# OPTIMIZING RURAL HEALTH

## A COMMUNITY HEALTHCARE BLUEPRINT



## RURAL & COMMUNITY HEALTH INSTITUTE
### TEXAS A&M UNIVERSITY

IN PARTNERSHIP

WITH

EPISCOPAL HEALTH FOUNDATION

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BUILDING A THRIVING DEEP EAST TEXAS

Robert Wood Johnson Foundation

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# Acknowledgements

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# Foreword

The Rural Health Team at the A&M Rural and Community Health Institute (ARCHI) has been honored to work with our funding partners in evaluating the status of rural health care delivery in Texas and particularly in beginning to seek solutions to the challenges faced by small towns and their hospital facilities.  The commitment of these philanthropic organizations to the people living in the rural parts of our country brings hope and new ideas to communities that often feel they have been forgotten.

As a result of the work funded by Episcopal Health Foundation, the Robert Wood Johnson Foundation, and the TLL Temple Foundation, ARCHI has been awarded funding by the Health Resources & Services Administration to create a technical advisory center for the vulnerable rural hospitals across the United States.  The financial support as well as the philosophic enthusiasm of these organizations helped motivate the early work that led to the development of the Center for Optimizing Rural Health.

The people who live in rural Texas benefit from the continued thoughtful investment by philanthropic organizations and the ongoing encouragement by the leadership of those organizations to continue to look for innovative programs to address rural health care challenges.  The US health care delivery system is undergoing continuous and ever more rapid change; rural communities must find ways to survive and even thrive in that changing environment.  Through academic/philanthropic partnerships, those communities can be provided possible options for meeting the change.

**Funders' Foreword**

In 2016, the Episcopal Health Foundation (EHF) engaged the Texas A&M University Rural and Community Health Institute (ARCHI) to better understand the scope of the rural hospital crisis in Texas. The report, entitled "What's Next? Practical Solutions for Rural Communities Facing a Hospital Closure," was released in May 2017 and has attracted widespread attention from policy makers and stakeholders in rural communities in Texas and beyond. The report outlined a range of practical options for Texas communities facing a rural hospital closure.

In late 2017, EHF invited the Robert Wood Johnson Foundation and the T.L.L. Temple Foundation to join forces in supporting ARCHI to conduct year-long, in-depth case studies in three rural Texas communities facing hospital closure. The purpose of these case studies was to learn more about the specific ways each community responded to this challenge.

In this new report entitled "Optimizing Rural Health: A Community Healthcare Blueprint," ARCHI builds upon its previous research and delves deeper into what influences hospital closure and what prevents closure. Additionally, the report includes a practical set of blueprints to optimize rural healthcare delivery in Texas.

ARCHI's research team conducted interviews with hospital board members and held focus groups with community members. The resulting, rich case studies illustrate that access to quality care is much more complex than distance to services. Transparency, quality, and community engagement are also critical factors to the future of rural healthcare.

One of the report's key messages is the importance of recognizing each community's individuality. However, the critical decisions needed to move forward and optimize rural healthcare delivery primarily lie in the following areas: community awareness, community engagement, community/management interface, redefining access, leadership, and finances.

We invite legislators, local leaders, healthcare administrators, and community members to read this report to learn more about enhancing access to quality care in rural Texas. Let's work together to optimize health and healthcare in rural communities.


Elena M. Marks, JD, MPH
President and CEO
Episcopal Health Foundation

Richard E. Besser, MD
President and CEO
Robert Wood Johnson
Foundation

Wynn Rosser, Ph.D.
President and CEO
T.L.L. Temple Foundation

# Executive Summary

In recent years, Texas has had an unprecedented number of rural hospital closures, and those that remain open are facing increasing legislative, regulatory, and fiscal challenges. While there are a number of known challenges, there is no single issue that determines when a hospital will close its doors. Focus groups in several Texas communities share the belief that all rural hospitals need to be saved, especially their own. However, a deeper dive into the health care needs of each community suggests that the true issue is a need to work with communities to balance needs, capacities, and resources in order to optimize rural health care delivery and preserve access to care.

Rural communities in Texas are as unique as the residents themselves, and so there isn't one right answer as to how to optimize rural health. Examples exist where a rural hospital in one community thrives, while a comparable facility in a similar town fails. Texas A&M Rural and Community Health Institute (ARCHI) worked with three communities this past year who self-identified as having a vulnerable hospital. The term, vulnerable, is subject to interpretation, and consequently, two facilities closed before community focus groups had a chance to begin. One of these facilities has since re-opened with a change in scope of service. Regardless of open vs closed status there were common lessons to be gleaned and shared. Common themes that emerged included Community Awareness, Community Engagement, Redefining Access, Hospital Board Leadership, and Finances. It is apparent that when people are aware of their hospital's vulnerability, they can be proactive, and are able to retain or create more options for health care access. The identified themes are intertwined and when leveraged effectively increase awareness of and actions towards optimized rural health care. It is unknown if similarly sized communities who do not identify as having a vulnerable hospital might have different commonalities. This is a line of inquiry that ARCHI plans to pursue.

Each of the participating communities received a detailed, specific "blueprint" in addition to a community presentation to share strategies and answer questions. The commonalities discovered are lessons learned for rural communities across America and are included on paper for this report, and is also available on the ARCHI website https://architexas.org/rural-health/activities.html. It is important now, more than ever, to ask the question, does the current health care delivery system meet the needs of this community? If not then let us work together to develop solutions for right-sized, accessible, affordable health care.

# Introduction

Rural communities are losing their hospitals across the United States. Eight-three hospitals have closed their doors since January 2010. According to the American Hospital Association, in 2018 there were 1,825 rural hospitals in the United States. [1] A significant portion of these remaining rural facilities are vulnerable, and many are on the precipice of closure. Michael Topchik's "Rural Relevance: Vulnerability to Value" study found that 41% of rural hospitals operate at a negative margin.[2] The 2016 iVantage report identified the highest rates of vulnerability in the southern states with Texas and Mississippi having the largest absolute number of vulnerable facilities.[3] Changing processes, payment strategies, and regulations within the health care system change place the small rural facility at particular risk. Therefore, rural solutions will be unique and not an urban solution downsized to a smaller population.

The Episcopal Health Foundation (EHF) reached out to the Texas A&M Rural and Community Health Institute (ARCHI) in 2016. EHF wanted to know the scope of the rural health care crisis in Texas. ARCHI conducted a systematic literature review regarding rural hospital closures and wrote a report entitled, "What's Next? Practical Solutions for Rural Communities Facing a Hospital Closure".[4] This report became a starting point for hospitals and communities to think about how to address the potential loss of their traditional hospital care.

In 2017, EHF asked ARCHI the critical question of "so, what is next for these rural communities?" Episcopal Health Foundation invited other concerned entities to join in an outreach effort to three Texas communities. Robert Wood Johnson Foundation and the T.L.L. Temple Foundation responded to the invitation. This report seeks to answer the question, "What's next for these rural communities?" and contains the findings from three rural Texas communities, a blueprint for next steps, and an appendix section of summary papers for further information.

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# Optimizing Rural Health Care:  A Series of Case Studies

In 2017, the Texas A&M Rural and Community Health Institute (ARCHI) looked at rural hospital closures and their impact on communities as well as access to care.  While a number of issues were raised, it was clear that there was no single issue, concern, or challenge that defined when a facility will close its doors.  Instead, there are instances where a facility in a small community thrives and yet a comparable facility in a similar community fails.  What contributes to one outcome over the other?  By looking at several communities that actually closed or faced possible closure, it was thought that common issues and possible solutions could be gleaned and shared.

In outlining findings, many issues were discussed including management and leadership; recruitment and retention of providers; community support; and the outmigration of patients in order to receive specialty care in a more urban facility.  However, it cannot be overemphasized that the changing health care delivery environment is having a tremendous impact upon care rendered in rural America.  While it is beyond the purview of this report to change or criticize the United States health care delivery environment, the changing environment with accompanying regulations and legislation must be taken into consideration as solutions are sought for maintaining access to care for those individuals who live outside the greater metropolitan areas.

METHODOLOGY

The following report examines three individual communities whose facilities were facing closure or had actually closed.  Selection of the three communities was relatively informal.  Communities were suggested by colleagues, or through interface with a community in other ARCHI outreach programs; or by our funders who had been approached by a struggling facility; or by individuals who heard about the project and wanted to suggest a particular community.  Diversity of vulnerability issues, community size, and community characteristics were considered important selection criteria.  Thus, of the three selected, two communities had just closed their facilities with one determined to find a way to reopen and the other determined to pursue alternative options for access.  The third facility was on the verge of declaring bankruptcy but was perceived to be vital to the health of that community. All three facilities were supported by tax districts with a publicly elected board whose responsibilities were to ensure the provision of hospital services and manage the funds collected to support the hospital.

ARCHI researchers constructed a series of questions to determine the health of a hospital.  These questions/data points were mainly derived from discussions with current and former hospital executives.  General question categories were:  hospital physical presence (age, critical access designation, number of beds, number of staff, distance to next hospital, etc.); service lines; patient demographics (source of admissions, top 10 diagnoses, payer mix, readmission rate, transfer data, average daily census, etc.); and standard financial markers.  Research team

members were surprised to find a paucity of financial and hospital performance information available from the two facilities that had closed.   Critical data, stored both electronically and hard paper format, appeared to have been removed by the contracted management company after they vacated the facility. This begs the question of who owns this data.

Data ownership should be detailed in any management contract. Not only should data ownership be contractually addressed, penalties for non-compliance of data ownership should also be included. One hospital district board's contract with a management company clearly stated the data was owned by the district.  However, the contract did not include any repercussions if the data was not provided to the district.  Without these details being contained in a contractual agreement, small rural hospital districts are left in a vulnerable situation because they do not have the financial resources to pursue legal remedies to acquire the data if the contract has no accountability clause.

Moving forward since the data was gone and closure had already occurred, attention was directed to issues impacting next steps rather than looking backward.  In the facility that remained open, time was spent with hospital administration evaluating the average daily census, payer mix, service lines, hospital board interactions, and community engagement & awareness.

Through consultation with hospital leadership and community leadership, feedback from community focus groups, and examination of available data, the ARCHI team arrived at a blueprint of potential actions for each community.  All community input was voluntary and there was no compensation for participation.

Focus groups provided the ARCHI team with a better understanding of perceptions about local health care, particularly the hospital status and the highest priority needs.   Focus groups were held in Communities 1 and 3. All focus group responses have been aggregated by community and are presented in each community section of this report.

The hospital district in Community 2 advised that they had recently gathered community feedback and advised against conducting focus groups.  The board members were sensitive to the possibility of the community responding negatively if asked to participate in another series of community meetings.  Rather, the hospital district shared the feedback that they received through various community meetings. The ARCHI team complied with the district's request and instead interviewed board members at two points in time during the study to determine initial status and changes in local health care status that occurred later in the project.

Community 1 Focus Groups

The team conducted a series of focus groups in Community 1 approximately six months after the hospital's closing and nearly six months prior to the reopening.  Focus groups were designed to capture the perspectives across community demographics and sectors.   Focus groups included hospital district board members; local elected officials; members of civic

organizations; low-income, uninsured individuals; the senior population; other communities within the county; and Spanish-speaking only community members, whose focus group was conducted in Spanish. A total of twelve focus groups and interviews were held over the course of two months. The duration of the focus groups and interviews averaged one hour. Focus groups held with elected officials were small due to the State of Texas' Open Meetings laws. In Texas, if the majority of a governing body assemble for any reason, the gathering is subject to these laws, which includes posting a public notice and recording minutes for public review. Therefore, the ARCHI team ensured that a majority of any public governing board, such as a hospital district or commissioner's court, did not assemble for a focus group.

Local stakeholders helped identify where and when to hold the focus groups to ensure maximum participation. The team did not document the identity of participants through such means as a sign-in sheet or by attributing any specific responses to any one individual in this report. The focus group format consisted of the following four questions and the duration of the focus group was typically 30 to 45 minutes.

1. In what ways did you utilize the local hospital and its related services?
2. How has the closure affected you and your community?
3. What do you feel are the health care service needs in the community now?
4. How could these needs be met?

Table 1. Community 1 Focus Groups and Interviews by Type and Number of Participants

| Focus Group Number | Focus Group Type | Number of Participants |
|---|---|---|
| 1 | Key Leaders (Hospital District) | 5 |
| 2 | Low Income | 15 |
| 3 | Seniors | 50 |
| 4 | Key Leaders (Elected Officials) | 2 |
| 5 | Key Leaders (Elected Officials) | 2 |
| 6 | Seniors | 18 |
| 7 | Key Leaders (Elected Official/Civic Leaders) | 2 |
| 8 | Spanish Speaking | 75 |
| 9 | Key Leaders (Elected Officials/Civic Leaders) | 5 |
| | TOTAL PARTICIPANTS | 174 |

Community 3 Focus Groups

As with Community 1, the ARCHI team conducted a series of focus groups in Community 3 to determine the perspectives of community members representing a cross section of community sectors and demographics. In addition to focus groups, interviews were held with certain stakeholders to gain additional context and insight beyond the focus group questions.  Focus groups and interviews included representation from the hospital district board; local government; employers; business and economic development organizations; health care providers; hospital administrators; community non-profits; low-income, uninsured individuals; and senior residents. A total of twelve focus groups and interviews were held over the course of two months. The duration of the focus groups and interviews averaged one hour. Focus groups held with elected officials were small due to the State of Texas' Open Meetings laws. In Texas, if the majority of a governing body assemble for any reason, the gathering is subject to these laws, which includes posting a public notice and recording minutes for public review. Therefore, the ARCHI team ensured that a majority of any public governing board, such as a hospital district or commissioner's court, did not assemble for a focus group.

Again, local stakeholders helped identify where and when to hold the focus groups and interviews to ensure maximum participation. The team did not document the identity of focus participants by use of a sign-in sheet or by attributing any specific responses to any one individual in this report.

Questions varied slightly from Community 1 due to the fact that this hospital had not closed and there is a second hospital in the community. The focus group format consisted of the following four questions and the duration of the focus group was typically 30 to 45 minutes.

1.  What services do you (or people you know) access at each hospital and why?
2.  What if one or both hospitals closed?  Where would you (or people you know) go for care?
3.  What additional services are needed in your community now?
4.  What could the hospitals do to make community members stay in town for care?

**Table 2. Community 3 Focus Groups and Interviews by Type and Number of Participants**

| Focus Group Number | Focus Group Type | Number of Participants |
|---|---|---|
| 1 | Low Income | 5 |
| 2 | Seniors | 50 |
| 3 | Key Leaders (Civic Leaders) | 2 |
| 4 | Key Leaders (Major Employers) | 3 |
| 5 | Health Care (Physicians) | 5 |
| 6 | Key Leaders (Hospital District) | 1 |
| 7 | Key Leaders (Hospital District) | 2 |
| 8 | Key Leaders (Hospital District) | 3 |
| 9 | Key Leaders (Elected Officials/Civic Leaders) | 4 |
| 10 | Health Care (Physician) | 1 |
| 11 | Health Care (Hospital Administration) | 1 |
| 12 | Health Care (Hospital Administration) | 1 |
| | TOTAL PARTICIPANTS | 78 |

Following the collection of data and community feedback, the team developed draft blueprints that were shared with the hospital boards and hospital management for input prior to a public discussion. The ARCHI team then presented the summary of findings in conjunction with hospital district board meetings and hospital staff meetings, to maximize community attendance. The blueprints were reviewed and recommendations discussed in detail. The meetings varied from highly interactive to relatively quiet acceptance. The goal was to help each community look at the options available to them, possibly help in selection of one or more options, and assist them where possible as they began to "right size" access to care for their community. These specific blueprints are private for the participating community.

Commonalities existed between communities and these shared themes comprise the overarching blueprint included in the publicly disseminated version of this report and on the ARCHI website. However, rural communities in Texas are as unique as the residents themselves, and so there isn't one right answer as to how to optimize rural health. Perhaps there are no right or wrong answers at all, but rather steps selected and supported by a community to ensure access to care.

*COMMUNITY 1*

*Background and Events Leading to Hospital Closure*

*Location and Population*

Community 1 is the county seat and located approximately 120 miles northeast of Houston.

Based on the U.S. Census Bureau, the 2010 population of 6,950 has since decreased to 6,526, (a loss of 6.1%), based on July 1, 2017 population estimates.[2] During this same time period, the county experienced an overall 3% loss in population, while several nearby counties and the state of Texas population increased by 11.1%.[3]

**Table 3. Surrounding Counties Population Changes - 2010 Census to 2017 Estimates[3]**

|  | 2010 Census | 2017 estimate | % Change |
|---|---|---|---|
| Angelina County | 86,771 | 87,805 | 1.2% |
| Anderson County | 58,458 | 57,741 | -1.2% |
| Cherokee County | 50,845 | 52,240 | 2.7% |
| Houston County | 23,732 | 23,021 | -3.1% |
| Leon County | 16,801 | 17,243 | 2.6% |
| Madison County | 13,664 | 14,222 | 3.9% |
| Trinity County | 14,585 | 14,667 | 0.6% |
| Walker County | 67,861 | 72,245 | 6.0% |

*Gender, Race, and Ethnicity[2,3]*

The majority (51.9%) of residents of Community 1 are female although the majority of county residents (53.4%) are male.

Persons under 5 years of age account for 8.3% of the population compared to 5.4% countywide. Persons aged 6-18 account for nearly a quarter (24.4%) of the population, while one-fifth (19.8%) of county residents are the same age. One in every five (20.1%) residents is over the age of 65, with the county population about the same, (21.6%). Forty-five percent (45.4%) of residents are white, forty-five percent (44.9%) are African American, and less than one percent are Asian. Sixteen and one half percent (16.5%) of residents are of Hispanic or Latino origin. Across the county, nearly three quarters of residents are white (71.7%), one quarter are African American (25.7%) and less than one percent are Asian. Eleven percent (11%) of residents are of Hispanic or Latino origin.

*Housing and Households[2,3]*

According to the U.S. Census, there are a little more than two (2.27) persons per household and 2,680 households in the community. While in the county, there are nearly two and a half persons (2.39) per household.

Just over half of the residents own their homes, with a median value of $77,500, while over seventy percent (70.1%) own their homes in the county, with the median home value slightly less ($77,400) than the city. In the community, the median gross rental payment is $624, slightly lower than the median cost of $633 across the county.

*Education[2,3]*

Nearly three-fourths (72.7%) of adult residents aged 25 and higher in Community 1 have high school degrees and almost sixteen percent, (15.9%) have bachelor's degrees or higher. Across the county, just over eighty percent (82.4%) have high school degrees while less than fifteen percent (14.5%) have a bachelor's degree or higher.

*Employment/Unemployment[4]*

The unemployment rate for the county in 2017 was 4.2%. City level data for 2017 was not available.  Across 2017, the average number of unemployed workers was 447.  The average labor force in 2017 consisted of 10,556 workers.

*Household Income[2,3]*

The median household income for residents in Community 1 between 2012 and 2016 was $25,190.  The per capita income during the same period was $15,706.  The 2016 American Community Survey indicated nearly forty percent (39.3%) of community residents live in poverty.  The federal poverty level for a family of four in 2016 was $24,300.

*Transportation[2,3]*

Travel time to work for workers aged 16 and over is 20.9 minutes indicating that most residents work outside the city and county limits. Being centrally located, the distance between Community 1 and the farthest county boundary is less than 20 miles.

