COOK COUNTY HOSPITAL DISTRICT
BOARD AGENDA
Thursday, March 21, 2024
9:00 a.m.
North Shore Health Board Room

1. **Call to Order**

2. **Recess to Closed Session (9:00 a.m.)**

3. **Closed Session:** The meeting will be closed as permitted pursuant to Minn. Stat. §145.64 subd. 1(d) to discuss decisions, recommendations, deliberations or documentation of a Review Organization; pursuant to Minn. Stat. §144.581, subd. 5, which permits closure to discuss contracts related to the Hospital's competitive position with other health care providers that offer similar services; and pursuant to. Minn. Stat. § 13D.05, subd. 2 to discuss not public medical data and pursuant to Minn. Stat. sec. 13D.05, subdivision 3 (a), to evaluate the performance of the hospital district's CEO/Administrator Kimber L. Wraalstad.

   Return to Open Meeting (9:30 a.m.)

4. **Roll Call**

5. **Board Presentation – Governance & Management for Health Care Boards –**
   Matt Anderson, JD – Atrede Consulting

6. **Public Comments** (10 minutes)

7. **Minutes of February 22, 2024**

8. **Updates:**
   a. Clinic Board
   b. County Board
   c. Board Members

9. **Financial Reports**
   - February 2024

10. **Old Business**
    a. Organizational Review Update
    b. Other

11. **New Business**
    a. Getting to Know North Shore Health, Monthly Article
    b. Other

12. **Management Report**
    a. Minnesota Hospital Association – A Primer on Minnesota Hospitals and Health Systems
    b. 2023 Financial Audit
    c. Amplification Devices
    d. Foreign Employee Recruitment
    e. Artist Reception
    f. Long-Term Care Imperative Advocacy Resources
    g. MHA 2024 Advocacy Areas
    h. Change Cyberattack
    i. American Hospital Association 2024 Rural Advocacy Agenda
    j. KFF Health News – Operating in the Red: Half of Rural Hospitals Lose Money, as Many Cut Service
    k. Wilderness Health Newsletter
    l. CONFIDE Services

13. **Next Meeting – Regular Meeting – Thursday, April 18, 2024 – 9:00 am**
    Schaap Community Center - 7401 Gunflint Trail, Grand Marais, MN

14. **Adjournment**

Community Access to Compassionate Care

COOK COUNTY HOSPITAL DISTRICT

BOARD MINUTES FOR FEBRUARY 22, 2024

Call to Order – Kay Olson called the meeting of the Cook County Hospital District Board of Directors to order on February 22, 2024 at 8:59 a.m. in the Board Room.

Adjourn to Closed Session – Mary Sanders made a motion to adjourn into closed session as permitted pursuant to Minn. Stat. §145.64 subd. 1(d) to discuss decisions, recommendations, deliberations or documentation of a Review Organization; pursuant to Minn. Stat. §144.581, subd. 5, which permits closure to discuss contracts related to the Hospital's competitive position with other health care providers that offer similar services; and pursuant to. Minn. Stat. § 13D.05, subd. 2 to discuss not public medical data. Steve Frykman seconded the motion and the motion carried unanimously.

Closed Session Summary - The Quality Improvement/Peer Review Report from January 17, 2024; the Medical Staff Report from January 17, 2024 and the February 21, 2024 Credentials Committee Report were discussed. The Board was provided information regarding cybersecurity events and communication with the Minnesota Board of Medical Practice.

Reconvene - The North Shore Health Board reconvened in regular session at 9:31 a.m.

Roll Call
Members Present: Steve Frykman, Kay Olson, Mary Sanders, Randy Wiitala and Patty Winchell-Dahl (remote via zoom). Ms. Winchell-Dahl is at the Grand Portage Community Center, 73 Upper Road, Grand Portage, which is open/accessible to the public.

Members Absent:

Others Present: Kimber Wraalstad, Troy Batchelor, Lori Ericson, Michele Silence, Jason Yuhas, Greg Ruberg and Community Members.

Approval of Agenda: Mary Sanders requested an additional item be added under New Business to discuss a microphone donation. Mary Sanders made a motion to accept the meeting agenda as modified; it was seconded by Steve Frykman. The motion carried unanimously.

Ms. Olson shared a change in process regarding questions from audience members. We, as a board, have been allowing the audience to ask questions during the meeting. In discussion with board chairs from other Hospital Districts, this is not something allowed. Going forward we ask that if you have questions to please submit them in writing to the CEO and/or Board chair. They can be emailed, mailed or dropped at the Registration Desk.

Public Comments: The following individuals provided public comments: Anne Deneen and Vicki Biggs on behalf of the Concerned Citizens for Cook County Healthcare, Steve Sande and Siri Anderson.

Approval of Minutes for January 9, 2024; January 18, 2024 and January 25, 2024 – Patty Winchell-Dahl made a motion to approve the minutes from the January 9, 2024; January 18, 2024 and January 25, 2024 meetings as presented and the motion was seconded by Mary Sanders. The motion carried unanimously.

Updates:

a. **Clinic Board:** Kate Surbaugh was unable to attend the meeting but shared a written summary of activities at Sawtooth Mountain Clinic (SMC). It was noted that Kristin DeArruda-Wharton, NP officially started at SMC on January 15. Welcome Kristin.

b. **County Board:** No report.

c. **Board Members:** Randy Wiitala congratulated Greg Ruberg on Lake View's recognition as one of the top 100 Critical Access Hospitals in the United States. Mary Sanders shared she purchased the book "Healthcare Leadership and Rural Communities" by Tim Putnam, Nikki King and Bill Auxier. Doug Sanders just completed the book and highly recommends it. Patty Winchell-Dahl expressed her gratitude for the assistance of the Care Center and Dietary staff for helping make Doris Blank's 100th birthday special. Ms. Olson suggested that the Board hold Board meetings in various locations throughout the County; similar to the process held during the building design. The members of the Board agreed that meetings should be rotated to different areas in the County.

Board Presentation – Human Resources, A Year in Review and Looking Ahead – Michele Silence

Ms. Silence presented the Year in Review and plans moving forward for the Human Resources Department. She shared information, addressed questions and provided clarification regarding the following:

- NSH Turnover rate – 19% compared with the national hospital employee turnover rate of 22.7% and high-rated nursing homes with an average turnover rate of 34%.
- Turnover by Reason
- NSH Staff Longevity
- Review Completion Rates – 95% in 2023 versus 77% in 2022.
- Introductions of Quarterly Reflections

- NSH Participation in Outside Organizations
- Earned Safe and Sick Time
- Short Term Disability Insurance
- NSH Benefit Package
- Educational Scholarship Program
- Immigration - Green Card Process
- Rural Healthcare Burnout Survey
- Culture and Gaps Survey
- Employee Engagement Survey – NSH has received quotes from two companies that were recommended by the Leadership and Development Educator at the Rural Wisconsin Health Cooperative: Press Ganey and Workforce Research Group.

After review of the information provided by Ms. Silence and discussion regarding the options for the employee engagement survey, Patty Winchell-Dahl made a motion to engage Workforce Research Group to conduct the employee engagement survey and the motion was seconded by Randy Wiitala. The motion carried unanimously

Financial Reports: Ms. Ericson presented the January 2024 financial statements. There was a Loss from Operations for the month of 299K. The Statements of Net Position, Statements of Revenue and Expenses and Change in Net Position were reviewed. Gross Patient Service Revenue for the month of $2.1M is 15.0% more than budget. Inpatient, Swing Bed, Outpatient and Home Care revenues are above budget with the Care Center being $10K under budget. Contractual Adjustments are $375K compared to the budget of $257K. Total Operating Revenue for the month of $1.755M is 9.82% more than budget. Total Operating Expenses of $2.054M are 3.11% less than budget. The days cash on hand, debt service coverage ratio, current ratio and payer mix were reviewed by Ms. Ericson. Steve Frykman made a motion to accept the January 2024 financial statements. The motion was seconded by Randy Wiitala and the motion carried unanimously.

Old Business:

a) **Organization Review Update:** NSH has received the culture survey from Dr. Bill Auxier and the AUXIER Group this week. The survey will be sent to all NSH staff, leaders, executives and the Board of Directors on Friday, February 23, 2024, with two weeks to complete the survey. The National Rural Health Association and Stroudwater is in the process of developing the engagement letter for the updated Strategic, Financial and Operational Assessment. It is taking longer to develop with the addition of the physician services evaluation.

b) **Other:** None.

New Business:

a) **2025 Ambulance Purchase:** Karla Pankow, North Shore Health EMS Director, discussed the fleet management program that has been developed for the ambulance service. In spring of 2023, members of the EMS Department began the research and planning process for a replacement ambulance as well as a remounting schedule for those rigs in the fleet that can be 'rebuilt' over time. Throughout the past year, the

group has met with various companies and brands, toured demo ambulances, and met with directors of other services. The current fleet consists of three, Type 3, 'box-style' ambulances that were reviewed in detail. As part of the fleet management program for 2024 and beyond, the EMS Department is now rotating the rigs to best accommodate the demands of 911 calls and transfers and to balance the wear and tear across the fleet. In planning for the future of the Department, there is consideration of the purchase of a new custom build, a Type 1, 4-wheel drive ambulance. This would be the first Type 1 and first 4WD in the fleet. The cost for a new replacement ambulance ranges from $250,000-$310,000. As supply and demand continues to impact the availability and pricing of new builds, the turn-around time on a replacement ambulance is currently at 530 days out from the time of a signed proposal. Approval is being requested to enter into a purchase agreement up to the amount of $310,000. This will be a 2025 capital budget item as no funds will be expended until delivery of the ambulance. Therefore, due to the extended delivery time this is not a 2024 unbudgeted capital equipment request, rather it is a commitment for 2025 capital budget. Grant opportunities will continue to be pursued as they have been in the past. Randy Wiitala made a motion to enter into a purchase agreement up to the amount of $310,000 for the purchase of a new custom build, a Type 1, 4-wheel drive ambulance. The motion was seconded by Steve Frykman and the motion carried unanimously.

b) **Microphone Donation:** At the request of Ms. Sanders, this item was brought for discussion. An anonymous donor has offered to purchase a microphone for use at the Board meeting. Ms. Olson stated that she has consulted with our IT coordinator and he is willing to look at the item being offered to see if it would work for North Shore Health. We are waiting for information about the microphone to review. There was a discussion about the value such a microphone might have in the space.

