Family Practice And The Health Care System

The Public Hospital District For Ambulatory Care: An Option To Stabilize Rural Health Services In Crisis

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As is well known to observers of rural health care in this country and abroad, the many problems involved in maintaining adequate health care services in rural areas are constant and often resistant to solution. In the United States many rural communities have experienced the disappearance of the venerable rural solo general physician. In 1977 the American Hospital Association sponsored an invitational conference on the delivery of health care in rural America. A summary of that conference contained an observation that "one person (physician) cannot supply all the benefits of modern medicine to a community — the community needs access to a system of health care, beginning with a group of physicians who share a practice (which can serve one or several communities), who cover health needs 24-hours per day, 7-days a week, and whose efforts are augmented by those of other skilled health care professionals."[1] Since then, the experience and problems of rural health care have demonstrated the crucial importance of this recommendation.

One-quarter of the US population resides in rural America, according to the definition of the Bureau of the Census whereby rural is defined as communities of less than 2500 population. By this measure one-third of the elderly population lives in rural America.[2] Providing ongoing viable health services to this population is fraught with challenging problems not seen in urban areas and unique to rural communities. Rural populations have many distinctive features, including an increased percentage of elderly people, increased numbers of chronic health problems, lower per capita income, increased accident rates, and common exposure to environmental and occupational hazards.[3] Residents in rural areas are less likely than their urban counterparts to have health insurance coverage.[4] The aging of the population and downturn of the rural economy in recent years represent additional negative impacts on hospitals and health care facilities in rural areas.[5] A further problem is caused by the shift to more technology in health care, leading many rural residents to question the quality of their local health care services, while seeking higher technology services in larger communities on the common assumption that "bigger is better."[6,7]

Long-standing problems concerning physician practice in rural communities include physician isolation, decreased reimbursement compared with urban physicians, difficulties in obtaining coverage after hours and on weekends, the high overhead of rural medical practice, increased costs of medical liability insurance, and issues relating to family life, such as schools and cultural activities. Solo practice is becoming a thing of the past throughout the country, and communities too small to support a group of 3 or more physicians are vulnerable to decreasing access to health services. Wallach and Kretz[8] have observed that primary care practices in rural areas have encountered particular difficulty in achieving self-sufficiency unless they include the capability to provide acute hospital inpatient services. They further note that low practice volume and rural-urban reimbursement differentials represent the primary obstacles for rural health facilities achieving self-sufficiency. In addition to the above problems, the overhead of rural health care facilities is typically higher than the overhead of similar facilities in urban areas.

As a result of the above conditions, the recruitment and retention of physicians in rural areas are frequently problems. More than 10 percent of the nation's rural hospitals closed during the last decade.[9] One-half of the rural hospitals that closed in 1987 had reopened by May 1989 as another kind of health care facility.[10]

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Among the various options available to rural communities as they struggle with these problems is the formation of a health service district as a mechanism to generate a tax subsidy. These districts have been most commonly used to provide support for ongoing rural inpatient facilities. To date only rarely have they been used to stabilize and maintain ambulatory health care facilities in rural areas. We report one such successful experience whereby a hospital district rescued a rural health care facility from closure and at the same time stabilized physician practice in the community. A case study is presented and discussed, including the possible application of this approach to other rural communities facing similar problems.

Background

The San Juan Islands are a group of more than 100 islands located in the northwest corner of Washington State. San Juan Island, about 55 square miles in size, is the most populous. The 1990 census showed the island to have a permanent population of 4962 of which 21 percent were 65 years of age or older. Two factors make the population of San Juan Island highly variable: the seasonal residency of many inhabitants, and the large tourist population that can temporarily double the number of persons during the summer months.

San Juan Island is reached by a ferry that departs from Anacortes, Washington, and requires at least 90 minutes travel time. The ferry provides service between San Juan Island and Anacortes about seven times each day and often includes long waiting periods. There is also a small airport on the island, and there are several commercial flights arriving and departing each day. In addition, many residents and visitors make use of the airport with private aircraft and of the port with their boats. Although the climate is relatively temperate, storms and fog frequently prevent air travel, and the ferries are occasionally forced to cease operation because of poor weather.

