WHITE PAPER

In 1997, Congress passed legislation establishing a hospital payment classification that came to be termed the "Critical Access Hospital (CAH)." The bill's intent was to improve Medicare reimbursement for small rural hospitals so that local residents would continue to have access to acute hospital care. There are two primary requirements for CAH status: a) a rural location; and b) 25 beds or less. Today, more than 60% of rural hospitals in the U.S. are designated as Critical Access Hospitals – roughly 1,200 facilities. The states with the most CAHs are in the nation's heartland: Texas, Kansas, Iowa, and others.

Lessons from Successful Critical Access Hospital Turnarounds

The early warning signs of financial/operational distress are markedly different for a Critical Access Hospital (CAH) than for urban and suburban hospitals.

This paper examines the symptoms of distress that every CAH board member needs to recognize, along with a roadmap for a successful turnaround.

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ELEMENTS OF DISTRESS FOR CRITICAL ACCESS HOSPITALS

Limitations of the Board

Given that CAHs are key community assets, the composition of most CAH boards is primarily local leaders such as bankers, businessmen, and politicians. Consequently, these boards often lack an essential level of healthcare expertise. Without the fundamental financial and operational knowledge to provide effective oversight, these boards usually depend on the hospital management team for the success or failure of these hospitals. Yet most CAHs have very limited management resources – and the administrative team often consists of only the CEO, CFO and CNO.

CAH board members often lack a necessary understanding of hospital finance, compliance, quality, and industry best practices. Especially in this era of health reform, board members need to dedicate more time to Board Development so that they understand their fiduciary responsibilities and have enough information to strategically address the challenges their hospitals are facing.

Although Medicare reimburses qualified CAHs at 101% of cost, some of these facilities still barely break even. Board members with an understanding of healthcare financials can review key financial indicators on a monthly basis, including days cash on hand, collection rates, and debt service coverage ratios, to assure that the hospital maintains tight financial controls. They also need to carefully monitor any significant changes to the cost structure.

Turning around a CAH often involves greater alignment of physician and hospital interests, especially as health reform compels greater hospital-physician integration. When a physician expresses interest in being employed or having his/her practice purchased, the board often turns to local legal counsel. Those attorneys may not have a comprehensive understanding of the compliance requirements of physician contracting – or how to attain the most favorable structures for the hospital.

Negative Community Perception

A not-for-profit hospital depends on community trust, and its board members are the public face of the organization. Because the hospital is such an integral part of the community, the local media will focus on your hospital during troubled times. It is a huge mistake to pretend that there's no problem or to hide from the media. Communication and transparency with the community and media are essential – especially during financial downturns. The board's first communication should be internal, making sure all employees and medical staff members understand the hospital's situation and the role they need to play in a turnaround. The external message to the community should be consistent - Don't paint a grim picture on Monday and a rosy one on Friday. This is not the time for "spin."

No Strategic Plan

Most troubled CAHs are not following an actionable, measurable strategic plan. Because the margin for error is razor-thin for small hospitals, it's imperative for the board to work closely with management and staff to create a strategic plan – and to communicate that plan clearly throughout the organization.

Increased Competition

If the community perceives that quality of care is higher at a competing facility, it's not unusual for a CAH to lose patients to that facility, even if it is an hour's drive away. Employed or not, physicians are willing to refer patients

to competing facilities if quality service isn't available locally. Moreover, many large metropolitan hospitals are now opening outpatient clinics in areas served by Critical Access Hospitals, in an effort to grow their own referrals.

A Major Surprise

Small hospitals are especially vulnerable to unexpected disruptions, such as the loss of a key physician or a mass layoff by a large employer. When the largest employer in a Northeastern town closed in 2003, more than 1,300 workers found themselves without jobs or health insurance. It was a huge blow to the CAH, but the board quickly reached out to turnaround experts. Their prompt action helped save the hospital and restore its profitability.[1]

CEO Turnover

A CEO's sudden departure is a challenge for any hospital, and especially for a CAH. It's been estimated that the aggregate direct dollar costs of replacing a CEO can equal three times the executive's annual salary – a financial hit that can cause real problems for a CAH. And recruiting a CEO to a rural community takes time – often a year or more.

Declining Inpatient/Outpatient Volume

This should be a "Code Red" for any board. Like retail chains that analyze "same store" data, the hospital board should compare volumes in the current quarter with those from the same quarter a year ago. It's important to get prompt explanations and corrective plans from the management team for any negative swings in volume.

Cost Structure Changes

Unique to Critical Access Hospitals is the impact of the Cost Report – and even board members who are financially astute might have difficulty understanding the complexities of the Cost Report. Without an effective model for monitoring the cost structure, any negative adjustment to the Cost Report can quickly deteriorate days cash on hand.

