difficult to integrate and coordinate a managed care plan. Likewise, with the shortage of providers, it is hard to generate cost savings for a managed care plan (Grimaldi, 1999, p.16). Managed care in the form of Health Maintenance Organizations has found its way into some rural communities (15% of small town employees are enrolled). But many providers in rural areas still view managed care negatively and are concerned that it would affect their practice habits (Grimaldi, 1999, p.16; Moscowicz, 1999, p.38). Also, most rural residents are also wary of managed care and would rather remain with their customary means of receiving medical services (Grimaldi, 1999, p.16).

Managed Care Incentives

The cost control and accessibility improvements that managed care might provide to the rural sector has motivated Medicare to encourage the growth of managed care programs in the rural sector (Mueller, 1999, p.19). For example, preferred provider programs such as the Medicare+Choice Program have tried to entice providers to join by lowering quality assurance requirements, adding the flexibility to tailor benefits for specific localities and by offering bonus payments for physicians to enter into previously unserved counties (Mueller, 1999, p.19).

[27]Some states require urban-based managed care plans to serve rural areas within a defined area of their urban markets (Grirnaldi, 1999, p.16)

In addition, Medicare has lowered enrollment for Provider Sponsored Organizations and has increased monthly capitation rates for rural beneficiaries (over 20 % in some cases) (Grimaldi, 1999, p.16).

The quality assurance provisions made by Medicare to encourage the growth of managed care in rural areas are enticing, yet these provisions only address one of the expenses related to managed care (Mueller, 1999, p.19). Keith Mueller (1999, p.19) asserts that "costs associated with medical management (to realize the efficiencies associated with managed care), marketing, plan development, and responding to member grievances remain". Although the difficulties associated with managed care development in the rural sector remain, Grimaldi (1999, p.16) maintains that "managed care has the potential to improve access and coordination for quality of care in the nation's rural areas".

Rural Health Care Infrastructure

With such a heavy dependency on Medicare, it's no wonder that rural hospitals have suffered greatly due to the recent Medicare cuts associated with the Balanced Budget Act of 1997 (Menninger, 1999, p.1). Rural hospitals are expected to become financially insolvent or curtail services under these recent spending cuts (Menninger, 1999, p.1). In the state of Kansas, a rural state, it is predicted that all (mostly rural) hospitals will lose $803 million in reimbursements through the year 2002 and profit margins that were at 7 percent are expected to fall to a minus 17.7 percent (Menninger, 1999, p.1). In addition, home and long term health care are also expected to sustain heavy financial losses.

Home and Long Term Care

With an increasing elderly population, it is not surprising that rural American communities depend on home and long term health care. Although spending for hospital services remains Medicare's single largest category for expenses, home health care agencies also depend heavily on Medicare for reimbursement. Since the Balanced Budget Act of 1997 took effect, more than 2000 home health agencies have gone out of business (Menninger, 1997, p.2). Many rural residents that are elderly or have chronic afflictions are doing without healthcare until they are gravely ill and have to be admitted to the hospital.

Emergency Medical Services

A significant casualty of rural hospital closures is emergency medical services (EMS). Rural EMS services are hindered by low population densities, long travel distances to emergency rooms, poor road quality, mountainous terrain, and severe winter weather. Traumatic injuries, which are more common in rural areas, contribute to a higher death rate for rural residents due to accessibility and transportation problems (AHRQ, 1996, p.2). Pratt claims that most major occupations in the rural areas such as farming and mining, are among the most hazardous with accident rates many times higher than the national average (Pratt, 1990, p.399).

Rural Hospital Economics

Claude Earl Fox, M.D., M.P.H. (1999, p.1) states that "rural hospitals are the anchors in our small towns and communities". In addition to increased accessibility to health services, community hospitals provide important economic stimulus for rural communities

(providing 10-15 percent of the jobs) (Fox, 1999, p.1). Hospitals are usually second only to school systems as the largest employer in a rural community (Fox, 1999, p.1). The benefits that a rural community hospital has to offer are very important to the community as a whole, but especially important to the healthcare and continuum[28] of care provided in the community.

Unfortunately, many rural hospitals are characterized by aging equipment, lack of capital for investment and limited services (AHRQ, 1997, p.1). Rural hospitals have few people to serve. Therefore it is difficult to justify investing in newer technology or paying for capital outlays in general. The financial pressures imposed by the recent Medicare spending cuts has forced many hospitals to diversify their services to provide skilled nursing and home health services that can be a substantial benefit for the community. Unfortunately, profit margins for these hospitals are low because the volumes of patient visits is low and stays are short (Fox, 1999, p.2). Aside from low profit margins, rural hospitals that are fortunate enough to offer diversified services often struggle because there are inadequate numbers of professionals to staff these services.

An Alternative Hospital Model

Given the circumstances facing small rural hospitals, it is clear that many rural hospitals cannot offer a full array of services and keep their doors open. An alternative model hospital that preserves emergency services, primary care and offers acute inpatient care appropriate to serve the needs of the community could abate rural hospital closures (NRHA, 1996, p.2).

[28] The entire spectrum of healthcare services from beginning (Prenatal Care) to end (Long Term Care).

Federally Designated Limited-Service Rural Hospital Programs

Initially, policy makers within the United States Legislature responded to the need of preserving access to essential care in rural areas by developing a limited-service hospital demonstration program. The facilities within this program focus healthcare delivery efforts on emergency and outpatient services, while offering limited inpatient services. These facilities are less regulated and receive a more favorable reimbursement level from Medicare (NRHA, 1996, p.2).

Medical Assistance Facilities

The Medical Assistance Facility demonstration program (MAF), developed in Montana in 1987, became the first limited-service type of facility supported by the Health Care Financing Administration (HCFA). The HCFA regulates Medicare reimbursement and has authority over facilities that participate in the Medicare Program (Wynn and Cade/HCFA, 1997, p.2). The HCFA allows the MAF hospitals to be reimbursed at a reasonable cost level for the provision of health services to Medicare beneficiaries (NRHA, 1996, p.2). In addition, the HCFA issues waivers that accept the MAF licensure rules in lieu of the Medicare hospital conditions of participation (Wynn and Cade/HCFA, 1997, p.1).

The Montana Health Research and Education Foundation (MHREF) and Montana Law defines a "Medical Assistance Facility" as follows:

- A facility that provides inpatient care to ill or injured individuals before their transportation to another hospital or that provides inpatient medical care to individuals needing care of no longer than 96 hours unless a longer period is required or due to inclimate weather or

emergency conditions. The 96-hour restriction may be waived on a case by case basis after review with a designated Peer Review Organization (PRO)[29]

- The facility is located in a county with fewer than six residents per square mile or is located at least 35 road miles from the nearest hospital.

The MAF quickly became a model for other state and federal limited-service rural hospital programs (Christianson, Moscovice and Tao, 1990, p.91). However, the waiver authority granted by Congress to the HCFA to ease regulations for the MAF Program was specific to that program only (Wynn and Cade/HCFA, 1999, p.1).

A Successful Alternative

The MAF Program has proven to be successful in creating a feasible alternative for providing limited acute inpatient and emergency services in isolated rural communities (Gaumer, Gabay and Geller, 1993, p.3). The MAF Program has received positive evaluations from the Office of the Inspector General of the Department of Health and Human Services (DHHS) and by the General Accounting Office (Gaumer, Gabay and Geller, 1993, p.3). In 1994, the MAF Program also received the Outstanding Rural Health Program Award by the National Rural Health Association (Gaumer, Gabay and Geller, 1993, p.4). The success of the MAF Program did not go unnoticed by Congress. In fact, in 1989, Congress created another limited-service rural hospital program modeled on the MAF Program.

[29] A PRO is the external agency that audits the quality of care and use of insurance benefits by physicians and patients for Medicare and other insurers (Griffith, 1999, p.680).

Rural Primary Care Hospital/Essential Access Community Hospital Program

In response to a growing interest in limited-service rural hospitals, Congress, in 1989, created the Rural Primary Care Hospital (RPCH) Program. These limited-service alternative model hospitals were to operate in close conjunction with larger more sophisticated hospitals known as Essential Access Community Hospitals (EACH). RPCHs have their own conditions of participation (created through legislation), which eliminate the need for waivers to receive Medicare payments (NRHA, 1996, p. 3).

RPCHs provide outpatient and short-term inpatient care on an emergency or urgent basis, then release the patient or transfer them (when stabilized) to an EACH or other full-service hospital. (Wynn and Cade/HCFA, 1997, p. 2). To be designated as an WCH, facilities must have no more than 6 beds for acute inpatient care and that they limit the average length of stay per patient to no more than 72 hours per patient (Wynn and Cade/HCFA, 1997, p.2).

When Congress created the WCH Program, they also created grants to fund it. The grants were primarily intended for the development of rural health networks consisting of RPCHs and EACHs (Wynn and Cade/HCFA, 1997, p. 1). The grants available for RPCHs, however, were limited to only seven states (California, Colorado, Kansas, New York, North Carolina, South Dakota and West Virginia).

States Left Out

Since the RPCH/EACH Program was limited to only seven states, many states that were interested in participating in a rural limited-service hospital program were excluded from doing

so (NRHA, 1996, p. **3).** Furthermore, implementing intrastate models could not be accomplished without obtaining a federal waiver[30], which is very difficult to obtain.

In response to the need for a national limited-service rural hospital program, Congress began to address a plan in 1995. The efforts by Congress led to two proposed models. Not surprisingly, one of the proposed models closely resembled both the MAFs and RPCHs. Although initial congressional efforts failed and neither model was incorporated into law, it was clear that a national limited-service rural hospital program would soon become reality.

Critical Access Hospital Program

In response to the growing need for a national limited-service rural hospital program, Congress finally passed legislation that created such a program. The Critical Access Hospital (CAH) program[30], as part of the Medicare Rural Hospital Flexibility Program (MRHFP), was created through the Balanced Budget Act of 1997 (Wynn and Cade/HCFA, 1997, p.3). This legislation replaced the seven-state RPCH/EACH Program.

The Medicare Rural Hospital Flexibility Program gives states the ability to designate rural health facilities as CAHs if they meet the Medicare's Conditions of Participation. Also, certification as a CAH is dependent on a survey conducted on behalf of the Health Care Financing Administration (HCFA)(Wynn and Cade/HCFA, 1997, p.4). In addition, CAHs are reimbursed by Medicare at a reasonable cost rate that is very close to the hospital's actual cost and allows for a margin of profit that is intended to increase financial viability (Moscovice and Rosenblatt, 1999, p.8).

[30] Limited-service rural hospitals are hospitals of a particular type and are therefore subject to the Medicare conditions of participation. If state requirements for these hospitals are less than Medicare, then a waiver from HCFA is needed in order to receive Medicare reimbursement (NRHA, 1999, **p.3).**

Moscovice and Rosenblatt (1999, p.8) suggest "the purpose of the Medicare Rural Hospital Flexibility/CAH Program is to improve the fiscal viability of emergency services, primary care, and locally relevant level of acute care services that are available for Medicare beneficiaries in rural communities with small rural hospitals". Wingert (1991, p.39), however, points out that issues concerning the quality of care provided in limited-service hospitals, such as CAHs, will be raised since these facilities provide a more limited scope of services than traditional rural hospitals.

Rural Health Quality of Care

The Institute of Medicine defines quality in medicine as "the degree to which health services for individuals and populations increase the likelihood of desired health outcomes and are consistent with current professional knowledge" (Bodenheimer, 1999, p.488). Quality assurance (QA) can be generally defined as all the activities that contribute to defining, designing, assessing, monitoring, and improving the quality of healthcare. Determining quality in healthcare, however, is especially difficult because it involves many different functions that must be linked to an eventual outcome (Moscovice and Rosenblatt, 1999, p.9).

Quality Assurance

According to Griffith (1999, p.246) quality assurance (QA) is an integrated set of activities that become part of an organization's daily approach to healthcare delivery.

---

[31] A comprehensive description of CAH and MRHFP legislation and requirements is contained within the Legal Settings Chapter.

The institutionalization of quality assurance within healthcare organizations is generally present when:

- QA activities are focused on studying and changing service delivery based on measures of objective data (process and outcome measures).
- The process of care is defined by scientifically sound evidence[32] and consensus based written standards of care which are known to staff (clinical expectations, patient care protocols).
- The level of compliance with standards is monitored (regulatory accreditation).
- A wide range of QA methodologies is employed in an ongoing manner to solve problems and enhance patient care.
- There is a system of accountability for QA activities.
- The primary indicator of success for QA activities is the level of compliance with well-developed standards and health outcomes (end results).

The functional processes that contribute to health outcomes are tied with expectations. These expectations are otherwise known as clinical expectations, which are a professional consensus for the correct response to a specific, recurring situation in patient care (Griffith, 1999, p.672). The clinical expectations and protocols that guide them contribute to the clinical outcomes[33] or end results. Furthermore, the predictability of these clinical expectations is vital to the implementation of a quality assurance program (Griffith, 1999, p.253). Additional related components of clinical outcomes include: a system to measure performance and identify future

[32] Evidence-based medicine is the concept that ideal medical treatment is supported by careful and systematic evaluation emphasizing rigorous controlled trials (Griffith, 1999, p.674).

[33] A key outcome measure for quality in limited-service rural hospitals is the volume/outcome measure, which simply implies that the more a procedure or service is performed the better the outcome will be (Moscovice and Rosenblatt, 1999, p.3). This is particularly important for designing service delivery.

improvement, a community outreach program of disease prevention and health promotion, and a mechanism to examine the local-based effectiveness of clinical expectations (Griffith, 1999, p.243). These components contribute collectively to the end result or health outcomes, which are based on local patient data.

Process and Outcomes Measures

There is debate between rural healthcare scholars and accreditation agencies, about whether quality assurance in the rural setting should be focused on measuring processes or measuring outcomes (Moscovice and Rosenblatt, 1999, p.15). For example, accreditation agencies such as the Joint Commission on the Accreditation of Healthcare Organizations (JCAHO) and the National Commission on Quality Assurance[34] (NCQA), rely heavily upon measures of processes rather than measuring the end results or outcomes for patient services (Moscovice and Rosenblatt, 1999, p.8). The Rural Policy Research Institute (RUPRI) (1999, p.19), however, argues that process measures are not truly indicative of healthcare performance or quality in a less sophisticated rural setting. RUPRI (1999, p.19) further contends that outcomes measures, which directly measure the end effect of health services on patients, are a more indicative measure of performance in a rural setting than process measures. In response to these concerns, the JCAHO is attempting to develop specific accreditation quality standards for rural limited-service hospitals that take into account the debate over outcomes and process measures as well as the limited infrastructure and knowledge within most rural hospitals (JCAHO, 2000, p.1).

[34] The NCQA is a nonprofit entity that accredits managed care organizations and manages the Health Plan Employer Data and Information Set (HEDIS), a set of 71 standardized measures used to evaluate and compare health plans. To date, approximately half of the managed care companies in the country have participated in the NCQA accreditation process (Moscovice and Rosenblatt, 1999, p.10).

Rural areas want healthcare quality, yet rural hospitals have constrained resources that make conformity to urban-based accreditation quality assurance standards nearly impossible. An overview of the different types of quality assurance activities that might be found in urban and rural hospitals is shown in **Table 3.1.** This table was developed from the literature and takes into account the differences in infrastructure, finance and quality assurance knowledge between urban and rural hospitals. This table reveals many similarities for the types of institutional quality assurance measures that might be present within urban and rural hospitals. This table further points out that the more demanding accreditation standards (JCAHO and HEDIS) might not be present within small rural hospitals.

Rural Managed Care Quality Assurance Measures

As **Table 3.1** points out, there are numerous similarities in the types of quality assurance activities that take place within urban and rural hospitals. Moscovice and Rosenblatt (1999, p.7), however, point out that "the capital, personnel, and expertise to develop and operate quality assurance programs are not readily available in most rural areas". Medicare, through its Medicare+Choice Program, has required participating rural hospitals to perform numerous quality assurance tasks that Moscovice and Rosenblatt posit might be beyond a rural hospital's capabilities. The Medicare+Choice Program requires rural hospitals to have quality assurance programs in place that accomplish the following:

- Data measurement and analysis for health outcomes.
- The evaluation and monitoring of high-volume and high-risk services
- Monitoring and evaluation of acute and chronic care conditions
- Evaluation of the continuity and coordination of care

Table 3.1 Urban and Rural Hospital Quality Assurance Activities

Urban Hospital	**Urban and Rural Hospitals Might Include:**
Takes into Account :	** ***Denotes Urban Hospital Only***
• Sophisticated Information Systems • Shared Information Systems • Large Patient Data Base • High Level of Knowledge • Adequate Professional Staffing • Large Medical Staff • Adequate Finances	**Regulatory** Approaches for Quality: - Joint Commission on Accreditation of Healthcare Organizations (JCAHO) certification ** - State Certification - Medicare/ Medicaid Certification - National Committee for Quality Assurance (NCQA) Certification ** Institutional Approaches: • Hospital Quality Assurance Policies and Procedures • Hospital Interdepartmental Quality Assurance Policies and Procedures • Clinical Quality Improvement Program • Evidence-based Quality Standards • Quantitative Process and Outcome Performance Measures • Personnel Evaluations • Staff Credentials Monitoring • Written Staffing Guidelines • Peer Review Procedures • Continuing Education Requirements • Utilization Reviews • Documentation of Patient Care • Patient Transfer Procedures • Patient Care Protocols (Treatment Plans) • Evaluation of continuity and coordination of care • Patient Satisfaction Surveys • Physician Satisfaction Surveys** • Monitoring and Evaluation of High-Volume and High-Risk Services and the Care of Acute and Chronic Conditions ** • Community Planning and health promotion.
Rural Hospital	
Takes into account:	
• Unsophisticated Information Systems • Limited Patient Data Base • Limited Quality Assurance Training and Knowledge • Limited Professional Staffing • Small Medical Staffs • Limited Finances • Geographical Barriers	

- Evaluation of effectiveness to include consumer satisfaction
- Established protocols for utilization review
- The presence of a quality improvement program
- Information on quality outcome measures available for beneficiary related comparisons of health plan options

Due to limited data availability, small medical and professional staffs, lack of infrastructure, and lack of shared data systems, it is difficult for small rural hospitals to comply with health plans that require these types of quality assurance requirements (Wingert, Christiansen, Moscovice and Rosenblatt, 1991, p.39). RUPRI (1999, p.19) asserts that realistic and applicable rural-based quality assurance standards must be developed and incorporated, especially in light of the recently enacted Critical Access Hospital Program.

