
**CRITICAL ACCESS HOSPITALS:
PLANNING FOR THE FUTURE**



**A Report of the CAH Vision Committee
Illinois Critical Access Hospital Network**

May 2010

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Background

Members of the Illinois Critical Access Hospital Network convened in late 2009 to identify their vision of the critical access hospital of the future, its role in the health care system post-reform, and the actions necessary to achieve both. The convergence of the federal efforts to reform the health care system, the unprecedented momentum directed to the adoption of health information technologies, and the continuing economic upheaval precipitated these frank discussions. Further complicating the health care landscape are the ever-increasing elderly population, the need to preserve the rural health care infrastructure, the increasing incidence of chronic diseases among all age groups, and the potential impact of universal health coverage on an already too-small health care workforce, especially in our rural communities.

Illinois has 51 critical access hospitals, 25 percent of the state's hospitals. The critical access hospital designation was created by the Medicare Rural Hospital Flexibility Program (Flex Program), established by the Balanced Budget Act of 1997. The first critical access hospital certification of an Illinois hospital was granted by the Centers for Medicare and Medicaid in 1999. The Flex Program awards grant funds to states to be used to provide technical assistance to critical access hospitals, encourage the development of rural health networks, assist with quality improvement efforts, and improve rural emergency medical services. The program has enabled Illinois' critical access hospitals to remain financially viable, improve and expand diagnostic and outpatient services, update and modernize facilities, attract healthcare professionals, focus on quality improvement efforts, and expand access to healthcare services for rural residents.

To sustain the achievements enabled by the Flex Program and the modified Medicare payment structure, and to successfully embrace the new opportunities emerging from health care reform and technological innovations, Illinois Critical Access Hospital Network's Critical Access Hospital Vision Committee agreed early in its discussions that there must be a re-engineered critical access hospital in the future. The committee also identified the value of similar discussions among all 1,305 critical access hospitals nationwide and a coalescence of ideas and recommendations into national policy statements. The roles of other state critical access hospital organizations, state offices of rural health, the National Rural Health Association, the federal Office of Rural Health Policy, American Hospital Association, and other rural health advocates in the development and promotion of new policies must be evaluated and coordinated. Critical access hospital leaders and staffs and their health care and community partners must determine their own futures, preventing non-rural health care stakeholders from promoting their visions at the expense of the critical access hospitals and those they serve.

Process

The Critical Access Hospital Vision Committee is chaired by Susie Campbell, CEO of Community Memorial Hospital in Staunton, and first convened in Summer 2009. Committee members include:

- Ada Bair, CEO, Memorial Hospital, Carthage
- Kathy Bunting, CEO, Fairfield Memorial Hospital
- Trina Casner, COO/CFO, Pana Community Hospital
- Dolan Dalpoas, CEO, Abraham Lincoln Memorial Hospital, Lincoln
- Anna Laible, Administrator, Eureka Community Hospital
- Mike Muzillo, COO, Valley West Community Hospital, Sandwich
- Susan Philhower, Board Trustee, Hammond-Henry Hospital, Geneseo
- Mark Rossi, CEO, Hopedale Medical Complex
- Bob Sellers, CEO, Clay County Hospital, Flora
- Greg Starnes, CEO, Fayette County Hospital, Vandalia
- Steve Tenhouse, John and Mary E. Kirby Hospital, Monticello
- Pat Schou, Executive Director, Illinois Critical Access Hospital Network, ex officio

Initial Discussion Points/Recommendations

The committee considered both the supportive and restrictive aspects of critical access hospital certification, what works today and what will be needed in the future. Issues were identified within the categories of Medicare Conditions of Participation, revenue sources, services, facilities, workforce, public awareness and perception of critical access hospitals, and interactions with public policy makers. The issues listed below are not exclusive, rather they should be viewed as starting points for continuing discussions to identify best options for critical access hospitals and the patients they serve. Committee members believe these recommendations will help ensure the sustainability of the critical access hospital as a key partner in the rural safety net and provide direction for discussion of new ideas and program adjustments to meet the needs of the critical access hospital in the future.

The recommendations have been grouped into seven categories of potential actions and are delineated below.

