## Background

The federal Office of Rural Health Policy (ORHP) is sponsoring a formative evaluation effort of the federal Rural Hospital Flexibility Program (RHFP). This effort is coordinated through the six rural health research centers affiliated with the ORHP and includes the centers at the Universities of Southern Maine, Minnesota, North Carolina, Washington and the center located at Project Hope in Washington D.C. In addition, the Rural Policy Research Institute (RUPRI) will also be contributing its expertise in disseminating results from the project. Each of the centers have collaborated in the development of a broad evaluation design to gather information from a variety of sources including existing data sets as well as informants that have experience in the program's implementation at the national, state, community and facility levels.

## Introduction

This instrument represents a key component of the facility and community level data collection effort. While the pre-site visit survey completed prior to this interview was highly quantitative, it is important to realize that the essence of this part of the evaluation focuses on more process related experiences.

## Respondents

The instrument is divided into nine (9) modules, each corresponding to a particular category of respondent. Page numbers in the upper right corner of each survey page identify the module and corresponding page for that section of the survey. A master respondent assignment document has been developed to guide the interviewer in identifying which respondents are targeted by each question and to provide a richer context for the questions and probes.

The modules are listed below along with their page numbers and an estimate of ***needed interview times.***

1. **Chief Executive Officer (1-1 to 1-7) - up to 3 hrs over two sessions**
2. **Chief Financial Officer (2-1 to 2-3) - 1 ½ hrs**
3. **Hospital Board Chair and/or Vice Chair (3-1 to 3-4) - 1hr**
4. **Hospital Medical Director/Medical Staff (4-1 to 4-4) -- 1hr**
5. **Hospital Director of Nursing/QA (5-1 to 5-3) - ¾ hr**
6. **Support Hospital(s) CEO and/or COO (6-1 to 6-4) -- 1hr**
7. **Rural Health Network Representatives (7-1 to 7-5) -- 2hrs**
8. **Community Representatives (8-1 to 8-3) -- 1hr**
9. **Emergency Medical Services Representatives (9-1 to 9-4) -- 1 ½ hrs**

**Data Collection and Write-ups**

The questions and probes included in the interview modules provide the general direction of our information interests; however, it will be important for each interviewer to also be sensitive to uncovering new paths of inquiry. Using the module as a guide, interviewers will record the respondent's comments on a legal pad or in a notebook. Care should be taken to clearly indicate who is being interviewed and which question is being asked. As we progress to the write-ups of the interviews and summary written reports, it will be important to identify the source and nature of information. Each interviewer will need to provide identifying information at the top of each page of their interview write-ups (could be done as a header).

The following four identifiers are to be used for each interview:

| ___ ___ | ___ | ___ ___ | ___ ___ ___ ___ |
|---|---|---|---|
| **Site** | **Hospital** | **Respondent** | **Date (mm/yy)** |

(1) Site represented by the two letter postal abbreviation used for the state in which the hospitals are located;

(2) Hospital will either be listed as 1 or 2 and will be determined at the time of survey by each center team;

(3) Respondent code should correspond with the number of the module used (e.g., CEO = 01 and EMS = 09), interviews with persons other than those listed in the modules should be coded 10; and

(4) Date on which the information was collected should be recorded as the month and year to differentiate it from subsequent survey efforts over the next few years.

With the possible exception of the network and the community modules, we expect modules to be used during interviews with one individual. Ideally, it would also be nice to conduct the network and community interviews individually and, if time allows, they should be set-up that way (this will be a local call depending upon time availability and the presence of tension and conflict among respondents).

Survey teams will usually not be able to field a note taker, as well as an interviewer, making it important for each interviewer to pace the process to allow for the most complete collection of information. This means, don't rush through the process, take side notes when necessary to keep an idea for later checking so as not to break the flow of thought of the informant and work with the module rather than against it. It will be important to cover as much of the questions and probes as possible but only to the extent that you cover each probe thoroughly. There will be times when time will not permit checking all probes; therefore, use whatever guides are available to target specific probes according to what the informant is covering and note which probes were not touched

upon. Including this information in your write-up will help us decide how an informant's comments should be gauged and if we need to follow-up to collect more information.

**The Interview Process**

It should not take longer than 5 to 10 minutes to cover the preliminaries of the interview process and begin the survey. Be sure to review the results of the pre-site visit survey prior to starting the interview and also verify that you have the correct interview module. A brief interview reference guide is outlined below to provide consistency in our relationships with the informants.

1. General Introductions **(3 minutes)**
   a. Identify yourself and anyone with you as a member of the evaluation team (note which research center you represent).
   b. Express appreciation to the respondent for taking time to participate.
   c. Note usefulness of pre-survey information in setting the stage for today.
   d. Point out whom, if any additional evaluation field staff, are present in the facility.

2. Purpose and potential benefits of the Interview **(5 minutes)**
   a. Provide information for an evaluation of the RHFP.
   b. Provide feedback to the ORHP and State Offices of Rural Health.
   c. Disseminate lessons learned to interested rural hospitals.

3. Briefly outline the structure of the site visit questionnaire with a time estimate for the current interview **(2 minutes)**

4. Begin the interview - Ask **bolded questions** and probe with bulleted sub-points if the respondent has not covered the issues in the course of their response. Use the probes as much as possible to guide your efforts but do not overlook any leads.

6. Be sensitive to subtle cues from the informant. Reschedule if necessary for later in the day or by phone - <u>check master interview schedule to minimize conflicts</u>.

7. At the completion of the interview process be sure to ask the informant if there are any questions or issues that s/he wanted to cover before we leave.

8. Bring closure to the interview and thank the informant for the time and energy they invested in the process.

9. Take a few minutes after the interview to collect your thoughts and add any additional comments to the survey form for clarification.

# CRITICAL ACCESS HOSPITALS STUDY

**Hospital Site Visit Data Collection Instrument**

## MODULE 1

**INTERVIEW QUESTIONS**
**FOR**
**HOSPITAL CHIEF EXECUTIVE OFFICER**

**I. Pre-Conversion Hospital and Area Characteristics** - Questions in this section focus on the broader organizational and environmental context that shaped the conversion experience of the hospital and area stakeholders.

1. **How knowledgeable was the community about pressing health care and financial issues facing the community and the hospital prior to conversion?**

   What were the most important factors that affected the degree to which the community was aware of issues?

   Do any particular community leaders stand out as being most or least aware of what was happening?