*Health*

Nearly fifteen percent (14.5%) of residents under the age of 65 have a health disability. According to the 2016 American Community Survey, almost 25% (24.5%) are uninsured. [2,3]

According to County Health Rankings[5], one-fifth of the county adult residents reported being in poor or fair health.  Out of the past 30 days, residents reported an average of 4.1 poor physical health days and 3.8 poor mental health days. Other health factors reported included rates of 28% obesity; 18% smoking; 29% physically inactive; 55% having access to exercise opportunities, 16% excessive drinking and 17% alcohol impaired deaths.  Table 4 shows comparisons to the state of Texas.

**Table 4.Comparison of Quality of Life/Health Factors between the County of Community 1 and the State of Texas[5]**

| Quality of Life/Health Factors | County | Texas |
|---|---|---|
| Poor or Fair Health | 20% | 18% |
| Poor Physical Health Days | 4.1 days | 3.5 days |
| Poor Mental Health Days | 3.8 days | 3.4 days |
| Obesity Rate | 28% | 26% |
| Smoking Rate | 18% | 14% |
| Physical Inactivity Rate | 29% | 20% |
| Access to Exercise Opportunities Rate | 55% | 91% |
| Excessive Drinking Rate | 16% | 13% |
| Alcohol Impaired Deaths | 17% | 13% |

The county is also considered a Health Professional Shortage Area, with fewer providers than needed for the size of the population.[6] The county lacks an adequate number of primary care, dental care, and mental health care providers.

*The Hospital*

Built in the late 1960s, the twenty-five bed hospital provides the only impatient and emergency care within 40 miles of the small, rural community in which it operates. For twenty-one years, the hospital had a strong partnership with a larger health system headquartered an hour and a half away in a small urban community.  The health system managed the hospital and, through transfers to the system's central location, offered access to a wide variety of health care specialties. Furthermore, in the first decade and a half of the new millennium, the alliance resulted in both desired and necessary additions and upgrades, including the addition of a labor and delivery suite and a surgical suite. Ultimately, the hospital campus, including a primary care clinic, grew the capacity to operate as a 55-bed unit.

As changes in reimbursement and health care delivery began to occur in recent years, the hospital district board and the health system made the mutual business decision to move in different directions. Over the next couple of years, the hospital district board pursued two sequential options first for self-management and then a new health system management. However, both resulted in losses in revenue and left the hospital district deeply in debt.  By 2017, the last management group pulled out of operating the hospital with only a few weeks' notice, leaving the board with no alternative but to shut down operations completely.

A number of factors led to the hospital's closure, all of which resulted in the financial shortfalls that ultimately led to the doors being permanently locked.  With a daily census of three, the hospital was overstaffed with more than 200 employees.  The patient payer mix also became less desirable as the demographics of the community's population shifted.  As evidenced in the 2010 U.S. Census and subsequent annual population estimates, the community, of less than 7,000, has steadily declined, the poverty rate has increased to nearly 40 percent, and nearly a fifth of the population is over 65 and growing annually.

Over half of the hospital's patients were either covered by Medicaid (11%) and/or Medicare (36%) or were self-pay (7%). Nearly 25% of the residents had no insurance coverage. This was further complicated by the fact that the hospital's management company did not accept the insurance coverage of the county's largest employers, whose employees were forced to travel out of town for everything from primary care to specialty care to in-patient care. Slow reimbursement became a major issue for the last management company, critically impacting cash flow. Finally, the hospital did not have critical access hospital designation, although the board was in the process of applying for it. With the closure of a nearby rural hospital, the opportunity had opened up because the "distance to the closest hospital" threshold no longer prevented the hospital from applying for the critical access designation.

Similar to findings from the study of other hospital boards, the local hospital district did not have the training and/or expertise related to contract management, hospital operational and financial management, or public relations to deal with the factors leading to closure. Although the board had retained legal representation, management contracts did not protect the board and local taxpayers as needed. There was no termination clause requiring a minimum number of days be given prior to notice of and acting on separation, meaning that a management company was free to withdraw its services with little or no advance notice. Nor were any specific expectations of performance measures related to operations, financial management, and reporting to the board included in the contract with the managing entity. While operational and patient data was stated to be owned by the board, no requirements on transfer of data from the management company to hospital district were included in the contract. As such, no penalties existed to hold the management company accountable when closure occurred and virtually all data went with the management company.

The lack of public relations/communications training for board members and/or the absence of a contracted entity to perform promotional, informational, and transparent management updates to community members proved to be an issue for the board. This type of training would either help the board in crafting their own communications or inform them of how to identify and contract with an appropriate entity to perform this service on their behalf. Promoting the hospital, sharing information, and publicly offering operational data – e.g. services provided, quality reports, provider updates, opportunities for community organizations to partner – is important to maintain community support and engagement.

There were several critical moments when the board needed a unified and clear message to ensure transparency of their efforts were being relayed to the public. This type of messaging might have clarified the challenges faced as well as the options available to either keep the hospital open or to consider "right-sizing" care to meet specific needs with the resources available. It may have also prompted the community to become engaged in developing and implementing, or, at the very least, supporting solutions to ensure a certain amount of care remained intact locally.

While the above discussion largely relates to board issues, there were clearly issues with hospital leadership as well. The hospital administration was employed by the management company and the communication between board and administration appeared to be controlled by the management company. Administration did not offer and the board did not request information outside that given at board meetings; board members indicated they were given data at each meeting but that data did not suggest the imminent demise of the hospital. Board members characterized their interaction with management as "we did not know what else to ask." There appeared to be no attempt from either side to develop strength through collaboration or shared governance between board and management.

Despite the closure of the hospital, the resulting financial burden, and the loss of community confidence, the hospital board remained resolute in their plans to ensure that the highest priority services would be once more made available to their community. The board immediately contracted with another major health care system located 90 miles away to continue providing primary care on the hospital campus.

Soon after, the board began seeking proposals from other hospital systems to reopen and manage the hospital. Given the board's debt situation, the inability to borrow additional money, and the unwillingness of the community to increase the tax rate to support the hospital, there were few interested parties. Nonetheless, within months, the hospital district and a new investment group led by physicians from a large metropolitan area signed an agreement to reopen the hospital. Nearly a year later, and with continuing challenges that must be proactively addressed, the hospital recently opened on a much smaller scale. If regulatory and financial issues can be successfully managed over the next few months, the board and the investment group, along with community input, will work to design, finance, and maintain the most high-priority services locally.

Just as important is whether the board and the hospital management group will be able to restore community faith in, support of, and utilization of the hospital. The next few months will be key. The community must see the commitment made by the investors and the board, feel confident that the care provided is of the highest quality, and trust that the care will be intact long-term. Many residents, particularly those that are privately insured and have the means to travel, have long since found new primary care providers and specialists in larger communities. They may not be willing to change providers again within such a short period of time or feel that they can count on local providers being around next year. It will be immensely important for both the hospital district and hospital management to communicate regularly, consistently, and transparently with the public to regain support and local utilization of care.

### *Community Feedback and Advice on Critical Health Care Needs*

Question 1: In what ways did you utilize the local hospital and its related services?

The majority of focus group participants had utilized the hospital's emergency department (ED), laboratory, and radiology services, including mammography. Several participants were

patients of physicians who practiced in the hospital's primary care clinic. Many focus group members had received inpatient or outpatient surgery at the hospital. Quite a few residents also received physical therapy and specialty care including orthopedics, urology, cardiology, and podiatry via the hospital. Although only a few focus group members had delivered babies at the hospital, every focus group mentioned that the birthing center was well utilized.

Across focus groups, the participants discussed their access to hospital services. In each focus group, one or more participants stated that they used the hospital's emergency department. Participants in the low income/uninsured group stated that they utilized the ED because they could not afford the cost of a primary care office visit. All but one focus group had one or more participants note that they utilized the hospital's primary care clinic for regular care. A majority of the focus groups had one or more participants state that they utilized the hospital for x-rays and labs. At least four focus groups had participants that accessed the hospital for surgery, orthopedics, and physical therapy.

Question 2:  How has the closure affected you and your community?

The majority of responses to this question focused on issues such as absence of emergency care, loss of primary care, residents not accessing care, distance to care, economic impact, and community tension over the loss of the hospital.

By far, the loss of the emergency care services was the biggest concern for most focus group participants. Travel time to the closest ED is 30 to 45 minutes and, because the closest ED is now overloaded, the wait time is long. There is also frustration that there is no coordination between ED care provided in another city and the primary care clinic in town. Patients leave an ED in another town, but no medical records are forwarded to their primary care physicians. Another issue is that all ambulances in the county are in use all of the time, which leaves the community vulnerable to longer response times if an ambulance must travel from another county or wait for the conclusion of a run in progress.

Limitations in the availability of primary care and absence of specialty care were frequently mentioned as well. Although the hospital board was able to negotiate with another hospital system to provide primary care on the hospital campus, the primary care physicians previously affiliated with the clinic left town.

Many participants expressed concern that residents were going without primary care or only accessing care via nearby EDs. Residents with the most limited resources stated that they no longer accessed primary care unless they could be transported to a neighboring ED. However, if a patient does not have a local primary care physician, they forgo follow-up after the ED visit. With the exit of many local physicians, the community's free clinic hours diminished from weekly to twice a month and appointments are limited so patients may not be able to access the free clinic's primary care for a couple of months. Some individuals stated that they were no longer managing their chronic conditions as a result, especially if new prescriptions were required. Quite a few individuals expressed alarm that uninsured children's only primary care was being provided via outlying EDs, if at all. The remaining local physicians were advising patients to go the nearest ED for specialty care or care after clinic hours.

Distance to care was repeatedly mentioned as an issue. Many people travel 30 to 60 miles for primary care and up to 100 miles to access specialty care – at least those that are mobile. Births are now being scheduled for delivery in larger community hospitals 45 minutes to 1 hour away from town.  Nursing home residents are taken to hospitals approximately 45 minutes to an hour away. Families are now moving loved ones from local nursing homes to other cities for improved proximity to care.

There is no public transportation system, taxi, or Uber service in place to transport patients to care although there is public transportation available for Medicaid patients to travel to care. Low-income patients and senior patients have the greatest need for transportation assistance with the former less likely to own a vehicle and the latter often limited in their physical ability to drive.   Many patients without transportation forgo care or are only seeking care in emergent situations via ambulance.

Focus group participants acknowledged the negative economic impact of the hospital closure. As expected, participants most often cited the loss of jobs as the primary impact. Realtors stated that many seniors are moving out of town to be closer to health care, particularly emergency and specialty care. One local school district expressed that recruitment of teachers and staff is difficult due to the limited, local availability of health care. This sentiment was echoed by local leadership that stated new businesses were reluctant to locate in the community for the same reason.

Finally, the closure of the hospital has taken its toll on community morale as well. Community members are divided in their response to the hospital closure. The majority are supportive of the hospital district board and are hopeful that a group will come in to reopen the hospital. However, others are vocally bitter about the hospital closure and have lost confidence in hospital district board members.

Question 3:  What do you feel are the health care service needs in the community now?

Most focus group participants acknowledged that the community could no longer support a full-service hospital, although there was a small minority that felt that the hospital should reopen at the same capacity.  Across all focus groups, the need for local, emergency care was the priority, along with sustaining emergency medical services.  Participants also desired to have an afterhours urgent care, some even suggested the need for 24-hour urgent care.

Many focus group members wanted laboratory, radiology, and physical therapy services to return to the community.  Others noted the need for additional primary and specialty care. Several participants were open to the idea of accessing certain types of care via telemedicine. Younger focus group members expressed hope that labor and delivery services would be available if the hospital reopened.  This was also mentioned by older residents who anticipated grandchildren in the future.  Additionally, residents stated a need to retain one or more local nursing homes.

If the facility did reopen to offer health care, participants advised that any new health care provider must accept all insurance coverage. Multiple focus group members expressed frustration that the previous hospital administrative entity did not accept insurance coverage offered through the largest employers in the area.

<u>Question 4:  How could these needs be met?</u>

As previously mentioned, most focus group participants accepted that their community could no longer support a 55-bed hospital or even a 25-bed facility.  Several focus group members were supportive of the idea of reopening the facility as a "micro-hospital" with 5-7 beds to admit patients for overnight observation if they were not transported to a larger hospital in a nearby community.

Participants recognized that the hospital facility space could be better utilized regardless of whether the hospital reopened. Suggestions included recruiting a physical therapist back to the area and using part of the facility as a wellness center or gym in which physical therapy services could be co-located.  Other participants stated that the facility would be a good place to hold wellness classes such as diabetes self-management education.  Several recommended holding support groups, (e.g. for Alzheimer's caregivers or cancer survivors), meetings at the hospital campus.

The need for additional mental health services prompted some participants to recommend that the facility be used to support the expansion of those services in the community. Mental health counseling is currently limited to one local psychologist who accepts private insurance only and the public mental health provider whose ability to see patients is limited to those with a diagnosis of major depression and anxiety and bipolar disorder.

**GOING FORWARD – THE BLUEPRINT FOR COMMUNITY 1:**

The first community appeared to have never considered NOT reopening the hospital. Immediately after the closure, the community leadership and the hospital/taxing board began to look for alternatives which would ultimately lead to reopening. Thus, the blueprint for Community 1 focused around helping the community and the selected partner to have a successful reopening and a successful functioning after reopening.

Community Awareness recommendations were targeted at developing activities and programs that would bring foot traffic into and through the hospital building. Because of the short notice regarding closure and the moderately prolonged period required to identify a partner for the reopening, there was a need to keep the community thinking about returning their care to the facility and providers therein. Things like a health resource center or health directed programs like nutrition or exercise class not only address some health needs but could be readily incorporated into the suddenly vacant space. Furthermore, developing a positive public relations message offered the possibility of sharing progress with the community and hopefully, rebuilding trust. Building on the concept that transparency with the community enhances community ownership and support, there were many recommendations regarding sharing information about hospital performance, seeking community input about needed services and their perception of the quality of care received when they use local services, and seeking ties with community entities that might help "feed" the hospital once it reopened.

Recognizing that selection of a new management group offered a clean slate, it seemed a good time to outline some best practices for the hospital/taxing board. Even as the community moved forward with selection of new board members and a new management group, strife continued to be evident in the board. That strife was often acted out in open board meetings and reported in local media. In a time when this small community needs a unified purpose, the board is the elected and logical lead for the necessary activities.

Finally, while the team had some interaction with the new management partners, they had a plan for moving forward. The recommendations under "Reopening Hospital" were shared with the new management group and they indicated some interest in having a capacity to continue to interface with ARCHI as they move through the steps of licensing and credentialing and contracting.

# Community 1

## Board Leadership

- Select Board education/training programs
- Develop an onboarding process
- Board reviews assessment findings
- Create a strategic plan relevant to service area demographics and assessment
- Anticipate and minimize potential contract issues

  For example, determine adequate time to evaluate alternatives if change in management group occurs

## Community Awareness

- Consider a publicly visible calendar/timeline as you work through reopening
- Move toward/plan a grand opening with extended period of celebration, communication
  - Tours
  - Lobby Celebrations
  - Staff Introductions
- Work toward the opening, talk to community service organizations about having a presence in the facility
- Consider developing a health resource center

## Reopening Hospital

- Hold Soft Opening
- Achieve necessary admissions
- Achieve licensing
- Initiate community awareness to increase traffic
- Work with local media to market hospital
  - Highlight medical staff
  - Encourage local newspaper/radio coverage
- Encourage walk-in traffic

- Outline current services lines
- Outline desired additional services lines
  - Mental Health/ Behavioral Health
- Look for outside funding sources for expanding services lines that are self-sustaining

1. Develop aggressive patient satisfaction measurement with transparent communication to address concerns

2. Monitor & aggressively address patient concerns/complaints

3. Begin to establish a niche for the facility

## Community/Management Interface

- Conduct community assessments regarding needs & priorities
- Consider using telemedicine and/or ECHO
- Regularly (quarterly) assess measures of facility health
- Ensure transparency
  - Quality data
  - Financial data
- Monitor what services are migrating out of town

- Interface with local nursing homes to determine needs/issues

  Be sure this group knows of the soft/hard opening timeline

- Consider creating a community advisory group to identify current care concerns with this population

## Community Engagement

- Conduct patient Phone surveys
  - How did we do?
  - What do you want to see?
- Develop a vehicle for active sharing with the community
  - Transparency of quality data
  - Initiation of programs
  - Sharing info regarding wellness, patient safety etc.
- Encourage community groups and individuals to participate in community needs assessments and share results
- Use school systems – both local and surrounding - to increase foot traffic
  - Pre-Participation physicals
  - Special clinics to evaluate post game injuries
  - Saturday morning clinics during football
  - Develop programs for special needs students

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**COMMUNITY 2**

*Background and Events Leading to Hospital Closure*

*Location and Population*

Community 2 is located approximately 90 miles slightly northeast of Houston. Based on the 2000 U.S. Census Bureau, 2,721 people resided in Community 2 which is larger than the county seat which had a 2000 population of 1,107.[7] (The U.S. Census does not publish QuickFacts data on cities less than 5,000 in population.) Community 2 and the county seat are the largest communities in the county and the only two incorporated cities.

According to the U.S. Census Bureau, the population of Community 2 increased slightly between the 2010 Census and the 2017 Population Estimates report.[8] During this same time period, the state of Texas population increased by 11.1%. Below are comparisons of population change in counties in the region of Community 2.

Table 5. County Population Changes from 2010 Census to 2017 Estimates[8]

|  | 2010 Census | 2017 estimate | % Change |
|---|---|---|---|
| Angelina County | 86,771 | 87,805 | 1.2% |
| Houston County | 23,732 | 23,021 | -3.1% |
| Polk County | 45,413 | 49,162 | 7.6% |
| Trinity County | 14,585 | 14,667 | 0.6% |
| San Jacinto County | 26,384 | 28,270 | 6.7% |
| Walker County | 67,861 | 72,245 | 6.0% |

*Gender, Race, and Ethnicity[8]*

The majority (51.5%) of residents in the county are female. Persons under 5 years of age account for 5.3% of the population and persons aged 6-18 account for a fifth (20.2%) of the population. Over one quarter (26.1%) of the population is comprised of residents over the age of 65. Eighty-seven percent (87.4%) of residents are white, nine and one half percent (9.5%) are African America, and less than one percent are Asian. Nearly ten percent (9.7%) of residents are of Hispanic or Latino origin.

*Housing and Households[8]*

According to the U.S. Census, there are a little more than two and one half (2.61) persons per household and 5,459 households in the county. A large majority (80.3%) of county residents own their homes, with a median value of $78,000. The median gross rental payment is $707 in the county.

*Education[8]*

The majority (83.7%) of the adult residents in the county aged 25 and higher have high school degrees. Slighter over one in ten residents (12.2%) have a bachelor's degree or higher.

*Employment/Unemployment[4]*

The unemployment rate for the county in 2017 was 5.5%. City level data for 2017 was not available.  Across 2017, the average number of workforce that was unemployed 296.  The average labor force consisted of 5,366 individuals over 2017.

*Household Income[8]*

The median household income for county residents between 2012 and 2016 was $35,865.  The per capita income during the same period was $19,661.  The 2016 American Community Survey indicated twenty percent (20.1%) of county residents live in poverty.  The federal poverty level for a family of four in 2016 was $24,300.

