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The Rural hospital dilemma: Will Nevada's rural hospital system survive?

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THE RURAL HOSPITAL DILEMA:

Will Nevada's Rural Hospital System Survive?

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ABSTRACT

This study, prepared for the Department of Public Administration, will review and discuss the rural hospitals in the State of Nevada. By virtue of its size and population distribution, Nevada has a need for rural hospitals. These hospitals, which are of critical importance for Nevada residents, are constantly struggling with how to build and support their limited health system capacity and infrastructure.

To survive, rural hospitals must offset the losses they have sustained as a result of decreased federal funding. Some ways these losses have been offset is by employing some of the programs created by the Balanced Budget Act of 1997 such as the Medicare Rural Hospital Flexibility Program. In addition, they have begun to better serve their constituent population by their involvement in other areas, such as becoming county hospital districts, developing telemedicine capacity, implementing long term care options and working with the Nevada Rural Hospital Project. It is the combination of these factors and changes to their everyday functioning and continued ability to accommodate changes in the health care environment that determine the ultimate survival of Nevada's rural hospital system.

CHAPTER ONE

INTRODUCTION

Since rural hospital closures became common in the 1980s, it has become increasingly important to understand how and why rural hospitals must change to meet the needs of the community and to keep their doors open. The distinction between urban and rural has particular significance for Nevada since 80% of the state's land mass has been categorized as rural by the federal government. Federal tax dollars, Medicare and Medicaid reimbursements, awards of research funds and even the allocation of equipment and medical staff, can be affected by the complex determination of whether a given geographic area within the state is designated rural, (Figure 1) urban, metropolitan or frontier (Figure 2).

There are two principal federal government definitions of rural. The definitions derive from the Office of Management and Budget's (OMB) "Metropolitan-Nonmetropolitan" system and the Bureau of the Census' "Urban-Rural" classification of populations (Ricketts, 1998).

According to the Census Bureau, urban and rural are "type-of-area concepts rather than specific areas outlined on maps" (U.S. Department of Commerce, Bureau of the Census, 1983a). The Bureau of the Census defines *urban* as comprising all territory, population, and housing units located in *urbanized areas (UAS)* and in places of 2,500 or more inhabitants outside *urbanized areas*. Territory, population and housing units that the Census Bureau

does not classify as urban, comprise the *rural population*, that is, those living outside urbanized areas in “places” with less than 2,500 residents and those living outside “places” in the open countryside. In the 1990 census, 24.8 percent of the national population was classified as rural (Ricketts, 1998). In addition, federal funding through Health Care Finance Administration (HCFA) sources distinguish between metropolitan and nonmetropolitan “rural” areas.

Metropolitan and nonmetropolitan areas are defined by the OMB on the basis of counties. Metropolitan Areas contain: (1) core counties with one or more central cities of at least 50,000 residents or with a Census Bureau-defined urbanized area and a total metro area population of 100,000 or more, and (2) fringe counties that are economically tied to the core counties. Nonmetropolitan counties are outside the boundaries of metro areas and have no cities with more than 50,000 residents. In 1996, 2,522 of 3,139 counties or county-equivalents were classified as nonmetropolitan. These counties included 52,393,300 persons or 19.8 percent of the total 1996 national population estimate of 264,100,960 (Ricketts, 1998).

Areas with six or fewer persons per square mile are considered *frontier* counties or communities. A total of 383 counties (excluding Alaska boroughs) met this criteria in 1995 (Ricketts, 1998). Frontier counties account for one-fifth of the population and 45 percent of the land mass in the United States. In Nevada, 80% of the land mass (a total of 94,835 square miles) is inhabited by only 321,000 people. This low density population, as well as the fact that medical services for these residents is more than one hundred miles away,

dictates that most of Nevada falls within the frontier county designation. As such, the preservation of rural hospitals is critical for the health and well being of these Nevada residents.

Clear evidence exists that the characteristics which distinguish rural and frontier places from urban communities have important effects on health service delivery and access. Lillie-Blanton and colleagues (1992) demonstrated that select characteristics of rural hospitals such as small size, low occupancies, less-intensive service mix, and declining or weak local economies almost ensure their closure.

In 1981, rural community hospitals accounted for 23.8% of all community hospital beds, but by 1991 this number had fallen 1.7% to 22.1%, accounting for approximately 2421 rural community hospitals in the country. Between 1981-1991 the drop of 12.4% was due to closures, mergers, or acquisitions by larger facilities according to the American Hospital Association (1992). By 1999, according to the American Hospital Association rural hospitals had decreased by 216 hospitals.

U.S. Community Hospitals by Urban/Rural Status

Urban.....	2,852
Rural.....	2,205
Total.....	5,057

The 1999, status of urban and rural hospitals (American Hospital Association, 1999).

The purpose of this paper is to determine what Nevada's rural hospitals are doing to remain viable. It will provide background about Nevada's rural hospitals including location, size, number of staff, management structure and financial status. The paper also examines the Nevada Rural Hospital Project, a

consortium of Nevada rural hospitals to determine whether it has been an effective mechanism to maintain facilities. Finally, the paper will present what Nevada rural hospitals are doing to survive and succeed.