The present medical community on San Juan Island includes a 3-family-physician group practice at Inter-Island Medical Center (IIMC), which serves the island and small neighboring islands with a regular call schedule 24-hours-per-day, 7-days-per-week. Although not an acute inpatient facility, the IIMC is fully equipped as an emergency care facility and can provide necessary laboratory, radiographic, and support services. There is an 85-bed convalescent center next to the IIMC, which is also served by the medical center physicians. The medical center has made space available to regularly visiting specialists in the fields of orthopedics, otolaryngology, podiatry, general surgery, and urology. Other services on the island include 1 internist in solo office practice, a mental health counseling center, 2 paramedics, and 20 voluntary emergency medical technicians. Because there are no acute hospital facilities on the island, patients requiring hospitalization are stabilized for helicopter transport to the mainland.

The present local health care system is stable, viable, and anchored by the IIMC and the organizational framework of a public hospital district. As is shown, however, by the following case study, the local health care delivery system very nearly collapsed 4 years ago, and it would have without a major organizational change.

Case Study

Methods

In addition to a review of existing pertinent literature, a series of in-depth interviews was conducted by the first author with many involved individuals on San Juan Island. Those interviewed included the newly elected hospital district commissioners, previous board members of the IIMC, all of the currently practicing physicians and some of those previously practicing in the community, citizens who had provided philanthropic donations to the IIMC, and other community leaders. Minutes of all meetings of the hospital district commission, as well as previous board of directors, were reviewed. Financial statements and budgets from the records of the medical center were analyzed. Data on local taxes were collected from the county assessor's office. A demand-analysis tool developed by the Community Decision Making Project was also used to analyze the supply and demand of physicians on San Juan Island.[11]

History

From 1950 to 1978 San Juan Island was served primarily by a single family physician. In the early years this physician served all of the islands in the area by flying or boating between them regularly.

During this period his practice consisted largely of emergency and episodic care. He was based on San Juan Island, where he first opened his practice in a small, rented building. In 1955 the Inter-Island Medical Center was formed by interested members of the community as a supporting and fund-raising organization for health services on the island. The IIMC was governed and owned by a board of directors, which rented the facility to the physician. There was no attempt by the board to manage the medical practice.

Twenty-one years later, in 1976, a new medical facility was built with a Hill-Burton loan from the federal government. Hill-Burton loan requirements called for construction of the facility to hospital specifications and for payback of the loan through providing free care to the poor for a period of 20 years. Also within the Hill-Burton requirements, the IIMC purchased the assets of the medical practice, and from that time on, all medical personnel were employees of the IIMC. The board of the IIMC became responsible for managing all aspects of the medical center.

As is typical of the transition from the old-time country doctor to physicians of the modern era, it took 3 physicians to fill the shoes of the solo practitioner, who also served for many years as the county health officer. The new physicians were less willing to have their entire lives dominated by medicine. They also found themselves providing care to a growing island population and expected coverage in rotation for after-hours care.

It was during the 1980s that the IIMC began to slide into financial and managerial difficulties. The board of directors was composed of lay persons from the community who had no background or expertise in many of the roles and responsibilities of such a board. There was no clear balance of power between the physicians and the board, and each perceived the other as having too much control. There was a tendency of the board to micromanage the medical practice, and the IIMC entered into a period of recurrent physician turnover (Figure 1).

Several avenues of alternative management were pursued, including off-island ownership of the facility by one of the three mainland hospitals in the region. At one point, the board was highly in favor of this option, but it never won the support of the physicians or the community, who preferred to retain local ownership of the facility. Another potential option involved the increased role of midlevel practitioners through either partial or full replacement of the physicians. It appeared, however, that the physicians were well liked within the community and that physician care was expected to be available.

Board meetings during this time focused on day-to-day struggles and micromanagement of the IIMC, and no long-range planning was attempted. One board member from this period describes an atmosphere of animosity between the physicians and the board that centered around management powers and physician salaries. This board member believed it would have been in the best interest of the IIMC to fire the current physicians and hire other physicians willing to work for lower salaries. There was little awareness by the board of the difficulties of physician recruitment. Realizing that the physicians had strong community support, the entire board resigned out of frustration in 1986, and a new board was elected.

The new board found themselves faced with a building that was falling into disrepair and an organization approaching staffing and financial failure. This new board hired a professional management group in an attempt to get the IIMC running smoothly. Studies were made of the center's finances and the management system, and an on-site manager was recruited. No major improvements were forthcoming, however, and the management contract was not renewed the following year.

