"ADAPT, IMPROVISE, OVERCOME!"

Creativity Is Vital in a Community Where Many of the Residents Are of Medicare Age

BY ROBERT A. DOCKTER

As we Americans make our way into the 21st century, the number of us who live longer continues to grow. This is wonderful for us as individuals, but it presents a difficult problem for many rural, frontier* health care facilities.

The problem has been a growing concern for Eureka Community Health Services/Avera Health (ECHS), Eureka, SD. Eureka is located in north central South Dakota. According to the 2000 census, our population is 1,101 (296 families, 528 households). Fifteen and a half percent of our population is under 18 years old; 4.4 percent in the 18-24 range, 14.7 percent in the 25-44 range, 20 percent in the 45-64 range, and 45.4 percent in the 65-and-up range. Eureka's median age is 61.

Eureka is in McPherson County, ECHS's primary service area. South Dakota's median age is 35.6 years of age. McPherson County's median age, 47.6 years, is the highest in the state. According to the 2000 census, 29.6 percent of the county's population is over 65, which makes it the ninth oldest in the nation.

The nearest tertiary health care facility, Avera St. Luke's, in Aberdeen, SD, is 75 miles away.

As the reader can imagine, in our county just about every hospital admission or outpatient registration begins with the question: "May I have your Medicare number?" The high number of elderly residents has created many dilemmas and opportunities for the Eureka community. In what follows, I'll describe some of the adjustments we have had to make over the years to accommodate the changing needs of our elderly population.

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A Skeptical Community

The building that today houses ECHS was formerly Eureka Community Hospital, which opened in 1929. In 1996 ECHS was formed as part of the federal Essential Access Community Hospital/ Rural Primary Care Hospital (EACH/RPCH) program,† in which South Dakota was a participating pilot state. This was a big change for our facility.

ECHS has two full-time physicians. At the time of the change, one was practicing obstetrics. But, partly because EACH/RPCH guidelines were rather stringent with regard to surgery and births, the physicians and the hospital agreed to discontinue delivery of babies at ECHS. Aiding the physicians' decision was the rising cost of malpractice insurance; the hospital was trying to meet the RPCH guidelines.

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*"Frontier" is a term often used in the western United States to describe lightly populated communities distant from urban centers and the services, including health care, commonly found in them.

†Congress created this program in 1989. Under it, a limited-service rural hospital (Rural Primary Care Hospital, or RPCH) operates in tandem with a larger, full-service facility (Essential Access Community Hospital, or EACH). Care provided in RPCHs is a covered service of Medicare. The states involved in the pilot program were, besides South Dakota, California, Colorado, Kansas, New York, North Carolina, and West Virginia. See National Rural Health Association, "The Need for a National Limited-Service Hospital Program," November 1996, available at www.nrhrural.org/dc/issuepapers/ipaper6.html.

With the Balanced Budget Act of 1997, the EACH/RPCH program became the Medicare Rural Hospital Flexibility Program, under which limited-service health care facilities would become known as critical access hospitals (CAHs).* ECHS was now a CAH. Access to grant funding and cost-based reimbursement were two key areas of relief for facilities meeting the CAH qualifications.

Our community was somewhat skeptical about the facility's change into, first, a RPCH and then a CAH. The majority of area residents suspected that our facility was becoming a "Band-Aid" station and that all inpatient care would require a transfer to Avera St. Luke's, 75 miles away. However, through community meetings and public awareness campaigns, we were able to explain the program to community members, and they became more at ease with the concept.

Part of the change involved reducing the facility's number of beds from 25 beds to six. At first we felt safe in doing this because research showed that, in the previous seven years, the facility had had seven patients or more on only two occasions. However, as Murphy's Law predicts, we admitted a seventh patient just five days after reducing the number of beds. To date, that has been the only occasion on which we've found ourselves with more patients than beds, but it was enough for the local "I-told-you-so" crowd.

Adjusting to Changing Needs

The bed-reduction decision was made so that we could put the facility's floor space to the most efficient use. Our long-range strategic plan was to expand ECHS's range of services beyond those offered at the time of the change, which were limited to outpatient laboratory and x-ray studies, inpatient care, and "swing bed" care. The need to diversify to meet our changing demographics was evident. Our board of trustees (seven people from Eureka and the surrounding area) accordingly began to develop a plan to meet the changing needs of our community's residents. Included in it were home health care, community nursing services, WIC (women, infants, and children) services, assisted-living units, increased outreach physician services, cardiac rehabilitation services, telemedicine projects, full-time physical and occupational therapy, and—to help fund them—an aggressive search for grants.

This plan has come to fruition over the last seven years. The home health agency was opened in 1995 and continues today. Our community nursing and WIC program, which we operate in partnership with the state, was established in 1997, the same year we began our cardiac rehabilitation service and telemedicine programs. The assisted-living center opened in November 1998; during this period, we also added treadmill stress testing and orthopedic, ophthalmology, and urology outreach. In 2001 we were able to arrange, with the help of Avera St. Luke's, to place a physical and occupational therapist in our community. We have, over this period, received more than $400,000 in grants from local foundations and the U.S. government.

