

# ILLINOIS RURAL HEALTH PLAN

## Rural Health Care Access and Critical Access Hospital Program Implementation

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The findings and conclusions presented herein are those of the CGS project team alone and do not necessarily reflect the views, opinions, or policies of the officers and/or trustees of Northern Illinois University nor those of the employees, officers, and/or members of the Illinois Department of Public Health or the Illinois Critical Access Hospital Network.

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Northern Illinois University's Center for Government Studies (CGS) gathered and analyzed the most current rural health care data and updated the plan that was originally published in March 1998 and revised in May 2002. The CGS project team consisted of Diana L. Robinson, Assistant Director, and Ruth Anne Tobias, Research Associate. Lina Rombalsky, Research Associate, provided research support. Andre Sobol, Research Associate, provided overall document layout and design.

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## I. Executive Summary

This plan provides a demographic and system wide context for considering the role of the small rural hospital in addressing the health care needs of residents throughout Illinois. Long a vital health care provider in rural areas, many of these small, financially vulnerable institutions struggled to remain solvent after Congress changed the Medicare reimbursement approach in 1983 to pay a fixed amount based on the patient diagnosis and whether the hospital was rural or urban. Low Medicare payments resulted in a lack of investment in modern facilities and medical equipment and many hospitals closed their doors.

Rural Illinois hospitals serve a population that, despite improved demographic and economic characteristics during the 1990s, is losing ground since 2000. Illinois' 83 rural counties are growing more slowly than the state's urban counties, and are becoming older and poorer. Rural residents are more likely than their urban counterparts to have such health risk factors as diabetes, high blood pressure, and limited activity due to disability.

Like other states throughout the U.S., rural Illinois continues to experience difficulty in attracting needed health care professionals. Almost one in six rural Illinoisans lives in a primary care shortage area. To help address the lack of adequate health care in the state, many Illinois health care organizations are focusing on the needs of rural residents and provide a broad array of programs and services. These programs, combined with rural hospitals, long term care facilities, home health and hospice care, emergency medical services, rural health clinics, federally qualified health centers, and local health departments, make up the system of health care available to rural Illinois residents.

As the backbone of the rural health network, rural hospitals are experiencing increased inpatient and outpatient utilization. While most rural hospitals struggle to achieve or maintain financial solvency, their patient and operating margins are improving. Yet, nearly one-fifth of all rural hospitals had negative operating margins in 2005.

The creation of the Illinois Critical Access Hospital Network (ICAHN) in 2003 provided the opportunity for the state's Critical Access Hospitals to integrate into a formal network. This has enabled its member hospitals to share information, collaboratively solve problems, provide leverage for purchasing goods and services, and promote advocacy for their unique needs. There is evidence that the capacity-building activities undertaken by ICAHN and its member hospitals are working. Recent CAH financial indicators for performance assessment show that most of Illinois CAHs' are in the top 25% nationally in terms of profitability.

The efforts made by Illinois Department of Public Health's Center for Rural Health and its many state agency, university and organizational partners have made a significant difference in improving the viability of the small rural hospital. However, persistent and serious resource and access issues continue to characterize rural health in Illinois. The partnerships forged among these rural health partners will become even more vital as the pursuit of needed improvements continues.

## II. State Rural Demographic Profile

Despite improvements in many of the demographic and economic characteristics of rural Illinois during the 1990s, recent data indicate that many of these trends have slowed or reversed since 2000. When compared to the state as a whole and to Illinois' 19 urban counties, the 83 rural counties<sup>1</sup> in Illinois display population growth that has slowed or shown a net loss. In addition, rural Illinois is characterized by growing concentrations of the elderly, lower income households, and higher unemployment and poverty rates, as well as the fact that rural residents are more likely than their urban counterparts to lack medical insurance. Moreover, they are confronted with the added physical barriers to health care that include fewer and more geographically dispersed medical facilities and a lack of public transportation. These demographic dynamics provide an important context to understanding the health care issues facing rural Illinoisans and are the focus of this section.

### A. Overall Population

Rural Illinois has experienced significant fluctuations in population over the last 40 years. Between 1970 and 1980, rural counties in Illinois gained nearly 117,000 people, a rate of increase greater than Illinois as a whole or the state's urban counties. Much of that increase was lost in the subsequent decade, but since 1990 the overall trend has been one of modest net growth. As illustrated in Table 1, the 1.9% population increase in rural counties was about one-fifth of the rate in Illinois urban counties. Moreover, while only five urban counties in Illinois lost population since 2000, 54 of Illinois' 83 rural counties experienced net population losses (See Appendix Figure A-1). If the fast-growing "rural metro"<sup>2</sup> counties on the edge of the Chicago metro region, such as Boone, Grundy, and Kendall (one of the fastest growing counties in the nation), are removed from the rural mix, the gain would slip to a loss of about 1.0% for the remaining rural counties.

These rural metro counties on the edges of metropolitan areas differ from other rural counties in the degree of rural-urban interaction and the characteristics of their populations. By contrast, several counties have experienced persistent losses either since 1970 or since 1980 (See Appendix Figure A-2). Five rural counties lost population in each decade since 1970, and 22 rural counties lost population between 1980 and 2006. These areas are concentrated in the southeast and west central parts of the state, relatively far from growth opportunities. Table 1 includes proprietary projections for 2011 that anticipate a decline in rural population through 2011.

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<sup>1</sup> A "rural" county is defined using the Illinois Department of Public Health Center for Rural Health criteria: a county that is either outside of a metropolitan area or part of a metropolitan area with less than 60,000 in population. The terms "metropolitan" and "non-metropolitan" are based on the size of the cities within those counties and on commuting ties with surrounding counties. Although metropolitan and non-metropolitan are often used to mean urban and rural, many metropolitan counties contain rural populations and non-metropolitan counties may contain urban populations. Approximately one-half of the nation's rural population lives in metropolitan counties.

<sup>2</sup> This designation is used by the U.S. Department of Agriculture Economic Research Service

**Table 1**  
**Population Growth in Rural and Urban Counties in Illinois: 1970 - 2011**

	1970	1980	1990	2000	2006	2011 Projected
<b>RURAL</b>	1,930,413	2,048,747	1,940,427	1,977,463	1,963,083	1,953,718
<b>% CHANGE</b>		6.1%	-5.3%	1.9%	0.7%	-0.5%
<b>URBAN</b>	9,062,347	9,236,019	9,341,662	10,256,933	10,631,275	10,941,405
<b>% CHANGE</b>		1.9%	1.1%	9.8%	3.7%	2.9%
<b>ILLINOIS</b>	11,113,976	11,427,518	11,430,602	12,419,293	12,821,472	13,161,821
<b>% CHANGE</b>		2.8%	0.3%	6.5%	3.2%	2.7%

Source: U.S. Census Bureau, 1970 – 2006; Easy Analytic Data, 2011.  
These data use the same rural/urban county definitions across the decades.

## B. The Elderly

Illinois' urban areas are growing younger as the rural areas are growing older. Approximately 15% of the population in Illinois rural counties in both 2000 and 2006 are considered 'seniors' at 65 years of age or older. This compares to 11% in urban areas for both years and 12% statewide. The percentage of rural elderly has increased one percentage point since the 1990s while the urban and statewide senior percentages declined one percentage point each. In 2006, 74% of rural counties had senior populations that were at least one-third higher than the state average. Census Bureau data show that between 2005 and 2006, more than one-half of Illinois rural counties had more deaths than births, the result of young people moving away from these areas and the elderly remaining where they were. No urban counties in Illinois had the same situation. The disproportionate number of elderly rural residents translates directly to demand for health care resources, particularly at the end of life when the largest share of health care expenditures occurs.<sup>3</sup> The relative concentration of the elderly and smaller number of youth in Illinois rural counties are summarized in Table 2.

<sup>3</sup> John M. Luce & Gordon D. Rubinfeld, "Can Health Care Costs be Reduced by Limiting Intensive Care at the End of Life?" *American Journal of Respiratory and Critical Care Medicine*, Vol. 165, No. 6, March 2002, pp. 750-754

**Table 2**  
**Illinois Youth and Senior Population in Rural and Urban Counties in Illinois: 2000 - 2011 (Projected)**

	2000	2006	2011
<b>% Less Than 18</b>			
RURAL	24.3%	25.5%	23.7%
URBAN	26.5%	26.5%	25.5%
STATEWIDE	26.1%	26.2%	25.2%
<b>% 65 and Over</b>			
RURAL	15.9%	15.4%	15.2%
URBAN	11.3%	10.8%	10.5%
STATEWIDE	12.1%	11.6%	11.3%

Source: U.S. Census Bureau, 2000; Easy Analytic Data, 2006, 2011.  
These data use the same rural/urban county definitions across the decades.

### C. Youth

Annual surveys of child well-being by the Annie E. Casey Foundation<sup>4</sup> indicate that rural children are often not as well off as their urban counterparts. Infant mortality rates per 1000 births in 2003 range from 3.0% to 20.0% in rural areas and from 2.7% to 11.0% in metro areas. And even though the percentage of children in poverty is the same, on average, in both geographies, the spread is much greater in rural areas (4.4% to 34.0%) than in urban counties (5.0% to 21.3%). Also, the incidence of child abuse and neglect is higher in rural areas where there are fewer social services available (Illinois Department of Children and Family Services, 2007).

### D. Employment and Poverty

As population grew across the state over the last 16 years, so did jobs and the number of people employed. Statewide, there were 616,000 more people employed in 2000 than in 1990, and another 138,000 more between 2000 and 2006, according to the Illinois Department of Employment Security. However, growth in jobs in Illinois was not evenly distributed across the state, with only 30 counties registering significant job gains since 2000, and only four counties outside the Northeastern region expected to meet or exceed the projected state rate of job growth.<sup>5</sup> As a result, the rural unemployment rate in 2006 is essentially unchanged since 1997 at 4.9%. Urban data show a slightly lower rate of 4.5%, a small increase from 1997.

<sup>4</sup> 2004 Kids Count Data Book: Moving Youth from Risk to Opportunity

<sup>5</sup> Northern Illinois University Center for Governmental Studies, The State of Working Illinois, 2005

**Table 3**  
**Unemployment Rates in Rural and Urban Counties in Illinois:**  
**1990 - 2006**

	1990	1997	2000	2006
RURAL	7.7%	5.0%	5.0%	4.9%
URBAN	5.1%	4.0%	4.3%	4.5%
ILLINOIS	5.6%	4.2%	4.5%	4.5%

Source: Illinois Labor Market Information, Local Area Unemployment Reports, 2006.  
 These data use the same rural/urban county definitions across the decades.

Even though there may be less unemployment in rural areas now, the work environment has also changed. Thousands of high-paying manufacturing jobs have been lost statewide since the mid-1990s, replaced for the most part by lower-wage service sector jobs. Nationally in 2005, one in four wage and salary employees in rural (non-metro) areas were low-wage workers, i.e. earning less than the poverty threshold for a family of four. Many of these low-wage workers are employed as seasonal and part-time workers and are often the sole family income earner. These facts contribute to a very high poverty level of 19.1% among this group.<sup>6</sup>

Although poverty is more prevalent among rural Illinois residents than in urban areas, official measures indicate that the rural poverty rate has decreased slightly since 1990. Estimates for 2004 identified 11.8% of rural residents as living below the federal poverty level compared to 10.0% of urban residents. However, this rate is an improvement over the 13.1% rural poverty level reported in the 1990 Census.

Other data sources suggest that more rural Illinoisans are living in poverty than reported in the Census. Proprietary estimates of household income for 2006 indicate that more than 28% of rural households had incomes of less than \$25,000, an amount that is 125% of the federal poverty level for a family of four. (Many federal and state agencies use 125% or 150% of the federal poverty levels to generate a more accurate measure of economically disadvantaged households.) As a result, a large segment of the rural population has limited resources to meet living expenses, particularly health care expenses. Figure A-3 in the appendix depicts poverty levels by county for Illinois.

