



CENTER FOR
RURAL HEALTH
OSU Center for Health Sciences

Can A Rural Hospital Lift A Community Out Of Poverty?

**National Organization of State
Offices of Rural Health
October 16, 2019**

Mark Woodring, DrPH, FACHE
Assistant Dean for Rural Health

Photo Courtesy of David Waters

OSU Center for Health Sciences @ Cherokee Nation



PISTOL PETE or CLASSIC AGGGIE?



PISTOL PETE or CLASSIC AGGIE?

Int. Cls.: 16 and 41

Prior U.S. Cls.: 2, 5, 22, 23, 29, 37, 38, 50, 100, 101 and 107

United States Patent and Trademark Office

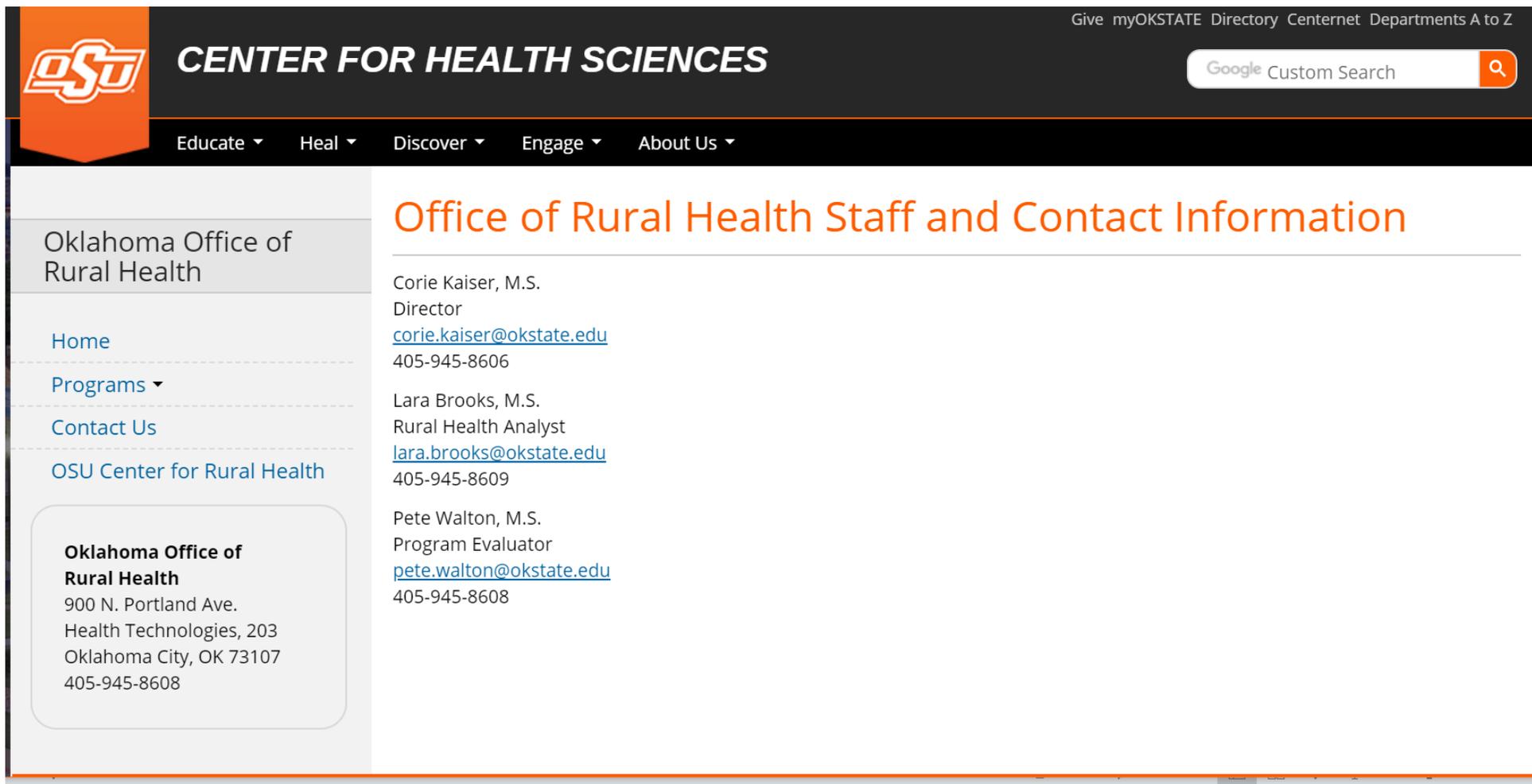
Reg. No. 3,187,429

Registered Dec. 19, 2006

TRADEMARK
SERVICE MARK
PRINCIPAL REGISTER



Thanks, Corie.



The screenshot shows the website for the Oklahoma Office of Rural Health. The header features the OSU logo and the text "CENTER FOR HEALTH SCIENCES". Navigation links include "Educate", "Heal", "Discover", "Engage", and "About Us". A search bar is present with the text "Google Custom Search". The main content area is titled "Office of Rural Health Staff and Contact Information" and lists three staff members: Corie Kaiser, M.S. (Director), Lara Brooks, M.S. (Rural Health Analyst), and Pete Walton, M.S. (Program Evaluator). Each staff member's name, title, email address, and phone number are provided. A sidebar on the left contains a navigation menu with links for "Home", "Programs", "Contact Us", and "OSU Center for Rural Health". A box in the sidebar provides the address and phone number for the Oklahoma Office of Rural Health.

Give myOKSTATE Directory Centernet Departments A to Z

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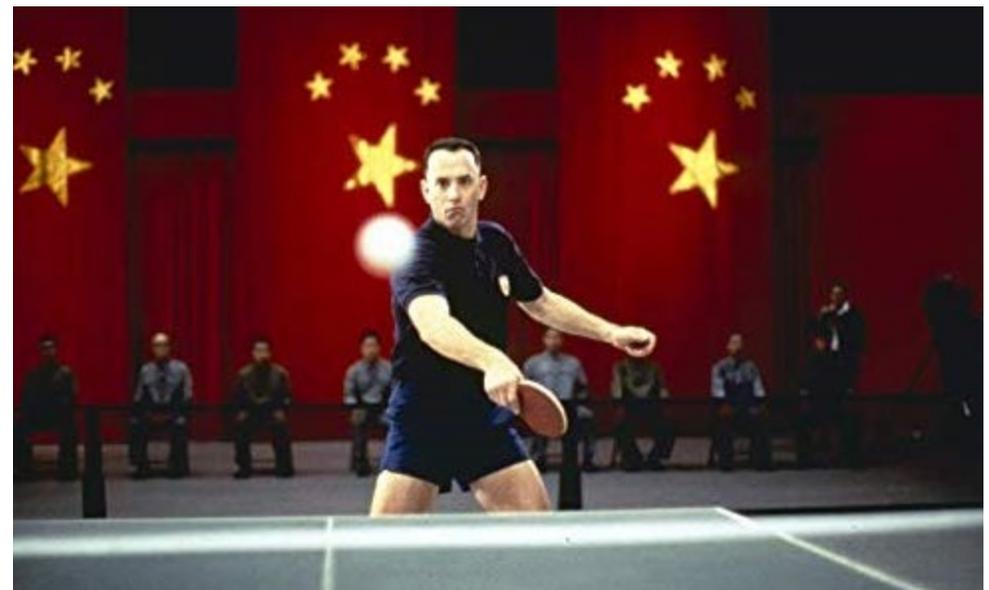
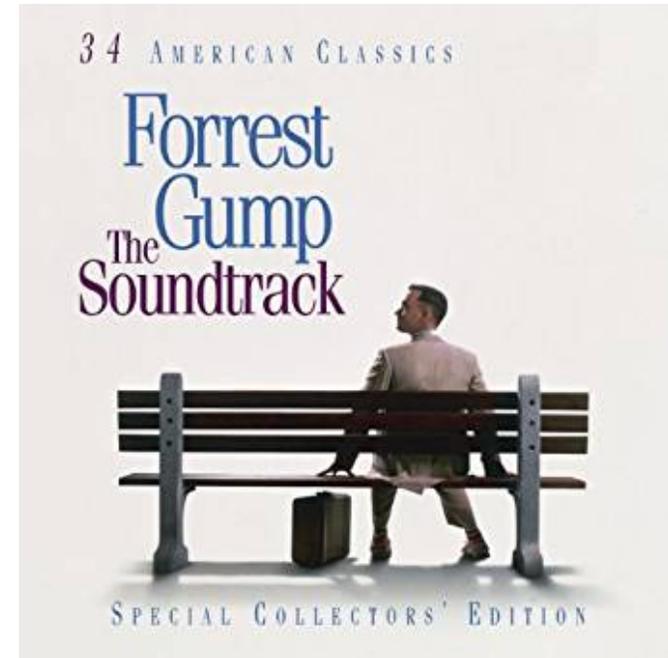
Presentation Overview