Medicare Conditions of Participation

1. Consider bed-count options

- a) flexibility is needed due to seasonal changes, pandemics, and the increasingly large number of elderly; use an average annual daily census of 25
- b) obstetrics should be considered a distinct unit and the beds excluded from the facility bed count

2. Maintain requirements for observation beds and for hospice services as written.

3. Maintain psychiatric, rehabilitation, and skilled nursing as distinct units.
4. Reinstate the state-defined necessary provider option.
5. Eliminate regulations that cause critical access hospitals to lose Medicare and Medicaid certifications if the service area changes from rural to urban or if the level of health professional shortage improves.
6. Use critical access hospital certification as the eligibility standard for all state and federal programs that require rural location for participation.
7. Develop additional categories of critical access facilities, such as a **Critical Access Center**.
 - a) provide only outpatient and emergency department services, with observation beds and swing beds as options
 - b) only previously-certified critical access hospitals eligible
 - c) Medicare and/or states to consider whether the requirements would include compliance with life safety standards

Revenue Sources

1. Seek cost-based reimbursement or comparable alternative, such as inclusion of related expenses in the cost report as bad debt, for critical access hospital-administered emergency medical services, regardless of distance from nearest provider, for psychiatric services, and for long term care.
2. Pursue an increase in surgery limits to 1,000 per year for critical access hospital eligibility for the CRNA pass-through exception.
3. Seek approval for critical access hospitals to bill for senior wellness and /or chronic disease management programs within the outpatient rehabilitation therapy billing option.
4. Add both home health and durable medical equipment services to the list of cost-based services provided by critical access hospitals.
5. Pursue policy changes to initiate telemedicine reimbursement for all services that are reimbursed when conducted in a face-to-face encounter.
6. Pursue Medicare reimbursement authorization for additional services, including but not limited to:
 - a) dietician counseling services performed by hospital-employed staff
 - b) hospital recruitment expenses for family physicians and general surgeons
 - c) respiratory treatments and EKGs performed by hospital-employed staff
7. Reinstate the bonus payments for all physicians practicing in Physician Scarcity Areas and increase the amount to match the bonus payments for practice by primary care physicians in Health Professional Shortage Areas.

8. Pursue Medicaid cost-based reimbursement for critical access hospitals.
9. Evaluate the effect of the Value-based Purchasing Initiative on critical access hospitals and determine appropriate actions.
10. Evaluate the potential for Lean and Six Sigma methodologies to be adapted to critical access hospital operations to improve efficiency and control expenses.
11. Develop methodologies appropriate to the critical access hospital environment to evaluate the impact of health information technology on efficiency, quality of care, and improved outcomes.

Services

1. Expand the use of telehealth services to improve local access to care in rural communities.
2. Identify opportunities to expand the Medicare Rural Health Clinic Program so financial support for operations and expansion incentives more closely matches that available to Federally Qualified Health Centers.
3. Increase the collaboration between urgent care and rural health clinics to improve access to and continuity of care for service area residents, to improve efficiency of care, and to decrease duplication of services.
4. Eliminate state statute restrictions on partnerships between public entities and hospitals to jointly provide emergency medical services.
5. Pursue collaborations with the professional organizations that represent advanced practice nurses and physician assistants to ensure maximum use of these professionals' skills in hospital and clinic settings.
6. Lead local efforts to increase the adoption of technology and Internet access by rural residents as a means of slowing and preventing the progression of illness.
7. Evaluate critical access hospitals' roles in the use of remote monitoring of patients who need care, especially for those with chronic diseases who do not need inpatient care. Also to be considered are Six Sigma and Lean process improvement methodologies, which have been documented to improve chronic disease care.
8. Identify the intellectual property of critical access hospitals and how it can be used as an important value-add for the critical access hospital of the future.
9. Identify critical access hospitals' roles in community-wide efforts to control the onset of chronic diseases among rural residents.

10. Evaluate critical access hospitals' roles in chronic disease care coordination for rural residents to promote improved health status and prevent unnecessary hospitalizations.
11. Promote the value of a formal patient-centered care approach for critical access hospitals, an achievable hallmark due to reasonable size, familiarity of communities, patients, staff, family and neighbors. Planetree Patient-Centered Care is an example.
12. Identify the level of support necessary that will enable critical access hospitals to provide outpatient mental health services.

