TENNESSEE HEALTH CARE CAMPAIGN

March 2024

Saving Tennessee's Rural Hospitals: Strategies for Success

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Executive Summary

Rural health disparities and declining access to essential health services in U.S. rural communities are well-documented. Tennessee, where hospital closures lead the nation per capita, is no exception. Between 2010 and 2021, the state witnessed the shuttering of 22 hospitals, most of which were rural.

In 2021, the Tennessee Health Care Campaign (THCC) released an in-depth report (Rural Hospital Closures: "The ambulance is our emergency room"-- the voices of rural Tennessee) of its first statewide qualitative study examining the impacts rural hospital closures have on communities. Yet numerous rural Tennessee hospitals have remained open for business, and little is known about how these hospitals have managed to weather the storm thus far. As members of the THCC Rural Health Equity Committee, we planned a second study to understand how these hospitals survive.

To better understand the factors contributing to the success of rural hospitals, our committee conducted interviews with key stakeholders, many of whom are serving in executive leadership positions. We aimed to answer two questions:

1. What state and local government strategies support the survival of hospitals or their successful transition to other essential health services?
2. What community-driven strategies played a role in the survival of rural hospitals or successful transition to other essential health services?

We carefully selected five hospitals, ranging in size from 25 to 125 beds. Four of these hospitals were located in Tennessee, and one hospital was located in Kentucky, a neighboring state with expanded Medicaid. Of the five hospitals, two were for-profit, two were nonprofit, and one was county-owned. Three hospitals were integrated into larger medical provider systems, while two functioned as independent service facilities. Over the course of fall 2022 to summer 2023, we conducted semistructured interviews with 14 participants from these five hospitals. We then transcribed and analyzed the interviews to identify recurring themes and make recommendations. We made our recommendations based on three different perspectives: hospital institutional leadership and policies, public policies at the national, state and local levels, and how the local community can contribute to hospital success.

Hospital Leadership Findings: Participants reported that hiring the “right” staff from the community or those familiar with rural communities’ needs was crucial for success. Some participants found it helpful to garner the resources of more extensive hospital systems. Participants also stressed the need to provide needed specialty services. These hospital leaders recognized that certain commercial factors, such as in-network insurance status, swing beds and affordable supplies, were essential in their ongoing operations. Being involved and engaged with their communities and responding to community needs was also extremely important. These hospitals still faced challenges, including community demographics, staffing shortages, specialty-care issues, and the need for more substance-abuse

treatment and mental-health services. It was clear that these facilities were surviving, but not all thriving, in the current Tennessee rural-health system.

Public Policy Findings. Participants highlighted the need for Medicaid financing reform, especially to cover low-income adults ages 19-64 who are not currently eligible for TennCare. Participants also emphasized that Medicare and Medicaid reimbursements are crucial to financial stability, but that the existing programs often fall short of the need. Specific concerns were raised about telemedicine expansion, 340B drug pricing, and support for recruitment and retention of staff. Some hospital leaders provided examples of support from state and local government, while others provided examples of inadequate support.

Community Engagement Findings: Participants credited the support and involvement of rural communities to the survival of their facilities. Several participants emphasized the importance of recruiting nurses and other staff from their rural communities. Participants also described how their hospital collaborates with community groups to help organize outreach events, such as job and health fairs, vaccination days and health promotion walks and races. They also offered health-education programs. Hospitals benefited from preparing a Community Health Needs Assessment and setting up Community Advisory Boards.

Based on our findings, we made the following overall recommendations:

- Hire staff with good community fit and dependability and encourage local workforce development.
- Investigate affiliation with hospital networks for resources, business strategies, and bargaining leverage.
- Offer specialty services that meet community needs to retain local patients and increase revenue.
- Advocate for increased Medicare and Medicaid reimbursement rates.
- Advocate for expansion of health care coverage for low-income, uninsured members of the community.
- Engage with the community through community needs assessments, county health councils, and community advisory boards to build relationships and understand community needs.

Detailed recommendations can be found on pages 11, 17, and 21 of the report.

The discussion starting on page 22 relates the findings and recommendations to current political and administrative issues and decisions before our state's officials and leaders.

The report concludes with a call for collaborative efforts among community members, policymakers, and hospital leaders to transform the narrative from rural hospital survival to revival in Tennessee.

Introduction

Rural health disparities and declining access to essential health services in U.S. rural communities are well-documented.[1-4] Rural residents are more likely than their urban and suburban counterparts to experience diminished access to care; poverty; chronic illness; substandard housing; food deserts; and limited transportation.[3] The result is that rural residents tend to live shorter, unhealthier lives.

The issue is particularly dire in the southeastern U.S., where many states experience the nation's worst health outcomes.[5,6] Health care facilities are curtailing services, such as maternal and newborn care. Often, they close their doors altogether. Tennessee, where hospital closures lead the nation per capita,[5] is no exception. Between 2010 and 2021, the state witnessed the shuttering of 22 hospitals, most of which were rural. While the numbers are somewhat fluid, (given that some facilities manage to reopen, often with different service offerings), the state's rural health infrastructure has suffered significantly, leaving residents with fewer services, declining economies, and uncertain futures.[7,8]

Numerous factors are responsible for hospital closures e.g., a significant uncompensated care burden, aging infrastructure, and staffing shortages.[1] But the overarching issue is financial instability. By the end of 2022, 59% of Tennessee's hospitals operated with negative margins, and 45% were at risk of closure due to persistent negative operating margins.[9] Some of these facilities found means of making up for their financial shortfalls (grant funds, foundation support, etc.). Still, many remain vulnerable to closure in the immediate or near future.[9,10]

In 2021, the Tennessee Health Care Campaign (THCC) released an in-depth report (Rural Hospital Closures: "The ambulance is our emergency room"-- the voices of rural Tennessee) of its first statewide qualitative study examining the impacts rural hospital closures have on communities.[11] As members of the THCC Rural Health Equity Committee, we heard from 40 community leaders from six Tennessee counties that had either lost their hospitals or were facing imminent closure. We learned that not only did these communities suffer the loss of a significant employer and provider of essential care, but they also lost an element of their identities and experienced communitywide anxiety about their futures.