Evolving Crisis

In the late 1980s, there was increasing financial insolvency and argument about physician salaries, which were at the national average for family physicians at the time. The IIMC had difficulty retaining a third physician, and the 2 currently employed physicians believed that they were overworked. After a smattering of negative press in the local paper, 1 of these remaining 2 physicians resigned, and the IIMC entered another phase of physician recruitment.

It became apparent to the board that the IIMC could not continue to provide its current spectrum of services because of large fiscal shortfalls: a deficit of $324,500 was projected for 1989. It was announced at a community meeting that the IIMC would have to close its doors if a solution could not be found.

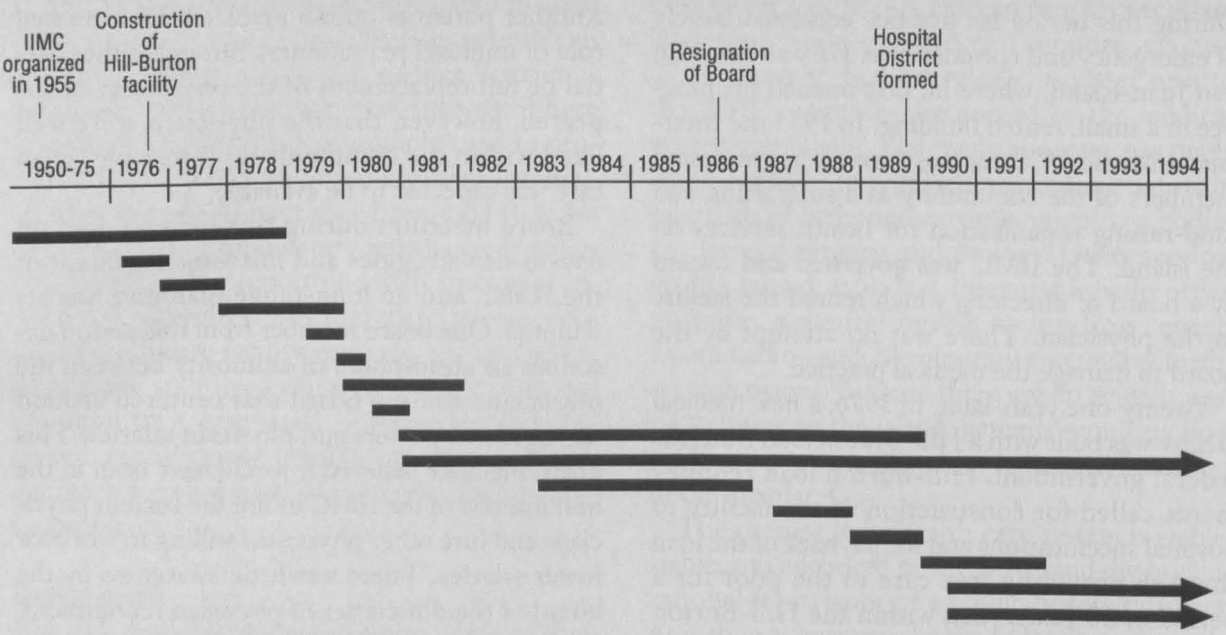

Figure 1. Time line showing the duration of individual physician employment at Inter-Island Medical Center.

The IIMC's financial insolvency resulted from a combination of reimbursement problems. From the beginning a major problem had been the inability to have emergency care services reimbursed by Medicare or other payers as an ambulatory care facility without acute inpatient beds. Because it was not a licensed acute inpatient facility, the IIMC did not qualify as an emergency department and was not eligible for reimbursement of emergency care services. Extensive and life-saving services were frequently provided to acutely ill patients for a number of hours or even overnight, particularly during times of inclement weather when these patients could not be airlifted off the island to a nearby hospital. Such care would be compensated at the level of a routine office visit.

So that it could provide full primary and emergency care around-the-clock, the IIMC required 3 physicians to create a call schedule conducive to retaining the physicians. Based on population data from the 1990 census, a supply-and-demand analysis showed inadequate demand to support a third full-time physician at the IIMC (Tables 1 and 2). Thus, the uncompensated dollar value for emergency and after-hour services could be estimated as including one full physician salary, one or two nurse salaries, and the cost of maintaining suitable space, supplies, and equipment.

