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A Context for Rural Health Systems

After Hospital Closure: Pursuing High Performance Rural Health Systems without Inpatient Care

RUPRI™

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- A part of the RUPRI Health Foundations Series
  - Primary Care: The Foundation for a High Performing Rural HC System
  - Toward a High Performing HC System: Key Issues from Rural Health Innovators
  - The Rural Hospital and Health System Affiliation Landscape

The Purpose and Context for RUPRI

- The Rural Policy Research Institute (RUPRI) provides unbiased analysis and information on the challenges, needs, and opportunities facing rural America. RUPRI's aim is to spur public dialogue and help policymakers understand the rural impacts of public policies and programs
- RUPRI has 8 areas of interest including Health Policy
- RUPRI Rural Health Panel Since 1993: The Panel has built a particular expertise linking policy suggestions to broader conceptual frameworks. The Panel has received support from the Federal Office of Rural Health Policy, the US Department of Agriculture, the Robert Wood Johnson Foundation, the Agency for Healthcare Research and Quality, and the Leona M and Harry B Helmsley Charitable Trust.
- http://www.rupri.org/areas-of-work/health-policy/

Hospital Closure in the U.S.

- The last few years have seen an increase in the rate of rural hospital closures; from 2010 through 2013, there were 7.5 rural hospital closures per year, compared to nearly 13 per year from 2014 through 2018.
- The causes of rural hospital closure …. can be roughly categorized into 4 broad groups:
  - (1) demographics (ie, low volume due to declining or aging population or decreases in women of childbearing age),
  - (2) economics (eg, lower insurance coverage or lower household income, which reduces ability to pay),
  - (3) technology and market trends (eg, consolidation, decreasing use of inpatient services, staffing requirements), and
  - (4) policy changes (eg, projected decreases in Medicare physician payment rates by 2025,[3] although improved financial performance of hospitals in states that expanded Medicaid[4] and Affordable Care Act provisions that shifted the financial costs of providing care from consumers to the federal government[5] could reduce the likelihood of hospital closure).
- Public policy is one tool that is often used to support rural hospitals, as a number of special Medicare payment provisions were established that recognized financial challenges facing rural hospitals by allowing cost-based reimbursement or supplemental payments.[6] The elimination of these special provisions has been identified as a potential federal cost-cutting strategy[7]; unsurprisingly, these cuts, if enacted, are projected to have considerable impact on hospital financial viability.[6]
- https://journalofethics.ama-assn.org/article/what-should-be-scope-health-networks-obligation-respond-after-hospital-closure/2019-03

Aside - I would add “Proximity” – Hill - Burton

After Hospital Closure: Pursuing High Performance Rural Health Systems without Inpatient Care

- Paper Addresses Key Questions:
  - What kind of Rural Health System is possible in places that cannot support a full-service hospital?
  - How does a rural community navigate the transition from hospital-centric care towards new, high performance models?
  - If service must be reconfigured, what are the options?
  - What implementation support is needed?

