TENNESSEE HEALTH CARE campaign

Rural Hospital Closures

***"The ambulance is our emergency room"*-- the voices of rural Tennessee**

March 2021

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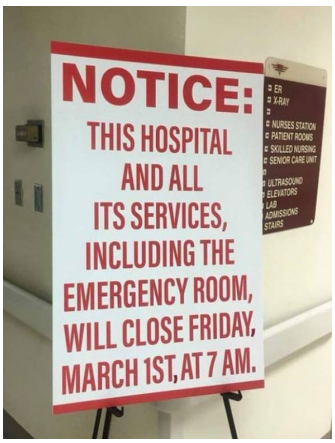
Page 11: The Tennessean February 14, 2019 *https://www.tennessean.com/story/money/industries/health-care/2019/02/14/rural-hospital-closures-ducktown-tn-gov-bill-lee-copper-basin-medical-center/2118872002/*

"The ambulance is our emergency room"--the voices of rural Tennessee

EXECUTIVE SUMMARY



Since 2010, Tennessee has had the second highest number of hospital closures in the nation, and the highest number of closures per population. In 2020 it was estimated that seventy five percent of Tennessee's 25 remaining essential access rural hospitals are at high risk of closure in the next few years if current healthcare policies and practices remain the same [*2020 Rural Hospital Sustainability Index: Trends in Rural Hospital Financial Viability, Community Essentiality, and Patient Outmigration*. https://guidehouse.com/insights/healthcare/2020/rural-hospital-sustainability-index]. A more recent report indicated that 24 of Tennessee's rural hospitals were at immediate risk of closure and another 6 were at high risk of closure [*The Crisis in Rural Health Care* released in January 2021 by the Center for Health Care Quality and Payment Reform https://ruralhospitals.chqpr.org/downloads/Rural_Hospitals_at_Risk_of_Closing.pdf]. Bottom line for Tennessee's rural communities: over one quarter of Tennessee's rural counties have no hospital, and one fifth have no emergency room services, and that number will continue to grow unless concerted effort is made to prevent that from happening.

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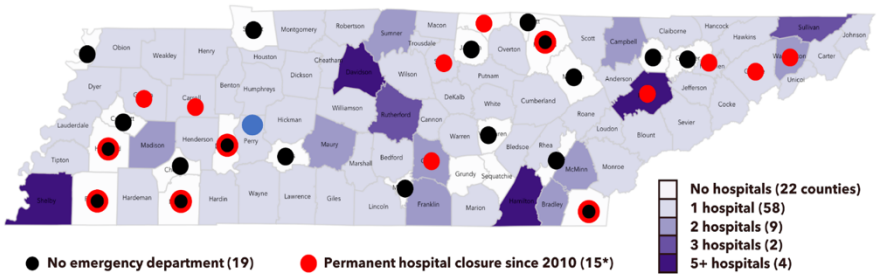
22 Tennessee Counties Do Not Have a Hospital, 19 Do Not Have an Emergency Department

Number of Hospitals by County (2020)



Includes only general/surgical hospitals, excludes specialty, exclusively children's, veterans, and psychiatric hospitals. Accounts for hospital closures and both hospital-based and freestanding emergency departments through October 2020. *16 permanent hospital closures in 15 counties. Source: The Sycamore Institute's analysis of information from the Tennessee Hospital Association, Tennessee Department of Health and news reports.

SycamoreInstituteTN.org

This map, which is reprinted with permission of The Sycamore Institute [SycamoreInstituteTN.org] was prepared in October of 2020. In December 2020, Perry County Hospital also closed. There was hope at the time of closure that it would reopen in 2021, but at the time of publication of this report it remains closed. That brings the number of Tennessee's counties that have no hospital to 23.

In response to the steady and harmful loss of Tennessee's rural hospitals, the Tennessee Health Care Campaign (THCC) developed a partnership with community representatives and academic partners to identify factors that influence these closures and their effects on rural communities. Our goals were to identify innovative strategies to reestablish health care infrastructures, learn lessons that might prevent future closures, and ultimately build a broader advocacy network to respond to the problem. During 2018-20, THCC gathered information from a panel of rural health experts, community listening sessions in six counties representing communities that had lost a hospital or were expected to, and a series of interviews with stakeholders including administrators, patients, and others, we explored the Tennessee hospital closure issue.

We learned from our community and other informants that recent rural hospital closures

- Impact the health of low-income residents, the elderly, chronically ill, and others who need specialized care especially hard

- Require police, ambulance, and other services to meet community health needs for which they are untrained
- Increase community anxiety about what will happen in emergency situations
- Reduce the viability and sustainability of local businesses, causing job creation to slow or stop
- Discourage in-migration from retirees and young families

The reasons for this crisis in our state are complex and interlocked. Over the decades since most rural hospitals were originally constructed, rural populations have declined in numbers. Remaining rural populations are older, often with a higher burden of chronic health conditions, and less likely to be insured. Tennessee's failure to draw down federal funds for Medicaid expansion and the rural patient mix of more uninsured and underinsured patients than privately insured, as well as trends toward corporate hospital ownership, rather than community ownership, in the US which favor the interests of shareholders over community members, are key factors.

In this environment, a rural hospital's financial situation is hidden from community members who have almost no notice of an impending closure, oftentimes not until the very day of closure. In addition, the state offers no assistance to rural community leaders to discourage hospital owners from closing the facility, finding a replacement administrative structure, or addressing the health needs after the loss. As one informant said, "Community members are crying out for some state oversight to this problem." Tennessee's Certificate of Need processes have been weakened, so that they also prevent problem solving that could help meet rural care needs.

The project also revealed that there are many strategies that can be employed to preserve a community's access to health care when facing a hospital closure. Community, as well as state and federal actions may be needed. Given the tremendous variety of rural characteristics across the state, no one strategy will work for every situation, but communities can be assisted to explore strategies that could be a good fit, capitalizing on the strengths within their community.

At the community level, these actions might include merging with another hospital or developing new service lines that meet local health needs, including freestanding or linked emergency, as well as urgent and primary care services.

State and federal support for collaboration among neighboring communities, global budget payments and telemedicine could be more strongly and effectively mobilized.

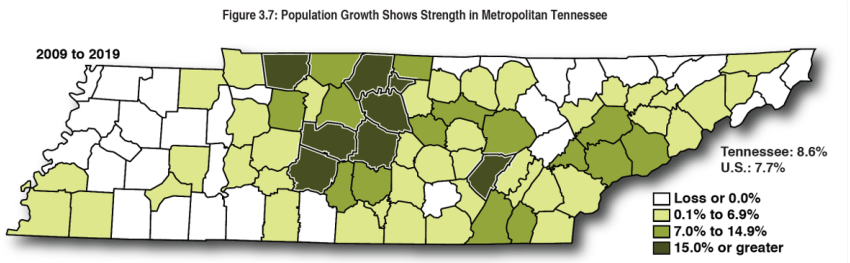
Finally, key policy changes are essential to stabilize Tennessee's rural hospitals and avert future closures, the most effective of which would be an acceptance of federal funds for Medicaid expansion. Others include:

- Requiring hospitals to provide communities with annual reports and notify them in advance of significant changes in services.
- Reforming the Certificate of Need program to investigate the failure of hospital operators to provide promised services and to encourage the use of mini-hospitals, stabilization sites, alternative critical care centers, and emergency transport services and other creative response to losses of hospital services.
- Developing free-standing Emergency Rooms
- Reforming insurance laws to allow rural communities near state borders to form multi-state insurance cooperatives and/or networks across state lines.

Federal funding and fiscal relief for all rural states would be essential as a long-term strategy for allowing rural hospitals to accommodate the disproportionately high number of low-income, uninsured, older, and chronically ill residents who live in these areas. Communities can promote this strategy by:

- Encouraging elected officials to engage in systematic problem solving to meet the health care needs of rural communities
- Challenging candidates for statewide offices to generate and follow through on proposals to address rural health care issues.
- Informing legislators of community health needs on a regular basis.

Population loss in rural Tennessee counties—a cause and effect of rural hospital closures.



This map, from the ***Economic Report to the Governor of the State of Tennessee 2020*** [Boyd Center for Business and Economic Research, Haslam College of Business, University of Tennessee-Knoxville. https://haslam.utk.edu/sites/default/files/erg2020.pdf] illustrates strong population growth in urban areas of the state over the past decade, but it also illustrates past population losses throughout rural Tennessee. Many young families and older retirees are attracted to rural and suburban living, but are looking for locations with a strong community health system with access to emergency care. Stakeholders in our listening sessions repeatedly mentioned real estate prospects that had fallen through when potential home buyers learned that there was no hospital in the county. It is also difficult to attract large employers to counties without access to hospital care in event of occupational injury.

INTRODUCTION

The Tennessee Health Care Campaign (THCC) was established in 1989 to advocate for affordable and accessible quality healthcare for all Tennessee residents, especially those for whom it is unavailable or unaffordable. THCC's work has advocated for the creation of TennCare, an expansion of Medicaid and the Affordable Care Act, and increases and improvements in the quality of mental health services and many other areas of healthcare. THCC also provides free assistance to those needing to enroll in ACA plans and TennCare.

In 2017, aware of the developing crisis in healthcare in rural communities caused by the rapid closures of rural hospitals, THCC leaders and Vanderbilt faculty member Velma McBride Murry, PhD developed a partnership, applying for a small grant from the Meharry-Vanderbilt Community Engaged Research Core to study the factors that influence rural hospital closures and the effects of those closures on Tennessee rural communities. By creating the THCC Rural Health Equity Team, the partners hoped to gain enough knowledge to develop a Citizen's Guide that could be used by communities facing the loss of their hospital. In 2018, using the grant funds to support a student intern and small stipends for community members who participated, the Team held its first listening sessions in two communities, one whose hospital had been closed for several years and another whose hospital had closed, then revived.

By the end of that year, eleven hospitals serving rural Tennesseans had closed. With closures spreading across the state, the Rural Health Equity Team received a second small grant to continue the listening sessions and deepen our understanding of factors that influence rural hospital closures. By the time we concluded our work in 2020, sixteen rural or rural serving hospitals had closed or stopped in-patient services. By adding interviews with providers and administrators, we learned that the tools available to communities to influence decisions about closure are very limited in our state.

In 2019 and 2020, we held additional listening sessions with residents of five more rural Tennessee counties, three that had experienced a recent closure of their hospital and two that faced imminent threat of closure. During these listening sessions and additional interviews with key informants, we met with county and city mayors, hospital administrators, healthcare providers, emergency services personnel, hospital board members, school administration and community citizens.

Through these conversations we learned that while each situation is unique, a set of common concerns and conditions drive closure decisions. We learned that there are steps the state can take to stabilize rural hospitals, and ways that communities can recognize the signs of impending closure and respond.

This toolkit describes what community members told us about the why Tennessee's hospitals are closing so rapidly, how these closures have impacted their communities, and actions that might have prevented these closures. While most of the responsibility for protecting rural health systems, rests with federal and state government, local communities need to be fully engaged in developing and coordinating services to improve health outcomes. We hope that this toolkit is also helpful to them.

WHAT WE DID

To better understand the context leading to Tennessee's rural hospital closures, the effects of the closures on the surrounding communities, and to identify ways to prevent or mitigate the effects, the THCC Rural Health Equity team conducted a three-year community-engaged research project to assess the impact of hospital closure on the health and quality of life in rural Tennessee communities. We agreed on the following goals:

- To identify innovative strategies to reestablish health care infrastructures.
- To learn lessons that might prevent future closures.
- To build a broad advocacy network to respond to the problem of rural hospital closures in in Tennessee.

