The revitalization of rural health care in Big Bear Lake, California

Cecelia Antoinette Callicott

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THE REVITALIZATION OF RURAL HEALTH CARE
IN BIG BEAR LAKE CALIFORNIA

A Project
Presented to the
Faculty of
California State University,
San Bernardino

In Partial Fulfillment
of the Requirements for the Degree
Master of Arts
in
Special Major

by
Cecelia Antoinette Callicott
May 1989
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IN BIG BEAR LAKE CALIFORNIA

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Approved by:

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Chairman of Graduate Committee
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Abstract

Closure of rural community hospitals in the United States is a growing and important trend with serious implications for rural communities and the overall health care system. A rural hospital’s survival will depend upon its ability to compete and adapt in a volatile, competitive health care marketplace. Allowing rural hospitals the flexibility to adapt and compete, while ensuring adequate quality health care to the rural resident, is suggested as a priority in the delivery of rural health care policy. This study will review the changes in Medicare payment, expansion of hospitals designated as sole community hospitals, the use of swing beds, the establishment of state offices of rural health, and short-term federal and state grants. In addition, a review of the revitalization of Bear Valley Community Hospital’s services and methodologies incorporated to keep the hospital a viable health care organization will be documented and completed.
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INTRODUCTION

The rural hospital is a vital component of the rural health care delivery system and a basic and important institution to all rural communities throughout our nation. In recent years, considerable concern has been expressed over the future of these institutions, many of which have experienced serious difficulties in maintaining fiscal and financial control and viability. The problems facing many rural hospitals today result from a number of inner related factors, both internal and external, which determine the environment the rural hospital operates and ultimately affects its performance (Frymier, 1983).

With the increasing number of problems facing the entire health care industry, rural health care and those responsible for its delivery are finding themselves focusing on the high cost of technology, changing reimbursement methods, declining utilization rates, and access to capital. These problems are real but are viewed as not insurmountable by the majority.

Rural hospitals, however, are unique in their importance to the local community, and the patients they serve. The failure of a rural hospital may force local residents to travel long distances to other communities for
their inpatient and outpatient care. Closure of a rural hospital may make it difficult for a local community to recruit and retain primary care physicians, since the existence of a viable hospital is associated strongly with physician’s decisions of where to locate.

The rural hospital represents the most important component of the rural health care system, and the role of the rural hospital must be defined in relation to the broad health care needs of the population it serves (Freidman, 1981).

The California Association of Hospitals and Health Systems in March 31, 1989 first reading states:

During hearings on the Medicare program by the Health Subcommittee of the House Ways and Means Committee earlier in March, representatives Robert Michael (R-IL) and Byron Dorgan (D-MD) both advocated eliminating the differential between urban and rural perspective payment systems (PPS) rates citing the large number of rural hospital closings and the shortages of health professionals, the representatives said the approximately 13% differential threatens the financial viability of many more rural hospitals.

Representative Michael, the minority leader of the House, pointed out that many rural hospitals have very large Medicare patient loads with the result that Medicare payments are "a major element in the economic viability of rural hospitals". Also testifying at the hearing was Stuart Altman, Ph.D., chairman of the Prospective Payment Assessment Commission, who reported that 50% of rural hospitals are losing money treating Medicare patients. An estimated 163 rural hospitals have closed since 1980, according to representative Dorgan who also predicted that as many as 600 hospitals face possible closure in the next 5 years.
Legislation introduced by Senator Lloyd Bentsen (D-TX) and Representative J.J. Pickle (D-TX) would provide for the elimination of payment differential beginning in FY 1992 and in the meantime guarantee that PPS payments to rural hospitals would at least equal their cost.

Plans to help world health care providers seem to be popping up like mushrooms in Congress' halls. However, it is hard to predict what will be harvested from the budget reconciliation process (Higgins, 1987). Stopgap measures have postponed a final reconciliation package and now looks as though the differential for rural hospitals and possibly for physicians may be narrowed somewhat by greater increases in the inflation update.

New in rural providers’ favor is that influential congressional hospital and physician payment review commissions are finding it difficult to rationalize the differentials (American Hospital Association, 1987).

Rural issues traditionally fare best in the Senate, where 75% of the members now belong to its rural health care caucus. That group, formed this past summer to counter the House tendency toward inaction, kept rural health care concerns alive in committees (Higgins, 1987).

As stated in the Medical World News, October 26, 1987:

The Ways and Means package favors: provide an extra 1% increase during each of the next 3 fiscal years for hospitals; extend volume adjustments for sole community hospitals when admissions drop by more than 5% due to circumstances beyond their control; expand the current swingbed option from 50 beds to 100 beds; provide 15 million over 3 years in grants to
struggling sole community hospitals to demonstrate innovation in rural health care> give primary care providers in every setting a 6% hike which would disproportionally benefit rural areas because most rural MDs are in primary care> boost the inflation update by an extra 1% for rural hospitals> provide a 10% bonus for all patient care services and health care worker shortage areas> conduct an impact analysis of new regulations on rural hospitals.

How will HCFA react to the increasing congressional pressure, no one really knows. HCFA agrees that medical services reimbursement does demographically correspond to the economic viability of rural health care. The suburban spread so to speak needs to be taken into account as payment for services rendered is evaluated and modified to meet the needs within the location.

As hospital administrators, economists and policy makers all struggle for solutions to the problems plaguing rural health care, the people whose lives are caught up in these struggles will tell you that the battle is very definitely worth fighting. Rural health is not just a geographic isolated location, it’s a fantastic way of life that many Americans have chosen. It should be viewed as supportive to the economic viability of any rural community and as important as the churches and school to a community’s stability and delivery of quality in life.

STATEMENT OF THE PROBLEM

Big Bear Community Hospital District incorporated in 1955, under the leadership of Mrs. Brenda Boss, who
launched a major fundraising and lobbying campaign to build the Bear Valley Community Hospital. Twenty years later, the community celebrated the first rural health care facility to be constructed in their community. What was to follow is the stereotype of rural health care throughout the nation, focusing on the high cost of technology, changing reimbursement methods, declining utilization rates, access to capital, and insurmountable management issues created by contracting management firms.

In July of 1987, Westworld, a for-profit corporation filed bankruptcy and forfeited the management of the Bear Valley Community Hospital 29-Bed Acute Care facility. Reasons cited were the financial jaws of health care reimbursement and overall inflationary costs of operations. Out of necessity to provide only emergency care to the community, the Bear Valley Community Hospital District, under the leadership of President Susan Thomas,\textsuperscript{2} assumed the operational responsibility for emergency care through the emergency department. During the next month, major decisions were made regarding the operational viability of the hospital, meaning that more than 50% of the employees were terminated and those that remained were not provided health care insurance or benefits of any kind. The skeleton crew, so to speak, began immediately to preserve the essential human element of caring for those coming to the
hospital for their health care. The team of professionals worked extra shifts to take care of their patients, paid special attention to their dietary needs, and remained available 24 hours a day to provide the competitive, quality health care product that the rural hospital in Big Bear was known for. Perhaps the largest hurdle to overcome was the declining amount of technical superiority available at the hospital. As a result of poor management by the previous managers; leased equipment such as X-ray machines, respiratory blood gas machines, EKG machines, mammography and fluoroscopy were removed by companies that had not received payment in some time. In addition, the equipment that remained was not in good working condition, requiring careful scrutiny when used, not to mention the lack of reliability from day to day. It was essential for the hospital to recognize and realize that all supplies were limited and credit was not available to vendors, either locally or from outside the area. Lifesaving equipment was at a bare minimum, there were no oxygen tanks, and linen was no longer being delivered, creating a real dilemma.

The external environment indicated a community that had no confidence in the delivery of health care, nor in the physicians on staff. Approximately 65% of the community members were seeking health care elsewhere, and the quality
physicians who remained were finding other communities to establish their practices.

There is no possible strategic vision that could have conceptually been in place to even plan for such a serious situation as this. The hospital definitely was facing a possible shutdown, with the job at hand of evaluating what the hospital meant to the community; what alternate access to health care may exist; and could local economy support the system. In this case the hospital was not the largest employer, however a very significant one, if it closes then jobs are lost. The financial interdependence of the Bear Valley Community Hospital and its community allude to the strong partnership between the two in not only accountability but public relations and communication of one's credibility. The previous management had overcharged way above third party payer allowable charges, leaving the impression that the economic stability of the community was not their concern.

The environmental characteristics of the community of Big Bear Lake revealed an average of 16,000 full-time residents with growth averaging approximately 1,000 per year. The unemployment rate during the non-seasonal period is approximately 30%, dropping to 8% during the winter months. Presently, the population consists of 48% small business entrepreneur, with no health insurance. Many major
insurance companies view the population in the Big Bear area as insignificant, and therefore do not feel it advantageous to penetrate the area. The largest work force with a health plan is the school district, with approximately 200 employees, the fire department and police, with approximately 45 employees, all of which have secured HMO services that are provided out of the Big Bear area. Approximately 25% of the population is over the age of 65 and growing on an average of 4% per year.

