Supporting CAHs during the COVID-19 Pandemic: Summary Results of a Survey of State Flex Coordinators

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SURVEY HIGHLIGHTS

- State Flex Programs (SFPs) are providing important support to Critical Access Hospitals (CAHs) during the COVID-19 pandemic.
- CAHs' needs are evolving as the pandemic progresses:
  - Initially, needs included assistance with accessing relief funds, understanding regulatory changes, purchasing PPE and other supplies, and implementing telehealth services.
  - As the pandemic continues, needs are shifting to reopening services, stabilizing and rebuilding clinical capacity, and revising systems to safely care for patients.
  - Over time, needs will shift to ensuring long-term financial stability, integrating telehealth, coping with payment and regulatory reform, and adapting to new models of care.
- SFPs need resources on CAH financial and clinical strategies, integrating telehealth, addressing public and population health, and adapting to new funding and delivery system models.

INTRODUCTION

The impact of the COVID-19 pandemic on hospitals, including Critical Access Hospitals (CAHs), includes revenue losses; reductions in utilization; shortages of personal protective equipment (PPE), testing supplies, and ventilators; and limited capacity to care for COVID-19 patients.[1] Many CAHs will emerge from this pandemic in significantly weakened financial states and at greater risk for closure. State Flex Programs (SFPs) can play an important role in addressing the evolving COVID-19 needs of their CAHs. The Flex Monitoring Team (FMT) surveyed SFPs to collect information on the impact of COVID-19 on CAHs, how SFPs are working to support CAHs during the pandemic, SFP promising strategies, and SFP immediate and anticipated post-pandemic technical assistance (TA) and resource needs. This brief summarizes key data obtained through the survey. The full survey report, with a list of COVID-19 resources for SFPs and State Offices of Rural Health, is available on request. We have also prepared a list of COVID-19 resources for CAHs and their communities which is available on the FMT website.

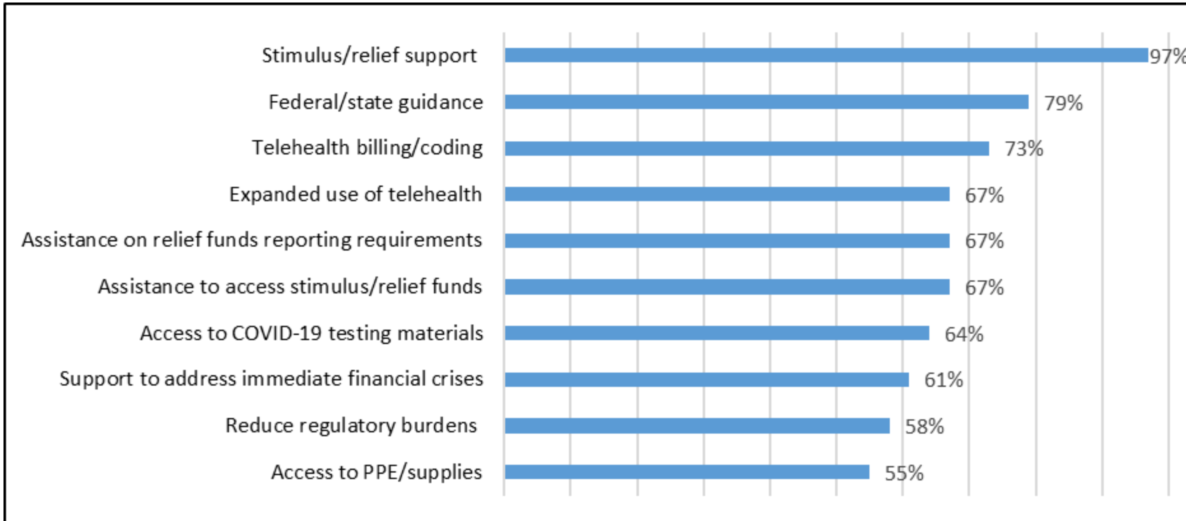
METHODOLOGY

An online survey of the 45 State Flex Programs was conducted from May 26, 2020 to July 2, 2020. The survey questions were developed with input from our Project Officers at the Federal Office of Rural Health Policy (FORHP) and Flex Program partners from the National Organization of State Offices of Rural Health (NOSORH) and the Technical Assistance and Services Center (TASC). The survey included a mix of closed-ended, multiple response questions and open-ended questions that allowed respondents to supply their own narrative answers. We obtained a 100 percent response rate.

