

Competing Narratives of Hospital Closure: A Case Study of Memorial Hospital of Rhode Island

KEVIN P. SAVAGE, MD, ScM; JEFFREY BORKAN, MD, PhD

ABSTRACT

BACKGROUND: Hospital closures have become commonplace in the United States but remain controversial. Memorial Hospital of Rhode Island was a 294-bed hospital in a disadvantaged community that closed in 2018 amid falling patient volume and rising costs.

METHODS: Immersion/crystallization method of qualitative analysis was employed in reviewing semi-structured interviews, public testimony, and public documents. Themes that emerged were organized into discrete narrative typographies, represented by illustrative quotations.

RESULTS: Three main narratives of the hospital's closure arose: 1.) financial inevitability; 2.) corporate mismanagement; and 3.) systems realignment.

CONCLUSIONS: Overlapping and discrepant narratives of the closure demonstrated the complicated role of hospitals within communities and health systems. Acknowledgment of both the hospital's financial straits and the negative impacts of closure on a marginalized community demonstrate the malalignment of economic incentives and the public good in the state's health care system. This case study may offer lessons for other communities facing or experiencing hospital closure.

BACKGROUND

Memorial Hospital of Rhode Island was established in 1901 and closed on New Year's Day 2018. At its founding, the hospital housed 30 beds and tended mainly to the millworkers of the Blackstone Valley. Over the ensuing decades, the hospital developed into a thriving independent community hospital, growing to 294 beds and employing more than 1,500 people at its peak. By the end of the 1990s, the hospital was home to a full slate of medical and surgical services, including an emergency department that saw over 30,000 patient visits in its busiest years in the mid-2010s.¹ It was a sponsor of health professional education including both nursing and physician training programs. By the time of its closure, the hospital had trained nearly two-thirds of all family physicians practicing in Rhode Island.²

In 2013, Memorial was acquired by Care New England (CNE), a non-profit entity and the second largest health

system in Rhode Island. By the time of the acquisition Memorial had been in increasingly dire financial straits for several consecutive years. By 2016, annual losses from Memorial alone totaled \$21 million, and the total number of patient days was down 43% from 2012.^{3,4} Citing these challenges, in November of 2017 CNE filed a motion with the Rhode Island Department of Health (RIDOH) to close Memorial. The closure was ultimately approved by RIDOH on December 28, 2017 after a period of written and verbal public testimony.⁵ In its decision to approve the closure, RIDOH made note that the closure would likely have significant consequences on care delivery state-wide, but especially in the Blackstone Valley. The decision stated that the closure would "unduly affect access to quality, affordable emergency services for traditionally underserved populations;" would "unduly impact the delivery of emergency services on the affected community;" and would "unduly impact the other licensed hospitals or health care providers in the affected community."⁵

This research focuses on the forces driving Memorial's closure as described by dozens of individuals involved in or affected by the closure. This research aims to explore the varied perceptions, viewpoints and opinions among groups of stakeholders, organizing the disparate narratives through which they understood the hospital and its closure. Ultimately, it offers a case study that may provide insights for other communities and health systems facing hospital closure.

METHODS

Data Collection

In-depth semi-structured interviews and public testimony were the primary data sources for this study. An interview guide was developed by the authors and interviews of 16 stakeholders were conducted by author KS. Interviews typically ranged between 30–60 minutes and were recorded when consent was granted by the interviewee. Public testimony included written statements from 45 individuals and groups submitted to RIDOH as well as transcripts of spoken testimony from 37 individuals at public meetings. Additional documents examined included public health and financial data from RIDOH, health system and consultant reports, and coverage of the closure in the lay media.

Recruitment of Subjects

Interview subjects were approached using purposive and snowball sampling based on their involvement in or familiarity with Memorial Hospital and its closure. Subjects were recruited until data saturation was reached. Interviewees included hospital leadership, physicians, health policy-makers, and elected officials. Public testimony includes representatives from these same groups, as well as several patients and community members.

Data Analysis

Recorded interviews were transcribed by author KS. These transcripts and transcripts from public testimony were analyzed using immersion/crystallization qualitative analysis methods.^{6,7} Themes that emerged from the data were organized into narrative typographies. Representative quotes are presented in discussion of these main themes. The conduct of this research was granted a non-human subjects' exemption by the Brown University Institutional Review Board.

RESULTS

Interviews, public testimony, other documents, and media reports provided rich material for analysis. Stakeholders disagreed considerably on the events leading up to the closure, the need for closure, and the closure process, though there was general consensus around the financial challenges facing the hospital. Through analysis of interviews and written and oral public testimony, three main narratives emerged: closure as a financial inevitability; closure as a result of corporate mismanagement; and closure as a consequence of systems realignment.

