

# Framing Rural Health Value Webinar Series

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## Summary Report August 2014



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## PROJECT OVERVIEW

### Purpose

The US health care industry is growing increasingly complex as it undergoes profound change in financing and service delivery. Today, critical access hospitals (CAHs) face the challenge of being successful in their current payment system, while preparing for a new value-based payment system. Complexity and change are best managed by using a comprehensive systems-based framework, including a balanced set of key strategies, initiatives, targets and measures. These systems-based frameworks are currently being used by many successful rural hospitals to achieve clinical, operational and financial excellence. Without a framework, hospitals may successfully carry out initiatives in some areas, but then may be thwarted by breakdowns in other areas that are not managed effectively. Meaningful work must be done in all of the areas to maximize a hospital's chance of achieving long-term excellence in major undertakings.

Just like CAHs, state Flex Programs are managing multiple, simultaneous projects and activities toward a multi-faceted goal of improving quality, financial, operational and health system delivery in CAHs. And just like CAHs, complexity and change are best managed by using a comprehensive systems-based framework. A framework for performance excellence assists state Flex Programs by providing a program design to link needs to activities and outcomes and eliminating silo-thinking when supporting a complex entity like a CAH. Not all components of a performance excellence framework need to be implemented all at once. The framework is meant to be flexible, and the components can be approached in steps that support the individual state Flex Program and its unique needs.

Participating in the *Framing Rural Health Value* webinar series aided state Flex Programs in understanding the changing and challenging landscape of rural health care as well as program design in preparation for the competitive grant cycle of the Flex Program in Fiscal Year 2015. This webinar series was held in place of past in-person national Flex conferences and aims to assist state Flex Programs with designing and maintaining responsive technical assistance and education for CAHs in the emerging value-based health care system. Through panel presentations, cohort conversations, applied exercises and case study review, state Flex Program participants:

- Explored how the core areas of the Flex Program can be supported by performance frameworks in the emerging value-based health care system
- Discovered CAH and state Flex Program examples of Flex-supported activities in alignment with performance excellence frameworks
- Understood Flex Program supportive interventions for financially distressed CAHs on the verge of closure

- Expanded the awareness and use of resources targeted to support state Flex Programs and their CAHs

## **Process**

The webinar series occurred periodically from May 14 through August 11, 2014 with a sequential curriculum focusing on strengthening the understanding and application of a performance excellence framework to support both CAHs and state Flex Programs. The performance excellence framework ensures a comprehensive and holistic approach to sustaining and improving the performance of CAHs in clinical, quality, finances, operations and customer service. This framework is not recommended as a one-size-fits-all concept or as sequential steps that need to be followed in an exact order. It is flexible; the use of such a comprehensive framework allows both CAHs and state Flex Programs to maximize and document success in the changing health care environment.

The webinar series included seven plenary webinars used to increase understanding of the holistic framework, its application and interrelated pieces. While sharing knowledge on the critical success factors used in a performance framework, participants learned from panelists representing national and state organizations, CAHs and peer state Flex Programs. Each webinar focused on how the performance excellence framework can be translated to activities and interventions by state Flex Programs.

To enhance learning and knowledge application, a case study of a CAH near closure was interwoven throughout the *Framing Rural Health Value* series. This CAH, based partially on a real rural hospital journey from crisis to excellence, is in need of turnaround in all areas of service and needs state Flex Program assistance. Webinar series participants completed three short application exercises interpreting information provided by webinar panelists to improve the case study CAH through recommendations. Exercises were submitted online through an online learning environment. Participants then joined a cohort small group setting webinar to discuss the application exercises connecting the concepts from the previous webinar to that of the case study and CAHs in their state.

At the conclusion of the webinar series, this summary document has been created reviewing all the recommendations for the case study CAH developed by the cohort groups, actionable items for future state Flex Program work and a list of best practices and resources that align with a performance excellence framework.

## CASE STUDY: COMMUNITY MEMORIAL HOSPITAL

### Service Area and Population

Community Memorial Hospital (CMH) is a CAH located in a rural area of the United States, 45 minutes from a large urban hospital and 30 minutes from another small rural hospital. One other small hospital is within one hour driving distance.

The community has been steadily losing population during the past two decades as young people often leave to seek employment in larger cities. A factory in town is the largest employer with 248 employees, and Blue Cross and Blue Shield is their insurance company. The insurance company has been relatively aggressive in negotiating hospital discounts. Of the 7,200 people in the service area, 21% are below the federal poverty level. Around 62% of CMH's inpatients and 38% of the outpatients are on Medicare. Approximately 18% of CMH's patients are on Medicaid, which has very low payment rates in this state. These Medicaid patients have a high utilization rate of the emergency room (ER), almost 30% of the total ER visits.

