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Critical Access Hospitals: Improving Access to Health Care in Rural Areas

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Small rural healthcare facilities face many challenges in implementing quality improvement initiatives, including limited resources, low patient volume, minimal staff, and dated information technology (Calico, Dillard, Moscovice, and Wakefield 2003; National Advisory Committee on Rural Health and Human Services 2003). The implementation of

the Critical Access Hospital (CAH) program has contributed significantly to the viability—both financial and in terms of quality of care—of small rural hospitals across the United States. The purpose of this *Rural Research Report* is to document the continuing evolution and maturation of CAH activities and the practices of CAHs in rural Illinois.

Trends in Rural Health

Reimbursement methods for healthcare services have changed considerably over the past two decades. These changes have had a significant impact on the financial standing of healthcare facilities in rural Illinois and throughout the United States. Demographic trends experienced by many rural Illinois counties during the same time period also contributed to the poor financial standing of small healthcare facilities. In terms of health care, the most significant demographic difference between rural and urban counties is the percentage of population over age 65. According to the Illinois Hospital Association (2002), “16.5% of the population in rural counties is over age 65, compared with only 11.3% of urban residents.” As a result, “rural hospitals derive 39.5% of their net patient service revenue from Medicare, while urban hospitals rely

on Medicare for 33.9% of their revenue.” The percentage difference, although seemingly small, carries significant financial implications. Since 1983, inpatient services provided to Medicare beneficiaries have been reimbursed using the Prospective Payment System (PPS) (McBride and Mueller 2002). PPS uses pricing formula calculations to produce a national standardized payment per discharge. High-volume hospitals in urban counties are often able to reduce costs to closely match PPS rates. Low-volume rural hospitals do not have the same ability (Dalton, Slifkin, and Howard 2000). Thus, services provided to Medicare beneficiaries in rural hospitals are often reimbursed well below cost.

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The Emergence of the Critical Access Hospital Program

The Medicare Rural Hospital Flexibility Program (MRHFP) was delineated in the Balanced Budget Act of 1997 (Casey and Moscovice 2004). The primary goal of MRHFP is to improve the quality of care offered by rural hospitals. This goal is achieved through the implementation of two components. The first component is a grant program that awards money to each state to be used to improve rural health care. This grant program is administered through the Federal Office of Rural Health Policy (RUPRI 2002a).

The second aspect of the plan is the Critical Access Hospital (CAH) program, which is administered by the Centers for Medicare and Medicaid Services (CMS). The CAH program allows hospitals meeting the following eligibility criteria—25 or fewer beds; average length of stay of acute patients 96 or fewer hours; and more than 35 miles by primary road and 15 miles by a secondary road from another hospital or certified as a “necessary provider” by their state with CMS verification (Casey and Moscovice 2004)—to receive cost-based reimbursement for services provided to Medicare beneficiaries (RUPRI 2002a).

The CAH program is based on two demonstration projects: (1) the Essential Access Community Hospital/Rural Primary Care Hospital (EACH/RPCH) program and (2) the Medical Assistance Facility (MAF) program (Reif and Ricketts 1999).

Seven states participated in the EACH/RPCH demonstration project. The project provided grant money to each state “to develop networks that consisted of the limited service hospital (RPCH) and the acute care referral hospital (EACH)” (Reif and Ricketts 1999). The RPCH

received cost-based reimbursement for services provided to Medicare beneficiaries.

The MAF program has operated in Montana since 1988. Under this program, hospitals designated as MAFs received cost-based reimbursement for “basic emergency care, outpatient services and inpatient care (limited to 96 hours)” provided to Medicare beneficiaries (Reif and Ricketts 1999).

Evaluation of both demonstration projects produced positive results. Alleviation of the financial burden created by the PPS preserved healthcare services in areas no longer able to support full-service facilities. In addition, hospitals in six of the EACH/RPCH states, as well as numerous hospitals in Montana, chose to apply for designation as limited-service facilities under their respective programs (Reif and Ricketts 1999). The Balanced Budget Refinement Act of 1999 revised criteria for designation as a CAH based on evaluation of these demonstration projects (Bushy and Bushy 2001). As of November 2003, 834 small rural hospitals throughout the United States have converted to CAH status. A primary benefit of converting to CAH status is to receive cost-based payments (rather than prospective payments) from Medicare. The small rural hospitals that converted in Fiscal Year 1999 experienced an average increase in Medicare inpatient and outpatient payments that exceeded \$500,000 in FY00 inflation-adjusted dollars. While Medicare payments increased by 36 percent, Medicare patient days declined by 8 percent (Strenslund, Davidson, and Moscovice 2004).

