OUR COMMUNITY HOSPITAL:

THE EVOLUTION OF A PRIMARY CARE HOSPITAL

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ABSTRACT

In the next few years, Our Community Hospital, located in the small town of Scotland Neck, N.C. (service area of 17,000 residents), will undergo dramatic changes that could prove an appropriate model for similar small hospitals in distressed rural communities. With technical assistance from the Office of Rural Health and Resource Development, N.C. Department of Human Resources, the hospital has begun to slowly phase out almost all acute care services and expand and strengthen its focus on primary care, emergency medical services, and senior services. The converted hospital will have 100 long-term care beds (skilled beds, intermediate beds and home-for-the-aged beds) and specialty services aimed toward health care and social support for the elderly.

The experience of Our Community Hospital during its transition process should be useful for other communities interested in converting a traditional rural hospital to a Rural Primary Care Hospital. This paper addresses five issues of greatest interest to other hospital administrators who may want to undertake a similar conversion:

- How community involvement was secured early in the planning process;
- How the needs assessment for the community was conducted;
- How the program's structure evolved;
- How financing was secured;
- How the project brought about cooperation between state and federal governments, foundations and private groups.

Our Community Hospital gave the State of North Carolina the opportunity to support a demonstration model that may have an impact on rural health care delivery throughout the nation. This provides a unique opportunity to develop a geriatric center of excellence and establish a model and training site for health professionals. This model may serve as one answer to the most acute health care problem in rural America—the viability of rural hospitals.

OUR COMMUNITY HOSPITAL:
THE EVOLUTION OF A RURAL PRIMARY CARE HOSPITAL

Scotland Neck, in the southern part of Halifax County, North Carolina, has a bustling main street, but most of the traffic just passes through on U.S. Highway 258. Some travelers may stop by the Idle Hour cafe or Hardee's for a bite to eat, but many more just keep going, typically heading toward the beach. Scotland Neck, whose population has hovered around 2,500 in recent years, has lost residents during the past three decades, and most of its jobs are in the declining sectors of agriculture and manufacturing. In many ways, Scotland Neck is typical of many small North Carolina towns struggling to compete in today's economy, for business and for health care services.

But on the edge of Scotland Neck, in an overgrown field, ground has been broken for a new 100-bed medical facility that will replace the town's aging 20-bed hospital, Our Community Hospital. The board members and leaders of the town's small hospital corporation have begun building a sophisticated primary and specialty care center that may change the way struggling rural facilities across the nation think about their future. The $4.2 million project will include a 100-bed long-term care complex with various levels of services, a 24-hour emergency room, public health and social services, and an expanded primary health care center. Our Community Hospital, which had been on the verge of financial failure for the last decade, will now serve as a national, innovative model of health care services.

Alternative hospital models have received increased attention from policy makers and researchers as the problems of rural hospitals have worsened. Developing models has become a sort of cottage industry in many states, including California, Wyoming, Montana, New York, and Florida. The federal government, through the Health Care Financing Administration (HCFA), has itself developed an alternative hospital model program in the Essential Access Community Hospital (EACH) program, designed to support the conversion of small rural hospitals. (Please see Appendix A.) Unlike other states, North Carolina, through its Office of Rural Health and Resource Development and Our Community Hospital leaders, went

forward with a transition plan in Scotland Neck without the benefit or complication of any state legislative changes or mandates.

Increasingly, rural health policy is being driven by central agencies, such as the federal Health Care Financing Administration, not by rural communities. The North Carolina hospital transition project is not a cookie-cutter or standardized model. Instead of coming from state or federal guidelines, Our Community Hospital's plan developed in response to economic realities and local community needs for improved primary health care services, expanded long-term care services and strengthened emergency medical care. A home-grown concept, the Scotland Neck project has community-based origins that make it unique and important for rural community hospitals across the nation.

Our Community Hospital and Scotland Neck

In the late 1940s, an enterprising obstetrician secured Hill-Burton funding to construct a small facility with overnight holding beds for obstetric and other patients.[1] One year later, the physician-owned and operated facility failed, but the community sponsored a fund-drive to preserve the facility as a hospital for the town, according to Dr. Vance Byrum, a physician who has practiced in Scotland Neck since 1955. The hospital reopened in 1953 as a not-for-profit facility known as Our Community Hospital and was designed to be a traditional acute care provider for the community.