The area has high rates of diabetes, heart disease and cancer, all of which are more than 20% higher than the national average.

### Hospital Profile

CMH converted to CAH status in late 2004, and now has 15 acute care beds with an average daily census of 3.2, and average length of stay is 2.9 days. CMH has 10 swing beds, but the Chief Financial Officer (CFO) acknowledges that they do not know how to maximize swing bed revenue.

CMH has four primary care physicians and one nurse practitioner on staff, all of whom are part of one independent group practice. Two of the physicians are foreign trained (J-1 visa). One of the physicians, Dr. Larry Holt, age 64, has been practicing in the community for 23 years and has been described by representatives of both staff and board as very outspoken and often difficult to work with. Turnover on the medical staff has been frequent. All of the physicians are independent primary care practitioners, and their clinic is located in an old building three blocks from the hospital.

CMH was built in the late 1950s, and no renovation has taken place for 11 years. Access to capital for new construction and needed equipment has been difficult to obtain, as their credit rating is relatively low. Although the hospital is city owned, the city lacks resources to help with the current crisis.

CMH is currently not a member of either a large health system or a hospital network. It has an opportunity to join a network of 11 rural hospitals in its state

that has been in existence for six years and that includes collaborative programs in quality and finance.

## **Hospital Leadership**

CMH is governed by a board of directors made up of nine local citizens. Three have business experience, including President Bob McGee, who is a local attorney. The board has not had any training in governance and is sometimes unsure of its proper role. Board meetings often last three or more hours, and there has been a tendency for board members to interfere with management and administrative duties.

CMH is currently without a permanent Chief Executive Officer (CEO). The previous administrator was fired two months ago, and 28-year old CFO, Dan Jordan, has been acting as interim CEO as well as CFO. Dan, who has been at the hospital for 18 months, has a degree in accounting but had no previous experience in hospital cost accounting when he assumed the CFO role.

The Director of Nursing (DON) is Diane Sheldon, Registered Nurse (RN), who has been with the hospital for five years. Lately she has been losing nurses to the urban center nearby, which can afford to pay almost 30% more in salary and benefits, and she is having difficulties recruiting a full nursing staff. She has frequently relied on expensive temporary nursing services. The hospital also is short on lab and other technicians as well as various other positions. Low wages and benefits again are cited as factors in the difficulty with recruitment and retention.

CMH has begun implementing electronic health records (EHRs) but has struggled to meet the deadlines to achieve incentives. A number of nursing staff and several physicians have actively opposed EHR adoption and now point to reduced hospital production as the inevitable outcome of this initiative.

Health information technology (HIT) skills of CMH staff are minimal. The hospital employs one full time IT person who graduated from a 6-month training program, and relies on outside IT consulting expertise.

CMH managers generally lack training in leadership, management, and performance improvement. Many of the staff do not have a high school diploma. Most lack college degrees, and it has generally been difficult hiring competent staff.

## **Hospital Finances**

CMH is financially troubled and has historically struggled to survive. Lately, community fundraising events have been unsuccessful and the town seems to have grown complacent about the risk of the hospital's closure after numerous predictions of closure in the past.

Financial data includes:

- 101 days in accounts receivable (The 2012 US median was 53 days)
- 12 days cash on hand. Most reserves have been exhausted. (The 2012 US median was 77 days)
- -4.5% operating margin (The 2012 US median was 1.6%)

The hospital charge-master has not been updated in three years. Preliminary examination of the hospital cost report and revenue cycle management process reveals significant errors and inefficiencies that, if corrected, could capture hundreds of thousands of dollars in additional revenue. As a CAH, the hospital now receives cost-based reimbursement for both inpatient and outpatient services, but is not using swing beds. The hospital has a high ratio of inpatient to outpatient days suggesting a lack of emphasis on outpatient business.

## **Hospital Quality**

CMH has faced several quality and infection control lapses recently. Several staff have expressed concern about lack of an effective performance improvement program. There have been an increased number of medication errors from the previous year. There have also been a number of patient transfer delays and patients transferred to neighboring facilities without their patient records and care assessment. Families have complained to administration about poor communication between hospital staff and inadequate patient discharge instructions. The Quality Improvement Coordinator, Barb Riley, reports that various quality programs have been attempted to correct these issues at the hospital, but all have lacked top leadership commitment and fizzled when other hospital crises occurred. She feels that hospital leadership has not recognized the importance of continuous quality improvement, and that she may be the only manager that truly cares about this issue. She has applied for a position with one of the neighboring hospitals.

