



From COVID to
Community Health:
The Opportunity
for Rural Health
Infrastructure
Investments

The COVID-19 pandemic has revealed key deficiencies in both our public health system and in the capacity of the nation's rural health infrastructure.

The crisis has also highlighted that sustainability requires adapting to changes in the market—sometimes very quickly. With the first wave of COVID-19 cases hitting urban areas hardest, rural healthcare providers had more time to develop preparedness plans encompassing their services, staff, and facilities. These plans identified how the organization would be able to continue to provide services (or not) and how they would treat COVID-19 patients while also maintaining the safety of staff and other patients. Preparedness planning is specific to each organization because it must consider the resources it has or constraints caused by the resources that are lacking.

The lack of adequate space designed to modern healthcare standards represents a major constraint for most rural hospitals, making preparedness planning more difficult and potentially less effective. Revisiting the COVID-19 preparedness plans specifically to identify the constraints created by the existing facility offers the opportunity for rural hospital leaders to evaluate their facility's capacity to provide the community with high-quality healthcare and to identify the strategic facilities plan for correction.

Example facility-related barriers to efficient service delivery revealed through COVID-19 planning or response include the following:

Inability to flex staff between key departments to match volumes due to the layout of the facility and lack of adjacency between service locations (e.g., emergency room and inpatient area separated requiring distinct staffing for both departments).

Lack of adequate storage for inventory of PPE and other supplies.

No separation of public and patient traffic within the facility leading to increased infection risks.

Poorly designed or old acute-care patient rooms, including:

Semi-private beds limiting the number and types of patients that can be safely treated to avoid one patient infecting another during the hospital stay and not mixing genders, etc.

Private rooms meeting the minimum code size (or waived from the modern sized room due to the age of the facility) that lack space for medical equipment and telehealth.

Lack of a negative pressure room to isolate a patient with an airborne illness.

Outpatient and ambulatory spaces co-located in the inpatient area of the hospital (re-purposing of unused inpatient rooms for outpatient services) exposing low acuity, ambulatory patients to sicker patients on the inpatient unit.

Service modalities (such as imaging) spread throughout the facility in available spaces creating inefficiencies for staffing.

Outpatient and clinic areas without adequate space for providing remote/telemedicine services

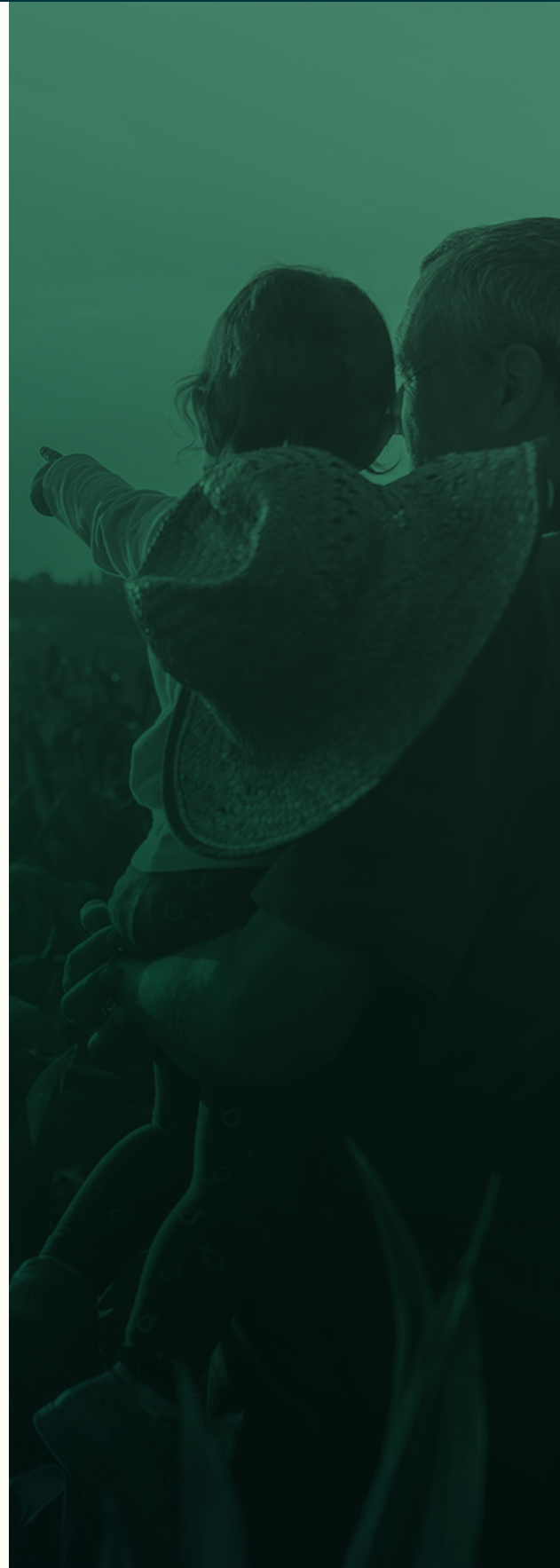
Infrastructure, such as air handling systems, that does not create adequate separation of the sickest, acute-care patients from those seeking routine outpatient care. The COVID-19 pandemic has demonstrated the need for greater access to negative pressure areas, whether in individual rooms or in larger suites.