Yet numerous rural Tennessee hospitals have remained open for business, and little is known about how these hospitals have managed to weather the storm thus far. Our committee, named at the end of this document, planned a second study to learn how these hospitals survive. We aimed to understand the factors contributing to their ongoing operations and success in their communities and to ascertain which challenges remain, challenges that

policymakers and stakeholders must grasp if they are to shore up rural hospitals and prevent further loss of essential services. We hope this report benefits communities across Tennessee as they seek to maintain and grow healthcare services and lead their residents to healthy, thriving futures.

Approach

To better understand the factors contributing to the success of rural hospitals, our committee conducted interviews with key stakeholders, many of whom are serving in executive leadership positions. We aimed to answer two questions:

1. What state and local government strategies support the survival of hospitals or their successful transition to other essential health services?
2. What community-driven strategies played a role in the survival of rural hospitals or successful transition to other essential health services?

We selected hospitals based on the following criteria:

1. Experienced the threat of hospital closure, yet succeeded in maintaining an operating hospital for at least three years after the initial threat.
2. Sociodemographic profiles and geographic characteristics suggest that the local hospital would be at risk, but there has not been the threat of hospital loss.
3. Established a mutually-productive relationship between a rural hospital and a metro or suburban hub facility.

We carefully selected five hospitals, ranging in size from 25 to 125 beds. Four of these hospitals were located in Tennessee, and one hospital was located in Kentucky, a neighboring state with expanded Medicaid. Of the five hospitals, two were for-profit, two were nonprofit, and one was county-owned. Three hospitals were integrated into larger medical provider systems, while two functioned as independent service facilities. It is worth noting that all five hospitals successfully stayed open during the COVID-19 pandemic.

We conducted semistructured interviews with 14 participants from Fall 2022 to Summer 2023. Interviews were recorded on Zoom. Interview questions can be found in the appendix. We recruited participants by gathering contact information from one of the five identified hospitals and reached out via phone or email. Initial contact involved sharing study details with the chief executive officer's (CEO) assistant. If the CEO agreed to participate, we identified additional participants by asking the CEO if they could connect us with other hospital staff. Participants held diverse roles, as displayed in Table 1.

Table 1. Roles of Participants

Total Participants	N=14
Board Chairman	1
Chief Medical Officer	1
Chief Nursing Officer	2
Director of Nursing	1
Hospital CEO	5
Parent company CEO	1
Pharmacy Director	1
Regional Hospital President	1
Volunteer Coordinator	1

We transcribed and analyzed the interviews to identify recurring themes and make recommendations. We made our recommendations based on three different perspectives: hospital institutional leadership and policies, public policies at the national, state and local levels, and how the local community can contribute to hospital success.

Hospital Leadership Findings

Participants revealed that solid hospital leadership and internal strategies were foundational to their ongoing operations. They stressed the importance of successfully recruiting and hiring a workforce familiar with rural communities and their health care needs; sharing resources within affiliated larger hospital systems; providing needed specialty care; recognizing essential commercial factors; engaging with the community (and establishing a community advisory board); and understanding the community's needs.

- **Hire the "right" staff** from the community or those familiar with rural communities' needs.

- One participant said, *"I can't take a hospitalist from Nashville and move [them] out here because they are accustomed to having people and resources. They don't know how to put somebody on a ventilator. They don't know how to intubate somebody. They haven't had to do it in years. They lost the skill to be able to work here. But training people here, giving them the experience and broader opportunity, offers rural areas a much higher likelihood of keeping that person who is really motivated to provide high-level, very diverse care."*

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  - Others said it was essential to build training programs, such as nursing student clinical programs and physician-resident programs, to emphasize retention and to limit travel nursing and contract staff sparingly. One CNO noted, *"I know all my employees and their kids' names…being there and praying with these people and being a shoulder to cry on when they need it helps grow the community inside the hospital."*
  - One CEO stated, "*For long-term success, we have to continue building the culture within our organization so people want to work here. When [the staff wants] to work here, people want to come here for their health care as well."*

- Some participants found it helpful to **garner the resources of more extensive hospital systems.**
  - One participant noted that hospitals belonging to more extensive systems can *"share resources effectively between the multiple facilities and move those resources around to where patients are."*
  - Another hospital executive stated that he learned from the successes of other hospitals and other leaders, noting, *"I've got the opportunity to glean information from other sources that I wouldn't normally have if I was an independent hospital."*

- The participants also stressed the need to provide necessary **specialty services.**
  - Without specialists, patients seek care elsewhere, often leading them to pursue all their care at hospitals where they see specialists. To keep local patients, *"bread and butter*" specialists, such as cardiology, must be available daily.

