Fighting for Rural Hospitals
THE TIME HAS COME FOR ADVOCACY INITIATIVES
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Over many decades, rural hospitals have demonstrated a remarkable ability to adapt to changing market forces, demographics and payment models. Facing a host of adverse conditions, they continue to deliver high-quality patient care with outstanding efficiency and cost effectiveness.

Operationally and financially, rural hospitals have had to weather an “imperfect storm” of factors, largely beyond their control, including a chronic shortage of physicians and other clinicians, aging facilities, daunting regulatory requirements, and declining reimbursements.

This white paper addresses three primary factors driving the awareness for rural healthcare advocacy:

- **Understanding the value** of rural hospitals from the perspectives of patients and communities, including the viewpoints of individuals who are directly impacted; this section looks at both patient care and economic considerations

- **Identifying the challenges** facing rural hospitals in 2012 and beyond, common misconceptions about rural healthcare – including the recent Medicare Payment Advisory Commission (MedPAC) report – and the pressure on many rural hospitals to be acquired by larger urban health systems

- **Advocacy efforts** by Healthland, in partnership with other organizations, on behalf of independent rural hospitals, including the “March for Rural Hospitals” in Washington and other Capitol Hill efforts to educate policymakers about the essential role of rural hospitals and to push for legislation that extends Medicare payment protections for rural hospitals.

Finally, this paper issues a “call to action,” urging hospital leaders and constituents to get involved in the fight for independent rural hospitals.
How does one accurately measure the value of America’s rural hospitals? Certainly, the “big picture” view offers a compelling story.

Rural hospitals serve an estimated 62 million Americans — or nearly 25% of the country’s population, according to the National Rural Health Association (NRHA). Rural hospitals deliver an impressive array of services, including primary, chronic, and long-term care, as well as home health care, hospice care, and assisted living. In many communities, the rural hospital is likely to be the sole provider of outpatient surgery, radiology, and clinical laboratory services.

But the value of rural hospitals extends well beyond direct patient care. They also serve as powerful economic drivers. In testimony to the U.S. Senate Committee on Appropriations, Mary Wakefield, PhD., RN, Administrator, Health Resources and Services Administration, U.S. Department of Health and Human Services, cited these findings regarding the impact of rural hospitals:

- Healthcare accounts for 15% to 20% of all jobs in rural communities (both primary and secondary employment).
- The presence of one physician accounts for 8.4 jobs in the local economy.
- Health services and schools are the most important quality-of-life factors attracting businesses, new residents, and retirees.

Some of the economic drivers are more indirect, but no less important. For example, it is estimated that every healthcare dollar spent locally recycles through the community one and one-half times, according to Dr. Wakefield.
When a Rural Hospital Closes Its Doors

The flip side of the big picture looks at what happens when a rural hospital closes.

Certainly, patients feel the impact. Without a local provider, they may have to drive long distances to receive primary, specialty, and emergency care. This presents significant obstacles to a patient’s ability to receive timely healthcare services. It may also increase the patient’s out-of-pocket costs for ambulance services, personal transportation, lodging, and meals.

Moreover, the delivery of patient care by rural hospitals may actually be more cost effective than the same services rendered in an urban hospital. Small rural hospitals, on average, have equal or better patient care outcomes compared with larger urban hospitals, yet Medicare payments for rural residents are 3.7% lower per beneficiary, according to a recent iVantage Health Analytics study. The healthcare business and technology intelligence company estimates that applying the average cost per rural beneficiary to urban beneficiaries would save Medicare $7.2 billion annually.

“Rural hospitals have achieved a noteworthy level of comparative performance (versus larger urban hospitals), including: demonstrated quality, patient satisfaction, and operational efficiency for the type of care most relevant to rural communities,” reports iVantage. “The misunderstanding that rural hospitals are more costly, inefficient, and have lower quality and satisfaction is empirically challenged.”

Losing a financially viable rural hospital also hurts the local economy. Besides the immediate loss of hospital jobs, the closure of a sole hospital in a rural community results in an average 1.6% increase in the local unemployment rate and a 4% reduction in per-capita income, concludes a Health Services Research study.