Expert Panel

In May 2019, THCC and the Vanderbilt University Student Health Coalition brought together physicians and practitioners who had lived and worked in these rural communities during their undergraduate and graduate years. This panel of professionals and community members explored the Tennessee hospital closure issue. They also described strategies that have been used to prevent closures or respond effectively to rural service issues in Tennessee and other states. Panel members included:

- Dan Johnson, former CEO of Copper Basin Medical Center, Copperhill, TN whose extensive experience working with rural hospitals includes recruiting and managing physician practices, developing a hybrid hospitalist/ER practice to increase hospital admissions and revenue, and helping reopen a rural hospital in south GA.
- Chuck Womack MD, the former chair of the Tennessee Medical Association and former Mayor of Cookeville TN. Dr. Womack led a 1995-96 fight to keep the Cookeville Hospital under local control, ultimately leading to the city's rejection of a multi-million dollar offer to purchase it from an outside investor.
- Terri Sabella, RN, JD, CEO of the Tennessee Primary Care Association, a membership organization of more than 30 non-profit primary care clinic organizations operating nearly 200 clinic sites in Tennessee, described clinics' and communities' reliance on local hospitals to meet the non-primary health care needs of rural communities.

Listening Sessions

This component of our community-based research was funded by the Meharry Vanderbilt Community-Engaged Research Core and approved by the Vanderbilt Institutional Review Board. Counties were selected to include representation from each of the three Grand Divisions of the state. Each county also had experienced a recent hospital closure or reduction in services in a hospital vulnerable to closure. Participants in the in-person listening sessions were given lunch and participants in all listening sessions were offered a $50 gift card as compensation for their time.

Listening sessions with community leaders from counties that had experienced a hospital closure or were at elevated risk for a hospital closure were held on the following dates:

1. Haywood County (Brownsville), March 23, 2018
2. Scott County (Oneida) June 18, 2018
3. Clay County (Celina), October 18, 2019
4. Henry and Carroll counties (McKenzie) February 12, 2020
5. Scott, Fentress, and Campbell Counties (virtual), April 9, 2020

The listening sessions consisted of semi-structured group interviews with open-ended questions. The focus of each discussion was the participants' experiences with hospital closure and strategies that may have, or could have, helped preserve a hospital or some health care services.

Participants included patients, educators, elected officials, first responders and other health care providers. They were recruited by members of Rural Health Equity Team and by leaders in the local community.

Total participants	***40***
Elected officials	**11**
County Mayors	3
City Mayors	5
Sheriff	1
City Council	1
Local Government Agency Representatives	**6**
Emergency Medical Services	2
Police	1
Fire	1
Schools	2
Health Providers	**8**
Hospitalists	2
Primary Care	4
Long Term Care	2
Current or Former Hospital Administrators	**6**
Current of Former Hospital Board Members	**3**
Business Leaders	**5**
Community Organization Leaders	**2**

The Rural Health Equity team created infographics for each represented county which were provided to participants before the discussion. These infographics for each county provided demographic, economic, health, and hospital financial information that is known to impact rural hospitals to help guide the conversation. They can be viewed beginning on page 29 of this report.

The listening sessions and interviews were recorded through audio or handwritten notes, and the audio recordings were transcribed with technology. Transcripts were analyzed for themes by members of the Rural Health Equity Team and the Vanderbilt University Qualitative Research Core. Transcripts from the listening sessions in Haywood County and Scott County in 2018 were also included in the qualitative analysis. The analyses generated by the THCC Rural Health Equity and Vanderbilt teams were compared to determine the final themes included in this report. The questions used to generate discussion for the listening sessions, interviews, and panel are included on page 28 of this report.

Key Informant Interviews

We interviewed five leaders at three different rural locations where a hospital had closed. These included two rural hospital CEOs with experience in several different states, and two physicians, one who had served as a hospital Chief of Staff and another as both a hospitalist and rural primary care provider. We also interviewed an emergency services chief official.

WHAT WE LEARNED

It is well documented that social differences in health insurance status, environmental exposures, occupation and income level can all influence a person's health. But only recently has our state begun to recognize that many of its rural residents face an additional barrier to good health, based solely on where they live. Too many rural residents have faced, or will face, the loss of access to essential health services caused by the closure a nearby hospital. This project helps describe the deep impact of the steady increase in hospital closures on rural Tennesseans and on the communities where they live.

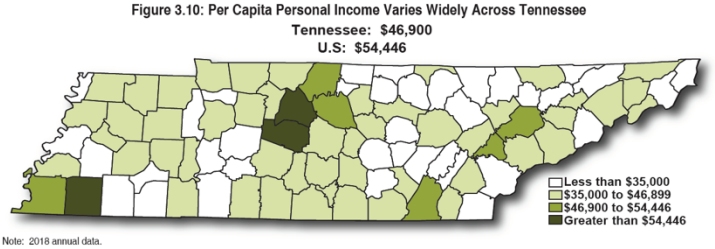
The historic role of a community hospital was to provide medical care to its home community. Many Tennesseans remember a time when community hospitals served as health care anchors in a local network of providers, specialists, and clinics. In addition to insurance payments, the hospitals were financed by local taxes, charitable contributions and (in the 1950's through the 1970's) direct federal investment through the Hill-Burton Act.

The presence of a local hospital helped attract small industry to a community, stimulating the development of other local businesses. In many communities today, hospitals continue to represent a large share of a rural communities' revenue. But when this key community institution goes out of business, both sick and healthy people feel the loss. Health services become harder to get. Seniors and those with serious chronic conditions and disabilities find it difficult to coordinate health care with supportive social services. The hospitals' well-paying jobs disappear, and that loss of income impacts other businesses. Local merchants who had once provided services and supplies to the hospital try to adjust to the loss of a major source of their dependable business while it becomes more and more difficult to recruit new jobs and new residents to the community.

Some of the primary and specialty health and service providers, medical practices, and vendors who were connected with the hospital leave the community when their source of business and referrals is gone. As families move away from the community in search of work, homes are sold to a smaller pool of buyers, and prices drop. The county government collects smaller amounts of local and state sales taxes. The school census drops as well, leading to further losses in state and federal funding for the community's schools. The community's sense of cohesiveness, security and well-being is impacted.

Over its expanse from the eastern Appalachian Mountains to its historic cotton and soybean growing country in the west, Tennessee has fewer than 60 rural hospitals left. In 2014 hospitals closed in Humboldt, Trenton and Brownsville. The next year, closures included Methodist Fayette in Somerville, Park Ridge West in Jasper and United Regional in Manchester. Losses in 2016 included McNairy in Selmer. Copper Basin Medical Center in Copperhill closed in 2017 and in 2018 McKenzie Regional closed along with Physicians Regional Hospital in Knoxville which served many rural patients, and Lakeway Regional in Morristown. Closures in 2019 and 2020 included Cumberland River hospitals in Celina Hospital in Clay County (which reopened briefly and then closed again in 2020), Jamestown Regional Medical Center in Fentress County) Takoma in Greenville, Greene County and Decatur Regional Medical Center in Parsons, Decatur County. (Cecil G. Sheps Center, UNC Center for Rural Health). The Perry County Hospital in Linden also closed at the end of 2020 and remains closed at the time this report is being prepared.

Figure 3.10: Per Capita Personal Income Varies Widely Across Tennessee



Note: 2018 annual data.
Source: Bureau of Economic Analysis.

RECENT CLOSURES OF RURAL GENERAL MEDICAL HOSPITALS IN TENNESSEE 2010-2020

Hospital	Location	Region	Closure Date	Current Services at Site	# Beds at Closure	Ownership at Closure	County Distress Index[6] (TNDECD 2021)	Poverty Rate[2] (ACS[1] 2019)	Labor Force Participation Rate[3] (ACS 2019)	Uninsured Rate[4] (ACS 2015-2019)	Per Capita Income[5] (ACS 2019)[4]
Riverview Regional Medical Center South	Smith County, Carthage	Middle	2012	None	63	Corporate	Transitional	15.30%	60.10%	11.50%	$28,797
Starr Regional Medical Center*	McMinn County, Etowah	East	2013	Emergency Room (ER)	60	Corporate	Transitional	14.50%	52.50%	12.70%	$23,885
Humboldt General Hospital	Gibson County, Humboldt	West	2014	ER maintained until 2019	42	Government	Transitional	14.30%	55.20%	11.10%	$23,211
Gibson General Hospital	Gibson County, Trenton	West	2014	None	41	Government	Transitional	14.30%	55.20%	11.10%	$23,211
Haywood Park Community Hospital	**Haywood County**, Brownsville	West	2014	None	36	Corporate	At-Risk	22.70%	55.60%	11.50%	$21,839
United Regional Medical Center	Coffee County, Manchester	Middle	2015	None	53	Non-Profit	Transitional	14.40%	59.70%	11.60%	$26,557
Methodist Healthcare	**Fayette County**, Somerville	West	2015	None	46	Non-Profit	Transitional	11.20%	56.50%	9.90%	$33,383
Parkridge West	Marion County, Jasper	East	2015	Retains ER, behavioral health, rehabilitative services	50	For-Profit	Transitional	15.30%	55.40%	11.50%	$25,467
Tennova Healthcare-McNairy County	**McNairy County**, Selmer	West	2016	None	26	For-Profit	At-Risk	17.00%	50.70%	13.00%	$20,934
Pioneer Community Hospital*	Scott County, Oneida	East	2016	Reopened as Big South Fork Medical Center	25	For-Profit	Distressed	22.00%	50.80%	13.20%	$20,849
Copper Basin Medical Center	**Polk County**, Copper Hill	East	2017	None	21	Government	Transitional	15.30%	55.60%	13.90%	$25,405
McKenzie Regional Hospital	Carroll County, McKenzie	West	2018	None	29	For-Profit	At-Risk	16.80%	55.20%	11.50%	$22,394
Lakeway Regional Hospital	Hamblen County, Morristown	East	2018	None	135	For-Profit	Transitional	14.40%	55.80%	14.40%	$23,519
Cumberland River Hospital*	**Clay County**, Celina	East	2020	None	33	For-Profit	Distressed	20.10%	44.50%	13.30%	$18,983
Jamestown Regional Medical Center	**Fentress County**, Jamestown	East	2019	None	85	For-Profit	At-Risk	20.90%	51.30%	13.40%	$20,093
Takoma Regional Medical Center	Greene County, Greeneville	East	2019	Renamed; rehabilitative, behavioral health services,	73	Non-Profit	Transitional	15.90%	52.40%	12.60%	$25,190
Decatur County General Hospital	**Decatur County**, Parsons	West	2020	None	45	Government	Transitional	15.90%	53.40%	12.50%	$23,857
Perry County Hospital	**Perry County**, Linden	West	2020	None	53	For-Profit	Distressed	14.40%	47.10%	13.50%	$27,970

NOTES: Bolded County names are those counties where there are **currently no other hospital services.** [1]American Community Survey, U.S. Census Bureau Quick Facts 2019. [2]For reference: US Poverty Rate: 10.5%/ Tennessee Poverty Rate: 13.9%. [3]US Labor Participation Rate (16 years and older): 63.0%/ Tennessee Labor Participation Rate: 61.0%. [4]US Uninsured Rate: 9.5%/ Tennessee Uninsured Rate 12.1%. [5] US Per Capita Income: $34,103/Tennessee Per Capita Income: $29,859. [6] Tennessee Department Economic and Community Development 2021 website based on Appalachian Regional Commission criteria for economic distress.

Tennessee is consistently one of the leading US states for rural hospital closures. Our discussions with rural Tennesseans reveal that while each situation has been unique, there are common concerns and conditions that drive closure decisions. While the scope of the rural hospital closure problem embraces many common financial, cultural, and political factors, specific local situations such as the nature of the local economy, geographic and transportation factors, details of ownership and governance, alignment of services with community needs, age of facility and equipment and more, all play key roles in the fate of the hospital.

The following table summarizes factors affecting rural hospital closures in Tennessee and their possible causes.

