Flex Monitoring Team

A Performance Monitoring Resource for Critical Access Hospitals, States, & Communities

A Vision for the Future: Critical Access Hospitals

2022 Michigan Critical Access Hospital Conference

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Presentation Overview

- Financial Status of CAHs
- Current and future challenges facing Critical Access Hospitals (CAHs)
- History of Support Programs for Small Rural Hospitals
- A vision for the future of CAHs/Opportunities to Re-Vitalize CAHs
    - Re-Imagining CAHs
    - Focus on Enhanced Primary Care
    - Workforce Strategies
    - Community Engagement, Partnerships, and Self-Determination community self-determination

Financial Status of CAHs (based on 2020 cost reports)

	2019	2020
Profitability (medians)		
Total margin	2.4%	5.41%
Cash flow margin	5.92%	8.45%
Return on equity	5.76%	9.89%
Operating margins	0.72%	3.62%
Liquidity		
Current ratios	2.52 times	1.87 times
Days cash on hand	71.23 days	192.28 days
Days in net accounts receivable	50.54 days	47.25 days
Days in gross accounts receivable	47.57 days	46.55 days

Flex Monitoring Team, CAH Financial Indicators Reports Summary of Indicator Medians by State, April 2021 and May 2022

Financial Status of CAHs (based on 2020 cost reports)

	2019	2020
• Capital structure		
• Equity financing	59.6%	49.15%
• Debt service coverage	3.95 times	4.16 times
• Long-term debt to capitalization	29.97%	31.19%
• Revenue		
• Outpatient revenues to total revenues	80.20%	81.01%
• Patient deductions	46.23%	46.0%
• Medicare inpatient mix	69.8%	66.8%
• Medicare outpatient payer mix	36.36%	34.3%
• Medicare outpatient cost to charge	42.51%	44.93%
• Medicare acute inpatient costs per day	$2,918	$3,158

Flex Monitoring Team, CAH Financial Indicators Reports Summary of Indicator Medians by State, April 2021 and May 2022

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Financial Status of CAHs (based on 2020 cost reports)

	2019	2020
• Cost		
• Salaries to net patient revenue	45.39%	47.13%
• Average age of plant	12.28 years	12.32 years
• FTEs per adjusted occupied bed	5.50 FTEs	5.72 FTEs
• Average salary per FTE	$61.605	$64,444
• Utilization		
• Acute average daily census (occupied beds per day)	2.42	2.16
• Swing/SNF average daily census (occupied beds per day)	1.62	1.54

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Challenges Impacting CAHs

Rural Hospital Closure Risks and Impact

- Closures and Risks
  - 181 rural hospitals have closed since 2005 (heavily concentrated among CAHs)
  - 453 are at risk for closure (three or more concurrent financial risk factors, including negative total operating margin, negative operating margin on patient services alone, negative current net assets, and negative total net assets)
  - 200 at high risk of closure
- Impact of closures
  - Reduced access to health care services
    - One-way travel time to services increased by 20 miles following closure. Travel time for less common services increased even more. (GAO 2020)
  - Reduced availability of health care workers
    - Between 2012 and 2017, the availability of physicians among counties with hospital closures decreased from a median of 71.2 to 59.7 per 100,000 residents
  - Loss of well-paying jobs and disruption to the local economy

Patient Bypass

- 76% of patients in rural counties with a local hospital bypassed the hospital to obtain care (35% suburban and 23% urban)
- 68% of these rural patients with lower acuity conditions that could be addressed at their local hospitals bypassed their local hospital
- Bypass patterns suggest:
  - Tension between the desire to save hospitals and local responsibilities
  - Need to reduce the emphasis on inpatient beds
  - Need for realistic expectations about the role of CAHs in the health care system – renew the emphasis on enhanced primary care, chronic care management, swing beds, and long-term care
  - Need for honest conversations between community leaders and CAH leaders

Continuing Rural Workforce Shortages

- Government Accounting Office estimates shortages of more than 20,000 primary care physicians (PCPs) in rural areas by 2025
- In the wake of COVID-19, rural hospitals report critical shortages of registered nurses and other essential staff.
- Workforce shortages impact rural hospitals, nursing homes, primary care clinics, emergency medical services (EMS), and public health departments
- Projected shortages of psychiatrists; clinical, counseling, and school psychologists; mental health and substance use H social workers; school counselors; and marriage and family therapists through 2025 as well as a maldistribution of these providers that favor urban areas