In November of 1987, St. Bernardine Medical Center entered into a management agreement with Bear Valley Community Hospital District to manage Bear Valley Community Hospital. As one can tell, it appeared that upon takeover there were virtually no available assets. This is true in part, however, enough remained to provide a starting point for the St. Bernardine management contract. Leanne Ballard was appointed at that time to manage the facility as Executive Director and assume the enormous task of propelling the "lame duck" into successful health care delivery.

The issue of good community relations was ever more important and, to this day, remains a continued vital element in the successes of the organization. The negative experiences that initially were relayed through previous management was not easily forgotten, particularly in a small
community such as Big Bear Lake. The product provided by any health care organization should be one of the highest quality of service. The community in close proximity to a health care facility is entitled to fair pricing, quality of care, versatility of services, and the utmost in kind, loving and compassionate care (Rosenblatt, 1979). In addition, there was ever more present the need to provide positive communication to the community regarding the stable environment within the confines of the hospital. The people of Big Bear Lake wanted to know that they could trust and, most importantly, place their life in the hands of competent professional people who could respond to an emergency irrespective of the acuity level. I must add that this continues to be a major issue as the residents cannot forget the immediate past, no matter who is communicating the future.

RESEARCH QUESTIONS ASKED

1. Is there community support for the continuance of Bear Valley Community Hospital?

2. Are there enough physician specialties to support an acute care facility?

3. Is it possible to recruit young qualified physicians to a resort community like Big Bear?
4. Will the specialists of St. Bernardine Medical Center provide support in diagnosing and treating specialized cases?

5. What equipment and supplies will be required to revitalize the hospital?

6. What will the staffing patterns need to be to provide 24-hour specialized and professional coverage?

7. What support will be required from St. Bernardine's management to ensure financial accountability?

8. Can the population in Big Bear adequately support the hospital?

9. Will the association between the Sisters of Charity of the Incarnate Word and Bear Valley Community effect its reputation positively in the community?

HYPOTHESIS DEVELOPED

1. Null hypothesis states that there is no association between the PPS Medicare system and failure of rural health systems. The alternative hypothesis states that there is an association between the PPS Medicare system and failure of rural health care systems.

2. Null hypothesis states that there is no association between the quality of a medical practice and rural health care. The alternative hypothesis states that there is an association between the quality of medical practice and rural health care.
3. Null hypothesis states that there is no association between a community’s economic viability and provision of quality rural health care. Alternative hypothesis states that there is an association between a community’s economic viability and the provision of quality health care.

4. Null hypothesis states that there is no association between exposure of patients to unnecessary risks and the rural health care system. Alternative hypothesis states that there is an association between exposing patients to unnecessary risks and the rural health care system.

5. Null hypothesis states that there is no association between the scope of services offered in a rural hospital and the success of rural health care. Alternative hypothesis states that there is an association between scope of services offered at a rural hospital and success of the rural health care system.

6. Null hypothesis states that there is no association between diversification into skilled nursing and long-term care and rural hospital survival. Alternative hypothesis states that there is an association between diversification into skilled nursing and long-term care and rural hospital survival.

7. Null hypothesis states that there is no association between closed rural community hospitals and JCAH accreditation. Alternative hypothesis states that there is
an association between closed rural community hospitals and JCAH accreditation.

LITERATURE REVIEW

Rural American is in transition. This transition is being fueled by changes in the social, economic, and demographic factors (Wennberg & Gittlesohn, 1982). For the first time in this century, the non-urban areas are growing faster than urban America, a turnaround of seemingly inevitable dissipation of the rural population (Peteus & Tseug, 1983). The transition under way in rural areas will have increasingly important implications for the future of the rural health care system (Frymier, 1983).

Recent changes in the supply of health professionals have enhanced the opportunity for rural communities to improve their health care systems. Larger increases in the supply of physicians, the emergence of the family practitioner, and the alternatives to physicians, such as nurse practitioners and physicians assistants, have all improved the supply of health professionals in rural communities (Puuch, 1982). These changes have focused even more attention on the small rural hospital.

The rural hospital is a vital component of the rural health care delivery system and an important institution to the rural communities (Freidman, 1981). The hospital, along with the church and the school, represent the major elements
through which rural communities define themselves. Despite the central importance of the rural hospital, it is often the weakest link in the elements that comprise health care in rural areas (American Hospital Association, 1987).

In the United States, almost half of all community hospitals are located in rural areas. Community hospitals are defined by the American Hospital Association as hospitals in which the mean length of stay is 30 days or less, which are not federally owned, and whose facility and services are open to the public (Bridgman, 1955). They may be privately owned for profit hospitals; privately owned, not for profit hospitals; or hospitals owned or managed by state or local government (Peteus & Tseug, 1983).

Rural community hospitals are community hospitals located outside a metropolitan statistical area as defined by the United States Senate. A metropolitan statistical area is an area containing either: (1) a city of at least 50,000 in population; or (2) an urbanized area of at least 50,000 with a metropolitan population of at least 100,000 (Sloane & Sloane, 1977).

In 1985, 21% of the country's inpatient admissions, 17% of all surgical operations, and 19% of all births took place in rural hospitals. Many factors in rural life such as hazardous occupations like farming, lumbering, and mining; chronic diseases associated with the use of pesticides and
other chemicals; rising unemployment; the diversity of transitory populations; high portion of poor and elderly residents; and land use for recreational purposes, make accessible quality acute care essential for rural communities (Rosenblatt & Moscovics, 1982).

The importance of the rural community hospital, however, extends beyond their role as a vital component to the health care system (Van Hook, 1985). A hospital is often a rural community’s largest employer, therefore, it can serve as a viable economic and psychological anchor for the community, in turn, often spurring investment and attracting professionals to the area (Peteus & Tseug, 1983). The quality of the health care institution likened to the schools and churches, will often indicate the success that a family has in making a move from a metropolitan to a rural area (Rosenblatt, 1979).

At present, the alarming fact that a rising trend in rural hospital closure is at hand has caused great alarm in government and communities within close proximity to the rural population (Mullner & McNeil, 1986).

Rural communities have experienced a marked economic downturn through the mid-eighties. Factors that reflect change are such things as high rural unemployment, decreased demand for the construction industry, an erosion of manufacturing, the immigration of young people from rural to
the urban areas, and the growing percentage of patients whose care is paid for by federal and state medical and medicare programs, not to mention an increase in uncompensated care, as well as rising costs (Snook, 1981).

The mandated prospective payment system (PPS) of payment under parlay of medicare, adopted in 1983, has added a tremendous burden (Higgins, 1987). Medicare, the federal program of health insurance for the aged, provides for payment of certain in-hospital costs. Part B of medicare covers physician’s services and is available on a voluntary basis to all citizens eligible for Part A (Flood, 1984).

Since 1983, medicare has utilized the diagnosis related group (DRG) categories to calculate payment rates determined by the projected cost of a patient’s illness (Accrediation Manual for Hospitals, 1983). For patients within these categories, PPS pays rural hospitals at a lower rate than their urban counterparts. The lower payment level is due to differences in case mix and labor cost among rural and urban hospitals (Robert Wood Johnson Foundation, 1987). Rural hospitals claim, however, that their high percentage of part-time employees leads to a wage index that underrepresents true wage levels, and the rural hospitals adjacent to urban areas must pay salaries competitive with those paid by the urban hospitals (Wennberg & Gittlesohn, 1982). The prospective payment system, based on average
cases, cannot take into consideration a rural hospital that treats patients who are older and sicker than the national average. Urban hospitals are thus reimbursed according to location, disregarding the type of patient many may actually serve (Accrediation Manual for Hospitals, 1983). In addition, the low volume of patients seen by the rural hospital exacerbates the stresses upon them (American Hospital Association, 1987). Cost in rural hospitals depend more upon medicare revenues than do their urban counterparts; this burden is one of the most significant factors in their financial stress (Kuntz, 1984). Adding to that stress is the level of acuity, which usually runs 25% to 30% higher because of the terrain, increased amount of outdoor activities, and a higher senior citizens census in the community (Rosenblatt, 1979). The rural setting often draws a resort population which frequently are cash paying consumers, more likely no cash at all, and after they leave, the financial responsibility is lost, resulting in an added cost of hard-core collection activities.

INTERNSHIP PROCESS

I began association with the Bear Valley Community Hospital District Board in July of 1987. As a result, I became the front runner, so to speak, of the organizational challenge that was ahead. As a result of the challenge to develop a management contract between the Bear Valley
Hospital District Board and St. Bernardine Medical Center, my internship was a natural evolvement, to be titled The Revitalization of Rural Health Care.

