

# **CAH/FLEX National Tracking Project**

## **FINDINGS FROM THE FIELD**

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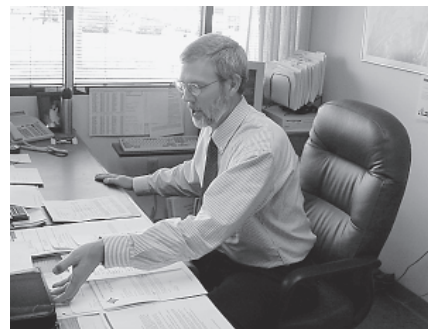
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## **Administration in Critical Access Hospitals**

Strong hospital administration is vital to the success of Critical Access Hospitals (CAHs). Rural Hospital Flexibility Program (Flex Program) Tracking Team members visited 40 hospitals over the first two years of the Flex Program and found a generally competent cohort of administrators and administrative teams who had led their organizations through CAH conversion.



Jeff Dye, CEO, in Socorro, New Mexico

There is an important relationship between successful hospitals and strong, knowledgeable administrators (or chief executive officers) (CEOs) who create partnerships with the communities in which their hospitals are located. We were not surprised that the first round of CAH conversions was accomplished by administrators who learned of the program earlier than many of their peers, because of strong connections with their hospital associations and/or by reading national publications. Many of these individuals were willing to take some risks and could technically navigate the largely uncharted waters of conversion protocols. They were also likely to have help and support from their associations and/or their state's office of rural health.

Our findings also show hospitals that converted to CAH status were likely to be in a financial-loss position (74% of them).

CAH administrators are doing remarkably well with scarce resources.

These two findings—that administrators who converted were strong CEOs, while grappling with serious hospital financial problems—are consistent with the literature on rural hospital administration. In 1996, Stephen Mick wrote, "Rural administrators manage quite well considering their resource-poor environments," and pointed out that they are particularly adept at finding funding sources from their communities to keep facilities open.<sup>1</sup>

### **Previous Research**

There is not an extensive literature describing the roles and practices of successful rural hospital CEOs. One of the most prominent writers on this topic, Mick (as referenced above), concluded that if states or the nation want to nurture a network of thriving acute care hospitals, policy makers should not rely on an approach that is based entirely on the "individual strategic actions of each rural hospital." He advocated a "coherent federal and state policy, with appropriate levels of underwriting and subsidies, that acknowledges that rural hospitals require special considerations and subsidies."

Programs such as the Flex Program would constitute "considerations and subsidies" as Mick described. Mick concluded, "Despite the findings of our own research and that of others, the fact is that most rural hospitals have *not* closed and have managed to keep going despite mediocre financial performance."

Despite Mick's recommendation that rural health policy avoid reliance solely on the individual hospital administrator's strategic initiative, most national and state policies have done just that. Individual hospital CEOs and their governing boards have been responsible for the success or failure of America's rural hospitals. In contrast, it is the rare urban or suburban hospital that sinks or swims depending on the performance of a single administrator and his or her board.

In Washington State, a long-time and well-respected rural hospital administrator, Gordon McLean, has likened the rural hospital to the bumblebee.<sup>2</sup> "There is no aerodynamic reason why a creature so designed should be able to fly." The implication is that it is the sheer death-defying will power and magical talent of administrators, boards, clinical staff, and communities that keeps these hospitals aloft.

## Survey Findings

Our telephone survey of administrators (winter 2001, University of Minnesota) revealed CEOs from hospitals that converted prior to the year 2000 were slightly more likely to report financial losses (79% of them) than those who converted during the year 2000 (71% of them), although this is not a statistically significant difference. State office of rural health staff are reporting that later converters in some states are larger, more stable rural hospitals.

Tracking Team members reported from site visits that CEO turnover can be a serious barrier to hospital stability and progress. Many small hospitals have experienced significant administrator turnover (the average CAH had two administrators in the last five years). Turnover, coupled with the fact that the boards that recruit and employ CEOs vary greatly in their skills and adeptness at governance, means hospital survival is dependent largely on the quality and stability of a few individuals in leadership positions.

On the positive side, CAH administrators, in general, tended to be more likely to praise their boards than bemoan their lack of competence. In an open-ended survey question, we asked CEOs to name the major strengths and weaknesses of their hospitals. While 37 administrators named a weakness in relation to their boards, 86 CEOs said their boards were sources of real strength for the hospital.

