A Path Forward for Rural Healthcare

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Rural America encompasses a broad geography. Almost 20 percent of the U.S. population lives within the 84 percent of the nation’s land area that the Federal Office of Rural Health Policy (FORHP) defines as rural.1 But rural America is a very diverse place, and there is no single solution that will address the healthcare needs of the many people who live there.

Two of this article’s coauthors—Ken Beutke and Erik Thorsen—are rural health executives. Ken is President of 97-bed OSF HealthCare OSF Saint Elizabeth Medical Center in Ottawa, Ill., and oversees a facility in Streator, Ill., that recently was converted from a hospital to a rural health center. Both Ottawa and Streator are in LaSalle County (Ottawa, the larger of the two, is the county seat). Erik is CEO of 25-bed Columbia Memorial Hospital in Astoria, Ore., the county seat of Clatsop County.

There are several similarities between the two counties that Ken’s and Erik’s facilities serve. Both are designated “micropolitan areas” by the U.S. Census Bureau—in other words, both counties have an urban core of at least 10,000 but not more than 50,000 people. Both have populations that trend slightly older. The U.S. average population above age 65 is 15.6 percent, compared to 18.5 percent for LaSalle County and 21.7 percent for Clatsop County. Both counties are approximately 100 miles away from major metropolitan areas (Chicago and Portland). They both have per capita and median household incomes slightly below the national average, and broadband internet access very close to the national average of 78.1 percent of households.2

But there also are important differences between the counties. Although designated as rural, LaSalle County has a higher population density than the U.S. national average, with just over 100 people per square mile (the U.S. average is 87.5 people per square mile). Clatsop County’s population density is significantly below the national average, with 44.7 people per square mile. LaSalle County’s population is slowly declining, with a negative 3.9 percent change in population from 2010 to 2018. Clatsop County’s population is growing; in the same period, its population grew by 7.4 percent, slightly ahead of the U.S. national population growth rate of 6.0 percent.

The trends we see in LaSalle and Clatsop counties are representative of differences in rural areas nationwide. The U.S. Department of Agriculture confirms that while the vast majority of older-age counties are rural, one-third are retirement destinations or have recreation-based economies. These counties have seen an upturn in population growth in recent years, similar to what we are seeing in Clatsop County. In contrast, another third of older-age counties are “persistent population loss” areas, which have been subject to long-term outmigration of young adults. LaSalle County may not yet be witnessing persistent population loss, but it is experiencing gradual population decline.3

The different population dynamics across rural areas are among many factors that call for different approaches to address the healthcare needs of rural residents. Some approaches require change at the national policy level, particularly the Medicare program, which is the primary payer for many rural hospitals. Other approaches should be taken up at the state level or by individual organizations, which are better situated to tailor efforts to the needs, opportunities, and challenges of their specific rural communities.

Challenges to the Future of Rural Healthcare

Provider organizations in rural America are subject to the same forces that are reshaping healthcare across the nation. Demand for inpatient services is weakening as many procedures and services migrate to outpatient settings and other alternative sites of care. The aging of the Baby Boom generation is shifting payer mix away from commercial insurance to Medicare. Technological advancements are enabling new healthcare delivery models that have the potential to significantly disrupt traditional care models.

These trends can have a unique or magnified impact on rural healthcare providers:

- **Declining demand for inpatient care.** Many critical access hospitals (CAHs) already have very low daily censuses. The national average daily census for CAHs was 2.7 acute beds in 2016.4 Further volume declines threaten not only the financial viability of low-census CAHs, but also the quality of care available to patients.

- **Shifting payer mix.** With populations that tend to be older,5 many rural areas will feel the impact of the shift of patients from commercial insurance to Medicare more acutely than metropolitan or suburban areas. That impact will be felt even more strongly in areas experiencing population growth driven by retirees.

- **Technological advancements.** The needs of rural patients were an early driving force in the development of telemedicine. Further advances in virtual care delivery may well have a disproportionate impact on more geographically isolated rural areas, especially if broadband access and related connectivity issues can be resolved.6
Given these pressures, significant changes in the nature and delivery of rural healthcare are inevitable.

The Future of the Rural Hospital

Reports on rural health often start with statistics on the number of hospitals that have closed, or are threatened by closure, in rural communities. It is true that 104 rural hospitals closed between January 2010 and April 2019. It also is true that, of these, only 63 facilities completely shut down. Five were converted to nursing or rehabilitation facilities; 16 were converted to outpatient/primary care/rural health center use; and 20 were converted to urgent or emergency care facilities. The most relevant question is not how many hospitals closed. Rather, it is whether the residents of affected communities retained access to needed healthcare services.

The facility in Streator, Ill., was one of the 16 closed hospitals that have been converted to outpatient, primary care, or rural health center use. The decision to close a hospital is never easy. Hospitals often are among the largest employers in a rural community, and local business and political leaders often feel a community needs a full-service hospital to attract economic development. Based on several factors, however, we believe the decision to convert the hospital to a rural health center with 24/7 emergency care will be the right decision for Streator in the long term.

