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Provision of Long Term Care Services by Critical Access Hospitals: Are Things Changing?

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Introduction

Rural America is older and is growing older faster than the rest of the country.¹⁻² These trends raise concerns about access in rural areas to post-acute and long term care (LTC) services.* Although rural hospitals, and Critical Access Hospitals (CAHs) in particular, have played important roles in providing these services, there is some evidence that this is changing.³⁻⁵

During the 1980s and early 1990s, diversification into LTC was a commonly recommended strategy for rural hospitals given the large elderly populations in rural communities and the stagnant demand for traditional inpatient services.⁶⁻⁸ Throughout the 1990s, the number of rural hospitals offering LTC services—including skilled nursing, home care, swing bed, and hospice services—grew. By 1999, 60% of rural hospitals offered swing beds; 43% offered skilled nursing, intermediate, or other LTC; and 59% provided home health services.⁸

Declines in the financial performance of rural hospitals in the 1990s and the shift from cost-based payment to prospective reimbursement in Medicare for Skilled Nursing and Home Health Services pursuant to the Balanced Budget Act of 1997 (BBA 97) have changed the financial landscape for rural hospitals. The reimbursement changes mandated by BBA 97 essentially reversed the positive relationship between diversification and financial performance.^{4,6} For some CAHs, this change in financial incentives has potentially discouraged the continued operation of distinct part skilled nursing units and home health care.

Because many of the studies of the role of rural hospitals and CAHs were conducted during the early years of the Flex Program, little is known about the extent to which these trends have continued among CAHs that converted in later years of the program. This Policy Brief uses data from the 2004 and 2008 American Hospital Association's

Key Findings

- CAHs play an important role in the provision of long term care (LTC) services in rural communities.
- CAHs are more likely than other rural and urban hospitals to provide “core” LTC including skilled and intermediate care nursing services.
- CAHs offering these “core” LTC services are also more likely than other hospitals to offer a wider array of LTC services such as home health, residential care, and other social support services.
- CAHs showed a somewhat greater decline in the provision of LTC services over the study period than other hospitals, suggesting that changes in LTC reimbursement policies could affect LTC access in rural communities.

* For the purposes of this Brief, the term ‘long term care’ is used to refer to both Medicare post acute care services (i.e. Skilled Nursing and Home Health) and other social and support services such as intermediate care, residential care, and adult day care. (see Appendix)

Annual Survey of Hospitals to assess whether and how the provision of LTC services by CAHs has changed and how CAH involvement with LTC services compares with other rural and urban hospitals. We also examine the characteristics of hospitals providing those services and discuss the implications of recent trends for rural health care. In the second phase of the study, we will explore reasons for the closure of SNF units by some CAHs as well as factors contributing to their continued operation by others using key informant interviews with staff from CAHs in both categories.

