

CAH/FLEX National Tracking Project

FINDINGS FROM THE FIELD

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A Case Study of Six Critical Access Hospitals

More than 750 small rural hospitals have been certified as Critical Access Hospitals (CAHs) since the inception of the Medicare Rural Hospital Flexibility Program in 1997 under the Balanced Budget Act. Despite rapid growth in the number of CAHs and the advantages of cost-based reimbursement and lower staffing requirements, CAH conversion has not proved universally successful in keeping small rural hospitals open. Five years after the program began, nine CAHs have closed. This *Findings from the Field* uses data gathered in telephone interviews to document the effects of six hospital closures on the communities they had served.

Major Findings

Consequences to Essential Services

- After their CAH closed, smaller and more isolated communities had greater difficulty maintaining access to emergency care in a “reasonable time.”
- Smaller and more isolated communities also had more difficulty maintaining resident physicians and non-emergency health services after CAH closure.

Consequences to the Community

- While the impact of the closure on former CAH employees varied, all but one community experienced a marked economic impact from businesses leaving or not moving into the community.
- CAH closure was reported to have negative effects in five of the six communities.

Reasons for Closure

- In five of the six cases, respondents felt that the closure resulted from poor management/administration.
- A lack of consistent and respected providers was also cited as a factor in CAH closure.

Data Collection

Six of the nine CAHs that closed between June 2000 and August 2002 were identified for inclusion in this study. These hospitals had been in operation as CAHs for between 5 and 25 months prior to closure. One additional CAH was studied, but local informants were not available for interview, so few conclusions could be drawn.

In the spring of 2003, 24 telephone interviews were conducted with individuals knowledgeable about the CAH closures and subsequent impact on their towns. Interviewees included six state office of rural health representatives, one county commissioner, four economic development officers, four hospital board members, a health coalition member, two emergency medical service (EMS) personnel, a rural health clinic (RHC) administrator, one former staff physician, two former study hospital administrators, a neighboring hospital administrator, and an Area Health Education Center (AHEC) official. Respondents were either currently living in the communities where closure occurred, or had been at the time that the CAH closed, with the exception of the state office of rural health representatives, the neighboring hospital administrator, and the AHEC official.

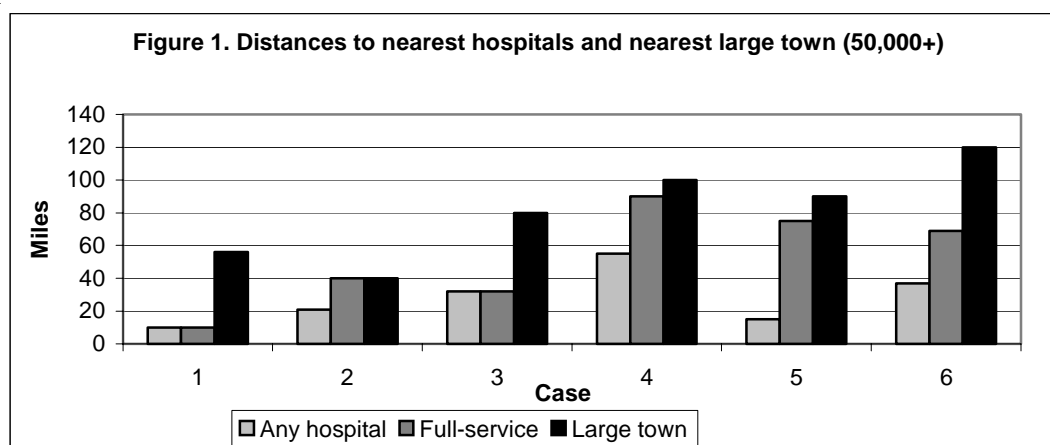
Community Characteristics

In general, the communities where these facilities closed can be characterized as small and isolated from urban centers. All six towns had small populations that did not change drastically over the 1990-2000 decade (Table 1). No community had a population change that exceeded 10% in either direction, and the three towns that experienced out-migration were those that had the smallest populations in 1990. All communities were at least 40 miles from a city with 50,000 or more residents and, after closure, all but community #1 were more than 20 miles from the nearest hospital and more than 30 miles from the nearest full-service hospital (Figure 1).

Table 1: Population and change in population 1990-2000

| Community | 1 | 2 | 3 | 4 | 5 | 6 |
|-----------------|------|------|------|------|------|------|
| 1990 population | 2708 | 2700 | 2465 | 1504 | 1003 | 831 |
| 2000 population | 2973 | 2905 | 2478 | 1447 | 941 | 816 |
| Percent change | +9.8 | +3.8 | +0.5 | -3.8 | -6.2 | -1.8 |

SOURCE: U.S. Census Bureau, Census data, 1990 and 2000.



