
ILLINOIS CRITICAL ACCESS HOSPITAL PROGRAM:

Learning From the Past, Building the Future

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EXECUTIVE SUMMARY

Critical access hospitals (CAHs) are important in rural areas not only in terms of access to health care, but also as local sources of employment, often the first or second largest employers in a region. The CAH designation was created by Congress through the Medicare Rural Hospital Flexibility Program (Flex Program) in 1997, allowing small rural hospitals to be licensed as CAHs and offer grants to state governments to strengthen rural health care infrastructure. Since the Flex Program's inception in 1999, Illinois CAHs have been able to improve services and become more financially stable. However, some smaller hospitals may still face the risk of closures or service reductions due to budget cuts, reimbursement issues, and demographic changes. Closures, or even serious cutbacks in services, would have major repercussions for rural health care.

The Illinois Critical Access Hospital Network (ICAHN)¹ has proactively addressed the emerging issues of health system change through research and collaboration. Since 2006, ICAHN and Northern Illinois University's Center for Governmental Studies (CGS) have partnered on several issue papers to highlight the economic impact, quality of care, collaboration, and community wellness efforts of CAHs. ICAHN is also working with rural hospitals on new delivery systems. ICAHN has also benefitted from collaboration with, and input from, the Illinois Department of Public Health's Center for Rural Health. The 15-year CAH program milestone is a chance to reflect on the program, explore current and emerging issues and challenges in rural health care, and look ahead to the future of CAHs and the CAH program in Illinois. ICAHN, along with financial partners Lancaster Pollard, Murray Company, Eide Bailly LLP, Nixon Peabody (formerly Ungaretti & Harris LLP), and Shive-Hattery, collaborated with CGS to gain a better understanding of major demographic, economic, and policy changes affecting rural health care and how CAH designation has benefited CAHs in Illinois. The most recent report, *Illinois Critical Access Hospital Program: Learning From the Past, Building the Future*, included a review of the CAH program and designation, a 2014 CGS-ICAHN survey of Illinois CAHs, and in-depth data analysis. Several important themes emerged in the January 2015, *Illinois Critical Access Hospital Program* report:

- » 47 of 84 rural counties had elderly proportions at least one-third higher than the state of Illinois, placing even more pressure on small rural hospitals to provide essential services for a less mobile population. This situation **increases the importance of local access to high quality health care services for population retention.**
- » Health care is a major industry for local employment, and in 2013 represented 15.5% of the employment in rural counties in Illinois, compared with 13.5% for the state and **health care as an industry has grown in importance in rural areas during the past decade.**
- » CAH administrators are evaluating current services and examining alternative delivery formats as they respond to the current and future needs of their communities, regardless of changes in legislation. **Collaboration allows the CAHs to focus scarce funding on services and specialties which are in great need in their communities yet are not offered by other entities.**
- » CAHs are most interested in **adding services such as community wellness centers, behavioral health practices, and hospitalist programs, showing responsiveness to the changing needs of their service population.**
- » Most respondents with hospitalist programs reported **increases in provider and patient satisfaction and hospital quality outcomes.**
- » Attracting and retaining staff is vital and CAHs recognize the importance of **creating a positive work environment that involves both the hospital and the larger community.**
- » In 2013, Illinois CAHs **started or completed nearly 100 capital projects** to improve technological capabilities, patient services, community wellness, rehabilitation or construction of hospital facilities, and other initiatives in response to changing service demands.
- » More than half of CAH survey respondents had successful quality improvement demonstration projects in the past three years, including the Hospital Engagement Network Programs, Project Better Outcomes by Optimizing Safe Transitions (Boost), and Project Re-Engineered Discharge (RED).
- » CAHs have had significant economic impacts statewide, especially in communities where the CAHs are located. **Statewide, CAHs support 10,157 full time equivalent workers (FTEs), earning \$578,004,218, or an average salary of \$56,906 per job.**