Today, the hospital, whose primary service area is southern Halifax County and portions of three contiguous counties, is licensed for 20 acute care beds. For more than 35 years, two general practitioners have served as the physician staff for the hospital, performing procedures ranging from removing fish hooks to delivering babies.

Our Community Hospital remained a central part of life in southern Halifax County for decades. But now, the hospital shares much in common with small rural

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1 The federal Hill-Burton program, established in 1946, funded hospital facilities for thousands of rural towns across the nation until 1974. Nearly 44 percent of all Hill-Burton projects were located in communities with fewer than 10,000 residents, according to the Office of Technology Assessment.

hospitals throughout the nation that are permanently closing their doors, unable to compete with larger facilities in bigger cities. These common characteristics include small size, small medical staff, low occupancy rates, high dependence on Medicare, increased outmigration of its patient base, and high incidence of poverty in the service community.[2] In addition, the hospital also faces the health resource problems associated with a shrinking rural economy, a large increase in the population of individuals 65 and older, difficulty recruiting physicians and other providers, and an aging physical plant.

Scotland Neck cannot expect significant economic growth in the near future to help stabilize the finances of its hospital. Farming and agriculture-related industry form the economic base of the town, which is surrounded by fields of peanuts, cotton and tobacco. Other industries include two lumber companies, a manufacturer of ladies' apparel, a hosiery mill, and an elastic manufacturer. The town also is home to one of the busiest cotton gins in the nation. Yet Scotland Neck's economy has grown slowly, and the town has not seen impressive growth in business or population since the mid-1950s.

While overall population trends in the county and town have been fairly stable or declining slightly, the population of older adults is expected to continue an upward trend. Between 1990 and 2000, the population 65 years old and older in the county is projected to grow by 13 percent, and the number of frail elderly, those 85 years old and older, is estimated to rise dramatically by 52 percent.[3] Slightly more than half of the county's population of about 55,000 is black. Almost one-third of Halifax County's population lives in poverty. An estimated 37 percent of the population is either uninsured or underinsured, lacking adequate coverage for health care services. All of these characteristics put additional pressures on the hospital.

The hospital itself suffers the same symptoms as many financially struggling rural hospitals its size. Its occupancy rate has been about 30 percent in recent years. All of

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2 For details, see General Accounting Office, "Rural Hospitals: Federal Leadership and Targeted Programs Needed," Report to the Chairman, Committee on Appropriations, House of Representatives, June 1990; Richard E. McDermott, Gary C. Cornia, and Robert J. Parsons, "The Economic Impact of Hospitals in Rural Communities," *The Journal of Rural Health*, Volume 7, Number 2, Spring 1991, pp. 117-133.

3 Most of the county's population lives in the northern half of Halifax County, but detailed demographic data are only available on the county level.

its 20 beds are designated as swing beds, and almost all of its services are to swing bed patients 65 years old and older; 84 percent of its charges came from Medicare in 1990. No obstetric services have been offered since 1983, and the hospital staff does not perform surgery.

The Board of Trustees of Our Community Hospital recognized that the hospital could no longer serve as an acute care provider in the region. Three full-service general hospitals, with 292, 190, and 127 beds, lie within a 30-mile radius of Scotland Neck. But the demographic changes in the county and region, particularly the growing aged population, signal an increased need for stable health care services in Scotland Neck.

In 1987, Board members approached the Office of Rural Health and Resource Development to request assistance in formulating a health care delivery system for southern Halifax County that would provide needed primary care services in a manner that was also financially viable. The result was a future-thinking plan that has evolved in piecemeal fashion, responding to community needs, over the course of four years. And members of this small community have done whatever they could at every step to support the project, according to Jesse Shearin, the hospital's attorney and a key organizer who has sponsored community concerts for the hospital.

