The Neighborhood Community Hospital: A Diminishing Societal Fixture

By Todd Sagin, M.D., J.D., Sagin Healthcare Consulting

Almost every community in the United States has at least one general hospital. Since the early 20th century, hospitals have been at the epicenter of the healthcare universe. Communities without a hospital are typically considered underserved and the importance of such facilities to local populations can be seen in the designation of many sole provider institutions as critical access hospitals. According to the American Hospital Association (AHA), there were 5,260 active community hospitals in the country in 2017.[1] While community hospitals may appear ubiquitous, their number has declined by more than 12 percent since 1975. The decline in hospital beds has been even more dramatic. The AHA reported more than 1.4 million hospital beds in 1975 and about 799,000 staffed beds in community hospitals in 2017, a decrease of more than 40 percent. As this article will highlight, the sustainability of community hospitals in the decades ahead is on an even more tenuous track than in the recent past. Drivers for the demise of community hospitals have historically been financial, but equally important going forward will be a dramatic diminution in the utility of the traditional four-walled inpatient facility.

One of the most important responsibilities of a hospital board is strategic planning. Any comprehensive planning effort should include examination of the competitive environment as it exists currently, in the near future, and in the more extended future. In a recent presentation at a Governance Institute Leadership Conference, Governance Institute advisor Mark Grube from Kaufman Hall described this as "now, near, and far" planning. Many community hospitals are overwhelmed by the challenges of today and struggle just to plan for changes in healthcare expected in the next three to five years. Nevertheless, as stewards of assets critical to the well-being of their communities and with institutional commitments to meet the broad health needs of their local populations, community hospital boards should also have a careful eye on the long-term horizon. As the famous hockey player Wayne Gretzky was reportedly taught, "Skate to where the puck is going, not where it has been." There is accumulating evidence that the long-term outlook for the neighborhood community hospital is a future in which most such hospitals will not be needed. If this outcome is probable, then it is not too soon for hospital boards to start preparing to meet their community health needs without the use of an acute care physical facility for overnight patient stays.

This special section describes the drivers behind declining inpatient hospital beds, strategic issues for boards to consider, and opportunities for transforming the care delivery model to shift care to where patients need it most. (For purposes of the discussion that follows, a community hospital means a secondary or limited tertiary care facility that provides inpatient services but does not typically have the full range of medical and surgical specialties. These hospitals may occasionally receive referrals from smaller facilities but are more often a source of referrals to large regional tertiary care institutions or quaternary care hospitals. These are neighborhood hospitals that may range from several dozen to several hundred beds and typically serve a well-defined community rather than a broad region.)

Drivers of Change

If many more communities will not have a local hospital in the future,

Key Board Takeaways

It is unlikely that all community hospitals, especially those facing declining hospitalization rates and high fixed costs, can be sustained into the mid-term future despite the best efforts of dedicated boards and administrators. There are many factors undermining the sustainability of the traditional community hospital, including a worsening financial climate, a growing physician shortage, patient demand for care delivered at home, disruptive technologies, consolidation through mergers and acquisitions, and the entry of aggressive new players in the healthcare arena. Today's community hospital boards should:

- Plan now for a possible future in which they oversee health services that do not include an acute inpatient hospital facility. In doing so, they should strive to achieve a "soft landing" for communities that will be impacted by the loss of inpatient beds. They should also work to preserve community board oversight of the new health services that will proliferate in the absence of a local hospital.
- Dedicate time at board strategic planning retreats to exploring worst-case scenarios that involve closure of their acute care inpatient hospital.
- Spend significant time (inside and outside of board meetings) learning about disruptive new technologies that will transform healthcare. In particular, attention should be paid to telemedicine and mobile health advances that will facilitate the shift of care away from the inpatient hospital.
- In the face of a worsening physician shortage, engage with physician executives and medical staff leaders to understand how to strengthen practitioner recruitment and retention. It will be difficult to maintain a community hospital without key specialties to support it.
- Anticipate the impact of an abrupt change to value-based reimbursement in the next few years. This will typically entail giving much more serious attention to how medical and health services will be delivered outside the walls of the hospital and helping pave the way for sustained services even if the hospital ultimately requires closure.
- Reflect on the possibility that they may one day oversee a panoply of healthcare services that do not include an inpatient acute care hospital. If community boards don't take on this task, then local healthcare is likely to be driven by distant actors, including for-profit, investor-driven entities that may give little attention to unique local needs and characteristics.