2. **How would you describe the awareness of the hospital leadership about the relative market position and financial stability of the hospital prior to conversion?**

3. **What were the relationships of area providers prior to the hospital's participation in the Rural Hospital Flexibility Program (RHFP)?**

   Was the market friendly, unfriendly, volatile, calm and to what degree did others share this view?

4. **What was the nature of the local emergency medical services delivery system and the hospital's ability to respond to emergency medical needs of the community?**

   Were local EMS resources and capacity adequate to meet the pre-hospital needs of the community (e.g., vehicles, equipment, personnel, medical control, response times, skill levels, coordination etc.)?

   Were there sufficient facility resources and infrastructure to provide for the emergency needs of patients that presented in the hospital ED?

   What relationships, if any, existed between the hospital and local EMS providers to meet community emergency needs prior to conversion (e.g., hospital-based ambulance service, medical control etc.)?

5. **What factors accounted for the development or lack of development of network relationships among area providers prior to conversion?**

Was your hospital involved in any network/collaborative activities with area providers prior to the RHFP (e.g., planning, joint purchasing, service provision, emergency medical systems development etc.)?

**1 - 2**

How did your hospital's prior experiences with collaborative activities affect its approach to the RHFP and the various required/suggested organizational linkages (e.g., support hospital, EMS etc.)?

Were there any state policies/initiatives that encouraged/discouraged network development prior to the RHFP (e.g., financial support, regulatory flexibility/relief etc.)?

**II. The Conversion Decision and Character of the Process** - This section focuses on the nature of the decision making process, who was involved, what enabled or limited the process as well as the path of action taken to implement the decision.

1. **What were the major reasons for considering conversion to a CAH?**

   Poor current financial/market conditions?

   Reaction to prior market or system failures?

   Pressure from outside public/private interests?

   Perceived opportunities that either paralleled or augmented existing planning efforts and goals?

   Preparation for expected changes in operating environment?

   Were any other options considered in lieu of conversion (e.g., reconfigure services, establish organizational linkages, closure, seeking special Medicare payment status such as a Sole Community Hospital etc.)?

2. **How did the decision-making process for CAH conversion take shape and what were the roles of various stakeholders in that process?**

   Were specific public relation strategies used to address the concerns and information needs generated by exploring conversion to a CAH (e.g., hospital staff, community residents, local businesses, local providers etc.)?

   What roles did the most influential stakeholders (e.g., administration/board, physicians, area providers, community representatives etc.) play in the decision process? Why were they

influential and in what areas did they exercise this influence in the decision-making process?

**1 - 3**

To what degree did community-based political/economic issues affect the decision process (e.g., jobs, health care costs, availability of care etc.)? How much input did the community provide for the decision making process? Was this proactive on the part of the community or the result of outreach/engagement activities by the hospital or network?

To what degree did the state and/or the state hospital association provide technical assistance and what seemed most useful?

Were outside consultants used and did you find them useful?

How active was the hospital board in the process? Were any issues more likely than others in fostering/limiting board member involvement? Why?

To what degree did the hospital's existing strategic plan play a role in guiding the conversion process?

**3. How were key issues resolved?**

To what extent was there consensus on the decision to convert to a CAH? What information/analyses generated this consensus or was needed to generate a consensus?

What were the key buy-in points that facilitated the decision-making process? How did this vary by key stakeholders mentioned above?

Were there other internal-hospital concerns that needed to be addressed in the decision-making process (e.g., scope of services, physician satisfaction, clinical/administrative personnel changes etc.)? How were these issues addressed (e.g., retained services over opposition, fostering support for personnel changes and degree that area providers and consumers were included in the process etc.)?

Were specific issues about the potential impact of conversion and participation in the Flex program on quality of care identified during the decision making process. If so, what were the main points and how were they addressed?

Were there other external (system-related) concerns that needed to be addressed (e.g., off-site contracting, organizational linkages and other arrangements that may have required relinquishing some degree of organizational autonomy to achieve the desired goal etc.)?



How was the decision to convert handled in the message going-out to the local community?

Were there any specific legal issues that created barriers to the integration of services into a network organization (e.g., primary care , public health, EMS etc.)?

Did competitive issues among network members create any particular barriers to the integration of services and support functions?

4. **What should have been done differently (e.g., data/arguments used, strategies employed, bargains made, parties included etc.)?**

Do you have any particular advice for hospitals/communities that might be considering this path of action that might improve their chances of success and reduce the time needed to initiate the needed changes?

**III. The Post-Conversion Experience** - This section explores the initial impact of converting to a CAH and developing network relationships.

1. **What internal changes have occurred as a result of conversion?**

How did the working relationship between hospital senior management and the board change with conversion?

How would you characterize the stability of management resources since the conversion (e.g., turnover, adequacy of training for new roles, morale etc.)?

To what degree were clinical and management operations modified to accommodate participation in the flex program (e.g., medical control, communications capacity, etc)? Were any barriers encountered and what strategies worked best to implement the changes?

To what degree have medical/clinical staffing levels and resource commitments for hospital service areas changed as a result of the conversion (e.g., emergency department, outpatient services, specialty services etc.)?

To what degree have hospital department roles and responsibilities changed and inter-facility service integration occurred as a result of conversion and change in internal structures (e.g., sharing of quality assurance responsibilities with network members, contracting for



ancillary services and/or administrative and general function responsibilities etc.)?

To what degree was your existing program for continuous improvement of quality and organizational performance modified to accommodate participation in the Flex program? If not, why not?

Has conversion resulted in a change in how non-clinical staff are viewed and used in the operation of the hospital (e.g., paramedics in the ED, lab-techs and x-ray techs in support services, volunteers etc.)?

To what degree has the hospital undergone physical plant modifications to better fit its role as a CAH (i.e., beyond changes required by life and safety code regulations and including those that would better position the CAH to take advantage of its new delivery system role in the region)? Are any of the changes a result of implementing pre-CAH strategic decisions, attempts to realize additional revenue streams or to consolidate network operations?

2. **What external dynamics/relationships have changed as a result of participation in the Flex program?**

To what degree has participation altered the way the hospital relates with local providers such as community-based physicians, clinics, behavioral health, long-term care and emergency medical services providers (e.g., communication, coordination, referral, admission/destination and transfer protocols etc.)?

Has conversion changed how the hospital interacts/relates with other hospitals in the region (e.g., joint agreements, clinical and operational protocols, regional trauma system participation etc.)?

To what degree have hospital relationships changed in terms of external suppliers (e.g., medical suppliers, laundry/maintenance services, utilities etc.)?