Beginning in the community in July of 1987, I began conducting a series of community forums to determine the wants and wishes of the community and to determine if St. Bernardine would be a viable option as health care managers. I represented St. Bernardine at clubs and organizations as I spoke of the mission and philosophy of the Sisters of Charity and state of the art technology available and in support of the Bear Valley Community Hospital. Prior to the interim management agreement, I conducted a number of SWOT analysis groups to determine what the opportunities for growth in the community were. As a result, St. Bernardine knew that the community was uneasy with any health care group as a result of past experience with Westworld and other management concerns. Since the inception of the Bear Valley Community Hospital, eight administrators passed through, meaning further mistrust on behalf of the community members.

Further, during the internship program, a substantial period of time was spent assessing and organizing administrative areas such as: finance, physician relations, staffing needs, community relations, quality assurance, employee remotivation, contracting and capital budget needs.
As a result, the findings and solutions have been documented, including a literature review in support of the project and recommendations for future consideration.

THE NEW HOSPITAL ORGANIZATION OF BIG BEAR

THE ORGANIZATION

The hospital has been termed a complex social system with conflicting participants, from patients to personnel. The diversity of the organization itself creates a major problem (American Hospital Association, 1987). I mean, there is the governing board of Bear Valley Community Hospital consisting of two members of the Board of Directors at St. Bernardine Medical Center, two members of the District Hospital Board at Big Bear, two lay persons from the community and one physician on staff at Bear Valley Community Hospital, who have legal authority over and responsibility for the institution. There are four primary functions of the Board of Directors, mutually agreed upon by all parties, and those are to (1) provide the legal responsibility for controlling the hospital and assuring the community that the hospital works properly; (2) assuring quality as a major concern in any health care facility and even more so in the rural environment; (3) assuring responsibility for community support; and (4) establish hospital objectives that could be reviewed periodically to determine their overall success.
Then the medical staff who possess the technical knowledge to make decisions regarding questions of patient care and treatment. The administrative staff that is responsible for the day to day operation of the hospital. At present the administrative staff consists of one executive director, who is also a clinician with the technical ability to cross-train and serve in other capacities of the institution as needed. In addition, the executive director has a manager of nursing, personnel assistant, manager of the business office and data systems, manager of maintenance, manager of laboratory, manager of radiology, manager of pharmacy, manager of central supply, manager of dietary, manager of quality assurance, risk management, medical records and medical staff office. Local authority has been granted by the governing board at St. Bernardine Medical Center, however, because Bear Valley Community Hospital is part of a multiple hospital system, ultimate authority is given to the Sisters of Charity Health Care System Board of Directors in Houston, Texas. It is very important to maintain local control and delegate authority to the administrative staff at Bear Valley Community Hospital. Even though ultimate authority is located in Houston, Texas, it is anticipated that authority of that nature will never surface or need to surface on the local front.
ORGANIZATIONAL PRIORITIES

The organizational plan for the development and implementation of priorities progressed as follows: (1) staff development to include better trained employees, promote in-service education, provide an increase in wages, provide employee benefits, and cross-train to multiple areas; (2) purchase needed equipment to produce revenue producing centers, which include respiratory care (arterial blood gas, EKG, holter monitors and pulmonary function testing), IV infusion pumps, cardiac monitors, telemetry, and the linen system), radiology (CT scan unit, ultrasound, nuclear medicine, fluoroscopy, mammography and the Pickert unit), laboratory (microscopy, reverse osmosis unit, blood cell analyzer, paramax chemistry analyzer, and microbiology unit); (3) the data processing system to include developing charges and a billing system on computer, purchase of typewriters and computers, paper shredder and development of a collection system and policies consistent with the St. Bernardine Medical Center mission and philosophy; (4) physician recruitment to include additional family practice specialties, internal medicine, OB/GYN, general and orthopedic surgeon; (5) negotiate insurance contracts, with particular attention to the private patients, HMO and PPO organizations focusing on the Big Bear resident’s employer
health plans and, last but not least, the medicare supplemental program.

NURSING SERVICE

I want to spend detailed time in discussing this very important patient care function within any health care setting. Nursing normally is the largest department in any hospital. At the head of the nursing department at Bear Valley is a Manager of Nurses who in turn has one assistant functioning as the 3 to 11 nursing supervisor and another for 11 to 7. Because the hospital is so small, it is not necessary to have special nursing units, such as med-surg, pediatrics, oncology, psychiatric, etc. Nursing in the rural setting requires a clinician who can perform all the functions necessary to qualify for an acute care facility (Robinson, 1976). Even though rural hospitals like Bear Valley do not have specific units so to speak, pediatrics is often mixed with med-surg and if a psychiatric patient requires long-term acute care, they may be stabilized at a rural facility and transferred to a health care center more appropriately staffed.

As we began searching for an appropriate Manager of Nurses, it was important for this position to have outstanding leadership skills in decision making, problem solving and interpersonal relations. We needed a person who could conduct staff development programs, identify certain
staff insufficiencies and make recommendations to offset any void in clinical persons. In addition, it was required that this position have an outstanding record in the maintenance of quality patient care and team nursing. Streamlining the system for greater cost control, clarifying procedures and the ability to implement nursing standards of equal value within the Mission and Philosophy of the Sisters of Charity of the Incarnate Word was also very important.

Nurses aides are utilized for patient care, and performing activities that relate to non-professional services in caring for the personal needs and comfort of the Bear Valley patients. Nurses aides can be of either sex, however, they must be well trained, particularly those that may perform certain duties in the operative area and/or physician assistant activities when called upon.

As is the entire Bear Valley Community Hospital held to JCAH standards, so is the nursing department which, in turn, I believe is scrutinized greater than other department as a whole. There are seven standards that any nursing service is judged upon, providing the impetus for Bear Valley’s nursing service to develop policies and procedures. The standards are as follows (Accrediation Manual for Hospitals, 1983).

The nursing services shall: (1) be directed by a qualified nurse administrator; (2) be organized to meet the
nursing care needs of patients and maintain established standards of nursing practices; (3) provide nursing care commensurate with the qualifications of nursing personnel; (4) provide goal-directed nursing care to patients through the nursing process; (5) be prepared through appropriate education and training programs for their responsibilities; (6) be guided by written policies and procedures reflecting optimal standards; (7) provide mechanisms for the regular review and evaluation of quality care and appropriateness of the nursing department.

Upon takeover of the hospital, it was necessary to review the existing nursing services policy manual which, much to our surprise, needed major revision and updating. A checklist was developed to serve as the road map for nursing policy generation and included such things as:

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As one would expect, the difficulty in finding nurses in a small community like Big Bear was very difficult. The supply simply did not meet the demand, therefore, nursing salaries were made very attractive as were the flexible work weeks and clinical nursing structures. It was necessary to maintain a float pool consisting of cross-trained nurses who may work in a unit at any time in addition to a part-time nursing list for those only desirous of one or two days a week. For some versatile nurses, their eight-hour shift at Bear Valley may consist of two hours in the emergency room, one hour in labor and delivery, three hours in the DOU unit
(Definitive Observation Unit) and the remainder of her day may be in the operating room. So, you can see that versatility is key for a 29-bed rural health care facility.

MEDICAL STAFF ISSUES

One of the biggest needs in Big Bear is well trained doctors, particularly those who specialize in family practice. With graduates increasingly choosing specialties that are more lucrative than family practice, the recruitment and maintenance of an adequate supply of family physicians, best qualified to provide care in rural areas, is diminishing.

There are few medical training programs in our nation that emphasize rural health care. And the National Health Services Corps, the federal program designed to bring physicians into areas that need physicians, has yet to realize its potential after 17 years of programming. The program has yet to result in a reduction of federally designated health manpower shortage areas, which now number approximately 2,000 (Flood, 1984). The National Health Services Corps was unpopular with the Reagan administration, each year the President took the program out of his budget, only to be resuscitated at the eleventh hour by Congress (Kuntz, 1984).

What many physicians see as a significant disincentive to practice out in the country can be traced to our PPS
system, i.e., Medicare. The physician payment differential is what I refer to as a frightening disparity and in some cases runs as much as 60% less than what an urban or suburban physician would be reimbursed. Yet, the cost of providing care in the rural community can actually be higher in part because of higher overhead costs, higher malpractice insurance premiums and often small numbers of patients seeking qualified care (Wennberg & Gittlesohn, 1982).

The American Medical Association currently is completing a study which, in turn, has gone before legislation to seriously address physician payment inequities. The current protect Medicare legislation is merely asking Congress to forestall payment reduction regarding the PPS system until a more in-depth study can be done to determine if cost savings can be achieved in any other fashion (Higgins, 1987). The rural physician, as well as those in all parts of our nation, must prepare for one of the most serious battles ever to be fought within the medical profession. With specialty pitted against specialty, region against region, and procedural doctor against cognitive doctor, all clamoring for a slice of the pie, physician groups such as the AMA may literally implode (Rosenblott & Moscovice, 1982).