- Background, Bias, Limitations, Disclosures & Acknowledgements
- Participation polling
- Research Methods & Key Findings
- A little more program participation
- Next steps and action items
- Open discussion, questions, and dialogue

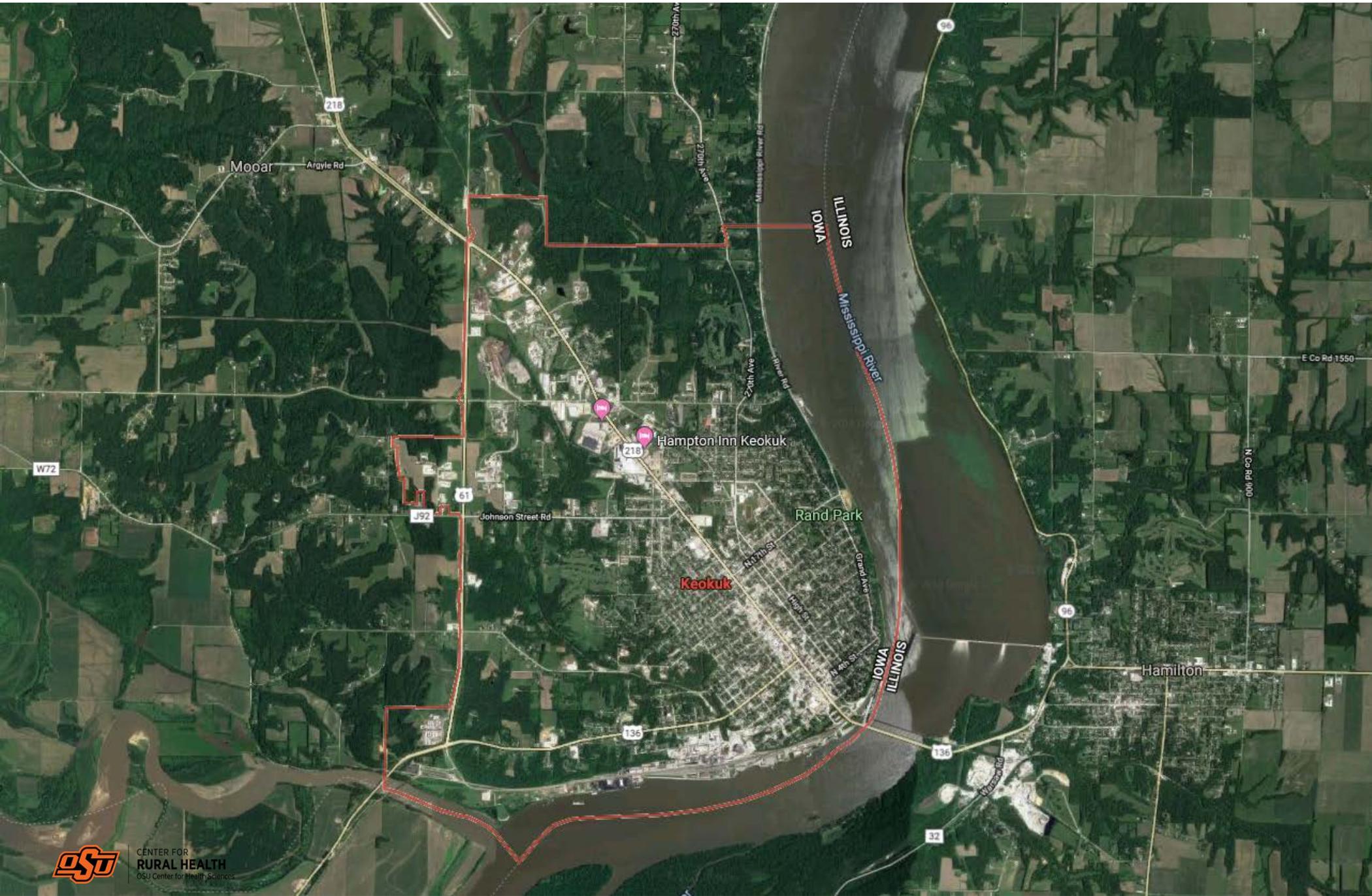
What does David Allan Coe's greatest hit and the *2010 Patient Protection and Affordable Care Act* have in common...

...stay tuned
for later in the presentation

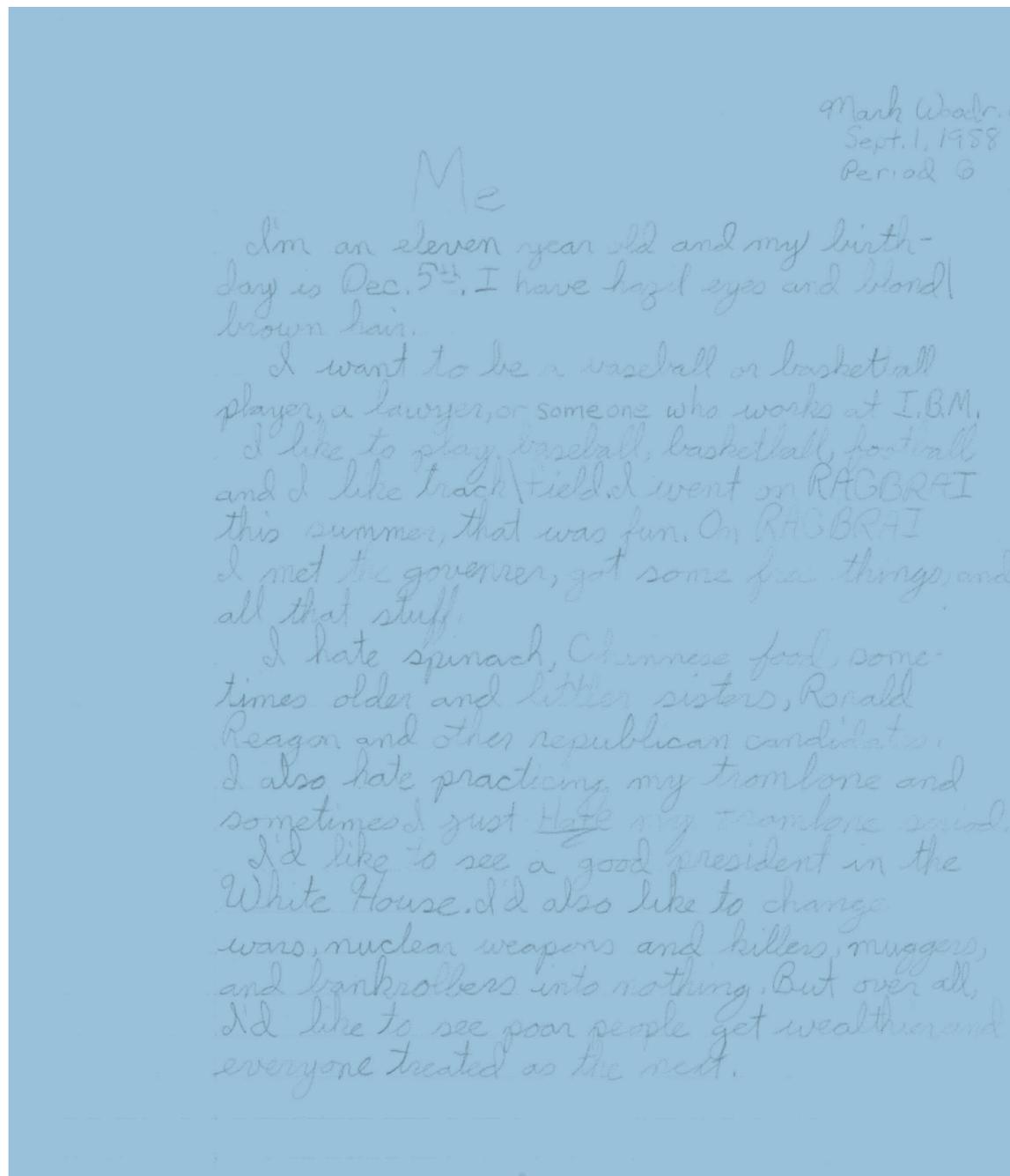
Floatin' around accidental-like on the breeze



Keokuk, Iowa



A journey that has started over 30 years ago...



R Date: 23/11/90

Venue: A 1

date: 20

by: [unclear] 1.2.12

at: [unclear]

no: [unclear]

How did Ryan taking Kellie to Homecoming 25 years ago impact my life?