Critical Access Hospital Quality Assurance Activities

The legislation that created Critical Access Hospitals incorporated quality assurance related requirements and expectations is intended to enhance the development of an effective quality assurance program (RUPRI, 1999, p.18). The legislation requires a state that participates in the Critical Access Hospital Program to, first of all, develop a State Rural Health Plan (ORHP, 1999, p.5). The State Rural Health Plan (SRHP) is designed to assist in the development of one or more rural health networks, which can improve access, increase quality assurance resources and strengthen healthcare infrastructure (ORHP,1999, p.5). In addition, CAHs are expected by the legislation to document that the patient care rendered is at least comparable to the primary network or predecessor hospital (Moscovice and Rosenblatt, 1999, p.8). Ideally, the documentation of care is to be used in conjunction with internal quality assurance/quality

improvement functions that are required by Medicare[35] and CAH legislation to occur within individual Critical Access Hospitals (RUPRI, 1999, p.5).

Conceptual Framework

The research performs an exploration for quality assurance activities within the Texas Critical Access Hospital Program. The rural health and CAH quality assurance scholarly opinions and requirements as derived from the literature sets the foundation for the conceptual framework within this research study. The conceptual framework consists four working hypotheses that were created from the scholarly and regulatory literature. Working hypotheses are appropriate for the research given the newness of the program and the exploratory nature of the research (Shields, 1998, p.215). The conceptual framework will be developed throughout the remainder of this chapter.

State Rural Health Plan/Office of Rural Health

Plan Collaboration

The mandated State Rural Health Plan (SRHP) is an essential factor of the Critical Access Hospital Program. The State Rural Health Plan is required by the legislation to be created through consultation with the hospital association of the state, rural hospitals, and the State Office of Rural Health (ORHP, 1999, p.5). The Health Care Financing Administration (HCFA) Regional Officer reviews the State Rural Health Plan and approves it if all necessary assurances and requirements have been met (Wynn and Cade/HCFA, 1997, p.4).

---

[35]Quality assurance requirements are contained within part III Interpretive Guideline-Critical Access Hospital, regulation 485.608 Condition of Participation (see *Appendix* E).

The SRHP must be based on a community health needs assessment for the population of concern (Wynn and Cade/HCFA, 1997, p.4). The Rural Research Policy Institute (RUPRI) (1999, p.5) encourages states to consider the quality of care-based advantages of close working relationships among local health entities such as emergency medical services, the health department, providers of primary care, and social services when designing the SRHP. The State Office of Rural Health plays a key role in administration of the SRHP and in the coordination of health care entities and resources for promotion of quality-based rural health care.

State Office of Rural Health

The State Office of Rural Health (SORH) administers the State Rural Health Plan, procures funding and provides guidance for individual CAHs through the designation process (ORHP,1999, p.2). Improvements to increase the accessibility for rural residents to hospitals and other health care facilities are a requirement for the State Office of Rural Health. In addition, the State Office of Rural Health can offer valuable assistance in gaining beneficial designations such as a Health Professional Shortage Area (HPSA) and programs for the recruitment of health professionals, which can be useful for receiving benefits to overcome personnel shortages and provide quality staffing (SoDaCAHP, 2000, p.1). In order to expand the quality related resources available for Critical Access Hospitals, State Offices of Rural Health are encouraged by the legislation to promote the regionalization and networking of rural health services (Wynn and Cade/HCFA, 1997, p.5). The quality related benefits provided by the State

Office of Rural Health leads to the following working hypothesis about the Texas Critical Access Hospital Program:

Working Hypothesis 1:
The Texas State Rural Health Plan/State Office of Rural Health provides guidance for Critical Access Hospital quality assurance activities.

Rural Health Network

As stated previously, State Offices of Rural Health are to encourage the development of rural health networks that will increase quality assurance resource availability. Wellever (1999, p.1) postulates that " rural health networks are commonly used to reduce fragmentation of health services in a community, improve access to health services, eliminate unnecessary services, and support clinical and administrative services". The most common networks are composed of hospitals, yet networks might also include physicians, information cooperatives, long term care facilities, primary care centers, behavioral workers, and emergency medical services. As of 1996, there were at least 180 rural health networks throughout the United States (AHRQ, 1997, p.1).

Critical Access Hospital Networks

The SRHP/SORH is encouraged to promote the development of rural health networks, which must include at least one Critical Access Hospital and one acute care hospital (ORHP, 1999 p.6). The legislation defines networks as simple bilateral relationships between two hospitals that focus on referral relationships, communications, credentialing and quality assurance (ORHP, 1999, p.6). Such networks are formalized through written agreements. The Health Care Financing Administration will not issue a provider agreement to a Critical Access Hospital until

all network agreement signatures have been obtained (Wynn and Cade/HCFA, 1997, p.5). Moscovice and Rosenblatt (1999, p.8) point out that CAHs are to have network agreements for patient transfer and referral, the development of informational and communication systems, protocols for emergency and nonemergency transportation of patients between the CAH and the acute care hospitals, and credentialing and quality assurance program relationships.

Critical Access Hospital Network Example

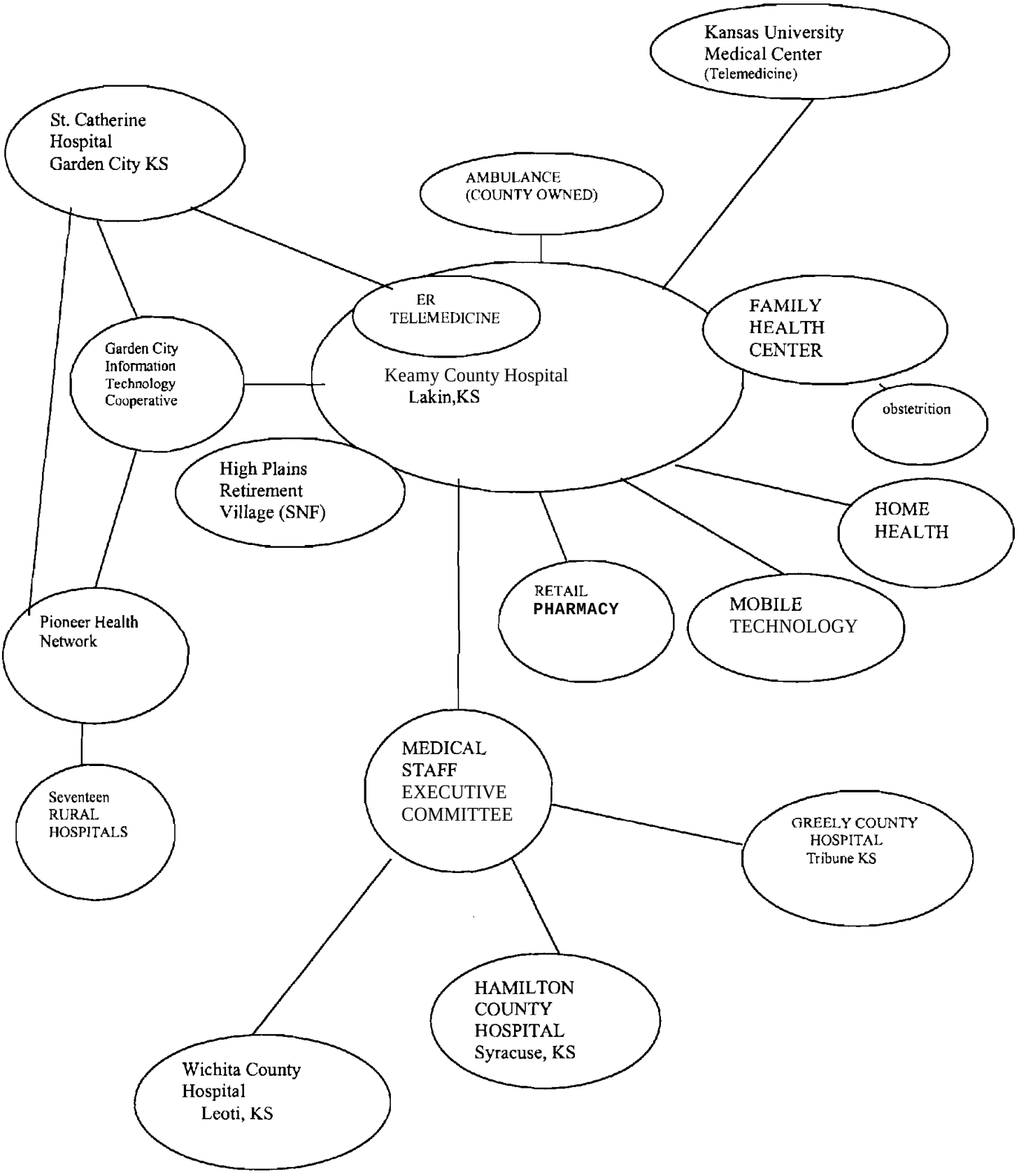
Anthony Wellever of Delta Rural Health Consulting and Research published an analysis for the U.S. Department of Agriculture in 1999 that examines the structure of three rural health networks. One of the networks belongs to Kearny County Hospital in Lakin, Kansas. An illustration of this network is provided in **Figure 3.1.** Kearny County Hospital is designated as a Critical Access Hospital, which operates 15 acute care beds and is licensed to operate 25 swing beds. The hospital offers radiology, laboratory, physical therapy, and a 24-hour emergency room.

Mobile services are provided through the hospital for ultrasound, mammography, osteoporosis screening, CAT Scan and dialysis. The mobile services are provided out of Garden City, Wichita or Topeka, Kansas. The hospital has a within community network with the High Plains Retirement Village that has resulted in the combining of administrations, improved economies of operation and single kitchen and dining facilities for both the home and the hospital. The hospital also built a family health center that was created to improve the retention of physicians and reduce unnecessary duplication of laboratory and radiology services within the community.

Kearny Hospital has a network agreement for referrals, transfers, medical staff credentialing, communications and quality assurance, with St. Catherine Hospital in Garden City, Kansas. The emergency room at Kearny Hospital is linked to St. Catherine Hospital by interactive video,

Figure 1: Rural Hospital Network

- Anthony Wellever. "Organizing for Achievement: Three Rural Health Network Case Studies." (1999 p.15)



Telemedicine Technology

"The Administrator of Kearny County Hospital (CAH) views telemedicine as the heart of its extra-local networks" (Wellever, 1999, p.12). In addition, the Health Resources and Services Administration (HRSA) have promoted the telemedicine network as being a "real boon" for rural hospitals (Fox, 1999, p.2). In response, the HRSA has created the Office for Advancement of Telemedicine to promote the clinical, educational and professional interactive uses of this technology (Fox, 1999, p.3). Also, there are grants available for rural hospitals that wish to participate in telemedicine technology. Moscowicz (1999, p.37) contends that telemedicine is one efficient way that a rural provider can tap into the expert advice of a distant specialist. Hence, the use of telemedicine technology contributes to a higher quality of care within rural hospitals (Wellever, 1999, p.12). The increased resource availability provided through rural hospital networks leads to the following working hypothesis about the Texas Critical Access Hospital Program:

Workinp Hypothesis 2:
The presence of Rural Health Networks within the Texas Critical Access Hospital Program increase resource availability for quality assurance activities within CAHs.

Internal Critical Access Hospital Quality Assurance

In addition to the mandated development of rural health networks, The CAH Program legislation requires applicants to describe the internal activities that will be in place for assuring the delivery of quality care (ORHP, 1999, p.6). Also, minimal quality assurance requirements within Critical Access Hospitals must meet the following Medicare/Medicaid interpretive guidelines for Critical Access Hospitals:

- Data collection and monitoring.
- Data analysis, problem prevention and identification.
- The identification, implementation and evaluation, of corrective actions.
- Quality improvement measures to include: performance measurement, documentation of care, personnel evaluations, staffing and credentialing guidelines, peer review, interdepartmental quality assurance measures, and patient care protocols.

The guidelines specify that Medicare will conduct a survey[36] to verify that all of the above quality assurance activities are used in an ongoing manner. The guidelines also specify that documentation from quality assurance committees and meetings will also be reviewed in order to assess the scope, methodology and organization of the QA program.

The basic QA activities such as performance measurement, documentation of care, peer review and community-based planning, are expected to take place within individual CAHs (ORHP, 1999, p.6). The Rural Policy Research Institute, however, advocates that certain allowances for less stringent quality assurance standards must be made to accommodate the lack of quality assurance resources available within Critical Access Hospitals (RUPRI, 1999, p.19).

[36] Surveys for Medicare can be conducted by designated state agencies on Medicare's behalf.

The CAH legislation, Medicare requirements, and rural quality assurance-based literature lead to the following working hypothesis about hospitals within the Texas Critical Access Hospital Program:

Working Hypothesis 3:
Internal quality assurance activities are present within individual Texas Critical Access Hospitals.

Community Input

The legislation requires rural community input in the development of the State Rural Health Plan and the CAH conversion process for individual facilities (ORHP, 1999, p.5). Moscovice and Rosenblatt (1999, p.12) suggest that the "quality of health care in rural areas depends not only on the quality of the providers or the sophistication of the medical equipment, but on planning that anticipates the health care needs of the population and arranges for their provision regardless of location". Community involvement for the identification of health care services to be delivered by CAHs is critical.

The Rural Policy Research Institute (1999, p.19) asserts that rural residents must have the ability to mold a health delivery system that is applicable to their community and not based on system designs that might be irrelevant to their needs. Griffith (1999, p.40) also points out that it is equally important that healthcare providers educate the community so that they can make the best community wide decisions.

Community Network Planning

As previously mentioned, the development of networks (such as Kearny Hospital) require community wide needs assessment and planning to enhance effectiveness and acceptance by the community (Wellever, 1999, p.16). In addition, network programs must recognize local community leaders and develop a credible relationship with the community (AHRQ, 1997, p.7). The Agency for Healthcare Research and Quality (1997, p.7) encourages development of public and private partnerships within the network and community that foster accountability and responsibility.

Collaborative Connection

Critical Access Hospital planning must be a collaborative effort among healthcare facilities, networks, providers and community representatives in order to best meet patient's needs (MRHRC, 1999, p3). The viability of the hospital is affected by the community's perception of the hospitals importance and legitimacy, as well as their commitment to the hospitals existence (McIntosh, Sykes, Segura and Alston, 1999, p.34). Likewise, the collaborative community planning process might avoid potential misperceptions within the community that a CAH is a lower quality hospital rather than a limited-service hospital. Community input is vital and necessary for both the decisions to become a CAH and for the ongoing quality-based healthcare delivery decisions that are made once designated as a CAH. The Critical Access Hospital community-based decision making literature leads to the following working hypothesis about the Texas Critical Access Hospital Program:

Working Hypothesis 4:
Critical Access Hospitals within the State of Texas utilize community input for quality based healthcare delivery decisions.

SUMMARY

The literature indicates a concern about the quality assurance standards currently used within the rural healthcare setting. Such concern is particularly important in light of the recently enacted CAH program[37]. The Rural Policy Research Institute (1999, p.19) asserts that urban-based quality assurance standards do not provide appropriate benchmarks to assess quality in rural areas. RUPRI (1999, p.19) further advocates that availability of services and outcomes measures should be the predominant measures of quality in rural areas.

The Critical Access Hospital Program stakeholders are hopeful that appropriate quality assurance standards for rural health care facilities and providers will soon be developed. Charles McGrew, director of the Arkansas Office of Rural Health and current chair of the National Organization of State Offices of Rural Health contends that "Unless we deal with quality and the perception of quality, CAHs are not going to be a success over time" (MRHRC, 1999, p.3).

Linking the Literature to the Conceptual Framework

The purpose of this Literature Review Chapter is to explore the scholarly-based quality assurance issues related to rural healthcare and more specifically, the Critical Access Hospital Program. The legislative requirements for the development and administration of the State Rural Health Plan through the State Office of Rural Health are explored for factors that contribute to quality assurance activities within CAHs. The literature supports the contention that quality assurance related activities are present within the Critical Access Hospital Program.

The development of the limited-service CAH model is also explored in a historical context within the scholarly literature. In addition, the literature review explores the rural barriers

[37] As of June **28, 2000** there were **174** Critical Access Hospitals within the United States Rural Policy Research Institute. www.rupri.org/srhf-eval/info/index.html

associated with the processes ofperforming quality assurance and delivery of patient care within a limited-service CAH.

The literature review asserts that rural communities must have the ability to shape the system of care within their community, especially within a limited-service hospital setting. Furthermore, the scholarly literature suggest that collaboration among all CAH stakeholders is key to the development and functioning of rural community based healthcare delivery systems.

The exploratory research ties the reviewed literature with the quality assurance activities that are expected to occur within the CAH Program. The scholarly arguments and explanations conceive the conceptual framework that links the literature to the research.

Summary of the Conceptual Framework

Working Hypotheses

The use of Working Hypotheses is appropriate for the research since it seeks to explore ongoing activities within a newly created program (Shields, 1998, p.215). The Working Hypotheses seek to identify the quality assurance activities that are actually taking place within the CAH Program. The exploration, through use of the Working Hypotheses, will either support or unveil quality assurance related discrepancies within the CAH Program. Also, the exploratory research might possibly identify areas for improvement and issues for further exploration.

