

Kansas Rural Health Options Project

Assessing Rural Health Network Development and Network-Level Activity in Kansas

Findings from a survey of Critical Access Hospitals and Supporting Hospitals

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Kansas Rural Health Options Project
Assessing Rural Health Network Development and Network-Level
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Executive Summary
December 2001

The Kansas Rural Health Options Project (KRHOP) commissioned a survey of rural health networks that was conducted during the month of August, 2001. Out of 61 total facilities who participate in the Medicare Rural Hospital Flexibility (FLEX) program, 57 participated in the phone survey (93% participation rate). Of the 61 total facilities who participated in the survey, 45 were CAH facilities and 12 were Supporting Hospitals or Essential Access Community Hospitals (EACHs). Surveys were conducted by phone. Appointments were set with respondents prior to calling to ensure adequate time to complete the survey, which averaged 40 minutes in length. All but one of the rural health networks were represented by more than one facility in the survey process.

Levels of network-based activities vary greatly among networks. Activity ranges from extensive to limited, based in large part, but not entirely on the size and “maturity” of networks, which appears to be generally related to the age of the network. Major network-based initiatives tend to reflect programmatic areas that were targeted for funding by the Kansas Rural Health Options Project Network Development Grants. A majority networks are involved with EMS integration activities (40%), and administrative activities such as using one another for consultation and sharing policies and procedures (66%). Other major initiatives include outreach clinics (66%), network purchasing arrangements (47%), quality activities such as credentialing (53%), annual strategic planning sessions (40%), continuing education (53%), network-provided imaging/radiology (40%), linked computer networks (33%), teleradiology (40%), and interactive TV (33%).

The network relationship between the CAH and supporting hospital was viewed as being “very important” or “important” to 80% of CAHs. Networks were rated relatively high for effectiveness. On a scale of one to ten, with ten being the highest, 64% of respondents rated their networks as a 7 or better. Turnover within the network was a factor for 39% of respondents, with the primary impact of turnover being a “slow down” in network-based activity while new personnel were brought “up to speed.” For some of the larger networks, turnover is an ongoing issue, and measures have been taken to address this challenge. Measures used to reduce the impact of turnover include providing new administrators with a “newcomer’s packet” that details the network’s history, it’s current activities, and ways to actively participate. Other networks are in the process of putting together web sites or web-based databases that will assist new administrators in getting oriented to the network. In only one network did turnover result in a facility withdrawing from a network. The amount of interaction between administrators at supporting hospitals and CAHs varies from once a month to several times a week but in all cases administrators felt like the amount of interaction was adequate.

As mentioned previously, networks are viewed as valuable assets, and the reasons cited are many. The most frequent responses regarding the value of rural health networks included:

1. the support/resources/encouragement received from the networking relationship;
2. the increase in communication that has resulted from networking; and
3. the decrease in the sense of isolation.

Areas listed as most in need of improvement were:

1. communication within the network and on down through the ranks at member hospitals
2. increasing the level of participating from all members in the network
3. bringing EMS/physicians to the table to better understand and buy into the networking concept.

Respondents view the most pressing issues in the next five years as:

1. manpower issues (32%)
2. reimbursement issues (16%)
3. financing/capital improvements (14%)
4. HIPAA (11%)
5. Maintaining technological capacity (5%)

22% of respondents cited “other” concerns as most pressing

As a state, Kansas has made significant progress under the Kansas Rural Health Options Project in conceptualizing rural health networks, developing a formal designation process, and incentivizing network development. However, the goal of KRHOP has not been to impose network models on local communities. A basic KRHOP philosophy is that “form follows function” and that network membership and activities are dependent on local circumstances and the nature of the problem(s) being addressed. These results suggest that local health care leaders in Kansas’ rural communities have been proactive, creative, and resourceful in pursuing local network development to address pressing local/regional issues. The results also appear to support the widely-held belief that networks hold potential for improving the delivery of rural health care by maintaining local access to care, enhancing the quality of service delivery, and hopefully improving the financial status of rural providers.

Survey Results

Activities of Designated State Networks

Total Number of Respondents: 57

Total Number of Networks Responding: 14

NETWORK ACTIVITIES

Clinical Services

EMS: 40% (6) of the networks are participating in some level of EMS integration beyond the required network transfer agreements. Several networks mentioned using first and second year grant funds to improve EMS services. These activities ranged from putting in distance learning stations for continuing education, sending EMTs to paramedic training, purchasing training equipment, to using actual grant funds to purchase consultative services to improve EMS integration.