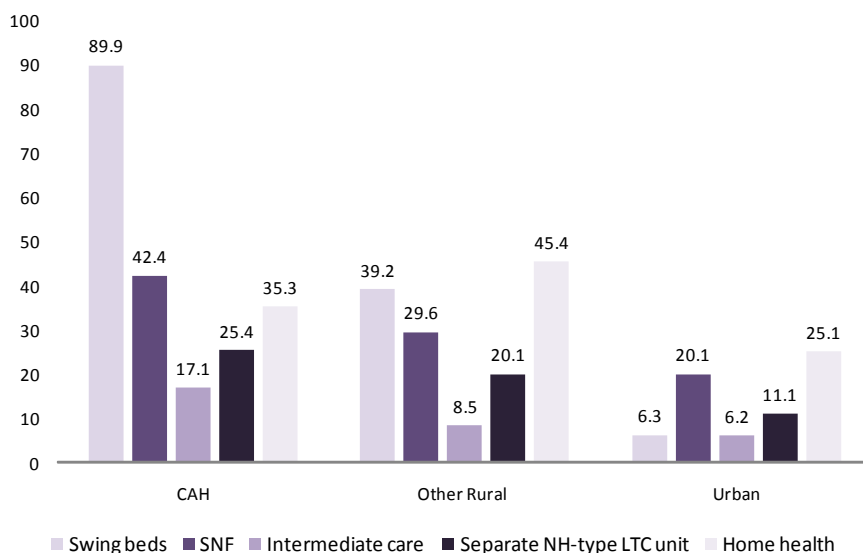
Methods

For this study, we used the 2004 and 2008 American Hospital Association (AHA) Annual Surveys to examine the provision of LTC services by CAHs.⁹ We linked the AHA surveys with the Flex Monitoring Team’s list of CAHs to identify CAHs in the AHA database and used the Rural Urban Continuum Codes to classify all non-CAH hospitals as either rural (i.e., non-metropolitan) or urban (metropolitan) using the county level measure of rurality. A total of 1,026 and 1,301 CAHs are represented in the 2004 and 2008 databases respectively. The analysis compared the provision of 12 long term care services by CAHs, other rural hospitals, and urban hospitals, examined changes between 2004 and 2008, and explored the relationship of key hospital characteristics to these trends (Appendix).

Key Findings

A significantly higher percentage of CAHs and other rural hospitals offered a wide range of LTC services compared with urban hospitals (Figure 1 and Table 1). CAHs are significantly more likely to offer swing bed services at 90% than other rural hospitals at 39%.[†] Forty two percent of CAHs offered SNF care in 2008 compared to

Figure 1: Provision of Select LTC Services in 2008 by Hospital Type



Source: 2008 American Hospital Association Annual Survey

Table 1: Provision of LTC Services by Hospital Type

LTC Services	Hospital Type		
	CAH	Other Rural	Urban
Swing beds	89.9%	39.2%	6.3%
SNF	42.4%	29.6%	20.1%
Intermediate Care	17.1%	8.5%	6.2%
Separate NH-type LTC unit	25.4%	20.1%	11.1%
Acute LTC	3.6%	4.7%	10.7%
Other LTC	10.5%	6.4%	4.6%
Adult day care	8.3%	3.7%	5.9%
Assisted living	9.5%	4.1%	2.6%
Hospice	21.3%	26.6%	23.0%
Home health	35.3%	45.4%	25.1%
Meals on Wheels	14.8%	9.7%	8.6%
Retirement housing	7.8%	2.7%	1.9%

Source: 2008 American Hospital Association Annual Survey

[†] To receive approval to operate swing beds, a hospital must be designated as rural (i.e., located in an area delineated as an urbanized area by the U.S. Census Bureau) and have fewer than 100 beds, excluding beds for newborns and beds in intensive care type inpatient units. Over time, population changes have resulted in changes to the rural status of the area in which some of these hospitals are located.

30% of other rural hospitals and 20% of urban hospitals. More than 25% of CAHs operated separate nursing home units compared to 20% of other rural hospitals and 11% of urban hospitals. Thirty-five percent of CAHs and 45% of other rural hospitals offered home health care in 2008 compared to 25% of urban hospitals.

The provision of LTC services declined between 2004 and 2008 across all hospitals.

Except for swing bed services (which increased by more than 4%), the percentage of CAHs offering LTC services declined across the spectrum of LTC services (Table 2) with the greatest declines reported for home health (-6.0%), separate NH-type LTC units (-4.6%), SNF (-4.4%), meals on wheels (-4.1%), and assisted living (-3.1%). Other rural and urban hospitals showed similar declines in the provision of LTC services during this period with some limited exceptions. The exceptions include acute LTC services, which increased slightly in other rural (0.4%) and urban (1.1%) hospitals, and hospice care, which increased in urban hospitals (0.8%).

