



Critical Access Hospitals: Catholic Social Teaching in Action

BY SUSAN C. THOMSON, M.A., M.B.A.

St. Joseph Memorial Hospital's vital signs were pointing in all the wrong directions. Medicare patients were becoming a greater share of a shrinking pool of inpatients. Revenue was falling short of costs that had been cut to the bone. The survival of the 50-bed hospital in small-town Murphysboro, deep in southern Illinois, was in doubt.

In 2004, administrators reversed the trends and ensured the hospital's future by grabbing a life-line that has saved hundreds of similarly stressed, small, rural hospitals. They converted St. Joseph to a critical access hospital, a move that freed it from the low, fixed Medicare payments that were strangling it and made it eligible instead for enhanced reimbursements for all of its Medicare services.

St. Joseph Memorial became thereby a survivor of an industry shakeout that began in the 1980s, when Medicare imposed flat reimbursement rates for various procedures, and accelerated in the 1990s. Between 1990 and 2000 alone, 504 U.S. hospitals, 208 of them rural ones, shut their doors, according to the Department of Health and Human Services' Office of the Inspector General, which gathered and analyzed the numbers. The casualties, all with relatively few beds and low occupancy rates, included 7.8 percent of all rural and 10.6 percent of all urban hospitals.

The media and members of Congress took special note of rural hospitals' plight. They heard stories of isolated communities that lost their only hospital and the resulting effects on rural residents—older, sicker, poorer and more place-bound than most and accounting for upwards of 20 percent of the whole U.S. population. They considered the long-term implications for the economic health of rural America if small but vitally important rural

hospitals closed.

Legislators hoped to find a solution in the Medicare Rural Hospital Flexibility Program, an element of the 1997 Balanced Budget Act. Flex, its nickname now, established a completely new category of rural hospitals called critical access and boosted their Medicare reimbursements to 101 percent of allowable costs.

The rollout took time. First, states had to adopt the program, as all but the relatively urban Connecticut, New Jersey, Maryland, Rhode Island and Delaware have now done. Then, rural, acute-care, public or not-for-profit hospitals in subscribing states could qualify as critical access if they met certain other requirements:

- Round-the-clock emergency service
- A 25-bed limit
- Inpatient stays averaging no more than 96 hours
- Location at least 35 miles from any other hospital, or 15 miles over rough roads. (The distance limit was later lifted for a time to open the program to hospitals their states deemed "necessary providers.")

John Gale, a health policy researcher at the University of Southern Maine who has followed critical access hospitals since their creation, said they "really took off in the early 2000s or so." As



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LUKE LARSON, VICE PRESIDENT, MISSION INTEGRATION
CATHOLIC HEALTH INITIATIVES

of July 2010, there were 1,305 critical access hospitals, about one quarter of all the nation's hospitals, according to the Flex Monitoring Team, which tracks these hospitals for the federal Office for Rural Health Policy.

Their number has held fairly steady for the last five years, according to Mark Holmes, an expert in rural health care at the University of North Carolina at Chapel Hill. "Pretty much" all of the eligible hospitals have now made the conversion and only a few have since dropped out of the program or closed, he said. (A few also have been built from scratch.)

Holmes, Gale and colleagues from the univer-

sities of North Carolina at Chapel Hill, Southern Maine and Minnesota make up the monitoring team, which offers its findings in papers, policy briefs and other presentations. (See *flexmonitoring.org* for information and download versions.)

The team's work sketches an image of critical access hospitals:

- They are less likely than other hospitals to provide substance abuse, dental, hemodialysis, psychiatric and palliative care services
- Pneumonia and heart failure are their most common diagnoses
- Two-thirds do inpatient and four-fifths do

CHA MEMBER CRITICAL ACCESS HOSPITALS

This list is based on a 2008 American Hospital Association survey cross-referenced with CHA membership data. A complete list of critical access hospitals in the U.S. is available at flexmonitoring.org/cahlistRA.cgi

ALASKA

Providence Seward Medical Center, Seward
Providence Kodiak Island Medical Center, Kodiak
Ketchikan General Hospital, Ketchikan

ARIZONA

Carondelet Holy Cross Hospital, Nogales

ARKANSAS

Mercy Hospital/Turner Memorial, Ozark
North Logan Mercy Hospital, Paris
Mercy Hospital of Scott County, Waldron
Crossridge Community Hospital, Wynne
St. Anthony's Medical Center, Morrilton

