Rural Hospital Closures

Housekeeping

• Q & A to follow – Submit questions using Q&A area

• Slides are available at https://www.ruralhealthinfo.org/assets/912-2968/hospital-closures-011818.pdf

• Technical difficulties please call 866-229-3239
Featured Speakers

Tom Morris, Director, HRSA Federal Office of Rural Health Policy

George H. Pink, Ph.D., Deputy Director of the NC Rural Health Research Program and Humana Distinguished Professor in the Department of Health Policy and Management

Dr. Shao-Chee Sim, Vice President for Applied Research at the Episcopal Health Foundation

Nancy W Dickey, MD, A&M Rural and Community Health Institute

Rural Hospital Closures

George H. Pink
Deputy Director, NC Rural Health Research Program
Humana Distinguished Professor

Rural Health Information Hub Webinar, January 18, 2018

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What is a hospital closure?

- Sometimes difficult to identify because:
  - Open, closed, open, closed
  - No media coverage because it is a community non-event or part of a system reconfiguration
  - Inpatient stays open, but ER closes, inpatient closes, but ER stays open, and other permutations
  - Hospital is being replaced by a new facility
- For this study, we defined closure as permanent cessation of acute inpatient care

2005-17 rural hospital closures:
Where were they?

83 rural hospitals have closed since January 2010
125 rural hospitals have closed since January 2005
2005-17 rural hospital closures:
When did they close?

2010-17 rural hospital closures:
Were they abandoned or converted?

10 rural hospitals have closed and reopened as acute care hospitals.
2005-17 rural hospital closures: Were they in Medicaid expansion or non-expansion states?

- Non-Expansion State 63%
- Expansion State 37%

2005-17 rural hospital closures: What were their bed sizes?

- 1-25 beds
- 26-50 beds
- >50 beds
2005-17 rural hospital closures: How far away is the next closest hospital?

A closure in August 2015 (Nye Regional in Tonopah, NV has 109 driving miles to the nearest hospital) is not pictured in the graph.

2010-17 rural hospital closures: Why did they close? (As reported by news media)

**Market Factors**
- Small or declining populations
- High unemployment (as high as 18%)
- High or increasing uninsured patients
- High proportion of Medicare and Medicaid patients
- Competition in close proximity

**Hospital Factors**
- Low daily census
- Lack of consistent physician coverage
- Deteriorating facility
- Fraud, patient safety concerns, and poor management

**Financial Factors**
- High and increasing charity care and bad debt
- Severely in debt
- Insufficient cash-flow to cover current liabilities
- Negative profit margin
2005-17 rural hospital closures:
How bad was their financial performance and condition?

In the year before they closed:

- Most hospitals were unprofitable, illiquid, and unable to service debt
- Most had less than:
  - 150 FTEs, $10 million in salary expense, and 30% occupancy rate
  - Negative or close to zero net income and net assets
- Most had already closed obstetrics

Here is the latest closure

Small Eastern North Carolina Town Losing its Hospital
Here is the latest closure

- Our Community Hospital, a CAH in Scotland Neck, NC closed on December 31, 2017.
- Due to financial issues and low inpatient volume, the hospital closed its emergency room and all acute care inpatient and outpatient services.
- Officials will continue to operate the 60-bed nursing home that is part of the hospital and will be talking to local physicians about operating a part time primary clinic as well.
- The FQHC next door will also be extending their office hours to evenings and half a day on Saturdays.
- The nearest hospital is approximately 20 miles away.

2005-17 rural hospital closures:
Summary

- Most closures in South (60%)
- Annual number of closures increasing until 2016
- Most are CAHs and PPS hospitals
- Most are in states that have not expanded Medicaid
- Patients in affected communities are probably traveling between 5 and 30 or more miles to access inpatient care
- Most hospitals closed because of financial problems
Rural hospital closures – the future

Beyond scheduled changes such as 340B, closures could rapidly increase if:

- Bizarro legislation such as Brady and Neal Medicare extenders bill that includes “modification of payments for critical access hospital swing beds, including HHS OIG recommendations”
- Loss of Medicaid expansion / block grants
- A rapid return to larger numbers of uninsured / underinsured patients. Effect of loss of individual mandate is uncertain but Congressional Budget Office has estimated that about 13 million people would give up their coverage by 2027.