FACTORS RELATED TO RURAL HOSPITAL CLOSURES	
Contributing Factor	***Possible Reasons***
Many patients have complex, costly medical needs	People who live in rural communities tend to be older, have higher rates of chronic health conditions, lower incomes and fewer resources than urban populations
Rural hospitals serve higher numbers of Medicare, Medicaid and uninsured patients, and lower numbers of privately insured patients	Fewer rural workers have insurance coverage through employers. They rely on Medicare and Medicaid, or are uninsured requiring that rural hospitals provide more uncompensated care than urban hospitals
Facility costs are high	Most rural hospital buildings and equipment are aging and costly to maintain
Problems recruiting and retaining staff	Urban areas provide more opportunities for medical training and higher patient volumes, especially for specialists. Current business models help with temporary staffing, but not with longer term retention of staff
Urban hospitals compete with rural hospitals to provide for non-emergency care	Patients with insurance that allows them a choice of provider often elect to have their non-emergency surgeries and procedures in newer urban facilities that specialize in this type of care
Falling operating margins rather than health care needs determine whether to keep a facility open	When hospitals are owned by entities from outside the community the potential for profit rather than health needs may drive decision making

Results of Listening Sessions

Tennessee's rural communities have a long and well-earned reputation for getting things done. Since the 1960's, Tennessee's rural citizens have built a strong network of community care services. Forging partnerships with college students, faith communities, non-profit organizations, community organizers and neighbors, rural residents established black lung clinics and community health centers across the state. But in the last decade, these achievements have come up against powerful national market forces, an unresponsive state government, and widespread rural poverty to threaten the health infrastructures so carefully built by rural Tennesseans in years past.

Below we list the questions and the themes that emerged from analysis of transcripts of listening sessions. Quotes from listening session participants substantiating the themes are listed in italics below each theme. In some cases, names of counties, towns, cities and corporations have been removed to preserve anonymity of speakers. The words which follow offer hope that things can change and suggest specific strategies and steps that government and others can take to resolve rural health inequity.

What happens to the community when a rural hospital closes?

1. **Low-income residents, the elderly, chronically ill, and mothers and babies lose access to the specialized care they need.**
    - *The poorest in the community are most impacted, especially when they don't have transportation to travel to health care facilities that may be 30, 40, 60 miles away.*
    - *When you take [the hospital] service away it really hurts the people who have chronic conditions.*
    - *When our hospital closed, they shut down the Ob-Gyn department so expectant mothers lost a source of obstetric care.*
    - *Nursing home residents used to be so close to the hospital [in our community] that they could be wheeled over. But now they have to go a distance for whatever problems [they have].*
    - *The farmers, we're physically broke down. I'm 42 and I've had three surgeries, worked three jobs, since [I was] 10 years old. Most of us didn't finish high school, or if we did, we worked in factories and things like that. We're not at an age that we can retire or draw anything. And so [we feel like we're] left with nothing.*

2. **Police, ambulance, and other services are seriously stretched as they try to meet community health needs with limited resources and training.**
    - *Our county ambulance suddenly became the only source of first aid for non- emergency accidents and injuries. Now we maintain a licensed physician's assistant on each shift and a wide array of first aid supplies on board.*
    - *People don't realize what law enforcement has to deal with [without a hospital]. As a police officer] I'm trained in CPR, but that's all that I can legally do [even] when I'm the only one standing there. [Do] you know how it feels to watch someone die in front of you because all you know how to do is CPR and apply a tourniquet?*
    - *Since the local hospital closed, ambulances from outlying counties have to wait for space at the [regional hospital] ED before they can bring in the patient. This plus the extra time before they get back to the community makes them less available here.*
    - *We have two ambulances in a county of 540 square miles. We need to replace one ambulance and add another. There is some limited grant support for this but the paying for staffing will mean increasing sales and property taxes, which will disproportionately impact lower income residents.*
    - *The increased travel time between an injury or accident and arrival at the hospital emergency room increased the cost of ambulance for our county to about $750,000 per year.*

3. **People worry about what will happen in emergency situations.**
    - *School nurses in [our] County schools have expressed deep worries about the outcome if a child experienced anaphylaxis or a serious asthma attack.*
    - *My office has three employees, if they get hurt now, they have to go a long way to have an emergency room.*
    - *The biggest things here in this county are hiking and horseback riding with two state parks, and two horse riding facilities. If something was to happen there, what if they [visitors] had to get [to a hospital]? If you have an accident, you [need] an emergency room.*
    - *This has come up in plans for emergency preparedness in event of tornado or school safety event.*

4. **Businesses suffer and job creation slows or stops**.
    - *The ripple effects go well beyond the [hospital] patients. It also affected our school system. The [former hospital] employees pulled their children out of school so our enrollment figures [went down], which impacts the amount of state assistance.*
    - *Our local pharmacies are having a terrible time right now.*
    - *When every mom-and-pop grocery store, gas station, restaurant has to close because [hospital] employees go out of the county to work, get their groceries, and fill up with gas, that revenue's not here anymore.*
    - *The owner of our McDonald's restaurant said in the first two weeks after [the hospital] shut down he could tell the difference in [sales from] the dollar menu.*
    - *You take 150 jobs out of a small county, it has a big economic effect.*
    - *For every dollar that it's created by employee's salary, it turns over seven times locally when people in town buy gas, groceries, or whatever.*

5. **It becomes harder to attract employers, residents, or retirees.**
    - *This is an ideal place for retirees, but you've got to have medical care to get retirees.*
    - *A lot of folks who are interested in moving here call the Chamber of Commerce first. They want to know what kind of healthcare facilities you have to offer. Without good health care to offer, [people don't want to come here].*
    - *[When] you're trying to recruit business and industry, they eliminate you if you don't have a hospital.*
    - *The fear of delayed treatment impacts families with special health needs and also those approaching retirement who need to be closer to emergency and specialist care.*
    - *And then you have [real estate] deals that actually come down to the closing and they won't go through with it because a local hospital is just so important.*
    - *Probably two dozen real estate deals have fallen through since the hospital shut down. We're talking about retirees mostly. They're going back where they came from. People say "We still have our home in Florida. We still have our home in Carolina."*
    - *The lack of obstetrical services and emergency pediatric care discourages younger people from deciding to stay or move into the community.*

Why is this tragedy happening in so many rural communities?

1. **Tennessee's failure to draw down federal funds for Medicaid expansion leads to less coverage for patients needing hospital care.**
    - *Across the country, there have been more rural hospital closures in non-expansion states than in those that expanded.*
    - *We see a lot of patients who don't have access to insurance or [they] have a high deductible so they do wait until the last minute [to get care].*
    - *In non-expansion states … uninsured individuals discharged from hospital care are less likely to afford follow-up specialty care.*
    - *The key to this whole thing…. comes down to a $2,000 a month insurance policy. And what has the government done? The government has to do something.*

2. **Rural hospitals care for a patient mix that is financially unsustainable due to a high proportion of uninsured and underinsured vs. privately insured patients.**
    - *Many of our patients do not have the corporate insurance. Even with what the state would pay the hospital couldn't begin to cover their costs.*
    - *Many indigent patients and expectant mothers didn't have insurance, but they were all served. And the bottom line of is that the hospitals couldn't get paid.*
    - *I don't know if there's a truly successful model for rural hospitals. Reimbursements are completely different, how you go about making [a hospital] run has changed dramatically.*
    - *How do you define a rural hospital anymore? It's not what it used to be. Through Hill Burton, I think [hospitals] all had to have 96 beds. I don't think [our] county or [a neighboring] county or any rural community of our size is going to fill up a 96 bed [hospital]. I just don't think that model works anymore.*
    - *[As an employer] I can't afford to provide [the] good cheap health insurance that people need. An insurance plan for a family, a husband and wife and a family of four, is going to cost $2,000 a month. Maybe nurses can afford it. But $10 an hour people can't. I mean it's their whole check. They [are] penalized by the system.*

- *Health care today has overpriced itself. And there's no subsidy to take care of poor people, and poor people are ours.*

3. **Rural hospitals that were formerly community owned have been purchased by corporations with no community mission and no track record in running a hospital.**
    - *When a [an out of state]-based laboratory firm purchased our hospital, we expected a success story, instead the hospital [was soon in] precarious financial shape, services were not being delivered, and the hospital's closure was expected soon.*
    - *With big corporations there's so much hidden at the local level because they're publicly traded companies. You don't know if they're stable or not.*
    - *The whole thing was kind of fishy with a company that's a diagnostic [business] saying "let's buy a hospital that's in trouble, for next to nothing. Maybe it will assist our diagnostics business where we've incurred losses."*
    - *Corporations want to make billions of dollars, not a two or three hundred-thousand-dollar profit. If they don't, they've got seven years to write that money off and then sell it to somebody else.*
    - *[The hospital purchaser] promised to keep the hospital open for 7 years. [Their] intent was to gradually consolidate the patients' care into their regional hospital in Jackson.… The contract contained a non-competition clause which kept [our community] from selling the hospital building to another health care facility.*
    - *Fraud is involved in some of these hospital closures. In Tennessee we let some idiot come in here and buy [our hospital], who can't [legally] come into the US and who owes the IRS tons of money.*
    - *I'm a stockbroker, so I keep up with this. About three years before the current owner bought our hospital, their stock was selling for about $50 a share. Then [after they bought our hospital] and they were trying to buy a second Tennessee hospital, their stock was worth about three cents per share…. It was very evident that they were not strong enough to take on [another] hospital. It felt like they were using the hospital to get mortgage collateral to help operate their laboratory business.*
    - *It's a corporate world now.*

4. **Communities are seldom meaningfully engaged by hospital systems in their planning and decision making.**
    - *[As mayor] I wasn't given any notice, but I started hearing rumors of the hospital not admitting patients, so I made the call [to the hospital] to find out what was going on.*
    - *The information that the board was given…. indicated that we might show a moderate profit or a moderate loss each year. Much to my surprise when the hospital closed, they claimed that we had lost an excess of $3 million per year for the last four years. We were never given that information. I don't know why.*
    - *Two weeks before [the announcement of the closure] some $60,000 [was spent] in re- doing the physical therapy department for a grand opening. We didn't expect them to close because they were still hiring. Employees thought things are all right, [we] had no clue.*
    - *We spent a lot of money on additional equipment to set us up to stay open. They were recruiting doctors up until the two weeks or the week that they found out the hospital was closing.*
    - *The hospital owners … told us "we're doing some upgrades. We're re-doing the paths and steps, so it looks good." And then I got a call and they said they had just gotten through informing the employees that they were closing. Later we learned that they'd known seven months.*

- *When the hospital board arrived for the meeting, it was like, "Well the agenda we sent you is not really what it is. Here's really what it is, we're closing you. Then the hospital board voted on [to close] in a matter of 17 minutes, I had never seen [such a thing], a vote to go ahead and dissolve it in 17 minutes.*
- *There was no forewarning. Everyone was caught off guard. They made us believe that everybody's jobs were fine. And then they walk in and say, "March 1st we're closed. See y'all later."*
- *It was almost like this whole thing was an ambush.*
- *Because this was a corporate hospital, they didn't have to tell us anything that was going on. If it had been [owned] by the city like it was at one time, or the county, then you can change strategy and decide what to do*
- *The average person is not aware of all this until it hits you. And [there's] no chance. It's done.*
- *We didn't know because the hospital felt that the employees would start jumping ship and looking for other jobs. The administrator said, "As the hospital administrator, the last thing we want to do for the last month or two is see all of our employees leave. And us not having any patients."*
- *I do not think that there was any group, or any people that could have been rallying troops together [before that] to try to make a difference [because] it's a corporate world now. These hospitals are not going to talk to the employees or the communities or anybody. You can't fix that problem.*
- *For profit hospitals and those managed by corporations do not utilize community boards for meaningful input.*
- *What could we have done differently? At this point I have no clue. I don't know that we could have done anything different. We did everything we could do.*

