Critical Access Hospitals: Adding Value to the American Healthcare System

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“We will review CAHs to profile variations in size, services, and distance from other hospitals. We will also examine the numbers and types of patients that CAHs treat. To be designated as CAHs, hospitals must meet several criteria, such as being located in a rural area, furnishing 24-hour emergency care services, providing no more than 25 inpatient beds; and having an average annual length of stay of 96 hours or less. (Social Security Act, § 1820(c)(2)(B).) CAHs represent a separate provider type with their own Medicare (CoP) as well as a separate payment method. There are approximately 1,350 CAHs, but limited information exists about their structure and the type of services they provide. (OEI; 00-00-00000; expected issue date: FY 2012; new start)”
Introduction

This paper has been developed to help the reader better understand the role that Critical Access Hospitals (CAHs) play in the United States healthcare delivery system. It has been developed in response to the authors’ multiple interactions with state and federal legislators, their staffs and the leadership and staff of the multiple state and federal agencies that oversee the Medicare and Medicaid programs and services.

It has been the authors’ experience that many policy makers have very little actual hands-on knowledge of CAHs. As a result, some policy makers believe that CAHs provide little value to Medicare and Medicaid beneficiaries; provide sub-standard care when compared to the urban, tertiary counterparts; are too numerous; and could easily be replaced by outpatient diagnostic centers or Federally Qualified Health Clinics (FQHCs) and certified Rural Health Clinics (RHCs).

The results of this lack of actual knowledge are policy proposals that don’t recognize the special role CAH’s play in the healthcare delivery system or, implement reimbursement and other policies that do or would result in substantial harm to CAHs with many potentially being harmed to the point of closure.

The following pages demonstrate that CAHs play a vital role in America’s health care delivery system and do so with great benefit to Medicare and Medicaid beneficiaries from the point of view of access, cost and the patient care experience. It is hoped that by educating policy makers regarding the role and patient care outcomes associated with CAHs that smart policies will be written in the future to enhance the care given and the viability of these organizations that are vital to both Medicare and Medicaid beneficiaries and communities the CAHs serve.
Summary

This brief has been developed to provide a means of discussing the correlation between the values CAH facilities bring to our systems of care and the IHI Triple Aim\(^1\), a framework for transformation and a means of achieving a higher performing healthcare system. The three components of the Triple Aim are described as Population Health, Experience of Care, and Cost per Capita.

The information provided in this brief includes observations and findings from a limited number of publications concerning CAH facilities and the impact they have on quality, healthcare cost, and community health. Some of the information is localized to the Thumb Region of Michigan where the authors’ facilities are located.

The cumulative findings through review of current literature show CAH providers as an essential part of achieving the IHI Triple Aim goals and CMS Partnership for Patients. There are only a few commonly used descriptors in the healthcare policy world when discussing Critical Access Hospitals (CAH); cost based –reimbursement, small, and rural. While each of these represent a characteristic of the facilities covered by the Medicare program approved in the Balance Budget Act of 1997, they fall terribly short of identifying the values such facilities bring to their communities and the larger healthcare system. This lack of understanding distorts policy discussions and decisions and may impact the future of this essential program.

I. Population Health

The key to successful management of population health is access to the broad support systems within the community including primary, acute, and diagnostic healthcare services. The distance one lives from a healthcare provider determines availability and can limit access. Remote communities with limited services have lower use rates by all categories as seen in Dartmouth Atlas, www.dartmouthatlas.org/ and Commonwealth Scorecard, www.commonwealthfund.org/ national data transparency web sites.

Primary Care

Critical Access Hospitals provide essential services in primary care clinics supported by a combination of employed and recruited private practice physicians. In 2010, thirty-six Michigan CAHs reported they employed 318 physicians and had nearly 900 physicians on medical staff.\(^3\) In the current environment, hospitals are the chief employers of physicians in the rural areas; most physicians desire to be employed when locating in a rural area. Rural communities without a CAH often have limited recruitment capability and may rely on larger hospitals interested in establishing a physician practice only if the local population is large enough to add to their market share. CAH facilities compliment primary care practices by providing a wide range of
diagnostic lab and imaging services. While lab testing can be accommodated through office specimen collection processes, local processing at a CAH often provides faster results reporting and testing required on a stat basis often have results reported in less than an hour rather than the next day.

