Challenges Facing Rural Hospitals and the Effect on Rural EMS

DON WOOD, MD

TOM NEHRING

Critical Access Hospital

"Critical Access Hospital" is a designation given to certain rural hospitals by the Centers for Medicare and Medicaid Services (CMS). This designation was created by Congress in the 1997 Balanced Budget Act in response to a string of hospital closures in the 1980s and early 1990s.

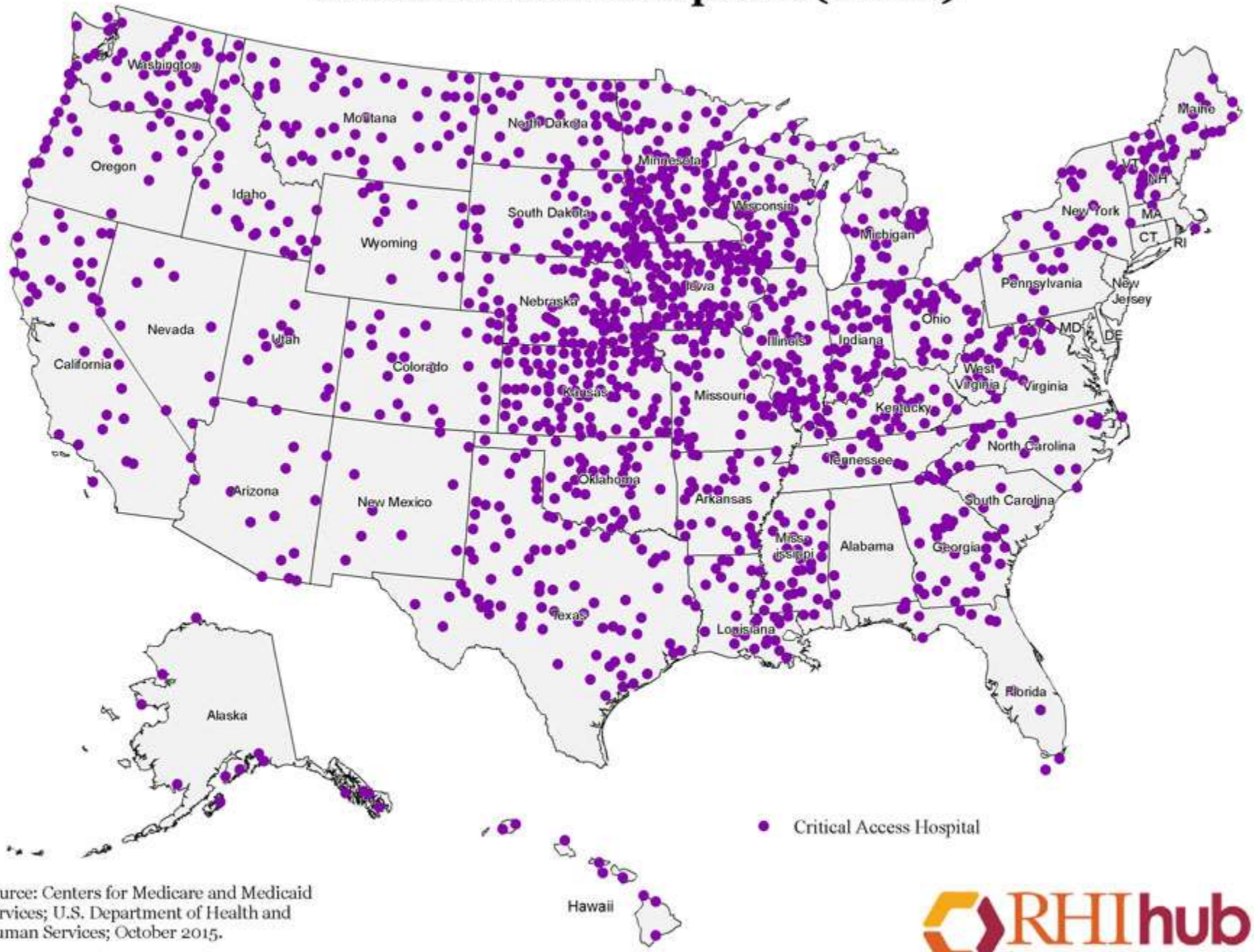
The CAH designation is designed to **reduce the financial vulnerability** of rural hospitals and **improve access to healthcare** by keeping essential services in rural communities. This is accomplished through cost-based Medicare reimbursement.

