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Voice of the REH CEO:

Perspectives from those who have led their organizations through REH conversion.

Brought to you by the RHRC's REH Technical Assistance Center
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Background

The rural emergency hospital (REH) is a Medicare provider type created to address the growing concern over rural hospital closures. The goal of this new designation is to provide a means to preserve access to essential services for rural residents, and to decrease the likelihood of hospital closures. The Centers for Medicare & Medicaid Services (CMS) establishes regulations for REHs.[1] As of January 2023, critical access hospitals (CAH) and small rural hospitals with no more than 50 beds that were open as of December 27, 2020, may opt to convert to the REH in accordance with the conditions of participation outlined in the CY 2023 hospital outpatient prospective payment and ambulatory surgical center payment system (OPPS) Final Rule. The REH is the first Medicare provider type since the United States Congress created the CAH designation via the Balanced Budget Act of 1997.

The Federal Office of Rural Health Policy (FORHP) was funded by Congress to provide technical assistance to prospective REHs.[2] To deliver this technical assistance, the Rural Health Redesign Center (RHRC) was awarded a Cooperative Agreement by FORHP to serve as the national REH Technical Assistance Center ('TAC'). Through the TAC, hospitals have access to a range of services including education, financial modeling, application tools, stakeholder engagement and communication toolkits, strategic planning, and more. Support is tailored to the needs of the individual communities and allows for 1:1 education and interaction with other organizations on a similar journey. In 2024, the TAC also launched its REH Network where it offers ongoing assistance and peer-to-peer learning experiences to any converted REHs in the country that choose to participate.

In addition to this technical assistance, FORHP provides funding to support the tracking of state REH policies and licensure by the National Conference of State Legislators (NCSL)[3] and the National Academy for State Health Policy (NASHP)[4], as well as coordination and dissemination of information with the State Offices of Rural Health (SORHs).

Introduction

The mission of all hospitals and health systems, regardless of size and location, is to provide quality care to patients and promote health in their communities. For the 61 million people who live in rural America, their local hospital provides essential services and programs to improve their health and the health of their communities. Executive leadership is critical to the success of these hospitals and health systems in rural areas which are often facing new regulatory and financial challenges. Their primary goal is to create an environment that is efficient while meeting the needs of the community and staff.

As the RHRC and its partners through the TAC work with CEOs across the country investigating the REH designation, it is evident that these individuals take their responsibility of deciding whether to convert seriously and with the utmost consideration for their community. Recognizing these individuals as the "boots on the ground", the RHRC

[1] CMS. (2023). Rural Emergency Hospitals. https://www.cms.gov/medicare/health-safety-standards/guidance-for-laws-regulations/hospitals/rural-emergency-hospitals

[2] Section 711 of the Social Security Act (42 U.S.C. 912); Consolidated Appropriations Act, 2022 (P.L. 117-103), Division H, Title II

[3] NCSL. (2024). Rural Emergency Hospitals. https://www.ncsl.org/health/rural-emergency-hospitals#toc2

[4] NASHP. (2023). Rural Emergency Hospitals: Legislative and Regulatory Considerations for States. https://nashp.org/rural-emergency-hospitals-legislative-and-regulatory-considerations-for-states/

team sat down with three CEOs of recently converted REHs to hear firsthand their experiences, perspectives, and lessons learned.

Table 1: Organization Overview of CEOs Interviewed

	Former Type	Bed Count	Conversion Date	State	Service Area Pop.
Kevin O'Brien, Harper County Hospital	CAH	15	10/1/2023	OK	3,200
Aaron Herbel, Mercy Hospital	PPS	15	1/1/2024	KS	2,000
Bob Moore, Helena Regional Medical Center	PPS	48	10/1/2023	AR	18,000

The following highlights their journeys from assessment through conversion.

Assessment of REH Feasibility Driven by the Need for Change

Rural hospitals often have low patient volumes which yield insufficient revenue, and consequently are at significant risk of closing. The REH was created to serve as a potential lifeline for rural hospitals on the brink of closure. "The problem was, even before COVID, we started to see declines in usages, we had to look for different ways to sustain us because we were suffering loss after loss. We only averaged 1.5 to 2 patients a day including swing bed and acute care, we haven't made money in ten years", explained Kevin O'Brien. Harper County, the location of his facility, is extremely rural, dominated by agriculture with ranches and farmland and many feedlots. Harper County Hospital's service area is 3,200 with a shrinking population, and the closest neighboring hospital is 35 miles away.

Just one state away sits Mercy Hospital, who was experiencing similar turmoil. According to CEO, Aaron Herbel, inpatient care in 2017 provided 65% of the hospital's total net revenue. Last year, acute inpatient care only provided 34% of the net patient revenue. Emergency room visits had increased while the inpatient case mix index was steadily declining. Herbel went on to share that the first year he was at Mercy, they received over $250,000 annually from the low-volume adjustment reimbursement and the last year of being a PPS hospital, they received only $95,000 while still providing the same services.

To the South, Helena Regional Medical Center is in the poorest county in Arkansas from a health and financial standpoint. "Converting to REH was the only mode to survival," shared former CEO, Bob Moore.

As these CEOs looked for the most viable option to keep their organizations open and provide much needed care in their communities, they turned to data to help assess whether REH could be the answer. Through the REH Technical Assistance Center, all three hospitals received detailed financial models of what an REH may provide in comparison to their current environment. This came in addition to detailed education regarding the REH regulations and requirements. The data provided from the financial models, in addition to that collected by the CEOs previously, went on to serve as the foundation for messaging the transition to their staff, boards, and communities.