Table 2: Changes in LTC Services Provided by Hospitals from 2004 to 2008

Hospital Type	LTC Service	2004	2008	Change
CAHs	Swing beds	85.7%	89.9%	+4.2%
	Skilled Nursing	46.8%	42.4%	-4.4%
	Intermediate Care	19.7%	17.1%	-2.6%
	Separate NH-type LTC unit	30.0%	25.4%	-4.6%
	Acute LTC	4.6%	3.6%	-1.0%
	Other LTC	11.9%	10.5%	-1.4%
	Adult day Care	10.6%	8.3%	-2.3%
	Assisted living	12.6%	9.5%	-3.1%
	Hospice	23.3%	21.3%	-2.0%
	Home health	41.3%	35.3%	-6.0%
	Meals on wheels	18.9%	14.8%	-4.1%
	Retirement housing	9.3%	7.8%	-1.5%
Other Rural Hospitals	Swing beds	40.7%	39.2%	-1.5%
	Skilled Nursing	33.8%	29.6%	-4.2%
	Intermediate Care	10.2%	8.5%	-1.7%
	Separate NH-type LTC unit	23.9%	20.1%	-3.8%
	Acute LTC	4.3%	4.7%	+0.4%
	Other LTC	6.8%	6.4%	-0.4%
	Adult day Care	6.0%	3.7%	-2.3%
	Assisted living	4.9%	4.1%	-0.8%
	Hospice	26.9%	26.6%	-0.3%
	Home health	50.0%	45.4%	-4.6%
	Meals on wheels	13.1%	9.7%	-3.4%
	Retirement housing	3.9%	2.7%	-1.2%
Urban Hospitals	Swing beds	8.0%	6.3%	-1.7%
	Skilled Nursing	26.4%	20.1	-6.3%
	Intermediate Care	7.7%	6.2%	-1.5%
	Separate NH-type LTC unit	15.3%	11.1%	-4.2%
	Acute LTC	9.6%	10.7%	+1.1%
	Other LTC	6.0%	4.6%	-1.4%
	Adult day Care	7.3%	5.9%	-1.4%
	Assisted living	2.8%	2.6%	-0.2%
	Hospice	22.2%	23.0%	+0.8%
	Home health	29.0%	25.1%	-3.9%
	Meals on wheels	9.6%	8.6%	-1.0%
	Retirement housing	2.1%	1.9%	-0.2%

Source: 2004, 2008 American Hospital Association Annual Surveys

In general, CAHs showed greater declines across the spectrum of LTC services than did other rural and urban hospitals. The exceptions included skilled nursing in which urban hospitals showed the greatest percentage point decline (6.3%) and adult day care in which other rural hospitals and CAHs showed equal percentage point declines at 2.3% each. A portion of the decline in the provision of LTC by all three types of hospitals can likely be attributed to the shift to a prospective payment system for SNF, home health, and other LTC services. Under the cost-based payment system used to reimburse CAHs for the delivery of inpatient, outpatient, and swing bed care, the provision of LTC and other services that are not cost-reimbursed reduces the hospital's reimbursement for acute inpatient care, swing bed, and ambulatory services by drawing costs away from those cost centers.

Table 3: Characteristics of CAHs in 2008 by LTC Status

Characteristic (% with LTC)	2008	
	% With LTC	% Without LTC
Hospital Control (Ownership)		
<i>Government (n=564)</i>	43.3%	56.7%
<i>Not-for-Profit (n=675)</i>	40.6%	59.4%
<i>Proprietary/for profit (n=62)</i>	21.0%	79.0%
Network participant (n=430)	57.2%	42.8%
Acute long-term care (n=39)	92.3%	7.7%
Other long-term care (115)	93.0%	7.0%
Adult day care (n=91)	82.4%	17.6%
Assisted living (n=104)	72.1%	27.9%
Hospice care (n=234)	52.6%	47.4%
Home health services (n=387)	55.3%	44.7%
Meals on Wheels (n=163)	59.5%	40.5%
Retirement housing (n=86)	75.6%	24.4%
Swing bed services (n=998)	50.9%	49.1%

Source: 2008 American Hospital Association Annual Surveys

Characteristics of CAHs Offering LTC Services

We examined the characteristics related to ownership/organizational control and participation in networks across two groups of CAHs; those offering “core” LTC services (i.e., skilled nursing, intermediate long-term care, and/or separate nursing home-type units) and those that do not (Table 3). The percentage of government-owned (i.e., state, county, city, city-county, hospital district/authority, and federal) CAHs offering core LTC services (43.3%) is only slightly higher than the percentage of non-profit (i.e., church operated and other not-for-profit) CAHs (40.6%). Proprietary (for-profit) CAHs were the least likely to operate core LTC services with only 21% of proprietary CAHs doing so. More than 57% of CAHs offering core LTC services reported participation in a network.

We also examined the provision of a wider array of LTC services across these two groups of CAHs. In general, CAHs offering skilled nursing, intermediate care, and/or separate nursing home-type units were more likely to offer a range of other LTC services such as home health services, adult day care, assisted living, and hospice care.

From 2004 to 2008, the number of SNF and intermediate care beds in CAHs declined slightly (Table 4). Medicare and Medicaid nursing home (NH) days and discharges as a percentage of total facility Medicare and Medicaid days and discharges also declined slightly.

Discussion and Implications

These findings are consistent with other studies⁷ that demonstrate the important and continuing role that CAHs and other rural hospitals play in providing SNF and other LTC services compared with urban hospitals. Nearly 45% of CAHs continue to provide SNF services despite the financial disincentives and the growing role of swing beds. In addition, a larger percentage of CAHs provide other LTC services such as home health care and assisted living.