- Successful hospitals recruit specialists who are a good fit culturally and happy to stay long-term, including through the J1 visa program for recruiting and retaining specialists.
- Researchers also heard that many of these hospitals saw the value of expanding their specialty service offerings, especially women's health care services, such as L&D and mammography.

- Furthermore, these hospital leaders recognized that **certain commercial factors** were essential in their ongoing operations.
  - Several placed a strong emphasis on in-network insurance contracts.
  - Others stressed the importance of providing needed (but strategic) programs like swing beds, (which allow hospitals to care for less-acute patients while receiving favorable reimbursement rates), cardiology treatment and rehab, and general surgery.
  - They said it was crucial to procure supplies and medical equipment cheaply enough to live within the hospital's and the community's means.
  - Others stated the value of finding competent management that holds the good of the institution and its community as central values.

- Others stressed the importance of hospital leaders **being involved and engaged with their communities**.

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  - *"A big part of my job was not only being here in this office at this desk but was… getting involved in the community."*
  - Other interviewees echoed this sentiment. They cited the importance of involvement with myriad community groups, including kiwanis and rotary clubs, chambers of commerce, and local community boards.
  - These interviewees also emphasized the importance of organizing events within the community, including job and health fairs, vaccination days, and health education events (like stroke awareness classes and AED training). One CEO also noted hosting a Paint the Town Pink event every October for breast cancer awareness. This interviewee said, *"And if you don't live in this community, you're not at those events. And you're not seen out and about, so as a result, you're not seen as a part of the community, and the loyalty and the relationship [aren't] there."*
  - Another hospital found that its strong community relationships resulted in an essential insurance contract that it could not close on its own. This CEO

explained, *"We got that contract signed with Blue Cross, not because of anything I did, but it was because of what the local community did. And you know, they called the governor's office, they called the insurance commissioner. And we were able to do that because of our relationships with the local community."*

- Strong community relationships also played out in **developing community advisory boards**, which participants found essential to maintaining their solid presence in the community.
    - One parent company CEO noted their success was very much about local control, stating, "*The advisory board is extremely important to us."*
    - Another CEO explained the importance of the hospital's advisory board relationship in how it relates to the more extensive health system: "*We have a local advisory council, and ours is made up of 12 community members: bankers, retired teachers. I have somebody from the health department. I have a nurse practitioner on there. I tried to get a mix throughout the community of ministers. …We meet quarterly. And then, our council chooses one person to sit on the (health system's regional) advisory council, which also meets quarterly. And then that regional advisory council chooses a member to serve on the (health system) board*."

"The advisory board is extremely important to us."

- Other participants stressed the importance of **understanding the community's needs.**
    - One CEO noted*, "Community members are giving their time to tell me what they think our community needs, so we need to try to be involved in things that need our attention, pick the top three priorities that we can focus on to make a change."*
    - Another said, *"We step up and try to at least be involved in things that have been brought as key factors that need our attention."*

While these hospitals were open for business, the hospital leaders we interviewed (including providers, staff, and administrators) were concerned about challenges to their facilities' ability to provide ongoing care. In other words, **they were surviving, but not necessarily thriving**.

Challenges identified:

- **Community demographics** (high unemployment, crime, violence, and poverty rates; a sizable uninsured population; and high proportions of Medicare and Medicaid patients) lead to inadequate reimbursement and uncompensated care.

- One participant noted, *"The hospital provides care to underserved patients that do not have health insurance. As a result, there are high rates of uncompensated care."*
- Another noted, *"The second problem that we have is TennCare…there are three TennCare providers: one's Amerigroup, one's United, one's Blue Care. Amerigroup and United pay--they don't pay great … but they're enough. Blue Cross Blue Shield pays about 50% below what those other two pay."*

- **Staffing shortages of qualified health care providers (mainly nurses)**:
  - One CNO noted, *"The biggest challenge that we're seeing is keeping nursing staff. ... We have big health care systems offering three times what nurses are making here. And a critical-access hospital, we cannot pay that and survive."*
  - Another participant noted that rural hospitals' unique demands require providers with specific skills to handle diverse and unpredictable trauma cases: *"You never know what's going to come your way. You have to be prepared for everything."*

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- **Specialty-care issues:**
  - *"It's very difficult to get a number of specialties to come into town because … they don't have a colleague to call. It can be hard to manage. And so many specialists like to have colleagues in the same specialty to bounce things off of and take care of patients."*
  - *"[OB care is] so cost-prohibitive from an insurance standpoint. And liability standpoint… you rarely see these critical-access hospitals do that."*

Participants also noted the dire community need for **substance-abuse treatment and mental-health services.**

- Participants revealed the significant barriers they face are serious:
  - *"Half of my ER's beds are filled with people who've threatened to kill themselves."*
  - *"There are 127 patients on the waiting list of the regional mental-health facility."*
- Many participants saw a need to offer geriatric psychiatric inpatient beds, other inpatient psych beds, and detox programs, including medication-assisted therapy and

neonatal abstinence syndrome care. Still, they recognized their limited capacity to launch such programs.

- The pandemic presented roadblocks as well. Rising cases of mental distress, staffing strains and shortages, and department closures played a role during and after the COVID-19 crisis. *"We were doing it [an outpatient geriatric psych program] pre-COVID. And we had to stop."*

Recommendations

Hiring Practices

- Have thoughtful and focused hiring practices to recruit staff with good community fit and long-term dependability.

Utilize Networks

- Seek beneficial hospital network affiliations, both formal and informal, to share resources, business strategies, and more collective bargaining leverage.