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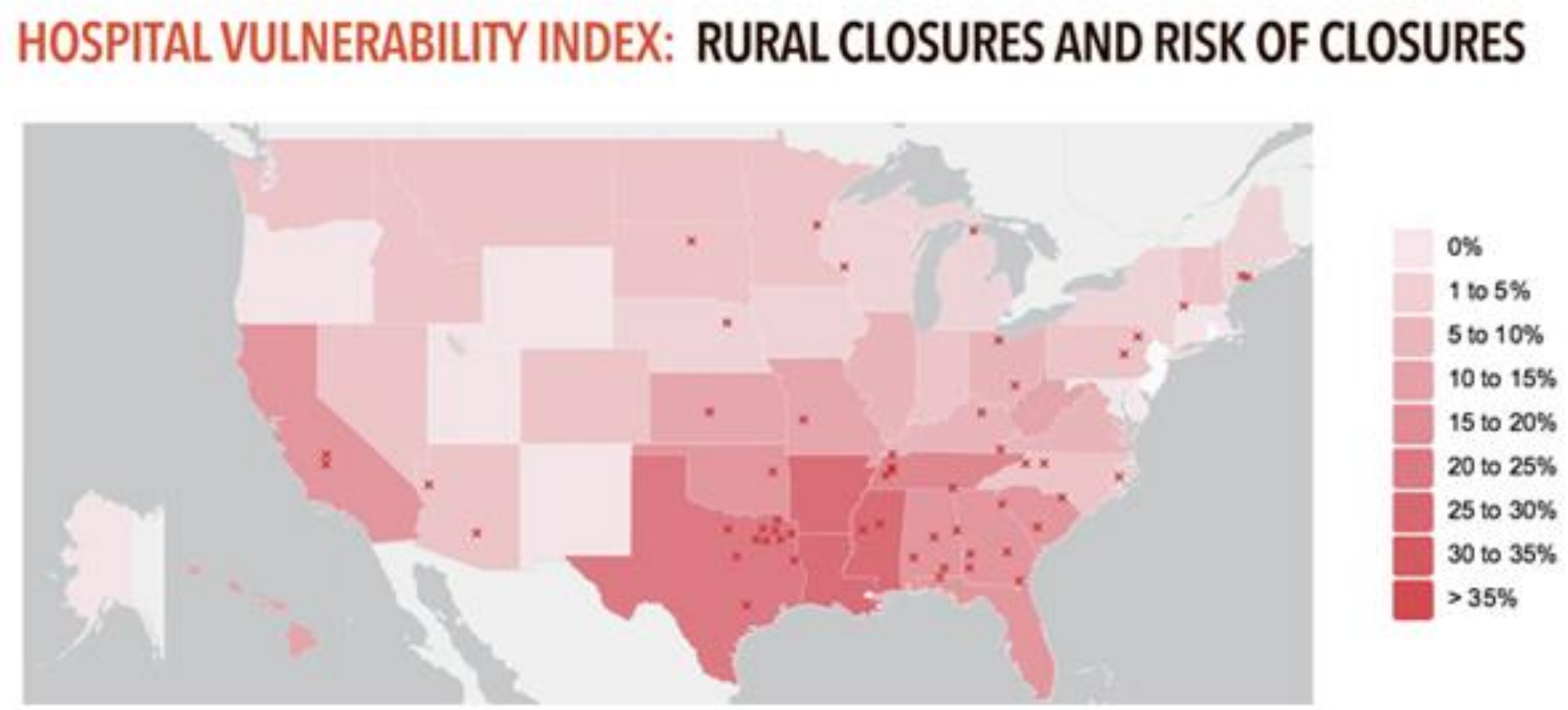