CALIFORNIA

Redwood Memorial Hospital, Fortuna
Mercy Medical Center Mount Shasta, Mount Shasta

GEORGIA

Saint Joseph's East Georgia, Greensboro

IDAHO

St. Mary's Hospital, Cottonwood
St. Benedicts Family Medical Center, Jerome

ILLINOIS

St. Joseph's Hospital, Highland
St. Francis Hospital, Litchfield
St. Joseph Memorial Hospital, Murphysboro

INDIANA

St. Vincent Mercy Hospital, Inc., Elwood
St. Vincent Williamsport, Williamsport
St. Vincent Jennings Hospital, North Vernon
St. Vincent Frankfort Hospital, Frankfort
St. Vincent Randolph Hospital, Winchester
St. Vincent Clay Hospital, Brazil
St. Mary's Warrick, Boonville

IOWA

Mercy Medical Center-Centerville, Centerville
Mercy Medical Center-Dyersville, Dyersville
Avera Holy Family Health, Estherville

Mercy Medical Center-New Hampton, New Hampton
Mercy Hospital of Franciscan Sisters, Oelwein
Mercy Hospital, Corning

KANSAS

St. John's Maude Norton Memorial Hospital, Columbus

KENTUCKY

Marcum & Wallace Memorial Hospital, Irvine
Saint Joseph Martin, Martin

LOUISIANA

CHRISTUS Coughatta Health Care Center, Coughatta

MICHIGAN

Borgess Lee Memorial Hospital, Dowagiac
Mercy Health Partners-Lakeshore, Shelby

MINNESOTA

LakeWood Health Center, Baudette
St. Francis Healthcare Campus, Breckenridge
Queen of Peace Hospital, New Prague



outpatient surgery

■ More than one-third are designated trauma centers

That's not to say these are either bare-bones or cookie-cutter operations. Beyond the required emergency care, the Flex program neither prescribes nor limits the services critical access hospitals can offer, allowing each to evolve in its chosen way.

At St. Joseph Memorial, a member of the Southern Illinois Healthcare system, administrator Scott B. Seaborn proudly pointed out some of the hospital's distinguishing features. Here are

six beds in an area where excess inpatient rooms were taken out of service. They now constitute the only accredited sleep clinic in southern Illinois. Down that hall is the Senior Renewal Center, a counseling service for older adults. This way is a diagnostic lab. Around another corner are two operating rooms. Their capabilities include podiatry, gall bladder and appendix removal and basic urological and plastic surgery. Also available are cardiac and pulmonary rehabilitation and physical and occupational therapy.

By contrast, Mercy Medical Center in Mt. Shasta, Calif., a member of Catholic Healthcare West, specializes in hospice care, obstetrics, cancer che-

