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CAH Application Checklist

CAH Application Checklist

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B. Is a public, nonprofit, or profit organization			
C. Has a Medicare a participation agreement as a hospital			
D. Is in compliance with the Medicare Hospital Conditions of Participation			
E. Meets the federal mileage criteria			
1. Located more than 35 miles from another hospital, or			
2. Located more than 15 miles in mountainous terrain or in areas with only secondary roads, or			
3. Meets CMS Mountainous Terrain criteria for conversion if not located 35 miles from another hospital			
4. Meets CMS Secondary Road criteria for conversion if not located 35 miles from another hospital			
F. Agrees to make available 24-hour emergency care services that the State determines are necessary for ensuring access to emergency care in each area served by a CAH			
G. Agrees to provide not more than 25 beds (of which any combination may be utilized for acute or swing bed services)			
H. Agrees to provide inpatient care limited to a 96 hour annual			
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J. Is a member of a Rural Health Network			
K. Has, or plans to have, an agreement with at least one hospital that is a member of the Rural Health Network for:			
1. Patient referral and transfer			
2. Development and use of communications systems			
3. Provision of emergency and non-emergency transportation			
4. Credentialing and quality assurance			
II. PROVIDER STATUS			
A. The hospital is located in an area that meets the criteria for designation as a HASPA (health professional Shortage Area)			
B. The hospital is located in a MUA (Medically Underserved Area)			

C. The hospital located in a county where the percentage of families with incomes less than 1005 of the federal poverty level is higher than the State average for families with incomes less than 1005 of poverty			
D. The hospital is located in a county with an unemployment rate that exceeds the state's overall unemployment rate			
E. The hospital is located in a county with a percentage of population age 65 or older that exceeds the State's average			
III. STATE REQUIREMENTS FOR DESIGNATION			
A. Member of a Rural Health Network			
1. Must include, at a minimum, one larger, acute care, referral hospital and a CAH			
B. Signed Network Agreements			
1. Network Agreement with area Emergency Medical Services			
2. Network Agreement with Affiliate Facility(ies)			
a. Specify which patients are to be in the CAH and which patients are to be transferred to the Affiliate Hospital			
b. If midlevel practitioners provide services, the agreement must specify the limits of practice imposed upon admission to the CAH			
c. The agreement must identify a process for classifying patients upon admission to the CAH			
d. The agreement must specify the roles and functions of personnel participating in the referral and transfer process			
e. The agreement must identify the patient information to be exchanged in the transfer and referral process and the means but which it is transferred. The agreement also stipulates the frequency with which the information will be communicated			
3. Development and use of communications systems			
a. The agreement must identify which patient data is appropriate to share and how and when the data is to be shared			

b. The agreement must specify a plan for routine communication between the CAH and the Affiliate Hospital on administrative and clinical matters unrelated to specific patients			
4. Provision of emergency and non-emergency transportation			
a. The agreement must identify the emergency medical services (ambulance) provider(s) serving the network and define the relationships between the parties			
5. Credentialing			
a. The agreement must identify a process for integrating CAH physician credentialing with the credentialing process of the Affiliate Hospital			
b. The agreement must stipulate that physicians accepted for medical staff membership at CAH will be given membership on the medical staff of the Affiliate Hospital in accordance with the medical staff and corporate by-laws of the Affiliate Hospital			
6. Quality Assurance			
a. The agreement must identify a process through which the Affiliate Hospital supports CAH quality assurance plan			
7. Clinical Services			
a. The agreement must identify the outpatient and inpatient roles of the CAH and the Affiliate Hospital in providing obstetrical care and establish protocols for emergency obstetrical cases			
b. The agreement must identify the outpatient and inpatient surgical procedures that will be performed in the CAH and establish protocol for emergency surgical cases			
c. The agreement must identify the relationship (clinical and administrative communication, referral and problem resolution) between health care services integrated into the CAH and the Affiliate Hospital			

d. The agreement must identify the clinical services, terms, cost of services Affiliate Hospital provides to the CAH			
8. Administrative Services			
a. The agreement must identify the services, terms, and cost of administrative services			
9.Governance			
a. The agreement must establish a governing body for the network to implement and monitor the covenants, plans, and protocols of the agreement, to identify an resolve differences related to service delivery within the network and to plan and develop new services to be provided by the network			
10. Other			
a. The agreement must stipulate that neither party will be held jointly and severally liable for the actions of their employees on behalf of the other party			
b. The agreement must stipulate that it will be in effect for a period of no less than two years			
11. Include copy of agreements(s) with signature pages signed by all signatory parties			
C. Community Needs Assessment/Local Health Service Delivery Plan			
1. Community Needs Assessment			
a. Advisory committee			
1. List the membership of the Community Needs Advisory Committee, including names and organization (or role in the community) represented			
2. List date of Advisory Committee meetings			
3. Describe how Advisory Committee involved hospital board, staff, and medical staff			
b. Service area information			
1. List of service area towns			
2. Include map with mileage to other health care facilities			
3. Describe the demographics of the population			

4. Describe the health status of area residents			
c. Service area providers			
1. Include the Services to be Evaluated Form			
2. Include the Area Provider Profile Form			
3. Assess the volume/capacity of hospital & Other providers			
4. Provide a list of current hospital services			
5. Provide an inventory of medical staff by name, age (>55) and medical specialty			
6. Describe the area health care infrastructure			
7. Describe telemedicine efforts in the area			
8. Describe provider needs			
9. Describe the accessibility of service			
10. Describe the perceptions of health care services and needs			
11. Describe the status of managed care and potential impact on CAH			
d. Summary of unmet needs			
1. Develop a summary that details the areas of need, resources available to meet the needs, unmet needs, and the strategy the Advisory Committee decides is most appropriate to address the unmet needs			
2. Identify unmet needs that cannot be met			
2. Local Health Service Delivery Plan			
a. Include a description of network development issues			
1. Describe networking opportunities with other area providers			
2. Define network development timeline			
3. Discuss theoretical financial impact of networking			
4. Discuss other factors influencing decision to network			

b. Describe the anticipated changes in CAH services, including the Community Service Profile Form			
c. Describe the plan for hospital program development other than CAH			
D. Financial Feasibility Study			
1. Describe the hospital's current and historic financial status			
a. Describe payor mix for visits, inpatient days, and discharges			
b. Describe the history of prior three year financial status			
2. Describe the hospital's current and recent historic operations			
a. List current inpatient services			
b. List current outpatient services			
3. Include three-year CAH income and expense projection. Include major assumptions:			
a. How were projected inpatient utilization and payor mix data determined?			
b. How were projected outpatient utilization and payor mix data determined?			
c. What are the projected inpatient per diam rates for each year and how were they calculated?			
d. What impact will the CAH program have on the facility's bottom line, exclusive of other changes in operations? Describe other operational changes and their impact on the facilities bottom line.			
4. Describe financial impact of network development plans			
5. Describe financial impact of hospital program development other than CAH			
6. Include a transition period plan			
a. Work plan			
b. Cash flows needs with particular attention to the impact of DASH (disproportionate share hospital) payments and other billing/reimbursement issues			
E. Document Inclusion of CAH Representative in the Conversion Process			
1. State staff receives notification of meetings (advisory committee and CAH board)			
2. State staff meeting with hospital board			

3. Hospital representation at meeting between state staff and Consultant(s)			
F. Document Inclusion of CAH Representative in the Conversion Process			
1. CAH board representative			
2. CAH medical staff representative			

GOVERNING BOARD RESOLUTION

Be it resolved that:

_____ submits to the Virginia Department of
(Applicant Hospital)

Health, State Office of Rural Health, this Application for Designation as a Critical Access Hospital.