1 This number includes all non-federal, short-term general, and other special hospitals. The number of non-government not-for-profit community hospitals was 2,968.

what are the drivers of this change? Multiple factors are contributing to the demise of the community hospital. These include financial pressures to reduce overall healthcare spending, the consolidation of hospitals into ever-larger health systems, the growing shortage of healthcare practitioners, the advent of new or greatly improved digital technologies, changing patient expectations for access to care, and the entry of new players into the healthcare services sector. Let's unpack these drivers one by one.

Financial Drivers

Community hospitals across the United States continue to struggle financially. The high fixed cost of keeping a hospital open is increasingly at odds with the broader value-improvement mandate that's becoming central to U.S. healthcare policy. Moody's 2019 Outlook shows revenue growth for hospitals will continue to decline under pressure from weak inpatient volume and low reimbursement payments. As healthcare costs breach 20 percent of GDP, there is little reason to believe these financial pressures will abate. Closures have been greatest for small rural hospitals, with nearly a hundred shutting their doors since 2010.[2] According to the consulting firm Navigant, more than a fifth of the nation's rural hospitals are near insolvency.[3] National Public Radio recently reported that more than 700 hospitals are at risk of closure across the country as they become financially unsustainable. About 800 U.S. hospitals have closed since 1990 and the closure rate is increasing.[4]

Often, when a hospital closes, local physicians and other providers leave the immediate area, creating an acute shortage of medical services. Local employment usually suffers as well, contributing to poorer health status in the community. Unfortunately, the boards of these hospitals usually have not planned for the aftermath of a closure, have failed to consider other service models not based on a local hospital facility, and have not explored the range of outpatient services that could be maintained in the absence of a hospital.

Urban safety-net hospitals also face jeopardy. The recent closure of Hahnemann University Hospital, a large academic hospital in Philadelphia, is an example of the financial challenges such institutions face. While urban hospital closures rarely leave communities without an alternative nearby hospital, access can be a problem for poor, uninsured, and underinsured patients.

The rise of suburban surgical centers and mergers of healthcare providers has led to shorter hospital stays, fewer patients, lower insurance reimbursements (especially for patients covered by Medicare and Medicaid), and a thinner bottom line for struggling urban non-profits.

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In 2018, Bloomberg News reported that out of roughly 6,000 public and private hospitals nationwide, 8 percent are at risk of closing, "with another 10 percent considered weak." The Web site reported that shutdowns in both rural and urban communities are likely to continue for the foreseeable future, at a rate of 30 per year according to AHA.[5]

Moving care out of the hospital continues to be problematic under fee-for-service reimbursement. But the tenacious grip fee-for-service has maintained on reimbursement is continuing to slip. A group of major payers and providers, the Health Care Transformation Task Force, said its members had more than half their business tied to value-based arrangements in 2018 and are aiming to hit the 75 percent mark by the end of 2020. The steady migration to value-based reimbursement (e.g., global budgets, bundled payment or shared-savings deals, etc.) is moving more and more care into the outpatient setting. Recently, United Healthcare, a commercial insurer with nearly 50 million covered lives, ramped up its prior authorization policy intended to shift outpatient surgeries to lower-cost settings outside of the hospital. This is the latest in a series of efforts from insurers to direct patients to lower-cost settings removed from the hospital.

Increased virtual, outpatient, or home visits can mean decreased utilization of bricks-and-mortar facilities and a consequent loss of important revenue. As new reimbursement models continue to migrate away from fee-for-service, the financial rationale for an inpatient acute care hospital facility with high fixed costs will progressively erode.