CHAPTER TWO

LITERATURE REVIEW

A review of the literature regarding the future of rural hospitals can be divided into three major areas of concern: 1) history; 2) availability of funds; and 3) potential solutions.

History

Health care is big business in the United States, accounting for nearly 14 percent of the nation's gross domestic product (Smith, et al., 1998). Despite today's cost containment rhetoric, national health care expenditures are almost certain to increase in the future as income and population (especially the elderly population) increase, and as new drugs and medical technologies come on-line. Smith and colleagues (1998) project national spending to double between 1996 and 2007, passing the \$2 trillion mark by 2007.

Rural hospitals in the United States operate at a disadvantage compared to urban hospitals because of their smaller size; because their clientele tends to be poorer; because of competition from other health care providers and because of their remote location. Between 1980 and 1987, 519 United States hospitals closed or ceased to provide in-patient medical care. Of the hospitals that closed 364 were community hospitals and 45% of those were rural hospitals. In addition, more than 70 percent of the rural hospitals that closed between 1983 and 1991 had fewer than fifty beds (American Hospital Association, 1994). This statistic reinforces the premise that rural hospital survival is contingent upon its

ability to become specialty centers or to collaborate with other rural or regional medical centers.

Another area of financial concern with rural hospitals arises from the Prospective Payment System, which differentially reimburses rural facilities at lower rates than urban facilities (Egan, 1997). This is one of the factors that indicates aftercare is poor due to cost-conscious organizations in rural areas.

Rural hospitals are suffering the consequences of high costs, technological inadequacies, chronic staffing difficulties, and dwindling Medicare reimbursements. According to Dale Bankston, senior vice-president and executive officer of VHA Gulf States in Baton Rouge, La., "It makes no sense to let rural hospitals fold, because their long-term survival is in doubt."

Rural medical facilities and hospitals occupy important positions in their communities. They are the focal points of local health care delivery systems, serve as an important element in the physician recruitment process, provide a source of civic self-esteem, and are an important aspect of the local economy. Rural hospitals provide jobs and the steady flow of public and private funds brought in from payment for services, act to stimulate local business and employment prospects.

Availability of Funding

The passage of the Balanced Budget Act of 1997 created some important opportunities for states trying to deliver and pay for health services in rural and frontier communities by the creation of , the Medicare Rural Hospital Flexibility Program and the State's Children's Health Insurance Program.

(1) The Medicare Rural Hospital Flexibility Program helps states and rural communities improve access to essential health care services by establishing limited service hospitals referred as “critical access hospitals”(CAHs). The Medical Critical Access Hospital (CAH) program, is a nationwide limited service hospital program that was built on the Essential Access Community Hospital/Rural Primary Care Hospital (EACH/ RPCH) and Medical Assistance Facility (MAF) demonstration programs. CAHs can provide outpatient, emergency and limited inpatient services and receive reasonable cost-based reimbursement for their services (Reif and Ricketts, 1999).

The CAH program, a Medicare hospital reimbursement program, is a major component of the Balanced Budget Act of 1997’s Medicare Rural Hospital Flexibility Program. The program allows states to designate rural facilities as critical access hospitals if they are located a 35-mile distance from other hospitals, provide 24 hour emergency care, maintain no more than 15 inpatient beds, and keep patients hospitalized no longer than 96 hours. Rural hospitals converting to critical access hospital status do not have to meet all the Medicare staffing requirements that apply to full-service hospitals. These hospitals are reimbursed on a reasonable-cost basis for inpatient and outpatient services provided to Medicare beneficiaries.

In order to participate in the program, states must submit a rural health plan to the federal Health Care Financing Administration and establish a process for designating local hospitals that meet specific program criteria as critical access hospitals

The Medicare Rural Hospital Flexibility Program also provides a grant program. The program, which began in 1998, authorized up to \$25 million annually over five years to support implementation of the CAH program, improvement of rural emergency medical services and other activities to strengthen rural health systems (Reif and Ricketts, 1999). States can also use the grant funds to provide technical assistance and support for hospital CAH conversions to:

- develop integrated networks of care;
- examine the conversion to CAHs;
- conduct a financial feasibility analysis;
- develop information systems and telehealth activities;
- improve quality assurance activities; and
- improve rural EMS systems.

State policymakers have the opportunity to develop creative and comprehensive CAH models that can include the integration of network development, emergency medical services, telehealth services, mental health services, and public health, depending on the needs of each community. To expedite appropriate and successful CAH conversions, states can encourage facilities considering conversions to:

- conduct a financial feasibility study;
- educate the physicians, the hospital staff and their governing board, and the community about the conversion; and

- partner with a fiscal intermediary that understands the nuances of the CAH program so that claims processing is simplified.

(2) The State Children's Health Insurance Program was established by Title XXI of the 1997 budget legislation. It provides states with approximately \$4.8 billion annually for five years to provide health insurance to uninsured children. According to Medical Expenditure panel Survey data for the first half of 1996, 27.9 percent of all uninsured children live in rural and frontier areas and might be eligible for this program.

Potential Solutions

(1) Telemedicine is the use of medical information exchanged from one site to another via electronic communications for the health and education of the patient or health care provider and for the purpose of improving patient care (American Telemedicine Association, 1999). The information exchanged may include medical images, live audio and video, patient medical records, output data from medical devices and sound files. Telemedical interaction between patients and health care professionals may include patients monitoring data from the home and transmitting this data to a clinic, or transmitting a patient's medical file from a primary care physician to a specialist.

