SPECIAL SECTION

# THE CHANGING FACE OF RURAL CATHOLIC HOSPITALS

## *A Study Uncovers Features That Separate Successful From Unsuccessful Hospitals*

**BY EDWIN FONNER, JR., DPH, & LARTIVIA HAMMOND**

Since the mid-1980s, socioeconomic trends and developments within the U.S. healthcare system have made it increasingly difficult for rural healthcare providers to remain viable. Depressed local economies, aging service-area populations, inadequate reimbursement for patient care, and other factors led six rural Catholic hospitals to close or convert to long-term care facilities between 1986 and 1989. During the same period, 17 rural facilities converted to non-Catholic ownership.

Although these trends have posed problems for virtually all rural providers, some Catholic hospitals have managed to maintain reasonably healthy margins—and even improve services—while others have struggled to survive. This study explores relevant factors characteristic of the most and least successful rural Catholic hospitals between 1982 and 1989. From a representative cohort of 127 facilities for which the Catholic Health Association (CHA) has complete annual information, the study identifies two groups of rural facilities—30 "consistently sound" and 22 "adversely affected" hospitals. The groupings were based on six financial measures (see **Table 1**) and annual profit margins (which declined from 8.25 percent to 6.94 percent from 1987 to 1989 for top-quartile hospitals, and from 1.03 percent to 0.94 percent for bottom-quartile hospitals). In addition to information from CHA records, the study uses data from American Hospital Association (AHA) annual surveys, Medicare cost reports, and the 1980 census.

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### RURAL CATHOLIC HOSPITALS: A CURRENT PROFILE

Of the 172 rural Catholic hospitals that were open and reporting to AHA in 1990, all but two

**Summary** Socioeconomic trends and developments within the U.S. healthcare system have challenged rural hospitals' ability to maintain adequate operating margins and offer needed services. However, some hospitals have fared better in this negative environment than have others.

To clarify factors that distinguish the most viable rural Catholic hospitals from the least viable, our study identified a group of 30 "consistently sound" hospitals and 30 "adversely affected" hospitals based on profit margins and six other financial measures. As a group, rural hospitals suffered from declining inpatient utilization, increasing levels of indigency, and adverse reimbursement.

However, the consistently sound hospitals' margins increased to 11 percent from 1985 to 1989, whereas margins at adversely affected hospitals fell nearly 8 percentage points during the same period.

Adversely affected hospitals were less likely to belong to a system and had significantly fewer average staffed beds than did the consistently sound facilities. Their communities had significantly lower per capita income, and they devoted a greater percentage of their resources to care for the poor. Adversely affected hospitals also reduced the scope of available services more drastically than did consistently sound hospitals during the period under study.

were short-stay, general medical-surgical facilities. Rural Catholic hospitals were as likely to be affiliated with multi-institutional systems as all Catholic hospitals (about 75 percent were in systems). However, rural facilities averaged only 121 staffed beds compared with 257 beds for all Catholic hospitals. Although 25 percent of all Catholic hospitals were teaching facilities, only 5 percent of the rural hospitals were. Characteristics of the 127 hospitals in the study group are provided in **Table 2** (p. 56).

About 30 percent of the nation's Catholic hospitals were located in rural communities. More than 60 percent of these rural hospitals were located in the north-central states (ranging from Ohio to Kansas and up to North Dakota). Although most Catholic multi-institutional systems included one or more rural hospitals, 12 systems had more than half of their facilities located in rural communities.

Average annual total margins for the 127 rural Catholic hospitals studied here stayed within the range of +2.6 percent to +4.5 percent from 1982 to 1989. Except in recent years, rural Catholic hospitals have always had lower margins than urban Catholic hospitals. Nearly 20 percent of the rural hospitals studied had negative margins in any one year from 1982 to 1989.

### FINANCIAL INDICATORS

Some financial indicators for these rural Catholic hospitals are presented in **Table 3** (p. 57). At least three factors have been associated with the below-average financial performance of rural Catholic hospitals during the 1980s: declining inpatient utilization, increasing levels of indigency, and adverse reimbursement from Medicare's prospective payment system (PPS) and other payers.

> Rural Catholic hospitals allocated 14.8 percent of their average gross patient revenue to care for the poor in 1989, slightly more than the national average for all Catholic hospitals.