Consolidation

Merger and acquisition activity in the hospital sector has been robust for many years. Historically, not-for-profit health systems were not acquisition-minded, but they have shown strong interest in expansion in recent times. In 2019, Rick Pollack, AHA President and CEO, issued a press release justifying this ongoing trend: "Mergers have become one of the critical means through which hospitals can provide their communities with high-quality, convenient, and cost-effective care. The benefits of mergers allow hospitals to create connected networks of care and keep the focus where it belongs: on improving care for the patient."[6] Hospitals' competitors are no longer one another, but rather new and deep-pocket players ranging from Walgreens and CVS/Aetna to Google, Apple, Amazon, and United Healthcare. According to consultant Ken Kaufman, mergers allow health systems to develop the scale to compete with new entities flooding the healthcare marketplace. "The normal response of any company in any industry in this situation would be

2 Ninety-seven (97) rural hospitals have closed since 2010 according to the University of North Carolina Cecil G. Sheps Center for Health Services Research.
3 David Mosley and Daniel DeBehnke, *Rural Hospital Sustainability: New Data Show Worsening Situation for Rural Hospitals, Residents*, Navigant, February 2019.
4 Caitlin Carroll, "Impeding Access or Promoting Efficiency? Effects of Rural Hospital Closure on the Cost and Quality of Care," NBER Working Paper, National Bureau of Economic Research, March 19, 2019.
5 Cristin Flanagan, "U.S. Hospitals Shut at 30-a-Year Pace, With No End In Sight," Bloomberg News, August 21, 2018.
6 AHA, "New Research Confirms: Hospital Mergers Reduce Costs, Enhance Quality of Care for Patients" (press release), September 4, 2019.

to seek scale in an effort to meet this different level of competition and adjust to a new business model. That is exactly what is happening among hospitals stakeholders." Kaufman sums up the challenge as follows: "The competitors that hospitals face are not just large, but are also among the smartest organizations on the planet. These companies draw on a huge amount of data, apply sophisticated analytics, and have the capability to develop radically new tech-enabled care and digital connections. This is the state of play today. Scale is the platform that will allow hospitals to acquire the resources—such as more working and intellectual capital, and significant digital capability—to compete in this brand-new healthcare marketplace."[7]

While most hospitals join larger systems in hopes of maintaining their physical presence in the community, this expectation is increasingly unreasonable. In the years ahead, it is likely that multi-hospital health systems will be compelled to shed acute care hospital facilities and consolidate care in fewer, centrally located, highly sophisticated tertiary and quaternary care sites. This trend might be accelerated by some health systems' increasing use of micro-hospitals. These 20–30 bed facilities are much like critical access hospitals, but they rely heavily on virtual consultation and protocol-driven care. Remote monitoring and home virtual care are utilized to prevent patient returns to the facility. Historic community hospitals in many health systems will evolve into outpatient platforms or be demolished as they become expensive, outdated albatrosses encumbering health system flexibility and care delivery innovation.

Practitioner Shortage

Someone once said that a hospital without doctors is just a hotel with bad food. Yet it is becoming increasingly difficult for hospitals to recruit physicians to their medical staffs. It is hard to keep the hospital doors open without general surgeons, a primary care base that provides referrals, and medical specialists to utilize the technology currently aggregated within hospital walls. Yet even hospitals in the most desirous locations are finding it difficult to recruit personnel as baby boomers retire in large numbers. Current shortages of physicians are challenging the ability of the U.S. healthcare system to provide patients with timely, appropriate care. This is a problem that is going to get significantly worse.