- Kellie's dad was the CEO of the hospital
- My dad covered hospital pharmacy every other weekend
- My mother was a huge community advocate and volunteer
- I took a nonprofit leadership course in undergrad and loved it
- Spring break '98 I was invited to meet with Al



Administrative Internship

- Launched new health insurance company that competed with Wellmark Blue Cross/Shield
- Opened new renal dialysis center
- Created hospitals OIG Compliance Program
- Completed Physician Recruitment Plan
- Filled in for staff taking summer vacations
- Attended board and medical staff meetings
- Attended community meetings
- WALLAPALOOZA

Ping Pong at Chippy's





One of the greatest traditions in all of sports today



Community Health Centers of SEIA



Community Health Centers of SEIA



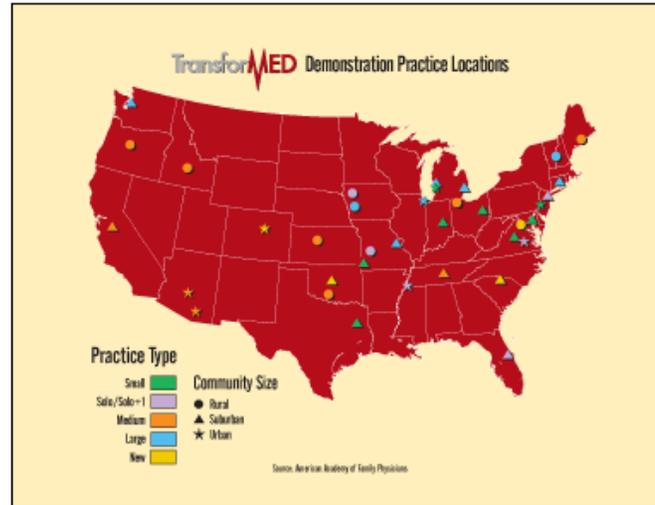
Harlan, Iowa needed a new hospital CEO



IOWA
NURSES ASSOCIATION

Harlan, Iowa really needed a healthier vision

Practices Participating in the National Demonstration Project



The 36 practices selected to participate in the NDP were randomized into two groups – 18 practices were engaged in facilitated implementation of the TransformMED Patient-Centered Model; 18 practices were engaged in self-directed implementation.

Facilitated Practices

Large Practices of 7 or more physicians

- » **Hays Family Medicine** - Hays, Kansas
- » **Myrtue Medical Center** - Harlan, Iowa
- » **Westshore Family Medicine** - Muskegon, Michigan
- » **Wood River Family Medicine Clinic** - Hailey, Idaho

Medium practice of 4-6 physicians

- » **Central Oregon Family Medicine, PC** - Redmond, Oregon
- » **Family Practice Partners** - Murfreesboro, Tennessee
- » **LifeScape Medical Associates** - Scottsdale, Arizona
- MHS Primary Care, Inc. - Cromwell Family Practice - Cromwell, Connecticut

Small practices with less than 3 physicians

- » **Bay Crossing Family Medicine** - Annapolis, Maryland
- » **Family Health Center of Joplin, Inc.** - Joplin, Missouri
- » **Family Medicine, Geriatrics and Wellness** - Lower Gwynedd, Pennsylvania
- » **Trinity Clinic - Whitehouse** - Whitehouse, Texas

Harlan is now one of the healthiest places in the country

HEALTHCARE

PETERSEN FAMILY WELLNESS CENTER

Click on the image below to download as a PDF

100

**CRITICAL ACCESS
TOP HOSPITAL 2019**
EIGHT-TIME RECIPIENT

THE CHARTIS GROUP
CONSTRUCTION FOR HEALTH CARE

iVantage
PROJECT MANAGEMENT



PETERSEN FAMILY WELLNESS CENTER

45,540 SQ. FT. | HARLAN, IA

- FEATURES:** Multiple building complex, portal frame bracing, eave and gable extensions using FSP (Flat Soffit Panel)
- ROOF PANEL:** Parchment MSC (Mechanically Seamed Construction)
- WALL PANEL:** Fieldstone AP (Architectural Panel)

PETERSEN FAMILY
WELLNESS CENTER
LEWIS FAMILY AQUATIC COMPLEX

Harlan is now one of the healthiest places in the country



Official Ground Breaking Ceremony 12/10/2008

Mr. Richard Wittrup, former CEO Brigham & Womens, native of Harlan, and just an all around great guy

“I have watched MMC develop over the years under the uncommonly capable leadership of Woodring and his predecessor Steve Goeser. It is a single corporation that employs the physicians of Harlan Clinic as well as the staff of MMH. It is of manageable size with low overhead and impressive operational flexibility. It refers patients in need of specialty care to larger facilities in Omaha, Nebraska, some 50 miles away, from which a number of specialists travel to MMC to hold clinics on a regular and scheduled basis.

It seems to me that MMC offers a model that ought to be looked at as part of the health system of the future. Now that protocols and quality reporting are relatively well established, clinical performance could be readily monitored. I see no reason why the model could not function in urban as well as rural areas. It could be a sort of McDonald's of health care, offering basic health services safely, at a high level of quality, and at reasonable cost.

In the past, all the glamour in health care has gone to the big urban teaching hospitals and little attention has been paid to institutions like MMC.”

<https://healthcarenew.blogspot.com> Saturday, July 28, 2007.

Recruited to Truman Medical Centers, Kansas City, MO



Recruited to Truman Medical Centers



Corporate Challenge – Kansas City “Workplace Olympics”



Program Participation

<https://create.kahoot.it/share/nosorh-conference/ce14b723-2098-48c6-8942-a159941d958e>

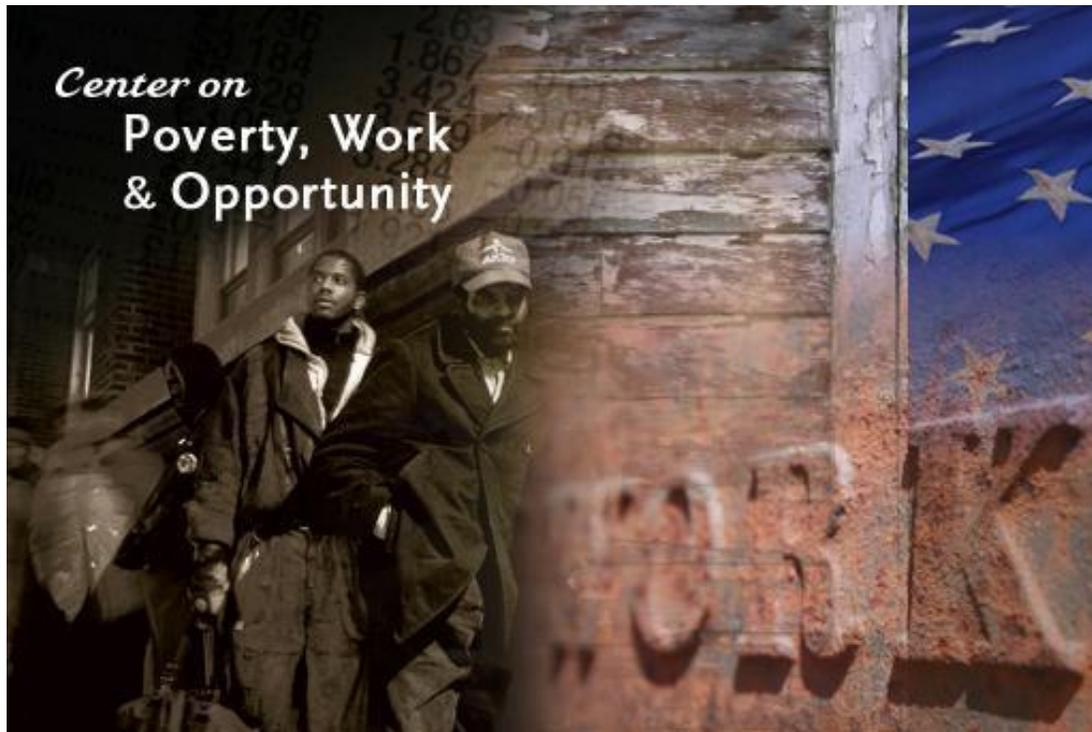


THE UNIVERSITY
of NORTH CAROLINA
at CHAPEL HILL

Can a hospital lift a community
out of poverty?

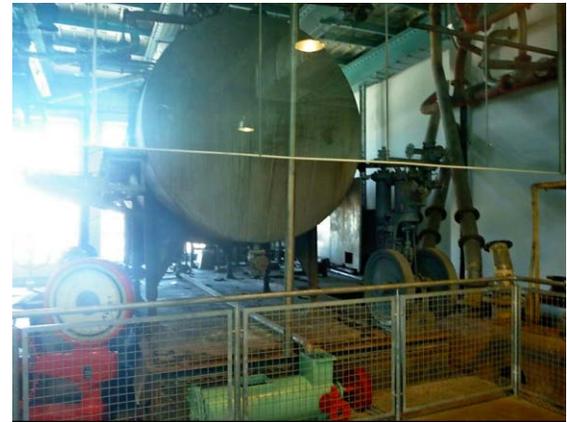
Acknowledgements

UNC Center for Work, Poverty, & Opportunity for their guidance and support



THE UNIVERSITY
of NORTH CAROLINA
at CHAPEL HILL







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What role do charitable, nonprofit hospitals have in community building activities post-2010 Patient Protection and Affordable Care Act reforms?