### **E. Median Household Income**

Median household income in Illinois has more than quadrupled between 1970 and 2000. Although household incomes are improving for residents of rural areas, as shown in Table 4, median household income (unadjusted for inflation) in the state's rural counties represents

<sup>6</sup> U.S. Department of Agriculture, Economic Research Service, *Amber Waves: The Economics of Food, Farming, Natural Resources, and Rural America*, June 2007, downloaded 06/25/07 at <http://www.ers.usda.gov/AmberWaves/>.

on average 76.2% of the overall median income for urban households. The most recent available data estimates the statewide median income in 2004 at \$47,711. Fully 88% of rural counties (73 in all) had incomes below the state median. Those above the state median fall into the “rural metro” areas described earlier and are either in metropolitan regions or on their borders. These areas are most likely to experience the spillover effects of wealth-building opportunities available in the nearby urbanized areas.

**Table 4**  
**Unadjusted Median Household Incomes in Rural and Urban Counties in Illinois: 1970 - 2011 (Projected)**

	1970	1980	1990	2000	2004 est.	2011 (Projected)
RURAL	\$8,213	\$15,711	\$24,428	\$36,776	\$40,361	\$52,157
URBAN	\$11,013	\$19,983	\$32,954	\$47,508	\$49,631	\$66,130
ILLINOIS	\$10,959	\$19,3232	\$32,252	\$46,590	\$47,711	\$65,328

Source: U.S. Census Bureau, 1970 – 2004; Easy Analytic Data, 2011.  
Dollar values are actual and have not been adjusted for inflation.

When household income is adjusted to 2006 dollars, as shown in Table 5, the apparent earnings gains are shown to be actual losses in buying power over time, as what cost \$1.00 in 1970 now costs \$5.49. The rebound in purchasing power during the 1990s brought adjusted median incomes back toward their 1970 levels, but the early 2000s saw further declines. Thus, Illinois’ rural households experienced income erosion in addition to income disparities when compared to urban households.

**Table 5**  
**Median Household Incomes Adjusted for Inflation in Rural and Urban Counties in Illinois: 1970 - 2011 (Projected)**

	1970	1980	1990	2000	2006 est.
RURAL	\$45,091	\$43,677	\$39,817	\$44,499	\$40,936
URBAN	\$60,464	\$55,552	\$53,715	\$57,485	\$51,799
ILLINOIS	\$60,165	\$53,718	\$52,571	\$56,374	\$49,899

Source: U.S. Census Bureau, 1970 – 2000; Easy Analytic Data, 2006.  
All dollars are adjusted using Consumer Price Index values.

Recent data indicate that there is increasing difficulty among working adults in maintaining a basic living standard. Statewide, rural workers with low incomes are up to 59% less likely to have health insurance coverage than are low-income workers in Chicago or other metro areas.<sup>7</sup> The result is poorer health outcomes as rural residents are less likely to seek preventative care and are more likely to rely on emergency room services.

<sup>7</sup> Illinois Department of Public Health, Illinois Behavioral Risk Factor Surveillance System, 2003

## F. Health Risk Factors

Rural residents in Illinois are at significantly higher risk for a number of negative health behaviors or circumstances. The Illinois Behavioral Risk Factors Survey gathers information on risk factors among Illinois adults 18 years of age and older. As summarized in Table 6, rural residents are more likely than their urban counterparts to have diabetes, high blood pressure, self-assessed poor health, no dental check-up within the past year, limited activity due to disability, no mammogram for women 40 years of age or older, and are more likely to smoke. The only factor for which rural residents have a lower health risk is for being overweight or obese, but this condition still affects almost two out of three rural inhabitants.

**Table 6**  
**Illinois Behavioral Risk Factor Surveillance Survey**  
**Selected Results for the Period: 2003-2005**

Area	Diabetes	High Blood Pressure	Self Assessed Poor Health	No Dental Check-up Last Year	Activities Limited by Disability or Health	Smoker Status Yes	Overweight or Obese	No Mammogram For Women Aged 40 & Over
Illinois	8.0%	25.5%	3.7%	29.6%	13.9%	19.9%	60.0%	9.9%
Rural	8.8	29.6	4.7	29.6	16.0	23.3	65.2	12.0
Urban	7.9	27.7	4.0	26.0	14.5	21.0	68.8	6.0
Southern Seven Counties*	10.4	36.7	7.6	43.3	25.4	29.0	67.5	10.9

\* Alexander, Hardin, Johnson, Massac, Pope, Pulaski, and Union counties

Source: Illinois Department of Public Health, Illinois Behavioral Risk Factor Surveillance System

The link between these high-risk health behaviors and rural Illinois is even clearer when considering the most remote and rural portions of the state. Residents of the seven southernmost counties in Illinois are more than twice as likely to assess themselves as in poor health and almost twice as likely to have their activities limited by a disability than all Illinoisans. With the exception of mammograms, all of the other health risks are also dramatically higher. Taken together, these seven counties also have an average poverty rate of 16.7%, well above the average of 11.2% for all rural counties, attesting to the strong relationship between income and health outcomes.

### III. State Health Care Resources

Like other states throughout the U.S., Illinois continues to experience difficulty in attracting needed health care professionals to practice in rural areas. As indicated in this section, almost one in six rural Illinoisans lives in a primary care shortage area. Other health care facilities available to rural residents are described, including long term care facilities, home health and hospice care, emergency medical services, rural health clinics, federally qualified health centers, and local health departments. These resources, in combination with the hospitals and programs and organizations described in the next two sections, make up the system of health care available to rural Illinois residents.

#### A. Primary Care Physicians

Illinois is one of the top states in the number of physicians it graduates each year with 1,027 in 2006<sup>8</sup>, or 6.4% of the nation's total medical school graduates. However, Illinois also has an estimated 19.5% of residents living in federally-designated Health Professional Shortage Areas (HPSAs). A HPSA is a geographic area, population group, or health care facility with a shortage of health professionals. A key designation criterion is population-to-clinician ratios, which are usually 3,500 to 1 for primary care and 30,000 to 1 for mental health care. Since 1990, the number of residents in HPSAs has increased with an estimated 2,074,528 Illinoisans or 19.4% of the state's population residing within a primary care HPSA in 2006.

	<b>1990</b>	<b>1997</b>	<b>2006</b>
Number	1,934,067	1,682,193	2,074,528
% of Total State Population	16.9%	14.1%	16.2%

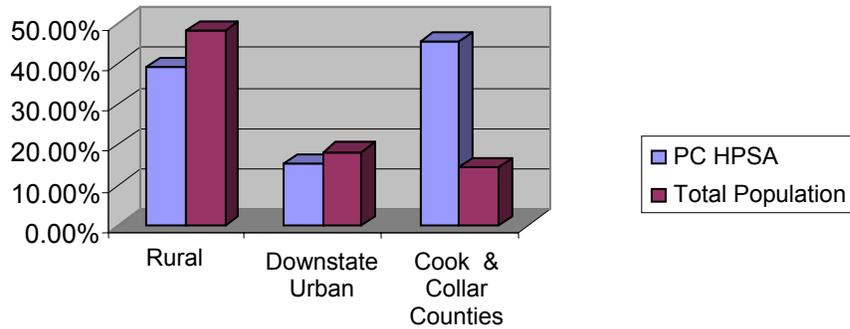
Source: U.S. Department of Health and Human Services, Health Resources and Services Administration, <http://datawarehouse.hrsa.gov/> accessed June 15, 2007

As apparent in Table 7, despite this overall increase in HPSA population, a drop occurred in 1997 in both the absolute number and percentage of all residents within a HPSA in 1997. Although the designation criteria have remained unchanged since 1992, the addition or loss of only one full-time equivalent physician, or even a part-time physician, can change the HPSA status of a service area.

Most primary medical care HPSAs in Illinois are located in Cook and the collar counties. However, as Figure 8 shows, rural areas of the state are disproportionately affected by the shortage of primary care physicians. Of 83 rural Illinois counties, 77 (93%) had some category of HPSA as of June 2007. Moreover, 38 (46%) of these rural counties are designated as whole county HPSAs. A map of current HPSAs is presented as Figure A-4 in the appendix.

<sup>8</sup> <http://www.aamc.org/data/facts/2006/schoolgrads.htm>

**Figure 8**  
**Distribution of Primary Care HPSA Population and Total Population by Geographic Areas in Illinois in 2007**



Like the rest of the nation, Illinois is experiencing a physician shortage. According to the U.S. Bureau of Labor Statistics, 6,470 primary care physicians were practicing in Illinois in May 2006. Of these, 44% were family and general practitioners, 31% were internists, 10% were obstetricians and gynecologists, and 15% were pediatricians. When divided into the 2006 total Illinois population, the result is a ratio of 50.4 primary care physicians per 100,000 Illinoisans. Table 9 presents the breakdown by specialty.

**Table 9**  
**Illinois Primary Care Physicians by Specialty - 2006**

Specialty	Number	% of Total
Family & General Practitioners	2,850	44.0%
Internists	2,000	31.0%
Obstetricians & Gynecologists	650	10.0%
Pediatricians	970	15.0%
Total	6,470	100.9%

Source: U.S. Bureau of Labor Statistics, 2006

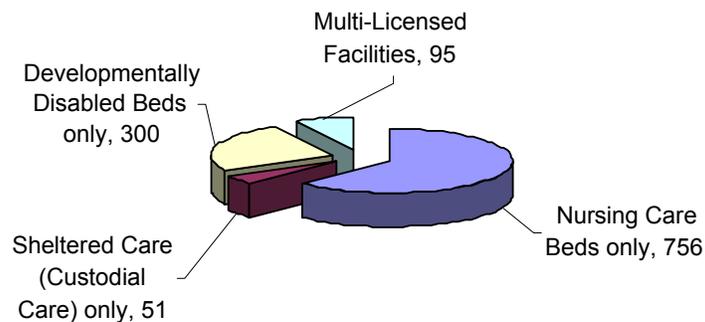
According to the Illinois Department of Professional Regulation, 34,972 physicians and surgeons have an active license to practice medicine in Illinois. While every active license holder may not be practicing or may not be practicing in the county designated on their license, when mapped by county additional insight is provided into the geographic distribution of this essential healthcare resource. As evident in Figure A-5 in the appendix, the highest ratios of physicians and surgeons to population tend to be in the metro counties. By contrast, the lowest licensure rates are all in the rural counties.

## B. Other Resources

### 1. Long Term Care Facilities

The Illinois Department of Public Health reported 1,202 long-term care facilities around Illinois.<sup>9</sup> Of these, 69 (5.7%) were hospital-based and 1,133 (94.3%) were free-standing facilities. By ownership type, there were 69 (5.7%) government owned, 455 (37.9%) not-for-profit owned, and 678 (56.4%) private for-profit facilities (see Figure 10). The percentage of Medicare-approved long-term care facilities in rural Illinois is available in the Centers for Medicare and Medicaid Services (CMS) Nursing Home Compare database. Of the 1,053 long term care facilities in the Illinois portion of that database, 35.4% are in rural counties.

**Figure 10**  
**Long-Term Care Facilities by Licensure Type**



Source: Illinois Department of Public Health, 2005

Long-term care (LTC) usually means custodial care with no skilled nursing, a service for which Medicare does not pay. In a nursing home that is a skilled nursing facility (SNF), 24-hour medical care is provided along with other rehabilitative services that will improve capabilities in the activities of daily living. Some portion of the beds in a SNF will be Medicare eligible, either for rehabilitation or longer term skilled care. Of the total LTC beds in Illinois in 2005, 45.4% were Medicare certified (all in SNFs) and 81.1% Medicaid certified in all types of facilities except sheltered care.

