Carolinas HealthCare System Anson facility

Rural health – rethinking care in the wake of hospital closures

By Lisa Chamoff

In July, the Carolinas HealthCare System Anson in Wadesboro, N.C., a town of about 5,800 people, opened the doors to its new facility and embarked on a bold experiment: replacing Anson Community Hospital, a 52-bed inpatient facility built in 1954, with a new model of delivering health care.

Built for $20 million, the new hospital kept the emergency department, but cut the number of inpatient beds by nearly three quarters, to 15. While the facility still offers radiology, digital imaging, laboratory, pharmacy, surgery, and inpatient services, there is a patient-centered medical home within the ED, in an effort to provide primary care while reducing costly and unnecessary ER utilization. There are also community-based partnerships to address chronic health issues, such as diabetes, in rural Anson County, which in 2012 was ranked 89th out of North Carolina's 100 counties in the County Health Rankings & Roadmaps program.

At a time when rural hospitals are closing at a rapid pace — more than two dozen have closed since January 2013, according to the National Rural Health Association — the leaders at the Carolinas HealthCare System knew things needed to change.

"We realized we needed to built a new model of care for the Anson community," says Michael Lutes, a senior vice president with Carolinas HealthCare System. "We didn't want to build the traditional model, especially with the challenges of rural medicine. We wanted to do something really different."

While it's too early to determine the full impact of the change in Anson, in the first few months the hospital has seen a significant decrease of ER utilization for health issues that can be treated by primary care doctors.

"A lot of these patients didn't have a primary care physician," Lutes says. "If the first 90 days is anything like the next five years is going to be, we're definitely on to something."

'Older, poorer, and sicker'

A majority of the rural hospital closures were in states with Republican leadership that blocked the Medicaid expansion offered under the Affordable Care Act. Still, many in the health care field agree that a number of issues affect rural facilities.

"Rural Americans are typically older, poorer, and sicker than their urban counterparts," says Brock Slabach, a senior vice president at the National Rural Health Association. "It's compounded if you're a senior or minority living in a rural area."

Indeed, data from the 2010 National Hospital Discharge Survey found that 51 percent of inpatients at rural hospitals were aged 65 and over, compared with 37 percent of inpatients in urban hospitals.

Mark Holmes, director of the North Carolina Rural Health Research Center, notes that in the south, where many of the closures have been, the economy tends to be weaker.

"A small change would manifest as a closure there," Holmes says. "States that have not expanded Medicaid have seen a larger portion of their hospitals close. We don't know if it's the Medicaid expansion or the region."

Medicaid Disproportionate Share Hospital (DSH) Payments have also been dialed down, and that's squeezing hospitals further, Holmes says.

In addition, a recent report by the U.S. Department of Health and Human Services' Inspector General found that because of the system that Medicare uses to calculate coinsurance amounts for beneficiaries receiving outpatient services at critical access hospitals, patients paid between two and six times the amount than they would have paid for the same services at acute care hospitals.

"Right now, Medicare is getting a bargain," Slabach says. "They're paying a lower portion for critical access hospitals and calling on the patient to pay the difference."

The primary care physician shortage has also hit rural communities particularly hard. Slabach says his organization recently started working on expanding the number of rural training tracks for primary care doctors.

"We have seen increased matches in terms of fill rates for these resident training programs," Slabach says. "We think this is a really good sign before we have the data."

Lutes, of the Carolinas HealthCare System, says that historically, Anson County has had a revolving door of physicians. With the new model, there is a primary care team of five providers, and four are from Anson County. They have also brought the family practice residency program to the Wadesboro facility.

Higher costs, bigger cuts

Some of the biggest challenges that rural hospitals face are the high costs that come with investing in electronic health records systems and avoiding meaningful use penalties.

"It's harder for hospitals in rural areas to invest in this technology," especially if they don't have the same volume, says Priya Bathija, senior director of health policy at the American Hospital Association. According to the National Hospital Discharge Survey data, 64 percent of rural hospital inpatients had no procedures performed while in the hospital, compared with 38 percent of urban hospital inpatients.

There have also been budgetary threats from proposed Medicare cuts. For example, President Barack Obama's fiscal year 2015 budget proposed to reduce critical access hospital payments from 101 percent to 100 percent of reasonable costs and to eliminate the CAH designation for hospitals that are less than 10 miles from the nearest hospital. The Center for Medicare and Medicaid Services recently indicated that it will begin more tightly enforcing the 96-hour rule for critical access hospitals, requiring physicians to certify Medicare and Medicaid patients will not be there more than 96 hours, or face loss of reimbursement.

"There's sort of a barrage of threats," Bathija says.

Improving population health

Holmes, of the North Carolina Rural Health Research Center, says that as the industry moves toward accountable care organizations — networks that coordinate patient care and are rewarded for delivering it better and for less money — it's not clear what the long-term role of rural hospitals will be.

Paul Bengtson, chief executive officer of Northeastern Vermont Regional Hospital in St. Johnsbury, Vt., who leads the American Hospital Association's Section for Small or Rural Hospitals, says his hospital is a member of one accountable care organization, OneCare Vermont, and works closely with two.

"I have never had anxiety about accountable care organizations," Bengtson says. "I actually like the concept. I like that they're pushing us to do things that we should otherwise do. What I don't like is the fact that there's another layer of bureaucracy layered on all the other layers of bureaucracy."

Like in Anson County, N.C., there is reason to shift to improving the health of the overall population. Bengtson notes that in Vermont, hospitals like his work closely with physicians, housing agencies, social service agencies, and agencies on aging.

"Vermont is a very interesting and progressive state," Bengtson says.

However, despite some progressive moves that can help address some of the special challenges that rural hospitals face, there are always going to be issues related to funding.

"The payment reform piece is not keeping up with the delivery reform piece, and that's what's causing most of the anxiety," Bengtson says. "We're living in a time of great ambiguity, so you have to have high tolerance."