Leadership perspectives from an exploratory, intrinsic case study of USDA persistent poverty leaver counties in rural New Mexico



Photo Courtesy of David Waters

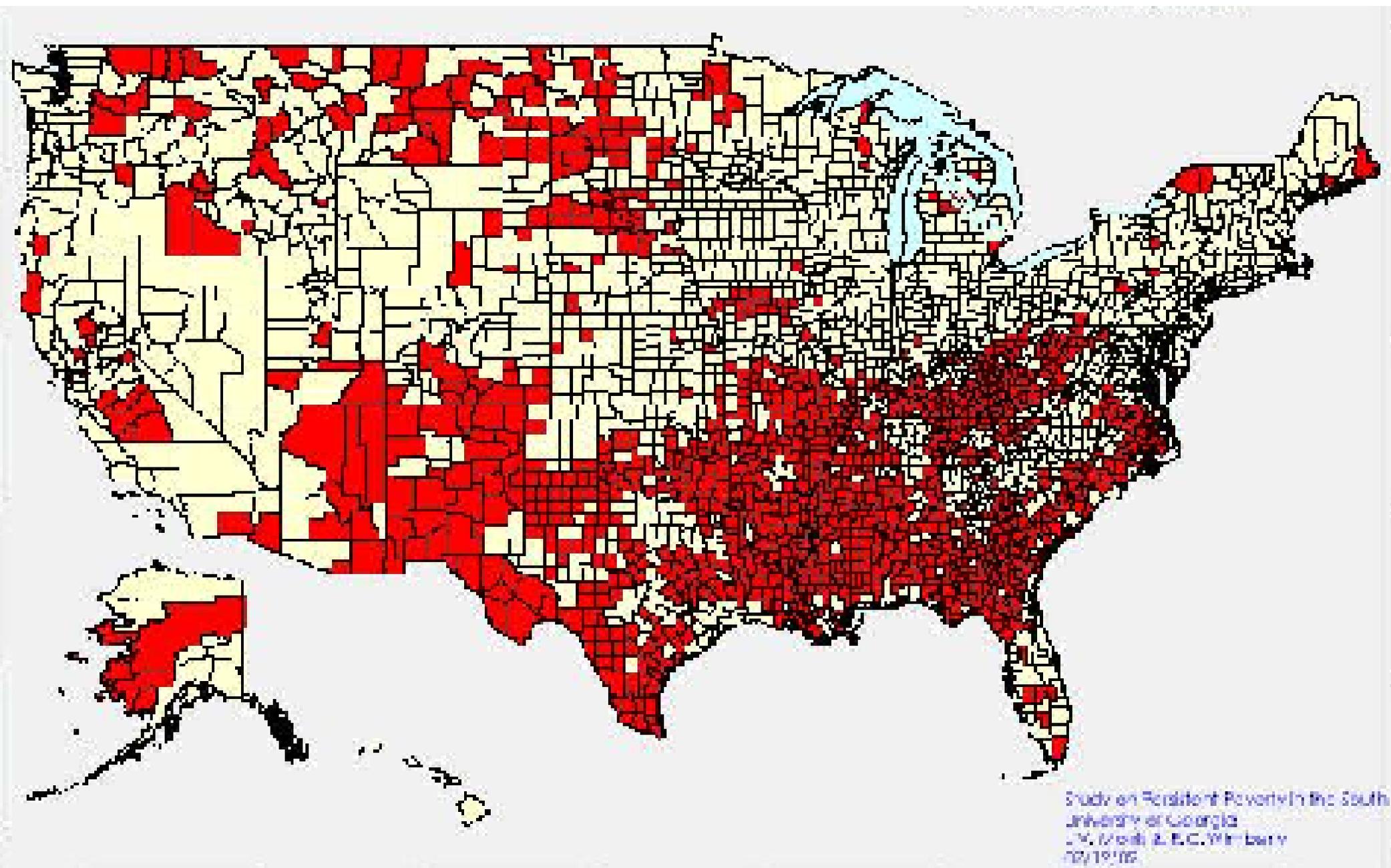
Background

- The 2010 Patient Protection and Affordable Care Act (ACA) was expected to expand health insurance coverage to many uninsured populations in the United States
- If the ACA reforms are successful, a reduction in the level of charity care provided by hospitals would be realized
- It is not clear if a distinguishing difference can be made between the value society derives from tax-exempt hospitals and other for-profit hospitals post-ACA

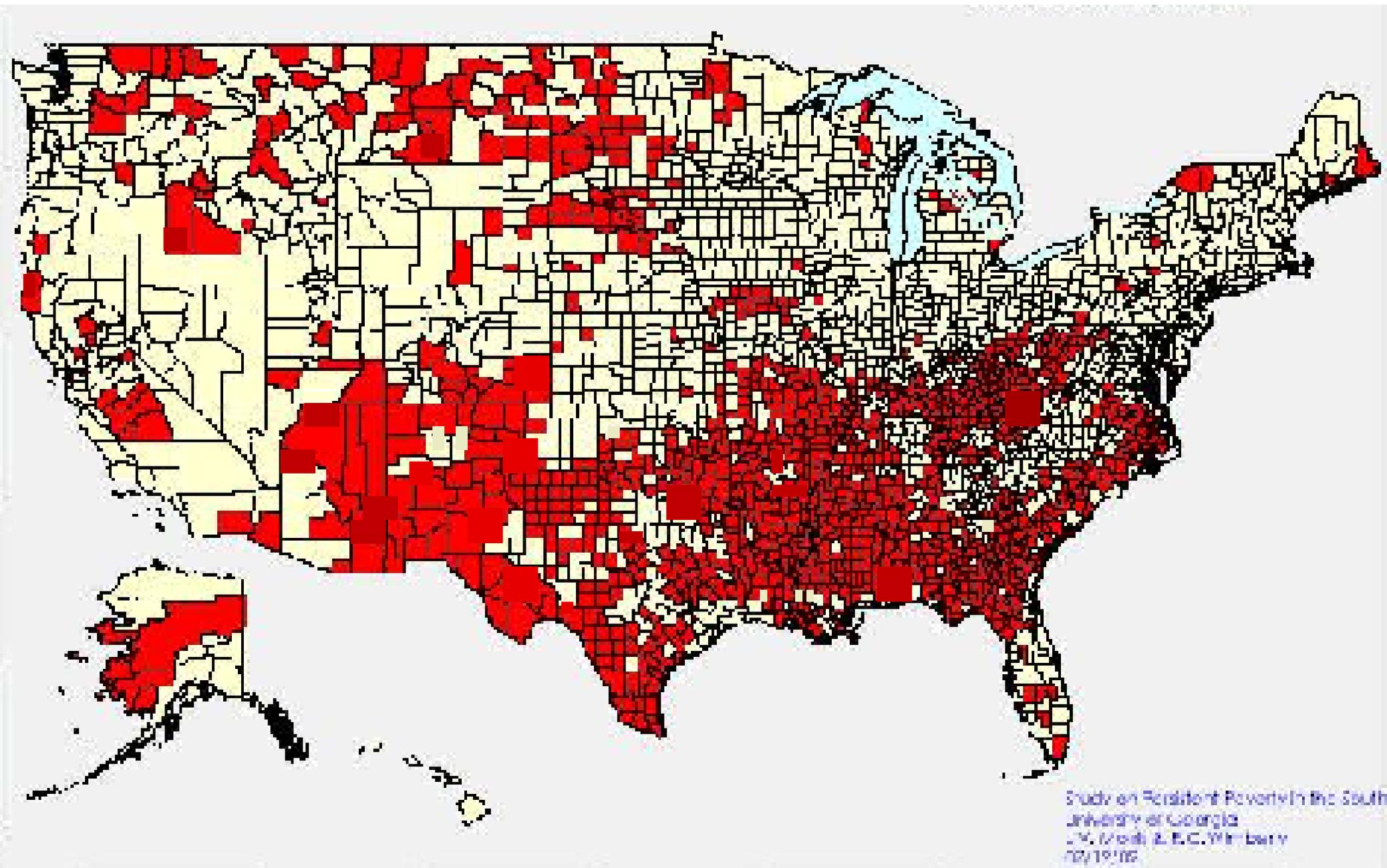
Methods

- Qualitative research design
- Two exploratory, intrinsic case studies were selected based on screening criteria that identified outlier performance in New Mexico persistent poverty counties
- Cordes specifically suggests alternative healthcare delivery systems to better serve persistently impoverished areas in February 1989 (HSR 23:6)