5. **Community leaders receive no assistance in dealing with this loss, either from the departing hospital owner or state officials.**
    - *When our hospital closed the [hospital] owner/operator pretty much straight up said, "We're moving out, good luck." We tried to get them to help [us] bring a new group in but they would not transfer the provider care number to the next hospital operator, which was a serious issue.*
    - *So, we eventually got a new group in. Later that group filed bankruptcy because there wasn't the volume of business they thought there would be. And then we were shut down [again].*
    - *When the hospital is being looked at or purchased by people who we know are, for want of a better word, the bad guys, who don't pay their taxes, they cheat. We know that, around the country.*
    - *You're an EMS provider, you're a doctor. You're not a businessperson and you don't even have privy to the information.*
    - *None of the [hospital] operators in [larger Tennessee cities] are rushing to these rural communities. I think part of that is that the business model has changed.*
    - *Why would the state let someone [buy a hospital] who has no hospital experience and never been in the hospital business? It seems like the state should say, "Before you do this, we're going to check you out, see if you've got experience to run the hospital.*

6. **Current Certificate of Need processes prevent problem solving that could help meet rural care needs.**
    - *Changes in CON authority in 2016 restricted creative options for rural hospital services such as development of free- standing emergency departments or flexible "mini-hospital" facilities that many rural communities see as their best option.*
    - *Outdated CON regulations discourage partnerships between urban hospitals and rural communities by restricting geographic distance between partners, no longer require review when services are terminated or transferred, and allow non- competition clauses when hospitals close.*
    - *The CON board is dominated by medical providers, hospitals, and nursing homes, while its three consumer representatives do not always reflect the needs of rural communities.*
    - *Because a hospital's CON is automatically transferred from the seller to the buyer, there is no point during a hospital sale or merger when the community can intervene to represent the interests of their residents.*

7. **In retrospect, there were signs that could have stimulated preparatory action by community residents and leaders.**
    - *We heard rumors of inaccurate billing, late payments to vendors liens on hospital property in excess of market value, clusters of staff resignations, occasional failure to make staff payroll, a shift to weekly contracting, loss of contracts.*
    - *After the news was released, several key people came together and tried to make a difference. We thought we were going to have to start from the ground up because once the licensure was gone, that building's not going to pass code. But then, you hear through the grapevine that they really didn't let the licensure go, [it's] just inactive, so we still have [the] grounds and we have time to make a difference.*
    - *When you hear [about] money owed and liens that upper management has taken against the property, you know they can't operate and also pay that money back.*
    - *I was hearing about monetary issues from a lot of angles…. I saw from the county side that liens were put on the property from the IRS, a direct indication [that] something's wrong.*
    - *A lot of fishy things were happening [like] a 15 and a half million-dollar loan taken out against the property when the building's only worth $2 million, tops.*
    - *We went through several cycles where employees were paid two or three weeks late, so the staff started leaving. When you don't have nursing staff, you can't operate a hospital.*
    - *When charismatic, devoted, dedicated people who love that place leave, it's a [bad] sign.*
    - *Even before the payroll issue a friend of mine who used to operate the ultrasound [said] they were being back paid.*
    - *The hospital had not admitted patients in several weeks, maybe two months, although the emergency room was still operating.*
    - *When we started seeing services dropped, when home health was closed and the nurses [were] transferred…that [was] a clue.*

Key Informant Interviews

To expand our body of information, we spoke in depth with several hospital professionals and providers who had lived through the closure of their hospitals and had relocated or found work elsewhere. We also reached out to two current hospital CEOs, a primary care physician, an emergency services official, a physician who had served as a hospital Chief of Staff and a local elected official. These leaders worked with publicly owned and privately-owned facilities, regional and metropolitan facilities that were publicly owned, including both non-profit and for-profit private facilities. Like the participants in the listening sessions, the key informants noted the increased cost of health care for rural residents after a community hospital closes, as well as delays in getting care which impact people already struggling to access it.

Advocates for closing small hospitals often point to the value of a "Hub and Spoke" system, where smaller communities are able to effectively funnel patients to a larger hub of care in a central area. In spite of the appeal of this design, our informants observed that *in Tennessee there has been a lack of willingness on the part of central care hubs to work with poorer, smaller hospitals in ways that would enable the smaller hospitals to financially and realistically address their needs*. In addition, informants point out that leadership of the urban hubs' limited understanding of rural life and challenges causes them to resist providing even emergency care, expecting rural patients to travel farther than is possible for them.

Themes that emerged from informant interviews

1. **Responsive state guidance and support is needed** to address the imbalance in power and resources between rural communities and government and health care corporations.
   When their hospital is threatened, rural communities must negotiate among confusing and sometimes misleading offers, limited choices, and difficult decisions which are not in the community's best interest. One interviewee said, "*It should be illegal for a company…to be allowed to abandon a community the way they did. Staff of that hospital worked without pay, and the corporation allowed them to do that knowing they would not be able to compensate them. State and federal government representative need to educate local officials about their legal responsibilities and rights in re: community hospitals."*
2. **Innovative, flexible, strategies that assist rural hospitals in generating revenue are needed** to support services and prevent closures. Effective in-patient and out-patient income-generating strategies need to be employed, including rotating specialist teams through the rural hospitals. Contracted physicians in rural communities (ER docs, hospitalists, anesthesiologists, radiologists and sub-specialists) need to be incentivized to join insurance networks used by rural residents. Current Medicare and Medicaid efforts to move toward value-based reimbursement need to take into account the resources available to smaller rural hospitals and communities.
3. In places where hospital have already closed, **targeted state regulations and CON policies are needed to support rural emergency health care** centers that can quickly stabilize a patient's status, and facilitate patient transfers to larger facilities in surrounding counties
4. **New models of public/private and regional collaboration are needed.** Community leaders must find ways to reduce some community members' desire to return to what they remember as "the Good Old Days" when every county had a hospital that was stable and financially secure. Without a common and accurate understanding of the 21st century healthcare marketplace, it is difficult for providers and community residents to collaborate effectively to save an older rural hospital. One interviewee said, "*They believed that they could have the hospital they had in 1985. Bluntly, that just wasn't going to happen. I think the most difficult thing for them was not imagining the same hospital they had in 1980*."

HOW COMMUNITIES IN OTHER STATES ARE ADDRESSING RURAL HOSPITAL CLOSURES

Based on a scan of the literature on rural hospital loss in the US, the committee identified numerous approaches which have been used, the selection of which may be related to the availability of local resources, state assistance, and other factors. Not every strategy works for every community, and communities should utilize the strategies that are the best fit for their situation and that capitalize on the current strengths within their community. In addition to community-based strategies, there are several organization-level, state, and federal policy strategies that would be effective in preserving access to health care services in rural communities in Tennessee. [Refer to the Policy Recommendations Section].

If you are a community member:

1. **Act quickly** once the community begins to recognize that a closure could occur.

2. **Systematically assess the situation.** For many reasons, hospitals actively try to hide the likelihood of closure from the community. They don't want to lose staff before a pre-determined closure date. Scheduled procedures need to be completed, and patients and their records need to be carefully transitioned to other physicians. If a hospital has accumulated debt, they may fear that creditors will soon start insisting on repayment. Don't be relieved by outward appearances. In an effort to disguise the closure decision, communities have seen new landscaping, ongoing staff recruitment or other investments designed to discourage the community from taking steps to intervene to prevent a full cessation of services.

3. **Maximize and appreciate the role of committed community leadership.** A study on multiple rural hospital closures in Canada found that strong and committed leadership helped improve the community's satisfaction with the outcome after the hospital closed (Liu et. al, 2001). Good communication among community members, leaders, and agencies mitigated negative outcomes for hospital closures (Liu et. al, 2001). Regional planning efforts helped mitigate the effects of a hospital closure for 3 communities in Kansas, Kentucky, and South Carolina (Wishner et. al, 2016). Encourage legislators to engage in systematic problem solving to meet the health care needs of rural communities. Challenge candidates for statewide offices to generate and then follow through on proposals to address rural health care issues and inform legislators of community health needs on a regular basis.

Community strategies for maintaining hospital or health services, which may be appropriate in your situation:

1. **Consider a merger with another hospital system.**
    - This was a successful strategy for maintaining hospital services in Neilsville, WI (Wisconsin Watch, 2019), Page County Virginia (Hausman, 2019) and Ironwood, MI (Hemmingsen, 2019).
    - Faced with a hospital closure, the community of Fort Scott, Kansas worked with a community health center to take over the primary care offices, the county to take over ambulance services, and a larger health care organization to take over the emergency room (Korte, 2019).

- Communities in Iowa have partnered with larger health care facilities to bring visiting specialists to their towns to enhance access to outpatient care (Hemmingsen, 2019).
- Mergers have not been successful in every community. A community in Kansas merged with a health care organization in Florida, and still wasn't able to maintain financial viability (Hemmingsen, 2019).
- When a rural clinic closed in Plains, GA, Mercer University worked with the community to open up a facility that offers both in-person and telemedicine services (Lichtenwald, 2018).
- Mergers can be small or large in scope. When two large hospital systems that spanned upper East Tennessee and Virginia decided to merge, the two states required that they develop a Population Health plan for the communities served, specify an amount of investment ($75,000,000) over ten years, set up a department to implement the Population Health Plan and work with community-based health practices to coordinate care. They also agreed to coordinate services that addressed social as well as medical and behavioral health needs of the region and to develop targeted health improvement goals and metrics to measure health improvement and to report these to the Department of Health.

2. **Evaluate the possibility of the community taking hospital ownership.**
   - When its privately-owned hospital closed, Haleyville, Alabama acquired the facility and reopened it as a public hospital (US News & World Report, 2019; MEDHOST, 2019).

3. **Encourage development of new services lines that meet health needs in community including freestanding or linked emergency, urgent and primary care services.**
   - Emergency departments provide healthcare services in life-threatening situations. Since many rural areas are at least 30 minutes and sometimes more than an hour away from the nearest hospital, travel time can amount to the difference between life or death for an individual. In Tennessee freestanding emergency departments must be hospital-owned (Williams, Song, & Pink, 2015). But a shift in policy could allow more emergency departments to open in areas where hospitals have closed or are not financially viable (Bipartisan Policy Center, 2018).
   - Urgent care centers provide services for situations that are not life-threatening but require immediate attention. These include sprains, stitches, setting broken bones, and radiology and laboratory services. Expanding reimbursement policy to allow urgent care centers to be reimbursed for more of their services would allow them to be a financially viable alternative to hospitals (Heath, 2017).

Steps the state can take to assist rural communities facing hospital closure:

1. **Promote collaboration**.
   - Encourage and assist neighboring communities with small population size and low patient volumes to work together to implement innovative purchasing and reimbursement models (Bipartisan Policy Center, 2018).

2. **Make feasible the use of fixed, global budget payments to rural hospitals in low-income communities, reimbursing the cost the costs of care regardless of insurance of patients.**
   - Require participation from all insurance providers in the state and use appropriate metrics to measure quality of care. For example, the Maryland All Payer Model tracks the reduction in readmission rates and the reduction in preventable complications as an indicator of quality of care (AHA, 2018).

- The Pennsylvania Rural Health Model has increased the financial viability of rural hospitals through transitioning to providing hospitals with a fixed amount for reimbursements regardless of patient insurance for all services provided (ASTHO, 2019; Murphy, Hughes, & Conway, 2018; Scotti, 2017). Global budget payment programs are intended to allow hospitals to accurately predict revenue to ensure that they will be able to cover all necessary costs.