A small rural facility must be able to adapt to its community's changing needs.

It is imperative for a small rural facility to be able to adapt to the changing needs of its community and service region. In our case, the large increase in elder care needs has very much influenced our planning for services. Our big concern has been accumulating sufficient revenue to continue operations. Because of its high proportion of Medicare patients, ECHS's operations do not yield large margins. In such a situation, opportunities for "cost shifting" are virtually nonexistent. You cannot cost-shift an 80-plus percent Medicare volume to the remaining 20 percent of the clientele. You need to concentrate your efforts in areas of need to continue a flow of traffic coming through your doors.

Surprising as it may seem, a big challenge for ECHS has been acclimating itself to cost-based reimbursement. Under the old diagnosis-related group reimbursement methodology, we had to crunch costs to the bare minimum, and, in many instances, crunch services as well. Today we can get reimbursement for our costs, but we do not have sufficient cash flow to make the capital improvements and other adjustments we need. This process takes time and goes much beyond obtaining cost-based reimbursement to survive as a CAH.

Assisted Living

Sorting out our service mix was an essential component to remaining solvent in our particular rural environment. After our conversion to CAH status, our biggest adjustment was the addition to our facility of 10 assisted-living units.

*The Centers for Medicare & Medicaid Services operate this program. For a full description, see "Medicare Rural Hospital Flexibility Program," available at www.cms.hhs.gov/media/press/release.aspCounter=331.

ECHS is a two-story building. To the second floor, which had previously been used exclusively for obstetric services, we moved our acute care hospital. The first floor, formerly the acute care site, we converted into assisted-living units. These units would, if we could keep them fully occupied, give us much-needed income stability. We were careful to budget for 100 percent Medicaid occupancy; rent from any private-pay residents the units might attract would help pay our operating costs.

We had researched the assisted-living project in conjunction with the South Dakota Office of Rural Health. Because of our facility's remote location, we were limited as to the number and size of the units we could construct. In November 1998 we opened our assisted-living center, which by March 1999 was filled to capacity. The center remains full at present; indeed, we have a waiting list for the units. We would like to construct additional units—our area certainly needs them—but the ECHS building has no space for them. We might conceivably build an additional structure or construct an entirely new medical facility in another location, but neither of these options is practical at this time.

Affiliating with Avera Health

A third step in our plan to meet our changing environment was affiliation with Avera Health, Sioux Falls, SD, one of the upper Midwest's largest health care systems. In 1996, ECHS's board decided that such an affiliation would improve the facility's stability and make its future brighter. A management agreement was reached among ECHS, Avera St. Luke's, and Avera Health itself. This relationship maintains local ownership* but allows the facility to get information and guiding principles from the system and the hospital.

Although we who work in health care tend to forget it, larger facilities need smaller facilities as much as, if not more than, smaller ones need larger ones. Consider, for a minute, where large facilities get the patient base they need to maintain a certain number and variety of practicing specialists. We smaller facilities send the referrals, provide the outreach sites, and help maintain the volume of patients necessary to keep those physicians happy and those practices busy. Working together benefits *both* the larger and the smaller facility. At ECHS, we have learned to make our voice heard at the negotiating table, rather than simply reacting to proposed changes.

Doing so has increased our ability to communicate with Avera St. Luke's. Because of Eureka's distance from South Dakota's cities, our ability to network with peer managers is limited at best. However, affiliation with Avera St. Luke's has enhanced networking opportunities for ECHS's managers with their counterparts in Aberdeen. System affiliation has been priceless if only because it helps us with issues involving corporate compliance, the Health Insurance Portability and Accountability Act, the Emergency Medical Treatment and Active Labor Act, and other federal mandates. Because of this networking and idea sharing, our managers don't have to constantly "reinvent the wheel."

Affiliation with Avera Health has another dimension as well. Because the system's affiliates pool their investment dollars, each of them—including ECHS—is able to realize a higher rate of return than if those investments had been made singly. In addition, the access Avera Health provides to foundation assistance in fund-raising activities and estate planning is very helpful to our facility. So also is the information gathered by the system's central office, which is then passed on to member hospitals, nursing homes, and clinics. It would take many hours for us to research all the issues that Avera Health's legal staff can review in detail in a much shorter period of time.

Affiliation with Avera Health has made our facility's future brighter.

A Part of the Community

Small rural health care facilities typically exist in a state of constant change and adjustment. In that regard, they are no different than large tertiary hospitals. However, in small rural facilities the case mix and the resources available are stressed on a continual basis. At ECHS, we must constantly remember to "improvise, overcome, and adapt" (to use the U.S. Marine Corps motto). The challenge can be both frustrating and exhilarating at the same time.