*Transportation[8]*

Travel time to work for workers aged 16 and over is 33.6 minutes indicating that most residents work outside the city and county limits.

*Health*

One in five residents (21.1%) of residents under the age of 65 have a health disability. According to the 2016 American Community Survey, slightly over one in five residents (21.7%) are uninsured.[8]

According to County Health Rankings, nearly one-fifth of county adult residents reported being in poor or fair health.  Out of the past 30 days, residents reported an average of 4.1 poor physical health days and 4.0 poor mental health days. Other health factors reported included rates of 32% obesity; 17% smoking; 29% physically inactive; 82% having access to exercise opportunities, 16% excessive drinking and 31% alcohol impaired deaths.  Table 6 shows comparisons to the state of Texas.[9]

**Table 6.Comparison of Quality of Life/Health Factors between the County and the State of Texas[9]**

| Quality of Life/Health Factors | County | Texas |
|---|---|---|
| Poor or Fair Health | 19% | 18% |
| Poor Physical Health Days | 4.1 days | 3.5 days |
| Poor Mental Health Days | 4.0 days | 3.4 days |
| Obesity Rate | 32% | 26% |
| Smoking Rate | 17% | 14% |
| Physical Inactivity Rate | 29% | 20% |
| Access to Exercise Opportunities Rate | 82% | 91% |
| Excessive Drinking Rate | 16% | 13% |
| Alcohol Impaired Deaths | 31% | 13% |

The county is also considered a Health Professional Shortage Area, with fewer providers than needed for the size of the population.[6] The county lacks an adequate number of primary care, dental care, and mental health care providers.

*The Hospital*

The 26-bed hospital provided care for local residents since the early 1950s. Prior to closure, the hospital had been managed by a large hospital system that operated several small rural hospitals across the region. The partnership resulted in several facility upgrades throughout the years with the last major improvements including the addition of a primary care clinic and two large operating rooms. The community sought to financially support local health care and pursued the creation of a hospital district through the state legislature. This provided the opportunity to assess a less than $0.20 fee per $100 valuation on taxable property within the town and a portion of the surrounding geographic area, but not the entire county. Funds collected would subsidize the hospital and clinic operations via a contract with the management company.

Despite the local support, the hospital system that had managed the hospital for the past 18 years determined that due to low utilization and declining reimbursement rates from Medicaid and Medicare, the hospital system could no longer afford to operate the hospital and the clinic. However, the hospital system committed to operating the facility for an additional two years so that the hospital district board could pursue alternative management.

After meeting with several hospital systems to discuss a transfer in management when the current management contract expired, a community owned hospital located about a half hour away agreed to assume operations. Unfortunately, after months of negotiation, the new hospital management group withdrew its offer with an administrative contract and lease pending signature just weeks before the expected transition. This turn of events left the hospital district board scrambling to find an alternative solution to ensure that the hospital remained open.

The board again hired financial and business consultants to determine the feasibility of the board self-managing the hospital or finding another health care system to operate the hospital. As the deadline on the existing contract loomed near, the board concluded that despite its two-year effort to find a solution to keeping the hospital open, they would not be able to do so prior to the contract lapsing with the current management company.

The estimated cost of operating the hospital for one year would be $3 million and although the district had enough in reserves to operate for one year, they could only borrow against one year of estimated tax revenue which was just over half a million dollars. Within a year, the hospital could be in the same situation if a new management group did not agree to take over the operations. Even the cost of operating a stand-alone ED and primary care clinic would be cost prohibitive.

Although the hospital would not remain open, the board was able to negotiate with a hospital system about 45 minutes away to take over operations of the primary care clinic. The day after the previous system moved out, the new management group moved into the clinic, becoming operational within six weeks. The group utilized a paper-based system for the first couple of

months and was unable to collect reimbursement for care until the necessary credentialing and other operational items were complete.

Not willing to accept responsibility for any existing or anticipated bad debt, the new management company required the board to pay off any debt incurred during the 150-day "bad debt" period. The board agreed, providing a substantial amount of clinical operational support in order to at least maintain local primary care. The new administrative group meets with the board once a month to review financials, clinic operational data, and personnel matters.

The board requested that the management group provide financials that indicated "what was incoming, outgoing," and to clearly demonstrate what each receivable and expenditure supported. The board stated that they had become "street smart" after recognizing that they were not asking for the most appropriate information from the previous management company in order to anticipate and proactively address potential operational challenges. Because of failure to be provided adequate or appropriate information, the board had not realized the gradual decline in utilization as the management company focused less on the viability of the hospital over the last two years. In hindsight, board members feel like they should have expedited their efforts to transition so that the hospital's numbers would have looked more attractive to a hospital management group.

With primary care still intact, the board acknowledged that one of the biggest challenges moving forward is community perception about the state of local health care. People do not understand why they are still taxed for a hospital since the hospital closed. They do not understand that the district is currently supporting primary care or how building up reserves will help the district negotiate to bring in emergency care later. Despite their best efforts to be transparent in the community, there is still a lack of understanding. The board has met with civic groups, neighborhood groups, had articles in the local newspaper, provided updates via Facebook, yet misinformation via word of mouth continues to be an issue. Despite these challenges, they feel like the community would support a tax increase if it meant that emergency care would return to town. The ARCHI team did not hold focus groups in this community at the request of the hospital board who felt like they had a good handle on community needs.

The board also emphasized that their members work very well together, cooperatively moving toward the same goals. Board members are developing a business plan to ask funders for start-up money for new service lines, (e.g. radiology) that will add an income line to sustain other desired services. Additionally, the board is working with the clinic operators to transition the clinic to a federally qualified health center with its enhanced reimbursement model and potentially opening an emergency department (ED) with a few observation beds in partnership with a nearby hospital system.

The board shared lessons learned with the ARCHI team, suggesting several areas in which the board would welcome additional expertise and resources: board training; best practices in contracting with operational management; strategies for communicating with the public; and developing resources to address continued access issues.

The board acknowledged that they do not have formal training for new members. Board members acknowledge that it takes about two years for members to become reasonably educated on their role and necessary aspects of health care delivery. A training series on the roles and responsibilities would be a helpful supplement to "on the job" training. Additional board training on contract provisions was also requested; they particularly noted needs related to transparency, maintenance, how to obtain data from management and be able to verify that data.

With regard to communicating with local stakeholders, board members are looking for direction on establishing a better relationship with the community and a stronger presence so that community is supportive of the board and their future investments in local health care. Specifically, the board is seeking guidance on effective messaging and new modes of communication beyond the weekly newspaper, Facebook, and presentations to local civic groups and churches.

Finally, access to local care as well as access to care only available in out-of-town locales is a concern for the board.  The board perceives that the mortality and morbidity rates have increased since the nearest emergency care is 40 miles away and the wait for care can be up to six hours after arrival. Furthermore, those without transportation are likely not getting care, especially seniors and low-income individuals. Other access concerns are related to limited, local prenatal care and the distance traveled for deliveries.  Additionally, mental health services are no longer locally available as a result of the hospital closure.

There is emerging evidence about the impact of using community workers or promotoras – individuals with relatively limited training – to help manage chronic disease, encourage patient commitment to a planned treatment regimen, and to communicate home health monitoring reports like blood pressures or blood sugars to the primary care provider.  While this is care of a different sort than providing an emergency room, it may actually better address the concerns about local access and morbidity/mortality rates. Texas A&M Health Science Center is successfully using community health workers to provide patients with diabetes and asthma prevention and management education; assistance in securing prescriptions at low or no costs; and navigation toward a medical home.[10]

The board would like particular guidance on eliminating access barriers such as transportation. Partnering with an entity to provide some type of local transportation services is a priority. Another priority is the implementation of telehealth to provide local residents with access to care that is only currently available remotely.  As discussed in the first report, this may be an opportunity to develop coordination of out-of-town care and transportation assistance for

those who lack transportation.  Use of community health workers instead of emergency room services (EMS) could provide a much less expensive means of access for urgent care (leaving EMS for emergent care response) or specialty care consultation.

Overall, the board has a positive outlook on returning certain services to the community and in garnering community support for those services.  As the board continues to determine what is feasible, the overriding philosophy as they move forward is designing care that is affordable and sustainable for the community.

**GOING FORWARD – THE BLUEPRINT for COMMUNITY 2:**

The Community 2 blueprint is centered on their thoughtful decision to ensure access to care in a tiered fashion, moving up the next step on the ladder only as they have a sound financial basis and community support for the current level and a plan for the next step. Much of the blueprint was fashioned following discussion of the community's needs and is directed at decisions that are intended to facilitate success in forward movement.

In Redefining Access, the blueprint outlines a number of steps that the board and community could take to evaluate possible additions of services as well as providing a means of expanding the foundation for support through partnerships or collaborations. This board appears to have a strong relationship with local media, and capitalizing on that relationship to provide transparency of the access process as well as publicizing the growing menu of services is one means of increasing local utilization of the expanding service lines.

While this board seems to be functioning effectively, they shared their belief that they might have had a different outcome to the closure if they had been more sophisticated about information they asked for in monthly reports and in understanding the information that was provided. The blueprint in this area was a confirmation of a number of things the board indicated an interest in and a need for.

Community awareness, community/management interface, and community engagement recommendations were, as with other blueprints, intended to glean information from the community, engage the community in a sense of ownership, and use the community to understand the highest priority needs and desires. Again, there are a number of recommendations that are intended to market the facility as an institution committed to advancing health even in the absence of inpatient beds; this includes wellness classes, information sources, and expanding sites of primary and behavioral health care.

# Community 2

## Board Leadership

- Select Board education/training programs
- Develop an onboarding process
- Board reviews assessment findings
- Create a strategic plan relevant to service area demographics
- Anticipate and minimize potential contract issues

  e.g. Determine adequate time to evaluate alternatives if change in management group occurs
- Develop a menu of information desired at regular board meetings from management

## Community Awareness

- Maintain current, strong relationship with newspaper
- Consider a publicly visible calendar of events where appropriate for discussion regarding next steps
- Consider developing a health resource center
- Involve community service organizations to increase use of facility and foot traffic
  - Yoga
  - Nutrition
  - Healthy Cooking
  - Any school program related to health Introductions

## Redefining Access

- Outline current services lines
- Outline desired additional services lines and prioritization of needs
  - Mental Health/ Behavioral Health
  - Sports medicine/rehab directed at school athletes and weekend sportsmen
- Look for outside funding sources for expanding services lines that are self-sustaining
- Determine if there are significant nursing homes for which you could develop service lines
- Determine if there are partnerships with prisons for their employees or inmates
- Develop prevention programs like colonoscopies or women's health
- Work sooner than later to develop lab & imaging capacity

- Work toward expansion to emergency services
- Determine extent of ED needs
- Continue to evaluate hospital partnerships for either stand alone ED or micro-hospital
- Outline and carry out implementation strategy

- Broaden community awareness to increase traffic
- Work with local media to market health services
  - Highlight medical staff
  - Encourage local newspaper/radio coverage
- Encourage walk-in traffic

1. Develop aggressive patient satisfaction measurement with transparent communication to address concerns

2. Monitor & aggressively address patient concerns/complaints

3. Begin to establish a niche for the facility

## Community/Management Interface

- Conduct community assessments regarding needs & priorities
- Consider using telemedicine and/or ECHO
- Regularly (quarterly) assess measures of facility health
- Ensure transparency
  - Quality data
  - Financial data

- Interface with local nursing homes and retirement communities to determine needs/issues

## Community Engagement

- Conduct patient Phone surveys
  - How did we do?
  - What do you want to see?
- Develop a vehicle for active sharing with the community
  - Transparency of quality data
  - Initiation of programs
  - Sharing info regarding wellness, patient safety etc.
- Encourage community groups and individuals to participate in community needs assessments and share results
- Use school systems – both local and surrounding - to increase foot traffic
  - Pre-Participation physicals
  - Special clinics to evaluate post game injuries
  - Saturday morning clinics during football
  - Develop programs for special needs students
- Reach out to local camps, golf courses, etc.
  - Host special events
  - Note readiness to meet their needs

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## COMMUNITY 3

### Background and Events Leading to Vulnerability

*Location and Population*

Community 3 is the county seat and is located in east Texas.

Based on the U.S. Census Bureau, the city had a 2010 population of 32,996 which has since increased to 33,614, (1.8%), based on July 1, 2017 population estimates.[13] During this same time period, the county experienced a small increase in population, while many nearby counties experienced a decrease and the state of Texas population increased by 11.1%.[14]

**Table 7. Surrounding Counties Population Changes - 2010 Census to 2017 Estimates[14]**

|                      | 2010 Census | 2017 estimate | % Change |
|----------------------|-------------|---------------|----------|
| Angelina County      | 86,771      | 87,805        | 1.2%     |
| Cherokee County      | 50,845      | 52,240        | 2.7%     |
| Nacogdoches County   | 64,524      | 65,580        | 1.6%     |
| Rusk County          | 53,330      | 52833         | -0.9%    |
| Shelby County        | 25,448      | 25,513        | 0.3%     |
| San Augustine County | 8,865       | 8,253         | -7.4%    |

*Gender, Race, and Ethnicity[13,14]*

The majority (54%) of community residents are female and the majority of county residents (52.1%) are female.

Persons under 5 years of age account for 7.6% of the population compared to 6.6% countywide. Persons aged 6-18 account for one-fifth (20.9%) of the population, while nearly a quarter (23.4%) of county residents are the same age.  Just over one in every ten (11.2%) city residents is over the age of 65, with the county population being 14.5%.  Nearly sixty-four percent (63.8%) of city residents are white, nearly thirty percent (29.2%) are African American, and just over three percent (3.3%) are Asian.  Just over seventeen and one half percent (17.6%) of residents are of Hispanic or Latino origin.   Across the county, over three quarters (77.3%) of residents are white, nearly one-fifth (18.5%) are African American and one and one half percent are Asian.  Nearly one-fifth (19.5%) of the residents are of Hispanic or Latino origin.

*Housing and Households[13,14]*

According to the U.S. Census, there are a little more than two (2.35) persons per household and 12,138 households Community 3.  In the county, there are two and a half persons (2.51) per household and 23, 942 households.

Less than half (38.5%) of the city's residents own their homes, with a median value of $130,400, while over half (56.5%) own their homes in the county, with the median home value of $114,300. In the city, the median gross rental payment is $756 and the median cost is $745 across the county.

*Education[13,14]*

A large majority (84.1%) of adult residents aged 25 and higher in the city have high school degrees and a third, (30.2%) have a bachelor's degrees or higher. Across the county, just over eighty percent (81.2%) have high school degrees while a quarter (25.2%) of residents have a bachelor's degree or higher.

*Employment/Unemployment[4]*

The average unemployment rate for Community 3 was 4.5% in 2017 which is about 663 workers out of the labor force of 14,672. The county unemployment in 2017 was 4.3%.   Across 2017, the average number of unemployed workers in the county was 1,217.  The county's labor force consisted of an average of 28,538 in 2017.

*Household Income[13,14]*

The median household income for Community 3 residents between 2012 and 2016 was $31,979.  The per capita income during the same period was $19,815.  The 2016 American Community Survey indicated that a third (30%) of city residents lived in poverty.  The federal poverty level for a family of four in 2016 was $24,300.  The median household income for county residents was $38,915 and the per capita income was $21,343.  A quarter (25.4%) of county residents lived in poverty.

*Transportation[13,14]*

Travel time to work for workers aged 16 and over is 15.6 minutes indicating that most residents work within the county limits and 19.8 minutes for county residents indicating that many may work outside the county.

*Health*

Just over ten percent (11.2%) of city residents under the age of 65 have a health disability, with about the same number (11.1%) of county residents are living with a health disability. According to the 2016 American Community Survey, almost 22% of city residents are uninsured, while a quarter (25.4%) of county residents are uninsured. [13,14]

According to County Health Rankings[15], nearly one-fifth of county adult residents reported being in poor or fair health.  Out of the past 30 days, residents reported an average of 3.9 poor physical health days and 3.9 poor mental health days. Other health factors reported included rates of 35% obesity; 17% smoking; 28% physically inactive; 67% having access to exercise

opportunities, 17% excessive drinking and 32% alcohol impaired deaths.  Table 8 shows comparisons to the state of Texas.

Table 8. Comparison of Quality of Life/Health Factors between the County and State of Texas[15]

| Quality of Life/Health Factors | County | Texas |
| --- | --- | --- |
| Poor or Fair Health | 19% | 18% |
| Poor Physical Health Days | 3.9 days | 3.5 days |
| Poor Mental Health Days | 3.9 days | 3.4 days |
| Obesity Rate | 35% | 26% |
| Smoking Rate | 17% | 14% |
| Physical Inactivity Rate | 29% | 20% |
| Access to Exercise Opportunities Rate | 67% | 91% |
| Excessive Drinking Rate | 17% | 13% |
| Alcohol Impaired Deaths | 32% | 13% |

The county is also considered a Health Professional Shortage Area, with fewer mental health providers than needed for the size of the population.[6] The county's federally qualified health center also lacks an adequate number of primary care, dental, and mental health care providers.

The community's oldest hospital opened its doors in the late 1920s, and ownership transferred to the county hospital district several decades later. One of two hospitals in a county of over 65,000, the hospital continues to be publicly financed and governed. Rather than assessing a tax on property owners to support the hospital, the community voted in the 1990s to allow for the hospital district to collect a 1% sales tax instead. The basis for the change in local support was that the sales tax was considered a more equitable way to collect contributions from the entire population so that the support was not just the burden of local property owners.  The community's other hospital, founded in the mid-1970s by local physicians, is now owned by a national for-profit health system headquartered outside the state.

Just as other health care systems faced challenges from declining reimbursement rates, rising uncompensated care numbers, and other delivery system changes that occurred over the past few years, the public hospital faced these and other issues as well.  Recently, the hospital was left reeling from years of poor leadership resulting in bad business decisions that have ultimately left the public hospital facing potential bankruptcy and a public loss of confidence in the administration and board's ability to meet their fiduciary responsibilities.

By all accounts, the hospital's dire financial status is linked to financial mishandling by previous executive management, much of which was conducted without the knowledge of hospital board members according to those who served at the time and continue in that capacity today. Liquidity and long-term debt are pressing concerns as a result of a series of actions taken by former management, including: 1.) unfavorable real estate deals involving hospital property that was sold and leased back to the hospital under a triple net lease agreement; 2.) the execution of contracts without board knowledge although by policy the contract amount

required board approval; 3.) the failure to submit paperwork to be an in-network provider for the health insurance plan carried by the largest employers in the community and the HMO plans available to any patient under the Affordable Care Act (ACA); 4.) facility renovations that exceeded projected timelines and were more costly than anticipated; and 5.) not conducting regular evaluation of service lines and eliminating those considered loss leaders.

The failure to be included as an in-network provider in plans offered by a major insurance carrier that provides health benefits to the city, county, educational institutions and the patients who access health insurance via the ACA, is considered to be one of the most egregious errors. The town's for-profit hospital was able to negotiate an exclusive contract with the health insurance provider that ensured that all patients could only utilize the for-profit hospital for care, unless treated for an emergency issue at another health care facility. This limitation of choice was acknowledged to be particularly frustrating for those patients who preferred to access care from the public hospital and/or affiliated physicians.

