



Nebraska
Center
for
Rural
Health
Research

**A Report to Nebraska Critical Access Hospital Steering
Committee: Findings From CAH Site Visits**

Project Report 00-2
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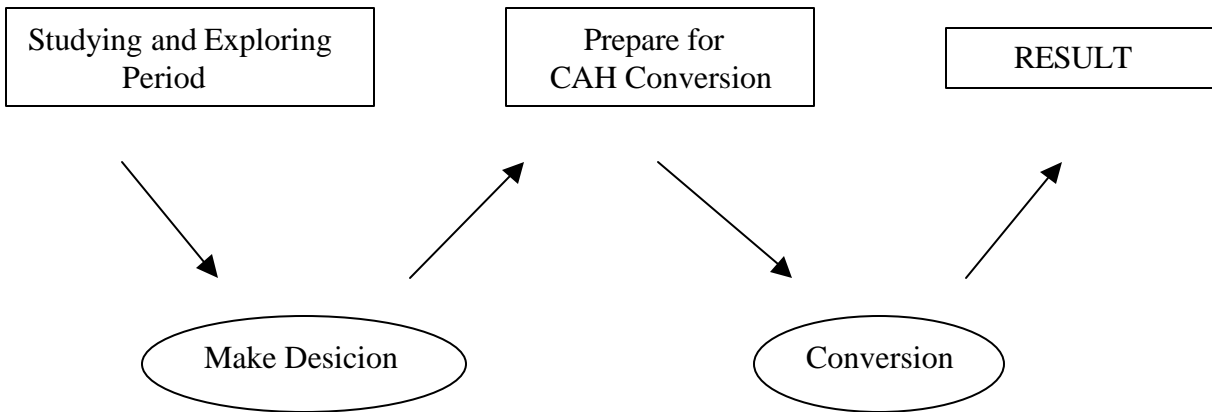
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CONCEPTUAL FRAMEWORK

The analytic framework of this report is based on the decision-making process of a hospital's converting to a Critical Access Hospital (CAH). This process can be illustrated as follows:



STUDY DESIGN

Four Nebraska hospitals were visited, each of which had been certified as a Critical Access Hospital (CAH) for at least 4 months at the time of the site visit. During each site visit the persons in the following positions were interviewed:

- Chief Executive Officer (CEO)
- Chief Financial Officer (CFO)
- Clinicians, usually the chief of staff
- Director of Nursing
- Member of the Board of Directors
- Other hospital staff

Each hospital provided information in advance of the site visit, using a form modified from the data collection instrument used by the national Tracking Team (national form can be found on the web site: Site visits were completed between June 1 and August 30, 2000.

OBJECTIVES

The site visits to the selected four hospitals intend to:

- Understand the rationale and reasoning behind their decision to convert;
- Examine how hospitals address relevant issues along the above process;
- Assess the outcome as a result of conversion; and
- Identify potential problems and lessons learned from the above process.

At this early stage of our evaluation efforts, the outcome or change as a result of CAH conversion may not be significant enough to be identified, because most hospitals were converted not long ago.

STUDYING AND EXPLORING THE REASONS TO CONVERT

At this stage, hospitals collect information about the CAH program, explore opportunities associated with this program, define their strategic goals and organizational needs, and achieve consensus among the critical persons needed to make the conversion a success. Two principal elements need to be in place before hospital leadership decides to move forward with conversion to CAH status: 1) the principal personnel needed for a smooth conversion need to be committed to making it happen; and 2) the community would not resist conversion.

1. Role of Key Persons

A) The Management

Not surprisingly, financial gain was the greatest driving force for these hospitals to consider converting to CAH status. All four completed financial feasibility studies which demonstrated positive effects on outpatient care margins, but mixed results for inpatient care. Those hospitals whose inpatient care would be financially worse off after conversion tend to experience shorter average lengths of inpatient stay. This in turn can, and often does, result in greater margins under the prospective payment system, because the actual length of stay is less than the average used to calculate payment. Converting to a cost-based system would lower payment from an average that exceeds cost to a calculation based on cost. The impact of CAH status on inpatient revenues will be a

function of the mix of conditions (diagnosis related groups) treated by a particular hospital. For some of those visited in this study, the projected impact of CAH designation on inpatient revenues was a net gain. When Medicare payments for inpatient and outpatient care are combined, all hospitals showed a positive financial net effect of CAH conversion. Another substantial financial difference was projected to be increased income from lab services. Based on these results, the conversion to CAHs was an appealing deal for them to pursue. The net financial impact among these four hospitals ranged from rescuing an otherwise sinking ship (net losses in some of the recent years) to strengthening the financial position of a hospital seeking maintain and even expand market share and services.