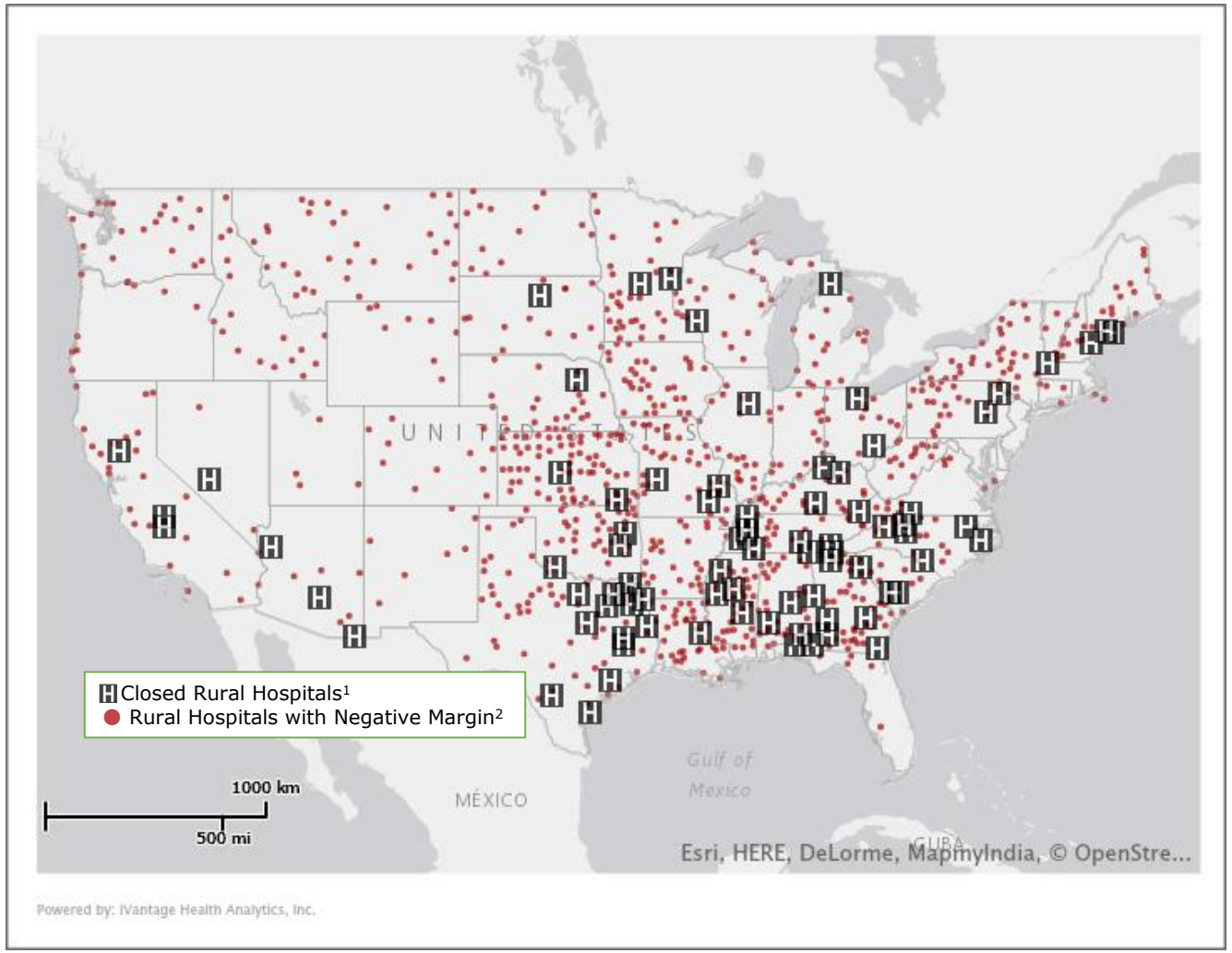
From 2016 – Washington News