3. **Build the rural health care workforce** (Bipartisan Policy Center, 2018).
    - Provide support to local programs that encourage middle and high-school students' interest in the health sector.
    - Incentivize universities and colleges to reserve spots in medical, nursing, and allied health programs for rural residents. Expand the reach of traditional care teams by using case managers, community health workers, and in-home providers.
    - A hospital in Arco, Idaho recruits semi-retired physicians to work part-time. Their efforts succeed due to a substantial benefits package of 10-weeks annual paid leave, with a focus on spending some of that time in medical mission.
    - Alaska and Mississippi offer loan repayment or financial support to practitioners working in rural areas. Mississippi specifically supports students from rural areas who want to practice where they live. Other states have enacted policies that target and enroll students in education programs who are interested in working in rural health care (Goodwin & Tobler, 2016).
    - Support training, certification, and reimbursement of services provided by Community Health Workers (CHWs), community members who provide health education, care coordination, home visits, and other health-related services (Goodwin & Tobler, 2016).
    - Tennessee offers loan repayments for health professionals who practice in counties designated as Primary Care Health Resource Shortage Areas (HRSAs) which have a low provider to individual ratio (HRSA, 2019). Expand this program to other rural counties that do not have a hospital, possibly including Chester, Clay, Crockett, Fentress, Grundy, Haywood, Lake, Lewis, Moore, Pickett, Sequatchie, Stewart, and Van Buren (Tennessee Health Care Capacity Dashboard, 2019).

4. **Support and expand the use of telemedicine** (Bipartisan Policy Center, 2018). Telemedicine uses video technology to bring a patient and a provider together without physically being in the same space. Many services can be provided via telemedicine, including behavioral health, dentistry, primary care, patient education, and some remote patient monitoring and diagnostics.
    - Remove limits on reimbursable use of telemedicine. Although other states use telemedicine to increase access to health care in rural areas via state-run Medicare/Medicaid programs, TennCare limits the reimbursable use of telemedicine to crisis-related services (CCHP, 2019).
    - Address other barriers to the use of telemedicine include reimbursement and legal and regulatory components, such as differences in licensure across state lines and ensuring patient privacy (NCSL, 2015).

POLICY RECOMMENDATIONS FOR STABILIZING TENNESSEE'S RURAL HOSPITALS

Tennessee's rural hospitals could be stabilized, averting future closures, through a series of policy changes. As a result of our listening sessions, key informant interviews in rural communities that have either lost their hospital or have a hospital that is at risk for closure, consultations with statewide organizations which have an interest in rural health care delivery, and debriefing discussions among THCC Rural Health Equity Committee members. we have formulated the following policy recommendations.

The goals of our recommendations are to:

1. Reduce the gap between Tennessee's current market health care model and rural communities' health needs.
2. Increase transparency regarding state and private resources and goals related to hospital operations in rural communities.
3. Increase the likelihood of coordination of resources and improved communication among state officials, community leaders, and hospital owners and operators.
4. Expand the reach of and use of innovative medical and community strategies for delivering emergency, diagnostic, specialty, and rehabilitative care.
5. Encourage the acquisition of operational funding to support rural hospitals, similar to the way that federal dollars are available for qualifying health centers (FQHCs).

The committee recognizes that a rural health equity agenda must address both health service infrastructure needs and the social factors and processes that have dire consequences for rural residents' health outcomes. For example, Tennessee is one of the most economically disadvantaged regions of the United States, with 17 percent or more of the population experiencing poverty (U.S. Census Bureau, 2016). Tennessee's rural residents are not only more likely to be poor but are also more likely to be living in conditions characterized by persistent, "deep" poverty, their health status continues to lag behind national averages (USDA, 2013).

We recommend that policymakers approach the rural hospital crisis comprehensively, incorporating federal, state, and local action and building on lessons learned in providing care to the underserved through alternative funding streams and mechanisms that maximize community participation in service delivery**.**

While the following recommendations set the stage for stronger and more sustainable rural hospitals, trust between hospitals and the communities they serve is at the core of any thriving health system. This trust grows through open dialog regarding the needs of the community and the hospital's activities performed to meet those needs. Multilateral community engagement involving patients, health care providers, government, and business leaders ensures that rural hospitals not only survive but prosper across Tennessee.

These recommendations are organized in two ways: in Table A by the level of government where such policies need to be initiated—federal/state/local; and in Table B by whether such policies are needed mainly to sustain viable health services, stabilize rural hospitals at risk, or enable communities to rebuild following a closure.

Table A. POLICY RECOMMENDATIONS FOR SUSTAINING TENNESSEE'S RURAL HOSPITALS

STATE ACTION

- Accept federal funds for Medicaid expansion to enable comprehensive health coverage for over 300,000 low-income uninsured Tennesseans.
- Reassess TennCare service reimbursements, value-based care, and supplemental payment systems to ensure that rural hospitals are fairly and sustainably compensated for care provided to disproportionately high number of low-income, uninsured, older, and chronically ill individuals that live in rural areas.
- Require hospitals to notify communities in advance of significant changes in services.
- Enable the Certificate of Need (CON) program or other agency to investigate failures of hospital operators to provide promised services and develop expectations for notification of communities and safe transitions in patient care and services in event of closure.
- Develop a comprehensive rural health services plan that enables the Tennessee Health Services and Development Agency or other state agencies to assist local communities in identifying the gaps in needed health services and designing innovative service options to fill these gaps.
- Invest in the development of free-standing emergency rooms, mini-hospitals, critical care centers, regionalized emergency transport and call center models in rural counties to ensure timely stabilization of trauma, stroke, and acute cardiac patients.
- Require insurers to streamline network licensing to prevent prolonged gaps in service and to include rural hospitals as in-network providers for appropriate services.
- Reform insurance laws to allow rural communities located near state borders to form multi-state insurance cooperatives and/or networks.
- Prioritize funding for improvements to roadways that link rural communities to hospitals through the Tennessee Department of Transportation.
- Expand broadband coverage throughout rural Tennessee.
- Provide targeted grant and investment opportunities in programs for the expansion of preventive care, primary care services, substance use disorders, behavioral health and oral health programs in distressed and at-risk rural counties.
- Develop regionalized emergency call centers to promote collaboration among hospitals and public and private emergency health services to ensure all patients have timely access to appropriate care.
- Extend and expand Rural Hospital Transformation Act grants beyond the act's expiration date of July 1, 2021.

FEDERAL ACTION

- Re-evaluate federal funding streams for rural hospitals that accommodate rural Tennessee's disproportionately high number of low-income, uninsured, older, and chronically ill individuals that live in rural areas.
- Enable global budgeting and adequate CMS reimbursement of other alternative health care delivery options that offer rural communities the opportunity to design rural health services that meet their needs.
- Expand/reform the Affordable Care Act (ACA), while adjusting value-based care criteria to reflect the limited resources available in rural hospitals and the communities they serve.
- Allow families and individuals to purchase ACA plans regardless of employer-based offerings and provide incentives to non-expansion states to expand Medicaid to low-income adults
- Expand Medicare to more Americans
- Provide grants for indigent hospital care through Health Resources and Services Administration, using a similar mechanism to that which funds Federally Qualified Health Centers
- Develop alternative funding streams for county-funded rural ambulance/emergency services and for expanded emergency medical services (EMS) response capabilities.
- Fund telemedicine through reformed reimbursement strategies for public insurers
- Expand efforts to retain and recruit health care providers in rural communities.
- Increase funding for student loan repayment programs for rural health care providers.
- Continue Coronavirus Aid, Relief, and Economic Security (CARES) Act funding for rural hospitals throughout the COVID-19 pandemic to ensure their ability to contribute to the pandemic response.
- Fund additional maintenance of service and/or supplement Disproportionate Share payments to rural hospitals.
- Continue Disproportionate Share Hospital and supplemental payments to communities after a hospital closes to fund alternative systems of care.
- Provide direct operational funding for rural hospitals that are sole community providers.

LOCAL GOVERNMENT AND REGIONAL COLLABORATIONS

- Fund Project Access programs in rural communities to link uninsured patients with hospitals and healthcare providers who are able to donate their services.
- Request state assistance in review of hospital ownership transfers, including verification of financing, experience in hospital management, maintenance of effort, and transparency.
- Require for-profit hospitals, in exchange for some tax relief, to conduct periodic Community Health Needs Assessments to document community benefit and provide annual reports to communities of their current service offerings and metrics of how each is meeting the needs identified in the Community Health Needs Assessment.
- Subsidize the costs associated with accreditation of rural hospitals.
- Educate communities regarding hospital reimbursement and financing.
- Encourage community members to support their local hospital.
- Sponsor training for all hospital board members on a routine basis through support to non-profit training entities.

ALTERNATIVE RURAL HEALTH CARE MODELS

The Tennessee Hospital Association, in conjunction with the American Hospital Association Taskforce Report, has focused on 7 strategies to support rural hospitals in developing solutions to ensure they are financially viable and capable of providing care. The graphic below, from the THA website and used with permission, illustrates how some of the policies referenced above and below would support rural services, and also helps understand the vital continuum of health care services that rural hospitals provide their communities. More information is available on the THA website: https://tha.com/focus-areas/small-and-rural/rural-hospital-viability/