Scotland Neck and Rural Hospitals

The Our Community Hospital model provides an opportunity to address one of the most pressing problems in rural America—the viability of rural hospitals. Analysts with the North Carolina Hospital Association, which represents almost all N.C. rural hospitals, estimate that 18 of the 75 rural hospitals in the state had net overall revenue losses in 1988 and that the average annual loss was $369,000.[4] Although acute care rural hospitals make up about 60 percent of North Carolina's hospitals, they accounted for only 37.5 percent of all hospital discharges in the state in 1989.

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4 Millie Harding, Director of Financial Services, North Carolina Hospital Association, conversation, April 1991.

Glenn Wilson, a health care economist at the School of Medicine at the University of North Carolina at Chapel Hill, cites five irreversible trends as having greatest impact on rural hospital systems in the state:

1. North Carolina, like other states, has excess hospital capacity—approximately 40 percent of the state's 25,000 licensed hospital beds are unoccupied.

2. Hospital use has declined by 25 percent in the past seven years, a trend that will most likely continue.

3. Patients who once went to small hospitals for low-tech medical care are now being cared for in doctors' offices or in ambulatory facilities.

4. The application of complex and expensive medical technology is beyond the reach, both in terms of money and personnel, of small rural hospitals.

5. When given a choice, North Carolina residents have since 1973 increasingly elected to receive their hospital care in larger urban centers.[5]

These trends led North Carolina, through its Office of Rural Health, to apply for participation in the federal government's Essential Access Community Hospital program. Under this program, a larger hospital with more than 75 beds, called an EACH, will link up with a Rural Primary Care Hospital (PCH), a rural hospital that will reduce the number of acute care beds to six or fewer and will phase out acute care services. (For more on the EACH program, please see Appendix A.)

In September 1991, North Carolina was selected as one of seven states to participate in the EACH program. The N.C. Office of Rural Health will implement its plan to link up six larger rural hospitals (with more than 75 beds) with a smaller hospital in their region. These smaller hospitals, including Our Community Hospital, are all struggling financially and have agreed to reduce their acute care services to no more than six beds and shift their services to primary care or other types of specialized, nonacute health care in a regionalized system.

Becoming a PCH will make Our Community Hospital's future financial viability stronger by formalizing links with Halifax Memorial Hospital, the larger EACH in

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5 Glenn Wilson, presentation, N.C. Governor's Conference on Rural Health, Research Triangle Park, N.C., September 6, 1990.

its network. But the community and the Office of Rural Health had been making plans that followed the EACH concept years before the federal government developed the program. In fact, the Office of Rural Health used its experiences in Scotland Neck as a model for its plans with the other five smaller hospitals that will become PCHs through North Carolina's program. Our Community Hospital, which had already begun to move toward down-scaling services, simply is ahead of the group in its development of primary care services.

The Evolution of the Our Community Hospital Model

Before the advent of the EACH program, in the mid-1980s, community leaders in Scotland Neck realized that their small hospital was struggling to survive and that its traditional role no longer suited the economic realities of the current health care system. Their concern about the future of their hospital was deeply rooted in events from the 1970s. With the advent of desegregation, the small town had lost an important symbol in their community–the town's high school. In a county-drawn desegregation plan, the historically black high school and predominantly white Scotland Neck High School were merged. Scotland Neck High School was closed, and the historically black high school, also located in the town, was made a junior high. A new consolidated high school was built 10 miles outside the town in a sparsely populated part of the county.

According to Mayor Ferd Harrison, Scotland Neck lost an important source of strength with the closure of Scotland Neck High School. The former high school building now houses the town's Municipal Offices, and the old auditorium has been renovated and often hosts shows sponsored by the local Arts Council. Although the building has been put to good use, the community pride and cohesion a high school generates are gone. When high schools are moved out of small rural towns, "you cut a part of (the town's) heart out," according to Harrison, who has been mayor of Scotland Neck since 1958 and is a past president of the National League of Cities. Still stinging from the closure of the high school, Harrison and others did not want to lose another symbol of their community. So in 1986 they formed a committee to develop a strategic plan to save the hospital from closure.