St. Joseph's Area Health Services,
Park Rapids

Saint Elizabeth's Medical Center,
Wabasha

Albany Area Hospital & Medical Center, Albany

St. Gabriel's Hospital, Little Falls

MISSOURI

St. John's Hospital-Cassville, Cassville

St. John's Hospital-Aurora, Aurora

St. John's St. Francis Hospital,
Mountain View

MONTANA

St. Joseph Hospital, Polson

NEBRASKA

St. Mary's Hospital, Nebraska City

St. Francis Memorial Hospital, West Point

Oakland Mercy Hospital, Oakland

Avera St. Anthony's Hospital, O'Neill

NORTH DAKOTA

St. Andrew's Health Center, Bottineau

Carrington Health Center, Carrington

Saint Aloisius Medical Center, Harvey

Oakes Community Hospital, Oakes

Presentation Medical Center, Rolla

Mercy Hospital, Valley City

Lisbon Area Health Services, Lisbon

OHIO

Mercy Memorial Hospital, Urbana

Mercy Willard Hospital, Willard

Community Allen Medical Center,
Oberlin

OREGON

St. Elizabeth Health Services,
Baker City

St. Anthony Hospital, Pendleton

Peace Harbor Hospital, Florence

Providence Hood River Memorial Hospital, Hood River

Providence Seaside Hospital, Seaside

PENNSYLVANIA

Muncy Valley Hospital, Muncy

SOUTH DAKOTA

Gettysburg Medical Center, Gettysburg

Milbank Area Hospital/Avera Health,
Milbank

Avera St. Benedict Health Center,
Parkston

St. Michael's Hospital Avera, Tyndall

Dells Area Health Center/Avera Health,
Dell Rapids

TENNESSEE

Hickman Community Hospital,
Centerville

TEXAS

Madison St. Joseph Health Center,
Madisonville

Burleson St. Joseph Health Center,
Caldwell

Grimes St. Joseph Health Center,
Navasota

Seton Highland Lakes, Burnet

Seton Edgar B. Davis, Luling

WASHINGTON

Mount Carmel Hospital, Colville

Enumclaw Regional Hospital,
Enumclaw

St. Joseph's Hospital, Chewelah

Lourdes Medical Center, Pasco

WISCONSIN

Langlade Hospital, Antigo

Franciscan Skemp HC-Arcadia Campus,
Arcadia

Good Samaritan Health Center, Inc.,
Merrill

Franciscan Skemp HC-Sparta Campus,
Sparta

Waupun Memorial Hospital, Waupun

St. Mary's Hospital of Superior,
Superior

Our Lady of Victory Hospital, Stanley

Eagle River Memorial Hospital, Eagle River

Door County Memorial Hospital,
Sturgeon Bay

motherapy and radiation, and ophthalmologic and orthopedic surgery, including hip and knee replacements.

Sports medicine is a specialty of St. Joseph Medical Center in Polson, Mont., a member of Providence Health and Services, which also runs a retirement center.

In May 2010, Saint Joseph-Berea in Berea, Ky., part of Saint Joseph Health System, Lexington, Ky., opened a wound-care center.

Still, whatever its menu of services, a critical access hospital is by definition not all things to all patients. Hence, all have relationships with fuller-service acute-care hospitals where they can transfer their more complex cases, Gale said. Rural ambulance services sometimes decide to deliver such cases directly to a larger hospital, bypassing

The stakes are high, not just for these hospitals but also for their communities where, as Jones said, they tend to be “the beating hearts,” the largest employers, sources of good jobs with full benefits and assets for economic development.

a nearer, local critical access hospital altogether. Other times, the critical access hospital initiates the transfer by calling an ambulance, perhaps after first stabilizing the seriously ill or injured patient. Seaborn tells of one patient who arrived at St. Joseph Memorial Hospital after falling on a knife and cutting his throat. The hospital hurriedly arranged to have him air-lifted to a hospital in St. Louis, 100 miles away. The patient survived.

Roughly 10 percent of critical access hospitals are Catholic, according to the Flex team’s data. Luke Larson, vice president, mission integration, for Catholic Health Initiatives (CHI), described these hospitals as “carrying on the legacy of the sisters in going to where the greatest need is.” Like all Catholic hospitals, Catholic critical access hospitals take a holistic approach to medicine, assuming responsibility for patients’ spiritual, emotional and social well-being along with their physical health, he said.

According to the Flex team, 37 percent of critical access hospitals answering a survey belonged to larger systems in 2007. The trend has since grown as more of them, for reasons both economic and medical, have given up going it alone.

St. Joseph Memorial, for example, was founded by the Sisters of the Adorers of the Blood of

Christ, who sold it and turned over management to Southern Illinois Healthcare in 1995 on the condition that the hospital maintain its Catholic identity. Headquartered in Carbondale, seven miles away, the Southern Illinois system consists of two larger hospitals and 16 clinics. Advantages of belonging to the system have included access to capital, to medical and business expertise and, for the sickest patients, to higher levels of care than St. Joseph Memorial can provide, Seaborn said.

That same year, Denver-based CHI carved out its Minnesota/North Dakota division, now consisting of 12 critical access hospitals that benefit from joint purchases of supplies and equipment.

A year later, CHI created the Saint Joseph Health System, spreading costs and health services among critical access hospitals in Berea and

Martin plus five other hospitals and an ambulatory care center, all in eastern Kentucky. The combination has given the group a larger voice to advocate for the poor and

underserved. At her hospital, where charity care accounts for nearly half of the total, being part of the system provides means to do more, said Kathy Stumbo, president of critical access Saint Joseph-Martin. The Kentucky and Minnesota/North Dakota groups realize even more economies of scale from their affiliation with the larger 18-state, 72-hospital CHI system.