The IIMC has experienced about $100,000 of contractual losses each year, including Medicare, Medicaid, and Hill-Burton contracts. Medicare reimburses an office visit at 30 percent less than what is paid by private insurers. Moreover, Medicare does not allow billing for certain types of equipment used during an office visit, such as catheters, dressings, and suture material. Further, Medicare reimburses rural hospitals and clinics at a lower rate than it does urban facilities under the false assumption that health services are less expensive in rural areas. In fact, health services can be more costly in rural areas in terms of overhead, equipment repair, and maintenance.[12] It has been estimated from population and demand-analysis data that 28 percent of the practice at the IIMC has been covered by Medicare. This segment of the population is often less able to leave the island for medical care and is more likely to have chronic care needs.

The newly developed resource-based relative value system (RBRVS) was not a positive factor in this equation. Although initially projected to produce an overall increase in physician reimbursement in family practice in a 5-year period of 30 percent, the actual gain to family physicians through RBRVS has been very limited. Recently, Graham[13] has estimated that 3 out of 4 family physicians have seen a slight increase in their reimbursement under Medicare (an average of 8 percent), but that 1 out of 4 family physicians still nets less than $65,000 per year.

Table 1. Demand Analysis for Primary Care for Residents of San Juan Island Based on the 1990 Census:* Estimation of Demand per Year.

Age	Population	No. of Primary Care Visits	Total Estimated Visits
Male (years)			
<18	629	1.725	1085
18–24	151	0.975	147
25–44	1037	1.2	1244
45–64	728	1.95	1420
>65	677	1.95	1320
Female (years)			
<18	639	1.725	1102
18–24	153	1.875	287
25–44	1053	2.4	2527
45–64	739	2.7	1995
>65	689	3.75	2584
Total demand			13,711

*Estimates for total demand do not include the considerable demands of seasonal and transient populations.
Source: Adapted from *Community Decision Making Project.*[11]

Genesis of a Hospital District

A tax-supported hospital district had been discussed by the board prior to the crisis in 1989, but the idea had never gained momentum, nor had it been presented to the public. Washington State law permits the funding of ambulatory health services by public hospital districts.[14] Other states have made provisions for special tax-supported health services districts for the support of non-hospital health care services (e.g., Arizona, Illinois, Oregon, and Utah) (P. Lopes and A. Nichols, unpublished data, 1990). The first hospital district supporting an ambulatory care facility in Washington State was developed in Cle Elum, a small community in central Washington. That district had been in place since the 1950s and remained intact when the hospital closed its doors in 1976 (personal communication, John Anderson, MD, December 1992).

One of the major hurdles in the formation of hospital districts is to make the community aware that it can take responsibility for and control of its medical services.[15] To bring about this awareness requires strong leadership from the community. At this critical juncture on San Juan Island, the key to success was the unprecedented leadership of a number of individuals who were able to rally the support of the community. Although the local physicians were supportive of this effort, the major impetus came from board members who were highly respected in the community and who possessed backgrounds in such fields as business, management, engineering, and other professional endeavors. A public education campaign was launched to explain the problems of the medical center and to promote the hospital district. Community members were asked to think about the health services that had been available to them in the past and the kinds of services that they wanted to have available to them in the future. A fund drive was organized and carried out in conjunction with promotion of the hospital district to keep the center open during an interim period. The fund drive was taken on a person-to-person basis to many prominent members of the community, and the local newspaper was actively supportive.

The results demonstrated strong community support for the availability of a wide spectrum of local medical services, including the willingness to pay for them. The fund drive generated $350,000, which was matched with funds from a philanthropic foundation started by a resident of the island. A medical guild was established so that additional support could be generated for the IIMC. In the election of November 1989, the hospital district was passed with an 80 percent vote. Washington State allows a property tax to be levied at a maximum rate of $0.75 per $1,000 of assessed valuation throughout the designated hospital district. This amounts to $150 of extra tax per year for a family that owns property of $200,000 assessed valuation. This modest tax, compared with that levied by the fire district (Figure 2), was instituted to give the IIMC a stable source of income to cover its operating deficit.

Table 2. Supply Analysis for Primary Care for Residents of San Juan Island Based on 1990 Census: Estimation of Supply per Year.