Specialty Clinics: 66% (10) of networks listed specialty clinics as a service provided by the supporting hospital.

Ancillary Services:

Imaging/Radiology: 40% (6) of networks provide imaging services. This ranges from a mobile diagnostic unit used by CAHs in two networks, to using radiologists at the supporting hospital to over-read tests or provide actual services.

Lab: 33% (5) of networks provide lab support. For two networks, the Supporting hospital serves as the reference lab for all the CAHs in the network.

Pharmacy: 33% (5) of networks provided either direct pharmacy support or served in a consultative role.

Rehabilitation Services: 33% (5) of networks provide rehab services.

Dietary: 27% (4) of networks provide dietary services or consultation.

Biomedical: 20% (3) of networks provide biomedical support.

Laundry: 20% (3) of networks provide laundry services.

Mobile Mammography: 13% (2) of networks provide mobile mammography services.

Surgery: 7% (1) of networks had a role in the provision of surgical services.

Information Systems

Thirty-three percent of networks (5) are linked to one another via a computer network. In most cases the supporting hospital is providing various clinical and administrative software components that CAHs can use as needed. In addition 40% (6) of networks use teleradiology and 33% (5) have interactive television that they use for continuing education, diagnosis/consultation and remote ER coverage. Only one network has a role in medical records in that the supporting hospital serves as a preceptor for new AARTs that are hired within the network.

Administrative

Sharing of policies and procedures were a major administrative activity for 66% (10) of networks. Group Purchasing was the next major administrative activity cited by 47% (7) of networks. Three

networks (20%) indicated they had management agreements between the CAH and the supporting hospital. Only one network indicated that billing/collections and payroll/accounts payable were provided by the supporting hospital.

Quality

Various forms of network wide credentialing was the most cited activity under quality with 53% (8) of the networks participating. These activities ranged from the supporting hospital providing background information and supporting documentation to efforts to completely centralize credentialing. Thirty-three percent (5) of the networks assist one another with peer review. Working together in the provision of quality assurance and risk management was cited by 20% (3) of the networks. Two networks (13%) are involved in continuous quality improvement initiatives; two (13%) are involved with quality indicators and benchmarking and two networks (13%) have initiated a network wide compliance strategy.

Workforce/Staffing

Using the network to access continuing education was cited by 53% (8) of networks. Thirty-three percent (5) of networks are involved in some type of staff sharing arrangement; 20% (3) assist with recruitment and retention of medical personnel; and 20% (3) provide locum tenens. One network was a health insurance pool and one network is currently involved in a nursing recruitment/retention initiative involving on-line nursing education through Washburn University.

Planning/Marketing/Programs

Forty percent (6) of networks are involved in network wide strategic planning. Network wide programming/community education was cited by 13% (2) of respondents. These activities ranged from a mobile occupational medicine van, cultural awareness program, nursing recruitment campaign, to the development of a Critical Instance Stress Debriefing Team. Two networks (13%) provide a transportation service and one network engages a part time grant writer to work on behalf of the network.

The table on page 8 indicates the activities that individual networks are involved in around the state of Kansas.

NETWORK RELATIONSHIPS AND PERCEPTIONS

Network Relationship

The FLEX program has had substantial impact on network development. Seventy (70) percent (40) of respondents stated they did not have a formal networking relationship prior to the EACH/RPCH or CAH program; 12% (7) indicated they had a previous formal relationship with their supporting hospital, in most instances a management agreement was already in place.

A majority of respondents, 61% (35) felt that referral relationships had not changed, those that felt they had, 21% (12) believed it to be only a slight increase in favor of the supporting hospital. In addition, respondents indicated that in many instances the supporting hospital worked very hard to reassure network communities that they always had the freedom to choose their hospital.

Critical Access Hospitals rated their supporting hospital as being “very important” to them, 58%, “important” 22%, and “important in that you have to have one in order to be a CAH” 4%.

Most networks gave themselves fairly high marks for network effectiveness. On a scale of one to ten with ten being the highest, 10 – 2%; 9 – 18%; 8 – 23%; 7 – 21%; 6 – 5%; and 5 and below 4%. Unable to rate due to being a new CAH or because new to the facility– 27%.