Foster Specialty Services

- Specialty services will help retain local patients and give the hospitals higher-earning service lines.

Strong Community Engagement

- The long-term success of hospitals depends on the relationship with and support from the community it serves.
- Seek opportunities to communicate directly with the community regarding community needs and priorities.

Clear Understanding of Challenges

- The low socioeconomic status of communities that leads to low reimbursement and high uncompensated care.
- The low reimbursement from Medicaid (seek opportunities to advocate at the state level for Medicaid expansion per the Affordable Care Act, adequate reimbursement, and reimbursement parity among the state's Medicaid MCOs).
- Staff shortages, particularly in nursing and specialists.
- High-need and low availability of substance-abuse treatment and mental-health services.

Public Policy Findings

Participants consistently highlighted two key and inter-related issues when sharing policy recommendations for state and federal decisionmakers:

1. There is a need for Medicaid financing reform, especially to cover low-income adults ages 19-64 who are not currently eligible for TennCare.
    - One CEO said, *"Medicaid expansion would have been glorious."*
    - Another CEO said, *"Medicaid expansion was a huge win for Kentucky when they decided to do that."*
    - A third CEO stated, *"Our state legislature's refusal to adopt the changes around Medicaid hurts us in a big-time way. …[Medicaid expansion] would be good for our state, it would be good for our hospitals."*

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    - A CMO said, *"Expanding Medicaid to include people who are working 40 hours plus a week or working multiple jobs is valuable."*
    - A board chairman said, *"Well, one [federal policy change] that comes to mind, particularly for me, is expansion of Medicaid. I think, you know, we're typical for small rural counties…having a lot of sick patients, a lot of obesity and diabetes. Poverty. And there's just an awful lot of our population in the county that don't have health insurance."*

2. Medicare and Medicaid reimbursements are crucial to financial stability, and the existing programs can help, but often fall short of the need.
    - One network CEO said, *"The federal government could solve all these closure problems, and all these rural hospital closures and issues with critical-access hospitals… if they allocated more resources. Even a billion or $2 billion to the program annually would fix these programs for critical-access hospitals… You know, right now, critical-access hospitals, by law, are supposed to be reimbursed 101% of cost. And they're only getting paid 99% of cost right now because of sequestration."*
    - A CEO at a critical-access hospital explained, *"We always get frustrated with reimbursements levels. I think the government could allow more funding for behavioral health care."*

- Another CEO had not forgotten a cut in reimbursement. *"With the Affordable Care Act, there was a cost reduction that was put in place. And that has hurt and stymied the health care industry."*
- A regional hospital president shared how bureaucratic details that might make sense in theory may be barriers in practice. This participant went on to say, *"There's a new designation coming out in January called 'Rural Emergency Hospital.' They are writing the rules for it right now. We're going to evaluate a couple of our facilities to see if it makes sense to designate them that way. The problem with that designation is that there is a lot of pushback on it, even from national organizations, because this designation doesn't permit any inpatient work. It's got to be a totally outpatient facility. Although a lot of these small rural hospitals only have a census of three or four, it's still a census of three or four. Giving that up makes it almost a wash [for the community], as opposed to a benefit."*
- A hospital CEO pointed out that a major flaw is how Medicare reimbursement is calculated. *"I wish there were relaxation or greater consideration around wage index. We don't pay as much, and so we don't get reimbursed as much for Medicare because our wages aren't as high."*
- On the other hand, a system CEO emphasized how important certain aspects of federal policies can be. *"There are some real advantages to doing a new hospital in a rural community, one of them being the way that critical-access hospitals do reimburse; they will actually reimburse you for the capital expenses in your reimbursement. So if you're 50%, Medicare, they're going to help pay for 50% of those capital improvements and construction. So it is a program that [the] federal government has designed to help these rural hospitals be able to add to their facilities."*
- Another CEO highlighted a different aspect of federal policies, particularly in relation to critical-access hospitals. *"The swing bed program and the swing bed reimbursement are particularly helpful to the hospital's survival."*
- In terms of current Medicaid funding, every little bit helps, as mentioned by this CMO: *"I think that anything we can do to standardize the rules and not change them every election cycle would be helpful. The rural hospitals certainly benefited from the Medicaid expansion [of coverage] during the pandemic."*

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- Another CEO reported, *"We do have TennCare, but we still see a lot of people that are in the gap that do not have health insurance. We see homeless. We still see some undocumented immigrants that are around in the area doing agricultural work."*

Participants also raised concerns about other policy issues, including:

1. Telemedicine services
    - A CMO stated, *"From a community perspective, if the state legislature will continue to support telehealth services, we can keep patients out of the ED. We can keep them out of the hospital…The state certainly could support a variation or variance and could allow it under the state programs and pressure the federal side to continue that or continue the expansions that we had under the pandemic."*

"From a community perspective, if the state legislature will continue to support telehealth services, we can keep patients out of the ED."