Closure as financial inevitability

The first-order causes of Memorial's closure were financial. One former RIDOH director summarized the case succinctly: *"We have a market, not a health care system. That's the quite specific and proximal cause [...] It closed because it didn't have enough business to stay open."* Despite broad disagreement over the need for closure, stakeholders were unanimous in acknowledging the difficult financial picture facing Memorial. Stakeholders cited several interdependent factors, including a poor payor mix, decreasing market share, and increasing costs.

Memorial's difficult payor mix was frequently cited as a driving force of the hospital's losses. The hospital's service area included two of the least affluent communities in the state of Rhode Island. Accordingly, a disproportionately large percentage of the care provided at the facility was either not reimbursed or reimbursed at relatively lower rates compared to hospitals in more affluent locales. Making matters worse, in 2008 the state of Rhode Island changed its Medicaid reimbursement model, reimbursing hospitals at a lower rate and temporarily reducing the total number of Medicaid enrollees

in the state.^{8,9} Amid the fallout from the rule change, Memorial was also contending with the consequences of the 2008 financial recession, which drained the hospital's substantial endowment.

Several stakeholders cited Memorial's aging infrastructure in defining the causes of its closure. Improvements in the physical plant had long been deferred as the then-independent hospital tried to make a go of it in the face of falling revenue and increasing costs. Two executives interviewed estimated that the facility needed tens of millions of dollars in capital improvements by the time of closure.

Some respondents reported a perceived gap in quality and safety of care delivered at Memorial compared with other local hospitals. This notion is demonstrated in Memorial's declining patient census. Between 2011–2017, Memorial provided just 21.5% of hospital admissions among service area residents, and 37% of emergency department visits.¹⁰ This lower patient volume resulted in lower revenue. A former president of the hospital pinned the closure on declining patient visits. *"Ultimately it was that the volume had begun to decline to the point where the finances just wouldn't work."* Those remaining patients were disproportionately lower income, as patients with the means to travel for care did so, while those without the means could not. One executive at a competing health system described it as: *"The patients who had options were choosing to go elsewhere because the 'elsewheres' were keeping up their physical plants and had the full range of specialty services available. Only the patients who couldn't go elsewhere ended up going to Memorial."*

This decline in patient volume and the resulting drop in revenue ushered Memorial into a vicious cycle. In response to falling revenues, hospital leadership began cutting services, which, once closed, were unable to generate revenue. The most notable example was the scaling down of Memorial's intensive care unit (ICU) to just four beds. The downsizing and eventual closure of the ICU was cited by several stakeholders as a key domino to fall in the closure process. Provision of ICU-level of care requires immense resources and staffing; however, it is reimbursed at an accordingly high rate, and often represents a substantial revenue stream for hospitals. Furthermore, limits on ICU capacity have downstream impacts on other hospital services, as a lack of ICU beds limits the number and acuity of patients brought to the emergency department. As services were discontinued, patient safety issues were raised by hospital administrators to state health officials charged with considering the closure application.

While some respondents were split over the inevitability of Memorial's closure, the executives and policymakers interviewed were unanimous in their belief that the finances were impossible to reverse, with one hospital executive calling the confluence of poor reimbursement, dwindling volume, and service reductions a *"self-fulfilling prophesy."*

Closure due to corporate mismanagement

While all respondents acknowledged the financial difficulties facing Memorial, a large majority also expressed the opinion that mismanagement by hospital and health system leadership contributed to the closure. Some of these respondents believed the hospital would not have closed but for poor management. The accusations of mismanagement focused on both historic hospital leadership prior to the acquisition by Care New England, as well as management decisions following the acquisition.

Among former Memorial physicians interviewed there was a pervasive opinion that hospital management had failed to optimally adapt to a changing landscape of care delivery beginning in the mid-2000s, years before the sale to CNE. Stakeholders pointed to a failure to address aging infrastructure, the spending down of the hospital's substantial endowment, a resistance to establishing internet connectivity and electronic medical records, and a failure to adapt and establish clinical service lines to maximize revenue, among other complaints.