Telemedicine "began" in the 1960's as a medical treatment rendered over the telephone and by wire by physicians who were physically remote in relation to their patients. Although the principles are largely the same today, the technology is advanced and socio-economic and legislative issues surrounding its use are vastly different. Prior to the Balanced Budget Act (BBB) of 1997,

Medicare did not have an explicit policy to pay for Telemedicine services. The passage of the BBA required Medicare to pay for Telemedicine consultation services using interactive video in rural “Health Professional Shortage Areas” (HPSA) by January 1, 1999 signaled a major change in policy. The legislation limits coverage to rural HPSAs and prohibits payment for line charges or facility fees. Physicians are reimbursed at 75 percent of the rate for an in-person consultation. The referring physician is eligible for the remaining 25% of the allowable reimbursement. Reimbursement under Medicare is contingent upon the type of provider that refers the patient. At present, rules are proposed to allow for payment for services to physician assistants, nurse practitioners, social workers, mid-wives, and clinical psychologists, to name a few (Kincade, 1998). According to HCFA, the BBA limits the scope of coverage to a consultation for which payment may be made under the Medicare program. These services include initial, follow-up, or confirmatory consultations in the hospital, outpatient facility or medical offices, using the Current Procedural Terminology (CPT) codes.

(2) Rural Utilities Service Nevada implemented the Rural Utilities Services (RUS) project to connect rural communities and providers to training opportunities, medical specialists, and other health professionals. RUS provides distance education, continuing education, Internet access, teleradiology, and telemedicine services to nine rural counties and two urban counties. It uses a combination of funds to equip compressed-video systems, Internet, teleradiology, and audio conferencing for the participating counties. The project

is responsible for training, education, statewide meetings, telehealth, and other activities that benefit rural residents, students, patients, and health professionals in Nevada. RUS is a joint effort of the University of Nevada School of Medicine, the Great Basin Community College, and the Nevada Rural Hospital Project.

A second grant awarded from the U.S. Department of Commerce's Technology and Information Infrastructure and Assistance Program has been used to add equipment to the backbone of RUS. Six rural hospital sites have been added to the RUS rural network through a combination of compressed-video, high-speed modems for still-image capture and store-forward technology for data, voice, and picture. Linkages connect rural Nevada hospitals to urban specialists for consultations, to designated urban trauma centers for emergency treatment support, and to the University of Nevada and the Great Basin Community College system for Internet connection and educational support.

(3) Integration A survey of 223 rural CEOs by Hospital & Health Networks showed that the respondents were aware of the need for integration of rural hospitals with major health care systems. The most significant reason for the surge in affiliations is the move to managed care. Approximately half of the survey participants have formal contractual affiliations with another hospital or health system.

It is questionable, however, whether or not integration will work in rural markets since one hundred thousand participants are needed to make a managed care plan financially viable and rural markets usually do not have sufficient population to cover the financial risk associated with a managed care

system. Rural areas are usually sparsely populated, therefore rural hospitals may have to adapt the system to their unique surroundings and fit their needs and service area (East, 1999).

If managed care systems can develop a creative mechanism for financing their programs on a smaller population base, integration may work in rural hospitals. Otherwise, each hospital may be left to create its own unique process for ensuring continued viability.

(4) Networking To help ensure the survival of rural hospitals, networking is starting to play a crucial role. Rural hospitals are embracing networking as one strategy to unify health care systems with minimal capitalization. Rural health care providers are being offered affiliations with large health care organizations. Rural provider-initiated networks can assure local representation when participating in the new market and improve the rural health infrastructure (Rosenthal, 1997). Rural hospitals need to affiliate with other groups such as rural hospital projects or large health care systems to provide management services and access group purchasing programs, and to concentrate on providing the clinical services performed best. Other benefits of networks include benchmarking and establishing best-of-practice standards among similar health care organizations in a region; access to new technology; and attracting and retaining primary care physicians and medical staff. Another advantage of networking with other facilities is that the rural hospitals then have access to specialists.

CHAPTER THREE

METHODOLOGY

In light of the stated purpose of this study, to determine whether and by what mechanisms Nevada's rural hospitals can overcome the environmental changes and pressures that contribute to their financial vulnerability and potential demise, survey research was conducted.

The purpose of the survey was to establish baseline data from each of the 12 rural hospitals in Nevada with regard to hospital size in terms of number of beds, number of staff; amount of population served; distance from the closest urban center; the facilities form of ownership; the age of the facility and whether or not it operates at a profit. The survey was conducted via interviews with hospital administrative staff employing questions from the 1991 study, "The Strategies and Environments of America's Small Rural Hospitals: A Survey of Strategic Approaches of Small, Rural Hospitals" by David E. Berry, John W. Seavey and Richard J. Bogue.

Based upon the baseline, data interviews were conducted with staff at the Nevada Department of Taxation for the purpose of analyzing the financial structure of rural hospitals; their assets and liabilities as well as operating revenues and expenditures within the context of the Counties in which they are located. Finally, interviews were conducted with the administrators; boards of directors and participants in the Nevada Rural Hospital Project Consortium to

determine whether participation in that project was a viable mechanism for ensuring long-term financial health for Nevada's rural hospitals.