Since the public revelation of the hospital's financial crisis, there has been harsh criticism of board members by the community, many of which have been publicly vocal about their lack of trust in the board. Many residents have expressed frustration over what they consider wasteful spending, e.g. perceived unnecessary renovations, and duplication of costly services offered by the for-profit hospital, e.g. the Neonatal Intensive Care Unit. Local media has been particularly negative. As a result, two new board members were elected to serve within the last year and it is anticipated that long-time board members will be challenged in the next election cycle. The board has recognized the fact that it needs to restore the public's confidence and is working with the interim CEO and staff to resolve the financial crisis as well as increase transparency of the actions being taken.

Additionally, the current board is taking action to remedy their situation first by hiring a law firm with experience in Chapter 9 bankruptcy matters in which debts may be restructured. The attorney is currently working to negotiate settlements with vendors to whom the hospital owes nearly $11 million. This effort will allow the board the time needed to find a partner for the hospital, perhaps another health care system, or another partner to buy or lease the hospital.

Community leaders have also approached the hospital with a proposed solution to increase local support through property taxes in place of the current 1% sales tax collected to support the hospital. As presented by supporters, the hospital can levy up to $0.75 per $100 valuation on property. Based on the maximum rate and current property valuations, the district could collect nearly $30 million annually. It is estimated that the sales tax collected annually is $6 to $7 million. The proposal - which is supported by the chamber, the city, and the county - does not eliminate the 1% sales tax, but reallocates it to the city who would use the additional funding to support basic city services and increased economic development activities.

However, there are critics of the sales tax proposal who believe that the hospital district would only collect up to $12 million in taxes after exemptions. Furthermore, both critics and proponents of the proposal acknowledge that property tax assessment would not be well received by the public at this time, even though the proposal calls for an annual graduated tax up to the maximum allowed. There is also concern that because the sales tax structure was legislatively mandated to support local indigent care, the repeal of the sales tax would likely require legislative approval first and voter approval after that.

Despite the differences of opinion in how to resolve the hospital's financial crisis, the local economic development corporation has formed a community leadership committee to work with, not only the public hospital, but also with the for-profit hospital to address local health care priorities through the development of community-based solutions.

Although some local key players in health care have stated that the climate between the two local hospitals has historically been non-collegial, changes in executive leadership at both hospitals appears to have opened the door to more coordination and cooperation. It has even been suggested that the hospitals consider developing a strategic partnership through which one hospital agrees to focus on a group of services and specialties in which they excel and the other hospital focuses on a different set of services and specialties in which they currently excel. Both hospitals were receptive to the initial idea of at least holding future discussions. Cautions about collusion and anti-trust implications were provided.

As the public hospital works through its current challenges, the board and executive leadership simultaneously work to address operational needs, including physician recruitment; elimination or outsourcing of services based on cost and utilization, and promoting the hospital as the place to access high quality care. To date, leadership has been successful in recruiting at least two new surgeons. Additionally, at least one service, EMS, is now being considered for outsourcing based on promising proposals that would ensure continued quality and quantity of services while costing the hospital much less.

***Community Feedback and Advice on Critical Health Care Needs***

Question 1: What services do you access at each hospital and why?

*Emergency Care*

The majority of participants noted that they most frequently utilized both hospitals predominantly for emergency care. Across all focus groups, the perception was that younger residents tended to opt for the private for-profit hospital and older, longtime residents more often preferred to access emergency care at the public hospital. This was also reflected when participants answered where they personally accessed emergency care. Younger participants most often stated that they accessed the for-profit emergency department (ED) and older participants most often stated that they preferred the ED at the public hospital. Multiple groups stated that the for-profit hospital was viewed by residents as the "rich people" hospital

and the public hospital was for low income, uninsured patients. However, it was also stated that patients will go to the hospital with which their physician is affiliated.

Participants also noted that, until recently, the for-profit hospital had shorter wait times for ED care and the staff seemed more competent and compassionate. However, the public hospital had recently renovated their ED and addressed the long wait times through a "fast track" program designed to expedite patient care in the ED. As a result, the majority of participants felt that the quality of care and wait times at both EDs were about equal.

There were two isolated issues raised concerning the public hospital, a greater than two-hour wait for emergency care and challenges related to patients obtaining copies of their medical records to share with their primary care physicians or specialists post ED treatment.

Of greater importance was the fact that some participants were not able to utilize the public hospital's ED because the services or the contracted physicians were not covered by their health plan.  This was a recurring issue across all focus groups and interviews.  The public hospital was not an in-network provider for many major employers, so the patient was limited to accessing care at the private for-profit hospital.

Participants of the low-income income uninsured/Medicaid focus groups faced multiple challenges in accessing primary and specialty care.  As a result, they often sought care at the ED. Some stated that they accessed the public hospital ED for their children's and grandchildren's health care needs, including primary care. This group also expressed that it is a challenge to find local physicians who accept Medicaid. The local urgent care clinics do not take Medicaid which results in individuals accessing the ED instead.  Furthermore, the participants believe that the level or thoroughness of care varies depending on the coverage the patient has. The better the coverage, the better the care received, in their opinion.

*Other Services*

Focus group participants listed a variety of <u>other services, e.g. MRIs, radiology, and labs</u> that are accessed at both hospitals equally.  Participants mentioned that the public hospital had "the best" labor and delivery department, though the patients deliver wherever their doctors prefer. The public hospital was mentioned several times as having excellent physical therapy services. At least one focus group appreciated the cooking classes provided by the public hospital.   Other focus group members commended the public hospital for encouraging community groups to utilize the facility to host meetings.

<u>Question 2: What if one or both hospitals closed?  Where would you (or people you know) go for care?</u>

Participants overwhelmingly felt like both hospitals needed to remain intact because if even one closed, the other would not have the capacity or infrastructure to fully care for local patients. More than one participant shared that the remaining hospital would not be able to survive without the other. Some participants suggested that the quality of care would decrease because of the loss of competition.

The loss of emergency care would be devastating. Focus group members stated that the ER volume would be overwhelming if only one hospital was operational. "Both ERs are swamped." Furthermore, the town's stand-alone ER is not a trauma center and is not perceived to have a good work flow.

Some believed the town would face an economic disaster if one or both of the hospitals closed. Businesses that provide supportive services to the hospital and to the staff and patient families, (e.g. business supplies, restaurants, retail), would suffer or close. The loss of physicians and their local spending would hurt the economy, too.

However, if both closed most residents stated that they would drive an hour and a half to seek care in a larger metropolitan area rather than drive thirty minutes away to one of two closer hospitals.

Again, it was noted that long-term residents, especially the older generations, tend to use the public hospital for care. Patients who are uninsured or have Medicaid/Medicare coverage - feel more comfortable seeking care at the public hospital because they will not be turned away. They felt that those without coverage assume the for-profit hospital is intimidating and not compassionate about their health needs.

Most participants felt that transportation was not a barrier to accessing local care. Various programs exist that help people with transportation. Others are able to secure a ride for care with family or friends. Transportation assistance also exists for military veterans wanting to access the VA in a neighboring community, 30 minutes away. However, if both hospitals closed, those without transportation probably would go without care.

Community leaders have privately expressed frustrations with the duplication of hospital services, most often citing the existence of a NICU at each hospital. There is support for a strategic partnership between the two hospitals in which they determine which hospital will take the lead in offering various services. The business community recently formed a health care committee to foster this discussion between the two hospitals.

Most people feel that the hospital issues are solvable because community stakeholders work well together and that "there are no turf issues in this town." Community leaders want to see the hospitals trim duplication and fat. It is generally acknowledged by the community that medicine can be an economic development driver, particularly because the local health care infrastructure has the capacity to support additional specialties for which residents are currently leaving town.

Question 3:  What additional services are needed in your community now?

Most focus group participants agreed that there is a lack of specialty care in the community. The specialties most often noted included gastroenterology, oncology, orthopedics, neurosurgery, and psychiatry/psychology. Some noted the need for additional cardiologists and urologists, but other participants felt that those specialties were well covered in the community.

Concerns ranged from there not being enough specialists to a perception that locally available specialty care was not as sophisticated or as high quality as that offered in larger hospital systems in metropolitan areas. Multiple participants noted that there was only one GI doctor in town which was further complicated by the fact that the doctor chose to no longer have privileges at either hospital. Likewise, there was only one neurosurgeon in town. Orthopedic care was also noted as being limited locally with wait times of over a month to see an orthopedist.

The lack of mental health providers is seen as a critical issue.  According to participants, only one local psychiatrist accepts Medicaid. Long-term, inpatient psychiatric care is also a need. Residents perceive that the judicial system would prefer to place individuals into long-term, inpatient care as appropriate rather than incarcerate them or release them from incarceration without needed follow-up care, such as counseling and/or appropriate clinical care.

A major issue for many residents is the lack of information about providers, services, and other resources available at both hospitals. Participants stated that many residents do not feel confident in selecting a primary care physician or specialist because they do not know where to find information on the provider or what questions they should ask when determining who will provide their care. Likewise, some participants acknowledged that both hospitals may offer services or programs from which they may benefit but that none are well promoted by the hospitals or local physicians.

Participants suggested that both hospitals employ personnel to assist people in accessing comprehensive care, from completing paperwork to assisting with referrals to enrolling in wellness programs. One group specifically mentioned that residents needed assistance in enrolling in Medicare and Medicaid and maintaining coverage because the application process is too complex. Participants stated that one of the most common issues is receiving a letter from the Medicaid office requiring action within a 10-business day period to maintain benefits but by the time the individual has the letter in hand, the 10-day period is nearly complete.  This leaves little time for response and results in beneficiaries being dropped from Medicaid.

Another frequent concern that participants noted is the <u>lack of coordination between provider offices when patients are referred to other physician offices</u>. Of particular frustration is when the referring physician's office and/or the receiving physician's office do not update and forward patient records. This has resulted in patients being rescreened for the same condition at multiple offices, and, at times, an inconsistency in medications prescribed to treat existing conditions. A local community action agency was recommended as an organization that could manage patient referrals to care and promote local programs through their current community outreach efforts.

Even within the same clinic, patients often are not seen by the same provider consecutively. One provider may provide an initial diagnosis, but the patient will be seen by another provider the next time.  The subsequent provider will seemingly not have reviewed patient records prior

to meeting with the patient.  This may also result in rescreening and a new diagnosis or different recommendations for treatment thereby frustrating the patient.

Question 4: What could the hospitals do to make community members stay in town for care?

Multiple focus group participants advised that physician clinics needed to expand hours, particularly to accommodate the working public.  Participants stated that clinics close at 5:00 p.m. Monday through Thursday and that most doctors do not see patients on Fridays. One participant suggested that the health systems consider replicating the Austin Regional Clinic Now (ARC Now) model which stays open until 9 p.m. M-F and offers same day care.  The clinic is also open 8-5 on Saturday and Sunday.  The co-pay is higher, but the participant stated that the convenience is worth it for people to have an alternative to ED care.  One of the most noted requests was for both hospitals to recruit additional specialists to the community. Currently, residents must travel 1.5 to 4 hours to receive certain specialty care.  Some participants even suggested that the hospitals establish telemedicine connections to allow for local physicians to consult with specialists affiliated with larger health systems in metropolitan areas if that particular specialty was not available locally. See the responses to Question 3 for the most requested specialties.

Participants also emphasize that customer service should be a priority for both hospitals. Several focus group participants shared personal experiences where they felt like hospital staff, particularly administrative staff did not show any compassion for their situation. There is also an expectation that all patients receive the same standard of high-quality care, regardless of whether the patient has commercial or public health coverage or are considered self-pay or indigent.

Focus group members advised that both hospitals needed to be community friendly and inviting. The hospitals need to continually assess the needs of the community by gathering feedback from a diverse representation of the community. Then, the hospitals should engage a broad cross section of the community in the planning of community health improvement activities.  Specifically, a local non-profit that serves as a clearing house for services to help stabilize at-risk, vulnerable families was named a key partner for the hospitals to consider.

The public hospital was applauded for marketing their cafeteria as a venue for community members from professionals to retirees to meet for lunch.  Additionally, the cafeteria has encouraged more community interaction and traffic to the facility through the sale of holiday desserts such as Thanksgiving pies and Valentine's Day cakes.

The focus groups also recommended that both hospitals expand their promotion of health and wellness services and programs available to patients. Participants felt like more advertising should be done via radio and social media platforms than the newspaper or local television news segments. They suggested that physicians should do a better job of referring their patients to hospital and community programs and resources that will benefit their health as part of the patients' "treatment plan".

The employer focus group advised that the hospitals should help educate the public on how to use the healthcare systems more efficiently. One example of this is the public hospital's training on how to appropriately understand and utilize the health system and their insurance benefits. The employer is particularly focused on educating their employees on the importance of accessing primary care in a clinical setting rather than the ED. Upon hearing about the training, another local major employer stated that the training would be useful for their employees as well as the employees of other local businesses in town. The public hospital is also working with the first employer to offer an onsite cooking class featuring healthy recipes.

Other suggestions for both hospitals included, 1.) a commitment to expedite turn-around times on lab results, especially when the results impact medication dosage, e.g. Coumadin; 2.) a request to work with services organizations to address transportation needed for patients to access specialty care only available in larger hospital systems, and 3.) an effort to continually look at best practices from other hospitals that can be replicated locally.

Finally, with regard to the current financial issues that the public hospital faces, participants encourage the hospital to recruit financial and administrative leadership with strong credentials to regain the community's faith in the hospital and to help in the recruitment of doctors. Furthermore, the hospital needs an imaging/branding campaign about how the district board will manage the public funds and the hospital's finances. There also needs to be a 1, 3, 5-year education plan for the public and patients on how to appropriately utilize hospital and primary care services so that the hospital minimizes the negative financial impact of inappropriate utilization of care, such as using the ED for primary care services.

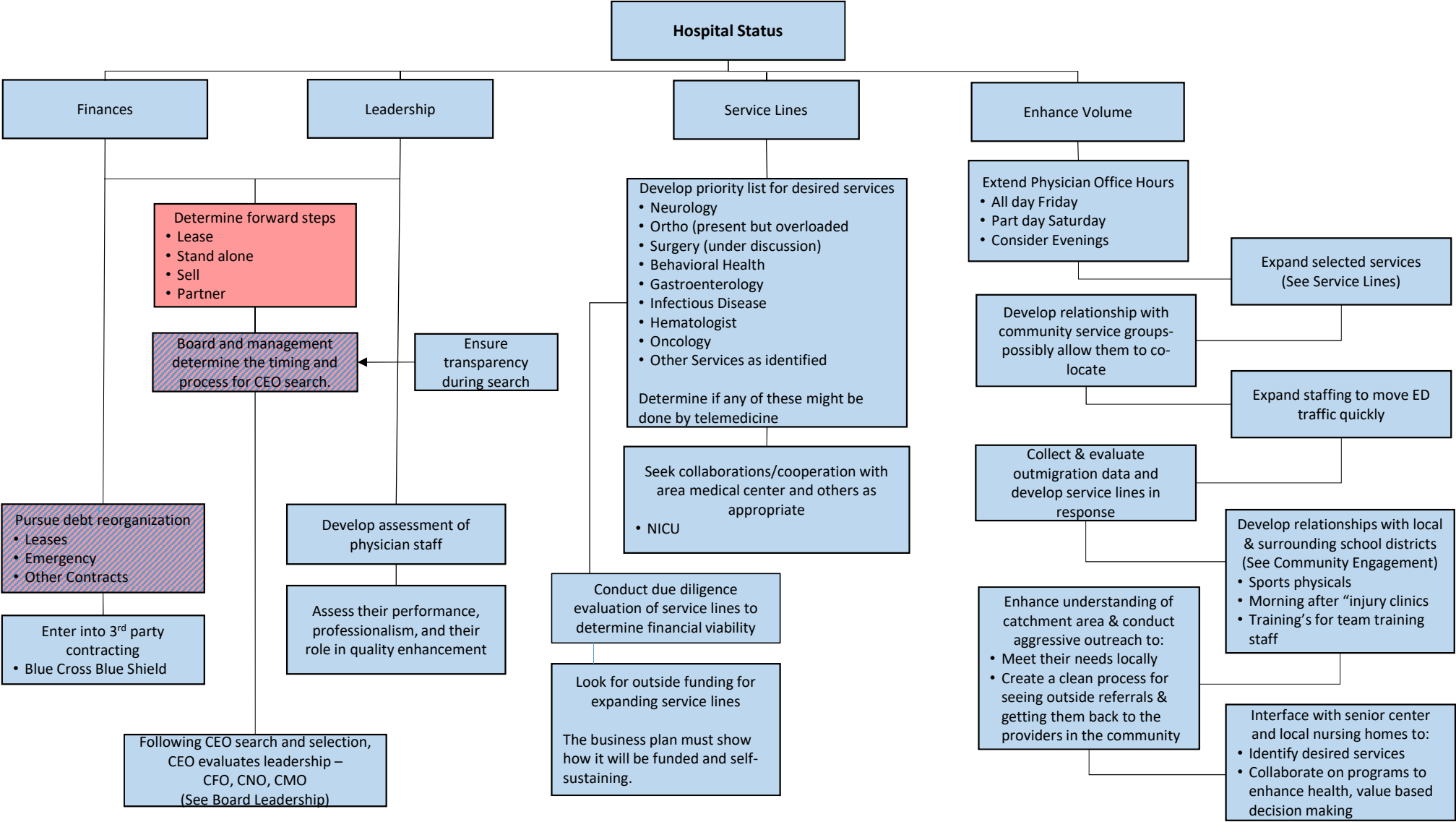**GOING FORWARD – THE BLUEPRINT FOR COMMUNITY 3:**

This hospital remains open with significant challenges particularly financial ones which need to be met in order for the facility to remain viable.  A good deal of time was spent looking at the actions planned by both the board and the administrative leadership.  The relationship between the two is somewhat difficult to read as the board itself is quite divided including in their support or lack thereof for the current administration.

Indicative of the financial issues, a significant portion of the blueprint for Community 3 is directed at hospital operations and administration.  There seems to be a need for improved, intense planning both short-term and mid- to long-term.  There is need to right-size the lines of service – eliminating those that are unproductive and adding services that are desired by the community and within the scope of the hospital's capacity.  There is need for a good deal of attention to cost issues like renegotiation of high-dollar contracts and low payment rate third party agreements.  The size of the hospital and the surrounding community should allow this facility and its leadership to look actively at solutions like value based care, maximizing Medicare and other third party incentives (and minimizing penalties in those same programs).  While the hospital and its leadership should do a variety of things to enhance community trust and thus utilization, they should also look at expanding their catchment area by looking at surrounding areas with whom they can partner to funnel business into this facility.

Community awareness and community engagement issues were similar to those of the other communities.  Listening to the community to identify areas of concern that need to be addressed, and hearing about priorities that service expansion might address, are important in order to cultivate strong community support of a local facility.  Particularly where there is a local alternative for care, the communication with the community and acknowledgement of community concerns can be a pivot point between strong support and lukewarm acceptance of the facility.

The discussion about board leadership seemed particularly important in this community as the division among the board was public and often acted out in the local media.  Having a publicly divided board at a time of crisis management is unlikely to induce community trust and support; in this community that has a local alternative, the lack of trust and support can be tremendously damaging.  In addition to information included in other blueprints, this section on board leadership sets forth some recommendations about reaffirming board roles versus administration/management roles.