First, Streator residents will continue to have access to emergency care and other essential services through the new health center. Continued access to emergency care was the greatest concern of area residents, and was among the first commitments OSF HealthCare made to the community.

Second, the decision had minimal impact on employment. When OSF HealthCare acquired the Streator hospital, employment was down to 200 employees. OSF has been able to retain approximately 180 employees to staff the new rural health center.

Third, Streator is in an area that is over-bedded. Within a 25-mile radius of the city are the 97-bed OSF Saint Elizabeth hospital in Ottawa, Ill., and the 42-bed OSF Saint James hospital in Pontiac, Ill.; two other hospitals are 35 miles to the northwest. The health system that ran the hospital simply could not maintain sufficient volumes to make the facility financially viable. By taking control of the site, OSF HealthCare had an opportunity to rationalize services within a local network of hospitals and other providers. Travel times to the hospitals in Ottawa and Pontiac are comparable to travel times for many living in the Chicago metropolitan area, and 24/7 emergency services remain available to Streator residents if travel to a hospital is not feasible.

In short, conversion of the Streator hospital to a health center with a free-standing rural emergency facility helped the community avoid the two greatest impacts associated with rural hospital closures: lost access to emergency care and the economic impact of lost jobs. And, as described later in this article, it has converted excess inpatient space into space that better supports the community’s long-term health.

Conversion of the Streator facility could serve as a model for other health systems seeking to rationalize the provision of services within an owned network of rural facilities. A health system can provide clinical, financial, operational, and technological support to a rural health center. In turn, the center can serve as a spoke to the hub of larger facilities within the system’s network. Within the context of a system as a whole, a rural health center’s return on investment can be tied to downstream revenues from referrals. A health center’s focus on improving community health also can result in savings under a system’s managed or accountable care contracts.

Without the backing of a health system, or the opportunity to capture downstream revenues or savings, independent rural hospitals have more limited options, particularly in communities that face both declining populations and declining inpatient volumes. One possible solution—found in both the Medicare Payment Advisory Commission’s recommendations to Congress and the bipartisan-sponsored (but not yet passed) Rural Emergency Acute Care Hospital (REACH) Act—would end the requirement that rural hospitals maintain inpatient beds to receive Medicare payments. Instead, rural hospitals could convert to stand-alone emergency departments, with the option of changing back to an inpatient hospital if circumstances change. A converted facility would still be able to offer ambulance and outpatient services, and be paid for these services as well as for emergency care.

The future of the rural hospital will be brightest in areas that are experiencing population growth. In areas were population trends are flat or declining, the number of hospitals that can be sustained by the local population likely will continue to shrink. The future of those hospitals will depend on the ability of larger health systems to grow and support the conversion of facilities in their networks, or the willingness of legislators to support a more flexible model for rural healthcare facilities.

The Sustainability of Market-based Competition

While competitive markets are a good thing, healthcare is susceptible to a range of market failures that can be especially acute in rural areas. For example, a healthy market can adjust supply to meet demand. But physicians in a number of specialties—particularly primary care—are in short supply. In rural areas that face heightened recruitment and retention challenges, the problem of supply is even more acute. Of the approximately 7,000 designated Health Professional Shortage Areas (HPSAs) in the U.S., more than 4,600—just over 65 percent—are in rural or partially rural areas.
Healthy markets also require competition, but it is unrealistic to expect competition to work in rural markets that may struggle to sustain one hospital, let alone two. Competition among rural hospitals may limit the services that the competitors can offer, rather than expand access to care.

It all comes down to numbers. Certain services require a minimum number of physicians. At Columbia Memorial Hospital in Oregon, for example, the obstetrics and general surgery practices require at least four to five physicians on staff to ensure call coverage. The other critical number is volume. If volumes are not sufficient, patients justifiably might start to question the quality of care. Columbia Memorial has good volume: its obstetricians deliver approximately 300 babies each year, and its orthopedics practice has two physicians who each perform three to six procedures a week. If these numbers were to decline significantly, however, the hospital would have to question the viability of continuing these services.

Columbia Memorial has competition from two other CAHs within an approximately 30-mile radius. It is fortunate to be the largest provider in a growing rural area that has been able to sustain a competitive model. But in rural communities that face declining volumes and greater difficulties recruiting and retaining physicians, duplicative services within an area that could be served by a single facility only multiply the number of physicians needed. Moreover, competition for already thin volumes increases the likelihood that no facility will have adequate volumes to ensure consistent quality of care, or sustain a financially viable practice. As noted in a recent New York Times article, the pressures of clinician shortages, dwindling volumes, and declining revenues are already creating “care deserts” for obstetric services in rural areas.11

Favoring collaboration over competition might better meet the needs of rural communities. Rural residents need access to essential services such as emergency care, diagnostic services, primary care, behavioral health, rehabilitation services, and certain specialties, such as general surgery and obstetrics. Rural communities also would benefit from services that help prevent the need for more acute care. In Streator, OSF HealthCare is promoting a “healthy village” concept that provides space for social service agencies and other collaborating service providers to have a co-located physical home along with OSF-provided services. OSF also is looking at the issue of service duplication across the health system, social service agencies, and other community service providers. The health system worked with the local YMCA to adopt OSF programs and streamline provision of those services within the community.