The range of time spent in studying the option to covert to CAH status varied among hospitals. Some hospitals started this process very early and devoted a great deal of efforts and time to it. The others acted as more conservative followers and did not commit to it until some evidence from early-takers was learned. In all sites both the Chief Executive Officer (CEO) and Chief Financial Officer (CFO) were strongly supportive.

Although CAH designation was financially attractive to these hospitals, some of them did not take real action until the rule of 96-hour hospital stay was changed. The change from 96-hour stay limit to 96-hour stay on average served as a determinant incentive for the conversion of certain hospitals. Physicians in particular were uncomfortable about a strict limit in length-of-stay, even though current practices were such that the limit was rarely exceeded. At nearly every site someone would identify the counter-balancing case of a specific condition that could be treated effectively in a limited service hospital (and was being treated there now) that might require more than a 96 hour stay. At one site the example was a bowel resection. Once the limit became an average the CEOs and CFOs were unconditionally supportive of conversion.

B) Internal Staff

In general, the staff (both clinical and non-clinical) of these four hospitals were very supportive to the idea of CAH conversion. However, clinical staff, especially the physicians, did highlight their concern and worry that their hospital would become either a “first-aid station” or a “secondary-care facility” due to the 96-hour stay limit requirement after conversion. This concern was greatly resolved after the 96-hour stay limit was changed to 96-hour stay average. Physicians were more concerned about the implication of CAH program on patients’ quality of care (i.e., whether patients can continue to receive adequate and appropriate care) and less concerned about the financial perspective of this program. Therefore, most of them were not deeply involved in the decision-making process of conversion, because they perceived this as a “business” decision.

C) The Board

Based on our interviews and observations, the boards of these four hospitals all recognized the financial situation of their hospitals before CAH conversion. The administrative teams of these hospitals regularly report their financial statements to their board. Therefore, hospital board members well knew about how their hospital was doing financially under previous payment system (inpatient prospective payment system), what would happen under new systems (prospective payment applied to outpatient payment, fee schedule to lab payments), and what converting to a CAH means in terms of its effects on hospital's future patient revenue and cash flow through cost-based reimbursement. In general, the administration of these hospitals received a strong support from their board in the decision to convert to CAHs.

Since most of these hospitals are owned by county, their board members are appointed by county supervisors or commissioners. Because members came from different districts of their own county, they served as a great channel of communication between hospital and community. And, this channel of communication has been quite stable because these boards all had a very low turn-over rate. At this early stage, the board obviously played a critical role of communication medium between hospital and community in the discussion of CAH conversion.

2. The Response of the Community

To achieve consensus among all groups of interests (community, board, county supervisors, and internal staff), hospitals used a great variety of means to communicate with them. These means include survey, newsletters, newspapers, community meetings, and outreach of staff through their affiliation with other organizations (e.g., public health agencies).

In general, these hospitals received no objection from community when seeking CAH conversion. However, all of these communities did clearly express their concern about the consequence of conversion and demanded that the "same health care services" at the "same quality" would still be provided by the hospital after conversion. Obviously, access to and quality of hospital care were two major concerns of the community. At one site examples were offered of earlier strong community outcry when particular services were discontinued, even though there almost utilization of those services locally.

The community reacted differently, though, when presented with options defined in terms of keeping hospitals operating in the black or risking financial solvency. Since the CAH conversion does not require (for almost all hospitals) decisions to discontinue services, or change the current practices of the clinicians, the strongest reasons for objections are not in play. On the other hand, the need for maintaining a hospital in community was also highlighted by these communities. Because most of these hospitals were the biggest

employers in local community, their presence had a great impact on the economy as well as the health care of local community.

3. Lessons Learned

- Administrative leadership (CEOs and CFOs) needs to consider the effects of conversion on the institution, and the perceptions of others about those effects. Financial analyses need to be objective and thorough.
- The clinical staff of the hospital need to have their concerns addressed, but need not be involved in the details of the process. Attempts to involve them in the process other than implications for quality assurance would be perceived as a misuse of their time.
- Informed Boards are supportive Boards.
- Financial reasons to convert need to be understood; they are most likely to be related to the hospital's outpatient business. The effect of CAH conversion on inpatient revenue may be negative, but outweighed by effects on outpatient revenue, including payment for clinical lab services.
- Successful conversions in Nebraska have engaged the community early during the process. The importance of community engagement, and knowledge from the early converters, led the Nebraska Association of Hospitals and Health Systems to produce the "Communication Tool Kit" for use by later converters.
- Early converters experienced "learning by doing" that has been helpful to others. Both the Nebraska Office of Rural Health and the NAHHS have been assets to early converters (and converters since then), helping with the following: framing the questions to consider; understanding the process for conversion; and communicating with others not directly involved at the hospital.