Eligibility Requirements

To ensure that CAHs deliver services to improve access to rural areas that need it most, restrictions exist concerning what types of hospitals are eligible for the CAH designation. The primary eligibility requirements for CAHs are:

- A CAH must have 25 or fewer acute care inpatient beds.
- It must be located more than 35 miles from another hospital (exceptions may apply).
- It must maintain an annual average length of stay of 96 hours or less for acute care patients.
- It must provide 24/7 emergency care services.

Critical Access Hospitals (CAHs)



Source: Centers for Medicare and Medicaid Services; U.S. Department of Health and Human Services; October 2015.

Note: Alaska and Hawaii not shown to scale

RHIhub
Rural Health Information Hub

Rural Hospitals

According to federal definitions, rural hospitals are those not located in metropolitan areas.

Some hospitals in metro areas also are considered rural, if they are in census tracts with low population densities and longer commutes.

Rural Hospitals

Rural hospitals typically have emergency rooms and inpatient care, but they often lack some of the services of city hospitals, such as intensive care and psychiatric units or chemotherapy and hospice services.

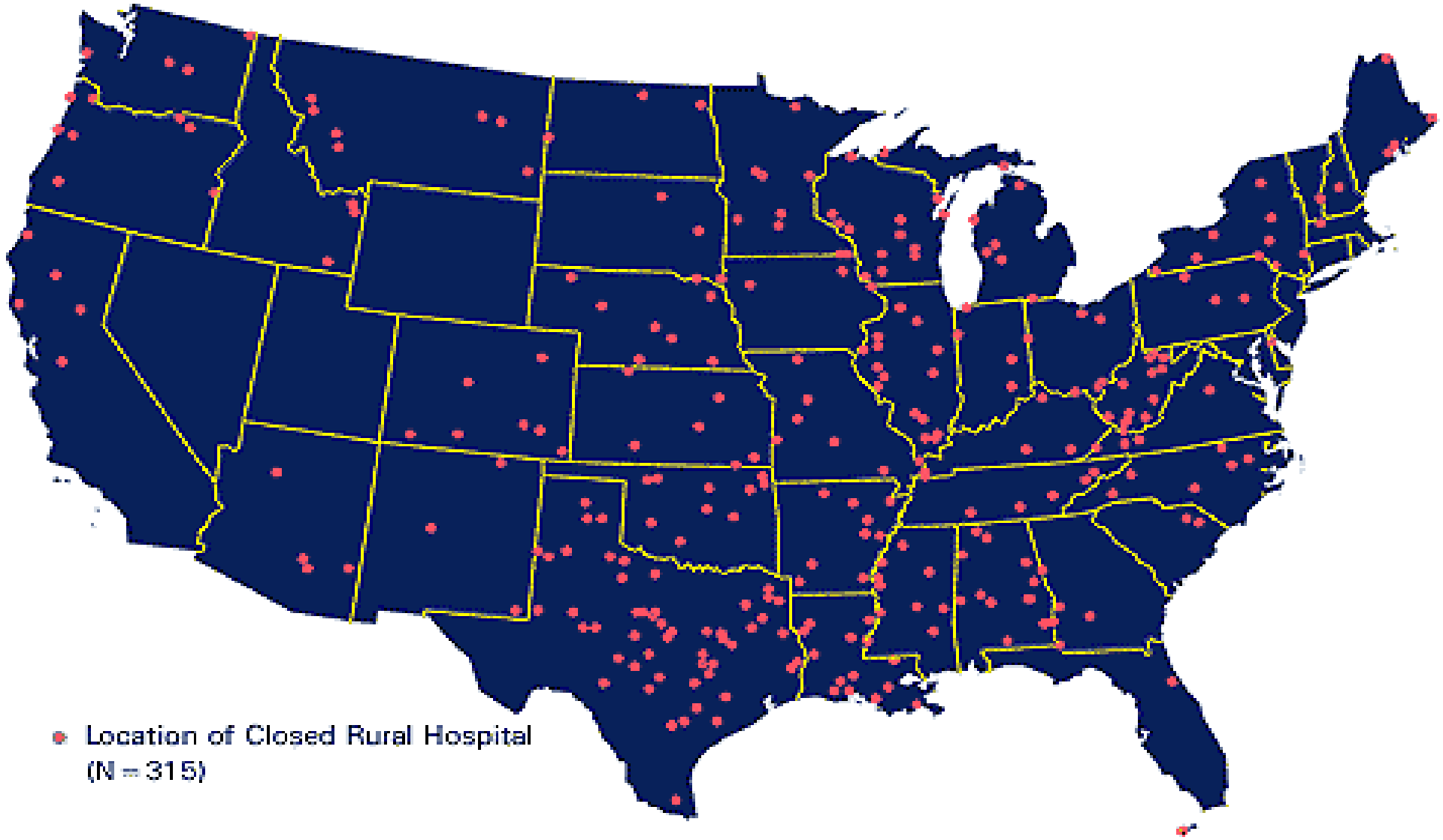
Rural hospitals also tend to be smaller. While about 75 percent of urban hospitals have more than 100 patient beds, just 12 percent of rural hospitals are that large, according to the Rural Health Research Program at the University of North Carolina.