A move from competitive to collaborative frameworks may involve significant trade-offs, including changes to payment structures and heightened state oversight. Payment structure changes likely would move toward global payments to designated facilities—perhaps existing rural hospitals—that could coordinate care and payments among collaborating providers, social service agencies, and others. In the absence of competition, state oversight likely would include rate setting, but also oversight of clinical outcomes, patient experience, and distribution of healthcare services.

Several states already are moving in this direction. Maryland has had an all-payer rate setting system for more than 40 years. Now the state is participating with CMS in an all-payer model test that is shifting virtually all hospital revenue into global payment models that incentivize collaboration among providers.14 Pennsylvania has begun a Rural Health Model with CMS that also uses all-payer global budgets to help stabilize the financial health of rural hospitals and promote collaboration among rural healthcare providers through development of Rural Hospital Transformation Plans.15 Vermont—a largely rural state—established a board in 2011 with regulatory authority over provider rate-setting and workforce plan approvals, and now has entered an all-payer accountable care organization (ACO) model with CMS intended “to make redesigning the entire care delivery system a rational business strategy for Vermont providers and payers.”14

Collaboration and competition need not be mutually exclusive. Columbia Memorial leaders see opportunities to improve competitive position through collaboration. The hospital recently strengthened a partnership with Oregon Health & Science University, the state’s only academic medical center, which allows more local access to specialist care. Market-based healthcare policies still may be appropriate for larger population centers that can support a sufficient degree of hospital competition across services, and attract an adequate supply of healthcare providers. This may include rural markets that are close to major population centers or are experiencing growth that can sustain a competitive model.

In rural areas where both competition and providers are in short supply, however, something along the lines of a public utility approach may be more appropriate. Such an approach can help ensure that limited resources are best mobilized to serve the needs of rural residents, and that facilities and providers are able to move forward on a sustainable financial footing.15 Such an approach could also help ensure adequate distribution of services across rural areas, avoiding “care desert” scenarios that already are developing in service areas such as obstetrics.

**The Impact of Disruptive Innovation**

The geographic isolation of some rural areas may create a sense of distance from innovations in the healthcare industry, but this is an illusion. One of the most significant recent innovations in
healthcare—telehealth—had its roots in the need to get medical resources and expertise into rural areas. The University of Mississippi Medical Center (UMMC) Center for Telehealth—which is one of only two Telehealth Centers of Excellence recognized by the federal Health Resources & Services Administration—got its start in 2003 with an effort that initially relied on television sets linked to T1 lines to bring emergency care support to rural facilities.  

Rural hospitals that have embraced telehealth have discovered several advantages. It can provide patients access to specialty care that otherwise would be unavailable, and reduce the number of hospital transfers required, allowing rural hospitals to treat more patients in a local setting. Medicare now pays for certain telehealth services, and soon will pay for more with changes authorized by the 2018 Balanced Budget Act.

Telehealth as it exists today, however, is just the tip of the digital iceberg. As the digital delivery of healthcare advances, rural hospitals may not see the same advantages. Digital management of chronic diseases, direct consumer access to telehealth providers, and other developments in digital healthcare might reduce the need for rural hospital services, regardless of geography. Similarly, the movement of care to retail settings and other emerging on-demand healthcare delivery services may pull more care from rural hospitals, especially in more densely populated rural areas that provide a solid consumer base for these services.

It is impossible to predict exactly how innovation and technological change will affect rural healthcare, but change is inevitable. The question is how a rural healthcare facility can establish its value as a hub that facilitates community access to innovation. Columbia Memorial Hospital, for example, has partnered with national telehealth provider American Well to give its patients 24/7 access to its white-label CMH Virtual Care service. In Illinois, the new Streator health center will have dedicated space where patients who do not have home internet can access digital health services. The center also will have a “tech bar” to help residents learn how to access telehealth services from home and use wearables to monitor chronic conditions. Some of these services may reduce demand for care from facilities and local providers, but staying on top of innovation keeps a rural provider relevant in the eyes of the community it serves. It is better to be a part of change than to be left behind when change occurs.

**Conclusion**

Significant movement on any of the issues discussed in this article could change the direction taken on others. For example, allowing more flexible facility models that do not require maintenance of inpatient beds could open rural areas to greater competition, as could innovations in digital health that enable national healthcare platforms to compete for business without the constraints of geography.

Today, however, we are very much in a world where on-the-ground delivery of healthcare services matters, and where some rural residents risk losing access to essential healthcare services. Rural healthcare needs new paths forward. These paths will vary, but will require solutions that bring financial stability to rural healthcare providers, support collaborative efforts to address the healthcare needs of rural communities, and give rural healthcare providers the flexibility they need to adapt to changes that already are occurring, and will only accelerate.

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2 Demographic data for the two counties are based on U.S. Census Bureau Statistics, accessed April. 23, 2019 https://www.census.gov/quickfacts/fact/table/lasallecountyillinois,clatsopcountyoregon/USPST045218.


