Chapter 9

Conclusions: Availability of Rural Health Services

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VIABILITY OF FACILITIES AND SERVICES

Rural health care facilities face ominous changes in their operating environment. ***Major declines in the number of inpatients have made it difficult for many rural hospitals to function under stable circumstances.*** Inpatient volume and occupancy levels often are insufficient to support the basic fixed costs of treatment, especially for the smallest facilities. But the strategies that such facilities might use to lower these fixed expenses are limited. Some basic services and staff must be maintained to address unexpected variations in utilization and meet Federal and State regulations. Small isolated hospitals serving sparse populations lack the economies of scale gained from providing high-volume services, and they are often unable to share resources with other facilities to help lower their freed costs.

Growing numbers of rural residents appear to be leaving their communities to obtain hospital care in urban areas, either to receive specialized care unavailable locally or because they choose not to use local services. The migrating patients tend to be those who are best able to pay for care, leaving local hospitals more dependent on the lesser paying patients and further weakening the hospitals' financial condition. The results of this trend for rural hospitals are significant increases in the proportion of care that is uncompensated and a heavy dependence on inflexible public payers (e.g., Medicaid and Medicare) that have not kept payments at pace with rising costs. Such revenue constraints have further pressured these facilities to reduce inpatient costs and to rely more heavily on local tax subsidies and fundraising. However, efforts to lower costs and improve revenues have had only limited success. Positive operating margins are now minimal or nonexistent for most rural hospitals.

The costs to rural hospitals of uncompensated care are probably much greater for uninsured and Medicaid patients than for Medicare patients. Enhancements to inpatient Medicare payments may help in the short-term to increase coverage of acute care costs and subsidize some nonacute care services in smaller hospitals. Over the long term, however, increased inpatient Medicare payments will do little to counter the general decline in demand for acute care, stimulate involvement in other ventures and services, and improve total hospital operating margins.

Community health centers (CHCs), a primary source of non urgent care for rural poor and uninsured residents, are providing ever greater amounts of under- and uncompensated service and remain heavily dependent on government grants and payers (e.g., Medicaid). Small and isolated CHCs, which are 'less able than others to cut expenses or collect additional patient revenues, are especially dependent on Federal grants for their survival. As with hospitals, costs are rising faster than total revenues in rural CHCs.

FACILITY ADAPTATION TO CHANGES

Many rural health facilities have inadequately developed new service missions and structures in response to these health system changes, in part because they face several obstacles to doing so.

Information on strategies is lacking. Although numerous short- and long-term strategies exist that might enable rural health facilities to adapt to changes, evidence of their existence and effectiveness is limited and comes largely from anecdotal sources. Few mechanisms exist through which information on prospects and efforts might be disseminated to rural facilities or to government policymakers who might wish to support such efforts on a larger scale.

The means for accomplishing change can be extraordinary and quite risky. Strategies by a few States to develop alternative delivery models for rural hospitals typically require major restructuring of facility services and operations. Most such models address the faltering condition of small, underutilized hospitals by limiting their scope of services to essential levels of emergency, subacute, and primary care. Patients needing other services would be stabilized and transferred under these models.

Adopting such measures is risky for both facilities and their communities. There are few precedents,

and there are no assurances of support from government or other sources. For example, hospitals in Montana that agreed to become medical assistance facilities would: 1) serve remote rural communities with limited access to care, 2) have to surrender their acute-care license, and 3) need a waiver of Federal regulations in order to receive Medicare and Medicaid payments.

One barrier that must be overcome for these alternative facilities to become viable are inflexible regulations **that affect scope of services, staffing,** facility specifications, and other factors. Existing laws and reimbursement policies now prevent many facilities from redesigning their structures and services to fit local needs and capabilities. The new Federal initiative creating essential access community hospitals (EACHs) and rural primary care hospitals (RPCHs) is designed to provide an alternative to some of these regulatory limits on hospitals. Some States, however, may find EACHs/RPCHs less appropriate than State-designed models that are more attuned to local needs.

Other barriers that may influence the development of alternative facilities include:

- *indefinite support from Federal and State governments* for planning and technical assistance, improved access to capital, and other forms of financial assistance;
- *opposition by health care professionals* concerned about quality of care and protecting traditional roles and authority; and
- *questionable acceptance and support from the community,* which may believe that inferior quality care will be provided.

