Rural Hospital Closure:

One Hospital's Tactics for Survival

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October 1989

*The NCRHRP is supported by Grant No. HA-R-000016-02,
From the Office of Rural Health Policy, Health Resources and Services Administration,
Public Health Service, U.S. DHHS.*

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Hospital closures in general, and rural hospital closures in particular, have received widespread attention from policymakers and the media. Between 1980 and 1987, 364 U.S. community hospitals closed or stopped providing inpatient chronic or acute medical care.[1] There is no single strategy to keep rural hospitals open in the many rural communities which are in danger of losing what is often their only source of medical care and an important component of their local economy. These hospitals do have some problems in common, such as an unfavorable differential in Medicare reimbursement rates between urban and rural areas, small size which often means higher costs and an inability to benefit from economies of large-scale purchasing, and slimmer margins and reserves which make them less able to absorb financial pressures. For example, when presented with a Medicare patient whose cost of care exceeds the amount allowed by Medicare, a small hospital will feel this deficit more keenly, as it has fewer patients over which to spread out and recoup the loss. The following case study of the decisions made by a small, rural hospital in eastern North Carolina illustrates how these institutions must stretch their resources in order to survive.

[1]Hospital Closures 1980-1987, A Statistical Profile, American Hospital Association, 1988, p.1.

One Rural Hospital's Story: Bladen County Hospital

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Today's hospitals are facing complex pressures, and rural hospitals seem to face a unique and difficult set of problems. They, like their urban counterparts, must seek out and then initiate a course of action which will facilitate the hospital's basic survival in the present as well as ensure its future prosperity. This means obtaining and then implementing plans for programs in the following areas: *strategy, productivity, finance, quality,* and *marketing.* The "catch-22" that faces the rural facility is this: the time, money and effort for these plans must come from resources which are already sorely strained, with no guarantees for success forthcoming. So what is the answer?

One small, rural hospital found that enduring the up-front expense and effort of planning brought about tangible results. That planning was tied in with a recognition that maintaining quality and the hospital's accreditation were also important parts of the process of making the hospital a viable community resource. As a community resource in trouble, it was also necessary to go to the community in order to raise capital for expansion and modernization through a bond issue. These components of Bladen County Hospital's revival as a modern health care organization are described in this paper with the hope that these experiences can be lessons for other small, rural hospitals.

Bladen County Hospital

Bladen County Hospital is a 62-bed rural hospital in southeastern North Carolina which has, in one year, gone from a hospital with a marginal future to one with as clear a path for survival and growth as a rural hospital can hope to have in these difficult days. Large losses, declining patient censuses, a failed building program, and a sense of questionable community support had left the hospital wondering whether a future beyond the end of the coming year really existed. The Board of Trustees, and a newly appointed but seasoned Administrator, determined that the only approach was to develop appropriate plans and to attack the problems head-on. By year end, five basic plans had been finalized, although outside assistance was still needed. Surprisingly, those plans with the most immediate paybacks turned out to be those least expensive to initiate.

Productivity Plan: This plan was the first to be put in place, since gaining systematic control of staffing and productivity seemed to be the most expedient way to deal with operational losses. For under $10,000, the hospital was able to contract for a hospital-wide productivity analysis. This, when combined with regional data available on similar size institutions, provided a basis for reducing FTEs

(fulltime employee equivalent[s]) without eliminating basic care services. According to this study, nursing represented the majority of FTE dollars. (The firm that did the original study was later brought back to complete a more detailed study designed to develop a nursing classification and severity staffing system for the hospital. The cost of this supplementary study, due to its more detailed nature, was in the same range as the broader original study.)

Financial Plan: This plan was the second element of the five-point basic survival planning scheme. It should be noted that although the hospital was a county hospital, it received no operational support from the county. Therefore, the following questions were of critical importance:

- What financial parameters did the hospital need to set for the next three to five years in order to survive?
- What were the limits on operational costs?
- Could the institution project for volume changes, for salary increases, and supply costs?
- How much more could be tolerated in terms of future contractual adjustments, bad debts, and free care, and what would have to be accomplished with rate increases?
- Did the hospital have any debt capacity with its history of operational losses?