    - A CEO said, *"Telehealth may allow the hospital to interface with more specialists. So I look for it to help them to be available via telehealth in the ER, because we transfer out so much."*
    - A CMO said about telehealth with specialists, *"I cover facilities in Tennessee; Illinois; Pennsylvania; Texas; [and] Alabama, where we are available nights and weekends. Patient falls or injuries, we can do those assessments and not send the patient to the emergency department. It's rewarding to be able to manage the patient appropriately, and not send them to the ED where they're going to sit and wait and pick up influenza or COVID, or RSV, or something else. So we can manage those patients. Anything the state will do to continue support for us under the waiver is great."*

2. 340B drug pricing
    - A regional hospital president said, *"340B drug pricing is kind of always on the chopping block. There's advocates, and there's opponents, so that issue just kind of depends on where the Congress goes with that."*
    - A pharmacy director at a hospital run by a for-profit network said, *"I know that nonprofits are able to participate and get the 340B to your lower drug pricing. If you're for-profit, you're not able to. But what if you're just a rural small hospital in a low-income community? We lose out on some business… like infusions, outpatient infusions, for people. The big names…they're able to buy these drugs*

at a fraction of what I can. People are forced to pass us by; their insurance basically forces them to go somewhere else."

3. Recruitment and retention

"There's going to be a critical RN shortfall that we're just on the infancy of it; …it's going to multiply and get two times worse. I don't know how we're going to deal with that if the state doesn't step in."

- One CEO noted, *"There's going to be a critical RN shortfall that we're just on the infancy of it; it's going to, it's going to multiply and get two times worse. I don't know how we're going to deal with that if the state doesn't step in."*
- A CMO focused on community health workers said, *"So the state should continue to support training programs for county-level paraprofessionals. And those programs do help with home visits. This is very important in the rural communities. We trained 15 or so last year, and it was their first program. The challenge for them was that they are only two people in the county. Now we have to go back and figure out how to set up and fund a program under our existing resources. It is going to take some funding and some financial support for those counties."*
- Another CEO gave this advice: *"The trick [in recruiting specialists] is that we use a program called the J1 visa program.", i.e. using foreign nationals."*

In regard to the role of state and local governments in rural hospital sustainability, some participants highlighted inadequate support:

- A CEO said, *"We're dealing with a situation right now…We're trying to open our ER to a dental group. But because of the state guidelines that we have, we can't do it because we have to have either a pediatric doctor or a family physician to sign off on any dental surgeries that are done, and the responsibility ends with them."*
- A network CEO said, *"I guess from a local-community standpoint, I think they need to come to the realization across the country, there's no one coming to help them, right? [The] state of Tennessee is not coming to help, the federal government's not coming to help. If you want a local hospital, then you might need to step up as a community and pass some type of local tax to support your hospital. And that's just a realization that I think some of these communities might need to get to."*

Some participants noted positive engagement with the state and local governments:

- One CEO said, *"We have partnered with the state on the rural tract, so we're going to have a physician that's going to rotate through [a small neighboring city] for the next couple of years."*
- A pharmacy director recalled that state officials helped by providing useful information. *"We got guidance on things… guidance on ways to make sure that we stayed within compliance. [For example], at a certain point, they'll come and make you shut down….If we had a closed down the ER, if we had closed [that facility] at some point, we would have lost our critical-access status. And that's very important to our survival now."*
- A pharmacy director noted, *"Local government? What did they do? They were trying to get us in touch with… government officials…to get the word out to advocate for us; ….just trying to use their knowledge of influence and knowledge of other people and contacts to help us move up and get the word out of how much we did not need to close….The local government and … our little local bank here worked together to establish this little credit line. [The bank president] had connections, but he also seemed to kind of really understand the importance of us staying open. Our local mayor…they really fought… to try to make sure that we stayed (open)."* She also noted how local influence helped in the hospital's previous bankruptcy process. *"We were assigned a great receiver. She was wonderful. And I mean, everybody feels that [she] was so instrumental because she was so protective of us. And,… being nonhospital, she had a different perspective. That was really nice to be in the position she was appointed to, to watch over us. She was, she was very invested in it…. She came to the groundbreaking for the new hospital."*

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- The volunteer coordinator at the same facility noted, *"Our state representative……definitely [played] a huge role. The county mayor and city mayor, those three, and then the chamber of commerce. Those three, four stick*

out in my mind. I know there must be others. I just know that those are the ones that come to my mind as really, really, really coming through."

- Finally on a different note, a CEO of a hospital run by a nonprofit network, but owned by the local city, said, *"I guess the best [local] policy is they have not tried to interfere in the operations of the hospital."*

Recommendations

Federal

- Increase Medicare and Medicaid reimbursement rates and implement policies to ensure rural hospitals receive adequate compensation for their services.
- Focus on other programs that support underserved communities, such as the 340B drug program, so they meet the needs of rural hospitals.

State

- Implement Medicaid refinancing by accepting federal funds to greatly increase TennCare reimbursement and improve coverage for the uninsured population in rural areas.
- Expand existing state programs that support the staffing of rural health care workers at all levels of practice.

Local

- Encourage and facilitate partnerships among hospital leadership, community supporters and local government officials.

Community Engagement Findings

Many of Tennessee's rural hospitals were founded and funded by their communities as government or charitable services, not businesses. But over the past 50 years, the United States has seen the ownership of hospitals shift from community-run models to corporate models, and, more recently, to investment-firm business models. Many physicians, nurses and technicians no longer live in the communities where they practice, but rotate through as employees of staffing agencies. Long-term management decisions are increasingly made by administrators headquartered in other states. THCC estimates that about 80% of our state's hospitals are now affiliated with larger nonprofit or for-profit health systems.

Yet the participants in our study still credit the support and involvement of rural communities to the survival of their facilities. One CEO explained, *"A big part of my job was not only being*

here in this office at this desk but was... getting involved in the community." That might include attending and cosponsoring community events, representing the hospital on local chambers of commerce and regional economic development agencies, or participating on local nonprofit health-agency boards.