How has your accreditation status changed as a result of participating in the Flex program? Any future intentions regarding accreditation?

To what degree has the hospital's relationships with regulators/payers changed since conversion (e.g., collaborative/punitive, vigilant/more relaxed etc.)?

How has the hospital's regional reputation changed as a result of participation in the RHFP and conversion to a CAH (e.g., willingness



of other acute care providers to collaborate, referrals from others, views of local communities etc.)?

Do you think that any of these changes would have occurred even if the hospital had ultimately decided to not become a CAH (e.g., result of on-going assessments consideration of growing options and exploring innovative strategies)?

3. **Has network development provided a value-added quality to the capacity of the delivery system in stabilizing provider relationships and meeting community health needs?**

   How important have network relationships, developed under the RHFP, been in the post-conversion operations of the CAH?

   To what degree have the network development activities affected the traditional relationships of area providers (e.g., increased frequency of collaborative discussions and actions in general, generated opportunities for collaboration that otherwise would not have been possible etc.)?

   Has network development contributed to the well-being of the community in any way (e.g., employment, access to care not previously available, economic stability for future planning etc.)?

**IV. Emerging Issues** - This section explores the on-going experiences of the CAH and its network members within the context of emerging local, state and federal issues.

1. **What do you feel are the most important issues facing hospitals that want to convert to a CAH?**

2. **What do you consider the most pressing concerns for the future viability of the CAH model?**

3. **Are there any state wide initiatives developing that you think will have a significant impact on the future viability of your facility?**

4. **What federal and/or state policies are critical for the continued success of the CAH model?**

5. **Do you anticipate any changes in the relationship between your hospital and the local EMS system or in your hospital's provision of emergency medical services under the new Medicare payment system for ambulance services?**

**1 - 7**

**V. Closing**

1. **What have been the most positive, successful aspects of the transition process experienced to date?**

2. **Do you have any specific advice for providers considering the CAH model? What worked and didn't work for you? Were there any surprises?**

3. **Do you have any specific advice for providers considering developing or participating in a rural health network and community development?**

4. **Do you have any specific advice for the Federal Office of Rural Health Policy to more effectively and efficiently meet the goals of this program?**

# CRITICAL ACCESS HOSPITALS STUDY

**Hospital Site Visit Data Collection Instrument**

## MODULE 2

### INTERVIEW QUESTIONS
### FOR
### HOSPITAL CHIEF FINANCIAL OFFICER

## I. Basic Data 1996 - Present

A. Complete Financial Statements [Attachment 1]

1) Income Statements
2) Balance Sheets
3) Cash Flow Statements
4) Notes to the financial statements

B. Completed Financial Information Form [Attachment 2]

C. Financial Ratios [Attachment 3]

D. Cost Reports [Attachment 4]

## II. Items of note on the Financial Statements, Operating Statistics and Ratio Analysis

A. Key Operating Statistics and Trends

B. Key Items and Trends in Overall Financial Condition

1) Financial Ratios

a. Profitability
b. Liquidity
c. Activity
d. Capital Structure

2) Profits and Losses

3) Credit Rating

C. Key Items and Trends Regarding Revenues and Cash Inflows

1) Net Patient Service Revenues

a. Payor mix by payor
b. Payor mix by service

2) Charity Care and Discounts

3) Non-Patient service Revenues

   a. Amounts and trends in revenues and cash inflows from the following sources
      (1) Medicare
      (2) Medicaid
      (3) State
      (4) County
      (5) Parent
      (6) Other

4) Other

D. Key Items and Trends Regarding Expenses and Cash Outflows

1) By Line Item
2) By Program
3) By Type (from cash flow statement)

E. Key Items on the Balance Sheet

1) Current and Non-Current Assets
2) Current and Non-Current Liabilities
3) Net Assets

## III. Major Items Which Help Explain the Financial Condition of the Hospital: Governance, Administration and Infrastructure

[Note: these items are drawn from the strategy-related information sheet. The items listed are examples and should be modified to fit the particular CAH]

A. Fiscal Services / Systems

1) Problems
2) Activities
3) Strategy

B. Customers/Patients/Community/Employers

1) Problems
2) Activities
3) Strategy

C. Patient Care: Clinical Services/Disease Management and Quality Improvement

1) Problems
2) Activities
3) Strategy

D. Employees

1) Problems
2) Activities
3) Strategy

E. Physicians

1) Problems
2) Activities
3) Strategy

## V. Major Items Which Help Explain the Financial Condition of the Hospital: Expenses and Cash Outflows

A. Infrastructure

1) Problems
2) Activities
3) Strategy

B. Fiscal Services

1) Problems
2) Activities
3) Strategy

C. Staffing

1) Problems
2) Activities
3) Strategy

# CRITICAL ACCESS HOSPITALS STUDY

**Hospital Site Visit Data Collection Instrument**

## MODULE 3

**INTERVIEW QUESTIONS**
**FOR**
**HOSPITAL BOARD CHAIR AND/OR VICE CHAIR**

**I. Pre-Conversion Hospital and Area Characteristics** - Questions in this section focus on the broader organizational and environmental context that shaped the conversion experience of the hospital and area stakeholders.

1. **How knowledgeable was the community about pressing health care and financial issues facing the community and the hospital prior to conversion?**

   What were the most important factors that affected the degree to which the community was aware of issues?

   Do any particular community leaders stand out as being most or least aware of what was happening?

2. **How would you describe the awareness of the hospital leadership about the relative market position and financial stability of the hospital prior to conversion?**

3. **What factors accounted for the development or lack of development of network relationships among area providers prior to conversion?**

   How did your hospital's prior experiences with collaborative activities affect its approach to the RHFP and the various required/suggested organizational linkages (e.g., support hospital, EMS etc.)?

**II. The Conversion Decision and Character of the Process** - This section focuses on the nature of the decision making process, who was involved, what enabled or limited the process as well as the path of action taken to implement the decision.

1. **What were the major reasons for considering conversion to a CAH?**

   Poor current financial/market conditions?

   Reaction to prior market or system failures?

   Pressure from outside public/private interests?

   Perceived opportunities that either paralleled or augmented existing planning efforts and goals?

   Preparation for expected changes in operating environment?

   Were any <u>other options considered in lieu of conversion</u> (e.g., reconfigure services, establish organizational linkages, closure,

seeking special Medicare payment status such as a Sole Community Hospital etc.)?

