Special Article

Analysis of Regulatory Issues with Critical Access Hospitals

Dakena M. Nelson, MSN, RN, CNL
NE-BC House Supervisor, Select Specialty Hospital Nashville, TN. USA

Danita R. Potter, PhD, APRN, PMHNP-BC, CAS
Psychiatric Mental Health Nurse Practitioner, CommuniHealth Services, Monroe Pediatrics Clinic, Monroe, LA. USA

Correspondence: Danita R. Potter, PhD, APRN, PMHNP-BC, CAS Psychiatric Mental Health Nurse Practitioner, CommuniHealth Services, Monroe Pediatrics Clinic, Monroe, LA. USA
Email drpotter41@yahoo.com; CommuniHealth Services, 1825 North 18th Monroe, LA. USA

Abstract

Critical Access Hospitals (CAH) refer to small healthcare facilities set up in rural areas to offer medical services to occupants who lack easy access to bigger emergency care facilities usually found in urban areas. A critical analysis of special regulations governing CAHs is discussed along with the latest trends on the number of CAHs. The impact of CAHs closure will reduce quality health care to local residents limiting immediate services to acute medical cases. Benefits of CAHs have a limited number of inpatients, which translates to better medical services. By maintaining and supporting these facilities, this will promote balance between patients and clinicians hence leading to improved quality of medical care.

Key words: *Critical access hospitals (CAH), regulatory issues, quality health care*

Introduction

People in remote areas suffer from serious medical illnesses that require special medical attention. Such aid is difficult to get in these areas because of the poor infrastructure and access to public resources such as healthcare services, education, and business activities. Everyone deserves a right to quality health care access and top-notch treatment outcomes. Critical Access Hospitals (CAH) refer to small healthcare facilities set up in rural areas to offer medical services to occupants who lack easy access to bigger emergency care facilities usually found in urban areas (Rural Health Information Hub, n.d.). These hospitals provide a wide range of care to rural patients at a lower cost, hence offloading their financial burden. They were started in 1997 to help the local communities easily enjoy improved healthcare. In this context, this paper seeks to analyze specific special regulatory rules, latest trends, and the impact of CAH closure on the local communities.

Special Regulations that Govern CAHs: There are special regulations enacted to govern CAHs. The main reason for these regulations is to ensure that all seriously ill patients are able to benefit from quality healthcare (Rural Health Information Hub, n.d.). To be eligible and change to CAH, all health facilities should adhere to the following regulations.

It is a requirement that all healthcare facilities that want to graduate into CAHs should be members of the Medicare program (Centers for Medicare & Medicaid Services [CMS], 2013; CMS, 2020). Medicare programs are specifically initiated to help the management of emergency cases. These regulations do not, however, hinder smaller community health centers that may want to graduate to CAHs, given that they meet all other

prerequisites (Seright & Winters, 2015). The importance of this rule is to ensure that only qualified hospitals give emergency services to acute cases. This means that such hospitals should also have professional acute care doctors and nurses and be equipped with appropriate medical tools. Those that lack these requirements can only worsen the patient's condition, hence do not qualify to provide critical care services.

All health facilities entitled to advance into CAHs should be recognized by the United States. This means that such centers should first register and acquire a valid license before it becomes legitimate (Rural Health Information Hub, n.d.). Moreover, selected centers should be situated in rural areas and be ready to serve the residents for emergency care. Those that lack license are not recognized by the law and are therefore operating illegally.

The total number of beds in a CAH ward should not exceed 25 (Rural Health Information Hub, n.d.). This is an important rule that helps to regulate the number of patients admitted in the wards. For instance, this allows health clinicians only to admit a maximum of 25 patients. This plays a significant in ensuring that only critically ill patients get admitted (Westfall, Ringel & Gardner, 2013). Those who are not very sick can be treated as outpatients, discharged, and followed up for a given period of time. Other patients can seek medical treatment from other healthcare facilities such as community health centers. This measure also improves the quality of medical care, and attention is given to acutely ill patients.