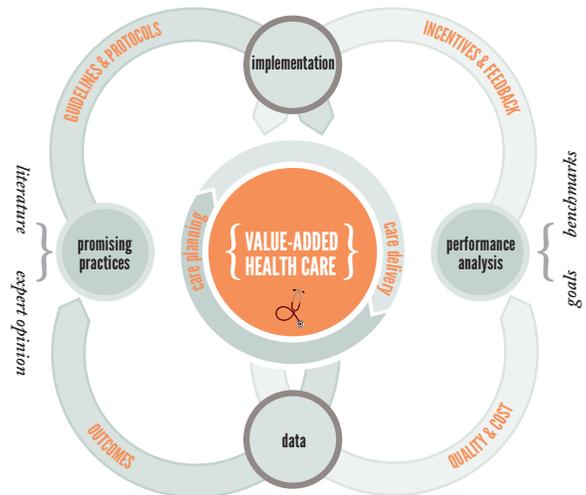
¹ ICAHN is a not-for-profit 501(c)3 corporation established in 2003 for the purposes of sharing resources, education, promoting efficiency and best practice and improving health care services for member CAHs and their rural communities. ICAHN, with 53 member hospitals, is an independent network governed by a nine-member board of directors. www.icahn.org

In early 2012, ICAHN executive director Pat Schou convened a Vision Committee including chief executive officers from Illinois CAHs to discuss issues facing rural health care organizations as implementation of the Patient Protection and Affordable Care Act (PPACA) began. The Vision Committee identified three top priority issues to address through a series of white papers: 1) quality of care initiatives; 2) the growing importance of collaboration for small health organizations; and 3) preparation for population health management and identification of new revenue models. ICAHN produced these issue papers aimed at helping policy makers understand the unique conditions in rural Illinois affecting the provision of health care and providing examples of successful strategies used to address these critical issues. The papers also identified barriers that complicate the replication of successful urban-based models of health care service expansion.

ENHANCING QUALITY OF CARE (APRIL 2012)

In April 2012, the first report in the series published by ICAHN, *Illinois Critical Access Hospitals: Enhancing Quality of Care in Rural Illinois*, demonstrated that CAHs are essential to the effective delivery of rural health care and are an important safety net for rural patients because they provide high-quality services in a challenging environment. The research showed that CAHs provide a high-value, affordable option for rural patients and rank high on several national quality measures including patient outcomes and patient satisfaction indicators.

In addition, many Illinois CAHs are involved with the Flex Program’s Medicare Beneficiary Quality Improvement Project (MBQIP) focused on improving the quality of care provided in rural CAHs through increasing the voluntary reporting by CAHs of relevant quality data. Voluntary reporting of data was identified in the 2012 *Enhancing Quality of Care* report as a challenge, but through increasing the number of CAHs reporting data, as well as defining and reporting rural-relevant quality measurements, CAHs can adopt proven clinical delivery models. In turn, CAHs can drive quality and performance-based value with better, more accurate data analysis.



COLLABORATING FOR EFFECTIVE RURAL HEALTH CARE (JANUARY 2013)

Released by ICAHN in January 2013, the second paper in the series, *Illinois Critical Access Hospitals: Collaborating for Effective Rural Health Care*, surveyed CAH staff in six Midwestern states and described effective approaches to achieving successful rural collaboration. The research found that some problems or challenges are too complex, or the solutions too costly, for one organization to manage alone reinforcing the importance of collaboration. Fortunately, many CAHs already represent small-scale integrated systems because they provide emergency and acute care services; offer rehabilitation services; most often employ the physicians; and provide or have relationships with local long-term care, home health, and hospice services. Across the nation, CAHs and their affiliated organizations have found solutions to fund capital improvements, obtain access to qualified staff, and begun to manage the population health of their service areas. As the U.S. transforms its health care delivery system, CAHs and other rural health organizations anticipate even greater demands and recognize the need to understand and learn how collaboration can enhance current and future service delivery as an option for long-term sustainability and viability.