With the hospital's financial woes well apparent for some time, interviewees questioned CNE's decision to purchase Memorial in the first place. As one state-level policymaker put it: *"I could not understand why they wanted it...It made no sense to me. And I thought it would undermine CNE's fiscal integrity over time."* This bewilderment regarding CNE's strategic plans in purchasing Memorial were common across interviews. A former Memorial physician asked: *"Who knows what they were thinking. Market share? They didn't have a general inpatient hospital other than Kent [south of Providence]. So geographically, in Rhode Island, that's a big deal."*

Several interviewees contrasted CNE's acquisition proposal with that of Lifespan, a rival health system that also discussed acquiring Memorial. Some stakeholders posited that CNE overpromised in its proposal and acquired Memorial in bad faith. According to a previous chief financial officer at Memorial, *"It looked like they were stripping the place. It looked like they bought it to close it."*

While interviewees differed in their estimation of CNE's decision to purchase Memorial, there was near universal questioning of its management of Memorial following the sale. Interviewees routinely cited a lack of proper capital investment in physical plant and high-revenue service lines and a failure to retain or replace providers of these high-revenue services. More broadly, interviewees alleged a failure to enact a plan to revive Memorial after its acquisition. Multiple former Memorial physicians interviewed raised poor communication of the hospital leadership's plan for Memorial as a particularly frustrating failure. The pervasiveness of temporary management consultants further added to concerns around communication and strategy.

A few former providers posited that CNE engaged in financial skullduggery to pin system-wide losses on Memorial. In April of 2017, CNE announced plans to merge with

Massachusetts-based Partners HealthCare (now Mass General Brigham), though the merger was ultimately abandoned before a deal was reached. Insinuations about pressures to close Memorial to facilitate a merger were common among interviewees, though CNE executives were adamant in denying the claim in both interviews and public statements.

Interviewees differed in the degree to which they blamed historical leadership versus new management, though most cited some combination of the two in assigning blame for Memorial's decline. As one former Memorial executive described it: *"The problems were pre-existing but the response of the system was not adequate."*

Closure as Consequence of Systems Realignment

The third major narrative that emerged from interviews and public testimony was the notion that the closure of Memorial was part of a systems realignment and transition from hospital-based care to an outpatient-care delivery model. Relatedly, a report citing an excess of hospital beds in the state of Rhode Island was referenced repeatedly in stakeholder interviews, public testimony, and coverage in the lay press around the time of closure.¹¹ What is more, Memorial's proximity to other nearby hospitals was frequently raised as justification for its closure in concert with these other factors.

Multiple interviewees cited changing care dynamics in their discussion of Memorial's low census and ultimate closure. A former hospital president and physician summed up this view: *"I used to admit patients with pneumonia. Now you give them a Z-pack. It's a totally different story than it was years ago. Those patients used to be in hospitals [...] They're not anymore."* Hospital leaders interviewed identified this trend as having explicit impacts on Memorial's long-term planning through the years, with decreased focus on inpatient services.

Another frequent justification for closure cited by a wide range of stakeholders was a 2013 report commissioned by RIDOH that averred that the state had a surplus of approximately 200 hospital beds.¹¹ This surplus was frequently cited retrospectively by interviewees, as well as contemporaneously in written and oral testimony and in the lay press as rationalization for the need for closure. Some of those interviewed saw the statistic as a convenient justification for bad policy, noting that many of Memorial's 294 licensed beds were not actually staffed or equipped to house patients. Others assessed the report's findings differently: they accepted the notion of a surplus of beds in the state but argued that the distribution of staffed and licensed beds was more important than the sum total. Several stakeholders cited the patient population served by Memorial – a group characterized by relative socioeconomic disadvantage – as cause to maintain hospital beds in Pawtucket.

Another frequently raised fact in discussion of the closure was that Memorial was in close geographic proximity to

other full-service hospitals. A former RIDOH director put it this way: “You can see Memorial from the roof of the Miriam. There are hospitals in line of sight. There’s no way in heck that you need two hospitals serving the same geographic area.” Indeed, the formal application for Memorial’s closure filed with RIDOH detailed the nine hospitals within a 16-mile radius of Memorial and 10 federally qualified health centers within a 10-mile radius. Not all stakeholders bought into this notion. Several respondents noted an aversion to travel – even within Providence County – among local patients, and a lack of transportation for those willing to travel.

In a representative statement, one former Memorial physician acknowledged the conclusions of the care realignment narratives, but cautioned against systems-level thinking without considering the local context: “It’s an apple and an orange, the human value of having a community hospital and the numbers value of using health care dollars more efficiently. They’re just two completely different things.”

