Rural Hospitals Face Many Challenges in Transitioning to Value-Based Care

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In North Carolina and across the country, a sea change is underway that is transforming how health care services will be delivered and paid for in the decades to come. Hospitals and health care systems are reorganizing to prepare for value-based care—preventive, coordinated, high-quality care that is focused on improving the overall health of communities. The struggle for hospital executives is how to position hospitals for the future while still providing care in a volume-based payment system. Balancing finances during this time of tremendous change requires hospital leaders to make difficult decisions. Hospitals must innovate, restructure, become more efficient, and continuously improve care in order to protect the community's health safety net. This transition is particularly challenging for rural hospitals.

There are 56 hospitals in North Carolina in counties that are classified as rural. These hospitals tend to have a higher-than-average mix of Medicare (48%), Medicaid (17%), and uninsured patients (10%), and they generally serve populations that have lower incomes, more chronic health issues, and low health literacy. Safety-net hospitals care for more Medicare, Medicaid, and uninsured patients; as a result, they experience lower (often negative) operating margins (the difference between reimbursement and expenses). For North Carolina's safety-net hospitals caring for high proportions of Medicare, Medicaid, and uninsured patients, average patient margins in fiscal years 2012 and 2013 were the lowest in the last 9 years [1].

Without Medicaid expansion or other solutions to provide insurance coverage for uninsured patients, and with additional cuts to Medicare and Medicaid reimbursement, the forecast for all hospitals in North Carolina is one of continuing challenges. This future will continue to include mergers, shared services partnerships, realignment or reorganization of services toward outpatient and ambulatory care, conversion of acute care hospitals into community-focused health care organizations, and in some cases, hospital closures. According to the research firm The Advisory Board Company, hospitals in states that did not expand Medicaid will see their profit margins drop precipitously by 2021 [2].

Rural hospitals have weathered this storm before. The Balanced Budget Act of 1997 led many small hospitals to successfully restructure as critical access hospitals (CAHs). Since then, 23 small rural hospitals in North Carolina have transitioned to CAHs. Implementation of the Patient Protection and Affordable Care Act of 2010 has dramatically accelerated the pace of such changes. In response to declining admissions, most hospitals outside of major metropolitan areas have joined integrated health systems or regional health networks. Partnership arrangements offer better access to capital for facility renovations and improvements in technology, as well as access to cost-saving efficiencies. According to membership data from the North Carolina Hospital Association, the number of independent hospitals in North Carolina has dwindled since 2012—from 24 to 18—with many of the remaining independent hospitals actively seeking health system partners.

In light of these challenges, many rural hospitals are

transforming their operations to prepare for a future of risk-based, accountable care. In Wadesboro, Charlotte-based Carolinas HealthCare System (CHS) replaced the 100-year-old Anson Community Hospital with a new medical home facility designed to promote a shared commitment between care providers, patients, and the community. While the hospital includes 15 inpatient rooms, the majority of its services are oriented to outpatients, with 24-hour emergency care and other traditional hospital services, as well as access to primary care physicians, wellness and prevention education facilities, patient navigation services, and pharmacy assistance. As part of an integrated health system, the new role for Anson Community Hospital is primary care; secondary acute care and intensive care are provided at CHS hospitals in Monroe (approximately 28 miles away) and Charlotte (approximately 55 miles away) [3].

In Burke County, CHS Blue Ridge announced plans in June 2014 to transition the hospital in Valdese to an outpatient health center and to transfer inpatient care to its nearby Morganton campus [4]. This realignment of services is not unique. In Watauga County, the Appalachian Regional Healthcare System strategically examined health care services provided by Watauga Medical Center in Boone and those of nearby Blowing Rock Hospital, along with the health needs of the communities; as part of a long-term strategy, health system administrators decided to transition Blowing Rock Hospital from a CAH to a post-acute care and rehabilitation center as of October 2013 [5].

The success of health care service transitions, restructuring, and partnerships in these examples illustrates the importance of rural hospitals to their communities. North Carolinians need hospitals in order to retain access to vital health and wellness services. Rural hospitals are also essential to local economies, as they provide jobs, stimulate local purchasing, and help attract industry and retirees. Because of this, the closure of a hospital can be detrimental to the health and economy of a rural community [6].

The status quo in health care is not a viable strategy for the future. North Carolina's hospitals—rural and urban—must continue to innovate, restructure, become more efficient, and improve care to meet their mission to ensure around-the-clock access to quality medical care and to protect the health of patients and the community. NCMJ

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Acknowledgments

Potential conflicts of interest. J.S.S. and S.C.S. have no relevant conflicts of interest.

References

1. Broome S. NCHA Advocacy Needs Data Initiative, State of the State 2013 and Hospital Trends. Cary, NC: North Carolina Hospital Association; 2013.
2. Respaut R. Rural hospitals pressured to close as healthcare system changes. Reuters News. September 3, 2014. http://www.reuters.com/article/2014/09/03/us-healthcare-rural-insight-idUSKBN0GY14620140903. Accessed November 18, 2014.
3. Carolinas HealthCare System Anson – FAQ. Carolinas HealthCare System website. http://www.carolinashealthcare.org/anson-frequently-asked-questions. Accessed November 18, 2014.
4. Carolinas HealthCare System Blue Ridge to transform Valdese campus [press release]. Carolinas HealthCare System website. http://www.blueridgehealth.org/valdese-hospital/Blue-Ridge-to-Transform-Valdese-Campus-Web%20ready.pdf. Published June 25, 2014. Accessed November 18, 2014.
5. Blowing Rock Hospital transitioning to post-acute care center [press release]. Appalachian Regional Healthcare System website. https://www.apprhs.org/news/blowing-rock-hospital/blowing-rock-hospital-transitioning-to-post-acute-care-center.html. Published September 12, 2013. Accessed November 18, 2014.
6. Holmes GM, Slifkin RT, Randolph RK, Poley S. The effect of rural hospital closures on community economic health. Health Serv Res. 2006;41(2):467-485.

Electronically published January 8, 2015.

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N C Med J. 2015;76(1):38-39.

0029-2559/2014/76113