Thank you Chairman Causer and Chairwoman Rapp. Good morning distinguished Committee members and guests. It is my honor to testify before you.

My name is Rick Allen and I serve as Chief Executive Officer at Warren General Hospital, Warren, Pennsylvania. Warren General Hospital is an 85 bed, general acute care, independent, private non-profit community hospital serving the residents of Warren County and the surrounding northwest Pennsylvania region. Warren General Hospital is the sole community hospital in Warren County. The Hospital and County are designated as rural and medically underserved. The Hospital receives disproportionate care funding and participates in the federal 340B pharmaceutical discounts and retail sales program.

I arrived in Warren, Pennsylvania seven years ago to help turnaround a failing hospital – an over 120 year old healthcare organization on the brink of bankruptcy facing closure or sale. The hospital had recorded years of multi-million dollar operating losses, had zero available cash, was in default on a long term loan, had in place unsustainable labor union contracts and a disjointed and apathetic medical staff and management team. I immediately began to work. With the guidance of the Board of Directors, a Vision of success and independence was developed. Next, we executed strategies to reduce expenses and increase revenue. Retention of the best and recruitment of new physicians followed. Finally, we sought an organizational partner. A partner who could bring needed capital along with clinical and operational support to Warren General while allowing the organization to remain self-directed and independent.

The results have been phenomenal. Through the collaborative efforts of the Board, management, physicians and staff we have transformed Warren General Hospital in to an award winning, high quality and fiscally stable hospital. We have won two *Top 100* Hospital awards and achieved positive operating margins in each of the past three fiscal years. Over the past two years we have spent nearly **$20 million** on infrastructure upgrades, equipment and new services. Of note, we recently completed a $1 million renovation to our Emergency Room and spent $ 5 million on a new Cancer Center Linear Accelerator and vault. We have cash on hand and zero debt. We have completed a long term Master Facility Plan and are evaluating a new inpatient tower at a cost of $60 million. Our minority partner Highmark, Allegheny Health Network and LECOM Health has brought value to our organization through financial, clinical and medical educational support.

The journey towards our Vision (and our strategic, operational and fiscal success to date) has *not* been easy. Many of our peer hospitals serving rural communities are struggling, particularly as we continue to grapple with the COVID-19 response and the capacity crisis resulting from the strain on the health care workforce. Statewide, during FY 2020, 35 percent of rural hospitals posted negative operating margins and one-in-five rural hospitals (20 percent) in Pennsylvania experienced margins between 0 and 4 percent, a rate below what is needed to maintain hospital infrastructure and long-term sustainability. At Warren General Hospital we have addressed, yet continue to face, many issues which are ***amplified*** by our rural setting. To list a few;

- Impact of pandemics
- Recruitment and retention of staff (specifically nurses), managers and physicians
- Access to behavioral health services
- Impact of Gen Y (millennial) and Gen Z
- Local access to specialty medical care
- Reliance on the federal 340 B program
- Demands by organized labor
- Stagnant reimbursement (specifically Medicare and Medicaid)
- Expansion of Affordable Care Act
- Proliferation of large health systems
- Unaligned payor (commercial and managed care health insurance) contracts
- Value based contracting (favoring large hospitals / Health Systems)
- Declining community population
- Loss of community business and industry

Allow me to elaborate on a select few of these issues facing hospitals operating in a rural community;

Pandemics

Of course (right now) I am talking about COVID -19. I offer however that we may face additional and more complex viruses in the future. Although we were fast out of the starting blocks in getting our community COVID -19 vaccinated and tested, progress has slowed. Vaccine hesitancy has taken over in our rural community and so we have seen a rise in COVID positive inpatients. We are now seeing more COVID -19 positive inpatients vs. the pandemic "peak" in December and January, 2021. Coupled with a rise in other very ill inpatients (most likely due to delayed medical care), we are working at capacity. Our staff and physicians are tired. Our staff are leaving. We must develop new ways to address a "surge" of patients while keeping hospital staff healthy and functioning. I want to add that Warren County does not have a local Health Department. There is an assigned nurse from the Pennsylvania Department of Health however no other resources or staffing. By default Warren General Hospital has served as the County "Health Department" throughout the COVID -19 pandemic. I offer this issue must be addressed as we (Warren General and other rural community hospitals) are not staffed, equipped, trained or financed to serve in this capacity. The majority of rural communities throughout the Commonwealth of Pennsylvania do *not* have a dedicated local Health Department yet have taken on the role and responsibility of public health response.