The community's two years of intensive planning involved extensive economic analysis and consideration of the consequences of continuing their current operations. Scotland Neck physicians and community leaders, along with consultants from the Office of Rural Health, formulated a strategy aimed to secure quality and cost-effective primary health care for the 17,000 residents in the hospital's 314-square-mile service area. The plan called for a new emphasis on primary care and care for patients older than 65, in response to changing demographics. Financial support for the plan was funded in part through the Hospital-Based Rural Health Care Program, sponsored by The Robert Wood Johnson Foundation. The goals of the project are to:

1. Secure and broaden primary care services in the service area.
2. Provide long-term care options currently not available to seniors in the area.
3. Provide independent housing for senior populations.
4. Expand and enhance in-home services.
5. Provide ancillary services to senior populations.

To meet these goals, Our Community Hospital will discontinue providing inpatient, acute care services and will upgrade its emergency services so that the hospital can stabilize patients before transferring them to Halifax Memorial Hospital, which is 28 miles away in Roanoke Rapids. The current physical plant will be replaced by a new, 100-bed facility that will specialize in senior care services and primary care medicine. The new medical center and additional buildings will support:

- 30 skilled nursing beds
- 30 intermediate care beds
- Specialty clinics
- Relationships with EACH and university teaching hospitals
- 20 units independent senior housing (private) (Phase 2)
- 20 swing beds
- 20 home-for-the-aged beds
- Specialized therapies
- County offices for the Health Department and Social Services
- Senior Center (Phase 2)
- In-Home services (Phase 2)

This collection of services will be combined with the existing physician practice. The current physician practice building, which is near the future hospital site, will undergo extensive renovations and will house county offices, such as Social Services and Health Department services. The original 20-bed hospital will be demolished, and the licensed beds will become part of the new facility. The new

structure will be completed prior to the demolition; therefore, there will be no interruption in services. Employment at Our Community Hospital will double after it converts from an acute care facility to a senior services/primary care facility.

The Board of Trustees gave itself time to make their final decision to convert the hospital. The pivotal event in their decision came when members of the Board visited Cle Elum, Washington, where the hospital had lost its physicians and been converted into a primary care center. Cle Elum's geography and health services differ a great deal from those of Scotland Neck (Cle Elum is closer to a major interstate, for example). Yet visiting a community that had actually converted their moribund hospital from acute care to primary care services and seeing its result was a crystallizing moment in the development of Scotland Neck's plan, according to Serge Dihoff, a hospital specialist with the Office of Rural Health who has worked on the project since its inception.

Initially, the plans for the new facility's senior services focused on nursing beds and home health care but did not include skilled nursing care other than swing beds. In 1989, the North Carolina State Medical Facility Plan (which regulates the number of facilities and/or beds that can be licensed in the state) designated that Halifax County was in need of 60 skilled long-term care beds. Competing with Halifax Memorial Hospital, the 190-bed hospital in the northern part of the county, Our Community Hospital leaders decided to apply for the Certificate of Need (CON) that would be awarded to meet that need. Filing for the CON designation was a logical and potentially profitable addition to their plans, and its timing was ideal. The smaller hospital was awarded the 60 beds and will integrate skilled long-term care beds into a larger facility with rest home (home for the aged) beds, which do not require a CON.

Despite losing the CON award to the smaller hospital, Halifax Memorial has cooperated with Our Community Hospital to apply as part of a federal program that will benefit both hospitals. As mentioned earlier, Our Community Hospital has joined with Halifax Memorial to form a Rural Health Network under the EACH program as part of North Carolina's program plan. Our Community Hospital's existing plan to eliminate inpatient acute care fits well into the federal guidelines for the EACH program. Its participation as a PCH in this federal program will enhance

the chances for success in its non-acute role and ensure that its traditional patient base retains access to quality acute care services .

As a PCH, Our Community Hospital and Halifax Memorial, the EACH, will develop a series of programs to improve access to care through their Rural Health Network. EACH/PCH funds will develop emergency room systems, patient transportation, communication systems, and other needed services. Halifax Memorial Hospital is located 28 miles north of Scotland Neck in the county's largest city, Roanoke Rapids, and has an active medical staff of 54 providers who will provide clinical back-up for the Scotland Neck facility.