It is the Flex program, however, that gets the biggest share of the credit for keeping hundreds of otherwise vulnerable hospitals afloat around the country.

“It’s how we can now stay alive,” Seaborn said. Without it, half or more of Illinois’ 51 critical access hospitals would be closed or on the brink, said Pat Schou, executive director of the Illinois Critical Access Hospital Network, a source of information for and about its 50 members.

Critical access status is by no means a cure-all, however. For one thing, it doesn’t guarantee the quality of such a hospital’s care — a point underscored by Chris Jones, director of strategy and business development for CHI’s Minnesota/North Dakota division. Nor does the program provide a hospital an automatic pass to get out of the financial woods. Using a complex formula factoring in a hospital’s total margin, cash position, debts and age of buildings, the Flex Monitoring



SMALL RURAL HOSPITALS HELP KEEP COST OF SYSTEM'S HEALTH CARE IN CHECK

BY STEVEN TAYLOR

The Denver-based health system Catholic Health Initiatives (CHI) operates 21 critical-access facilities, 12 of which stretch across sections of North Dakota and Minnesota.

Considering the breadth and scope of this involvement with small hospitals in largely rural areas, CHI serves as something of a laboratory for surviving and thriving in these sometimes-demanding markets. We recognize the value of critical access hospitals to the overall health of the many communities we serve, and we find that critical access hospitals in rural communities also are an important part of controlling and reducing costs for a health system overall

That is because of what these small facilities do: They provide primary medical care for a population that, for various reasons, is underserved. It sounds simplistic, but the economic implications are immense. Access to health care is a primary component to reducing costs. If a rural patient forgoes treatment for a simple diagnosis, that diagnosis can become more complex and acute, sharply increasing the cost when the patient must have care.

In 2007, CHI's top leadership created an operating division composed of the seven CHI hospitals in North Dakota and the five in Minnesota, along with related health facilities including those for assisted living and the developmentally disabled. (See related story on LakeWood Health Center, page 60.)

Through collaboration within the division, we were able to consolidate capital spending, and the collective buying power of all 72 CHI hospitals helped reduce costs and improve efficiencies. For instance, the consolidation resulted in several purchase/lease arrangements for imaging equipment that might not otherwise have been feasible. This alignment across the division also helps pave the way for these small hospitals to share some staff and makes it possible to bring expertise from across the division — and the entire CHI system — to where it is most urgently needed.

The basic economics of critical access hospitals represent a challenge. With a limit of 25 acute-care beds, these hospitals usually exist in rural sections of the U.S., serving populations that are underinsured or that are represented by a disproportionately large percentage of senior citizens.

Over the years, the federal Medicare program has not covered all the costs of providing necessary care to its target group, those ages 65 and older. This rapidly growing demographic also tends to incur more health care costs overall than other age groups, so, in many cases, critical access hospitals support a growing percentage of senior citizens through a federal entitlement program that often does not provide adequate funding.

To be sure, critical access hospitals by definition are eligible for a Medicare adjustment to help support them and subsidize services that might not otherwise be available. For example, these hospitals are required to maintain the kind of professional staffing that allows the facility to stabilize the most serious patients and help transfer them to a larger hospital for more specialized care.

However, staffing is a serious challenge for health care in general and critical access hospitals in particular. The economics of rural communities often inhibits recruiting and retaining physicians and supporting staff. Funding pressures directly affect salaries and benefits, and many recent graduates of medical schools and other professional training programs are burdened with sizeable student loans. New doctors, nurses and other health professionals often are reluctant to relocate to rural communities where salaries, benefits, amenities and cultural attractions don't match what is available in urban centers.

The practice environment itself can represent another stumbling block. Since many critical access hospitals have fewer than 10 people on the medical staff, the on-call obligations for physicians are significant and require that they not only provide care between 8 a.m. and 5 p.m., but that they also see patients after hours in the hospital or through the

emergency department.

Helping them build a family connection to the market itself is one of the best ways to attract and keep physicians. There is a significant amount of work to “grow our own” in our markets, but as the numbers of youth decline in rural areas, it becomes more difficult to find young people interested in medicine who want to return to their home communities. It is also tough to recruit a family to a small market if there are limited local job prospects for spouses.