Recruitment of staff

Certainly a topic that has received much attention in the media is retention and recruitment of hospital staff. Specifically at the center of the discussion is retention and recruitment of nurses. This issue is of course very concerning to hospitals. Nurses are leaving to accept non-healthcare positions and are "following the money" to lucrative traveling nurse agencies. For your information the cost of a traveling

nurse is now up to $210 / hour. This is almost double what we pay our primary care physicians and four times the pay of our advanced practice providers (Nurse Practitioners and Physician Assistants). This price "gouging" by traveling nurse agencies must stop.

I applaud the efforts of the Commonwealth to offer nurses tuition reimbursement specifically those working in designated medically underserved areas. Coupled with incentives rural hospitals individually offer, this becomes a very potent or valuable recruitment tool. I encourage the Commonwealth to continue offering students in select healthcare professions tuition reimbursement and other monetary awards to work and locate to rural and underserved communities.

In addition to nurses, we are also experiencing difficulty recruiting other medical professionals including Medical Technologists (Lab Technologists) and Respiratory Therapists and support personnel such as Medical Assistants, Housekeeping and Dietary Aides and Facility / Maintenance Staff.

Regarding physicians, we have had success at Warren General Hospital however it takes a lot of work finding those interested in a rural community. Often we pay a premium base salary with generous benefits. Similar to nurses, I ask that tuition reimbursement and other monetary awards continue to be offered to physicians to help us recruit to our rural community hospital.

Access to behavioral health services

Access to behavioral health services has been a persistent concern in our community. The strain on the behavioral health system has been magnified by the pandemic and the staffing shortages. We have an 18 bed Behavioral Health (inpatient) Unit and a 4 bed medical detox area. Both are always filled. With said we have been down staff (BH nurses as well as BH techs) and have had to "cap" admissions at 10 on the Behavioral Health Unit for the past four months. In addition to capacity and staffing difficulty, we see the Behavioral Health crisis as one of outpatient services. We discharge and then patients wait and wait for outpatient follow up treatment. In our area, and across the state, there is a clear shortage of Behavioral Health providers (specifically psychiatrists).

Local access to specialty care

Typically, the population of rural communities cannot support fulltime medical specialists such as cardiologists, neurologists or pulmonologists. This creates an access issue as community residents are required to drive long distances to the city for specialty care. Often, once under the care of specialty physicians in larger markets (cities), basic or primary care follows. The result is the rural community hospital is left without a population seeking medical services. Telemedicine has helped. Rural community residents can access specialty medical care in their hometown through technology. Affiliations or partnerships with larger hospitals or health systems can also help address medical specialty access through agreements to rotate physicians through rural communities weekly. In Warren we use both telemedicine and rotating specialist visits to offer a whole range of care without having to drive out of Town. I encourage loosening of telemedicine rules and increasing reimbursement for this new and valuable approach to care delivery.

340 B Pharmaceutical discount and retail sales program

Perhaps one of the *best* programs offering significant economic value to rural hospitals is the federal 340 B pharmaceutical program. Through a combination of drug purchasing discounts and retail pharmaceutical sales, the federal 340 B program is valued at over $5.0 million / year to Warren General Hospital. It is critically important that this program remain in place. The economic support provided to rural hospitals through the federal 340 B program is a true life line allowing many to remain open and fiscally stable.

Proliferation of large hospitals / health systems

Warren General Hospital chose a path of independence and self-direction allowing the community Board of Directors to decide services offered and physicians practicing in the area. This decision has been difficult to execute but we have been very successful. In many other rural Pennsylvania communities, hospital independence was not an option strategically or economically. In these cases larger hospitals or health systems have acquired the rural hospital and proceed to centralize and outsource services favoring the larger hospital and community. Rural communities are left wondering what happened to our hospital and how can we access needed medical care locally. A rural hospitals decision to remain independent or to be acquired by a larger hospital or health system is a very, very important decision which must be made with appropriate due diligence and the community's best interest in mind.

