Federally Qualified Health Center Strategies for Coping with Hospital Closure:

Community Health Center of Southeast Kansas (CHC/SEK)

INTRODUCTION

When Mercy Hospital Fort Scott (Mercy) closed its doors in Fort Scott, Kansas, after 132 years in operation, the rural community of 7,800 was left without a hospital. In the tumultuous aftermath of this closure, Community Health Center of Southeast Kansas (CHC/SEK or CHC), a Federally Qualified Health Center based 30 miles away in Pittsburg, Kansas, stepped forward to take over two of the closed hospital's primary care clinics, providing a range of primary and preventive care services in Fort Scott, partially filling the gap left by the hospital's closure.

The circumstances leading up to the hospital's closure and its impact on the community have been well-documented by Sarah Jane Tribble in NPR's nine-episode podcast, "Where it Hurts, Season 1: No Mercy." This case study focuses on CHC's response to the closure and its efforts to restore access to primary care in Fort Scott, while the community grieved the loss of its hospital.

Through interviews with CHC/SEK's leadership, Capital Link explored CHC/SEK's response to Mercy's closure, the subsequent impact on the community and the current state of the situation, in order to highlight lessons learned for rural centers in similar situations.

BACKGROUND

When the close knit community of Fort Scott, Kansas, learned that their only hospital was closing for good in late 2018, a shared feeling of confusion and loss swept the 7,800-person city. Though devastating, the situation in Fort Scott is only a microcosm of a much larger, ongoing trend of hospital closures in rural America.

Declining populations, rising medical costs, and resistance to adopting expanded Medicaid eligibility as allowed by the Affordable Care Act contributed heavily to these closures; unfortunately, the remaining patient populations are often left in the lurch. In rural locations especially, the population is more at-risk and in need of health care as compared to other areas. In Fort Scott specifically, without a hospital close by, expectant mothers face the risk of giving birth in the Ascension Fort Scott emergency room instead of in a maternity ward.

Given the higher rates of poverty, unemployment, teen pregnancy, and lack of health insurance compared to the rest of the state, the residents of Fort Scott, Kansas, could have been in a dire state without a hospital when Mercy closed in 2018. However, despite outward objections, CHC/SEK proved that perhaps a hospital wasn't the only viable health care solution for this rural community. In fact, a local health center may have been just what Fort Scott didn't know it needed.

MERCY CLOSURE

For many years, Mercy Fort Scott was the center of specialty care in Southeast Kansas and quite literally the only healthcare provider in town, facing virtually no competition and garnering great loyalty from the community.

As one of the 25 largest health systems in the U.S., Mercy is an integrated, multi-state health care system serving millions of patients every year. Currently, it has 900 physician practices and outpatient facilities and nearly 2,500 clinic physicians across Arkansas, Kansas, Missouri, and Oklahoma. Founded in the early 1800s by what would later be known as the Sisters of Mercy, the Mercy health system was built upon the desire to help those in need.

As Fort Scott's first hospital, the town wanted to preserve Mercy's presence, according to Krista Postai, CEO of CHC/SEK. "The more time I spent in Bourbon county, the more I realized there was really nothing Mercy had not touched. I have never encountered a health system that was such a big part of the community," she said.

RURAL AMERICA
BY THE NUMBERS

Between 1999 and 2016, the rate of suicide among Americans ages 25 to 64 rose

41%

with the greatest increase in rural counties

Rural residents have

9%

greater risk for severe morbidity and mortality compared to urban residents

181

rural hospitals have closed since January 2005, and..

65

rural hospitals closed between 2017 and January 2022—equaling the rate of the previous five-year period

FORT SCOTT,
KANSAS

$35,000

median household income

86%

of CHC's patients live at or below 200% of the Federal Poverty Level

20%

of CHC's patients are uninsured

26%

of children in Bourbon County (where Fort Scott is located) live in poverty, compared to...

15%

for the state of KS, and...