Management Report:
The Management Report for February 2024 included in the Board materials was reviewed. LeadingAge Minnesota held their 2024 Institute from February 7 – 9. North Shore Care Center sent five staff members (Veronica Heslop, Mary Tank, Vicky Tuorila, Kimber Wraalstad and Jason Yuhas) to the Institute. Congratulations was offered to Jason Yuhas on his graduation from the LeadingAge MN Leadership Academy Not only did Jason graduate, he was also invited to serve in the role of one of the coaches starting this year. Jason joins Kelly Swearingen, Kathy Bernier, Malorie Brazell, Kris Phillips and Sarah Groth who are graduates of the Leadership Academy. The LeadingAge Minnesota and the Long Term Care Imperative 2024 legislative priorities were reviewed: Financial Policy Reform, Workforce Solutions and Regulatory Reform. LeadingAge Minnesota is hosting their 2024 Day at the Capitol on Wednesday, March 20, 2024. Those willing and interested in participating at the Day at the Capitol should contact Kimber Wraalstad to be registered. The Minnesota Hospital Association (MHA) 2024 advocacy areas are as follows: Finance and Reimbursement, Workforce, Mental Health, Protect the 340B Program and Stop Bad Mandates. Cibola Health has officially begun the initial steps for the analysis of developing a Minnesota High Value Network. At this time, 17 members committed, along with a few hospitals who may yet join later in February. An information request has been sent to all members to begin to gather data to define High Value Network potential. Cibola Health will be scheduling individual meetings with each organization during the month of March. In December, North Shore Health was notified that UCare (Insurance Company) is moving all Medicare Certified Home Health Providers from the LUPA (Low Utilization Payment Adjustment) methodology to PDGM (Patient Driven Grouping Models) methodology. This will

have a negative impact to the reimbursement for service of Home Care clients with UCare Insurance. We continue to negotiate with UCare to receive a payment neutral contract. Employees who have any patient or resident contact may be required to wear personal protective equipment (PPE) including a respirator, such as an N95 face mask. Employees must be fit tested before they use a respirator for the first time and then once each year. Fit testing is the method for finding the respirator that fits the employee's face and making sure it provides a tight seal to help provide protection. During the next month, fit testing will be completed for the employees with patient or resident contact. An analysis completed by the American Hospital Association that "Hospitals are Critical to Preserving Access to Care for Rural Communities" was shared. A report from the Chartis Center for Rural Health noting that "Unrelenting Pressure Pushed Rural Safety Net Crisis into Uncharted Territory" was also shared. The report notes that rural health has been in crisis mode for years and the challenges are increasing as are the number of rural hospitals that have closed or that are "vulnerable to closure."

Adjourn:

A motion to adjourn the meeting was made by Mary Sanders and seconded by Steve Frykman. The motion carried unanimously. The next regular meeting will be held on March 21, 2024.

The regular meeting adjourned at 11:53 a.m.

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Chair **Clerk**

NORTH SHORE HEALTH
MANAGEMENT REPORT
March 2024

Minnesota Hospital Association – A Primer on Minnesota Hospitals and Health Systems: The Minnesota Hospital Association created a primer, Hospitals 101, as a resource for Hospitals to share with community leaders to provide information about the value hospitals and health systems to the local community and State of Minnesota. This document explains how Minnesota's hospitals and health systems are financed, educates about the many contributions of these organizations and explores current challenges that are impacting patients and potential solutions that are being explored. A copy of the primer is attached.

2023 Financial Audit: The audit team from Clifton Larson Allen (CLA) has been working on the audit fieldwork since March 4. As is the "new" norm, the fieldwork was completed offsite using remote access. The Auditors email requests for information with Lori Ericson and Kelly Swearingen responding to the requests within 24 – 48 hours. The presentation of the 2023 financial audit to the Board is still scheduled for the May Board meeting.

Amplification Devices: North Shore Health has purchased microphones and a speaker, together with several additional personal amplification devices, for use in the Board Room.

Foreign Employment Recruitment: North Shore Health continues our foreign recruitment efforts for employees. The Department of Labor submission of the prevailing wage documentation has been approved, applications from candidates have been received and interviews for Dietary and Housekeeping have been completed. It is now required that advertisements for these jobs be in the newspaper for two consecutive weeks and posted on websites for the Minnesota Department of Employment and Economic Development (DEED) for 30 days. The advertisements are very prescribed and that is why the recent employment ads look much different from the North Shore Health standard ad. At the end of the 30 days, applications will then be submitted for permanent resident visas to the United States Citizenship and Immigration Services. Once the applications have been submitted, we wait. The waiting time can be several years depending upon the visas available from the applicants' Country and the existing backlog.

Artist Reception: North Shore Health will be hosting an Artists' Reception on Monday, April 22, 2024 from 4:00 p.m. to 6:00 p.m. The Artists confirmed to participate include Carol Morgen, Jon Gunderson, Ladona Tornabene and Marie Zhuikov. The reception will give community members, Care Center residents and employees the opportunity to view the work, meet and speak with the Artists who are displaying their work. North Shore Health is grateful to the Artists for displaying their works that enhance the healing environment at North Shore Health.

Long Term Care Imperative Advocacy Areas: LeadingAge Minnesota and the Long Term Care Imperative continue to encourage Legislators to prioritize seniors and our caregivers during this session by:

- Supporting ongoing funding for older adults and their caregivers, and
- Removing regulatory barriers that prevent innovation and limit the ability to recruit and retain new caregivers.

Attached are documents that specifically highlight the key themes including workforce, wages, and regulatory barriers.

MHA 2024 Advocacy Areas: The Minnesota Hospital Association (MHA) continues to highlight needed legislative action:

- Hospital finances are in critical condition.
  - The most recent finance report from MHA shows that two thirds of hospitals and health systems had negative operating margins, declining from -0.5% to -2.7% in the first half of 2023.
  - Expenses are up - both labor and supply costs.
  - Payers are not keeping pace with inflationary cost increases. This includes both federal and state government payers and private commercial insurance. The Minnesota Department of Human Services recently calculated that Medical Assistance is paying, on average, 68.5% of the actual, 2019 costs, for inpatient hospital care. Previously proposed legislation would have brought Critical Access Hospitals up to 100% of costs and would have updated payments to more current costs for larger hospitals.
- Workforce initiatives need ongoing support to address systemic challenges.
  - There are 32,000 open health care positions in Minnesota. Initiatives for continued progress include:
    - Increase funding for health care professional loan forgiveness.
    - Work to change guidelines in the Dual-Training Pipeline program.
    - Expand health care career exposure initiatives such as the Summer Health Care Internship Program.
    - Push for new efficiencies at the Health Licensing Boards and expand the timeframes for temporary healthcare professional licenses.
    - Pursue scholarships for individuals enrolled in allied health professional education programs.
- Mental health services need funding to keep up with growing demand.
  - The ongoing demand for mental health care outpaces the supply of providers and services. Initiatives for continued progress include:
    - Increase mental health provider reimbursement rates, both inpatient and community based.
    - Eliminate the sunset on audio-only telehealth services in 2024 or 2025, before the sunset expires.
- Nurse staffing mandates jeopardize access to patient care in Minnesota.
- Protect the 340B outpatient drug program.

MHA continues to monitor legislation and advocate on behalf of hospitals and our patients.

Change Cyberattack: On February 21, 2024, Change Healthcare (Change), a subsidiary of Minnesota based UnitedHealth Group, was the victim of the most significant cyberattack on the United States health care system in American history. In a letter to Congressional Leadership, the American Hospital Association shared that "Change Healthcare is the predominant source of more than 100 critical functions that keep the health care system operating. Among them, Change Healthcare manages the clinical criteria used to authorize a substantial portion of patient care and coverage, processes billions of claims, supports clinical information exchange, and processes drug prescriptions. Significant portions of Change Healthcare's functionality have been crippled. As a result, patients have struggled to get timely access to care and billions of dollars have stopped flowing to providers, thereby threatening the financial viability of hospitals, health systems, physician offices and other providers." Change processes 1 in 3 healthcare claims in the United States. It has been estimated that the cash flow impact to Hospitals due to delayed claims ranges from $1.84 billion to $2.53 billion each week. North Shore Health has not been impacted to the same degree as experienced by many other hospitals and healthcare providers in Minnesota because Change does not provide our clearinghouse services. However, we do use Change to process our private pay statements and certain insurers, such as UCare, use a Change platform to accept insurance claims from providers. As with other providers, we are developing workarounds to address these interruptions.

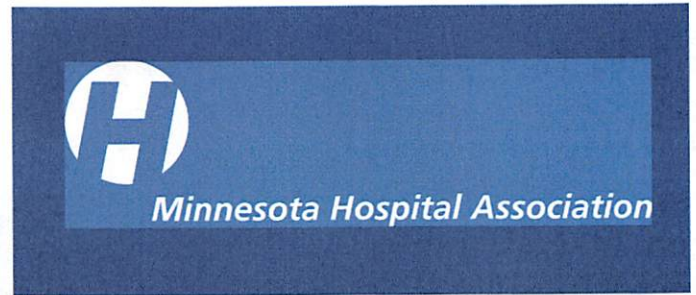
American Hospital Association 2024 Rural Advocacy Agenda: Attached is the American Hospital Association 2024 Rural Advocacy Agenda. The focus of the American Hospital Association's federal rural advocacy includes:

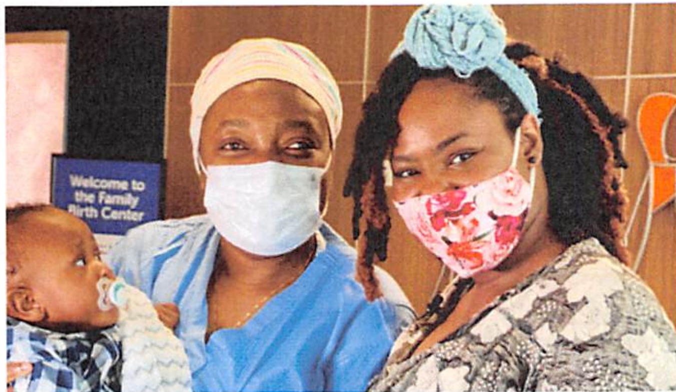
- Commercial Insurer Accountability
- Support Flexible Payment Options
- Ensure Fair and Adequate Reimbursement
- Bolster Workforce
- Protect the 340B Program

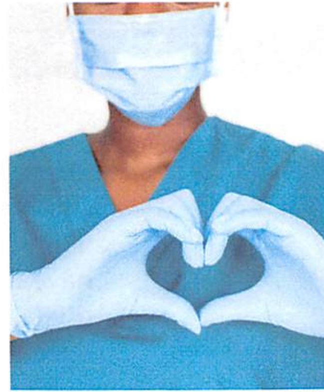
KFF Health News – Operating in the Red: Half of Rural Hospitals Lose Money, as Many Cut Service: On March 7, 2024, KFF published an article about challenges facing rural health care highlighting the data from the Chartis Center for Rural Health information shared last month. A copy of the article is attached.

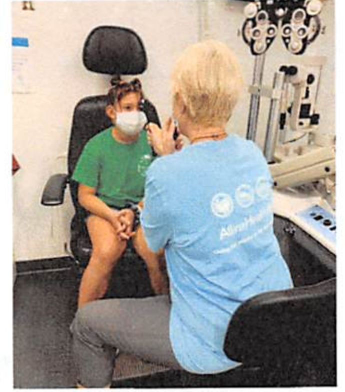
Wilderness Health Newsletter: Attached is the February 2024 Newsletter from Wilderness Health that provides a nice summary of just some of the programs and activities happening at Wilderness Health.

CONFIDE Services: The Minnesota County Insurance Trust (MCIT) Employee Assistance Program has established a service for elected officials of member organizations. It provides no-cost, confidential professional counseling specifically designed to aid elected leaders and their families. A copy of the CONFIDE brochure is attached.









HOSPITALS 101:

A Primer on Minnesota Hospitals and Health Systems

Minnesota's 141 hospitals and health systems are cornerstones of their communities, providing state-of-the-art care when and where patients need it most. This includes routine primary and preventive care, chronic care management, mental health services, emergency care, rehabilitation, and specialized and advanced treatments.

Hospitals and health systems are also a key component of the state's economy, with more than **127,000 employees** and **$10.9 billion** in payroll in 2021.