Two factors may account for the large percentage of CAHs continuing to offer SNF services. First, hospitals that continue to provide SNF services may need these beds to manage patients in high hospital census situations. Secondly, CAHs may face community needs and sentiments that would make it difficult to close their SNF units and/or downsize their SNF beds. As mentioned earlier, we are exploring these and other factors in the second phase of this project in which we will interview key informants from CAHs that have closed and maintained SNF services.

The implications of the continuing decline in the provision of SNF and other LTC services by CAHs are potentially worrisome and merit further study. This trend may be a harbinger of a growing gap between the increasing concentration of older adults needing LTC services in many rural areas and available LTC options.

Table 4: Profile of CAH Provided LTC Services

Characteristic	2004		2008	
	Mean	# of reporting hospitals	Mean	# of reporting hospitals
Skilled nursing care beds	12.2	872	10.5	1100
Intermediate LTC beds	4.1	872	3.2	1100
Other LTC beds	2.7	872	2.3	1100
Medicare discharges–NH	21.6	275	23.6	245
Medicare days–NH	944.7	277	940.9	246
Medicaid discharges–NH	19.1	280	17.2	252
Medicaid days–NH	10247.0	279	10818.8	253
Medicare and Medicaid nursing home discharges as a percentage of total Medicare and Medicaid discharges	9.9%	281	7.9%	252

Source: 2004, 2008 American Hospital Association Annual Surveys

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Appendix: Key Study Variables

Long Term Care Services and Definitions

Acute LTC Specialized acute hospital care to medically complex patients who are critically ill, have multisystem complications and/or failure, and require hospitalization averaging 25 days, in a facility offering specialized treatment programs and therapeutic intervention on a 24-hour/7 day-a-week basis.

Adult day care Supervision, medical and psychological care, and social activities for older adults who live at home or in another family setting, but cannot be alone or prefer to be with others during the day.

Assisted living Combination of housing, supportive services, personalized assistance and health care designed to respond to the individual needs of those who need help in activities of daily living (ADLS) and instrumental activities of daily living (IADLS).

Hospice care Palliative care, chiefly medical relief of pain and supportive services, addressing the emotional, social, financial, and legal needs of terminally ill patients and their families.

Home health services Nursing, therapy, and health-related homemaker or social services provided in the patient's home.

Intermediate care Health-related services (skilled nursing care and social services) provided to patients with physical conditions or functional disabilities that do not require the care provided by a hospital or skilled nursing facility, but do need supervision and support services. (Primarily reimbursed by Medicaid.)

Meals on Wheels Meals delivered to the homes of people, usually the elderly, who are unable to prepare their own meals.

Other LTC Long term care, other than skilled nursing care or intermediate care including residential care, elderly housing services for those who do not require daily medical or nursing services, but may require some assistance in the activities of daily living, or sheltered care facilities for the developmentally disabled.

Retirement housing Housing and social activities for senior citizens, usually retired persons, who do not require health care, however some short-term skilled nursing care may be provided.

Separate nursing A separate (non-hospital-based) nursing home type unit/facility that provides home-type LTC unit care for the elderly and chronic care in a non-acute setting including any of the following: skilled nursing care, intermediate care, and other LTC.

Skilled nursing (SNF) Non-acute medical and skilled nursing care services, therapy, and social services under the supervision of a licensed registered nurse on a 24-hour basis. (Primarily reimbursed by Medicare.)

Swing bed services A hospital bed that can be used to provide either acute or long-term care depending on community or patient needs. Available only to hospitals with a Medicare provider agreement in place, fewer than 100 beds, located in a rural area, without a 24 hour nursing service waiver in effect, have not been terminated from the program in the prior two years, and meet various service conditions.

Hospital characteristics

Health system membership As defined by the AHA, systems can be either a multihospital or a diversified single hospital system. A multihospital system is two or more hospitals owned, leased, sponsored, or contract managed by a central organization. A diversified single hospital system includes the membership of three or more freestanding hospitals, and at least 25% of their owned or leased non-hospital pre- or post-acute health care organizations.

Hospital organizational/control structure Organizational/control structure responsible for establishing policy for overall operation of the hospital.

Hospital is part of a network A group of hospitals, physicians, other providers, insurers and/or community agencies that work together to coordinate and deliver a broad spectrum of services to their community.