Preparing The Community for Conversion

The most significant theme across all three CEO interviews was the emphasis on transparent, timely, and data-driven communication to the staff and public. Once it was determined that REH conversion was likely, they began holding public town halls and initiating frequent conversations with the board, medical staff, and other prominent stakeholders. In one instance, the Patient and Family Advisory Council was engaged to get feedback from well-connected people who had been patients and lived in the community their entire lives. "Making the conversation not so much about what the community was losing, but what they were keeping made it a positive," according to Herbel.

Despite these activities, communities still struggled to understand the conversion and what it meant for accessing care. "Based on payor class, many residents have left the county to seek care elsewhere. Community rumors abound that the hospital is closed, however, that rumor was there long before the REH conversion.", stated Moore. Similarly, in Oklahoma, O'Brien shared that ER visits went down 20% due to misconceptions in the community such as the hospital being closed, believing that they would receive substandard care, or that they would be transferred out to another hospital. To counteract this mindset, the hospitals increased their advertising and communication efforts. "Before the conversion, we didn't have any money to focus on public relations. Now, we have the ability to market the hospital and to partner with organizations in the community", said O'Brien.

Staffing and Service Line Adjustments

In alignment with REH regulations, 24/7 emergency services, laboratory testing, and radiology all continue to be available at these facilities. While the hospitals had to forgo all inpatient care, they have been able to maintain, explore, and expand other services such as physical therapy, outpatient surgery, Meals on Wheels, wound care, dietary and diabetic education, sleep studies, and more. "We timed the opening of the [walk-in] clinic with the REH conversion to show the community that in addition to the services that were not changing, they could now utilize the clinic at nights and on Saturdays", shared Herbel. In Harper County, Oklahoma, O'Brien shared that they have added outpatient pulmonary rehab, which is currently at capacity and has a waiting list. He also shared that the hospital intends to enhance its efforts to connect with the Hispanic population in the community, ensuring that they are being reached and their healthcare needs are being addressed.

Conversion to REH and adaptation of service lines did lead to changes in staffing models at these facilities. "The conversion did affect the hospital's staffing model, reducing it by 15 FTEs overall.", shared Moore of Helena Regional. He went on to detail the current staffing which includes three registered nurses per shift for ER and observation beds; three laboratory personnel during the day and one technician at night, following 12-hour shift rotations; and four radiology technicians during the day, one on call after 4 p.m., and one covering in-house at midnight. He also stated that Housekeeping, Registration, Business Office, Dietary, Administration, and Maintenance were reduced as well. Speech and Physical Therapy remained the same, but hours were reduced based on volume. With Helena Regional being a former PPS hospital, it is recognized that this level of staff separation may not be applicable to former Critical Access Hospitals.

Impact

When asked of the most significant impact the conversion had on the hospitals, all three CEOs share similar sentiment - The transition to an REH has allowed their hospital to stay

open to deliver healthcare services in the community. “We have made money every month since the change except one and we’ve never done that before”, shared O’Brien of Harper County. For Helena Regional, this meant the hospital was able to stay open long enough to be sold to a new operator and under a new lease with the city so that it can continue to provide healthcare services, employment, and economic stability for many years to come. “This new management aims to provide more comprehensive, integrated healthcare services to the community. They have intentions to reintroduce surgical services as well as focus on rural health clinics to broaden the range of services available in the community,” shared Moore.

Moore and O’Brien acknowledge that the transition has not always gone as well as they hoped, especially as it relates to community buy-in and understanding. “Volumes have decreased slightly as residents bypass the ER, especially if they believe they will need to be admitted”, stated Moore. This is recognized as an opportunity for education as the hospital had about 28 ER visits per day and 18-20% of the patients seen were transferred to other facilities prior to conversion. In looking at the recent data, Moore shares that these metrics remain consistent since becoming an REH.

Legislative Considerations

Based on their experiences navigating the REH landscape, these CEOs shared their thoughts on the legislation and changes that would make it more palatable for rural hospitals. Some of these recommendations included eligibility requirements to be based on average daily census instead of licensed beds; 340B programs to be allowed; and certain traditional inpatient stays like obstetrics to be permissible.

Conclusion:

Despite their differing geographies, community needs, and cultural environments, these three hospitals all underwent REH conversion to provide financial stability that will enable them to continue providing healthcare services in their community. Their conversion journeys heavily prioritized leveraging data to inform their decision-making and messaging to the community and proactive communication to their boards, staff, patients, and other key stakeholders. They also emphasize the importance of ongoing community education to address misconceptions and ensure that patients understand the whole breadth of services they still have available. While not all of their conversions went as smoothly as they had hoped, they are seeing positive cash flow and have been able to expand services to better meet the healthcare needs of their service area.

Get Connected:

If you are interested in hearing more from CEOs navigating the REH designation, as well as other updates and key learnings from the REH Technical Assistance Center, subscribe to our newsletter or visit the RHRC website. To receive support from the REH Technical Assistance Center, contact us at REHSupport@rhrco.org.

Disclaimer

The writing of this document was based on direct interviews with stakeholders and does not necessarily represent the opinions of the RHRC and its partners. These interviews took place in May of 2024. Any information provided does not constitute legal advice and relevancy of content may vary as time progresses due to regulatory updates and changes.