Thirty percent (30%) of respondents stated that turnover was not a factor in their network. For others, 14% said turnover occurred but that it had no effect on the network, while 39% indicated that turnover occurred and did impact the network. This was usually in the form of slower network activity as new people get oriented. In a few cases, turnover had the opposite effect as new people brought in a spirit of better cooperation and activity actually increased.

The amount of interaction between CAH administrators and their supporting hospital counterpart, either by phone, e-mail or face to face ranged from once a month (19%), 2-4 times per month (58%) to five or more times per month (23%). In all instances, the amount of interaction was just right for meeting their needs.

Other department heads within the network meet routinely in 48% of the networks and are meeting only on an as-needed basis in the other 50%. In all cases, when staff get together, the interaction is perceived to be very useful.

When asked what was the best thing about their network, respondents gave answers that were all over the board. However, a “top three” set of answers did emerge which include:

1. the support/resources/encouragement received from the networking relationship
2. the increase in communication that has resulted from networking, and
3. the decrease in the sense of isolation.

Areas in most need of improvement were

1. communication within the network and on down through the ranks at member hospitals
2. increasing the level of participation of all members in the network
3. bringing EMS/physicians to the table to better understand and buy into the networking concept

Sixty-one percent (61%) of respondents participate in other networks and again, rated other networks fairly high in effectiveness, among others, GPHA, Med-Op, HINK and Pioneer Health Networks all were given an average score of 8.

What will be the most pressing issue for these hospitals in the next two to five years? Respondents stated:

Manpower issues (32%)

Reimbursement (16%)

Finances/Replacement of assets/Capital Improvement (14%)

HIPPA (11%)

Keeping up with technology – 5%

	NKHA	MKHN	SCKHN	NCKRHN	BRHN	FHN	AVCT	NEKHN	CVHN	SEKHA	JPHN	SCKHN	SPHN	SWKRHN
Clinical/Support Svc														
EMS Integration	X			X				X		X		X		X
Specialty Clinics	X	X				X		X	X	X	X	X	X	X
Ancillary Services:														
Pharmacy	X		X			X				X	X			
Lab	X			X					X	X				X
Surgery														
Dietary	X							X		X				X
Biomedical	X									X				X
Laundry						X				X				X
Rehab Svcs.						X		X		X			X	X
Imaging/Radiology	X	X		X						X		X	X	
Mobile Mammog.	X										X			
Wound Care								X						
Information Systems														
Computer Linkages	X									X		X	X	X
Teleradiology	X			X		X		X	X					X
Interactive TV	X							X	X			X		X
Medical Records														X
Administrative														
Mgmt Agreement				X						X	X			
Policies/Procedures	X	X	X	X		X		X	X	X	X			X
Billing/Collections										X				
Purchasing	X							X	X	X	X		X	X
Payroll/Accts Payable										X				
Quality														
QA/RM/UR						X				X				X
CQI Initiatives	X							X						
Credentialing	X							X	X	X	X	X	X	X
Peer Review	X	X		X						X		X		
Benchmarking	X													X
Compliance	X			X										
Workforce														
Staff Pools/Sharing	X			X		X							X	X
Continuing Education	X	X		X				X		X	X		X	X
Washburn Initiative								X						
Recruitment/Retention	X								X					X
Locum Tenens	X									X				X
H.R. forms/policies														
Health Insurance Pool				X										
Plan/Mktg/Program														
Strategic Planning	X			X				X	X	X				X
Program/Comm.Edu	X													X
Transportation Svc										X		X		
Grant Writing	X													

What follows are brief descriptions of the various activities in which networks are engaged. Appendix I on page 13 provides the name of the network acronyms used in the table and in these descriptions, as well as a list of facilities currently in these rural health networks.

EMS Integration:

- NKHA - Grant funded equipment upgrade; EMS training over ITV; recruitment & retention strategy involving media campaign for EMS recruitment.
- NCKRHN – currently working on a grant funded EMS integration strategy.
- NEKHN – granted funded recruitment/retention/education plan – direct EMS scholarships, purchase of training resources (video equipment for individual training centers); standardized all transfer forms within the network.
- SEKHA – grant funded effort to explore feasibility of 3-county EMS integration underway.
- SCKHN – grant funded EMS recruitment and training assessment and planning effort underway.
- SWKRHN – long-distance learning stations for EMS training, training coordinator for each CAH community.