CHAPTER FOUR

RURAL HOSPITALS IN NEVADA

There are presently a total of twelve rural hospitals in Nevada. The brief descriptions of each hospital gives an insight into the differences between them and yet some of the similarities that makes them each individually unique. The information contained in the following chapter and illustrated in tables 1.1 through 1.4 was derived from a sample survey (Appendix 1). The survey has a 100% response rate with respondents coming from either the human resource or finance department of the surveyed facility.

Battle Mountain General Hospital (Lander County)

Battle Mountain General Hospital located in Lander County was founded in 1968 and originally was organized as a public hospital. In 1984 the taxpayers voted to approve Battle Mountain to become part of the County Hospital District, serving a population of 7,500 and distanced 54 to 75 miles from another medical facility (Table 1.1). In 1968, the original structure that now houses the medical clinical and administrative offices was built. Three years ago in 1997 a county bond issue was approved for an additional 18,000 square foot facility.

Information from the Nevada Department of Taxation revealed that in 1999 Battle Mountain General Hospital showed a \$1.4 million loss (Table 1.4). Battle Mountain General Hospital bed size is 23 with 7 acute and 16 long term care and 75 employees of which ninety percent are local residents (Table 1.2).

An average patient stay of 2.4 days the hospital maintains a clinic as well as emergency room, and home health services. The payor mix includes Medicare, Medicaid, government assistance, insurance and private pay (Table 1.3). The hospital has two full-time physicians and one nurse practitioner and uses specialty physicians from Elko.

Boulder City Hospital (Clark County)

Boulder City Hospital located in Clark County was founded in 1931, owned by the government for dam employees. Boulder City Hospital was restructured in 1954 as a not-for profit, serving a population of approximately 16,000 and is only 27 miles from the nearest urban facility (Table 1.1). Boulder City Hospital today serves the areas of Boulder City, Kingman, Searchlight, as well as Henderson and parts of Las Vegas. Boulder City Hospital is the only rural hospital in Southern Nevada.

Information from the Nevada Department of Taxation revealed that in 1999 Boulder City Hospital showed a profit (Table 1.4). Boulder City Hospital bed size is 67 with 20 acute and 47 long term care and over 200 employees (Table 1.2). An average patient stay of 5.8 days the hospital maintains long term care as well as full medical, surgical and outpatient services. The payor mix includes Medicare, Medicaid, insurance and private pay (Table 1.3). The hospital has no full time physicians on staff, but grants privileges to local physicians.

Carson-Tahoe Hospital (Carson-Tahoe County)

Carson-Tahoe Hospital located in Carson-Tahoe County was founded in 1949, as a not-for-profit community hospital. Carson-Tahoe Hospital serves a population of a 100,000 and distanced 32 miles from another urban medical facility (Table 1.1). Today Carson-Tahoe Hospital is the process of funding a Cancer Resource Center with grants for research.

Information from the Nevada Department of Taxation revealed that in 1999 Carson-Tahoe Hospital showed a profit before non-operating income (Table 1.4). Carson-Tahoe Hospital bed size is 128 acute and 658 employees making it the second largest employer in the area (Table 1.2). An average patient stay of 3.0 days the hospital maintains a staffed emergency room and clinic facilities. The payor mix includes Medicare, Medicaid, insurance and private pay (Table 1.3). The hospital has no salaried physicians, but contracts the emergency room physicians.

Churchill Community Hospital (Churchill County)

Churchill Community Hospital located in Churchill County was founded in 1958, as a not-for-profit hospital. In 1990 Banner Health Systems of Fargo, North Dakota, started managing the facility and sometime between 1994 and 1996 they became part of the Banner Health Systems. Churchill Community Hospital serves a population of 45,000 and distanced 60 miles from another medical facility (Table 1.1).

Information from the parent company Banner Health Systems revealed that in 1998-1999, the hospital broke even and is currently making a slight profit. Churchill Community Hospital bed size is a 40 bed acute facility and employs a

staff of 416 full and part-time (Table 1.2). An average patient stay of 3-4 days the hospital maintains surgical and outpatient services. The payor mix includes Medicare, Medicaid, insurance and private pay (Table 1.3). The hospital has two full-time salaried physicians and one relief physician as well as private physicians with privileges.

Grover C. Dils Medical Center (Lincoln County)

Grover C. Dils Medical Center located in Lincoln County was originally founded in 1943 as a non-for profit hospital. In 1974 the taxpayers voted to approve Grover C. Dils medical Center to become part of the County Hospital District., serving a population of 4,800 and distanced of over a 100 miles from another medical facility (Table 1.1).

Information from the Nevada Department of Taxation revealed that in 1999 Grover C. Dils Medical Center even with non-operating funds showed a loss (Table 1.4). Grover C. Dils Medical Center bed size is 20 and has 54 employees (Table 1.2). An average patient stay of 1.2 days the hospital maintains outpatient services. The payor mix includes Medicare, Medicaid, government assistance, insurance and private pay (Table 1.3). The hospital contracts the physicians.