Rural Hospital

The study says a typical rural hospital has 25 beds and averages seven patients a day.

Rural hospitals have a median profit margin of 2.7 percent, just half that of urban hospitals.

Rural Hospital Closures: 1980-90



NRHA

NATIONAL RURAL HEALTH ASSOCIATION

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New report indicates 1 in 3 rural hospitals at risk

New research indicates that sustained Medicare cuts threaten the financial viability of more than one-third of rural hospitals in America. As rural hospital closures continue to escalate, the National Rural Health Association calls on Congress to act swiftly.

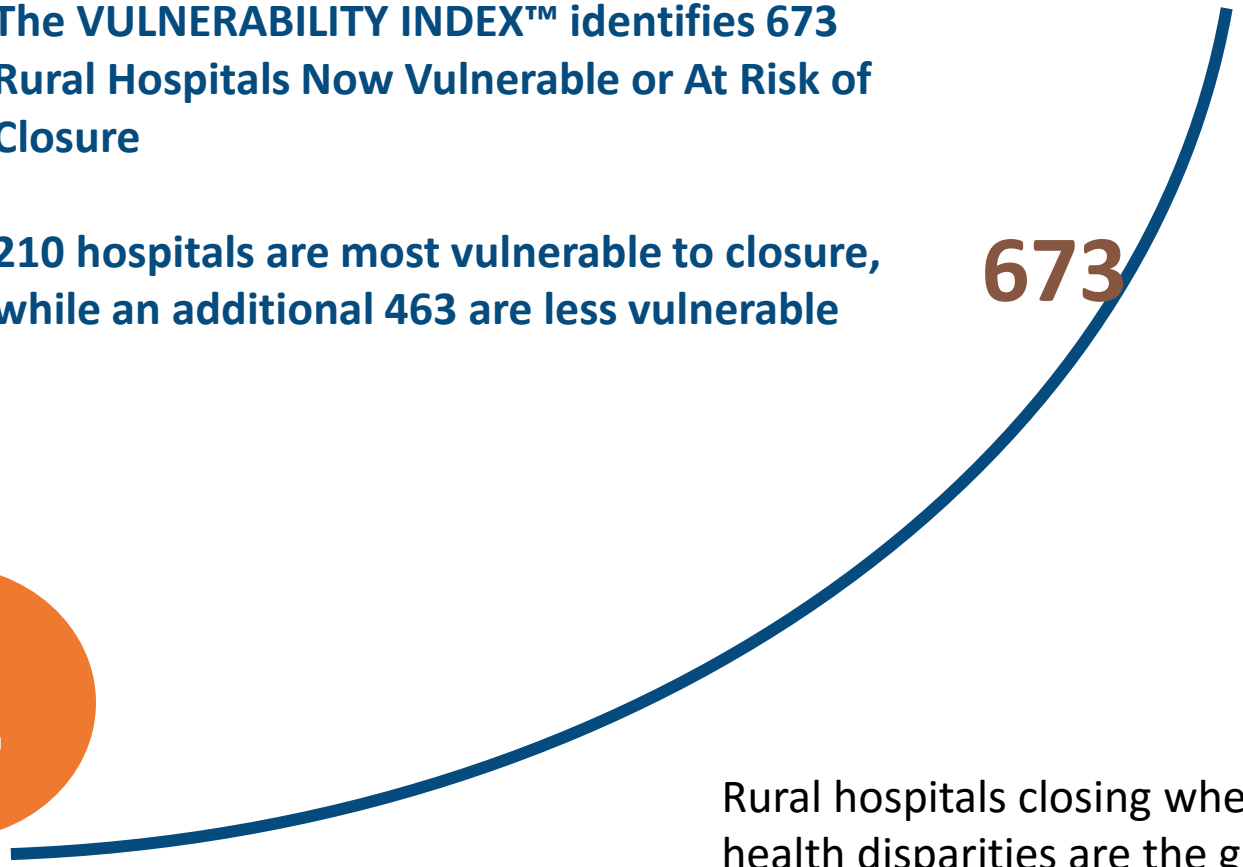
RURAL Hospital Closures Escalating

68 Hospitals have closed since 2010.

The VULNERABILITY INDEX™ identifies 673 Rural Hospitals Now Vulnerable or At Risk of Closure

210 hospitals are most vulnerable to closure, while an additional 463 are less vulnerable

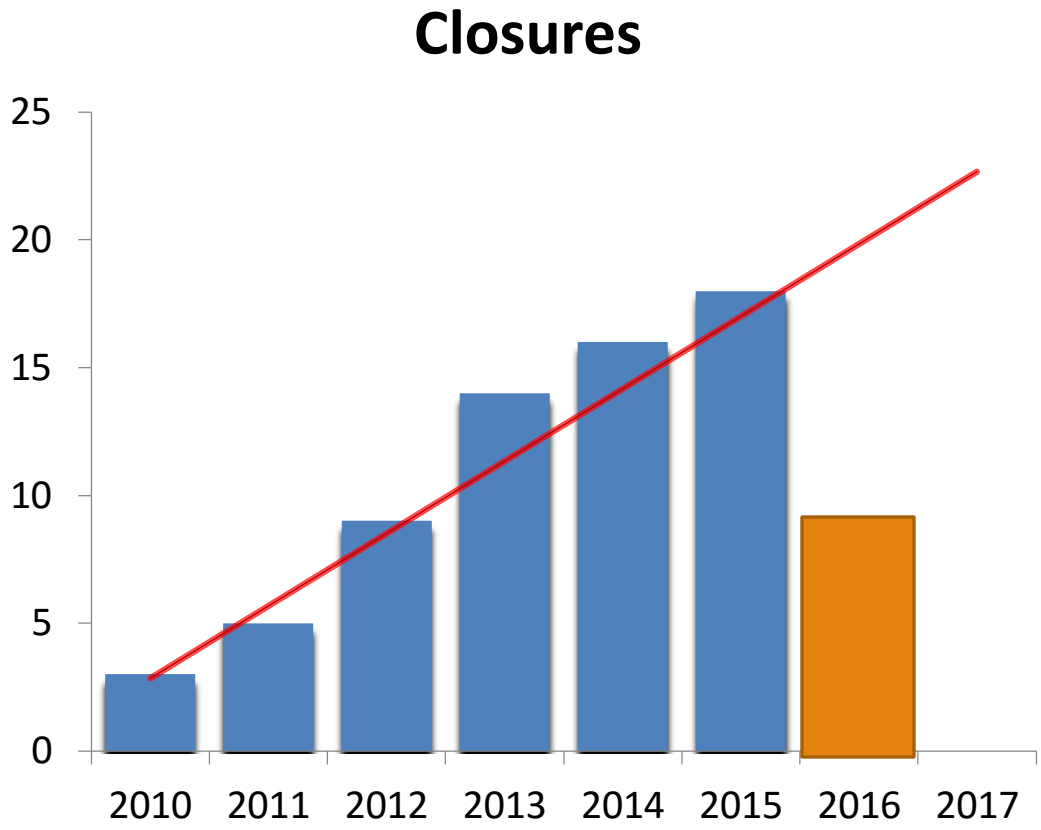
since 2010



Rural hospitals closing where health disparities are the greatest.