Clinical/Support Services

- NKHA – all CAHs within network use supporting hospital for biomedical engineering and mobile diagnostics; several use supporting hospital for dietary, lab and pharmacy support.
- MKRHN – radiology service provided to CAH.
- SCKHN – supporting hospital provides pharmaceuticals to CAHs and their pharmacist serves as a consultant.
- NCKRHN – network owns and operates a bone densitometry system, a reference lab subsidiary and mobile radiology.
- FHN – working on a shared services agreement which includes operational type things such as laundry, maintenance, financial services, respiratory therapy, pharmacy, network administration, shared surgical nurse and merging QA programs.
- NEKHN – provides number of services view ITV – psychiatry, dietary, social services and oncology/hematology.
- CVHN – supporting hospital provides reference lab.
- SEKHA – supporting hospital provides almost all ancillary services to one CAH as it is a wholly owned subsidiary of supporting hospital.
- JPHN – supporting hospital provides pharmacy oversight, mobile mammography.
- SCKHN – radiology service provided to CAH.
- SPHN – CAHs contract with supporting hospital to provide radiology, PT, OT and speech therapy and social services.
- SWKRHN – supporting hospital reference lab or all CAHs, provide speech therapy, dietary consultation, biomedical support, laundry and back-up support for mid-levels at all CAHs.

Information Systems:

- NKHA – network all linked to same base computer system (SMS4), additional products used on individual CAH basis. All CAHs hooked into same teleradiology system; ITV; currently working on remote cardiac monitoring system.
- NCKRHN – teleradiology
- FHN – teleradiology; working on a network wide computer systems implementation plan.
- NEKHN – teleradiology; network wide ITV system; working on technology assessment.
- CVHN – teleradiology and ITV
- SEKHA – computer linkages (patient accounting system) between supporting hospital and CAH.
- JPHN – supporting hospital provides router for computer system to CAHs.
- SCKHN – CAH linked into supporting hospital information system; ITV.
- SPHN – one CAH linked into supporting hospital information system.
- SWKRHN – one CAH linked into supporting hospital information system; ITV and teleradiology; consultative supporting for medical records.

Administrative

- NKHA – uses a request log to track administrative requests and document follow-up; have a policy & procedure manual for new CAHs; group purchasing opportunities; e-mail newsletter for network.
- MKRHN – share policies & procedures as needed.
- SCKHN – share policies & procedures as needed.
- NCKRHN – management agreement between supporting hospital and one CAH. Policies & procedures shared as needed.
- NEKHN – policy manual for new CAHs; policies & procedures shared as needed; working on template for staff directory and web-based database for network; group purchasing.
- CVHN – share policies & procedures as needed, group purchasing.
- SEKHA – share policies & procedures as needed, group purchasing.
- JPHN – share policies and procedures as needed; group purchasing. Supporting hospital has management agreement with two CAHs.
- SPHN – group purchasing.
- SWKRHN – share policies and procedures as needed; group purchasing.

Quality

- NKHA – in process of implementing quality project, hired part-time quality coordinator, assessing what technology is in place that can be used for quality benchmarking. Have identified a core group of quality indicators, developing a how-to book for switching from QA to CQI; plan to host a CQI conference. Working on cross-network peer review and credentialing.
- MKRHN – physicians at supporting hospital provide peer review for physicians at CAH.
- NCKRHN – beginning work in area of ER quality (indicators are being identified). Supporting hospital directly involved with peer review in one CAH.

- NEKHN – currently working on formalizing a network wide credentialing process; working with KU to implement a training program in CQI techniques for network members.
- CVHN – network verification system for credentialing.
- SEKHA – consulting support for QA and RM; supporting hospital provides all credentialing and peer review for one CAH; locum tenens as needed. Supporting hospital provides physician recruitment for one CAH.
- JPHN – supporting hospital assists with credentialing.
- SCKNH – network wide peer review and credentialing.
- SPHN – supporting hospital assists with credentialing.
- SWKRHN – working on network response to EMTALA issues; working on creating CAH credentialing program; consultation for QA and RM; quality indicators in place for EMS transfers; benchmarking program being developed that will have identified both operational as well as financial indicators/best practices; program for assessing, refreshing or increasing competencies; staff shadowing.