Let's keep it this Way



The Rural Health Safety Net is Under Pressure



113 Rural Hospital Closures Since 2010

National Rural Health Association
Presentation week of 9/9/19

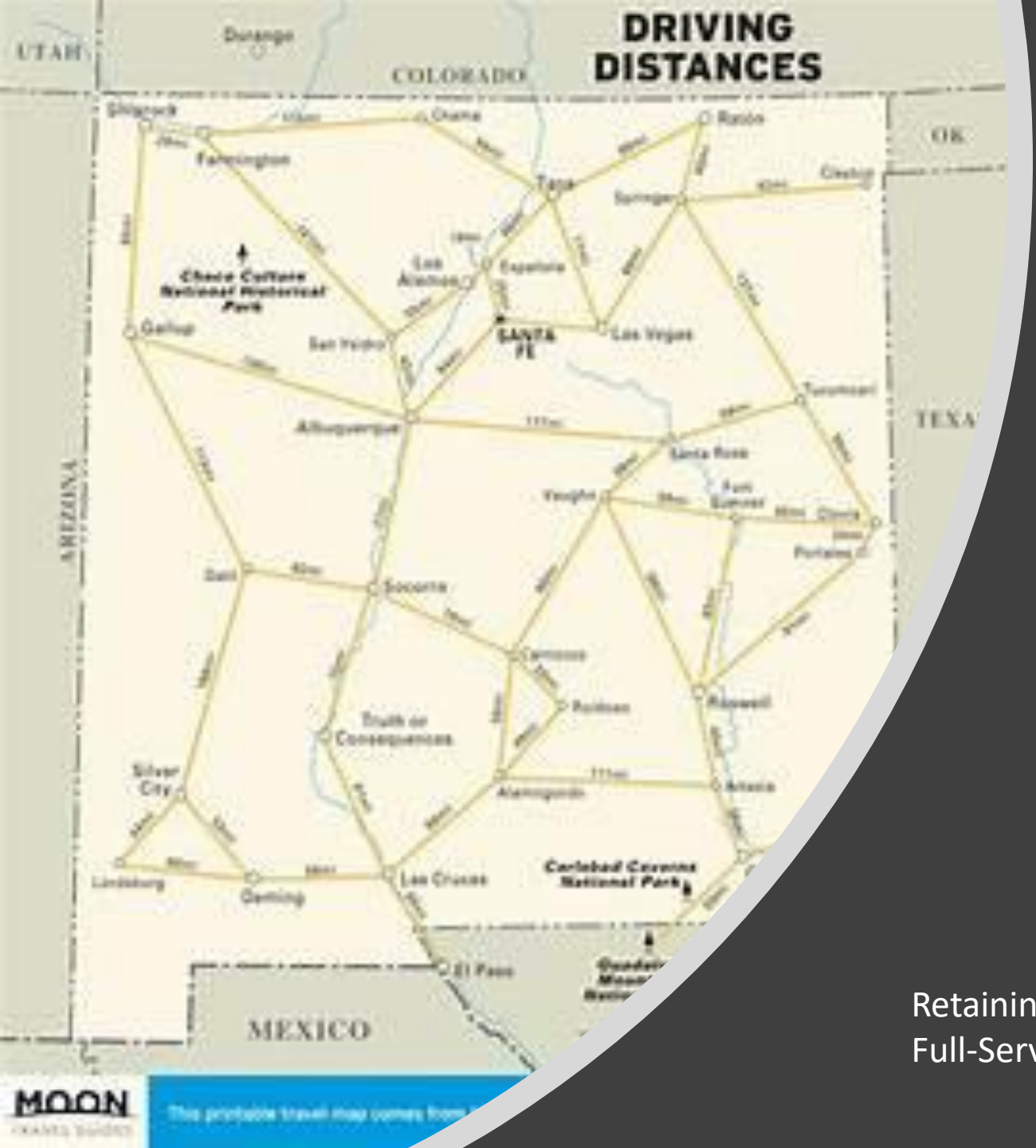
A Hospital is More Than Beds

Hospital closure is defined as ceasing inpatient care, but oftentimes it also results in the elimination of other services typically provided in a hospital, such as emergency care, laboratory, radiology, physical and occupational therapy, and skilled nursing or long-term care services

The number of Primary Care Providers in the Community Can also be impacted as well as access to pharmacy services.

Why Not in New Mexico?

- Historical Role Reversal
  - State Operated Public Health Offices
  - Local / County Options for Hospital Survival
    - Hospital Funding Act
    - Hospital Districts
    - County-Owned Hospitals
    - Indigent Fund Support
    - Sole Community Hospital Payments
- Strong Trade Association Representation
  - Creative Problem Solving
- Medicaid Policy
  - Expansion
  - IGTs to Sustain Medicaid
- Economic Bulwark
- Visionary Community Leaders



Distances Between Hospitals in New Mexico is both a Health Care Access and Community Viability Discussion

Retaining Certain Hospital Services is critical. Alternatives to Full-Service Systems Needs Significant Collaborative Planning

Profit and Public Policy – Are local deliveries a Priority for a Rural Community?