Along with staffing, medical specialization also comes into play as an issue for a critical access hospital in a rural community. As the practice of medicine becomes more specialized, as well as the corresponding technology, the necessary resources to provide specific services increases. But a critical access facility may serve too few residents to spread the costs associated with specialized services across its general area.

Take state-of-the-art magnetic resonance imaging, for example. Offering MRIs requires an institution to purchase or lease very expensive, high-tech equipment, hire someone with the expertise to operate it, and maintain the patient volume necessary to justify the investment. It can be agonizing for decision-makers to realize it may not be in the community's best interest to outfit a small hospital with expensive equipment for comparatively tiny numbers of patients.

CHI's 12 critical access hospitals in North Dakota and Minnesota have achieved excellent results in the last year or so. Yet, there is more work to be done as we focus on the quality of care, improving the patient experience and fulfilling our mission as a health ministry to create healthier communities.

STEVEN TAYLOR is Catholic Health Initiatives' vice president, division finances, based in Fargo, N.D.

Team in 2008 found the financial health of critical access hospitals improving as a group. By that same measure, however, only 22 percent of the hospitals were in excellent shape while 19 percent were faring poorly.

“Many of them still have poor financial strength,” said Holmes. “A number of them are losing money every year.” Plus, he added, like all hospitals, they have taken a fiscal bruising from a recession that has swelled the ranks of patients on low-reimbursement Medicaid and those with no insurance at all.

Nearly all critical access hospitals face challenges that come with their very territories. It’s true that a few are in attractive, resort-like settings like Boothbay Har-

bor, Maine, Aspen, Colo., and Lake Geneva, Wis. The vast majority, though, are in out-of-the-way, map-dot places like Crete, Neb.; Sylvester, Ga.; and Eden, Texas. This puts them at a serious disadvantage, compared with urban hospitals, in the competition to hire medical professionals. General surgeons, anesthesiologists, nurse anesthetists and lab and diagnostic technicians are particularly hard for these towns to come by, Gale said.

As for patients, he said, “There is a particular population that has tended to be loyal to these hospitals because they grew up in the community. They tend to be a little bit older.”

They represent just part of the whole rural population, he said, which also includes people who prefer to travel to larger, farther-away hospitals for their care as well as increasing numbers of minorities, including foreign-born whose first language isn’t English. To reach these potential patients, he said, critical access hospitals are going to have to learn how to market themselves to “a whole new generation.”

For all hospitals and health care providers, the elephant in the waiting room at the moment is the Patient Protection and Affordable Care Act, the health care overhaul bill President Barack Obama signed into law in March 2010. Just how the details will work out remains to be seen.

Critical access hospitals stand to benefit from some of the law’s less publicized provisions, including some applicable under certain circumstances to all rural providers. According to the National Rural Health Association, these include Medicare bonuses of 3 percent for rural home health services and 10 percent for Medicare services performed by general surgeons and various primary-care specialists in areas where these pro-

fessionals are in short supply. The law also specifically allows critical access hospitals to begin buying outpatient drugs below wholesale prices. Brock Slabach, the association’s senior vice president, estimated resulting savings on drug purchases will reach between 30 and 50 percent.

In the reform’s promise to reduce the ranks of the uninsured, Holmes noted a plus for all hospitals, critical access included. “Any time you have more people with more insurance coverage, that will help the bottom line,” he said.

Schou, however, identified a possible downside in the law’s expansion of Medicaid unless states, taking a leaf from the Flex book, start reimbursing critical access hospitals for their actual Medicaid costs rather than at the arbitrary lower rates now the norm.

The stakes are high, not just for these hospitals but also for their communities where, as Jones said, they tend to be “the beating hearts,” the largest employers, sources of good jobs with full benefits and assets for economic development.

“There are things that people look for when they’re coming to a community to live or to bring a business in, and a hospital is right at the top of the list,” said Murphysboro mayor Ronald L. Williams. He lauded St. Joseph Memorial as an up-to-date facility, notable for its “great emergency care,” “expanded services” and “religious aspect.” And, he added, the town is lucky to have it.

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JOURNAL OF THE CATHOLIC HEALTH ASSOCIATION OF THE UNITED STATES

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Reprinted from *Health Progress*, September-October 2010
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