Similar to lab testing, there are a number of ways to provide low and high level technology services in rural areas. However, diagnostic imaging services such as CT scanning, Fluoroscopy examinations and screening like mammograms and bone density cannot be done on a quality basis through some of the more common itinerant imaging services used in areas without the presence of a hospital.

While insurance coverage is the primary determinant of access in urban areas, even when insurance coverage exists for rural individuals and families, access can be limited for a number of reasons. These reasons include the need for extended excused absences from work when required to travel long distances for routine medical services that are not available locally. Beyond the basic support system for such testing and screenings, the majority of CAHs offer local access to needed procedures, i.e. general surgery programs that provide convenient access for screening colonoscopy and procedures.

One way to evaluate the effect of a hospital on a community is by reviewing the potential impact of closure. The effect of hospital closure on primary care services in a community was documented in a study published in November 2011. “Three major themes emerged regarding the impact of the closure on the affected physicians: (1) reduced local access to specialist consultations, direct hospital admissions, and timely emergency department evaluation; (2) more patient delays in care and worse health outcomes because of poor patient understanding of the health care system changes; and (3) loss of colleagues and opportunities to teach residents and medical students.” This highlights a major part of value brought to a community by a CAH facility and is a description of impact when one closes.

While Critical Access Hospitals are prohibited from operating a Federally Qualified Health Center (FQHC), many take advantage of the certified Rural Health Center (RHC) program. As a result of the underserved status of local communities that surround most CAH facilities, they can extend their safety net provider activities through this essential primary care provider status. In 2010 the 36 Michigan CAHs reported operating 48 certified RHCs.
Emergency Department Services

Emergency Department services provided by CAHs are critical to the local community. As quality and resource measures continue to be refined the importance of a CAH emergency department is evident as highlighted in the I Vantage Health Analytics, Inc report dated February 3, 2012. The Summary of Findings include key facts on wait times that indicate, on average, total throughput time is 24% faster than mean times reported by CDC for all hospitals and it takes about half as long, on average, to see a physician. Approximately 5% of CAH emergency department visits end with admission compared to a 12.5% rate for all emergency departments. The transfer rate from CAHs is 4% compared to 1.8% rate reported by CDC. And a review of patient acuity indicates that 21% of CAH Emergency Department utilization was for non-urgent visits and 32% of visits were for semi-urgent visits. This emphasizes the role CAH emergency departments play in extended and after hour primary care.

This multiple role of the CAH in serving a community is not well understood and is not measured in terms of effectiveness and impact. Emergency care provided in rural areas constitutes the first steps in starting care for the most critical of medical and trauma conditions. The unique risk of farm trauma makes the role of the CAH emergency department critical to minimize the potential of disability and death. The American College of Surgery identifies the farm as a workplace that remains dangerous with high morbidity and mortality from injury to the worker and often to observing family members. While fatal injury has decreased, nonfatal injuries have increased annually, and long-term disability is significant. CAH Emergency Departments provide immediate consultative relationships with larger tertiary facilities and specialty care hospitals like trauma and burn centers. These first steps are essential to stabilization of the patient and preparation for coordinated transfer to increase the likelihood of minimized potential disability and death. The news story that crossed the World in one day in 2011 about a pilot of a small plane that crashed in Lake Huron off the coast of Michigan to be rescued 14 hours later and taken to a CAH Emergency Department to start acute care is a dramatic example of what happens every day in such facilities. After several hours of initial treatment and stabilization the patient was transferred to a larger facility to complete treatment and start rehabilitation.

The rescue and treatment on that day represented a small part of the CAH impact story. The robust systems: EMS, water rescue, emergency room triage, transfer coordination, and flight care can only exist in a community that has an engaged hospital team. Local EMS services in rural areas rely on support from the CAH facility for operations in a number of ways including shared employment of paramedics, provision of core training, patient transfer support and community

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emergency preparedness support. Without the presence of a CAH in the community none of these services can be maintained in the form described.