Shutting down a rural hospital ripples throughout the local economy in other ways. For example, the city and county may lose property and other tax revenues previously generated by physicians and hospital employees who have moved away. Local businesses suffer, too, from the loss of purchases by the hospital, as well as personal spending by displaced employees. Indeed, a closed rural hospital can mean as much as a 20% loss of revenue to the local economy.
Personal Stories, Real-life Impacts

As with almost any major public policy issue, this story has countless individual proof points — the stories and perspectives of local stakeholders, including patients, employees, and community leaders.

In Colorado City, Texas, the presence of Mitchell County Hospital is summed up succinctly by County Board of Trustees Chair Jerry Reynolds: “It’s very important to the community that we have this hospital. Without the hospital, Colorado City would just dwindle and die. It’s the lifeblood of the city.”

The following snapshots illustrate how other rural hospitals are making a tangible difference in their communities.

Norton, Kansas

Scott Sproul, Economic Development Executive Director in Norton, Kansas, doesn’t mince words when describing the importance of rural hospitals: “When you look at western Kansas as a whole, if you have a strong hospital, you have a strong community.”

Mr. Sproul calls Norton County Hospital the “nucleus of the community.” In particular, it’s essential for the elderly population, but it’s also instrumental in developing a younger population, he contends.

“It’s important to have the services we need here in Norton so we don’t have to go out of town for healthcare. We’re very fortunate that our whole family lives in Norton County, and the major part of us being able to stay here is because of our hospital where we can get all the services that we need…from the 1 year old, up to the 95 year olds in our family.

“Our hospital is more than just a line item in a county budget or a doctor in an office,” continues Mr. Sproul. “It’s caring about the community and making sure everyone has the services they need, delivered in the most caring and compassionate way.”

Watford City, North Dakota

In Watford City, North Dakota, Dan Kelly, CEO of McKenzie County Healthcare Systems, paints a similar picture: “Day in and day out, we are the heartbeat of McKenzie County,” he asserts.
From a patient care perspective, McKenzie County Memorial Hospital plays a crucial role in what Mr. Kelly calls the region’s healthcare ecosystem. “For many patients, if we didn’t exist, they would have to travel one to two hours to receive care,” he explains. “Time and again, there are instances in which we really made a difference in an individual’s life. We provide assessment and stabilization. We are a vital link in keeping people alive until they are transferred to a tertiary facility.”

Besides operating the local ambulance service, the organization offers an impressive array of services, including many that emphasize wellness.

“Today, the focus in our society is on healthier communities. To that end, we are opening a new 20,000-square-foot wellness center in December 2012. It will include a suspended running track, two therapy pools, and a full complement of wellness programs.”

Mr. Kelly points to expanded services in other areas, as well. For example, McKenzie County Memorial now offers cardiopulmonary rehabilitation, ultrasound imaging, and a worksite wellness program. “These are services that maybe aren’t considered core product lines for a healthcare system such as ours, but with the current focus on wellness, we think they’re important.”

The healthcare system definitely plays an important role in creating a healthy local economy, he adds. “We have an approximately $12 million expense budget, and the vast majority of that is spent within McKenzie County. We do drive the local economic engine.”

**Ballinger, Texas**

Rural hospitals own a reputation for delivering highly personal patient care. Ballinger Memorial Hospital in Ballinger, Texas, exemplifies this attribute, according to Mike Dankworth, local business owner and Chairman of the hospital’s Board of Directors. “When you’re there, you’re family...they really treat you like family.”

Mr. Dankworth knows this firsthand through his own encounters, as well as through the experiences of numerous family members and friends. This lifetime Ballinger resident has also witnessed how vital the hospital is to the full continuum of care for residents of Ballinger and surrounding Runnels County.
“First and foremost, Ballinger Memorial is a critical access hospital (CAH) and the initial point of healthcare for our community,” he explains. “If you need emergency care, the hospital will make the most of your golden hour before a transfer to your ultimate care destination, giving you the best opportunity to have a quick and complete recovery.”