2. **How did the decision-making process for CAH conversion take shape and what were the roles of various stakeholders in that process?**

   To what degree did <u>community-based</u> political/economic <u>issues</u> affect the decision process (e.g., jobs, health care costs, availability of care etc.)? <u>How much input</u> did the community provide for the decision making process? Was this proactive on the part of the community or the result of outreach/engagement activities by the hospital or network?

   To what degree did the <u>state</u> and/or the <u>state hospital association</u> provide <u>technical assistance</u> and what seemed most useful?

   How active was the <u>hospital board</u> in the process? Were any issues more likely than others in fostering/limiting board member involvement? Why?

   To what degree did the hospital's existing <u>strategic plan</u> play a role in guiding the conversion process?

3. **How were key issues resolved?**

   To what extent was there <u>consensus on the decision</u> to convert to a CAH? What information/analyses generated this consensus or was needed to generate a consensus?

   What were the <u>key buy-in points</u> that facilitated the decision-making process? How did this vary by key stakeholders mentioned above?

4. **What should have been done differently (e.g., data/arguments used, strategies employed, bargains made, parties included etc.)?**

   Do you have any particular advice for hospitals/communities that might be considering this path of action that might improve their chances of success and reduce the time needed to initiate the needed changes?

**III. The Post-Conversion Experience** - This section explores the initial impact of converting to a CAH and developing network relationships.

1. **What internal changes have occurred as a result of conversion?**

How did the working relationship between hospital senior management and the board change with conversion?

How would you characterize the stability of management resources since the conversion (e.g., turnover, adequacy of training for new roles, morale etc.)?

To what degree has the hospital undergone physical plant modifications to better fit its role as a CAH (i.e., beyond changes required by life and safety code regulations and including those that would better position the CAH to take advantage of its new delivery system role in the region)? Are any of the changes a result of implementing pre-CAH strategic decisions, attempts to realize additional revenue streams or to consolidate network operations?

2. **What external dynamics/relationships have changed as a result of participation in the Flex program?**

To what degree have hospital relationships changed in terms of external suppliers (e.g., medical suppliers, laundry/maintenance services, utilities etc.)?

How has your accreditation status changed as a result of participating in the Flex program? Any future intentions regarding accreditation?

To what degree has the hospital's relationships with regulators/payers changed since conversion (e.g., collaborative/punitive, vigilant/more relaxed etc.)?

How has the hospital's regional reputation changed as a result of participation in the RHFP and conversion to a CAH (e.g., willingness of other acute care providers to collaborate, referrals from others, views of local communities etc.)?

Do you think that any of these changes would have occurred even if the hospital had ultimately decided to not become a CAH (e.g., result of on-going assessments consideration of growing options and exploring innovative strategies)?

3. **Has network development provided a value-added quality to the capacity of the delivery system in stabilizing provider relationships and meeting community health needs?**

   How important have network relationships, developed under the RHFP, been in the post-conversion operations of the CAH?

   Has network development contributed to the well-being of the community in any way (e.g., employment, access to care not previously available, economic stability for future planning etc.)?

**IV. Emerging Issues** - This section explores the on-going experiences of the CAH and its network members within the context of emerging local, state and federal issues.

1. **What do you feel are the most important issues facing hospitals that want to convert to a CAH?**

2. **What do you consider the most pressing concerns for the future viability of the CAH model?**

3. **Are there any state wide initiatives developing that you think will have a significant impact on the future viability of your facility?**

4. **What federal and/or state policies are critical for the continued success of the CAH model?**

**V. Closing**

1. **What have been the most positive, successful aspects of the transition process experienced to date?**

2. **Do you have any specific advice for providers considering the CAH model? What worked and didn't work for you? Were there any surprises?**

3. **Do you have any specific advice for providers considering developing or participating in a rural health network and community development?**

4. **Do you have any specific advice for the Federal Office of Rural Health Policy to more effectively and efficiently meet the goals of this program?**

# CRITICAL ACCESS HOSPITALS STUDY

**Hospital Site Visit Data Collection Instrument**

## MODULE 4

**INTERVIEW QUESTIONS**
**FOR**
**HOSPITAL MEDICAL DIRECTOR/MEDICAL STAFF**

**I. Pre-Conversion Hospital and Area Characteristics** - Questions in this section focus on the broader organizational and environmental context that shaped the conversion experience of the hospital and area stakeholders.

1. **What were the relationships of area providers prior to the hospital's participation in the Rural Hospital Flexibility Program (RHFP)?**

   Was the market friendly, unfriendly, volatile, calm and to what degree did others share this view?

2. **What was the nature of the local emergency medical services delivery system and the hospital's ability to respond to emergency medical needs of the community?**

   Were local EMS resources and capacity adequate to meet the pre-hospital needs of the community (e.g., vehicles, equipment, personnel, medical control, response times, skill levels, coordination etc.)?

   Were there sufficient facility resources and infrastructure to provide for the emergency needs of patients that presented in the hospital ED?

   What relationships, if any, existed between the hospital and local EMS providers to meet community emergency needs prior to conversion (e.g., hospital-based ambulance service, medical control etc.)?

3. **What factors accounted for the development or lack of development of network relationships among area providers prior to conversion?**

   How did your hospital's prior experiences with collaborative activities affect its approach to the RHFP and the various required/suggested organizational linkages (e.g., support hospital, EMS etc.)?

**II. The Conversion Decision and Character of the Process** - This section focuses on the nature of the decision making process, who was involved, what enabled or limited the process as well as the path of action taken to implement the decision.

1. **How did the decision-making process for CAH conversion take shape and what were the roles of various stakeholders in that process?**

   How active was the hospital board in the process? Were any issues more likely than others in fostering/limiting board member involvement? Why?

To what degree did the hospital's existing strategic plan play a role in guiding the conversion process?



2. **How were key issues resolved?**

   To what extent was there consensus on the decision to convert to a CAH? What information/analyses generated this consensus or was needed to generate a consensus?

   Were there other internal-hospital concerns that needed to be addressed in the decision-making process (e.g., scope of services, physician satisfaction, clinical/administrative personnel changes etc.)? How were these issues addressed (e.g., retained services over opposition, fostering support for personnel changes and degree that area providers and consumers were included in the process etc.)?

   Were specific issues about the potential impact of conversion and participation in the Flex program on quality of care identified during the decision making process. If so, what were the main points and how were they addressed?

   Were there any specific legal issues that created barriers to the integration of services into a network organization (e.g., primary care , public health, EMS etc.)?

   Did competitive issues among network members create any particular barriers to the integration of services and support functions?