17%

of Fort Scott residents age 65 and under live with a disability

Kansas is one of **12 states** that has not adopted Medicaid under the Affordable Care Act.

As technology and medical care evolved away from inpatient care, Mercy's more than 40 beds were increasingly empty. At the time of Mercy's closure, the population was swiftly declining in Bourbon County—a common trend throughout most of rural America.

> **We analyzed the situation.**
> It was a smart, calculated risk—it wasn't a crazy idea.
>
> *-Jason Wesco, CHCSEK President & Chief Strategy Officer*

In addition to declining patients and growing expenses, Mercy had not been able to obtain Critical Access Hospital (CAH) designation, although it had twice applied for this status. As a result, it was not eligible to receive the special reimbursement associated with the designation—further contributing to its serious pecuniary dilemma. By 2015, as it became clear the hospital was facing an untenable financial situation, corporate leadership began looking at service line closures as well as selling and/or closing the hospital entirely.

When a sister hospital in Independence, Kansas, closed its doors, many saw the writing on the wall for Mercy Fort Scott. With an average daily census of fewer than three patients, the hospital formally announced its closing in late 2018—much to the consternation of the community.

Meanwhile, CHC/SEK had long had its eye on Fort Scott as a possible site for a new access point and had reached out for years to Mercy to discuss potential collaborations—to no response. Eventually, executives from Mercy's corporate offices in Joplin reached out to CHC/SEK, asking for a tour of the center's facility in Pittsburg.

CHC/SEK, which began as a community outreach project of Mount Carmel Regional Medical Center in Pittsburg, Kansas, in 1997, originally opened with the intention of providing free health care to children and eventually expanded to provide affordable health care for all ages. By 2003, they became an independent organization with 11 employees that cared for 3,300 patients. Today, a Federally Qualified Health Center (FQHC), the health center employs more than 600 individuals who help provide medical, dental, behavioral health, pharmacy, and support services to more than 70,000 patients annually.

Recognizing the mission alignment between the health center and the Mercy system, the organizations began discussing the option of CHC/SEK taking over not only the hospital's Medical and Walk-in Care clinics in Fort Scott, but also Mercy sites in Arma, Pleasanton and Columbus, Kansas, and Miami, Oklahoma.

TRANSITION FROM MERCY FORT SCOTT TO CHC/SEK

Though based in Pittsburg at the time of Mercy's closure, CHC/SEK recognized the great need for care in Fort Scott, as it was serving many of the town's uninsured patients at its various sites, according to Jason Wesco, CHC/SEK President and Chief Strategy Officer.

Fort Scott had always been on CHC/SEK's radar screen as it assessed growth opportunities as part of its ongoing strategic planning processes, but without an invitation or meaningful relationship with the hospital, they did not proceed until contacted by Mercy Joplin. However, once invited in, CHC/SEK moved swiftly to make the transition.

To start this massive undertaking, CHC/SEK hired a consultant to help them assess the situation. This analysis confirmed what the center already suspected: they were already serving most of the area's uninsured and taking over the Fort Scott practices would not only improve their payer mix, but would provide more convenient care for ~14,000 total patients in the community. The analysis showed the Fort Scott practice was likely to improve CHC/SEK's payer mix in the Fort Scott service area from 49% uninsured to 18% uninsured and with a substantial portion of the population aging into Medicare eligibility.

"We analyzed the situation," Wesco said. "It was a smart, calculated risk—it wasn't a crazy idea."

Despite the positive feasibility analysis and Mercy's blessing, the city pushed back. The hospital had status that CHC/SEK lacked, Postai said, and the health center got the brunt of the city's anger about the decision for Mercy to close.

"We knew it was going to be painful but at the end of the day, other corporations couldn't have provided what we could," Postai said. "So we persisted. I have to salute Mercy, because it was not easy to get from point A to point B. They hung in there with us and went above and beyond. The people from Joplin were sincere in wanting to preserve the mission."

