

Critical access hospitals have higher transfer rates after surgery

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Hospital transfers happened more often after surgery at critical access hospitals (CAHs) but the proportion of patients using post-acute care was equal to or less than that of patients treated at non-CAHs.

The CAH designation was created to provide financial support to rural hospitals. As such, they are exempt from Medicare's Prospective Payment System and instead are paid cost-based reimbursement. The proliferation of CAHs after the payment policy change has increased interest in the quality and cost of care these facilities provide.

The authors used data from the Nationwide Inpatient Sample and the American Hospital Association to examine [patients](#) undergoing six common surgical procedures (hip and knee replacement, hip fracture repair, colorectal cancer resection, gall bladder removal and transurethral resection of the prostate [TURP]) at CAHs or non-CAHs. The authors measured hospital transfer, discharge with post-acute care or routine discharge. The authors identified 4,895 acute-care hospitals reporting from 2005 through 2009: 1,283 (26.2 percent) of which had a CAH designation.

For each of the six inpatient surgical procedures, a greater proportion of patients from CAHs were transferred to another hospital (after adjustment for patient and hospital factors), ranging from 0.8 percent for TURP to 4.1 percent for hip fracture repair for CAH patients and from with 0.2 percent and 1.2 percent for the same procedures, respectively, for non-CAH patients. However, patients discharged from

CAHs were less likely to receive post-acute care for all but one of the procedures (TURP) examined. The likelihood of receiving post-acute care ranged from 7.9 percent for gall bladder removal to 81.2 percent for [hip fracture](#) repair for CAH patients and from 10.4 percent to 84.9 percent, respectively, for non-CAH patients. The authors note there must be future work to define the causes for the disparity in transfer rates.

"These results will affect the ongoing deliberations concerning CAH payment policy and its implications for health care delivery in rural communities" Adam J. Gadzinski, M.D., M.S., of the University of Michigan Health System, Ann Arbor, Mich., and colleagues said in their *JAMA Surgery* article.

In a related commentary, Matthew J. Resnick, M.D., and Daniel A. Barocas, M.D., M.P.H., of Vanderbilt University, Nashville, Tenn., write: "The article by Gadzinski and colleagues raises important questions about how best to maintain access to surgical care in underserved communities."

"There remains no obvious mechanism to ensure the financial viability of individual CAHs, particularly in the era of the integrated [health care delivery](#) system. Medicare will probably have to continue subsidizing these hospitals to maintain broad access to financially unsuccessful service lines; the challenge will be to keep the quality and cost corners of the triangle from growing too obtuse or acute."

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