The Working Hypotheses are summarized and linked to individual scholarly support in **Table** 3.2. The Working Hypotheses postulate that the State Rural Health Plan and the State Office of Rural Health should provide guidance for quality assurance activities within the CAH Program. Also, the Working Hypotheses surmise that the presence of rural health networks

within the CAH Program will potentially increase the resources needed to conduct quality assurance related activities for individual CAHs. In addition, the Working Hypotheses state expectations that internal quality assurance activities are present within individual CAHs. Finally, there is also an expectation within the Working Hypotheses that CAHs will utilize community input in the formation of quality-based healthcare delivery decisions. The Working Hypotheses are tested using a triangulation of methodologies. **A** discussion of the research methodologies employed for the research is the main topic of the ensuing chapter.

Table 3.2
Working Hypotheses link to literature-Critical Access Hospital Quality Assurance:

Working Hypotheses	Scholarly Support
WH1: The Texas State Rural Health Plan/State Office of Rural Health provides guidance for Critical Access Hospital Quality assurance activities.	AHRQ (1997) Moscovice and Rosenblatt (1999) Wynn and Cade/HCFA (1997) RUPRI (1999) SoDaCAHP (2000)
WH 2: The presence of Rural Health Networks within the Texas Critical Access Program increase resource availability for quality assurance activities within CAHs.	AHRQ (1997) Fox (1999) Moscovice and Rosenblatt (1999) Moscowicz (1999) Wellever (1999) Wynn and Cade/HCFA (1997)
WH 3: Internal Quality assurance activities are present within individual Critical Access Hospitals.	AHRQ (1997) Bodenheimer (1999) Griffith (1999) Moscovice and Rosenblatt (1999) Mueller (1999) RUPRI (1999)
WH 4: Critical Access Hospitals within the State of Texas utilize community input for quality based healthcare delivery decisions.	AHRQ (1997) Griffith (1999) McIntosh, Sykes, Segura, and Alston, (1999) Moscovice and Rosenblatt (1999) Wellever (1999) Wynn and Cade/HCFA (1997)

CHAPTER FOUR: METHODOLOGY

Introduction

This chapter discusses the research methodologies used to test the working hypotheses. A triangulation of methods that include document analysis, interviews and survey methodologies were determined to be the best approach for the exploration of quality assurance activities within the Texas CAH Program. The working hypotheses are appropriate for the research since the subject program is new[38] and the research population is small (Shields, 1998, p.215). **Figure** 4.1 (CAH map) illustrates the location of the eight certified CAHs within the State of Texas at the time of this research.[39]

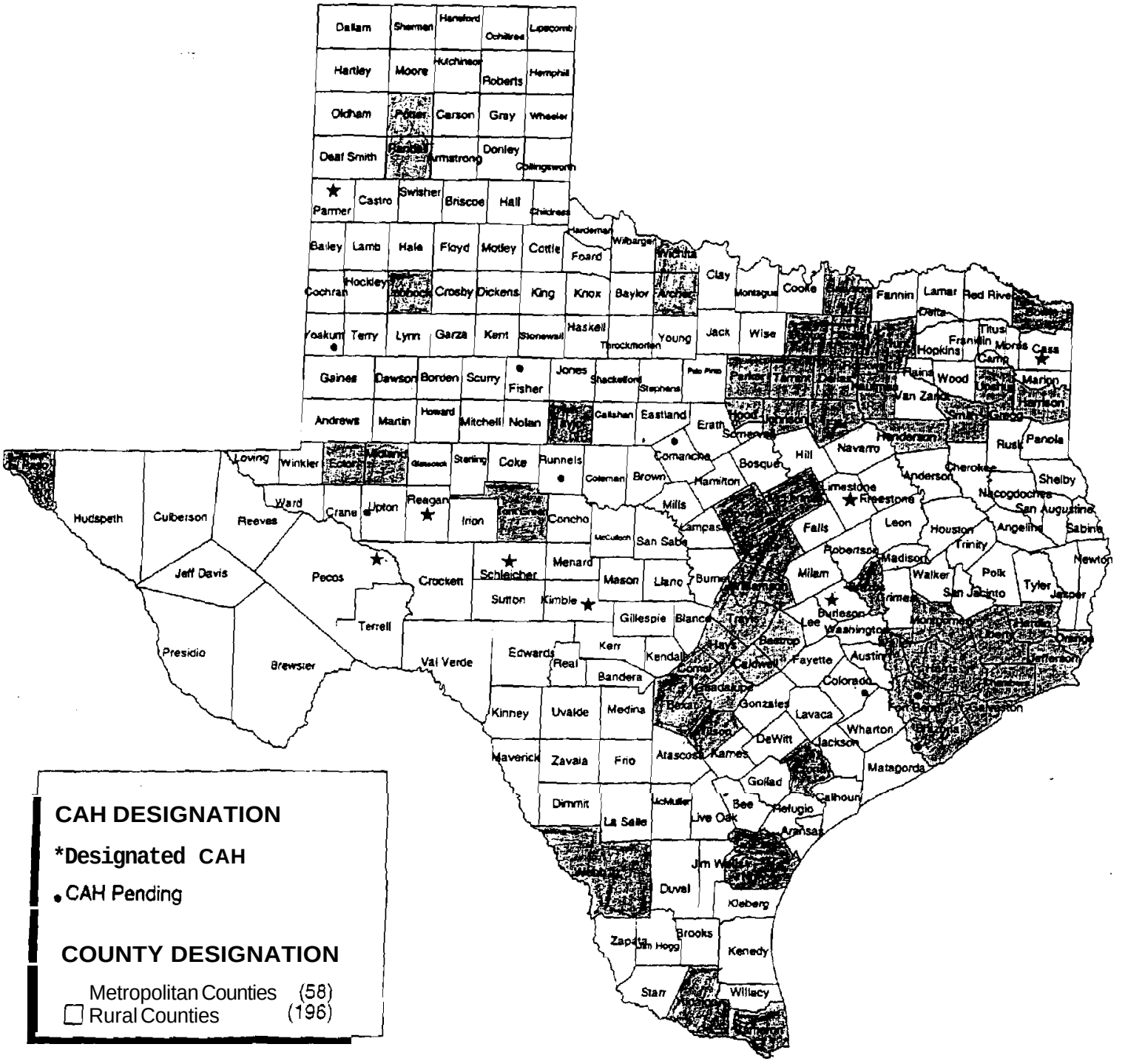
Overview of Methods

Document Analysis

Document analysis research is used to gather and corroborate data related to quality assurance activities within the Texas Critical Access Hospital Program. The documents analyzed by the research provide data related to the CAH quality assurance requirements and provisions of Medicare.[40] Center for Rural Health Initiatives (CRHI) and the Texas State Rural Health Plan.[41] CRHI is the state agency within Texas (state office of rural health) that supervises and enacts the provisions of the state rural health plan and the Critical Access Hospital Program. The research also analyzes documents related to the CAH Program from this agency. Operationalization of the documents for analysis is

[38] The first CAH within Texas was designated on December 1, 1999.
[39] Although all eight CAHs were surveyed for the research, only six completed the surveys.
[40] See ***Appendix*** E Medicare Quality Assurance requirements.
[41] Also, see ***Appendix*** F for the "Center for Rural Health Initiatives Rural Health Work Plan 1999-2000"

Figure 4.1:
CRITICAL ACCESS HOSPITALS



Prepared by:
CENTER FOR RURAL HEALTH INITIATIVES
State Office of Rural Health
July, 2W0

Source:
CEMER FOR RURAL **HEALTH** INITIATIVES
State Office of Rural Health
July, 2000
CAH00700map

shown in **Table** 4.1. The operationalization of the documents is tied directly to the stated quality assurance-based expectations within the four working hypotheses.

Document analysis is useful in this research as a method for providing specific details, making inferences for further exploration, and for corroboration of other data (Yin, 1994, p.81). Difficulty with document retrieval was not an issue for this research.

Interviews

Structured interview research methodology was used for further data gathering purposes. A total of five structured phone interviews were performed for the research. Internal CAH quality assurance activity data was received through phone interviews with three CAH administrators and a Quality Improvement Coordinator of four CAHs that have at least 6 months of longevity in the program. In addition, a broad-based quality assurance perspective of the CAH Program was provided to the research through a phone interview with the Texas Critical Access Hospital Program Administrator/Executive Director of the Center for Rural Health Initiatives.

The operationalization for the lines of questioning for the interviews is tied directly to the research question and the working hypotheses, which are derived from the literature. Operationalization of the lines of questioning for the CRHI interview is shown in **Table** 4.1. The CRHI interview specifically explores for agency and policy-based quality assurance related activities. The operationalization of the lines of questioning for the four CAH administrator/Quality Improvement Coordinator interviews is contained within

Table 4.1

Operationalization of the Lines of Questioning for CRHI interview and Document Analysis.

Lines of Questioning tied to Working Hypotheses	Sources of Evidence
WH 1: What specific programs or activities does your organization promote to assist CAHs in the areas of CAH designation, program compliance, personnel recruitment and funding?	Q1. What kind of assistance does CRHI provide potential CAHs during the designation process? Q2. What assistance does CRHI provide CAHs in maintaining CAH program compliance? Q3. How does CRHI assist CAHs in medical personnel recruitment? Q4. What types of funding and grant resources are available through CRHI? * Document Analysis of State Plan and CRHI CAH documents and web site
WH 2: What Does CRHI do to assist in rural health network development within the CAH program?	Q5. What does CRHI do to assist CAHs in the development of rural health networks? Q6. What are the resources available through CRHI for Telemedicine Technology? * Document Analysis of State Plan and CRHI CAH documents and web site
WH 3: What types of activities or programs are available through CRHI to assist individual CAHs with internal quality assurance activities?	Q7. What kind of programs or activities does CRHI have to assist CAHs with internal quality assurance activities? *Document Analysis of State Plan and CRHI CAH documents and web site
WH 4: Does CRHI have programs or activities to assist or promote CAH community health?	Q8. What specific resources does CRHI have available to assist CAH community health? *Document analysis of State Plan and CRHI CAH documents.

Table 4.2
Operationalization of Lines of Questioning for CAH Interview

Lines of Questioning linked to Working Hypotheses	Sources of Evidence
WH 1: Does The Center For Rural Health Initiatives/State Rural Health Plan provide guidance and/or assistance for quality assurance activities?	Q1. What kind of assistance was provided by CRHI during your facility's CAH designation process? Q2. What kind of assistance does CRHI provide for maintaining CAH program compliance? Q3. Has your facility received grants or funding through CRHI? If so, what types? Q4. What type of personnel recruitment assistance has CRHI provided? Q5. What type of assistance has CRHI provided your facility for the development of Rural Health Networks'?
WH 2: What type of Rural Health Network quality assurance activities does your facility engage in?	Q6. What are the names and locations of the hospitals or hospital that your facility has a formal affiliation with? Q7. What specific agreements or assistance is provided for accreditation, information systems, patient transfer, quality assurance, telemedicine, and other related areas?
WH 3: What kind of internal quality assurance activities take place within your facility?	Q8. What kind of performance measures does your facility use? Q9. At what levels of patient care is documentation of care performed? Q10. If your facility performs medical record or chart reviews, how often are these performed? Q11. How often are personnel evaluations done? Q12. What are your minimal nursing and physician staffing guidelines? Q13. Does your facility have an agreement with the Texas Medical Foundation for peer review services? Q14. What type of patient transfer agreements and procedures does your facility have?
WH 4: Does your facility use community-based input for your healthcare delivery decisions?	Q15. How often and what type of community input is used for your facility's healthcare delivery decisions? Q16. What type of activities does your facility engage in to promote health within the community? Q17. Are patient satisfaction surveys performed on an ongoing basis?

Table 4.2. The lines of questioning within **Table 4.2** specifically explore for quality assurance activities within individual CAHs.

The research was better able to explore the consistency and consensus for quality assurance activities throughout the CAH Program with the multi-level interview scheme. It was possible that the interviewees might display bias or reflexivity in their responses (Yin, 1994 p.80), however, the multi-level interviews, as part of the triangulation of methodologies, minimized the unperceived bias within the research.

Survey Research

Survey research was used to gather data on all certified CAHs within the State of Texas. Surveys (see Appendix A) were distributed to five CAH administrators during a CAH workshop on July 28,2000. Surveys were also mailed to the three CAH administrators not present at the workshop. It is important to note that the design of the survey instrument is tied directly to the research question and derived from the conceptual framework, which was created from the literature. **Table 4.3** links the specific stated expectations within the working hypotheses to the survey instrument.

The use of survey research is appropriate for this project because the research is exploratory in nature (Babbie, 1998, p.256). Survey research also adds a useful element of flexibility to the questioning process (Babbie, 1998, p.273). The population of CAHs to be surveyed was small, so there was a risk of not obtaining enough relevant data, however, since all the participating hospitals have a measurable stake in the CAH Program, success was anticipated for capturing the whole CAH population with the survey.

Table 4.3

Linking the Conceptual Framework to the Survey Instrument

(Y=Yes, N=No, UNK=Unknown)

Conceptual Framework Components	Measurement	Item # *
WH 1: State Rural Health Plan/Office of Rural Health		
Assistance with CAH designation and compliance	Y/N/UNK	Q1, Q2
Improved access to grants and funding	Y/N/UNK	Q3
Recruitment of Personnel	Y/N/UNK	Q4
Assistance with Network Development	Y/N/UNK	Q5
WH 2: Rural Health Networks		
Evidence of Rural Health Networks	Y/N/UNK	Q6
Network Affiliation Provisions	Y/N/UNK	Q7a,7b,7c,7d, 7e,7f
WH 3: Internal Quality Assurance		
Performance Measures	Y/N/UNK	Q8
Documentation of Care	Y/N/UNK	Q9
Personnel Evaluation	Y/N/UNK	Q11
Transfer Procedures	Y/N/UNK	Q17
Staffing and Credentialing Guidelines	Y/N/UNK	Q12,13
Peer Review Procedures	Y/N/UNK	Q10,14
Patient Care Protocols	Y/N/UNK	Q15
Departmental Quality Assurance	Y/N/UNK	Q16
WH 4: Community Input		
CAH Decisional Input	Y/N/UNK	Q18
Ongoing Community Input	Y/N/UNK	Q19
Patient Satisfaction Surveys	Y/N/UNK	Q20
Community Health Promotion	Y/N/UNK	Q21

* See ***Appendix A*** for Survey Instrument

Statistics

Since the population of CAHs is small, raw numbers will be used to describe the data. Therefore, no summary statistics will be used by the research. The results of the employed methodologies are contained within the next chapter.

CHAPTER FIVE: RESULTS

Introduction

This chapter includes the results of the data collection from the survey, interviews and document analysis that were used to test the working hypotheses. The findings of the results are evaluated for how they address the research question. Therefore, the findings of the exploration research will determine if the Critical Access Hospital (CAH) quality assurance activities derived from the literature are present within the Texas Critical Access Hospital Program. The chapter presents a summary of methodologies and results using a table and text format.

Methodology Review

As identified in Chapter Five, the research uses a triangulation approach of methodologies to explore quality assurance activities within the Texas CAH Program. The triangulation approach specifically employed surveys with CAH administrators, document analysis and phone interviews with three CAH administrators, a CAH quality improvement coordinator and the Texas State Office of Rural Health Executive Director/CAH Program Administrator. **Table** 5.1 presents a summary of the methodologies employed for the research study. The methodologies employed by the research are preferred because the research population is small and the Texas CAH Program is in its early developmental stages.[42]

[42] The first Texas CAH was designated on December 1, 1999. At the time of the research, there was a total population of eight CAHs in Texas (see Appendix *C*).

Table 5.1: Summary of Methodologies

SOURCE	SURVEYS*	INTERVIEWS**	DOCUMENT ANALYSIS
CAH Administrator	**Five** Surveyed on July 28,2000 **One** Surveyed on Aug. 10,2000 **Total of Six Surveys**	***Structured Phone Interviews*** **Three** conducted on October 2,2000 ***Avg. Length:*** Twenty Minutes	No documents analyzed from administrators
CAH Quality Improvement Coordinator	Not Surveyed	***Structured Phone Interview*** October ***4,*** 2000 ***Length:*** Twenty Minutes	No documents analyzed from coordinator
Center for Rural Health Initiatives Executive Director/CAH Program Administrator	Not Surveyed	***Structured Phone Interview*** October 20,2000 ***Length:*** Thirty Minutes	Received and **analyzed the following** from the Center for Rural Health Initiatives: •***State Rural Health Plan*** ****Centerfor Rural Health Initiatives Rural Health Work Plan 1999-2000 (see Appendix F)*** ****Medicare Interpretive Guidelines for Critical Access Hospitals (see Appendix E)*** *** ****TexasCAH Application Packet (see Appendix D)*** •Center for Rural Health Initiatives web site.[43]
		Total of Five Interviews	

* See *Appendix A* for Survey Document
** See ***Appendix*** B for Interview Transcripts
******Appendix*** E contains Medicare's quality assurance interpretive guidelines.

[43] Web Address: www.crhi.state.tx.us

Surveys

As previously discussed in Chapter Four, the research administered surveys to the administrators of the eight currently certified CAHs within the state of Texas. Five surveys were administered during a CAH workshop and three were mailed to the administrators not present at the workshop. As **Table** 5.1 Illustrates, a total of six surveys were returned for use in the research. The survey findings are displayed within four tables that are individually and conceptually linked to the working hypotheses. A text-based summary of the findings is also presented.

Interviews

As **Table** 5.1 illustrates, the research employed a total of five structured phone interviews. Interviews were conducted with three CAH administrators and a CAH quality improvement coordinator. These interviews were in follow-up to the CAH administrator survey and are intended to provide further detail and corroboration for the research purpose. In addition to the CAH administrator and quality improvement coordinator interviews, the research performed an interview with Mr. Dave Pearson, the Executive Director/CAH Program Administrator at the Center for Rural Health Initiatives (Texas State Office of Rural Health). This interview provides the research with state agency program data. More specifically, the interview research explored for the exact types of assistance offered by the Center for Rural Health Initiatives. The cumulative findings from both sets of interviews are provided in conjunction and integrated within the survey results. The interview findings are also presented according to their specific relevancy to each of the four working hypotheses.