3. **What should have been done differently (e.g., data/arguments used, strategies employed, bargains made, parties included etc.)?**

   Do you have any particular advice for hospitals/communities that might be considering this path of action that might improve their chances of success and reduce the time needed to initiate the needed changes?

**III. The Post-Conversion Experience** - This section explores the initial impact of converting to a CAH and developing network relationships.

1. **What internal changes have occurred as a result of conversion?**

   To what degree were clinical and management operations modified to accommodate participation in the flex program (e.g., medical control, communications capacity, etc)? Were any barriers encountered and what strategies worked best to implement the changes?

To what degree have medical/clinical staffing levels and resource commitments for hospital service areas changed as a result of the conversion (e.g., emergency department, outpatient services, specialty services etc.)?

To what degree was your existing program for continuous improvement of quality and organizational performance modified to accommodate participation in the Flex program? If not, why not?

Has conversion resulted in a change in how non-clinical staff are viewed and used in the operation of the hospital (e.g., paramedics in the ED, lab-techs and x-ray techs in support services, volunteers etc.)?

2. **What external dynamics/relationships have changed as a result of participation in the Flex program?**

To what degree has participation altered the way the hospital relates with local providers such as community-based physicians, clinics, behavioral health, long-term care and emergency medical services providers (e.g., communication, coordination, referral, admission/destination and transfer protocols etc.)?

Has conversion changed how the hospital interacts/relates with other hospitals in the region (e.g., joint agreements, clinical and operational protocols, regional trauma system participation etc.)?

How has your accreditation status changed as a result of participating in the Flex program? Any future intentions regarding accreditation?

How has the hospital's regional reputation changed as a result of participation in the RHFP and conversion to a CAH (e.g., willingness of other acute care providers to collaborate, referrals from others, views of local communities etc.)?

Do you think that any of these changes would have occurred even if the hospital had ultimately decided to not become a CAH (e.g., result of on-going assessments consideration of growing options and exploring innovative strategies)?

3. **Has network development provided a value-added quality to the capacity of the delivery system in stabilizing provider relationships and meeting community health needs?**

How important have network relationships, developed under the RHFP, been in the post-conversion operations of the CAH?



**IV. Emerging Issues** - This section explores the on-going experiences of the CAH and its network members within the context of emerging local, state and federal issues.

1. **What do you feel are the most important issues facing hospitals that want to convert to a CAH?**

**V. Closing**

1. **What have been the most positive, successful aspects of the transition process experienced to date?**

2. **Do you have any specific advice for providers considering the CAH model? What worked and didn't work for you? Were there any surprises?**

3. **Do you have any specific advice for providers considering developing or participating in a rural health network and community development?**

4. **Do you have any specific advice for the Federal Office of Rural Health Policy to more effectively and efficiently meet the goals of this program?**

# CRITICAL ACCESS HOSPITALS STUDY

**Hospital Site Visit Data Collection Instrument**

## MODULE 5

**INTERVIEW QUESTIONS**
**FOR**
**HOSPITAL DIRECTOR OF NURSING**

**II. The Conversion Decision and Character of the Process** - This section focuses on the nature of the decision making process, who was involved, what enabled or limited the process as well as the path of action taken to implement the decision.

1. **What were the major reasons for considering conversion to a CAH?**

2. **How were key issues resolved?**

   Were specific issues about the potential impact of conversion and participation in the Flex program on quality of care identified during the decision making process. If so, what were the main points and how were they addressed?

   Were there other external (system-related) concerns that needed to be addressed (e.g., off-site contracting, organizational linkages and other arrangements that may have required relinquishing some degree of organizational autonomy to achieve the desired goal etc.)?

**III. The Post-Conversion Experience** - This section explores the initial impact of converting to a CAH and developing network relationships.

1. **What internal changes have occurred as a result of conversion?**

   How would you characterize the stability of management resources since the conversion (e.g., turnover, adequacy of training for new roles, morale etc.)?

   To what degree were clinical and management operations modified to accommodate participation in the flex program (e.g., medical control, communications capacity, etc)? Were any barriers encountered and what strategies worked best to implement the changes?

   To what degree have medical/clinical staffing levels and resource commitments for hospital service areas changed as a result of the conversion (e.g., emergency department, outpatient services, specialty services etc.)?

   To what degree have hospital department roles and responsibilities changed and inter-facility service integration occurred as a result of conversion and change in internal structures (e.g., sharing of quality assurance responsibilities with network members, contracting for ancillary services and/or administrative and general function responsibilities etc.)?

To what degree was your existing program for continuous improvement of quality and organizational performance modified to accommodate participation in the Flex program? If not, why not?

Has conversion resulted in a change in how non-clinical staff are viewed and used in the operation of the hospital (e.g., paramedics in the ED, lab-techs and x-ray techs in support services, volunteers etc.)?

2. **What external dynamics/relationships have changed as a result of participation in the Flex program?**

   To what degree has participation altered the way the hospital relates with local providers such as community-based physicians, clinics, behavioral health, long-term care and emergency medical services providers (e.g., communication, coordination, referral, admission/destination and transfer protocols etc.)?

   Has conversion changed how the hospital interacts/relates with other hospitals in the region (e.g., joint agreements, clinical and operational protocols, regional trauma system participation etc.)?

   How has the hospital's regional reputation changed as a result of participation in the RHFP and conversion to a CAH (e.g., willingness of other acute care providers to collaborate, referrals from others, views of local communities etc.)?

3. **Has network development provided a value-added quality to the capacity of the delivery system in stabilizing provider relationships and meeting community health needs?**

   How important have network relationships, developed under the RHFP, been in the post-conversion operations of the CAH?

   Has network development contributed to the well-being of the community in any way (e.g., employment, access to care not previously available, economic stability for future planning etc.)?

IV. **Emerging Issues** - This section explores the on-going experiences of the CAH and its network members within the context of emerging local, state and federal issues.

1. **What do you feel are the most important issues facing hospitals that want to convert to a CAH?**



## V. Closing

1. **What have been the most positive, successful aspects of the transition process experienced to date?**

2. **Do you have any specific advice for providers considering the CAH model? What worked and didn't work for you? Were there any surprises?**

3. **Do you have any specific advice for providers considering developing or participating in a rural health network and community development?**

4. **Do you have any specific advice for the Federal Office of Rural Health Policy to more effectively and efficiently meet the goals of this program?**

# CRITICAL ACCESS HOSPITALS STUDY

**Hospital Site Visit Data Collection Instrument**

## MODULE 6

**INTERVIEW QUESTIONS**
**FOR**
**HOSPITAL CHIEF EXECUTIVE OFFICER**
**SUPPORT HOSPITAL**

**I. Pre-Conversion Hospital and Area Characteristics** - Questions in this section focus on the broader organizational and environmental context that shaped the conversion experience of the hospital and area stakeholders.