Unaligned payor contracts (favoring the insurer)

Over the past few years' payors (insurance companies) have made effort to lower reimbursement to all hospitals through various inpatients stay "designations". I am referring to categorizing a hospital admission as "observation" vs. an "inpatient stay". This categorization may be made as a patient stays in the hospital for up to 72 hours (3 days). An "observation" patient's reimbursement is approximately 1 / 3 of that for an "inpatient" stay. Large hospitals address this categorization and care delivery through designated "observation units". Small and rural hospital cannot afford this physical segmentation and staffing therefore integrate "observation" patients in the general medical / surgical units. Care is exactly the same for observation as it is for inpatients. Up to 40% of all inpatient admissions are now being categorized as "observation" costing the small and rural hospital millions in revenue while expenses remain the same.

Expansion of the Affordable Care Act

Although access to health insurance coverage is a very good thing for individuals and families facing major healthcare procedures and the associated cost, expansion of high deductible and co-pay plans hurts the small and rural community hospital. Often medical care at small and rural hospitals such as Warren General Hospital is for primary care services including diagnostic tests, ER visits and minor elective procedures. Plans offered through the ACA, often have $5000 to $8000 deductibles and very high co-pays. The small and rural hospital is left attempting to collect the deductible with very limited

success. I offer that expansion of Medicaid is a more fiscally viable option when considering the economic burden of the high deductibles and co-pays have on small and rural hospitals.

"Value based" contracting (favoring large hospitals / Health Systems)

Many health insurance plans and in fact CMS (Medicare and Medicaid) have begun to use quality metrics to financially reward (or penalize) hospitals. Often the complex nature of data collection and submission requires staffing and technology above and beyond what the small and rural hospital has available. We end up spending as much as we may gain in rewards. Also, in some cases the metrics are such that low volumes will not allow calculation and submission therefore inappropriately penalizing the small and rural hospital. As an example, at Warren General Hospital we have recorded zero hospital acquired infections but because we cannot submit a zero (0), we lose all credit for this extraordinary performance. The quality metrics and data submission approach favors large hospitals and Health Systems.

Declining population

In 1980 the population of Warren County was 47,449. In 2000 this number had decreased to 43,704. The latest data (2019) has the County population at just fewer than 40,000. Of course the population also continues to age as the large Baby Boomer cohort moves on. Although a declining population may numerically mean fewer patients (and fewer hospital visits), "aging" increases usage of certain services. Overall, a fewer people means less hospital usage. More older patients may require service changes and adjustments to the payor mix (more Medicare reimbursement).

Demands of organized labor

A "perfect storm" of events has opened the door for organized labor to push for increased salary and benefits directly impacting the fragile economics of small and rural hospitals. I am referring to the surge of volume and critical nature of care resulting from the pandemic, shortage of clinical staff being trained (in schools) and willing to work at the bedside and exorbitant pay offered by agency / traveling staff companies. Labor unions are seeking to take advantage of this crisis to organize and make unsustainable demands. Further, an effort is being made in the Commonwealth to mandate staffing ratios on hospital nursing units through legislation or regulation reform. This is **not** an effort that would help hospitals and would particularly *harm* small and rural hospitals that cannot segment patients based on illness or care status. Hospital management must have the ability to manage and schedule staff using available metrics such as acuity (case mix index) as well as type and number of support staff. To be specific, small and rural hospitals often integrate patients recovering from surgery, pediatrics, transitional care and those identified as "observation. With all inpatients combined together, the required nurse to patient ratio is difficult to determine but it is not a specific number. Larger hospitals may have the ability to segment patients having as an example a separate "observation" unit or "transitional care" unit where the ratio of nurse to patients is much lower (i.e. a nurse in these units caring for these lower acuity patients can handle more patients). I offer that standard or mandated nurse to patient ratios do not allow for the uniqueness of hospitals and appropriate staffing as determined by professional unit managers.

Thank you Chairman Causer, Chairwoman Rapp and distinguished Committee members for allowing me to testify before you today. I hope my comments have shed light on a few of the many issues facing small and rural hospitals operating throughout the Commonwealth of Pennsylvania. I am open to your questions.

Richard Allen

Chief Executive Officer

Warren General Hospital