Cash & Cash Flow Deterioration

Almost any adverse event can push a CAH over the edge when it has less than 90 days' cash on hand. Most boards are not adept at monitoring cash flow. They're not coached to look at earnings before interest, depreciation and taxes. Without adequate cash on hand, the hospital's turnaround strategies become more limited.

Staff Reduction / Perceived Drop in Quality

When a hospital's cash flow worsens, the board's first impulse in many cases is to reduce staff size. While a careful, one-time staff reduction may be warranted, wholesale staff reductions often do more harm than good. The cuts don't remedy the underlying problems, so more staff reductions follow. That sets the stage for the calculated departure of key staff and physicians and creates a community-wide perception that quality is declining. Appropriate analysis can show where effective, long-term benefits can occur from staff reductions – that don't adversely affect patient quality.

Federally Qualified Health Centers (FQHC)

The number of FQHCs in the United States – and the comprehensiveness of services they provide – are on the rise and should skyrocket in the next five years as $11 billion in new federal funding is included in the health reform package. The FQHC designation was originally created to greatly expand access to high-quality primary care healthcare, while reducing patient loads on hospital emergency rooms.

While new and improved FQHCs will help provide access and services to millions of citizens in our nation's underserved areas, they are likely to challenge the role and services of rural and critical access hospitals.

CAHs will be forced to compete in small markets where many have traditionally been sole providers. CAHs will have the ongoing responsibility for inpatient and emergency services, but potentially lose other revenue producing services, such as outpatient diagnostics. Some CAH services may be nearly identical to those provided by FQHCs, but without the grant support, medical liability coverage and recruiting leverage that comes with the FQHC designation.

Here are the clinical and non-clinical services FQHCs are required to provide:

- Primary care
- Diagnostic x-ray and lab
- Health screenings and immunizations
- Emergency medical services
- OB/GYN services, including prenatal and perinatal and well child
- Preventive dental
- Pharmacy
- Mental health, substance abuse and specialty services, via referral
- Case management and counseling
- Follow-up and discharge planning
- Support for Medicaid enrollment
- Health education
- Transportation, translation and outreach

Your Hospital's Crisis Point

Because it takes 180 days minimum – and usually longer – to properly assess, stabilize and begin turning around an ailing hospital, board members need to act swiftly to save the facility. This may require bringing in outside consulting support and/or strong interim leadership. There's no time for delay and finger-pointing.

KEYS TO A CAH TURNAROUND

Many hospitals, both large and small, often fail to acknowledge that they're in distress –and wait until there's a significant drop in patient volumes or a significant, unexpected dip in days cash on hand. In short, hospitals delay rather than take decisive action, causing a crisis to worsen and accelerate. When acting early in a crisis, turnaround experts can get better results – faster.

Many CAHs are waiting to see whether health reform will provide financial relief. But experts stress that those benefits may be two years away – valuable time that shouldn't be squandered.

Find Dynamic Leadership

A turnaround begins with energetic leadership, decisive action, and a team effort to rally community support.

A CAH in the Northwest launched its turnaround effort by hiring a CEO who believed that small hospitals can deliver quality and service rivaling large metropolitan ones. Within a few years, this CAH was operating a Level III trauma center and winning national awards for customer service.[2]

Create a Strategic Plan

The CAH strategic plan should feature the input of all stakeholders: hospital management, medical staff, nursing, quality/compliance committees and the community. It's essential that employees at all levels understand their roles in achieving the plan. And the board should monitor progress toward achieving the plan's objective as a regular board meeting agenda item.

Leverage Community Support

Communities have a vested interest in keeping Critical Access Hospitals healthy, both to retain local access to acute healthcare, and to protect local employment, since the CAH is often one of the largest employers in the area. And a community without a local hospital struggles to grow and attract new employers to the area. Boards must continuously reach out to the political and business leaders in the community with courage and candor. A CAH cannot thrive without community trust and support.

Reduce Costs

Turnaround specialists have helped pull many small hospitals back from the brink of bankruptcy or closure by quickly and astutely cutting their costs. They view all costs as controllable and every cost is evaluated. For example, turnaround experts often analyze physician contracts. In addition, hospitals can dramatically lower supply chain costs by closely examining and enforcing existing purchasing contacts. CAHs can also enjoy savings by closely examining other existing vendor contracts. In one case, a Critical Access Hospital saved nearly $500,000 in GPO savings in one year from a recent review of contracts.[3]

Develop Revenue Opportunities

In most cases, a hospital can't simply cut its way to a sustainable turnaround. For sustainable success, it's

important to find and grow significant new revenue streams. For example, a Critical Access Hospital can collaborate with a nearby tertiary system to start or enhance a cardiology service line so that local residents won't need to drive an hour or more for treatment/rehab that could be provided locally, while creating a feeder of referrals for more specialized services.