Additional Challenges

- Increases in the pace of mergers and acquisitions
- Loss of essential services – obstetrical care, chemotherapy, and other critical services
- Continued acquisition of physician practices and employment of physicians by rural hospitals
- Declining need for inpatient hospital
- Increased competition by non-hospital providers
- Growth of advance and value-based payment models
- Growth in the adoption of Medicare Advantage plans, accountable care organizations, and managed care
- Growing influence of private equity funding

Future Challenges

- An increased focus on containing healthcare costs
- Greater demand for health equity
- Growth in patient-centered care and consumerism
- Evolution of non-traditional competitors including “retail” healthcare
- Continued transition of care from hospitals to the community and homes
- Focus on mental health and wellbeing
- Use of technology to transform healthcare

History of Rural Hospital Support Programs

History of Rural Hospital Initiatives

- Concerns about rural hospital closures are not new
  - Small rural hospitals have struggled with regulatory and reimbursement challenges since the implementation of Medicare and Medicaid in 1965
  - The first effort to address regulatory issues dates back was a 1973 report funded by the U.S. Department of Health, Education, and Welfare (DHEW) that first raised the issue of the limited-service hospital
- Numerous state and federal support programs have been developed in response to waves of rural hospital closures
  - Montana's Medical Access Facility
  - Essential Access Community Hospital/Rural Primary Care Hospital demonstration (7 states)
  - Medicare Rural Hospital Flexibility Program and Critical Access Hospitals
- We are now in another wave of closures – what to do next?

What has Driven the Waves of Closures?

- 1970's: Wrestling with Medicare Conditions of Participation
  - By the early 1970s, small rural hospitals began to complain that Medicare Conditions of Participation (COPs) were inappropriate for very small and isolated facilities
  - DHEW study drafted standards for a limited-service rural hospital targeted to hospitals of 50 beds or less; located 30 minutes from another hospital; and willing to limit services in a manner consistent with staff and facility capabilities
- Set the stage for the future of limited-service hospitals by:
  - Defining the role of the states in developing models to meet their needs
  - Establishing the concept of the limited-service rural hospital model
  - Use of a 30-minute driving time to distinguish "isolated" facilities
  - Balancing regulatory relief and limitations on service capacity to support small rural hospitals and assure patient safety and quality of services

Waves of Closures (cont'd)

- 1980s: Dealing with Medicare Prospective Payment System (PPS)
  - The limited-service hospital model received little attention during the remainder of the 1970s and early 1980s
  - Growing numbers of closures, declining rural economies, and the implementation of the Medicare prospective payment system in 1983 re-kindled interest in the limited-service hospital model
  - States, rather than the federal government, led the way in the 1980s and early 1990s
  - Options to support small rural hospitals included limited-service hospital models, alternative licensing standards, and alternative models for delivering essential health care services in rural areas

Waves of Closures (cont'd)

- 1990s Forward: Dealing with market forces, utilization patterns, managed care, commercial payers, and a changing healthcare environment
  - The Essential Access Community Hospital/Rural Primary Care Hospital (EACH/RPCH) was created by the Omnibus Reconciliation Act of 1989 to ensure the availability of primary care, emergency services, and basic inpatient care through a limited-service hospital linked to a network of at least on supporting hospital
  - Seven states and potential hospitals received funding to implement the program with the first awards made in 1991
  - Rules and regulations were developed and finalized in 1994
  - In the late 1990's, the EACH/RPCH program evolved and successfully expanded to all 50 states as the Critical Access Hospital with grant funding provided to states under the Medicare Rural Hospital Flexibility Program

Waves of Closures (cont'd)