Ballinger Memorial offers many diagnostic services, such as CAT scans, MRIs, bone density testing, and laboratory testing, he continues. “Patients don’t have to commit an entire day to drive 40 or 50 miles away to receive these services. If the patient needs to be referred to another facility, the specialist can review the results beforehand (via teleradiology) and get a good picture of the patient’s condition.”

As a businessman, Mr. Dankworth is keenly tuned into how the existence of Ballinger Memorial affects the local economy.

“We’re very fortunate to have two large manufacturing companies in Ballinger,” he says. “One of the companies originated here, but later reorganized. I do not believe they would have kept their corporate offices and main manufacturing facility in Ballinger had it not been for the hospital. The second company, which relocated from Florida to Ballinger, was looking for a logistics city between the Mississippi River and the West Coast. It was the same situation: They would not have considered Ballinger if not for a good healthcare facility.”

Contrast this picture with the West Texas community where Ballinger Memorial Hospital CEO Lance Keilers grew up. The hospital in his hometown was one of many that closed in the 1980s due to financial cuts and other pressures on rural hospitals. Mr. Keilers observed the impact firsthand.

“Once a hospital closes, the chances of attracting business and industry to the community go down to zero,” he comments. “Businesses start to go away, and the school system has to close or downsize because the population is declining.”

Mr. Keilers says when he arrived at Ballinger Memorial about 14 years ago, “this hospital was on its last legs financially. Fortunately, we had a dedicated staff and a community that supported us. We were also very aggressive in going after the CAH designation, which we received. This allowed us to stabilize our finances.”

Ballinger Memorial, he notes, is actually a hospital district, supported by a local tax levy. “Access to local healthcare is important to the people who pay those taxes,” he says. “If they didn’t feel it was important, they wouldn’t pay the taxes, and we would go away.”
If the hospital went away, the economic consequences for the Ballinger area would be far reaching. For starters, the community would lose one of its top three employers. “Our employees enjoy competitive wages and benefits, typically higher than those offered in other industries,” explains Mr. Keilers. “The trickle-down effect in our community is huge. Those dollars are multiplied significantly.”

**Challenges Facing Rural Hospital Leaders**

Rural hospitals operate under circumstances and in an environment where they are confronted with a number of ominous challenges. These challenges put them at a distinct disadvantage compared with larger urban hospitals. According to the NRHA:

- Only about 10% of U.S. physicians practice in rural America, despite the fact that nearly 25% of the population lives in those areas.

- Rural residents are less likely to have employer-provided healthcare coverage or prescription drug coverage, and the rural poor are less likely to be covered by Medicaid benefits than their urban counterparts.

- Rural hospitals provide approximately 18% of all patient care, yet receive only 13.3% of all Medicare payments. This correlates closely with the fact that more than 470 rural hospitals have closed in the past 25 years.

- Rural Americans are typically older and sicker than their urban counterparts.

- Rural residents tend to be poorer. On the average, per capita income is $7,417 lower than in urban areas, and rural Americans are more likely to live below the poverty level.

- People who live in rural America rely more heavily on the federal Supplemental Nutrition Assistance Program (SNAP).
Financial, Regulatory and Operational Challenges

The inherent challenges of serving a rural population are compounded by a variety of financial, regulatory, and operational pressures, including:

- **The push to comply** with a host of regulatory requirements, such as Meaningful Use, HIPAA 5010, and ICD-10
- **Difficulty recruiting** physicians and other skilled workers
- **Aging plants and equipment** — more than half of critical access hospitals are 40-plus years old
- **Lack of IT staff, resources, and capital** to implement electronic health record (EHR) technology
- **Decreasing reimbursements**, coupled with increasing costs, lower rates of insured patients, and declining inpatient occupancies
- **Lower rate of EHR adoption**; according to a report from the General Accounting Office (GAO), rural hospitals are 2.4 times less likely to receive Medicare electronic health record (EHR) incentive payments than larger urban hospitals
- **Possible sequestration**, which means a 2% reduction, representing $477 million, in Medicare payments.

According to a recent analysis performed by the Sano Group, limited operating margins, combined with a reduction in Medicare reimbursement, could cause about 57 hospitals that are currently scratching out a minimal positive margin to immediately begin operating at a loss. This number will increase each year as margins continually get smaller.