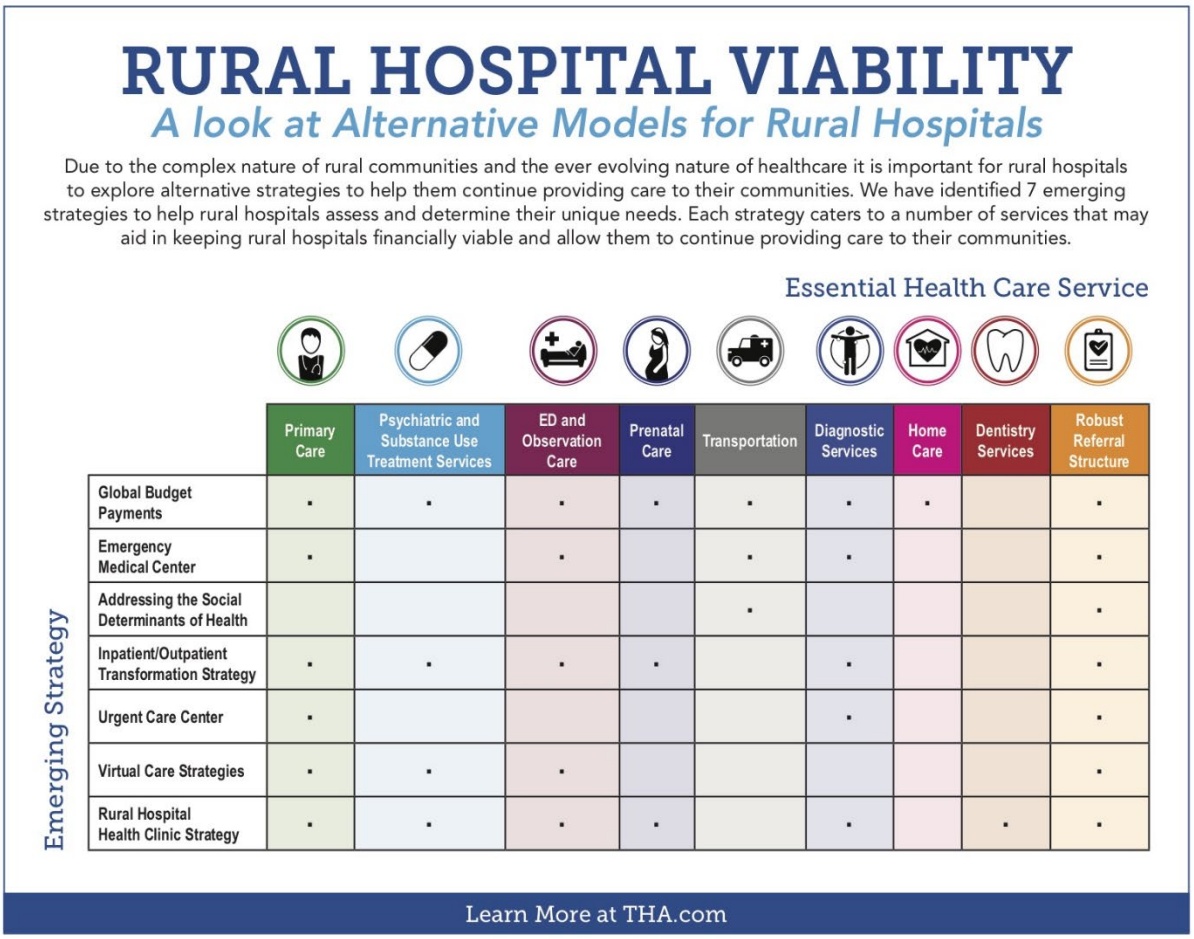


Table B. RECOMMENDATIONS FOR POLICY CHANGES THAT WILL SUPPORT RURAL HEALTH EQUITY IN TENNESSEE

POLICIES THAT WILL SUSTAIN ALL RURAL HEALTH SYSTEMS

- Enable global budgeting and adequate CMS reimbursement of other alternative health care delivery options that offer rural communities the opportunity to design rural health services that meet their needs.
- Provide grants for indigent hospital care through the Health Resources and Services Administration, using a mechanism similar to the funding of Federally Qualified Health Centers.
- Review and revise value-based care criteria and other CMS reimbursement structures to rural hospitals to reflect the disproportionately high number of senior, chronically ill, low-income and underinsured individuals that live in rural areas and the limited patient support resources available in rural hospitals and the communities they serve.
- Develop alternative funding streams for county-funded rural ambulance/emergency services and expanded emergency medical service response capabilities.
- Require Community Health Needs Assessments and Implementation Planning for all hospitals accepting Medicare, not just tax-exempt facilities.
- Increase Medicare reimbursement for telehealth services and provide telemedicine grants to rural communities needing to increase their connectivity.
- Require insurance carriers on the ACA exchanges to include hospitals across state lines in networks available to consumers living in rural border communities.
- Maximize federal coverage options for individuals living in non-expansion states by lowering Medicare age, removing ACA requirements that low-income families must enroll in employer-based insurance, providing a lower cost public options, and maintaining incentives for states to reconsider Medicaid expansion.
- Increase TennCare's supplemental hospital payments and provide maintenance-of-service payments to rural hospitals.
- Annually review Joint Annual Reports of Tennessee hospitals and provide analysis of financial health of community hospitals to community leadership.
- Invest in rural broadband infrastructure to maximize potential for telemedicine.
- Develop regionalized emergency call centers to promote collaboration among hospitals and public and private emergency health services to ensure all patients have timely access to appropriate care

POLICIES THAT WILL PREVENT MORE RURAL HOSPITAL CLOSURES IN TENNESSEE

- Continue Coronavirus Aid, Relief and Economic Security (CARES) Act funding for rural hospitals throughout the full duration of the pandemic to ensure their ability to contribute to the pandemic response. Extend repayment periods and use state funds if needed to assist in repayment of federal loans.
- Revisit the decision to reject Medicaid expansion funds to enable coverage of over 300,000 low-income Tennesseans.
- Require hospitals to notify community leadership in advance of significant changes in services.
- Extend Rural Hospital Transformation Act grants beyond 2021 and provide added funding for loans to hospitals to implement recommendations.
- Require insurers to include rural hospitals as in-network providers, restrict balance billing by contracted physician services at these hospitals, and streamline network licensing procedures to prevent prolonged gaps in services.
- Incentivize the opening and operation of opioid treatment centers in rural hospitals.
- Engage local health councils or other collaborations to support discharge and follow-up planning for patients without adequate social supports to improve outcomes.
- Provide support to rural hospitals to support outreach, community engagement, chronic disease management, and preventive health opportunities.

POLICIES THAT WILL ENABLE RURAL COMMUNITIES TO REBUILD HEALTH INFRASTRUCTURE

- Enable Federally Qualified Health Centers in communities without emergency room services to explore adding urgent care and emergency stabilization services.
- Create a rural health equity master plan and funding to incentivize the development of emergency medical stabilization sites so that no Tennessee resident is more than 20 minutes away from qualified medical emergency treatment for stabilization of trauma, stroke, and acute cardiac events.
- Intensify expansion of broad band infrastructure in rural areas to promote telemedicine options.
- Amend the Certificate of Need Program to facilitate the development of public/private partnerships to fund the development of innovate model rural health programs that will provide continuum of primary care, specialty care, acute care and rehabilitative care services for rural populations.
- Prioritize funding for improvements to roadways to link rural communities without emergency services to nearby hospitals.

MORE WAYS FOR COMMUNITY TO IMPACT HOSPITAL DECISIONS

1. **Get involved in your hospital's community health needs assessment process and monitor your hospital's implementation plan.**

   OPPORTUNITIES FOR COMMUNITY ENGAGEMENT ***(Appendix 3 to this report),*** is a tool created for this project. It describes the ***Community Health Needs Assessment*** process required of all Tennessee hospitals that receive federal funding and how Tennesseans can get involved in the process. Links to examples of Community Health Needs Assessments and implementation plans for Tennessee Hospitals are included. This tool also describes how consumers can become engaged with the growing number of ***Accountable Care Organizations*** being developed throughout our state. This tool can be accessed on the Tennessee Health Care Campaign website: tnhealthcarecampaign.org.

   More Tool-kits on Community Health Needs Assessments:
   - https://www.healthycommunities.org/resources/community-health-assessment-toolkit
   - https://www.communitycatalyst.org/initiatives-and-issues/initiatives/hospital-accountability-project
   - https://www.communitycatalyst.org/initiatives-and-issues/initiatives/hospital-accountability-project/body/Questions-for-Reviewing-the-CHNA.pdf
   - https://www.communitycatalyst.org/initiatives-and-issues/initiatives/hospital-accountability-project/community-benefit-tools-and-resources-for-chna
   - https://www.communitycatalyst.org/resources/publications/document/CC-HospitalCommenefitDashboard-Report-F2.pdf

2. **Join local health councils and hospital advisory and governance boards.**

   Hospital Advisory Boards
   Patient and Family Advisory Boards provide hospital staff with important feedback on the patient experience of communication with providers, and safety and quality of care received. These advisory structures provide confidence to patients that providers care about continually improving the quality of care they are receiving and provide linkages of communication with the community. They can be crucial mechanisms for making hospital policies and practices transparent to the community and it is important for health care justice advocates to become involved.
   - Guide for developing a community-based patient safety advisory council: https://www.ahrq.gov/patient-safety/patients-families/engagingfamilies/index.html
   - Guide to Patient and Family Engagement in Hospital Quality and Safety: https://www.ahrq.gov/patient-safety/patients-families/engagingfamilies/index.html

   Resources on how to be effective hospital board member:
   - https://www.ahrq.gov/patient-safety/patients-families/engagingfamilies/strategy1/index.html
   - links to resources on hospital board trainings provided by THA, HAT, others

3. **Assess the health of your hospital.**

The THCC Rural Health Equity Project tool ***HOW TO ASSESS THE HEALTH OF YOUR HOSPITAL*** **(Appendix 2 to this report)** describes how to access and interpret financial and utilization data reported annually by every hospital in publicly available **Joint Annual Reports** submitted to the Tennessee Department of Health. This tool can be viewed or downloaded from the Tennessee Health Care Campaign website: tnhealthcarecampaign.org

This THCC tool discusses:

- Trends in a hospital's "bottom line": *a consistent trend of expenses exceeding revenue, especially if a hospital must consistently dip into its assets to pay its expenses, is a clear sign of trouble ahead for the survival of the hospital.*
- A hospital's "payor mix", including patient health coverage through *private or commercial insurance plans*, *government sponsored coverage and self-pay.*
- The amount of care provided that is uncompensated by any source, including the amount of financial assistance or charity care provided by the hospital and the amount of bad debt that results from patients are unable to pay their hospital bills.
- A hospital's average daily patient census rates over time and changes in utilization of services.

4. **Assess the health of your community.**

Many rural counties are continuing to lose their population base to more metropolitan areas in our state. Populations remaining in rural communities are often older, poorer and have more chronic illnesses and disabilities. The smaller population base with more complex health care needs makes it harder to support rural hospitals economically, but also make access to acute care and specialty care services even more critical. The resources below can help county health councils and residents better identify and plan for meeting the changing health care needs in their communities.

- Robert Wood Johnson Community Health Rankings and Roadmaps: *https://www.countyhealthrankings.org/*
- Commonwealth Fund State Healthcare Score Cards: *https://2020scorecard.commonwealthfund.org/*
- Tennessee Department of Health Dashboard on COVID-19 and County Health Data: *https://www.tn.gov/health/cedep/ncov/data.html*
- Tennessee Department of Economic and Community Development County Profile Tool: *https://tnecd.com/county-profiles/*
- The Sycamore Institute Tennessee County Health Profiles:
  - *https://www.sycamoreinstitutetn.org/health/county-profiles/*
  - *https://www.sycamoreinstitutetn.org/2019-income-poverty-education-insurance/?utm_source=newsletter&utm_medium=email&utm_content=Get%20the%20Details&utm_campaign=general*

LISTENING SESSION AND INTERVIEW QUESTIONS

The following questions were used to guide discussion in each listening session conducted as part of our Community Engaged Research project.

1. What is your favorite thing about living in this community?

2. In this community, which groups of people have been impacted most negatively by the hospital's closure?

3. The impact of a hospital closure may go beyond the loss of hospital inpatient services. Are there other ways that people in the community have been impacted by the hospital's closure?

4. What strategies are you using to respond to hospital closure? Are they effective?

5. As you look back on how the closure occurred, what additional resources (information, technical support, policy influence, funding etc.) might have helped prevent the closure or would help the community now in responding to the closure?

6. What information, technical resources, tools or policies would be helpful to communities dealing with hospital closure issues?

7. Is anyone in this community documenting or tracking the impact of the hospital closures?

8. Have any individuals or groups of people actually benefitted from the closure? Who and how?

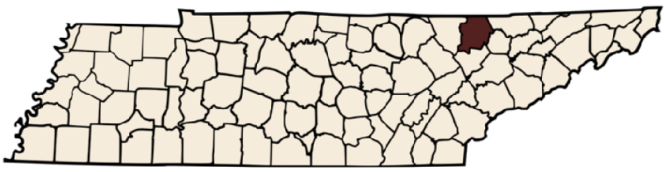
9. Have any organizations or individuals been key allies to the community to help prevent the closure or to help develop solutions to problems caused by the closure?

Campbell County Health Profile

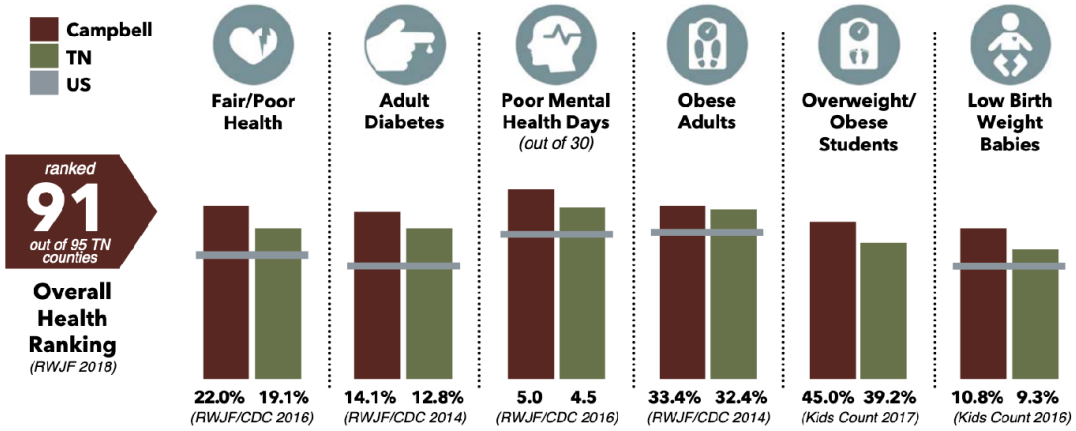
Prepared by Tennessee Health Care Campaign Rural Health Equity Project Team

CAMPBELL COUNTY OVERVIEW (Sycamore Institute, 2019)

QUICK FACTS
2017 Population: **39,648**
Age <18: **20.7%**
Age 65+: **20.4%**
Median Age: **44**
Percent Rural: **55.0%**
(Census 2010, 2017)



HEALTH OUTCOMES IN CAMPBELL COUNTY



FACILITIES IN CAMPBELL COUNTY (Sycamore Institute, 2019)

2
HOSPITALS
There are 2 hospitals within Campbell County.

0
HOSPITAL CLOSURES
No hospitals have closed in Campbell County from 2010-2019.

2
EMERGENCY DEPARTMENTS
There are currently 2 emergency departments located within Campbell County.

10,233
ED VISITS
In 2018, there were 10,233 visits to the emergency department at Jellico Community Hospital.