DISCUSSION

The narratives surrounding the closure of Memorial Hospital of Rhode are multiple and overlapping. These discrepant narratives demonstrate the varied understandings of a hospital’s role within both communities and wider health systems. The finding that perceptions differed on the causes of and need for the hospital’s closure is consistent with the existing literature on hospital closures.^{12,13} As in other studies, community members and hospital providers held generally positive opinions of the hospital and called upon personal experiences in defending against its closure.^{14,15} Those opposed to the closure also frequently raised a concern for vulnerable populations affected by the closure, and raised the importance of the hospital’s broader significance in the community.¹⁴⁻¹⁶ Administrators advocating closure in light of the hospital’s financial distress faced a difficult task in navigating a system that views health care as both a public good and a private commodity.¹⁷

Considering the competing closure narratives is not to impugn the motives of executives or policymakers, but to recognize the complex and unwieldy set of circumstances that created the conditions for closure. Indeed, community hospitals across the country are closing or consolidating at a steady clip in response to the same market forces that ultimately doomed Memorial.¹⁸⁻²⁰ Moreover, the long-term clinical outcomes of the hospital’s closure may be difficult to discern, as previous studies have shown mixed results on the impacts of closure on mortality and hospitalization rates.²¹⁻²⁸ It is possible that Memorial’s closure and others like it represent an appropriate realignment of health care markets toward a more efficient system.^{29,30} It is not the aim of this research to substantiate accusations of mismanagement, but rather to analyze the closure narratives expressed by those close to the process. Whether or not the hospital’s

fate was accelerated by managerial decisions or policy aims, Memorial faced a difficult outlook. Acknowledgment of this difficult picture is not to discount the immense loss that Memorial’s closure presented to the Blackstone Valley, or the individual sorrows of the patients who fought to keep it open.

Under the systems-of-care delivery as presently designed in the United States, hospital closure may well be inevitable while still running counter to community concerns and equity measures. This misalignment of economic incentives with community needs and moral value belies our imperfect system. Absent significant planning, such a system risks causing clinical harm to economically disadvantaged communities through decreasing services. Understanding the varied narratives and perceptions of hospitals’ roles in communities may help to guide stakeholders facing the prospect of hospital closures now and in the future.

References

1. Lawrence AC, Burke C, Birster J, Ferrante D, Beaudoin FL. Evaluating the Impact of Hospital Closure on Local Emergency Department Operations. *Rhode Island Medical Journal*. June 2019:37-42.
2. Fine M. *Decision With Conditions: Affiliation of the Care New England Health System, Southeastern Healthcare System, Inc., and The Memorial Hospital d/b/a Memorial Hospital of Rhode Island Under the Hospital Conversions Act of Rhode Island*. 2013. Accessed February 2, 2022. <https://health.ri.gov/applications/submitted/merger/carenewenglandandmemorial/Decision.pdf>
3. Alexander-Scott N. *Decision for Approval with Conditions from the Director of the Rhode Island Department of Health with Respect to the Application of Care New England Health System for the Elimination of the Emergency Department at Memorial Hospital of Rhode Island*. 2017. December 28, 2017.
4. Care New England. *Annual Report*. 2016. Accessed February 8, 2022. https://issuu.com/carenewengland/docs/ar_final
5. Alexander-Scott N. *Decision for Approval with Conditions from the Director of the Rhode Island Department of Health with Respect to the Application of Care New England Health System for the Elimination of the Emergency Department at Memorial Hospital of Rhode Island*. 2017. December 28, 2017.
6. Borkan J. Immersion/Crystallization. In: Miller BFCaWL, ed. *Doing Qualitative Research*. 2nd Edition ed. Sage Publications, Inc.; 1999:179-194.
7. Borkan JM. Immersion-Crystallization: a valuable analytic tool for healthcare research. *Fam Pract*. Nov 25 2021;doi:10.1093/fampra/cmab158
8. Kaiser Commission on Medicaid Facts. *Medicaid Enrollment: December 2009 Data Snapshot*. 2010. *Medicaid and the Uninsured*. Accessed January 29, 2022. <https://www.kff.org/wp-content/uploads/2013/01/8050-02.pdf>
9. Rhode Island Annual Medicaid Expenditure Report – State Fiscal Year 2008 (2009). Accessed April 23, 2024. https://eohhs.ri.gov/sites/g/files/xkgbur226/files/2021-03/RI_Medicaid_Expend2008_final.pdf
10. John Snow I. *Community Health and Health Systems Impact Assessment Related to the Closure of Memorial Hospital of Rhode Island (MHRI) Report*. 2020. February 2020.
11. The Lewin Group. *Rhode Island Coordinated Health Planning Project Final Report*. 2013. February 21, 2013.
12. Martin GP, Carter P, Dent M. Major health service transformation and the public voice: conflict, challenge or com-

