

Profile of Rural Hospitals in Minnesota

Hospitals are an integral component of the health care system providing basic primary care services to communities. The distribution of services among acute care hospitals in greater Minnesota and the expanding role of rural hospitals are the focus of this profile.

Background

Greater Minnesota has a disproportionate number of smaller hospitals (70 percent have less than 50 beds) and only 6 hospitals with over 200 beds. See Table 1. The number of hospitals in Minnesota has decreased in recent years. Since 1991, 19 hospitals in greater Minnesota and 5 hospitals in the Twin Cities metropolitan area have closed.¹

Table 1

Number of Hospitals by Size, 2000*			
Number of Beds	Greater MN	Metro	Total
<25	27	1	28
25-49	52	1	53
50-199	27	11	38
200+	6	12	18
Total	112	25	137

Percentage of Hospitals by Size, 2000*			
Number of Beds	Greater MN	Metro	Total
<25	96.4	3.6	20.4
25-49	98.1	1.9	38.7
50-199	71.1	28.9	27.7
200+	33.3	66.7	13.1

Source: 2000 Health Care Cost Information System
 *Does not include hospitals that have closed since 2001.

Quick Facts:

- ◆ In 2000, there were 91 greater Minnesota hospitals that had an average bed size of 48.
- ◆ In 2000, the percentage of hospital beds that are rural is 34%.
- ◆ In 2000, the average length of stay in rural hospitals was 3.6 days compared to 4.6 days in urban hospitals.
- ◆ Nationally, a greater proportion of rural residents are more likely to use hospital services, including emergency room visits (22% vs. 18%) and overnight hospital stays (9% vs. 7%). This may be due in part to a shortage of primary care physicians in rural areas.¹

¹ Center on An Aging Society, Institute for Health Care Research and Policy, *Rural and Urban Health: Health Care Service Use Differs, Data Profiles - Challenges for the 21st Century: Chronic and Disabling Conditions*, No.7, Georgetown University, Washington, DC, Jan. 2003.

¹ Metro area includes Anoka, Carver, Dakota, Hennepin, Ramsey, Scott and Washington counties.

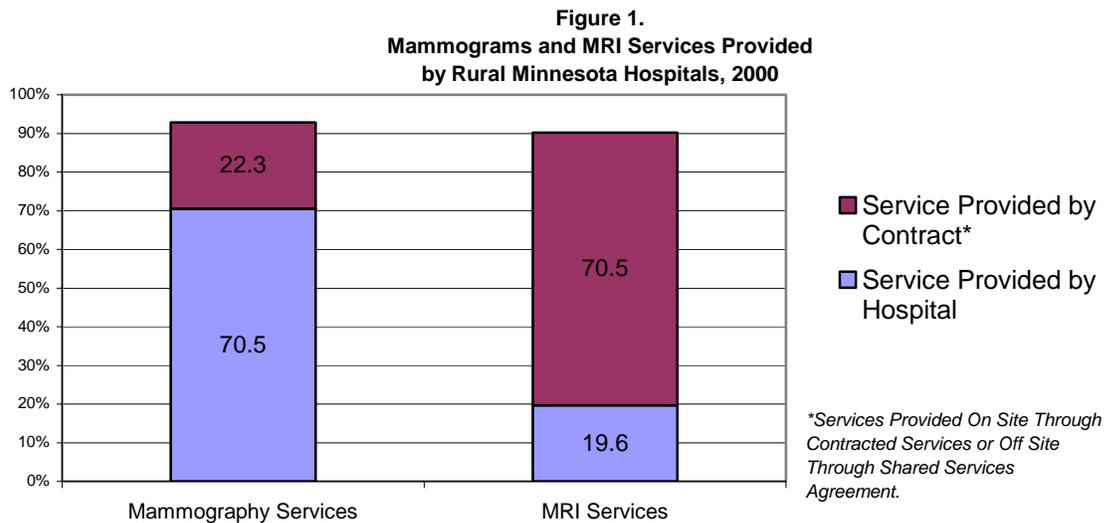
Among the 24 acute care hospitals that have closed since 1991, approximately 1435 urban beds and 532 rural beds were eliminated.² While the statewide rate of 3.4 beds per 1,000 population remains well above the national rate of 2.9, bed rates vary by region. For example the central portion of Minnesota has the lowest bed rate of 2.2 while the Southeast region has the highest bed rate at 6.0. See Table 2.