PREPARATION FOR CAH CONVERSION

1. Becoming Certified: The Survey Process

A first step being used in Nebraska is to notify state government of the decision to move ahead. At that time the state begins offering advice to the local hospital, including timing decisions about when to file with the state and when to schedule a site visit from the state surveyors. The survey is a critical step, as it is the basis for certification by the Health

Care Financing Administration (HCFA), the final step is to obtain a provider number as a CAH. There are two formal steps then, making application to become a CAH, and completing a successful site visit for certification.

Considerable effort is required to complete this process. One of the important lessons offered by the four hospital administrators was that there needs to be an individual on the hospital staff responsible for completing all of the necessary steps. This could be the CEO, but only if one assumes the CEO can spare the time. Even the smallest hospital we visited had delegated this responsibility to someone else on the staff. Since the survey will require that all manuals and procedures are up to date, in somewhat larger hospitals (of course by definition they are all small; but there are differences between hospitals with single physician staffs and hospitals with multiple providers on staff) committees are needed to complete this process.

There were several characteristics of the process in Nebraska that made the overall survey process run smoothly and quickly:

- A) The state surveyors have been committed to making this work, and have provided technical assistance to the hospitals. The state surveyors have also kept in constant communication with the regional HCFA office to be sure in advance that the decisions they are making will be approved by that office.
- B) The Nebraska Association of Hospitals and Health Systems (NAHHS), one vice president in particular, provided a great deal of time to hospitals needing assistance with understanding all the forms needed for completing the survey, and how to update procedures and manuals.
- C) The Nebraska Office of Rural Health (NORH) provided advice on how to complete the process, including when to complete which steps.
- D) Both the NAHHS and the NORH helped hospitals explain the process and decision to their communities.
- E) Clinical staff were involved in this process, although in some places that was the Director of Nursing without direct engagement by the physicians.
- F) Serving on the CAH Advisory Committee, attending its meetings, and attending workshops sponsored by the state were all helpful activities to at least some hospitals.

2. Foundation for Success: Staffing and Medical Management

A critical element of being ready to function as a CAH is medical management. This is related in part to the requirement that all inpatient stays not exceed an annual average of 96 hours, but it included compliance with new systems of quality assurance as well. All four sites described meetings with clinical staff to review the implications of the 96 hour rule. In two sites these discussions started with the 96 hour meant a limit for each stay instead of an annual average. There are two elements in the medical management which could require additional staffing in hospitals with average daily censuses close to the 15 bed ceiling of this program:

- providing information to clinicians during an inpatient stay so they are aware of the number of days the patient has been in the hospital; and
- coordinating a plan of care upon discharge so that patients needing a higher level of post-discharge care receive the services they require.

An important decision for CAHs, recognized by some of the persons with whom we visited, is how to use swing beds effectively. That is, patients can be discharged from inpatient care and remain in the hospital as skilled nursing patients. A related point that arose in three of the sites, then, is being prepared to complete the necessary paperwork, specifically the Multiple Data Set (MDS) forms, now required when patients are in swing beds. For some hospitals this will require additional administrative staff; in others the nursing staff will need to be trained in this process.

3. Continuous Success: Keeping the Community Involved

CEOs at all four sites described efforts to keep their communities informed throughout the process of converting to CAH status, including specific steps taking the conversion:

- maintaining strong working relationships with the local newspaper so that the CEO is relied on as a source of information about what is happening with the hospital and can therefore “get the word out;”
- using flyers developed by the NAHHS;
- conducting special community meetings and forums;
- using a community newsletter;
- working through the hospital auxiliary;
- working through the hospital Board; and
- meeting with local business leadership, including the Chambers of Commerce.