_____ is hereby authorized to execute contracts
(Name and Title of Authorized Official)

and certifications as required implementing the organization's participation in the Virginia Rural Hospital Flexibility program as a Critical Access Hospital.

I certify that the above resolution was adopted by the _____
(Governing Body)

of _____ on _____.
(Applicant Hospital) (Date)

SIGNED:
Signature_____
Title_____
Date_____

WITNESSED:
Signature_____
Title_____
Date_____

Section II

Critical Access Hospital Application for Designation

Narrative Instructions

Critical Access Hospital Application for Designation

Narrative Instructions

I. Federal Requirements for Designation

A. The hospital is located in a rural area

For purposes of the Flex Program (Virginia Rural Hospital Flexibility Grant Program), "rural" is defined as not located in an area designated as an MSA (Metropolitan Statistical Area), in an urban area or have been classified by HCFA as an urban hospital. A map of Virginia MSAs is included as Attachment A. As shown, 65 of Virginia's 89 areas, or 73%, are designated as rural, i.e., "non-metropolitan." There are 36 hospitals located in rural communities; 24 of those hospitals have 49 beds or fewer and are designated as small rural hospitals. Seven of the 24 small rural hospitals have 25 beds or fewer and are designated as Virginia's critical access hospitals.

The application narrative must provide evidence that the CAH candidate is located in a rural area.

B. The hospital is a public, nonprofit, or for-profit organization

The application narrative must provide verification of ownership and corporate status.

C. The hospital has a Medicare participation agreement as a hospital

The application narrative must provide evidence that the hospital is currently licensed as a hospital participating in the Medicare program.

D. The hospital is in compliance with the Medicare Hospital Conditions of Participation

The application narrative must provide evidence that the hospital is currently compliant with all Medicare Conditions of Participation for Hospitals.

E. The hospital meets the federal mileage criteria

The hospital must meet **one** of the following criteria:

1. Located more than 35 miles from another hospital
2. Located more than 15-Mile Distance: In the case of mountainous terrain or in areas with only secondary roads available, the CAH must be located more than a 15-mile drive from any hospital or other CAH.
3. Meets the CMS criteria for mountainous terrain if less than 35 miles from another hospital and 15 miles away from another hospital with secondary roads located in mountainous terrain.

The application narrative must provide evidence that the hospital meets the federal mileage criteria.

F. The hospital makes available 24-hour emergency care services that the State determines are necessary for ensuring access to emergency care in each area served by a CAH

The Virginia Flex Program has established requirements that define emergency care services for CAHs, as listed below. The application must include a discussion of the arrangements the CAH has made to assure continuing access to emergency services.

These points are also to be documented in written agreements between the CAH, the Affiliate Hospital, and emergency providers, and are to include the following:

1. Patient referral and transfer

a. The agreement must specify which patients (by diagnosis or level of care required) are to be treated in CAHs and, by implication or explicitly stated which patients are to be transferred to the Affiliate Hospital.
b. If midlevel practitioners provide services, the agreement must specify the limits of practice imposed upon the midlevel practitioner by the supervising physician.
c. The agreement must identify a process for classifying patients upon admission to the CAH that takes into consideration the availability of staff, equipment, and other services in the CAH and the community. It must also assure that patients are periodically evaluated during their stay and changes in patient classification are noted.
d. The agreement must specify the roles and functions of personnel participating in the referral and transfer process.
e. The agreement must identify the patient information to be exchanged in the transfer and referral process and the means by which it is transferred. The agreement also stipulates the frequency with which the information will be communicated.

2. Development and use of communications systems
    a. The agreement must identify which patient data is appropriate to share and how and when the data is to be shared (e.g., hard copy physically transferred, telefacsimile and telemetry). Note: it is likely that data sharing media will be mixed.
    b. The agreement must specify a plan for routine communication between the CAH and the Affiliate Hospital on administrative and clinical matters unrelated to specific patients.

3. Provision of emergency and non-emergency transportation
    a. The agreement must identify the emergency medical services (ambulance) provider(s) serving the network and specify the roles that each plays.
    b. The agreement much identify a CAH emergency services plan which specifies the hours during which emergency services are available at the CAH, the procedures for obtaining emergency medical services when the CAH emergency services are not staffed, and treatment and transfer protocols.
    c. The emergency medical services plan is signed by emergency medical services provider(s) acknowledging its participation in the network.
    d. The agreement identifies a plan (staff, role, equipment, schedule, and evaluation) for providing non-emergency transportation to the CAH service area.
    e. The agreement must identify the outpatient and inpatient roles of the CAH and the Affiliate Hospital in providing obstetrical care and establish protocols for emergency obstetrical cases.
    f. The agreement must identify the outpatient and inpatient surgical procedures that will be performed in the CAH and establish protocols for emergency surgical cases.

The application narrative must address this federal requirement in a narrative discussion and must include copies of the signed agreements including these required points. The agreements are discussed again in a later section.

G. The hospital provides not more than 25 beds (of which any combination may be utilized for acute or swing beds for facilities with extended care agreements in place)

Critical Access Hospitals may not have more than 25 beds for acute or swing (hospital level) inpatient care. The 25 beds do not include bassinets.

The CAH program does not prohibit any CAH from participating in any other service that is established as a distinct part service of the hospital. Distinct part services are not bound by, or considered in, the CAH Conditions of Participation or Medicare/Medicaid reimbursement.

The application narrative must provide assurances that the hospital will limit the number of acute care or swing beds to 25.

The application should describe any distinct part services offered, or planned to be offered within the next three years, by the CAH.

H. The hospital agrees to provide inpatient care for a period not to exceed 96 hours, unless exceptions exist consistent with CAH regulations/policies

The CAH agrees to keep each inpatient for no longer than 96 hours (averaged over a one-year period), unless a longer period is required because of inclement weather or other emergency conditions, or a PRO (peer review organization) or other equivalent entity, on request, waives the 96-hour restriction.

The application narrative must describe how the CAH plans to manage admissions to ensure compliance with the 96-hour length of stay restriction.

I. The hospital agrees to meet CAH staffing requirements

CAH staffing must include a physician on staff and physician(s) and/or midlevel practitioners available to furnish patient care during hours of operation and after hours for emergencies. Nursing staff must be on duty whenever the CAH has one or more inpatients. Specific staffing requirements are found in the Interpretive Guidelines at C250-C256.

The application narrative must list the CAH staff, describe how staffing will be managed to appropriately handle after hours care and describe how inpatient services will be staffed.

J. The hospital is a member of a Rural Health Network

Federal requirements do not mandate that a CAH be a part of a formalized network with another hospital. However, federal requirements do mandate that a state administering a Flex Program must have at least one rural health network. This is defined as an organization with at least one CAH and at least one full-service hospital, the members of which have entered into agreements regarding patient referral and transfer, communications, and patient transportation.

Virginia requires specific elements to be included in this agreement. These are described in **Section III. State Requirements for Designation**.

The application narrative must list the members of the Rural Health Network and include a copy of the network agreements between the CAH and the Affiliate Hospital. All parties of the agreement must sign agreements included in the application.