Additionally, in the instances of medical conditions such as trauma, myocardial infarction, and stroke the time between onset of symptoms and initial treatment by trained medical personnel in an emergency room has a direct impact on the quality of outcome. The presence of CAHs in the rural population centers shortens the timeframes between onset and initial treatment. Many CAHs have direct telephone access to tertiary hospital Emergency Departments and stroke centers that provide immediate consultations to the CAH Emergency Department physician, which serves to improve outcomes.

Inpatient Care

While CAH facilities are noted for low inpatient volumes, the variety of treatments provided are as diverse as their larger rural and urban counterparts; this is shown in the 2010 Medicare fee for service Clinical Product Line DRG Weights Report7. The nation’s CAH facilities discharged 382,164 patients and had patients with a DRG in every category but Cardiac Surgery. One Michigan facility started an extensive neurosurgery program in 2010 that includes procedures thought to only be appropriate for larger facilities. The program demonstrates the capability of such facilities when a high quality clinical team performs within the CAH structure. Of note is the high level of inpatient satisfaction achieved by the program, a characteristic seen in most CAH facilities and described in greater detail in section II. Experience of Care.

Additionally, what studies do not adequately show is the positive impact that admissions to local CAH facilities have on the health and wellbeing of the spouses and other elderly family members of Medicare beneficiaries. Many CAH hospital personnel are direct witnesses to the tremendous strain having to travel 50-100 miles per day or having to stay in an unfamiliar city has on the spouses and other family members of elderly patients. Such inpatient admissions to tertiary facilities take these elderly family members away from their support systems. Often the effect on these family members taken out of their routines causes them to get away from medically prescribed diets and missing dosage times of their own medications. The end result is a family member who is now ill or having a relapse of a chronic condition resulting in a trip to the Emergency Department or an inpatient admission. Having a local CAH that handles admissions for lower acuity or chronic conditions in the elderly population keeps the admission local and keeps the spouse and other family members within their local support systems.

“Several studies have found that AMI patients who are not transferred are older, sicker, have more comorbidities, and are at higher risk for adverse outcomes than transferred patients” University of Minnesota Rural Health Research Center/Flex Monitoring Team Response to JAMA Article on Quality in CAHs Published July 6, 2011
Specialty Care

Within the limit of current laws most if not all CAH facilities act as hubs for physician and other specialists to provide itinerant visiting clinics. The availability includes surgery, cardiology, pulmonary, obstetrics, vascular, and the list goes on. Telemedicine has become a main link for adding and supporting increased access to psychiatric services including nursing home care resident medication assessment. Distance is access and with the higher proportion of elderly if this clinical hub does not exist; access does not exist for highest priority disabled and low income individuals. Provision of charity care by the CAH often carries over into these itinerant specialty clinics. Care coordination for those living long distances from the acute care centers that discharged them for specialty services is improved through locally available specialists and follow-up treatment for major inpatient care.

Community Benefit

The CAH community support programs are more focused on the demographic characteristics of the rural communities where they are located. As in all communities, it is recognized that more needs to be done to improve community health status and there are roles for this subset of small safety net providers. It is common place to see highlights of the programs that do exist in the respective state offices of rural health annual reports.

In 2007, the Flex Monitoring Team conducted phone surveys of CAH facilities to determine the level of community benefit interaction. The survey indicated that CAHs are active in monitoring the health and health system needs of their communities; are engaged with other community organizations and stakeholders to address those needs; and provide services (often free) for patients and other provider organizations. Nearly all CAHs offer financial assistance to patients in the form of both charity care and discounted charges. In addition to free and discounted care provided to patients, CAHs are engaged in community needs assessments, gap-filling service development and other activities that demonstrate their attention and responsiveness to community and rural health system needs. Over three quarter of CAHs have relationships with other

“In fact, there is considerable research to make us question the assumption that keeping small hospitals open is always a good idea, especially running as they have historically: as independent, community based organizations.

Practice does matter. When it comes to certain health-care services, doing more of something is associated with better, safer outcomes for patients. Small hospitals don’t have the volume necessary for staff to practice the full range of service needs that larger hospitals do.”