They also stand ready to respond to natural disasters and other emergencies, caring for 5,000 emergency department patients a day. There have been nearly 80,000 hospital stays related to the COVID-19 pandemic in Minnesota, so far.

Now, hospitals and health systems are facing significant financial, workforce, and capacity challenges. While caring for an aging population and meeting rising demand for mental health and substance use treatment, they are coping with record tight labor markets and soaring supply costs. All the while, hospitals and health systems are routinely paid well under the cost of care by both the state and federal government. At the same time, private payers are not keeping up with inflation.

In this primer, we explain how Minnesota's hospitals and health systems are financed, overview many contributions by hospitals and health systems to Minnesotans' health and communities, and explore current challenges and potential solutions.

Hospitals and health systems by the numbers

515,000

Inpatient stays annually

123 Emergency departments

OPEN

2m

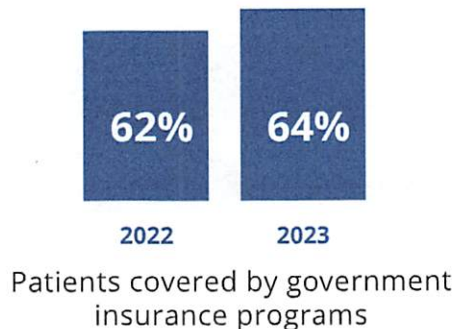
Patients treated annually in emergency departments

Minnesota has several large health systems and small community hospitals across our state. They care for about 515,000 individuals on an inpatient basis every year and have nearly 8 million outpatient visits. Hospitals are often the largest employer in a community, and statewide employ over 127,000 people.

Minnesota hospitals are the safety nets of their communities providing 123 emergency departments that are open 24 hours a day, 365 days a year, that treat 2 million patients annually.

This care is paid for with reimbursements from a mix of payers, including federal and state governments, insurance companies and patients themselves. The charges reflect the cost of room and board, inpatient and outpatient care, medications, supplies and host of other health care inputs. Hospital expenses are largely driven by salaries, wages, and benefits, accounting for over half of hospitals' costs, in addition to pharmaceuticals, supplies, high-tech equipment, facilities and maintenance costs.

In recent years, the gap between the costs of providing care and the actual payments to hospitals has widened alarmingly. Medicare, the federal program that covers people with permanent disabilities and seniors, has been reimbursing hospitals as much as 20% below the cost of care, leaving a $1 billion annual gap in Minnesota in 2021.



Patients covered by government insurance programs

Discharge Delays 2023

No payment for these patients

195,000

"Avoidable days"

$487 million

unpaid care

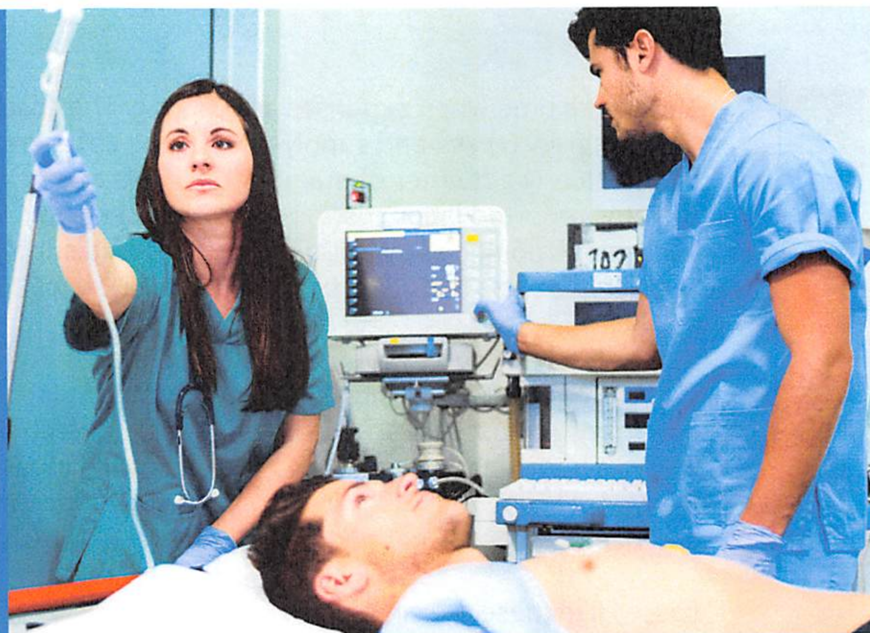
The state's Medicaid program, which provides health coverage for people with low incomes and the disabled, pays even less, about **27% below the cost of care**. That deficit amounted to $868 million in 2021.

Those shortfalls resulted in more than **$400 million in losses** reported in the first half of 2023 in a survey of more than 70 hospitals and health systems by the Minnesota Hospital Association.

Adding to the crisis are demographic changes that mean a growing share of hospital patients are covered by the Medicare and Medicaid programs. A survey found the mix of patients covered by government insurance programs grew from 62% to 64% in the last year alone. For several hospitals, this number has grown to more than 70% of their patient mix being enrolled in a government insurance program. This means a **higher base of patient care is delivered at reimbursements that do not cover the actual costs.** This is unsustainable.

Another factor affecting hospitals is the **inability to move patients ready for discharge to appropriate alternate levels of care such as nursing homes, transitional care units, rehab facilities, group homes, and residential treatment facilities.** Some patients are being housed in emergency department beds because they have been dropped off at a safety net hospital. Often these patients do not qualify for inpatient care. They would be more appropriately cared for in community support facilities.

According to surveys by the MN Department of Human Services and MHA, there were nearly **195,000 patient days of avoidable and unpaid care in just the first 10 months of 2023.** This patient gridlock not only reduces overall capacity for hospital care; it also cost Minnesota hospitals and health systems an estimated $487 million in unpaid care.



This is at a time when expenses are soaring. The costs of labor grew by 7%, and supply and service costs grew by 6%. Nearly a quarter of member hospitals and health systems reported labor costs rising by double digit percentage points, and a third of hospitals said supply and service costs had risen by more than 10% over 2022.

This year's MHA survey found the median margin for the first half of 2023 stood at a negative 2.7%. In fact, two thirds of hospitals and health systems in the MHA analysis had negative operating margins, which means they were losing money. This is up from 55% of hospitals and health systems that had negative margins in 2022.

Losses like these are simply unsustainable. If they continue, Minnesotans will see serious cuts in services at their local hospitals, longer wait times for outpatient procedures, longer waits in emergency departments, and even potential closures.

The costs of labor grew by

7%

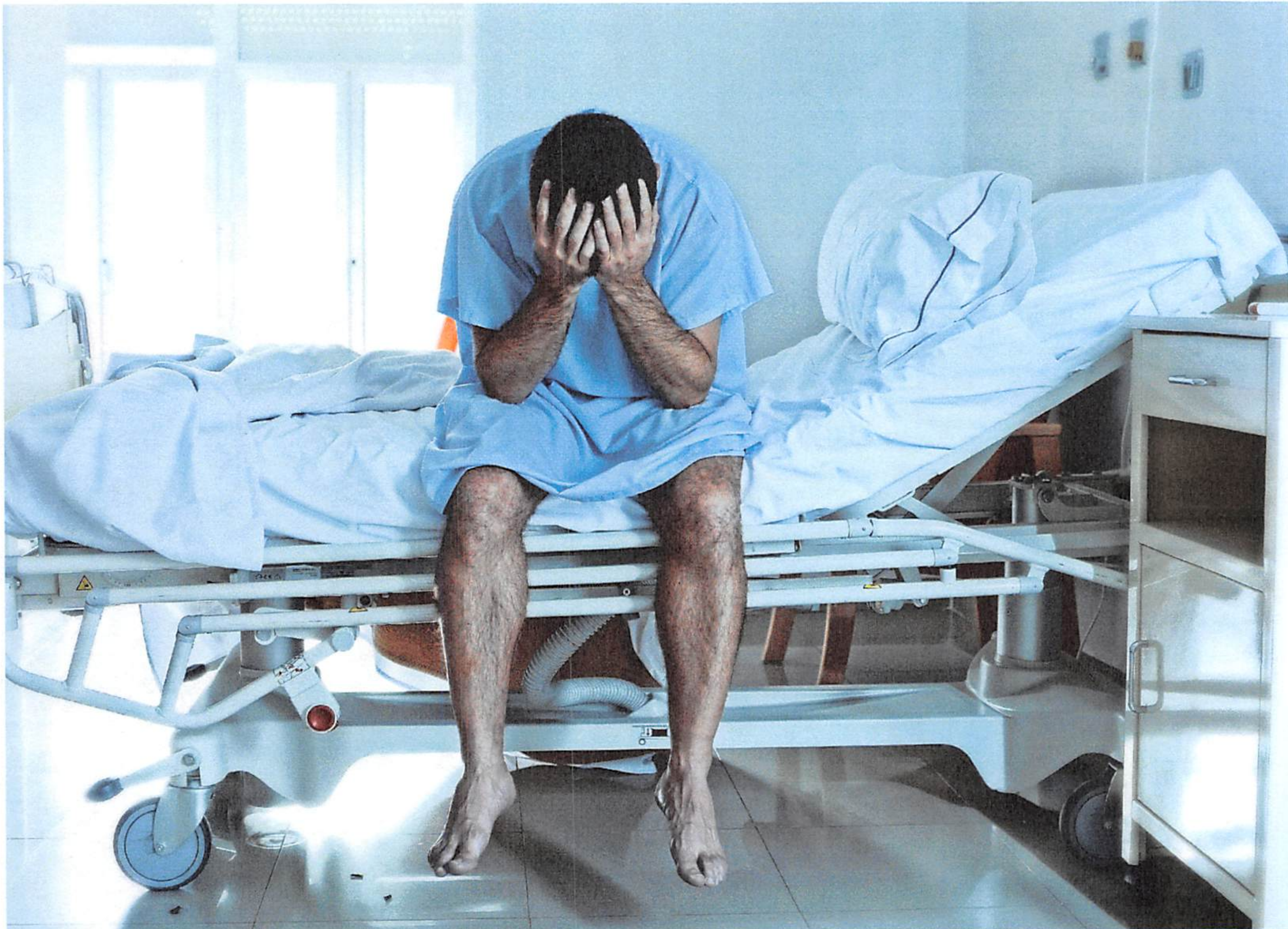
Supply and service costs grew by

6%

Operating margins have dropped from

-0.5% in 2022 to

-2.7% in 2023



Minnesota hospitals and health systems have also made historic investments in tracking and improving the quality of care. In 2005, Minnesota became the first state to publicly report adverse health events, by hospital. Today hospitals routinely report data on key indicators of the quality of care such as preventable readmissions, complications, delivery of timely and effective care, and more. In 2021, the federal Agency for Healthcare Research and Quality ranked Minnesota among the best states for health care quality. Hospitals are working together to build a culture of safety and adopt the latest advancements to promote the health of all Minnesotans.

Nurse Anesthetist "Stops the Line" to Ensure Safety

One example of hospital efforts to improve safety and quality was recognized last year with a Minnesota Hospital Association "Good Catch" Award.

Nurse anesthetist Joshua Scharback, of Children's Minnesota, was preparing a tranexamic acid bolus and infusion for a child's cranioplasty. Joshua noted an issue with the infusion rate and put into practice the error prevention technique known as STAR: Stop, Think, Act, and Review. He paused the procedure, worked with his team to consult references and literature, and called a pharmacist and surgeon to confirm the correct infusion rate.