If these factors remain unnoticed on Capitol Hill, many rural hospitals will be forced to trim staff. According to Mr. Keilers, “If a small rural hospital has to cut three to five employees, that could be as much as 5% of its total workforce. Chances are, the hospital is already operating at minimum staffing levels, so we’re not talking about deleting positions that have been open for two years. In other words, this could have a direct impact on patient access to care and the quality of care.”
To be clear, many rural hospitals are surviving this convergence of challenges and are taking steps to safeguard their future. Strategies include offering mix of services that dovetails with the needs of the community, achieving a sustainable employee-to-patient ratio, and reaching their daily patient census objectives.

Technology is playing an increasingly central role in a rural hospital’s ability to weather the storm and maintain a viable operating margin into the future. For example, inpatient and ambulatory EHR solutions, such as those offered by Healthland, are bringing significant new efficiencies to hospitals and clinics, while enhancing the delivery of patient care.

Even so, rural hospitals cannot do everything by themselves to ensure that rural healthcare flourishes in the future. They need allies — and this must start with a shift in prevailing wisdom.

**Battling Misconceptions about Rural Healthcare**

Despite the awareness being raised by NRHA, Sano Capital Group, rural hospital leaders, and other organizations, there is a widespread opinion in Washington and elsewhere that rural hospitals and urban hospitals operate on a level playing field.

The June 2012 report to Congress by the Medicare Payment Advisory Commission (MedPAC) epitomizes this mindset.

Required under the Patient Protection and Affordable Care Act (PPACA), the report examines healthcare issues in rural areas, including an evaluation of patient access to care, quality of care, and the adequacy of Medicare payments. The MedPAC report states that access to healthcare in rural America is no longer a significant concern and rural hospital reimbursement rates are adequate.

This view contrasts sharply with statements from the NRHA and other organizations that are intimately involved with rural healthcare.

“The National Rural Health Association strongly disagrees with this report,” declares Alan Morgan, NRHA CEO. “Rural patients and providers will ultimately pay the price as rural hospitals will be forced to eliminate services or close their doors if this report is enacted. The MedPAC report’s conclusions are counter to national data. Primary care workforce shortages remain a significant challenge in rural areas.”
A statement from the NRHA and MDRHC provides further elaboration, citing a finding from the Rural Health Research Center that 77% of rural U.S. counties are defined as health professional shortage areas (HPSAs). “In fact, 164 rural counties lack a primary care physician.”

Regarding Medicare reimbursements, a study by the Sano Capital Group found 35% of rural hospitals operating at a financial loss in 2009, with this number continuing to grow.

“The MedPAC analysis comes up short, and it leaves Congress and others who eagerly await these analyses wanting for more,” states Eric Zimmerman, a partner at McDermott Will & Emery and counsel to the MDRHC. “To be complete and intellectually honest, MedPAC should have gone further with its analysis and provided Congress with information on how these margins would be impacted if Congress were to discontinue some of the payment protections.”

A study conducted by McDermott Will & Emery, found that Medicare margins for Medicare-dependent hospitals (MDHs) would degrade considerably without hospital-specific, transitional outpatient payments.

“Since at least 60% of an MDH’s patients are Medicare beneficiaries, these hospitals would have had to achieve positive margins of 18% on non-Medicare patients to break even without these supplemental payments,” says Mr. Zimmerman. “Without transitional outpatient payments, margins for hospitals receiving these payments in 2009 would have been a negative 16.2%.”

**Affiliation, Consolidation —Viable Options?**

Given the difficult financial climate, it’s not surprising many are choosing to affiliate with larger urban health systems.

A prime example is the recent agreement between McKenzie County Healthcare Systems and St. Alexius Medical Center in Bismarck, North Dakota.

“We decided to partner with St. Alexius, which is a tertiary facility, principally to help us with physician recruitment and our master facility planning,” explains McKenzie County Healthcare System’s Mr. Kelly. “As an added benefit, we’ve been able to take advantage of their pricing structure and volume.”
McKenzie County Healthcare Systems remains independent, he emphasizes, allowing the organization “to respond solely to the needs of our community. When you’re part of a larger entity, you relinquish those decisions to somebody else.”