Document Analysis

As illustrated in **Table** 5.1, the research performed document analysis on relevant portions of the State Rural Health Plan, CRHI Rural Health Work Plan 1999-2000, Medicare's Interpretive Guidelines for Critical Access Hospital and the Texas CAH Application Packet. Analysis was also performed on the CRHI web site. The document analysis is summarized in conjunction and integrated within the survey and interview findings.

State Plan/Office Provides Guidance

Working Hypothesis 1: *The Texas State Rural Health Plan/State Office of Rural Health provides guidance for Critical Access Hospital quality assurance activities.*

As discussed in Chapter Three, rural health care and CAH quality assurance literature provides theoretical support for the quality assurance related responsibilities and programs administered by the State Office of Rural Health (SORH). The Texas SORH is also known as the Center for Rural Health Initiatives (CRHI).

According to the literature, the CRHI/SORH has responsibility for the advancement of rural health and administration of the State Rural Health Plan. The Center for Rural Health Initiatives also administers the CAH Program and is expected to provide guidance through the certification process in addition to ongoing assistance to CAHs. The CRHI can also provide access to funding, personnel recruitment and network development that, according to the literature, should enable CAHs to increase or maintain quality patient care delivery.

The questions for Working Hypothesis 1 are designed to measure the effectiveness of the CRHI/SORH in providing assistance and programs that facilitate and enhance quality assurance within the CAH Program. **Table 5.2** summarizes the CAH administrator survey results for CRHI quality assurance related activities.

Table 5.2: State Rural Health Plan/Office of Rural Health Guidance
N=6

Activities	**"Yes"**	**"No"**	**"Unknown"**
Designation/compliance **Total**	**6**		
Access to grants/funding **Total**	**6**		
Personnel Recruitment **Total**	**4**	**2**	
Network Development **Total**	**2**	**2**	**2**

Overall, the data within the table confirms a belief among the CAH administrators that the Center for Rural Health Initiatives does provide beneficial guidance. The administrators interviewed had very positive comments and high praise for Mr. Dave Pearson (Executive Director/CAH program administrator) in regard to the designation assistance offered by CFU-II.

Mr. Pearson confirms that CFU-II offers technical assistance throughout the whole designation process. He also states that CRHI provides financial feasibility studies for potential CAHs in addition to assistance for meeting eligibility and program requirements. Documents obtained from CFU-II displayed many useful factors for assisting potential CAHs

through the designation process. For example, CRHI provides a useful application checklist and designation flowchart within the CAH application packet to help guide potential CAHs through the designation process. Also, document analysis revealed that CRHI's web page provides a wide range of useful information such as resources for CAH funding, personnel assistance and compliance issues. Several of the administrators also voiced a favorable opinion about the grant opportunities and personnel assistance offered by CRHI, however, only one hospital thus far has benefited.

The data within **Table** 5.2 portrays less than positive findings related to network development. The data reveals that only two (out of six) CAHs have received or are aware of receiving any type of assistance from CRHI for network development. Mr. Pearson (see ***Appendix B***) confirms that the assistance offered by CRHI in regard to network development to date has been limited to workshops and informational sources thus far. He also suggests that Texas is behind the rest of the country in the development of rural health networks.

Networks Increase Quality Assurance

Working Hypothesis 2: ***The presence of Rural Health Networks within the Texas Critical Access Hospital Program increases resource availability for quality assurance activities within CAHs***

As noted in Chapter Three, the rural health care and CAH literature provides theoretical support for the role of rural health networks in regard to the increased provision of quality assurance resources for CAHs. The network segment of the CAH administrator survey is

designed to assess the types of quality assurance resources provided through a network relationship. **Table 5.3** displays the results of the network section of the survey.

Table 5.3: Rural Health Networks
N=6 *** facility that does not have affiliation agreement did not answer these (*) questions**

Presence of Network		"Yes"	"No"
Affiliation Agreement	Total	5	1
Accreditation Assistance	Total	1	4*
Information System Assistance	Total	3	2*
Patient Transfer Agreements	Total	5	*
EMS Transfer Agreements	Total	5	*
Quality Assurance Assistance	Total	2	3*
Telemedicine Agreement	Total	4	1*

The survey data in **Table 5.3** surprisingly reveals that one CAH does not have a formal affiliation with another hospital. Mr. Pearson at CRHI states that "network development requirements are somewhat relaxed and that the development of networks in Texas has been slow". Mr. Pearson further suggests that "it is difficult for hospitals to form natural relationships due to the distance bamers in a large state such as Texas".

A majority of administrators (4) deny receiving any assistance with accreditation from another facility. Of the four administrators interviewed, only one stated that his facility

is JCAHO accredited. Document analysis revealed that CAHs do not have to be JCAHO accredited, but are required to meet less sophisticated standards in Medicare's Conditions of Participation (see ***Appendix E***).

The literature explicitly states that assistance with quality assurance activities is an expectation of a network relationship, however, the data reveals that only two CAH administrators are aware of receiving assistance with quality assurance from a network affiliate. It is also worth noting that three out of four administrators interviewed stated that their facilities do not have telemedicine technology and this does not correlate with the findings of the survey. Mr. Pearson states that the infrastructure to support telemedicine technology in rural areas needs further development. Overall, the consensus among all five interviewees indicate the need for further rural health network development in the State of Texas.

Internal Quality Assurance Present

Working Hypothesis 3: ***Internal quality assurance activities arepresent within individual Critical Access Hospitals.***

As discussed in Chapter Three, the literature on Critical Access Hospitals supports the need for internal quality assurance (QA) activities within individual CAHs. Also, specific requirements such as Medicare certification and state licensing procedures further mandate the presence of internal QA activities. **Table** 5.4 displays the results of the CAH administrator survey as it relates to CAH internal quality assurance activities.

Table 5.4: Internal Quality Assurance
N=6

Activities	"Yes"	"No"
Performance Measures Total	5	1
Documentation of Care Total	6	
Medical Record Reviews Total	6	
Annual Staff Evaluations Total	6	
Staffing Guidelines Total	4	2
Credentials Monitoring Total	6	
Peer Review Organization Total	5	1
Patient Care Protocols Total	6	
Departmental Quality Assurance Total	6	
Transfer Protocol Agreements Total	6	

The survey data in **Table 5.4** indicates an overall positive response by the administrators to the presence of internal quality assurance activities. One administrator response interestingly indicates the use of no performance measures. In contrast, one of the administrators interviewed said his facility uses the more sophisticated and demanding JCAHO quality indicators, while others stated they use basic quality assurance/improvement measures such as the type found in Medicare's CAH Conditions of Participation.

Surprisingly, one administrator's response in the survey indicates no written agreement with a peer review organization. The literature and document analysis indicates that a written peer review organization agreement is a program requirement. Mr. Pearson states that the

reason for this might be due to the slow response of the Texas Medical Foundation towards assisting the CAH program. He also adds that CAH regulations have been flexible. One administrator voiced criticism about the lack of response from TMF in regard to quality assurance assistance.

Community Input for Health Care Decisions

Working Hypothesis 4: *Critical Access Hospitals within the State of Texas utilize community input for quality based health care delivery decisions.*

According to the literature within Chapter Three, community input is an essential requirement for the decision to become a CAH and for assuring ongoing quality patient care delivery. **Table** 5.5 displays the results of the CAH administrator survey as it relates to community input for CAHs.

Table 5.5: Community Input
N=6

Types of Input	"Yes"
Becoming a **CAH** **Total**	**6**
For Health Care Delivery **Total**	**6**
Patient Satisfaction Surveys **Total**	**6**
Community Health Promotion **Total**	**6**

The administrator survey data represents an overwhelming positive *(6)* response to the involvement of the community in the CAH decision making process. All of the administrators interviewed (4) stated that their facilities engage in ongoing community health promotion. Interestingly, one of the CAH administrators denied using patient satisfaction surveys and this does not correlate with the CAH administrator survey data .

Mr. Pearson states that "CRHI will be conducting a patient utilization and satisfaction survey for CAHs in the near future". In addition, Pearson advises that CRHI will be providing four $10,000 community outreach grants to target underserved people in the community. Document analysis of the "Center for Rural Health Initiatives Rural Health Work Plan 1999-2000" reveals a strategic plan for rural community health and economic development, Further comments and summaries on these and related research findings are found within the Conclusions Chapter.

CHAPTER SIX: CONCLUSIONS

This chapter presents the conclusions of the research in relation to the quality assurance activities within the Texas CAH Program. The four Working Hypotheses related to the Texas State Rural Health Plan/State Office of Rural Health, rural health care networks, internal CAH quality assurance and community involvement provide the framework for the analysis and closing discussions. The interpretations of the results, limitations for the study and recommendations for further research are also included.

Summary of Research Results

Table 6.1 represents a summary of the research evidence relevant to the quality assurance activities within the Texas Critical Access Hospital Program. The evidence includes results of the surveys, structured phone interviews and document analysis.

Table 6.1 Evidence in Support of Conceptual Framework

Working Hypotheses	Survey	Interviews	Document Analysis	Overall
WH 1: The Texas State Rural Health **Plan/State Office** of Rural Health provides **guidance** for Critical Access Hospital **quality assurance activities.**	**Supports**	**Supports**	**Supports**	**Supports**
WH 2: The presence of Rural Health **Networks** within the Texas Critical Access Hospital program **increases** resource availability for **quality assurance** activities **within CAHS**.	**Partial Support**	**Partial Support**	**Partial Support**	**Partial Support**
WH 3: Internal quality assurance activities are **present** within Texas Critical Access Hospitals.	**Partial Support**	**Partial Supports**	**Supports**	**Partial Support**
WH 4: Critical Access Hospitals within the State of Texas **utilize community input** for quality based **health care** delivery **decisions.**	**Supports**	**Supports**	**Supports**	**Supports**

As displayed in **Table 6.1,** the results of the survey support to WH 1 which concern the guidance provided by the Texas State Rural Health Plan and the State Office of Rural Health. Interview and document analysis methodologies also support WH1. As previously discussed in Chapter Three, WH 1 is created from the literature. Overall, the Critical Access Hospital administrators and State Office of Rural Health (SORH) Executive Director/CAH Program Administrator predominantly agree that the SORH does provide appreciable guidance/assistance in all areas except network development.

The data for WH 2, concerning the increased quality assurance resources available through rural health networks, only partially supports the stated expectations within WH 2. The expectations within WH 2 were developed from the literature. The surveys displayed only partial support in part due to the overall negative responses to direct network quality assurance and accreditation assistance. The interviews and document analysis further confirmed the lack of overall network development to date within the Texas CAH Program.[44]

The data reveals that WH **3,** concerning internal quality assurance activities within Texas CAHs, is partially supported.[45] WH 3 was developed through a review of the literature. The survey data reveals that Texas CAH administrators in general recognize, value and employ health care quality assurance measures. The interviews and document analysis also confirm a legitimate respect for basic quality assurance measures within Texas Critical Access Hospitals.

The overall results for WH 4, concerning community input for Texas Critical Access Hospitals, are overwhelmingly positive. As previously discussed in Chapter Three, WH 4 is

[44] Mr. Pearson informs that CRHI will be offering four $10,000 grants for network development to interested **CAHs** in the near future.

developed through the literature. In addition, the survey data, interviews and document analysis also provide strong support in regard to community input for Texas Critical Access Hospitals.

Conclusions and Recommendations

The Working Hypotheses for the research are supported by the data results of the survey, interviews and document analysis. The survey questions were designed to explore quality assurance activities within the Texas Critical Access Hospital Program. The document analysis was employed for objective exploration and verification purposes. The follow-up structured phone interviews with CAH administrators, CAH quality improvement representative and the Executive Director/CAH Program Administrator were used as an alternative method to support the survey results and document analysis. The following are conclusions and recommendations supported by the research methodologies:

1) The Texas State Office of Rural Health/Center for Rural Health Initiatives is providing commendable leadership in the overall development of the Texas Critical Access Hospital Program. Areas of concern identified through the research, such as the development of networks, were previously recognized and are being fully addressed by CRHI. In addition, the Center is continuing to proactively identify and address other areas in need of further development and support. The ongoing assistance

[45] One of the CAHs in the survey did not have an agreement with a Peer Review Organization and such an agreement is a written requirement for the CAH Program.

and programs provided by the Center in areas such as personnel recruitment, funding and continuing education for CAH stakeholders are useful if taken advantage of.

2) Texas CAH administrators must take full advantage of the resources offered by the Center for Rural Health Initiatives. In addition, they must let their voices be heard in order to secure additional funding and assistance to support the further development of rural health networks, information systems networks, telemedicine technology and and infrastructure. Also, CAH administrators must prepare for to meet JCAHO accreditation standards, since they will likely receive authority to conduct CAH quality assurance accreditation surveys by Medicare.

3) The Texas Medical Foundation must take a greater role in providing Texas Critical Access Hospitals with quality assurance resources.[46]

These conclusions are drawn from the research data and the scholarly literature to provide a synthesis of the findings for the study. This exploration ventured into the complex array of factors that contribute to quality assurance within the Texas Critical Access Hospital Program. This exploratory research ultimately suggest that the Texas CAH Program is responding appropriately to the quality-based challenges of rural health care as a new and developing program.

[46] **Mr. Pearson states that The Texas Medical Foundation is sponsoring a** Quality **Workshop for** CAHs **in early December 2000.**

Concluding Remarks

All of the stakeholders within the Texas Critical Access Hospital Program should be commended for addressing the health care needs of our rural communities. The research recommends additional related follow-up studies as the population of Texas CAHs increases. The research acknowledges the limitations of the findings due to the small population of CAHs within Texas, however, through use of the triangulation of methodologies, there is a high level of confidence that the recommendations from the research have merit.

Bibliography

Agency for Healthcare Research and Quality (AHRQ). "Strengthening the Rural Health Infrastructure: Network Development and Managed Care Strategies" workshop summary. http://www.ahcpr.gov/research/ulpstren.htm (November 19-21, 1997).

Agency for Healthcare Research and Quality(AHRQ). "Improving Healthcare for Rural Populations". Publication No. 96-p040. http://www.ahcpr.gov/research/rural.htm (1996).

American Hospital Association. "Conversion to a C A H . October 1997. pp. 13-19.

American Hospital Association. *Hospital Closures 1980 thru 1991: A Statistical Profile.* February 1992. P.2.

American Hospital Association. "Distribution of Rural Hospitals, by Ownership 1991 and 1994-1995." *A Profile of Nonmetropolitan Hospitals, 1991-1995.* AHA Center for Health Care Leadership, Section for Small or Rural Hospitals. 1997. P.5.

American Medical Association "Table 45. Mean Physician Net Income (in thousands of dollars) after Expenses before Taxes, 1996". *Socioeconomic Characteristics of Medical Practice,* 1997/98. p.106.

Babbie, Earl R. *The Practice of Social Research*-8th ed. Wadsworth Publishing Company. 1998 p. 256-258.

Bodenheimer, Thomas. "The American Health Care System-The Movement for Improved Quality in Health Care." *The New England Journal of Medicine*-vol.340,No.6.(1999). pp.488-492.

Braden and Beauregard. "Health Status and Access to Care of Rural and Urban Populations." Agency for Health Care Policy and Research. 1994. (AHCPR Pub. No. 94-0031.)

Center for Rural Health Initiatives "Rural Health Work Plan 1999-2000." 1999 pp. 1-20. **http://crhi.state.tx.us/strat plan.pdf**

Center for Rural Health Initiatives. "Rural Health in Texas, 1999:A Report to the Governor and the 76th Texas Legislature". Jan. 1999, pp. 20-85.

Center For Rural Health Initiatives. "Critical Access Program is up and running in Texas." *The Rural Reporter.* crhi.state.tx.us/pdf/rh2_reporter/dec_14.html Dec. 1999 p.1.

Center for Rural Health Initiatives. "10 things you should know about designations". *Texas Rural Health Reporter.* Vol.2 (2). June 2000, p.8.

Center for Rural Health Initiatives. "New Critical Access Hospital Program Soon to Debut in Texas". *Texas Rural Health Reporter.* June 1999 p.1.

Christianson, J.B., Moscovice, I.S., & Tao, G. (1990). *Medical Assistance Facility certification criteria.* Minneapolis, MN: University of Minnesota. p. 91.

Dagata, Elizabeth M. "The Socioeconomic Well-Being of Rural Children Lags that of Urban Children." *Rural Conditions and Trends* vol. 9(2), February 1999, pp. 85-90.

Department of Health and Human Services, Office of Inspector General. *Hospital Closure: 1996.* January, 1999. P. 4.

Department of Health and Human Services, Office of Inspector General. *Hospital Closure:1997.* February, 1998. P. 3.

The Economist. "Don't fall sick on the prairie." *The Economist Newspaper Ltd.* V353 i8143 (1999) p.30.

Fox, Claude Earl. "Senate Testimony: The Potential Crisis Facing Rural Hospitals and the Impact on Rural Communities." Texas Department of Health. http://www.tdh.texas.gov/scripts/mch/news_37.htm (1999) p.1-3.

Gaumer, Gabay and Geller. The Montana Assistance Facility Demonstration Evaluation: Final Evaluation Report, July, 1993. Abt Associates (HCFA Contract #500-870030.) pp.iii-vii.

Ghelfi, Linda M. "Rural Per Capita Income Grows Slightly Faster than Urban." *Rural Conditions and Trends* vol. 9 (2), February 1999, pp.63-65.

Griffith, John R. *The Well-Managed Healthcare Organization.* 4th ed. Health Administration Press. (1999) pp. 40-672.

Grimaldi, Paul L. "Managed Care's Move to Rural Areas." *Nursing Management* 30(4), (1999) pp16-17.

Health Care Financing Administration. "Medicare Program Payments, by area of Residence". *Health Care Financing Review: Medicare and Medicaid Statistical Supplement.* 1998, p.44.