Region	Acute Care Beds	2000 Population	Beds Per Population
Central	1,354	610,139	2.2
Metro	8,269	2,642,056	3.1
Northeast	1,472	322,073	4.6
Northwest	567	194,633	2.9
South Central	826	280,332	2.9
Southeast	2,743	460,102	6.0
Southwest	843	230,085	3.7
West Central	463	180,059	2.6
Minnesota	16,537	4,919,479	3.4

Source: 2000 Health Care Cost Information System

Hospital Services

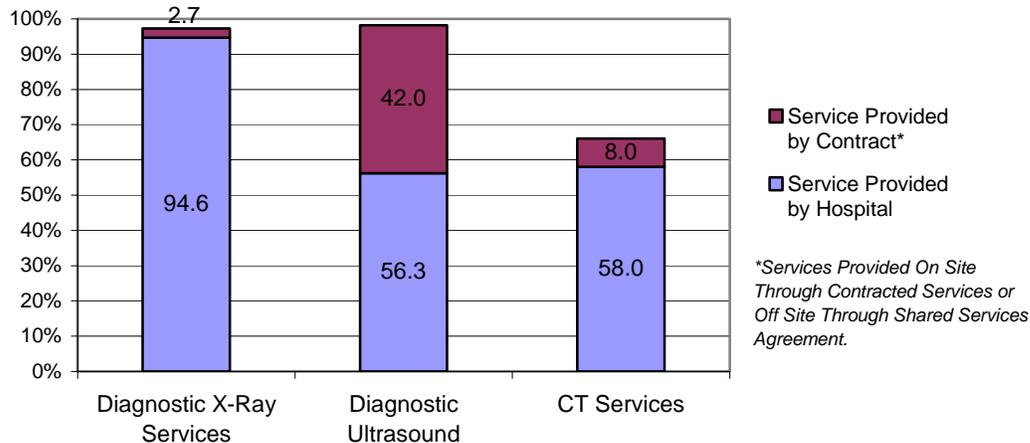
Most rural hospitals in Minnesota are providing medical services that meet current standards of care at their facilities onsite or through contract agreements with a hospital-affiliate. Computerized tomography scanning (CT), ultrasounds, magnetic resonance imaging (MRI), X-ray and mammography services are examples of diagnostic imaging services being offered at rural hospitals. See Figures 1 and 2. Occasionally some diagnostic services may also be available through a local community clinic, which have not been included here.



Source: 2000 Health Care Cost Information Services

² Minnesota Statute 144.551, subd 1 (8) places a moratorium on the addition of new hospital beds.

Figure 2.
X-ray, Ultrasound and Computerized Tomography Services
Provided by Rural Minnesota Hospitals, 2000



Source: 2000 Health Care Cost Information System

Emergency Room Services/Trauma Centers

Information collected on the services of hospital emergency rooms in Minnesota is minimal. Analysis of the information available on rural hospitals shows that 98 percent provide organized emergency room services for conditions requiring immediate care. Only three rural hospitals do not provide emergency room services, and two rural hospitals have an emergency department open part-time only.³ It is assumed that the types of emergency services in Minnesota vary by hospital depending on the availability of resources and staff, volume of patients, and geography.

In 1993, MDH established a Traumatic Brain Injury/Spinal Cord Injury (TBI/SCI) registry in which all hospitals in the state must participate. However, participation in a comprehensive trauma registry is not required nor does one exist. Only four hospitals have received the American College of Surgeons verification as Level 1 Trauma Centers: Hennepin County Medical Center, Minneapolis; Regions Hospital, St. Paul; St. Mary’s Hospital, Rochester; and North Memorial Health Care, Robbinsdale.

In 2002, the Minnesota EMS Regulatory Board (EMSRB) asked the Minnesota Department of Health (MDH) to assume the lead state agency role for developing a statewide trauma system. The essential elements of a trauma system will include triage and transfer guidelines for trauma patients, standardized facility verification for hospitals handling trauma patients, and the development of trauma data elements necessary for system evaluation and improvement.

Telemedicine

Telemedicine technology can make specialty care more widely accessible to underserved rural and urban populations. For example, telemedicine alleviates prohibitive travel and associated costs when consultation with a specialist is required. A total of 30 rural hospitals or 27 percent report having telemedicine capability via their emergency departments.⁴ The use of

³ HCCIS Data 2000.

⁴ Ibid.

telemedicine also can attract and retain health care providers in rural areas by providing ongoing training and interaction with other providers.