The AMA Physician Masterfile shows that more than 40 percent of physicians in the U.S. are 55 years or older. Currently 46 percent of general surgeons are over the age of 55 and over 50 percent for orthopedic, thoracic, urologic, and plastic surgeons. Surgeons in rural areas tend to track even older. Some medical specialties likewise trend older with 73 percent of pulmonologists, 60 percent of psychiatrists, and 54 percent of non-invasive cardiologists 55 or older.[8] A recent report from the American Association of Medical Colleges (AAMC) projects that physician demand will grow faster than supply, leading to a projected total physician shortfall of between 46,900 and 121,900 physicians by 2032.[9]

As older physicians retire, their replacements largely shun private practice and seek employment opportunities. As competition for physicians continues to grow, community hospitals are finding it harder to generate the capital for physician employment and to sustain the financial "losses" from carrying large numbers of contracted practitioners. This has been one motivation for community hospitals to merge into larger entities with more resources that can be devoted to provider recruitment and retention. Hospitals aren't just competing with one another for scarce physicians. Many new players have entered the healthcare marketplace who are anxious to retain physician services. The largest employer of physicians today in the United States is Optum, a unit of United Healthcare. Private equity firms have been buying up physician practices in various specialties ranging from urology and orthopedics to emergency medicine and dermatology. Some large employers are hiring their own doctors to treat their workforces, as are retailers offering physician health services directly to the public (e.g., Walmart, Walgreens, and CVS/Aetna).

Younger doctors coming behind the retirees and who will have practices based wholly or partially in the hospital will be selective in where they locate. They will seek out hospital employment where they can utilize the latest technology, where they have enough colleagues to mitigate burdensome call schedules, where a critical mass of fellow specialists creates a professionally stimulating work environment, and where there is reasonable financial stability. These attributes will not characterize many community hospitals, which will have increasing challenges in terms of physician recruitment and retention.

Disruptive Technologies

In the coming years, there will be an increasing drive to provide healthcare at home. The technical ability to deliver hospital-level care at home exists today. However, an aggressive shift to hospital-level homecare has been limited by reimbursement issues and in

7 "Kenneth Kaufman: Why Hospitals Need Scale," AHA Insights and Analysis, December 18, 2018.
8 Merritt Hawkins, *Physician Supply Considerations: The Emerging Shortage of Medical Specialists*, 2017.
9 Association of American Medical Colleges, *2019 Update: The Complexities of Physician Supply and Demand: Projections from 2017 to 2032*, April 2019.

some areas by poor broadband Internet access. The slow migration away from fee-for-service has made transitions of care more difficult. Nevertheless, as the move to value-based reimbursement accelerates and telehealth technology improves, there will be a seismic shift in the locus of care.

This shift is already well under way aided by improvements in remote telemonitoring. Contessa Home Recovery Care is a company created to "…combine all the essential elements of inpatient care in the comfort of the patient's home." According to the company's Web site, "Contessa brings together evidence-based home recovery care models for acute care, post-acute care, and surgical procedures with administrative support…and our proprietary technology platform." The company offers a turnkey solution to provide at-home hospital services for hospital partners and payers. Among the investors in Contessa is BlueCross BlueShield Venture Partners. According to the company, its current partners also include Mount Sinai Health System (New York), Ascension's Saint Thomas Health (Tennessee), and Marshfield Clinic Health System (Wisconsin).

Marshfield Clinic Health System offers a home recovery care program that allows patients to receive care at home, rather than in the hospital, for conditions like congestive health failure, pneumonia, cellulitis, deep vein thrombosis, chronic obstructive pulmonary disease, and urinary tract infections. "Instead of the patient being cared for in the hospital, they're admitted to their home," says Marshfield's CEO, Susan Turney, M.D. "Healthcare nationally is amending patient care models to bring care closer to the patient and closer to the home. We see this as a great option for those people in our communities who can benefit from recovering in their homes." A Recovery Care Coordinator organizes and communicates care with the patient's doctor(s). Treatment is provided via telemedicine and home visits by a registered nurse who can take vitals, administer IV medications, and do physical assessments. A registered nurse is available to patients 24/7 as needed. Patients talk to their doctor(s) daily through use of a computer tablet provided by the Marshfield Clinic.