SURVEY RESULTS

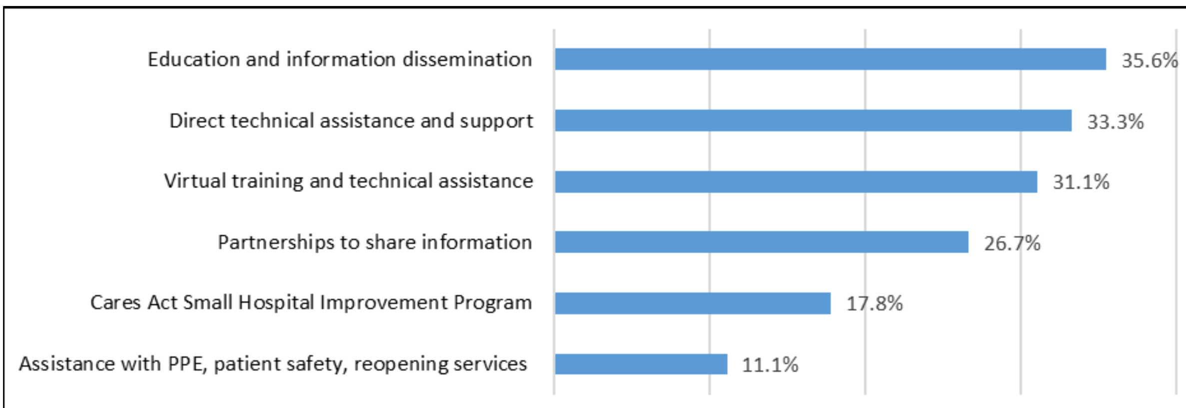
The survey data highlighted the negative impact of COVID-19 on CAHs with more than 50 percent indicating that their CAHs were reporting revenue reductions, financial difficulties, increased costs, shortages of PPEs, inadequate access to tests and long waits for results, and staffing furloughs (data not shown). Nearly 75 percent (33 of 45) of SFPs received requests for support from their CAHs. Figure 1 summarizes those requests reported by 50 percent or more of SFPs. Figure 2 describes the six most common ways that SFPs are supporting CAHs during the COVID-19 pandemic.

FIGURE 1: Support/Assistance Requested by Critical Access Hospitals (n=33)*



** SFPs reported multiple types of requests for assistance from CAHs in their states.*

FIGURE 2: State Flex Program Support for Critical Access Hospitals during the Pandemic (n=45)*



** SFPs had the opportunity to identify multiple promising efforts to support CAHs.*

The following are examples of promising SFP practices to support CAHs during the COVID-19 pandemic:

Supporting clinical and service improvement

- **Arizona** worked with IPCWell, a consulting firm, to support CAHs on PPE use and reopening safely. IPCWell helps CAHs create plans to isolate COVID-19 rooms and ensure staff and patient safety.
- **Montana** engaged a clinical pharmacist to provide support to other CAH pharmacies on medication lists and inventories and treatment protocols.
- **Oklahoma** hosted a COVID-19 response webinar featuring an emergency medicine physician who shared protocols for patient care processes from intake through discharge.
- **Nevada** used Project ECHO technology to conduct sessions to review and discuss the testing and treatment of patients and other COVID-19 topics.