It is very difficult for a physician from an urban setting, particularly one who is trained in an urban setting
with an urban background, to enter a small community and appreciate its differences and history from a larger community. It is also difficult for the physician to be comfortable in practicing medicine without a wide variety of technical equipment and technical personnel (Flood, 1984). For example, the Big Bear physician has not had a CT scanner on site until just recently, or angiography, which many physicians believe is necessary for the diagnosis and treatment of many of their patients. It therefore will take a special kind of physician to be comfortable in a rural, isolated environment, whereby split decisions without technology often mean the end of life.

Clinicians who have been trained in the tertiary centers and thus go to the rural communities often feel intellectually starved at first because the stress and pressure of learning are not always present in the rural areas (Van Hook, 1985). The rural communities now must find links for education, such as through the hospital satellite network and the sparking of new ideas, the ability to do research, and perhaps hookups with the tertiary centers so that there is a constant feeding back and forth between the tertiary and the primary care settings. Primary care physicians who interact with tertiary care specialists receive a broad viewpoint that they would not otherwise obtain. In addition, many sub-specialty physicians will
conduct clinics weekly to provide the needed clinical support for the rural physician, also to reconfirm a diagnosis and/or lend credibility to the existing health care setting (Petkus & Tseug, 1983).

I would be remiss if I did not discuss the turnover of physicians in rural communities. For some physicians, rural communities are not as challenging as they expected or perhaps have the environment they wanted to practice medicine in. There still remains the aura of the Marcus Welby, MD and the rural physician who means everything to his constituencies. Therefore, rural communities may attract the young, caring physician fresh out of medical school who truly cares about humanity and desires to practice a compassionate type of health care not often seen today. Or, the physician we jokingly talk about and know of the retiring doctor who may not want long hours of practice in a major tertiary center, and mostly desires a "laid back" practice. And finally, there is the physician who just can't keep pace with the urban environment, possibly his medical practices may not be of the quality and nature desirous of a major health care center.

Many physicians are still trying to determine what kind of model they want to practice medicine in. Do they want to be the sole practitioner in a rural community? (Flood, 1984) Most communities are still actively recruiting physicians
and will probably continue to try to increase the number of physicians entering rural health care in the next three, four, or five years.

As specialists move into rural hospitals, there is increased pressure on the hospital’s administrative staff to provide the knowledge and background expected by these specialists. The request for new technology is putting tremendous pressure on the capital reserves of hospitals. There are many hospital communities and boards that are telling physicians they might not have the technical capability to meet their needs or the money to either train the support staff or buy new equipment to meet the physician’s level of expectation (Van Hook, 1985). Big Bear is no exception as the hospital district board upon many occasions were not able to allocate appropriate funds to maintain technical health superiority.

Physician recruitment is vital to provide the variety of services to meet the level of expectation of your community (Puuch, 1982). Oftentimes a physician recruitment firm is used to assist you in matching the skills of the physician with your health care center, and to persuade the physician to change his lifestyle, relocate his family, and initiate a new unknown business (Snook, 1981). It is important to select a good recruitment firm in order to prevent loss in your investment, and to select one that
understands your mission and philosophy in other words, talks your same tune. As is the case in Big Bear, a cost of approximately 300,000 dollars was allocated to recruit five board certified physicians, respectively, specializing in orthopedic medicine, surgery, OB/GYN, internal medicine, and family practice.

The credentialing process is a key factor in the practice of good medicine at any health care center. Presently, in Big Bear, there are 20 physicians practicing in and around the area of Big Bear Lake. Of those 20, 9 have active admitting privileges at Bear Valley Community Hospital. One can rest assured that those with admitting privileges have been carefully scrutinized for credentials, background, malpractice, and any or all historical data that helps the chief of the medical staff and hospital board make a decision regarding the probability of associating with the physician.

The medical staff took on the same identity and organizational structure as found at St. Bernardine Medical Center. This includes the active medical staff who are responsible for the greatest amount of medical practice within the hospital; associate medical staff consisting of physicians who are being considered for advancement to the medical staff; courtesy medical staff are those who have privileges to admit and treat patients only occasionally,
i.e., specialty areas; provisional staff includes all initial appointments to the medical staff except honorary and consulting; and temporary staff privileges are extended to physicians who have been granted temporary privileges for a limited period of time by the chief medical staff officer or on the recommendation of the administrator.

All medical staff functions are under the guise of an executive committee who are empowered to act on behalf of the total medical staff, conducting such business as developing policies and procedures. They are accountable to the governing board for quality care, and pursue corrective action when warranted, serving as a liaison between the medical staff and hospital administration. Because the medical staff at Bear Valley is so small, it has been difficult to identify the need for department chairmen as normally their duties and functions are as a result of the complexity of a service much too large for the administrative body of the health care center to manage. Presently we're working toward identifying department chairmen, however, this is not a priority at this time. The committee structure within the medical staff is quite varied and each are normally found in all JCAH accredited hospitals. These committees will include medical records, infectious control, pharmacy, utilization review, medical audits, credentials, critical care, continuing medical education, OB/GYN,
pediatrics, family practice, surgery, medicine, radiology, and the list can go on and on. At Bear Valley not all of these committees have been specifically activated upon, however, if a particular issue arises within the respective disciplines, the executive committee will provide leadership as required.

QUALITY ASSURANCE

Quality, and quality assurance programs, are undoubtedly the utmost important and valuable component to a health care center’s success. As you know, to validate the quality of a health care program, is increasingly becoming the means to a successful end.

Far too often, people consider that a small or rural hospital is "okay" for such things as minor injuries or illnesses, but definitely not for serious health care problems. If hospitals can validate the quality of their health care, and in turn let the community know that they are constantly looking and validating this care, they will have a successful marketing tool (Sloane & Sloane, 1977). The community, in turn, must be informed and confident that care is appropriate and outcomes of that care are every bit as good as at any tertiary or major health care center (Accrediation Manual for Hospitals, 1983).

Probably the prime factor in a successful quality assurance program is the hospital’s willingness to deal with
the issues that the program raises. Most programs generally look at quality through a negative process, i.e., examining those occurrences that should not have happened. When such problems are unearthed, they must be dealt with and resolved, showing the willingness of a hospital to work collectively with the physician, the staff, and community to assure the highest quality health care center possible (Bridgman, 1955).

It is important to tailor a quality assurance program to the health care center. It must reflect the facilities resources, the number of physicians on the medical staff who support the program, and the scope of services offered (Robert Wood Johnson Foundation, 1987). In many small hospitals, for example, the scope of services offered may not be large enough to require full time quality assurance personnel. In fact, probably one of the most successful techniques in a rural facility is daily, or concurrent, quality assurance. Data gathered within minutes after an occurrence are not strictly "concurrent", but routine daily logs are still a very cost effective and personnel-efficient way to monitor several standard measures of quality, including such things as: (1) the incidence of infections; (2) the number, type and outcome of all surgical cases; and (3) the amount and type of blood and drugs utilized during the normal treatment processes. Routinely logging
information on such measures of quality is probably the most efficient way for a small hospital to engage in quality assurance without draining its resources (Robert Wood Johnson Foundation, 1987).

One problem faced by many rural hospitals undertaking quality assurance is that many of its physicians are referral dependent for their income. It is difficult to choose physicians for quality assurance committees, since many do not have the freedom to take corrective measures without worrying about peer pressure (Flood, 1984).

Rural hospitals can deliver care that is of equal quality to that found in the major tertiary setting, if they are careful to define their scope of services and then support these services by appropriate training, equipment and monitoring (Mullner & McNeil, 1986). This is not always as easy and straightforward as it might appear. In Big Bear, for example, cross-training of employees has been necessary to maintain the current patient population and treatment modalities. In view of this, many physicians may require assistance from employees who have not and could not be adequately trained. To be more specific, a visiting orthopedic surgeon may desire to complete an operative procedure, asking possibly a physical therapist or orthopedic technician to assist during the operation. The issue here is not the staff who are not appropriately
trained, however, it may be the visiting surgeon who is trying a medical procedure that far outweighs the technical superiority of the staff postoperatively.

Quality of care is one of the most delicate and controversial aspects of a rural hospital's operation (American Hospital Association, 1987). On one hand, those residing in a rural community should have reasonable availability of health care services without an undue travel burden. On the other hand, there is evidence that certain aspects of rural hospital care, or rather rural health care, may expose the community member to unnecessary risks (Snook, 1981). There clearly is a trade off between providing a full range of services and maintaining an acceptable level of care. The difficulty lies in defining where that trade off should occur for each service in the rural community.

Multiple attempts have been made by the American Medical Association, HCFA, and JCAH to develop selective criteria by which we may monitor and judge the quality of care delivered. Data availability, cost, government and the third party payor demands have subjected rural health care to a lack of appropriate criteria. Relatively little is understood about the specifics of rural health care delivery, therefore, it has been most difficult to determine the wide variation in quality of care in different settings, and to provide a fair and equitable evaluative process.
Unfortunately, quality assurance in a rural hospital is often dependent on outside factors that have a controlling value (Snook, 1981). Obstetrics is the best example of this observation that I know whereby the early identification of a patient at risk must depend upon the physician far in advance of the onset of labor. A certain segment of the obstetric population is not suitable for delivery in the rural hospital setting, and most likely will experience a much better outcome if delivered in a more specialized hospital, possibly housing an NICU and OB specialist trained in the field of difficult deliveries.