K. The hospital has, or plans to have, an agreement with at least one hospital that is a member of the rural health network for:

1. Patient referral and transfer

The application must include a copy of any and all agreements for patient referral and transfer. All parties of the agreement must sign agreements included in the application. The application narrative should include a summary of the basic points of the agreement(s).

Virginia requires specific elements to be included in this agreement. These are described in **Section III. State Requirements for Designation**.

2. Development and use of communications systems

The application must include a copy of any and all agreements for communications systems, including telemedicine where appropriate. All parties of the agreement must sign agreements included in the application. The application narrative should include a summary of the basic points of the agreement(s).

Virginia requires specific elements to be included in this agreement. These are described in **Section III. State Requirements for Designation**.

3. Provision of emergency and non-emergency transportation

The application must include a copy of any and all agreements for emergency and non-emergency transportation. All parties of the agreement must sign agreements included in the application. The application should describe how patients would be triaged for care at the CAH or for transfer to another hospital. The application narrative should include a summary of the basic points of the agreement(s).

Virginia requires specific elements to be included in this agreement. These are described in **Section III. State Requirements for Designation**.

4. Credentialing and quality assurance – The agreement for credentialing and quality assurance must be with at least one hospital that is a member of the Rural Health Network, or with a PRO or equivalent entity, or with another appropriate and qualified entity identified in the state plan.

The application must include a copy of any and all agreements for credentialing and quality assurance. All parties of the agreement must sign agreements included in the application. The application narrative should include a summary of the basic points of the agreement(s).

Virginia requires specific elements to be included in this agreement. These are described in **Section III. State Requirements for Designation**.

Note: Virginia requires an additional agreement with area Emergency Medical Services, described in **Section III. State Requirements for Designation**.

II. Provider Status

As of January 1, 2006, the ability to obtain the Necessary Provider Status is no longer available. Therefore, any hospital wishing to convert to a CAH that is less than 35 miles away or 15 miles away in mountainous areas from another hospital and/or 15 miles away from another hospital with secondary roads located in mountainous terrain, is no longer eligible for conversion after this date.

Provide the information in this section to develop the information needed for the qualifications for state conversion to CAH.

III. State Requirements for Designation

A. Member of a Rural Health Network

The Rural Health Network must include, at a minimum, one larger, acute care, referral hospital and a CAH.

The application narrative must describe the Rural Health Network and its members and must include a copy of any and all agreements with area Rural Health Network members. All parties of the agreement must sign agreements included in the application. The application narrative should include a summary of the basic points of the agreement(s).

B. Signed Network Agreements

Federal law does not require that a CAH be a participant in a Rural Health Network. However, Virginia does require CAHs to be part of a Rural Health Network. The State leaves a great deal of latitude for specific components of agreements within the Rural Health Network; however, written agreements are required among the CAH, the Affiliate Hospital(s), and emergency medical service agencies within the service area.

Guidance for Agreements may be changed to reflect the specific circumstances of the network participants and the service area.

1. Transport agreement with Emergency Medical Services
    a. The agreement must identify the emergency medical services (ambulance) provider(s) serving the network and specify the roles that each plays within the Rural Health Network. The goal of Rural Health Networks is development of collaborations to ensure access to and maintenance of quality health care systems.
    b. The agreement is signed by emergency medical services provider(s) and CAH representative(s) acknowledging participation in the network.

2. Patient referral and transfer agreement
    a. The agreement must specify which patients (by diagnosis or level of care required) are to be treated in CAHs and, by implication or explicitly stated, which patients are to be transferred to the Affiliate Hospital.
    b. If midlevel practitioners provide services, the agreement must specify the limits of practice imposed upon the midlevel practitioner by the supervising physician.
    c. The agreement must identify a process for classifying patients upon admission to the CAH that takes into consideration the availability of staff, equipment, and other services in the CAH and the community. It must also assure that patients are periodically evaluated during their stay and changes in patient classification are noted.
    d. The agreement must specify the roles and functions of personnel participating in the referral and transfer process.
    e. The agreement must identify the patient information to be exchanged in the transfer and referral process and the means by which it is transferred. The agreement also stipulates the frequency with which the information will be communicated.

3. Development and use of communications systems agreement

    a. The agreement must identify which patient data is appropriate to share and how and when the data is to be shared (e.g., hard copy physically transferred, telefacsimile and telemetry). Note: it is likely that data sharing media will be mixed.

b. The agreement must specify a plan for routine communication between the CAH and the Affiliate Hospital on administrative and clinical matters unrelated to specific patients.

4. Credentialing agreement
    a. The agreement must identify a process for integrating CAH physician credentialing with the credentialing process of the Affiliate Hospital. Note: the governing board of the CAH is responsible for approving medical staff membership and privileges to members of the CAH medical staff.
    b. The agreement must stipulate that physicians accepted for medical staff membership at the CAH will be given membership on the medical staff of the Affiliate Hospital in accordance with the medical staff and corporate bylaws of the Affiliate Hospital.

5. Quality assurance agreement
    a. The agreement must identify a process through which the Affiliate Hospital supports the CAH quality assurance plan. Some level of assistance by the Affiliate Hospital to the CAH is required.

6. Clinical services
    a. The agreement must identify the outpatient and inpatient roles of the CAH and Affiliate Hospital in providing obstetrical care and establish protocol for emergency obstetrical cases.
    b. The agreement must identify the outpatient and inpatient surgical procedures that will be performed in the CAH and establish protocols for emergency surgical cases.
    c. The agreement must identify the relationship (clinical and administrative communication, referral, and problem resolution) between health care services integrated into the CAH and Affiliate Hospital.
    d. The agreement must identify the clinical services, terms, and costs of services the Affiliate Hospital provides to the CAH (e.g., diagnosis, reference laboratory, clinical consultation, or staffing).
7. Administrative services
    a. The agreement must identify the services, terms, and costs of administrative services (e.g. patient billing, payroll, purchasing, and administration).

8. Governance
    a. The agreement must establish a governing body for the network to implement and monitor the covenants, plans, and protocols of the agreement, to identify and resolve differences related to service delivery within the network, and to plan and develop new services to be provided by the network.
9. Other
    a. The agreement must stipulate that neither party will be held jointly and severally liable for the actions of its employees on behalf of the other party.
    b. The agreement must stipulate that it will be in effect for a period of no less than two years.

Note: All agreements submitted as part of this application must be signed by all signatory parties.

Community Needs Assessment/ Local Health Service Delivery Plan

C. Community Needs Assessment/Local Health Service Delivery Plan

INTRODUCTION

Program Intent:

The intent of the CAH program is to stabilize health services in communities and surrounding areas where current, small, rural hospital facilities are at a risk pf service reductions and/or failure. Through the provision of enhanced reimbursement, hospitals can often reach fiscal stability. However, the **CAH program is not a simply a new reimbursement method to sustain current hospital operations.**

Network Planning:

The CAH is a facility based on a downsized hospital that converts from reliance on impatient, acute care as its primary function to a multifunction health care organization providing a broad range of outpatient services. Furthermore, the CAH program is a tool for developing a local, integrated service network. Through this network development, the CAH becomes part of the local health care system. Perhaps it will be lead agency in that system. The development of the system is integral to the CAH program because failure of a local hospital often begins a domino effect of the entire local system. Private practice physicians who can no longer depend on an emergency room to help them care for patients after hours may leave the area. Without a local physician, other health services will also be at risk.