Several participants also emphasized the importance of recruiting nurses and other staff to or from their rural communities. These nurses and staff were some of the reasons local patients visited rural facilities for care. Participants also described how their hospital collaborates with community groups to help organize outreach events, such as job and health fairs, vaccination days and health promotion walks and races. They also offered health-education programs. This is not only a way for them to promote health, but it is also a way for families to learn about hospital services and meet hospital staff. This is particularly the case for smaller hospitals with fewer resources. Some participants described how their hospitals still support auxiliary organizations that join together to raise funds to purchase a new piece of equipment, or to extend the ability of the hospitals to provide charitable care. Other potential avenues for community engagement are discussed below.

Community Health Assessment and Planning

The Affordable Care Act requires that nonprofit hospitals contribute to community benefit by engaging with their service communities to prepare a *Community Health Needs Assessment* every three years. Community benefit is the *"unreimbursed goods, services, and resources provided by health care institutions that address community-identified health needs and concerns, particularly of those who are uninsured or underserved... **Community benefit is about improving the overall health and access to care in a community."***[12]

Preparation of the Community Health Needs Assessment is an opportunity for hospitals to learn from the community about health needs that are not being met. The Community Health Needs Assessment process usually involves surveys of and listening sessions with other provider agencies and diverse stakeholder groups that are representative of the service area's population in terms of age, race, and income levels. This input is intended to help hospitals prioritize investments in new services or new approaches to providing and coordinating care. Community members should

"Community members are giving their time to tell me what they think our community needs, so we need to try to be involved in things that need our attention, (and) pick the top three priorities that we can focus on to make a change."

also participate in developing *Implementation Plans* to help achieve the needs that have been identified and prioritized. As one hospital CEO we interviewed stated: *"Community members are giving their time to tell me what they think our community needs, so we need to try to be involved in things that need our attention, (and) pick the top three priorities that we can focus on to make a change."*

Both the community health needs assessments and their implementation plans are required to be posted on hospital websites and can be ways of establishing accountability and transparency. In Tennessee, each rural county also has a *community health council* to advise the local health departments. These health councils also conduct Community Health Needs Assessments and often work in collaboration with their local hospitals to produce joint reports. This provides an opportunity for hospital staff to meet with local provider agencies and develop closer collaborations to serve the needs of vulnerable patients when these patients are discharged from hospitals. For example, participants in our study consistently noted mental health and substance misuse have continued to be among the top priorities identified in Community Health Needs Assessments across Tennessee. As one hospital administrator noted, "*Mental health [care] is absent everywhere, but particularly in rural America."*

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While not all the hospitals in this study provided psychiatric beds, participants reported that patients with behavioral-health needs were having long stays in their hospitals while waiting for beds in more appropriate facilities, or for non-hospital based services to become available elsewhere. Solving this problem requires close collaboration between hospital leaders; behavioral-health providers; families of mental-health patients; and local and state government agencies in ongoing ways to make a full continuum of care accessible in rural Tennessee communities. Health councils can be vehicles for enabling this level of collaboration.

While serving on a hospital board of directors may require special expertise that patients and their families don't have, many hospitals have benefitted from setting up *community advisory boards* that meet throughout the year to advise administrators and staff on decisions regarding patient care, renovation designs, the development of new services, or to help address health issues that might emerge in between the three-year community health needs assessment process. One CEO we interviewed explained: *"We have a local advisory council, and ours is made up of 12 community members, bankers, retired teachers. I have somebody from the health department. I have a nurse practitioner on there. I tried to get a mix*

throughout the community of ministers. We meet quarterly, and our local council chooses one person to sit on the regional hospital system board, which also meets quarterly. Then, the regional council selects someone to sit on the corporation's advisory board."

Community advisory boards are recognized to have significant long-term benefits, including improving connections with public policymakers and local provider groups, strengthening connections among agencies in the community who can assist in meeting the needs of vulnerable patients after discharge, and reflecting the perspectives of diverse members of the community to improve their understanding and utilization of hospital services.[13]

Community Advocacy

Rural hospitals struggle with responding to large social problems that are bigger than any one community. Joining statewide health-advocacy efforts, working closely with elected leaders to understand how policy changes will impact hospitals, and building coalitions across facilities are strategies to address ongoing statewide problems, such as the insurance coverage gap in Tennessee and the mental health and substance-misuse crises across the state.

In Tennessee, rural communities have large populations of uninsured residents, sometimes as high as 20% of the adult population aged 19-64. When uninsured residents need hospital services, that puts a strain on already-tight hospital finances. Participants from each hospital in our study noted our state's failure to take advantage of Medicaid expansion with the federal government's 9:1 match and $900 million in additional incentives that would provide coverage of over 300,000 adults under age 65 through our state's TennCare program. This failure, as noted elsewhere in this report, creates an undue burden of uncompensated care that jeopardizes their hospitals' bottom lines. In contrast, participants from the Kentucky hospital in our study pointed to that state's Medicaid expansion program as a key to financial sustainability. One Tennessee CEO we interviewed put it this way: *"We live in a red state, and I live in a very red county. Our state legislature's refusal to adopt the changes around Medicaid hurts us in a big-time way. By the way, I'm Republican. So when I talk about red, I'm talking about myself too."*

"We live in a red state, and I live in a very red county. Our state legislature's refusal to adopt the changes around Medicaid hurts us in a big-time way. By the way, I'm Republican. So when I talk about red, I'm talking about myself too."