### 2. Home Health and Hospice Services

According to the CMS, there were 330 licensed home health agencies in Illinois in 2004. Home health organizations, many based in local health departments, enable people to remain in their homes and out of institutional settings. Hospice programs are available in 29 of the 83 rural counties (34.9%), represented by 34 programs.

<sup>9</sup> [www.idph.state.il.us/about/hfph/pdf/LTC%20State%20Summary%202005.pdf](http://www.idph.state.il.us/about/hfph/pdf/LTC%20State%20Summary%202005.pdf)

3. Emergency Medical Services<sup>10</sup>

In 2007, there are 304 organized emergency service providers serving Illinois rural counties. Of these, 28 are first responders or enhanced 911, without transport services. In Illinois, while 90% of the population is covered by 911 service, only 50% of the land area is covered by this vital communication tool. In 25 counties, or 30% of rural areas, there is only one emergency service provider; however, half of these provide advanced life support. Another 27 counties have 24-hour emergency service providers, while an additional 27 counties have five or more providers. Four counties lack any EMS.

4. Rural Health Clinics

Medicare-certified rural health clinics have been in place since 1977 to serve Medicare and Medicaid beneficiaries in rural Health Professional Shortage Areas and Medically Underserved Areas. Appendix Figure A-6 illustrates the location of the 225 rural health clinics in Illinois. Of these facilities, 13.8% are under government control, 30.7% are non-profit organizations, and the remaining 52% are for-profit operations (see Table 11). This clinic program provides improved access to primary health care services for Illinois rural citizens in the Medicaid and Medicare programs, partly by the increased use of nurse practitioners and physician assistants. A December 2006 snapshot dataset from the HRSA data warehouse shows about 520 physicians, 99 nurse practitioners and 128 physician assistants employed in these rural clinics.

Type of Control	Total
For Profit - Corporation	85
For Profit - Individual	31
For Profit - Partnership	9
Government - Federal	1
Government - Local	24
Government - State	6
Non-Profit Corporation	67
Non-Profit Individual	2
Grand Total	225

Source: Rural Assistance Center, 2007

<sup>10</sup> Data in this section are from [www.ilems.com/main/areacare.htm](http://www.ilems.com/main/areacare.htm), the Illinois Emergency Services website.

5. Federally Qualified Health Centers and Community Health Centers

Federally Qualified Health Centers (FQHCs) and FQHC “look-alikes” were designed in 1991 as Medicare safety net providers to deliver primary and preventive health care to rural and other underserved areas around the country, with support from the federal government in the form of funding and all-inclusive per visit Medicare payments. Congress recently approved a dramatic increase in funding for these centers, however, there is still a shortage of physicians and other health personnel to support the need. Illinois currently has 178 FQHCs.

6. Local Health Departments

Only two counties in Illinois, Edwards and Richland, do not have public health department coverage. Local health departments are locally governed and organized by municipality, township, district, city-county, county, or multi-county level. They receive a combination of local and state tax support, plus an array of categorical grants and fee-for-service reimbursement. There are several consortia of local health departments which serve multiple counties, mostly in rural areas.

These agencies are on the front lines of providing both community health programs, such as restaurant and water well inspections, and specific personal health programs to local residents for whom no other health resources, besides hospital emergency rooms, exist. Major programs include well child screening, Women, Infants and Children Food Supplement program, family planning, Healthy Mom/Healthy Kids programs, school physicals, influenza vaccine shots, blood lead testing, and tuberculosis and AIDS testing. Rural health clinics and Federally Qualified Health Centers (both urban and rural) are vital health care resources in underserved areas

7. Assistance Available to Rural Illinois Communities

Members of community-based organizations, staff of health care facilities, and residents of communities in rural Illinois have access to various forms of assistance from organizations, agencies, and universities as they address complex local concerns. Several of these technical assistance programs are described in Section V of this plan.

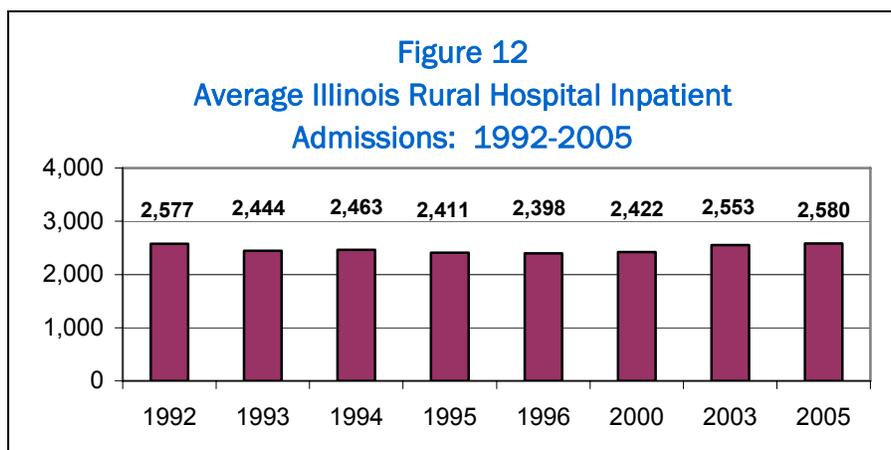
## IV. Rural Hospital Profile

Rural hospitals are different from urban hospitals in the patients they treat, the services they provide, and the dollars they generate.<sup>11</sup> This section provides an overview of rural hospital capacity and utilization, rural hospital payment sources and personnel, key hospital financial indicators and ownership types, and a hospital profile summary. There is also information on the economic viability of Illinois' Critical Access Hospitals.

### A. Rural Hospital Capacity and Utilization

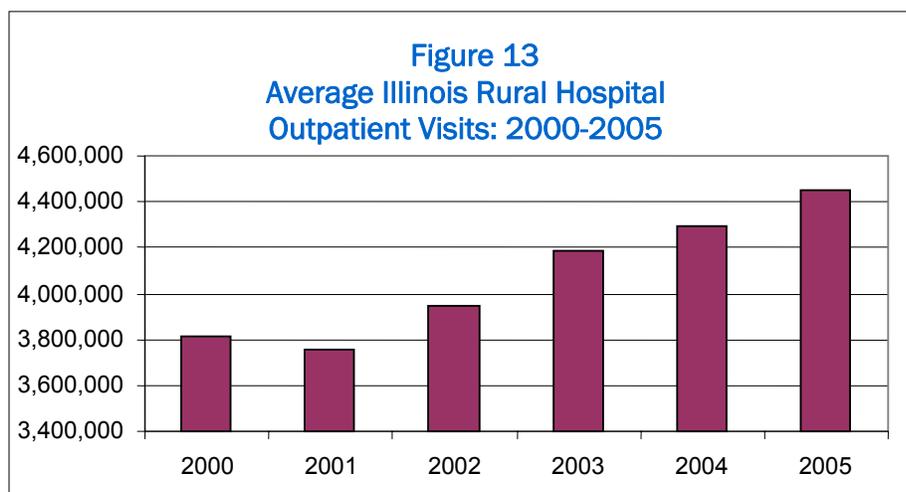
In 2005, there were 67 rural hospitals serving 1.7 million Illinois residents (approximately 14% of the state's total population). Three of these hospitals serve special populations, such as veterans or mental health patients. The remaining 64 hospitals are community hospitals, representing 29.8% of all open Illinois hospitals. Most (more than 80%) rural hospitals are small with fewer than 100 beds. Of these small rural hospitals, 51 are federally-designated Critical Access Hospitals and are limited to 25 beds or less. Among the urban hospital group, over 80% have more than 100 beds.

Utilization of rural hospitals is increasing. Inpatient increases are relatively modest with average lengths of stay increasing from 4.2 to 4.3 days between 2000 and 2005, and admissions increasing from an average of 2,422 to 2,580 during the same period. Figure 12 charts the change in average rural hospital inpatient admissions between 1992 and 2005.



Source: American Hospital Association, 1992-2004

<sup>11</sup> Data sources for this section included the American Hospital Association's Annual Survey of Hospitals and the Illinois Hospital Association's *Facts About Illinois' Rural Hospitals* and *Focus on Rural Community Hospitals in Illinois* reports.



Source: Illinois Hospital Association, 2007

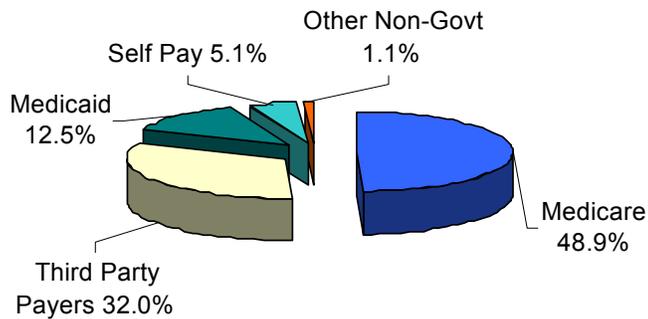
Illinois rural hospitals are continuing their outpatient orientation to keep pace with market changes that demand higher quality care at lower cost. Outpatient visits to Illinois rural hospitals jumped from 2.2 million in 1991 to 3.8 million in 2000 and again to 4.4 million in 2005. Included in those visits are outpatient clinic visits, ambulatory surgeries, and emergency room visits. Outpatient clinic visits experienced the largest increase of the three services, 18.7% between 2000 and 2005, and more than doubling the number from 1991. Ambulatory surgeries have increased 6.7% since 2000, while emergency room visits also increased at almost 10%. In 2005, 73.7% of all rural hospitals' surgical procedures were performed on an outpatient basis, compared with 68.4% in 1996 and 71% in 2000. On an average day, about seven patients receive inpatient care and another 190 receive care in an outpatient clinic, in outpatient surgery, or in the emergency department of a rural hospital.

#### **B. Rural Hospital Payment Sources and Personnel**

Outpatient services are growing increasingly vital to the survival of rural hospitals. In 1991, outpatient services contributed 33.7% of rural hospital's gross revenues. By 2005 that percentage had increased to more than 54%. In contrast, urban hospitals receive 36% to 40% of gross revenues from outpatient services.

The gross revenues of Illinois rural hospitals are derived from three major sources: Medicare, private insurance, and Medicaid. More than 60% of all hospital revenue comes from government sources. As illustrated in Figure 14, Medicare represented the largest share of total Illinois rural hospital gross revenues in 2005 at 48.9%, down from 61.6% in the 1990s, but up from 47.8% in 2000. Private insurance providers are the second largest revenue source at 32%, which showed the largest increase since last measured. Medicaid is the third largest dollar source at 12.5% of gross revenue, up slightly from a 10% share in 1996 through 2000.

**Figure 14**  
**Rural Hospital Revenue Sources 2005**

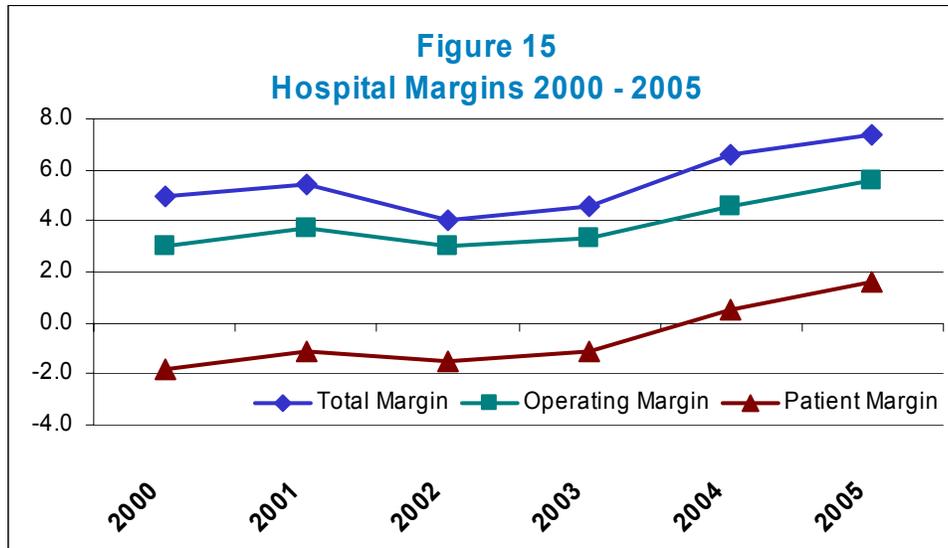


Source: AHA, IHA surveys 2005

In 2005, Illinois rural hospitals employed an average of 359 Full Time Equivalent Employees (FTEs), up from 268 in 1992 and 321 FTEs in 2000. This translated to a total of 22,962 FTEs in Illinois rural hospitals in 2005 or about 12% of the total Illinois hospital workforce. Critical Access Hospital status and associated funding allowed many facilities to increase their staffs to provide more direct care personnel to care for their communities. Workforce costs constituted 51% of all expenses. The total rural hospital payroll expense was \$1.2 billion, which included 77.6% for wages and salaries and 22.4% for benefits. In 41% of rural counties, the hospital is one of the top three employers and is vital to the economic health of the community and the surrounding area.