Rural Hospital Closures on the Rise

The rate of closure is six times higher in 2015 than in 2010



At this rate, 25% of rural hospitals will shut down in less than 10 years.

Closures in past year

Illinois

Minnesota

Maine - 2

Kansas

Nevada

Arizona

North Carolina

Texas – 5

South Carolina

Tennessee

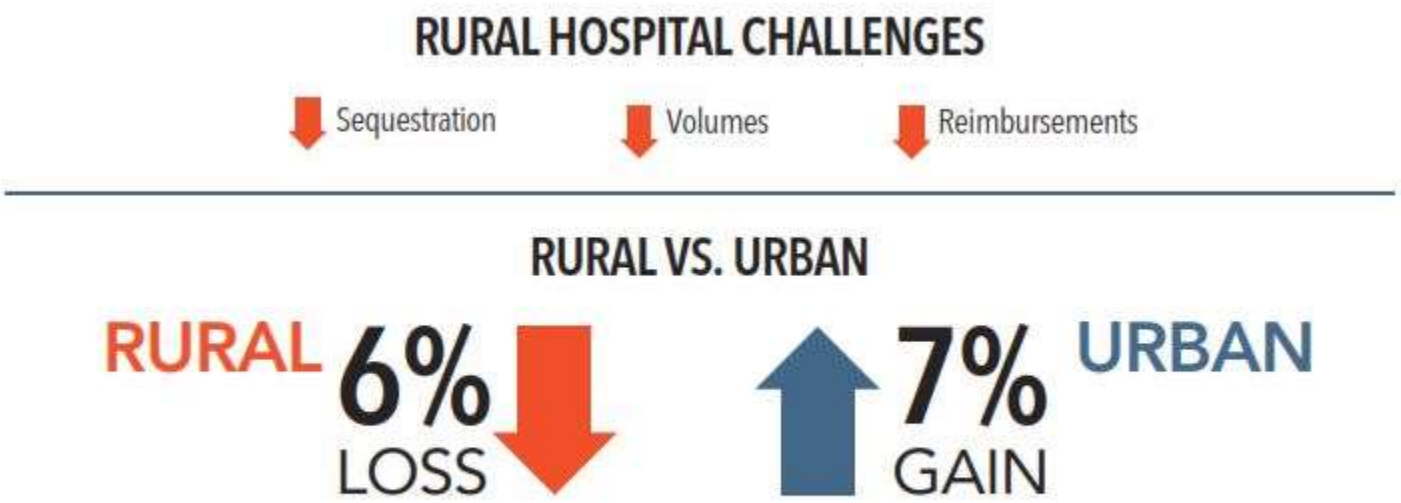
Kentucky

Mississippi - 3

Ohio

Missouri

Rural Hospital Closures Escalating



In each year from FY11 to FY13, rural hospitals posted a **median operating profit margin that was at least 1.66 percentage points lower** than that of urban hospitals, and the gap is widening.

Source: Rural Relevance Under Healthcare Reform (2014 HCRIS)

The Impact of Rural Hospital Closures

The **Vulnerability Index™** identifies **673** rural hospitals statistically clustered in the bottom 2 tiers of performance.

The loss of these Hospitals would mean...