# Community 3

**Hospital Status**

## Finances

## Leadership

## Service Lines

## Enhance Volume

**Determine forward steps**
- Lease
- Stand alone
- Sell
- Partner

**Board and management determine the timing and process for CEO search.**

**Ensure transparency during search**

**Develop priority list for desired services**
- Neurology
- Ortho (present but overloaded)
- Surgery (under discussion)
- Behavioral Health
- Gastroenterology
- Infectious Disease
- Hematologist
- Oncology
- Other Services as identified

Determine if any of these might be done by telemedicine

**Extend Physician Office Hours**
- All day Friday
- Part day Saturday
- Consider Evenings

Expand selected services (See Service Lines)

Develop relationship with community service groups- possibly allow them to co- locate

Expand staffing to move ED traffic quickly

**Pursue debt reorganization**
- Leases
- Emergency
- Other Contracts

Develop assessment of physician staff

Seek collaborations/cooperation with area medical center and others as appropriate
- NICU

Collect & evaluate outmigration data and develop service lines in response

Develop relationships with local & surrounding school districts (See Community Engagement)
- Sports physicals
- Morning after "injury clinics
- Training's for team training staff

Enter into 3rd party contracting
- Blue Cross Blue Shield

Assess their performance, professionalism, and their role in quality enhancement

Conduct due diligence evaluation of service lines to determine financial viability

Enhance understanding of catchment area & conduct aggressive outreach to:
- Meet their needs locally
- Create a clean process for seeing outside referrals & getting them back to the providers in the community

Look for outside funding for expanding service lines

The business plan must show how it will be funded and self-sustaining.

Interface with senior center and local nursing homes to:
- Identify desired services
- Collaborate on programs to enhance health, value based decision making

Following CEO search and selection, CEO evaluates leadership – CFO, CNO, CMO (See Board Leadership)

# Community 3

## Board Leadership

**Evaluate the current training and determine need for additional independent training**
- Onboarding
- Board fiduciary responsibilities
- Ongoing training

**Identify and provide training to assist Board in making data driven decisions**
- Conflict resolution training
- Contracting issues
- Messaging/Public Communication
- Quality Measures of Facility's Health

**Review Board's Role in Management**
- Board oversees and evaluates the CEO only
- The CEO oversees and evaluates all other executive staff

**Board Best Practices**
- Vigorous discussion inside
- Act with a single voice outside

## Community Awareness

**Develop a resource center (housed in medical facility)**

Aggressively conduct outreach to mid-life employed population to identify service lines they desire
- Develop 1 or more of these lines

**Aggressively track patient satisfaction & response to issues**

Aggressively track quality measures with effective plan of responding to identified issues

Ensure transparency of efforts

**Promote & Market**
- Services
- Strategic Direction

Utilize social media
- Promote links to news
- Make brief announcements
- Provide visual overview of success

## Community Engagement

**Conduct patient surveys**
- How did we do
- What do you want to see?

**Develop a vehicle for active sharing with the community**
- Transparency of quality data
- Initiation of programs
- Sharing info regarding wellness, patient safety etc.

**Encourage community groups and individuals to participate in community needs assessments and share results**

**Use school systems – both local and surrounding to increase foot traffic**
- Pre-Participation physicals
- Special clinics to evaluate post game injuries
- Saturday morning clinics during football season
- Develop programs for special needs students

**Establish Patient Advisory Committee**

## DISCUSSION:

There were a number of issues that surfaced in virtually every community that participated. Those issues have been divided into five categories with several subheadings under each.  In the web-based version of the common blueprint, many of these subheadings have more detailed information such as resources and web links that are a mere click or scroll away. Interested facilities and communities may opt to view only what is of interest or value to their situation.  We found commonalities in these three challenged communities, but it must be questioned whether similar size communities that have less vulnerable facilities share these same commonalities or perhaps have a measurably different set of things common to them. A positive deviance community assessment was not within the scope of this paper.

For the purposes of this report, the team **differentiated between community awareness and community engagement** because the two terms represented significantly different perspectives but it was recognized that another point of view might see them as nearly the same thing.  COMMUNITY AWARENESS is an issue of knowledge about the healthcare delivery system in the community, its problems and challenges.  It represents the need for those who live in a community to know how well (or not well) a facility is performing in order to determine each individual's decisions about using that facility.  And in an environment where a facility may be undergoing change, it represents knowledge about the facility and how changes in the status of that facility might impact individuals.  COMMUNITY ENGAGEMENT on the other hand represents the degree to which a community or some aspects of a community are actively involved in decisions impacting their facilities and in using energy to direct those decisions.  It may represent individuals, service organizations, or a community at large but represents the essence of a community directed at next steps for healthcare access and the facilities within their community that impact that access.

### *COMMUNITY AWARENESS*

While the literature often points out the central role a hospital plays in a rural community, it was perceived that there was a lower level of community awareness of the dire situation at each of these hospitals than one would expect in a small town.  As a major employer, a key to economic development, and a "lifeline" in times of emergency, the health of the hospital asset should be a community priority. All of the communities noted that it was a challenge to **honestly communicate the status of issues or concerns** and all noted that community perception had an impact on the viability of the facility.

One of the overarching issues common to all three communities was the delay in identifying the level of trouble that a hospital was experiencing and thus the delay in seeking possible solutions or alternatives for continued access to care.  In one case, the management company provided only two weeks' notice regarding the intent to close the hospital doors.  There was NO time to examine alternative partnerships to keep the doors open, no incentives to keep providers in town, and no alternatives for patients who were about to lose their local access.  It

cannot be emphasized enough that **communities and facilities should be very cognizant of the contractual language in any collaborations or partnerships**; they should make every effort to assure that there be a requirement for reasonable notification of impending closure or information about local metrics that would lead to a decision for closure of the local facility.

In the instances where the hospital closed very early in the proposed evaluation, community awareness issues were expanded to evaluate how to make awareness a positive factor in plans for providing access post-closure.  Once a facility closes, patients often quickly redirect their care by following their providers out of town.  Because there has already been a demonstration of failure to keep the doors open, the community loses confidence in the facility's leadership, even if there are plans/steps to reopen. The community does not necessarily know, and so is unable to separate, the actions of the external management company from the hospital staff leadership from the hospital board leadership.  Thus, **programs and outreach need to occur to educate the public about what is (or is about to be) available, when services will be available, the extent of the return of services**, and so on.  Transparency is crucial to rebuild trust within the community.

Another way to increase community awareness of hospital services is to **increase foot traffic through the facility**.  An empty parking lot in front of a hospital building with no lights on is not inviting to the public.  Conversely, if the hospital can be utilized for other community activities while right-sizing or refocusing then it is still perceived as a place to go for services. Cooking classes, sports physicals, in-door walking circuits, physical therapy, even a health resource center are some examples of community activities that can be hosted in a hospital building.  Once people are in the door for one reason, they can see signage with information on what is coming or anticipated changes to available health care delivery services.

One universal recommendation was consideration of **creating a Health Resource Center within the hospital walls**.  A Health Resource Center serves as a navigation tool for identifying programs to meet a variety of needs ranging from transportation, to availability of mental health services, to scope of local health department services, or even guidance with application for assistance programs like Medicaid or CHIP.  The more that such programs can link individuals to needed support, the less "charity" care that the tax district, the hospital, or the providers need to provide and the better the financial performance of the system. Health Resource Centers are a "one stop shop" for health care logistics which are helpful in rural communities that on average have older and poorer patients that face multiple barriers to accessing healthcare. The multi-purpose of educating the public, linking services with those in need, and using the closed facility to enhance access can help to keep the facility in the public's eye and prepare them for resuming services as they come on line.

In the situation **where a hospital has closed, and a reopening is planned, creating and maintaining communications with the community is paramount to maintain confidence**. Certainly, utilization of traditional media as well as newer social media platforms are important to tell the story.  **Media is a vehicle to publicize successes, market new services, introduce**

**new team members** – physicians, nurses, pharmacists, etc., and to begin to create a link with those people the facility needs to attract and retain. Word of mouth will rapidly transmit any bad news stories. Getting the good news stories out often requires more work. Transparency of the good news along with the bad opens a dialogue between hospital and community. This dialogue encourages sharing of priorities and reassures the community that their health care needs are recognized.

Transparency in public communication cannot be stressed enough. This is a lesson learned by experience and supported by the literature. **Recommendations are that quality and patient safety data should be made available, even if it is not as positive as desired**. Share the data and THEN outline the programs being implemented to address any performance issues. Continue to regularly report the improvements that are being seen as a result of the implemented programs. In a similar fashion, aggressive tracking of patient satisfaction and responding to any identified issues is useful in attracting and retaining patients.

Finally**, involvement of community organizations, such as church groups, service organizations, and school clubs, can create a sense of ownership and relationship with a facility**. Small projects like planting flower beds to create curb appeal or painting murals in the children's ward can be done by community members. These projects effectively create community ambassadors who are invested in the current and future services of the health care facility.

### *COMMUNITY ENGAGEMENT*

Those who lead change have a saying that "culture trumps strategy". The culture of the community and region, with regards to healthcare, can either facilitate or block change. It is important to identify the existing culture while simultaneously looking at ways to change this culture in regards to innovations that can reduce cost, enhance access, and improve patient satisfaction. Engage the community and culture in order to gain a partner in facilitating change.

Across every community it became clear that **the level of community engagement, and the tone of that engagement, is one of the predictors of a hospital's success**. The engagement level also serves as a predictor of the energy likely to be expended in identifying and standing up alternative access solutions.[16] Finding ways to engage the community in a positive fashion is an important leveraging tool.

In the instance of the community that still had an open hospital, there appeared to be a desire to create a community sense of urgency *before* the urgent issues reached a level of crisis. Creating a sense of ownership may help encourage members of the community to develop interest in the health of the facility and in ways they can maintain that health. **Transparency and communication before, during, and after the critical period is important in developing a single voice supporting the optimal solution for community healthcare access.**

**Creation of patient and family advisory councils** is not a new idea. Federally qualified health centers are encouraged to have one, primary care practices have used this tool, and institutions serving handicapped populations find these advisory councils important in involving the support systems for their population. Creation of patient and family advisory councils is one way of seeking input and garnering perspective regarding proposals for change. In small towns the individuals serving on such councils are likely to be a conduit of public opinion into the hospital leadership and may be able to serve as a vehicle to take messages from the hospital board or management back to the community at large.

Spending time **inventorying specific things that make up a community can pay off during planning processes**. Is the community, in question, a retirement destination? Are there a significant number of retirement communities, nursing homes, or assisted living facilities? This finding would suggest health care programming aimed at the senior population. Are there summer camps or church retreats or other services and sites that attract a young population? That array of activities might lead to sports medicine, urgent care, or development-oriented programming. At least one of the communities in this study had a large prison at the periphery of their community. The employees of this institution are an insured group; the inmates may have facilities, staff, or capacity that might be leveraged for the community good. Every community has schools and student programs. Healthcare services that serve the student athletes, their coaches and trainers, and that potentially utilize the healthcare staff in innovative ways can lead to increased lines of service that keep people in town and loyal to the local hospital. **A community health assessment provides an overview of a community's health status, needs, resources, and priorities**. These findings should help inform strategic and operational planning of healthcare facilities. A health assessment is an assessment valid for the point in time when it was conducted and so should be redone every few years in order to maintain a finger on the pulse of the community.

A tried and true way to engage the community is to conduct surveys: surveys of patients and/or their families, surveys of the community at large, or surveys of segments of the population. **Surveys can garner information about satisfaction with existing services, suggestions about what kinds of services might encourage them to keep their care local, or about concerns that could then be addressed**. Whether it is gathering information or sharing information, it is important the leadership of the healthcare system be honest and transparent. Building trust is important in healthcare; that is true whether it is the hospital or the physician, the nurse or the technician.

### *REDEFINING ACCESS*

The current healthcare delivery system is not friendly to the small facility with a patient mix heavily weighted toward governmental payers and the uninsured. Thus, a good deal of energy must be expended to maximize patient volume, offer the right combination of services to attract as many insured patients as possible, and address the perceived needs of the community to minimize the outmigration of patients.

The researchers at Dartmouth have measured the average U.S. recommendations as approximately 2-3 acute care hospital beds per 1000 population.[17] Literature suggests 1,500-2,500 patients per primary care physician. Communities that have been struggling with maintaining their hospital should take some care to measure the geographic size and the population base of the area they serve. A community of 3,500 people with a sparsely populated region around the town is likely to find it challenging to have enough people seeking service to make the margin positive at year's end; they might even have difficulty retaining physicians or other health care providers. Communities like these may need to look at surrounding areas and the breadth of service and the time and distance to access those services; establishing a vigorous primary care/emergency services-stabilization center with plans to rapidly transport following stabilization or initiation of the appropriate interventions for stroke or heart attack may be a more sustainable means of providing access to care for the community.

The term service lines refers to the variety of groups of services that are available or being considered such as orthopedics, obstetrics, or rehabilitation services. For the small hospital, evaluation of their service lines should be an ongoing process to minimize or eliminate the lines that are not profitable or not utilized and to respond to the community need by creating new lines when a business plan can be developed to demonstrate a positive margin. Certainly, the first step of any **evaluation of service lines must be a detailed inventory of existing service lines**. Knowing what is actually being delivered and examining the quality and financial data for those lines can be helpful in deciding the future of such services. It is also necessary to create and maintain a priority list of services that need to be developed. These new services may be ones requested by the local community, identified in a community health assessment, or in response to recruitment of new clinicians. They might be locally provided services or implementation of innovative technology services such as telemedicine. In considering new lines, facilities should study ways to collaborate with other area facilities. One success story had two small hospitals sharing an orthopedist. This provided a full book of business for the orthopedist and allowed both hospitals to offer a group of services they had not previously been able to proffer. Another innovative strategy might be to entice a specialist who has a number of local people traveling to his/her office to begin to offer services locally in the manner of circuit preacher who travels to a different town on different days.

Another way to look at possible service lines is to regularly evaluate patient transfer data and information from local and surrounding hospitals to identify what services people are seeking out of town. Are those service lines that the local facility could develop in an effective way? If transfers out are for things that should be treated in tertiary facilities, then consideration should be given to develop service lines specifically to encourage early transfer back for the patient needing rehabilitation, prolonged supportive care, etc. This not only allows the local facility to increase their census but returns the patient to their support system of family and friends. Family and friends increase foot traffic through a facility which increases community awareness of services.

Because of the very slim financial margins for these facilities, it is a challenge to find start-up funds to initiate a new service. However, this is, perhaps, one of the positive ways to engage area philanthropies. Having a sound business plan and evidence of the sustainability of a program would make financing such a proposal more likely. If the new service is in partnership with either a larger system, a specialty consultant or others, partnering in the funding may also be a possibility.

Most importantly, when redefining access, high quality, affordable healthcare can be delivered outside of a brick and mortar hospital. The fifty bed hospital on Main Street, where grandmother was born, may no longer be the ideal location for her great-grandchild to have knee surgery. Engage the community to ensure access to healthcare is optimized.

## *FINANCES*

All three of the communities that were part of the study have tax districts with a hospital board that also serves as the taxing district board. However, it appeared that there was less than ideal understanding of the taxing district, in terms of the processes, obligations, and restrictions that were encompassed by being elected to these two entities. The fiduciary responsibilities to the tax payers are significant. These responsibilities require reasonable use of the money collected and oversight to ensure efficient operation of the hospital as a means of ensuring the best use of tax money. Looking at operations, in terms of volume and finance, requires enough knowledge to ask probing questions regarding hospital census to be able to understand hospital performance. However, across the entirety of the study, boards suggested they knew very little. Board members reported accepting information they were given by the external hospital management company and rarely asking questions that might have uncovered issues or concerns in time to take action. This may be acceptable early in a term before the on-boarding process is complete but is less acceptable in those that have served for a period of time. **A strong education and training program for hospital board members is a necessity regardless of the size of the facility**.

While a good deal of attention has been paid to the role of the board and elected leadership, it is clear that hospital administrative leaders play an important role. However, even the relatively straightforward question of the competency of the hospital administration requires a hospital board to have enough management and fiscal knowledge to question the level of performance of senior leadership. To further complicate matters, when an external management group hires and pays the senior administrator(s), it may be difficult to discern poor performance versus competing goals of the local community versus a large system.

The obligations of those voted or appointed to serve the tax district are made more difficult by a perception that many in the community did not know what taxes they were paying or in the case of a hospital or health district tax, what that money would or could be used for. In at least one community, it was felt that if the community believed they would see an increase in services, they would vote in favor of an increase in the tax rate. Interestingly, while this

particular board expressed concern about the community's understanding, there did not appear to be concerted activity to address the lack of knowledge or understanding.

When the hospital management and their well-educated board conclude that their facility is in financial trouble, they may have time to make adjustments and move toward a healthier bottom line.  One of the things that can help to right size the income/expense ratio is **to look at the larger contract commitments** that must be paid regularly.  These may include large ticket items like the electronic medical record or the emergency services contract.  Attempts should be made to renegotiate these contracts in order to avoid more dire decisions like reorganization or bankruptcy which could leave the contractor with less favorable payment agreements.  **Third party payer contracts are also important to be managed**.  Small hospitals often have less bargaining power and end up with lower rates.  However, if they can demonstrate good case management, reduction of unnecessary emergency department visits, and other cost savings for third party payers, they may be able to negotiate a better rate.  Cost sharing or at-risk contracts can also be considered.  Small rural cooperatives are looking at forming accountable care organizations that bring together several facilities, with similar populations and problems, and thereby increase their collective negotiating power.

Management and the board should also be looking with a finer tooth comb for operating efficiencies or service issues.  Tracking the frequent, high cost utilizers of hospital services can at times allow the healthcare delivery system to identify opportunities for improved utilization.  Identifying primary care options and assisting a patient to use a clinic even on a frequent basis can reduce the emergency department use of a heart failure patient or someone who does not understand and manage their diabetes.  Reduced ED use almost always reduces admissions as well.  The board might also want to look at possible ways of stretching the tax dollars.  Using a small copay for those who qualify for tax support can give a sense of responsibility to those who might otherwise not consider the cost aspect of access and potentially generate a small cash flow. And as has been mentioned in other places**, having onsite assistance to evaluate all possible sources of financial assistance can direct some –even many – of these individuals to Medicaid, Texas Women's Medicaid, Children's Health Insurance Program (CHIP), or other assistance programs** which will leave a smaller reliance upon the local tax dollars.

As alluded to earlier, the healthcare delivery system is changing quickly and often.  For a small facility it can be difficult, nigh onto impossible, to keep up with and respond to these changes.  However, failure to know which changes are optional and which are mandatory could cost the facility significant money.  The hospital readmissions rules have been in place for some time.  However, the number of facilities that will pay a penalty for 2019 is significant; 82% of hospitals have incurred a penalty.  The Centers for Medicare & Medicaid Services (CMS) withholds up to three percent (3%) of regular reimbursements for hospitals if they have a higher-than-expected number of 30 day readmissions for any of six conditions including chronic lung disease, coronary artery bypass graft surgery, heart attacks, heart failure, hip and knee replacements, and pneumonia.  The struggling hospital needs to **look at the things that will earn incentive payments, such as quality performance metrics,**

**and to put programs in place to avoid penalties from 30 day readmissions for example.**
They need to join networks or programs that will help them target their meager dollars to select where to put efforts to maximize income and minimize penalty.