Effective change is stifled by facility financial problems and shortsighted government policies. For example, the increase in outpatient and post-acute care services in most rural hospitals has brought these facilities a new source of cost-based revenue. However, these new revenue sources are endangered by:

- increased efforts of hospitals to have these services absorb losses accruing from inpatient care;
- current plans by Medicare to pay for ambulatory surgery and other outpatient services on a prospective basis, which could potentially disadvantage many rural hospitals; and
- regulatory requirements associated with providing hospital-based post-acute and long-term care (e.g., the requirement that a skilled nursing facility have its own nursing station).

Hospitals operating at a loss develop poor credit ratings, forcing lenders to deny these hospitals capital to invest in new equipment and facilities for diversified services. Some providers applying for certification as rural health clinics have difficulty complying with certain regulations (e.g., midlevel staffing). Others experience lengthy waits prior to approval of participation, delaying their receipt of Medicare and Medicaid payments.

Parochialism, inertia, or lack of planning resources may prevent some facilities from effectively exploring prospects for change. Anecdotal reports suggest that some rural hospital executives have been slow to accept and address rapid changes in their financial condition, market, and regulatory environment. Trustees and management often are mindful of community pride in past accomplishments and desires to maintain the status quo and are oriented more to service delivery than business management. In certain cases, this situation may be exacerbated by the lack of dynamic leadership and access to specialized management and legal counsel.

It appears that rural facilities are either skeptical of the benefits of interinstitutional affiliations or simply lack the opportunity to participate. Less than 15 percent of rural hospitals have joined cooperatives, and the number in multihospital systems appears to be declining.

To help rural facilities overcome their problems and implement strategies to adapt to changes, Federal and State governments can intervene in two broad areas:

- ***assessing Federal and State regulations and removing those that prevent useful approaches to change,*** and
- ***providing incentives to States*** *and local communities to help restructure facilities and services.*

Changes in regulation, however, must assure patient safety and quality of care. Assessing the impact of new facility models and other strategies on the quality of care should be an explicit component of evaluation efforts.

AVAILABILITY OF SERVICES

Most rural hospitals are within reasonable travel time or distance to another hospital. However, rural hospitals located in more rugged terrain and in less densely populated regions of the Western United States are farther apart. Not *much* is known about the characteristics and accessibility of hospitals nearest these facilities. Hospitals in isolated areas are often the only providers of accessible emergency and acute care for widely dispersed populations—yet this role may be impeded by a lack of physicians and patients. For example, frontier hospitals have significantly fewer staff physicians and acute-care admissions than do other similarly sized rural facilities.

Some financially troubled rural hospitals can no longer survive as hospitals, due mainly to declining inpatient volume and rising costs of maintaining underused acute-care capacity. The excessive supply of hospital beds in many rural areas has been created by a combination of the prolific hospital construction of the Hill-Burton era, health system changes producing more outpatient care, and greater use of sophisticated technology that cannot be provided economically in small hospitals.

Those rural hospitals that have closed are relatively near other hospitals, small in size, and few in proportion to the number of open hospitals. The effects of hospital closures are felt most keenly where the hospitals are the only providers of acute care over large areas. But apparently, few closed hospitals thus far have significantly affected access to care for local residents. Little is known about the comparability of open hospitals nearest these closed facilities in terms of scope and quality of services, geographic and financial accessibility, or operational stability.

There are no well-defined criteria or designations for rural health facilities that: 1) are essential sources of emergency, primary, and acute-care services for residents geographically isolated or unable to pay; and 2) may need special protection to maintain the provision of essential services. The Medicare sole community hospital (SCH) designation was intended to serve this purpose, but as a group, SCHs no longer represent critical sources of hospital care in rural areas. In fact, only about 30 percent of Medicare-designated SCHs meet current eligibility criteria. Furthermore, under past payment rules many SCHs were in poor financial condition, and the value of SCH designation has been questionable to most rural hospitals until recently. Changes in SCH reimbursement (Public Law 101-239) may improve the financial solvency of many SCHs, but smaller SCHs (like many small rural hospitals in general) will probably remain financially vulnerable despite higher Medicare payments. ***Classification of sole community hospitals in geographically isolated rural areas should more accurately designate and protect critically needed facilities.*** Also, beyond Medicare's prospective payment system, new sole community provider criteria might: 1) give special attention to hospitals in rural areas that have a large proportion of low-income or uninsured residents, and 2) be expanded to include nonhospital providers (e.g., primary care centers, long-term care facilities).