There were three notable\* findings from the administrator survey with relation to turnover:

1. Hospitals in a more desperate financial condition were more likely to have had more than two CEOs during the last five years.
  - Among the 50 hospitals with high turnover in the last five years, 90% were financially "desperate" (posting \$10,000 or less in revenues over expenses).
  - Among the 114 with lower turnover, 70% were in financial trouble. Among those, 36% had high turnover, compared to 13% among the "not desperate."

### Results from the survey of CEOs also show:

- Just over one-third of the administrators (35%) were promoted from within the facility to the CEO job.
- The average administrator had held his or her job for almost six years.
- The average hospital had two administrators during the past five years.
- Almost one-third of hospitals (30%) had more than two administrators during the last five years.
- One-half the administrators ended their formal educations with an undergraduate college degree.
- Sixteen percent of the CEOs had a Master of Health Administration (MHA) degree, 13% had an MBA (business administration), and 2% held MPH (public health) degrees.
- The average age of administrators was 48.
- Thirty-five percent of administrators were female.
- Forty-one percent of the CEOs reported their relationships with physicians to be excellent, and 43% indicated that their relationships were very good (84% excellent or very good).

\*We present findings significant at the P<.10 level.

2. Hospitals with lower turnover tended to be in communities that were rated “supportive” by their administrators.
  - While 62% of the low-turnover hospitals (one or two CEOs in five years) were in reportedly “high support” communities, only 46% of high-turnover hospitals were in “high support” communities.
  - Among “high support” communities, 75% had low turnover, compared to 58% low turnover in low support communities.
3. Communities that support their hospitals with tax dollars have lower CEO turnover.
  - While 37% of communities providing no tax support had high turnover, only 25% of those with tax support experienced high turnover.
  - Fifty-six percent of high-turnover hospitals received no tax support, and 57% of low-turnover hospitals received tax support.

One of the benefits of the Flex Program is that it allows grantees at the state level to bring together hospital CEOs for CAH meetings, where discussion and education can take place about current trends in the profession, common problems, and the celebration of successes. It has also allowed state office representatives and consultants to work directly on site in communities with hospital boards, facilitate networking among providers within towns, and promote networking among hospital administrators within a region.

State offices of rural health and the Federal Office of Rural Health Policy may want to explore the creation of opportunities for CEOs to gain continuing education in areas such as:

- Team building and communication
- Strategic planning
- Assessing community needs
- Improving governance
- Strengthening finances
- Networking with other health providers in the same community
- Networking with health providers in other communities
- Improving quality of care
- Working with physicians

Baldrige National Quality Program<sup>3</sup> criteria for performance excellence in health care:

- Leadership
- Strategic planning
- Focus on patients, other customers, and markets
- Information and analysis
- Staff focus
- Process management
- Organizational performance results

The Tracking Team conducted a focus group with a group of CAH administrators in Washington State (June 2001) in which the administrators indicated they very much appreciated having a new peer group with which to interact, and benefited from learning opportunities offered by the state office of rural health that they could attend together. CEO relationships and skills are being enhanced through their participation in Flex Program activities.

We conclude rural hospital administrators can do their jobs better and are more likely to stay in their jobs if they get support from the community, from the state office of rural health, and from each other through their hospital association.

#### REFERENCES

<sup>1</sup>Mick, S. (1996). Commentary: The future of rural hospitals in the United States. *Health Care Management Review*, 21(2), 26-28.  
<sup>2</sup>McLean, G. (March 2001). Speech to NW Regional Rural Health Conference, Spokane, Washington. Contact: Whitman Hospital and Medical Center, Colfax, Washington 99111; 509-397-3435.  
<sup>3</sup>The Malcolm Baldrige National Quality Award was created by Public Law 100-107, adopted in 1987. The Award Program recognizes managerial excellence in U.S. industries. Malcolm Baldrige served as Secretary of Commerce from 1981 until his tragic death in a rodeo accident in 1987 and is recognized for contributing to long-term improvement in efficiency and effectiveness of government.

### **Where Can I Get More Information?**

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About this project: Check our website: <http://www.rupri.org/rhfp-track/>

### **Background**

The Rural Hospital Flexibility Program is a federal initiative to strengthen rural health. The Program:

1. Allows small hospitals the flexibility to reconfigure operations and be licensed as Critical Access Hospitals (CAHs).
2. Offers cost-based reimbursement for Medicare acute inpatient and outpatient services.
3. Encourages the development of rural-centric health networks.
4. Offers grants to states to help implement a CAH program in the context of broader initiatives to strengthen the rural health care infrastructure.

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