To begin the treacherous process of moving into Fort Scott, CHC/SEK first interviewed all Mercy hospital clinic staff and offered them the opportunity to come on board at CHC at their previous Mercy salary level. CHC/SEK also did not require provider non-compete agreements, which was perceived as very fair by oncoming staff. Though some opted to seek other opportunities, many decided to join the CHC/SEK team. The center also made a special effort to preserve critical community services not available elsewhere. For example, while FQHCs often do not offer mammography, CHC/SEK also brought over the 3D mammography staff, retaining this important service in the community.

However, incorporating the new staff was not smooth sailing initially.

BEFORE AND AFTER:
MERCY FORT SCOTT TO CHC/SEK

The former Mercy Fort Scott Hospital

The current CHC/SEK Fort Scott clinic, in the former Mercy building

"It was hard because our culture was well defined," Wesco said. "We don't want to say it's our way or the highway, but there are some things we're not giving up. Mercy staff figured that out pretty quickly and some didn't want to come over," he said.

Merging a corporate health care culture with the ethos of a health center caused initial growing pains, especially because Mercy staff previously had an entirely different, Relative Value Unit (RVU) payment structure. At Mercy, the hospital charged co-pays up front, which meant "no payment, no service," according to Dr. Pankaj Gugnani, CHC/SEK Chief Information Officer and former Mercy physician. This financially-driven model is the exact opposite of the health center model—and both models bring challenges.

"If you're in a system where you get paid whether you see someone or not, it doesn't make you want to see more," Wesco said. "But there is always a need to see more people. Patients want to get in—they don't want to wait three months before they see their doctor."

After realizing the differences between Mercy and CHC/SEK's payment structures, Dr. Gugnani restructured the provider payment system to adjust from "corporate America to community health America." This helped bridge the gap between Mercy's physician-centric, financially driven, maximum reimbursement culture and the health center's "access first," patient-centric model. Gugnani implemented a report card for physicians to show productivity, intensity and quality metrics, tied to a bonus-based structure that is reviewed semi-annually.

While the culture shift for providers was profound, Gugnani said most former Mercy staff appreciated CHC/SEK's model and found it was ultimately better for patients and more satisfying for providers—allowing them to "treat patients, not their wallets."

To help assist with the transition, CHC/SEK hired former Mercy Hospital Fort Scott President Reta Baker, who now runs CHC/SEK's family medicine residency program, helping attract and retain providers in Southeast Kansas. Though merging Mercy and CHC/SEK staff was not seamless in the beginning, Baker said the shared mission helped bridge the divide.

"CHC/SEK brought back to life the mission for the providers and the staff. It was very exciting to see the need—and meet the need—without worrying whether you've been out of compliance with budget," Baker said.

When approached about the transition, Dr. Gugnani, who had been with Mercy since 2004, along with most of Mercy's primary care providers (doctors and nurse practitioners) decided to stay on at the health center while Mercy specialists and surgery staff scattered.

"Everybody that came over agreed with the mission of CHC/SEK," Gugnani said. "What really matters in the end is the patients and the community that we live and work in, and that we serve them well."

Downtown Fort Scott, KS.

ADJUSTING TO A NEW REALITY

Though CHC/SEK hit the ground running when they opened their doors in Fort Scott to get patients in the door, the town was not as enthusiastic to embrace the change.

According to Baker, many felt blind sided by Mercy's closing, despite being warned on many occasions regarding the hospital's financial distress. In hindsight, Baker said that the community education could have been improved, as everything happened quickly and in the shadow of the community's grieving process.

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>
> *-Dr. Pankaj Gugnani, CHCSEK Chief Information Officer*

"From 2014 until 2018 when Mercy pulled out of Fort Scott, I was on my soapbox all the time. My tag line became: "Use the hospital or lose the hospital. Nothing should have surprised the community," she said.

Though many of the initial growing pains have been sorted out over the last few years, some community members are still not content without a full blown hospital, Wesco said.