Supporting CAH and Rural Health Clinic (RHC) financial performance

- **Arizona** supported studies of the economic impact of COVID-19 on CAHs as well as a Financial Impact Survey Tool for CAHs produced by the Arizona Hospital Association.
- **Oregon** provided TA to CAH-based RHCs on emergency preparedness, new telehealth policies, and billing and coding issues and hosted RHC listening sessions to share best practices.
- **Pennsylvania** offered two RHC coding and billing boot camps to educate staff and providers on the new COVID-19 waivers and guidance.
- **Idaho** provided one-on-one TA on CAH financial and operational issues through an SFP contractor and organized bimonthly peer sharing webinars to discuss COVID-19 lessons learned.

Improving communication of COVID-19-relevant guidelines and information

- **Illinois** used its Illinois CAH Network (ICAHN) listservs and webinars to provide CAHs with information on changing telehealth regulations and TA from subject matter experts.
- **Pennsylvania** compiled a daily email consolidating state and federal updates on COVID-19 changes, stimulus funding, webinars, and other pertinent information for CAHs and RHCs.
- **Kentucky** worked with a consultant to prepare a COVID-19 social media campaign that hospitals, clinics, and health departments could brand and share on social media and within communities.

Stakeholder/hospital workgroups

- **Florida** organized a COVID-19 TA workgroup with representatives from the Florida Hospital Association, the Florida Rural Health Association, and rural health networks. The Deputy Secretary for Health also participates in the workgroup.
- **Massachusetts** coordinated a weekly virtual rural hospital CEO/CFO forum to encourage peer sharing and support and provide a clearinghouse for federal, state, and industry information.

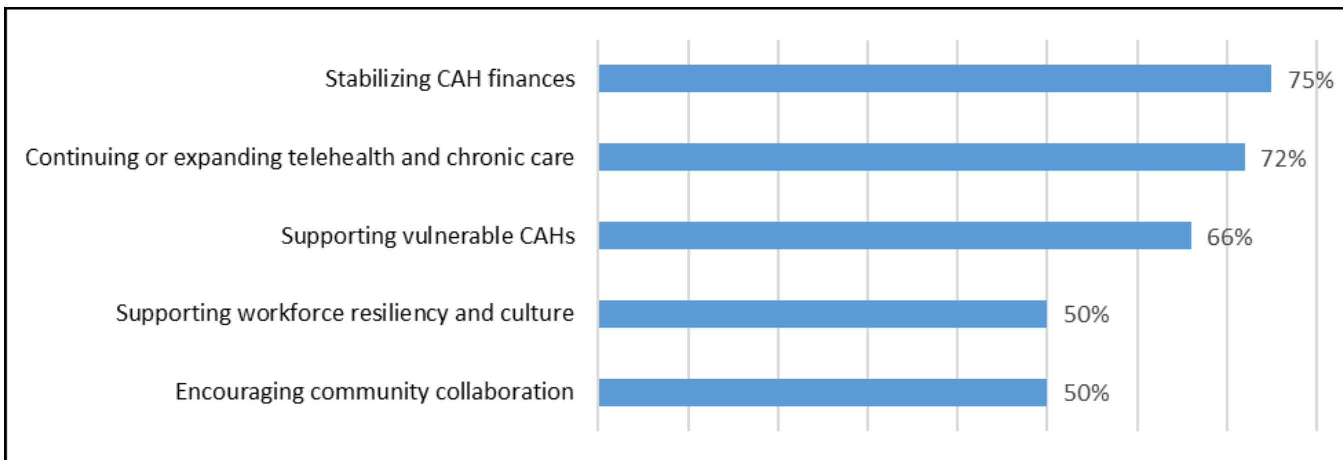
To assist SFPs in meeting the COVID-19 needs of CAHs, FORHP offered the flexibility to redirect Flex Program funding and initiatives in the short-term, provided the proposed activities fit within the Flex Program's legislative mandate.Working closely with their Project Officers, SFPs were able to respond to requests for assistance from their CAHs on COVID-19 issues. This flexibility to respond to the changing needs of CAHs is an important feature of the Flex Program and greatly appreciated by SFPs.