Another example is the Hospitalization at Home (HaH) program run by Mount Sinai. Most of the patients enrolled in this program first arrive in the hospital's emergency department and are screened to see if they meet the medical and social criteria for triage to the HaH program. Johns Hopkins' Hospital at Home program found that total costs of care were reduced by 19 percent and only 2.5 percent of 323 patients in a pilot study required transfer to the hospital from home.

Some health systems have created mobile units to facilitate hospital care outside its four walls. The University of Colorado Health has created a mobile stroke unit that is dispatched to patient homes. A specialized ambulance is equipped with a small CT scanner, point-of-care testing capabilities, and virtual care access to stroke specialists to provide remote diagnosis and prehospital administration of thrombolytic treatment. This is an example of tertiary care delivered in a non-hospital setting.

> As changes in technology and reimbursement accelerate the trend to treat patients with low-acuity conditions in alternative settings, fewer secondary and tertiary care hospitals will be needed to care for given populations. This is a radical shift from pulling patients into the hospital to sending care out.

Geisinger Health System has instituted a community paramedicine program it calls the "Mobile Health Team." It utilizes well-trained paramedics and EMTs to care for patients with congestive heart failure in their homes. They can assess patients and if necessary, administer IV diuretics and other patient-centered interventions.

Such programs allow the hospital to be reserved for patients needing the most expensive technology and intensive support while the less compromised patients are treated in alternative settings. As changes in technology and reimbursement accelerate this trend, fewer secondary and tertiary care hospitals will be needed to care for given populations. This is a radical shift from pulling patients into the hospital to sending care out.

In his book, *Deep Medicine,* cardiologist and futurist Eric Topol, M.D., expounds on the power of an ongoing revolution in deep learning and

Case Example: One Brooklyn Health System

One Brooklyn Health System (OBHS) brought together three local safety net hospitals—Brookdale University Hospital Medical Center, Interfaith Medical Center, and Kingsbrook Jewish Medical Center—to form a unified system to preserve and enhance access to healthcare services in Brooklyn. In 2016, the NYS Department of Health commissioned a feasibility study that proposed a roadmap to transform the health system, and in 2018 Governor Andrew Cuomo announced that OBHS would receive $664 million as part of the "Vital Brooklyn" initiative. The plan included developing a robust primary care network, partnering with community health centers, investing in a health information technology system, and carving out clinical niches for each of the three hospitals:

- Converting Kingsbrook Jewish Medical Center from an inpatient facility into a medical village with a mix of outpatient, emergency, and post-acute care services.
- Increasing Brookdale University Hospital Medical Center's inpatient capacity by 100 beds and undergoing renovations supporting its role as a regional trauma center.
- Updating Interfaith Medical Center's emergency department and developing a psychiatric emergency program to support the integration of behavioral health and primary care.

The OBHS mission is to provide greater access to high-quality medical care and keep its communities healthy through an integrated care system that respects the diversity of its communities and addresses both the health needs and the unique factors that shape them.

For more information, see *The Brooklyn Study: Reshaping the Future of Healthcare* (available at http://bit.ly/2Q2FoJj) or visit their Web site at https://obhs.org.

artificial intelligence to upend medical practice.[10] A huge inventory of new players, start-ups, and Fortune 500 companies is pouring into healthcare to take advantage of this revolution. New technology from wearable sensors to robotic caregivers will challenge the need to provide care in hospital settings. Hundreds of companies are currently focused on how to deliver healthcare services of varying complexity to where the patient is located (i.e., home) rather than transporting the patient to where healthcare technology has been historically aggregated (i.e., the hospital).