- Hospital Review Magazine 9/12/19
-
- Williamston, N.C.-based Martin General Hospital will **close its obstetrics unit** Oct. 21, forcing women in the community to travel **more than 30 miles** to give birth, according to local news station *WITN.*

- The decision to close the unit is because the number of births at the hospital has declined in recent years. **To keep the unit profitable**, Martin General **needed 300 deliveries per year**, but the hospital **averaged only 160**, hospital officials said.
- Labor and delivery nurses jobs may be at risk due to the closure, according to the report.
- "Our staff has been so hurt by this shocking decision. Most will have to go to other hospitals for employment," one nurse told *WITN.*
- The hospital is working to find **new physicians** for its labor and delivery patients.

Non-Closure / Service Reduction Considerations

Hospitals / Other providers might, downsize, restrict or eliminate service lines to avoid closure

>57% of Rural Hospital Ob Units have closed nationally

Consider the correlation between service options and financing priorities

Often the least economically viable services are the most needed

- Obstetrics
- Behavioral Health
- Emergency Room

You get what you pay for

RUPRI Perspectives

- "There is no single model for reconfiguring the rural health system after hospital closure; local assets, affiliations and partnerships, and financial and delivery flexibility and capacities must be critically assessed to determine the community's options and strategies"

- Community Health Systems Development:
  - The experiences of rural communities that have lost their hospital demonstrate the importance of broad community engagement to develop and implement strategies for ensuring local availability and access to essential primary care, emergency, and other services.

What are the Incentives for Systems thinking in New Mexico?

Who Supports a Broad, Inclusive Range of Community Assessments of Direct Service Delivery IN NM?

Systems Planning: Asset Assessment

- Financial
  - Local Investments Opportunities
- Facilities
  - Bricks and Mortar
- Equipment
  - Imagining, Lab, IT
- People / Stakeholders
  - Health
  - Elected Officials
  - Economic Engines
- Local Organizations
  - Public Health
  - Clinical Service Providers
  - FQHCs / RHCs
  - EMS Providers
- Non-Local Support
  - State Agencies
  - Regional Health Systems
  - Foundations

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Systems Planning Continued:

Resource Development Opportunities

Close the Gaps in Community Health Needs

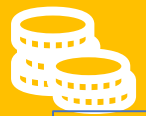
- Transportation
- Tele-Health
- Provider Integration

Stakeholders Determine System Design Moving Forward

Ownership

Partnerships

Regionalization



Alternative Funding Mechanisms

Public Payments should reflect models for sustaining access

Health System Reorganization / Affiliations

Identifying and Analyzing Alternatives to Inpatient Care

Assessing the local health care landscape can help a community identify and analyze alternatives to inpatient care that build health system capacity that is locally appropriate and supports the goal of ensuring continued local access to essential, high-quality health services.

Currently Available Options for Communities without Inpatient Care

Current Options	Care Delivery Features
Independent Practice Clinic	• Provides primary care-focused outpatient services • Clinic providers often own the practice • May be a part of an Independent Practice Association • Not required to provide 24/7 services, emergency services, or inpatient hospital services
Hospital-Owned Primary Care Practice	• Provides primary care-focused outpatient services • Owned by a rural hospital • Limited daily hours and services
Provider-Based RHC	• Provides outpatient primary care-focused services located in rural areas • Must operate in a rural area and a Health Professional Shortage Area • Owned and operated as an essential part of a hospital, nursing home, or home health agency participating in the Medicare program (most provider-based RHCs are hospital-owned) • Not required to provide 24/7 services, emergency services, or inpatient hospital services

Who monitors health systems development to ensure state financing supports existing and enhanced access

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Currently Available Options for Communities without Inpatient Care