The affiliation of the two hospitals offers their patient populations a broader range of services than before the formation of their network. Without the EACH affiliation, the decision for Our Community Hospital to downsize and limit acute care would have been, if possible at all, a very difficult one, according to Board members. Halifax Memorial will receive an increase in referrals and market share. For example, Our Community Hospital will provide space and support staff for specialty physicians from Halifax Memorial to establish clinic rotations. In addition, Halifax Memorial will send some of its more chronic long-term care patients to "heavy care" nursing home beds at Our Community Hospital.

Without the incentives provided by the EACH program, Halifax Memorial had been hesitant to enter into agreements with Our Community Hospital. Past experiences of mistrust and competition, such as for the CON, had prevented the formation of cooperative ventures between the two hospitals until the development of the EACH program. With the Office of Rural Health serving as a liaison, the two hospitals entered into negotiations and developed a network plan that has pleased both sides. Any past ill will did not appear during negotiations, and the EACH planning process served as a healing process for the leaders of the two hospitals.

Aspects of Our Community Hospital's Plan

Primary Care. Perhaps the most pressing reason why the town's leaders moved to restructure their hospital services was the advancing ages of their two-person medical staff. In 1986, both of the town's two general practice physicians, who have

served the community since the mid-1950s, were older than 55 and nearing retirement. For years, their efforts to recruit younger physicians to take over their established joint practice had failed. Today, one of the two physicians has retired from active practice, and the other is planning on retiring in the next few years.[6] Both long-time physicians in Scotland Neck have sold their practice and property, which is near the proposed hospital campus, to the hospital.

Given the solid financial base projected for the new facility and the innovations planned for the complex, the recruiting potential for the expanded primary care site has improved from bleak to promising. An internist joined the practice in September 1991, and together with the Office of Rural Health, the medical center is recruiting one additional primary care physician as well as a physician assistant.

The expanded primary care site will provide a wide array of family medicine services. Adding other primary care services also will be examined, with technical assistance coming from the state Office of Rural Health, which has provided sophisticated technical assistance to rural health centers across the state since 1973. This assistance includes financial analysis, quality assurance surveys, office management analysis, and capital grants. Currently, the Scotland Neck primary care practice is investigating the feasibility of becoming a certified Rural Health Clinic, under Public Law 95-210, with the assistance of the Office of Rural Health's reimbursement specialist.

Long-term care. During the last decade, North Carolina had a shortage of long-term care beds. The nursing home bed-to-population (65 and older) ratio has doubled since 1973, to about 36 beds per 1,000 population 65 and older. However, between 1980 and 1986, because of a temporary moratorium on new construction, the ratio actually declined. The North Carolina average (46.6 per 1,000 population 65 and older in 1986) continues to lag behind the national rate (55.5). Swing bed programs in many of the state's rural hospitals have met a portion of this excess demand for nursing home care.

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6 The practice employed a temporary full-time physician until they recruited a permanent internist to the practice to replace the retired physician.

(Implementation of 24-hour EMS coverage by professional staff is anticipated in the near future.) EMS is financed through public funds (including a district tax) and private, creative fund drives, which recently included a benefit concert by an Elvis Presley impersonator.

The EMS staff of seven full-time employees, including four certified paramedics, will be housed at the new complex and will receive upgraded equipment as part of the new plans. Four of the EMS team's emergency medical technicians have received paramedic training, which will broaden the scope of the emergency services offered by the hospital.

Many of the benefits emerging from the hospital's restructuring will address some of the problems that have plagued other small rural hospitals. The hospital will no longer be burdened by the high costs of maintaining acute care services. The formal linkages with the EACH, Halifax Memorial Hospital, will strengthen the quality and variety of acute care services readily available to the Scotland Neck service population. The enhanced primary care and senior care center will serve as a strong magnet for physician recruitment.

Financing the project

One significant challenge for the Scotland Neck leaders was capitalizing the project at interest rates low enough for financial success while ensuring that high quality services are offered. With assistance from staff members of the Office of Rural Health, the project organizers were able to secure grants and loans from private foundations that will reduce the amount of required capital and allow the hospital to borrow smaller amounts of other needed funds at high interest rates. This provides lasting savings for the duration of the loans taken out by the hospital. Financing of the project is detailed in Appendix B.

