Critical Access Hospitals

AND THEIR ROLE IN RURAL HEALTHCARE

Objectives

1) Summarize the origins and history of Critical Access Hospitals in the United States
2) Differentiate between the levels of care and services provided by Critical Access Hospitals and larger hospital systems
3) Discuss the challenges faced by Critical Access Hospitals in today's economic climate

*We have no financial conflicts of interest to disclose.

The Not-So-Long and Storied History of Critical Access Hospitals in the US

1946	Congress passes the Hill-Burton Act → federal funding for construction of hospitals, even in rural areas.
1982	New legislation allows CMS to reimburse hospitals using flat-rate payments (PPS) → birth of DRGs.
1980s -90s	550 hospitals close, 200+ of them in rural areas.
1997	Congress passes the Balanced Budget Act → creates the CAH designation.

Goals of the CAH Designation

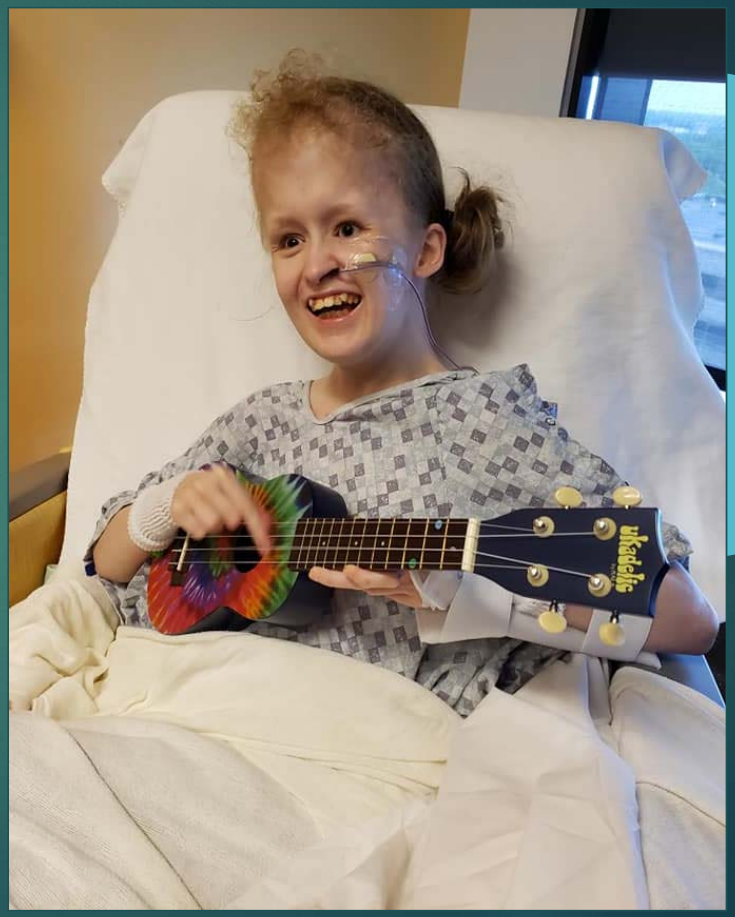
1) Preserve healthcare access by keeping essential healthcare services in rural communities
   - *What are the possible benefits of this for rural communities?*
   - *Individual/family benefit: Reduced need for travel to urban areas (more savings), increased property values, personal connection*
   - *Community benefit: Keep healthcare dollars in community, job creation*
2) Put financial safeguards in place to protect rural hospitals from additional closures.

What *is* a Critial Access Hospital?

- Designation given to certain rural hospitals by CMS
- Must meet the following criteria:
  - Participate in the Medicare program
  - ≤25 acute beds that can also be used as swing beds
  - Annual average acute-care length of stay <96hrs
  - 24-hour emergency services, 7 days a week
  - Must be located:
    - >35mi drive from the nearest hospital, OR
    - >15mi drive from another hospital if on mountainous or 2° roads, OR
    - Certified as a "Necessary Provider" by the state prior to 2006

Staffing Requirements

- ≥ 1 MD/DO and 1 RN
- Must provide the following:
  - Patient activities
  - Social services
  - Comprehensive care plan
  - Discharge-planning services
  - Specialized rehabilitation
  - Dental services
  - Nutrition care



Levels of Care/Services Provided

Inpatient

- Acute care (med/surg)
- ICU beds
- Skilled (SNF) care
- Observation status
- Acute hospice
- Respite care/private pay
- Obstetrics
- Respiratory therapy
- Pharmacy

