If you were working in health care in the 1980’s and 1990’s the current headlines and webinars on the closures of rural hospitals may give you a sense of déjà vu. A 2014 headline in the USA today read “Rural Hospitals in Critical Condition”. O’Donnell and Ungar went on to report that 43 rural hospitals have closed since 2010 and that that the rate of closure is intensifying. This data comes from the North Carolina Rural Health Research Program where a national study is being conducted on hospital closures. You can access an archived webinar http://www.ruralhealthresearch.org/alerts/archive/42 on the Rural Health Research & Policy Center website (Holmes, 2014) which includes their research on issue of profitability and closure of rural hospitals.

Remember why the Critical Access Hospital (CHS) program was created? As hospitals began to receive prospective payment vs. reimbursement for cost, there was a rash of hospital closures, and these closures were occurring disproportionately in rural areas. These closures made access to health care in rural populations problematic but were also a financial strain on the rural communities themselves. Rural hospitals are often a major employer in rural communities. Critical Access Hospitals have higher reimbursements than usual, which have helped many survive; however, these reimbursement rates are under review. Even with the high level of reimbursement CAHs are operating on slim profit margins. What these facilities bring to rural communities, is available health care and peace of mind – someone is there to provide care 24 hours per day. They are critical indeed to the rural populations they serve. The care in CAHs should be high quality and these hospitals have a responsibility to assess and maintain quality of
care. There may well be some rural hospitals that need to close but many provide a valuable service and help to meet the basic goal underlying the Affordable Care Act, access to care.

References