Workforce trends

All this is happening amid historic changes in the labor market.

The disruptions and stress of the pandemic prompted some health care workers to leave the hospital setting, go to another hospital setting, resign, work part-time, or retire, adding to long-standing workforce shortages in Minnesota and across the country. Shortages extend beyond physicians and nurses to other crucial roles, including mental health clinicians, lab tech professionals, and others. The workforce challenges aren't only due to the pandemic, nor are they short-term issues. More than half of nursing staff, for example, are only working part time. The retirement of the baby boomer generation will also increase demand for care, just as more health care workers are retiring, and becoming patients themselves. Nearly 20% of Minnesota's job openings in 2022 were in health care.

Potential state-imposed nurse staffing mandates could make this situation even more difficult, by adding cost, reducing flexibility, and limiting innovation, like new automation technologies. All these factors may also have an inevitable effect: cutting hospital capacity and care to meet a state mandate.

Without a robust workforce, the capacity to care for our communities is threatened. Staffing shortages throughout the health care sector have both immediate and multiplying effects. Staffing shortages threaten to limit access to critical care for Minnesotans."

Minnesota Hospital Association
President and CEO
Rahul Koranne

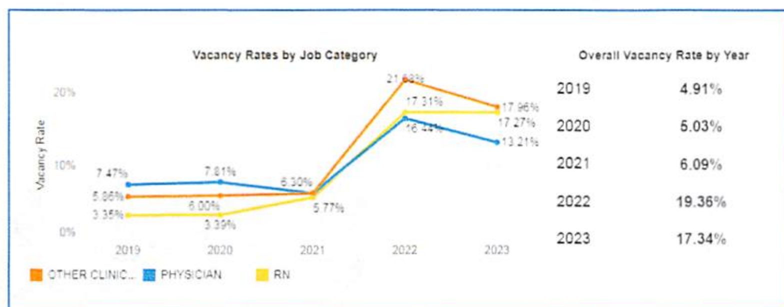
Hospital leaders are focused on building a strong health care workforce by increasing salaries and offering flexible schedules, bonuses, tuition reimbursement, and other incentives. They are also partnering with high schools, colleges, and medical schools, to build a pipeline of health care professionals. Wallethub, a personal finance research company, listed Minnesota as the third best state in the country for nurse salaries this year, adjusted for cost of living.

Some of these efforts are paying off: in 2023, there was a 10% decrease in hospital job vacancy rates from the previous year. Still, vacancy rates in the most recent workforce data were 17% — two-and-half-times greater than in 2019.

Vacancies

Despite a **10% decrease** in vacancy rates since report year 2022, vacancy rates remain critically high at 17% for report year 2023 - a **253% increase** since report year 2019.

Continued burnout and stress from the COVID-19 pandemic and changing demographics are just some of the factors that contribute to the high vacancy rates in Minnesota and across the nation. MHA is working diligently with its members to address key factors in vacancy rates to ensure that all Minnesotans have access to the care they need when they need it - now and into the future.



Trend chart: Vacancy Rates by Job Category

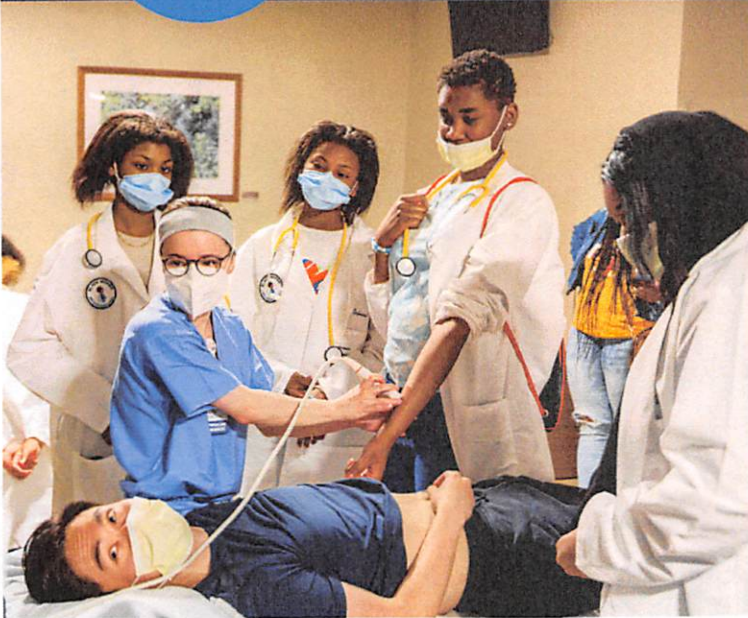
2023 Workforce Report | Tableau Public

The Summer Health Care Internship Program — administered by the Minnesota Hospital Association on behalf of the Minnesota Department of Health — gives students across the state opportunities to gain firsthand experience working in hospitals, clinics, and long-term care facilities.

Legislative attention and funding are needed to bolster and grow the state's health care workforce. This includes raising reimbursement rates for Medicaid and Medicare to create sustainable public programs. Potential solutions include:

- Increased funding for loan forgiveness and scholarships for students in all areas of health care, including allied health professionals.
- Significant investment to build the health care workforce pipeline, including programs for career laddering, inspiring, and exposing students to health care careers at an earlier age.
- Accelerated entry into the professional workforce by simplifying the administrative processes at the health care licensing boards, especially the Board of Nursing.

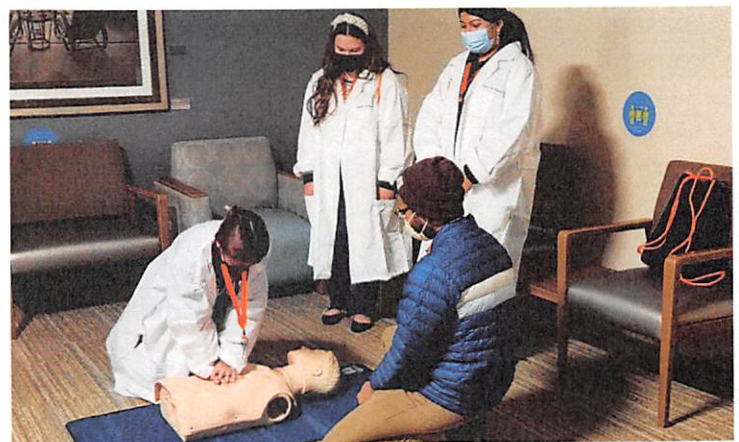
Reflecting Minnesota's diversity



In 2022, more than 296 youth participated in summits at Hennepin Healthcare, in Minneapolis. The summits — Black Men with Stethoscopes, Black Women with Stethoscopes, Latino Youth with Stethoscopes, and the Summer Talent Garden Youth Internship Program — give young people hands-on experiences in health care careers.

One encouraging trend is that Minnesota's health care workforce is becoming increasingly diverse. The number of Black, Indigenous, and other people of color working in health care increased 6.5% from 2022 to 2023 — and by 84% since 2017. These trends are playing out in cities, and rural parts of the state.

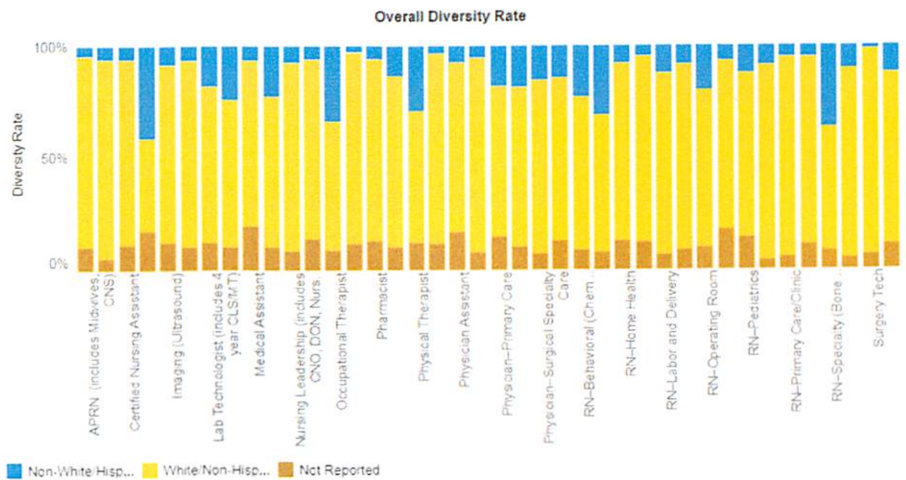
Hospitals across the state are also responding to calls from their staff and patients to identify and reverse racial inequality and bias in health care.

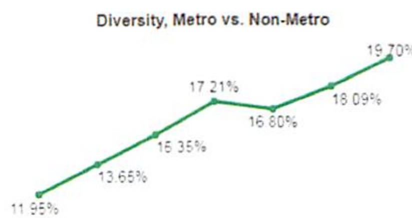


Diversity

In addition to a **9% increase** in the diversity of metro-area health care workers to **20%** in report year 2023, non-metro (outside the 13-country metro area) diversity grew **14%** in report year 2023 and a massive **124%** from report year 2019.

Certified Nurses Assistants (CNAs) are the most diverse job category with approximately **41%** identifying as BIPOC - followed by Rehabilitation Registered Nurses at **36%** and Nursing Station Technicians **34%.**





Diversity Charts
2023 Workforce Report | Tableau Public

Rural hospitals

While Minnesota is home to large health systems, much of the state is rural. 78 of the state's 141 hospitals are critical access hospitals, small rural hospitals (with 25 or fewer beds), generally located 35 miles from another hospital. In an effort to shore up the finances of rural hospitals and ensure access to essential health care, the federal government created the critical access hospital designation in 1997. These hospitals receive cost-based reimbursement for Medicare services and other benefits.

As the name suggests, critical access hospitals often care for patients throughout their lives, providing essential services that would otherwise be hours away.

Despite this federal program, rural hospitals in Minnesota and around the country are struggling; six in Minnesota have shut their doors since 2005, part of a years-long wave of 199 rural hospital closures across the country. Often, rural hospitals struggle because of twin challenges: not only are they more dependent than other hospitals on public payers, which pay lower rates, they are also often unable to negotiate adequate reimbursements from private payers due to low volume and lack of bargaining power. They also have even more challenging workforce issues than large systems. Still, many are responding by extending their reach and their access to expert care through telehealth.

Prescription medication affordability

Since 1992, the 340B Drug Pricing Program has provided financial help to safety-net hospitals and clinics to manage rising prescription drug costs and preserve access to needed health care services in communities. Under the 340B program, pharmaceutical manufacturers participating in Medicaid are required to sell outpatient drugs at discounted prices to eligible health care organizations that care for a significant percentage of uninsured and low-income patients. A patient's health insurance status and income level does not affect a hospital or health system's ability to access 340B discounted medications. If the hospital or health system's overall patient population meets the 340B requirements, discounts are available for all eligible outpatient drug purchases. The 340B program also helps offset Medicaid underpayments and exorbitant prices from pharmaceutical companies.

Nearly 100 Minnesota hospitals participate in and rely on this program, as do federally qualified health centers, the Ryan White HIV/AIDS Program, and Planned Parenthood.

Mental and behavioral health demand continues to grow and impact other care

Another major challenge to health care in Minnesota is the sharp rise in demand for mental and behavioral health care.