Our challenge is to stay in constant touch with the demographics and resources of our community and service area. We must be ready to do whatever is necessary, whether that means seeking help from the South Dakota Health Care

Continued on page 52

*ECHS is a community-owned, not-for-profit organization that retains the formal name it was given in 1929: Eureka Community Benevolent Association.

CHALLENGES AND OPPORTUNITIES

Continued from page 22

because there is a need, whether or not the projects are likely to be profitable. Such willingness is increasingly absent in the commercially driven systems that have come to dominate urban communities.

All these rural characteristics provide a fertile environment for the kind of creative and humane innovation that our society so desperately needs. □

NOTES

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2. Timothy Egan, "Amid Dying Towns of Rural Plains, One Makes a Stand," *New York Times*, December 1, 2003, available at http://query.nytimes.com/gst/abstract.html?res=F20E15F93B5E0C728CDDAB0994DB404482.
3. Stephen Jencks, et al., "Quality of Medical Care Delivered to Medicare Beneficiaries," *JAMA*, vol. 284, no. 13, 2000, pp. 1,670-1,676.
4. Tom Nesbitt, et al., "Local Access to Obstetric Care in Rural Areas: Effect on Perinatal Care, Birth Outcome and Cost," WWAMI Rural Health Research Center Working Paper, August 1993; the article also appeared in the *American Journal of Public Health*, vol. 80, no. 7, July 1990, pp. 814-818.
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6. Howard Rabinowitz, et al., "A Program to Increase the Number of Family Physicians in Rural and Underserved Areas," *JAMA*, vol. 281, no. 3, January 1999, pp. 255-260.
7. Dale Newton, et al., "Trends in Career Choice by U.S. Medical School Graduates," *JAMA*, vol. 290, no. 9, September 2003, pp. 1,179-1,182.
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9. Bruce Amundson, "Myth and Reality of the Rural Health Service Crisis: Facing Up to Community Responsibilities," *Journal of Rural Health*, vol. 9, no. 3, Summer 1993, pp. 76-87; Heartland Center for Leadership Development, "20 Clues to Rural Community Survival," Lincoln, NE, available at www.heartlandcenter.info.

"ADAPT, IMPROVISE, OVERCOME!"

Continued from page 33

Association or the state Office of Rural Health, or contacting legislators, or serving on local community boards. Serving on the local development corporation board is especially important because each of its members has an interest in the community's economic future. How many times have we heard someone say, "If the school and hospital go, so does the town." At facilities such as ECHS, we need to be able to recognize changing conditions and be proactive rather than reactive.

When you have a community the size of Eureka's, your staffing pool is not very deep and you thus become vulnerable when vacancies arise. Filling positions in medicine, management, radiology, laboratory, and nursing is not easy. Recruiting specialists for a community as small and isolated as ours can be a difficult proposition.

We at ECHS have worked with a number of area facilities and a local educational institution to provide a variety of classes using two-way videoconferencing equipment. The program was designed to help single parents (and others) who wanted to get additional education and further themselves but could not travel to attend classes. Through this program, over a period of three years, we were able to graduate quite a few registered nurses, licensed practical nurses, and medical technicians. However, as happens more times than not, we could not renew our funding for the program, and now it has been lost.

Education through video conferencing is one way rural health care can triumph over the challenges it faces. Don't get me wrong. I'm not saying, "The future is so bright that we have to wear sunglasses." But I do feel that we have a lot of energy and talent out there, and with it we will come up with ways to get past the hurdles before us.

Our community's ever-increasing number of elderly residents is just one of the problems we face on a daily basis. At ECHS, we chose not to ignore it but, rather, to research the needs of that segment of our population and adapt to meeting those needs. Among the services that our elderly need to receive in their own community: increased access to various specialists; physical and occupational therapists to help treat arthritic problems; assisted-living units to help fill the gap between acute care, on one hand, and nursing home care, on the other; and increased availability to home care, to mention just a few.

Creativity Will Be Needed

The first thing a facility like ours needs is an educated and progressive board of trustees that can help us meet these challenges. I am a strong believer in educating boards as much as possible so that they are aware of the barriers they face and can recognize what is coming down the road. The second critical item is keeping your staff informed about both the changes ahead and their role in those changes. And third (but not least) in importance is involving your medical staff in the growth process. You have to have a "buy-in" attitude in all of these groups.

ECHS has received national recognition for its ability to get this message across and move forward in filling our facility's needs. This recognition has created opportunities for us to present our case before a variety of state health care associations, hospital boards, and various other health care groups across the nation. Our goal continues to be education of board members, management, physicians, staff—and community residents as well. One year, for example, we launched a referendum for a *local one-cent city sales tax* with which we planned to retire a large federal loan. After hearing the specifics and our long-term plan, the community rallied behind us and approved the tax. In fact, the initiative got 85 percent of the vote!

Unfortunately, we do not expect our community's percentage of people over the age of 65 to grow smaller in the years to come. We need to continue to be proactive in our approach to health care services. If we can continue to take an aggressive approach to meeting continually changing service needs, we should be able to beat the odds and maintain our small rural community hospital for many years to come. □