Provider	Number of Providers	Number of Encounters	Total Estimated Encounters
Family physician	3	5700	17,100
Internist	1	3300	3300
Nurse practitioner	1	3000	3000
Total supply			23,400

Source: Adapted from the Community Decision Making Project.[11]

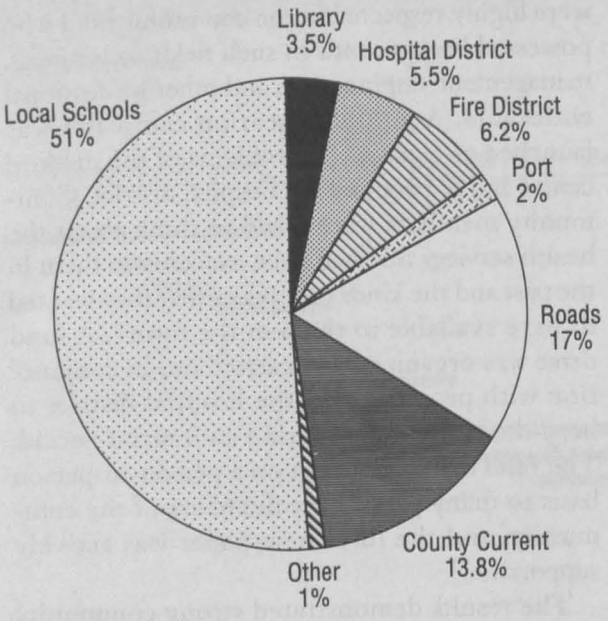

Figure 2. Distribution of local tax dollars for San Juan Island, 1991. Source: Tax Assessor's Office, San Juan Island, WA.

Experience of the Hospital District

Process of Governance

A board of 5 commissioners was elected by residents of the district to take fiscal and policy responsibility for the IIMC. The elected commissioners were well-respected community leaders who had considerable expertise in business, management, and other fields and who had an active interest in health care. They were provided with materials on district governance and board responsibilities, and physician recruitment received the initial highest priority. A full-time family physician with 27 years of practice experience elsewhere in the state was recruited. He also brought considerable organizational and administrative experience to the IIMC, having established and maintained a group practice, including two urgent care centers. With the additional responsibilities to serve as administrator of the IIMC, he worked closely with the newly elected commission. A positive relationship was established and has since been maintained between the commission, physicians, and employees of IIMC. Micromanagement by the commissioners has been steadfastly avoided, and the physician-administrator has been charged with ongoing operational responsibility for the IIMC and the medical practice. Monthly commission meetings involve the active input and collaboration of the physician-administrator, and the other physicians are also welcome at these meetings.

One of the first tasks carried out by the new commission was to develop an overall mission statement to provide policy, direction, and stable leadership. It included the following:

1. Creating high-quality, primary and emergency care in a personalized way, including coordination of specialized services
2. Actively identifying, addressing, and providing a progressive range of medical services within the district setting
3. Promoting public education programs
4. Working with the Inter-Island Health Care Foundation, the Medical Guild, and other community organizations to accomplish their mutual objectives

The mission statement was an important step in establishing a unity of purpose, and it reflects the unified goals of the commission, administrator, medical staff, and community. It was followed by specifying 18 additional concrete objectives to strengthen and expand health services on the island through development of a model rural health care facility. Values expressed in these objectives included full access to high-quality primary and emergency care, comprehensiveness of personal care, and increased liaison and coordination with other health care services within the community and region.

With the election of the new district commissioners, the old board of 9 members transferred governance of the IIMC to the commission. Rather than dissolve, however, it reorganized itself into a supporting foundation for the IIMC. Its purposes are fund raising, community health education, and the establishment of an endowment fund for the medical center.

Physician Recruitment and Retention

The fund drive permitted the IIMC to keep up its previous level of operations until the first monies from the hospital district became available in the spring of 1991. This stable source of income allowed recruitment of a cohesive group of 3 family physicians, together with a 4th part-time physician for coverage of every 4th weekend and during vacations or illness times of the regular physi-

cians. The physician salaries were maintained at approximately the same level that they had been in the recent past, namely, at about $90,000 per year for a full-time physician plus a bonus based on a productivity formula and a 12 percent fringe benefit package. In addition, an administrative stipend was paid to the physician-administrator of the IIMC. As can be seen in Figure 1, the previous turbulence of physician attrition has been arrested, and a stable physician group has been established at the IIMC. The tension within some parts of the community about physician salaries has also largely resolved, probably as a result of a broader recognition within the community of the importance of the IIMC, as well as greater understanding of salary levels required for physician recruitment and retention. Current physician salaries at the IIMC are still somewhat less than the national average in 1993 of $111,500 net income per family physician.[16]