Rural health networks are unique. Large hospitals, which are affiliates of the CAH, any attract a complex set of new costs and revenues are a result of program participation, and CAHs are not simply lower order manifestations of full service hospitals, but are a new and unique service provider type. A successful planning effort will recognize the distinctive nature of the CAH program ad building its planning tools accordingly.

Given the importance of system development, it is critical to realize that the services delivery-planning process is composed of three distinct parts.

The three required parts of the process to:

- Obtain initial state CAH certification.
- Complete a community-based health needs assessment, which describes the demographics and health status of the community, as well as the current health services
- Complete local health service delivery plan, which focuses on the remediation of unmet needs and the improved coordination and/or integration of health services.

A test of the financial feasibility of the delivery plan based on anticipated utilization, payor mix and reimbursement methodologies of the various third parties.

The Community Needs Assessment does not start with a value neutral base, but, instead, begins with the assumption that collaboration and cooperation are desirable and achievable.

Based on this assumption, the guidelines for the Community Needs Assessment include an evaluation of all the health care services in the area. Through this extensive assessment, not only are the unmet needs of the area defined, but also opportunities for service expansion within the CAH are identified, as well as opportunities for merger or integration.

Interorganizational Planning:

Staffs and boards of potential CAHs will need to be sensitive not only to the value of reason in decision-making, but also to the role of consensus in interorganizational planning. By its very nature, compromise means that not all players will be able to maximize their positions.

Rural health network planning will be composed of large measures of interorganizational bargaining and jockeying for position that are carried out in front of the background of traditional health care planning.

The extensive community needs assessment described in this document is a tool to develop a multiyear business plan that anticipates both the short-term goal of continuation of essential services and the long-term goal of service integration and expansion.

Defining Scope of Services:

There is no set definition of a CAH and a scope of services appropriate for the CAH. It is a goal of the CAH program to integrate local services in order to accomplish efficiencies that will improve the fiscal stability of all local services and provide for more comprehensive and coordinated patient care. Ideally, the CAH will become the hub of local service delivery system-the local center for community health. While it is true that any health care delivery plan should be based on the needs of the community and the ability of the community to pay for the service, the prescriptions of the CAH program place new demands on planning efforts. It is inappropriate (and potentially dangerous) merely to use existing planning tools for this program.

The CAH has a great deal of latitude in defining the services it will provide. It may choose to develop services not traditionally provided by a hospital, such as meals for the elderly or expanded laundry services for other institutions.

The CAH will certainly evolve. While the initial intent of the CAH program is to stabilize essential services, other service development could be implemented over a period of time.

Process

Goal: To produce an objective source of data to support the development of a local health services delivery plan that addresses to the delivery of acute, primary, preventive and emergency services in a coordinated and cost effective manner through a rural health network.

In order to accomplish this goal, an Advisory Committee (as described below) is required. This committee will function in the role of supporting the development of an initial CAH needs assessment. It is required that this committee undertakes the process described, or very similar process.

Once, the initial needs assessment has been completed, the committee may disband, or may continue at the direction of the CAH. However, it is recommended that this committee be replaced by an operational committee that includes representatives of the affiliate hospital and the CAH.

The needs assessment is required for initial CAH certification. It becomes a strategic planning tool; essences. A business plan. While there is no requirement for annual updates to the needs assessment, it is strongly recommended that CAHs conduct annual strategic planning, review their business plans and update goals and objectives.

However the strategies defined during the needs assessment process, and listed in the required forms, will be used as part of the State's annual evaluation process. This Evaluation is described in the Virginia Rural Health Plan.

Following is a suggested process for conducting the Community Needs Assessment.

1. Identify and appoint a Community Advisory Committee. (Example of seven member committee: CAH board member, representative of country or municipal government =, representative of local chamber of commerce, chief of CAH medical staff, representative of farm bureau or agricultural extension office, local clergyman, representative of American Association of Retired Persons.

2. Identify primary and secondary service areas.

3. Inventory providers of acute care, primary care, preventive services, and ancillary services delivered in the service area. Compare provider to populations to ratios to reported regional and national averages.

4. <u>First Advisory Committee Meeting:</u>

    - Conduct an overview of the CAH program.
    - Provide orientation to community needs assessment and local health service delivery plan goals, expected outcome and planning process.
    - Identify 20-25 community leaders for key informant interviews. Key informants should have knowledge of the local health care delivery system. Committee members may serve as key informants.

5. Assess utilization of health care services. Distinguish between (1) services provided locally and those for which residents out-migrate and (2) the type of services provided. Types of indicators and data sources are:

    - **Acute Care:** Inpatient utilization by payor by DRG for the last four years (available from the hospital or HCCRA); out-migration by DRRG for the last four years (available from HCCRA).
    - **Primary Care:** Medicaid visits may serves as a proxy for all primary care visits. Patient origin may be studied by comparing zip code of residence for primary services reported on the Medicaid Management Information System.
    - **Emergency Medical Services:** Destination of ambulance runs (data available from EMS unit of the safe).
    - **Health Status:** Review vital statistics and health outcome data (data available for Health Statistics Center)

6. Conduct key informant interviews. Interviews will focus on identification of perceived strengths and weakness of health care delivery system, and the most profound needs of the services areas. Tabulate interview results.

7. Secondary Advisory committee Meeting:

    - Review health services area assessment:
        i. Service area
        ii. Provider inventory
        iii. Utilization
        iv. Health status
    - Identify key service delivery planning issues.
    - Identify alternatives for delivering acute, primary, ancillary, and preventive care services.
    - Evaluate proposed alternatives.
    - Establish rank order priorities for implementing the alternatives
    - Determine which alternatives should be pursued

8. Document Community Needs Assessment and Local Health Services Delivery Plan. The document should include the following sections:

    A. A description of the area service by the proposal network (geographic and demographic).
    B. A description of current health care delivery system (providers, utilization, patients)
    C. An assessment of unmet need and out-migration.
    D. A description of network, i.e. description of reorganized health care delivery system.
    E. An explanation of how network will affect access, quality, and cost of health care services.

9. Develop financial feasibility studies for CAH.

10. Obtain letters for intent from providers who will participate in the network.

11. Third Advisory Committee Meeting:

    - Review proposed needs assessment and plan.
    - Modify proposed needs assessment and plan.
    - Approve proposed needs assessment and plan.
    - Recommend plan to CAH board of directors.

12. Present plan to CAH board of directors.

13. Draft, amend, and sign network agreement.

14. Incorporate plan and network agreement into application for final designation of the rural health network.

15. Have Advisory Committee members and public hearing to defend plan.

Sample Workplan and Timetable

This sample timeline for completion of the needs assessment and financial feasibility study in six weeks is aggressive. Some planning processes encourage a rime period of up to nine months. However, CAHs are encouraged to complete a needs assessment in a much shorter time frame since the increased reimbursement could be of substantial financial benefit to the institution.

Community Needs Assessment

Objective: To create a local health service delivery plan for the targeted critical access hospital service area, which addresses the provision of prevention, emergency, primary, ancillary, and acute care services in a coordinated and cost effective manner.