An action plan for FTE reduction had already been implemented under the productivity plan. A small regional financial healthcare firm was hired to provide the hospital with a four-year financial plan, to include guidelines for dealing with the critical budgetary questions. The key variable in the financial analysis, as in the productivity analysis, was FTEs. This plan cost the hospital just under $6,000. By implementing these two plans, Bladen County Hospital was able to produce a realistic budget for the coming year, and expects the first in-the-black operational bottom line in four years. Certainly this constitutes a basic survival step, and one to be proud of.

Strategic Plan: It is a well-documented fact that strategic plans are vital to small hospitals, but the cost of this type of plan, as well as the the time involved, has prevented many hospitals from acquiring these basic and necessary documents. At Bladen County Hospital, an attempt to get a building program off the ground failed rather badly, due in part to the lack of any focused strategic direction. Because the hospital project was stalled, it was determined that this was an ideal time to reassess the institution's present strengths and weaknesses, as well as the demographics of its service area. It was thought that from that vantage point some conclusions could be drawn as to what the community needed, and as to whether or not Bladen County Hospital was the institution to deliver these services.

It was decided that the continued demand for any kind of hospital services (inpatient or outpatient) would result in the need for a building program. Accordingly, the most expeditious strategy seemed to be to find an architectural firm capable of doing quality long-range planning. Given the lack

of resources within the community for a construction program, it was further decided to hire a design/build firm which could provide a full range of services. Such a firm was identified, and for a cost of approximately $25,000 (the estimated cost of what an independent planning firm would charge), a strategic plan was commissioned.

After several months of analysis and dialogue, a strategic plan with twelve major recommendations was approved. The plan's formulation included a first-time-ever "retreat" for the Medical Staff, the Board of Trustees, and the Hospital Management Group. There was also a kind of thirteenth recommendation, which identified a host of other opportunities that our hospital needed to begin evaluating and considering. The major emphasis of the document was the reaffirmation of the need for a building program. With this document and the supporting data in place, the Hospital was now in a position to go to the community and present its case for a Bond Referendum which would allow the building program to go forward.

Quality Plan: The development of the Quality Assurance Program not only reaffirmed and improved the existing level of care within the institution, it also greatly improved communication and dialogue between all levels of the Hospital's management and medical staff. A community input program, called "Please Tell Me," was borrowed from a commercial organization, and has been quite successful in increasing the hospital's sensitivity to its community image. An Emergency Room Pledge outlining goals of services in the E.R. area has been developed and highly publicized, and a number of other activities are being evaluated to support the concept of a quality healthcare environment. Up to this point, except for about two thousand dollars used to bring in an outside consultant to meet in a "retreat" format with the Board and Medical Staff, no major expenses have been undertaken in the development of a Quality Assurance Program. The results, however, have been quite significant.

Marketing Plan: For virtually all small hospitals located within an hour of major metropolitan areas, there is severe competitive and financial pressure at all levels of the organization—from personnel recruitment to patient retention. A marketing program to increase market share requires a great deal of work. Our marketing plan, if pursued to its fully developed form, was the most expensive of the five plans. Proposals were received in the $50-$79,000 range, however, given the hospital's previous financial history, these funds were simply not available. As a viable alternative, an individual currently serving as the senior marketing person in a major medical center (who had previous experience with small and rural hospitals) was brought in at a cost of under $3,000 to do a "quick and dirty" survey. Since many of the attitudes of rural communities toward their hospitals have been researched and shown to be similar despite different geographical locations, it was decided that this consultant's experience, although obtained elsewhere, would still be applicable to Bladen County Hospital. Employing this particular consultant was further justified by reasoning that if, by some chance, a small market share gain could be achieved with very conservative budgeting, these extra funds could then be applied to a more expansive marketing program in the future. The

recommendations made were essentially short-term and relatively inexpensive, but as with the other plans they included basic positioning and action plan objectives for management.