### **C. Key Hospital Financial Indicators and Ownership**

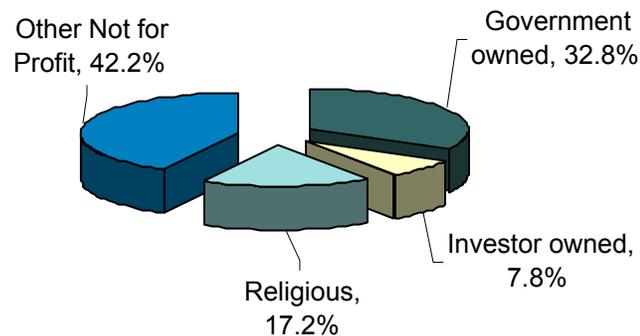
While the struggle for financial solvency is often more difficult for rural hospitals, there are signs that efforts to assist in this regard are working. Hospital margins are often used as a measure of profitability in health care and represent the difference between total revenue and costs as a percentage of total revenue. As indicated in Figure 15, the total operating margin of Illinois rural hospitals, which includes such non-operating income as contributions, public appropriations, investments, and income from subsidiaries or affiliates, increased from 5.0% in 2000 to 7.4% in 2005. Operating margins, which reflect only the revenues and costs associated with patient care, similarly improved from 3.0% to 5.6% during this period.



Despite this overall improvement, nearly one-fifth of all rural hospitals had negative operating margins in 2005. Smaller hospitals, those with 50 or fewer beds, often have greater difficulty holding on to a positive margin. Illinois has seen positive changes in this trend because more than 60% of the state's rural hospitals have been designated as Critical Access Hospitals. The bottom line of many CAHs has been positively affected due to their ability to recover the cost of treating Medicare patients. Unpaid patient bills and the need for charity services are two other financial factors that impact hospitals, but rural hospitals are hit harder than their urban counterparts. Bad debt for rural hospitals almost tripled between 1991 and 2004 (a 287% increase), and charity care obligations more than quadrupled (a 468% increase) in that period. Urban hospitals saw about half of these rates of increase.

Most hospitals are owned by general not-for-profit organizations. In Illinois, 42.2% of rural hospitals fall into this category. Rural hospitals are also more likely to be government-owned than urban facilities (32.8% vs. 4.9%). These government owners include hospital districts or authorities (72.7%) or cities or counties (27.3%). Figure 16 depicts the ownership types for Illinois rural hospitals in 2005.

**Figure 16**  
**Illinois Rural Hospital Ownership Type: 2005**



Source: American Hospital Association, 2007; Illinois Hospital Association, 2007

Illinois hospitals do not receive adequate reimbursement to cover the cost of providing health care services to Medicaid patients. Medicaid represents on average 13% of Illinois hospitals' gross revenues, yet Medicaid payments covered only 81.5% of costs in 2006.

#### **D. Illinois Rural Hospital Summary Profile**

- Sixty percent of rural hospitals are now Critical Access Hospitals (CAHs) – ICAHN has 51 member hospitals.
- Of the 51 CAHs, 46 are designated as rural with an average of 20,000 residents in their service areas.
- Average length of stay declined from 4.7 days in 1996 to 4.3 days in 2005.
- Outpatient visits increased by more than 94% since 1991, and nearly 13% since 1996.
- Medicare still represents the largest source of revenue for both rural/urban hospitals, but third party payer revenue is on the increase.
- Patients are generally older and have multiple chronic and more complicated medical needs with higher hospitalization rates in rural areas.
- Rural hospital operating margins have begun to climb again and were an average of 7.4% in 2005. However, nearly one-fifth of rural hospitals still had negative margins at that time.
- The average patient margin among rural hospitals was 1.6% in 2005, up from less than 1.0% in 2004. Many facilities had negative patient margins.
- In 41% of rural counties, the hospital is one of the top three employers and represents significant workforce and economic development contributions.
- Rural hospitals employed more than 27,000 workers in 2005, equal to 12% of the state's hospital workforce.
- Rural hospital payrolls and expenditures generate an additional \$1.2 billion in goods and services annually.

## V. Programs and Organizations Supporting Health Care

This section provides a brief overview of a number of the state-based organizations and resources that support rural health care providers in Illinois. These entities provide a broad array of programs and services, including:

- advocacy
- career information for health care occupations
- communication tools
- community health planning
- education
- health-related data and information
- health care professional scholarships, loans, and incentives
- leadership development
- networking
- public awareness
- technical assistance

### A. Illinois Department of Public Health (<http://www.idph.state.il.us/>)

Created in 1877, the Illinois Department of Public Health (IDPH) is responsible for promoting the health of the people of Illinois through the prevention and control of disease and injury. Through its nearly 200 programs that address health issues ranging from abandoned newborns to zinc exposure, the IDPH is a major provider of essential public health care resources and services. A number of these programs assist rural areas and are described below.

#### 1. Center for Rural Health

Since 1989, the Center for Rural Health at IDPH has offered resources in support of state policies intended to positively affect rural health and providers of health care. The main goal of the Center is to improve access to primary health care in rural and underserved areas of Illinois and to encourage community involvement in health issues. A secondary goal is to serve as an information clearinghouse on rural health issues.

In order to address the most pressing health issues in their area, local policy makers often work with Center staff to identify priority issues, discuss potential solutions, and implement plans of action. The Center also offers programs to help build the capacity of rural health systems such as health professional scholarships, education loan repayment programs, identification of underserved areas, and rural health networking. Examples of the Center's programs follow.

- *Allied Health Care Professional Scholarship Program*  
Focuses on increasing the number of nurse practitioners, physician assistants, and certified nurse midwives who will practice in areas underserved by primary care providers.
- *Medical Student Scholarship Program*  
Provides funds to Illinois residents attending medical schools in the state. Illinois physician shortage areas have gained several hundred physicians from this program.
- *Nursing Education Scholarship Program*  
Provides assistance to individuals pursuing a nursing career, either through a certificate in practical nursing, an associate degree in nursing, a hospital-based nursing diploma, a bachelor's degree in nursing, or a graduate nursing degree. Those pursuing a graduate degree are required to teach nursing in Illinois.
- *National Health Service Corps – State Loan Repayment Program*  
Assists communities in recruiting health professionals. Program funds, matched by the IDPH, are used to repay education loans incurred by physicians, nurse practitioners, physician assistants, nurse midwives, dentists, and psychiatrists who agree to serve in federally designated Health Professional Shortage Areas (HPSAs) in Illinois. There are currently 16 health professionals in the state repayment program and 121 in the federal program that will be practicing in rural Illinois.
- *J-1 Visa/Waiver Physician Placement*  
Foreign-born and trained physicians and nurses with federal or state J-1 visas provide a vital function in both rural and urban underserved areas, supporting otherwise unavailable primary health care. Illinois may request up to 20 waivers of the two-year residency program for those working in HPSAs.

IDPH's Center for Rural Health is a member of the National Organization of State Offices of Rural Health (NOSORH). NOSORH fosters and promotes legislation, information exchange, education, and liaison with all 50 State Offices of Rural Health, the Federal Office of Rural Health Policy, and the National Rural Health Association. Their actions are designed to support the development of state and community leadership for rural health, to facilitate partnerships at state and national levels to enhance sharing and collaboration, and to help communities promote a healthy rural America through enhanced access to quality health care services.

## 2. Illinois Project for Local Assessment of Needs (IPLAN)

IPLAN is a community health assessment and planning process that is conducted every five years by Illinois' local health jurisdictions. It was developed to help state

and local public health agencies meet the responsibility they have to fulfill society's interests in helping citizens stay healthy (Public Health Charter for Illinois, 1988). This process considers organizational capacity within a community, conducts an assessment of community needs, and creates a community health plan with a focus on three priority health problems for each area studied. The IDPH Web site adjunct of IPLAN is now a mature local data delivery system, providing more than 100 indicators of local county and pre-selected special area health needs for assessment and planning purposes. Thirty-nine indicators are also available at the community level.

The IPLAN electronic data delivery system is constantly upgraded and allows users to manipulate the data by sorting, charting, and saving outputs for future use. Instructions help users create a number of different types of reports to support the IPLAN process and meet the health care information needs of rural areas.

### 3. Behavioral Risk Factor Surveillance Surveys (BRFSS)

The Behavioral Risk Factor Surveillance Surveys (BRFSS) were initiated as a collaborative effort between the U.S. Centers for Disease Control and Prevention and state departments involved in planning for good public health. In Illinois, the state system is now the Illinois County Behavioral Risk Factor Surveys. These surveys gather information on risk factors among Illinois adults aged 18 and over through monthly telephone calls, and have become the primary source of information on behaviors and conditions related to the leading causes of adult mortality in the general population.

Since data are made available for each Illinois county by selected demographic characteristics, the BRFSS represents another valuable tool to help local health departments and rural health care stakeholders identify and address rural health care issues. The availability of this information on the Internet provides easy access to a powerful set of descriptive health-related data.

The Center for Disease Control's National Center for Chronic Disease Prevention and Health Promotion recently released the 2005 BRFSS Maps, an interactive Web site that allows users to generate maps that graphically display the prevalence of behavioral health risk factors by state and metropolitan/micropolitan statistical areas. Maps and data are available from 2002 through 2005 at <http://apps.nccd.cdc.gov/gisbrfss/default.aspx>.

## **B. Illinois Hospital Association**

<http://www.ihatoday.org/membership/smallrural/index.html>

The IHA Small and Rural Hospitals Constituency Section supports small and rural hospitals as they provide health care services to the communities they serve. Available support includes providing meeting opportunities, visioning processes, communications across rural geographies, and communication tools (including an annual rural hospitals report). The IHA's Small and Rural Hospitals Constituency Section participated in the Illinois General Assembly's Joint Task Force on Rural Health and Medically Underserved Areas, whose newest report is now available. Five major priorities have been identified: improve the Medicaid payment process, increase funding for downstate medical services, increase basic grants for local health departments, increase telemedicine capabilities, and increase access to specialty and sub-specialty medical care for underserved populations.

IHA's Policy Information and Analysis Section monitors policy issues, analyzes trends, and produces several key fact sheets on important rural hospital characteristics including capacity, utilization, workforce, payer mix, finance, rural demographics, and health care needs. Much of their data was used in the development of this plan.

## **C. Illinois Rural Health Association (<http://www.ilruralhealth.org/>)**

The Illinois Rural Health Association (IRHA) is a statewide public voice for individuals and organizations committed to improving the health status of Illinois' rural residents and communities through education programs, legislative advocacy, public awareness, and networking. Through its newsletter, annual conference, educational programming, and annual awards of excellence to physicians and other practitioners, the IRHA pursues its commitment to obtaining the best medical care for rural residents. The most recent focus has been on promoting development of both oral and mental health services in these areas. The IRHA also offers four scholarships each year to nurse practitioner, physician assistant, and physical therapy students.

