The Vanishing Community Hospital — An Endangered Institution
1:15 – 2:15 pm
Craig B. Garner
Garner Health, LLC
EVERY HOSPITAL TELLS A STORY

Regardless of whether it serves a small rural setting or a sprawling urban population, an area’s local hospital plays an integral role in shaping and defining its community.

THE HEARTBEAT OF A NEIGHBORHOOD

An area’s local hospital is often the driving force of its surroundings, providing support in times of need while also creating jobs and stimulating the economy.

In many ways, the history of a neighborhood hospital is both the story of its patients and a snapshot of the times in which they lived.
WHAT THE PAST CAN TEACH US
Too often, however, such tales are forgotten once a hospital is forced to close its doors. Still, there is much to be learned by these now defunct facilities that have cared for America’s inhabitants and shaped the evolution of her health care system.

THE MEANING OF HEALTH CARE, PAST AND PRESENT
These stories emphasize what provision of care has meant in the United States since the first almshouses tended to the poor and downtrodden in colonial America.

By recognizing the changes affecting our hospitals over time, we are better able to grasp what we as a nation value in the institution we call health care.

HOPE FOR TOMORROW
Such insight will allow us to assist the hospitals of the future in their struggle for survival, rather than lament the hospitals we have lost.
THE CHANGING LANDSCAPE OF THE AMERICAN HOSPITAL SYSTEM

- The trend of multi-hospital systems replacing freestanding community hospitals picked up speed after 1965.
- The five hospital consolidations noted in 1961 ballooned to upwards of 50 per year in the 1970s.
- By the 1980s, an estimated 30% of hospital beds in the United States existed within hospital systems.
- In 2008, the American Hospital Association estimated that almost half of the nearly 6,000 U.S. hospitals belonged to a hospital system.

THE LURE OF CONSOLIDATION

Even many of the non-profit, faith-based hospitals directly descended from the original almshouses and charity hospitals of the 18th and 19th centuries have come to seek refuge in consolidation.

In 1872, there were approximately 75 Catholic hospitals in the United States.

Today, most of these institutions have been incorporated into regional “systems” in an effort to survive.

CREATING THE IDEAL HOSPITAL

“An ideal hospital would be a small hospital, with small, detached wards, well ventilated, and with beds far apart, remote from [centers of] population, and surrounded by open walks and grounds. Hospitals that are situated in the outskirts of towns – in the open field, so to say.”

–Michael Levy, Consulting Member of the Board of Health of France, 1862
PROBLEMS FACING CALIFORNIA'S HOSPITALS

MILESTONES FROM THE PAST

- The 1946 Hospital Survey and Construction Act (Hill Burton Act)
- The 1965 passage of Medicare
- The 1983 introduction of Medicare’s diagnosis-related groups (DRGs)
- The 1986 Emergency Medical Treatment and Active Labor Act (EMTALA)
- The 1994 Northridge Earthquake
- The 1996 Health Insurance Portability and Accountability Act (HIPAA)

CALIFORNIA'S LEGISLATURE RESPONDS

- The Medi-Cal disproportionate share program (DSH)
- The Private Hospital Supplemental Fund
- Distressed Hospital Funds
- Construction and Renovation Reimbursement Program
- The Hospital Fee Program
- SB 1953
- California's Physician Outpatient Referral Act
THE FEDERAL GOVERNMENT WEIGHS IN

• American Recovery and Reinvestment Act of 2009
• HITECH
• The Affordable Care Act
• Accountable Care Organizations
• Stark and Anti-Kickback Laws
• RACs, MACs, MIDs and ZIPCs
• Performance-based reimbursement

TRACKING HOSPITALS IN CALIFORNIA

HOSPITAL INPATIENT DISCHARGE DATA BY COUNTY (1996-2001)
WHILE CALIFORNIA LEGISLATION MAY SEE THE ISSUES . . .

• “Rural hospitals serve as the "hub of health," and through that role attract and retain in their communities physicians, nurses, and other primary care providers.”
• “The rural hospital is often one of the largest employers in the community.”
• “Economic development of a rural area is, in part, tied to the existence of a hospital.”
• “Rural hospitals are an important link in the Medi-Cal program.”

[Health and Safety Code § 124800]

. . . THE SOLUTIONS DO NOT ALWAYS PRESENT THEMSELVES

From CHA’s January 2012 Environmental Scan and View of the Future:

"Components of the health care delivery system, including safety-net and rural hospitals, will become increasingly fragile unless private marketplace practices and government programs improve. Even with a recovering economy, most California hospitals face increasing financial challenges."

Is there hope for the future?
HOPE STANDS AT A CROSSROADS

"Hope is the thing with feathers –
That perches in the soul –
And sings the tune without the words –
And never stops -at all."