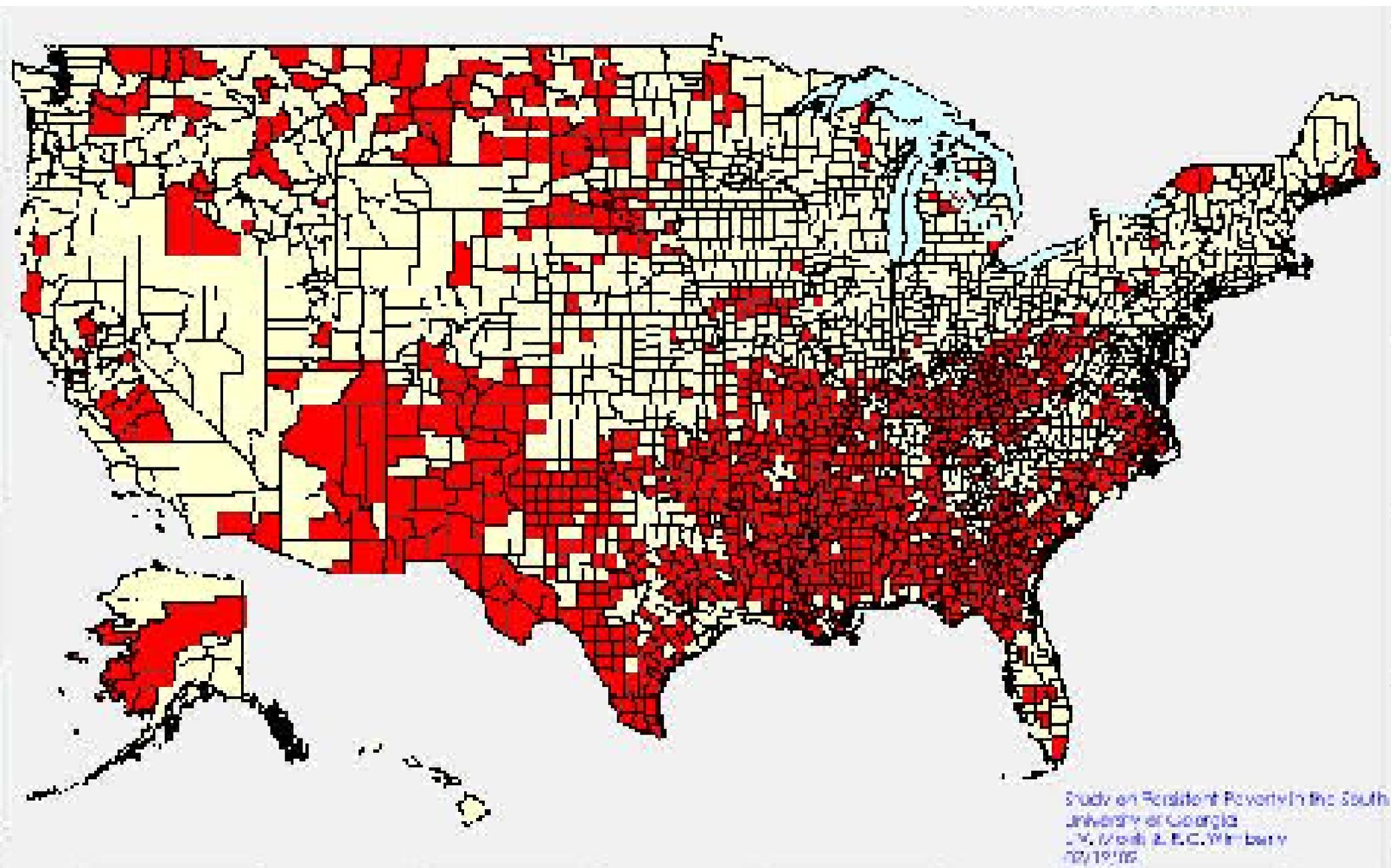
Map of Persistent Poverty in America



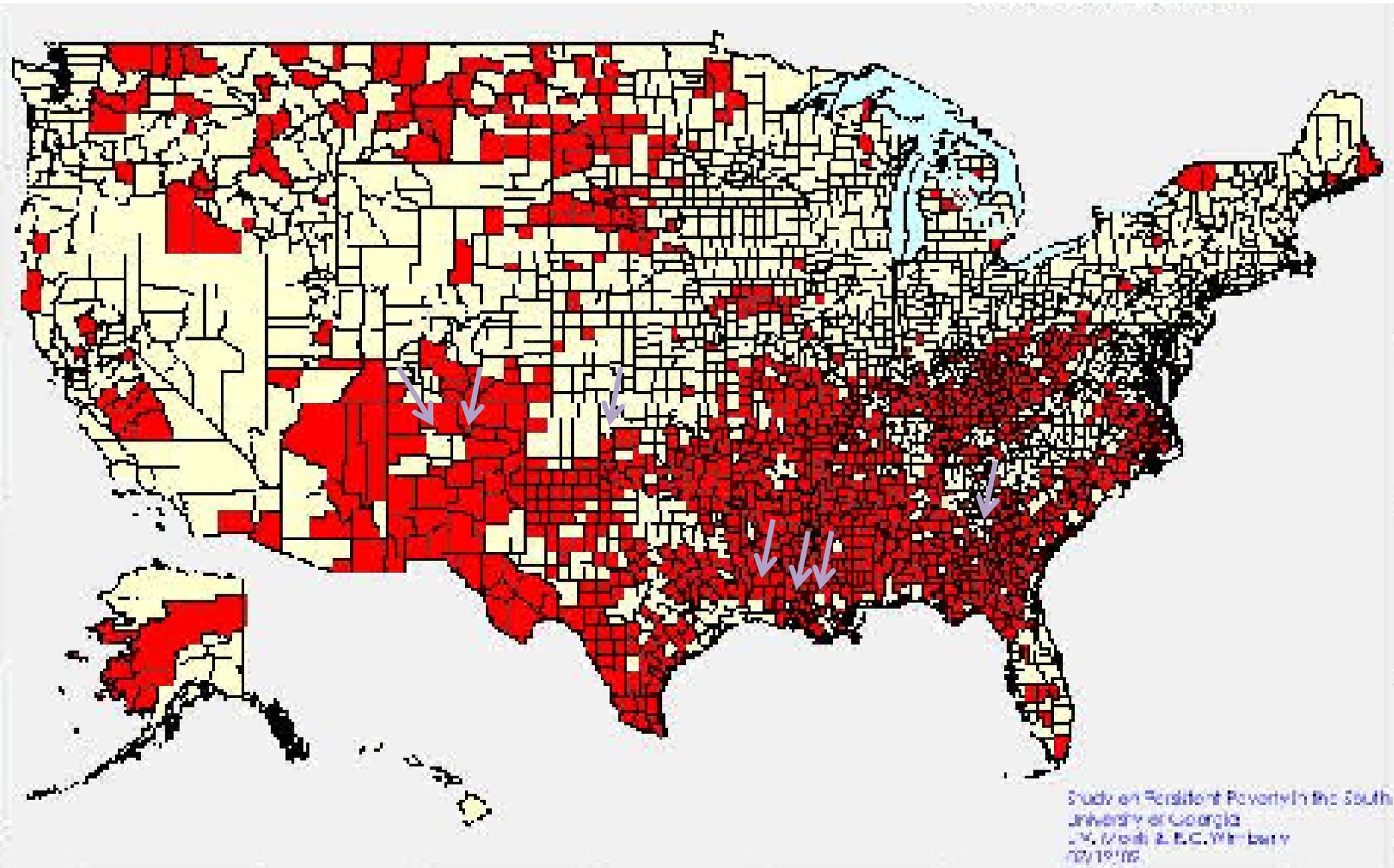
Simulated Map of Persistent Poverty in America (2010)