Humboldt General Hospital (Humboldt County)

Humboldt General Hospital located in Humboldt County was originally built in 1908, as a public hospital and has undergone several renovations. The taxpayers voted to approve Humboldt General Hospital as part of the County Hospital District, serving a population of 16,000 and distanced 164 miles from

another medical facility (Table 1.1). In 1994 the clinic building was demolished to allow for the construction of a new Skilled Nursing Facility. The Skilled Nursing Facility was completed in April 1995; includes 30 beds, a large solarium, activity area, cosmetology room, and staff lounge. A new surgery suite was completed in April 1995 which consists of a special procedure room, two operating suites and four recovery beds. A new administration building was completed in July, 1995 along with the new Radiology and Laboratory wings. The radiology department includes mammography, ultrasound, fluoroscopy, and C.T. Remodeling of the 22 bed acute care wing was finished in November, 1995. Acute care services includes a two bed fully equipped intensive care unit.

The emergency department at Humboldt General Hospital has 24 hour-a-day coverage by rotating in-house emergency physicians and nurses. Construction of the new emergency room was completed in January, 1996. This facility is fully equipped with a trauma room to care for major trauma or life threatening cardiac problems the obstetrics department completed in early 1996, and includes a labor/treatment room, two birthing rooms, four postpartum rooms, and a nursery.

In March, 1997, an ambulance facility was completed, supporting the volunteer ambulance corps. There is a full time paramedic as coordinator/liaison for pre-hospital services as well as four paramedics in addition to the EMTs. This is one of the busiest services in the State.

Information from the Nevada Department of Taxation revealed that in 1999 Humboldt General Hospital showed a profit after non-operating income

(Table 1.4). Humboldt General Hospital bed size is 52 with 22 acute and 30 long term care and 158 employees (Table 1.2). An average patient stay is 6.07 days the maintains a fully equipped facility. The payor mix includes Medicare, Medicaid, government assistance, insurance and private pay (Table 1.3). Medical staff consists of two family-practice physicians, two internists, a general surgeon, and two pediatricians. In 1994, a medical office building was constructed, which presently houses three physicians. A pathologist and radiologist are on the associate staff. Consultant physicians offer specialty services on a regular basis. The emergency room staff is provided by contract physicians on a rotational basis.

Mt. Grant General Hospital (Mineral County)

Mt. Grant General Hospital located in Mineral County was founded originally in the 1900s as a not-for-profit hospital. In 1964 the taxpayers voted to approve Mt. Grant General Hospital to become part of part of County Hospital District, serving a population of 5,000 and distanced 60 miles from another medical facility (Table 1.1).

Information from the Nevada Department of Taxation revealed that in 1999 Mt. Grant General Hospital showed a profit after non-operating income (Table 1.4). Mt. Grant General Hospital bed size is 35 with 11 acute and 24 long term care and employ 100 people making them the second major employer in Hawthorne (Table 1.2). No information available on average patient stay the hospital maintains emergency services and a clinic. The payor mix includes

Medicare, Medicaid, government assistance, insurance and private pay with statistics available (Table 1.3).

Pershing General Hospital (Pershing County)

Pershing General Hospital located in Pershing County was founded in 1962 as a not-for-profit hospital. The taxpayers voted to approve Pershing General Hospital to become part of the County Hospital District, serving a population of approximately 4,000 and distanced over 60 miles from another medical facility (Table 1.1).. This year they have initiated a rehabilitation facility to better serve the community.

Information from the Nevada Department of Taxation revealed that in 1999 Pershing General Hospital showed a \$304,883 loss (Table 1.4) Pershing General Hospital bed size 37 with 5 acute and 32 long term care and 100 full and part time employees (Table 1.2). An average patient stay of 2 .5 days the hospital maintains outpatient services and nursing home. The payor mix includes Medicare, Medicaid, government assistance, insurance and private pay (Table 1.3). The hospital has a staff of three physicians.

Nye Regional Medical Center (Nye County)

Nye Regional Medical Center located in Nye County was established in the early 1960s as a not-for-profit hospital. In August of 1999, Nye Regional Medical Center was purchased by Mina Medical Group and leased back to Prime Care Nevada. Nye Regional Medical Center has also applied for admission to the Critical Access Hospitals program run by the Health Care Financing

Administration (HCFA). If Nye Regional Medical Center is accepted into the program, the designation will allow it to acquire the funds necessary to remain open. Nye Regional Medical Center serves a population of 3,616 and distanced over 300 miles from another medical facility (Table 1.1).

Information from the Nevada Department of taxation revealed that since April, 1997 until August of 1999, the Nevada Department of State Taxation had managed the facility, due to it losing 100,000 to 150,000 dollars per month. In February, 1999, the Nye County Commissioners, voted 4 to 1 to expend an additional 350,000 dollars to allow operations to continue until March, 1999.

Nye Regional Medical Center is one of those rural hospitals that has less than 50 beds, employs 60 people, and is one of the largest employers in Tonopah (Table 1.2). The payor mix includes Medicare, Medicaid and government assistance (Table 1.3).

South Lyon Medical Center (Lyon County)

South Lyon Medical Center located in Lyon County was founded in the 1953 as public owned hospital. In 1998, Taxpayers voted to become part of the County Hospital District, serving a population of 11,300 and distanced 81 miles from another medical facility (Table 1.1). In 1998 a long term facility was completed.