In other instances, hospitals agree to become acquired entirely by a larger health system. While such a move may make sense from an operating margin perspective, it can also come with a steep price, especially for the rural hospital’s patients and the community at large. Among the potential undesirable consequences of consolidation:

- Service offerings are based on economies of scale and how well they fit into the broader network, not necessarily the needs of the community.
- Centralized purchasing reduces the goods and services sourced locally, creating a negative impact on small businesses and possibly even resulting in their closure.
- Jobs deemed redundant are eliminated, increasing local unemployment and reducing per-capita income.
- The elimination of services may require residents to drive long distances for care.

On September 9, 2011, the U.S. House of Representatives Committee on Ways and Means Subcommittee on Health held a hearing to examine stepped-up consolidation in the wake of health reform legislation. Subcommittee Chairman Wally Herger (R-CA) cited a Rand Corporation study published in the September 2011 edition of Health Affairs as evidence “that consolidation limits beneficiary choice, compromises patient care, and drives up prices.”

Recognizing the tremendous value of rural healthcare — and the huge void that would be left without it — Healthland, provider of comprehensive healthcare information systems to rural community and critical access hospitals, has joined forces with other stakeholders to advocate on behalf of independent rural hospitals.
“Providing safe, accessible, and affordable healthcare in rural areas may be challenging, but it’s absolutely essential to preserve the quality of life in rural communities.” says Angie Franks, Healthland President and CEO, who adds, “Maintaining the independence of rural hospitals means economic stability in those communities.”

The need for action is urgent, contends Ms. Franks, which is why Healthland is pursuing advocacy initiatives on multiple fronts, in partnership with the National Rural Health Association, McDermott Will & Emery, the leaders of rural hospitals, and other organizations. Key initiatives include:

- **Gold-level corporate sponsorship** of the NRHA by Healthland; in February 2012, Ms. Franks was a speaker at the NRHA-hosted Rural Health Policy Institute, one of the largest rural advocacy events in the country

- **“March for Rural Hospitals”** in Washington, DC, July 2012, led by the NRHA with participation by Healthland, rural hospital executives, and other organizations, in support of bipartisan bills (Senate Bill 2620 and HR Bill 5943) which would renew the MDH program and extend critical funding for Medicare low-volume hospitals

- **A strategic partnership** with McDermott Will & Emery, the nation’s leading law firm in healthcare matters

- **Legislative advocacy**, including regular visits by Healthland executives to federal and state legislators on behalf of rural hospitals

- **Healthland sponsorship** of state organizations that advocate for rural hospitals, such as Texas Organization of Rural & Community Hospitals (TORCH) and HomeTown Health in Georgia

- **Partnering with Sano Capital Group**, which specializes in helping critical access hospitals understand the performance benchmarks of a successful organization and then use this information to improve their financial health, even during times of economic and policy upheaval

- **Healthland’s financial support** for rural communities in the form of monetary donations, in-kind product donations, and employee volunteerism; a key element in Healthland’s giving program is “Better. Together,” an annual cash award given
to a client that makes significant contributions to the health and quality of life in its local communities

- **Ongoing Healthland communications** with clients and employees regarding a host of issues that are crucial to rural hospitals

Ms. Franks emphasizes that much more needs to be done to help rural hospitals rise to the challenges ahead. “It can’t just be Healthland, the NRHA or lobbyists fighting for rural hospitals,” she maintains. “We need to hear the voices of many friends at many levels.”

One of those friends is Collin Peterson, U.S. Representative for Minnesota’s 7th Congressional District. Rep. Peterson is a long-time champion of rural hospitals and rural healthcare. Rep. Peterson understands the intimate relationship between rural healthcare and healthy rural communities. He understands that local access to healthcare instills peace of mind, which means people are more likely to stay on the farm or in the local community.

Local healthcare is also an essential ingredient in attracting new residents and businesses to rural areas, helping to keep the economy strong, according to Rep. Peterson. In turn, economically strong rural communities contribute to viable rural hospitals.