Action Steps:		**Week**					
		1	2	3	4	5	6
1.	Provide orientation for Community Advisory Committee on community needs assessment goals, methods, process and expected outcomes.	X					
2.	Perform a preliminary review of available health services.	X					
3.	Assemble information necessary to define specific primary and secondary service/catchment's areas, including previous hospital admissions patterns by DRGs, provider location, existing geographic ties between primary and ancillary services, employment travel and other retail/ commercial trade patterns.	X	X				
4.	Analyze data and present summary charts and maps of hypothetical area definitions to Advisory Committee.		X	X			
5.	Develop guidelines for Committee evaluation of the area definitions to assist them in choosing among alternative area outlines.		X				
6.	Compare data from state and local sources for indications of health status problems.	X	X				
7.	Inventory of full cross section of other health services available in catchments areas under review.	X	X	X			
8.	Analyze historical health services utilization data for the area, in light of the area population mix and identified health status problems.		X	X	X		
9.	Review list of potential key informants and draft interview protocols with committee to hone focus to fit local situation/issues.		X				
10.	Conduct 20-30 informant interviews of knowledgeable community representatives to identify perceived strengths and weaknesses in the local health care system. (At least 15 informants will be non-committee members.)		X	X			
11.	Summarize interview results for Committee, including all recurring problems/issues reported.				X		
12.	In concert with the Advisory Committee develop a preliminary area service delivery plan with recommendations on closing identified service gaps through a cooperative, area wide development process.				X	X	
13.	Document needs assessment process, including data gathered, in a format suitable for CAH Board study and possible public presentation.					X	X
14.	Prepare outline of those identified service needs to be incorporated into the CAH financial feasibility study. (Note that the timeline for the financial feasibility study begins in week 4.)				X		
15.	Modify CAH plan as needed based on input from Advisory Committee and other key decision-makers.				X	X	X
16.	Present plan for service delivery and proposed CAH scope to CAH board of directors.				X		
17.	Incorporate relevant components of plan into network agreements.				X	X	X

Strategic Operational Planning

Objective: To prepare strategic operating plan for the critical access hospital, including services, which can be eliminated to improve operational efficiencies, and new services to be added based on identified community service need.

Action Steps:		**Week**					
		1	2	3	4	5	6
1.	Prepare full profile of existing services and data on utilization of the hospital and other services (i.e., local primary care).	X	X				
2.	Compare scope of current service offering to specific CAH service parameters.	X	X				
3.	Assemble data on the age, sex, payment source and geographic distribution of patients by relevant service categories.	X	X	X			
4.	Determine physician need by specialty in each CAH service area.		X				
5.	Examine other elements of the area's service delivery capacity, including emergency services, skilled nursing care, long-term care, home health, mental health, and support services.	X	X	X			
6.	Identify services for possible elimination through analysis of the projected potential demand, cost/staffing requirements, and complexity of delivery and revenues.			X	X		
7.	Identify potential new/expanded services that fit within the allowable scope for CAHs.			X	X		
8.	Present preliminary alternative service packages to CAH board.			X	X		
9.	With CAH board input, select optional service packages to be tested in the financial feasibility process.				X	X	
10.	Based on completed financial feasibility study, advice board on establishing strategic operational plans for hospital services by the CAH and affiliate hospital in the network.						X
11.	Develop plan for facilitating expansion of other (non-hospital) services to fill gaps identified in the community needs assessment process, including recruitment of additional physician staffing, or expansion of community services.					X	X
12.	Outline service expansion options (e.g. home health, mental health etc.) within the CAH.					X	X
13.	Present strategic options identified to Advisory Committee and CAH boards.					X	X

Financial Feasibility Studies

Objective: To prepare a financial feasibility study, which assesses the impact of revenues from Medicare and other sources under the proposed strategic operational plans, developed for the critical access hospital.

Action Steps:		**Week**					
		1	2	3	4	5	6
1.	Analyze service diversification options including extended care, emergency services, home health, mental health, and durable medical equipment.	X	X	X			
2.	Forecast inpatient, outpatient, and ancillary service utilization at CAH hospital based on alternative service configurations identified as part of community needs assessment and strategic plan development.			X	X		
3.	Estimate CAH costs and gross revenues by payor type for alternative models selected for testing and determine impact on Medicare and other revenues.				X	X	
4.	Based on analysis of total facility profitability, recommend most advantageous service mix to CAH board.					X	X
5.	Facilitate review of CAH recommendations by CAH and affiliate hospital boards.					X	X
6.	Share analysis with Advisory Committee and boards of both CAH and affiliate hospital.				X	X	
7.	Outline a cooperative strategy to assure an adequate supply of health professionals, focusing on the benefits to recruitment of improved coordination, cross coverage and emergency after hour's services.				X	X	X
8.	Involve local providers in discussion on options for improving recruitment and retention of needed health professional supply in the service area.					X	X

1. Community Needs Assessment
    a. Advisory Committee

        (1) List the membership of the Community Needs Advisory Committee, including names and organization (or role of the community) represented.

A community based Advisory Committee is a required element of the CAH conversion process. Local or regional representatives of the county health department, primary care center, emergency medical services, and behavioral health centers must be part of the Advisory Committee.

The application must list the members of the Community Advisory Committee and describe what population group and/or organization the individual is representing in the committee.

        (2) List the dates of Advisory Committee meetings with a brief discussion of the tasks of the meeting.

The application must list the dates of the Community Advisory Committee and describe (in general terms) the contents of those meetings.

        (3) Describe how the Advisory Committee involved the hospital board, medical staff, and entire staff.

The application must describe how staff and board members of the hospital were included in the deliberations leading to the decision to pursue CAH status. This description should include a discussion of how the medical staff was educated regarding the low acuity of patients to be treated at the CAH, the 96-hour length of stay restriction, the integration of credentialing and quality assurance efforts with the Affiliate Hospital and other issues directly relating to the medical staff.

b) Service Area Information

(1) List service area towns.

The application must include a description of the geographic boundaries of the CAH service area, including a list of all the towns in the area.

(2) Include a map with mileage to other health care facilities.

The application must include an indication of the distance to other providers, particularly other hospitals and primary care centers.

(3) Describe the demographics of the population.

The application must include a description of the basic demographics of the population in the service area, such as:

(a) Age

(b) Race

(c) Poverty

(d) Unemployment

(e) Insurance

However, do not limit the discussion to the suggested list of items, rather, focus of those demographics that are relevant to the service delivery system.

(4) Describe the health status of area residents.

The application must include a description of the basic health status statistics of the population in the service area, such as:

(a) Total population and distribution by age and sex

(b) Prenatal indicators:

(i) Total births
(ii) Infant deaths
(iii) Teen birth rates
(iv) Trimester of enrollment in prenatal care

(c) Mortality:

(i) Compare area and state rates for 10 leading causes of death
(ii) Compare area and state rates for mortality by age
(iii) Delineate the number of cases represented by the rates

c) Service Area Providers

1) Indicate the services to be evaluated on the Community Needs Assessment Services to be Evaluated, **Attachment D**.

The application must include a list of relevant services the Community Advisory Committee decides should be specifically evaluated.

2) Document current services in the Area Provider Profile, **Attachment E.**

The application must include a list of those providers furnishing the list of services. If multiple providers for each service are available, the list should be expanded. If no provider is furnishing the service, indicate "Not Available." This gap in services then becomes a point of discussion for possible new service development by the CAH.