Federal Eligibility Criteria

Before hospitals in any state may begin applying for CAH designation, a State Rural Health Plan must be submitted for approval to CMS (Reif and Ricketts 1999). Within the first year of the CAH program, “the Illinois Hospital Association, the Illinois Department of Public Health’s Center for Rural Health and rural Illinois hospitals [had] developed a State Rural Health Plan that received [CMS] approval in April 1998” (Illinois Hospital Association n.d.).

To be eligible for conversion, hospitals must meet all federal requirements. According to Christiansen (2002) and IDPH

(2002), federal requirements for CAH conversion state that a CAH must . . .

- be owned by a public or nonprofit entity.
- be located in an area not part of a Metropolitan Statistical Area in a state participating in the MRFHP.
- be at least 35 miles from another hospital or be certified by the state as a “necessary provider” of healthcare services.

- be a member of a rural health network and have an agreement with at least one network hospital that addresses (1) patient referral and transfer, (2) development and use of communication systems, (3) provision of emergency and nonemergency transportation between the CAH and referral hospital, and (4) credentialing and quality assurance procedures.
- provide 24-hour emergency care services.
- provide no more than 15 beds for acute inpatient care or up to 25 inpatient beds if swing beds are approved.
- ensure that inpatient lengths of stay average no more than 96 hours.

Necessary Provider Criteria

Within the CAH eligibility criteria is a provision for hospitals that do not meet federal guidelines for mileage but are viewed as a critical service to the population served. This provision allows states to certify hospitals as Necessary Providers. Necessary Providers meet all CAH federal criteria with the exception of mileage. Each state has the authority to develop additional criteria for designating

hospitals as Necessary Providers. Once designated as Necessary Providers, hospitals receive the same benefits as hospitals possessing CAH designation. As of April 2003, 442 hospitals nationwide have been designated as Necessary Providers under this provision, including 26 in the State of Illinois (RUPRI 2003).

Illinois Necessary Provider Criteria

State requirements for designation as a Necessary Provider vary. According to the IDPH (2002), hospitals seeking the Necessary Provider certification must meet the following criteria. The hospital must . . .

- be located in an eligible rural county having either a state or federal designation as a physician shortage area, in a county where poverty levels exceed the state level, or in a county where a proportion of residents over 65 years of age exceed the state's proportion.
- be affiliated in a regional Emergency Medical Service (EMS) network.
- have completed or have agreed to complete the fiscal assessment included in *Transforming Health Care for the 21st Century: A Resource Manual for Rural Hospitals*.
- have participated or have agreed to participate in the local public health department's IPLAN process.

Increasing Acceptance

Since its creation, acceptance of the CAH program has steadily increased. As of November 2003, 834 small rural hospitals have converted to CAH status (Strenslund et al. 2004). The majority of CAHs are concentrated in the Midwest. Nebraska leads the nation with 58 certified CAHs. Kansas, Iowa, and Minnesota are close behind with 54, 49, and 46 designations, respectively. Three states, Delaware, New Jersey, and Rhode Island, are not participating in the MRHFP. Two states, Connecticut and Maryland, although participating in the MRHFP, do not currently have hospitals certified as CAHs (RUPRI 2003).

The concentration of CAHs in the Midwest may be attributed to several factors. The first, and most obvious, is a greater

number of hospitals meeting eligibility criteria. Nebraska, for example, has 58 hospitals designated as CAHs and an additional 63 eligible for a total of 121 hospitals meeting all criteria for conversion. Similarly, Kansas has 54 hospitals designated and an additional 66 eligible for a total of 120 hospitals meeting all necessary criteria. These numbers contrast sharply to states such as California with 13 CAHs certified and 28 eligible for a total of 41, and Michigan with 16 certified CAHs and 19 eligible for a total of 35 hospitals meeting eligibility criteria (RUPRI 2003).

