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NF00-438 Critical Access Hospitals: An Opportunity For Rural Nebraska

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Critical Access Hospitals: An Opportunity For Rural Nebraska

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The advantages of living in a rural community are many. Sometimes rural Nebraskans choose this lifestyle, giving up the conveniences of a larger city, to live what they perceive to be a better life.

Quality health care, however, is not a convenience; it's a necessity. Because rural hospitals are so unique, they require more flexibility from government regulations and federal policies. This helps them continue to provide access to cost-effective, quality health care services.

When Congress made changes to the Medicare program in the mid-1980s, it changed the way in which hospitals are paid for treating Medicare patients. Their actions unintentionally hurt small rural hospitals. Medicare no longer pays many of these rural hospitals for the actual cost of providing care to their patients, forcing hospitals to lose money on certain procedures.

Rural hospitals are very dependent on Medicare and Medicaid dollars for reimbursements. The changes made by Congress caused a financial burden on small hospitals that rely on Medicare to pay for 60 to 80 percent of the health services provided. In addition, Congress passed the Balanced Budget Act of 1997, further cutting the Medicare program and even more heavily impacting small hospitals.

Before Congress established the Critical Access Hospital program through the Balanced Budget Act of 1997, the Nebraska Unicameral established a Critical Access Hospital (CAH) category. This new type of hospital is not all that different from other hospitals. The primary difference is that the Medicare program uses a different method to pay CAHs for services than is used for larger hospitals. This method of payment helps smaller hospitals remain financially viable and maintains access to care for many rural communities.

If a hospital chooses to become a Critical Access facility, most local patients will not notice any

changes. Because so many of the surgeries and procedures done today are on an outpatient basis or require a short stay at the hospital, a vast majority of patients will continue to receive all of their health care services in their local hospital. A Critical Access Hospital can have 15 patient beds for acute care services and up to 25 beds for long-term care or skilled nursing services. Hospitals that become Critical Access most likely have an average of fewer than 15 patients on a daily basis.

Another hospital requirement for Critical Access status is to maintain an average length of stay of no more than four days. This is reviewed on an annual basis. While this may sound like a short period of time, it actually is not. New technologies and advances in surgical procedures have significantly lowered the number of days a patient will stay in a hospital.

In Nebraska, patients spend an average of 3.2 days in rural hospitals. The four-day rule does not apply to each individual patient, but rather the average length of stay for all patients combined. Therefore, patients admitted to CAHs should see little or no change.

The Critical Access plan for Nebraska was developed by the Nebraska Association of Hospitals and Health Systems (NAHHS) working in partnership with the Nebraska Health and Human Services System Office of Rural Health. In Nebraska, an estimated 67 hospitals are now eligible for the CAH program, with the likelihood of 40-45 hospitals being certified as CAHs by the end of 2000.

In September 1999, Vice President Al Gore announced that Nebraska's Critical Access Hospital program was awarded $750,000 in grant funding for its excellent CAH plan. Nebraska's funding was substantially larger than that received by the other 42 applicant states, with the exception of Montana. Nebraska has been a leader in exploring the Critical Access model for its rural communities. These funds were used to implement Goals 1 and 2 below. As of July 2000, 37 hospitals in Nebraska have been certified as CAHs and six more have applied to the program.

In July 2000, Nebraska received another federal grant of $720,000. This money will assist in reaching Goals 3 through 5 below. About four to five pilot projects relative to Goals 3 through 5 will occur over the 2000-2001 fiscal year.

The five goals of the CAH program are as follows:

Goal 1. Provide guidance through a statewide steering committee.
This group includes the NAHHS, rural hospitals, the Nebraska Medical Association, the State EMS Program, the State Facility Credentialing Program, the State Medicaid Program, Blue Cross and Blue Shield of Nebraska and others.

Goal 2. Provide technical assistance to the hospital converting to CAH status.
Technical assistance activities may include community, board and medical staff education; community planning and needs assessment; financial feasibility analysis; application and Medicare survey preparation; etc.

Goal 3. Foster Rural Health Networks.
The networks (comprising the CAH and supporting local health organizations) will be required to develop a strategic plan that includes vision and mission statements, major goals and a work plan.

Goal 4. Integrate EMS Services.
Training efforts will be made to integrate EMS services into the CAH and

other network activities.

Goal 5. Improve the quality of care in Critical Access Hospitals.
CAHs will collaborate to develop a clinical outcomes measurement system. This will pinpoint areas for improvement. The CAH hospital program will assist rural hospitals in providing high quality, affordable health care services to rural Nebraskans.

For more information, contact your local hospital administrator or the Nebraska Association of Hospitals and Health Systems, (402)458-4900

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