The Joint Commission on Accreditation of Healthcare Organizations (JCAHO). Web page: http://www.jcaho.org/whatwedo_frm.html. (2000).

The Joint Commission on Accreditation of Healthcare Organizations (JCAHO). "Joint Commission to Address Critical Access Hospitals." http.//www.jcaho.org/newse_frm.html (2000) pp.1-2.

Kusmin, Lorin. "Nonmetro Employment Growth Slows, but Unemployment Continues to Fall." *Rural conditions and Trends* vol. 9 (2), February 1999, pp. 42-47. http://www.econ.ag.gov/epubs/pdf/rcat/rcat92/index.htm

The Montana Area Health Education Center. *The Critical Access Hospital Resource Center:Montana Medical Assistance Facilities*.http://healthinfo.montana.edu/cah/maflist.html

Maine Rural Health Research Center-MRHRC. "State Roles Critical in Encouraging CAHs."http://www.muskie.usm.maine.edu/mrhc/d_indexMRHRC.html (1999) pp.1-4.

McIntosh, Sykes, Segura and Alston. "Conlmunity perceptions and commitment affect the survival of rural hospitals." Agency for Healthcare Research and Quality. http://www.ahcpr.gov/research/jan99/ra19.htm. (1999) pp. 1-2.

Menninger, Bonar. "Rural Hospitals Hit Hard by Medicare cuts." *Kansas City Business Journal* v17i42, (June 25, 1999) pp. 1-2.

Moscovice and Rosenblatt. "Quality of Care Challenges For Rural Health." Rural Health Research Center. http://www.hsr.umn.edu/centers/rhrc/rhrc.html . (1999) pp. 1-8.

Moscowicz, Daniel B. "Managing care in rural America." *Business and Health* v17i12, (Dec. 1999) p.37.

Mueller, Keith. "Rural Implications of the Medicare, Medicaid, and SCHIP Balanced Budget Refinement Act of 1999: A Rural Analysis of The Health Policy Provisions." Rural Policy Research Institute. http://www.rupri.org/pubs/archive/reports/p99-11/index.html (Dec. 1999).

Nord, Mark. "Rural Poverty Rate Unchanged."*Rural Conditions and Trends* vol. 9(2), February 1999, pp. 81-84.

Office of Rural Health Policy (ORHP). "Rural Hospital Flexibility Program". Guidance for Program Grant Funds for FY 1999. *Catalog of Federal Domestic Assistance*. No: 93.241. 1999, pp.1-11.

Orloff, Tracy. "Issue Brief: State Challenges and Opportunities in Rural and Frontier Health Care Delivery." National Governors Association Homepage www.nga.org/Pubs/Issue Briefs/1998/980929RuralHealth.asp (1998).

Pratt, D.D. "Rural occupations and health." *Journal of Rural Health,* 6(4), 399-418.

Provost, Glen. "Health Care and the Greying of Small Town Texas." The Center for Rural Health Initiatives. *The Rural Reporter* crhi.state.tx.us/pdf/rh2_reporter/dec_46.html (1999) p.1-2.

Rogers, Carolyn. "Changes in the Older Population and Implications for Rural Areas." Food and Rural Economics Division, Economic Research Service, US Department of Agriculture. Rural Development Research Report No. 90. http:// www.econ.ag.gov/epubs/pdf/rdrr90/

Rural Policy Research Institute(RUPRI). "Implementation of the Provisions of the Balance Budget Act of 1997: Critical Issues for Rural Health Care Delivery." Rural Policy and Research Institute report #p99-7-5. www.rupri.org (1999) pp. 4-22.

Rural Policy Research Institute (RUPRI). *Location of Critical Access Hospitals.* May 19,2000. http://www.rupri.org/srhf-eval/info/index.html

Rural Policy Research Institute (RUPRI). *SRHF Implementation state by state.* http:// www.national rural network.org/ 2000.

Shields, Patricia M. "Pragmatism as philosophy of science: A tool for public administration." *Research in Public Administration.* 1998. Volume 4. pp.199-230.

South Dakota Critical Access Hospital Program(SoDaCAHP) http//www.state.sd.us/doh/rural/plan.htm (2000)

Texas Sunset Advisory Commission report. "Center for Rural Health Initiatives". 1998. www.sunset.state.tx.us./sunset/reports.

Wellever, Anthony. "Organizing for Achievement: Three Rural Health Network Case Studies."Federal Office of Rural Health Policy. www.nal.usda.gov/orhp/organizing.htm (1999). pp. 1-16.

Wingert, Christiansen and Moscovice. "Quality Assurance Issues Raised by Proposed Limited Service Rural Hospitals". *Quality Assurance and Utilization Review.* 1991. Vol. 6, pp.38-46.

Wynn, Barbara O., Cade, David. "Medicare Rural Hospital Flexibilty Program." Health Care Financial Administration (HCFA) www.hcfa.org (1997) pp. 1-5.

Yin, Robert K. *Case Study Research:design and methods*-2nd ed. SAGE Publications Inc. (1994), pp. 80-81.

Yawn, Barbara. "Telemedicine: A New Framework for Quality Assessment." *Rural Health Reporter.* http://crhi.state.tx.us/pdf/rhl reporter/sept 63a.html. (1999). pp. 1-4.

Appendix A: Survey Tool

Survey for Quality Assurance Activities within the Texas Critical Access Hospital (CAH) Program (This survey is intended for representatives of individual CAHs)

I. State Office of Rural Health/State Rural Health Plan

1. Did the Center for Rural Health Initiatives(CRHI) provide guidance and/or assistance for your facility to be designated a CAH? yes____ no____ unknown____

2. Does CRHI provide useful guidance and/or Assistance in maintaining CAH program Compliance? yes____ no____ unknown ——

3. Does CRHI improve your facility's access To grant and funding resources? yes____ no____ unknown

4. Does CRHI assist your facility with recruitment of medical personnel? yes____ no unknown ——

5. Does CRHI assist your facility in the development of Rural Healthcare Networks? yes____ no____ unknown ——

11. Rural Health Networks

6. Is your facility formally affiliated with at least one other hospital? yes____ no____ unknown ——

7. If your facility is formally affiliated with at least one Other hospital, do provide assistance with the Following?

   a. Accreditation yes____ no____ unknown ——

   b. Information Systems yes____ no unknown ——

   c. Patient Transfers yes____ no—— unknown ——

   d. Emergency Service Transfer Procedures yes____ no____ unknown ——

   e. Quality Assurance yes____ no____ unknown____

   f. Telemedicine Technology yes____ no____ unknown ——

   g. Other:

III. Internal Quality Assurance

8. Does your facility use performance measures? yes____ no____ unknown____

9. Does your facility perform documentation of care? yes____ no____ unknown____

10. Does your facility perform chart or medical record reviews? yes____ no____ unknown____

11. Are personnel evaluations performed within your facility on a yearly basis? yes____ no____ unknown____

12. Does your facility have written staffing guidelines? yes____ no____ unknown____

13. Are the credentials of the medical and professional staff monitored and updated on a continual basis? yes____ no____ unknown____

14. Does your facility have an agreement with a Medical Peer Review Organization? yes____ no____ unknown____

15. Does your facility have written patient care protocols? yes____ no____ unknown____

16. Do individual departments within your facility have written policy and procedures for quality assurance? yes____ no____ unknown____

17. Does your facility have written transfer protocols and agreements with another facility? yes____ no____ unknown____

IV. Community **Input**

18. Was community input an important factor in your facility's decision to become a CAH? yes____ no____ unknown____

19. Does your facility use community input in your healthcare delivery decision process ? yes____ no____ unknown____

20. Does your facility perform patient satisfaction surveys? yes____ no____ unknown____

21. Does your facility engage in healthcare promotional activities within your community? yes____ no____ unknown____

Name of Facility:_____ Your Title:_____

Appendix B: Transcriptions for Critical Access Hospital representative Phone Interviews

Phone Interview Participants:

Reed Edmundson CEO/Administrator
Burleson St. Joseph Health Center
Caldwell, Texas

Bill Neely CEO/Administrator
Parmer County Community hospital
Friona, Texas

Richard Arnold CEOlAdministrator
Linden Community Hospital
Linden, Texas

Larry Price
Quality Improvement Coordinator
Limestone Medical Center
Groesbeck, Texas

1. What kind of assistance was provided by the Center for Rural Health Initiatives (CRHI) during your facility's designation process?

Edmundson: CRHI provided assistance throughout the application process. In particular, They provided answers to specific questions and helped to coordinate the surveying and licensing processes with the Texas Department of Health. Dave Pearson was a great help.

Neelv: CRHI helped with any questions and gave general guidance for the process. They gave helpful information on state and federal regulations.

Arnold; The Center sponsored helpful and collaborative workshops with the various agencies involved in the program. They coordinated the process and provided technical advice.

Price: The center provided basic assistance through the process. They coordinated the process and headed us in the right direction.

2. What kind of assistance does CRHI provide for maintaining CAH program compliance?

Reed: No assistance is provided.

Neelv: They provide any problem related assistance. Also, they provide state and federal regulation updates along with Medicare and Medicaid provider reimbursement updates and information.

Arnold: Updates on policies and procedures.

Price: They answer questions, provide updates and information through mailings and provide workshops.

3. Has your facility received grants or funding through CRHI? If so, what types?

Reed: The opportunity to receive grants is available. We applied for two capital grants. One grant was worth $50,000 and the other was worth $100,000, but we didn't get either.

Neelv: We have not received grants or funding.

Arnold: No.

Price: Yes, $40,000 for equipment and patient beds.

4. What type of personnel recruitment assistance has CRHI provided?

Reed: None, but offers have been made.

Neelv: No assistance has been provided.

Arnold: We've tried to get assistance with no results.

Price: We are currently viewing applicants through the Prairie Doc. Program and we have recruited a nurse practitioner with assistance.

5. What type of assistance has CRHI provided for the development of Rural Health Networks?

Reed: None

Neelv: Nothing other than informational meetings.

Arnold: None, other than to describe them at workshops.

Price: Have provided network information at workshops

6. What are the names and locations of the hospitals or hospital that your facility has a formal affiliation with?

Reed: St. Joseph in Bryan, Caldwell Hospital, and Madison St. Joseph.

Neelv: Baptist St. Anthony in Amarillo, N.W. Texas Hospital in Amarillo, We have a network agreement with Hereford Hospital in Hereford and we are affiliated with Covenant Hospital in Lubbock.

Arnold: We have transfer agreements with Atlanta Memorial in Atlanta TX, Wadley Hospital in Texarkana, East Texas Medical Center in Tyler, Marshall Regional Hospital in Tyler, Pittsburg Hospital and St. Michaels Hospital.

Price: Hillcrest and Providence Hospitals in Waco, Parkland Hospital in Dallas and Cook Childrens Hospital in Ft. Worth.

7. What Specific agreements or assistance is provided for accreditation, information systems, patient transfers, quality assurance, telemedicine, or other areas through your hospital network?

Reed: We have telemedicine agreement with St. Joseph and also a Residency agreement.

Neelv: We have just a network agreement, nothing for QA, and no telemedicine.

Arnold: We have transfer agreements with all network hospitals and the agreements can be modified for other needs. We have no telemedicine, but are interested. It's just too expensive.

Price: Our agreements are for patient transfer. We have no telemedicine.

8. What kind of performance measures does your facility use?

Reed: We are JCAHO accredited and use their performance indicators along with monthly Quality assurance monitoring with process and outcomes measures and primary care teams.

Neelv: We use general quality assurance measures and performance measures.

Arnold: A lot of the terms are "gobble gook." We do use continuing quality improvement and we also use the TMF guidelines and general quality assurance. Measures based on outcomes are

difficult because our patients are 85% Medicare and they are also old. If they are in bad shape they are usually transferred out, so it is difficult to gauge an outcome.

Price: We use basic Quality Improvement indicators, quality control, process and outcomes measures.

9. At what levels of patient care is documentation of care performed?

Reed: All levels.

Neelv: All levels.

Arnold; We document at all levels.

Price: We document at the nursing, physician, therapy and specialty clinic levels.

10. If your facility performs medical record or chart reviews, how often are these performed?

Reed: We review 10% of medical records on a monthly basis.

Neely: Quarterly review is done.

Arnold: We perform medical records reviews on an ongoing basis and 100% of records are done.

Price: We perform a monthly review for utilization, nursing and medical records. We try to have the physicians involved in the process.

11. How often are personnel evaluations done?

Reed: Annually along with an employee satisfaction survey done every 6 months.

Neelv: Annually

Arnold: Annually

Price: Annually

12. What are your minimal nursing and physician staffing guidelines?

Reed: 1 family practitioner for every 4,000 people. The ER is staffed with at least one physician 24 hours a day. A Specialist visits 2 times a month. Nurses are staffed at a 1 to every 5 acute inpatient.

Neelv: We have no direct policy for staffing, although the ER is staffed by a physician 24 hours a day.

Arnold: We use Medicare's minimal staffing guidelines and the ER is staffed 24 hours a day by a physician.

Price: We have guidelines that are: 1 ER doc 2417, 1 RN, 1LVN on duty for an avg. of 2 inpatients and 1 RN on call.

13. Does your facility have an agreement with the Texas Medical Foundation for peer review services?

Reed: Yes

Neely: Yes

Arnold: Yes, although they haven't sent guidelines for chart review procedures yet. We have an agreement, but difficulty with using them as a resource.

Price: Yes

14. What type of patient transfer agreements and procedures does you facility have?

Reed: We transfer to several facilities like St. Joseph in Bryan, Hermann in Houston, Methodist in Houston and a lot of our trauma goes to Scott and White in Temple.

Neelv: We have formal agreements with the Hospitals I stated previously, but we also utilize University Medical Center in Lubbock and we also have agreements with Prairie Acres Nursing Center and Farewell Nursing Center.

Arnold: We have agreements for all types of transfers with the facilities previously mentioned.

Price: Trauma goes to Hillcrest, Cardiac goes to Providence, Bums go to Parkland, and pediatric goes to Cooks.

15. How often and what type of community input is used for your facility's healthcare delivery decisions?

Reed: An Initial town meeting for the conversion process was held. We also have a hospital district monthly meeting and a bi-monthly board meeting.

Neelv: We have a monthly board meeting and an annual community meeting.

Arnold: Monthly Board Meeting

Price: We have a monthly board meeting, a quarterly forum with citizens, and business meetings with community businesses.

16. What types of activities does your facility engage in to promote health within The community?

Reed: We participate **in** health fairs where we perform various screening checks. We have prostate and mammography screening and we also distribute pamphlets to create patient awareness and promote dietary and preventative medicine.

Neely: We offer monthly health screenings and home health to both Friona and Bovina.

Arnold: We have community health fairs and have literature booths to give out information. We also sponsor community fair health related activities.

Price: Healthfairs, basic health screening, mammography screening and prostate screening.

17. Are patient satisfaction surveys performed on an ongoing basis?

Reed: Yes on a quarterly basis through the National Research Corporation and Franciscan Health Services. These are discharge surveys.

Neely: Yes

Arnold: We have ongoing inpatient, discharge and ER patient satisfaction surveys.

Price: No

Appendix B: Transcription for Center for Rural Health Initiatives Executive Director/CAH administrator Interview

Phone interview: Oct. **20,2000**

Mr. Dave Pearson BS HA
Interim Executive Director/CAH Program Administrator
Center for Rural Health Initiatives/State Office of Rural Health

Q. 1.) What kind of assistance does CRHI provide potential CAHs during the designation process?

Pearson: We offer technical assistance throughout the whole process. More specifically we assist with financial feasibility studies and we subcontract with THA to mediate and facilitate with hall meetings. We also assess potential facilities to see whether they meet eligibility criteria and we help to configure facilities to meet program requirements. We work closely with the TDH in trying to get things done. We also collaborate with HCFA, TDH, Medicare surveyors and others in order to expedite potential facilities through the designation process.

Q. 2) What assistance does CRHI provide CAHs in maintaining program compliance?

Pearson: We send out updates, newsletters, adhoc Medicare transmittals and legislation updates. We also provide workshops, quality workshops, EMS workshops and Network workshops.

Q. 3) How does CRHI assist CAHs in medical personnel recruitment?

Pearson: We provide the prairie doc. Program which Limestone hospital has benefited from. We also sponsor the Healthfind Job Fair and provide scholarship programs such as the Outstanding Rural Scholar program and the Medically Underserved Community Grants Program. We also will be sponsoring recruitment and retention workshops in the future.

Q. 4) What types of funding and grant opportunities are available through CRHI?

Pearson: We provide capital improvement fund grants of which Limestone Hospital has benefited. This upcoming year we are going to provide several new grants. Four grants for $10,000 will be provided for Networking and four grants of $10,000 will be provided for development programs that serve new underserved populations.

Q. 5) What does CRHI do to assist CAHs with the development of rural health networks?

Pearson: We have had workshops that have dealt with network development. We are currently collaborating with Texas A&M's School of Rural Public Health in the creation of education materials intended to educate CAHs in the development of Networks and also the Network grants for next year. Network development in Texas is behind the rest of the country and we look to address this issue. But really when you consider the physical size of Texas, it can be really hard for hospitals to form natural relationships.

Q.6) What are the resources available through CRHI for telemedicine technology?

Pearson: Telemedicine technology for the program is still in development. We have given a telemedicine conference for all rural hospitals that described how it might be used clinically by physicians.

4.7) What kinds of programs or activities does CRHI have to assist CAHs with internal quality assurance activities?

Pearson: We are developing a manual devoted to educating clinical staff and physicians about CAHs and the rural health environment. We are also sponsoring a TMF quality workshop in Dec. 2000 and this will focus on clinical quality indicators and Medicare quality improvements.

4.8) What specific resources does **CRHI** have available to assist CAH community Health?