- Emily Dickinson

An Article from Fortune Magazine:

"Today physicians who practice privately are subject to the sort of controversy long familiar to management . . . that involves charges of overpayment and hints of incompetence. Lay gossip about the physician's abilities and his fees is harsher than it used to be, and articles in popular magazines are irreverent . . .

Today, however, the old-fashioned doctor has gone with the old-fashioned family. With new aids to diagnosis, new treatments, and new drugs, any competent physician can accomplish more and quicker cures than he can with any amount of bedside attendance. Under these circumstances patients credit the treatment, not the physician, with keeping him well."

An Article from the Sacramento Bee:

"Judging from recent media reports, American medicine must be on the verge of utter decay. Government officials complain that we doctors do vast amounts of unnecessary surgery. We are accused of inappropriately hospitalizing too many patients and in discharging them prematurely.

We are being harassed by government and big business for over utilizing sophisticated and expensive medical technology — while at the same time, the courts hold us liable when we fail to admit a patient who turns out to be sicker than we originally perceived.

And lawyers and patients consider us negligent and irresponsible if we fail to use sophisticated tests which would detect early and curable disease."
An Article from the New York Times:

“Patients and doctors often complain that appointments are rushed, but the time that doctors spend with each patient — 16 to 20 minutes, on average — has remained largely unchanged for years.

Instead, patients have gotten sicker and treatments more complex. Half of American citizens have a chronic disease like high blood pressure or diabetes, and a quarter have two or more such conditions. . . . For many of their patients, doctors must increasingly rush through a blizzard of questions and tests, leaving little time for the kind of intimate chit-chat for which doctors and patients alike yearn. Some patients must schedule two or three office visits to have all of their medical issues addressed.”

“History may not repeat itself, but it does rhyme a lot.”
- Mark Twain

UNDERSTANDING, FACING AND SOLVING THE PROBLEMS AT HAND
REMEMBERING OUR MISSION

• The 44 rural counties in California are home to 5.3 million people (2010 census).
• In 2010, the 168 acute care hospitals in California’s rural counties treated one-third (3.3 million) of all emergency department visits in California.
• An estimated 1.3 million children live in California’s rural counties.

REMEMBERING THE DIRECTION WE WANT TO AVOID

“Patients displaced by a closing often take months or years to re-weave the fabric of their medical services. Vulnerable patients are made more vulnerable when hospitals close.”
- Professor Alan Sager, Boston University School of Public Health

CALEXICO HOSPITAL, CALEXICO

Calexico Hospital was one of California’s smallest hospitals in one of the state’s most economically depressed communities.

After 47 years of service, the 34-bed facility closed in October 1998, leaving the Imperial Valley border town of 24,000 without a hospital.

The governing body of the hospital was forced to surrender its license to the Department of Health Services (predecessor to the California Department of Public Health), which cited repeated violations of state health codes involving record keeping, cleanliness and training of personnel. Before the hospital closed, Medicare and Medi-Cal had it decertified.

Eight years after the hospital closed, a local jury found for the plaintiffs in a suit blaming the hospital’s closure on the actions of “rogue” state regulators and awarded Calexico’s owners $12 million.
When Desert Palms closed in 1996, the 110,000 townspeople of Palmdale found themselves without a hospital or emergency department.

With over 90% of Desert Palms’ admissions coming from the emergency department, hospital administration blamed the closure on the financial impact caused by a disproportionately high number of uninsured patients and an infrastructure destabilized by the entry of health maintenance organizations.

Prior to its closing in May 2010, Kingsburg District Hospital was one of the last remaining rural hospitals in the San Joaquin Valley. Since opening in 1961, Kingsburg had managed to overcome bankruptcies and cutbacks to continue providing essential services to local residents.

Originally named Santa Fe Coastlines Hospital, this facility was constructed in 1904 to provide medical care to Santa Fe Railroad employees.

In its early days the hospital thrived, and in 1924 it expanded to accommodate an increased patient census.

After the Second World War, East Los Angeles County slowly transformed into a less affluent area, and in turn the hospital found itself with less funding.

By the 1980s, Linda Vista Community Hospital was regularly treating a fair number of gunshot wounds and stabbings from surrounding local neighborhoods.

Further changes in hospital demographics and an increase in uninsured patients ultimately forced the hospital to stop accepting ambulance runs in its emergency department. Finally, in 1991, the hospital ceased operations.
Treating patients in California’s South Bay for over 70 years, RFK Medical Center was a comprehensive medical complex with a multi-specialty medical staff and 24-hour emergency department that provided adult and pediatric care.

When the 274-bed facility shut its doors in 2004, it was the sixth Los Angeles County emergency department that year to close due to financial concerns, a trend many attributed to the financial losses incurred by treating uninsured and underinsured patients.