It should also be noted that not all hospitals that are eligible for conversion are in a position to benefit financially from conversion to a CAH. These hospitals are financially

stable under the PPS. In Alabama, for example, 15 financial feasibility studies conducted for hospitals meeting CAH eligibility criteria found only one to be in a position to benefit financially from CAH conversion (Greene 2002a).

Finally, the concentration of CAHs in the Midwest might also be attributed to differences in the ways states have utilized

grant monies received through the MRHFP. Nebraska, for example, used grant money and “with the help of the state hospital association, focused on identifying candidates quickly, analyzing their finances and making the application process simple” (Greene 2002a, 51).

Critical Access Hospitals in Illinois

Illinois has a total of 228 hospitals. Seventy-seven hospitals, or 33.8 percent of all Illinois hospitals, are located in the rural areas of the state. Of these, 72 are community hospitals, which are nonfederal, short-term hospitals that are open to the general public. In 1999, the first Illinois hospital received CAH certification. As of April 6, 2004, 32 hospitals in Illinois have been designated as CAHs (Illinois Hospital Association 2004). An additional 14 hospitals are eligible for conversion (RUPRI 2003). The Appendix provides a list of the CAHs in Illinois, the contact for each hospital, and the date of certification. Characteristics shared by many of these hospitals, not only in Illinois but nationwide, include being located in a sparsely populated county with an aging

population. According to the Illinois Hospital Association (2004), while Illinois’ rural hospitals serve a relatively small proportion of the state’s population, they cover a large geographic area. Although only 1.9 million people (14.8% of the population) live in rural areas, they are scattered across 259,573 square miles (69.6% of the state’s land mass) and 74 counties. The population served is generally homogenous, with small percentages of minority residents. The typical CAH has a low patient volume with Medicare reimbursing below cost, which contributes to operating losses. Finally, many of these hospitals are located in Health Professional Shortage Areas or Medically Underserved Areas.

Evaluating the Critical Access Hospital Program

Since its inception, numerous reports of financial salvation as a result of CAH conversion have circulated. Galloro (2002) reports that the conversion of Johnson County Health Center in Mountain City, Tennessee, not only allowed the center to trim losses, but has also allowed the center to add services as a result of grant monies provided within the CAH program. Services added through these grant monies included “a pharmacy, a nuclear camera for cardiac-stress testing, a mammography unit, and a mobile electrocardiogram” (17). Greene (2002a) recounts a similar story in Cottage Grove, Oregon. In 1998, prior to its CAH designation, Cottage Grove Community Hospital was forced to close its doors. In 1999, after forming a network with a regional health system and receiving official certification as a CAH, the hospital reopened. Not only have services been restored, but the hospital began construction of a new facility. Another hospital, Randolph County Hospital in Indiana, has been able to halt operation losses and add services such as “five rural clinics, a spiral CT scanner and expanded occupational medicine” (Greene 2002a, 51) since receiving its CAH designation in 1999. Bertie Memorial Hospital in Windsor, North Carolina, was able to open “a new

\$10 million, 48,000-square-foot, six-bed inpatient facility” (Rees 2002, 34) after becoming a CAH in 1999. Atoka Memorial Hospital in Oklahoma reports CAH conversion moved them from operating at a “loss of \$497,293 in 1996 to an operating profit of \$311,189 in 1999” (Jaklevic 2000, 36). The conversion has also allowed the hospital to add services such as a mobile mammography unit and a stroke management program. The Community Memorial Hospital in Syracuse, Nebraska, has reported operating at a loss of approximately \$230,000 prior to CAH conversion and operating at a profit of \$80,000 subsequent to conversion (Greene 2002b). Finally, the most recent papers from Strensland et al. (2004) and Casey and Moscovice (2004) continue to report dramatic improvements in the financial standings of rural hospitals, but also in the implementation of quality improvement standards.

These stories represent those hospitals having experienced striking turnarounds as a result of the CAH program, but what is the more typical experience? Formal evaluations conducted at the state level have produced positive but more modest results.

Formal Evaluation

States participating in the MRHFP are required to formally evaluate their respective programs. To date, only modest progress has been made in evaluating effects of the CAH program on hospitals across the nation (RUPRI 2002a). It is difficult to compare the results of these MRHFP evaluations because of variations in evaluation methods. Each state designs its own respective method of evaluation. Thus, in the future, to truly assess the impact of the program, standardization of evaluation should be performed.