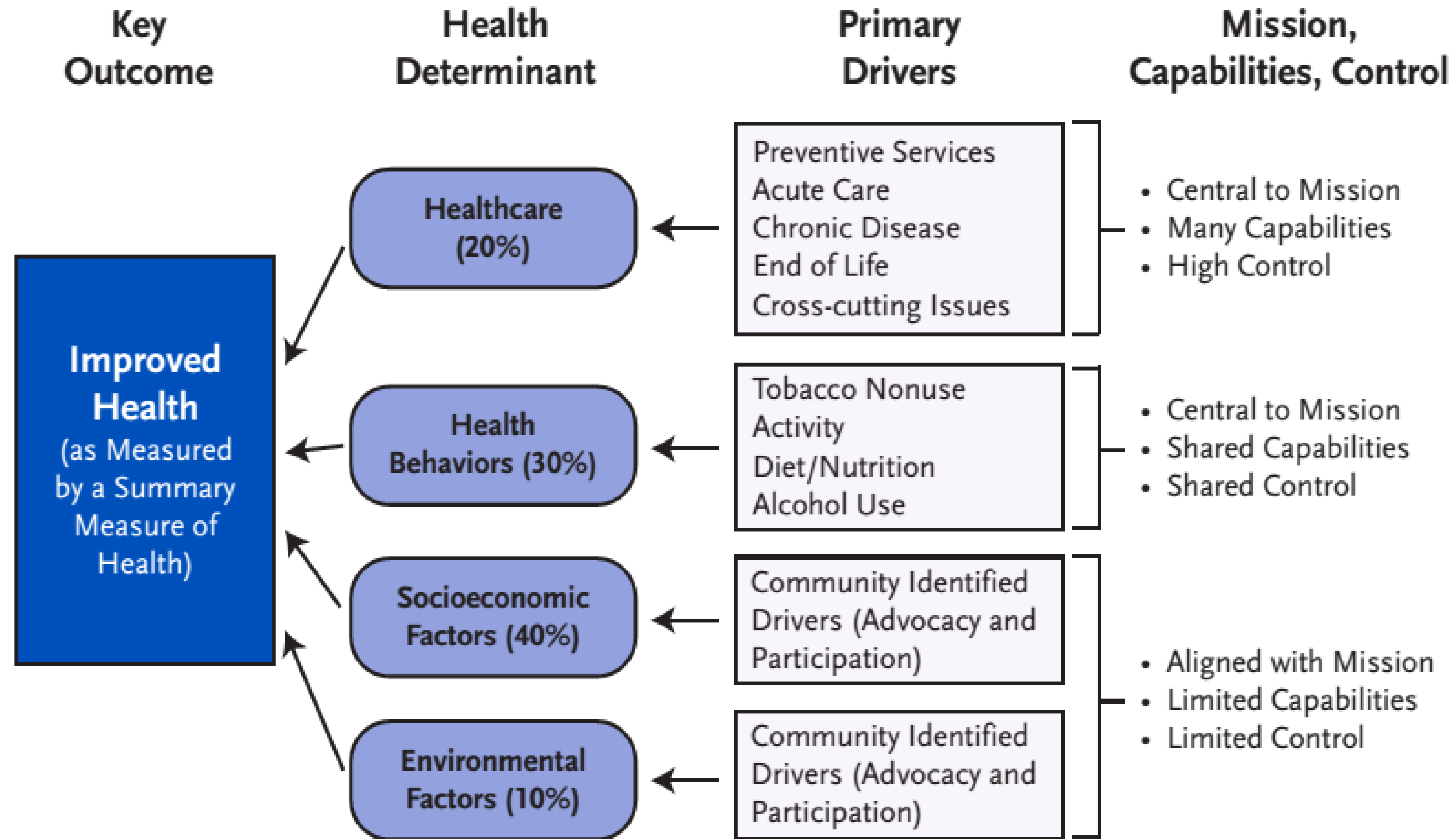
- States continue to experiment with support programs/alternative models
  - Georgia's Rural Hospital Stabilization Program – hub and spoke model
  - Kansas' Primary Health Center Model
- Federal demonstrations are experimenting with new payment models
  - Pennsylvania Rural Hospital Model
  - Vermont's All-Payer Accountable Care Organization (ACO) Model
  - The Rural Emergency Hospital
  - Community Health Access and Rural Transformation (CHART) model
- COVID-19 has further impacted the financial instability of rural hospitals
  - 19 rural hospitals closed in 2020, exceeding the 2019 record of 18 closures
  - Chartis estimates that over 450 rural hospitals are at risk with 200 are at high risk
  - Since 2005, 181 rural hospitals have closed

Opportunities to Revitalize CAHs

Re-imagining the Role of CAHs

- Changing delivery landscape –more services can be provided in ambulatory, virtual, or home settings
- Some experts suggest that we will have 1.6 times the number of inpatient beds needed in 2030 and that many of these beds will be of the wrong type
- CAHs are frequently the foundations of local delivery systems and economies
- Support the role of CAHs as "anchor institutions" and hubs of local systems of care
  - Hub and spoke models in Ontario and Georgia
  - Create "Rural Community Health Improvement Systems" involving partnerships of rural hospitals and providers and build on the Accountable Communities for Health models (Shortell, et al, 2021)
  - Re-visit service mix to focus on outpatient and ambulatory care, long term care and support services, chronic care management within larger integrated systems of care

Health Partners Drivers Program



Source: Kindig, D. A., & Isham, G. (2014). Population health improvement: A community health business model that engages partners in all sectors. Frontiers of Health Services Management, 30(4), 3-20.