Travel time to services is an important potential criterion for determining when a provider is an essential sole source of local care. But determining an acceptable standard of travel time or distance to health care for residents in remote areas is difficult and controversial. ***Travel guidelines being debated for application to hospital care in rural areas are overly simplified (e.g., apply to all rural areas and all levels of treatment).***[1] Most recent studies examining travel distances have not considered important access issues such as the urgency of the care required, the mobility of the patient, and the variability among facilities in the scope and quality of services and policies for care to indigent patients.

COORDINATION AND INTEGRATION OF SERVICES

Health services have developed in response to myriad factors (including various government policies, programs, and reimbursement mechanisms). Consequently, many services might appear fragmented and uncoordinated, particularly for the poor and elderly individuals commonly thought to have the greatest difficulty in gaining access to health services. ***Hospitals in rural communities generally have developed and operated independently of other hospitals and area health services. Their lack***

[1]For example, the 1978 National Guidelines for Health Planning (now repealed) suggested that travel time to a hospital for a majority of residents of rural areas should be no greater than 30 minutes (43 FR 3056).

of coordination between services can have serious consequences. For example, some rural county health departments in Florida providing primary care to the indigent have until recently lacked the funds and planning assistance to arrange necessary followup care with area hospitals and specialists (322).

In other situations, one may find:

- *Rural facilities delivering duplicative or underutilized* services-For example, some transportation services to primary care clinics are available from various local agencies; however, there may be little coordination or information on how to obtain these services. Consequently, some residents may forego important care or be prematurely institutionalized because they are unaware of vital services.
- *Rural facilities endangering continuity of care when referring patients to distant providers*—For rural hospitals and physicians not engaged in cooperative transfer and referral arrangements with distant providers, ensuring appropriate and coordinated care for referred patients is difficult. Also, because of the lack of locally available care, some rural elderly persons must be referred to distant communities for both hospitalization and post-acute support services. Thus, some residents relocate and fragment the relationship with their local primary provider.
- *Rural hospitals having difficulty discharging patients effectively--Nearly all rural* (and urban) hospitals have difficulty finding appropriate post-acute care for discharged patients (613). This is a problem in rural communities where no skilled nursing facility beds or full-service home health agencies are conveniently available.

The lack of effectively coordinated and integrated health services in many rural communities underscores the need for creating new or better delivery networks of various providers. Current efforts to improve rural health service delivery have given scant attention to the development of facility networks. Examples include:

- *New delivery models in areas with limited access—In* general, State efforts to create rural alternative delivery models have only involved individual hospitals. No States have considered developing networks of different types of facilities that improve access to and continuity within a more comprehensive set of services. The recent Federal initiative that allows the creation of EACHs and RPCHs addresses the importance of rural health care networks; however, it is not clear to what extent nonhospital facilities and providers will be encouraged to have a role in the networks (e.g., only hospitals are now eligible to become RPCHs). Also, few State models address problems of rural areas with large proportions of low-income or uninsured persons.
- *The Federal Rural Health Care Transition Grants Program (see* ch. *3)* is laudable in its intent to encourage rural hospitals to adapt to changes and promote cooperative activity among facilities. However, the program lacks the resources to offer hospitals incentives that are appropriate and adequate for major structural change and long-term solutions. The program would also be more effective if grant funds were better prioritized and targeted (e.g., to facilities and networks in areas with critical access problems).

Many rural facilities are either unaccustomed to cooperative delivery networks or may be less inclined to participate in networks because of possible government restrictions (e.g., antitrust, antikickback, and tax-exemption rules). ***An appropriate Federal role would be to provide guidelines and incentives for States and local facilities to plan and demonstrate networks.*** Networks developed in areas with critical access problems may need special treatment to ensure their existence.