Of the formal, state-level reports, nearly all states found the CAH program to have had a positive financial impact on converted hospitals. These financial changes range from hospitals that have experienced a cut in losses after conversion to those that had experienced losses prior to conversion that are now thriving under the program and financially stable.

Evaluation of Illinois' CAHs

To evaluate Illinois' MRHFP, three different evaluations were conducted. The first evaluation analyzed the financial impact of CAH conversion using a set of financial and operations indicators: "Data sources for these indicators include[d] IDPH, Medicare Hospital Cost Reports, the IDPH Hospital Profiles from 1995 to 1999, and financial information supplied by the hospitals" (McNamara and Straub 2002, 6). Three pilot hospitals were chosen to test the evaluation tool.

A second analysis was undertaken comparing financial indicators of five Illinois hospitals with CAH designation to a group of rural Illinois hospitals without CAH designation.

The CAHs were among the first Illinois hospitals to convert, having received designation by May of 2000. The comparison group consisted of 10 to 13 Illinois hospitals with less than 40 total beds (McNamara and Straub 2002).

Finally, to gather qualitative data regarding the impact of CAH conversion, "a set of structured questions was developed for the CEO/CFO, as well as a set for hospital governing members and one for medical staff" (McNamara and Straub 2002, 1). Data collection for this evaluation began in June 2001 and was completed in October 2002.

Financial Impact of CAH Conversion

The first evaluation undertaken analyzed a set of financial and operations indicators from three hospitals that had converted to CAHs. The analysis produced mixed results; however, it is important to note that this conversion is limited by the short time each hospital had had CAH designation: "Post-CAH financial data, in the form of Medicare Cost Report or IDPH data, were minimal at the time the evaluation was undertaken. For the three hospitals examined on an individual basis, Hospital A received the designation in mid-2000, Hospital B in late-2000, and Hospital C early 2001" (McNamara and Straub 2002, 7).

Total Margin. One financial indicator that did not seem to be positively impacted by conversion was Total Margin:

Total Margin is defined as the net income or loss for the period divided by the net patient revenues combined with total other income. The values for

Total Margin can vary from positive to negative and the margins have become weaker for each of the hospitals over the last several years. (McNamara and Straub 2002, 9).

Days Cash on Hand. One of the financial indicators that appears to have benefited from conversion was Day's Cash on Hand:

Days Cash on Hand gives a view of the hospital's financial cushion as embodied by availability of cash. After a decline in FY 1999, the cash on hand indicator improved for both Hospitals B and C, and this appears to be as a result of CAH participation. Current information on cash on hand was not received from Hospital A. (McNamara and Straub 2002, 9-10)

Financial Comparison

The second analysis undertaken compared financial indicators of five Illinois CAHs to rural Illinois hospitals without CAH designation. Again, the analysis produced mixed results, and this may be attributed in part, to the limited time that the CAH group has operated under their respective designations.

Average Operating Margins. One of the financial indicators used for comparison that did not appear to be positively impacted by conversion was Operating Margins:

Operating Margins are defined as $(\text{Net Patient Revenue} + \text{Total Other Income} - \text{Contributions} - \text{Investments} - \text{Operating Expenses}) / (\text{Net Patient Revenue} + \text{Total Other Income} - \text{Contributions} - \text{Investments}) * 100$. Analysis showed that the CAH group experienced declining average Operating Margins over the period from FY97 through FY00. The comparison group of hospitals, however, experienced an increase in average Operating Margins during the same time period. (McNamara and Straub 2002, 11)

Current Ratio. Another financial indicator used for comparison was current ratio: "Current ratio is defined

as Current Assets/Current Liabilities. Current ratio for the CAH group improved slightly over the period from FY96 through FY00" (McNamara and Straub 2002, 11).