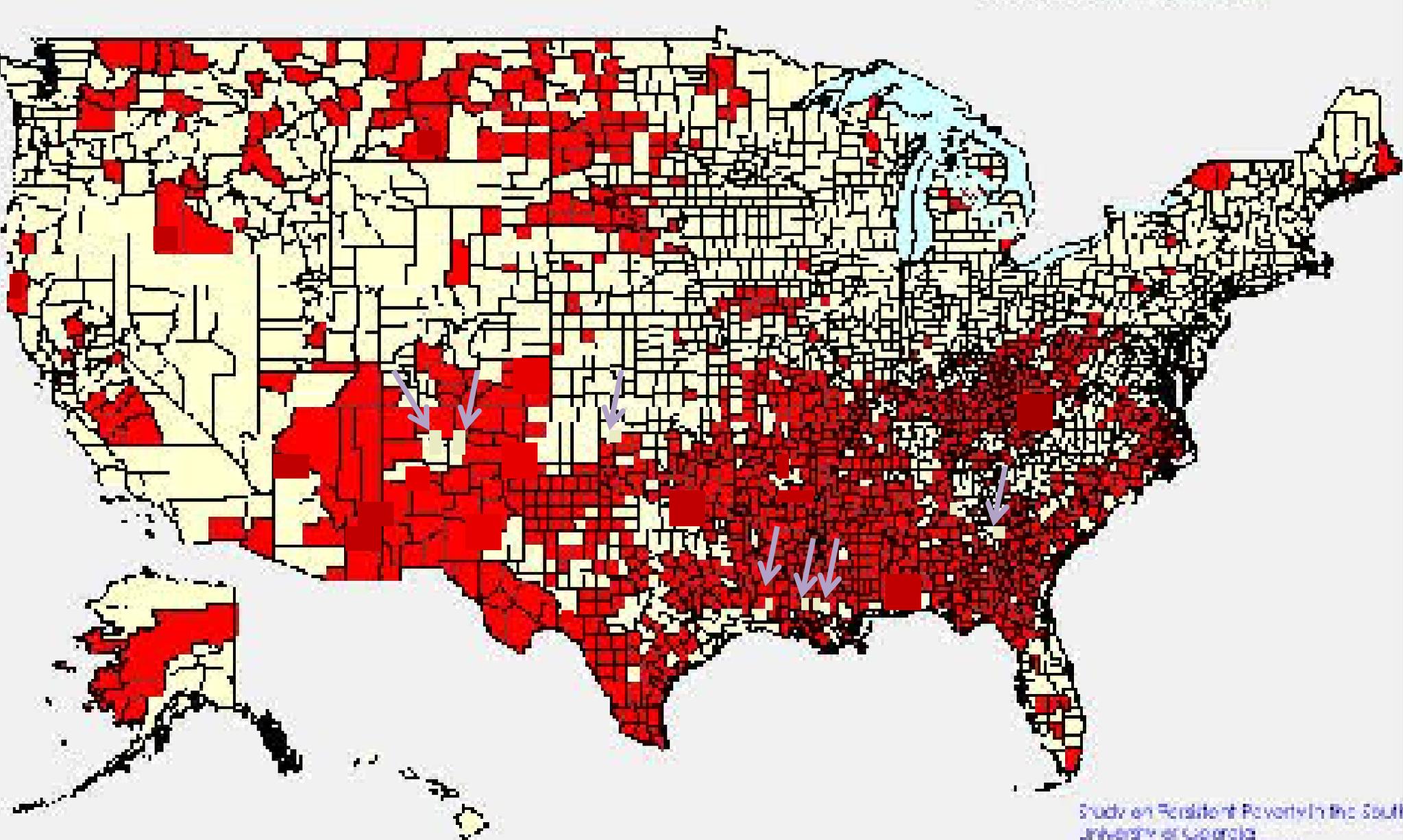
Map of Persistent Poverty in America



Simulated Map of Persistent Poverty in America (2010)

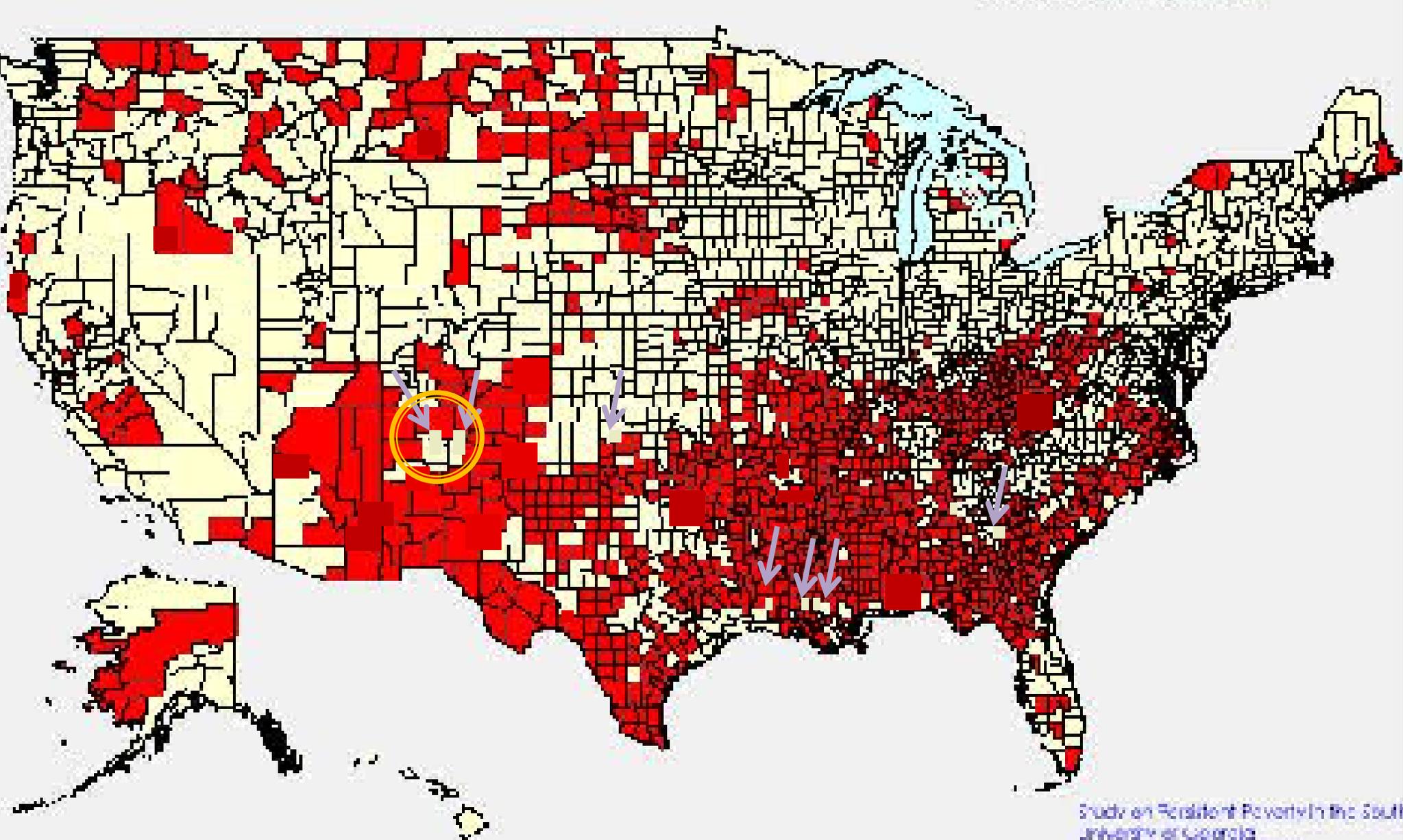


Simulated Map of Persistent Poverty in America (2010)



Study on Persistent Poverty in the South
University of Georgia
J.M. Smith & E.C. Wilentz
02/19/09

Taos County, New Mexico and Rio Arriba, New Mexico



Study on Persistent Poverty in the South
University of Georgia
J.M. Smith & E.C. Wilentz
02/19/06

Methods

- Leaders identified by their potential direct relationship to the community building activities listed on IRS Form 990 were then contacted for participation
- The two hospital CEOs agreed to participate in the study
- Both CEO interviews and most key informant interviews of the county leaders were conducted in New Mexico to learn more about the hospital roles in the community

Key Informant Interviews

County Leadership Role	Community Building Activity Theme
County Executive	Economic Development/Environmental Improvements
Economic Development Official	Economic Development/Physical Improvements
Education Administrator	Workforce Development/Leadership Development
Chamber President	Coalition Building/Workforce Development
Public Health Executive	Community Health Improvements
United Way/Community Foundation Exec. Director	Community Support

Data Analysis

- Key informant interviews were audio recorded and transcribed within 48 hours of interview
- Transcripts of the interviews were uploaded into qualitative analysis software, MAXQDTA
- Transcripts were coded to identify emerging themes

Study Limitations

- Qualitative research is subject to personal bias. Career experiential biases are inherent with the analysis process.
- Reliability of data is high, but replicability of study is limited.
- Inter-rater reliability of transcribed themes is low
- External validity is limited
 - Yin suggests analytical generalization may exist to help warrant further research or introspection
- Sample limitations—the research is only a partial reflection of leadership in the specific counties. Additionally, the hospital service areas do not necessarily coincide with county boundaries, which may have colored interviewees' responses.
- Reliance upon one indicator based on U.S. Census Bureau data may not fully describe the economic status of a county

Other Bias and Disclosures

- “Closures in communities with alternative sources of hospital care in the county had no long-term economic impact” after a 24-month decrease of per capita income.