**Declining Inpatient Utilization** Average annual patient admissions fell 14 percent from 1985 to 1989, accompanied by an 11 percent decline in inpatient days. These declines left average occupancy at a relatively low 48 percent in 1989. (By comparison, average admissions declined only 8 percent, while average inpatient days dropped 7 percent, for a broader group of 476 Catholic hospitals studied during the same study period.) Reduced inpatient activity was at least partially offset by a 57 percent average increase in outpatient visits from 1985 to 1989 and a shift to performing 85 percent of all surgeries on an outpatient basis in 1989.

**Increasing Levels of Indigency** Despite overall declines in inpatient activity, average Medicaid admissions increased 20 percent from 1985 to 1989, and Medicaid inpatient days increased 8 percent. Rural Catholic hospitals allocated 14.8 percent of their average gross patient revenue to care for the poor in 1989, slightly more than the national average for all Catholic hospitals. Only large urban Catholic hospitals had higher levels of care for the poor in 1989.

**Adverse Reimbursement** Although Medicare PPS margins averaged +7.2 percent in 1984 (PPS year 1) and +9.0 percent in 1985, they fell to +0.2 percent in 1988 and −1.4 percent in 1989 (the latest year of available data when this research was conducted). The decline in the average PPS operating margin accompanied an increase in average Medicare inpatient days from 49 percent of all inpatient days in 1985 to 51.3 percent in 1989. Over the same period, average total deductions from gross patient revenue rose from 14.9 percent to 23.9 percent, and the proportion of revenues from third-party payers declined from 34.3 percent to 30.9 percent.

## TABLE 1: STUDY SELECTION CRITERIA

| Criterion | Consistently Sound Hospitals (N = 30) | Adversely Affected Hospitals (N = 22) |
|---|---|---|
| Occupancy rate | > 74%* | < 39.6% |
| Age of plant | < 6.7 years | > 9.4 years |
| Long-term debt/total assets | < 26% | > 53% |
| Days in accounts receivable (1987-89) | < 67.0 | > 93.8 |
| Change in admissions (1987-89) | > +3.4% | < −9.0% |
| Change in total margins (1987-89) | > +2.3 percentage points | < −3.8 percentage points |

*Figures are for 1989 unless noted.

In addition, rural Catholic hospitals reported an average of four fewer available services in 1989 compared with 1985—a 13 percent reduction. Over the same period the average age of rural Catholic hospitals increased from 9.1 to 9.8 years.

### Variations in Performance

**Total Margins** Average annual total margins for the two groups of rural Catholic hospitals began to diverge significantly from the norm after 1985 (see **Figure**, p. 58). Margins for consistently sound hospitals climbed steadily from +7.6 percent in 1985 to +11.0 percent in 1989. At the same time, margins for adversely affected hospitals dropped nearly 8 percentage points from +2.6 percent to −5.1 percent. Although none of the consistently sound hospitals had negative margins in 1989, all but one of the adversely affected hospitals did.

**Other Performance Indicators** These two groups of hospitals diverged in other areas as well. The average 1989 Medicare PPS margin declined to −3.4 percent for the adversely affected hospitals, but only declined to +3.3 percent for the consistently sound hospitals. The adversely affected hospitals also relied on a greater share of debt for asset financing then did the consistently sound (37 percent of total assets versus 23 percent). Several other financial ratios for the two groups are presented in **Table 3**.

Margins for consistently sound hospitals climbed steadily from +7.6 percent in 1985 to +11.0 percent in 1989.

**Hospital Characteristics** The consistently sound hospitals were more likely to be affiliated with a system and to be teaching facilities than were the adversely affected hospitals (see **Table 2**). The average number of staffed beds was 129 for the consistently sound hospitals compared with 100 for the adversely affected hospitals. Whereas the consistently sound hospitals were more likely to be located in the Midwest, a disproportionate number of the adversely affected hospitals were located in the Mountain and Mid-Atlantic states. A larger percentage of adversely affected hospitals were designated disproportionate share and sole community providers, but they were less likely to be rural referral centers (**Table 2**).

**Community Characteristics** The rural communities served by the adversely affected hospitals in 1980 had significantly lower per-capita income and a significantly higher proportion of impoverished families than did the communities served by the consistently sound hospitals. Communities served by the adversely affected hospitals also had a greater proportion of elderly and young dependents supported by lower-income working-age populations.