MAIN INDUSTRIES IN CAMPBELL COUNTY

- Auto parts and appliance manufacturers
- High skill machine operations
- Defense contractors
- Biotech
- (East TN Economic Development Agency, 2020)

JELLICO COMMUNITY HOSPITAL DATA (2018)

Employees:
140

Patient Beds:
54 (37 staffed)

Inpatient Census:
947

Average Daily Census:
7

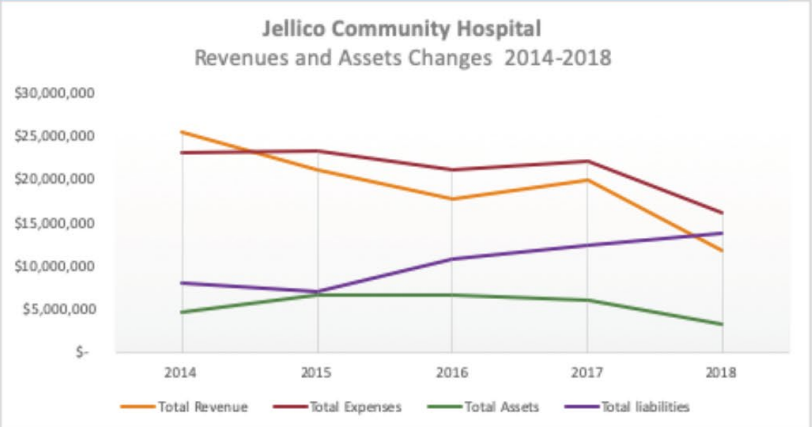
Percent Patient Revenue by source:
Medicare 41%

TennCare 36%

Self-pay 3%

Commercial 16%

Other 7%



12% of residents do not have health insurance. (RWJF, 2019)

30% of residents are on TennCare. (TennCare, 2019)

19.7% of residents are at or below the poverty line. (US Census, 2017)

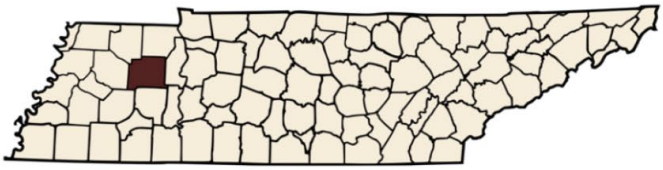
Carroll County Health Profile

Prepared by the Tennessee Health Care Campaign Rural Health Equity Project Team

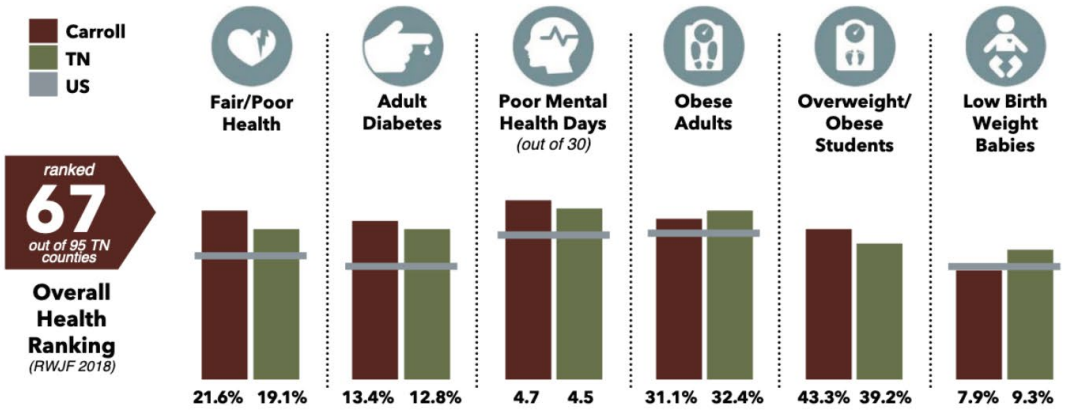
CARROLL COUNTY OVERVIEW (Sycamore Institute, 2019)

QUICK FACTS

2017 Population: **27,860**
Age <18: **21.3%**
Age 65+: **20.2%**
Median Age: **43**
Percent Rural: **83.1%**
(Census 2010, 2017)



HEALTH OUTCOMES IN CARROLL COUNTY



FACILITIES IN CARROLL COUNTY (Sycamore Institute, 2019)

1

HOSPITAL

There is one hospital in Carroll County: Baptist Memorial, Huntington.

1

EMERGENCY DEPARTMENT

There is currently one emergency department located within Carroll County.

13-25

MINUTES

Average time for transport to the nearest ED (from Carroll County towns).

0

OBSTETRICS

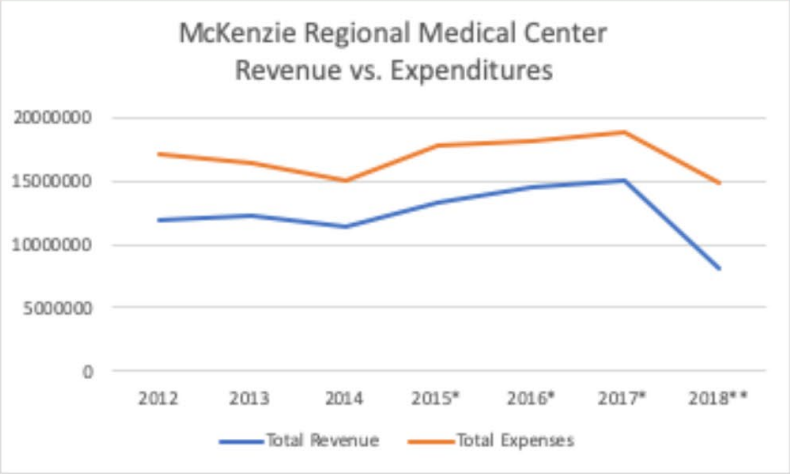
As of 2020, there are zero obstetric units in Carroll County.

MAIN EMPLOYERS IN CARROLL COUNTY

- Healthcare & medical devices
- Advanced manufacturing
- Transportation and logistics
- Chemical, plastics, and rubber production
- (Carroll County Chamber of Commerce, 2020)

MCKENZIE REGIONAL HOSPITAL DATA (for year prior to closure)

Net Income or Loss: $-3,770,594	**Total ED Visits:** 6,728
Patient Beds: 45	**Total Hospital Employees:** 119
Annual Discharges: 1,016	**Total Births:** 342



*indicates change of ownership from Community Health Systems to Quorum Health

**MRMC closed in September 2018

10% of residents do not have health insurance. (RWJF, 2019)

26% of residents are on TennCare. (TennCare, 2019)

19.8% of residents are at or below the poverty line. (US Census, 2017)

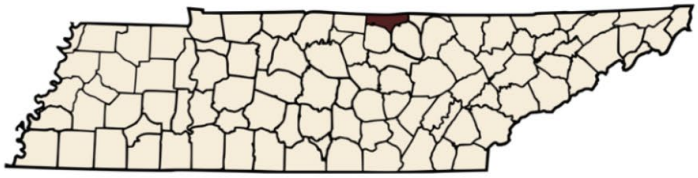
Clay County Health Profile

Prepared by Tennessee Health Care Campaign Rural Health Equity Project Team using data from The Sycamore Institute

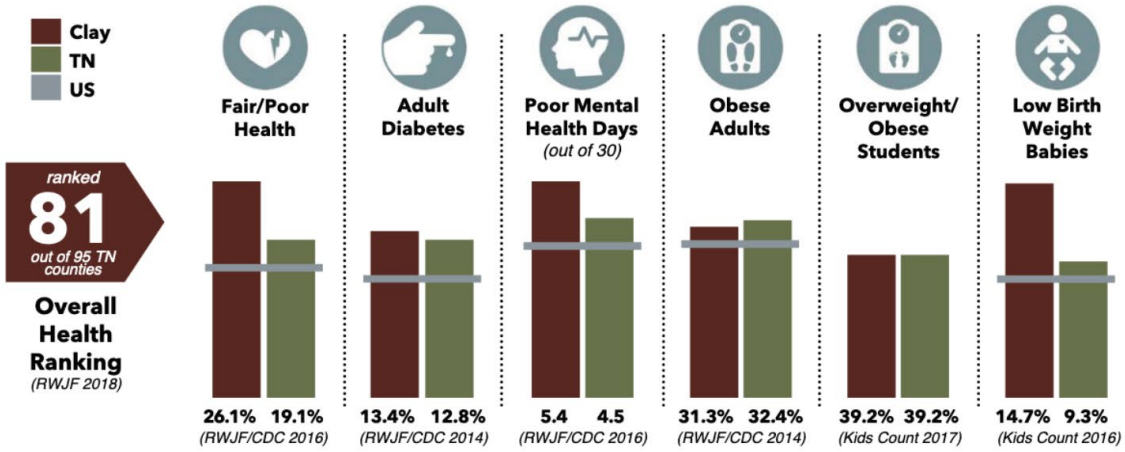
CLAY COUNTY OVERVIEW

QUICK FACTS

2017 Population: **7,703**
Age <18: **20.1%**
Age 65+: **24.1%**
Median Age: **47**
Percent Rural: **100%**
(Census 2010, 2017)



HEALTH OUTCOMES IN CLAY COUNTY



FACILITIES IN CLAY COUNTY

0

HOSPITALS

As of 2019, there are no hospitals within Clay County.

1

HOSPITAL CLOSURES

One hospital has closed in Clay County from 2010-2019.

0

EMERGENCY DEPARTMENTS

There are currently no emergency departments located within Clay County.

20

MINUTES

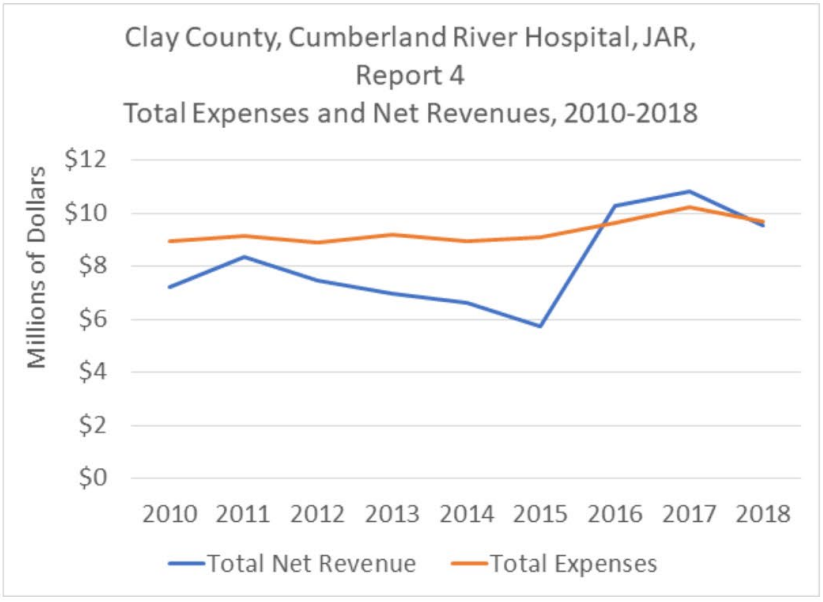
Average distance for transport to the nearest hospital (Livingston Regional).