SOURCES: Study interviews, with distances verified by Rand McNally Road Atlas, 2002.

Hospital Characteristics

Before closing, five of the six hospitals had the CAH maximum of 15 acute care beds; one had only six acute care beds. The average daily census (in acute care) ranged from only one patient to four. Only one facility had the ten allowed swing beds, and two had nursing home beds. Of those in the four most isolated communities, three were located in counties currently designated as Health Professional Shortage Areas (HPSAs), and the HPSA designation for the fourth was unavailable.

Reasons for Closure

In five of the six communities, respondents felt that one important cause of the closure was poor management or administration. Underuse of the facility was consistently mentioned, and in four communities, this was attributed to a lack of consistent and respected providers. In three communities, old-fashioned and unattractive physical plants played a role in underuse. In one community, respondents felt that the state's unwillingness to use mid-level personnel in the ways that CAH guidelines allow was an important factor. In only one case did respondents consistently indicate that the hospital was not really needed.

Change in Access to Non-emergency Medical Transportation

All six communities reported a considerable need for transportation for non-emergency care. Many respondents commented on the large number of senior citizens in their communities who no longer drive. Before the closure, three of six communities had free or low-cost transportation available for everyone. After closure, this was true for only one community; three communities had a free or low-cost van service for seniors, Medicaid patients, or both, but had nothing for others who might need transportation, and two communities did not appear to have a low-cost option at all.

Access to Emergency Medical Transportation After Closure

While every community had a functioning volunteer EMS, inadequate emergency transportation was a matter of considerable concern to many respondents. In four communities, respondents said that they were *not* in a good position to get someone to a hospital “in a reasonable time in an acute life-threatening situation.” In addition, several respondents said there were fewer EMS volunteers after the local emergency room was closed, due to the increased distance to the nearest emergency room.

Change in Health Care Provider Supply

Four of the six communities studied lost physicians as a result of the hospital closure, one community had no change, and the other actually gained physicians after the hospital closure. Three communities lost mid-level providers, two maintained their supply, and one gained mid-level providers after the closure.

Job Loss Due to Closure

The six CAHs studied had each provided jobs for between 35 and 85 full-time workers prior to closure. In three communities, substantial relocation was reported (a quarter to a third of the former hospital employees left the community); and one community was hit particularly hard as half the hospital workers left, and many who stayed were unable to find work in health care. In two communities, only a few former hospital employees had to relocate to find work after the hospitals closed.

Businesses Closed or Not Acquired

Respondents from four communities felt that CAH closure had influenced local businesses’ decisions to close and/or kept new companies from establishing in their towns. In one community, respondents were unsure of the impact of the closure on business. In only one case, community #1 (that still has reasonable access to a hospital post-closure), did respondents feel that their town had not suffered financially from the hospital closure.

Current Facility Use and Future Plans

After closure, portions of three of the former CAHs were maintained as RHCs; the other three facilities were vacated and remain empty. One building where an RHC is operating was under renovation at the time of the interviews, and was expected to reopen as a CAH within two years. Members of another community intended to build a new CAH over the next year. In the two smallest communities, there were no plans to restore the local hospitals, and respondents were unhappy about the closing; they expressed concern for the health and safety of themselves, their families, and their neighbors, and for their town’s economic viability without a hospital.

Summary and Conclusion

In five of the six communities studied, CAH closure had a negative impact on both access to health care and local economies. In only one community did respondents generally agree that there was adequate access to nearby hospital services and both non-emergency and emergency transportation, the local provider supply had actually increased, and there had been no deleterious effects on the economy following the closure.

In small, low-volume hospitals, the cost-based reimbursement and lower staffing requirements allowed under the CAH option sometimes fail to guarantee hospital survival. These factors cannot compensate for poor management/administration, inadequate provider supply, or an unattractive physical plant. While some communities are highly resourceful, and may be able to remedy these deficits and re-open their CAH, others are unable to do so. Serious consideration should be given to finding additional ways to help communities maintain adequate local emergency services when keeping a hospital open is no longer feasible.

Where can I get more information?

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About this project: Check out our website: <http://www.rupri.org/rhfp-track/>

Previous Findings From The Field and Tracking Project Reports

- Report: Rural Hospital Flexibility Program Tracking Project Year Three
- Vol. 3, No.1: The Role of International Medical Graduates in America's Small Rural "Critical Access" Hospitals
- Vol. 2, No. 8: State Medicaid Payment Policies for Critical Access Hospitals
- Vol. 2, No. 7: State Flex Programs--Perspectives of the Flex Coordinators
- Vol. 2, No. 6: A Critical Access Hospital Update, September 2002
- Vol. 2, No. 5: Reauthorizing the Medicare Rural Hospital Flexibility Grant Program: Lessons from the Field
- Vol. 2, No. 4: Critical Access Hospitals and Community Development
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