"People are still holding onto the idea they need a hospital but nobody knows what that means," he said. "This trauma is relived all the time up there. Why don't we embrace what we have and stop talking about what you think we might need?"

According to Gugnani, Fort Scott initially felt betrayed by the closing of its nearly 135-year-old hospital. The town felt that history was being erased, he said.

However, three years later, Baker said she believes the majority of the town now appreciates and values the work of the health center. In the transition, the city gained services not before offered, including pharmacy, behavioral health services, and engagement with schools—and above all, access to care regardless of ability to pay. In addition, the pandemic allowed the health center to step up to be an important presence in the community, providing testing, vaccines, and education.

"Now, everybody feels and knows if there is another crisis, CHC/SEK will step up and do what has to be done," Baker said.

CHC/SEK invested approximately $1.5 million in the transition, with $300,000 provided through Mercy's foundation. In retrospect, CHC/SEK leadership admits they should have negotiated for a larger contribution from the hospital. However, Mercy did donate equipment, land behind hospital and its helipad, the convenient care clinic building downtown, and lease of hospital space. The health center, which is currently in the process of developing a new facility at a closed former Price Chopper in Fort Scott (slated to open by the end of 2022), has committed to making a substantial additional investment in Fort Scott, putting down roots in the community—while the City and County still refuse to give up on the idea of reopening the hospital, committing $1 million for another feasibility study conducted by a venture capital-backed firm from Kansas City.

IMPACT

Expanding into Fort Scott has substantially impacted the community and the health center. Not only did CHC preserve access to primary care in Fort Scott, it expanded the range of services available in the community—and in the process transformed the health center's vision of itself. No longer are they a small actor in the health care system; now they are an organization capable of successfully managing explosive growth in a difficult environment, with a strong leadership team, committed board members and a compelling vision. Today, CHC/SEK is the largest FQHC in Kansas and the 15th largest rural FQHC in the country. [1]

Patient and FTE Growth

While the health center has always understood its worth in the community, there is also data to back up its impact. Since CHC/SEK opened in Fort Scott, they have experienced more than 30% growth in patients, according to CEO Postai, dramatically transforming the communities they serve and the health center itself.

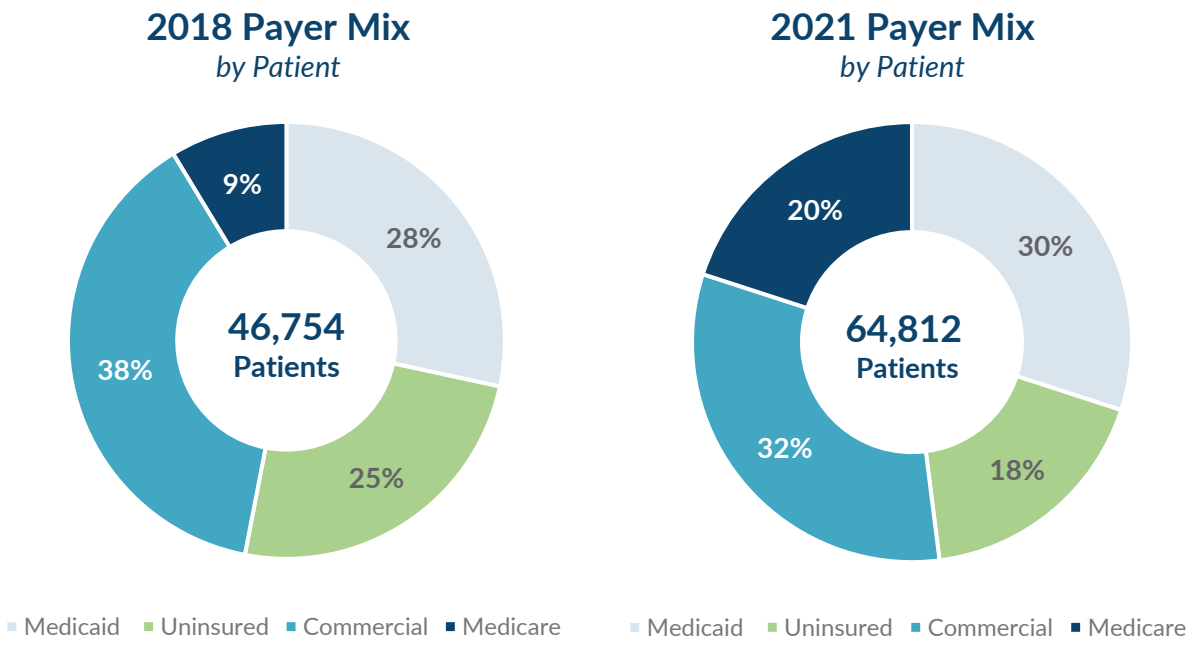
"We have been very aggressive and innovative, willing to take risks. We have a long history of growing, so [the Fort Scott growth] wasn't completely shocking. We were already at 46,000 patients system-wide and we grew 35% overnight," Wesco said.