## **D. Illinois Critical Access Hospital Network ([www.icaahn.org](http://www.icaahn.org))**

The Illinois Critical Access Hospital Network (ICAHN) is a not-for-profit 501(c)(3) corporation established in 2003 to share resources, provide education, promote operational efficiencies, and improve health care services for member Critical Access Hospitals and their rural communities. ICAHN's 51 member hospitals comprise an independent network governed by a nine-member Board of Directors with standing and project development committees facilitating the overall activities of the network. ICAHN partners with the Illinois Department of Public Health's Center for Rural Health, the Illinois Hospital Association, academic institutions, and other rural health and economic development organizations to deliver its core activities and special projects. Additional information about ICAHN is provided in Section VII.

#### **E. Illinois Primary Health Care Association ([www.iphca.org](http://www.iphca.org))**

The IPHCA represents Community Health Centers (CHCs) throughout Illinois and in bordering states that operate 296 primary care sites that provide health care to migrant, homeless, public housing, and other medically underserved residents. CHCs are funded through the Federally Qualified Health Center provision under Medicare and are private, not-for-profit community-owned and -operated centers that have multi-disciplinary practices. While not primarily rural in their focus, they do provide care for 8% of rural Americans across the U.S. who are likely to experience geographic, economic, cultural or other barriers to accessing health care and preventive services.

#### **F. Rural-Focused Programs at Illinois Medical Schools**

Three medical schools in Illinois offer specialty training for rural practitioners: the University of Illinois at Rockford's Rural Medical Education Program (U of I Rockford RMED); the University of Illinois at Peoria's Rural Student Physician Program (U of I Peoria RSPP); and Southern Illinois University's School of Medicine (SIU Med).

Both the U of I Rockford RMED and U of I Peoria RSPP programs recruit 12 to 15 students each year who have roots in and plan to practice in rural Illinois as family physicians. These institutions assign students to community-oriented primary care projects designed to address a local health need. The Family and Community Medicine Department at SIU Med is one of the largest in the nation with 75 students annually, and provides vital medical student health experiences across central and southern Illinois.

#### **G. Area Health Education Centers (<http://bhpr.hrsa.gov/ahec> and <http://www.ihec.org>)**

Five Area Health Education Centers (AHECs) in Illinois address the needs of underserved populations in rural and urban Illinois: Ujima AHEC, Immigrant/Refugee AHEC, Latino Communities AHEC, Northern Illinois AHEC (Rockford), and Western Illinois AHEC (Quincy). Statewide, the Illinois AHEC encourages young people, especially from minority and rural areas, to pursue a health career; facilitates community-based education for health care students, medical residents, and providers; and implements community health and prevention programs, such as health literacy, among its residents. Programs include TeleHealth networks at Western Illinois University (WIU) for Critical Access Hospital workers and participation in the Arthritis Foundation Self Help Course for Rural Seniors via TeleHealth videoconferencing. WIU also offers the Illinois Rural Interdisciplinary Network for health care providers and educators to share ideas and expertise.

#### **H. Technical Assistance Resources for Community Health Planning and Development**

##### **1. Rural Health Resource Center Technical Assistance and Services Center ([www.ruralresource.org](http://www.ruralresource.org))**

Funded by the federal Health Resources and Services Administration Office of Rural Health Policy, the Technical Assistance and Services Center supports rural communities and the nation's Critical Access Hospitals with technical assistance for

the Rural Hospital Medicare Flexibility (Flex) Program. Assistance takes a variety of forms, including providing information, process tools, community development support, EMS tools, grant funding, Flex grant guidance and program evaluation, health information technology support, quality and performance improvement monitoring, and links to other state resources including organizations and other Rural Assistance Center information.

2. The National Rural Recruitment and Retention Network (3RNet) ([www.3Rnet.org](http://www.3Rnet.org))  
Members of 3RNet are not-for-profit organizations that help health professionals find practice opportunities in rural and underserved areas throughout the country. The organization's annual conference often focuses on access, community development, and national advocacy; and regional conferences can focus on topics such as telehealth resources and assistance centers.
3. National Association for Rural Mental Health ([www.narmh.org](http://www.narmh.org))  
This professional organization focuses its efforts on rural areas to improve access, availability, and acceptability of mental health and substance abuse services and research in rural and frontier areas. The NARMH carries out its mission through electronic (Web site and listservs) and print communication, an annual national conference, participation in national policy making, and special projects.
4. Mapping the Future of Your Community's Health Care  
([www.iira.org/outreach/mapping/health](http://www.iira.org/outreach/mapping/health))  
A joint project of Western Illinois University's Illinois Institute for Rural Affairs and the Illinois Department of Public Health's Center for Rural Health, this community visioning process helps community leaders create action plans to address specific local needs and resources. Health mapping is one of three programs offered by the IIRA that also include "Mapping the Future of Your Community" and "Mapping the Future of Your Schools." The health mapping process has been broadened to include access and availability of health care services, health education and prevention, and environmental health.
5. Center for Rural Health and Social Service Development, Southern Illinois University Carbondale ([www.siu.edu/~crhssd](http://www.siu.edu/~crhssd))  
The Center for Rural Health and Social Service Development conducts research, needs assessment, demonstration projects, program evaluation and training; tests new models of health care delivery; and develops policy recommendations for improving the health of Illinois' rural communities. Staff and students use SIU resources to partner with area agencies to address the most pressing health and social service problems of the region through grant and project development, research and evaluation, and training and curriculum development.

6. Rural Community Development and Assistance Group ([www.ilruralassistgrp.org](http://www.ilruralassistgrp.org))

Supported by the Illinois Department of Commerce and Economic Opportunity, the Rural Community Development and Assistance Group (RDCAG) serves as a clearinghouse for information and communication about technical support available for community development and health care delivery in Illinois. RCDAG participants volunteer to assist individuals and groups working to better their community.

7. Illinois Rural Partners ([www.ruralpartners.org](http://www.ruralpartners.org))

Illinois' Rural Partners is the state's rural development council. Rural Partners pursues a comprehensive approach to rural development and revitalization with economic development and community leadership development as its main focal points. Its mission is to link individuals, businesses, organizations and communities with public and private resources to maximize the potential of rural Illinois.

8. Illinois Rural Affairs Council ([www.ruralaffairsCouncil.il.gov](http://www.ruralaffairsCouncil.il.gov))

The Governor's Rural Affairs Council, started in the 1980s, includes representatives of government agencies, academic institutions, and rural citizens committed to improving the economy, environment, and health of Illinois' rural communities while providing a link between state and local government services. The Lieutenant Governor serves as chair of the group which works with community organizations and leaders throughout Illinois. The most recent annual report available (2005) details the results of the latest survey of rural residents on quality of life issues, and presents state policy challenges in broadband deployment, economic development, renewable energy, affordable housing, and public transportation. Some aspect relating to access to health care is present in almost of these initiatives.

## **VI. Critical Access Hospitals**

### **A. Background**

The role of the rural hospital in maintaining and enhancing access to health care and providing emergency services is critical in rural communities. Rural hospitals also play social and economic roles that are critical to the integrity and quality of life in their communities.

Beyond offering inpatient care, many rural hospitals in Illinois have developed primary care clinics including 225 Medicare-certified rural health clinics. Recruiting and employing physicians places rural hospitals in key positions in local efforts to ensure adequate access to primary care services. Many rural hospitals are also providers of long-term care services in their communities.

The role of the hospital as the central coordinator of care in rural communities is essential. Section II described the age, income, and behavioral factors that influence patient utilization of Illinois rural hospitals. The effects of these characteristics on patient utilization of Illinois' rural hospitals are clear:

- Rural Illinois residents experience higher hospitalization rates than urban residents: 141.9 per 1,000 residents compared to 133.3 admissions.
- Almost one-half (46%) of inpatients in rural hospitals were 65 years of age or older in 2004<sup>12</sup> compared to only one-third of patients in urban hospitals.
- Rural hospitals treat more patients for age-related conditions or diseases (e.g. heart disease, chronic obstructive pulmonary disease, and influenza/pneumonia) than urban hospitals.
- Hospitalization rates for ambulatory care-sensitive conditions are higher in rural areas as well, suggesting rural residents' access to primary care is limited.

### **B. Criteria for Critical Access Hospitals**

To help small and rural hospitals survive while serving the health care needs of their communities, the Medicare Rural Hospital Flexibility Program (Flex Program)<sup>12</sup>, created by Congress in 1997, allows small hospitals to be licensed as Critical Access Hospitals (CAHs) and offers grants to states to help implement initiatives to strengthen the rural health care infrastructure. To participate in the Flex Program, states are required to develop a rural health care plan that provides for the creation of one or more rural health networks; promotes regionalization of rural health services in the state; and improves the quality of and access to hospital and other health services for rural residents of the state. Consistent with their rural health care plans, states may designate eligible rural hospitals as CAHs.

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<sup>12</sup> The legislative authority for the Flex Program and cost-based reimbursement for CAHs are described in the Social Security Act, Title XVIII, Sections 1814 and 1820 ([http://www.ssa.gov/OP\\_Home/ssact/title18/1800.htm](http://www.ssa.gov/OP_Home/ssact/title18/1800.htm)).

CAHs must be located in a rural area (or an area treated as rural); be more than 35 miles (or 15 miles in areas with mountainous terrain or only secondary roads) from another hospital; or be certified before January 1, 2006 by the state as being a necessary provider of health care services. Certification by the state as a “necessary provider” requires that a hospital be located in an eligible rural county with one or more of the following requirements:

- Designation as a federal health professional shortage area;
- Designation as a state physician shortage area;
- A poverty rate above the overall state level (based on 200% of the federal poverty level); and
- A proportion of residents over 65 years of age that exceeds the overall state proportion.

CAHs are required to make available 24-hour emergency care services that a state determines are necessary. CAHs may have a maximum of 25 acute care and swing beds, and must maintain an annual average length of stay of 96 hours or less for their acute care patients. CAHs are reimbursed by Medicare on a cost basis (i.e. for the reasonable costs of providing inpatient, outpatient, and swing bed services).

### **C. CAH Status in Illinois**

Following federal approval in 1998 of the Illinois State Rural Health Plan for implementing the Critical Access Hospital program, the first CAH in Illinois was approved in July 1999. The Center for Rural Health hired a CAH program coordinator in September 1999 to assist hospitals with the CAH certification process, provide technical assistance to the hospitals, and to coordinate the CAH process with certifying state and federal agencies. With the establishment of the Illinois Critical Access Hospital Network (ICAHN) in 2003 a mechanism was put in place to administer an estimated \$850,000 in available federal grant programs (Flex and State Health Improvement Program grants and Southern Illinois University’s Telehealth grants) for CAHs and other Illinois rural hospitals. ICAHN has supported member hospitals by providing network connectivity, telehealth activities, information technology upgrades and support, listservs, user groups, network health benefits insurance program, and shared purchasing agreements – all of which strengthen the state’s hospital system.

By 2006, 51 (60%) of Illinois’ rural hospitals were participating in the CAH program (see appendix Figure A-7). The Medicare Rural Hospital Flexibility Program has allowed many rural areas to maintain access to emergency, inpatient, and primary health care services provided or coordinated by a hospital. By allowing flexibility in providing services and in staffing levels and providing Medicare payment on a reasonable cost basis, the CAH designation has enabled many rural hospitals to continue to meet the needs of local residents. A 2006 economic impact study of Illinois CAHs by Northern Illinois University found immediate and sustained improvements in revenues for almost every surveyed hospital, including increased third party payer revenues, increased Medicare payments, and increased admissions. This study also found that CAH status allowed many hospitals to

increase their staffing levels, especially in primary care coverage. Rural communities with strong health care systems are more effective in attracting and retaining businesses and workers. Also, CAH local expenditures and employee salaries have a ripple effect through their communities: the total estimated economic impact of all CAHs on their host counties in 2005 was \$763.8 million. Recent and future capital improvements will generate an additional \$32.9 million through 2011. CAHs are reimbursed by Medicare on a cost basis plus one percent or 101% (i.e. for the reasonable costs of providing inpatient, outpatient and swing bed services).