4. Lessons Learned

- Representatives of state government, including the staff of state surveyors, can be of tremendous assistance in making the process of application and certification proceed quickly and smoothly.
- Hospitals need to delegate specific responsibility to staff that has time and resources to complete the necessary paperwork and coordination to guide the institution through the process.
- Clinical staff need to be informed of the process, and some element of clinical activity (physician or perhaps Director of Nursing) needs to be engaged in the survey process and implementation of some innovation in medical management.
- Information needs to be shared with clinical staff and the community throughout the process.

RESULT OF CONVERSION

1. Financial Performance

Were these hospitals financially better off after converting to CAHs? This is probably the most important question to ask when evaluating the success of CAH program. Based on our observation through site visits, the answer to this question cannot be definitive, since at that time there was not yet a full 12 months of experience. Therefore, audited financial statements after conversion were not available. Some hospitals did have preliminary information in their own monthly statements that was encouraging. As yet, though, even when positive net revenue figures were available (as high as \$80,000 higher than previous experience in less than 4 months), attribution to CAH status versus other changes in patient flow could not be affirmed.

2. Utilization of Hospital Care

Two hospitals reported increased inpatient and outpatient activity after conversion. Some of this may have been seasonal variation, but some may have been a result of the increased community focus on the local hospitals as a result of the open dialogue about conversion. Does this indicate that the utilization patterns of patients have changed as a result of CAH conversion? If this is true, we may be interested in knowing why and how it was changed. Was this change a result of physicians' changing practice? Or it was

caused by the new referral pattern between CAHs and their network partners? And, was there any change in the configuration of patients served by these hospitals? If so, how did that change affect the hospital's financial performance? All of the above questions should be addressed in the following years of this project. Quantitative data covering a bigger sample of hospitals which include hospital inpatient discharge and outpatient visit information and cost report data can be used to investigate these issues.

In general, hospitals have not observed any big change in terms of services provided or the number of staff. Since it has not been very long since they were converted to CAHs, this still needs to be tracked continuously. Items to be addressed include:

- influence of communications related to CAH conversion on community use of the local hospital;
- impact of the CAH on the local economy; and
- interaction of changes in management practices with improvements in revenue and medical management.

3. Internal and External Change of Organization

As a result of conversion, the nursing staff of these hospitals seemed to have a heavier workload than before. Because of the requirement on 96-hour stay average, they need to "watch" closely the practice of physicians and "track" carefully the medical charts of patients over time. This may require improved communications between nursing staff and physicians; frustration in communicating with physicians about this issue was expressed by the nursing staff of some hospitals.

There is an increase in paper work as a result of participation in the CAH program, which for most hospitals will require additional administrative staff (which in turn becomes a cost to be included in cost based reimbursement). Hospital staff described improvements in record keeping related to monitoring the quality of care being delivered by institutions, and therefore benefitting directly from the process of keeping records and procedure manuals current.

At the time of the site visits CAHs were beginning to build working relationships with larger hospitals designated as their partners in the program. These relationships will include developing quality assurance protocols for patient transfers.

4. Lessons Learned

- The administrative burden associated with being a CAH requires additional staffing.
- Financial improvements resulting from conversion appear to be significant but will need to be verified with audited data.
- Assessment of the impact of CAH activity needs to include economic impacts on the community.
- CAH status may result in increased use of the local hospital, in part because of enhanced hospital-community communications.

DISCUSSION

The conversion to CAHs has had a significant impact on the survivorship and well-functioning of these rural hospitals. One hospital expressed that it might have been closed within 18 months if it had have not been converted to a CAH. Generating more patient revenues also enabled some hospitals to update their equipment and to compete for capable employees with other local employers.

When we analyze the behavior of a hospital's seeking conversion to a CAH, we must keep in mind that this behavior or process should not be examined in isolation. The decision on conversion was just part of each hospital's whole strategic plan or action, which reflected the philosophy of each hospital's management and responded to each hospital's unique operating environment. In other words, the conversion to a CAH was part of a bigger picture in terms of a hospital operation over time.

1. Operating Environment

A) Geographic Location

Some hospitals were located in remote rural areas, while some hospitals operated in rural area near an urban/metropolitan region. Although the potential market (number of patients) was greater for the hospital in the latter area, the competition for patients in the market was also more fierce for this type of hospital. On the other hand, although the hospital in a urban-proximity rural area needed to compete for employees with more other attractive employers (both health care providers and non health care providers), this type of hospital would have a greater pool of well-qualified employees (both clinical and non-clinical) to choose from than the hospital in a remote rural area.