In 2018, just prior to opening in Fort Scott, CHC served 46,754 patients. In 2021 when most health centers served fewer patients because of the pandemic, CHC served 64,812, a 39% increase from 2018 and a 5.4% increase over 2020.

	2018	2021	Percent Change
Total Patients in Fort Scott/Bourbon County	1,411	9,276	557%
Total Patients all Sites	46,754	64,812	39%
Total FTEs – Fort Scott/Bourbon County	12	109	808%
Total All FTEs	312	611	96%

The center's payer mix also changed dramatically, achieving a better balance of payers that allowed it to grow while maintaining financial stability and without additional HRSA grant funding. In Fort Scott, they concentrated on assisting patients in signing up for Medicaid or other programs for which they were eligible. System-wide between 2018 and 2021, the center added more than 18,000 patients—6,200 covered by Medicaid, 8,900 covered by Medicare and 2,800 patients covered by private insurance—all while holding steady the number of uninsured patients.

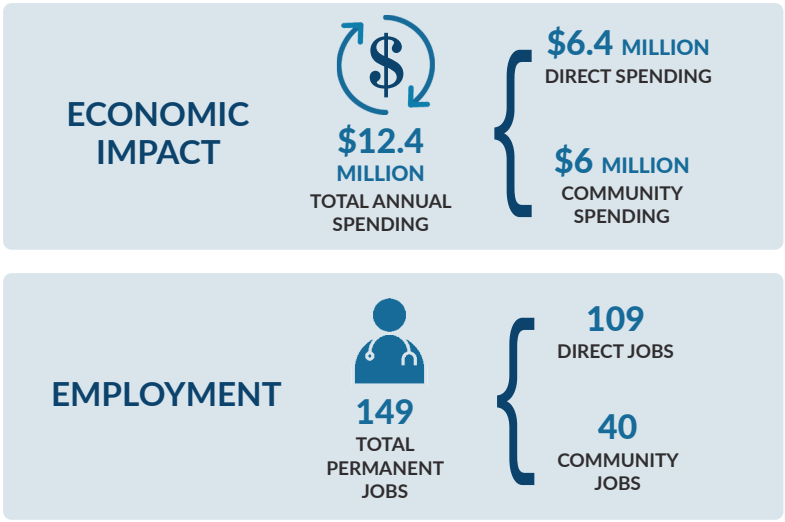
The charts below show the change in payer mix:



Economic Impact - Operations

In the process of taking over the Mercy clinics, CHC saved jobs in the community, which greatly benefitted the local economy. In 2021, the health center spent $6,395,000 million on its Fort Scott operation and employed 109 FTEs at an average salary of more than $55,000—more than twice the per capita income of the county ($23,102, per U.S. Census). This spending has positive direct economic impact on the lives and pocketbooks of those employed, but also indirect and induced impact, as this spending ripples through the local economy. As measured by IMPLAN[2], an econometric modeling program developed by the USDA and the Minnesota IMPLAN group, CHC's 2021 operations generated the following economic impact in the Fort Scott area:

ECONOMIC IMPACT OF 2021 FORT SCOTT OPERATIONS

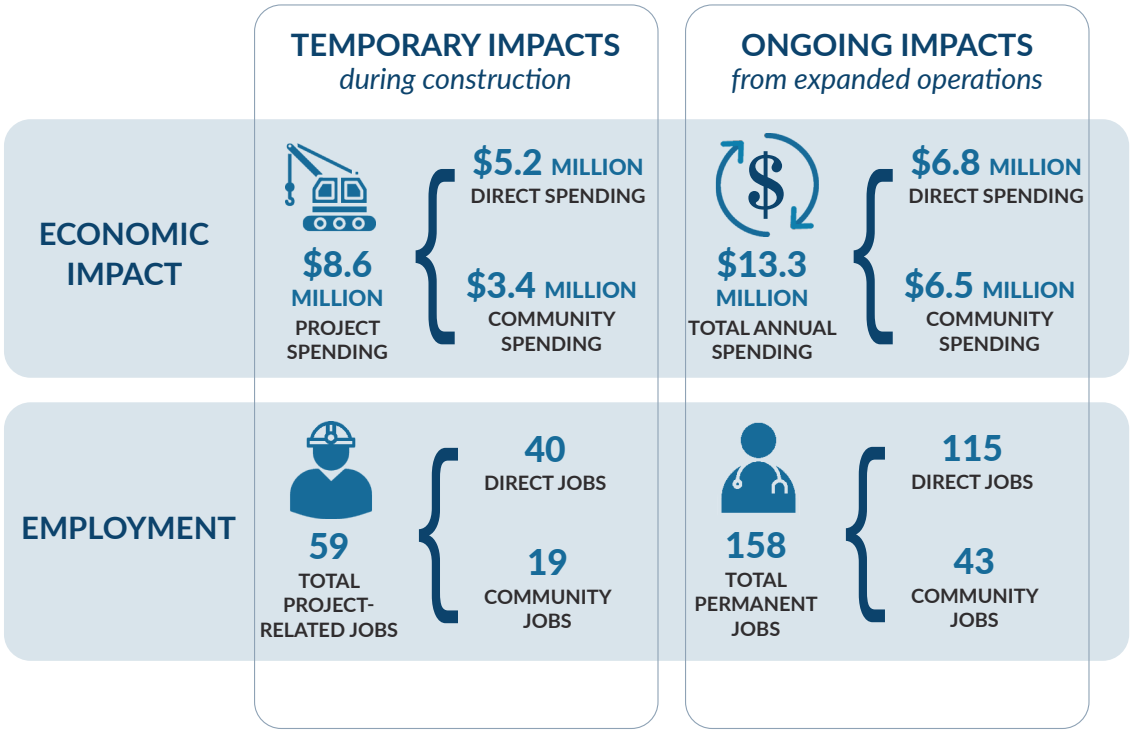


Economic Impact – Capital Project

In May 2021 CHC purchased a closed Price Chopper (regional grocery chain) building and has begun to renovate it into a new 40,000 SF health center facility to house Fort Scott services, once their lease in the former Mercy hospital expires. The new facility will consolidate two locations, the "main" clinic and the Walk-In Care clinic and will include: pharmacy, a wellness center, space for specialty providers and diagnostic imaging including CT, mammography, bone density and ultrasound.

The project requires an investment of $8.6 million, including purchase and renovation costs, which CHC will fund through investing $3.6 million of its cash reserves into the project and by taking out a loan of $5 million to finance the project. This capital project spending also has positive economic impacts for the local community, as illustrated below.

FORT SCOTT CAPITAL PROJECT ECONOMIC IMPACT



Marketing and Messaging

FQHCs are often categorized as "safety net providers," caring only for low-income patients. This characterization is especially incomplete in rural America, where FQHCs generally serve the entire community. Nevertheless, they are often dismissively referred to "as the poor people's clinic" by hospital systems that seek to limit services to those who can't pay and by the general public that is not aware of what health centers have to offer. CHC is working to change that image.