Information from the Nevada Department of taxation revealed that in 1999 South Lyon Medical Center had a loss. South Lyon Medical Center bed size is 63 with 14 acute and 49 long term care and employs approximately 100 people including both staffed physicians and “contract” emergency room physicians

Table 1.2). An average patient stay is 3 days the hospital maintains long term as well as clinic serves. The payor mix includes Medicare, Medicaid, government assistance, and insurance (Table 1.3).

William Bee Ririe Hospital (White Pine County)

William Bee Ririe Hospital located in White Pine County was founded in 1969 as a not-for-profit hospital. The taxpayers voted to approve William Bee Ririe Hospital to become part of the County Hospital District, serving a population of 13,000 distanced 300 miles from another medical facility (Table 1.1).

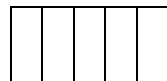
Additions to the original structure include a clinic adjacent to the hospital that was completed in February of 2000.

Information from the Nevada Department of taxation revealed that in 1999 that William Bee Ririe Hospital showed a profit after non-operating income (Table 1.4). William Bee Ririe Hospital bed size is 40 beds and 98 employees with both staff and “contract” physicians (Table 1.2). An average patient stay of 2.3 days the hospital maintains a clinic as well as long term care facility. The payor mix includes Medicare, Medicaid, government assistance, and insurance (Table 1.3).

Elko General Hospital (Elko County)

Elko General Hospital located in Elko County was established in 1921 and was originally organized as a public hospital. June, 1998, became a private hospital when purchased by Province Healthcare, serving a population of 50,000 and distanced over a 180 miles from another medical facility (Table 1.1).

According to Province Healthcare in 1999, Elko General Hospital showed a profit, but the figures were not available for review. Elko General Hospital bed size is 50 with 300 employee (Table 1.2). The average patient stay information was no available for review. The payor mix includes Medicare, Medicaid, and insurance (table 1.3). The hospital employs two full time salaried physicians.



CHAPTER FIVE

NEVADA RURAL HOSPITAL PROJECT

The Nevada Rural Hospital Project (NRHP) is a voluntary consortium of ten of the twelve Nevada small rural and frontier hospitals with Elko General Hospital and Nye Regional Medical Center (Appendix 2).

Consortium hospitals are community, county and/or district not-for-profit hospitals, with each hospital represented with an equal vote on the NRHP Board of Directors. Definition of county hospital districts is found in (Appendix 3).

The consortium has a history (1978) of working together as members of the Rural Council of the Nevada Hospital Association. In 1988, the consortium received a grant from The Robert Wood Johnson Foundation (TRWJF) as one of thirteen grantees in the “Hospital-Based Health Care Program.” The goals for that program were to improve the viability of rural hospitals, access to health care by rural residents and the quality of health services in rural areas. These goals continue to be the mission of NRHP.

The mission of NRHP is to strengthen member hospitals through the development of public policy, which supports the viability of Nevada’s rural facilities. Generally, NRHP resources are used to address issues which impact all member hospitals, although NRHP is also responsive to a hospital’s specific needs and problems.

Services Provided to Members

Since the original grant, there have been many other vital projects and programs undertaken and accomplished by NRHP. The following describes many of these projects and programs.

- Group Health Insurance Program: Member hospitals are able to benefit from a group health insurance program negotiated at a discount rate. The member hospitals are able to control health insurance costs for their employees through this program. NRHP was instrumental in getting legislation passed that would allow public, not-for-profit hospitals to pool their monies for an insurance program.
- Distant Learning Program: NRHP has worked with Nevada educators, the rural Directors of Nursing and the School of Medicine's Area Health Education Center (AHEC) to develop a distant learning program to deliver an LPN/AND Degree in Nursing to three rural communities via compressed video. Over 30 students have graduated from the program. Additionally, baccalaureate nursing and continuing education courses are delivered through this network.
- Teleradiology: Recognizing the need for access by rural residents to basic diagnostic services, NRHP has implemented a teleradiology network in ten communities (those with limited radiologist services). The network allows rural physicians and patients access to radiologic consultation around the clock. This program is coordinated and administrated by NRHP on behalf of its members.
- Telemedicine: The Nevada Rural Hospital Project was successful in obtaining a grant from the U.S. Department of Commerce's National Telecommunications and Information Administration's Telecommunications and Information Infrastructure Assistance Program (TIIAP). This grant

program has provided five rural hospitals with compressed video telemedicine equipment. The hospitals are now part of an eight-site network that includes the University of Nevada's School of Medicine and an urban tertiary hospital. Rural citizens now have access to cardiology, ENT and dermatology consultations without leaving their community. The hospitals are: Battle Mountain General Hospital; Grover C. Dils Medical Center; Humboldt General Hospital; Mt. Grant General Hospital; Nye Regional Medical Center; Pershing General Hospital; South Lyon Medical Center; and William Bee Ririe Hospital.