Workforce

- NKHA – supporting hospital provides network with physician recruitment assistance; low-level staffing pools for network; supporting hospital provides network-wide continuing education, provide remote ER coverage for mid-levels and locum tenens as needed. Working on providing on-line in-service training for employees.
- MKRHN – provides continuing education opportunities to CAHs.
- NCKRHN – network has a written agreement where hospitals can share staff. Supporting hospital provides continuing education opportunities; network operates a shared health insurance plan for employees; network wide COBRA compliance project completed; currently working on a network wide HIPAA program.
- NEKHN – grant funded initiative with Washburn University to implement an on-line CAN to LPN and LPN to RN degree completion program. Working on employee satisfaction program to help retain good employees; continuing education.
- CVHN – network recruiter for physicians; continuing education.
- SEKHA – provide continuing education, share x-ray tech.
- JPHN – continuing education
- SPHN – low-level staff sharing; provide continuing education; staff shadowing; quarterly network publication.
- SWKRHN – network provides full time recruitment service to CAHs; education packet for hospital boards who want to recruit on their own; working on developing a staff nursing pool; ad/public relations campaign to increase number of nursing graduates.

Planning/Marketing/Programming

- NKHA – network-wide strategic planning; working on network marketing strategy for nursing recruitment; network wide community education; network-wide response to legislative issues. Supporting hospital funds part-time grant writer to work on applications on behalf of the network.

- NCKRHN – network participated in the Community Health Improvement project using the BRSFF survey; awaiting the results to be incorporated into planning efforts. Network wide strategic planning done annually.
- NEKHN – network wide strategic planning.
- CVHN – network wide strategic planning.
- SEKHA – supporting hospital provides all marketing/planning functions to one CAH; in addition operate a transportation services between facilities.
- SCKHN – transportation services between facilities.
- SWKRHN – grant funded agricultural/occupational medicine program being implemented; cultural awareness/sensitivity campaign; annual network wide strategic planning; Critical Instance Stress Debriefing program.

Networks have made significant progress under the Kansas Rural Health Options Project in conceptualizing rural health networks, developing a formal designation process, and incentivizing network development. Results from this survey suggest that local health care leaders in Kansas' rural communities have been proactive, creative, and resourceful in pursuing local network development to address pressing local/regional issues. The results also appear to support the widely held belief that networks hold potential for improving the delivery of rural health care by maintaining local access to care, enhancing the quality of service delivery, and hopefully improving the financial status of rural providers.

Network Activity Legend

NKHA – Northwest Kansas Health Alliance: Hays, Atwood, Dighton, Hill City, Kinsley, Oakley, Plainville, Ransom, St. Francis, Hoisington, Greensburg, and Alma, NE.

Contact: Jodi Schmidt, Vice President, Regional Development; Hays Medical Center, 2220 Canterbury, Hays, KS 67601. jschmidt@haysmed.com 785-623-2301

MKHN – Mid-Kansas Health Network: Great Bend, Ellinwood, Ness City.

Contact: Thomas Sommers, President and CEO, Central Kansas Medical Center, 3515 Broadway, Great Bend, KS 67530-3633. tomsommers@chi-midwest.org 620-792-2511

SCKHN – South Central Kansas Health Network: Hutchinson, Lyons, Stafford

Contact: Gary Montford, Physician Information, Hutchinson Hospital, 1701 East 23rd Ave., Hutchinson, KS 67502-1105. montfordg@hhosp.com 620-665-2304

NCKRHN – North Central Kansas Regional Health Network: Salina, Ellsworth, Mankato, Minneapolis, Herrington.

Contact: Rob Coleric, Salina Regional Health Center, PO Box 2568, Salina, KS 67402-2568. rcoleric@srhc.com 785-452-7602

BRHN - Bluestem Rural Health Network: Wesley Medical Center, Wichita and Eureka

Contact: Bruce Birchell, CEO, Greenwood County Hospital, 100 W. 16th, Eureka, KS 67045, bbirchell@gwch.org 620-583-7451

FHN - Flint Hills Network: Manhattan, Wamego, Washington (Future CAH)

Contact: Jim Murguia, COO/CFO, Mercy Health Center of Manhattan, PO Box 1289, 1823 College Ave., Manhattan, KS 66505-1289. jim_murguia@via-christi.org 785-776-2838

AVCT - Ark Valley and Chisholm Trail Health Network: Arkansas City, Via Christi, Wichita and Caldwell.