The Expanding Role of Rural Hospitals

When hospitals and other health services join together to coordinate and deliver a wider range of services, communities frequently benefit from increased service availability. Minnesota’s rural hospitals have begun to provide more services directly or have joined forces with other providers to expand the number of services available in rural areas. For example, 98 percent of rural hospitals provide outpatient medical rehabilitation services on site or at the facilities of a hospital affiliate. See Figure 3.

Rural hospitals have also broadened their patient services to include long-term care. Seventy-four percent of rural hospitals report having home health services available, while 26 percent provide geriatric day care and 56 percent offer outpatient hospice services. See Figure 4.

While chemical dependency recovery programs are not as widely available in rural hospitals, 27 percent of rural hospitals report having chemical dependency treatment services and 18 percent provide detoxification services on site or via a hospital affiliate. See Figure 5.

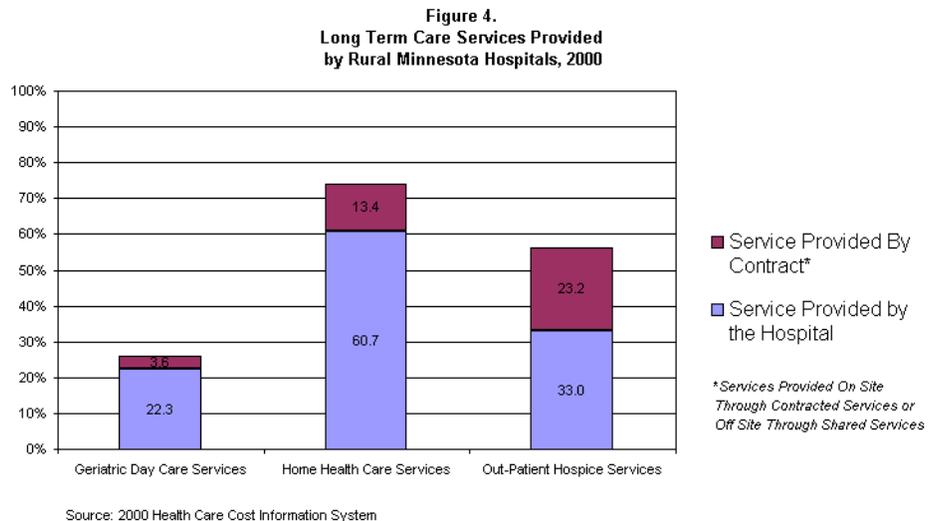
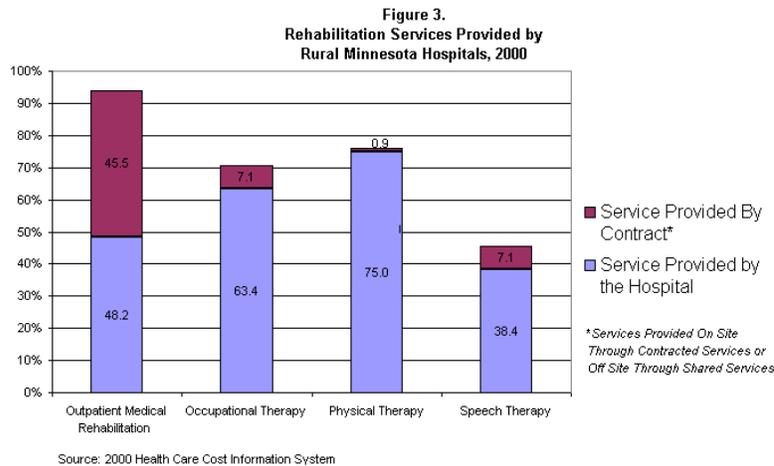
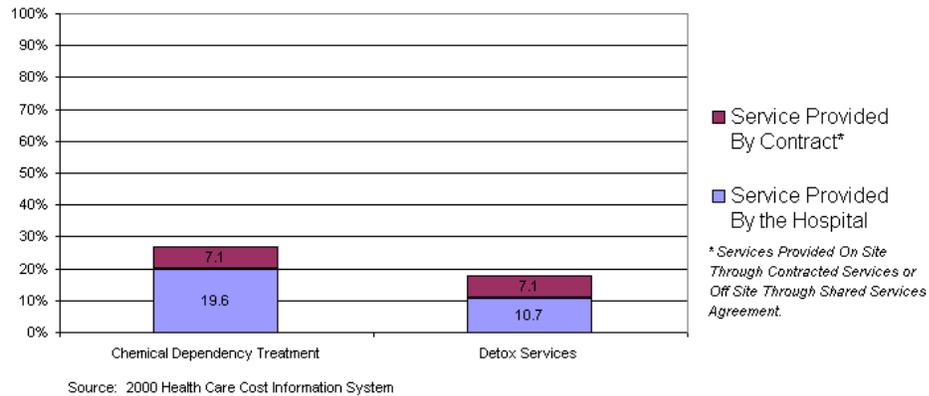