Marianne Udow-Phillips
Director of the Center for Healthcare Research Transformation
Ann Arbor, MI

June 19, 2012 Bridge Magazine
Guest Column on the closing of Cheboygan Memorial Hospital
CAHs and non-CAH hospitals, EMS, schools, and public health agencies in an effort to address community needs.\textsuperscript{14}

A similar Flex Monitoring Team study published in March 2010 included responses from over 1,200 CAHs and found that CAHs outperform other hospitals primarily in areas that include ambulance services and long-term care. However, the report also indicated that CAH community support efforts have less diverse programs in place to respond affirmatively as compared to core areas found in place in non-metro non-CAH facilities. The report suggested that this may be a function of their size and relatively vulnerable financial situations.\textsuperscript{13}

Nonprofit CAHs, like all nonprofit hospitals, have the responsibility to complete a Community Health Needs Assessment under the Affordability Care Act (ACA) and develop a plan to address those priority areas as identified by community members themselves. It is difficult to believe that this process can be as effective if hospitals do not exist to conduct such plans. While larger facilities can include a rural area as part of their catchment area the impact will be diluted.

\textbf{II. Experience of Care}

\textit{Experience of care relates to the quality of care delivered, the percentage of recommended care processes used in all types of settings, and the satisfaction of patients when receiving care.}

\textbf{Performance Measures}

The uniqueness of the CAH financial model has driven the Federal Office of Rural Health Policy to fund the Flex Monitoring Team at the University of Minnesota to complete ongoing evaluation of the Medicare Rural Hospital Flexibility Program. Under the microscope of review the CAH program has been the subject of critical evaluation since its inception. The initial CAH Hospital Compare Participation Report was published in February 2006. At that time there were 1,141 CAH facilities nationwide with a participation rate of 41\% (464 CAHs). It is important to note that unlike Prospective Payment System (PPS) hospitals, CAH facilities are not required to participate in the Hospital Compare program and do so on a voluntary basis without reward of payment incentives or risk of penalties. In a follow-up report completed in April 2011 the number of CAHs had increase by only 15\% to 1,312, however their participation in Hospital Compare had doubled (933 CAHs). This is particularly impressive when one takes into consideration the lack of resources available within the largest number of these smaller rural hospitals.

“CAH conversion was associated with significantly increased performance of risk-adjusted rates of iatrogenic pneumothorax, selected infections due to medical care, accidental puncture or laceration, and a composite score of four PSIs.”

\textit{Effect of Critical Access Hospital Conversion on Patient Safety, Pengxiang Li, John E. Schneider, and Marcia M. Ward Health Serv Res. 2007 December}
Although the percent of CAH patients receiving recommended care increased from 2006-2009 for all measures, in 2009 CAH facilities still did not perform as well as did other rural and urban PPS hospitals. In other words, while showing significant improvement, CAHs continued to have lower scores relative to improvements made by other rural and urban PPS hospitals on most measures.  

The number of participating CAHs in the formalized Hospital Compare transparency program has increased significantly and will continue to do so as statistically significant rurally relevant measures are adopted and implemented by CMS. The new Medicare Emergency Department Throughput measures have such potential and the writers of this brief are anxiously waiting for the first published report of CAH performance comparing physician engagement and wait time in comparison to the urban centered facilities.

In 2011, the Federal Office of Rural Health Policy started a new program to encourage CAH facility leaders to commit to an effort called Medicare Beneficiary Quality Improvement Project (MBQIP). The MBQIP includes a three phase implementation of quality measurement and reporting including participation in the Hospital Compare transparency web site. As of May 2012 more than 1,000 CAH CEOs nationwide signed a memorandum of understanding participation agreement.

In April 2012, IVantage Health Analytics, Inc. published an independent report titled, “Rural Relevance Under Healthcare Reform.” This report provides an analysis of rural hospital values that will determine the strength of CAHs in the new era of change. The report included the following key findings concerning hospital performance:

- Neither the rural nor urban facilities dominate performance in current hospital process of care measures.
- There is no significant performance variation in 30 day readmission rates.
- Rural hospital performance on HCAPHS patient experience survey measures is better in comparison to their urban counterparts.