Range of Services

As the financial structure for the IIMC has stabilized, the range of health care services has been expanded. Examples of new services include mammography, colposcopy, sonography, and spirometry. An interactive linkage has recently been established with a Seattle-based diagnostic radiology facility for the interpretation of mammograms and sonograms. An improved computerized information system has been installed accommodating expanding data retrieval and literature search capacity, including MEDLINE and the development of a CD-ROM medical library. Computer links have also been established with the closest mainland hospital in Anacortes and the nearest medical laboratory in Mount Vernon, Washington.

Finances

Table 3 summarizes the recent experience in expenses and revenue of the IIMC. It has been anticipated that it will take time for the 3 full-time–equivalent physician practice to build the medical practice to full capacity. In earlier years the IIMC was viewed as a source of episodic and emergency care, and there are still many in the community who neither expect nor want comprehensive care. Still others seek services off the island that are available locally. The hospital district raises approximately one-third of the IIMC budget,

Table 3. Inter-Island Medical Center Annual Income and Expenses, 1990–1993.

	1990 $	1991 $	1992 $	1993 $
Income	661,023	1,203,882	1,225,990	1,217,548
Expenses*	956,153	1,104,213	1,215,354	1,245,520
Net	295,130	99,669	10,636	27,972

*Expenses in 1991–1993 include capital expenditures for new equipment and annual major building remodeling of $44,973, $131,400, and $105,000.

enough to compensate for those services that cannot pay for themselves, specifically the 24-hour emergency care and the contractual losses incurred through Medicare, Medicaid, and Hill-Burton contracts. Active private community support has been maintained through the efforts of the Inter-Island Health Care Foundation and the Medical Guild through their collective annual contributions averaging $50,000 to $60,000 per year. These funds have allowed the IIMC to upgrade its level of services, including the addition of mammography, colposcopy, sonography, and an improved computer system. Collections have steadily increased through the efforts of the physician-administrator and the office staff and have been maintained at 97 percent for the past 2 years. As a result of increased efficiencies within the IIMC and continued private funding contributions, the hospital district collected tax monies last year at a rate of less than $0.50 for $1000 assessed property ($140,000 below potential collections at the legally authorized $0.75 per $1000 rate).

Facility Improvement

A number of capital improvements have been made to the facility of the IIMC, including remodeling of the minor surgery and treatment room and medical transcription and nursing areas. Some underutilized space has been made available for visiting consultants, and a 3rd family physician office has been provided. A new roof and a new heating system have been installed, as well as a new computerized information management system. New cabinets have been added to all the examination rooms.

Quality Assurance

A quality-assurance program had been established within the medical practice. Regular

monthly meetings are held involving the family physicians and the nurse practitioner. These meetings include discussion of problem cases, as well as sharing of highlights of recent continuing medical education conferences. In addition, the physicians regularly overread each other's radiograph interpretations, and quality-assurance protocols have been established in accordance with the Clinical Laboratory Improvement Amendment of 1988 (CLIA) regulations for the x-ray film processor, the mammography unit, and the laboratory.

Teaching and Research

An ongoing linkage has been established with the Department of Family Medicine at the University of Washington School of Medicine for both a preclinical family medicine preceptorship experience and a clinical family practice clerkship elective. In addition, 2 students have already carried out their required research project at the IIMC, the first represented by the first author's work on the experience of the hospital district, and the second involving a study in progress of the island's experience with out-of-hospital cardiac resuscitation. Another research project is currently being explored that involves a study of prescription patterns on the island through the combined data base of the local pharmacy and the IIMC.

Linkages within the Community and Region

Within the community closer collaboration has been developed with the regional emergency transport service (MedFlight), visiting specialists, the local health department, the adjacent 85-bed convalescent center, home health, and the local hospice. Emergency services (Aid Unit) have been relocated to the IIMC facility. Discussions are in progress with the Washington State Health Department toward designation of the IIMC as a level 5 trauma center with provisions for direct funding of emergency services. Negotiations are proceeding with the Department of Health and Human Services regarding the designation of IIMC as an ambulatory surgery center. Exploratory discussions are also in progress with various capitation plans that have emerged within the area, as well as discussions with third-party payers about improved reimbursement for presently unreimbursed or underreimbursed services. Two such contracts have already been concluded, which for the first time provide reimbursement for previously uncompensated emergency care services.