Pearson; We are going to be conducting a patient utilization and satisfaction survey for CAHs in the upcoming year. Also, the four $10,000 outreach grants for new underserved populations will be useful,

Additional Comments:

Pearson: At the center we believe that the more low cost training that we can offer, the better the quality will be at CAHs. We also believe that recruitment and retention of medical personnel at CAHs is essential to maintaining and increasing the quality of care provided. In some areas such as networking, and with TMF, the development has been slow, and regulations are still changing,

Appendix C: CAH List of July 20, 2000

Critical Access Hospital Sfafus *as of 7/20/00*

City	Application Received	Forwarded to TDH	Medicare Survey	Designation received	Comments or Current Status	# Beds Ac/Sw
Friona	09/08/1999	10/15/1999	complete	12/01/1999	CAH as of 12/01/99	15/10
Linden	10/02/1999	10/19/1999	complete	02/01/2000	CAH as of 02/01/00	15/10
Big Lake	10/02/1999	10/19/1999 add info	complete	01/01/2000	CAH as of 01/01/00	12/2
Junction	10/15/1999	10/25/1999	complete	02/15/2000	CAH as of 02/15/00	15
Groesbeck	10/30/1999	11/05/1999	complete	03/0112000	CAH as of 03/01/00	11/7
Caldwell	11/19/1999	12/03/1999	complete	02/29/2000	CAH as of 02/29/00	15/10
Iraan	12/15/1999	01/25/2000 add info	complete	05/15/2000	CAH as of 05/15/00	14
Eldorado	01/10/2000	01/25/2000 add info	complete	03/02/2000	CAH as of 03/02/00	15/8
Rotan	02/09/2000	02/22/2000	complete		Survey completed	15/4
Denver City	03/23/2000	04/27/2000 add info	pending		Application forwarded to TDH	15/9
De Leon	04/1112000	04/28/2000	pending		Application forwarded to TDH	15/10
Eagle Lake	04/24/2000	07/06/2000			Application forwarded to TDH	15/10
Sweeny	05/12/2000	07/06/2000			Application forwarded to TDH	15/5
Ballinger	05/1812000	06/08/2000			Application forwarded to TDH.	15/10
McCamey	071201 2000	add info			Awaiting additional information	15
Kermit	08/03/2000	add info			Awaiting additional information	0

CENTER FOR
RURAL HEALTH
INITIATIVES

Mail: P.O. Drawer 1708, Austin. TX 78767-1708
Street: 211 E. 7th Street. Suite 915, Austin. TX 78701
Telephone: (512)479-8891 Fax: (512)479-8898
E-mail: crhi@crhi.state.tx.us
Internet: www.crhi.state.tx.us

TEXAS
STATE OFFICE
OF RURAL HEALTH

Executive Director
Robt. J. "Sam" Tessen, MS

July, 1999

The Rural Hospital Flexibility Program, more commonly called the Critical Access Hospital Program, is corning to Texas. This new federal program offers a new approach to help ensure ongoing access to health care for citizens of some rural communities. The Critical Access Hospital Program offers a limited service rural hospital model based upon past experience with other similar programs.

The Center for Rural Health Initiatives, the State Office of Rural Health for the State of Texas, serves as the administering agency for this program, in conjunction with the Texas Dept. of Health. The enclosed material constitutes the application package for hospitals wishing to apply for this new certification. The application process is intended to be straightforward but comprehensive in order to assist rural hospitals in making an informed and community-based decision whether to convert to a limited service model.

This package contains all the materials necessary to institute the application process. Also included are a number of items to provide reference and assistance in completing the process. The flow chart and checklist will also assist in tracking and monitoring the complete process.

Timeliness and preparedness are of the utmost importance in this process as are community-based decision-making and a sound financial evaluation of the model's advantages and limitations. Applications will be processed in a timely manner but applicants must consider all the various parties that play significant roles in the process.

Special thanks to the organizations and entities represented on the working group that have developed this program from scratch and will continue in its advisory role. These organizations include the Texas Dept. of Health (hospital licensure, hospital certification, EMS, and trauma divisions), Texas Hospital Association, Texas Organization of Rural and Community Hospitals, Texas Medical Foundation, and Texas Health & Human Services Commission (State Medicaid Office). This working group is an excellent example of what collaborative efforts can accomplish.

Please address any questions to the Center for Rural Health Initiatives at the numbers or contacts listed on this letterhead. The Center and all the members of the working group stand ready to help make this program a successful transition for those rural hospitals and their communities for whom the program can be beneficial.

Robt. J. "Sam" Tessen, MS
Executive Director

CRITICAL ACCESS HOSPITAL APPLICATION PACKAGE CONTENTS, July 1999

Enclosed in this application package are the following materials:

1. Cover letter from the Center for Rural Health Initiative (CRHI) outlining the application process, a description of the materials listed below, and timelines related to the application process.

2. *Conversion to a CAH,* from the American Hospital Association's *Executive Briefing and Case Examples, Critical Access Hospitals.*

3. *Critical Access Hospital Program Application Process* Flowchart.

4. *Critical Access Hospital Application* that is to be completed and returned to CRHI.

5. *Preliminary Analysis of Critical Access Hospital Status* that is to be completed and returned to CRHI.

6. *Critical Access Hospital Application Package Checklist* to help ensure that each required item is completed and enclosed with your application.

7. TDH's *Eligibility Criteria Table* arranged by county. This table assists hospitals in determining if their county is eligibility for this program

8. Sample of a formal *Letter of Application* (on letterhead and addressed to the Center for Rural Health Initiatives) that the governing body or representative can submit with your completed CAH application.

9. Sample of a formal letter (on letterhead and addressed to the Texas Department of Health) requesting *Conversion to a Critical Access Hospital.* This letter must be submitted with your completed application.

10. HCFA Form 1514, *Requestfor Certification.* Complete and submit with your CAH application.

11. Copy of TDH's *Licensing Requirements for Critical Access Hospitals.*

12. Copy of HCFA's *Interpretive Guidelines* for participation as a CAH. (Medicare Survey)

13. Interpretive Guidelines – *Guidelines of Medicare Participating Hospitals in Emergency Cases.* These are included to remind you that the Emergency Medical Treatment and Labor Act (EMTALA) still applies, even if you convert to a Critical Access Hospital

14. A copy of the *COBRA/EMTALA (Examination and Treatment for Emergency Medical Conditions and Women in Labor)* law.

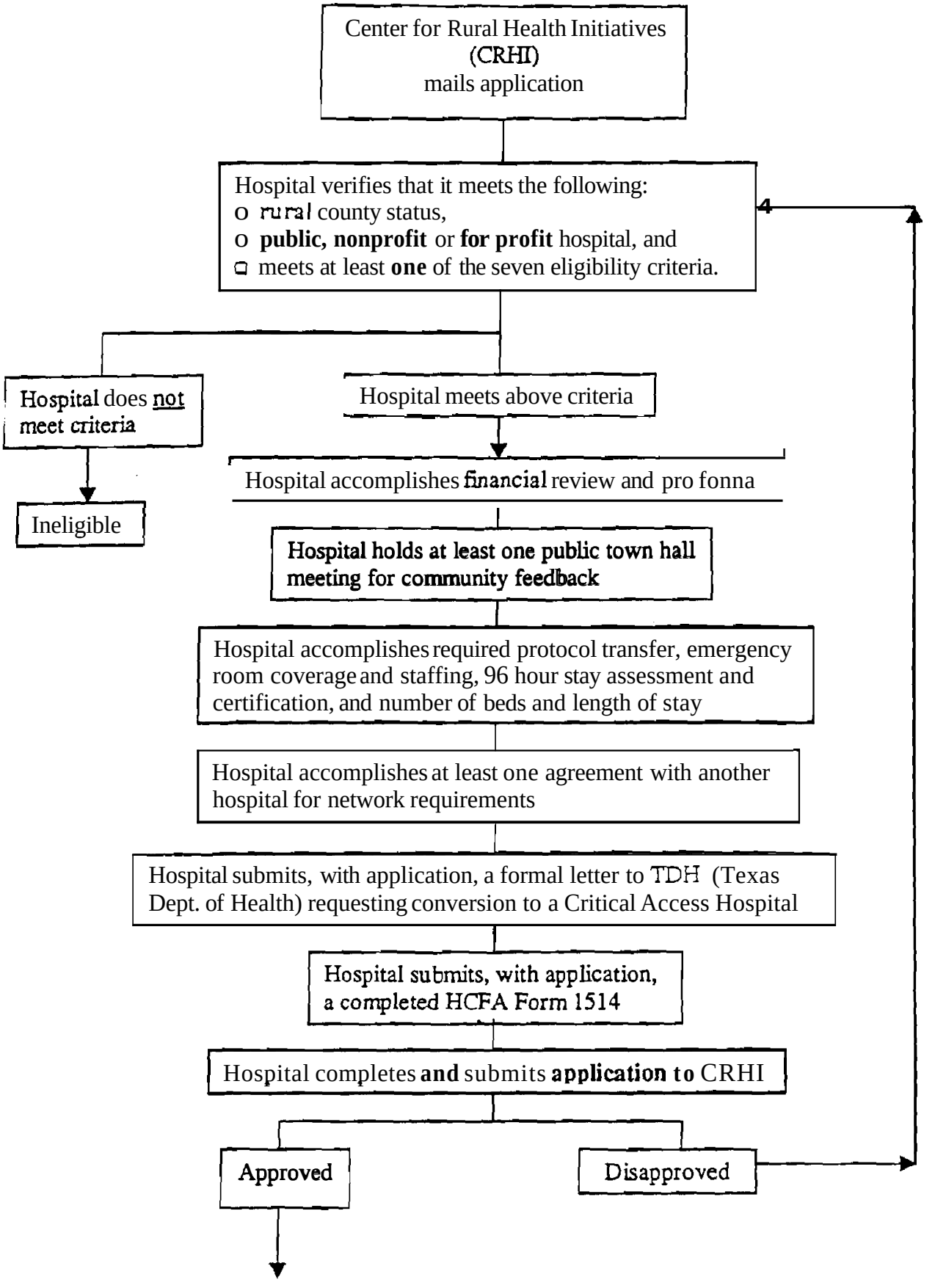
15. Copy of HCFA's *Billing Procedures* (HCFA-Pub.10) for payment of CAHs.

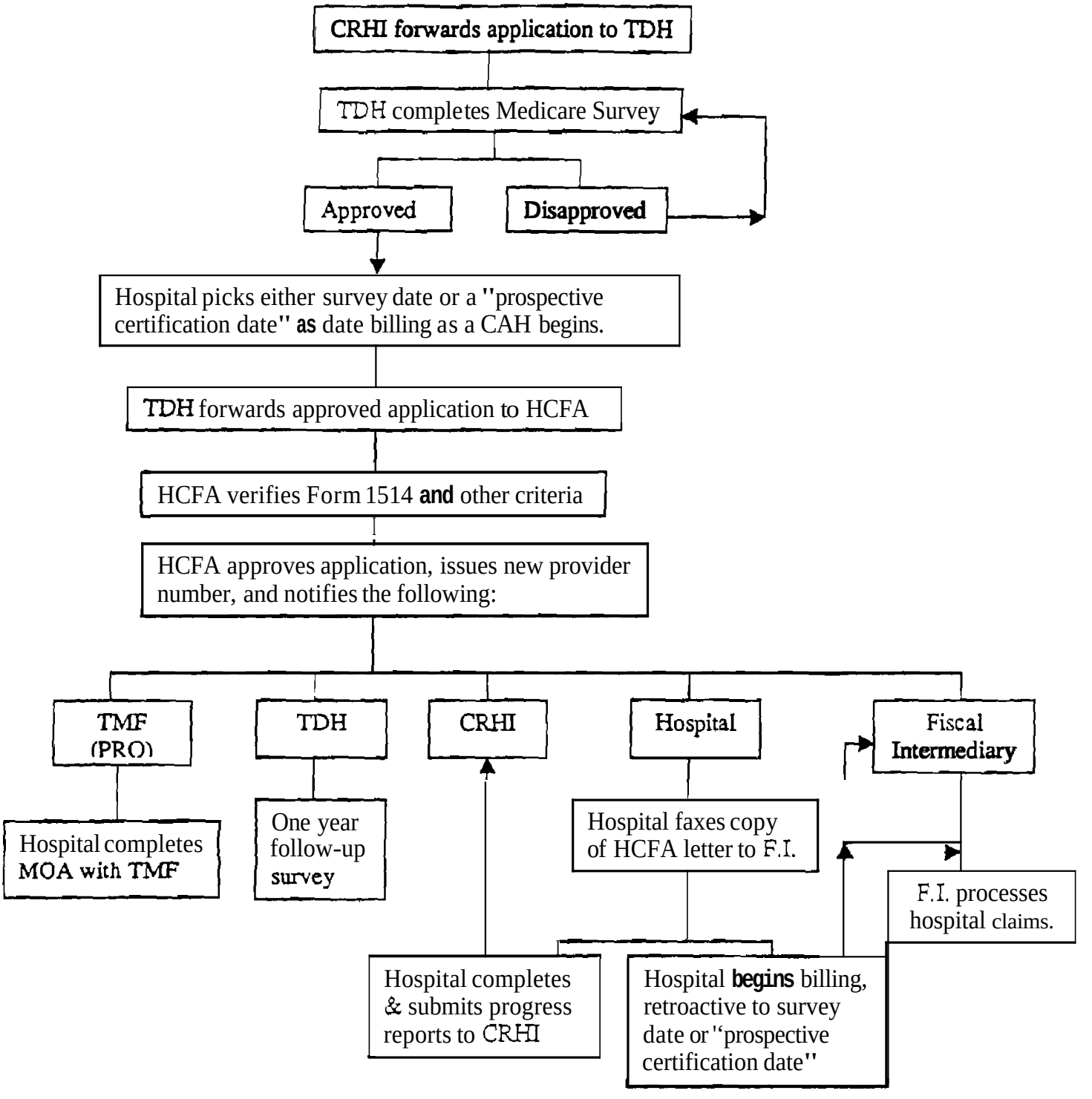
16. *Medicare Reimbursement Questions and Answers* and *Medicare Intermediary Manual Part 3 – Claims Process* from TrailBlazer Health Enterprises, LLC.

17. Texas Department of Health's *Medicaid Provider Cost Reporting and Review.*

18. Copy of the Texas Medical Foundation's (TMF) *Review Requirements for Critical Access Hospitals.* These are the guidelines for approval of inpatient stays at CAHs, as well as the exception process for patients requiring care and treatment beyond the 96 hours.

TEXAS CENTER FOR RURAL HEALTH INITIATIVES
CRITICAL ACCESS HOSPITAL PROGRAM
Application Process, April 2000




CRHI forwards application to TDH
TDH completes Medicare Survey
Approved
Disapproved
Hospital picks either survey date or a "prospective certification date" as date billing as a CAH begins.
TDH forwards approved application to HCFA
HCFA verifies Form 1514 and other criteria
HCFA approves application, issues new provider number, and notifies the following:
TMF (PRO)
TDH
CRHI
Hospital
Fiscal Intermediary
Hospital completes MOA with TMF
One year follow-up survey
Hospital faxes copy of HCFA letter to F.I.
F.I. processes hospital claims.
Hospital completes & submits progress reports to CRHI
Hospital begins billing, retroactive to survey date or "prospective certification date"

CRITICAL ACCESS HOSPITAL APPLICATION

April 2000

I. HOSPITAL INFORMATION

Hospital Name _____

Mailing Address _____ Street Address _____

City _____ State _____ Zip _____

Telephone _____ Fax _____ E-mail _____

County Name _____ County Status:* ☐ Rural ☐ Urban or Metro

Medicare Provider Number _____ Medicaid Provider Number _____

*Refer to Title 42, Volume 3, Part 485, §485.610 of the Code of Federal Regulations. (b) Standard: Location: The CAH meets the following requirements:

(1) The CAH is located outside any area that is a Metropolitan Statistical Area as defined by the Office of Management and Budget, or that has been recognized as urban under the regulations in Sec. 412.62 (f) of this chapter.

(2) The CAH is not deemed to be located in an urban area under Sec. 412.63 (b) of this chapter.

(3) The CAH has not been classified as an urban hospital for purposes of the standardized payment amount by HCFA or the Medicare Geographic Classification Review Board under Sec. 412.230 (e) of this chapter, and is not among a group of hospitals that have been redesignated to an adjacent urban area under Sec. 412.232 of this chapter. See the enclosed TDH *Eligibility Criteria* Table for your county status.

II. HOSPITAL STATUS

Check facility status and attach the appropriate documentation,

☐ Public (attach enabling legislation) ☐ Non profit (attach articles of incorporation)

☐ For profit (establish that legal responsibility for determining, implementing and monitoring policies governing the CAH's total operation remain at the local level)

Is this hospital currently licensed in accordance with the Texas Department of Health licensure standards? ☐ Yes ☐ No

III. ELIGIBILITY CRITERIA

A facility must meet at least **one** of the following seven criteria in order to be eligible. Check **all** criteria that apply. Information regarding your county can be found on the enclosed *TDH Eligibility Criteria Table.*

1. ☐ The hospital is at least 35 miles from the nearest hospital; OR
2. ☐ The hospital is at least 20 miles from another hospital located in a county of 50,000 persons or less and it must be the sole provider in the county; OR
3. ☐ The hospital is located in a Federally designated frontier area (designated by the Federal Census); OR
4. ☐ The hospital is the only acute care hospital in the county; OR
5. ☐ The hospital is located in a county that has death rates higher than state averages on at least three of the five leading causes of death: heart disease, cancer; chronic obstructive pulmonary disease, stroke, and unintentional injuries; OR
6. ☐ The hospital is located in a county that has death rates that exceeds the state average for all causes of death: OR
7. ☐ The hospital is at least 20 miles from another hospital and meets one of the following criteria:
   a. ☐ The hospital is located in an area that meets the criteria for designation as a Health Professional Shortage Area (HPSA); or
   b. ☐ The hospital is located in a Medically Underserved Area (MUA); or
   c. ☐ The hospital is located in a county where the percentage of families with income less than 100% of the Federal poverty level is higher than the State average for families with income less than 100% of poverty; or
   d. ☐ The hospital is located in a county with an unemployment rate that exceeds the States overall unemployment average; or,
   e. ☐ The hospital is located in a county with a percentage of population age 65 or older that exceeds the State's average.