**Care for the Poor** The adversely affected rural hospitals allocated an average of 20 percent of their resources to care for the poor, while the consistently sound hospital allocated 12 percent. Medicaid as a percentage of average gross patient revenue was nearly 16 percent for the adversely

## TABLE 2: FACILITY CHARACTERISTICS OF CATHOLIC HOSPITALS IN RURAL AREAS

| Performance Measure | All Study Hospitals (N = 127) | Consistently Sound Hospitals (N = 30) | Adversely Affected Hospitals (N = 22) |
|---|---|---|---|
| **Bed Size** | | | |
| Under 50 beds | 15.0% | 10.0% | 31.8% |
| 50-99 beds | 37.0 | 36.7 | 31.8 |
| 100-199 beds | 33.9 | 40.0 | 27.3 |
| 200-399 beds | 12.6 | 13.3 | 4.5 |
| 400+ beds | 1.5 | 0.0 | 0.0 |
| **Other Characteristics** | | | |
| Affiliated with system | 78.0% | 83.3% | 77.3% |
| Teaching hospitals | 5.5 | 10.0 | 4.5 |
| Disproportionate share | 7.0 | 3.3 | 13.6 |
| Rural referral centers | 22.8 | 37.0 | 9.0 |
| Sole community providers | 23.6 | 16.3 | 27.3 |

affected hospitals in 1989, representing a negligible change compared with 1985. Although this figure was much lower for the consistently sound hospitals (8.3 percent in 1989) and did not change from 1985, they experienced an average 35 percent increase in Medicaid admissions from 1985 to 1989.

**Sources of Revenue** Although the number of Medicaid patients increased at most of the consistently sound rural hospitals, these hospitals' average proportion of Medicaid revenue stayed the same from 1985 to 1989. Medicaid revenue as a percentage of total gross patient revenue did not increase because the consistently sound rural hospitals did not experience significant decreases in Medicare revenue, revenue from self-paying patients, or revenue from third-party payers. On the other hand, the adversely affected rural hospitals experienced a 4.6 percentage point increase in the proportion of Medicaid revenue from 1985 to 1989, and a 7.3 percentage point decline in the proportion of revenue from third-party payers. The consistently sound hospitals received 33.2 percent of their gross patient revenue from third-party payers, compared with 25.9 percent for the adversely affected hospitals.

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**Mix of Available Services** While consistently sound rural hospitals were changing their mix of available services during the study period, many adversely affected rural hospitals were reducing the scope of available services. The adversely affected hospitals discontinued an average of 20 percent of their services from 1985 to 1989. Their average number of staffed beds decreased by 6 percent during the same period, while the average number of staffed beds at consistently sound rural hospitals increased by 7 percent. The average number of outpatient visits climbed 33 percent from 1985 to 1989 for the adversely affected hospitals, but climbed 82 percent for the consistently sound hospitals.

Few of the adversely affected rural hospitals provided much beyond standard services such as emergency care and respiratory and physical therapy. In comparison, although the consistently sound rural hospitals reduced the average number of services by 10 percent from 1985 to 1989, many of them added technology-intensive ser-

## TABLE 3: SELECTED FINANCIAL PERFORMANCE MEASURES FOR RURAL HOSPITALS (1989)

| Performance Measure | All Study Hospitals (N = 127) | Consistently Sound Hospitals (N = 30) | Adversely Affected Hospitals (N = 22) |
|---|---|---|---|
| **Utilization** | | | |
| Occupancy | 47.9% | 52.6% | 41.8% |
| Change in admissions (1985-89) | −14% | −7% | −24% |
| Change in inpatient days (1985-89) | −11% | −9% | −15% |
| **Financial Characteristics** | | | |
| Total margin | 4.0% | 11.0% | −5.1% |
| Uncompensated care (bad debt and charity) | 3.8% | 3.9% | 4.0% |
| Deductions from gross patient revenue | 23.9% | 22.0% | 23.8% |
| Days in accounts receivable | 73 days | 72 days | 72 days |
| Average payment period | 54 days | 54 days | 61 days |
| Cash flow as percentage of total debt | +29% | +45% | +2% |
| Long-term debt as percentage of total assets | 31% | 23% | 37% |
| **Selected Sources of Hospital Revenue (Percentage of Gross Patient Revenue)** | | | |
| Medicare | 46.3% | 46.2% | 44.5% |
| Medicaid | 11.0% | 8.3% | 15.8% |
| Third-party payers | 30.9% | 33.2% | 25.9% |
| Self-paying patients | 8.5% | 9.0% | 10.0% |

vices (e.g., CT scanners, magnetic resonance imaging, and intensive care units). The consistently sound hospitals also added specialized services for the elderly, home healthcare, and hospice care. In addition, they offered significantly more outpatient rehabilitation services than did the adversely affected hospitals.

