The Right Number of Doors

One location beats zero. One profitable location beats four that lose money.

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In an earlier article I wrote that one location beats zero. Having a service available in one place is better than having it available nowhere. I still believe that.

But there is a second half to that truth, and it is harder to say out loud: one profitable location beats four that lose money.

Both statements are true. The work of leadership is knowing which one applies to the decision in front of you.

Let me say plainly: deciding which doors stay open is likely the most difficult decision a healthcare leader will ever make. It touches jobs, community pride, history and, above all, patients who depend on that door being there. There is no version of it that pleases everyone. But avoiding it is also a decision, and usually the worst one.

The slow fade

Most communities do not lose access all at once. They lose it one service at a time. The Chartis Center for Rural Health's 2026 report found that more than 300 rural hospitals have eliminated obstetrics, more than 300 have eliminated general surgery, and more than 450 have stopped offering chemotherapy. It counted 417 rural hospitals vulnerable to closure.

Anyone who has sat on a health care board has heard some version of the sentence that puts those decisions off: “We can't close the Main Street clinic. It has been there forty years.” So every site stays open, and each one gets a little thinner. Fewer staff. Shorter hours. Older equipment. A provider who covers three locations and is never fully present at any of them.

From the outside, it looks like access. From the patient's side, it is a sign on the door that says “closed Wednesdays,” a three-week wait, and a clinic that cannot keep a nurse. And when the money finally runs out, it often runs out everywhere at once. Four struggling doors can fail together and leave a community with none.

That is the conundrum. Keeping every door open can be the very thing that puts them all at risk.

Fewer, stronger doors

There is evidence that choosing fewer, stronger services can preserve access rather than end it. In 2023, Medicare created the Rural Emergency Hospital designation. Hospitals that convert give up inpatient beds but keep emergency, observation and outpatient care, with added federal support.

The early results are encouraging. An early review of Medicare cost reports found that most converted hospitals saw a substantial increase in margins, though some are not yet profitable. One Kansas hospital went from an operating margin worse than negative 20 percent to positive 2 percent after converting, and its leaders made the case to their community with data on how many patients they could keep serving. Of the 56 hospitals that had converted as of this summer, two have closed.

I want to be honest: this is not a cure. Conversions mean layoffs and lost services, and at least one converted hospital closed anyway. But the principle holds. A smaller door that stays open serves more patients than a bigger one that shuts.

More means better

The same logic applies to services inside the walls. If you don't deliver enough babies or do enough heart procedures to keep a team sharp, consolidate. For complex care, more volume means better outcomes. Researchers have documented the link between hospital volume and outcomes since 1979, and a federal review of 88 studies found a consistent trend toward better results at higher-volume hospitals. Experts still debate exactly where the cutoffs belong, but the gap between the busiest and the least busy hospitals remains large. A team that does a procedure every day is better at it than a team that does it once a month.

Obstetrics deserves special care. When a rural hospital stops delivering babies, mothers drive farther, and some deliver on the way. Consolidating labor and delivery can still be the right call, but only with a road built first: prenatal care close to home, a clear transfer plan and a relationship with the hospital that will do the delivery.

Access is not a building

Here is the part leaders cannot skip. If you close a door, you owe the patients a road.

Consolidating into one strong site only serves the patient if care still reaches the people who used the others. That means transportation help, telehealth, visiting specialists, mobile services, community paramedics, and partnerships with federally qualified health centers or independent practices that can fill the gap. The goal is not fewer buildings. It is more care that lasts.

How to find the right number

Start with facts, not history. For every location, put four things on one page: its margin, its volume, its staffing gaps and how far its patients travel to get there. Then ask the harder questions. Which site has the people to be excellent? What care could go mobile or virtual instead of needing a building? And if a door closes, what is the plan to bring care to the patients behind it?

Then test every option with my two questions. Does it serve the patient? Can it keep doing so? Four struggling sites may pass the first test today. They rarely pass the second.

What to do Monday morning

Map your doors. All of them. If you find you are spread too thin, don't wait for a crisis to make the decision for you. A planned consolidation, explained honestly to the community, protects far more access than an unplanned closure.

If you are facing one of these decisions, I would welcome the conversation. My goal is to help you become your own best consultant, with the patient at the center of the map.

When it seems crazy out there, and it sometimes is, remember that the patient is still a reliable true north. The right number of doors is the number that will still be open for them next year.

Sources

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