According to Wesco, since moving into Fort Scott, CHC/SEK has completely transformed its messaging and how the center markets itself, with the goal of eventually changing how the community views health centers in general and for the naysayers to gain an understanding of the quality of services provided.

"Once you come and see us, you'll see healthcare the way it should be. That's what is going to change behavior—not a billboard, and not us talking about who we are. It's, 'come see us, we're open all the time,'" he said. In addition to changing the perception of health centers, Wesco said, "the community also needs to better understand the state of health care in rural areas, and accept that hospitals are becoming unsustainable in communities like Fort Scott."

Baker noted that beginning in 2012, the Kansas Hospital Association began looking at the challenges facing rural hospitals in the state and developed a series of recommendations focused on maintaining the following critical services at the local level in the smallest rural areas: primary care; EMS services; diagnostic services and Emergency Departments to stabilize and then transport patients to larger hospitals as needed.[3]

"I would love for people in rural America to better understand healthcare. They have to understand—we're going to lose hospitals—we're going to lose a lot—but FQHCs are good, viable alternatives," Wesco said.

LESSONS LEARNED

In distilling "lessons learned" from CHC's experience, we offer the following guideposts for FQHCs facing similar circumstances:

1. **Lead with Mission:** While not immediately receptive to the health center's outreach, it was CHC/SEK's mission that eventually resonated with hospital administrators as they contemplated closure and with hospital staff as they transitioned to the health center.

> *"Mission motivated us. It was not the money; we felt called to go to Fort Scott. They needed us."*
>
> -KRISTA POSTAI

2. **Bolster Mission with Strategy**: Investigate areas of opportunity and determine priority areas for expansion—so you are ready to move as opportunities arise.

> *"Your strategic plan must be a living plan."*
>
> -KRISTA POSTAI

3. **Hospital Engagement:** Think about who really has power in the health system in your community. Try to reach out at the local level to build relationships and educate hospital leaders on the FQHC model and what the center could bring to a collaboration. If outreach at the local level does not work, consider interfacing with the hospital's corporate leadership, many of whom are looking at how to manage hospitals in difficult circumstances; they may be more open to outreach from FQHCs.

   Most hospital administrators do not understand the FQHC model—pointing to a need for more outreach/education. Postai noted that, "It's difficult to overcome territoriality and competitiveness, but seeking opportunities for 'win-wins' may open doors that help preserve services in the community and break down barriers."

"While I was at Mercy, I was familiar with CHC/SEK, but we 'back-burnered' conversations regarding collaboration. Looking back, I realize now I did not have a full understanding of FQHCs or what they could bring to the community."

—RETA BAKER

4. **Staff is Your Most Important Asset:** Try to retain as many staff from the closing hospital as feasible. Local jobs are important. In addition, it is difficult to recruit in rural communities and you will need the added staff capacity to make a smooth transition and to build trust with the community.

"Keeping salaries at the same rate without non-compete agreements was perceived as very fair; It eased the transition."

—DR. PANKAJ GUGNANI

Challenges: Change is difficult on many levels and so much change all at once can be disorienting for existing and new staff. It is important to clarify critical workflow issues, such as "Who's on call?" It is also important to think carefully about how you integrate new staff into the day-to-day operations and into your culture. All of the CHC/SEK leaders interviewed discussed the same "sore point," noting it as the biggest mistake they made during the transition: while staff were being orientated on turnkey day, CHC/SEK removed all Mercy hospital logos and other familiar/needed work resources in offices. Staff felt offended, disoriented and that they were not being treated as part of the team.

"The most difficult part was 'flipping the switch overnight'; it's a huge lift. Who's on call over the weekend?"