- licity? *J Health Serv Res Policy*. Jan 2018;23(1):28-35. doi:10.1177/1355819617728530
13. Barratt H, Harrison DA, Fulop NJ, Raine R. Factors that influence the way communities respond to proposals for major changes to local emergency services: a qualitative study. *PLoS One*. 2015;10(3):e0120766. doi:10.1371/journal.pone.0120766
 14. Romero D, Kwan A, Swearingen J, Nestler S, Cohen N. Impact of the closure of a large urban medical center: a qualitative assessment (part I). *J Community Health*. Oct 2012;37(5):982-94. doi:10.1007/s10900-012-9550-3
 15. Stewart E. A sociology of public responses to hospital change and closure. *Sociol Health Illn*. Sep 2019;41(7):1251-1269. doi:10.1111/1467-9566.12896
 16. Moon G, Brown T. Closing Barts: Community and Resistance in Contemporary UK Hospital Policy. *Environment and Planning D: Society and Space*. 2016;19(1):43-59. doi:10.1068/d35j
 17. Rosenbaum L. Losing Hahnemann – Real-Life Lessons in “Value-Based” Medicine. *New England Journal of Medicine*. 2019;381(13):1193-95.
 18. Carrol C. Impeding Access or Promoting Efficiency? Effects of Rural Hospital Closure on the Cost and Quality of Care. *NBER Working paper*. 2020.
 19. Mosley D, DeBehnke D, Gaskell S, Weil A. *2020 Rural Hospital Sustainability Index: Trends in Rural Hospital Financial Viability, Community Essentiality, and Patient Outmigration*. 2020. Accessed 1/21/2022. <https://guidehouse.com/-/media/www/site/insights/healthcare/2020/guidehouse-navigant-2020-rural-analysis.pdf>
 20. Cecil G Sheps Center for Health Services Research. Rural Hospital Closures. Accessed 1/21/2022. <https://www.shepscenter.unc.edu/programs-projects/rural-health/rural-hospital-closures/>
 21. Joynt KE, Chatterjee P, Orav EJ, Jha AK. Hospital closures had no measurable impact on local hospitalization rates or mortality rates, 2003-11. *Health Aff (Millwood)*. May 2015;34(5):765-72. doi:10.1377/hlthaff.2014.1352
 22. Gujral K, Basu A. Impact of Rural and Urban Hospital Closures on Inpatient Mortality. Working Paper. *National Bureau of Economic Research*. June 2020;(Working Paper 26182)doi:10.3386/w26182
 23. Carson S, Peterson K, Humphrey L, Helfand M. Evidence Brief: Effects of Small Hospital Closure on Patient Health Outcomes. *VA Evidence Synthesis*. June 2013.
 24. Buchmueller TC, Jacobson M, Wold C. How far to the hospital?: The effect of hospital closures on access to care. *Journal of Health Economics*. 2006;25(4):740-761.
 25. Hsia RY-J, Shen Y-C. Rising Closures of Hospital Trauma Centers Disproportionately Burden Vulnerable Populations. *Health Affairs*. October 2011 2011;30(10)doi:10.1377/hlthaff.2011.0510
 26. Sun BC, Mohanty SA, Weiss R, et al. Effects of hospital closures and hospital characteristics on emergency department ambulance diversions, Los Angeles County, 1998-2004. *Annals of Emergency Medicine*. April 2006;47(4):309-316. doi:10.1016/j.annemergmed.2005.12.003
 27. Bazzoli GJ, Lee W, Hsieh H-M, Mobley LR. The effects of safety net hospital closures and conversion on patient travel distance to hospital services. *Health Services Research*. 2012;47(1):129-150. doi:10.1111/j.1475-6773.2011.01318.x
 28. Hsia RY, Shen Y-C. Emergency Department Closures And Openings: Spillover Effects On Patient Outcomes In Bystander Hospitals. *Health Affairs*. 2019;38(9):1496-1504. doi:10.1377/hlthaff.2019.00125
 29. Lindrooth RC, Lo Sasso AT, Bazzoli GJ. The effect of urban hospital closure on markets. *Journal of Health Economics*. 2003;22(5):691-712. doi:10.1016/s0167-6296(03)00060-2
 30. Capps C, Dranove D, Lindrooth RC. Hospital closure and economic efficiency. *J Health Econ*. Jan 2010;29(1):87-109. doi:10.1016/j.jhealeco.2009.10.006

Authors

Kevin P. Savage, MD, ScM, Boston Medical Center, Boston University School of Medicine.

Jeffrey Borkan, MD, PhD, Warren Alpert Medical School of Brown University.

Disclosures

Author JB served as Chief of Family Medicine for Care New England at the time of Memorial Hospital of Rhode Island's closure. The authors have no relevant financial disclosures.

Correspondence

Kevin Savage
 Boston University Medical Center
 Internal Medicine Residency Program
 72 East Concord Street
 Evans 124
 Boston, MA 02118
 kevin.savage@bmc.org