Built in 1972 with assistance from the city, the hospital quickly experienced financial difficulties due to its largely uninsured and underinsured patient population.

Struggling for nearly 20 years as Southeast San Diego’s only hospital, high debt and lack of government funding ultimately forced a shutdown in 1991.

In the words of City Councilman Wes Pratt: “It’s a shame we can spend billions liberating Kuwait but we can’t find the funds to free our citizens from disease and inadequate health care right here in America.”

In 1930, the Carmelite Sisters of the Most Sacred Heart founded Santa Teresita Hospital as a sanitarium.

By the mid-1950s, it had upgraded to an acute care facility.

In 1964, the hospital added a skilled nursing facility and continued to expand, including the construction of an office center in 1981 and surgery wing in 1986.

The hospital closed its 30-bed acute care facility in January 2004, citing California’s implementation of statewide nurse staffing ratios as a contributing factor.
Forged by an informal partnership between local governments and merchants, this hospital formed one of the oldest health care "systems" in the nation. Tuolumne was built in 1849, offering a range of medical, surgical and diagnostic services.

On July 1, 2007, Tuolumne General closed its ER and discontinued all ancillary services, citing financial difficulties incurred from operating an emergency department. Prior to its closing, a study concluded that only 41% of Tuolumne's emergency department visits were actual emergencies.

BE MINDFUL OF WHAT WE CANNOT CONTROL

- The national economy
- Labor disputes
- Seismic activity
- An evolving digital world
- The uncertainty of health care reform
- A changing climate for compliance

Maintain perspective

NAVIGATING THROUGH CHANGES - THEN

In 1987, the House of Representatives, Select Committee on Aging and the Task Force on the Rural Elderly noted that the delivery of health care in rural areas is complicated by geography, economy and public policy.

- The DRG system was blamed for putting the elderly at great risk, as older patients were released from the hospital much faster, or not admitted at all.
- Medicare's Prospective Payment system reimbursed rural hospitals at a lower rate than comparable urban facilities for care provided to an elderly patient with the same illness.
- Rural hospitals did not usually benefit from a teaching adjustment to the DRG.
NAVIGATING THROUGH CHANGES - THEN

“Some argue that as many as 1,000 hospitals will close by the end of this decade, resulting in a decline in the training of needed medical personnel, and the creation of serious problems of care to select populations and communities. They argue, for example, that the hospitals that are especially at risk of closure are the small rural hospitals, many of which are the only providers of medical care to their local communities. . . . In contrast, others argue that rural . . . hospitals . . . through adapting to these changes and through increasing support of their local communities and state governments, will not have to close but, rather, will reshape their mission and continue to provide needed medical care.” —Health Affairs, Fall 1986

NAVIGATING THROUGH CHANGES - NOW

• The DRG system will be replaced beginning in October 2012.
• Under the Affordable Care Act, CMS will start paying hospitals Medicare “bonuses” based upon overall performance, adherence to quality measures, patient satisfaction and total spending per beneficiary efficiency levels.
• This epic change is designed to transform a system that has historically been based on cost and volume into one that focuses primarily on quality and performance.
• Funding for value-based purchasing comes from base operating DRG reductions (1% in 2013, 1.25% in 2014, 1.5% in 2015, 1.75% in 2016, and 2% thereafter).
• Hospitals with poor performance ratings may be excluded from bonus opportunities.

NAVIGATING THROUGH CHANGES - NOW CONTINUED

• A hospital’s chance of survival in Medicare's new world may ultimately depend on the sophistication and implementation of its core systems (both technical and practical), leaving little room for error.
• In this vein, Medicare's hospital value-based purchasing program may create a disadvantage for freestanding community hospitals, many of which lack the resources of larger, better funded institutions needed to both implement and monitor all of the components established by Medicare to be eligible for reimbursement based on quality and performance.
NAVIGATING THROUGH CHANGES - NOW CONTINUED

• Lacking the necessary resources to effectively combat rising health care costs and ever-expanding regulatory oversight, the smaller facility must be savvy in its approach to our nation’s new reimbursement structure if it is to maintain its existence.

• In order to survive, this once iconic institution must find ways to adapt to a constantly evolving health care system for which health care conglomerates appear better suited.

THE AFFORDABLE CARE ACT’S TRILLION DOLLAR GAMBLE

“The affordable care act helps stop health problems before they start.”
-HHS Secretary Kathleen Sebelius

The Affordable Care Act promotes:

• Pilot programs
• Preventative health care services
• Forward thinking research

EMBRACING TECHNOLOGY

• In 1951, the UNIVAC I was the first commercial computer to attract widespread public attention. The manufacturer, Remington Rand, sold 46 units at more than $1 million each.