Discussion

San Juan Island serves as an excellent example of a rural community in which a hospital district has provided a successful resolution to many of the problems facing its rural health care facility. Problems of physician recruitment and retention have been alleviated with a stable source of income, and the medical center is now able to compensate for its operating losses while maintaining its full spectrum of services. The hospital district has brought structural and organizational strength to the medical center. The community's increasing awareness and interest in its medical services will be an ongoing asset for the IIMC.

Although hospital districts have often been used to help small communities keep their hospitals open, the uniqueness of this case is that a hospital district was created to resuscitate a rural *ambulatory* health care facility. States that do not have this option might find it useful to pass legislation allowing the formation of a special tax-supported ambulatory health services district. These districts are discussed in some detail by Lopes and Nichols (unpublished data) who have proposed a model statute for states that do not have existing legislation permitting the formation of such districts.

Several factors common to the districts studied by Lopes and Nichols were also present in the case of San Juan Island. These factors can be seen as important components for special district formation:

1. *Crisis.* The IIMC very nearly closed its doors.
2. *Isolation.* The San Juan community is especially isolated because of its island setting.
3. *Moderate tax base.* Property values on the island are higher than that of many rural communities.
4. *Existing medical facility.* The IIMC was fully operable in an existing Hill-Burton facility.
5. *Outside help.* Advice was received from the hospital district in Cle Elum.
6. *Local leadership.* A few key individuals came forward and gave their time, skill, and energy to the creation of the hospital district.

The hospital district structure has allowed organizational and financial stability for the IIMC. As community awareness of the problems of its rural health services has increased, a productive working relationship has been established among the hospital district commissioners, the physician-administrator, the medical staff and employees of the IIMC, and the community. The administrative expertise and organizational abilities of the physician-administrator have facilitated effective operational management of the IIMC while avoiding destructive micromanagement by the commissioners. A proactive anticipatory approach to problem solving has been adopted, replacing the crisis resolution mode of previous boards.

The experiences of San Juan Island, with its ambulatory care hospital district, provide some useful lessons that might be applied in other rural settings:

1. The health services district (presently available in only a few states and not yet widely known) offers an important component in the overall strategy for rural health services in crisis.
2. Dynamic community leadership, together with the support and involvement of local physicians, is crucial to a successful outcome.
3. Hospital commission or board member education about the process and special problems of rural health care is essential to the development of an effective health services district, including the ongoing involvement of local physicians and others experienced in health care policy and organization.
4. Physician recruitment and retention in rural practice today is facilitated by a cohesive 3-physician group so that full, around-the-clock coverage for the population can be provided.
5. To prosper in today's evolving health care system, which involves primary, secondary, and tertiary providers in new relationships with an increasing role of managed care of defined populations, a rural health facility must redefine itself with a maximal range of primary care services, as well as interactive linkages with other health care providers and agencies in the community.
6. Reimbursement through third-party payers and allocation formulae in managed care systems need to cover the full range of services offered by a rural health facility, including the higher overhead costs that are frequently inescapable in rural medical practice.

The IIMC is now entering a period of further maturation and expansion of its services. Exploratory discussions are going forward concerning the development of several swing beds for admission of acutely ill patients at the adjacent convalescent care facility for up to 24 to 48 hours. An expanded campus is being contemplated, which includes housing for such additional services as physical therapy, public health, and classroom-teaching space for patient education and preventive services. Contracts have been initiated with two state-managed care programs. Such capitation programs will further stabilize IIMC revenue through capitation management fees. It can be anticipated that the ongoing solid group practice structure will become the principal, if not the exclusive, organizational framework for all medical services on the island.

A study of physician perspectives on the causes of rural hospital closure was recently reported.[17] In accompanying editorial commentary, Mick acknowledged the widespread fragility of rural hospitals and facilities and called for examples of success against adversity to be reported in an effort to learn how best to deal with the unique challenges of rural health systems.[18] This case study is offered as such a success story with the hope that the hospital or health services district can be more widely appreciated and considered as an important component of a strategy to deal with rural health services in crisis.

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