Lindsborg Community Hospital
Salina Regional Health Center
Partners caring for the health of the Smoky Valley communities.

To: Senate Committee on Public Health and Welfare

From: Larry Van Der Wege, Administrator

Date: February 16, 2021

Re: SB 175 – Rural Emergency Hospital Act

I am Larry Van Der Wege, Administrator of Lindsborg Community Hospital (LCH). I had the opportunity of serving on and at one point, leading the Kansas Hospital Association's (KHA) working group who developed the new model that the Rural Emergency Hospital is tailored after. I also have the privilege to be the current KHA Board Chair. I am honored and appreciate the opportunity to provide comments in support of SB 175, which creates the Rural Emergency Hospital for our state.

My hospital is a 15 bed Critical Access Hospital in Lindsborg, midway between Salina and McPherson. Since 2012, we have also been part of the Salina Regional Health Center system though a management agreement. To be clear, I'm not only a representative of LCH but also speaking on behalf of all rural hospitals in Kansas who face the mounting business pressures to remain financially operational.

Between the hospitals that have closed since 2010 and mounting analytics describing the financial plight of many hospitals in our state, it is clear that Kansas hospitals are struggling. There is rarely one specific cause for the financial decline of a rural hospital, rather it has been described as death by many paper cuts.

First and foremost, like most other businesses, we are volume dependent. We are predominantly paid when we provide the service. It is true that market share and customer service often drive volumes but the reality is that in many of our rural communities, the loss of or aging of population is the primary determinant. One can capture a majority of the market but if the market is small, limitations still exist. Also, acute care inpatient volume has decreased across the country due to improvements in medical interventions and treatments in the outpatient settings. Plus, those who do need hospitalization are often sicker and require more specialized medical care.

Reimbursement for that service is also dependent on the payer of that service. The insurance company or private individual typically has more control on what the hospital will receive than the facility. Some pay more and others less. A small hospital has very little leverage over private or governmental insurance and patients paying privately are still neighbors in our small communities.

Expenses continue to climb, as employees deserve raises and benefits. The cost of supplies, equipment, pharmaceuticals and renovations to maintain the standard of care continue to apply pressure. Nobody wants to provide sub-standard care to their community.

The expense of staffing goes beyond salaries and benefits. The difficulty in recruitment of vital clinical staff such as physicians, nurses, lab and radiology techs, etc. all add to the stress to an organization. Often agency/traveling replacements are used but the cost is high and they can't match the consistency of a permanent employee.

The population demographic forces not only apply pressure to hospitals, but also impact the tax base and donation pool for the greater community. The same taxes and charitable contributions often needed to maintain hospital services are also required for the infrastructure and operations of the rest of the community or county. As you all well know, the pie is only so big.

There are other challenges to be sure, and the local board, administration and medical staff can make the best decisions and these all still exist. It is not necessarily a failure of leadership but instead, just running out of options. Current options include licensing as a community hospital (CAH or PPS), emergency/urgent care facility or as a clinic or Federally Qualified Health Center.

Advocacy and efforts to address the previously mentioned challenges continue but the KHA and I believe another option needs to be available. The work to create that option began in 2012 and is culminating with the action taken at the federal level to approve the Rural Emergency Hospital. It is developed after the Primary Health Center model created by our working group – a Kansas common sense creation.

Our approach was to develop an "off ramp" for those hospitals that don't currently have a volume to financially sustain acute inpatient beds. At the same time, provide the services needed to sustain and hopefully maintain the population in that rural community – primary care, emergency/urgent care, lab, radiology, therapy, etc. There would also be the ability for post-acute care, vital for many coming back from the tertiary hospital prior to returning home safely. Our goal was also to create a model that did not increase the cost to payers and followed the quality standards our patients deserve.

This model wouldn't be needed for all, but will be a life-saving option for some. Life-saving for that organization and for members of that community.

Thank you very much for your service and for your consideration of SB 175.