#### **D. CAH Hospital Profile 2006**

The average population surrounding each of the 51 CAHs in Illinois is 15,000 people in the primary service areas and an additional 5,000 in the secondary service areas. However, since five of the 51 hospitals are in counties designated as urban or urbanizing by the Center for Rural Health, the number of rural residents using a CAH hospital as their primary care center is 920,000. The number of active medical staff members averages 10 for each hospital, with an additional 30 consulting or courtesy medical staff in each, and a total of 1,250 beds. The CAH program has contributed much to each of their host communities they are in.

## VII. Health Care Integration and Regionalization

The changing health care environment driven by managed care has resulted in the creation of health networks or integrated delivery systems. These combinations of hospitals and other health care providers have come together to achieve economies of scale, deliver a range of services across the continuum of care, and contract collectively with managed care companies. Regional health networks and systems can offer comprehensive coverage for firms with employees spread across a broad geographic area.

In the case of rural hospitals, while managed care has driven some integration, other factors have also played a part. Affiliating with a larger parent has given small hospitals advantages such as access to capital and specialists and the ability to draw upon the resources and expertise of the larger institutions in coping with environmental pressures. There are also many benefits to the community. Administrative and clinical expertise, capital access, and partnered strengths enable these smaller hospitals to improve their flexibility in responding to local need. Not only is there enhanced access to the specialists most rural areas actively seek, but also coordinated strategic planning that helps develop responses to community needs.

Illinois rural hospitals have become involved in a wide range of affiliations, ranging from loose transfer arrangements to fully integrated relationships. Due in part to the requirement that Critical Access Hospitals be a member of a rural health network, a preponderance of the state's rural institutions have formalized relationships with a partner. These relationships vary in number, in the nature of the relationship (mergers, affiliations, or alliances), and in the resulting range of coverage.

The creation of the Illinois Critical Access Network (ICAHN) in 2003 provided the opportunity for the state's Critical Access Hospitals to integrate into a formal network, and in many cases simply formalized an integration strategy that was already occurring. ICAHN's formation has enabled its member hospitals to share information, engage in collaborative problem-solving, provide leverage for purchasing goods and services, share consultative expertise in implementing regulatory and quality improvement programs, and promote advocacy for their unique needs.

There is evidence that the capacity-building efforts undertaken by ICAHN and its member hospitals are working. The July 2006 Flex Monitoring Team report<sup>13</sup> on CAH financial indicators for performance assessment shows that more than half of Illinois CAHs are in good fiscal shape relative to the national rankings. Twenty-eight Illinois CAHs with the necessary Medicare cost reporting for the last 360 days participated in the study. ICAHN members reported among the top 10 states on two profitability measures – total margin and

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<sup>13</sup> CAH Financial Indicators Report Team Report Team (2006). *CAH Financial Indicators Report: Summary of Median Indicators by State*. North Carolina Rural Health Research and Policy Analysis Center. [http://www.flexmonitoring.org/documents/DataSummaryReportNo2\\_Nov06.pdf](http://www.flexmonitoring.org/documents/DataSummaryReportNo2_Nov06.pdf)

cash flow margin, and in the top 12 for return on equity. Relative to the U.S. averages, Illinois had above average ability to manage costs with newer physical plant, more service with higher FTEs per occupied bed, and better average daily census counts. Even with lower than average Medicare revenue earned per day, Illinois CAH'S had higher than average in- and outpatient day utilization rates.

In addition to the national CAH funding program, the Illinois Flex Program provided financial assistance to support the development of ICAHN in 2003. The first statewide CAH member network in the nation, ICAHN provides a wide array of operational support functions for its members, including access to grants, health information technology infrastructure and network support, educational and leadership programs, and other connectivity activities. These efforts foster the financial stability of Illinois CAHs through the sharing of resources and best practice models.

Other ICAHN programs with positive financial impacts for members include a new insurance health benefits plan for members, negotiated contracts with consultants for member services (e.g., managed care, after hours pharmacy, and critical access recruitment services), a peer review network, a quality benchmarking electronic based scorecard, partnerships with the state's medical schools to provide telemedicine and video conferencing for educational improvements, joint educational and project initiatives with the Illinois Hospital Association, and group purchasing power for services such as electricity. These programs are developed with the assistance of members themselves through committees, user groups, list serves, conferences and other ICAHN project initiatives, all to meet the goal of access to appropriate health care services for rural residents.

Two CAHs are in the process of building replacement facilities, and three more are in the process of state approval and acquiring capital to build a replacement facility. Over 15 CAHs have begun or completed major building renovation programs since the conception of the CAH reimbursement program.

## VIII. Current Rural Health Care Issues

A number of important forums have been held in the past three years that have focused on current and anticipated issues in rural health care. Three of these are described below.

### 1. State Rural Health Planning Meeting

In November 2005, the Illinois Department of Public Health's Center for Rural Health and ICAHN convened a state rural health planning meeting to learn about current and future rural health care needs, identify barriers to rural health care delivery, and explore how the Flex Program can be expanded to other rural hospitals and rural programs given the December 31, 2006 deadline for CAH certification. Twenty individuals representing Illinois health, educational, and government attended.

Of the 15 key issues in Illinois rural health identified by the meeting participants, five were singled out as priority issues. These are listed below.

Inadequate Resources. Rural health care providers are challenged to recruit and retain qualified staff at all levels and in such specialty areas as mental health and oral health. This situation is worsened by inadequate reimbursement levels, the reliance of many uninsured individuals on emergency departments, and the increasing age and obsolescence of rural health infrastructure.

Expectations and Attitudes. An "entitlement" expectation on the part of many consumers combined with increases in average life expectancy and advances in medical technology and medications will only intensify the demand for scarce rural health care resources.

Information and Communications. Better healthcare data and information are needed to improve decision-making for consumers, providers, and policy-makers. Partnerships and networks to use this information must be strengthened and coordination of care throughout the system improved.

Quality Care Standards. The development and adoption of appropriate standards of care for rural providers must be encouraged. Education and training to these standards must then be made available to rural healthcare workers and professionals, and health information technology incorporated in all aspects of care.

Demographics. The unique characteristics of rural Illinois – including the lack of population density, disproportionate numbers of the poor and elderly, high numbers of uninsured residents, and the out-migration of residents from rural areas to urban and suburban areas – need to be taken into account when health care programs are designed.

## 2. Illinois General Assembly Joint Task Force Report

In December 2006, a Joint House/Senate Task Force Report on “Rural Health and Medically Underserved Areas” was released by the Illinois General Assembly. Five recommendations were identified as priorities for legislative consideration. They included:

- a. Resolving chronic Medicaid provider payment issues, particularly relating to low and slow reimbursements.
- b. Increasing funding for essential programs and services authorized by the Rural/Downstate Health Act, including restoring funding to IDPH’s Center for Rural Health, extending loans and grants to cover health care professional preparation, expanding the Rural Medical Education Program and SIU’s Rural Health Initiative, increasing funding for Community Health Centers, and expanding mental health services.
- c. Improving and expanding core public health programs and services including increased preventive health and dental health services.
- d. Expanding telemedicine capabilities for medical and psychiatric providers.
- e. Increasing access to specialty and sub-specialty care.

## 3. IRHA Community Forums on Emergency Medical Services

In February 2005, a report by the Illinois Rural Health Association was released that reported on the findings of 10 town meetings held throughout rural Illinois. Focusing on emergency medical services in rural Illinois, more than 350 individuals from 48 Illinois counties participated in these discussions. The resulting “Agenda for Improvement” identified five major issues.

- The inability to recruit and retain EMS
- The inability to generate revenues to pay expenses
- Lack of community awareness regarding the complexity of providing EMS
- The burden of regulatory requirements
- The lack of collaboration within rural EMS systems

In summary, the efforts of the Illinois Department of Public Health's Center for Rural Health and its many state agency, university and organizational partners have made a significant difference in improving the viability of the small rural hospital. However, persistent and serious resource and access issues continue to characterize rural health in Illinois. The partnerships forged among these rural health partners will become even more vital in the effective pursuit of needed improvements.