Many rural hospitals provide **great quality of care** despite their facilities.

The healthcare infrastructure for rural areas was primarily funded through the Hill Burton program in the late 1940s, 50s, and 60s, when the average acute hospitalization lasted over 20 days (by comparison, it is now between four and five days nationally, and significantly lower in rural communities). As a result, many rural facilities are both dated and designed for the wrong type of healthcare; rural hospitals that were built for providing inpatient care must adapt to the market shift toward effective outpatient and ambulatory care. The challenges of vintage buildings include both the existing conditions of the building itself (such as the presence of health hazards like lead paint and/or asbestos) and the layout of the facility in which services are not appropriately configured for patient and staff efficiency. The location of services in the facility translates directly into the hospital's throughput—how much time it takes to provide a service—as both measures of efficiency and patient experience. When services are typically provided together, such as imaging for Emergency Room patients, then the services should be adjacent in the facility to minimize transport times between departments and patient inconvenience. When adjacencies between services are poor, the typical result is that staff workloads are increased, patients experience longer wait times, and patient privacy is often compromised.

Facilities built 60, 50, 40, or even 30 years ago often lack the space and resources to provide modern healthcare services efficiently and effectively.

Facilities built 60, 50, 40, or even 30 years ago often lack the space and resources to provide modern healthcare services efficiently and effectively. In fact, many rural hospitals provide great quality of care despite their facilities. One key limitation is the lack of space for ambulatory services and the common reuse of old inpatient rooms for outpatient care, as mentioned previously. For patients requiring hospitalization, facilities' struggle to adapt to changing needs is evident when hospitals provide most overnight care in shared, semi-private patient rooms. Shared rooms inherently limit how many patients with any kind of infectious condition can be served safely. In addition, older facilities lack negative pressure spaces to prevent airborne threats from spreading throughout the building, and outpatient and clinic spaces that may be available are often inadequate for testing and remote services.



Investing in new facilities to deliver the services that the **community needs** for the long term.

Historically, capital investments required for rural hospitals to modernize facilities have been unavailable, but the expansion of the USDA Community Facilities program, the stabilization of finances with Critical Access Hospital status, and other federal programs over the past decade has changed this. Today, over 200 rural hospitals have successfully modernized, significantly renovated, or replaced their core clinical service spaces. As of 2019, USDA's portfolio totaled \$5.4 billion in rural healthcare infrastructure and USDA is seeking to expand upon these investments; however, it is a loan program that not every rural hospital is ready to pursue. USDA rates, like the broader market, are at or near historical lows. These low rates create an opportunity to address long-standing facility deficiencies to create a more adaptive and flexible infrastructure for responding to future needs or crises.

With unprecedented access to affordable capital, rural hospitals have an opportunity they have lacked for the last 50+ years.

Considering the lack of resources available historically for rural hospitals, the tendency was to limit one's vision to something that is "realistic" or "affordable"; however, incremental planning is rarely transformational. By failing to address the big picture of market and community healthcare needs in a holistic and comprehensive manner, capital investment may solve a short-term problem without improving the hospital's overall strategic positioning. The piecemeal, incremental approach very often fails to inspire the cultural and organizational changes resulting from a facility investment that measurably improves the quality, availability, and or efficiencies in providing care. With unprecedented access to affordable capital, rural hospitals have an opportunity they have lacked for the last 50+ years—to resolve short-term problems of aging infrastructure while also investing in new facilities to deliver the services that the community needs for the long term.