To determine distance, refer to the Texas Mileage Guide, found at **www.cpa.state.tx.us/comptrol/texastra.html**

IV. FINANCIAL FEASIBILITY

☐ Attach a statement from your financial Consultant and/or Chief Financial Officer stating that you have conducted a formal financial feasibility analysis and what impact a CAH status will have on your hospital's bottom line for a specific comparative financial period.

V. COMMUNITY INVOLVEMENT

☐ Attach a copy of the minutes from at least one public "town hall" meeting* as evidence that the plan was discussed.

*The hospital must hold at least one public "town hall" meeting with the hospital representatives present who represent the board, administration, and medical staff members, to:

- Explain the concept of a CAH,
- Explain how a CAH would impact care and access locally, and
- Seek input and support of local citizens for pursuing CAH status.

VI. ORGANIZATIONAL STRUCTURE

☐ Attach a list of the names and addresses of the governing body members.

☐ List names, titles and addresses for the following parties:

➢ Governing body or representative that assumes full legal responsibility for determining, implementing and monitoring policies governing the CAH's total operation:

Name of Governing Body: _____

Designated Representative:

Name _____ Title _____

Mailing Address _____ Street Address _____

City _____ State _____ Zip _____

Telephone _____ Fax _____ E-mail _____

➢ Include one of the following:

☐ A formal letter of application from this governing body or representative or

☐ A copy of the minutes from a Board meeting where the governing body endorsed the administration's recommendation to seek CAH status

➢ Owners or those with a controlling interest in the CAH or in any subcontractor in which the CAH directly or indirectly has a 5 percent or more ownership interest. (If more than one, attach an additional sheet of paper.)

Name _____ Title _____

Mailing Address _____ Street Address _____

City _____ State _____ Zip _____

Telephone _____ Fax _____ E-mail _____

➢ Person who will be principally responsible for the operation of the CAH (e.g. Administrator):

Name _____ Title _____

Mailing Address _____ Street Address _____

City _____ State _____ Zip _____

Telephone _____ Fax _____ E-mail _____

➢ Person who will be responsible for medical direction of the CAH (physician):

Name _____ Title _____

Mailing Address _____ Street Address _____

City _____ State _____ Zip _____

Telephone _____ Fax _____ E-mail _____

VII. TRAUMA AND EMERGENCY SERVICES

Each CAH is required to actively participate in its Regional Advisory Council for Trauma and Emergency Services.

☐ List the name of the designated representative for attendance at RAC meetings:

Name_____ Title_____

Mailing Address_____ Street Address_____

City_____ State_____ Zip_____

Telephone_____ Fax_____ E-mail_____

☐ Attach a letter from your RAC, which states that your hospital meets the RAC's participation requirements.

☐ Do you agree to make available 24-hour-a-day emergency care? ☐ Yes ☐ No

VIII. NUMBER OF BEDS AND LENGTH OF STAY

A. Number of Beds and Direct Services

Check the boxes below to indicate the services *currently* offered by your hospital and the services that *will* be available if your hospital is designated as a CAH.

Services	Services Currently Available	CAH Services Available
Inpatient beds	☐ Number of Beds ____	☐ Number of Licensed Beds ____
Swing beds	☐ Number of Beds ____	☐ Number of Beds ____
Skilled Nursing Facility	☐ Number of Beds ____	☐
Rehabilitation Unit	☐ Number of Beds ____	☐
Chemical Dependency	☐ Number of Beds ____	☐
Rural Heath Clinic	☐	☐
Home Health Care	☐	☐
Geri-psychiatric Services	☐	☐
Other:		
_____	☐	☐
_____	☐	☐
_____	☐	☐
_____	☐	☐

'A CAH may maintain no more than 15 acute inpatient care beds at one time.

**A CAH with swing beds may have up to 25 beds but no more than 15 may be used for acute inpatient care at one time.

B. Length of Stay

☐ Include a copy of the policies and procedures addressing patient transfers. Inpatient discharges or transfers must occur within 96 hours of admission, unless a longer period is required because of inclement weather or other emergency conditions.

➢ Approved CAHs will be required to sign a memorandum of agreement (MOA) with TMF. The MOA will include TMF's review procedures for obtaining a waiver review when the patient's medical condition requires an inpatient stay longer than 96 hours.

IX. RURAL HEALTH NETWORK*

A. Network

☐ Include a letter indicating which rural health care network your hospital is participating in and who the other participants are.

B. Patient Referral and Transfer Aereernent

☐ Attach a copy of the hospital's patient referral and transfer agreement with at least one secondary or tertiary care hospital, preferably in the same trade area.

C. Communications System

☐ Attach a copy of the agreement your hospital has with other area secondary and tertiary care hospitals in your network for the electronic sharing of patient data, telemetry, and medical records.

D. Emergency and Non-Emergency Transportation

☐ Attach a copy of the agreement your hospital has with other area secondary and tertiary care hospitals in your network to provide or arrange for emergency and nonemergency transportation.

*Refer to Title 42, Volume 3, Part 485, $485.603, Rural health network.

A rural health network is an organization that meets the following specifications:

(a) It includes –

(1) At least one hospital that the State has designated or plans to designate as a CAH; and

(2) At least one hospital that furnishes acute care services.

(b) The members of the organization have entered into agreements regarding –

(1) Patient referral and transfer;

(2) The development and use of communications systems, including, where feasible, telemetry systems and systems for electronic sharing of patient data; and

(3) The pronsion of emergency and nonemergency transportation among members.

Type Name of Authorizing Certifying Official _____ Title _____

Signature of Authorizing Certifying Official _____ Date _____

CRITICAL ACCESS HOSPITAL APPLICATION PACKAGE CHECKLIST

The following is a list of the items that must be completed and returned with your Critical Access Hospital application. This checklist is intended for your use and should not be returned with the completed application package. It is to help ensure that each item is enclosed with the completed application.

ITEM	COMPLETED
1. Critical Access Hospital Application	
a. Is your facility status documentation, either the enabling legislation or the articles of incorporation, attached?	☐
b. Is a statement from your financial Consultant and/or Chief Financial Officer stating that you have conducted a financial feasibility analysis and what impact a Critical Access Hospital status will have on the hospital's bottom line for a specific comparative financial period attached?	☐
c. Is a list of the names and addresses of the governing body members enclosed?	☐
d. Is a formal letter of application from your hospital's governing body or representative or a copy of the minutes from a Board meeting where the governing body endorsed the administration's recommendation to seek CAH status attached?	☐
e. Is a copy of the minutes, or a portion thereof, from at least one public "town hall" meeting where hospital representatives explained the concept of a CAH, explained how a CAH would impact care and access locally, and sought input and support of local citizens for pursuing CAH status included?	☐
f. Is a letter indicating which rural health care network your hospital is participating in and who the other participants are, included?	☐
g. Is a copy of the hospital's patient referral and transfer agreement with at least one secondary or tertiary care hospital, preferably in the same trade area attached?	☐
h. Is a copy of the agreement your hospital has with other area secondary and tertiary care hospitals in your network for the electronic sharing of patient data, telemetry, and medical records attached?	☐
. Is a copy of the agreement your hospital has with other area secondary and tertiary care hospitals in your network to provide or arrange for emergency and nonemergency transportation attached?	☐
j. Is a letter from your RAC, which states that your hospital meets the RAC's participation requirements attached?	☐
k. Is a copy of the policies and procedures addressing patient transfers attached?	☐
l. Is the application complete and signed by the authorized representative?	☐
2. Is your letter to the Texas Department of Health requesting conversion to a Critical Access Hospital enclosed?	☐
3. Is the completed HCFA Form 1514, *Request for* Certification, attached?	☐

The following is a list of items to be aware of once the CAH application has been submitted and approved.

1. Have you established a hospital protocol for assessing 96-hour stays?

2. Approved CAHs will be required to sign a memorandum of agreement (MOA) with the Texas Medical Foundation (TMF). The MOA will include TMF's review procedures for obtaining a waiver review when the patient's medical condition requires an inpatient stay longer than 96 hours. This MOA will be sent to your hospital by TMF.

3. Once CRHI receives and completes the initial approval of your application, it is sent to The Texas Department of Health (TDH) for the Medicare Survey. Is the hospital prepared for the state Medicare Survey?

4. You will be receiving a new Medicare provider number from HCFA Fax a copy of this letter to the F.I. and use this number to submit Medicare claims.

5. Inpatient Medicare reimbursement will be cost-based. At the time of the Medicare survey, the hospital can choose either the date of the survey or a future *prospective certification date*. This is the date when CAH billing would begin.

6. There will be no changes in your Medicaid number or reimbursement.

7. Remember that regular progress reports are required by CRHI.

8. Throughout the year, prepare for a one-year follow-up survey by TDH.

TAG NUMBER	REGULATION	GUIDANCE TO SURVEYORS
C336	(b) Standard Quality assurance. The CAH has an effective quality assurance program to evaluate the quality and appropriateness of the diagnosis and treatment furnished in the CAH and of the treatment outcomes. The program requires that--	Survey Procedures and Probes 6485.641(b) There is nothing in the requirement at §485.641(b) to preclude a CAH from obtaining QA through arrangement with a hospital (e.g., a hospital in the same rural health network). Wether the CAH has a freestanding QA program or QA by arrangement, all of the requirements at $485.641(b) must be met. If a CAH chooses to have a freestanding QA program, the QA program should be facility wide, including all departments and all services provided under contact. For services provided to the CAH under contract, there should be established channels of communication between the conbaclor and CAH staff. "An effective quality assurance program" means a QA program that includes: o Ongoing monitoring and data collection; o Problem prevention. identification and data analysis; o Identification of corrective actions; o Implementation of corrective actions, o Evaluation of corrective actions; and o Measures to improve quality on a continuous basis. Review a copy of the CAH QA plan and other documentation regarding QA activities, (e.g., meeting notes from QA committees, reports produced by the QA director and/or QA committees, if designated, and follow-up communication relative to corrective actions) to become familiar with the scope, methodology and organization of the CAH QA program.
C337	(1) All patient care services and other services affecting patient health and safety, are evaluated;	Survey Procedures and Probes §485.641(b)(1) Who is responsible to evaluate CAH patient care services? How are patient care services evaluated? What other services are evaluated? How does the CAH ensure quality assurance data is provided to the medical staff and governing body?
C338	(2) Nosocomial infections and medication therapy are evaluated;	Survey Procedures and Probes 6485.641(b)(2) What methodology does the CAH use to evaluate nosocomial infections and medications therapy? Review committee meeting minutes for current issues or projects, etc.

TAG NUMBER	REGULATION	GUIDANCE TO SURVEYORS
C339	(3) The quality and appropriateness of the diagnosis and treatment furnished by nurse practitioners, clinical nurse specialists, and physician assistants at the CAH are evaluated by a member of the CAH staff who is a doctor of medicine or osteopathy or by another doctor of medicine or osteopathy under contract with the CAH;	Survey Procedures and Probes 6485.641(b)(3) How does the CAH ensure that the quality of care provided by mid-level practitioners in the CAH is evaluated by a doctor of medicine or osteopathy? How is clinical performance of mid-level practitioners evaluated? What evidence demonstrates that there is an ongoing evaluation of care provided by mid-level practitioners (e.g., reports, periodic written evaluation. QA meeting notes?) How does the reviewing physician inform the CAH if he/she determines that there are problems relative to the diagnosis and treatment provided by mid-level practitioners? What follow-up actions are called for in the QA plan?
C340	(4) The quality and appropriateness of the diagnosis and treatment furnished by doctors of medicine or osteopathy at the CAH are evaluated by-- (i) one hospital that is a member of the network, when applicable; or (ii) one PRO or equivalent entity; or (iii) one other appropriate and qualified entity identified in the State rural health care plan, and	
C341	(5)(i) The CAH staff considers the findings of the evaluations. including any findings or recommendations of the PRO, and takes corrective action if necessary.	Survey Procedures and Probes 6485.641(b)(5)(i) Who is responsible for reviewing the PRO's findings and recommendations for the CAH? Who is responsible for ensuring that corrective actions are taken?
C342	(ii) The CAH also takes appropriate remedial action to address deficiencies found through the quality assurance program.	Survey Procedures and Probes 6485.641(b)(5)(ii) and (iii) How does the CAH ensure that proper remedial actions are taken to correct deficiencies identified in the quality assurance program? Who is responsible for implementing remedial actions to correct deficiencies identified by the quality assurance program?
C343	(iii) The CAH documents the outcome of all remedial action.	How does the CAH document the outcome of any remedial action?

Center for Rural Health Initiatives
Rural Health Work Plan 1999-2000

MISSION STATEMENT:

Advocate for rural Texans to ensure viable opportunities and resources for access to health services in a healthy community environment

GOAL ONE: ***Serve as the centralized resource center for information for rural Texans***

OBJECTIVE	PRODUCTS/ACTIVITIES/SERVICES	PROGRESS & PROCESS MEASURES	QUALITATIVE IMPACT
I.A. Disseminate information concerning rural health issues.	I.A.1. Generate and promote interest in rural delivery system maintenance, rebuilding, diversification and innovations: telemedicine/ distance learning, Critical Access Hospital Program, managed care, network development, primary care recruitment/retention, community involvement and support, National Health Services Corps, etc.	I.A.1. Implement strategic plans for rural health information dissemination, including via telecommunications and other advanced methodologies.	I.A.1. Stakeholders use sources of information for betterment of rural health, including from telecommunications systems and other advanced methodologies.
	I.A.2 Participate in planning and hosting forums for discussion of rural health issues among policy makers.	I.A.2. Number and type of attendees, number of forums held and program agendas.	I.A.2. Rural health policy at the state level is influenced as indicated in changes in legislation, public policy or rules/regulation changes.
	I.A.3. Hold or co-sponsor annual conference on rural health issues.	I.A.3.a. # of conference attendees.	I.A.3. Conference evaluations indicate participants received new and useful information.
		I.A.3.b. # of organizations represented.	I.A.3.b. Conference reflects the diversity of the rural stakeholder groups.

Center for Rural Health Initiatives
Rural Health Work Plan 1999-2000

OBJECTIVE	PRODUCTS/ACTIVITIES/SERVICES	MEASURES	QUALITATIVE IMPACT
I.A. Disseminate information concerning rural health issues.	I.A.4. Encourage the use of advanced communications technology.	I.A.4.a. Maintain interaction and rural advocacy with the Public Utilities Commission. Telecommunications Infrastructure Fund Board, the General Services Administration, and other state and federal telecommunications entities.	I.A.4.a. Rural stakeholders are apprised of opportunities to use advanced communications technology.
	I.A.5.a. Solicit the assistance of and participate with other offices or programs of rural health, including university-based, in the state.	I.A.5.a. Maintain collaborative relationships with other offices or programs of rural health in Texas.	I.A.5. Rural stakeholders have access to data and resources to use for community planning.
	I.A.5.b Maintain an informational resource center with database on health care for rural populations.	I.A.5.a.1. Staff and maintain resource center. Inform stakeholders about resource center.	same as above
		I.A.5.a.2. Disseminate statistics. charts, graphs & maps as requested.	same as above

Center for Rural Health Initiatives
Rural Health Work Plan 1999-2000

OBJECTIVE	PRODUCTS/ACTIVITIES/SERVICES	PROGRESS & PROCESS MEASURES	QUALITATIVE IMPACT
I.A. Disseminate information concerning rural health issues.	I.A.6. Provide information to rural health care stakeholders through various mediums.	I.A.6.a. Schedule to have an information booth display at 15-20 statewide health care organizational conferences and meetings.	I.A.6. Rural Stakeholders have a source of information.
		I.A.6.b. Maintain a statewide health care website.	same as above
		I.A.6.c. Maintain mailing list.	same as above
	I.A.7. Dissemination of information concerning the NHSC, RICHS, RRR Network, Rural Health Resource Center, etc.	I.A.7. Establish and maintain ongoing mmmunications with NHSC, RICHS, RRR Network, Rural Health Resource Center. etc.	I.A.7. Rural Stakeholders have a source of information about these programs.
	I.A.8.a. Work with local and statewide media to ensure dissemination of information to the general public regarding health care in rural communities.	I.A.8.a. Establish and maintain ongoing communication with media representatives in rural communities; provide them with pertinent information.	I.A.8. Rural stakeholders and providers receive information thmugh local, regional, and statewide media.

Center for Rural Health Initiatives
Rural Health Work Plan 1999-2000

OBJECTIVE	PRODUCTS/ACTIVITIES/SERVICES	PROGRESS & PROCESS MEASURES	QUALITATIVE IMPACT
I.A. Disseminate information concerning rural health issues.	I.A.8.b. Establish channels through which the rural health community is apprised of local health care media coverage.	I.A.8.b. Subscribe to statewide news clipping service.	I.A.8. Residents of rural communities are informed about factors that influence access to care in their communities.
	I.A.8.c. Edit and distribute statewide newsletters.	I.A.8.c. Publish 4 newsletters a year with a distribution of 6,000 or more.	same as above
	I.A.9. Be a contributing editor to other statewide health care newsletters.	I.A.9. Provide news articles to different statewide newsletters.	I.A.8. Rural Stakeholders have a source of information.
	I.A.IO. Conduct, encourage and/or disseminate studies, surveys, bibliographies, briefs and updates.	I.A.IO. Studies, survey results, biographies, briefs, and updates are mailed to appropriate constituents. Mailing lists are maintained.	I.A.IO. Rural Stakeholders have a source of information.

