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# Rural hospitals an ever more endangered species

*Many risk closure, rely on entrepreneurial relief*

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While hospitals in urban areas and suburbs face formidable challenges regarding crunching the numbers, navigating complex regulations and serving the public, the overwhelming majority of them are survivors.

Rural hospitals, however, are an endangered species.

Seventy-six of these facilities — often referred to as critical-access hospitals — have closed nationwide since 2010. And 30 percent of the country's 2,000 rural hospitals are likely to cease operations during the next two years.

According to Leawood, Kansas-based nonprofit National Rural Hospital Association, 673 rural hospitals, or about one-quarter of all such health care facilities, are “vulnerable or at risk for closure” during the next decade.

The numbers are disturbing considering rural hospitals are often the only places that provide health care within a 50- to 100-mile radius of their respective communities. In addition, many are a significant source of employment for the communities they serve.

Six rural hospitals in Tennessee have shuttered in the past six years, according to industry publication Becker's Hospital Review. They are Gibson General Hospital in Trenton, Haywood Park Community Hospital in Brownsville, Humboldt General Hospital in Humboldt, Parkridge West Hospital in Jasper, Starr Regional Medical Center in Etowah and United Regional Medical Center in Manchester.

"Like a lot of things in health care, issues surrounding rural hospitals are complex and have a lot of players and regulations," says Bill Anderson, CEO and president of Medhost, a Franklin-based IT company that offers a cloud-based health care management system involving clinical and financial solutions for hospitals.

"Rural hospitals face an economic squeeze and resource shortages," Anderson adds. "Because of [increased] regulation and more sophisticated treatment options, fixed costs are increasing — sometimes dramatically because of federal regulations requiring technology."

Indeed, factors negatively impacting rural hospitals are intensifying. Throughout America, small towns and rural communities are losing population, which dissuades physicians from feeling comfortable about their prospects of establishing viable practices and careers in such places.

Even more glaring, CAHs increasingly — compared to their urban counterparts — must treat a disproportionate number of low-income, indigent and aging patients, many with chronic conditions such as diabetes, and heart disease. And they must do so with a modest number of doctors and specialists, no less.

Furthermore, revenue at most rural hospitals is stagnant — or dwindling — because so many patients are on Medicare or Medicaid or are either uninsured or underinsured. Even when they are insured, many folks don't seek help until health conditions have deteriorated because their insurance policies have high deductibles, Anderson says.

"Plus, many health care plans encourage treatment outside of walls of the hospital," he adds. "That means the percentage of inpatient health care being delivered is declining. It means shorter hospital stays and more services delivered outside of the hospital setting. Many of these hospitals are in a very difficult place."

Alan Morgan, CEO of the aforementioned National Rural Hospital Association (NRHA), agrees that the situation surrounding rural hospitals "appears to be going in the wrong direction."

But Morgan points out the crisis is motivating health care innovators, entrepreneurs and visionaries to invent "new models, systems and solutions" he believes will eventually help stabilize rural hospitals. He sees a lot of promise in "telehealth," which refers to advanced technologies that deliver health care education and support via computers.

"One of the most successful applications [of telehealth] is the teleconsultation," Morgan says. "We're seeing a widespread application of teleradiology and telepsychology. These are the kinds

of applications that show a lot of promise. For example, just think about how telepsychology can help with the opioid addiction crisis.”

Morgan points to physician-to-physician teleconsultations and virtual patient support groups for everything from weight loss to depression as a part of the solution.

“Rural doctors are now able to link with peers [via technology] and discuss procedures and protocols,” Morgan adds. “This is a great way to have access to top specialists. As we move forward to address problems, I believe telehealth solutions will thrive, and we’ll move towards direct patient access (for example, a rural patient talking to a health care professional remotely via a computer).”

Industry veteran Clare Moylan agrees.

“Telehealth will play a significant role in rural health care,” says Moylan, managing director of Healthcare Management Partners, a Nashville-based consulting firm that specializes in engineering turnarounds at distressed hospitals.

Moylan sees the rural hospital of the future changing from a primarily inpatient facility to an “important emergency/ambulatory care/outpatient providers for communities.”

“They may have ‘swing’ beds for skilled nursing patients, but inpatient care will primarily be provided by larger regional ‘hub’ hospitals,” she says. “The best rural hospitals will know their core services and do very well by eliminating other services. Most back office operations will be outsourced.”

Moylan is certain the disruption surrounding rural hospitals will cause growing pains.

“There will also be fallout from the distress we currently see in the market,” she says. “Hospitals will be put through bankruptcy. Some may close, others may be successfully restructured. The goal is to protect healthcare services in rural areas, recognizing that the traditional rural hospital model is changing, whether we like it or not.”

Medhost’s Anderson offers a similar take, noting non-urban hospitals are “going in two directions.”

“Hospitals that are situated well geographically and have good leadership will start to expand their communities of care,” he says. “Other hospitals — by virtue of competition or because of the market they’re in — will end up looking for alternative operating models. They will be less of a full-service hospital and more of an immediate care facility. Unfortunately, I do believe you are going to see a number of hospitals go out of business.

“The reality today is the country cannot afford to deliver health care the way it has in the past,” Anderson adds. “There are inefficiencies and some excess capacity in the system. There are better and worse operators. As a result, we’ll see some of the capacity taken out, and the operators who are left will be more efficient.”

Anderson also sees some creative “repurposing” on the horizon.

“Take the example of behavioral health care,” Anderson says. “Many states have shortages of inpatient care. I think we’ll see situations in which existing [underutilized] facilities will be repurposed for different types of health care.”

Anderson predicts that many solutions — particularly those based in technology — will rise from the private sector.

Indeed, Medhost is on the front lines addressing the problem with free-market solutions. Anderson says the company’s rural health division, which provides consultation, marketing and technology products for the rural health market, is among the firm’s fastest growing.

Despite the innovation and restructuring needed to bolster rural hospitals, many proposed changes won’t occur unless laws are changed at the federal level, says Maggie Elehwany, vice president of government affairs and policy at NRHA.

Elehwany, the association’s main lobbyist, says current regulations pertaining to rural hospitals are restrictive and outdated, and don’t allow providers to establish new and more flexible models.

Elehwany is working to improve the outlook for rural hospitals by promoting the Save Rural Hospitals Act. The bipartisan bill, co-sponsored by Republican and Democratic members of the U.S. House of Representatives, is aimed at adjusting how rural hospitals are reimbursed and setting guidelines for the creation of innovative delivery models.

“Rural hospitals have also endured Medicare cuts for years,” Elehwany says. “If Congress doesn’t intervene, we almost certainly will lose a quarter of our rural hospitals in the next 10 years. One in three rural hospitals are under financial risk, and 69 percent of rural hospitals operate at a loss.”

Elehwany says there are now “health care deserts” caused by rural hospital closures. She describes a domino effect that often occurs when a community loses a hospital.

“The hospital closes, which means the physicians leave and the pharmacist leaves,” she says. “Health care is not the only thing that shrivels up. You see home values fall and families stop wanting to move there. People get stuck and you see the erosion of an entire community.”

Elehwany and her NRHA colleagues are optimistic that the Save Rural Hospitals Act will pass in 2017.

“We are just trying to stop the cuts and stabilize the system; we’re not trying increase reimbursements,” she says. “The bill will offer much-needed regulatory relief and stop the bleeding. Maybe we can’t save all rural hospitals, but we can create a path forward for hospitals that don’t need inpatient beds anymore.”

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