UNDERLYING ISSUES FOR MIDWEST CAHS...

- » **Growing Elderly and Shrinking Youth Populations** affect payer mix for hospitals and collaborative efforts such as providing health care services that allow rural seniors to remain in their communities.
- » **Uninsured and Underinsured** populations may have higher rates of unmet medical needs caused by postponing necessary treatment. While the PPACA may address the problem of a high number of uninsured, it may contribute to an equally important issue--an increase in number of persons who are underinsured.
- » **Aging Medical Workforce** including only about 10.0% of physicians practicing in rural America despite the fact that nearly one-fourth of the population lives in these areas. Physician and other health care professional shortages will continue because the average age of physicians providing active patient care in rural Illinois was 56 years old in 2010.

MANAGING HEALTHY COMMUNITIES (OCTOBER 2013)

The third report in the series on population health management released in October 2013, *Illinois Critical Access Hospitals: Managing Healthy Communities in Rural Illinois*, was guided by a panel of CAH administrators from several regions in Illinois which examined population health model (PHM) challenges, alternative revenue models, and promising practices. Six major recommendations stemmed from this research report and align with many of the initiatives proposed in the PPACA. Each of the six recommendations necessitate a continuous improvement process and CAHs throughout Illinois are successfully implementing demonstration projects and sharing best practices.

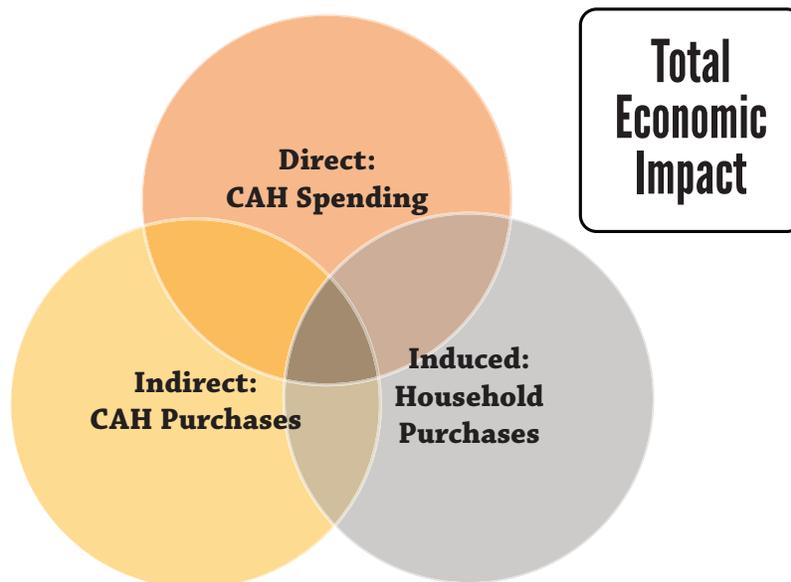
RECOMMENDATIONS FOR MANAGING A HEALTHY COMMUNITY

1. Start in your own backyard;
2. Take health promotion activities beyond the confines of the hospital;
3. Consider a regional approach to assessment and planning;
4. Public health is really the public's health;
5. Strive for the Triple Aim and collective impact; and
6. Identify upstream, midstream, and downstream strategies, engage partners.

ECONOMIC IMPACTS OF CAHS IN ILLINOIS

The roles that rural hospitals play in their communities as employers, health care providers, and partners in development are critical. According to the National Rural Health Association (NRHA), hospitals create approximately 138,000 jobs nationally. If a CAH were to close, substantial economic declines in the rural community could result, especially if other physicians, nurses, pharmacists, and other health care providers in the community are also affected. The NRHA report further discusses patients having to travel farther distances for care or delaying care resulting in poorer health outcomes. In fact, businesses, families, and retirees often will not relocate to a rural area without quality health care. Given the importance of hospitals to rural economies, ICAHN and CGS analyzed the economic impacts of CAHs on their communities in 2006, 2010, and in the most recent report.