- Loan Pool Fund: NRHP has developed a \$900,000 capital pool through grants and a low interest rate loan from The Robert Wood Johnson Foundation (TRWJF). Each member hospital has access to low cost (5.7%) loans for equipment and capital improvement.
- Shared Financial Management Services: This program provides financial support and education to participating hospitals. By sharing the cost of a financial manager, the hospitals are able to reduce costs while benefiting from expertise to which they would not otherwise have access. These services include the development and implementation of financial analysis tools as well as the training and education of hospital staff. The financial manager evaluates the hospitals' financial information and assists with the implementation of any appropriate corrective action.
- Board Development: Rural Hospital Board members are often overwhelmed by the complexity of hospital governance. NRHP has sought to support these voluntary hospital board members by providing educational opportunities in

rural settings. These seminars are offered free or for a very modest registration fee.

- Technical Assistance: Technical assistance to individual hospitals is a service provided by NRHP. Resources have been used for strategic planning, licensure issues, the development of alternatives to ownership and service delivery methods, community education and financial management. One strength of the consortium is its ability to draw on expertise available in one facility to help another.
- Group Purchasing: NRHP negotiates group discount rates on capital purchases. To date, this has included copy machines, computers and interactive communication equipment.
- Reference Laboratory Services: NRHP negotiated group discount for specialty lab work, saving ten participating hospitals 50% over previous costs.
- Quality Assurance: NRHP developed a model Quality Assurance (QA) plan for members and also developed a step-by-step implementation manual for hospital department heads. NRHP has served as a resource for the hospital QA Coordinators.
- Information Source: NRHP serves as a clearinghouse and resource center for its member rural hospitals and other rural Nevada health care providers. Questions about any issue relating to rural facilities may be directed to NRHP and NRHP staff will assist its member in anyway it can.

- Improve Rural Hospital Credibility: The greatest accomplishment of NRHP has been the improved credibility of member hospitals, both within the state and nationally. While this benefit is not always tangible, it allows hospitals to influence rules, regulations, and laws to improve hospitals' ability to operate. On the state level, NRHP has been called upon regularly to act as a resource or to perform special health related projects. At the federal level, NRHP has been invited to participate in many nationwide committees and organizations as an expert of rural healthcare.

NRHP has become an important element in the prosperity of the small, rural and frontier hospitals in Nevada. NRHP's intent is to maintain current programs, as well as create and implement many more. When looking for new programs, the three main qualifications to consider, in respect to the member hospitals, are:

1. Improve quality of care;
2. Increase access to quality care; and
3. Improve financial viability.

CHAPTER SIX

DEPARTMENT OF TAXATION: State of Nevada

Given the downward financial trend in some of the Nevada rural counties and the problems faced by those hospitals this report prepared on February 7,

2000, Jack W. Moore, Supervisor - Local Government Finance, explains and analyze the ratios, financial statements and graphs.

Ratio Analysis of Nevada Hospitals

This analysis is designed to give the reader a “feel” for a particular facility’s financial position and operation based upon what is occurring in the other facilities along with a comparison to some subjective ratios as a standard.

This analysis is presented as follows:

1. A summary of each entity’s audited financial statement. The financial statement comparison (Figure 3) explains for the counties of White Pine, Humboldt, Lincoln, Lander Pershing, Mineral, and Carson-Tahoe the current, fixed and other assets; current and long-term liabilities; and fund balances. Then operating revenue from patients through reimbursements from Medicare, Medicaid, private insurances and private cash pay less operating expenses. Shows the operating income(loss) and then the net income(loss) after the nonoperating revenue which comes from property tax allocations, interest and other nonoperating revenues. These summaries reports each entity’s assets, liabilities and fund balance, along with a summary of the operations for the fiscal year ended by the balance sheet date.

The information presented is based upon the audited financial statements received by the Nevada Department of Taxation for the fiscal years ended June 30, 1999 and 1998. The Nevada Department of Taxation in an over view with these figures shows that the hospitals with exception of Carson-Tahoe showed a

loss before government assistance. That being part of the County Hospital Districts helps offset the losses except for Grover C. Dils Medical Center in Lincoln County and Pershing General Hospital in Pershing County. These two facilities even after taxpayer dollars still show losses.

CHAPTER SEVEN

CONCLUSION

This study presented just tipped the iceberg regarding the factors and problems facing Nevada rural hospitals. Findings regarding the financial condition of rural hospitals, their involvement in the Nevada Rural Hospital Project and a review of each rural hospital was presented.

Nevada rural hospitals perform many critically important functions in their communities. They provide an array of health services, even though they do not

always include more intensive services. They employ people and sometimes will be the biggest employer in the community. They also give back to the community because as the biggest employer they indirectly support other businesses and even help attract businesses because of their accessibility.

Given the sparse population of Nevada, rural hospitals are a necessity to ensure the delivery of quality care to all citizens. The viability of rural hospitals in Nevada will be determined in the first instance by whether these hospitals can reduce costs without reducing the quality of medical care that rural residents need and deserve and in the second instance by whether these hospitals can provide these services in a manner that still makes the hospital economically viable.