Although the community's financial contribution makes up a relatively small portion of the total $4.2 million of funds needed for the project, its more than $200,000 contribution could be said to be the most important. The 1990 Community Fund Drive exceeded its goal of $180,000 by more than $25,000, an impressive accomplishment for a county that has a 31 percent poverty rate. Moreover, the

This North Carolina trend is evident in Scotland Neck. Almost all of its current patients (before the transition) were swing bed patients, reflecting the need for skilled nursing beds in the communities the Our Community Hospital serves. In 1988, Halifax County had 235 skilled and intermediate nursing beds. Given its age-adjusted population, the State Medical Facilities planning staff estimated the county would require 334 beds by 1991.[7]

The Certificate of Need award the hospital received in 1990 for skilled nursing beds is part of meeting that need. As described earlier, the CON beds will be integrated into a larger 100-bed facility specializing in care for the aged. The hospital has signed a management agreement with VHA Long Term Care for the operation of the nursing facility. For a reasonable cost, VHA Long Term Care will bring needed experience and management expertise to the project.

Ancillary senior services and other services. In addition to long-term care, the expanded senior services will include home health care, the Meals-on-Wheels program, physical therapy, occupational therapy, and an active adult day health/senior center. In addition, county government will house a variety of services in the renovated primary care facility, including mental health services, social services, public health, and the federal Women, Infants and Children (WIC) nutrition program.

By providing this wide array of services, project leaders hope to minimize the travel and cost involved for many residents who seek out assistance and health care services. They also expect to benefit from greater economies of scale by consolidating services. This collection of services is expected to attract medical and nursing students interested in geriatrics and will serve as the basis for increased linkages with teaching universities.

Emergency Medical Services (EMS). With financial support from the Scotland Neck Emergency Medical Services Authority, EMS has been upgraded to 12-hour coverage by professional staff; the remaining 12 hours will be covered by volunteer staff.

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7 For information on how North Carolina allocates its long-term care beds and other regulated medical facilities or on Halifax County's allocation, please see the *State Medical Facilities Plan*, years 1989, 1990 and 1991, N.C. Department of Human Resources, Division of Facility Services, State Health Planning Office, 701 Barbour Drive, Raleigh, N.C., 27603.

money raised by the community demonstrated its commitment to the project. In many ways, the Community Fund Drive money served as seed money for the other foundation and government loans and grants. In addition, the service area's four townships levy a hospital district tax on property owners that has contributed more than $150,000 annually for the last five years.

The second most important piece of the project's financial foundation came from The Robert Wood Johnson Foundation of Princeton, New Jersey. The Johnson Foundation has agreed to provide the hospital with a $500,000 loan at 4 percent interest. The foundation's involvement came at an important time, during its critical early stage, according to Jim Bernstein, Director of the Office of Rural Health and Resource Development. The loan commitment brought greatly needed focus and direction to the project. The Johnson Foundation also funded the Office of Rural Health's Hospital-Based Rural Health Assistance Program, which allowed staff members to become intensively involved with the project.

Other important funding comes from major grants from the Duke Endowment, the Kate B. Reynolds Health Care Trust, a hospital transitional grant from the Health Care Financing Administration, and the N.C. Office of Rural Health. The project has also been awarded a grant through the federally-funded Community Development Block Grant Program. The project's finance drive was capped by a $1.7 million low-interest loan from the Farmer's Home Administration, in the U.S. Department of Agriculture.

A financial analysis of the long-term care facility (conducted by an independent accounting firm) indicates that its structure and organization mesh well with the community's needs. The facility also will provide the project with a solid financial base for operation.

The Involvement of the N.C. Office of Rural Health and Resource Development

The Office of Rural Health and Resource Development, which has established 50 community-based rural health centers throughout the state, typically provides each of its newly-established centers with capital funding from its state-funded capital grant program. For the Scotland Neck project, the Office has pledged $300,000, the

maximum allowed under state guidelines for a project of its size. The Office has been providing technical assistance to rural hospitals since 1985 through its Community Hospital Technical Assistance Program, which is funded by the state and has received capital support from the Robert Wood Johnson Foundation.