Holmes, G.M.; Slifkin, R.T.; Randolph, R.K.; Poley. The effect of rural hospital closures on community economic health Health Serv Res. 2006.

- “Clearly, rural hospitals that are in full operation are major economic engines of these communities. However, once the point of closure has been reached, the economic impact is severely diminished.”

Pearson, D. and Tajalli, H. The Impact of rural hospital closure on the economic health of the local communities. Texas Journal of Rural Health. 21 (3) pp 46-51.

Other Research Bias and Disclosures

- Rural hospital closures may decrease death rates by nearly 10% for patients suffering from asthma/COPD (NBER Working Paper Aug 2019 Gujral & Basu)
- Not every hospital closure is necessarily a bad outcome that leads to other bad outcomes.
- Medicare Spending Per Beneficiary? Quality data?

155 Rural Hospital Closures:
January 2005 – Present

113 Closures Since 2010

Source: UNC Sheps Center for Health Research

Low Cost High Quality?	High Cost High Quality?
Low Cost Low Quality?	High Cost Low Quality?

Final Disclosures

- My experiences from the field lead me to believe if half of our rural critical access hospitals have an average acute care census of less than two (as some states report), that is not a sustainable model for our rural communities, payors, and government.
- My experiences from the field also lead me to believe if large, nonprofit charitable health systems are earning hundreds of millions of dollars of operating surplus each year, and possess hundreds of millions of dollars in investment reserve accounts (some offshore, as some hospitals report), that is not an equitable model for our rural communities, either.

Hospital Community Benefit

- Community benefit is a legal standard for hospitals to provide and report measurable charitable benefit to their communities in exchange for tax-exempt status
- A range of opinions exist on both the expectations and the value of community benefit by non-profit hospitals
- “Schedule H” was recently added to IRS Form 990 to help quantify community benefit
- Part II of Schedule H allows hospitals the opportunity to disclose investments made in local community building activities

Hospital Community Building

- Community building activities can consist of workforce development, housing improvements, environmental improvements, economic development and leadership training initiated by the hospital
- The potential benefits of non-profit hospitals vigorously participating in these community building activities is well documented
- Community building can address social determinants of health, improve health disparities, strengthen the economy, and can also help reduce poverty

Part II Community Building Activities Complete this table if the organization conducted any community building activities during the tax year, and describe in Part VI how its community building activities promoted the health of the communities it serves.

	(a) Number of activities or programs (optional)	(b) Persons served (optional)	(c) Total community building expense	(d) Direct offsetting revenue	(e) Net community building expense	(f) Percent of total expense
1 Physical improvements and housing						
2 Economic development						
3 Community support						
4 Environmental improvements						
5 Leadership development and training for community members						
6 Coalition building						
7 Community health improvement advocacy						
8 Workforce development						
9 Other						
10 Total						

Part III Bad Debt, Medicare, & Collection Practices

Section A. Bad Debt Expense

		Yes	No
1	Did the organization report bad debt expense in accordance with Healthcare Financial Management Association Statement No. 15?	<input type="checkbox"/>	<input type="checkbox"/>
2	Enter the amount of the organization's bad debt expense. Explain in Part VI the methodology used by the organization to estimate this amount		
3	Enter the estimated amount of the organization's bad debt expense attributable to patients eligible under the organization's financial assistance policy. Explain in Part VI the methodology used by the organization to estimate this amount and the rationale, if any, for including this portion of bad debt as community benefit.		
4	Provide in Part VI the text of the footnote to the organization's financial statements that describes bad debt expense or the page number on which this footnote is contained in the attached financial statements.		

Section B. Medicare

5	Enter total revenue received from Medicare (including DSH and IME)	5	
6	Enter Medicare allowable costs of care relating to payments on line 5	6	
7	Subtract line 6 from line 5. This is the surplus (or shortfall)	7	
8	Describe in Part VI the extent to which any shortfall reported in line 7 should be treated as community benefit. Also describe in Part VI the costing methodology or source used to determine the amount reported on line 6. Check the box that describes the method used: <input type="checkbox"/> Cost accounting system <input type="checkbox"/> Cost to charge ratio <input type="checkbox"/> Other		

Section C. Collection Practices

9a	Did the organization have a written debt collection policy during the tax year?	9a	<input type="checkbox"/>	<input type="checkbox"/>
b	If "Yes," did the organization's collection policy that applied to the largest number of its patients during the tax year contain provisions on the collection practices to be followed for patients who are known to qualify for financial assistance? Describe in Part VI	9b	<input type="checkbox"/>	<input type="checkbox"/>

Literature Gaps

- Despite grim, recessionary statistics of the past decade, some persistent poverty counties have steadily reduced poverty since 1980 though it is not clear how
- There is little empirical focus on hospitals that operate in persistent poverty counties
- Current hospital economic impact studies do not focus on the development potential of supporting the poor
- There is still much to learn about “small town health care safety nets”

How can your hospital best benefit the community?

<https://create.kahoot.it/share/nosorh-conference-2/1b860d42-d50a-4430-8cfe-486f660f5a70>

Key Finding:

- The hospital CEOs and other community leaders described the benefit of their local nonprofit hospital in the exact same themes, none of which appear distinguishable from for-profit hospitals:
 - 1) As a large employer and economic engine;
 - 2) As a source for emergency care; and
 - 3) As a beacon to make the county more attractive for population and industrial growth
- No perceived role of the hospital leading community building work “outside of the traditional walls” was mentioned by the leaders.

Quotes

- ***“The hospital is extremely important for accidents that occur here, and it provides a great economic impact as well. The hospital provides many of the higher paying jobs in the county. There is no way a company would come here without the hospital.”***
- ***“The hospital plays a vital role providing higher paying jobs and is one of the largest employers in the region. Without it I don’t think the town would be sustainable.”***
- ***“The hospital is a lifeline for the citizens of this community and county. The nearest hospital is probably, with new technology and roads, probably a 25 minute drive at a high rate of speed, but if you are having a life and death emergency its too far.”***



Literature Review

- “Because hospitals do not close at random, county economic environments influence closure and vice versa.”

Probst, Samuels, Hussey, Berry and Ricketts. Economic Impact of Hospital Closure on small rural counties: 1984-1988. J of Rural Health. Fall 1999.

Quotes

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It wasn't the only hospital in the county...

THE JOURNAL
INSPIRATION FOR CIVIC LEADERSHIP IN KANSAS

10 / 03 / 18

How Independence, Kansas, survived losing its hospital and what it means for endangered health care in rural Kansas

<https://klcjournall.com/how-independence-kansas-survived-losing-its-hospital-and-what-it-means-for-endangered-health-care-in-rural-kansas/>

Literature Review

Christiansen and Faulkner write, “The actual impact on community income of a rural hospital’s closure would depend greatly on the community’s response to that event. At one extreme, the closure could result in out-migration of hospital employees, loss of the community physician, and a graduate decline in the attractiveness of the community as a living environment...nonetheless, one could construct an equally plausible scenario resulting in an entirely different outcome...of maintaining the economic and social structure of the community.”



Quotes

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Societal Questions, Health Equity, and Policy Proposals

“What kind of healthcare do we want in our communities, how much subsidy will it require, who will pay for it and how?”

Cordes, February 1989, HSR 23:6 Page 778.



24⁺HR
Emergency Room?

Other Key Findings

- Would leaders support posting online the estimated value of their nonprofit hospital's tax exemption?
- The value of tax exemptions accruing to non-profit hospitals has been estimated at nearly \$25 billion per year (Rosenbaum 2015, Health Affairs)
- While a range of opinions exist on both the expectations and the value of community benefit by non-profit hospitals, no participant disagreed with this idea
- Some believed the value of the hospital's tax exemption was already reported through the IRS 990 (it isn't)
- One participant identified their nonprofit hospital as a "for-profit" entity (twice)

Other Key Findings

- Would leaders support a PILOT* concept to fund more community building activities?
- While considerable **conceptual optimism** was expressed by participants of contributing nonprofit hospital PILOTS into community building activities through a locally controlled, public health foundation...

Leaders working in the healthcare industry were **guarded** if such an approach would be financially viable for nonprofit hospitals.