3) Include an assessment of the volume/capacity of the hospital and other related health care resources.

The application must include a description of the current volume of services for area providers, and an estimate of whether the provider needs additional capacity to meet the need, or if the provider has excess capacity. Specific information may not be available for this discussion. Information should be gathered from members of the Community Advisory Committee, hospital staff, and key individual interviews.

4) Provide a list of current hospital services.

The application must include a list of the current hospital services provided for inpatient and outpatient care. Services provided in communities other than where the hospital is located should also be listed, such as mobile units.

(a) Inpatient
(b) Outpatient diagnostic
(c) Primary Care
(d) Swing bed
(e) Long term care
(f) Specialty physician/clinics
(g) Inpatient surgery
(h) Deliveries
(i) Outpatient surgery
(j) Other

(5) Provide an inventory of medical staff by name, age (~55) and medical specialty.

The application must include a list of CAH medical staff by name, specialty, and approximate age. Actual age is not required. Indicate those providers who are older than 55 years in order to anticipate those who may choose to retire in the near future, leaving a vacancy in the service capacity.

(6) Describe the area health care infrastructure.

The application must include a list of the basic infrastructure of the local health care delivery system, including areas such as:

(a) Current networking arrangements
(b) Information exchanges
(c) Case management
(d) Medical information systems
(e) Turf issues
(f) Opportunities for networking
(g) Opportunities for increased efficiencies
(h) Viability of area providers
(i) Positioning for health care reform

(7) Describe telemedicine efforts in the CAH area, including current and planned activities.

The application must include a discussion of how the CAH is using telecommunication technology to support local services and how its vision of telecommunications supports could be expanded.

(8) Describe area provider needs.

The application must include a discussion of the needs of area providers, such as:

a) Dependence on grant funding that may be diminishing
b) Services provided
c) Adequacy of facilities (lease/own)
d) Utilization
e) Staffing
f) Reimbursement
g) Plans for the future

(9) Describe the accessibility of services.

The application must include a discussion of the accessibility of services, such as:

a) Medically underserved area/population designation
b) Health professional shortage area/population designation
c) Services available to Medicare, Medicaid and medically indigent populations
d) Services available during nontraditional times
e) Transportation needs
f) Other barriers to receiving services

(10) Describe the perceptions of health care services and needs.

The application must include a discussion of the perception of services. These perceptions can be obtained through interviews of key individuals. Perceptions may include the following:

a) Adequate capacity
b) Quality
c) Accessibility
d) Needs

(11) Describe the status of managed care, and potential impact on CAH.

The application must include a discussion of the how managed care initiatives and programs might impact the CAH. This discussion should address issues such as CAH acceptability to managed care companies in view of the inability of CAHs to be JCAHO certified, the acceptability of midlevel practitioners, effect on reimbursement, etc.

d) Summary of Unmet Needs

Area of Need	**Resources**	**Unmet Need**	**Strategy**
High rate of infant mortality	Public Health Department	Additional providers	Recruit providers (Nurses, MLPs, MD)
	One local physician (anticipating retirement)	Outreach	Local prenatal care
		Case management	Education classes
		Increased prenatal education	Outreach
		Increased early enrollment	Referral sources for deliveries

(1) The application must include a summary of findings of the needs assessment, including details of the area of need, resources available to meet those needs, unmet needs and the strategy the Advisory Committee decides most appropriate to address the unmet needs. The following table is an example of this summary.

(2) Identify unmet needs that cannot be met.

2. Local Health Service Delivery Plan

a) Include a plan outlining network development issues

1) Networking opportunities with other area providers

The application must include a discussion of opportunities for network development with other providers. Please note that "network development" does not necessarily mean merger. The term can mean many levels of cooperation, including shared after hour's call, shared staff, collaboration on a specific project and possibly merger. The discussion should address the opportunities, and the type of networking which is anticipated.

2) Network development timeline

The application must include a timeline (Workplan) for the networking opportunities described earlier.

3) Theoretical financial impact of networking, such as why one program would provide preferential payment over another program.

The application must include a discussion of the financial incentives and/or impacts that have either precipitated networking discussions or might be the result of networking activities.

4) Other factors influencing decision to network

The application must include a discussion of other considerations that might support or hinder network developments, such as political considerations.

b) Describe the anticipated change in CAH services.

The application must include a discussion of the capacity and quality of providers to furnish those services on the Community Service Profile list. Methods for estimating capacity are discussed earlier. In addition, some services will have industry standards available, such as those used by the National Health Service Corps to evaluate capacity. The assessment of quality is subjective, and can be accomplished through the key informant interviews and discussions with the Community Advisory committee. Those services currently provided by the CAH should be indicated, as well as those, which could be part of the CAH through a merger or the development of new services. Finally, indicate those services that will be provided by the Affiliate Hospital.

1) Include the Community Service Profile, **Attachment F.**

c) Describe the plan for hospital program development other than CAH.

The application must include a discussion of service development that would be owned by the CAH, but that would be functionally separate. These are the services, which would be operated as a "distinct part" of the hospital, and not as an integral part of the CAH, such as:

1) Rural Health Clinic/primary care
2) Swing bed
3) Dental services
4) Assisted living
5) Long term care
6) Home health
7) Hospice
8) Respite care

Financial Feasibility Study

D. Financial Feasibility Study Introduction

Introduction

The presentation of the Financial Feasibility Study data should demonstrate that sufficient information has been made available to the hospital's administration and board of directors to make an informed decision regarding the implications for conversion to CAH status. For this review process, it is not so important that conversion to CAH status has a positive impact on a facilities bottom line, but that instead, enough information is available to understand the implications associated with conversion. There is no "correct answer" pertaining to the results of the financial impact of the feasibility study. Instead, a clear presentation of the assumptions and results is required.

1. Describe the hospital's current and historical financial status.
    a) Describe the payor mix for outpatient visits, inpatient days, and discharges
    b) Describe the history of prior three-year financial status. Use the CAH Financial Impact Study Revenue and Expense Data Form, **Attachment G**, to report income and expense data for three-years of historical data and the data for the current period. At the top of the "current column" in each worksheet indicate the number of months represented by the data.
2. Describe the hospital's current and recent historic operations.
    a) Include a list of inpatient services appropriate for each year. Use the Financial Impact Study Utilization Statistics Form, **Attachment H**, to report the prior years' utilization of each service, by payor type. At the top of the "current column" in the worksheet indicate the number of months represented by the data.
    b) Include a list of outpatient services appropriate for each year. Use the Financial Impact Study Utilization Statistics Form to report the prior years' utilization of each service, by payor type. At the top of the "current column" in the worksheet indicate the number of months represented by the data
    c) Use the generic Financial Impact Study Utilization Statistics Form to report additional services provided.
3. Include three years of projected income and expense data for the CAH on the Financial Impact Study Revenue and Expense Form. Include major assumptions:
    a) How were projected inpatient utilization and payor mix determined?
    b) How were projected outpatient utilization and payor mix data determined?
    c) What are the projected inpatient per diem rates for each year and how were they calculated?
    d) What impact will the CAH program have on the facilities bottom line, exclusive of other changes in operations? Describe other operational changes and their impact on the facilities bottom line separately. For example, a hospital may convert an outpatient clinic to RHC status. This could be accomplished regardless of CAH status. Therefore the RHC should not be included in the presentation of the impact of converting to CAH status, but should be reported separately.
4. Describe financial impact of network development plans including costs and revenues to the converting hospital.
5. Describe the financial impact of hospital program development other than CAH. These should involve activities that are not dependent upon conversion to CAH.
6. Include a transition period plan.
    a) Include a work plan that delineates tasks and associated timelines.
    b) Include cash flow requirements, with particular attention to the impact of DSH payments and other billing/ reimbursement issues.