Independent RHC	• **As with Provider-Based RHC, but not as a hospital department** • **Owned by a provider or a provider entity** • **More than half of independent RHCs are owned by clinicians**
FQHC and Community Health Centers (CHC)	• Provides expanded community-based services that include primary care, dental care, and behavioral health care • A Medicare Certification category of Community Health Center that receives Federal funding through section 330 of the Public Health Service Act • Majority of governing board of directors composed of FQHC patients • Serves a Medically Underserved Area/Population • Not required to provide 24/7 services, emergency services, or inpatient hospital services (FQHC regulations require having referral arrangements with local inpatient facilities and emergency medical services) • Must accept Medicare and Medicaid patients and provide discounted fees based on income below 200% of poverty
FQHC Look-Alikes	• Health centers that have been certified as meeting all the Health Center Program requirements under section 330 of the Public Health Service Act, but do not receive funding under the Health Center Program • Must accept Medicare and Medicaid patients

Who monitors health systems development to ensure state financing supports existing and enhanced access

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Currently Available Options for Communities without Inpatient Care

Urgent Care Clinic	• **Provides urgent care, not typical primary care or chronic care services** • **Not required to provide 24/7 services, emergency services, or inpatient hospital services**
Off-Campus Emergency Department	• Provides emergency care, not typical primary or chronic care services • Operates as a remote hospital department • Hours of operation may be 24/7 or more limited • Licensing and operating regulations differ by state
Freestanding Emergency Department	• Provides emergency care, not typical primary or chronic care services • Not a provider-based facility since not affiliated with a hospital • Hours of operation may be 24/7 or more limited • Licensing and operating regulations differ by state

Who supports health systems development to ensure state financing supports existing and enhanced access

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Policy Proposals for Inpatient Care Alternatives

Options	Care Delivery Features
24/7 Emergency Department (Option 1) **Proposed by MedPAC**	• Fee-for-service payment, including the Medicare Physician Fee Schedule and the Outpatient Prospective Payment System • Inpatient space may be converted to Skilled Nursing Facility • Fixed payment may allow greater flexibility to use telehealth services • Existing outpatient clinic(s) would continue to operate
Clinic and Ambulance (Option 2) **Proposed by MedPAC**	• Outpatient clinic – independent, RHC, or FQHC • Affiliated 24/7 ambulance service
Frontier Extended Stay Clinic (FESC) **Demonstration under CMS authority**	• Outpatient clinic with expanded hours of operation and emergency care capacity • Minimal inpatient capacity (up to 48 hours) for observation services and stabilization prior to transfer • Comprehensive primary medical, dental, mental health and other services offered

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Policy Proposals for Inpatient Care Alternatives

Rural Emergency Hospital **Proposed by Senators Grassley (IA), Klobuchar (MN), and Gardner (CO)**	• **CAHs and Prospective Payment System hospitals with 50 or fewer beds may convert to Rural Emergency Hospitals** • **Emergency care services, but no inpatient care** • **Existing or expanded outpatient clinic(s) would continue to operate**
12-Hour Primary Health Center **Proposed by the Kansas Hospital Association, Rural Health Visioning Technical Advisory Group**	• Provides care like an FQHC • Open 12 hours/day, 365 days/year • Supported by a robust EMS plan • Supported by a formal relationship with a larger partner organization to assist with operational and clinical aspects of delivering services • Communities retain local governance, but also affiliate with a strong partner in a regional system
24-Hour Primary Health Center **Same as above**	• As above, but open 24 hours a day, 365 days a year