Recognition of the valuable role rural hospitals have played in the COVID-19 pandemic has sparked a new appreciation for these community organizations and increased support for planning rural health facility investments. Every project, in fact every innovation, starts with a concept or vision. At the broadest level, rural leaders must consider how their organization's vision is supported by strategic investments in capital that empower them to serve a larger role in their communities, whether by reducing outmigration of care (and healthcare dollars) for routine services or by improving capacity to respond to unusual events like the current pandemic.

Planning for high-impact facility investments is complex and challenging in the best of circumstances and is further complicated by the uncertainty in the marketplace and the management of the pandemic. The following are 10 planning best practices that lead to successful rural facility investments:

- 1 Initial idea and understanding of market need**
Clearly define the vision, how it meets community healthcare needs, and how it may be supported by an investment in equipment, facilities, and infrastructure.
- 2 Identify third parties**
Complete due diligence for a team experienced in rural health financing to assist and guide the process, including accountants, consultants, architects, attorneys, and bankers.
- 3 Determine debt capacity**
Identify the prudent borrowing amount using historical financial data and likely financing terms. This includes quantifying the impact of pass-through capital reimbursement for Critical Access Hospitals.
- 4 Develop an integrated process of engagement**
Engage senior management, departmental leadership and the community on future volume projections, facility planning, and financial impact. Share debt capacity to demonstrate concept viability and establish a clear planning budget leading to a refined discussion of community service needs and the documented plan to address these.
- 5 Project total project costs**
In addition to construction and equipment costs, ensure the project budget reflects all the costs that will be incurred to fund the project successfully, including but not limited to, other 'soft costs' such as architectural and engineering fees, feasibility study, appraisal, legal fees for loan documentation, and banker fees.
- 6 Identify and evaluate the site for environmental factors**
Ensure the site is suitable for development (no historical significance to be preserved and is not contaminated, in a floodplain, or includes wetlands).
- 7 Create a Preliminary Architectural Report**
Documentation of the community need, alternatives for addressing that need, and the high-level facility plan and costs for facility investment.
- 8 Validate feasibility with an examination-level financial study**
The examination feasibility study is the highest level of review and due diligence according to accounting standards and provides both the organization's board and USDA with an external, unbiased perspective on the impact of the project and the ability to repay debt obligations.
- 9 Complete an appraisal**
The appraiser offers another perspective by validating that the projected project "as built" will be completed within costs that are less than or equal to the organization's total value as measured by equity. USDA will finance projects up to 100% of a loan to value.
- 10 Secure USDA financing commitment**
The USDA funding application is reviewed at both the state and national levels involving USDA staff that is expert in healthcare as well as other staff members that may have never done a healthcare project previously. It is important to work effectively with all agency levels to engage and educate the staff on the project.

A unique opportunity for rural hospitals to solidify their vision as **center of healthcare.**



There is a unique opportunity now for rural hospitals to solidify their vision as center of healthcare not only in a crisis, but also in supporting the community's health and wellness after the immediate crisis has passed. Developing this vision and envisioning how the facility can be improved requires multi-disciplinary input. While the Facilities Director understands the inner working of the buildings better than anyone in the hospital, the vision must also be grounded in how it will enhance clinical care, which requires both input from clinical service line leaders and a clear data-driven understanding of the community need. Board members must also be engaged effectively in the planning to support their roles in oversight and in communicating the vision and project rationale to the community. Multi-million-dollar facility investments are "once in a career projects" for most rural healthcare leaders, and with the day-to-day challenges of operating a rural hospital, most choose to assemble a team of expert advisors. These advisors assist in the technical planning and analysis connecting the proposed facility investment to a clear need in the community, and help to ensure that the project is both affordable and sustainable.