*Payment in lieu of taxes (PILOT)

Quotes

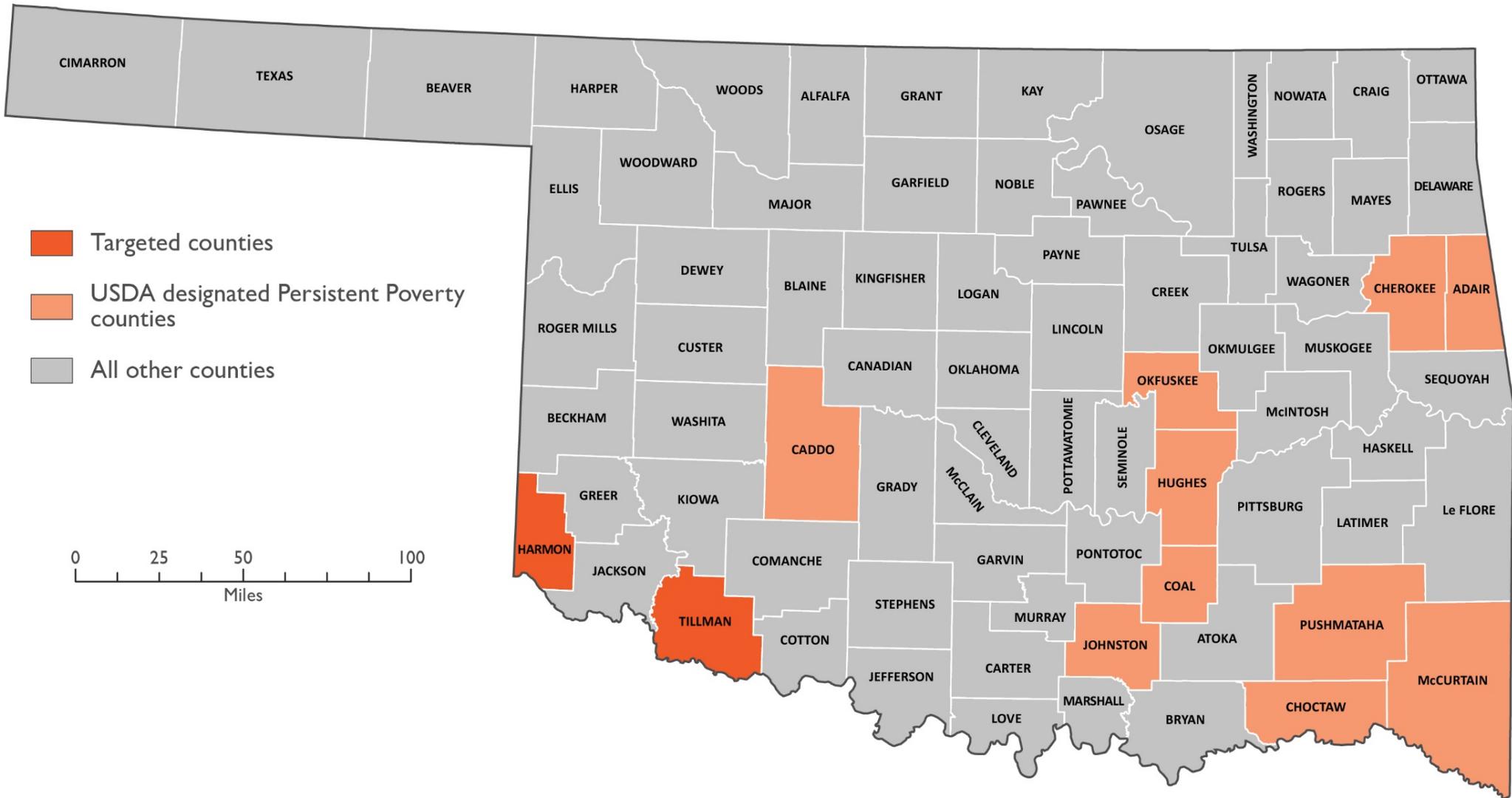
- *“You know, part of me sort of hesitates when people go well, we should take this thing, and try to make it do all these other things...”*
- *“My sense is hospitals are suffering in general, and my sense is they are pulling back and really focusing on what their core missions are, so I’m not sure they have extra dollars to be doing extra things.”*
- *“Hospitals cost a lot of money to run, and if we did that I don’t know if we could necessarily stay open. If hospitals were to do things like that I don’t think most would survive. The other thing is, I don’t necessarily trust the money would be spent in the best manner that would be most effective.”*

THE RURAL INITIATIVE

ENSURING THE FUTURE OF RURAL OKLAHOMA

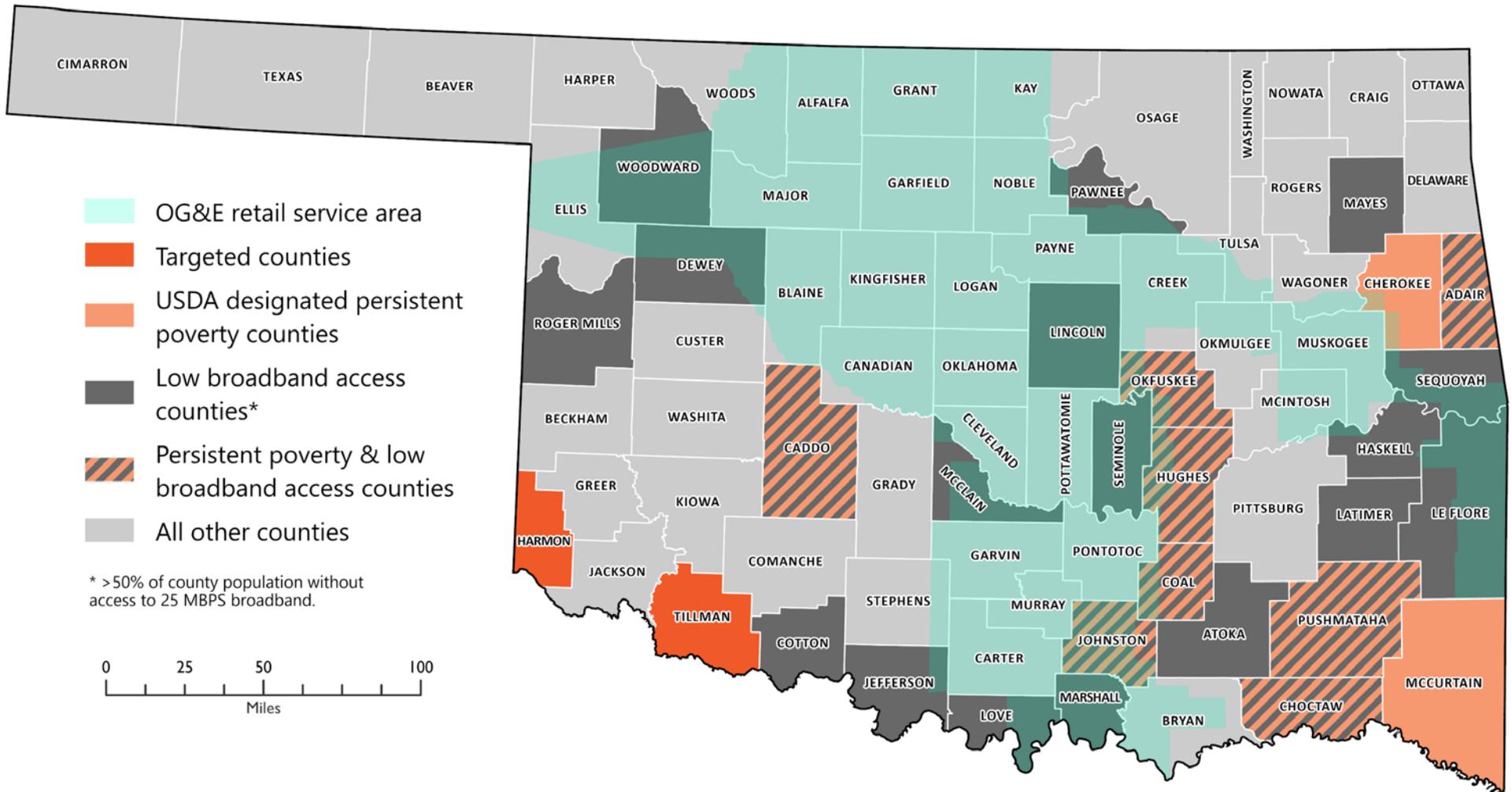


Proposed Oklahoma State University Rural Renewal Institute: Phase I



Map Produced by
 OSU Center for Rural Health
 OSU Center for Health Sciences
 Tulsa, Oklahoma
 July 25, 2019
<http://ruralhealth.okstate.edu>

Proposed Oklahoma State University Rural Renewal Institute: Rural Health Extension Project - Phase I



Final Thought Before Questions & Reflections

“Living conditions of poor people—such as housing, nutrition, and employment—are a result of economic and political realities that cannot be changed without fundamental and highly unlikely system changes.”

Patrick, Stein, Porta, Porter, & Ricketts. Poverty, Health Services, and Health Status in Rural America. *The Milbank Quarterly*, Vol. 66, No 1 (1988).

So can a rural hospital lift a community out of poverty?

- Yes, definitely!
- It depends on how you define rural and poverty
- I don't think so

○ **Let's find out!**



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