Over the past decade, visits to Minnesota's emergency departments for issues related to mental health and substance use increased a staggering 77%. There are not nearly enough mental health and addiction treatment providers — nine of Minnesota's 11 geographic regions are designated as mental health professional shortage areas by the Health Resources and Services Administration. Too often, this means people can't find help they need, fall into crisis, and wind up in emergency departments. And because of the scarcity of community mental health providers, hospitals struggle to find other, more appropriate care for these patients, driving up costs and making acute care beds unavailable for others.

Minnesota needs a system of mental health and addiction treatment, with accessible services, including telehealth and community clinics, that keeps people out of crisis. Increased reimbursement could also improve recruitment of mental health providers, as would state and federal investments in training programs.

Hospital gridlock

Lack of mental and behavioral health services is also one of the causes of another major challenge facing hospitals: discharge delays. Those happen when a patient is no longer in need of acute medical care and would be better cared for in another community setting.

For example, emergency departments are boarding adolescents with mental health challenges and violent behaviors because there is no room for them in other care facilities. Other patients in Minnesota hospitals are no longer in need of round-the-clock hospital care, but can't find a bed in a nursing home, rehabilitation facility, or other services.

Surveys by the Minnesota Hospital Association and the Minnesota Department of Human Services in 2023 found more than 195,000 days of unnecessary hospital care. This patient gridlock not only reduces overall capacity for hospital care; it also cost Minnesota hospitals and health systems an estimated $487 million in unpaid care.

Building healthy communities and bolstering local economies

Almost all Minnesota hospitals are not-for-profit or government-run institutions that pursue a mission to provide care to all residents, regardless of their ability to pay. Every three years, nonprofit hospitals conduct community health needs assessments that explore their communities' assets and identify unmet needs. Hospitals then develop plans to meet those needs in partnership with nonprofit organizations, schools, and other community leaders.

Health care is also one of Minnesota's economic engines, contributing $39 billion in 2021. It is the largest private-sector source of jobs, directly employing more than 127,000 people and employing another 105,000 people in jobs tied to health care. Particularly in Minnesota's many small towns, hospitals are often the largest employers in their communities.

Providing care to all

2021 community benefit data

$3.4 BILLION

$162M
Charity Care

$837M
Cost in excess of government Medicaid payments

$493M
Unrecoverable Debt

$61M
Community Services

$4.06M
Community Building

$164M
Medicaid fee paid by hospitals to the state

$142M
Subsidized Health Services

$1B
Cost in excess of government Medicare payments

Seismic demographic changes in Minnesota's workforce, overwhelming demand for mental and behavioral health care and the long lasting impact of the COVID pandemic have brought unprecedented challenges to the state's hospitals. While they have a history of providing some of the best care in the nation, they also cannot continue down the current financially unsustainable path. They will require innovation, realistic reimbursement by public and private payers and the continued dedication of tens of thousands of medical professionals. The health of Minnesotans depends on it.

You can find out more from the Minnesota Hospital Association at http://www.mnhospitals.org

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HELP STRUGGLING MINNESOTANS.
SUPPORT CARE FOR SENIORS.

Minnesota's long-term care sector has reached a critical point. The state's senior population continues to rise while we face an ongoing and severe workforce shortage, making it increasingly difficult for seniors to find care where they live.

Today, 17,000 caregiver positions in our senior care settings remain unfilled, with one in five nursing homes reporting that they have vacant positions.

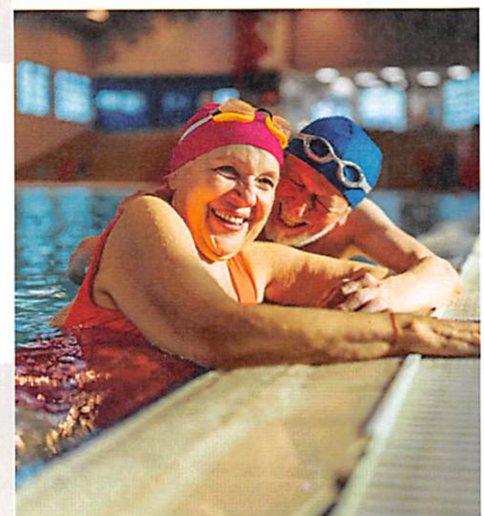
In 2023, the Minnesota Legislature invested $300 million in one-time nursing home funding. This critical funding has helped to temporarily preserve access to care for older adults across Minnesota. However, the state continues to underinvest in our seniors – even as demand for care continues to rise.

Minnesotans Agree – Care Comes First

Every senior in Minnesota deserves access to the housing, care and support that they need in their home communities. Likewise, caregivers in nursing homes and assisted living facilities deserve wages that reflect the challenging work they do.

The State of Minnesota is our partner in caring for our one million seniors. Permanent and comprehensive funding increases will help secure access to care for older adults in every corner of the state.

87% of Minnesotans agree that seniors have a right to basic housing, care and support.



Addressing the Workforce Crisis

Our workforce is filled with compassionate and selfless individuals who provide incredible care for our seniors. These skilled professionals deserve better pay for the demanding work they do. Many caregivers are leaving long-term care for higher-paying, less stressful jobs.

In January of 2024, assisted living settings reported that 15% of caregiver positions remain vacant.

The State's Responsibility to Ensure Access to Care

As care options continue to disappear across Minnesota due to workforce shortages, families are making incredible sacrifices to care for their older loved ones. Asking our seniors or their families to travel an hour or more away to find care is unacceptable. The state must ensure families and communities can remain whole.

In long-term care, wages are directly affected by the state's role in reimbursing providers. State leaders set reimbursement rates for care. The current rates do not provide enough money for caregivers to make a family-sustaining wage.

In addition, outdated data means that senior care settings are receiving payments that do not reflect current costs to provide care. Unless the state increases funding and makes long-overdue updates to the payment system, senior care leaders cannot recruit and retain the caregivers needed to provide Minnesota seniors with the care they need.

To address the workforce crisis, support caregivers and improve access to care for older adults in their home communities, our legislative priorities this year include:

Expanding and accelerating workforce pipelines to aging services careers. HF3979 / SF4235

Addressing financial payment problems such as the 21-month reimbursement delay for nursing homes and outdated wage data benchmarks for Elderly Waiver rates. HF3390 / SF4547

Seeking legislative funding for a pay increase for nursing home workers resulting in $25/hour by 2025. HF3391 / SF4130

Improving the accountability, quality, safety and training of supplemental agency/temporary staff.

Regulatory simplification, administrative relief for assisted living providers and ensuring that LPNs are able to work to the top of their scope (144G). HF2080 / SF1969

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RAISE SENIOR CAREGIVER WAGES.
IMPROVE ACCESS TO CARE.

Minnesota's senior population is growing while care options for older adults in the communities they call home continue to disappear. Nearly 20 percent of caregiver positions remain unfilled, causing seniors to be turned away from the care they need. Minnesota families are making incredible sacrifices to care for our seniors. **We must ensure that families and communities remain whole.** The State of Minnesota is our partner in caring for our one million Minnesota seniors. Permanent and comprehensive funding increases will help secure access to care for older adults in every corner of the state.

THE CHALLENGE

Caregivers are leaving long-term care for higher-paying, less stressful jobs.

The senior care workforce is filled with compassionate and skilled professionals who provide incredible care for seniors. But long-term care providers have an increasingly difficult time recruiting and retaining quality staff due to inadequate state funding.

Without state investment to permanently raise wages for caregivers, staff shortages will persist, and seniors will continue to be turned away from care they need.

THE SOLUTION

$25 by 2025

A $52 per day rate increase for nursing homes will provide caregivers with family-sustaining wages. This proposal requires nursing facilities to develop a distribution plan and post a plan summary for staff, and funding received will be audited by the Minnesota Department of Human Services.

Caregivers deserve family-sustaining wages. Raising wages for workers in nursing facilities by $5/hour would, on average, raise caregiver wages from $20 per hour to $25 per hour.

THE CHALLENGE

Elderly Waiver rates lag five years behind.

Elderly Waiver (EW) is a state program that provides various care options for seniors ages 65+ who are eligible for Medical Assistance. **Though the Legislature invested in a better payment framework for EW, the 2023 legislation locks important comparison benchmarks to 2017 wage data.**

Currently, Elderly Waiver rates do not have an updating function. They are the only Medicaid waiver that does not.

THE SOLUTION

Automatic rate updates

This proposal directs the Minnesota Department of Human Services to annually update the wage data used to calculate Elderly Waiver rates.

Automatic Rate Updating for Elderly Waiver will help ensure that caregiver wages are responsive to labor market demands and help ensure access for Medicaid beneficiaries.

THE CHALLENGE

Reimbursement rates for nursing home care are delayed 15 to 27 months.

Senior care providers face obstacles due to delayed reimbursement from Minnesota state.

Nursing home providers must wait for 15-27 months for payments that cover the actual cost of care provided to residents.

THE SOLUTION

Reduce the impact of the reimbursement delay by accounting for inflation.

The application of a known cost change factor to the audited and allowable nursing facility costs incurred 15 to 27 months prior to their use for establishing rates will incent and reward nursing facility investment.

Nursing facilities spend money on staff that is not reimbursed by the government for 15-27 months. This proposal will add an inflation factor that covers the period between cost report and rate attainment.

REAL STORIES. REAL IMPACT.

SARAH WIELAND
Caregiver at Oak Hills Living Center in New Ulm, MN

"There are times I am unsure if I'm going to be able to put food on the table for my kids. Or if I am going to be able to put gas in my car to get here. I'm a single mom. I have two kids. I don't get a lot of help."

Support $25 by 2025 to help raise wages for caregivers like Sarah and ensure every Minnesota senior has access to care when they need it.

"It's very important to be able to stay in a community with family close by so that you're able to do things with them, visit with them... I've known people that have had to leave from their families and it really affects them emotionally and physically because they don't have that contact with their family members."

NANCY SALO
Senior resident at St. Clare Living Community in Mora, MN

Support Automatic Rate Updating for Elderly Waiver and an inflation factor for rate reimbursement to help ensure every Minnesota senior like Nancy can access the care they need in the places they call home.

REMOVE WORKFORCE BARRIERS.
IMPROVE ACCESS TO CARE.

Across Minnesota, the pervasive workforce shortage in senior care is limiting access to care for our state's most vulnerable residents. Today, 17,000 caregiver positions remain unfilled, causing seniors to be turned away from the care they need.

In addition to investing in family-sustaining wages for caregivers, expanding career opportunities will attract more people to the caregiving profession.

The State of Minnesota is our partner in caring for our one million Minnesota seniors. Removing workforce barriers will help build the workforce needed to secure access to care for older adults in every corner of the state.

THE CHALLENGE

Foreign-Trained Nurses Face Progression Obstacles

Foreign-trained nurses who desire to be trained as a Medication Aide can only obtain training from a higher education institution.

Training opportunities are expanding for domestically-trained staff and nurses, and Minnesota should not create a two-tier system for people seeking this training.

THE SOLUTION

Equal Progression Opportunities for Foreign-Trained Nurses

Foreign-trained nurses bring valuable skills and expertise and can fill positions as the workforce shortage continues in senior care. Prioritizing equal opportunity for progression for foreign-trained nurses benefits Minnesota's diverse talent pool and strengthens our health care system.