Emphasize Comprehensive Primary Care

- David Johnson (January 2022)
  - *"Americans do not receive the vital primary care, health promotion, behavioral health and care management services they require to sustain their well-being"*
  - *"More of the same crisis-care delivery will yield more of the same dismal health outcomes"*
- Basu, et al (2019)
  - *Every 10 additional primary care physicians per 100,000 people was associated with a 51.5 day increase in life expectancy from 2005 to 2015, compared to a 19.2 day increase for 10 additional specialists*

Strategies to Emphasize Primary Care

- Emphasize Comprehensive Primary Care
  - Primary care, wellness and prevention, mental health and substance use, chronic care management, oral health, public health
- Expand services
  - Utilize Rural Health Clinics and other ambulatory services– develop additional sites and expand range of services
  - Focus on population health and social determinants of health
  - Align with hospital accountability requirements - community benefit obligations, community health needs assessment requirements, and related implementation strategies
  - Partner with health systems and local providers to expand key services

Examples - Rural Health Clinics

- Regional Medical Center (RMC), Manchester, IA
  - RMC has 5 Rural Health Clinics (RHCs) that provide an expanded array of primary care and mental health services primary care in rural Iowa
- Weeks Medical Center (WMC), Lancaster, NH
  - WMC has four that provide comprehensive primary care, mental health, and substance use services throughout the Lakes Region of New Hampshire. The mental health program was described as the fastest growing department in the WMC system
- Ozarks Community Hospital (OCH), Gravette, AR
  - OCH operates 12 RHCs and two other clinics in rural Missouri, Arkansas, and Oklahoma and serves primarily Medicare and Medicaid patients. Most of its 12 RHCs provide comprehensive primary care as well as mental health services using a mix of staff

Examples – Oral Health with Community Partners

- Waldo County General Hospital,
  - Board stretch goal–create dental program in 2013
  - Serves safety net clients only
  - Staffing: Dental hygienist, employed dentist, private dentists. dental assistant, receptionist, Access-to-Care coordinator, CarePartners staff
  - 700 individual patients, $203 average cost per visit, most had no dental care in 10 years
  - Funding: hospital funds, grants, fundraising, in-kind contributions, patient co-pays, some Medicaid
  - Reduced ED use – 20% of ed visits for 18-49 year olds for dental pain / no safety net program in county/$100,000 in uncompensated care annually
  - Improve patients' overall health, employability, and personal well-being.
  - Dentist shared with program in Knox County
  - Planning/advisory board: Board members, private dentists; public health hygienists; physicians; denturists

Examples – Behavioral Health

- Wabash Valley Telehealth Network
  - MH patients clogging EDs
  - Hub & spoke model: CMHC provides crisis services to 6 CAHs using 24/7 access center Standardized protocols/algorithms to assess pts
  - CMHC prepares consultation report and disposition plan
  - ED LOS reduced- 16-18 hours to 240 minutes
  - CAHs pay a consulting fee per encounter
  - Many patients are already in the CMHC system
  - Savings – lower ED length of stay, fewer unnecessary psychiatric admissions

Examples – Behavioral Health

- Nor-Lea General Hospital
  - Created Heritage Program for Senior Adults in 2003
  - Provides O/P mental health services to seniors
  - Staff-psychiatrist, therapists, RN, and MH technicians
  - Services: individual and/or family therapy and group therapy, both focus and process
  - Van is available to transport clients to the hospital for services
- Essentia Health St. Mary's
  - Collaborative Care Mgt of Depression in Primary Care
  - Priority need identified in CHNA
  - Team approach- behavioral health specialist, psychiatric nurse practitioner, care coordinator
  - Coalition of EH-St. Mary's and community mental health professionals
  - Community outreach and education

Examples – Prevention, Wellness, Public Health

- New Ulm Medical Center
  - Heart of New Ulm Project applied evidence-based practices
  - Reduce # of heart attacks over 10 years
  - Collaboration with Minneapolis Heart Institute Foundation, local employers and providers
  - Results: Improvements in consumption of fruits and vegetables, taking daily aspirin, participation in exercise
- Redington Fairview General Hospital
  - Redington Fairview houses the Greater Somerset Public Health Collaborative
  - Developed community-based employee wellness program for very small businesses
  - Small businesses can offer workplace wellness activities that would not normally be economically feasible for groups their size (cost is $2.00 annually per employee)
  - Developed other programs with grant funding