The distance between one CAH to the next should not be less than 35 miles. This is an important regulatory principle that ensures that the hospitals are equally spaced and well distributed in a given locale. This makes it possible for all rural residents to have equal access to CAHs. Poor distribution of these hospitals in a given setting will make it difficult for acutely ill patients to access medical assistance on time. Therefore, this will increase morbidity and mortality rates. All medical hospitals that want to convert into CAH facilities should be well distanced from each other (Joynt, Orav, & Jha, 2013; Joynt, Harris, Orav, & Jha, 2011). Those that are found in poor terrains such as hilly areas should be 15 miles away.

Eligible CAHs are only allowed to admit a critically ill patient for at least 96 hours. This period gives health experts ample time to take a comprehensive history, do a complete physical examination, carry out laboratory and imaging studies, and draw an appropriate plan of management (Rural Health Information Hub, n.d.). Acute care patients should be monitored closely, and any changes in the severity of the illness should alert the clinician to search for alternative options. Only patients who require referral to intensive care units are allowed to leave before the designated period.

It is a primary requisite for all CAHs to work all round the clock (Rural Health Information Hub, n.d.). Time is always one of the major factors in the management of patients. This means that those who fall sick either during the day or at night should quickly be taken to a CAH without delay. Doctors and nurses should always be on the look to admit all serious cases and make early referrals wherever possible. Patients should get full medical attention immediately on arrival at the hospital. Early treatment helps to save lives as most medical conditions worsen with time. These facilities should also offer services all through with no breaks in between; hence should operate from Monday to Sunday. This is significant since medical emergencies are unpredictable and can happen at any time.

Latest Trends in the Numbers of CAHs: CAHs stemmed from Medicare program, which started in the U.S early in 1966 (Rural Health Information Hub, n.d.). This gradually increased the need to provide more emergency services to the residents. The Federal Government resorted to converting certain rural hospitals that met the conditions into CAHs. Since then, there have been significant changes that have led to the immense growth of these facilities.

The United States has made a great milestone in setting up CAHs since its establishment in 1997. At this time, there were only a few CAHs available (Rural Health Information Hub, n.d.). Four hundred small healthcare facilities converted to become CAHs, hence increasing the number. Starting under the Balanced Budget Act, these hospitals were only scattered in a few states. People from other states could not benefit from the

program and this translated to the need for more hospitals (Lipsky & Glasser, 2011; Wright, Jung, Feng, & Mor, 2013). The main reason behind this program was to aid rural occupants to access quick emergency services and shun them from covering long distances in search of professional acute care services.

There has been a steady growth in the number of CAHs since 1997 (Rural Health Information Hub, n.d.). This growth is attributable to the fact that the hospitals were found to serve a very important function to the locals. The U.S government, therefore, decided to set up more hospitals in other states as a measure of improving emergency care to all American citizens. This number has been on the rise annually, and by 2018, 1,343 CAHs had been constructed in various states (Rural Health Information Hub, n.d.). The conversion of local health facilities to CAHs has greatly boosted their financial standards because of the increased funding from the federal government.

As of July 19, 2019 there was a total of 1,350 CAH in the United States (Rural Health Information Hub, n.d.). Most of the small hospitals will soon convert to CAH as their financial standards are highly at risk (Hearld & Carroll, 2015). This is expected to grow even further in the next ten years as a measure for the establishment of equal healthcare services.

Impact of CAH Closure to the Local Residents: CAHs are put in place to provide quick services to acute medical cases (Rural Health Information Hub, n.d.). These are cases that would otherwise walk several miles to access suitable medical aid. Since its establishment, millions of United States rural residents have greatly benefited from the program (Rural Health Information Hub, n.d.). This provides no room for the closure of such hospitals, which would otherwise result in serious consequences both to the locals and to the community health centers.

According to recent surveys, decreasing the number of CAHs in various states will lead to a marked increase in the number of emergency cases to other facilities elsewhere (Rural Health Information Hub, n.d.). The fact that the few remaining hospitals can only accommodate a maximum of 25 patients means that more patients would be forced to seek alternative treatment. For this reason, patients will be forced to *dig* deeper into their pockets to meet the air ambulance costs.

One way that local communities would be affected is through poor access to better medical centers. In the United States, such centers are located several miles from rural areas, hence creating the need to spend lots of cash before one can get to these destinations (Traynor, 2018). People in rural areas will be required to wait for several hours or even days before getting access to top-notch medical facilities that are rampant only in major cities.