To summarize, then, the *productivity plan* and *financial plan* became the two basic survival building blocks for Bladen County Hospital. These two programs were obtained and implemented for under $16,000. The operational control achieved through these plans ensured at least short-term existence. The dollar return, which was more than tenfold, clearly marked these areas as mandatory management initiatives. The *quality plan*, which can vary in cost, required a great deal of internal effort, but assured a competitive product which small hospitals must have in order to survive. It also produced a number of side benefits, such as improved internal communication. The prosperity-oriented programs of *strategic planning* and *marketing* require relatively expensive outside guidance, but, once initiated, they delineate clear avenues of action which result in clarity and direction for the Board of Trustees, medical staff, and management.

The Accreditation Issue

Rural hospitals face a double-bind, in that they need to increase care to keep their revenues up. However, increasing volume through managed care, negotiated and/or discount rates, as well as a host of other approaches, is not dealing with the basic issue, and this is especially true in public and rural hospitals. Often, after the productivity studies and standardizations are done, and the administrator still must cut to a budget level that has everyone screaming, he is told that the answer is quality, and that quality will pay for itself. However, in order to achieve and sustain this standard of quality, the aim of which is easing financial woes, he must acquire people and things (hardware, software, consultations, etc.) which require money.

"Quality can't be achieved without money, and money won't come without quality care, and at times it feels like a decidedly losing battle. So, save the money, save on the people and machines, and don't be publicly (or internally) embarassed by a lot of JCAHO fault-finding or focused surveys. Just drop out of the accreditation program! Adequate standards will come from state surveys for licensure and Medicare conditions of participation." Have any administrators and boards ever been seduced by this line of reasoning? The Board of Trustees of at least two hospitals with which the author has been involved have subscribed to this or a parallel logic. Usually the argument is supported by medical staff who insist that there are plenty of other internal and external standards which will act to maintain the quality level. The reality is that without the combination of external standards and strong external review (most state review teams are neither as thorough nor as adept as the JCAHO), the Board of Trustees and Management lose the primary control standards for quality care.

There are a few examples that shed some light on the importance of accreditation. One large northern public chronic-disease hospital voluntarily dropped accreditation. Within three years, a federal validation survey was prompted by a series of complaints and an oversight review by the state

survey team, and the hospital was subsequently decertified from participation in the Medicare program. The author, who had been CEO of this hospital six years earlier, was able, through luck, an infusion of money, an incredible team effort on the part of the remaining management people, and the cooperation of two local voluntary acute hospitals, to lead a recertification effort to success within sixty days. It took, however, another difficult seven months to lock in all the necessary organizational changes which would prevent a recurrence, and another two years for the hospital to be reviewed and notified that it was once again accredited. On the basis of a remarkably similar set of rationalizations, a small southern rural hospital had, back in the seventies, also dropped accreditation. By the mid- to late-eighties, the hospital was still functioning at mid-seventies standards and was in deep trouble financially, with decreasing censuses and a questionable level of public support. The underlying problem was this: the lack of current accreditation had meant no effort over the years to meet the increasingly higher standards of the JCAHO, and this meant no present-day assurance of a quality product. A turnaround iniative was undertaken by an assertive Board of Trustees. This effort, one year later, has all the appropriate action plans in place, but will require at least two more years, a building program, a staggering amount of work, and a great deal of money to be even minimally prepared for a survey.

These two hospitals were fortunate. Once a hospital has started on a path of decay, it is never easy to recover, regardless of the effort and/or money expended. So, in conclusion, saving the hospital a few dollars or yourself a little embarrassment may not be worth the risks involved. Don't endanger your organization--hold on to your JCAHO Accreditation.

The Importance of Working With the Community

You are in a fiscally conservative southern rural area and you desperately need a hospital bond passed. So conservative is this county, in fact, that a bond issue with a direct impact has not been passed since 1956. The hospital, a county-owned, sixty-two bed institution, houses most of its direct patient care activities in a 1952 Hill-Burton built facility. The plant, which fits the dinosaur category recently described in a *Hospitals* magazine article, needs, and has needed for years, replacement or substantial renovation. In the mid-seventies the hospital voluntarily dropped accreditation because the voters rejected, by a 56-44% margin, a bond issue which would have replaced the plant. The hospitals's operating loss history prevented any consideration of a revenue bond, so the only open avenue was a public general obligation bond referendum.