Facilities

1. Accelerate efforts with Medicare and, especially, Medicaid to reduce payment delays and the significant levels of payment discounting as mechanisms to improve credit ratings of critical access hospitals, resulting in improved access to funds for capital projects.
2. Document the impact of a streamlined application process for the U.S. Department of Agriculture's Rural Development Program and the U.S. Department of Housing and Urban Development support for critical access hospital capital projects.
3. Promote the use of evidence-based design to build facilities that support improved patient safety and care outcomes, and that best meet staff needs.
4. Evaluate the potential use of the *Green Guide for Health Care* building standards modeled on the U.S. Green Building Council's Leadership in Energy and Environmental Design, known as LEED, and identify standards that are appropriate for critical access hospitals. The GGHC aligns environmental health considerations with health systems priorities.
5. Promote healthy food choices in the critical access hospitals' food services for patients and staff, and use the examples as an educational opportunity community-wide.

Workforce

1. Actively support private, state, and national efforts to expand financial incentive programs for health professionals who pursue rural practice, especially at critical access hospitals.
2. Identify training opportunities in critical access hospitals and related rural health clinics for physicians, nurses and other health professions students.
3. Initiate dialogue with a state's medical schools and residency programs to identify best approaches to provide medical students and medical residents of all specialties with increased information about provider-to-critical access hospital relationships, and inter-specialist-to-hospital relationships.

4. Identify new Stark exemptions and cost-report options that enable greater financial interactions between critical access hospitals and physicians, both primary care specialists and other specialists.
5. Work with health professions education programs to include telemedicine experiences in the curricula and identify case studies of particular relevance to critical access hospitals.
6. Initiate discussions with representatives of the professional associations that represent family physicians and general surgeons to promote the development of a combined family practice/general surgeon specialty.
7. Initiate discussions among health professional organizations about possible new categories of workers – the *rural multi-specialty health worker* as an example – and identify the rationale for and best approach to develop new professional categories.
8. Identify best approaches for critical access hospitals to implement activities such as Magnet recognition or Clinical Nurse Leader programs that result in improved job satisfaction among nurses, improved patient care, shorter length of patient stays, and lower mortality rates.
9. Identify the work environment changes that result from technology implementations and other scientific-based advancements, and develop processes to assist the health care workforce remain current in their fields of expertise.
10. Identify best practices for critical access hospitals to stay current with team-based care models being promoted by MedPAC and health professions education institutions.
11. Develop models for sharing of highly skilled staff among multiple critical access hospitals as a mechanism to overcome workforce shortages and to offer competitive salaries and work environments.
12. Develop new employment and volunteer models for emergency medical services staff that overcome the challenges associated with recruiting staff in rural communities. Challenges most frequently encountered in rural communities includes retirements due to the aging rural populations, the decreasing number of individuals employed locally in rural communities, and the increasing inability of workers to be absent from their places of employment.

Public Awareness and Perception of Critical Access Hospitals

1. Identify the core competencies and values of critical access hospitals and ensure that rural residents, legislators, and congressional members are aware of this information.
2. Encourage university researchers at the state level as well as at the Rural Health Research and Policy Centers funded by the federal Office of Rural Health Policy to conduct evaluations of the outcome quality, cost efficiency, care and cost values associated with the diversity of care that can be provided and coordinated by critical access hospitals. Use existing research reports when possible to develop public awareness documents.

3. Develop quality improvement measures specific to critical access hospitals and other small rural facilities that can be used to promote the value of critical access hospitals with the public and with policy makers. Examples of quality improvement measures include comparison of emergency department wait times with those of urban facilities; outpatient surgery outcomes; diagnostic wait time; decubitus rates in acute care/swing beds and discharge status from swing bed units; and lower incidence of urinary tract infections and falls for patients in critical access hospitals compared to larger or urban facilities.
4. Encourage 100 percent participation of critical access hospitals and their employed physicians in quality reporting and PQRI programs, and use the reported information to demonstrate the quality of care provided at critical access hospitals.
5. Pursue elimination of multiple co-payments for Medicare beneficiaries who receive services in an emergency department, observation unit, and as an inpatient within a 24-hour period.

Interactions with Policy Makers

1. Create opportunities for an increased national focus on critical access hospital-specific issues.
2. Develop a coordinated effort among all Illinois Critical Access Hospital Network members to provide standardized information to state and federal elected representatives to promote a common understanding of the value of critical access hospitals and to develop a relationship built on the knowledge base, timeliness, and accuracy of information.
3. Become proactive supporters of the National Rural Health Association policy agenda and other healthcare organizations that support rural health care and the critical access hospital community.
4. Encourage advocacy organizations in each state to develop their own critical access hospital visions and prioritize necessary action steps.