One area in which adversely affected hospitals appear to have offered enhanced services was skilled nursing care. The number of rural hospitals in the study reporting skilled nursing care beds increased from 24 percent in 1985 to 31 percent in 1989. However, skilled nursing care beds were available in only 27 percent of the consistently sound hospitals, while they were available in more than 45 percent of the adversely affected hospitals.

The average case-mix index (a measure of complexity and costliness of patient care compared with the national average) was 1.19 in 1989 for the consistently sound hospitals, compared with 1.04 for the adversely affected hospitals. Seventy percent of the consistently sound hospitals received outlier payments from Medicare, whereas only one-third of the adversely affected hospitals did.

**Medical and Nursing Staff** In 1989 significantly fewer physicians were admitting patients to the adversely affected rural hospitals compared with the consistently sound hospitals. Adversely affected hospitals' medical staff size decreased slightly from 1985 to 1989, whereas the size of the consistently sound hospitals' medical staff increased by 2 percent. These hospitals also had significantly more physician specialists on staff than did adversely affected hospitals. The number of general practitioners and family medicine physicians decreased slightly from 1985 to 1989 for both groups of hospitals (2.7 percent for the adversely affected and 4.4 percent for the consistently sound).

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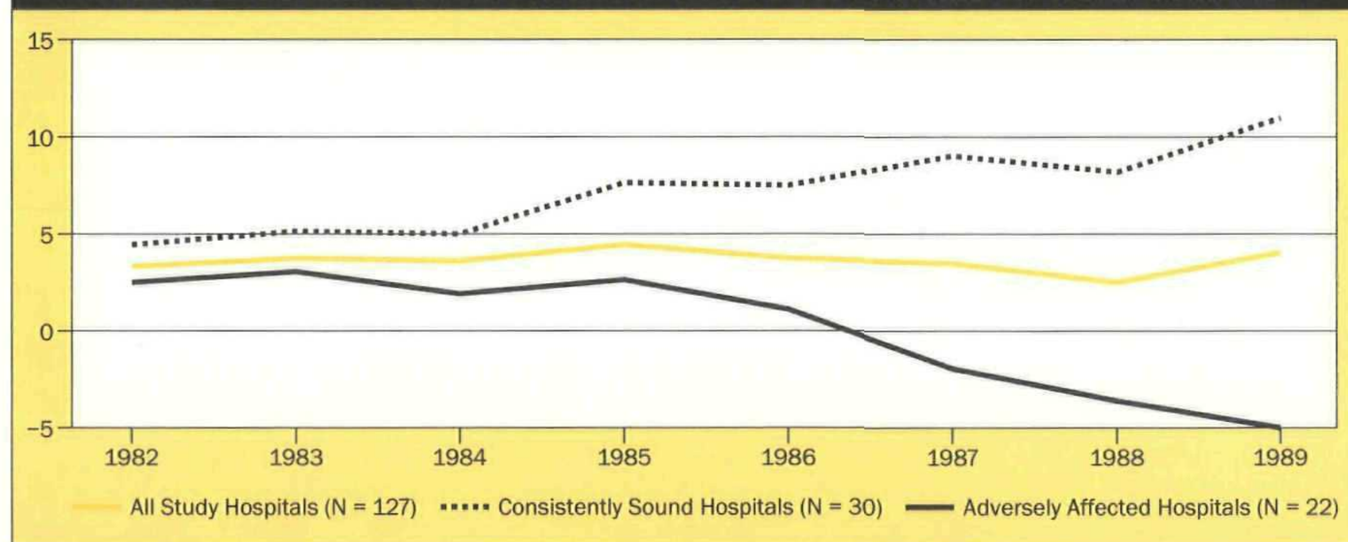
During the same period the adversely affected rural hospitals reduced their use of part-time employees by almost 10 percent, whereas the consistently sound rural hospitals increased their use by 24 percent. The adversely affected hospitals reduced their average number of part-time registered nurses (RNs) by 5 percent and their average number of part-time licensed practical nurses (LPNs) by 12 percent from 1985 to 1989, compared with a 14.1 percent increase and a 12.4 percent decrease, respectively, for consistently sound hospitals. On the other hand, the adversely affected hospitals increased their use of full-time RNs by 39 percent from 1985 to 1989, compared with a 20.8 percent increase for the consistently sound hospitals.