Addressing Workforce Shortages

- Key – better use scarce resources
- Expanding the use of team-based care
- Explore new staffing types – community health workers
- Use technology such as telehealth and artificial intelligence using evidence-based clinical guidelines to expand access to care, transform clinical paradigms, and improve provider productivity
  - Forward in Los Angeles, CA - a direct care model that charges members a $149 monthly fee with no copays or deductibles. Uses artificial intelligence and predictive analytics. Forward uses technology to reduce payroll costs and create better outcomes for patients. Forward uses AI to follow what doctors do, step-by-step.
  - Use telehealth technology to improve productivity and reduce the emphasis on 15 minute visits, particularly for chronic care management

Community Engagement and Ownership

- Implement community engagement tools to assist communities in taking control of their health systems
  - Reducing loss of community input and control
  - Reducing bypass behavior
  - Improve population health and health equity
- Maine - Making Informed Decisions about Rural EMS
  - Informed Community Self-Determination Model was developed to engage residents of St. George in making informed decisions about their struggling EMS system through:
    - Assessment of the reality and adequacy of the current EMS system (response, operational, and financial characteristics as well as clinical level and performance)
    - Alternative models and cost impact (what levels of services and response capacity, outside of the box alternatives, costs of each alternative)
    - Decision makers forum (broad representation of interests, reports from meetings, straw poll)
    - Choose operating model and commit to funding (designate follow up reporting)

It Takes a Village to Improve Health

Source: Hospital Research Education Trust, *Managing Population Health, The Role of the Hospital, AHA, 2012*

Partnering and Leadership

- Mt. Ascutney Hospital and Health Center
- Create partnerships, give away credit, promote open communication, decentralized control
  - Partnering to support community health infrastructure
  - Goal-address fragmented/decentralized services
  - 14 health promotion programs implemented; trust improved
  - Challenges–skepticism over control/management
  - Mission-promote community health/wellness
  - Activities funded over time by different grants
  - Key factors-assessment/evaluation, community health metrics
  - Clear, consistent dedication to mission

Comprehensive Community Strategies

- 100% Community: Ensuring 10 Vital Services for Surviving and Thriving
    - By Ortega Courtney and Capello
- Focused on developing the following services
    - Food
    - Housing
    - Medical and Dental Care
    - Behavioral Health Care
    - Transportation
    - Parent Supports
    - Early Childhood Learning
    - Community Schools
    - Youth Mentoring
    - Job Training

Comprehensive Community Strategies (cont'd)

- Camden Coalition Core/Complex Care Model
- Based on partnerships and data
- An evolving community-focused model focused on creating an ecosystem for complex care based on the following core domains

Addiction
Benefits and entitlements
Education and employment connections
Health maintenance, management, promotion
Identification support
Medication and medical supplies
Reproductive health
Patient wild card (unique needs)
Advocacy and activism
Family, personal, and peer support
Food and nutrition support
Housing and environment
Mental health support
Provider relationship building
Transportation support

Closing Thoughts

- COVID-19 Public health emergency has increased the vulnerability of CAHs
- Many challenges facing CAHs are chronic and relatively intractable
  - Financial risks, risks of closure, patient bypass, and workforce shortages
- Other challenges
  - Mergers and acquisitions, loss of essential services, declining need for inpatient care, competition by non-hospital providers, growth of value-based payment models and managed care, influence of private equity funding
- Evolving challenges
  - Renewed focus on cost control, demand for health equity, growth in patient centered care and consumerism, non-traditional competitors, transition in care from hospitals to the community and homes, focus on mental health and wellbeing, growth in technology

Closing Thoughts (cont'd)

- Traditional policies to support rural hospitals and workforce are important but insufficient to transform the operations and performance of CAHs
- Important areas of focus
  - Re-imagining the role of CAHs – hub and spoke models, re-visit service mix
  - Emphasize comprehensive primary care
  - Better use scarce workforce resources - team-based care, new staffing types, and use of technology to improve access, utilization, and productivity
  - Community engagement and responsibility for their healthcare systems
- Important policy changes in terms of CAH reimbursement and financing models will be needed to fully transform CAHs
  - In the short run, CAHs can begin to move their systems in the right direction to better meet the needs of their communities

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Thank you!

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