The above disparities resulting from the difference in geographic location explain, in part, the distinction of rationale behind hospital's seeking CAH conversion. For instance, based on our observation from site visits, one critical reason for the CAH conversion of a hospital in a urban-proximity rural area was to be able to pay their staff better so that they can compete more effectively with other local employers for staff. On the other hand, because of the small volume of market and the aging population, survivorship was a relatively more critical motivation for a hospital in a remote rural area. In fact, both hospitals did benefit from CAH conversion in the ways that they had hoped. In both instances, the benefits were directly related to the change in payment to cost-based reimbursement.

B) Community Resources

The amount of resources varied greatly among communities where hospitals were located. One community was relatively well off (more private insurance and support for strong local foundation) and its residents supported enthusiastically building the health care infrastructure. As a result, the hospital in this community received considerable donations from its residents, thus helping the operation of the hospital.

In addition, there seemed to be a positive association between the penetration of commercial insurance in community and the financial well-being of hospital. Hospitals located in the communities with greater commercial insurance activities tended to do better financially than their counterpart hospitals operating in communities where Medicare and Medicaid dominated the payment source of patients.

Since hospitals operated in different types of communities with different amount of resources, they also perceived CAH conversion differently. For some hospitals, it was a "do or die" critical choice, while it helped some hospitals to better meet the needs of their community.

2. Ecology of Hospital Networking; Horizontal and Vertical

Horizontal Networking Among Small Rural Hospitals

The hospitals operated in different regions of the state. Every region had its own unique ecology of hospital networking. One hospital was located in an area where a formal network of hospitals has existed for several years. The network has provided a forum for addressing common problems facing all member hospitals (e.g., strategic actions targeting patient out-migration). Other hospitals operated in regions where a formal network or alliance among hospitals had not been formed. It might be because of the "autonomy" issue or some other factors such as the complexity of health care market (e.g., the market is too competitive and the overlapping of potential markets served are

great among hospitals).

Networks of hospitals help member facilities through the use of integrated resources. Member hospitals would benefit from their network's strategic actions, such as comprehensive marketing initiatives and joint purchasing arrangements, through some form of scale economies. Moreover, collaboration might, to some extent, substitute for competition among hospitals in the same region so that hospitals can use their resources in a more efficient way.

Vertical Integration with Network Partner Hospitals

Since a CAH needs to, by law, work with its designated network hospitals in areas of patient referral and quality assurance, hospitals may have different conceptions about networking with other hospitals based on their previous perception of the ecology of hospital networking in their regions.

3. Management Style of Hospital

The way the management of a hospital addresses its problems and opportunities is a critical factor determining the success of hospital's performance. Conversion to a CAH may represent a great opportunity for hospitals to address their existing problems (e.g., cash flow, reputation, quality assurance, etc.) using new financial support from government and new clinical support from network hospitals. Therefore, how a hospital perceives and processes its conversion to a CAH reflects the philosophy and style of its management.

From our observations, hospitals can use the CAH process to improve managing patient care, conduct active peer utilization review, and achieve close collaboration with their network hospitals. We observed this strategic behavior when hospitals used CAH designation as integral to their overall business strategy. For example, a CAH was linked to expanding business in long-term care, remodeling facilities, and stabilizing and strengthening staff.

4. Integration With Other Services

Critical Access Hospitals are essential providers of medical care in their communities. Since the designation indicates some degree of isolation and a low volume of total patient business, one can infer that other services are likely to be financially unstable as well. For this reason it is important that the activities of the CAH be integrated with other medical services in the community. In the four site visits, the experiences of CAHs ranged from being part of system that included all essential services in the area, to being the local hospital with no controlling influence in delivery of others services such as emergency medical services, skilled nursing care, home health services, or other community based services. The "full package" of medical services in the local

community should be a focus of further planning activities in this program.

FEEDBACK FROM HOSPITALS

During the site visits hospitals expressed opinions about both program and policy issues affecting the future of the State Rural Hospital Flexibility Program, which are summarized below.

- Some hospitals expressed their concern about whether the CAH program can last for an expected period of time, especially after a great number of hospitals nationwide are converted to CAHs. They fear that if too many hospitals convert, especially larger rural hospitals, the federal government will end the program.
- The most important issue facing hospitals that seek CAH conversion is the perception held by physicians and the community about the consequence of becoming a CAH. Missperceptions could be formed during the decision-making process, including that the hospital must be failing to consider this strategy, and that it will become a “first aid station.”
- Some physicians suggested authorization for local EMS to call choppers in urgent situations such as car accidents so that time delay in patient transfer can be minimized.