In summary, CAHs provide care that is within expected ranges in process measures, patient safety, mortality, and readmissions. At the same time, HCAPHS scores since the release of the first report indicate that these facilities outperform urban facilities in patient satisfaction in a statistically significant way. For example, when comparing the performance of the CAHs in the Thumb of Michigan to the surrounding tertiary care hospitals, we find the Thumb CAHs consistently (and sometimes by a wide margin), outperform the tertiary centers in all categories. This also holds true for CAHs in the

“Rather than asking why CAHs aren’t more like large tertiary teaching hospitals... the question that should be asked is, how can CAHs provide the best possible care to patients given their available resources and expertise?”

University of Minnesota Rural Health Research Center/Flex Monitoring Team Response to JAMA Article on Quality in CAHs Published July 6, 2011
western Lower Peninsula of Michigan and the Upper Peninsula of Michigan (charts included on page 14). If Michigan Medicare beneficiaries are a representative subset of the rest of the Medicare beneficiaries in the country, we can make the case that the results hold true when comparing all CAHs to their surrounding tertiary hospitals.

Put another way, Medicare beneficiaries benefit from a better hospital experience when admitted to Critical Access Hospitals versus their local tertiary counterparts as measured by patient satisfaction and inpatient quality measures.

III. CAH and Cost per Capita

The ability to achieve universally accessible healthcare in the US is dependent on our ability to address the exponential growth in expenditures that exceed all other industrial nations in both total dollars per capita and share of gross domestic product (GDP).

The 1,300 hundred CAH facilities receive about $8 billion in Medicare payments\(^{10}\), (5 % of Medicare Total Hospital Payments). There is growing pressure to limit the CAH program to defined isolated facilities (less than 15 miles) to another hospital. While cost differential issues exist within the structure, the marginal savings that can be achieved in such a way can only be described as miniscule. Furthermore, it does not address the accessibility and lost services of such a proposal, or the economic impact of job and balance provided to the social economic system in agricultural based communities. The authors also believe the analysis is flawed as a health policy proposal in the current Affordable Care Act environment that is focused on reducing per capita health costs.

The ACA legislation included accountable care organization (ACO) provisions to move Medicare payment processes to population capitation rates. The core principle of this structure is to incentivize healthcare systems to increase available healthcare, improve quality, and lower cost by paying providers on a capitation basis that rewards high performance and penalizes poorer performance. It is interesting that in this time when the cost per population is the driving force for change, policy evaluators continue to use incidental service charges and costs as the measure of effectiveness. Even though CAHs have higher incidental costs, i.e. cost per day and higher cost to charge ratios, they contribute to lower cost per population in the regions they serve.

Dartmouth Atlas uses the Medicare FFS costs during the last two years of life as a measure of effectiveness in delivery of services. A review of the Michigan CAHs Dartmouth Atlas data was completed in 2010 and (seen in the charts on page 15) serve to demonstrate that on this measure all but one facility performed below the national average\(^{11}\), even though more than 50% had inpatient payment rates above the national average.

A new database and transparency web site has been released by the Commonwealth Fund. This website was developed by the same researchers that created the Dartmouth Atlas. The database
has relevant measures from multiple payers and uses 43 metrics of evaluation. Data is available for state and Health Resources Region (HRR) level comparisons. Using this reporting website state comparisons were completed for two states that have a higher percentage of CAH facilities: Iowa and Montana. The selected measure was “Total Medicare (Part A & Part B) Reimbursements per Enrollee” on the premise that if CAH cost and charge structures drive higher costs\(^\text{10}\) these states would have worse performance.

The chart below shows the result of the average reimbursement comparison and performance rank of the two states with the best performance, Hawaii, and the worst, New York. On the surface of this one review is an indication that as in earlier Medicare FFS Dartmouth Atlas reviews, regions with higher proportions of CAH facilities in a community contribute to more effective delivery and care. There are a number of other measures within the Commonwealth site that support this assertion as well.