Another area of importance to track regularly **and insist on metrics level performance is coding, billing, and collecting**. If bills are not coded correctly then substantial money can be left on the table. If bills are not submitted in a timely manner, then the allowable period may run out and no payment is collected. If a third party sends a denial, a process must be in place to either correct or appeal to assure that payment is ultimately made. Finally, billings and collections must be tracked to confirm that they are timely and have regular follow up.

*HOSPITAL BOARD LEADERSHIP*

The role of the hospital board - which is the same as the tax board in all three instances– is complex and challenging. It is often an elected position though in some cases it is an appointed position. Whether putting one's name on a ballot, or accepting an invitation to serve, each individual should spend some time soul searching their willingness to learn the complexities of healthcare, the fortitude to deal with conflict and frustration, and the stamina to do it all over again in what feels like a repeating cycle. The primary role of the board in the hospital leadership environment is to hire and fire the CEO, to interface with the CEO in discussion of hospital performance, and development of the strategic plan. It is not a hospital management role per se.

However, as discussed earlier, it is important that board members learn relatively quickly about finance, payment within the healthcare delivery system, incentive and penalty issues, contracts, etc. Several members of the boards that were interviewed, felt that they were not getting the right information to be able to recognize the level of vulnerability or to suggest alternative pathways. They all noted that they were getting information, but it was usually information selected by, prepared by, and presented by the external management company.

There appears to be a **need for development of a straight forward tool to be able to assess on an ongoing basis the financial health of a hospital**. A financial dashboard of that sort could give boards a method to know the relative health of their facility compared to previous times. The hospital board could identify trends, areas that are doing better than last year and areas that are doing worse. If benchmarks were available, then the hospital's health could be compared to others of similar size and service to provide perspective on new normals.

**Every board should look at its policies and procedures**. How are new members on-boarded? What kind of training are they asked to take? Is it a one-time quick skim or is there an ongoing education process that builds upon the knowledge base? Is there a process that each member follows or is the process different for each new board member? If there is not a consistent process then there can be no expectation of a common knowledge base upon which to base expectations. Again, virtually every board member interviewed believed they would have benefitted from more training on financials, the system of healthcare delivery, and the

regulations and legislation impacting their hospital. There are many sources of board training that are ongoing and hierarchical, building upon previous knowledge, to continually increase depth of understanding.

The **best boards do self-evaluations** which allow a board to assess its performance and identify means of improving their functioning. This sort of self-knowledge can allow a board to support one another, encourage less committed members to strive for improved performance, and create a sense of team that can prove useful when the board needs to tackle difficult issues. Establishing expectations regarding conflict resolution, within the board as well as between the board and management, prior to having to deal with such conflict can enhance the board's effectiveness. **Transparency and effective communication between management and the hospital board should help reduce times of conflict**.

Just as there needs to be transparency between management and the board, there needs to be transparency between the medical staff, the board, and management. While oftentimes the medical staff works under contract to the hospital, they have a vested interest in the performance of the facility. They need to have knowledge of areas needing improvement, concerns expressed through patient satisfaction surveys, and information regarding service lines that are not performing financially well enough to be maintained. Often the medical staff may have ideas of how to make changes, process modifications to reduce safety concerns, or mechanisms to enhance service delivery. Such interaction should not be limited to medical staff but should include a broad group of all staff; particularly in small towns they are the vehicles to help understand the community's perception of the healthcare being delivered.

Finally**, boards should participate in strategic planning** to remain relevant and in a leadership role rather than in a reactive role. Such strategic planning should include both planning for board self-improvement and for the facility for which they serve in a leadership and stewardship capacity. Flexibility and adaptability within the mission, vision, and goals of a healthcare facility will help steer an organization in the most advantageous direction to meet the needs of the community.

**SUMMARY**

Populations that live in rural areas are categorized as suffering from disparities in healthcare. There are limited resources, a relative lack of access to care, and a higher proportion of uninsured or underinsured and so populations living in rural regions demonstrate healthcare disparities. The changing healthcare delivery system, particularly with regard to regulations, reporting processes, and risk based payment mechanisms, places small, rural facilities and the communities they serve in a precarious state. The increasingly technological and subspecialized aspects of medical care are often restricted to mid-sized or large cities with broad populations to be served; access to such services virtually always requires travel to secondary or tertiary centers. The distances alone make rurality stand out as a cause of disparity.

While virtually every community states a desire to have access to as much healthcare locally as the community can provide, it is increasingly clear that many communities need to have a conversation other than "save our hospital".  However, even as data strongly suggests that a different organization of the care system will need to be developed, some communities persist in efforts to save or recreate traditional hospital care processes.  The conversation on redefining access has begun.  In order to have an informed discussion, communities must be aware of the situation and aware of options.  Community members need to become engaged with currently available healthcare resources and local leaders to ensure right-sized, accessible healthcare is a reality.  Hospital boards and hospital leadership need to transcend what is best for the hospital bottom line and act as stewards for the bigger need of healthcare access.  This shift in perspective does not remove the fiduciary responsibility of hospital leaders but rather increases the scope of responsibility and the breadth of the possible solutions.
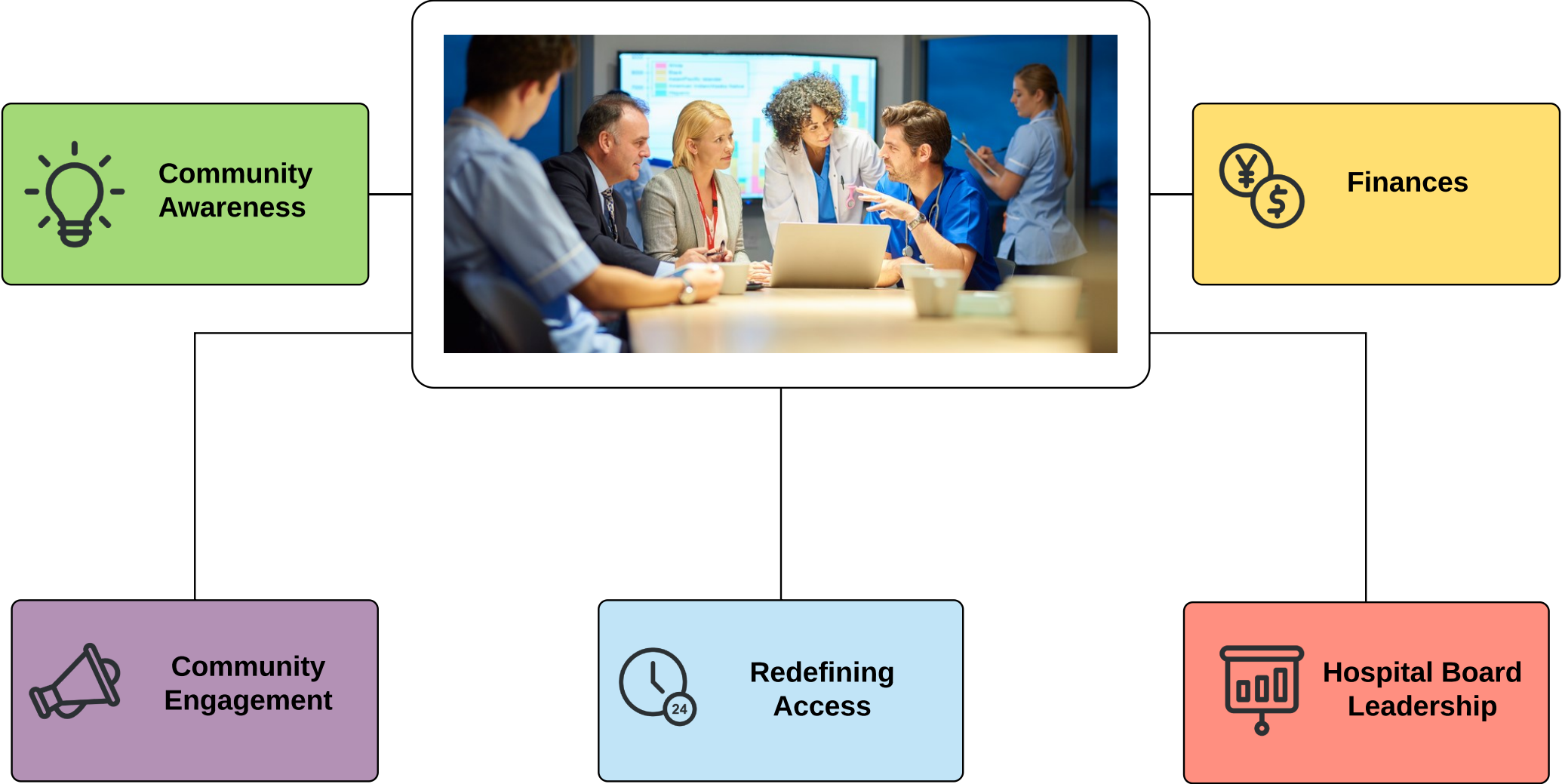
Change is rarely easy.  While the three communities, specifically addressed, generated individual blueprints, there was great commonality among the steps forward.  An "n" of three is certainly not enough to draw broad sweeping conclusions, the overlap in the concerns and possible steps for facilities and communities suggests that the recommendations are not specific to size of community, rurality of a community or to Texas communities but can likely be applied to vulnerable rural hospitals across the country.  Certainly, the specific situation of any given community raises the opportunity to take advantage of their strengths and the admonition to be aware of any known weaknesses; community awareness and engagement, strong board leadership, and collegial cooperation between management and board/community leadership appear to be almost universal foundation stones toward strong local facilities and access.  The common blueprints and supplements in the Appendix section are intended as conversation starters with guides to next steps.  Each community, its leadership and its healthcare providers need to look at suggested steps and determine which steps make sense for the community, the facility, and the geographic area served by the facility.  There is not easy or single answer but rather a variety of things that a community can do to help assure access to care sized and organized for their community needs.

Partially as a result of the work that ARCHI has done on behalf of the Episcopal Health Foundation and more recently Temple Foundation and the Robert Wood Johnson Foundation, ARCHI has been funded to become a technical advisory center for vulnerable rural hospitals.  As a result of that funding, ARCHI has recently created the Center for Optimizing Rural Health which will be coming online to provide technical assistance nationwide to vulnerable rural hospitals.  Access to the resources of the Center, including people and information, can be found at www.optimizingruralhealth.org; together communities, policy makers, and the academic health center will work through these challenging times for rural communities to ultimately have better care at an acceptable cost and improved patient experience in accessing that care.

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# Web Based Dissemination



**Community Awareness**

**Finances**

**Community Engagement**

**Redefining Access**

**Hospital Board Leadership**

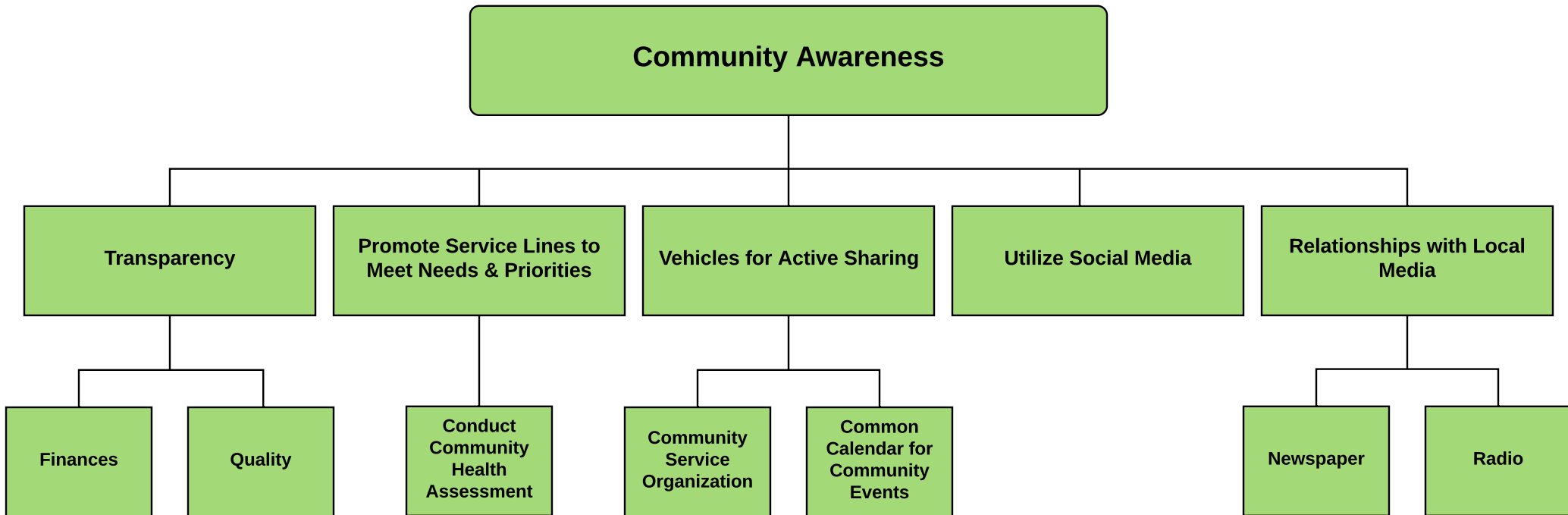**https://architexas.org/rural-health/activities.html**

## Dissemination Plan

The overarching goal of this project was to work with specific rural communities in Texas to evaluate their needs and outline specific next steps to obtain or retain effective, efficient, and affordable healthcare for their community.  Thru discussions with our National Advisory Board as well as with stakeholders attending a national rural healthcare conference, we have confirmed that the healthcare problems in rural Texas are not unique.  This knowledge compels us to disseminate our report beyond the original contracted participants.  Towards that end we have identified several opportunities for outreach.

- Publication opportunities via partnerships with Episcopal Health Foundation, T.L.L. Temple Foundation, and Robert Wood Johnson Foundation
- Link out from the ARCHI website  *https://architexas.org/*
- Inclusion in the knowledge repository of the Center for Optimizing Rural Health (CORH) website located at optimizingruralhealth.org
- Include in social media outreach of the CORH
- RHIhub at *https://www.ruralhealthinfo.org/*
- Pushouts to membership by State Offices of Rural Health and hospital organizations such as Texas Organization of Rural & Community Hospitals (TORCH)
- Inclusion in panel discussions at gatherings of stakeholders such as Philanthropy Southwest Annual Conference or the Annual meeting of the National Rural Health Association (NRHA)
- Partner with resources such as HRSA (Health Resources & Services Administration) to include in their weekly announcements or link to their web based resources
- NRHA Today newsletter that is sent weekly to all subscribers with valid email addresses in order to provide updates on government affairs, funding, educational opportunities, and national news that impacts rural health.

# Common Blueprint

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                         │     Community Awareness       │
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| Transparency | Promote Service Lines to Meet Needs & Priorities | Vehicles for Active Sharing | Utilize Social Media | Relationships with Local Media |
|---|---|---|---|---|

| Finances | Quality | Conduct Community Health Assessment | Community Service Organization | Common Calendar for Community Events | Newspaper | Radio |
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## Community Awareness Interface with Community Service Organizations

Individual health is influenced on a daily basis by numerous factors that are outside the scope of clinical interventions. This is emphasized in the World Health Organization's definition of health – "a state of complete physical, mental and social well-being and not merely the absence of disease or infirmity". Lack of access to affordable and safe housing, public transportation, places to be physically active, healthy food, and jobs can all compromise a person's well-being.

Health care is a continuum and relationships between hospitals, providers, community organizations, and patients facilitate the patient's understanding of the community's role, the health care system's role and the individual's role in maintaining health. Beyond clinical care, there are a number of federally and state funded agencies, local public health departments, community non-profits, civic organizations, and local government that collectively address the determinants of health, which include the social and economic environment, the physical environment, and a person's individual characteristics and behaviors.

As hospitals increase their focus on improving population health in response to meeting the Centers for Medicare and Medicaid Services adoption of the Triple Aim, collaboration with local community services organizations is essential. These relationships provide an entryway for hospitals to provide patients with referrals to information, services, and educational opportunities to address a patient's non-medical needs that may impact their overall wellness.

In many local communities, local services organizations have already established interagency collaborations to share information and network about services. Health care systems should consider joining such collaborative groups. In general, the local United Way agency serves as a facilitator of these types of interagency groups or can assist hospitals to join these entities. In Texas, Community Resource Coordinating Groups (CRCG) are a mechanism for state and local agencies and organizations to conduct shared client management. Although focused on jointly managing the needs of shared clients, the groups often include a networking and information session as part of their regular meetings which may be of benefit to hospitals.

Source:  National Rural Health Resource Center

Link: *https://www.ruralcenter.org/resource-library/improving-population-health-a-guide-for-cahs*

Type of Resource:  Guide for Improving Population Health

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Source:  Community Resource Coordinating Groups Link

*https://crcg.hhs.texas.gov/*

Type of Resource:  Guide for Improving Population Health

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Source:  Hospital and Health Networks

Link: *https://www.hhnmag.com/articles/8096-know-your-community-to-improve-population-health*

Type of Resource:  Article

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Source:  Health Affairs

Link: *https://www.healthaffairs.org/do/10.1377/hblog20160405.054312/full/*

Type of Resource:  Article and blog

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# Community Awareness Community Health Assessments

Community health assessments provide hospital boards and administrators with an overview of a community's health status, needs, resources, and priorities. The findings from these assessments not only help inform the strategic and operational planning of local hospitals, but also that of the entire local health care delivery system including public health departments, clinics, pharmacies, home health, and social services organizations that address social determinants of health, such as availability of safe housing, transportation, etc.

Following are key principles of community health assessment, which include:
- All phases of community health improvement: assessment, planning, investment, implementation, and evaluation.  These are joint processes shared and owned by a multi-sector community collaboration that includes but is not limited to health care, social services, education, local government, civic organizations, and community advocates.
- The process engages a broad cross-section of the community that ensures proactive, and diverse participation to improve results
- The community, as defined by the stakeholders, must be a significant enough area, (e.g. region, county, zip codes in largely populated areas), to allow for population-wide interventions and results that can be measured and evaluated. Additional focus should be given to address disparities among subpopulations, (e.g. uninsured or minority).
- All phases of the process should be conducted with maximum transparency to encourage community engagement and provide a mechanism for public accountability.
- Health improvement strategies will include the implementation of evidence-based interventions and the development of innovative practices that will be rigorously evaluated.
- Evaluation of interventions will provide the data to design and implement a continuous improvement process.
- The assessment will produce high quality data that will be available to a wide variety of public and private sources.

Although these types of assessments have been conducted by health care systems for years, the 2010 Patient Protection and Affordable Care act requires all non-profit hospitals to conduct a community health needs assessments every three years and implement strategies to address local health issues identified.  The assessment process generally includes collecting information from a broad representation of the community members via discussion groups and/or surveys.  Community feedback gathered through this process is analyzed and contextualized with existing data such as community demographics, chronic disease rates and prevalence, and mortality rates.

Source:  Center for Disease Control and Prevention

Link:  *https://www.cdc.gov/stltpublichealth/cha/plan.html*

Type of Resource:  Overview with links to assessment guides

Source:  Association for Community Health Improvement

Link:  *http://www.healthycommunities.org/Resources/toolkit.shtml#.W6v4CmhKiUl*

Type of Resource:  Overview with links to assessment guides

# Community Awareness Transportation Concerns

One of the most commonly mentioned barriers to access to care in rural communities is the lack of transportation, particularly for low-income and elderly residents. Transportation options such as public transit, ridesharing services (e.g. Uber, Lyft), or taxis are limited, if available at all, in rural areas.  If services are available, affordability and reliability are issues for those who depend on transportation assistance. Alternatively, residents will inappropriately utilize emergency transportation as a means to accessing care which drives up the cost of care for all.