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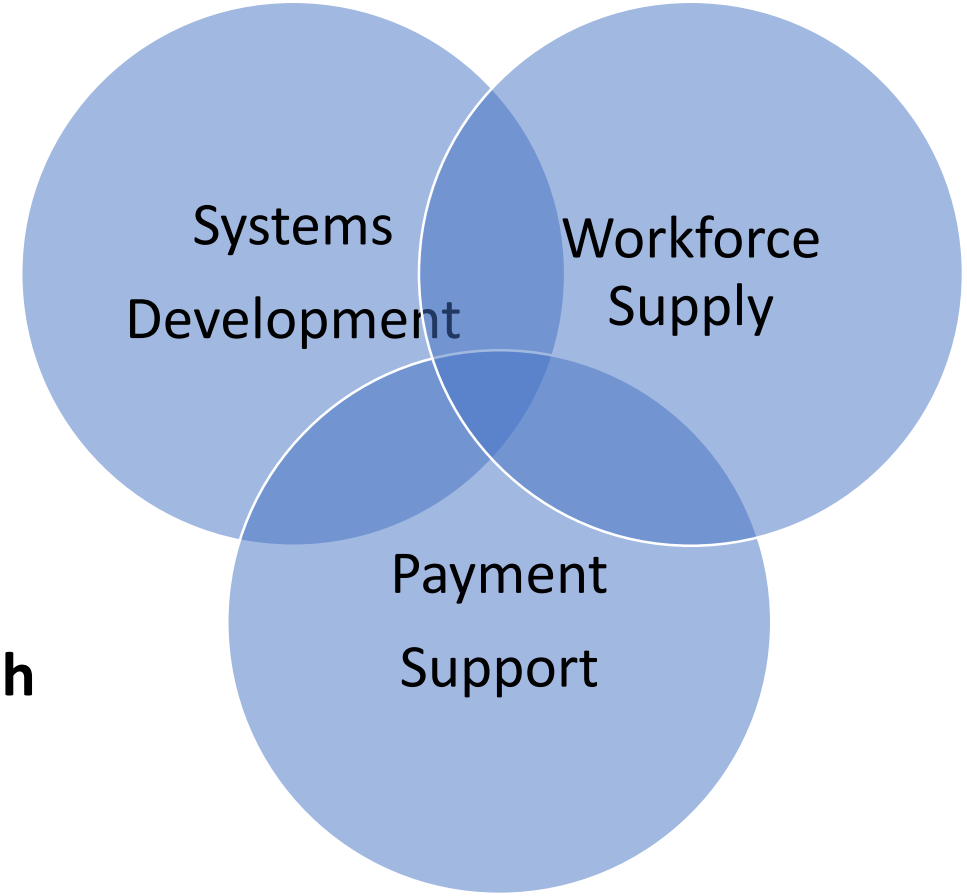
Rural Community Viability – The Economic Question

- If you are a young family seeking to live in Rural New Mexico, what services would you need or want available locally to make that decision?

Oftentimes we say that improvements in health care or rural health care systems are too expensive,
yet the system is primarily publicly funded (Medicare, Medicaid, Public Employee Coverage) and grows
at the will of private investment decisions and insurance products with little or no public purpose, input or accountability

CHI Perspective: Rural Hospital Service Availability is Tied to Rural Economic Viability

Aligning Public Investments Through Policy



Health System Payments Should be **Strategic** and Designed to meet the **Health and Medical Needs of The Population**

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Related Workforce Issues

- Decentralized Training and Decision-Making
  - Residencies
  - Rotations
  - “Grow Hour Own” Programs – AHECs/HCOP – Other Programs
  - “Brain Gain” not “Brain Drain”
- Comprehensive Primary Care Focus
  - Value / Team Based Non-Hospital Care
  - Inpatient Coverage and Continuity of Care
  - Intentional Design
    - Community Involvement
    - Multi-Service / Provider Collaboration
- Incentives for Service Integration and Scope of Services based on Community Needs
- Finance the System to Sustain Services and Retain Providers

Strategic Financing of Rural Health Service Viability

- Expand concepts of Primary Care funding to ensure continuation and viability of necessary services
  - Not necessarily by Provider Type but Provider Scope
- Decentralized Training and Financial Support such as Loan Repayment priorities to locally trained and placed providers.
  - Emphasize New Mexicans in Training
  - Consider Broader range of Services ie EMS including ER providers in high need areas
- Payment Systems favor Comprehensive Rural Health Systems (Ob, Psych, etc.). There should be the same profit opportunities in rural health care as urban health care if our health care system is a profit driven model that is publicly financed to a large degree.

Contact

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