SFPs are aided in their efforts to support CAHs during COVID-19 through partnerships with hospital associations (95 percent), health departments (63 percent), rural health networks (44 percent), other state agencies such as emergency medical services (42 percent), and rural health associations (40 percent). SFPs work with these partners to focus on the needs of CAHs and other small rural hospitals, which can be under-represented in state policy deliberations. Another important resource is the TA, information, and education available to SFPs through FORHP-funded entities including the FMT, TASC, NOSORH, Rural Quality Improvement Technical Assistance (RQITA), Telehealth Resource Centers, Rural Health Value Project, Vulnerable Rural Hospital Assistance Program, and Rural Health Research Centers.

The Evolving COVID-19 Needs of Critical Access Hospitals

Seventy-one percent (32 of 45) of SFPs reported that they have begun to plan for the post-COVID-19 needs of their CAHs. Figure 3 describes planning efforts identified by 50 percent or more of those SFPs that have begun these planning efforts. Not surprisingly, these planning efforts correspond to the impact of COVID-19 on the financial, operational, and clinical operations of CAHs.

FIGURE 3: State Flex Program Planning Efforts for CAH Post-COVID-19 Needs (n=32)*



**Respondents had the option to identify multiple planning efforts*

Based on information reported by survey respondents, CAHs continue to struggle with the impact of COVID-19 and will likely do so for the foreseeable future. At the onset of the pandemic, CAHs needed immediate assistance with accessing federal and state relief funds; understanding funding opportunities, regulatory changes, telehealth, and clinical issues; purchasing PPE and other supplies; and implementing telehealth services under the new regulations. As the pandemic continues, CAHs' needs are shifting to: reopening services; stabilizing hospital finances; rebuilding clinical capacity; and revising systems, facilities, and services to safely care for COVID-19 and non-COVID-19 patients. As they emerge from the pandemic, CAHs will need long-term support to ensure financial and operational viability; integrate telehealth and other technologies into their systems of care; rebuild clinical capacity; cope with payment and regulatory reform; regain patient and community trust; and adapt to new models of care.

The short and long-term TA and resources needed by SFPs mirror the evolving needs of CAHs as the COVID-19 pandemic progresses. The most commonly reported SFP TA and resource needs include:

- Updated information on policies, regulations and funding opportunities (short/long-term);
- Tracking/complying with federal funding reporting requirements (short-term);
- TA on telehealth implementation and regulations (short/long-term);
- Operational and clinical strategies to cope with COVID-19 (short-term);
- Financial, operational, and workforce strategies to stabilize CAHs (long-term); and
- Developing emergency preparedness capacity (long-term).

CONCLUSIONS

SFPs have played an important role in supporting CAHs during the early stages of COVID-19 by:

- Providing TA and support to CAHs;
- Connecting CAHs to appropriate experts;
- Disseminating information on funding, regulatory, telehealth, and clinical issues; and
- Convening meetings/taskforces of experts, hospitals, and partners.

COVID-19 has had a significant impact on health care providers and the health care system. CAHs and small rural hospitals have been particularly hard hit by COVID-19, which has exacerbated their underlying financial and operational vulnerabilities. SFPs, with funding from the Flex Program, are an important resource for the 1,352 operating CAHs as of April 28, 2020. To assist CAHs throughout the pandemic and beyond, SFPs will need resources and TA on financial, operational, and clinical strategies to help CAHs reopen non-emergent services, care for COVID-19 and non-COVID-19 patients safely, implement telehealth services, address the public and population health needs of their communities, and adapt to potential new funding and delivery system models. To accomplish this mission, SFPs must tailor their efforts to the unique needs of CAHs and their communities through partnerships with state and national rural health and hospital stakeholders and Flex Program partners.

REFERENCES

1. Office of the Inspector General. *Hospital Experiences Responding to the COVID-19 Pandemic: Results of a National Pulse Survey March 23-27, 2020.* OIG;2020. OEI-06-20-00300. Accessed July 28, 2020. https://oig.hhs.gov/oei/reports/oei-06-20-00300.pdf

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