E. Inclusion of State staff in CAH conversion process

1. State staff receives notification of meetings (Advisory Committee and CAH Board)

Notices of Advisory Committee and CAH Board meetings are to be sent to the Program Administrator, Rural Hospital Flexibility Program, 109 Governor Street, Suite 1016E, Richmond, Virginia 23219. Staff from this office will not necessarily participate in the meetings, but they do need to be assured that the meetings are being conducted in a timely manner.

The application narrative must provide evidence that these notifications have occurred.

2. State staff meeting with hospital board

Arrangements must be made with the Director, Rural Hospital Flexibility Program for staff from that office to attend at least one hospital board meeting at which conversion to CAH status is to be discussed.

The application narrative must provide evidence that this participation did occur in at least one board meeting.

3. Hospital representation at meetings between state staff and consultant(s)

CAH candidates that utilize consultants to assist with the planning and application process must remain involved in that process. A representative of the hospital should attend all substantive meetings that the consultant has with staff in the Rural Hospital Flexibility Program office.

The application narrative must provide evidence that these hospital representatives participated in meetings between consultants and state staff.

F. Inclusion of CAH representative's participation in the conversion process

1. CAH board representative

The application narrative must include a discussion and other evidence (such as board minutes and/or resolutions) of how the CAH board was involved in the consideration of CAH status and the decision to pursue that status.

2. CAH medical staff representative

The application narrative must include a discussion and other evidence (such as medical staff minutes and/or resolutions) of how the CAH medical staff was involved in the consideration of CAH status. In particular, the narrative should describe how the medical staff was educated about the handling of emergency care, hospital staffing, and the 96-hour length of stay restriction.

Section lll

Process for State Designation

Process for State Designation

A. CAH application is submitted to the Office of Community Health Systems and Health Promotion (OCHSHP), Division of Rural Health and Recruitment (DRHR).

B. DRHR declares an application complete or incomplete within 30 working days following receipt.

C. Application, upon being deemed complete, is reviewed by Rural Hospital Flexibility Program staff and a summary, including comments, is submitted to the Director of the Office of Community Health Systems and Health Promotion within 45 days.

D. Flex staff may require additional information from applicants, including requiring the presence of the applicants at scheduled meetings.

E. Director of OCHSHP will submit a letter of recommendation (or non-recommendation) to the Commissioner of the Bureau for Public Health within ten working days of receipt of a summary from DRHR/Flex.

F. Commissioner of the Bureau for Public Health will make a final designation determination within ten working days following the recommendation from the Director of OCHSHP.

G. The Commissioner will communicate the decision to the applicant and OHFLAC within ten working days.

Upon submission of application for designation the applicant is encouraged to consult with OHFLAC in order to anticipate the steps necessary to obtain certification by the Centers for Medicaid and Medicare Services, such as applying for changes in Medicare provider status and scheduling the CAH survey. Following the survey, OHFLAC will recommend CMA certification or denial of certification as a CAH.

Section IV
Attachments

Attachments

(Required Attachment needed for Application)

A. Virginia Metropolitan Statistical Areas Map

B. Virginia designated HPSA Areas Map

C. Virginia designated MUA/P areas

D. Services to be Evaluated Form

E. Area Provider Profile Form

F. Community Service Profile Form

G. Financial Impact Study Revenue and Expense Data Form

H. Financial Impact Study Utilization Statistics Form

I. Network Agreement By and Between CAH and EMS Provider

J. Resource list of certified CAHs in Virginia

K. Financial Feasibility Study

L. Community Needs Assessment

Attachment D

Services to be Evaluated

(This form is required)

Those services already checked are a required part of the assessment. Unchecked services should be added as appropriate for the CAH service area.

X	Acute Care	**X**	Public Health Services
X	Emergency Medical Services		Specialty Services
X	Primary Care		Adult Day Care
X	Preventive Services		Respite Care
X	Prenatal Care		Pediatric Day Care
X	Obstetrical Services		Long Term Care
	Dental Care		Homemaker Services
X	Mental Health Services		Pharmacy Services
	Substance Abuse Counseling		AIDS Care
	Inpatient Substance Abuse		Services for Developmentally Disabled
	Rehabilitation		Social Services Assistance
	Home Nursing Care		Patient Education Services
	Optometry Services		Health Services for the Incarcerated
X	Hospice Services		Respiratory Therapy Services
	Case Management Services		Health Care for Migrants
	Outreach Services		School Health Services
X	Physical Therapy Services		Healthcare for the Homeless
	Other:		Other:
	Other:		Other:

Attachment E

Area Provider Profile

(This form is required)

	Provided in Service Area	Provided in Contiguous Area	Not available	Provider Name (for multiple providers of one service, attach list)	Provider Town
Impatient					
Acute Care					
Observation Bed					
Swing Beds-SNF					
Swing Bed-NF					
Inpatient Sub. Abuse Rehabilitation					
Impatient Psychiatric Care					
Impatient Hospice					
Emergency Care					
Emergency Response and Transport					
Emergency Room					
Primary Care					
Primary Care Practices					
Federally Funded Clinics					
Public Health Dept. Primary Care					
Prenatal Care					
Obstetrical Services					

Attachment E (continued)

Area Provider Profile (This form is required)

	Provided in Service Area	Provided in Contiguous Area	Not available	Provider Name (for multiple providers of one service, attach list)	Provider Town
Supportive Care					
Adult Day Care					
Respite Care					
Pediatric Day Care					
Homemaker Services					
Home Nursing Care					
Meal Services					
Home Hospice Services					
Long Term Care					
Boarding Homes					
Skilled Nursing Facilities					
Nursing Facilities					
Assisted Living Arrangements					
Congregate Housing					
Other Health Services					
Mental Health Service					
Substance Abuse Counseling					
Specialty Services					
Pharmacy Services					
Optometry Services					
Dental Care					
School Health Services					
Preventive Services					
Public Health Services (non-primary care)					

Attachment E (continued)

Area Provider Profile (This form is required)

	Provided in Service Area	Provided in Contiguous Area	Not available	Provider Name (for multiple providers of one service, attach list)	Provider Town
Special Populations					
AIDS Care					
Services for Developmentally Disabled					
Health Services for the Incarcerated					
Health Care for Migrants					
Health Care for Homeless					
Social Services					
Social Services Assistance					
Case Management Services					
Patient Education Services					
Outreach Services					
Diagnostic Testing and Treatment					
Respiratory Therapy Services					
Physical Therapy Services					
Laboratory					
Radiology					
Dialysis					
Chemotherapy					

Attachment F

Community Service Profile

(This form is required)

	Capacity is Adequate for the Area	Quality is Adequate	Currently Provided by CAH Hospital	To be Considered as a New CAH Service		Will be Provided by the Affiliate Hospital
				Potential Merger of Existing Service into CAH	New Service which could be developed by the CAH	
Impatient						
Acute Care						
Observation Bed						
Swing Beds-SNF						
Swing Bed-NF						
Inpatient Sub. Abuse Rehabilitation						
Impatient Psychiatric Care						
Impatient Hospice						
Emergency Care						
Emergency Response and Transport						
Emergency Room						
Primary Care						
Primary Care Practices						
Federally Funded Clinics						
Public Health Dept. Primary Care						
Prenatal Care						