The team should be highly experienced in serving rural healthcare and often includes the following expertise:

- Strategic planning consultant
- Certificate of Need (CON) preparer (when applicable)
- Banker – investment banker for bond financing or USDA banker
- Architect/Construction cost estimator
- Environmental engineer
- Attorneys – expert in healthcare bond/loan financing
- Feasibility accountant
- Appraiser



The typical out-of-pocket costs for planning a substantial facility investment and securing a USDA commitment to support that investment is \$250,000. This can be included as part of the loan package, but the hospital must have sufficient liquidity to pay the architects, consultants, and attorneys throughout the process. For operations, the hospital should have between 25 and 40 days of unrestricted cash on hand to cover operating expenses.

From a financial perspective, a track record of profitability and consistent financial results is important, but profitability can vary by market. There is no specific threshold requirement of profitability, and year-to-year performance may vary with some years being losses if there is a clear explanation for the factors associated with that performance. The hospital also must evaluate its liquidity (i.e., available resources) to be sure that there are monies for both funding the upfront planning of the facility investment and meeting ongoing operating needs.

Opportunities enabled by facility investment.

Estimating the affordability of the project early in the process ensures planning is completed with a clearly defined budget. Determining what level of investment is sustainable, i.e. “debt capacity,” requires converting historical profitability and the availability of resources into how much debt is supported by projected cash flows. This can be performed by the organization’s accountants, consultants, or by the banker that will be financing the project if the study examines hospital services and the historical profitability to determine how much cash is projected to be available to support debt repayment. This is expressed as a maximum loan amount under the preferred financing source (such as USDA) considering prevailing rates and terms. The team of advisors presents the debt capacity analysis to the organization’s Board of Directors, educates them on the methodology and assumptions, and facilitates a discussion of what percentage of the debt capacity is prudent to support their decision-making and fiduciary responsibility.

With the overall budget for the project estimated, leadership can continue engaging staff on the vision and begin to “drill down” into how the project will impact staff and benefit the community. The Rural Hospital Replacement Study is a useful resource for this purpose in documenting the effects of a facility investment on the organization’s quality of care, physician and staff retention, and patient satisfaction, among other factors. While the study examined only replacement hospitals to understand the “before and after” effect, the lessons learned are equally applicable to renovation and expansion projects that effectively replace major services on the existing site.

Increase market capture, provide care efficiently, and improve quality and patient satisfaction.

Often working with its planning consultant, architect, or a design-builder, the organization creates a strong business case for the facility investment when service line leaders unearth different opportunities for increasing market capture, providing care more efficiently, or improving quality and patient satisfaction measurably. The key is to focus externally on the market—both locally and nationally—and engage service line leaders on how the market for the organization’s services is changing and what opportunities would be enabled by a facility investment to meet the community’s overall need for healthcare.

The recommended approach of considering the facility investment as a strategic initiative stands in contrast to evaluating facility needs from the perspective of deficiencies that require correction but are not tied to the overall service program or long-term strategies for success. Because of the lack of capital availability historically, many rural healthcare leaders have been through “stop and start” facility planning projects where they were asked to document their needs, but then the project lost momentum or ended up being prohibitively expensive. Alternatively, when the project is developed around a specific strategic yet realistic vision, there is a stronger sense of purpose to carry the project forward and then “solve for” the amount that is sustainable to invest in facilities to support the long-term strategy. The net result is a plan that articulates the desired impact of the facility investment within the constraints of what the organization can afford (i.e., the debt capacity).





Community goodwill toward rural hospitals has been enhanced by their leadership during the COVID-19 crisis.


Identifying the facility constraints embedded within in the pandemic preparedness plan combined with the on-the-ground experiences providing care using antiquated hospital facilities, rural hospital leaders can leverage this renewed appreciation for their community value and move beyond the status quo to address long-standing facility constraints and strengthen their future.

The expansion of the USDA Community Facilities program, the stabilization of finances with Critical Access Hospital status, and other federal programs over the past decade have created an opportunity to overcome historical limitations for capital investments required for rural providers to modernize facilities. Low-interest rates under the USDA program create an opportunity to address long-standing facility deficiencies and instead create a more adaptive and flexible infrastructure for responding to future needs or crises, as well as increasing market capture, providing care more efficiently, and improving quality or patient satisfaction measurably; all of which reposition the organization as the center of healthcare not only in a crisis but also in supporting the community's health and wellness after the immediate crisis has passed.




Are you ready to learn more about Stroudwater Capital Partners and see if our services are the right fit for your healthcare project?

Get in touch with our team.

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