# Appendix

## Figure A-1

### County Population Growth 2000-2006

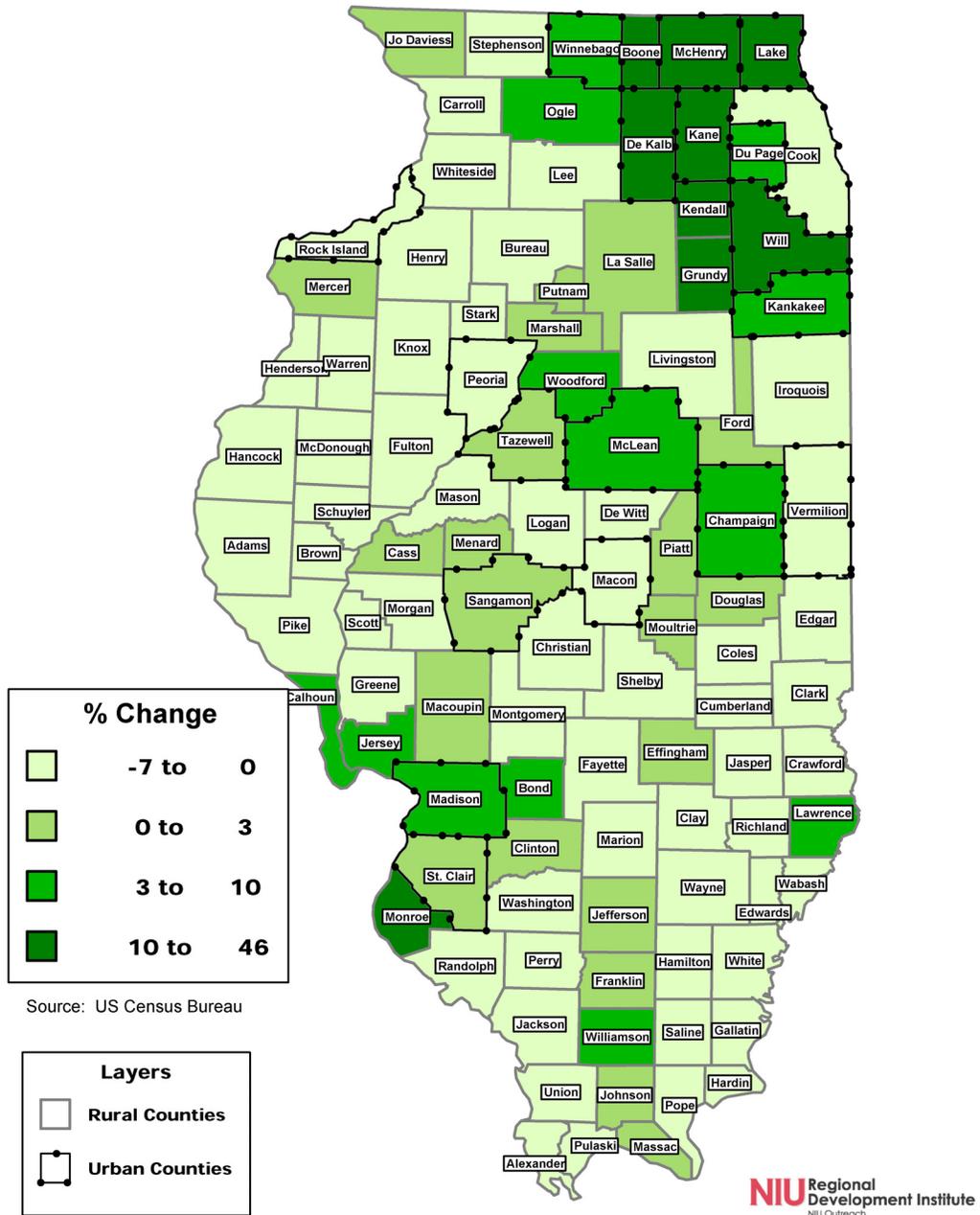


Figure A-2

### Counties with Population Losses in Each Decade

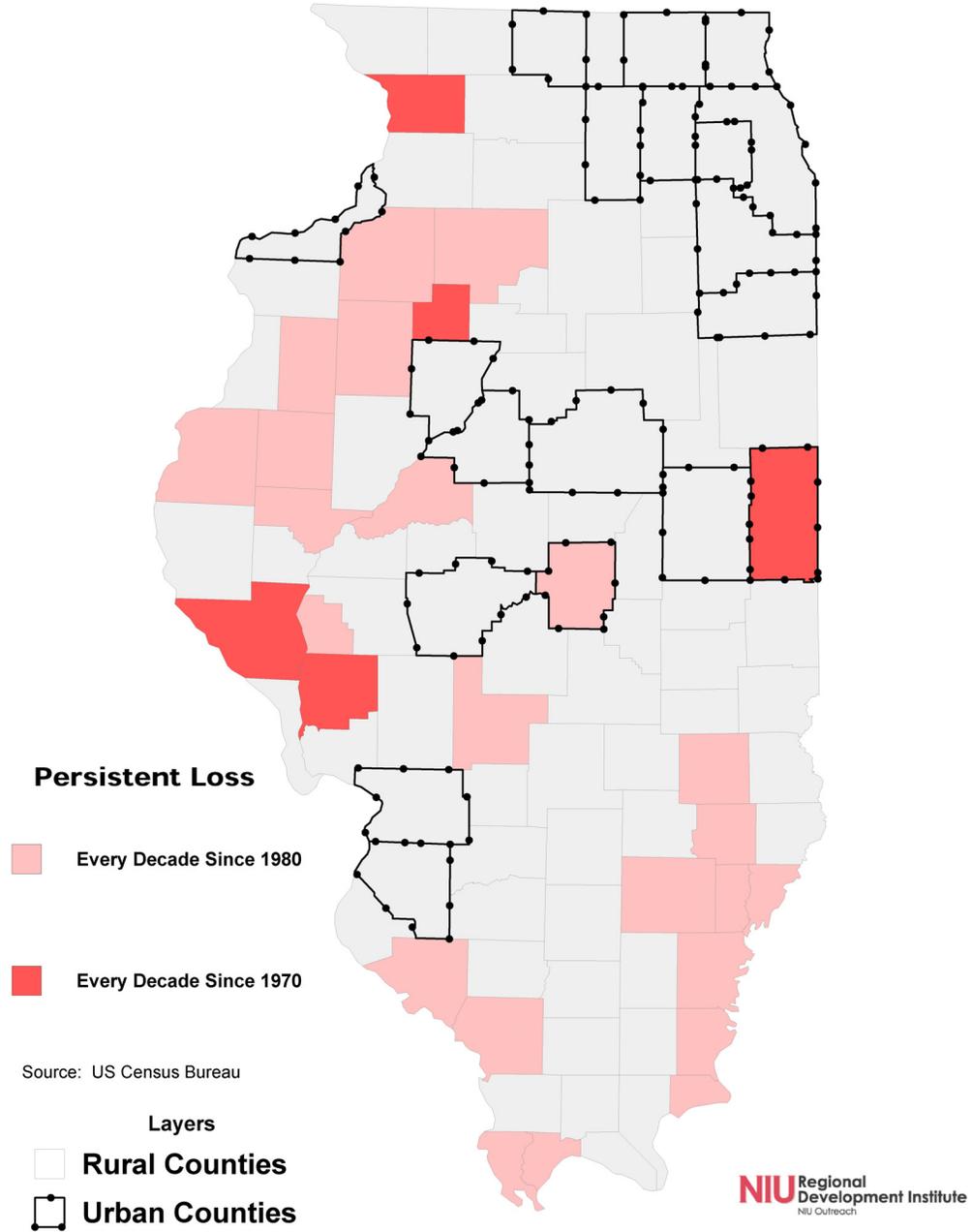
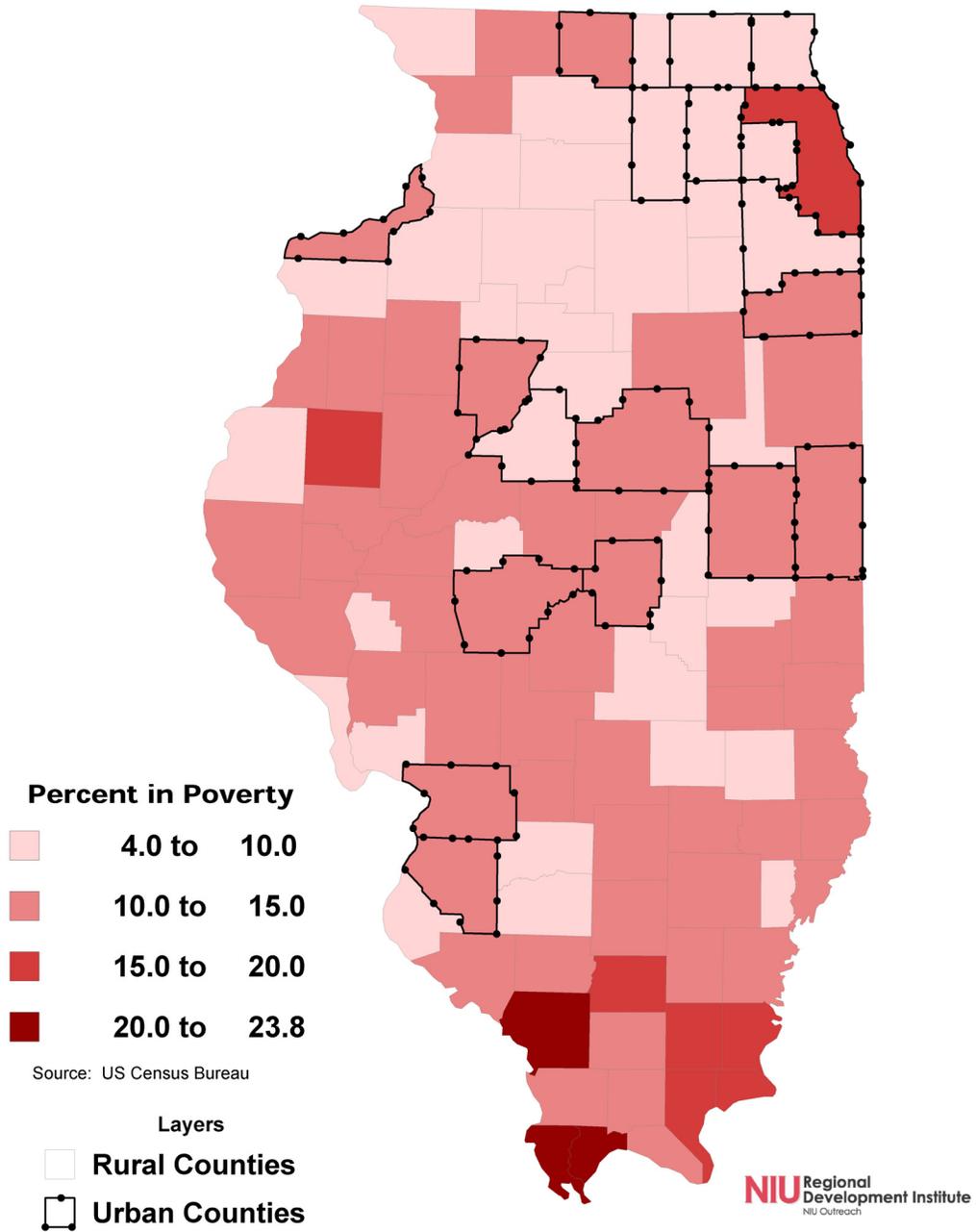