Contact: Janell Moerer, Vice President of Business Development, Via Christi Health System, 818 N. Emporia, Suite 100, Wichita, KS 67214. jmoerer@via-christi.org 316-268-5000

NEKHN - Northeast Kansas Healthcare Network: St. Francis, Topeka, Winchester, Holton, Seneca, Hiawatha and Horton

Contact: Steve Granzow, Regional Marketing Representative, St. Francis Hospital and Medical Center, 1700 SW 7th St., Topeka, KS 66606-1674

steve.granzow@stfrancistopeka.org 785-295-8399

CVHN – Cedar Valley Health Network: Shawnee Mission Medical Center, Merriam; and Garnett

Contact: Keith Richardson, SFO, Shawnee Mission Medical Center, 9100 W. 74th St., Shawnee Mission, KS 66204-4004 krichardson@smmc.saint-lukes.org 913-676-2000

SEKHA – Southeast Kansas Health Alliance: Pittsburg, Columbus, Oswego and Joplin, MO

Contact: Krista Postai, Vice President Planning/Marketing, 1102 E. Centennial Dr., Pittsburg, KS 66762-6643 kpostai@viachristi.org 620-231-6100

JPHN – Jane Phillips Healthcare Network: Bartlesville, OK; Sedan and Neodesha

Contact: Ron Dunkle, Administrator, Pawhuska Hospital, 1101 E. 15th St., Pawhuska, OK 74056. 918-287-3232.

SCKHN – South Central Kansas Healthcare Network: Winfield, Cedar Vale

Contact: Richard Vaught, Administrator, William Newton Hospital, 1300 E. 5th Ave., Winfield, KS 67156-2407 admin@wnmh.org 620-221-2300

SPHN – Southern Plains Health Network: Via Christi, Wichita, Pratt, Coldwater, Kiowa and Medicine Lodge

Contact: Butch Ashley, Vice President Regional Development, Pratt Regional Medical Center, 200 Commodore, Pratt, KS 67124-2903 bashley@prmc.org 620-672-7451

SWKRHN – Southwest Kansas Regional Health Network: Garden City, Leoti, Syracuse, Lakin, Satanta, Meade, Hugoton, Ashland and Johnson

Contact: Jason Friesen, Business Development Coordinator, St. Catherine Hospital, 410 East Walnut, Garden City, KS 67846-5672 jfriesen@phn.org 620-272-2566

Survey Participants

Via Christi, Wichita
St. Francis, Topeka
Mercy Health Center, Manhattan
Holton Community Hospital, Holton
Wamego City Hospital, Wamego
Northeast Kansas Center for Health, Horton
Washington County Hospital, Washington
Nemaha Valley Community Hospital, Seneca
Mt. Carmel Medical Center, Pittsburg
Jefferson County Memorial Hospital, Winchester
Maude Norton Memorial City Hospital, Columbus
Hiawatha Community Hospital, Hiawatha
Oswego Health Center, Oswego
Shawnee Mission, Merriam
Greenwood County Hospital, Eureka
Anderson County Hospital, Garnett
Sabetha Community Hospital, Inc., Sabetha
Wilson County Hospital, Neodesha
St. Catherine Hospital Garden City
Sedan City Hospital, Sedan
Ashland Health Center, Ashland
William Newton Hospital, Winfield
Kearny County Hospital, Lakin
Cedar Vale Community Hospital, Cedar Vale
Wichita County Health Center, Leoti
Meade District Hospital, Meade
Satanta District Hospital, Satanta
Hamilton County Hospital, Syracuse
Stevens County Hospital, Hugoton
Stanton County Health Care Facility, Johnson
Pratt Regional Medical Center, Pratt
Comanche County Hospital, Coldwater
Kiowa District Hospital, Kiowa
Hays Medical Center, Hays
Grisell Memorial Hospital, Ransom
Plainville Rural Hospital, Planville
Lane County Hospital, Dighton
Graham County Hospital, Hill City
Cheyenne County Hospital, St. Francis
Harlan County Health System, Alma, NE
Rawlins County Hospital, Atwood
Edwards County Hospital, Kinsley
Kiowa County Memorial Hospital, Greensburg

Clara Barton Hospital, Hoisington
Logan County Hospital, Oakley
Phillips County Hospital, Phillipsburg
Central Kansas Medical Center, Great Bend
Ness County District No. 2, Ness City
Hutchinson Hospital, Hutchinson
Rice County Hospital District No. 1, Lyons
Stafford District Hospital, Stafford
Salina Regional Health Center, Salina
Ellsworth County Medical Center, Ellsworth
Lincoln County Hospital, Lincoln
Herington Municipal Hospital, Herington
Cloud County Health Center, Concordia
Jewell County Hospital, Mankato