Figure 5.
Substance Abuse Programs Provided
by Rural Minnesota Hospitals, 2000



Networks & Alliances

Since the enactment of the Medicare prospective payment system, voluntary integration with other rural hospitals through a rural health network has become more popular among rural hospitals than affiliation with multi-hospital systems.⁵ Networks can be formal or informal in structure allowing rural hospitals to remain autonomous while still gaining access to a larger supply of financial, technical and human resources. The composition of networks may change frequently as goals and needs change. The following table gives some examples of Rural Health Networks in Minnesota. In addition to these examples, all Critical Access Hospitals in Minnesota have formal network agreements with regional partner hospitals.

Network Name/Location	Description
Itasca Partnership for Quality Healthcare Grand Rapids, MN	Providers and businesses working toward a community-oriented network
Lac Qui Parle Health Network Madison, MN	Madison and Dawson Hospitals joint venture.
Medisota Willmar, MN	A consortium of 19 area hospitals in Southwest Minnesota. It was developed to foster physician recruitment and retention through specialty outreach services with the University of Minnesota. Since its inception, the group has evolved and provides continuing education and managed care members; negotiates and develops contracts with preferred providers for its members; fosters local identity and autonomy; works with the Minnesota Rural Health Coop; and supports membership in planning, development, compliance, recruitment and retention.
Minnesota Rural Health Cooperative Willmar, MN	Initiated by physicians and hospitals in an effort to increase the managed care competencies of it members. Those involved in the cooperative include: 17 hospitals, 20 clinics, and public health from 11 counties. The cooperative develops single signature contracts with HMOs, covering approximately 2,200 lives.

⁵ Institute for Health Services Research, *Rural Hospital Networks*, Research Brief ,vol.2, no.2, Feb. 1994, University of Minnesota.

Network Name/Location	Description
North Region Alliance Grand Forks, MN	A provider cooperative consisting of 9 hospitals and 160 physicians. It was created to enable local providers to compete in a managed care environment and to develop regional strategies to meet regional health care needs.
Rural Health Alliance Alexandria, MN	A consortium of 9 hospitals. While hospital oriented, they also work with clinics and nursing homes. The network shares equipment, participates in joint contracting and extensive telemedicine, develops regional purchasing contracts, and provides education via interactive television.
Minnesota Clinic St. Cloud, MN	This network has a service area of 10 counties in Central Minnesota. The network consists of physicians, allied health professionals, specialty providers, hospitals, and primary care clinics which serve approximately 31,000 customers/enrollees.

Critical Access Hospitals

Over the last decade, the number of hospital closures occurring in rural America has led to the recent passage of federal programs intended to preserve the rural community's access to primary and emergency health care services. One such program is the Medicare Rural Hospital Flexibility Program (Flex Program) established by the Balanced Budget Act of 1997 and revised through the Medicare, Medicaid and SCHIP Balanced Budget Refinement Act of 2000. The Flex Program authorizes designation of Critical Access Hospitals (CAHs). Small rural hospitals can choose to convert from an acute care facility to a CAH if they meet federal and state eligibility requirements.

Minnesota currently has 46 designated CAHs and 4 designations in process. See Map 1. By late 2003, another 10-15 hospitals are expected to have converted to CAH status. It is the intention of the Office of Rural Health and Primary Care to continue to support CAHs through the broader objectives of the Medicare Rural Hospital Flexibility Program.

Resources:

Publications:

Minnesota Department of Health, Health Policy and Systems Compliance Division, Health Economics Program, *Minnesota Hospitals: A Decade in Review 1990-2000*, not yet published.

Minnesota Department of Health, Health Policy and Systems Compliance Division, Health Economics Program, *Minnesota's Aging Population: Implications for Health Care Costs and System Capacity*, not yet published.

Minnesota Planning, Critical Issues, *Fiscal Futures: A Guide to Minnesota Health Care Spending*, January 2003.

Center for an Aging Society, Institute for Health Care Research and Policy, Georgetown University, *Rural and Urban Health: Health Care Service Use Differs, Challenges for the 21st Century: Chronic and Disabling Conditions*.