1. **What were the relationships of area providers prior to the hospital's participation in the Rural Hospital Flexibility Program (RHFP)?**

   Was the market friendly, unfriendly, volatile, calm and to what degree did others share this view?

2. **What factors accounted for the development or lack of development of network relationships among area providers prior to conversion?**

   Was your hospital involved in any network/collaborative activities with area providers prior to the RHFP (e.g., planning, joint purchasing, service provision, emergency medical systems development etc.)?

   Were there any state policies/initiatives that encouraged/discouraged network development prior to the RHFP (e.g., financial support, regulatory flexibility/relief etc.)?

**II. The Conversion Decision and Character of the Process** - This section focuses on the nature of the decision making process, who was involved, what enabled or limited the process as well as the path of action taken to implement the decision.

1. **How were key issues resolved?**

   What were the key buy-in points that facilitated the decision-making process? How did this vary by key stakeholders mentioned above?

   Were specific issues about the potential impact of conversion and participation in the Flex program on quality of care identified during the decision making process. If so, what were the main points and how were they addressed?

   Were there other external (system-related) concerns that needed to be addressed (e.g., off-site contracting, organizational linkages and other arrangements that may have required relinquishing some degree of organizational autonomy to achieve the desired goal etc.)?

   Were there any specific legal issues that created barriers to the integration of services into a network organization (e.g., primary care , public health, EMS etc.)?

Did competitive issues among network members create any particular barriers to the integration of services and support functions?

2. **What should have been done differently (e.g., data/arguments used, strategies employed, bargains made, parties included etc.)?**

   Do you have any particular advice for hospitals/communities that might be considering this path of action that might improve their chances of success and reduce the time needed to initiate the needed changes?

**III. The Post-Conversion Experience** - This section explores the initial impact of converting to a CAH and developing network relationships.

1. **What internal changes have occurred as a result of conversion?**

   How would you characterize the stability of management resources since the conversion (e.g., turnover, adequacy of training for new roles, morale etc.)?

   To what degree were clinical and management operations modified to accommodate participation in the flex program (e.g., medical control, communications capacity, etc)? Were any barriers encountered and what strategies worked best to implement the changes?

2. **What external dynamics/relationships have changed as a result of participation in the Flex program?**

   To what degree has participation altered the way the hospital relates with local providers such as community-based physicians, clinics, behavioral health, long-term care and emergency medical services providers (e.g., communication, coordination, referral, admission/destination and transfer protocols etc.)?

   Has conversion changed how the hospital interacts/relates with other hospitals in the region (e.g., joint agreements, clinical and operational protocols, regional trauma system participation etc.)?

   How has the hospital's regional reputation changed as a result of participation in the RHFP and conversion to a CAH (e.g., willingness of other acute care providers to collaborate, referrals from others, views of local communities etc.)?

Do you think that any of these changes would have occurred even if the hospital had ultimately decided to not become a CAH (e.g., result



of on-going assessments consideration of growing options and exploring innovative strategies)?

3. **Has network development provided a value-added quality to the capacity of the delivery system in stabilizing provider relationships and meeting community health needs?**

   To what degree have the network development activities affected the traditional relationships of area providers (e.g., increased frequency of collaborative discussions and actions in general, generated opportunities for collaboration that otherwise would not have been possible etc.)?

   Has network development contributed to the well-being of the community in any way (e.g., employment, access to care not previously available, economic stability for future planning etc.)?

**IV. Emerging Issues** - This section explores the on-going experiences of the CAH and its network members within the context of emerging local, state and federal issues.

1. **What do you feel are the most important issues facing hospitals that want to convert to a CAH?**

2. **What do you consider the most pressing concerns for the future viability of the CAH model?**

3. **Are there any state wide initiatives developing that you think will have a significant impact on the future viability of your facility?**

4. **What federal and/or state policies are critical for the continued success of the CAH model?**

5. **Do you anticipate any changes in the relationship between your hospital and the local EMS system or in your hospital's provision of emergency medical services under the new Medicare payment system for ambulance services?**

## V. Closing

1. **What have been the most positive, successful aspects of the transition process experienced to date?**

2. **Do you have any specific advice for providers considering the CAH model? What worked and didn't work for you? Were there any surprises?**

3. **Do you have any specific advice for providers considering developing or participating in a rural health network and community development?**

4. **Do you have any specific advice for the Federal Office of Rural Health Policy to more effectively and efficiently meet the goals of this program?**

# CRITICAL ACCESS HOSPITALS STUDY

**Hospital Site Visit Data Collection Instrument**

## MODULE 7

**INTERVIEW QUESTIONS**
**FOR**
**RURAL HEALTH NETWORK REPRESENTATIVES**

**I. Pre-Conversion Hospital and Area Characteristics** - Questions in this section focus on the broader organizational and environmental context that shaped the conversion experience of the hospital and area stakeholders.

1. **How knowledgeable was the community about pressing health care and financial issues facing the community and the hospital prior to conversion?**

   What were the most important factors that affected the degree to which the community was aware of issues?

   Do any particular community leaders stand out as being most or least aware of what was happening?

2. **How would you describe the awareness of the hospital leadership about the relative market position and financial stability of the hospital prior to conversion?**

3. **What were the relationships of area providers prior to the hospital's participation in the Rural Hospital Flexibility Program (RHFP)?**

   Was the market friendly, unfriendly, volatile, calm and to what degree did others share this view?

4. **What was the nature of the local emergency medical services delivery system and the hospital's ability to respond to emergency medical needs of the community?**

   Were local EMS resources and capacity adequate to meet the pre-hospital needs of the community (e.g., vehicles, equipment, personnel, medical control, response times, skill levels, coordination etc.)?

   Were there sufficient facility resources and infrastructure to provide for the emergency needs of patients that presented in the hospital ED?

   What relationships, if any, existed between the hospital and local EMS providers to meet community emergency needs prior to conversion (e.g., hospital-based ambulance service, medical control etc.)?

5. **What factors accounted for the development or lack of development of network relationships among area providers prior to conversion?**

Was your hospital involved in any network/collaborative activities with area providers prior to the RHFP (e.g., planning, joint purchasing, service provision, emergency medical systems development etc.)?