—DR. PANKAJ GUGNANI

Staff Training: "Flipping the switch" is a huge lift. CHC/SEK hired 80 people overnight, under enormous time pressure. Dr. Gugnani noted, "we were flying by the seat of our pants," but through this process the center further developed and improved its on-boarding processes. Thought and planning in this area is important and time consuming. Be patient, building in time for staff to learn new systems, a new EMR, and a new culture is time well spent.

5. **Community Engagement and Education is Critical:** Consider how you can reposition the FQHC "brand" in your community. In rural communities, FQHCs care for the whole community and bring many positive benefits: access to care, a broader range of services, capital investment, employment, and new investment.

"Show them": While marketing is important, showing the community what you can offer is even more important. Focus on creating a great experience of care. The COVID-19 pandemic offered an opportunity for the health center to step up in a very visible way and showed the community that the center would be there for them.

Longer-term there is a need for broader planning and education in the community about the state of health care in rural America and community-based solutions to address the challenges. Consider how your health center, primary care association, hospital association or local foundation could initiate or support community planning efforts to spur conversation regarding developing a sustainable health care delivery system in your rural area.

"No one is going to come in from the outside to save us. We are going to have to save ourselves. We have to develop sustainable services in rural America to convince people to stay here. Rural America is great."

—KRISTA POSTAI

6. **Look for Opportunities to Build Your Capacity:** If you are working from a reasonably stable base with a strong management team and with board support, taking on a big challenge can catapult you to a new level of excellence.

"The experience and strength of the management team—and the trust of the Board—was critical to CHC's success; we were strong going into this transition, and even stronger on the other side. It was so helpful having an in-house general counsel as part of our team. This skill set allowed us to move quickly to resolve legal, regulatory and contract issues, without the cost of hiring outside legal counsel."

—KRISTA POSTAI

"What doesn't kill you makes you stronger. We were ready to make a big leap and we proved to ourselves that we could handle 35% growth overnight. We expanded our human infrastructure and expertise. It was difficult, but it was worth it."

—JASON WESCO

CONCLUSION

While every community is unique, many smaller rural communities share the common challenge of reckoning with a financially unsustainable health care system, with rural hospitals in precarious financial condition. FQHCs offer a unique model of care that can help retain important primary care services in communities that need them, while also providing substantial community benefits including job retention and positive economic spin-off effects related to spending in the community and capital investments. While navigating the treacherous waters that roil communities when hospitals close is not for the faint of heart, the rewards of rising to this challenge are significant. Patients and communities benefit and FQHCs themselves can further develop their infrastructure and expertise, allowing them to become even more effective advocates and providers in communities that are too often left behind.

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About Capital Link

Capital Link is a national, non-profit organization that has worked with hundreds of community health centers and primary care associations for over 25 years to plan for sustainability and growth, access capital, improve and optimize operations and financial management, and articulate value. Established through the health center movement, Capital Link is dedicated to strengthening health centers—financially and operationally—in a rapidly changing marketplace. For more information, visit us at www.caplink.org.

Thanks

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Krista Postai, Chief Executive Officer
Jason Wesco, President and Chief Strategy Officer
Reta Baker, Vice President of Medical Education and former President of Mercy Fort Scott
Dr. Pankaj Gugnani, Chief Information Officer

Endnotes:

1. 2020 Uniform Data System for all FQHCs, based on number of patients served.
2. Economic impact was measured using 2020 IMPLAN Online from IMPLAN Group LLC, IMPLAN System (data and software), 16905 Northcross Dr., Suite 120, Huntersville, NC 28078, www.IMPLAN.com. Learn more here.
    - Full-Time Equivalent (FTE) of 1.0 is equivalent to one full-time employee. In an organization that has a 40-hour work week, an employee who works 20 hours per week (i.e., 50 percent of full time) is reported as "0.5 FTE." FTE is also based on the number of months the employee works. An employee who works full time for four months out of the year would be reported as "0.33 FTE" (4 months/12 months).
3. Vision: A sustainable rural health delivery system for Kansas: Report and Recommendations, Kansas Hospital Association, 2016.