Clearly the hospital was moving outside of its element. The political arena in most rural communities is usually not highly organized, very conservative in nature, and fraught with danger for the uninitiated. The Hospital Board had decided to ask the County Commissioners to schedule a bond referendum only after years of trying to resolve the problem in other ways, and with a pervasive sense of potential doom as to the results. Neither of the two groups would even speculate that the bond had a

better than 50-50 chance. Yet even in this difficult, albeit fairly typical, environment, a combination of quality professional advice, a current information base, and lots of hard work was able to produce a success beyond what anyone could have anticipated.

It was decided that professional help was necessary. The fact that the Administrator was new to the community turned out to be an asset, in that care was taken to avoid assumptions regarding knowledge or understanding of the local political process. It was evident that the tenor of the political arena demanded a political consultant. Avoiding the smoke filled back room "wheeler-dealer" stereotype, a professional firm with some understanding of the health field was sought. The particular firm selected in this case was an organization called "Independent Opinion Research" from Wrightsville Beach, North Carolina, a company overseen by Sue Bullock and a nationally known political consultant, Walter DeVries. The importance of,the company and their approach to our problem cannot be overemphasized. Simply hiring a marketing firm (whether a hospital marketing firm or not) is a long way from the answer. One must also consider that we were dealing with a short-term problem totally dependent on timing, rather than a long-term marketing approach; i.e., this was a political campaign effort and not a marketing effort.

Once the professionals were on board, a telephone survey (political poll) was conducted. It was a random sample survey of over 1% of the county's population, and proved to be invaluable in terms of the information obtained, as well as its accuracy. One result of this study was that there was a very strong perception of community need and community support, as well as a significant sense of willingness to endorse a bond issue. There was, however, substantial disparity between the number of people who indicated that they would vote for the bond issue themselves (64%), and the number of people who thought others would vote for the bond issue (40%). Most of the people were completely unsure of how their neighbors would react, and this was a point of concern. In retrospect, the results of the survey seemed somewhat self-evident, given the nature of the community. This also meant, however, that a lot of the previous feedback we had been receiving had been greatly misread.

We decided, therefore, to organize a campaign that would be concise, factual, and hard-hitting in its basic message, and then take that message to the community's primary information sources, which we had identified through our poll. The campaign combined hard facts with basic wellsprings of community pride and personal health concerns. The hospital would, in a few years, be forced to close if the bond issue did not pass. That, in turn, would impact upon all facets of public and private life. Doctors would leave, new industry would not come. A major existing industry, the hospital itself, would be gone. Most of the county would be more than half an hour away from emergency care, etc. The major public source of information was through the two local newspapers which were each published twice weekly. The second most common source of information was essentially the local grapevine. It became obvious that it was important to get people to talk about the bond issue since the polls showed we had a high level of support. We felt that we could count on active discussion reinforcing the votes of those in

favor, while tending to prevent the emergence of a negative vote, on the basis that community members did not want to be thought different from their neighbors.

We then entered into the third element of the campaign, which consisted of a massive amount of hard work devoted to actually communicating our concern and objectives to the community. We discovered that much of the local contact had to be done by the Hospital Administrator, as information was not readily accepted unless it came "direct from the top." We thereupon began scheduling the Administrator's time with as many organizations as could be met with, and only when absolutely necessary did we use a backup speaker. We scheduled a series of local community hearing-type meetings that would have an impact on every precinct and population pocket in the county. Before the campaign was over 100 groups were reached, with the vast percentage reached by the Administrator. Some of the groups, such as church and civic groups, had good turnouts, but many of the community meetings had only a few people attending. We worried about that as an indicator of voter interest. We learned after the vote, however, that those meetings were vitally important regardless of how many people attended, in that the overall perception was that these meetings demonstrated an interest on the part of hospital management in individual communities. People were impressed that the hospital recognized the existence and importance of the county's numerous small population pockets. A strong local newspaper campaign, including an early front page headline article based on a speech given by the Administrator at the local Chamber of Commerce, lent support to the actual speaking engagements. This was followed by a series of articles about the various hospital departments and their physical problems. The information for these articles, though submitted by the hospital, was published as news and thus at no cost to the hospital. The paid newspaper activity consisted of a supplement that was included in both local papers on the day closest to the election. The supplemental tabloid was an advocacy piece as well as an information piece. In addition, there were county-wide mailings done twice during the campaign. The first mailing invited people to the public hearing-type meetings, which were held in various areas around the county. The second was in a question-and-answer format, and was sent out about three weeks before the bond vote. The survey and the information pieces were eligible for public funding because they were not viewed as advocacy. Only the newspaper tabloid required separate fundraising.