In hospitals, the output is the total value of care provided, or total inpatient and outpatient revenue plus the actual value of charity care provided. Output is greater than the sum of value added and labor income, since it includes intermediate inputs, such as energy costs or the purchase of manufacturing and construction materials in impacted industries.



CAHs impact their communities on two levels: long-term and short-term. They create long-term economic impacts through their permanent employment at the hospitals. CAHs also create temporary, but significant, support for local businesses through large, one-time spending for capital projects such as construction and equipment. Knowing the economic impacts of a critical access hospital can assist policy makers in making future decisions. CAHs have significant impacts statewide but especially in communities where the CAHs are located. Several important economic impacts were identified in the *Illinois Critical Access Hospital Program* report:

1. The health care industry is a **major economic driver in rural communities** and in 2013 was the largest employment sector in 22 of the 62 rural Illinois counties, as well as the second largest employment sector in 21 additional rural counties. The health care industry represented 15.5% of the employment in rural Illinois counties, compared with 13.5% for the state as a whole.
2. **A quality rural health care system is essential in order to continue attracting businesses and employers.**
3. In FY 2013, CAH operations supported an additional 7,722 jobs, which are jobs created or retained because CAHs purchased goods and services or because CAH employees spent their wages. In total, CAHs in Illinois support an estimated 17,879 jobs statewide, **which means every \$100 the CAHs spend for operations generates an additional \$87 in output in the state economy.**
4. Many capital expenditure projects during the past several years have included adding space for specialties such as oncology and community wellness initiatives, showing a **responsiveness of CAHs to changing patient demand and population health factors.** Hospitals invest in capital projects to better serve their communities as well as increase viability, and that investment has a ripple effect of additional jobs and spending. **Illinois CAHs have also been able to modernize their facilities either through major renovations or construction of nine replacement facilities.**
5. Rural areas are experiencing changes in demographics including two important growing population segments: residents 65 years and older and those between 35 to 44 years of age. The specific services needed by these two groups differ but their local availability is important in stabilizing rural populations. **For retirees and young families to locate to rural areas, job opportunities and health care facilities must exist to meet their changing needs.**
6. Thirty-four independently-owned hospitals in Illinois have remained **financially viable partly because of the CAH program. No CAH has closed in Illinois since 2005. In addition, CAHs that are part of larger health care systems have been self-sustaining within those systems.**
7. **Collectively, CAHs in Illinois provided health care, including charity care, valued at \$1.3 billion,** with approximately 45.0% reporting an increase in charity care in past years. While this amount is not income *per se*, it is part of the 'value' that CAHs provide in their community beyond the direct economic benefits.
8. Many CAHs surveyed reported increases in the number of Medicaid cases since PPACA was implemented, partly because the number of Medicaid eligible patients increased. In addition, the percentage of CAHs with an increase in Medicare patients unable to pay (38.9%) outnumbered those reporting a decrease (5.9%). These two factors involving Medicaid and Medicare could explain why some CAHs have had an increase in charity care. **The additional costs combined with delayed or decreased reimbursement affect the ability of CAHs to maintain levels of services.**
9. Illinois CAHs report quality measures in Hospital Compare and **are above the national average in all but two quality measures.**

The CAH program has been critical to the viability of small rural communities. It has enabled rural hospitals to maintain access to care, modernize facilities, establish quality of care standards, create wellness services, and provide a safety net for rural residents. Rural areas will continue to face challenges with population and economic trends, but CAHs can be an integral part of the economic strength and stability of the community and provide an attractive place to live and work.

Full versions of all of the reports can be found at: http://www.cgs.niu.edu/services/CWED/Health_Care_Policy/index.shtml or on the ICAHN website at www.icahn.org. For additional information, please contact Melissa Henriksen, mhenriksen@niu.edu or Pat Schou, pschou@icahn.org.