Ensure there is equal opportunity for progression for foreign-trained nurses. Allow all nurses and staff to equally access TMA programs approved by the Dept. of Health.

THE CHALLENGE

Language Barriers Impact ELL Caregiver Candidates

Certified Nursing Assistant (CNA) applicants must pass a written exam and a skills exam. MDH currently does not provide the written exam in languages other than English.

Due to language barriers, it is difficult for English language learners to pass the written exam.

THE SOLUTION

Equal Testing Opportunities for ELL Caregiver Candidates

Minnesota's workforce needs require solutions that consider the changing demographics of our talent pool.

Require accommodation for the written exam to be available in languages other than English.

REAL STORIES. REAL IMPACT

JOHANNA KEGG
CO-OWNER VIDA:
VITAL INTERPRETING DELIVERING ACCESS
Long Prairie, MN

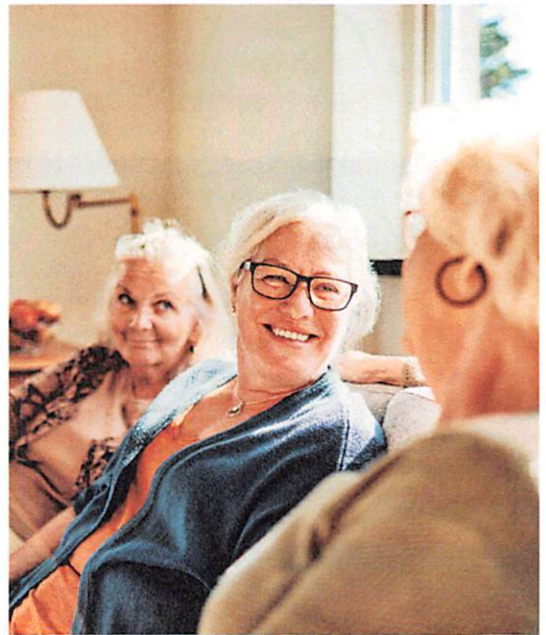
ELIZABETH QUILLO
CO-OWNER VIDA:
VITAL INTERPRETING DELIVERING ACCESS
Long Prairie, MN

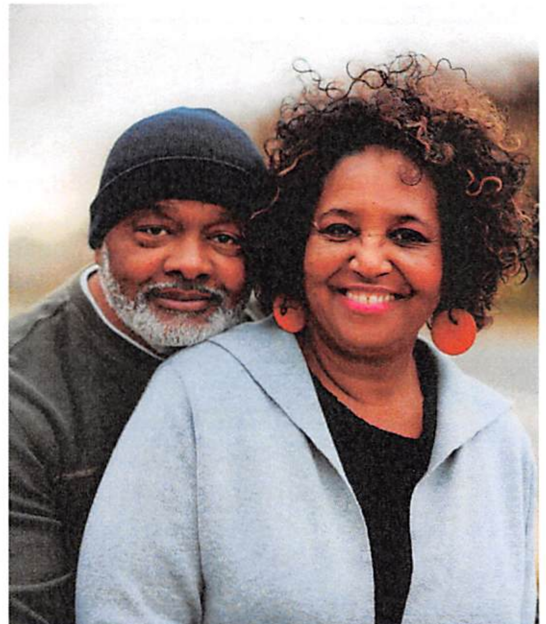
"THERE ARE ENTIRE COMMUNITIES ACROSS MINNESOTA WHO ARE FACING LANGUAGE BARRIERS TO BOTH ACCESSING AND PROVIDING CARE. WE WORK DIRECTLY WITH ELDERS IN THE COMMUNITY WHO ARE UNABLE TO FIND CAREGIVERS WHO SPEAK THEIR LANGUAGE AND WITH INDIVIDUALS WHO ARE SEEKING TO ENTER THIS WORKFORCE BUT ARE UNABLE TO DO SO AS A RESULT OF THE LANGUAGE RESTRICTIONS ON THE TESTING REQUIREMENTS. THESE ARE MINNESOTANS, THESE ARE FAMILY MEMBERS, THESE ARE MEMBERS OF OUR COMMUNITY WHO HAVE EARNED A RIGHT TO CARE."

"IT'S REALLY HARD TO RECRUIT AND RETAIN GOOD PEOPLE. I KNOW THAT THERE'S PEOPLE WHO WOULD LOVE TO BE A CAREGIVER BUT THEY CAN'T AFFORD TO RAISE A FAMILY ON THIS SALARY—THEY CAN GO DOWN THE STREET TO STATE FARM OR MCDONALDS OR WALMART AND RECEIVE HIGHER WAGES."

CANDAS SCHOUVIELLER
ADMINISTRATOR AT OAK HILLS LIVING CENTER
New Ulm, MN

Support **equal progression opportunities** and equal testing opportunities to help caregivers like Johanna, Elizabeth and Candas ensure every Minnesota senior has access to care when they need it.





REGULATORY ADJUSTMENTS
TO BEST SERVE OUR SENIORS

The Long-Term Care IMPERATIVE
A Minnesota Collaboration for Changes in Older Adult Services

Minnesota's seniors deserve access to safe, quality care that meets their individual needs. As caregivers, we know those we serve well and pride ourselves on the person-centered care we provide for everyone who walks through our doors.

To meet these needs, we must find a way to balance the regulatory requirements that ensure standards are met, while delivering timely, person-centered and affordable care, given our significant workforce shortages. As those directly responsible for care, we urge the state to consider regulatory changes that will improve the care we're able to provide.

THE CHALLENGE

Little Recourse for Bad Actors

One of the key realities of our workforce shortage is that facilities are provided temporary staff by SNSAs. When these temporary staff act negligently, there is currently no recourse to recover penalties resulting from their actions.

THE SOLUTION

"Must"

With a simple language change, providers will have the option to sue the SNSA to recover civil monetary penalties for negligently assigning a SNSA staff who is insufficiently trained or incompetent, deterring bad actors and providing financial relief for settings seeking to keep their seniors safe.

THE CHALLENGE

Limitations on Scope of Practice for our Licensed Practical Nurses (LPN)s

LPNs cannot practice to their full scope due to statutory barriers in 144G, even though they can perform similar tasks in other health care settings. This limits their contributions, which further hinders our capacity to care for seniors amidst a severe statewide RN workforce shortage.

THE SOLUTION

Allow LPNs to Work to Their Training and Scope

Allowing LPNs to work to the top of their scope by doing focused assessments, as they can already do in other health care settings, maximizes the care and service experience for those we serve.

REAL STORIES. REAL IMPACT

ROBBIE STANGELAN
LPN AT GOOD SAMARITAN SOCIETY-ALBERT LEA ASSISTED LIVING
Albert Lea, MN

"I AM TRAINED AND CERTIFIED TO PERFORM A NUMBER OF PATIENT-CENTERED ACTIVITIES TO HELP OUR SENIORS. WITH THE CURRENT STAFFING SHORTAGE, WE NEED TO MAXIMIZE ALL AVAILABLE SUPPORT IN CARING FOR OUR SENIORS. CURRENTLY, I'M BEING RESTRICTED NOT DUE TO MY SKILLS OR CERTIFICATION BUT BASED ON TECHNICALITIES. I WANT TO HELP BUT MY HANDS ARE TIED. WE OWE IT TO OUR SENIOR COMMUNITY TO MAKE THIS CHANGE."

"WE NEED MORE SUPPORT FROM THE PEOPLE IN HIGHER POSITIONS TO ENABLE US TO PROVIDE AND HELP OUR RESIDENTS MAINTAIN A QUALITY OF LIFE THAT IS RESPECT-ABLE TO WHO THEY ARE. TO HAVE US OPEN, TO HAVE US HERE AND AVAILABLE TO THE COMMUNITY IS AN ASSET BECAUSE WE HAVE AN OLDER COMMUNITY."

ROBIN JANOUSEK
RN AND MINIMUM DATA COORDINATOR FOR ST. CLARE LIVING COMMUNITY
Mora, MN

Support **making a simple language change and allowing LPNs to work to the top of their scope** to help caregivers like Robbie and Robin ensure every Minnesota senior has access to care when they need it.

2024 Rural Advocacy Agenda

American Hospital Association™

Advancing Health in America

Rural hospitals and health systems are committed to ensuring local access to high-quality, affordable health care. However, these hospitals continue to experience ongoing challenges that jeopardize their ability to provide local access to care and essential services. These include continued workforce shortages, emerging challenges posed by commercial and Medicare Advantage plans, soaring costs of providing care, severe underpayment by Medicare and Medicaid, and an overwhelming regulatory burden.

The AHA continues to work with Congress and the Administration to enact policies to support rural hospitals. We also are working to support a public policy environment that will protect access to care, advance innovation and invest new resources in rural communities.

Commercial Insurer Accountability

Underpayment by commercial insurance plans and systematic and inappropriate payment delays for medically necessary care are putting patient access to care at risk.

Cost-based Reimbursement for Critical Access Hospitals (CAHs) from Medicare Advantage (MA) Plans. Congress created a special statutory payment designation for CAHs in recognition of the unique role they play in preserving access to health care services in rural areas. As certain MA plans in rural communities rapidly grow, there is an erosion of this important financial protection. A greater portion of a CAH's revenue will be subject to negotiations with MA plans that often result in below-cost payment terms and involve onerous plan requirements that contribute to administrative burden, unnecessary delays and denials in approving and paying for patient care, and additional strains on the health care workforce. **We support legislation to ensure CAHs receive cost-based reimbursement for MA patients.**

Prompt Pay. Ensure prompt payment from insurers for medically necessary, covered health care services delivered to patients. **We support policies to increase oversight and accountability of health plans including establishing more stringent standards for timely payment** to address certain insurer tactics to delay and deny payment to health care providers.

Prior Authorization. Hold commercial health insurers accountable for ensuring patients have timely access to care, including by reducing the excessive use of prior authorization, ensuring expeditious prior authorization decisions, and eliminating inappropriate denials for services that should be covered. Insurers must also be held accountable for applying prior authorization requirements in ways that contribute to clinician burnout so that clinicians can focus on what matters most: patients. **We support building on recent regulations and legislation that further streamline and improve prior authorization processes.**

Support Flexible Payment Options

As the health care field continues to change at a rapid pace, flexible approaches and multiple options for reimbursing and delivering care are more critical than ever to sustain access to services in rural areas.