Another area going hand and hand with OB, is the quality of surgical procedures. Surgical rates vary widely from region to region, and this variation is due more to the organization of the medical services and supply of surgeons than any intrinsic difference in the medical need of the patient undergoing surgery. High surgical rates carry with them the risk of excess surgical morbidity and mortality, and thus excessive surgery may, in itself, contribute to a lower quality of care (Wennberg & Gittlesohn, 1982). I hate to say this, however, rural hospitals are often under financial pressure to utilize their surgical facilities, and the retention of a surgeon in a rural area requires that the surgeon has the opportunity to perform surgery. The
consequence can be inappropriate interventions that lead to very poor outcomes.

Rural hospitals face unique difficulties in implementing functional quality assurance programs because their medical staffs are small and it is impossible to create the full spectrum of committees that exist to deal with different aspects of quality in the larger hospitals (Waters & Murphy, 1979). At Big Bear, for example, we have consolidated these activities into one committee, thus joining medical records, utilization review, medical audit, tissue, blood, and antibiotic committees into one structure. Since all of these activities are different facets of the same surveillance function, it appears logical that we deal with them together at Big Bear.

A very recent technique for establishing quality assurance grows out of the increasing malpractice premiums with which many hospitals are faced. Hospitals are combining risk management activities with their existing quality assurance committees. Risk management is essentially a process of avoiding malpractice suits, but by preventing situations that lead to these suits, hospitals are forced to improve on the quality of care (Van Hook, 1985). Risk management also tends to motivate physicians much more intensely than the somewhat nebulous concepts of quality assurance. Because physicians also face rising
malpractice premiums and are increasingly familiar with the concept of risk management, they are more likely to participate actively in quality assurance programs established under the guise of risk management (American Hospital Association, 1987).

The goal of quality assurance in Big Bear is to pre-establish criteria by which each individual specialty and department will be guided. The criteria will be based upon criteria found at the managing medical center (St. Bernardine Medical Center), however, cannot be judged solely on the high standard of quality as found in an urban environment versus a rural. The 1989 specific goals will be: (1) determine the depth of services offered to include technical and staff support; (2) determine the perceived relative quality of those services, including the standards and criteria by which they will be judged; (3) determine the overall financial viability of the institution versus the type of technology required to deliver the expected levels of quality.

MEDICAL RECORDS

The organization and staffing of the medical records department reflects the tasks and functions, however large or small. The specific reason for a medical records department is to provide medical transcriptions, coding and abstracting of the diagnostic and protocol codes, storage of
patient data and retrieval of such, and the admission and discharge analysis, test statistics and record keeping (Waters & Murphy, 1979). Of particular interest to me is the hospital discharge data that is the responsibility of medical records to obtain and update on a regular basis, thus forwarding material to the state Office of Health Planning, the hospital counsel and others responsible for the maintenance and disposition of pertinent patient data.

MATERIALS MANAGEMENT

Bear Valley did not have good materials management efficiency, or cost control. As we approached our management contract, the biggest asset we had to offer in addition to overall management was the opportunity to consolidate such things as storage, distribution and disposal of supplies and equipment, group purchasing, and processing of equipment and supplies. The national average for expenditures in materials and management is approximately 46% of the total hospital budget (Barnett, 1979). Bear Valley was closer to 50% upon management takeover. Again, policies and procedures had to be developed, including such things as product specification, centralized purchasing, receiving and accounting for all supplies, stocking adequate supplies, review utilization of materials, standardize all products, processing and re-processing reusable supplies and materials, and controlling
unofficial inventories as well as reviewing and servicing patient care equipment and charges. The important thing in materials management is CENTRALIZING AUTHORITY AND RESPONSIBILITY FOR ALL SUPPLY, PROCESS AND DISTRIBUTION.

Now, all of Bear Valley's supplies are controlled through materials management at St. Bernardine Medical Center, including distribution, ordering and accountability.

PHARMACY

Even though all of the pharmaceutical products for Bear Valley are purchased and controlled from St. Bernardine, there is a hospital pharmacist there on a regular basis to dispense drugs and other diagnostic and therapeutic chemical substances. The pharmacist, of course, is licensed and able to provide a full range of pharmacy activities in consultation with the pharmacist at St. Bernardine. The pharmacist will review written prescriptions of physicians to determine if appropriate and that overdoses or toxic compounds will not result from prescribed ingredients. In addition, the pharmacist supervises the stock in the pharmacy, places orders with St. Bernardine's pharmacy, and maintains formularies, sources of information, standards on pharmaceuticals, reference texts and journals for use by other qualified personnel.

The entire stock of any hospital pharmacy is subject to governmental controls at all levels. Perhaps the most
rigidly regulated items are the various drugs. It is imperative that the pharmacist, medical staff and all employees authorized to deal with drugs understand the manner in which they are regulated. Through JCAH, standards of safe administration of drugs have been developed and must be maintained to ensure ongoing JCAH accreditation (Accreditation Manual for Hospitals, 1983).

FINANCE

Bear Valley's low patient census (10 to 12 occupied beds per day out of 29), payment limitations on government programs, new payment systems, tighter capital expenditures and geographic location, all provided greater financial risk for St. Bernardine Medical Center.

Initially, managing costs were considered to make the difference between success and failure. In addition, financial success has often been associated with volume increases, and aided by the recruitment of new physicians into the community (Flood, 1984). Maximizing revenues through medical specialties and quality of service will increase efficiency and reduce costs.

Not to overemphasize financial viability, however, if I were to choose a number one priority at the hospital, I would certainly say that if there is no margin there can be no mission to the community, therefore, financial management and viability is absolutely the key.
The aging population is a driving factor when considering the financial viability of a health care facility (Grimaldi, 1988). Presently, the medicare inpatient days represent approximately 35% of the total. It is projected that this will remain fairly stable for the next two years, or through 1991.

United States' expenditures for health care to the medicare population has increased from 16% in 1982 to projecting 18% in 1990, and 19% by 1995. This represents a 19% total increase during the period. We can clearly see that, by 1995, persons 65 years of age plus will make up the total of 13% of our population, which is up from 11% in 1980 (Sloane & Sloane, 1977). Meaning that nationally these figures may apply to every health care organization and that the United States government continues to be the single largest purchaser of health care (Rosenblatt, 1979).

Bear Valley does not anticipate any change in the medical population currently occupying 20% of the total patient days. Private insurers and other third party payors occupy approximately 30% of patient days. The remainder may present a serious dilemma if bad debt and voluntary fee care outweigh the cash payors.

Nationally, annual admissions to acute care facilities is projected to decrease from 170 per thousand population in 1984 to 165 in 1990 and 160 in 1995. The average length of
stay (ALOS) has dropped from the 1984 level of 7.6 days to 7.0 in 1990 and to 6.0 days in 1995. The combined effects of these reductions will mean an overall 20% decrease in hospital patient days per one thousand population between 1984 and 1995 (Anderson, 1984). As projected, the United States population is expected to grow less than 12% during the same period, the net result would be an absolute decrease in hospitalization in the next 10 years (Wennberg & Gittleson, 1982). Because future projections are the combined effects of national averages, historical financial data and our best guess, St. Bernardine anticipates the same decline for Bear Valley Community Hospital.

By 1985, the outpatient revenue comprised 13% of the total hospital patient care revenue. It is anticipated by 1990, 20% of the total hospital patient care revenue will be from outpatient services and will grow to 25% by 1995 (Anderson, 1984). Because of the demands placed on health care centers by the community, hospitals are expanding ambulatory services to counter the intrusion of new providers, such as surgery centers and urgent care centers, all fighting against the traditional hospital market (Freidman, 1981). In addition, third party payors are placing greater emphasis on ambulatory services and monitor much more closely technology practices and procedures once requiring lengthy hospital stay and repeat analysis to
project a disease process (Frymier, 1983). In addition, with the changes in payment incentives, home care, hospice and outpatient surgery, as well as extended care, physical therapy and rehabilitation will become more profitable as each service enhances the quality of inpatient care (Van Hook, 1985).

The bottom line in finance is to improve productivity as a key strategy for countering the negative effects that many changes in the health care industry will be imposing in the next five years. Improvements in operating revenues will be increasingly difficult to effect through either volume or price increases. Attention to all cost will be imperative through such things as group buying, productivity improvement and cross-training of personnel. Particularly in personnel and through performance evaluations where productivity is tied to compensation, success fills your pocketbook with rewards for a job well done.