Many of these companies (e.g., CareSkore, HealthEC, VitreosHealth, and Lightbeam Health Solutions) use predictive analytics to support population health management. How can this impact hospitals? Currently about 60 percent of Americans die in the hospital, although 80 percent indicate a preference to die at home. A shortage of palliative care physicians means that less than half of the patients admitted to hospitals needing palliative care receive it.[11] Predicting when someone will actually die is critical to whether or not a patient can die at home. Numerous studies have shown that doctors have an extremely difficult time making such predictions. However, new algorithms driven by advances in neural networks and artificial intelligence are having remarkable success at such predictions. As companies pursue the goal of predicting the time of mortality, it becomes likely that many more people could die at home, further emptying hospital beds and reducing the need for a neighborhood inpatient facility. Artificial intelligence isn't just making huge strides at predicting mortality. It is achieving amazing accuracy at predicting length of stay, unexpected hospital readmission, kidney failure, bleeding complications after surgery, and more. The result will not only be better care, but less time in the hospital for patients.

> Today, remote monitoring, wearables, faster wireless communication devices, robust EHR platforms, virtual health visit capabilities, and eventually, prescriptive intelligence are making it less necessary for patients and physicians to always interact within the four walls of a hospital or clinic. Whereas such technology previously was reserved for the purpose of providing care in the most remote areas, an entire industry is increasingly leveraging the power of "mobile health" to connect patients with providers.
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> —*Jennifer Wiler, M.D., Hir J. Harish, M.D., and Richard D. Zane, M.D., in "Do Hospitals Still Make Sense? The Case for Decentralization of Healthcare,"* NEJM Catalyst, *December 20, 2017*

Case Example: Carolinas HealthCare System Blue Ridge-Valdese

In 2013, Carolinas HealthCare System Blue Ridge (CHSBR) brought in a new CEO, Kathy Bailey, whose first task was to assess the system's business model and identify areas of weakness. One identified weakness was a decreasing need for inpatient beds, especially at the system's Valdese hospital. This hospital was only eight miles from its larger Morganton hospital, which was resulting in a direct duplication of services. With an average daily census hovering around 10, leaders knew they had to make a tough choice. Consultants who were working with the board and senior management at the time presented four different options for the Valdese location:

1. Keep as is
2. Create a specialty hospital
3. Reinvent the facility for outpatient care
4. Completely close

A task force was developed to consider each option and come up with a recommendation. Ultimately the board approved the task force's plan to turn the Valdese inpatient, acute-care hospital into an outpatient care site. Today, the facility has a full-service, 24-hour emergency department, outpatient surgery, and upgraded cancer treatment center, advanced diagnostic imaging, laboratory services, a wound healing center, and physician practices.

While the future of healthcare is hard to predict with all the changes in reimbursement and regulations, Bailey and the board believe this was absolutely the right decision for the system. "We knew this was going to be difficult. We knew it would be hard to get people to understand. But we knew for the survival and long-term viability of our system it was the right thing to do," Bailey said.

Patient Expectations

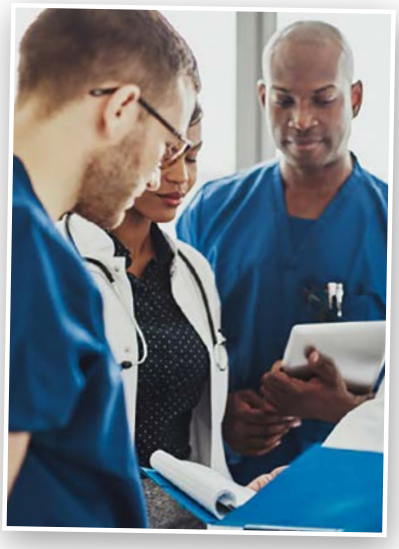
Easy access to care has always been a priority for patients. The fragmented nature of U.S. healthcare requires patients to run to multiple locations as they tend to various acute and chronic conditions. Precious time must be taken from work and home life to pursue such care, which is characterized by long wait times, scheduling frustrations, and transportation challenges. When patients are ill enough to require hospitalization, they are separated from caring family members and familiar and comforting surroundings. It is no wonder that the promise of healthcare delivered at home is so appealing. As Americans increasingly shop from home, bank from home, get their entertainment at home, telecommute from home, and "dine out" at home with quick restaurant deliveries, is it any wonder that so much attention is moving to healthcare at home. The 1990s and early 2000s saw many traditional hospital services move to outpatient diagnostic and surgicenters. The coming decades will see many more hospital and medical care services move into the home or into patients place of employment. Freestanding emergency rooms may become more ubiquitous, but will triage all but the most difficult and urgent