North Carolina Rural Health Research Program

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Resources

North Carolina Rural Health Research Program

Rural Health Research Gateway
[www.ruralhealthresearch.org](http://www.ruralhealthresearch.org)

Rural Health Information Hub
[www.ruralhealthinfo.org/](http://www.ruralhealthinfo.org/)

National Rural Health Association
[www.ruralhealthweb.org](http://www.ruralhealthweb.org)

National Organization of State Offices of Rural Health
[www.nosorh.org](http://www.nosorh.org)
RURAL HOSPITAL CLOSURES WEBINAR

SHAO-CHEE SIM
EPISCOPAL HEALTH FOUNDATION

JANUARY 18, 2018

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GEOGRAPHIC SERVICE AREA

57 counties in Southeast Texas
42 are rural counties

- 10.7 million people
- 38 Rural Hospitals
- 33 FQHCs
- 72 Rural Health Clinics
- 14 Local Mental Health Authorities

EPISCOPAL HEALTH FOUNDATION
OVERVIEW OF RURAL TEXAS

177 out of 254 Texas counties are “rural”

11% of the population in Texas lives in rural areas (3.1 million people total)

Rural areas in Texas experience significant healthcare provider shortages:

- 185 counties have no psychiatrist
- 158 counties have no general surgeon
- 147 counties have no obstetrician/gynecologist
- 80 counties have five or fewer physicians
- 35 counties have no physician

*1 in 5 hospital closures in the country occurred in Texas (19 out of 78 since 2010)

WHY IS RURAL HEALTH IMPORTANT TO EHF?

75% of EHF service area is rural

Rural health system resources & structure are fundamentally different

Adequate and equitable access to health services

Ensure rural residents have a voice in their healthcare
EHF RURAL HEALTH WORK

Stakeholder Engagement

- State Associations (Texas Organization of Rural & Community Hospitals & Texas Association of Rural Health Clinics)

- State Agencies (Texas State Office of Rural Health & Texas Office of Primary Care)

- Funding Partners (St. David’s Foundation, Methodist Healthcare Ministries, T.L.L. Temple Foundation, Robert Wood Johnson Foundation)

EPISCOPAL HEALTH FOUNDATION
EHF RURAL HEALTH WORK

Community Convening

- Madison, Grimes and Robertson Counties (Texas A&M University Southwest Rural Health Research Center)
- 11 rural counties in Northeast Texas (UT Health Northeast)

EHF RURAL HEALTH WORK

Research

- State of rural hospitals in Texas (TORCH)
- In-depth analysis of rural health clinics (TORCH and TARHC)
- Development of community options to address rural hospital closures (TAMU College of Medicine)
- Key factors related to the sustainability of community health resource centers (HRCs)
- Rapid response survey of Texas Gulf Coast residents impacted by Hurricane Harvey
- Environmental scan of current telehealth services in the region
EHF RURAL HEALTH WORK

Grant Investment

- $9.5 million total investment
- 13 FQHCs, 3 RHCs, 2 LMHAs, 5 Charity Clinics
- Focus on partnerships/collaborations, rather than silo investments

OPTIMIZING RURAL HEALTHCARE PROJECT


- TAMU team to develop a process that can be used by rural communities, healthcare systems, state offices of rural health or others to evaluate the resources and needs of a community that are facing challenges in maintaining their current healthcare delivery systems
Optimizing Rural Health Care:
Identifying Tools/Tactics That May Help

Nancy W Dickey, MD
A&M Rural and Community Health Institute
January 18, 2018
THE SITUATION:

- As described by George and Shao-Chee, the issue(s) are not limited to Texas
  - 20% of the population in 80% of the geography

- The rapidly changing healthcare delivery system is contributing to the demise of rural healthcare
  - Specialization
  - Technology
  - Mergers and acquisitions

- Most communities remain anchored in an outdated perception of possibility

GETTING DOWN TO SPECIFICS:

- Following the paper regarding Rural Closures: What’s Next

- Identification of 3 communities who were facing closure
  - Seeking commonalities
  - Seeking understanding of the processes and underlying assumptions being followed

- Examination of specific issues
  - Situation leading to crisis
  - Hospital leadership
  - Sophistication of leadership/business acumen
DISCERNMENT OF ISSUES/OPPORTUNITIES:

• Identifying the need for discussion/planning before a crisis exists

• Perception that there is a need for training and support systems for rural facility leadership

• Developing a robust set of alternatives that are “off the shelf”
  • 24 hour emergency centers
  • Telemedicine

• Developing facilities and workforce for a different approach to rural delivery

WHAT’S NEXT?

• Development of a “blue print” or plan with each community about how they will maintain access to health care for their community

• Identification of common steps/processes for development of an algorithm for other communities to follow

• Consideration of issues that might be addressed through legislation/regulation
Questions?

Thank you!

- Contact us at ruralhealthinfo.org with any questions
- Please complete webinar survey
- Recording and transcript will be sent to you
  - Slides are available at https://www.ruralhealthinfo.org/assets/912-2968/hospital-closures-011818.pdf