• In 1961, DEC’s PDP-1 sold for $120,000. The company manufactured 50 units.

• “Lisa” by Apple Computer sold for $10,000 in 1983. The following year Apple introduced the Macintosh at the price of only $2,950.

• Similarly, a time may come when we will understand the concept of “meaningful use” and hospitals can enjoy the golden age of digital medical records, as well as the innovations and efficiencies that follow shortly thereafter.

As the health care industry continues its push toward electronic health records, we must be mindful of the speed with which technology changes, and the dilution of privacy expectations that progress from generation to generation.
The modern day hospital does not exist in a vacuum, nor do the constantly moving parts and pieces contained therein. The OIG's push toward vigilance in response to its perceived climate of fraud and abuse should be balanced by equal attention to efficiency and performance.

- Lean Six Sigma
- Fresh air and sunshine
- The ACO application
- Best practices in health care

In this digital age, never underestimate the value of "analog," especially when responding to changes.

EMBRACING COLLABORATION

Border 2012 – This 10-year program takes a bottom-upward, regional approach to bringing together a wide variety of stakeholders in an attempt to prioritize sustainable actions and improve the environment of the border area between the United States and Mexico (www.epa.gov/usmexicoborder).

- Goal #1: Reduce Water Contamination
- Goal #2: Reduce Air Pollution
- Goal #3: Reduce Land Contamination
- Goal #4: Improve Environmental Health
- Goal #5: Emergency Preparedness and Response
- Goal #6: Environmental Stewardship
Always be mindful of the doctor/patient relationship, from Marcus Welby, M.D. to Gregory House, M.D.

**EMBRACING COLLABORATION CONTINUED**

- Administration
- Health care practitioners
- Employees
- Vendors
- Your community
- Patients

**EMBRACING GRANT FUNDING**

- California Endowment Grant Programs
- California Wellness Foundation Grants
- California Wellness Foundation Program
- HELP II Financing Program
- Humana Foundation Community Grants
- Medicare Rural Hospital Flexibility Program
- Rural Community Assistance Corporation
- Sierra Health Foundation Leadership Program
- Small Rural Hospital Improvement Program (SHIP)
- Student/Resident Experiences and Rotations in Community Health Program (Cal-SEARCH)
- Wells Fargo California Grant Program

Additional information is available on the Rural Assistance Center website (www.raconline.org).

**TRAINING NEW HEALTH CARE PRACTITIONERS**

On February 13, 2012, the National Health Service Corps (NHSC) awarded $9.1 million in funding to medical students who commit to serving as primary care doctors in communities with limited access to care.

“This new program is an innovative approach to encouraging more medical students to work as primary care doctors. This is an important part of the Administration’s commitment to building the future health care workforce.” - HHS Secretary Kathleen Sebelius
“The future influences the present just as much as the past.”
- Friedrich Nietzsche

Thank you
Craig Garner
Garner Health, LLC
(310) 458-1560
craig@craiggarner.com
TRACKING HOSPITALS IN CALIFORNIA

- # of Hospitals in California
- Population in California

Garner Health, LLC
HOSPITAL INPATIENT DISCHARGE DATA BY COUNTY (1996–2001)

<table>
<thead>
<tr>
<th>County</th>
<th>Percentage</th>
</tr>
</thead>
<tbody>
<tr>
<td>Amador</td>
<td>0.12%</td>
</tr>
<tr>
<td>Calaveras</td>
<td>0.122%</td>
</tr>
<tr>
<td>Contra-Costa</td>
<td>2.615%</td>
</tr>
<tr>
<td>El Dorado</td>
<td>0.442%</td>
</tr>
<tr>
<td>Sacramento</td>
<td>3.521%</td>
</tr>
<tr>
<td>San Joaquin</td>
<td>1.719%</td>
</tr>
<tr>
<td>Solano</td>
<td>0.975%</td>
</tr>
</tbody>
</table>

Garner Health, LLC
### HOSPITAL INPATIENT DISCHARGE DATA BY COUNTY (1996–2001)

<table>
<thead>
<tr>
<th>County</th>
<th>Percentage</th>
</tr>
</thead>
<tbody>
<tr>
<td>Imperial</td>
<td>0.441%</td>
</tr>
<tr>
<td>Los Angeles</td>
<td>30.535%</td>
</tr>
<tr>
<td>Orange</td>
<td>7.826%</td>
</tr>
<tr>
<td>Riverside</td>
<td>4.937%</td>
</tr>
<tr>
<td>San Bernardino</td>
<td>5.537%</td>
</tr>
<tr>
<td>San Diego</td>
<td>7.53%</td>
</tr>
<tr>
<td>Ventura</td>
<td>2.085%</td>
</tr>
</tbody>
</table>

**Garner Health, LLC**