10 Eric Topol, *Deep Medicine: How Artificial Intelligence Can Make Healthcare Human Again*, New York: Basic Books, 2019.
11 Anand Avati et al., "Improving Palliative Care with Deep Learning," BMC Medical Informatics and Decision Making, December 12, 2018.; Jackie Snow, "A New Algorithm Identifies Candidates for Palliative Care by Predicting When Patients Will Die," *MIT Technology Review*, November 28, 2017.

problems to settings other than acute care hospitals. Where hospitalization is clearly indicated, patients will expect to go to centers with stellar reputations for quality and safety, a full spectrum of specialists, and the latest technology. Instead of thousands of acute care hospitals, perhaps 400–500 high-end, regional medical centers will provide this kind of care. Stays will be short as patients are quickly moved back into home settings where they can be monitored and cared for surrounded by family members.

New Players

It is not surprising that 21st-century entrepreneurs, investors, and innovators have not turned their attention to sustaining a 20th-century hospital model. While hospitals struggle to adapt to changing times, they may simply be the wrong infrastructure on which to build for the future. That seems to be the conclusion of corporations like Berkshire Hathaway, Amazon, and J.P. Morgan, which have formed a consortium known as "Haven" to change the healthcare paradigm. A quick survey of their executive team reveals no one with hospital management expertise. Haven leadership includes CEO Atul Gawande, a surgeon and writer on healthcare; Vice President of Clinical Strategy Sandhya Rao, known for his background in population health; COO Jack Stoddard, a seasoned health-tech executive; Chief Technology Officer Serkan Kutan, previously the CTO of ZocDoc, a doctor-booking app; Dana Gelb Safran, who will run analytics projects, from Blue Cross Blue Shield in Massachusetts; and David Smith, an executive hired from United Health's Optum unit. Gawande has described his new company as being an "ally" to doctors, insurance companies, and patients. Left out is any mention of hospitals.



Haven and many other large companies are moving to reduce healthcare costs for their employees through selective contracting with hospitals for needed services. These companies are looking for lower costs and clear evidence of high-quality care. Such contracting will accelerate the shift of care to larger, regional hospitals that have volumes that will support cost-effective delivery and superior outcomes. Employees of these companies will pass by their local community hospital to go directly to these "centers of excellence." Numerous new companies have formed to assist large employers (and also payers) in their selection of such centers, utilizing large databases of information, the latest in informatics, and predictive analytics.

Strategic Opportunities for Community Hospitals

Community hospitals are not standing still in today's challenging environment. Most have moved aggressively into the outpatient sphere—expanding ambulatory facilities, opening community-based office practices, investing in freestanding surgical centers, and more. This trend will and should continue. Furthermore, many hospitals have begun to explore population health initiatives and more far-seeing organizations have experimented with "hospital at home" models.

Many community hospitals are recipients of telemedicine services, but others have become providers of telehealth services. This is an important activity that brings content to patients rather than expecting patients to come to the hospital or its facilities.

A practice trend seen in some institutions with large numbers of employed doctors is movement toward practice co-location. Many community hospitals have employed physicians in geographically disparate office settings. This may be because they have maintained practices they acquired in their historic settings or because they seek multiple access points for patient convenience. However, co-locating specialists, primary care physicians, and ancillary services (e.g., lab, radiology, pharmacy, patient education, and counseling support) in a single location provides a powerful delivery platform for non-hospital-based care. Such offices provide one-stop shopping for patients, allow for greater care integration among physicians, and are more efficient and cost-effective than a string of traditional doctors' offices. Large group practices such as Kaiser and academic group practices (e.g., Penn Medicine of the University of Pennsylvania Health System) have long delivered care out of such facilities.