Medicare-dependent Hospital (MDH) and Low-volume Adjustment (LVA). MDHs are small, rural hospitals where at least 60% of admissions or patient days are from Medicare patients. MDHs receive the inpatient prospective payment system (IPPS) rate plus 75% of the difference between the IPPS rate and their inflation-adjusted costs from one of three base years. **AHA supports making the MDH program permanent and adding an additional base year that hospitals may choose for calculating payments.** The LVA provides increased payments to isolated, rural hospitals with a low number of discharges. **AHA also supports making the LVA permanent.** The MDH designation and LVA protect the financial viability of these hospitals to ensure they can continue providing access to care **(S. 1110 / H.R. 6430).**

Rebasing for Sole Community Hospitals (SCHs). SCHs must show they are the sole source of inpatient hospital services reasonably available in a certain geographic area to be eligible. They receive increased payments based on their cost per discharge in a base year. **AHA supports adding an additional base year that SCHs may choose for calculating their payments (S. 1110).**

Necessary Provider Designation for Critical Access Hospitals (CAHs). The CAH designation allows small rural hospitals to receive cost-based Medicare reimbursement, which can help sustain services in the community. Hospitals must meet several criteria, including a mileage requirement, to be eligible. A hospital can be exempt from the mileage requirement if the state certifies the hospital as a necessary provider, but only hospitals designated before Jan. 1, 2006 are eligible. **AHA urges Congress to reopen the necessary provider CAH program to further support local access to care in rural areas (H.R. 1128).**

Rural Emergency Hospital (REH) Model. REHs are a new Medicare provider type that small rural and critical access hospitals can convert to in order to provide emergency and outpatient services without needing to provide inpatient care. REHs are paid a monthly facility payment and the outpatient prospective payment system (OPPS) rate plus 5%. **AHA continues to support strengthening and refining the REH model to ensure sustainable care delivery and financing.**

Ensure Fair and Adequate Reimbursement

Medicare pays only 82 cents for every dollar spent caring for patients, according to the latest AHA data. **Given the challenges of providing care in rural areas, reimbursement rates across payers need to be updated to cover the cost of care.**

Telehealth. The pandemic demonstrated telehealth services are a crucial access point for many patients. AHA supports legislation to make permanent coverage of certain telehealth services made possible during the pandemic, including lifting geographic and originating site restrictions, allowing Rural Health Clinics and Federally Qualified Health Centers to serve as distant sites, expanding practitioners who can provide telehealth, and allowing hospital outpatient billing for virtual services, among others **(S. 2016 / H.R. 4189).**

Infrastructure Financing for Rural Hospitals. As the hospital field engages in significant transformation, rural hospitals are seeking ways to adapt while continuing to meet patient needs. **The AHA urges Congress to help ensure that vulnerable communities are able to preserve access to essential health care services by providing infrastructure funding for hospitals that restructure their facilities and services to match community needs.**

Reverse Rural Health Clinic (RHC) Payment Cuts. RHCs provide access to primary care and other important services in rural, underserved areas. **AHA urges Congress to repeal payment caps on provider-based RHCs** that limit access to care.

Ambulance Add-on Payment. Rural ambulance service providers ensure timely access to emergency medical care but face higher costs than other areas due to lower patient volume. **We support permanently extending the existing rural and "super rural" ambulance add-on payments to protect access to these essential services (H.R. 1666).**

96-hour Rule. We urge Congress to pass legislation to permanently remove the 96-hour physician certification requirement for CAHs. These hospitals still would be required to satisfy the condition of participation requiring a 96-hour annual average length of stay, but removing the physician certification requirement would allow CAHs to serve patients needing critical medical services that have standard lengths of stay greater than 96 hours **(H.R. 1565).**

Wage Index Floor. AHA supports legislation that would place a floor on the area wage index, effectively raising the area wage index for hospitals below that threshold with new money **(S. 803).**

Maternal and Obstetric Care. Maternal health is a top priority for AHA and its rural members. **We urge Congress to continue to fund programs that improve maternal and obstetric care in rural areas, including supporting the maternal workforce, promoting best practices and educating health care professionals.**

Behavioral Health. Implementing policies to better integrate and coordinate behavioral health services will improve care in rural communities. **We urge Congress to enact a number of policies that authorize, expand and better integrate behavioral health programs.**

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American Hospital Association
Advancing Health in America

Bolster the Workforce

Recruitment and retention of health care professionals is an ongoing challenge and expense for rural hospitals. Nearly 70% of the primary care health professional shortage areas (HPSAs) are located in rural or partially rural areas. Targeted programs that help address workforce shortages in rural communities should be supported and expanded. Workforce policies and programs also should encourage nurses and other allied professionals to practice at the top of their license.

Graduate Medical Education. We urge Congress to pass additional legislation to increase the number of Medicare-funded residency slots, which would expand training opportunities in rural settings and help address health professional shortages **(S. 1302 / H.R. 2389).**

Conrad State 30 Program. We urge Congress to pass the Conrad State 30 and Physician Access Reauthorization Act **(S. 665 / H.R. 4942)** to make permanent and expand the Conrad State 30 J-1 visa waiver program, which waives the requirement for physicians holding J-1 visas to return home for a period if they agree to stay in the U.S. for three years and practice in federally-designated underserved areas.

Loan Repayment Programs. We urge Congress to pass legislation to provide incentives for clinicians to practice in rural HPSAs. We support expanding the National Health Service Corps and the National Nurse Corps, which incentivize health care graduates to provide health care services in underserved areas **(S. 862 / S. 940 / H.R. 1711)**.

Visa Recapture. We urge Congress to pass the Healthcare Workforce Resilience Act (**S.3211 / H.R. 6205**), bipartisan legislation that would recapture up to 40,000 unused employment visas for foreign-trained workers (25,000 for nurses and 15,000 for physicians).

Protect the 340B Program

The 340B Drug Pricing Program helps CAHs, Sole Community Hospitals, Rural Referral Centers and other rural disproportionate share hospitals serving vulnerable populations stretch scarce resources. Section 340B of the Public Health Service Act requires pharmaceutical manufacturers participating in Medicaid to sell outpatient drugs at discounted prices to health care organizations that care for many uninsured and low-income patients.

Hospitals use 340B savings to provide free care for uninsured patients, offer free vaccines, provide services in mental health clinics, and implement medication management and community health programs. **The AHA opposes any efforts to undermine the 340B program and harm the patients and communities it serves, especially as it relates to community pharmacy arrangements.**

To learn more and view AHA's full 2024 Advocacy Agenda, visit www.aha.org.

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American Hospital Association
Advancing Health in America

KFF Health News

Operating in the Red: Half of Rural Hospitals Lose Money, as Many Cut Services

By Jazmin Orozco Rodriguez
MARCH 7, 2024

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(E+ / GETTY IMAGES)

In a little more than two years as CEO of a small hospital in Wyoming, Dave Ryerse has witnessed firsthand the worsening financial problems eroding rural hospitals nationwide.

In 2022, Ryerse's South Lincoln Medical Center was forced to shutter its operating room because it didn't have the staff to run it 24 hours a day. Soon after, the obstetrics unit closed.

Ryerse said the publicly owned facility's revenue from providing care has fallen short of operating expenses for at least the past eight years, driving tough decisions to cut services in hopes of keeping the facility open in Kemmerer, a town of about 2,400 in southwestern Wyoming.

South Lincoln's financial woes aren't unique, and the risk of hospital closures is an immediate threat to many small communities. "Those cities dry out," Ryerse said. "There's a huge sense of urgency to make sure that we can

maintain and really eventually thrive in this area."

A recently released report from the health analytics and consulting firm Chartis paints a clear picture of the grim reality Ryerse and other small-hospital managers face. In its financial analysis, the firm concluded that half of rural hospitals lost money in the past year, up from 43% the previous year. It also identified 418 rural hospitals across the U.S. that are "vulnerable to closure."

Mark Holmes, director of the Cecil G. Sheps Center for Health Services Research at the University of North Carolina, said the report's findings weren't a surprise, since the financial nosedive it depicted has been a concern of researchers and rural health advocates for decades.

The report noted that small-town hospitals in states that expanded Medicaid eligibility have fared better financially than those in states that didn't.

Leaders in Montana, whose population is nearly half rural, credit Medicaid expansion as the reason their hospitals have largely avoided the financial crisis depicted by the report despite escalating costs, workforce shortages, and growing administrative burden.

"Montana's expansion of Medicaid coverage to low-income adults nearly 10 years ago has cut in half the percentage of Montanans without insurance, increased access to care and preserved services in rural communities, and reduced the burden of uncompensated care shouldered by hospitals by nearly 50%," said Katy Mack, vice president of communications for the Montana Hospital Association.

Not one hospital has closed in the state since 2015, she added.

Hospitals elsewhere haven't fared so well.

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Michael Topchik, national leader for the Chartis Center for Rural Health and an author of the study, said he expects next year's update on the report will show rural hospital finances continuing to deteriorate.

"In health care and in many industries, we say, 'No margin, no mission,'" he said, referring to the difference between income and expenses. Rural hospitals "are all mission-driven organizations that simply don't have the margin to reinvest in themselves or their communities because of deteriorating margins. I'm very, very concerned for their future."

People living in rural America are older, sicker, and poorer than their urban and suburban counterparts. Yet, they often live in places where many health care services aren't available, including primary care. The shorter life expectancies in these communities are connected to the lack of success of their health facilities, said Alan Morgan, CEO of the National Rural Health Association, a nonprofit advocacy group.

"We're really talking about the future of rural here," Morgan said.

Like South Lincoln, other hospitals still operating are likely cutting services. According to Chartis, nearly a quarter of rural hospitals have closed their obstetrics units and 382 have stopped providing chemotherapy.

Halting services has far-reaching effects on the health of the communities the hospitals and their providers serve.

While people in rural America are more likely to die of cancer than people in urban areas, providing specialty cancer treatment also helps ensure that older adults can stay in their communities. Similarly, obstetrics care helps attract and keep young families.

Whittling services because of financial and staffing problems is causing "death by a thousand cuts," said Topchik, adding that hospital leaders face choices between keeping the lights on, paying their staff, and serving their communities.

The Chartis report noted that the financial problems are driving hospitals to sell to or otherwise join larger health systems; it said nearly 60% of rural hospitals are now affiliated with large systems. South Lincoln in Wyoming, for example, has a clinical affiliation with Utah-based Intermountain Health, which lets the facility offer access to providers outside the state.

In recent years, rural hospitals have faced many added financial pressures, according to Chartis and other researchers. The rapid growth of rural enrollment in Medicare Advantage plans, which do not reimburse hospitals at the same rate as traditional Medicare, has had a particularly profound effect.

Topchik predicted sustainability for rural health facilities will ultimately require greater investment from Congress.

In 1997, Congress responded to a rural hospital crisis by creating the "Critical Access Hospital" designation, meant to alleviate financial burdens rural hospitals face and help keep health services available by giving facilities cost-based reimbursement rates from Medicare and in some states Medicaid.

But these critical access hospitals are still struggling, including South Lincoln.

In 2021, Congress established a new designation, "Rural Emergency Hospital," which allows hospitals to cut most inpatient services but continue running outpatient care. The newer designation, with its accompanying financial incentives, has kept some smaller rural hospitals from closing, but Morgan said those conversions still mean a loss of services.

"It's a good thing that now we keep the emergency room care, but I think it masks the fact that 28 communities lost inpatient care just last year alone," he said. "I'm afraid that this hospital closure crisis is now going to run under the

radar."

"It ends up costing local and state governments more, ultimately, and costs the federal government more, in dollars for health care treatment," Morgan said. "It's just bad public policy. And bad policy for the local communities."

Jazmin Orozco Rodriguez: jorozco@kff.org, @jazmin1orozco

RELATED TOPICS

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Newsletter

WILDERNESS HEALTH

February 2024

Upcoming Events

- Nursing Leadership Roundtable: February 23rd
- Wilderness Health Orientation: February 28th, 12-1 pm
- Human Resources Roundtable: February 29th
- Imaging Roundtable: March 13th
- SDoH Roundtable: March 25th
- https://wildernesshealthmn.org/membership/2024-wh-events-activities-calendar/

About Wilderness Health

Formed in 2013, Wilderness Health is a nonprofit organization that supports independent health systems through advancement of the Quadruple Aim.

Patients waiting too long for mental health therapy? Let us help!