### Opportunities and Constraints

During the 1980s, virtually all providers of Catholic healthcare located in rural American communities were adversely affected by a variety of circumstances, many of which were beyond the control of managers and sponsors. Highlighted below are four factors that have constrained many rural healthcare providers' adaptability. Also discussed are four opportunities that a number of healthcare providers have capitalized on to enhance their organizations' viability.

**Constraints to Adaptability** Although many circumstances have inhibited rural providers' ability to



remain viable, four broad sets of conditions, largely beyond the control of managers and administrators, are important to note:

• *Community socioeconomic status.* Communities with very low per-capita income, high levels of unemployment, concentrated indigency, large numbers of transient or immigrant workers, and high percentages of young or elderly dependents created additional problems for rural institutions already beset by financial difficulties.

• *Age of facility.* Older rural facilities (with fewer amenities) are less appealing than more modern facilities to healthcare consumers, physi-

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## PERSPECTIVES ON RURAL CATHOLIC HOSPITALS

Rural hospitals provide affordable access to high-quality healthcare and also serve as an important community source of employment and income. Without a local hospital, rural communities find it difficult to sustain or improve their changing economies and to recruit and retain employees.

### IMPORTANT FACTORS

Many factors affect rural hospitals' viability. Some of these are within their control, while other factors, such as federal reimbursement, the national shortage of key healthcare professionals, and certain demographic changes, are less controllable. Some of the most crucial factors facing facilities in the Midwest are as follows.

**Physicians** The biggest challenge in the Midwest is the scarcity of family practitioners or general practitioners. Practically every rural hospital is recruiting physicians, making it almost impossible to attract doctors. The guarantees of $90,000 to $120,000 per annum, plus moving expenses and other benefits such as healthcare, life insurance, and retirement, are so astronomical that some rural hospitals cannot take on this obligation. They will either have to merge or become a primary care center, affiliating with a larger hospital with specialists who could conduct clinics at the primary center. Some hospitals have turned to physician assistants or nurse practitioners, but they too are in short supply.

**Financial Factors** Some hospitals in the Midwest are "consistently sound" because they have paid their debts, especially for construction, so the leverage interferes less with the cash flow. However, the reserves to purchase and replace equipment are meager.

The delay between provision of services and payment by third-party payers is another important factor. This "float" places a real crunch on cash flow and forces hospitals to borrow or spend down reserves. Ironically, third-party payers are benefiting from interest on money that rightly belongs to the hospital providing the service.

**Competition** Increasing competition between hospitals is creating havoc. Higher medical costs caused by duplication of services and equipment have raised the ire of employers, who feel they carry the brunt through higher premiums. It is difficult to change from a competitive to a collaborative approach. Collaboration is beginning, not so much to contain costs but for the sake of survival.

**Regulations** The safe harbor regulations and unclear guidelines militate against joint ventures and encourage duplication of services. In many instances government regulations seem to be the biggest factor in rising costs. Some of the state regulations are entirely devoid of common sense. For example, the surveyors for the state regulations go "by the books" but have varying interpretations. One surveyor may require a change, and the next surveyor may change it back. One surveyor required us to move the mirrors above the sinks so residents would not clog them with hair that falls out during combing.

**Excess Beds** Bed overcapacity is another factor pushing up costs. A bed has a fixed cost whether it is occupied or not. Many hospitals have turned excess beds to other uses, but they may be reluctant to do so for fear of losing their licensure for acute care.