Access to essential, affordable health care should be a bipartisan issue. Community members need to continue to reach out to their legislative representatives, regardless of party, as well as to the governor, lieutenant governor, and speaker of the state house of representatives, urging them to reconsider Medicaid expansion. Since Governor Haslam's Insure Tennessee proposal was rejected in 2015, and as the impacts of a wave of rural hospital closures continue to be felt in communities across the state, more and more rural state representatives privately acknowledge the need for expansion. However, many are waiting for the majority party's leadership to signal its support. Community members can stress the importance of Medicaid expansion in candidate forums and town halls during election cycles, and through calls, letters and emails to their representatives throughout the year.

Community advocacy can also focus directly on the private sector. In one of the hospitals we examined, a community intervention resulted in an essential insurance company contract that the hospital could not have secured on its own. That hospital's CEO explained: "*We got that contract signed with Blue Cross, not because of anything I did, but it was because of what the local community did. And you know, they called the governor's office, they called the insurance commissioner. And we were able to do that because of our relationships with the local community."*

In another hospital THCC examined, the local bank offered a special loan to a hospital during a transition in ownership to enable it to make payroll and keep its emergency-room doors open while a new mix of services was put in place.

Recommendations

- Encourage elected officials to expand TennCare's support of rural hospitals[14]
    - Connect with elected state representatives and state senators—via phone call; email; letter; virtual or in-person meeting—to urge them to reconsider expanding TennCare to low-income adults and to improve reimbursement rates for care delivered to patients covered by TennCare. Visit Tennessee Health Care Campaign's website, tnhealthcarecampaign.org, for talking points and sample emails on the needs for expanding access to care or for help setting up a constituent meeting.
    - Connect with local elected officials, too. Uninsured individuals should talk to city council or county commission representatives about the need to find insurance options for county residents, and to buffer the impact of uncompensated care on local hospitals. Ask them to share any concerns with state government leaders and encourage them to pass a formal resolution in support of TennCare

expansion and increased reimbursement of essential services. (See THCC website for samples.)

- Get involved with county health councils and hospitals' community health needs assessment process. Past needs assessments should be posted on local hospital and health department websites, as is contact information for the hospital staff responsible for community outreach. To learn more about county health councils, visit local health department websites. A description of the roles and responsibilities of county health councils is posted on the Tennessee Department of Health website: County Health Councils (tn.gov)[15]
- Find out if your hospital has a community advisory board, meet with members of that board, or consider joining it if you have the time to do so. Community Advisory Boards have proven essential for improving the quality and continuity of services to members of the community, particularly those with special needs. A well functioning Community Advisory Board has a clear mission and guidelines, is led by members of the community whose time is often compensated, and whose advice and recommendations are respected and implemented.[13]

Discussion

Tennessee's state legislature has consistently refused to accept $1-2 billion per year in new federal money for Medicaid expansion. To date, 41 other states have elected to accept these funds, resulting in positive impacts on both their state budgets and the health of their population.[16] Under the terms of Medicaid expansion, starting from 2014, every dollar invested by the state of Tennessee in safety-net services for adults earning below 138% of the federal poverty level could have been matched with $9 in federal funds.[17] In 2021, as part of the American Rescue Plan, a special offer was made: Tennessee would also receive a 5% higher overall match rate for its TennCare program for up to two years.[18] This amounts to an additional estimated $900,000,000 from the federal government that could be invested at the state's discretion in rural health system support, economic development or other needed services.[19] Tennessee needs to open its doors to this large additional influx of federal resources for health care.

Under the TennCare Managed Care system, the MCOs (Managed Care Organizations) that contract with TennCare to provide coverage to eligible Tennesseans are responsible for negotiating rates of reimbursement for hospital services with hospitals in their networks. Rural hospitals are usually in weaker negotiating positions than urban counterparts, and MCOs, as participants in our study clearly reported, can take advantage of this and reimburse far below cost. There are state Medicaid supplemental payments that are distributed to hospitals that

bear a disproportionate share of uncompensated care, but the methodology for distributing them is murky, at best. Even with these back end supplemental funds, the actual cost of providing care is often not fully reimbursed. A recent nationwide examination of these back end supplemental funds indicated that Tennessee only reimburses hospitals an average of $24.51 per low income patient (under 200% of the federal poverty level) served, and only $78.46 per uninsured patient, which amounts to about 20% of the national average disproportionate share payments.[20] Tennessee needs to re-evaluate this program, make it more transparent, and ensure that TennCare reimbursements are reimbursing more reasonable costs of uncompensated care in rural settings.

Currently, the Centers for Medicare and Medicaid designates some rural hospitals as critical-access hospitals (CAHs) or Medicare-dependent, or rural emergency hospitals. These designations enable higher reimbursement levels, peaking at 101% of costs for patients in the standard Medicare program. However, the costs of care for seniors with Medicare Advantage plans are reimbursed at rates negotiated with the commercial Medicare Advantage carriers that are often well below standard Medicare rates. The rapid growth in Medicare Advantage plans in rural areas has put many hospitals in rural areas, especially freestanding ones, at a distinct disadvantage. Congress needs to address these widening disparities in payment.[21]

Medicare also bases reimbursements, in part, on local wage rates, which are generally lower than those in urban areas. This tends to lower reimbursements for rural care, when the cost of providing some care may actually be higher in rural areas.[22]

Rural hospitals can't compete with salaries that urban hospitals are offering, so many rural hospitals lose staff and have additional difficulties in recruiting them. Tennessee should continue and accelerate recruitment and retention programs for nurses, physicians and medical technicians needed to staff rural hospitals and emergency-care centers. Efficient and reliable telehealth and additional financial supports are needed to increase the numbers of specialists willing to provide services in the more remote rural areas of the state. The state also needs to consider investing in community health workers who can help hospitals identify local resources to support discharged patients and lower preventable readmission rates.