Throughout the Northland, people are waiting months for their first therapy appointment. Wilderness Health has worked with member hospitals and contractor Adaptive Telehealth to cut wait times and meet the needs of patients. In 2020 the Wilderness Health network applied and received a HRSA Rural Health Network Development grant focused on telemental health. The goal of this grant was to bring in mental and behavioral health resources through telehealth. This program has fostered two pilots: an Emergency Room telepsychiatry program at North Shore Health and an Ambulatory Therapy and Diagnostic Assessment program.

The Ambulatory Therapy and Diagnostic Assessment program allows primary care providers to refer patients to an easy-to-use platform. This platform, developed by Adaptive Telehealth, connects patients to available mental health providers. Adults and kids can easily be supported. Patients can view what insurances each provider takes, a list of times they are available and their special areas of interest. This helps patients or parents pick the provider that is best for them. Appointments are available within two weeks of the referral.

Through this program patients can be referred for diagnostic assessments, long-term therapy, or short-term therapy. Short-term therapy can be used to fill the gap until patients are able to get into another practice, get a learning plan in place with a school, or address short term goals the patient may have. Wilderness Health believes that the short-term therapy will help to cover the wait times for long-term therapy options and provide patients with options in the in-between.

Lake View Clinic in Two Harbors helped develop and pilot the project. Now, primary care clinics participating with the program include St. Luke's Pediatric Associates, St. Luke's P.S. Rudie Medical Clinic, St. Luke's Mt. Royal Clinic – and the list is growing. Northeastern Minnesota is known for our tough winters and hardy people. We don't think a "toughing it out" mindset should stop patients from receiving care. Let us help! For more information, reach out to Zomi Bloom, telehealth program manager, or visit our webpage at: https://wildernesshealthmn.org/telemental-health/.

Mark Thelen, PsyD

Matthew Skinner, LPCC, LIMHP, NCC

Taylor Baez, MA LPCC

Talent Pool

Wilderness Health launched a new education advisory group with representation from all members to inform education needs, gaps, and opportunities for the network. A 2023 education plan was developed and we contracted with two primary vendors to provide services: Rural Wisconsin Health Cooperative (RWHC) and the Mayo Health Education Division.

RWHC provided education focused on leadership development that was comprised of a series of workshops and a yearlong leadership residency cohort to develop new and revitalize existing leaders.

Mayo provided quality improvement training across two tiers: the first tier was a Bronze level introductory 90-minute online self-paced foundational quality improvement training with a goal of providing our members with a baseline knowledge about QI and to emphasize that QI is critical to each function and role across the health system. The second tier training was the Silver Academy training that was a more rigorous instruction and included an active improvement component to execute a six month quality improvement project.

For our education opportunity and corresponding number of participants, the Mayo Bronze Level Training had 107 participants, the Mayo Silver Level Academy had 24, the RWHC Year-long Leadership Residency Cohort had 29, the Coach 'Em to Keep 'Em Workshop had 12, and the Belonging by Design education opportunity had 14 participants.

To learn more about future education offerings, contact Michelle Hargrave: michelle.hargrave@wildernesshealthmn.org.

Intern Highlight

UMD student and public health major Minh Phan took up the task of digging through Community Health Needs Assessments (CHNAs) during his internship with Wilderness Health. These documents are foundational in understanding the health needs of a community, as well as to pinpoint what needs should be prioritized by legislators and health leaders.

Phan delved into multiple reports, totaling 335 pages, from nine hospitals in northern Minnesota, and drew many important conclusions. Mental health providers are sorely needed, with the ratio of population to mental health providers being 1,080:1 in Cook County. For context, the US average is 380:1.

"It is my steadfast belief that we are all here, in our lifetimes, to not only enhance our own lives but also to extend a helping hand to others and diminish the pervasive pain and suffering in the world."
- Minh Phan

Roundtables

- Child & Teen Checkup
- Coordination of Care
- Education
- Finance Leadership
- Human Resources
- Imaging
- Nursing Leadership

WH currently has 7 peer-to-peer roundtable and advisory groups as listed. These are wonderful opportunities to engage with your peers across the network for sharing, learning, troubleshooting, and networking. They are generally held 3-4 times a year.

For a full calendar of events please click on the link here: https://wildernesshealthmn.org/membership/2024-wh-events-activities-calendar/

Patient Success Story

Participating in the Curbside Consults with Dr. Rengo directed me into using a new medication on a patient who was struggling with depression and anxiety. Through discussion, I learned how to begin the dose safely without my patient having to wait for a specialist. The medication has been successful, as well as the therapy sessions; she is very pleased with her progress. Dr. Rengo's service is easy, efficient, and beneficial.

Executive Directors Corner

2023 was a busy year for Wilderness Health. A few of the highlights include new outreach to families about the importance of childhood preventive visits, expansion of the telemental health program to new primary care clinics and an emergency room at a rural hospital, new training and educational opportunities for Wilderness members, and several intensive quality improvement projects that improve patient care. We hosted a roundtable with Senator Tina Smith and some of our Wilderness Health CEOs that discussed current landscape and challenges for healthcare. We received word that we were awarded a 4 year $1.2 million federal grant from HRSA's Rural Health Network Development program to build on our work to support care coordination for patients with serious mental and physical health needs. And, Wilderness Health and its members were named the 2022 Minnesota Department of Health's Rural Health Team of the Year.

For more information, contact Cassandra Beardsley: cassandra.beardsley@wildernesshealthmn.org

Cheers to some great projects planned for 2024!

Quality-Focused Care: 2023 Recap

Spotlight on Child & Teen Checkups

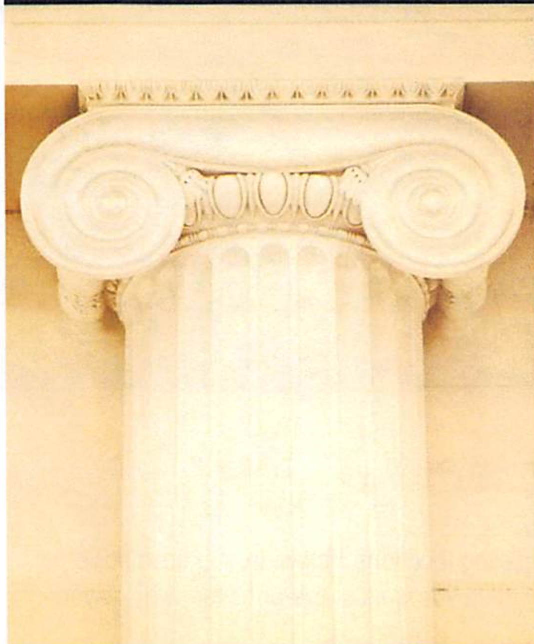
We were able to attend 34 events across the region, ranging from Health Resource Fairs to vaccine clinics to community celebrations like Pride. We were able to engage with 1,176 community members, sharing resources regarding Child and Teen Checkups, dental care, childhood immunizations; as well as mental health and telehealth resources.

In addition to these events, we mailed outreach letters to 8,717 patients across our network reminding them the importance of preventative well visits for children.

We are looking forward to a busy year of outreach events in 2024. Hope to see you out there!

CONFIDE

Professional Counseling Services for Elected Officials



What Is CONFIDE?

CONFIDE is a confidential, professional consulting and counseling service to support the well-being of Minnesota's county commissioners and other local government leaders. It is offered as part of the MCIT Employee Assistance Program and provided at no cost to MCIT member commissioners/government leaders and their dependents.

Why CONFIDE?

The life of a county elected leader is demanding and often stressful. Your dedicated service to the county and constituents may take a toll on your happiness, peace of mind or family life. In its desire to assist Minnesota's county commissioners and other elected leaders, MCIT has established a professional consulting and counseling program specifically to aid commissioners/elected leaders and their families during difficult and challenging times.

Trusted Provider

CONFIDE is delivered throughout the state of Minnesota by Sand Creek, MCIT's partner in providing the Employee Assistance Program to its members for more than 20 years.

CONFIDE Offers …

- Confidential counseling and consultation on personal issues related to public service, work or home life
- Short-term, solution-focused, in-person counseling for commissioners, spouses and other dependents
- Pre-approved, qualified, professional licensed counselors in every Minnesota county
- Assistance in identifying long-term resources when needed
- Sound advice and experienced wisdom in dealing with difficult personalities and situations

Who Can Use CONFIDE?

All MCIT member county commissioners, other local government leaders and their dependents are eligible for assistance through CONFIDE as part of the MCIT Employee Assistance Program at any time. As a government leader, you are encouraged to contact CONFIDE if you experience circumstances that you need help handling.

For consultation or counseling services
CALL 1.800.550.MCIT (6248)

CONFIDE
Is Simple to Use.

It Is Confidential.

It Helps.

CONFIDE Provides Support for Many Issues

Concerns related to elected leadership:

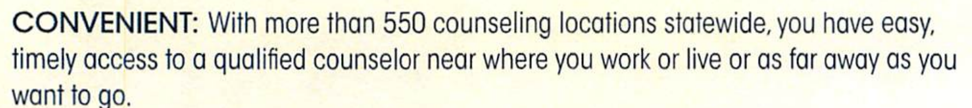
- Leadership fatigue
- Stress of public life
- Peer-to-peer interpersonal conflict
- Impact of elected life on family
- Feelings of being overwhelmed
- Regret and dissatisfaction
- Communication breakdown
- Additional professional concerns

Personal concerns:

- Stress
- Conflict
- Depression and anxiety
- Grief and loss
- Relationships
- Family issues
- Financial concerns
- Substance abuse
- Additional personal issues

For counsultation or counseling services: **1.800.550.MCIT (6248)**

CONFIDE Counseling Is ...



CONVENIENT: With more than 550 counseling locations statewide, you have easy, timely access to a qualified counselor near where you work or live or as far away as you want to go.

CONFIDENTIAL: Counselors are required by state and federal law to protect the confidentiality of anyone using this program.

CRISIS READY: Phones are answered 24 hours a day, every day to offer assistance when you need it. Call the main number at **1.800.550.MCIT**.

VOLUNTARY: You decide when and if you use this program.

NO COST: You and your dependents are eligible for up to six sessions of counseling at no cost as part of MCIT membership.

CONFIDE

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MINNESOTA COUNTIES INTERGOVERNMENTAL TRUST

For questions about the program, contact MCIT:

TOLL-FREE: 1.866.547.6516
FAX: 651.209.6496
WEB: MCIT.org
MAIL: 100 Empire Dr., Suite 100, St. Paul, MN 55103-1885

For no-cost consultation, contact CONFIDE:
1.800.550.MCIT (6248)

Sand Creek

Beginning in 1996, MCIT partnered with Sand Creek to provide professional counseling services at no cost to MCIT member leaders, employees and their dependents. Sand Creek is a behavioral health care corporation based in Stillwater, Minn., and is an AllOne Health company. The organization is experienced in providing services to counties, cities and federal government with hundreds of qualified counselors accessible across the state. With so many years of experience providing services to Minnesota local governments, Sand Creek brings its reputation of excellence, creativity and innovation to MCIT's membership.

Anniversaries

Renae Smith	Dietary	38 Years
Kay Groth	Housekeeping	13 Years
Lisa Bloomquist	Activities	6 Years
Lori Boody	Patient Access	6 Years
Todd Ford	Public Information	2 years
Patty Wilson	Dietary	1 year

New Hires

Amber Eggenberger Patient Account Rep.