### THE CORE OF THE PROBLEM

The inability of communities to develop and maintain a set of health services that meet the expectations and needs of rural residents lies at the core of the healthcare problem. Some of the factors that explain the difference between a "consistently sound" hospital and an "adversely affected" hospital are poor public image of local facilities and services, limited technology, the absence of local planning, weak institutional governance, inadequate management, weak financial systems, intracommunity conflict, ineffective recruitment and retention of providers, minimal collaboration among community providers, and a limited local understanding of the pressure facing the community health system.

### ATTEMPTS TO HELP

The swing-bed concept has been helpful to rural hospitals. Programs such as Essential Access to Community Hospital (EACH) and the Health Transaction Grants Program are federal attempts to assist in downsizing or developing models of care more consistent with the expectations and needs of rural residents. South Dakota has formed the Office of Rural Health, which will actively support and assist efforts of rural hospitals to participate in these programs and to create more effective models of care. The EACH program is rigid and narrow in applicability, so it remains to be seen how successful it will be.

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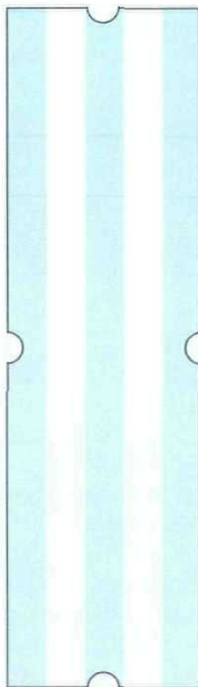

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cians, and other hospital staff. Patients may decide to commute to suburban or urban hospitals because facilities are newer and because of payer preferences. Unfortunately, rural hospitals with depleted reserve funds, significant amounts of long-term debt, and declining admissions are finding it increasingly difficult to secure capital for much-needed improvements to physical plant.

• *Capacity and size.* Small rural facilities are more vulnerable than larger urban facilities to declining patient volume or to the loss of patients if a key physician retires. More than 31 percent of the adversely affected rural hospitals studied had fewer than 50 beds (see **Table 2**). Such hospitals have been at greatest risk of closure in recent years. Also, facilities with fewer services and declining availability of key services usually do not appeal to third-party payers, consumers, physicians, and other hospital workers.

• *Financial position.* Rural hospitals with an unfavorable mix of patients (i.e., proportionately more Medicaid and Medicare patients), reimbursements less than incurred costs, and limited opportunities to generate nonpatient revenue have led a marginal financial existence in recent years.

**Sources of Opportunity** A number of rural Catholic hospitals have benefited from more favorable Medicare reimbursement because they have been designated rural referral centers, because they are in wealthier areas, or because of their unique position as sole community providers. Some managers used four other "levers" or tools to capitalize on the strengths and good fortune of their institutions and local community resources:

• *Patient mix.* Rural hospitals serving larger numbers of patients covered by third-party payers are more able to generate a financial surplus from patient care. More sophisticated record-keeping and patient management systems may better control costs and optimize reimbursement from government payers. Significantly lower levels of poverty in some communities reduce the amount of resources dedicated to caring for the poor.

• *Scope of services.* A broad range of services permits more successful rural hospitals to respond more effectively to local needs. Managers at hospitals with greater resources can periodically refocus their services to adapt to the changing needs of their constituencies and practitioners.

• *Use of technology.* Effective use of medical technology enhances hospitals' ability to maintain market share, treat patients with higher levels of acuity, and compete for third-party payers. State-of-the-art diagnostic and treatment technologies also create a business environment conducive to pursuing joint ventures and recruiting physician specialists.

• *Recruitment and retention of staff.* Managers of more successful rural hospitals have hired more RNs (and fewer less-skilled LPNs) and at the same time improved staffing flexibility by employing more part-time nurses. In addition, a desirable patient mix and availability of modern technology make these facilities attractive to young family practitioners and specialists seeking a viable community in which to establish their practices.

## COMPREHENSIVE SURVIVAL STRATEGY

Future survival of the missions of Catholic hospitals in rural areas depends on their ability to meet the needs of their communities while remaining strong. Rural Catholic hospitals were reduced in number by 12 percent from 1982 to 1990, and five more were lost in 1991 (because of two closures and three conversions to non-Catholic ownership). The need for more comprehensive community-based strategies for supporting rural healthcare delivery systems is apparent. Further closures and reduction of necessary healthcare services will only heighten unmet needs of this and future generations. □