### Total Medicare (Part A & Part B) Reimbursements per Enrollee

<table>
<thead>
<tr>
<th>Reimbursement/Enrollee</th>
<th>Commonwealth Fund Rank</th>
<th># CAHs</th>
</tr>
</thead>
<tbody>
<tr>
<td>Hawaii</td>
<td>$5,311</td>
<td>1</td>
</tr>
<tr>
<td>Iowa</td>
<td>$6,572</td>
<td>7</td>
</tr>
<tr>
<td>Montana</td>
<td>$6,340</td>
<td>5</td>
</tr>
<tr>
<td>New York</td>
<td>$9,564</td>
<td>51</td>
</tr>
</tbody>
</table>

In 2011 MEDPAC released a review highlighting costs associated with CAH swing beds and co-pays. In the report MEDPAC estimates that the additional cost for swing bed care delivered by CAHs compared to PPS hospitals is $2 billion; $1 billion for swing bed charges and $1 billion for outpatient co-pays. The authors believe a key point has been missed: the largest part of swing bed cost is simply shifted from CAH inpatient and outpatient costs. In other words the hospital cost based reimbursement is reduced as the costs are redistributed to the swing bed program\(^\text{12}\).

The reference to outpatient co-pay costs is misleading in the fact that some of these beneficiary co-pays are due to specific policy requirements implemented by CMS to treat same day services in CAH emergency and inpatient departments differently than PPS hospitals. PPS hospitals have one combined bill for ED &

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observation when patients are admitted on the same day but CAHs are required to split bill; therefore a patient has a $1,156 inpatient deductible in the PPS hospital compared to $1,156 inpatient plus the ED services copay in the CAH. Concern for the impact of higher co-pays on Medicare beneficiaries would lead one to eliminate this difference and allow the CAH to bill the same as PPS facilities. And on one final note, increased co-pays have been implemented by CMS in the past as a means to reduce over utilization of diagnostic services. It would seem that higher co-pays in the CAH reduce utilization and not be a cost burden to CMS.

IV. Conclusions

CAH facilities represent 25% of all community hospitals, 60% of all rural hospitals, yet they account for less than 5% of Medicare expenditures. These facilities provide more than 1,300 essential access points and provide safety net services in some of the most isolated areas of the country. As demonstrated in this limited brief, and will become more apparent as statistically significant relevant measures are developed, it is clear that these CAHs provide the same quality of services and contribute to effective cost of care in a significant way when compared to larger rural and urban setting hospitals.

Transparency databases and web sites are providing pictures and correlations of information that support that not only are CAHs essential for primary, emergent and clinical care needs, they are essential to achieving new levels of population health and cost improvement.

If there is an increased understanding that much of the policy literature on CAHs lacks adequate evaluation and data to support assertions of waste and lower quality, the intended purpose of this brief has been met. It is critical that CAH policy decisions be based on objective and sound data; that CAHs be recognized as an essential part of achieving the CMS Partnership for Patients and IHI Triple Aim goals.
References

1. IHI Triple Aim Mission
   - Better health care by improving all aspects of patient care, including Safety, Effectiveness, Patient-Centeredness, Timeliness, Efficiency, and Equity (the domains of quality in patient care as defined by the Institute of Medicine).
   - Better health by encouraging healthier lifestyles in the entire population, including increased physical activity, better nutrition, avoidance of behavioral risks, and wider use of preventative care.
   - Lower costs through improvement by promoting preventative medicine, improved coordination of health care services, and by reducing waste and inefficiencies. These efforts will reduce the national cost of health care and lower out-of-pocket expenses for all Medicare, Medicaid, and CHIP beneficiaries.

2. Kara Odom Walker, MD, MPH, MSHS, Robin Clarke, MD, Gery Ryan, PhD, Arleen F. Brown, MD, PhD: Annuals of Family Medicine Volume 9, No. 6, November/December 2011, Effect of Closure of a Local Safety-Net Hospital on Primary Care Physicians’


4. 2011 National Rural Emergency Department Study, Establishing Rural Relevant Benchmarks, IVantage Health Analytics, Inc.