Were there any state policies/initiatives that encouraged/discouraged network development prior to the RHFP (e.g., financial support, regulatory flexibility/relief etc.)?

**II. The Conversion Decision and Character of the Process** - This section focuses on the nature of the decision making process, who was involved, what enabled or limited the process as well as the path of action taken to implement the decision.

1. **How did the decision-making process for CAH conversion take shape and what were the roles of various stakeholders in that process?**

    Were specific public relation strategies used to address the concerns and information needs generated by exploring conversion to a CAH (e.g., hospital staff, community residents, local businesses, local providers etc.)?

    What roles did the most influential stakeholders (e.g., administration/board, physicians, area providers, community representatives etc.) play in the decision process? Why were they influential and in what areas did they exercise this influence in the decision-making process?

    To what degree did community-based political/economic issues affect the decision process (e.g., jobs, health care costs, availability of care etc.)? How much input did the community provide for the decision making process? Was this proactive on the part of the community or the result of outreach/engagement activities by the hospital or network?

    Were outside consultants used and did you find them useful?

2. **How were key issues resolved?**

    What were the key buy-in points that facilitated the decision-making process? How did this vary by key stakeholders mentioned above?

    Were specific issues about the potential impact of conversion and participation in the Flex program on quality of care identified during the decision making process. If so, what were the main points and how were they addressed?

Were there other external (system-related) concerns that needed to be addressed (e.g., off-site contracting, organizational linkages and other arrangements that may have required relinquishing some degree of organizational autonomy to achieve the desired goal etc.)?



How was the decision to convert handled in the message going-out to the local community?

Were there any specific legal issues that created barriers to the integration of services into a network organization (e.g., primary care , public health, EMS etc.)?

Did competitive issues among network members create any particular barriers to the integration of services and support functions?

3. **What should have been done differently (e.g., data/arguments used, strategies employed, bargains made, parties included etc.)?**

Do you have any particular advice for hospitals/communities that might be considering this path of action that might improve their chances of success and reduce the time needed to initiate the needed changes?

**III. The Post-Conversion Experience** - This section explores the initial impact of converting to a CAH and developing network relationships.

1. **What internal changes have occurred as a result of conversion?**

To what degree were clinical and management operations modified to accommodate participation in the flex program (e.g., medical control, communications capacity, etc)? Were any barriers encountered and what strategies worked best to implement the changes?

To what degree have hospital department roles and responsibilities changed and inter-facility service integration occurred as a result of conversion and change in internal structures (e.g., sharing of quality assurance responsibilities with network members, contracting for ancillary services and/or administrative and general function responsibilities etc.)?

2. **What external dynamics/relationships have changed as a result of participation in the Flex program?**

To what degree has participation altered the way the hospital relates with local providers such as community-based physicians, clinics, behavioral health, long-term care and emergency medical services

providers (e.g., communication, coordination, referral, admission/destination and transfer protocols etc.)?



Has conversion changed how the hospital interacts/relates with other hospitals in the region (e.g., joint agreements, clinical and operational protocols, regional trauma system participation etc.)?

How has the hospital's regional reputation changed as a result of participation in the RHFP and conversion to a CAH (e.g., willingness of other acute care providers to collaborate, referrals from others, views of local communities etc.)?

Do you think that any of these changes would have occurred even if the hospital had ultimately decided to not become a CAH (e.g., result of on-going assessments consideration of growing options and exploring innovative strategies)?

3. **Has network development provided a value-added quality to the capacity of the delivery system in stabilizing provider relationships and meeting community health needs?**

How important have network relationships, developed under the RHFP, been in the post-conversion operations of the CAH?

To what degree have the network development activities affected the traditional relationships of area providers (e.g., increased frequency of collaborative discussions and actions in general, generated opportunities for collaboration that otherwise would not have been possible etc.)?

Has network development contributed to the well-being of the community in any way (e.g., employment, access to care not previously available, economic stability for future planning etc.)?

**IV. Emerging Issues** - This section explores the on-going experiences of the CAH and its network members within the context of local, state and federal issues.

1. **What do you feel are the most important issues facing hospitals that want to convert to a CAH?**

2. **Are there any state wide initiatives developing that you think will have a significant impact on the future viability of your facility?**

3. **What federal and/or state policies are critical for the continued success of the CAH model?**



**V. Closing**

1. **What have been the most positive, successful aspects of the transition process experienced to date?**

2. **Do you have any specific advice for providers considering the CAH model? What worked and didn't work for you? Were there any surprises?**

3. **Do you have any specific advice for providers considering developing or participating in a rural health network and community development?**

4. **Do you have any specific advice for the Federal Office of Rural Health Policy to more effectively and efficiently meet the goals of this program?**

# CRITICAL ACCESS HOSPITALS STUDY

**Hospital Site Visit Data Collection Instrument**

## MODULE 8

**INTERVIEW QUESTIONS**
**FOR**
**COMMUNITY REPRESENTATIVES**

**I. Pre-Conversion Hospital and Area Characteristics** - Questions in this section focus on the broader organizational and environmental context that shaped the conversion experience of the hospital and area stakeholders.

1. **How knowledgeable was the community about pressing health care and financial issues facing the community and the hospital prior to conversion?**

   What were the most important factors that affected the degree to which the community was aware of issues?

   Do any particular community leaders stand out as being most or least aware of what was happening?

**II. The Conversion Decision and Character of the Process** - This section focuses on the nature of the decision making process, who was involved, what enabled or limited the process as well as the path of action taken to implement the decision.

1. **What were the major reasons for considering conversion to a CAH?**

   Poor current financial/market conditions?

   Reaction to prior market or system failures?

   Pressure from outside public/private interests?

   Perceived opportunities that either paralleled or augmented existing planning efforts and goals?

   Preparation for expected changes in operating environment?

   Were any <u>other options considered in lieu of conversion</u> (e.g., reconfigure services, establish organizational linkages, closure, seeking special Medicare payment status such as a Sole Community Hospital etc.)?

2. **How did the decision-making process for CAH conversion take shape and what were the roles of various stakeholders in that process?**

   Were specific <u>public relation strategies used to address the concerns</u> and information needs generated by exploring conversion to a CAH (e.g., hospital staff, community residents, local businesses, local providers etc.)?

What roles did the most influential stakeholders (e.g., administration/board, physicians, area providers, community representatives etc.) play in the decision process? Why were they influential and in what areas did they exercise this influence in the decision-making process?

To what degree did community-based political/economic issues affect the decision process (e.g., jobs, health care costs, availability of care etc.)? How much input did the community provide for the decision making process? Was this proactive on the part of the community or the result of outreach/engagement activities by the hospital or network?