11.7M
Patient Encounters

99,000
Healthcare Jobs Lost

137,000
Community Jobs Lost

$277B
Loss to GDP (10 years)

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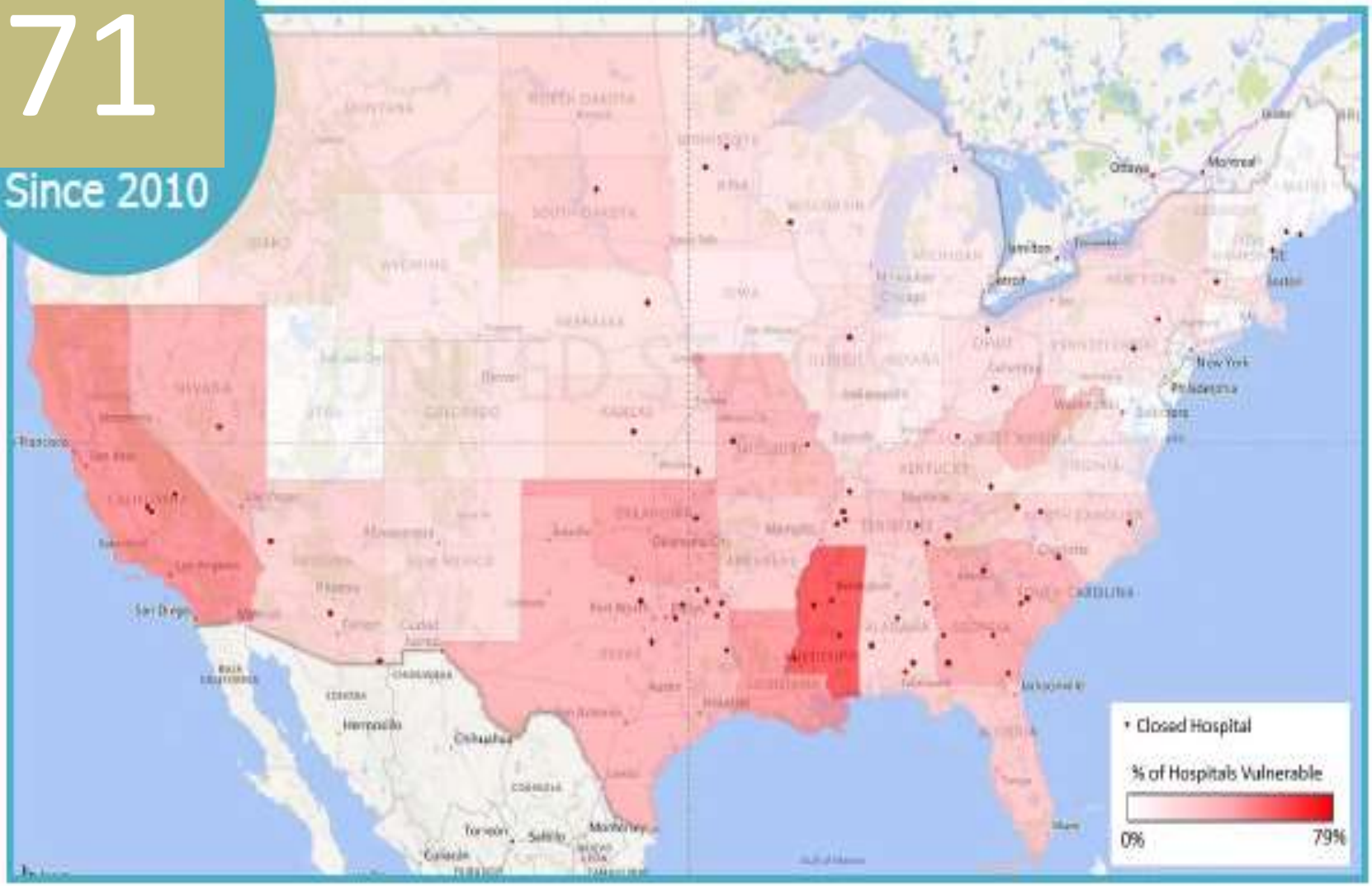
Rural Hospital Closures and Risk of Closures

Closures Escalating

71

Since 2010



Factors Affecting Rural Hospitals and EMS

Loss of providers

Hospital designation for time critical conditions

- Trauma system
- Cardiac system
- Stroke system

May result in bypass and much longer transport time in an already fragile network

Regionalization of healthcare – shorter stays and longer transports

Factors Affecting Rural Hospitals and EMS

Staffing shortages

- High cost of contract labor
- Still caught in traditional staffing models

- Opportunity to share workforce
- If hospital closes EMS agencies may be the only medical providers left in the community

“When rural hospitals close, towns struggle to stay open.”