Outpatient

- Clinic visits (including telehealth)
- Specialty clinic visits
- ER services/ambulance service/helicopter
- Ambulatory surgery
- Cardiac stress tests
- Radiology/imaging
- Electrodiagnostic tests
- Lab services
- PT/OT/speech & cardiac/pulmonary rehab
- Health coaching/dietetics
- Sleep studies
- Dialysis
- Wound care
- IV infusions

Admissions Criteria

Acute Care

- Physician certification:
  - IP stay is medically necessary
  - Expected hospitalization for ≥2 midnights
  - Either D/C or transfer within 96hrs
- Estimated length of stay
- Recommendations for any post-acute care

Skilled Care (SNF)

- Must have had a 3-midnight "qualifying stay" in acute care (waived during COVID-19)
- Need daily skilled care:
  - Nursing/IV antibiotics
  - PT
  - OT
  - Speech

Pop quiz: Would a hospital stay in Observation Status count towards the 3-midnight "qualifying stay"?

Suzie's Story: How Critical Access Hospitals Coordinate Care

- Diagnosis: Congenital hydrocephalus, holoprosencephaly
- Underwent 3 shunt placements/revisions throughout her life, with the most recent in May 2019
- Required intensive care to return to baseline, necessitating PT, OT, and speech pathology services
- Therapy plan of care set by ChildServe
- Medical care overseen by UIHC
- Individualized care provided locally by her hometown critical access hospital
- Seen frequently in the ER, with transfers to e-ICU and UIHC arranged as needed

Challenges Facing CAHs

Recruiting Challenges

- Limited "home-grown talent"
- Visiting specialists → decreased access to care

Sustainability Challenges

- Small population
- Turnover
- Minimal market competition

Financial Liabilities

- Staff your own department vs.
- Hire contract services

Practice Trends and Contemporary Issues in CAHs

- Affiliations with larger hospital systems
- Access issues: Broadband internet availability
- Community engagement
- Fitness/wellness: Medically-oriented gyms
- Partnerships with local schools
- Addressing the opioid epidemic

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Incredibly Common Myths About Rural Healthcare and CAHs

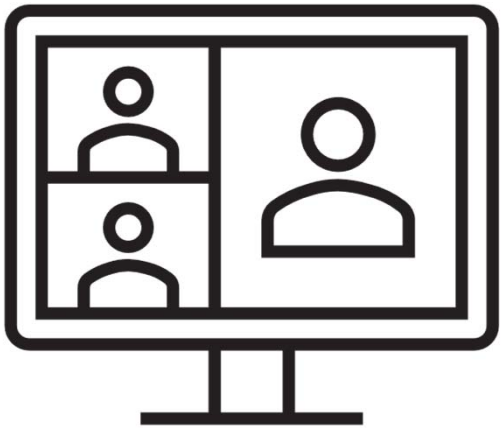
- Myth #1: "You must only treat farmers and cowboys or little old ladies."
- Myth #2: "Healthcare providers in rural settings must be nearing retirement and be out-of-date/out of touch."
- Myth #3: "You'd make more money working in a bigger city."
- Myth #4: "You must not be very busy."
- Myth #5: "Must be nice to have a local hospital that's just down the street."
- Myth #6: "Do they even have electricity there?"

Slide 12

D1 DrsPlum, 6/6/2020

Telehealth: The New Post-COVID19 Frontier

- Bridging the gap in care: Do not qualify for home health services but cannot or do not want to travel for outpatient services
- Telemedicine or telerehabilitation may be used for "maintenance care" to manage certain long-term or chronic conditions.
- Has been shown to improve patient outcomes satisfactorily and be financially feasible



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Telehealth: How Does It Work?

- Use a secure (encrypted) platform to ensure patient privacy
- Patients may prefer to use a non-encrypted platform based on their own preferences
- Document patient acknowledgement of the lack of encryption and security with using particular platforms
- Document: Patient initiated the visit, what platform was used, and where practitioner/patient are for the duration of the call
- Certain CPT codes (e.g. manual therapy) not reimbursable
- Billing remains the same, but must change location of service

Telehealth: What Does It Look Like?

Telehealth: What Does It Look Like?

"So what's this got to do with me?": The roles of providers in urban and metropolitan settings

- Recognize that the world has enough space for both generalists and specialists, and there are multiple points of entry into the healthcare system.
- Know that there's no such thing as over-communication:
  - Clearly state your role
  - Communicate directly when possible
  - Ask "How can I help?" & SPEAK UP
- Respect others and do not over-step your professional practice act.
- Advocate for greater access to care

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