The increasing costs of prescription medicines also affect rural hospitals negatively.[23] The federal government needs to strengthen 340B drug pricing and other federal negotiation mechanisms to make needed medicines more readily available and less expensive for hospitals to purchase and administer.

In addition to the complete closing of many rural hospitals, others are having to cut essential services, such as obstetrical care. Tennessee needs to address the existence of emergency care, obstetrical care, acute behavioral health care and other essential- care deserts and work with

existing hospital networks to fill those gaps. For example, regionalization of perinatal care can help fill gaps in access to obstetrical care and improve maternal and neonatal outcomes.[24]

Many struggling rural hospitals, especially those not affiliated with larger hospital systems, need proactive technical assistance and financial grants to develop new service lines, and to market their services and expertise to their communities.

Community-needs assessments have helped identify services that communities value, and several interviewees suggested that the state could make grant funds available to communities and hospitals to actually develop and implement these programs.

Local government officials and community stakeholders, especially those serving on boards, need more education on the crisis in rural health care and resources and strategies available to them to help sustain their hospitals.

Conclusion

In summary, members of the THCC Rural Health Equity Committee conducted interviews with key stakeholders from five rural hospitals to understand the factors contributing to the success of rural hospitals' continued operations. These interviews provided critical perspectives on leadership, community engagement, and public policies crucial for the ongoing viability of rural hospitals. While the hospitals in this study display resiliency, it is clear that rural hospitals continue to face challenges, including high rates of uncompensated care and inadequate Medicare and Medicaid reimbursement rates. This report provides actionable recommendations based on participants' perspectives to address these challenges.

Call to Action:

1. **Advocate for Medicaid expansion:** Expanding Medicaid is a critical step to strengthening the viability of rural hospitals in Tennessee.
2. **Advocate for fair TennCare reimbursement rates:** Increasing TennCare reimbursement rates will help rural hospitals receive adequate compensation for the services they provide.
3. **Support your local hospital:** Engage in community advisory boards, get involved in county health councils, and participate in community health needs assessments.

Our findings highlight the need for all stakeholders, including community members, policymakers, and hospital leaders, to work collaboratively to save Tennessee's rural hospitals. Together, we can transform the story of rural hospital survival to one of rural hospital revival, ensuring that these anchor institutions continue to provide essential health care services in rural communities of Tennessee in the years to come.

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About the Research Team

Tennessee Health Care Campaign is a nonprofit, nonpartisan organization, working since 1989 for equitable, affordable access to quality health care. It advocates for policies and programs that improve the health and well-being of all Tennesseans. In collaboration with the Meharry Vanderbilt Alliance, THCC's Rural Health Equity Committee conducted participatory research, interviewing key stakeholders at five rural hospitals to learn about strategies needed to save Tennessee rural hospitals from closure.

As of December 1, 2023 the Rural Health Equity Committee consisted of:

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Appendix: Interview Questions

Possible questions for hospital administrators/senior staff

1. What do you consider the key metrics for success for a rural hospital of your size?
2. How has COVID impacted your hospital's operation?
3. What community policies have supported the success of the hospital?
4. What state or federal policy changes would make the hospital more sustainable?
5. What services would you add, if it were possible?
6. How do you attract and retain staff?
7. Have you participated in the Community Health Needs Assessment process? Do you feel that has been a helpful and meaningful process for the hospital? Community?
8. What partnerships have contributed to the success of the hospital?
9. What is your perception of the community's support for the hospital?
10. What percent of people in the community are using the hospital as their first choice?
11. Does the hospital offer non-medical community services (wellness ctr, nutrition program, etc.)?
12. In what ways does the hospital engage with the community (health fairs, etc.)? Do you have staff to do that?
13. How do you communicate/engage with the community?
14. What are some things that the community has done to help ensure the hospital's survival?
15. What are the factors that will enable your hospital to survive over the next 5-10 years?
16. What is your proudest achievement at the hospital?

Possible questions for board members

1. Tell us about the history of the hospital. How has it changed?
2. To what do you attribute your hospital's success/survival when so many rural hospitals have failed and closed?
3. What federal policies are helping?
4. What state or federal policy changes would make the hospital more sustainable?
5. What other sources of funding does the hospital receive? Has this been facilitated by any changes in policy?
6. What do local folks think of the hospital?

a. What percent of people in the community are using the hospital as their first choice?

b. How do your services align with the health care needs of your community?

c. What services would you like to add, if it were possible?

7. What are the key metrics for success for a rural hospital of your size?
8. What is your proudest achievement at the hospital?

Possible questions for medical/nursing/other staff

1. What accounts for the hospital's success?
2. What do you consider the key metrics for success for a rural hospital of your size?
3. Does the hospital offer mental health, substance abuse, or perinatal services?
4. Does the hospital have partnerships that are local, national, regional, state?
   a. To what extent is the hospital staff from the local area?
   b. Tell us about turnover (docs, nurses, others).
   c. Tell us about recruitment efforts, and how successful they may be.
5. How do your services align with the health care needs of your community?
6. What services would you add, if it were possible?
7. How has COVID impacted your work?
8. What is your proudest achievement at the hospital?