Center for Rural Health Initiatives
Rural Health Work Plan 1999-2000

OBJECTIVE	PRODUCTS/ACTIVITIES/SERVICES	PROGRESS MEASURES	QUALITATIVE IMPACT
I.A. Disseminate information concerning rural health issues.	I.A.11. Facilitate research into rural health issues and needs, including primary care.	I.A.11.a. Establish and maintain relationships with state agencies, universities, foundations, public and private interest groups and others interested or involved in rural health issues.	1.A.11. Researchers have access to opportunities for for rural health research opportunities
		I.A.11.b. Number and nature of efforts to explore primary health research networks.	1.A.11.b. Issues identified by rural constituencies are brought to the attention of rural health researchers.

Center for Rural Health Initiatives
Rural Health Work Plan 1999-2000

GOAL *TWO: Develop, manage, and* ***facilitate statewide resources*** *and* ***activities*** *related to* ***rural*** *health*			
OBJECTIVE	**PRODUCTS/ACTIVITIES/SERVICES**	**PROGRESS PROCESS MEASURES**	**QUALITATIVE IMPACT**
II.A. Administer and/or supports statewide rural health care programs.	**II.A.1.a. Administer specific programs mandated to the Center: Medically Underserved Community State Matching Incentive Program; Physician Assistant** Loan Repayment Program; Outstanding Rural Scholar Program; Community Scholarship Program; Texas Health **Service** Corps Program.	**II.A.1.a. Number of grants or awards made** per individual program	II.A.I. Health care delivery in rural areas is enhanced by resources received.
		II.A.1.b. Number of communities **assisted through one or more of the** specific programs.	**II.A.1.b.** Rural communities are able **to provide for current and future health care needs.**
		II.A.1.c. Number of individual providers or students assisted **through** specific programs.	**II.A.1.c. Health care professionals and students receive assistance to facilitate rural health work.**
		II.A.1.d. Maintain existing state funds or increase state funds available to rural health care.	**II.A.1.d. Funds assist in improving** access to health care.
		II.A.1.e. # of grants awarded.	**II.A.1.e.** Grants assist in improving access to health care.

Center for Rural Health Initiatives
Rural Health Work Plan 1999-2000

OBJECTIVE	PRODUCTS/ACTIVITIES/SERVICES	PROGRESS & PROCESS MEASURES	QUALITATIVE IMPACT
		II.A.1.f. Amount of money available to rural communities.	II.A.1.f. Monies assist in improving access to health care.
II.B. Promote and facilitate regulatory and financial policies constructive lo the delivery of primary care, rural hospital. and public health services in rural areas.	II.B.1. Promote regulations and policies designed to assist the service and financial delivery of primary care, rural hospital, and public health providers.	II.B.1. Number of regulations, policies, and rules impacted.	II.B.I. Rules, regulations, and policies provide a constructive environment for delivery of health care services in rural areas.
	II.B.2. Work with federal and state entities to identify impact of regulations and policies on rural primary care, hospital and public health providers.	II.B.2. Number of incidences of policy and/or regulatory advocacy for primary care, rural hospital, and public health rural providers.	II.B.2. Regulatory entities have access to the unique perspective of rural health care delivery needs and demands.
	II.B.3. Facilitate effective communication between regulatory bodies and rural providers on issues and concerns.	II.B.3. Number of contacts facilitated between regulators and providers.	II.B.3. Rural providers have access to regulators responsible for health care regulations and policies relating to rural delivery.
II.C. Leverage dollars to attract resources for rural health care stakeholders.	II.C.1.a. Facilitate community economic development; coordinate with entities in rural economic development (entities beyond health care) to leverage dollars for rural communities.	II.C.1.a. Number of economic development possibilities explored with other entities.	II.C.1.a. Rural communities benefit from health care as an integral component of community development.

Center for Rural Health Initiatives
Rural Health Work Plan 1999-2000

OBJECTIVE	PRODUCTS/ACTIVITIES/SERVICES	PROGRESS & PROCESS MEASURES	QUALITATIVE IMPACT
II.C. Leverage dollars to attract resources for rural health care stakeholders.	II.C.1.b. Increase available financial resources to rural communities.	II.C.1.b. Number of technical assistance workshops and/or meetings held.	II.C.1.b. Leverage of funds for rural communities.
	II.C.1.c. Provide information and technical assistance to rural communities on the availability of grants, loans, and other resource programs.	II.C.1.c. Number of methods and times CRHI provides information to rural communities to assist them with obtaining additional resources.	II.C.1.c. Communities have information useful in their efforts to seek grants, loans, and other resources.
		II.C.1.d. Amount of dollars assisted in leveraging into rural communities, directly or indirectly impacting local health care.	II.C.l.d. Dollars impact health care and assist in improving and maintaining access to health care.
		II.C.1.e. 6–12 newsletters issued per year.	II.C.1.e. Newsletters provide information of use to rural providers, rural communities, and rural health advocates.
	II.C.2. Maintain relationships with organizations which have the potential to increase funding for or the ability to partner with rural areas.	II.C.2.a. Number of organizations /identified and number of organizations CRHI is working with.	II.C.2. Leverage number of partners working with rural communities.

Center for Rural Health Initiatives
Rural Health Work Plan 1999-2000

OBJECTIVE	PRODUCTS/ACTIVITIES/SERVICES	PROGRESS & PROCESS MEASURES	QUALITATIVE IMPACT
II.C. Leverage dollars to attract resources for rural health care stakeholders.		II.C.2.b. Level of participation with PCO (Primary Care Organization), PCA (Primary Care Association) and Texas Rural Health Association.	same as above
		II.C.2.c. Level of participation with SRDC and Cooperative Extension.	same as above
II.D. Develop contacts with local, state and national foundations.	II.D.I. Increase available funding resources to rural communities.	II.D.1. Number of communities assisted in working with foundations.	II.D.I. Leverage of funds for rural communities.
II.E. Encourage development of regional emergency transportation networks that constructively serve rural citizens.	II.E. Provide a mechanism for rural input in the regional trauma and emergency transportation network regulators.	II.E. Maintain a mechanism for rural input into the trauma and emergency regulatory process by rural health care professionals end citizens.	II.E. Rural providers and others have access to the process involving trauma and emergency transportation decision-making.

Center for Rural Health Initiatives
Rural Health Work Plan 1999-2000

OBJECTIVE	PRODUCTS/ACTIVITIES/SERVICES	MEASURES	QUALITATIVE IMPACT
II.F. Encourage the active participation of physicians and other health care providers in Texas Health Steps (Early and Periodic Screening, Diagnosis, and Treatment Program).	II.F.1. Work with the responsible state agency to identify rural areas needing further promotion.	II.F.1. Maintain working relationship with the responsible state agency.	II.F.1. Rural providers have access to increased information on the program and how to utilize it.
	II.F.2. Pmvide promotional material to rural providers on the benefits of the program to children and on program mechanisms.	II.F.2. Number of promotional efforts made to rural providers.	same as above
II.F. Study the efficiency and effectiveness of rural health clinics.	II.F.I. Work with identified state agencies to develop and accomplish a study of rural health clinics in Texas.	II.F.1. Study is completed and results shared with the State Legislature and other interested federal and state entities.	II.F.1. State Legislature will have results of the study with which to help with future legislation and regulations.
	II.F.2. Develop and initiate a quality assessment program to evaluate health outcomes of rural patients treated in rural health dinics.	II.F.2. Work with public and private resources to develop a quality assessment program to be implemented by rural health clinics to measure health outcomes.	II.F.2. Rural health clinics will have a voluntary mechanism with which to objectively assess the outcomes of health interventions; consumers will have access to the results.

Center for Rural Health Initiatives
Rural Health Work Plan 1999-2000

GOAL THREE: ***Provide technical assistance on rural health issues***			
OBJECTIVE	**PRODUCTS/ACTIVITIES/SERVICES**	**PROGRESS & PROCESS MEASURES**	**QUALITATIVE IMPACT**
III.A. Provide health system infrastructure support.	III.A.1. Monitor and work with state and federal agencies to assess the impact of proposed rules on rural areas.	III.A.1. Number of impact statements on proposed rules issued by CRHI.	III.A.1. Rules promote a positive regulatory environment for rural health care providers and patients.
	III.A.2.a. Participate in infrastructure development activities.	III.A.2.a.1. Number of technical assistance (TA) workshops and other forums held on various health issues, i.e. managed care, critical access hospitals, etc.	III.A.2. Maintaining access to health care in rural areas.
		III.A.2.a.2. Number of critical access hospitals assisted.	same as above
		III.A.2.a.3. Number of communities requesting and receiving TA.	same as above
	III.A.2.b. Support/facilitate mechanisms for assessment of local community infrastructure.	III.A.2.b.1. Assessments of 'who's doing what where when and how' in local community health care.	same as above

Center for Rural Health Initiatives
Rural Health Work Plan 1999-2000

OBJECTIVE	PRODUCTS/ACTIVITIES/SERVICES	PROGRESS & PROCESS MEASURES	QUALITATIVE IMPACT
III.A. Provide health system infrastructure support.		III.A.2.b.2. Assistance in development of a state rural health plan. HCFA accepts state rural health plan.	same as above
		III.A.2.b.3. Participation in statewide or local community development planning processes.	same as above
	III.A.2.c. Support and participate in the development and implementation of the Rural Community Health Systems pmgram and/or other efforts to encourage local community investment in local health care delivery.	III.A.2.c.1. Number of statewide networks considered and/or developed by communities.	same as above
		III.A.2.c.2. Number of rural community health systems initiated and maintained.	same as above
		III.A.2.c.3. Coordinate rural managed care initiatives.	same as above

Center for Rural Health Initiatives
Rural Health Work Plan 1999-2000

OBJECTIVE	PRODUCTS/ACTIVITIES/SERVICES	PROGRESS & PROCESS MEASURES	QUALITATIVE IMPACT
III.A. Provide health system infrastructure support.	III.A.3. Provide assistance to state Legislature and agencies end federal regulators to streamline regulations to assist in the development of service diversification of health care facilities.	III.A.3. Number of bills and regulations impacted.	III.A.3. Bills and regulations promote service diversification of rural health care facilities.
	III.A 4. Provide information to appropriate persons concerning National Health Services Corp. programs.	III.A.4. Number of individuals receiving information concerning NHSC recruitment programs,	III.A.4. Leverage of federal assistance programs to assist state's rural communities.

Center for Rural Health Initiatives
Rural Health Work Plan 1999-2000

*GOAL FOUR: **Facilitate** the **availability** of **essential components** of a viable health care **infrastructure***			
OBJECTIVE	**PRODUCTS/ACTIVITIES/SERVICES**	**PROGRESS & PROCESS MEASURES**	**QUALITATIVE IMPACT**
IV.A. Support community efforts to recruit and retain health professionals in rural communities.	IV.A.1.a. Identify and track health care professionals searching for practice opportunities.	IV.A.1.a. Maintain database of interested candidates.	IV.A.1.a. Time to fill rural vacancy is reduced.
	IV.A.1.b. Coordinate with professional organizations land academic health science centers to assist healthcare providers with the evaluation of practice opportunities.	IV.A.1.b. Number of professional organizations and academic health science centers involved in coordinated efforts.	IV.A.1.b. Resources available to health care professionals is increased or facilitated,
	IV.A.2. Link rural communities and health care professionals by tracking and providing information on practice opportunities.	IV.A.2. Disseminate notices of available practice opportunities.	IV.A.2. Communities secure and retain adequate numbers of health care providers.
	IV.A.3. Collaborative 'locum tenens' relief service studied and/or facilitated for short-term relief of rural providers.	IV.A.3. Number of provider relief services programs or services facilitated.	IV.A.3. Providers receive relief services to assist them in securing CME, time away, etc.
	IV.A.4. Identify community needs regarding recruitment and retention.	IV.A.4. Number of communities assisted with identification of recruitment and/or retention needs.	+D84IV.A.4. Communities recognize recruitment and retention needs in order to more readily address future and current needs.

Center for Rural Health Initiatives
Rural Health Work Plan 1999-2000

OBJECTIVE	PRODUCTS/ACTIVITIES/SERVICES	PROGRESS & PROCESS MEASURES	QUALITATIVE IMPACT
IV.B. Participation in recruitment and retention programs.	IV.B. Provide information concerning recruitment and retention programs to rural communities.	IV.B. Estimated number of persons using recruitment programs such as the Rural Recruitment and Retention Network and the Texas PRAIRIE OOE program.	IV.B. Average time to fill rural vacancy is reduced.
IV. C. Facilitate local health care workforce analyses and planning.	IV.C.1. Assist in developing or facilitating availability of health care workforce 'snapshots' of rural county, community and/or region.	IV.C.1. Number of communities, counties and/or regions for which health care workforce data or 'snapshots' are available.	IV.C. Communities secure health care workforce data with which to objectively plan current or future provider recruitment.
	IV.C.2. Provide training on how to recruit and retain.	IV.C.2. Number of training events and resources made available to communities.	same as above
	IV.C. 3. Assist communities in utilizing health care workforce information in planning for current and future health care provider needs, focusing on early, proactive identification of provider need, e.g. provider retirement.	IV.C.3. Number of communities assisted with proactive need identification and planning.	same as above

Center for Rural Health Initiatives
Rural Health Work Plan 1999-2000

OBJECTIVE	PRODUCTS/ACTIVITIES/SERVICES	PROGRESS & PROCESS MEASURES	QUALITATIVE IMPACT
IV.D. Participate in promotion of loan repayment programs administered by other agencies.	IV.D.I. Provide information needed to determine the necessity for and appropriateness of programs.	IV.D. Number of programs actually made available to rural communities.	IV.D.I. Communities/providers value the services provided.
			IV.D.2. Programs are monitored/evaluated for retention.
IV.E. Advocate for access to quality health care for rural populations facing geographic, cultural, gender, ethnic, or other barriers.	IV.E.1.a. Identify needs, barriers and effects of those barriers on rural communities.	IV.E.1.a.1. Number of needs, barriers and effects identified.	IV.E.1. Barriers to access to health care are effectively reduced in rural communities.
		IV.E.I.a.2. Number of interventions developed and implemented.	same as above
	IV.E.1.b. Work with local, regional, and statewide organizations and entities to develop effective programs to address those barriers.	IV.E.1.b. Number of entities engaged or involved in programs and services.	IV.E.1.b. Programs are developed with representationfrom a broad spectrum of rural health care stakeholders.

Center for Rural Health Initiatives
Rural Health Work Plan 1999-2000

OWECTIVE	PRODUCTS/ACTIVITIES/SERVICES	PROGRESS 6 PROCESS MEASURES	QUALITATIVE IMPACT
IV.F. Advocate for availability of other rural health care services necessary for healthy living, including: pharmacy. dental. behavioral. and nutrition services.	IV.F.1.a. Identify needs, barriers and effects of those barriers on rural communities.	IV.F.l.a.l. Number of needs, barriers, and effects identified.	IV.F.1. Health care needs and barriers are addressed to improve access to health care.
		IV.F.1.a.2. Number of interventions developed and implemented.	same as above
	IV.F.1.b. Work with local, regional, and statewide organizations and entities to develop effective programs to address those barriers.	IV.F.1.b. Number of entities engaged or involved in programs and services.	IV.F.l.b. Programs are developed with representation from a broad spectrum of rural health care stakeholders.

Center for Rural Heaith Initiatives
Rural Health Work Plan 1999-2000

OBJECTIVE	PRODUCTS/ACTIVITIES/SERVICES	PROGRESS & PROCESS MEASURES	QUALITATIVE IMPACT
IV.G. Advocate for the reduction of ancillary and/or related barriers to access to local rural health care including: transportation, enrollment, and language barriers.	IV.G.1.a. Identify needs, barriers and effects of those barriers on rural communities.	IV.G.1.a.1. Number of needs. barriers and effects identiid.	IV.G.1. Barriers to access to health care are reduced in rural communities.
		IV.G.I.a.2. Number of interventions developed and implemented.	same as above
	IV.G.1.b. Work with local, regional, and statewide organizations and entities to develop effective programs to address those barriers.	IV.G.1.b. Number of entities engaged or involved in programs and services.	IV.G.1.b. Programs are developed with representation from a broad spectrum of rural health care stakeholders.

Center for Rural Health Initiatives
Rural Health Work Plan 1999-2000

*GOAL FIVE: Leverage state and **federal partnerships** to **optimize resources** for **rural** Texans and promote **rural Texas issues***

OBJECTIVE	**PRODUCTS/ACTIVITIES/SERVICES**	**PROGRESS & PROCESS** MEASURES	**QUALITATIVE** IMPACT
V. Influence and develop health related policies through inter-organization collaboration.	V.I. Participation in state, regional, and national organizations whose mission is to promote the interests of rural communities.	**V.I.a.** Participation in statewide and national Rural Health Association.	V. **I. CRHI** staff hold leadership positions in slate, regional and national rural health care organizations.
		V.1.b. Attendance at the annual NOSORH meeting, the regional NOSORH meeting, and the annual National Rural **Health** Association meeting.	same as above
		V.1.c.. Number of state, regional, and national organizations CRHI staff serve in governance or policy positions.	same as above
		V.1.d. Participates in national and regional **efforts** to promote access to health care.	**V.1.d.** Efforts result in increased resources for rural health in the State of Texas.

Center for Rural Health Initiatives
Rural Health Work Plan 1999-2000

OBJECTIVE	PRODUCTS/ACTIVITIES/SERVICES	PROGRESS & PROCESS MEASURES	QUALITATIVE IMPACT
V. Influence and develop health related policies through inter-organization collaboration.	V.2. Provide state perspective on national rural health care policy issues.	V.2. Review and comment, upon request from NOSORH, NRHA. etc. on a variety of documents effecting rural health at state and national levels.	V.2. Comments present a realistic picture of rural health care issues and needs in the State of Texas.
	V.3. Participation in the National Organization of State Offices of Rural Health (NOSORH).	V.3.1. Serve as NOSORH regional representative officer or on a NOSORH committee.	V.3. CRHI staff hold leadership positions in state, regional and national rural health care organizations.
		V.3.2. Participate in NOSORH meetings and conference calls.	same as above