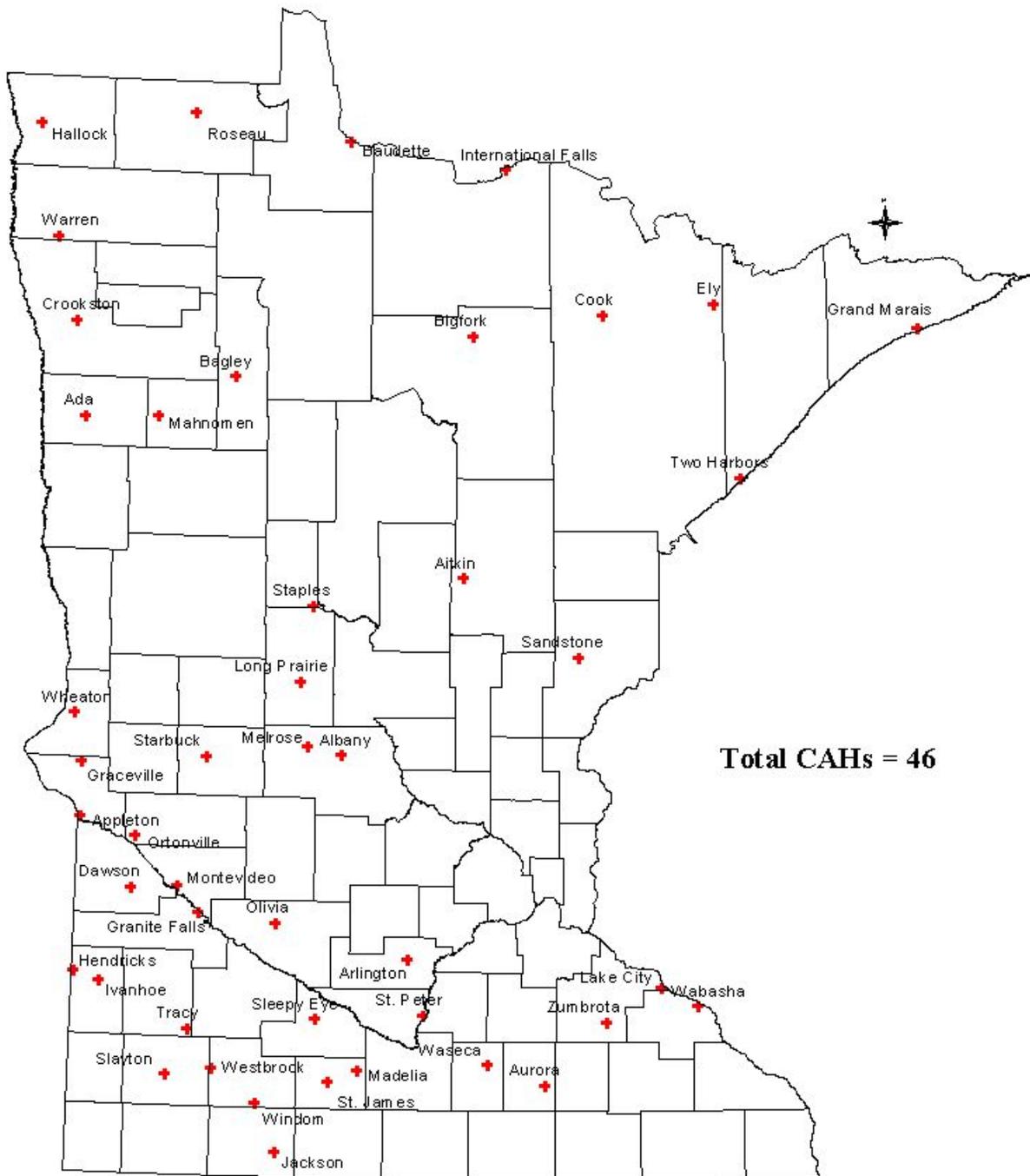
Websites:

<http://www.health.state.mn.us/divs/fpc/directory/providersselect.cfm> - An interactive website of the Division of Facility & Provider Compliance at the MN Department of Health. Contains information on all health care providers including home care, home health agencies and hospices licensed and registered with the state of Minnesota.

<http://www.health.state.mn.us/divs/chs/rhpc/cah/index.html> - A website containing information on the Rural Hospital Flexibility Program and Critical Access Hospitals (CAH). Includes CAH eligibility requirements, application details and other related information. The website is maintained by the Minnesota Office of Rural Health and Primary Care.

Map 1

Critical Access Hospitals (CAHs) - Minnesota 2003



Source: Office of Rural Health & Primary Care

A complete list of CAHs can be found at:
<http://www.health.state.mn.us/divs/chs/rhpc/cah/mnhospitals.htm>