MAIN EMPLOYERS IN CLAY COUNTY

- Clay County
- City of Celina
- Dura Plastic Products
- Honest Abe Homes
- ~~Cumberland Hospital~~ *loss of 108 full time jobs due to hospital closure

CUMBERLAND HOSPITAL DATA (for year prior to closure)

Net Income or Loss: $-1,966,576	**Annual Discharges:** 296
Patient Beds: 36	**Average Daily Census:** 17



13.7% of residents do not have health insurance.

23.2% of residents could have had insurance via Medicaid expansion.

26% of residents are on TennCare.

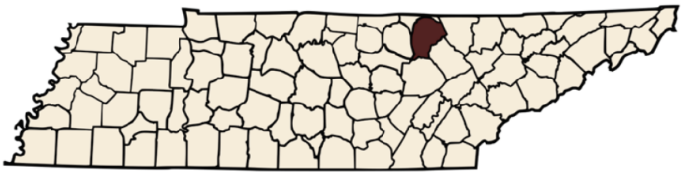
24.8% of residents are at or below the poverty line.

Fentress County Health Profile

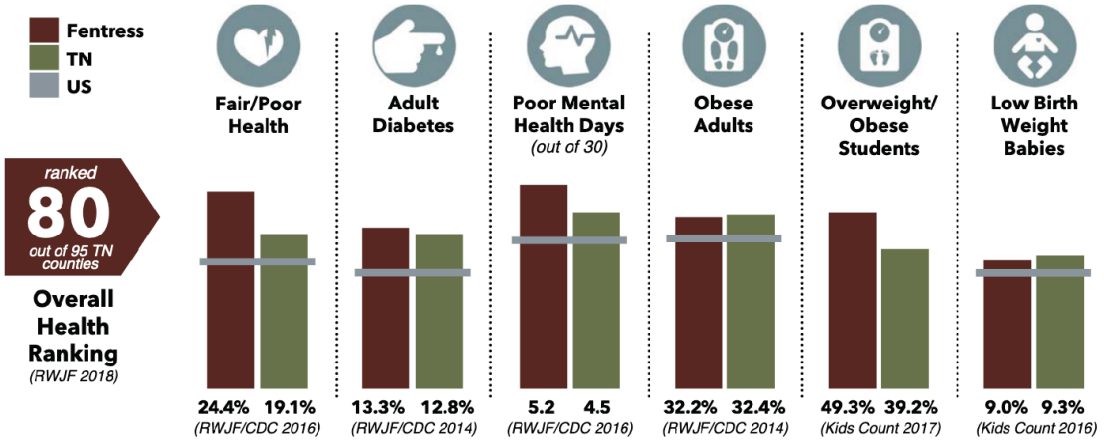
Prepared by Tennessee Health Care Campaign Rural Health Equity Project Team

FENTRESS COUNTY OVERVIEW (Sycamore Institute, 2019)

QUICK FACTS
2017 Population: **18,136**
Age <18: **21.2%**
Age 65+: **21.4%**
Median Age: **45**
Percent Rural: **100%**
(Census 2010, 2017)



HEALTH OUTCOMES IN FENTRESS COUNTY



FACILITIES IN FENTRESS COUNTY (Sycamore Institute, 2019)

0
HOSPITALS
There are no hospitals within Fentress County.

1
HOSPITAL CLOSURE
One hospital has closed in Fentress County from 2010-2019.

0
EMERGENCY DEPARTMENTS
There are currently no emergency departments located within Fentress County.

49
MINUTES
Average distance for transport to the nearest hospital (Cumberland Medical Center).

MAIN INDUSTRIES IN FENTRESS COUNTY

- Automotive manufacturing
- Engineering
- Transportation
- Metal manufacturing
- (Fentress County Economic and Community Development, 2020)

JAMESTOWN REGIONAL MEDICAL CENTER DATA (2018)

Net Income or Loss:
-3,941,139

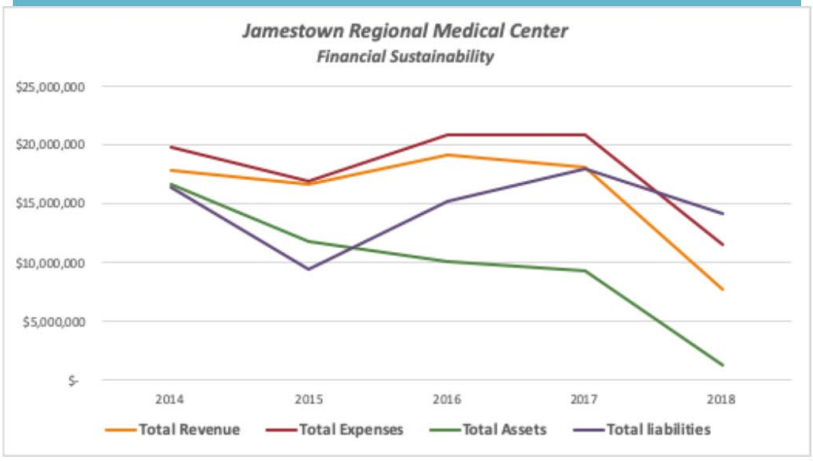
Patient Beds:
75 (25 staffed)

Total Inpatients:
480

Average Daily Census:
10

Percent Patient Revenue by Source:

Medicare	62%
TennCare	16%
Self-pay	7%
Commercial	17%
Other	11%



12% of residents do not have health insurance. (RWJF, 2019)

31% of residents are on TennCare. (TennCare, 2019)

20.6% of residents are at or below the poverty line. (US Census, 2017)

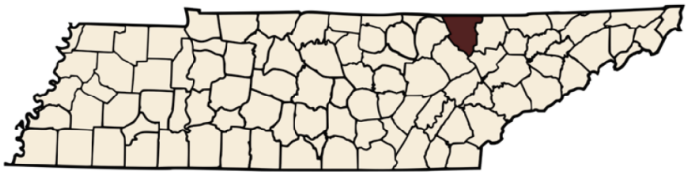
Scott County Health Profile

Prepared by Tennessee Health Care Campaign Rural Health Equity Project Team

SCOTT COUNTY OVERVIEW (Sycamore Institute, 2019)

QUICK FACTS

2017 Population: **21,989**
Age <18: **24.4%**
Age 65+: **16.4%**
Median Age: **40**
Percent Rural: **80.6%**
(Census 2010, 2017)

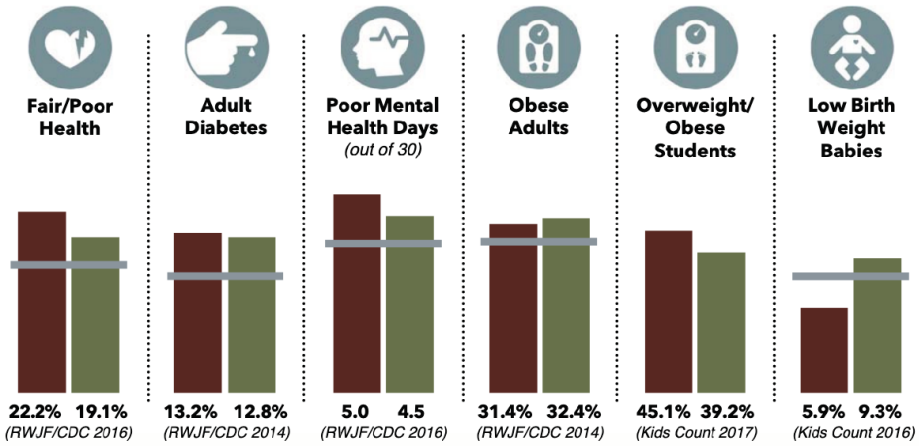


HEALTH OUTCOMES IN SCOTT COUNTY

Scott
TN
US

ranked **90** out of 95 TN counties

Overall Health Ranking
(RWJF 2018)



FACILITIES IN SCOTT COUNTY (Sycamore Institute, 2019)

1

HOSPITAL

There is 1 hospital within Scott County.

4

HOSPITAL OWNERSHIP CHANGES

The hospital in Scott County changed ownership 4 times from 2010-2019.

1

EMERGENCY DEPARTMENT

There is currently 1 emergency department located within Scott County.

4,526

OUTPATIENT VISITS

There were 4,526 outpatient visits at Big South Fork Medical Center in 2018.

MAIN INDUSTRIES IN SCOTT COUNTY

- Barna Log Homes
- Armstrong wood flooring
- Great Dane Trailers
- Tennier Industries
- (Scott County Chamber of Commerce, 2020)

BIG SOUTH FORK MEDICAL CENTER DATA (2018)

Net Income or Loss:
$22,487,015

Patient Beds:
25 (19 staffed)

Total Inpatients:
428

Average Daily Census:
10

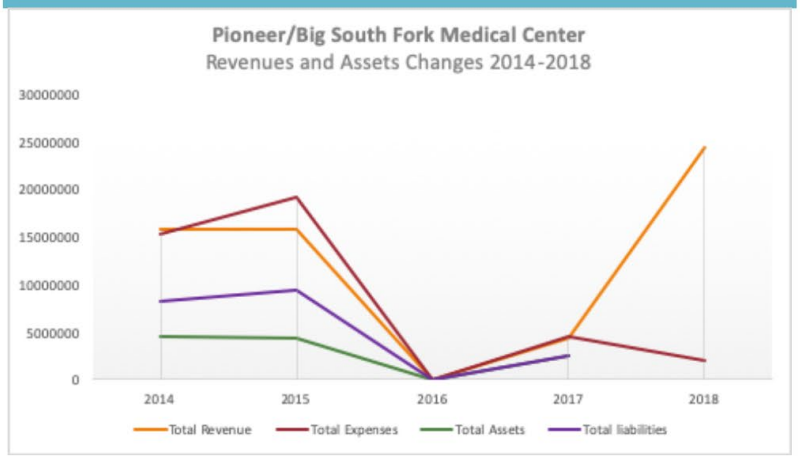
Percent Patient Revenue by Source:
Medicare 35%

TennCare 12%

Self-pay 3%

Commercial 8%

Other 42%



Note: There was no JAR report filed for BSFMC in 2016. In 2017 assets and liabilities were reported as equal. No assets or liabilities were reported in 2018.

11% of residents do not have health insurance. (RWJF, 2019)

34% of residents are on TennCare. (TennCare, 2019)

27.7% of residents are at or below the poverty line. (US Census, 2017)

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ADDITIONAL TOOLS AND RESOURCES

The following appendices and additional TOOLS referenced in this report are posted on the Tennessee Health Care Campaign website: ***tnhealthcarecampaign.org.***

APPENDIX 1. ADDITIONAL RESOURCES: provides links to other organizations and key resources and reports that focus on the causes and prevention of rural health inequities.

APPENDIX 2. HOW TO ASSESS THE HEALTH OF YOUR HOSPITAL: describes the data available in Joint Annual Reports filed by Tennessee Hospitals and how to use that data to understand the financial health of your community hospital.

APPENDIX 3. COMMUNITY ENGAGEMENT IN HEALTH CARE--OPPORTUNITIES IN TENNESSEE: describes the Community Health Needs Assessment process required of all non-profit hospitals in Tennessee and how advocates can get involved in that process.