

Overview

In November 2021, leaders at Charles A. Cannon, Jr. Memorial Hospital (Cannon) formed Appalachian Regional Behavioral Health (ARBH) Hospital, a 37-bed, walk-in inpatient facility — and the first Critical Access Hospital (CAH) in the country to also house a behavioral health hospital on its campus. Cannon leaders formed the 37-bed hospital by converting an existing, 10-bed, distinct part unit, which had historically operated as part of the CAH. They also added 27 newly licensed psychiatric beds.

Critical Access Hospitals are traditionally not allowed to operate within 35 miles of other hospitals (15 miles in mountainous terrain), per a Centers for Medicare and Medicaid Services' (CMS) rule. But when the behavioral health needs in the mountainous region of western North Carolina skyrocketed, the leaders at Appalachian Regional Healthcare System (ARHS) knew they had to make a change.

While many of Cannon's medical beds sat empty, the demand for behavioral health beds skyrocketed. "Cannon's emergency departments were full of people who were experiencing mental health crises, but had no place to go," said Chuck Mantooth, president and CEO of ARHS. "And while they waited for transfer for days or weeks, we were running up operating expenses and delaying care for a very fragile patient population."

ARHS sought and eventually received a historic exemption to the CMS rule, allowing it to become the first CAH to build another hospital nearby. This exemption now paves the way for others to do the same. Federal law dictates that co-located hospitals be independently licensed and physically distinct from acute care facilities. Fortunately, Cannon already had a fire barrier which separated the existing unit from the rest of the hospital.



ARHS renovated the unit with a \$6.5 million grant from the North Carolina Department of Health and Human Services, enabling them to increase their psychiatric bed capacity overall by 27 beds. The grant covered the majority cost of the construction, but the bigger challenge was securing the exemption. Without it, Cannon would lose its CAH status and cost-based reimbursement for Medicare services, threatening Cannon's financial stability.

Communication and Bureaucracy

Obtaining the exemption required months of strategy, planning and communication from ARHS's leaders. It also took support from local and state advocacy groups. "The key to this effort was conveying the urgency of Cannon's situation to those who could help the most," said Rob Hudspeth, ARHS senior vice president, external affairs. "In that regard, we had support from law enforcement, surrounding community hospitals, emergency medical services and first responders, outpatient behavioral health agencies and our local management entities and managed care organizations. Together, we were very effective at sounding the alarm."

But ARHS leaders still faced what some described as insurmountable legal challenges. With the help of

outside counsel, ARHS appealed to federal legislators, and the United States Department of Health and Human Services eventually awarded ARHS a precedent-setting exemption. The North Carolina Health Care Association (NCHA) was also instrumental in connecting the hospital leaders with key entities and organizations. North Carolina Medicaid leaders even had to persuade CMS to change some clinical service definitions to accommodate the exemption. “The process was long and painstaking,” said Stephanie Greer, ARBH services director, “but the NCHA was particularly effective in helping us navigate it. When we were able to tell our story to the people in positions of power, the NCHA stood up and helped us.”

“We faced audiences that had no concept of what we were trying to accomplish,” Greer said. “We had to get very adept at telling our story in a way that people could understand.”

Impact: Financial Sustainability

Once Cannon received the exemption, it saw an opportunity to gain economies of scale and make its acute care facility more financially sustainable. Inpatient volume had been slowing — Cannon’s census count had fallen to an average of four patients — making it expensive to keep running the 24-hour laboratory services that hospitals are required to maintain. This is a common issue for CAHs, Greer said, as patients are increasingly flocking to tertiary care centers for their inpatient needs.

As Cannon’s patient volume lagged, ARBH’s boomed. So ARBH leaders decided to subcontract from Cannon their full gamut of acute care services, including lab, pharmacy, nutritional services and diagnostic supports. This helped Cannon maintain operations and fulfilled ARBH’s legal obligation to offer its own acute care services. Cannon and ARBH, with external legal help, created contracts that legally distinguish the two entities and honor the co-location stipulations. For example, ARBH leases its space from Cannon.

“We created a new behavioral health facility, but we didn’t add lab staffing; we didn’t add environmental services staffing; we didn’t add plant operations staffing. We just subcontracted for it,” said Greer. “Those positions that were not going to be sustainable long term, will now become so - because we’ve created more service volume.” This has both strengthened access to

behavioral health care and improved Cannon’s overall business model, Greer says. “We’ve gained some economies of scale because we haven’t added new positions to those departments — it’s the same number that was required to be available and present for the critical access hospital,” said Greer. “But now when you have low census days, it’s not really an issue because the behavioral health volume more than makes up for that.”

“The patients that walked in and said, ‘I need help’ — those are patients that did not have to go through an emergency department and get backlogged for hours or longer”

Stephanie Greer, Appalachian Regional Behavioral Health services director

Impact: Eliminating Long Waits in the ED

A key element to success was the creation of a walk-in assessment option so patients could avoid spending time in the emergency department. “Because of that co-location model, we can do all of the medical screening that we need to on the ARBH side,” Greer said. “If someone needs inpatient admission, then we just admit them straight into the psychiatric bed. If they don’t, then we discharge them with outpatient followup.” This reduces the burden on the system’s emergency departments, which is traditionally the most expensive area of care. It also creates a dramatically better experience for patients.

“The patients that walked in and said, ‘I need help’ — those are patients that did not have to go through an emergency department and get backlogged for hours or longer,” Greer says. “Those are patients that, because it was an easier way to access care, may not have been in as much of a crisis state as they would have been, had they been forced to go through the emergency department.”

Appalachian Regional Behavioral Health leaders have not yet publicized their walk-in option, but news of it spread

through word of mouth. In the first five months of operation, ARBH processed 40 walk-in patients, “which is a big number for a rural hospital,” Greer said. While it’s too soon to quantify ARBH’s total impact, Greer says Cannon’s net income per unit is already up. And more importantly, patients can access better, more straightforward behavioral health care.

Paving the Way


Greer cautions others wanting to replicate the model to make sure they have the wherewithal to meet the physical demands of a co-location model before seeking a CMS exemption. For example, if your CAH has multiple buildings, make sure you have the appropriate physical separation between facilities. Although in some cases, new construction may be cheaper than trying to renovate existing space, Greer said.

Establishing shared services contracts has been challenging, Greer said. As far as the exemption itself: The precedent has been set. “We genuinely believe that this is a model of care that can support rural health in a meaningful way and can meet the crisis that we’re seeing across the country, relative to access to behavioral health supports,” Greer said.

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