In other communities, hospitals have begun to explore repurposing of their bricks-and-mortar legacy facility. Converting inpatient beds to rehabilitation or skilled nursing units may provide a purpose and remuneration for acute care hospital floors with a negligible census. Today, many communities have far greater need of inpatient behavioral health beds than acute care medical and surgical beds. Sometimes hospitals have been able to identify partners with whom they can collaborate on such conversions.

Questions Worthy of Board Consideration

In today's challenging environment, it is natural for board members to feel like the little Dutch boy trying to save the day by putting his finger in the dike. All

their energy is going into plugging one leak after another. If their community hospital can take a step forward in its struggle to stay viable, it is easy not to notice that it has also taken two steps backward. The realities facing every hospital are different and some have more potential for sustainability than others. Nevertheless, board members must assess their situation with their eyes wide open.

Many boards will hope for the best and give sustainability a full-court press. Innovation, flexibility, determination, and luck may carry the day. They should nevertheless be doing some thinking about a worst-case scenario. The challenge for the board of a threatened community hospital is to recognize when their local institution has an untenable long-term future and is likely to require closure or conversion into some other type of facility. Board members should engage in some discussion with management regarding how this should be accomplished, including exploration and development of additional care platforms other than the traditional inpatient hospital.

Some boards are punting on this planning issue by merging into large health systems. This passes the challenge on to the system board. However, multi-hospital system boards have many communities to worry about and may not give adequate attention to a "soft landing" for neighborhoods where they must eventually close a hospital. Such mergers may delay the day of reckoning, but ultimately just pass the buck to different decision makers.

Board members will have to resist the desire of physicians and administrators to purchase the latest and greatest of every technological breakthrough that comes down the pike, piling money into a hospital facility that has a limited future. Keeping up with the Jones's in the hospital world may be the quickest way to a rapid demise.

How can board members stay abreast of rapid changes in healthcare that will impact their options for deploying hospital or health system resources? Management should regularly produce reading lists of important articles in the health press that describe some of the drivers enumerated in this special section that are impacting the future of their hospital. Board members can also educate themselves through attendance in conferences where they not only hear knowledgeable speakers, but also can network with colleagues who are likely facing similar challenges. Some portion of every board meeting might be devoted to discussing a particular trend impacting hospital survival.

Board strategic planning retreats should carve out time to consider the options for downsizing the hospital and creating alternative care platforms for the community. These may be "back pocket" plans that are only pulled out when necessary, but chance favors the prepared mind. In such planning sessions, board members may consider the use of a facilitator who can force them out of hospital groupthink and push them to consider life without their local hospital resource.

Communities have a lot riding on the future of their local hospital. It may be the largest employer in the area and a critical source of well-paying jobs. Alternative health facilities may only be available at considerable distance. Closure may see out-migration of medical professionals and leave a community with a dearth of medical resources. Yet all of these things can be mitigated with thoughtful planning and foresight. This will only occur if board members are willing to accept the real possibility that they may need to supervise a controlled shut down or conversion of the facility.

An important consideration is that boards of local not-for-profit hospitals have always had a fiduciary responsibility to look out for the best interests of their communities. Most of the new players aggressively entering the healthcare space and seeking to displace hospitals are private or investor-driven enterprises with no community roots and no public service mission. The demise of a local community hospital can leave the public exposed to services that are driven solely by a profit motive and determined by distant investors and management. To avoid this future, community hospital boards should work hard to ensure they become stewards of the new healthcare delivery models in their region, the purveyors of technology-driven changes in services, and the deployers of professional resources that will be needed by their neighbors in the decades ahead.

The healthcare landscape of the future will look very different than in years past. There will certainly be fewer hospitals and their departure will be part of an evolution that hopefully will bring greater cost-effectiveness, quality, and patient accessibility to healthcare. Community hospital boards can and should play an important role in shaping this future.

The Governance Institute thanks Todd Sagin, M.D., J.D., President and National Medical Director of Sagin Healthcare Consulting and Governance Institute Advisor, for contributing this article. He can be reached at tsagin@saginhealthcare.com.