Greater emphasis has been placed on controlling cost, increasing productivity, and better understanding of how much it actually costs to treat a patient at Bear Valley. The cost accounting system was put in place within the first year of operation, merging financial and clinical information together for the first time. Through the St. Bernardine information systems, accurate, timely and relevant information is provided to not only calculate the
risk of new ventures, but to effectively manage the current operation. The computerized information provided a system to make well informed decisions based on factual information and the data.

The cost accounting system is not new to the health care industry, however, new to Bear Valley. Cost management is a process of converting the basic resource input of such things as labor and materials into intermediate services such as laboratory, X-ray, and patient days, etc (Snook, 1981). The emphasis in cost management is on productivity which is primarily controlled by cost centers who, in turn, have department directors or managers responsible for the maintenance thereof. I guess one could refer to this as product line management involving the conversion of intermediate services into the ultimate product.

With the advent of DRGs and other forms of payment (HMO and PPO), the patient is automatically grouped in a cost center, much beyond the control of that product line manager or director. The emphasis naturally is on profitability which largely is controlled by that manager and the medical practices of the physician and the health care organization. Regardless of how costs are measured, the information obtained must be timely and reviewed on an ongoing basis in order to effect any modification that may be required for profitability (Snook, 1981)
Starting from scratch upon the implementation of St. Bernardine's management contract, established standards and criteria was developed and implemented focusing on productivity systems, incentives and disincentives, all new to the Big Bear organization. Immediately, purchasing and inventory control practices were given high priority as well as contractual agreements with suppliers not known to the organization. Engineering monitors were used to evaluate the plant efficiency and charged with analyzing functions of all equipment to determine the greatest degree of usage and performance.

Not to be forgotten is the necessity of communicating to the physician, the importance of appropriate equipment utilization, pharmaceutical ordering, ancillary service utilization and most importantly, the need to control demands on the employee for their time, such as operating room nurses, laboratory and X-ray personnel, and others who may be on a 24-hour call basis.

As you can see, finance is clearly a matter of every manager within the health care setting not excluding the physician who, in reality, serves as a pivotal point for the entire health care team. Viewing productivity and cost containment as critical to our future, the successful CEO of Bear Valley will plan for financial change and scrutiny and take more business risks in order to succeed in the years to
come. Doing all of this without losing sight of the human side of health care that the patient, the physician, the community and employees all expect.

CENTRAL SUPPLY

Many individuals do not know that central supply has the responsibility of maintaining all supplies and equipment required for the care rendered to patients. It is the department that collects, receives, processes and stores supplies and equipment, including sterilizing to ensure an aseptic condition in all supplies, equipment, and instruments. Central supply services every unit within the health care center and provides accountability for such things as dressings, IV solutions, gloves, special trays, needles and syringes, linen, basin sets, airways, suction catheters, etc. The controlling practices as set by central supply will ensure that such items as surgical instrumentation, gloves, needles and syringes will not literally walk out the door. Theft can be a major money loser, particularly with needles and syringes as a result of the Aids scare.

Again, Bear Valley is fortunate to have the services of central supply at St. Bernardine to assist in technical sterilization and control of equipment and supplies. Even though there is the control of the larger health care center, a checklist was established to ensure credibility as
we conducted inventory control, calibration of equipment, safety inspections, and maintenance of all equipment and supplies.

FOOD SERVICE

Recently, in conducting a patient satisfaction survey, it was discovered that the one service within the hospital needing improvement was food service. On the other hand, I don't know of many hospitals, with the exception of Cedars Sinai, that meet the level of dietary expectations of their patients. At Bear Valley, however, the existing food director that we acquired was relieved of her responsibilities and was replaced by a qualified dietitian who could not only meet our standards as a dietitian but could compliment the array of foods provided to our patients, physicians, and staff.

Food preparation should be done in accordance with local and state public health regulations, served in an attractive manner, and have excellent flavor and nutritional value (American Hospital Association, 1987). The new dietitian immediately began to maintain and develop files for quantity cooking, consisting of formulas to be followed, and indications in terms of numbers and size of servings. A diet manual was immediately prepared and circulated to the medical staff and nursing department for their use.
A program of menu planning began with a cycle of menus that was approved by nursing and the medical staff. It was felt that there were several advantages to cyclic menu planning, which would include minimizing planning time, coordination, promoting standardization, increasing labor efficiency, simplifying purchasing, improving inventory control, and maximizing the utilization of equipment.

I am happy to report that patients of Bear Valley are very pleased with their menus and the individual attention given in cooperation with their individual tastes.

HUMAN RESOURCES

Because a sizable percentage of Bear Valley's expenses is represented by payroll (42%), human resources receives much attention by management. The fact that there are 112 jobs at Big Bear Valley indicates the complexity and importance of the departmental function.

Human resources is managed through St. Bernardino Medical Center's wage and salary administration, job analysis and specifications, compensation and personnel policies. Labor relations is not a big issue with any SCH hospital as presently they are not under any unionization. Recruitment was the biggest issue initially faced and determining whether those presently on staff were professionally competent to do their job. In addition, all new applicants were scrutinized to determine their
qualifications and did they meet the requirements for employment.

As St. Bernardine began their management contract, it was apparent that the existing human resource pool was without benefits and was not paid fairly for the amount of work completed. St. Bernardine's salary administration program kicked into action, reviewing the different requirements for different jobs and analyzing salary levels consistent with those prevailing in the area. In addition, benefits were provided immediately to include health and dental for the employee and family members. It was soon determined that the benefits became a recruiting tool, good productivity incentives, and the bottom line was good employee relations.

PUBLIC RELATIONS AND MARKETING

The public relations and marketing department did not exist at Bear Valley Community Hospital. And to this day, they are still void of this very important activity. Unfortunately, marketing and public relations came from the St. Bernardine marketing office and, in turn, could only be administered intermittently. With such severe community issues at hand and the importance of communicating quality, this area has been greatly overlooked by administration.

All of the basic promotional tools which include brochures, news releases, internal newsletter, public
service announcements, advertising, direct mail, community workshops, lecturing, etc., have only been completed on a very minimal scale.

A marketing committee was activated by the director of the hospital to include the director of marketing from St. Bernardine, two board members, and key hospital staff. It is my hope that this committee can activate a marketing plan consistent with the needs of the community and develop targets and deadlines for implementation. In addition, I have recommended the use of an external agency to generate their newsletter, journalistic fact sheets for the local paper, and a newsletter for physician communication. To date, this has not been accomplished, much to my dismay.

AUXILIARY

Traditionally, an auxiliary department is headed by a director of volunteers who usually is a salaried, full-time individual. However, in small rural health care facilities, this position generally cannot be a paid one and essentially must rely on the volunteer president and her board for the operation of the department. The mission of the auxiliary is to supplement services provided by the hospital employees and to provide hospitality services at the reception desk, gift shop and other specialized departments throughout the health care facility not requiring professionally licensed personnel.
At Bear Valley, the auxiliary has been instrumental in conducting fund-raising programs to supply maintenance for the vans used in transporting patients, purchasing needed equipment, and practicing good public relations as they serve as an extension of the Sisters of Charity in the community.

ANCILLIARY SERVICES

Respiratory care continues to grow not only in scope of responsibility, but also as a cost and revenue center for the hospital. In Big Bear, the department is not as large, naturally, as a major tertiary center, however, it provides both diagnostic and therapeutic treatment of inpatients and outpatients. A respiratory care manager has been identified to work in unison with the physician, nursing staff and patient to provide therapeutic procedures as prescribed in writing by the physician.

Physical medicine and rehabilitation at one time in Big Bear was a product line of distinction and was closely aligned with the Bear Valley Hospital facility. As St. Bernardine began their management contract, the physical medicine department was deleted as a key service to the community. Our goal in the first year of operation was to offer acute care services in line with the mission and philosophy of the Sisters of Charity. To do this, it was necessary to determine what services would remain that were
appropriate in quality and resource utilization. Physical medicine has a place in an acute care facility, only as the department relates to the orders of a physician and needs of the patient and community. Therefore, a physical therapist is on staff at Bear Valley Community Hospital, providing both inpatient and outpatient rehabilitative services. At this time, there appears to be no need for extensive physical medicine services and/or enough revenue possibilities to warrant further examination.

The social services department has taken on an important role in aiding the process of quality assurance. I would judge that the most important role today of social services is their important contribution to the area of discharge planning. Discharge planning leads to extended care, rehabilitation, home health services and other supportive elements found within a community. Bear Valley contracts with an LCSW in the community who meets with the discharge planners on a weekly basis to review case format, discharge planning and other pertinent social service concerns. In addition, social services contracts with the Mountain Medical Supply Company to provide home hospital equipment and Meals on Wheels to assist with menu preparation and dietary needs.

To further assist in the discharge process of the Bear Valley patients, home health services are secured through
the Bear Valley Home Health Agency. The Agency contracts with RNs, LVNs and nurses aides to provided needed daily visitation, treatment modalities, and support of the physician in the home setting. As one would expect, home health has become increasingly important as a result of the DRG regulations and need to discharge a patient earlier than normally recommended.