Residents who do not have reliable transportation options are more likely to delay going to a doctor, picking up medications, or attending follow-up treatment such as physical therapy. Missed appointments and the inability to secure prescriptions result in individuals who struggle to manage chronic disease which, in turn, leads to poorer health status.

Solving transportation issues in rural communities may require implementing a combination of smaller scale services that can be coordinated and sustained locally.  Funding and maintaining a public bus system in a rural area, for example, is not a realistic option because the cost of the operations could not be recovered through an affordable bus fare. However, there are rural communities who have successfully implemented and continue to operate locally-based transportation options.  These vary from volunteer drivers who use personal vehicles or church vans to transport people to health-related destinations to partnerships between hospitals and social services agencies that leverage their resources to extend and manage transportation options to their patients and clients.

Source:  Rural Health Information Hub

Link: *https://www.ruralhealthinfo.org/toolkits/disabilities/2/transportation*

Type of Resource:  Website and toolkits

Source:  Community Health Resource Centers:  A toolkit Center for Community Health Development

Link: *https://cchd.us/*

Type of Resource:  Toolkit

## Community Awareness Interacting with the Local Media

The hospital's public relations officer has many opportunities to set the stage and to establish transparency between facility and community. How and in what venue a message is delivered is just as important as the message itself. While the traditional communication methods of tv, radio, and print may be familiar, remember to include social media to reach all community members. When a hospital is facing challenges and threats, it is vital that the message NOT lead with a negative. Too often, a story that leads with a negative leaves a negative residue unable to be overcome by a more positive message buried under the lead. Teachers and supervisors employ the "sandwich" method – lead with a positive, give a criticism or bad news, end with a positive. The message is still delivered but it is easier to find the silver lining.

Former president, Ronald Reagan was a master at knowing his audience and while his platform or message was ultimately the same regardless of which region of the country he spoke, he custom fit his introduction and summary for each audience...he made it personal and memorable. Those who carry the burden and opportunity of being the communicator should study ways of message delivery that gives all the necessary information and leaves the audience with hope, enthusiasm, and eagerness for the next steps. In "Speaking My Mind," a collection of Reagan's speeches, the president said that his ability to give a good speech was based on two things: "to be honest" in what you are saying, and "to be in touch with [your] audience." In his early career as a radio broadcaster in Iowa, he discovered a basic rule that he followed all his life: "Talk *to* your audience, not over their heads or through them. Don't try to talk in a special language of broadcasting or even of politics, just use normal everyday words."

It is of upmost importance that the message, given to the community, be agreed upon by leadership (the board, the CEO, the medical staff), put into language that the community can understand, and insist that part of the message includes expectations, next steps, or "now what". Put into somewhat different words: Plan the message – what information do you plan to convey. Be brief in delivering the message– don't ramble and start rationalizing. Justifying the bad news will make the situation worse. Finally, deliver a message that has clarity. Remember to have empathy and be human. Take some time to listen and respond after your message is delivered. While it may not change the course of your message, listening can go a long way towards showing you care about the community.

Links:
http://www.yourthoughtpartner.com/blog/bid/36461/leadership-communication-6-steps-to-handling-tough-conversations   by David Grossman as part of the Leader Communicator Blog

https://fowmedia.com/4-tips-delivering-difficult-messages/   by Daniel Newman as part of the Future of Work website articles
Type of Resource: Web based articles

## Social Media

How do you know what is going on in your community and conversely, how does your community know what is changing at the hospital?  The days where an open meeting and a synopsis in the local newspaper reached the vast majority of the population is over.  Social media is emerging as a new, and free, medium for dialogue that can cut across social divides.  It can be used to engage your community as well as to increase awareness of what the hospital has to offer. It can also increase awareness of what the community prioritizes in terms of health care.

A best practice to utilize social media platforms is to start with the mission and vision of the health care facility.  Strategically think about how to build ethics and privacy into your feeds.  A health care facility can easily spark conversations on health related topics and yet you want to protect participants from full disclosure of personal information that, once made public on the internet, can never fully be redacted.  Honesty and transparency are critical in social media exchanges as the public places a high value on authenticity.  Along the lines of authenticity, make sure your employees are engaged in your social media efforts.  If your employees do not follow your feeds, then that also sends a message to the community.

Next, decide on which venue(s) you want your health care facility to be active. Each major site has a different capacity and may attract a different audience.  It is essential to match your message to what is appropriate for the venue; however, the etiquette and norms for the major sites are easy to learn.  Be committed to keeping your message fresh.  It is better to maintain a dialogue on one platform than to be an unattended presence on multiple venues.  Also, regularly monitor your feed. This will allow you to address complaints and problems quickly.  Additionally, this shows your commitment to customer service.  Remember that a happy patient will tell their family about the wonderful care they received at your hospital;  an unhappy patient will post negative reviews to hundreds of people.  Social media platforms enable you to respond directly and quickly to these people.  Utilize the data available with social media platforms to track your engagement and outreach.  The data can give you an idea of how any particular issue is perceived by your community and enable you to join the conversation in a meaningful manner.

Source:  Carleton Philanthropy and Nonprofit Leadership

Link:  *https://marcopolis.org/wp-content/uploads/2017/09/Social-Media-as-Strategy-Lowe_Carleton_2014.pdf*   Social Media as Strategy:  A tool for Community Engagement and Development by Sophia J Lowe

Type of Resource:  Online report

# Community Awareness   Patient Feedback:  Transparency in Quality

Evaluating and processing patient feedback is important for understanding and solving quality of care issues in hospitals. It is critical for rural communities to understand their demographics in order to target specific care options. By involving patients in the process of identifying community needs and weak areas of service within the hospital, administrators can expect to see specialized patient care oriented feedback. Quickly, the process of patient feedback and changes made by administration becomes a positive feedback loop of quality care improvement.

Hospitals should consider patient feedback as a toolkit for improving the quality of care in their hospital. Multiple approaches should be implemented so that information from the widest range of patients possible is received. The process of implementation as described by Planetree is to begin analyzing survey information, implement Patient Advisory Committees (PAC) with agendas based on survey data, and finally identify patients from the committee that can serve as patient leaders in the hospital. Maintaining diversity while recognizing the demographics of your community is essential for this process. A misrepresentation of the community within the PACs can provide information without value to the majority of the population.

In small communities, hospitals need to use their distinct populations to their advantage. Increasing quality of care for patients as well as the increase in community support is too valuable to pass up. With information gained from surveys, PACs, and patient leaders, administrators can make positive & sustainable change.

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Sources: Planetree.org Agency for Healthcare Research and Quality (AHRQ), American Academy of Family Physicians (AAFP), American Medical Association (AMA), Health Affairs
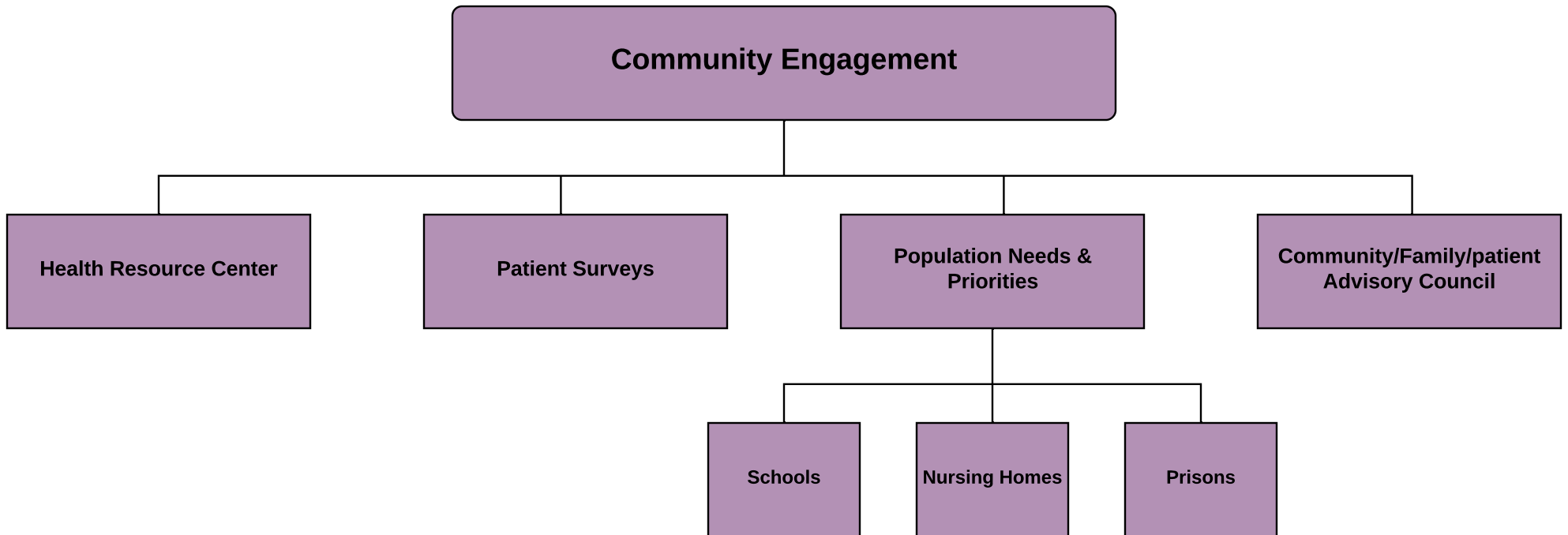
Links: *https://www.aafp.org/fpm/2015/0700/p22.html*  AAFP discussion piece on patient advisory councils. Great information for modeling, building, and maintaining a PAC
*https://www.stepsforward.org/modules/pfac*  Interactive step by step guide to PFACs with very good information and links to other sources

Type of Resource: websites
*http://planetree.org/wp-content/uploads/2017/09/Patient-Engagement-in-Research-A-Toolkit-for-PFACs.pdf*  Toolkit for implementation of PACs

*https://www.ahrq.gov/sites/default/files/wysiwyg/professionals/systems/hospital/ engagingfamilies /strategy1/Strat1_Implement_Hndbook_508_v2.pdf*  AHRQ complete handbook for working with patients in a constructive capacity

Type of Resource: Document

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Optimizing 6o

## The Need for Community Engagement

Engaging one's community may be challenging but rural hospitals exist much closer to the members of the entire community than do their urban counterparts. Additionally, rural hospitals often represent a large slice of the economic well-being of the community. Thus, finding ways to engage the community in tracking the health of the local delivery system and in helping to move the community's health forward is challenging, necessary, and important.

The access to health care problems of rural areas are best understood by those who live there. Thus, the most likely solutions are those that are proposed by or at least supported by those who live in rural areas. Community engagement is the process through which hospitals work collaboratively with individuals and local stakeholders to identify needs and then create and implement meaningful strategies to meet those needs. As the United States healthcare system transitions to paying for value, community engagement will only increase in importance. A healthier population will almost by definition spend less on health care, a community that invests in keeping its population healthy becomes an ideal partner for health care delivery systems that want to care for a healthier population.

Whether engaging to improve the health of the hospital or the health of the population, it appears that having the community engaged will improve the likelihood of successful development and preservation of access to healthcare for all of the community.

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Source: Washington State Hospital Association

Link: *http://www.wsha.org/wp-content/uploads/CommEngagementToolkit_1_1.pdf*

Type of Resource: Toolkit

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Source: HRET (Health Research and Educational Trust) in partnership with AHA

Link: *http://www.nonprofithealthcare.org/resources/where_do_we_go_from_here.pdf*

Type of Resource: Report on how hospitals can engage with communities to improve the health of everyone

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# Community Engagement Community Health Resource Centers

Rural residents' ability to access health care and social services is often limited due to a variety of factors such as the absence of locally available care, lack of public transportation, distance to care, and poor promotion of existing services in the community.  In 2002, a regional health partnership in Texas, comprised of health care providers, social services organizations, and rural community stakeholders, organized to address these rural "access-to-care" issues.  Through a process of assessment, planning, and commitment of local resources, the concept of community health resource centers – "one-stop shops" for health and human services – emerged.

To incentivize providers to offer services in rural communities, the partnership developed a community health resource center (HRC) model in which communities would donate local facility space and administrative support to health care providers and social services organizations. The types of facilities range from free-standing community buildings to space allocations inside hospitals.  Overhead costs - e.g. rent, utilities, internet – are covered by a combination of funding and in-kind donations from community stakeholders such as county and/or city government, hospital districts, health care systems, and school districts.

Services available through each HRC vary based on facility size, community needs, local financial and in-kind support, and provider availability. Common resource center services include information and referral, case management, free transportation to health-related destinations located in the regional hub, and telehealth access to remote services such as mental health counseling. Other services offered through HRCs include evidence-based health education programs, support groups for patients and caregivers, free legal aid, counseling for at-risk youth, audiology, and substance abuse prevention screenings.

Source:  Community Health Resource Centers:  A Toolkit Center for Community Health Development

Link: *https://cchd.us/*

Type of Resource:  Toolkit

## Community Engagement  Patient Surveys

In the evolving healthcare industry, *availability of care, quality of service, and patient satisfaction* are important considerations when looking to improve volume in your hospital. Understanding the healthcare needs of a community is the first step to solidifying a hospital as the "go to" source for medical care in an area. Maintaining the quality of care is also imperative, especially for services that have been identified to be critical in an area. Patient wait times, call success rate, and the communication between healthcare provider and patient cannot be overlooked when attempting to increase volume. Using patient satisfaction metrics, a hospital can understand from a patient prospective how to improve performance.

The Hospital Consumer Assessment of Healthcare Providers and Systems (HCAHPS) Survey, is a standardized data collection method for hospitals to collect and report patient satisfaction data. This data is then analyzed by CMS and reported publicly on a quarterly basis. While reporting on the satisfaction of your patients publicly could be viewed as a poor decision for struggling hospitals, it is clear that transparency is important to patients. Hospital administrators that are willing to recognize and address concerns publicly, especially in smaller communities, can help community leaders understand and lobby for beneficial legislation, help rally local support for new service lines, and even address personnel issues. With an understanding of the issues facing their community healthcare services and a clear plan for improvement, citizens are more likely to support locally provided services and less likely to have a negative reaction to tax increases.

Accepting the patient as a consumer is essential for understanding the importance of patient satisfaction and understanding how to improve it. Using satisfaction metrics like the HCAHPS survey and other data collection methods to improve patient satisfaction; hospitals can reduce costs and increase community support.
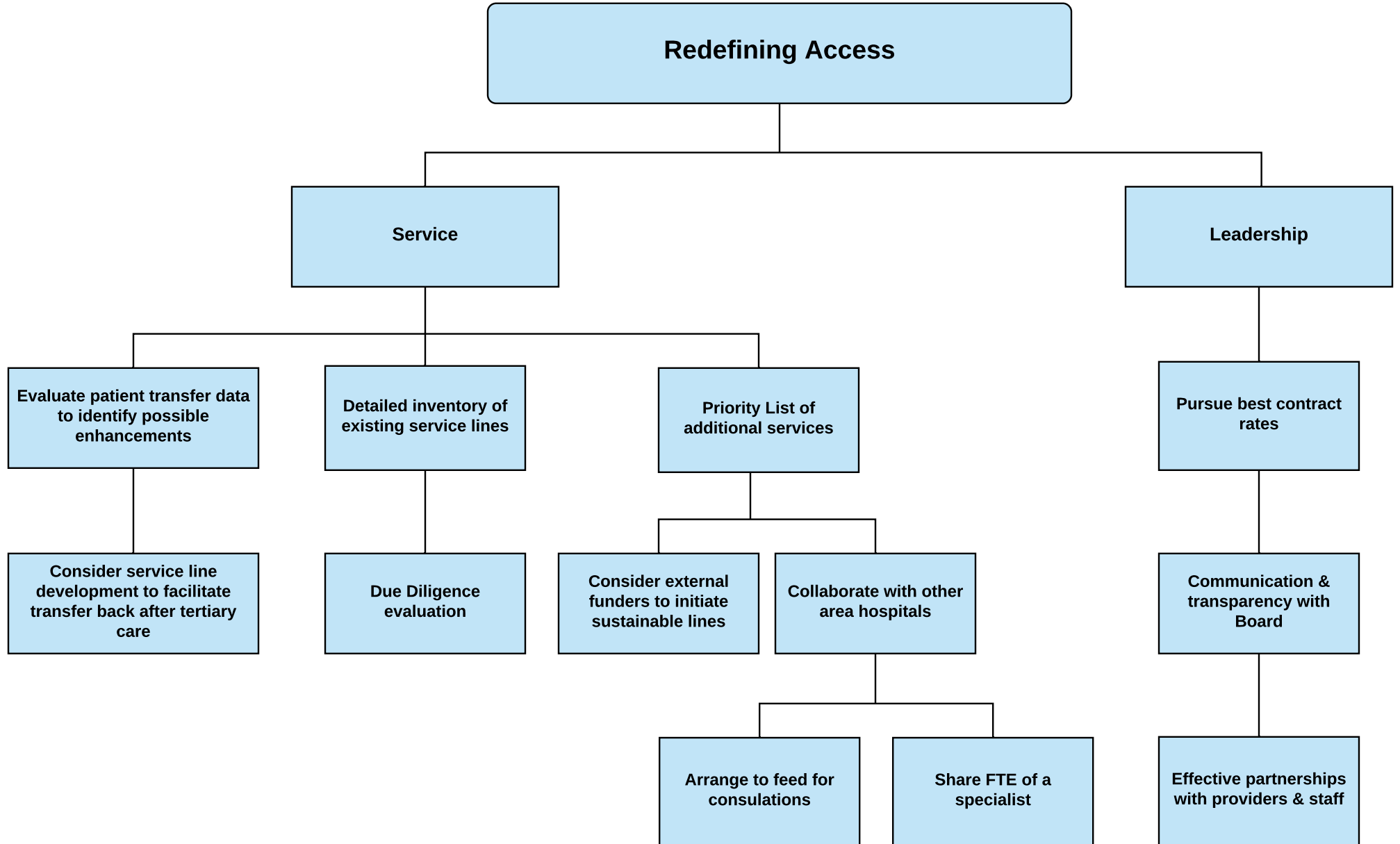
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Source: Centers for Medicare and Medicaid Services

Links:
*https://go.cms.gov/2cdIRiF*  CMS HCAHPS survey general information and reporting instructions
*https://www.webpt.com/blog/post/are-your-patients-really-satisfied-5-metrics-find-out*
Blog post about using information from surveys to make informed decisions

Type of Resource: Websites

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# Redefining Access

## Service

- **Evaluate patient transfer data to identify possible enhancements**
  - **Consider service line development to facilitate transfer back after tertiary care**
- **Detailed inventory of existing service lines**
  - **Due Diligence evaluation**
- **Priority List of additional services**
  - **Consider external funders to initiate sustainable lines**
  - **Collaborate with other area hospitals**
    - **Arrange to feed for consulations**
    - **Share FTE of a specialist**

## Leadership

- **Pursue best contract rates**
  - **Communication & transparency with Board**
    - **Effective partnerships with providers & staff**

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## Service Lines:  Adding, Removing, Right sizing

Small and rural hospitals are challenged to offer the services that will keep patients in their facility, are appropriate for the physician and provider staff they can maintain, and which will be profitable with their patient mix.  Constant evaluation of the service lines should be part of management's role – removing services that are not profitable or cannot be provided with high quality, and adding services that will slow or stop outmigration, as well as enhancing services that are profitable and popular.  According to Mark Loos, system vice president for clinical services at Palmetto Health, "Service lines (should be) designed not only for improved clinical care and outcomes, but also with an eye to the manner in which the organization can attract (patients) into the system".