Long-Term Debt. Finally, long-term debt was analyzed for both groups. This is one of the few indicators that provides a glimpse of a facility's financial future:

Analysis of this indicator showed that while long-term debt has increased for the CAH group, it still is at levels below the average for the comparison group of hospitals During interviews with CEO/CFOs some of the hospital management reported taking on significant debt in FY99 and FY00 to help finance the operations of the hospital and facilitate transition to CAH status and financial stability. It remains to be seen whether or not the debt levels for the CAH group will continue to increase, stabilize or decline. Furthermore, judicious use of debt to help finance needed capital improvements and facility upgrades to improve market position is sound financial strategy. (McNamara and Straub 2002, 11)

Qualitative Assessment

The final evaluation was a qualitative assessment in which CEO/CFOs, the hospital board, and other medical staff responded to a set of questions. The information gathered through this assessment provided evaluators with a clearer picture of the actual changes having occurred subsequent to conversion. The types of changes noted in the qualitative assessment were those unable to be measured through more formal financial analyses:

The hospital CEOs and CFOs reported the actual financial impact (net contribution to revenues) appeared to range from approximately \$250,000 annually for the smallest of the hospitals visited to around \$1,000,000 for the largest. In some cases, the actual financial impact exceeded the projected impact because changes in utilization tended to amplify the financial benefits of cost-based reimbursement. However, each stated an impact figure should be interpreted with some caution because over the time period from CAH

conversion to the present, changes in other aspects of the hospital's operations had also affected the cost structure. Nonetheless, each CEO and CFO reported the CAH program had significantly improved the hospital's financial position improving the hospital's ability to deliver health services and strengthen the quality of care.

In addition to the impact on key financial measures, hospital management also reported the move to CAH status had allowed financial breathing room to afford salary packages targeted at key hospital staff in order to maintain a competitive staff structure. CEO/CFOs also indicated the hospitals are using financial gains experienced from the program for: capital/equipment, building improvements, and retention of ER coverage. (McNamara and Straub 2002, 15)

Conclusion

The Critical Access Hospital program presents an opportunity for small, rural hospitals to receive cost-based reimbursement from services provided to Medicare enrollees. Acceptance of the CAH program, especially in Midwestern states, has steadily increased since its inception.

Formal, state-level evaluations of the impact of the CAH program have produced positive results overall, although the degree of impact varies greatly. While some hospitals have experienced a cut in losses subsequent to conversion, others have experienced more dramatic turnarounds and

have gone from experiencing losses to experiencing surpluses subsequent to conversion.

Conversion to a CAH is not appropriate for every hospital meeting eligibility criteria. Financial feasibility studies are important in determining if a hospital is in a position to benefit financially from conversion.

Continued, state-level evaluation of the program is important in understanding the true impact of the CAH program in Illinois. In the future, standardization of evaluation would facilitate comparison among states.

Appendix

Forrest “Woody” Hester, President & CEO

Abraham Lincoln Memorial Hospital
315 8th Street
Lincoln, IL 62656
(217) 732-2161
(#24 – February 1, 2003)

Donald Brown, CEO

Community Medical Center
1000 W. Harlem Avenue
Monmouth, IL 61462
(309) 734-3141
(#19 – May 1, 2002)

Patrick Heise, CEO

Community Memorial Hospital
400 Caldwell
Staunton, IL 62088
(618) 635-2200
(#6 – August 25, 2000)

Patricia Luker, CEO/Administrator

Dr. John Warner Hospital
422 W. White Street
Clinton, IL 61727
(217) 935-9571
(#4 – March 1, 2000)

Steve Holman, Administrator

Eureka Community Hospital
101 S. Major Street
Eureka, IL 61530
(309) 467-2371
(#10 – January 1, 2001)

Mike Brown, CFO

Steve Dawkins, COO

Kathy Bunting, CNE

Fairfield Memorial Hospital
303 NW Eleventh Street
Fairfield, IL 62837
(618) 842-2611
(#12 – April 1, 2001)

William Hartley, Administrator

Ferrell Hospital
1201 Pine Street
Eldorado, IL 62930
(618) 273-3361
(#25 – February 1, 2003)

Hervey Davis, CEO

Franklin Hospital
201 Bailey Lane
Benton, IL 62812
(618) 439-3161
(#22 – August 1, 2002)

Kurt Jeff Hill, CEO/Administrator

Galena-Stauss Hospital & Healthcare Center
215 Summit Street
Galena, IL 61036
(815) 777-1340
(#3 – February 1, 2000)

Gary Petersen, CEO

Gibson Area Hospital & Health Services
1120 N. Melvin Street, P.O. Box 429
Gibson City, IL 60936
(217) 784-4251
(#18 – January 3, 2002)