Obstetrical Services						
Supportive Care						
Adult Day Care						
Respite Care						
Pediatric Day Care						
Homemaker Services						
Home Nursing Care						
Meal Services						
Home Hospice Services						
Long Term Care						
Boarding Homes						
Skilled Nursing Facilities						
Nursing Facilities						
Assisted Living Arrangements						
Congregate Housing						
Other Health Services						
Mental Health Service						
Substance Abuse Counseling						
Specialty Services						
Pharmacy Services						
Optometry Services						
Dental Care						
School Health Services						

Preventive Services						
Public Health Services (non-primary care)						
Special Populations						
AIDS Care						
Services for Developmentally Disabled						
Health Services for the Incarcerated						
Health Care for Migrants						
Health Care for Homeless						
Social Services						
Social Services Assistance						
Case Management Services						
Patient Education Services						
Outreach Services						
Diagnostic Testing and Treatment						
Respiratory Therapy Services						
Physical Therapy Services						
Laboratory						
Radiology						
Dialysis						
Chemotherapy						

Attachment G

Critical Access Hospital Financial Impact Study Revenue and Expense Data		Actual/Prior Years			Based on ___Mos.			Projected with CAH Designation		
		Y3	Y2	Y1	Current			Y1	Y2	Y3
Revenues	Room & board (see detail)									
	Ancillary Services (see detail)									
	Other (see detail)									
	Total Revenues									
	Deductions from Revenues									
	Contract Allow. - Medicare									
	Contract Allow. - Medicaid									
	Contract Allow - Commercial									
	Charity Care									
	Other Discounts or Allowances									
	Total Deductions from Revenues									
	Net Revenue from Patient Services									
	Other Operating Revenues									
	Total Operating Revenues									
Expenses	Direct Service									
	Administrative & General									
	Interest									
	Depreciation									
	Bad Debts									
	Other									
	Total Operating Expense (see detail)									
	Operating Gain/(Loss)									
	Financial Impact of CAH									
	Projected CAH Per Diem Rate									

Critical Access Hospital Financial Impact Study Revenue and Expense Data		Actual/Prior Years			Based on ___Mos.			Projected with CAH Designation		
		Y3	Y2	Y1	Current			Y1	Y2	Y3
Details of Operating Revenues:										
Room & board	Acute Care									
	Swing Bed									
	Observation Bed									
	Distinct Part Units									
	Total Room & Board									
Ancillary Services:										
Laboratory	Inpatient									
	Swing Bed									
	Observation bed									
	Outpatient									
	Total									
Radiology & Bed Other Services	Inpatient									
	Swing Bed									
	Observation bed									
	Outpatient									
	Total									
Surgical Services	Inpatient									
	Swing Bed									
	Observation bed									
	Outpatient									
	Total									
Rehab. Services	Inpatient									
	Swing Bed									
	Observation bed									
	Outpatient									
	Total									
Cardiology	Inpatient									
	Swing Bed									
	Observation bed									
	Outpatient									
	Total									
Clinic Services	Inpatient									
	Swing Bed									
	Observation bed									
	Outpatient									
Other	Inpatient									
	Swing Bed									
	Observation bed									
	Outpatient									
	Total									
	Total Ancillary Services Revenues									

Attachment G (continued)

Critical Access Hospital Financial Impact Study Revenue and Expense Data		Actual/Prior Years			Based on ___Mos.	Projected with CAH Designation		
		Y3	Y2	Y1	Current	Y1	Y2	Y3
Details of Operating Expenses:								
Expenses Related to Room and Board	Payroll							
	Fringe benefits							
	Supplies							
	Other							
	Total							
Expenses Related to Ancillary Services	Payroll							
	Fringe benefits							
	Supplies							
	Other							
	Total							
Expenses Related to Admin & General	Payroll							
	Fringe benefits							
	Supplies							
	Other							
	Total							
Total Operating Expenses								

Attachment H

Critical Access Hospital Financial Impact Study Utilization Statistics:		Actual/Prior Years			Based on ___Mos.	Projected with CAH Designation		
		Y3	Y2	Y1	Current	Y1	Y2	Y3
Discharges	Medicare							
	Medicaid							
	Commercial							
	PEIA							
	Self-Pay							
	Totals							
Patient Days	Medicare							
	Medicaid							
	Commercial							
	PEIA							
	Self-Pay							
	Totals							
Swing bed Admissions	Medicare							
	Medicaid							
	Commercial							
	PEIA							
	Self-Pay							
	Totals							
Swing Bed Days	Medicare							
	Medicaid							
	Commercial							
	PEIA							
	Self-Pay							
	Totals							
Observation Beds/Other Short Bed Days								
OP Registrations	Medicare							
	Medicaid							
	Commercial							
	PEIA							
	Self-Pay							
	Totals							
ER Visits	Medicare							
	Medicaid							
	Commercial							
	PEIA							
	Self-Pay							
	Totals							
Clinic Visits	Medicare							
	Medicaid							
	Commercial							
	PEIA							
	Self-Pay							
	Totals							
Total Facility FTE's								

Attachment H (continued)

Critical Access Hospital Financial Impact Study Utilization Statistics:	Actual/Prior Years			Based on ___Mos.	Projected with CAH Designation		
	Y3	Y2	Y1	Current	Y1	Y2	Y3
(Indicate Service) Medicare							
Medicaid							
Commercial							
PEIA							
Self-Pay							
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(Indicate Service) Medicare							
Medicaid							
Commercial							
PEIA							
Self-Pay							
Totals							

Attachment I

Network Agreement By and Between

(Hospital – A Critical Access Hospital)

And

(Ems Provider)

WHEREAS, (Hospital) is a private, (non-profit or for-profit) organization serving (service area) and

WHEREAS, (EMS Provider) is a duly licensed provider of Emergency Medical Services (EMS) to the residents of (service area) and

WHEREAS, the (EMS Provider) has sufficient personnel and equipment to provide 24-hour emergency and non-emergency services to the area - including pre-hospital services and inter-facility transfers, both now and when (hospital) converts to Critical Access Hospital status.

BE IT THEREFORE RESOLVED:

That (hospital) recognizes the (EMS Provider) as one of its principal providers of emergency and non- emergency transportation services; and

Both parties assert that they have and will continue to maintain sufficient resources to operate effectively when (hospital becomes a Critical Access Hospital; and

Both parties pledge their full cooperation to help one another maintain appropriate levels of access to and coordination of high quality pre-hospital, hospital emergency department, and inter-hospital emergency capabilities in the (service area) region: and

Both parties stipulate that (hospital and the EMS Provider) will collaborate with one another to assure a smooth transition to a Critical Access Hospital environment.

BE IT FURTHER RESOLVED:

That this agreement shall remain in effect and shall be automatically renewed on an annual basis, unless either party gives the other 60 days advance notice of intent to cancel.

_____	_____
(Hospital)	(EMS Provider)
_____	_____
(Date)	(Date)

Attachment J

Virginia Critical Access Hospitals

Attachment K

Virginia Critical Access Hospitals

State Map