7. Analysis of MS-DRG Changes for Federal Fiscal Year 2012-Based on 2010 Medicare Claims Data

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9. Hospital Compare HAI data release April 2011

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11. Gamache E, Promoting the Value of CAHs in Health Care Reform Annual MCRH CAH Conference October 29, 2010

12. Steven M. Thompson, CPAHealth Care Partner, Wipfli LLP Testimony before the Michigan Legislature March 2011

13. Melanie Race, John Gale, MS, and Andrew Coburn, PhD, University of Southern Maine: Community Benefit Activities of Critical Access Hospitals, Non-Metropolitan Hospitals and Metropolitan Hospitals Flex Monitoring Team, 2011 March


15. Rural Relevance Under Healthcare Reform, A Tracking Study Monitoring Performance of Rural Healthcare Under the Affordable Care Act, IVantage Health Analytics June 2012

16. Developing Regional STEMI Systems of Care: A Review of the Evidence and the Role of the Flex Program, John Gale, MS, Maine Rural Health Research Center, University of Southern Maine
Chart 1

Western Michigan Hospital Compare Ratings
June 2012

Would Recommend
Hospital Rating of 9 or 10
Info About Home
Area Always Quiet at Night
Room and Bath Always Clean
Staff Always Explained Meds
Paid Always Well Controlled
Always Received Help
Doctors Always Comm Well
Nurses always comm well

Chart 2

Michigan Thumb Hospital Hospital Compare Ratings
June 2012

Would Recommend
Hospital Rating of 9 or 10
Info About Home
Area Always Quiet at Night
Room and Bath Always Clean
Staff Always Explained Meds
Paid Always Well Controlled
Always Received Help
Doctors Always Comm Well
Nurses always comm well

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Chart 3

**MICAH Medicare Inpatient Payment Per Day Last Two Years of Life**

Source: Dartmouth Atlas Online
http://www.dartmouthatlas.org/

100% of National Rate Line

Rates Above National Rate

Inpatient ptnt. per day

Chart 4

**MICAH Medicare Inpatient Payment Per Stay Last Two Years of Life**

Source: Dartmouth Atlas Online
http://www.dartmouthatlas.org/

100% of National Rate Line

Rates Above National Rate

Rates Below National Rate

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About the authors

Mike Falatko
Mike Falatko is the President and CEO of Hills and Dales General Hospital in Cass City, Michigan and has been working in the Thumb of Michigan since he joined that facility in January 2006.

Prior to coming to Hills and Dales he served from 1993-2003 as the CEO of Doctors Hospital, a 70 bed urban hospital located in Jackson, Michigan and prior to that he served from 1983 - 1992 as the COO of Memorial Hospital, a 185 bed rural hospital located in Fremont, Ohio.

He received his Bachelor of Arts Degree in English (1976) and his Associate Degree in Nursing (1978) from Youngstown State University and his Masters Degree in Healthcare Administration (1983) from Ohio State University.

He is currently the Chairman of the Hospital Council of East Central Michigan and serves on the Board of the Michigan Health and Hospital Association. He also serves on several of the Association’s committees and councils.

He was named the 2011 AHA Grassroots Champion in Michigan for his successful work on improving Medicaid funding and payments for Critical Access and Small Rural Hospitals in Michigan.

Mr. Falatko lives in the town of Cass City in the heart of the Thumb of Michigan with his wife Judy.

Ed Gamache
Ed Gamache is the CEO of Harbor Beach Community Hospitals and has been working in the Thumb of Michigan since May of 1997 when he became the Administrator/CEO of Deckerville Community Hospital.

He was the Director of the Department of Veteran Affairs Hospital in Ann Arbor, Michigan, from 1991-1997. Over the course of his VA career, Mr. Gamache served as Director (Administrator) at two VA hospitals, Associate Director of three other facilities, and completed his health administration training at the VA Hospital in Long Beach, California. He received his Bachelor of Science Degree in Electrical Engineering from the University of Missouri, Rolla in 1970.

He currently serves on the boards of the Michigan Critical Access Hospital Quality Network (President), Thumb Rural Health Network, Sanilac County Community Foundation (Vice Chair & Fund Development Chair), Hospital Council of East Central Michigan, Sanilac Medical Control Authority (Chair), and the Michigan Health Information Alliance (Co-chair Quality Committee).

Mr. Gamache received the 2005 Michigan Center for Rural Health Loren O. Gettel Award for Outstanding Leadership and Commitment to Michigan’s rural residents.

Mr. Gamache lives in the town of Port Sanilac, MI along the Lake Huron Shoreline with his wife Robin.