Another supporter of rural healthcare is Erik Paulsen, U.S. Representative for Minnesota’s 3rd Congressional District. Rep. Paulsen recently toured the mock-hospital at

*Angie Franks, Healthland president and CEO, and Tracey Schroeder, SVP marketing and sales support meet with U.S. Rep. Collin Peterson (MN), a long-time champion of rural hospitals, to discuss the challenges of rural healthcare.*
Healthland’s corporate office in Minneapolis and met with company leaders to discuss the importance of hospitals in rural communities. Afterwards, he stated: “I’m impressed with Healthland’s commitment to rural healthcare. They have gone beyond the role of a products and service provider and have actually become an advocate for rural hospitals across the country.”

Healthland looks forward to working with Rep. Peterson, Rep. Paulsen and other leaders in government to cultivate additional champions who will fight to ensure the viability of rural hospitals.

The most influential advocates of all, however, contends Ms. Franks, are the individuals who work in or who are served by rural hospitals. She especially urges the leaders of rural hospitals to contact their representatives in the U.S. House and Senate.

“I was very encouraged to see so many hospital representatives participate in the ‘March for Rural Hospitals’ this past July,” she says. “At the same time, I appreciate the tremendous burden shouldered by rural hospital executives, who are pulled in so many directions on a daily basis.”

Both Mr. Keilers and Mr. Kelly are very active in advocacy efforts at the state and national levels. In fact, Mr. Keilers is currently President of the NRHA. They agree they couldn’t do it without the support of their hospital boards of directors and their employees.
“Many rural hospital administrators either don’t have the time or resources to get involved with the issues going on in Washington,” says Mr. Kelly. “As a result, there is a shortage of hospital leaders who are stepping forward to advocate for rural health.”

This needs to change, declares Mr. Keilers. “The only way for rural hospitals to remain viable in the future is for all of us to come together with a common purpose and advocate as one, regardless of whether we’re a critical access or PPS hospital. People living in rural areas of the U.S. deserve access to quality healthcare close to home. That’s what we’re really fighting for.”

Mr. Keilers urges his peers to utilize several informational/advocacy resources developed by the NRHA for the “March for Rural Hospitals.” These materials may be accessed through the Governmental Affairs page on the NRHA website: www.ruralhealthweb.org.

Conclusions

From a “30,000-foot view” or at ground level, it is clear that rural hospitals are a tremendous asset to our nation, to the communities they serve, to individual patients, and to the people who work in these facilities.

Equally obvious are the increasing challenges rural hospitals face today. The most imminent concerns are the pending Medicare payment cuts and, perhaps even more alarming, the prevailing misconceptions about rural healthcare among decision makers in Washington.

Securing the future of independent rural hospitals will not be easy, admits Healthland President and CEO Angie Franks.

“However, I am confident that, by deploying the right strategy with the right messaging, we can create a healthcare model that sustains independent rural hospitals for years to come,” she says. It will require:
• Spreading the compelling message about independent rural hospitals and their paramount importance to patients and communities

• Generating involvement in advocacy efforts by rural hospital executives, community leaders and the citizens who depend on rural healthcare

• Contacting lawmakers to prevent Medicare payment cuts to rural hospitals

• Supporting the National Rural Health Association, state associations, and other organizations that advocate for rural hospitals

As a first step, Ms. Franks encourages interested individuals to educate themselves about the multiple challenges to rural hospitals. While this white paper touches on key points, more in-depth information is available through NRHA at: www.ruralhealthweb.org.
Healthland is America’s largest provider of fully integrated health information technology solutions to rural community and critical access hospitals, serving more than 500 clients across the country. Software and services from Healthland, including its electronic health record (EHR) solution, empower community hospitals to deliver the best possible healthcare by providing a central repository of patient information in all care settings, be it a hospital, clinic, or extended care facility.

With more than 30 years of experience in the rural healthcare market, Healthland solutions are uniquely suited to the size and needs of rural hospitals, enabling them to focus on what they do best – care for neighbors, family, and friends. Founded in Glenwood, Minn., population 2,600, Healthland is headquartered in Minneapolis, Minn. More information is available at: http://www.healthland.com.