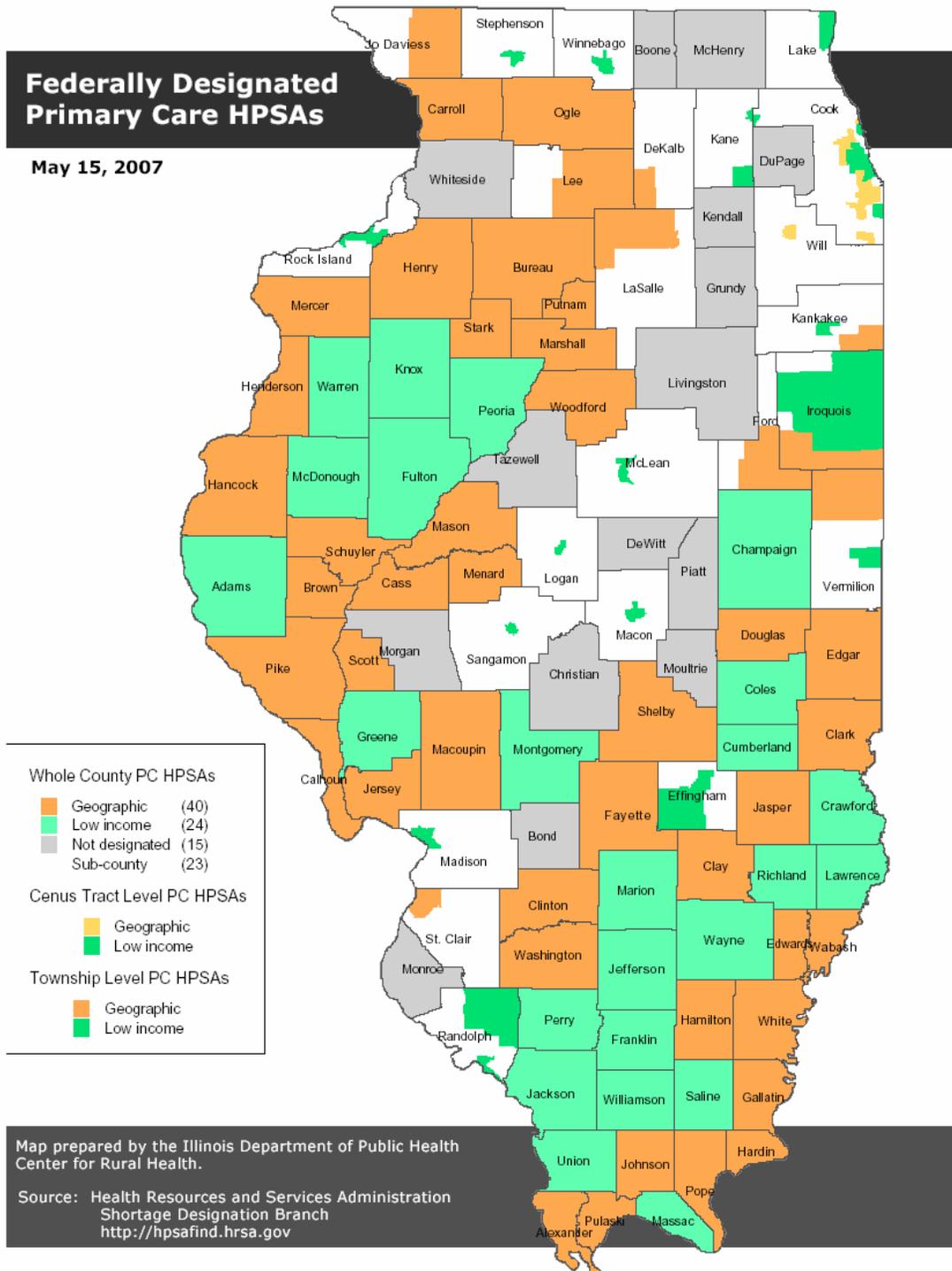
Figure A-3

### Share of Population in Poverty 2004



# Appendix

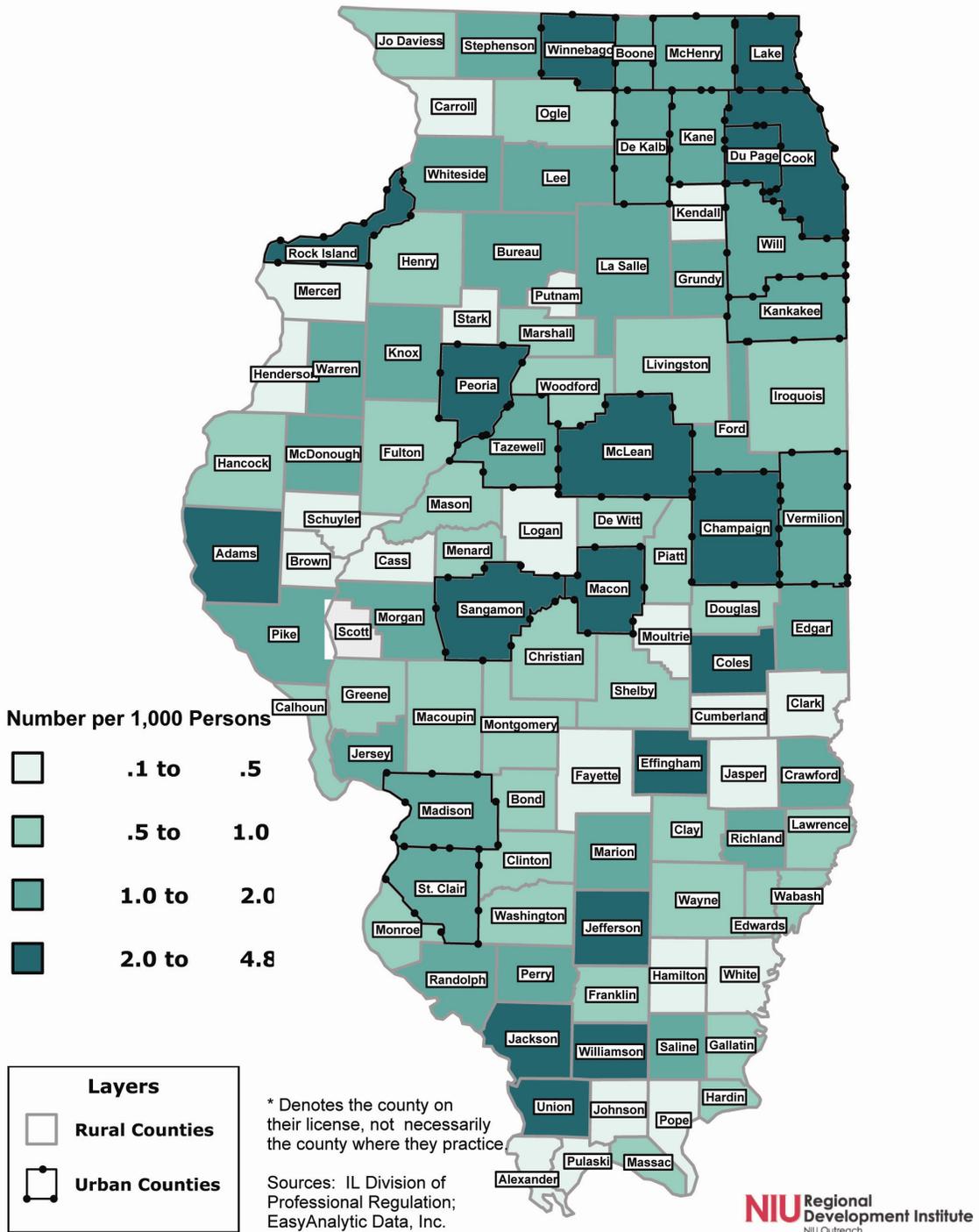
## Figure A-4



# Appendix

Figure A-5

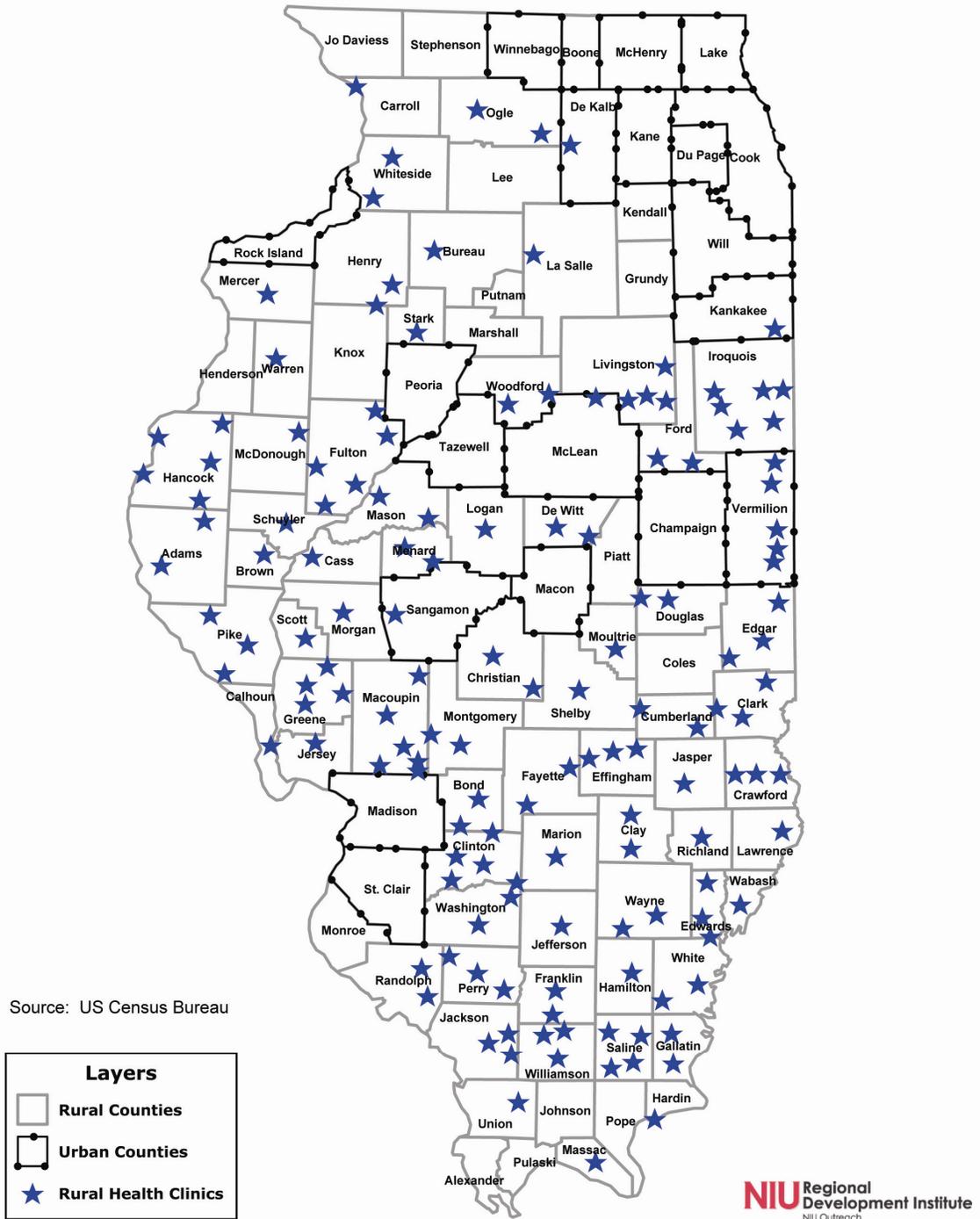
## Physicians with Active Licenses\* 2007



Appendix

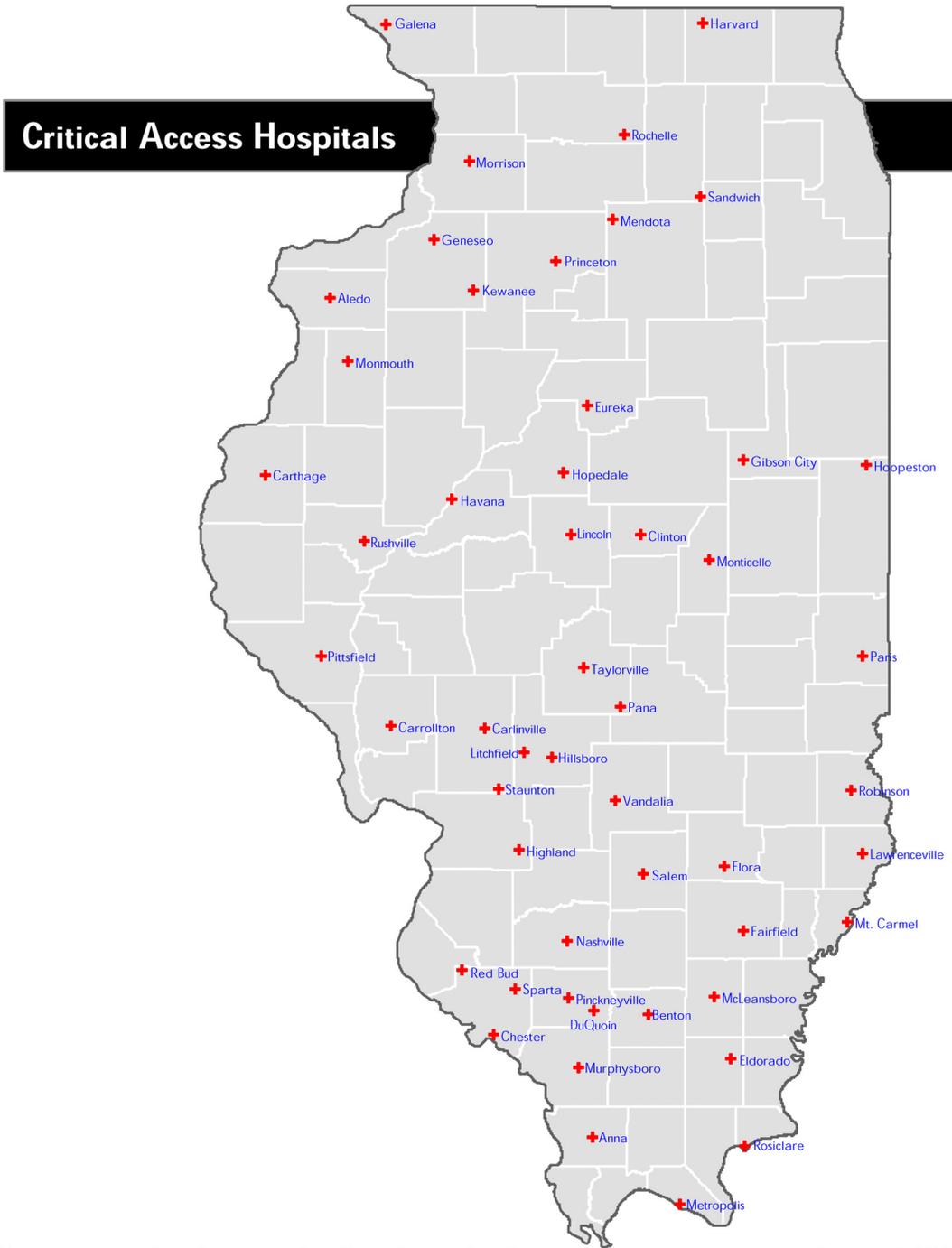
Figure A-6

# Rural Health Clinics



# Appendix

## Figure A-7



Map prepared by the Illinois Department of Public Health, Center for Rural Health

September 7, 2006