Marketplace, April 2014

The Impact

10,000 rural jobs lost.

1.2 million rural patients who have lost access to their nearest hospital.

Community and Local Governments

No planning

No communication within the continuum

Hope of rescue inhibits proactive planning

Input from key people along the continuum to prepare for the future.

Are We Alone?

The decline of volunteerism in EMS is a national trend.

A 2008 national study of the EMS workforce concludes that the decline in volunteerism will continue and is not likely to be reversed.

A return to the days of willing volunteers and full rosters is not likely

For many communities, volunteer-only staffing is not a sustainable staffing strategy for the future.

What are the Dangers?

The obvious danger is that ambulance services and hospitals will close, leaving rural residents without rapid access to quality EMS

As rosters shrink, the risk that an ambulance will not respond or be delayed increases

With fewer people shouldering the workload, stress and exhaustion may impact quality of care, driving and safety practices which in turn places patients, the public and providers at increased risk

Change is Essential

We must navigate a major change in how rural communities understand, envision, value, structure and fund EMS.

With these dangers and risks in mind, the overarching challenge is one of ensuring rural communities can make a transition from a failing model to something new without harm coming to anyone

Our Challenges

Lack of local, regional and statewide EMS systems

An appropriate response is a timely response with a qualified crew

Adjacent ambulance services on the verge of closing.

Current solution to a service closing is to expand the remaining ambulance service's response area regardless of their capacity

Our Challenges (cont.)

Available money spent on the wrong issues.

Unavailable and/or no recruitment and retention program.

Who is responsible for ambulance services (local, county wide, statewide). There is no mandate for provision of services.

Lack of uniform local financial support

Regulations

Our Challenges (cont.)

What caused the rural ambulance service and/or hospital to close?

Who is responsible for covering the area previously served by the closed ambulance service?

- Was input sought before the service area was re-allocated?
- What was the redistribution of services to adjacent areas?

Invest in new service lines

Save Rural Hospitals Act, HR 3225

Rural hospital stabilization (Stop the bleeding)

- Elimination of Medicare Sequestration for rural hospitals;
- Reversal of all "bad debt" reimbursement cuts (*Middle Class Tax Relief and Job Creation Act of 2012*);
- Permanent extension of current Low-Volume and Medicare Dependent Hospital payment levels;
- Reinstatement of Sole Community Hospital "Hold Harmless" payments;
- Extension of Medicaid primary care payments;
- Elimination of Medicare and Medicaid DSH payment reductions; and
- Permanent extension of the rural ambulance and super-rural ambulance payment.

New Grants Available to CAHs and Rural PPS Hospitals

- $12 million appropriated annually for Quality Improvement and Compliance Grants.
- $15 million appropriated annually for rural population health needs.
- $ 2 MILLION EMS GRANT FUNDING — to develop EMS programs to meet community needs, address workforce and funding problems.

Our Challenges (cont.)

What is the change in workload caused by the closure?

- Is the change in workload manageable for the existing ambulance services?

What is the change in travel time and distance for ambulance runs caused by the closure?

- Are any changes resulting in different event outcomes?

What are the changes in service areas for the remaining ambulance services?

Positives from Hospital and Ambulance Closure

- Opportunity to communicate better
- Opportunity to increase integrations
- Opportunity for system development

Other Issues

- Asking more when capacity is at a all time low and eroding every day.
- We need a vision of the future.
- Paid providers in rural areas at certain times of days may help
- Prepare EMS personnel in basic primary care.
- Regional networks are substantially less expensive

Other Issues

- Leadership training at hospital and EMS agency level
- Do not eat the whole elephant – pilot projects
- Remove silo thinking
- Public health – where does it fit in

Questions?

- Don Wood, MD
  - donwood@Utah.gov
- Tom Nehring
  - trnehring@nd.gov

Thank You