Existing service lines should be evaluated for performance.  Are quality benchmarks being met?  Is the average length of stay meeting state or national standards?  Are there process changes that can make each service line shine so that it serves to attract patients and reduce outmigration?

Changes in the healthcare delivery system offer some relatively new possibilities for the rural hospital to consider.  The new focus on the continuum of care includes the initial admission, how services are provided within that admission to create the most efficient process for a quick, yet appropriate discharge, a discharge to the appropriate post-acute setting, follow-ups, and ultimately return of the patient to continuity care. Few, if any, small hospitals will do a joint replacement program.  However, seeking to use local facilities to enhance a tertiary facility's program can be a win for both.  Surgical outcomes are improved when patients' chronic diseases are well managed, and they engage in preoperative exercise and toning.  Re-engaging the patient post-discharge to resume chronic care management and oversee rehabilitation can get the patient back to their support community while enhancing the full recovery from a major intervention.  "Selling" this sort of partnership to a tertiary center could increase their surgical program and increase the small hospital's traffic as well.

Hospitals are increasingly asked to create formal population health management programs in order to gather health data analytics on local patients as a way to address potential health problems before they become costly, chronic issues.  Controlling costs of healthcare and starting to bend the cost curve downward, will require looking at things from the perspective of population health management.  If hospitals can analyze data and cost figures associated with chronic diseases — such as diabetes, cardiovascular disease, asthma, hypertension and others — they can reach out to their communities to start chronic care programs to mitigate costly, long-term health problems.  Management of the population that costs most per capita per year will make a community hospital attractive to new organizations like accountable care organizations.

Surveys of community desires, evaluation of outmigration data, and consideration of tools like ECHO or telemedicine should be considered when evaluating service lines.

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Source:  Barton Associates and HealthLeaders

Links:
*https://www.bartonassociates.com/blog/hospital-leaders-see-potential-in-service-line-expansion/?p=2013/03/29/hospital-leaders-see-potential-in-service-line-expansion/*

*https://www.healthleadersmedia.com/strategy/hospitals-rethink-service-line*

Type of Resource: Healthcare blogs

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## Service Lines    Swing Beds

The Omnibus Reconciliation Act of 1980 (part A: section 904) provides the initial definition, standards and procedures of swing-bed programs. The goal of this program is to give rural and critical access hospitals the ability to provide extended post-op and post diagnostic care to patients without the need to transport them to another facility at an unreasonable distance. To furnish swing-beds, hospitals may use any acute care patient beds with the exception of beds located in their inpatient prospective payment system excluding rehabilitation or psychiatric unit, intensive care, or newborn unit. This flexibility allows minimal physical and procedural restructuring of the hospital when implementing the swing-bed program.

Swing-beds can provide a necessary service to rural communities in need at a relatively low cost to hospitals that currently provide inpatient care. Reducing travel times for aging residents, reducing the need for transfer, and increased flexibility of hospitals are extremely valuable products of the swing-bed system. However, hospitals considering implementing swing-beds should do a thorough analysis of the community's needs, the hospital's assets, and the amount of time and resources it would take to establish this program in their community. Swing-beds can have a significant positive impact, but the resources used to implement them might be better put towards other community needs. Certain communities might want to look into other ways to invest resources.  These communities might already have competent, skilled nursing facilities in the area, a lack of ability to provide inpatient care, and a population that isn't under significant stress due to overcrowded nursing facilities or facing extreme driving distances to urban centers.

Source:  Centers for Medicare and Medicaid Services

Links:  *https://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNProducts/downloads/SwingBedFactsheet.pdf*  CMS swing bed fact sheet

*https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/SNFPPS/SwingBed.html*  Requirements and Payment information from CMS

Type of Resource:  Websites

## Service Lines Telemedicine

Rural hospitals around the country are looking for alternatives when it comes to specialized care options. Telemedicine can provide hospitals with providers they might not have locally. Hospitals using telemedicine, can fill provider gaps to better serve their communities, and reduce the amount of travel the community is doing for healthcare. One barrier to these services in rural areas is the lack of connectivity. However, a dedicated connection is only required for emergency services. With a recommended internet speed of 10mb/s, hospitals should be able to host this service even with satellite internet connection.

One roadblock for many hospitals when considering Telemedicine services is the reaction of their community. Will rural communities be overwhelmed with technology or not have a positive reaction to seeing a provider over the internet? An executive, from Avera eCare, states that hospital staff plays a key role in helping the community adapt to a new service. If the staff treats the telemedicine service as another tool to help the patient then generally the patients receive it well.
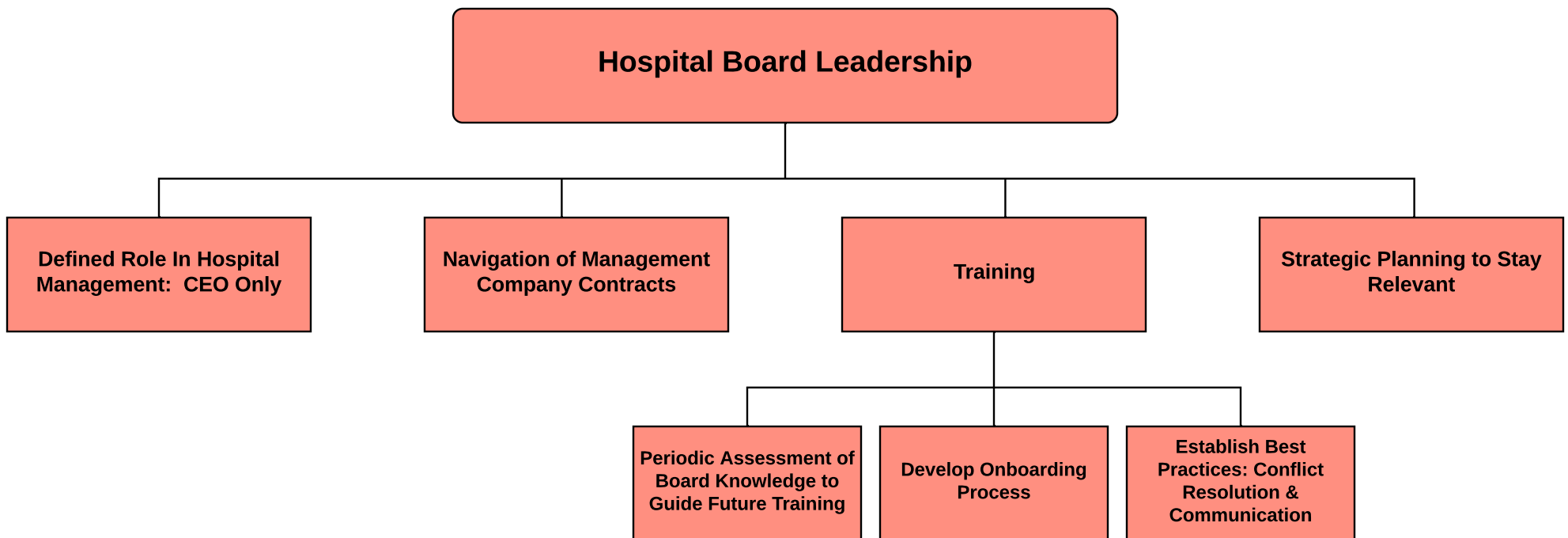
Telemedicine should be seen as an innovative way hospitals can provide services that are not available in their communities. Companies like Avera eCare are not a replacement for local providers, but rather a resource for those providers.

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Source: Interview with Avera eCare

Links:
*https://www.averaecare.org/ecare/* Contact portal and eCare resources
Type of Resource: Website

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# Hospital Board Leadership

- **Defined Role In Hospital Management: CEO Only**
- **Navigation of Management Company Contracts**
- **Training**
  - **Periodic Assessment of Board Knowledge to Guide Future Training**
  - **Develop Onboarding Process**
  - **Establish Best Practices: Conflict Resolution & Communication**
- **Strategic Planning to Stay Relevant**

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# Board Leadership Contracting Issues

There is a growing trend for rural hospitals to contract with management companies to oversee the day-to-day operations of the facility.  Management companies can provide a level of expertise that is not otherwise available to the hospital locally.  Unfortunately, the hospital is often left in a lurch if the management company closes and the contract contains no penalties for closing without notice.

Anecdotal reports show several common issues with contracts and one resounding piece of advice.  The lesson learned is that while it may be financially difficult to a struggling hospital, it is essential to hire appropriate legal counsel to review contracts.  Contracts need to contain protection for the hospital so there is adequate notice of the management company closing (90-180 days at least).  Data and technology ownership must be discussed so that the facility can resume function as soon as possible after a management company leaves.  There are examples of management companies leaving hardware with no operating software and electronic medical records (EMRs) that are not accessible by the staff and providers who stayed in town.  Other management companies have left an operating EMR, but the cost of that contract was more than the struggling hospital could afford.  Skilled legal review, in addition to connecting to a network of fellow rural hospitals to discuss common contract problems can help hospital board members navigate contracts in a more knowledgeable and strait forward manner.

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Source:  Texas Organization of Rural and Community Hospitals

Link: *https://www.torchnet.org/*  Texas Organization of Rural & Community Hospitals, members have access to a legal line

Type of Resource:  Membership organization

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# Board Leadership Education Programs

The healthcare sector underwent a major transformation with the Affordable Care Act and continues to evolve.  As a result, hospital boards find themselves being held to a higher standard while working within newly defined strategic and financial parameters.  It is essential that board membership be broad and strong to meet the challenges of rural hospitals today.  Board members need to have a deep understanding of health insurance, risk management, quality of care, and finance, as well as expertise in information technology.  Fortunately these skills can be learned.  Equally important, the composition of the board must reflect the diversity of the community.

In 2017, the American Hospital Association (AHA) focused its trustee education efforts on the emerging challenges in healthcare as well as the good governance practices crucial to success and advancing health in every community in America.  There are numerous resources on their website and AHA has created a Trustee track of programming at their three flagship meetings.  The American College of Healthcare Executives (ACHE) is a professional society dedicated to advancing healthcare management excellence.  Their website provides many resources regarding hospital board education.  Additionally, ACHE offers live classes with a focus on hospital board skills and can customize a course and deliver it on site.  The state of Texas has the benefit of TORCH (Texas Organization of Rural and Community Hospitals), an organization that provides leadership in addressing the special needs of rural hospitals.  These needs include education and guidance for hospital boards.

Hospital boards are responsible for ensuring quality of patient care as well as the financial health of their hospital.  Baseline education is recommended to help board members fulfill their responsibilities.  Continuing education will help board members navigate the rapidly changing landscape of healthcare.

Source:  American Hospital Association, American College of Healthcare executives, Texas Organization of Rural & Community Hospitals

Links:  *http://trustees.aha.org/*  American Hospital Association resource repository to foster high-performing hospital boards.  Link out for resources, webinar library, and bi-monthly digital resource.

*http://www.ache.org/*  American College of Healthcare Executives searchable resource center

*https://www.torchnet.org/* Texas Organization of Rural & Community Hospitals

Type of Resource:  Websites

## Board Leadership On-Boarding process

While education is essential, board members should undergo an on-boarding or orientation process to ensure their success.  This process should cover not only the board members responsibilities to the hospital, but also their responsibility to the community.  Orientation should start with a written job description as well as the hospital's mission, vision, and goals.  These three components (mission, vision, and goals) drive strategic planning which is a Board responsibility.

New board members will also need an orientation to the health needs and concerns of their community which may best be achieved via a community needs-assessment.  The history of the hospital within the community in terms of funding and politics should also be considered essential orientation material.  On-boarding should be viewed as a process rather than a singular event; an effective orientation may take up to a year.

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Source:  American College of Healthcare executives (ACHE)

Link: *https://www.ache.org/pubs/BiggsCh1.pdf*  Healthcare Governance, A Guide

for Effective Boards by Errol L. Biggs available via the ACHE Management Series.

Type of Resource:  Online book

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# Board Leadership Strategic Planning

Rural hospitals, and their hospital boards, are facing unprecedented challenges in today's changing healthcare landscape.  Members of the board are accountable for the well-being and success of their hospital which directly links to the need for involvement in strategic planning.  Board members need to work with management to create the long range vision that will ensure sustainability of their hospital.  Essentially, a strategic plan details where we are now, where we are going, and how we will get there.  Planning enables the hospital to avoid the "Cheshire cat" trap as written by Lewis Carroll in his book, Alice in Wonderland.  "Would you tell me, please, which way I ought to go from here?"  That depends a good deal on where you want to get to," said the Cat.  "I don't much care where…" said Alice.  "Then it doesn't matter which way you go," said the Cat.

Healthcare is changing rapidly.  Board members need to stay current with these changes and suggest alterations to the strategic plan.  Flexibility and adaptability within the mission, vision, and goals of a hospital will help steer an organization in the most advantageous direction.  Connecting with an organization(s) created to provide guidance to rural hospitals is a recommended action step.  Several member organizations, listed below, provide early warnings of healthcare change, gatherings of experts to discuss what the change means and how the change can be navigated successfully.  In addition, there are many educational resources available to assist in decision making.

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Source:  National Rural Health Association, American Hospital Association, American College of Healthcare executives, Texas Organization of Rural & Community Hospitals
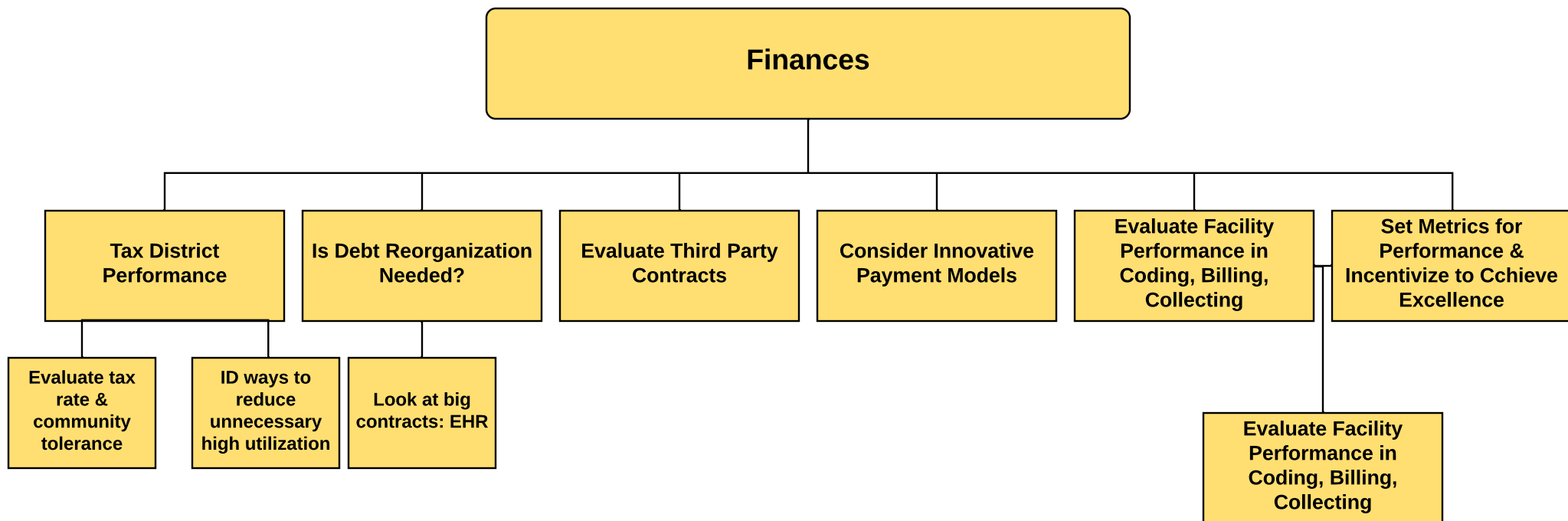
Links:  *https://www.ruralhealthweb.org/* National Rural Health Association resource center with a mission to provide leadership on rural health issues through advocacy, communications, education, and research.

*http://trustees.aha.org/* American Hospital Association resource repository to foster high-performing hospital boards.  Link out for resources, webinar library, and bi-monthly digital resource

*http://www.ache.org/* American College of Healthcare Executives searchable resource center

*https://www.torchnet.org/* Texas Organization of Rural & Community Hospitals

Type of Resource:  Websites

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**Finances**

- **Tax District Performance**
  - **Evaluate tax rate & community tolerance**
  - **ID ways to reduce unnecessary high utilization**
- **Is Debt Reorganization Needed?**
  - **Look at big contracts: EHR**
- **Evaluate Third Party Contracts**
- **Consider Innovative Payment Models**
- **Evaluate Facility Performance in Coding, Billing, Collecting**
- **Set Metrics for Performance & Incentivize to Cchieve Excellence**
  - **Evaluate Facility Performance in Coding, Billing, Collecting**

# Third Party Contracting and other Financial Strategies

Managing to keep the doors open when a hospital is struggling is a juggling act between volume, collections, service mix, and community support. One aspect of the juggling act is maximizing third party contracts. While it may be a grim time with Medicare reimbursement reductions, the decision by Texas to not take the Medicaid expansion, and ever more competitive and complex third party contracting, there are some things that hospitals can do to maintain or enhance solvency.

Roughly 80 percent of uninsured patients who come into the ER are eligible for some type of publicly funded program. Hospitals should make it a priority to help ER patients complete applications for publicly funded health coverage like Medicaid or identify other programmatic assistance including DARS, Texas Women's Medicaid, CPRIT and others.

Maintaining a good relationship with payors and renegotiating contracts in a timely fashion is imperative. Approximately 35% of the bottom line comes from non-governmental, third party payors. Poor contracts or contentious relationships with carriers can be problematic. Hospitals must take the time to understand existing contracts, benchmark contracts against each other, conduct research to know what percentage of the insurer's business comes from the hospital, routinely update stagnant and evergreen contracts, and look for carve-out opportunities. Hospitals must be prepared, when renegotiating contracts, to maintain a level of respectful dialogue in order to avoid fallouts which could impact reimbursement as well as public relations. Often times, people don't consider that mutual respect must occur between the payor and institution. That relationship is earned over time in a manner that allows a facility to help collaborate, design, and develop the care delivery models and product designs that those payors will ultimately use.

There are specialized consultants who evaluate contracts, review billing/and collecting procedures, and otherwise help hospitals achieve maximum impact. However, many small rural facilities cannot afford a consultant; these facilities must develop their own internal expertise. This includes understanding their contracts to ensure all terms are met, identifying coding issues and leaks in the processes, i.e. the time it takes to get a bill out the door, what percentage of those are returned to be reworked due to inaccuracies or holes in the bill, etc. Many organizations that represent either hospitals or their providers have services that may be able to assist with negotiating competitive contracts within the state.

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Source: Beckers Healthcare

Link: *https://www.beckershospitalreview.com/finance/10-ways-for-hospitals-and-health-systems-to-increase-profitability-in-2012.html*

Type of Resource: Online article

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