Randall Dauby, CEO

Hamilton Memorial Hospital District
611 S. Marshall Avenue, P.O. Box 429
McLeansboro, IL 62859
(618) 643-2361
(#27 – May 1, 2003)

Brad Solberg, President & CEO

Hammond-Henry Hospital
600 N. College Avenue
Geneseo, IL 61254
(309) 944-6431
(#20 – June 4, 2002)

Roby Williams, Administrator

Hardin County General Hospital
Ferrell Road, Box 2467
Rosiclare, IL 62982
(618) 285-6634
(#29 – July 9, 2003)

Rex Brown, President

Hillsboro Area Hospital
1200 E. Tremont Street
Hillsboro, IL 62049
(217) 532-6111
(#33 – April 1, 2004)

Michael Brown, CEO

Hoopeston Community Memorial Hospital
701 E. Orange Street
Hoopeston, IL 60942
(217) 283-5531
(#17 – November 1, 2001)

Mark Rossi, COO

Hopedale Medical Complex
107 Tremont Street
Hopedale, IL 61747
(309) 449-3321
(#31 – October 1, 2003)

Connie Schroeder, President & CEO

Illini Community Hospital
640 W. Washington Street
Pittsfield, IL 62363
(217) 285-2113
(#16 – September 1, 2001)

Tom Dixon, Administrator

John and Mary E. Kirby Hospital
1111 N. State Street
Monticello, IL 61856
(217) 762-2115
(#2 – August 8, 1999)

Margaret Gustafson, CEO

Kewanee Hospital
719 Elliott Street, P.O. Box 747
Kewanee, IL 61443
(309) 853-3361
(#26 – February 1, 2003)

William Huff, CEO

Marshall Browning Hospital
900 N. Washington Street, P.O. Box 192
Du Quoin, IL 62832
(618) 542-2146
(January 1, 2004)

Harry Wolin, Administrator & CEO

Mason District Hospital
615 N. Promenade, P.O. Box 530
Havana, IL 62644
(309) 543-4431
(#14 – July 1, 2001)

Jeffrey Durham, CEO

Massac Memorial Hospital
28 Chick Street
Metropolis, IL 62960
(618) 524-2176
(#23 – February 1, 2003)

Ada Bair, CEO

Memorial Hospital
402 S. Adams Street, P.O. Box 160
Carthage, IL 62321
(217) 357-3131
(#7 – August 8, 2000)

Susan Urso, Administrator & CEO

Mendota Community Hospital
1315 Memorial Drive
Mendota, IL 61342
(815) 539-7461
(#11 – January 15, 2001)

Tim Putnam, Administrator

Mercer County Hospital
409 NW 9th Avenue
Aledo, IL 61231
(309) 582-5301
(#5 – May 1, 2000)

Terry Amstutz, CEO
Morrison Community Hospital
303 N. Jackson Street
Morrison, IL 61270
(815) 772-4003
(#30 – August 11, 2003)

John Fajt, CEO
Paris Community Hospital
721 E. Court Street
Paris, IL 61944
(217) 465-4141
(#21 – June 30, 2002)

Thomas Hudgins, Administrator/CEO
Pinckneyville Community Hospital
101 N. Walnut Street
Pinckneyville, IL 62274
(618) 357-2187
(#8 – November 3, 2000)

Gregg Olson, CEO
Rochelle Community Hospital
900 N. Second
Rochelle, IL 61068
(815) 562-2181
(#13 – June 1, 2001)

Deborah Campbell, Administrator
Thomas H. Boyd Memorial Hospital
800 School Street
Carrollton, IL 62016
(217) 942-6946
(#1 – July 12, 1999)

Jay Purvis, CEO
Wabash General Hospital District
1418 College Drive
Mount Carmel, IL 62863
(618) 262-8621
(#28 – June 1, 2003)

Nancy Newby, President & CEO
Washington County Hospital
705 S. Grand Avenue
Nashville, IL 62263
(618) 327-8236
(#9 – December 1, 2000)

Mark Manuel, Interim CEO
White County Medical Center
400 Plum Street
Carmi, IL 62821
(618) 382-4171
(#15 – July 1, 2001)

Source: Illinois Hospital Association 2004

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