The Office has invested significant amounts of time and money in this project because its staff believes that the problems of Scotland Neck will appear in small rural hospitals throughout the state. Thus the staff wants to examine every aspect of Our Community Hospital's transition in order to fully understand the dynamics of the model being implemented in this community. The Office will continue its intensive and cooperative involvement in the project and hopes to replicate it in other similar sites.

From past experiences with rural hospitals and health centers, the Office of Rural Health has learned these lessons:

1. Community support is essential to any project involving significant change.
2. If caught unprepared with a hospital in financial crisis, the community's first reaction will be to save the hospital at all costs and retain traditional acute care services.
3. It takes great amounts of time to build trust in a community and educate them on alternatives to traditional acute care services.
4. Timing is critical in that certain decisions must be made before a crisis erupts. Such crises can lead to uninformed decisions.

In Scotland Neck, community support for the project has grown steadily and remains one of the key strengths of the project. Members of the hospital's Board of Trustees and fundraising committees were instrumental in educating the town's residents about the hospital's options and helping them gradually become more accustomed to the idea of hospital conversion.

In order to secure the $300,000 grant from the state, the community was required to raise $60,000 from at least 750 households. The Office of Rural Health requires this minimum contribution as a way of securing that community support for the program is widespread throughout the community. As a reflection of community support, its fund drive raised more than three times the amount needed for the matching grant. According to Burnie Patterson, assistant director for the Office of Rural Health and a veteran of dozens of community fund drives, the Scotland Neck

campaign was the most broad-based with which the Office has been involved. The fund drive had support among both black and white residents, among all age groups, and from many of the major businesses in the area.

In addition, the hospital leaders were forward-thinking in their judgments and did not delay their decision to convert the hospital until a financial crisis arose. Although the project has been delayed by many unexpected events, they have been able to carefully plot their course and make decisions without the pressure of time constraints.

Scotland Neck as a Model: Problems and Promise

During the entire process of the hospital's conversion, several problems have arisen, which are certain to arise in similar settings with other small hospitals. These include professional recruitment; unavoidable construction delays; and the general financial and regulatory environment faced by rural hospitals.

First, physician recruitment has been, and remains, a critical problem. Nationally, the pool of primary care physicians willing to locate in towns the size of Scotland Neck is small. According to a survey by the American Academy of Family Physicians, only 10.6 percent of medical students nationwide are choosing to enter family practice, the specialty most appropriate for rural communities. Compounding this shortage of physicians, fewer family physicians are interested in small town rural practices: less than 11 percent of family physicians are choosing to settle in towns with populations of fewer than 2,500. Should recruitment problems persist, the success of this program and others like it will be in severe jeopardy.

Second, the program has taken four years to develop and has experienced numerous, unavoidable delays. Ground-breaking ceremonies for the new facility took place one year behind schedule, in May 1991. A major delay was caused when organizers of the project learned that part of their chosen site lies in the 100-year flood plain and a greater portion lies in the 500-year flood plain. Originally, Our Community Hospital's board had planned to develop the new facility on the campus of the current building. But the project would not qualify for Community Development Block Grant money from the N.C. Department of Economic and

Community Development if it were built on that site. To avoid any problems with construction or with approval of the project by CDBG, the site for the new hospital structure was moved 250 yards due north to 11 acres of land donated by a town native. The new tract, which currently is a cotton field, is on higher ground and is more suitable for development.

Because of this and other delays, community enthusiasm for the project often waned because the community had not yet seen tangible results from its fund-raising efforts. According to board chairman John Allison, a retired teacher and school principal, in early 1991, the community had become more anxious about the project. Residents had become enthused about the fund raising drive in 1990 but had not seen any tangible results for almost one year.

At such critical times and throughout the process, board members provided critical leadership to maintain community interest in and enthusiasm for the project. To curb the impatience that arose from the construction delays, hospital board members did a diligent job of renewing community support by meeting with key leaders and residents. Throughout the process, board members sought support from throughout the community. The fund raising drive of 1990 involved organizers representing all segments of the community—blacks and whites, older residents and younger residents.