In addition to a fairly intensive information blitz, certain other elements of negative community concern received attention. There had been unsettled questions going back many years about the Emergency Room. As part of a general community information input program about hospital likes and dislikes, it was determined that the Emergency Room still represented a serious bone of contention within the community, while it remained the most visible and used community contact point. A lot of emphasis was directed toward making the Emergency Room entry point more responsive to public need, and this was reinforced by a written pledge of service. This eight-point pledge was included on the back page of the initial mailout which invited people from the area to the local community meetings.

The operating deficit which had been steadily increasing for the past four years was reversed so that at the end of the first quarter of the fiscal year, which was the last reportable period before the bond issue, the hospital was actually able to show a small operating profit. This was not made a focal point of information, as the period of reversal was too short to justify making of any promises. The information was instead used to point out that it *was* possible to deal with the hospital's fiscal plight. In the process of being able to explain how the hospital could have possibly gotten into such a situation in the first place, a little discussion about the essential unfairness of Medicare rural reimbursement rates took place. This created somewhat of an "us versus them" atmosphere in which the hospital and the voters were "us." The "us" identity was also used to bring home the message that without passage of the bond issue, they would likely lose *their* hospital.

The week immediately preceding the election we, through the use of volunteer personnel, called every residence in the community with a telephone (over 10,000 households) to determine whether or not people were going to vote and to get a sense of where we stood. If we had felt that we were in trouble, we would have noted the yes votes and called them back on the two nights before the election. We had always felt that to win the election, even by one vote, would be to accomplish what we had set out to do. We further felt that if we could, in the actual election, substantiate what our original polls had shown, that that would be a spectacular result, especially given the conservative nature and voting history of the county. The result: the right combination of professional advice, good information, and lots of hard work brought us a win with 76% of the vote.

Summary

The strategies that worked at Bladen County Hospital reflect strategies suggested by the American Hospital Association. Their guide, Hospital Closures 1980-1987, A Statistical Profile (AHA, 1988), suggests the following approaches as useful in avoiding closure or crisis:

- flexibility and diversity in services and facilities
- matching new services with community needs—e.g., expanding into long-term care, health promotion, or other new services
- affiliation with a referral center to attain access to valuable specialists in return for referrals
- joining a multihospital system
- converting to non-inpatient service.

They further emphasize four elements of hospital survival strategy for rural communities:

- innovative combinations of traditional acute care services with preventive and educational services to emphasize a comprehensive care philosophy
- design of a service mix appropriate to the needs and demands of the local population

- development of referral networks among local providers
- integrated systems of hospitals and clinics.

The rural hospital is often indispensable to its particular community. As the community feels involved in its operation and success, the hospital represents a more than economic stake in the community. The first and second elements in the second list given above deal with analyzing the specific care requirements and educational/preventive needs of a given community, letting the community know about this concern and intent, and attempting to implement strategies tailored to meet the needs of that particular population. By demonstrating its concern for the community the hospital further develops a mutually constructive and interactive relationship which can only work to the benefit of both.

The third and fourth elements have to do with these same goals, but through more provider-oriented means. Whereas the first and second items have to do with inextricably attaching the community and the hospital, the third and fourth have to do with linking providers to the hospital, to one another, and to the community. When these linkages can be utilized to deliver the services and programs the community *really* wants and needs, the hospital, as the driving force behind these interactions, will see its chances of survival, as well as of real-life worth and value, greatly increased.

As every community is different, there can be no set strategy which will work for every community or for every hospital. Bladen County Hospital took the approach of hiring an outside consulting firm to come in and evaluate the hospital, and then went about making the hospital what the community wanted. It tailored its programs and service goals such that it could become effectively indispensable to its community and it, unlike many rural hospitals, is still in existence to enjoy the inherent satisfaction realized by its efforts.