Improve Revenue Cycle Management

This is an area where outside experts can have an immediate impact by helping the CAH identify areas for improvement, such as clinical documentation, billing & coding, and case management. They can also provide training to strengthen hospital employees' skills. The result can be a dramatic drop in accounts receivable days and improved cash flow.

Improve Quality and Customer Satisfaction

Once the CAH is financially stabilized, it's time to grow the organization and push toward excellence. A once-troubled Southeastern CAH completed its turnaround by obtaining funding for two sleep study suites, an expanded ED, and a neurodiagnostics center.[4]

Reduce Staff Turnover

No turnaround can be deemed a complete success if employee turnover is high and morale is low. And there are financial implications as well. Replacing a nurse carries a high cost: lost revenue, recruitment expenses, new hire training, etc. It's possible to implement innovative programs that can reduce a runaway turnover rate (20% or higher) to 4% or lower – and lower your costs.[5]

Promote Physician/Hospital Alignment

CAH board members should never underestimate the long-term strategic importance of physician/hospital alignment and joint ventures. It's prudent for the board to seek outside expertise on how to cultivate relationships with area physicians. When one CAH and surgery group jointly financed an ambulatory surgery center instead of competing, both surgical volumes and hospital market share increased.[6]

Federally Qualified Health Centers (FQHC)

For a CAH with no existing FQHC in the county or primary service area, the most important tactic moving forward is to focus on exceptional customer service in outpatient services, especially ER, lab, imaging and outpatient surgery. While FQHCs may be perceived by some as nothing more than a competitive threat, CAHs with an eye toward the future will understand that FQHCs can also provide myriad opportunities for friendly and/or collaborative relationships. These relationships can improve access to primary care; support physician recruiting and retention efforts; serve as a platform for primary care physician employment; reduce medical malpractice coverage costs and liability; provide access to grants and loans to support program and facility expansion; and mitigate future competition in financially critical outpatient services. The board should consider the following strategies to manage FQHC competition:

- A FQHC can own and operate a CAH
- City/county/hospital district public hospitals may own a FQHC, if FQHC governance requirements are achieved, i.e. the "Public Entity Model"
- Non-public, state-owned or independent 501c3 CAHs may own a FQHC, if the governing body (Board of Directors) is reconstituted to meet the governance requirements of a FQHC.
- CAHs can develop and own a Rural Health Clinic (RHC), but a CAH cannot convert the RHC to a FQHC and maintain control unless the CAH's governing body is reconstituted to meet the governance requirements of a FQHC.
- A 501c3 may operate a CAH and develop a FQHC to control the respective "system" by reconstituting the Board to meet the governance requirements of a FQHC. (For example: Minnie Hamilton Health System, Grantsville and Glenville, WV)

CONCLUSION

Because of the ongoing impact of the 2008 financial crisis, many Critical Access Hospitals are still in danger of slipping into financial insolvency. It's imperative for

board members to recognize the early stages of hospital distress so solutions can be found as soon as possible. The longer a board waits, the worse the damage is to the balance sheet – and the longer and more difficult the journey to turnaround the organization becomes.

With swift intervention, the hospital can continue to serve the community – and potentially reduce risk for financial stakeholders. Board members should seek advice from turnaround experts *immediately* if:

- Accessing capital is extremely difficult
- The hospital is approaching bond covenant default
- The organization is unable to fund new facilities and service lines
- The hospital cannot achieve operating margins of 1 to 3 percent
- Physician recruitment is increasingly difficult

QHR Intensive Resources provides short-term, high-intensity support to hospitals and health systems at every point on the distress spectrum discussed in this paper. Our experts can help refine the board's strategic plan and improve financial/operational oversight. We also help hospitals deal with the later stages of distress: bond covenant default, loss of accreditation, sale/merger issues, and bankruptcy.

QHR Intensive Resources is a wholly owned subsidiary of Quorum Health Resources (QHR), the seventh largest healthcare management consulting firm in the U.S. and the market leader in hospital management, serving about 150 nonprofit hospital clients across the nation. QHR is a national leader in meeting the needs of rural hospitals and health systems, as the largest manager of not-for-profit, rural and Critical Access Hospitals in the U.S., the 7th largest hospital consulting firm (ranked by Modern Healthcare), and the largest provider of hospital management education programs in the country through the QHR Learning Institute.

If you would like to learn more about how QHR can help your hospital address its specific challenges, please contact Doug Johnson, Vice President of QHR Intensive Resources, at 888.766.2799, or by emailing doug.johnson@intensiveresources.com. For more information about QHR Intensive Resources, please visit our website at www.intensiveresources.com.

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