By closing CAHs, most of the rural residents will experience increased morbidity and mortality rates (Rural Health Information Hub, n.d.). This will negatively affect the populations in local communities. People will develop serious complications from conditions that would otherwise be managed by a CAH since these are easily accessible. These hospitals have highly experienced specialists who are well-trained on how to manage acute cases. Such conditions cannot be managed by local health centers since they lack expert knowledge and appropriate medical equipment.

Closure of CAH predisposes local hospitals to financial vulnerability. CAHs are located 35 miles from each other, meaning that local residents are able to drive to the nearest hospital for emergency treatment easily (Rural Health Information Hub, n.d.). This eases regular health centers from carrying a huge financial burden. If CAHs are otherwise closed, local hospitals will be adversely affected in terms of financial vulnerability (Gautam, 2012). This is stems from the fact that these hospitals will be crowded, and therefore, medical resources will not be adequate to support all patients.

Another impact of the closure of CAH is reduced quality health care (Nelson-Brantley, Ford, Miller, & Bott, 2018). CAHs have a limited number of inpatients, which translates to better medical services since the patient-doctor ratio is well balanced. This will, however, be affected and will shift towards the negative end if this ratio becomes compromised in any way. By shutting down these facilities, there will be a huge imbalance between patients and clinicians hence leading to decreased quality of medical care (Nelson-Brantley, Ford, Miller, & Bott, 2018). For instance, it will be

difficult for healthcare experts to diagnose, treat, and closely follow-up every patient to ensure better outcomes.

References

Centers for Medicare & Medicaid Services (2013). Critical Access Hospitals. Retrieved January 25, 2021 from https://www.cms.gov/Medicare/Provider-Enrollment-and-Certification/CertificationandComplianc/CAHs

Centers for Medicare & Medicaid Services (2020). Critical Access Hospitals. Retrieved January 25, 2021 from https://www.cms.gov/Medicare/Provider-Enrollment-and-Certification/GuidanceforLawsAndRegulations/CAHs

Gautam, S., Hicks, L., Johnson, T., & Mishra, B. (2012). Measuring the Performance of Critical Access Hospitals in Missouri Using Data Envelopment Analysis. *The Journal of Rural Health*, *29*(2), 150–158.

Hearld, L. R., & Carroll, N. W. (2015). Interorganizational Relationship Trends of Critical Access Hospitals. *The Journal of Rural Health*, *32*(1), 44–55.

Joynt, K. E., Orav, E. J., & Jha, A. K. (2013). Mortality Rates for Medicare Beneficiaries Admitted to Critical Access and Non–Critical Access Hospitals, 2002-2010. *Jama*, *309*(13), 1379.

Joynt, K. E., Harris, Y., Orav, E. J., & Jha, A. K. (2011). Quality of care and patient outcomes in critical access rural hospitals. *JAMA*, *306*(1), 45–52. https://doi.org/10.1001/jama.2011.902

Lipsky, M. S., & Glasser, M. (2011). Critical access hospitals and the challenges to quality care. *JAMA*, *306*(1), 96–97. https://doi.org/10.1001/jama.2011.928

Nelson-Brantley, Ford, Miller, & Bott (2018). Nurse executives leading change to improve critical access hospitals outcomes: A literature review with research-informed recommendations. *Online Journal of Rural Nursing and Health Care*, *18*(1). DOI: http://dx.doi.org/10.14574/ojrnhc.v18i1.510

Rural Health Information Hub (n.d.). Critical access hospitals (CAHs). Retrieved December 4, 2019 from https://www.ruralhealthinfo.org/topics/critical-access-hospitals

Seright, T. J., & Winters, C. A. (2015). Critical Care in Critical Access Hospitals. *Critical Care Nurse*, *35*(5), 62–67.

Traynor, K. (2018). Critical access hospitals make interprofessional rounds work for them. *American Journal of Health-System Pharmacy*, *75*(19), 1441–1442.

Westfall, J. M., Ringel, M., & Gardner, J. (2013). Mortality Trends in Critical Access Hospitals. *Jama*, *310*(4), 429.

Wright, B., Jung, H.-Y., Feng, Z., & Mor, V. (2013). Trends in Observation Care Among Medicare Fee-for-Service Beneficiaries at Critical Access Hospitals, 2007-2009. *The Journal of Rural Health*, *29*(s1).