CONCLUSION

Rural hospitals are discovering a whole new mission in identifying who they are and what they are about. They are having to provide more technology for some of the specialists who are moving into the community and that, of course, is stretching their resources (Mullner & McNiel, 1986). The consumer is aging in some communities, and this is bringing about different demands on the health care system. With new technology, they have an opportunity to deliver health care in different ways, such as outpatient services, home care, rehabilitation, and mental health programs. Rural hospitals are being asked to deliver services in many areas that they had not delivered in the past. They need to know where to go to find the resources and the ideas to meet those needs (Rosenblatt, 1979).

Rural hospitals, like other institutions, respond to a variety of internal and external factors. Their viability is determined by internal management strategies, the nature
of existing services and facilities, and by external factors such as population composition, competition from other facilities, and relative location (Freidman, 1981).

Rural health care in the United States and Big Bear should address strategies that are necessary for a hospital’s continued viability, as well as ensure that needed care is delivered in rural communities. This will involve needs assessment, determination of policy alternatives most likely to address local problems, and the establishment of a funding mechanism to put the necessary policies and practices into operation. Only through careful monitoring and analysis of program planning, accountability and human resource control will rural health care develop agendas that are essential for their survival. Like the first rain after a long hot summer, the increasing attention given to rural health care issues today is heartening for us as providers. For the first time, legislative initiatives promise to offer some relief from what everyone sees as rural providers’ biggest curse: DRGs and rural/urban reimbursement differential (Higgins, 1987). Even upping rural hospital’s reimbursement rates to double what is paid to urban facilities will not take away our present troubles, certainly though will add some relief. Some hospitals are just bound to fail. However, when those hospitals are the only access to health care within a vast rural region, the
problems associated with closure can be interpreted into increased mortality and morbidity and greater health care dollar utilization resulting from lack of preventative health care measures (Mullner & McNiel, 1986).

Several findings from this internship are particularly significant within the community of Big Bear Lake. First, the elderly population is increasing at the rate of 4% per year. As a result, this may lead toward a swing bed proposal in the very near future. Second, the association of Bear Valley Community Hospital with St. Bernardine, provides an avenue for inservice education to include physician education, all very important for the recruitment and retention of professional staff. Third, a communication system designed to provide ongoing information to the public about quality, new technology, personnel changes, etc. is very important to have firmly in place. People will leave the rural area for their health care if they are not assured that a quality system is effectively in place in their community. Fourth, as a result of the PPS system and stringent guidelines on payment for services rendered, support services such as home health, hospice and home pharmacy become an important management agreement for the rural hospital. If swing beds are not in place, patients must be moved from the acute care facility to home much quicker than ever before. Fifth, the monitoring of quality
assurance in the day to day operations and of expeditious actions as a result of an inequity can save the rural hospital millions of dollars if not closure.

For Big Bear, the hospital will continue to play a vital role in building and sustaining a strong rural health care system. The hospital will continue to strengthen and become involved in the community as they collectively define the optimal role of the hospital as part of the large SCH health care system. The administration will continue to build local leadership through human resources and provide an important link in health care planning for the community and County of San Bernardino. All of this takes place as the administration of the facility continues to define the specific elements of the hospital system and the integration of that system into a total community health care plan.

St. Bernardine Medical Center will continue seeking local community support as we collectively define and achieve an optimal range of health care services. Bear Valley Community Hospital is the logical focus for health care in the small mountain community of Big Bear and continues its trend to be the symbolic and actual center for all health care services in the area. The hospital is a direct expression of the community’s aspirations and involvement in developing a health care model that they, the community, will never stand for its demise.
RECOMMENDATIONS

A commonly suggested approach to the problem of rural hospital utilization has been the implementation of swing beds. Swing beds are specially designated beds that can be used to provide care to either acute or long-term care patients.

Growing numbers of hospital wards are modifying their institutional goals to include skilled or immediate nursing home services. Services of this nature can be rendered in a free-standing facility, a distinct hospital-based unit, or swing beds (Grimaldi, 1988). Through the use of swing beds, patients who might otherwise receive care in a nursing home can utilize a hospital. The rural community may not have the luxury of a nursing home facility thereby causing the patient to leave the community and oftentimes their family to secure long-term care. To be eligible to implement a swing bed program, a hospital must be rural, have 50 or fewer acute care beds (excluding intensive care and newborn beds), 24-hour nursing coverage, obtain a state-approved certificate of need for provision of skilled nursing services, and obtain approval from Medicare to participate in the swing bed program. And, unlike the conversion of unused acute care beds to long-term care beds, a hospital need not surrender its license for the acute care beds in which swing bed services are provided.
Effective April 1, 1988, the federal swing bed program was extended to rural hospitals with between 50 and 100 beds, subject to two constraints: swing bed days cannot exceed 15% of available annual inpatient days, and swing bed patients must be transferred within five weekdays when a nursing home bed is available, unless a patient's physician certifies that transfer is medically inappropriate (Grimaldi, 1988).

Some analysts have expressed fear that implementation of a swing bed program will deplete the resources of nursing homes, even as it strengthens hospitals by providing them with more patients. In areas where swing bed programs are already in place, it has been noted that significant increases in hospital utilization was as a result of meeting the demands that had previously not been met, rather than taking patients away from already existing nursing facilities. In Big Bear, there are no skilled or intermediate nursing facilities, indicating that the demand of the elderly population is not presently being met. It is my contention that a rural acute care facility, in meeting the needs of its public, must offer as many services or product lines from cradle to grave, so to speak, to maintain financial viability. I also suggest that implementation of a swing bed program reduces acute care lengths of stay, partially because the DRG based reimbursement for the
Medicare patient in a swing bed provides a hospital with an overall incentive to be more efficient.

For those rural community hospitals at risk I am not convinced, the economic pressure will be relieved as a result of implementing a swing bed program. I suggest that further research be accomplished to determine whether a swing bed program can strengthen a faltering rural institution, or if swing beds serve to further enhance the position of a hospital that is already strongly competitive in the market.

The governing board of Bear Valley Community Hospital should carefully scrutinize the swing bed program from a financial and operational point of view. Depending on the proposed program size and revenue involved, the board may wish to appoint a planning committee to further determine the feasibility of such a major change for the hospital. It will be important to determine if the swing bed program is consistent with the hospital’s mission, goals and existing strategic plan. The big question is will the demand far exceed available services at Bear Valley Community Hospital. In addition, will the Board of Trustees be willing and able to make the necessary changes to implement the program and develop the criteria on types of patients to be cared for to include the program’s goals and objectives. In satisfying federal standards for acute care facilities, hospitals must
demonstrate their ability to meet the general health and safety needs of long-term care patients. To meet the patient’s rehabilitative and psychosocial needs, a hospital swing bed program must comply with specific standards for care including rehabilitative, dental and social services in addition to appropriate patient activities, patient rights and discharge planning.

I would have definite concerns as we approach the concept of this magnitude and certainly would want to gather all the facts prior to any administrative presentation. I would strongly recommend to the hospital board that the following be completed concerning the possibility of swing bed services: (1) undertake a financial feasibility study concerning the program; (2) consider all avenues of financial resources and possible revenue generating services as a result of a swing bed program; (3) support education programs to inform the staff about the possibility of a program and determine if any resistance exists; (4) formulate strategies to promote the program within the general public, community leaders and organizations using key selling points of access, quality and continuity of care. Once our questions are answered and we know the financial feasibility does not indicate a major risk, then careful implementation of the program and identification of beds would be appropriate.
The Omnibus Budget Reconciliation Act of 1987, establishes a federal grant program for certain rural hospitals beginning October 1, 1988 (Anderson, 1984). The program aims to help private, not for profit and public, non-federal rural hospitals with fewer than 100 beds to modify their services in response to changing community circumstances. Under this program, qualified hospitals may be awarded $50,000 a year for two years through the Governor of the State of California and Secretary of Health and Human Services. I strongly suggest that the management of Bear Valley Community Hospital review the possibility of submitting a grant application for funds to provide additional revenue to assist in new program implementation.

It has been suggested that a full understanding of the vast changes taking place in rural health care delivery is hindered by the lack of available data on hospital behavior and overall rural economic trends. When regional health planning fell out of favor in California, we lost the major impetus to regional health care planning. Looking at the current trends in health care planning and the over-saturation of specialty services in urban areas, it appears as though the regional health planning consortium, is now more necessary than ever before. Part of that health planning consortium used to be a state office of rural health services which would oversee, coordinate and
implement state rural health policy. One always knew that at the helm were committed and interested persons who not only understood rural health needs but had the authority to apply pressure in Sacramento and Washington DC where policies concerning rural health delivery are made. I strongly recommend the redevelopment of the State Office of Rural Health here in California feeding into a regional planning function such as what the Inland Health Counties Regional Resources used to provide. As a result of the reawakening of the State Office of Rural Health in California, we could then be assured that we had an advocate for rural health and our community of Big Bear. Other functions of that office could include: (1) to house a regional health personnel center for personal planning, recruitment and placement; (2) stay on top of public rural policy issues and provide analysis thereof; (3) be supportive legislatively, regulatory, and in major reimbursement initiatives; (4) be available to assist with community needs assessments and market surveys to ensure the delivery of service is on target; (5) provide technical assistance when needed; (6) assist rural hospitals in transforming their facilities to other services when appropriate; (7) most importantly, create that support system for the rural physician to also include their recruitment; (8) last but not least would be to coordinate
and support networking of agencies and organizations all involved in the present day issues of rural health.