Third, the financial and regulatory environment works against small rural health facilities. Small hospitals have great difficulty raising capital. Only after effective research and aggressiveness were staff members of the Office of Rural Health able to piece together financing (see Appendix B). Navigating the regulatory systems also was difficult. Certification for alternative services under Medicare and other programs is a maze of unnecessary paperwork. Also, federal and state regulations regarding licensing and reimbursement favor larger facilities and inhibit innovation.

Coupled with these lessons from previous experiences, the staff's involvement in and analysis of the transition of Our Community Hospital has led to the development of a valuable model, particularly for those small hospitals seeking to become a Rural Primary Care Hospital. By planning years ago to give up acute care services and assume other roles, Our Community Hospital was becoming a PCH

before HCFA even thought up the term. This model will be particularly helpful in the South, where health care access is more often hampered by the barriers of social isolation and poverty, not only geography.

The Scotland Neck model will enhance the health care delivery system of rural North Carolina by proving that alternatives exist for struggling rural hospitals. Rural communities that have financially unstable hospitals can see they have options for securing health care services. The fragmented and contradictory nature of government rules and regulations pose great barriers to the success of such problems. More importantly, for the Scotland Neck model to succeed in other rural settings, the problems of physician recruitment, federal and state policies, and finance must be addressed and solved.

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Appendix A

ESSENTIAL ACCESS COMMUNITY HOSPITAL PROGRAM

Under a new federal program to encourage and assist rural health care networks, small rural hospitals may receive grants and cost-based reimbursement to become Rural Primary Care Hospitals (PCHs) and, as Essential Access Community Hospitals (EACHs), larger hospitals forming a network with these small hospitals can receive grants and favorable reimbursement rates. This program will be available to seven states chosen through a competitive application process.

Rural Primary Care Hospitals

Criteria:

- rural hospitals that have no more than six (6) acute care beds providing inpatient care for a period not to exceed 72 hours to patients requiring stabilization before discharge or transfer to a hospital; †
- facility has agreement to participate in a network including a communications system;
- facility makes available 24-hour emergency care (could be "on-call" with a registered nurse who would call providers; physician's assistants or nurse practitioners could be used as staff);
- physician, physician's assistant or nurse practitioner must be available to provide services, provide routine diagnostic services and dispense drugs and biologicals;
- may participate in swing bed program.

Benefits:

- up to $200,000 in federal grants per facility;
- cost-based reimbursement (hospital will no longer be on the DRG payment system);
- financial stability while retaining needed health care services;
- flexible staffing options;
- variety of options for remaining beds converting to non-acute care;
- participation in a rural health network.

Essential Access Community Hospitals

Criteria:

- rural hospital with at least 75 inpatient beds that forms a network with at least one PCH and provides emergency and medical backup services to PCHs in its network;
- hospital must agree with its PCHs to accept patients transferred from PCHs, receive patient data from and transmit data to PCHs and provide staff privileges, if requested, to physicians providing care at PCHs.

Benefits:

- up to $200,000 in federal grants per facility;
- reimbursement as a "sole community provider";
- participation in a rural health network.

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† Regulations have not yet been published and will be available for comment before finalization of the program; the Secretary of Health and Human Services will be able to grant exceptions to regulations.

Appendix B

THE OUR COMMUNITY HOSPITAL PROJECT

Financing the Project

	Amount
Total Project Cost	$4,286,149
Long-term Care Facility	
Kate B. Reynolds Health Care Trust	$ 138,500
Community Fund Drive	150,000
Duke Endowment	500,000
Community Development Block Grant	600,000
Robert Wood Johnson loan	200,000
Farmer's Home Administration	1,744,149
Hospital District Tax	88,500
Subtotal	$3,421,149
Primary Care Facility	
Community Fund Drive	$ 60,000
N.C. ORHRD	300,000
Physicians Promissory Note	175,000
Robert Wood Johnson loan	300,000
HCFA Rural Health Transition Grant	30,000
Subtotal	$865,000