RECOMMENDATIONS

Recommendations for future studies regarding Nevada rural hospitals are as follows:

The payment changes included in the Balanced Budget Act are predicated on the assumption that health care providers and delivery systems can adjust to lower federal funding (Medicare reimbursement payments) by operational cost-cutting. Cost cutting may be realized through further development of local and regional networks. Another mechanism for finding cost savings is to increase the volume of service per provider such that economies of scale yield savings. Two other possibilities exist: large rural networks or consolidation of providers. The challenge for rural providers will be how to cooperate across a sufficient number of service locations to generate the

number of patients needed to use new techniques of medical and administrative management, without sacrificing local autonomy.

Policy makers examining the Medicare program are obligated to be fiscally prudent in setting payment policies, but they are also charged with the responsibility of doing what they can to assure that services are available to the beneficiaries. These twin responsibilities pose what has become a core dilemma in recent years - meeting an obligation to finance services without spending more than is affordable in the context of the Medicare Trust Fund and the General Fund of the federal budget. The unavoidable obligation to constrain Medicare spending cannot be met by simply imposing continuing and significant payment reductions on small rural providers since to do so jeopardizes access to care for rural beneficiaries. Providers should be able to cut costs in a manner that contributes to savings deemed necessary for the future of Medicare, albeit not at the same levels as larger providers. Consequently, public policy changes will need to be implemented. For example:

- Changes in payment policies should include a “rural differential,” accounting for different impacts on providers as a function of size and location,
- Policies designed to encourage change in the organization of health care services should include resources and suggested models that encourage rural providers to participate in the changes (Mueller & McBride, 1999).

Both of these public policy examples are founded upon a market position analysis. The possibility that hospitals can avoid direct competition by establishing a distinct market position has significant implications for the

competitive dynamics among rural hospitals. Failure to consider a hospital's market position may overestimate the competitive pressure the hospital experiences in a given market (McKay, 1998).

The market position framework employs three service domains to evaluate the market position of a local hospital in a given market area. The attributes are geographic distance, size and service configuration.

(1) Geographic Distance: Likely to affect the competitive dynamics among rural hospitals. Hospitals at a distance from other hospitals may avoid direct competition for patients and physicians and have better prospects for survival.

(2) Relative Size: The relative size of a hospital may determine where patients and physicians go, therefore if rural hospitals are adequate in size to meet the needs of the population they serve, they will have better prospects for survival.

(3) Service Configuration: The relationship between market position and hospital closure is explored by considering the effects of service configuration within three service domains: basic, high-tech, and outpatient/outreach. Basic services are defined as primary acute medical services that are generally associated with "traditional" hospital inpatient activity (e.g., respiratory therapy, general medical/surgical care). High-tech services are specialized clinical services involving the use of advanced technological facilities (e.g., cardiac catheterization lab). Outpatient/outreach services are those nonacute services that are often used to supplement or replace acute care services (e.g., ambulatory surgery, hospice) (McKay, 1998).

Using the market position framework, it is important to consider a rural hospital's position in these service domains relative to other hospitals in the market. The focus, therefore, is not on the absolute number of services provided in a particular service domain, but the relative number as it relates to the market area.

The role of the hospital in the American health care system is changing rapidly, just as there has been a dramatic change in the access to rural health care services in Nevada in the last five years. The number of physicians and physician assistants has more than doubled and the rural communities are receiving new or improved services. While recruitment of health care personnel continues, the main concern becomes maintenance of these basic primary health care services as well as building on the recent growth to insure a stable health care delivery system for rural Nevadans.

A rural health care system is only as strong as its weakest link. The interconnected links which constitute a rural health care system include the hospital and its separate components, such as buildings and equipment; management; health care personnel; the community support structure for health care services-health insurance programs, county subsidy programs, public health programs, pharmacy services, physicians, and the patients.

If any portion of this complex set of interrelationships does not function, the entire system has the potential for collapse. In a rural setting, this stability is much more at risk because of the relatively small size of the system. Any loss could have critical consequences in a rural setting.

Each area of the health care system must maintain its own individual competence while supporting and maintaining faith in the balance of the system. Therefore, health care systems must keep communication between the various units open and supportive. To keep costs down, the administrations of rural hospitals must always look for ways to reduce costs and maintain a high quality of care.

Finally in an age of increasing economic pressures the survival of any rural health care system is dependent upon a combination of hospital administrators with the expertise and vision to recognize the need to maximize relationships with larger urban medical facilities and community residents who use, albeit do not abuse, the services provided by the rural hospitals.

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APPENDIX 1

SURVEY

1. Name of the rural medical facility:_____
2. What year was the hospital founded?_____
3. How was the hospital originally organized (for example, not-for-profit, public, physician-owned)?_____
4. In what year was the hospital last organizationally restructured?_____
5. What organizations associated with for support?_____
6. How hospital compensates the physicians?_____
7. How many employees?_____
8. Number of nurses employed:_____
9. What geographic areas are included in the hospital's service area?_____
10. County:_____
11. The population estimates for your county:_____

12. Average patient days: _____

13. Profit or Loss as of last budget year: _____

14. Things doing to keep the doors open: _____

15. Sources of funds: _____

16. Number of bed: _____

APPENDIX 2

MEMBERS OF NEVADA RURAL HOSPITAL PROJECT

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Pershing General Hospital

Jon Smith, Interim Administrator

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South Lyon Medical Center

Joan Hall, Administrator

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William Bee Ririe Hospital

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Rural Hospital - Nonmember

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Nye Regional Medical Center

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