Because Big Bear is an isolated community and the difficulty of recruiting qualified personnel will always be at hand, I recommend adding a physician management component to include personnel, accounting, billing, and marketing/community relation activities. I particularly like that because physician bonding will be key to the success of the Bear Valley facility and their success in practice means long-term viability in the community.

I further recommend an analysis be conducted regarding ambulatory care services and how far can a rural health facility go in expanding outpatient services to better meet the need of the PPS system and patients in general. Can we package price some of the procedures that are classified as outpatient, particularly surgically can Bear Valley Community Hospital have a surgi-center type environment and pricing structures.

With the addition of two outstanding family practice physicians, I recommend at least beginning discussions for joint venture with them in a family practice center. As time goes by, other physician specialties may want to participate, creating an image to the public of consistency, coordination, and delivery of quality for the entire family.

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Eventually, I feel the need to develop our own HMO, to be offered to the major employee groups in the area. The issue of HMOs now is one of control and contracting with physicians to provide appropriate coverage for Bear Valley’s residents. I recommend another feasibility to determine if (1) the need is truly there and, (2) would it be a sound financial decision to develop.

My final recommendation is one of management and authority generated from St. Bernardine Medical Center. It has been traditional with the Sisters of Charity health care system to appoint sisters for on-site management, visibility and pastoral and patient care services. Therefore, I recommend that a minimum of two sisters be appointed to the Bear Valley Community Hospital and a convent of reasonable stature be developed. In addition, the administrative personnel of St. Bernardine Medical Center should make greater attempts to provide leadership in strategic planning, marketing and community relations, and physician relations. I would urge the development of a one-year management team to firmly take control in all areas of hospital management and provide the supportive element to the existing executive director. Through the demonstration of commitment to the viability of the organization and implementation of appropriate teaching tools for the management staff, there is no doubt in my mind that Bear
Valley Community Hospital will remain a viable entity for the community for years to come.
FOOTNOTES

A special acknowledgment goes to Mrs. Brenda Boss, a retired teacher in Big Bear Lake and resident off and on for approximately 40 years. As I have worked with her this past two years and interviewed her especially for this report, my thoughts were that every community needs a Brenda Boss.

Brenda has served on the Bear Valley Hospital District Board of Directors since the incorporation in 1955. She has served in many capacities throughout the past 33 years, however, most importantly served as the founding member of the Bear Valley Community Hospital. Brenda is very warm and charismatic and in talking with me about how the hospital came about, she told many delightful stories of early medicine in Big Bear. As an active schoolteacher, many times children in her classes became critically ill and were either hospitalized at St. Bernardine Medical Center or Loma Linda University Medical Center. Many people in the Big Bear area have limited transportation, making a trip down the hill on a daily basis impossible to accomplish. Brenda, always showing concern for all of mankind, often would transport parents and grandparents and other relatives up and down the hill to visit sick children and provide transportation for them to and from doctors appointments.

Thirty-three years ago, Brenda realized the importance of having a well-founded and managed hospital in their community. She began a major drive to raise funds for the proposed hospital, secured Hill Burton monies and passed a bond issue which, all collectively and ultimately created the Bear Valley Community Hospital. As Brenda’s appeal continued, she was introduced to the wife of Mr. Fluor, president of the Fluor Corporation. After a personal visit to Mr. Fluor, a donation of one million dollars to the Bear Valley Community Hospital District was made. As one can imagine, this provided the impetus to do bigger and better things. From the moment of incorporation in 1955 to the actual dedication of an edifice in 1976, you can see that the provision of rural health care is not easy.

My heartfelt thanks to Mrs. Brenda Boss for her ingenuity, sense of community well being, strong dedication, and most importantly, her ability to manage, plan and pull people together in an organized fashion. I doubt very much that the tourist trade taking advantage of either the lake for fishing and water skiing, or the ski slopes for wonderful winter activity know the history behind the hospital except to know that it’s there when needed, thanks to Brenda Boss.
I was introduced to Mrs. Susan Thomas back in July of 1987 when she approached my office asking for help with the Bear Valley Community Hospital. Susan, at that time, served as the president of the Bear Valley Community Hospital District Board and was charged with literally saving the hospital, as Westworld, the management firm, was filing Chapter 11.

Westworld was at one time a very large management concern, managing the Bear Valley Community Hospital, Lake Arrowhead Mountains Hospital, Needles Community Hospital, and others in Southern California of similar stature. In the beginning of their contract with Westworld (a 30-year lease), Westworld was charged with a monthly lease payment to the Bear Valley District Board of $7500 and was to maintain the entire facility including equipment upgrading, maintenance, employment management, and all administrative and fiscal services appropriate for a health care facility. Westworld came in with a bang, utilizing high caliber administrative people who, in turn, effectively communicated with the community and laid the ground for a trust relationship between the medical staff, hospital and community. Building up the reputation of the facility, Westworld began to overcharge for services, causing people of the community to seek services elsewhere. The community began to see Westworld as a giant who had their corporation at heart more than the people residing in Big Bear.

As the president of the Bear Valley District Board, Susan Thomas was very concerned that the community was soon to be without a health care facility. Coming to St. Bernardine, she asked that we consider an interim management contract to at least keep the emergency room open, as the summer season was providing very aggressive injuries and winter season was right around the corner. Susan’s drive and continued communication with the administrator of St. Bernardine ultimately yielded an inter-management agreement, commencing November 1, 1987 and an official management contract effective January 1988 as awarded by the federal judge through a bankruptcy hearing.

The importance of a community activist cannot be overlooked or overemphasized. Susan Thomas is that type of person who realizes a void in addition to acknowledging the needs of the community, and thus never tiring through the ordeal of her pursuit. I am sure that larger communities have a Susan Thomas, however, but because the populations are so great and diverse, it is often difficult to identify people of this great magnitude and strength. Susan spent many sleepless nights and days in negotiating with
attorneys, St. Bernardine, and the community in general, to assure that what was the dream of Brenda Boss in 1955 remained a reality for the community of Big Bear Lake.

In July of 1987, Leanne Ballard was hired at Bear Valley Community Hospital as director of nurses and assistant administrator. Her first day on board she was greeted with hugs, tears, warmth all mixed with fear, anger, hate and absolutely no trust from the employees. Fifty percent of the employees were laid off, leaving only a skeleton crew for her to work with.

In July of 1987, the Bear Valley Hospital District Board assumed control over the facility as a result of Westworld's bankruptcy proceedings. Leanne was hired in the midst of the "tornado" and immediately had to overcome what she termed the "adventurous situation". Her first inclination was to observe and listen to employees and assess the attitude and capability of the team. She knew that the acute health care hospital was desperately required and deserved by the community of Big Bear, thus she began setting goals for staffing patterns to cover 24 hours of health care with minimal supplies and cash. Leanne literally bartered with other hospitals to ask their assistance in ordering supplies, and many of the personnel actually used their own money to place and pay for orders. She began building unity out of diversity through communication of responsibility, honesty and validation of each employee.

Thus in January, when the management contract was signed with the Sisters of Charity, Leanne Ballard was named the executive director effective in February of 1988. An outstanding characteristic of Leanne is that she believes people are the greatest asset any manager could hope to utilize. Management has no power, management has only responsibility, managing means making the strength of people effective. Leanne actively began working her people and promoting communication to and from in every instance. She continued helping employees realize how valuable they were and provided constant validation of their strengths, which ultimately resulted in unity of the team effort. She put good management skills into action, providing a logical plan to accomplish the company's goals and communicated the plans to everyone concerned. She provided feedback to the staff, doctors and community, constantly appraising them of any change that would effect them as a person.

Leanne knew that negative experiences in the community are relayed rapidly and not easily forgotten, particularly
in a small community as Big Bear. She also believed that the community members were entitled to fair pricing, quality care, versatility of services provided through the utmost in kind and loving personnel. She has worked diligently to communicate these things to the public, however, she is only one person and it is very difficult to be everything to everybody. There is no doubt in my mind that Leanne has been an excellent manager for the facility, however, she has not received the corporate support necessary nor communication from St. Bernardine to fully achieve her potential. I have a sense that this is indicative of the management company and their expression in treating the Bear Valley Community Hospital as a stepchild. My hat is off to Leanne for her stamina and continued leadership and support for this dynamic health care facility.
REFERENCES