3. **How were key issues resolved?**

To what extent was there consensus on the decision to convert to a CAH? What information/analyses generated this consensus or was needed to generate a consensus?

What were the key buy-in points that facilitated the decision-making process? How did this vary by key stakeholders mentioned above?

How was the decision to convert handled in the message going-out to the local community?

Were there any specific legal issues that created barriers to the integration of services into a network organization (e.g., primary care , public health, EMS etc.)?

Did competitive issues among network members create any particular barriers to the integration of services and support functions?

**III. The Post-Conversion Experience** - This section explores the initial impact of converting to a CAH and developing network relationships.

1. **What external dynamics/relationships have changed as a result of participation in the Flex program?**

How has the hospital's regional reputation changed as a result of participation in the RHFP and conversion to a CAH (e.g., willingness of other acute care providers to collaborate, referrals from others, views of local communities etc.)?

Do you think that any of these changes would have occurred even if the hospital had ultimately decided to not become a CAH (e.g., result



of on-going assessments consideration of growing options and exploring innovative strategies)?

2. **Has network development provided a value-added quality to the capacity of the delivery system in stabilizing provider relationships and meeting community health needs?**

   To what degree have the network development activities affected the traditional relationships of area providers (e.g., increased frequency of collaborative discussions and actions in general, generated opportunities for collaboration that otherwise would not have been possible etc.)?

   Has network development contributed to the well-being of the community in any way (e.g., employment, access to care not previously available, economic stability for future planning etc.)?

## IV. Closing

1. **What have been the most positive, successful aspects of the transition process experienced to date?**

2. **Do you have any specific advice for providers considering the CAH model? What worked and didn't work for you? Were there any surprises?**

3. **Do you have any specific advice for providers considering developing or participating in a rural health network and community development?**

4. **Do you have any specific advice for the Federal Office of Rural Health Policy to more effectively and efficiently meet the goals of this program?**

# CRITICAL ACCESS HOSPITALS STUDY

**Hospital Site Visit Data Collection Instrument**

## MODULE 9

**INTERVIEW QUESTIONS**
**FOR**
**HOSPITAL EMERGENCY SERVICES REPRESENTATIVES**

**EMS Environment in the Hospital's Service Area Before Conversion**

**Describe the EMS system that supported your hospital prior to conversion.**
[If we have data from pre-site visit questionnaire, just confirm. Otherwise ask.]

- Number of providers
- Ownership (County?, Hospital?, Private?)
- Paid/volunteer staff
- Advanced Life Support capability (all? Some?)
- Interfacility-transport by ground? By air?
- Participation in regional trauma system
- 911 coverage
- Dispatch (who provides)
- Its evolution (if relevant)

**Was the EMS system in your area adequate prior to conversion to CAH status? If not adequate, where did the local system fall short?**

- Vehicles
- Equipment
- Personnel
- Response times
  - Financial viability

- **II. Role of Hospital in EMS Support Before CAH Conversion**
[Confirm data from pre-site visit questionnaire. If not provided ask.]

1. **Prior to CAH conversion did your hospital own and operate an ambulance service?**

   - If yes, did this ambulance service provide:
     - 9-1-1 emergency response?
     - emergency transports between facilities?
     - non-emergency transports (between facilities and/or patient's home)?

   - If no, did your hospital have specific contractual arrangement(s) with EMS transport provider(s)?

2. **Did your hospital provide?**

   - Medical direction?

- Nurses for interfacility transfers?
- Paramedic intercept services?
- Billing on behalf of local EMS providers
  - Medicare
  - Other payers

## III. Impact of CAH Conversion on EMS Situation

**1. How has CAH conversion affected the EMS system?**

- volume of patient transports
  - Increased or decreased?
  - Why?

- level or type of emergency personnel (ED staff/EMS personnel) required by your hospital?
  - More paramedics or nurses due to increased inter-facility transports?
  - Use of physicians to provide around-the-clock ED coverage?
  - More non-physician clinical staff with ED/EMS training to cover the ED?

- training arrangements regarding EMS and ED staff?
  - Is the hospital providing training for ED and/or EMS staff?
  - Is the hospital participating with local EMS providers in joint training of emergency staff?

- Communication needs or capabilities?
  - Telemetry, cell-phone contact

- Provision of medical direction?

- Patient transfer protocols?

- Contractual arrangements with EMS providers?

- Number of EMS providers serving the hospital ?

- Participation in a regional trauma system?

- Any other aspect?
  - Increased collaboration between EMS agencies?

- Mutual aid agreements (between EMS agencies)?



- Interagency financial assistance (pooling of capital resources)?
- Joint recruiting and training?
- Shared staff between EMS providers and hospitals/clinics?
- Shared capacity for billing, supplies, etc.?
- Other shared resources?
- Standardized dispatch and treatment protocols?
- Medical direction?
- Other quality improvement measures?
- Expanded scope of practice for emergency personnel (e.g., injury prevention and health promotion activities)?

**3. Do you expect any further changes in the future?**

Short-term or longer term?

## IV. Impediments to Integration of EMS into CAH Network

**1. Are there any barriers to further integration of EMS into the larger rural health network? What is being done to overcome these?**

legal restrictions

competition between existing providers

lack of data?

**2. Beginning in January 2001, Medicare is scheduled to begin implementing a new payment system for ambulance services that may not allow CAHs to count ambulance costs when computing their basis for cost-based reimbursement. Do you anticipate that a change like this would have any impact on your hospital's relationship with EMS providers or on your own provision of EMS services?**

## V. Impact of the CAH-Related EMS Changes.

**1. Have you seen any impact of the CAH-related changes to EMS on:**

- hospital costs?

- process of emergency care (e.g., availability of paramedics, response times)?

- patient outcomes? quality of care?



2. **Do you expect any further impacts on costs or quality in the future?**

    - What types?
    - When?

3. **Are you aware of any changes in the financial situation of local EMS agencies as a result of the CAH-related changes to EMS? Do you expect to see any such financial impacts in the future?**

## VI. Lessons Learned and Closure

1. **Is there anything about this county that make the experience you just described generalizeable to other counties? Other states?**

2. **What advice would you give EMS stakeholders in other counties with a hospital considering CAH conversion based on your experiences?**

3. **From your perspective is the RHFP a good vehicle to strengthen rural EMS systems? Why or why not?**

4. **Is there anyone else we should speak to regarding EMS issues and the CAH rural health network?**