CMH voluntarily participates in the federal Medicare Beneficiary Quality Improvement Program (MBQIP) for quality measure data collection and reporting. However, most hospital staff have minimal skills in data analysis. Information that is gathered is used for compliance purposes, and little time is spent analyzing the data or using it for strategic decision-making on where quality could be improved. The hospital does not currently use evidence-based best practices.

The hospital has a rapidly growing uncompensated care caseload and the state has, to date, refused to accept federal funding to expand Medicaid coverage.

CMH has no formal patient satisfaction program but does have a suggestion box with mostly positive feedback from the patients. The hospital and physicians have been dealing with several malpractice suits.

No formal community survey has ever been conducted to assess health care needs or to obtain community feedback about hospital quality. Reportedly, word on the street is that CMH is fine for emergencies when you can't go anywhere else, but "we go to the city for our health care."

### **Community Health System**

An estimated 60% of the population in the local community go to the nearest big city to receive health care. No information exists as to why they do not use the local hospital, but word on the street is that "the hospital has serious quality problems." Some people have heard this from the hospital employees themselves.

CMH leadership has limited interaction with either public health or mental health providers. There is also little coordination or communication with the independent nursing home and assisted living facility in town, often resulting in readmissions to the hospital within 30 days of discharge. The local ambulance service is staffed by volunteer emergency medical technicians with no advanced life support skills. Hospital transfers are generally to the tertiary care facility 45 minutes away, with no formal relationship and limited communication between the hospital and the referral center.

The referral center is part of a new accountable care organization (ACO), which has recently approached the local independent physicians about participating in their ACO. CMH leaders are concerned that the ACO may attempt to purchase the practice and refer patients away from CMH.

## **TOP 10 RECOMMENDED INTERVENTIONS**

Flex webinar series participants were asked to complete three applied exercises. In the exercises, participants identified types of interventions recommended to CMH for implementation over the coming year to maximize the effectiveness of the hospital's:

- Leadership
- Strategic planning
- Workforce and culture
- Community, customers and population health
- Operations and processes
- Measurement, feedback and knowledge management
- Outcomes and impact

Participants were allotted 10 points on each of the three applied exercises to assign to recommended interventions from a list of options provided. Instead of allowing an indefinite pool of resources, participants were allotted only 10 points to reflect the reality of finite funding and resources of their state Flex Program. The cohort

calls reviewed the point allotment for each cohort as a whole, focusing discussion on why certain interventions were assigned the majority of points and sharing best practices and lessons learned of actual implementation of similar interventions by state Flex Programs. Points allocated to interventions from all submitted exercises were totaled, resulting in the below list of the top ten recommended interventions, ranked descending from highest point total.

### **Top 10 Recommended Interventions**, ordered by highest scoring intervention

<b>Performance Excellence Framework Category</b>	<b>Recommended Intervention</b>
<b>Leadership</b>	1. Providing CAH leadership development and management education support to improve overall CAH performance
<b>Community, Customers and Population Health</b>	2. Exploring partnerships with larger systems or rural health networks (facilitating network activities, care transitions and data sharing)
<b>Community, Customers and Population Health</b>	3. Facilitating and prioritizing community health needs assessments and implementation plans
<b>Leadership</b>	4. Educating CAH (leaders, staff and board) regarding health industry trends in reimbursement models, quality, health service delivery, community engagement and their potential impact on the organization
<b>Operations and Processes</b>	5. Assist CAH in identifying potential areas of financial and operational performance improvement
<b>Strategic Planning</b>	6. Providing or arranging for direct technical assistance to CAH for scope of service assessment, physician-hospital alignment or market analysis
<b>Operations and Processes</b>	7. Providing or arranging for direct technical assistance to CAH for technical experts on finances, business processes, quality of care and patient satisfaction
<b>Workforce and Culture</b>	8. Developing a workforce that is change-ready and adaptable (Baldrige, Lean, Studer, AHRQ Culture of

	Patient Safety, TeamSTEPPS)
<b>Operations and Processes</b>	9. Developing efficient business process with a particular focus on revenue cycle management
<b>Workforce and Culture</b>	10. Creating a culture within the CAH that is patient-focused and customer-driven (Studer, Lean, providing education on value-based reimbursement)

## ALIGNMENT OF INTERVENTIONS WITH PERFORMANCE EXCELLENCE FRAMEWORK

### Leadership

Leadership has the strongest relationship to organizational outcomes and value, more than twice the effect of any other component of the performance excellence framework. Excellent rural hospitals invariably have excellent leadership. Due to the complexity of the changes, some rural leaders are unaware of or refute how their organization may be impacted. The day-to-day trials of running a rural hospital can take precedence over strategy, and, as illustrated in the case study, turnover of CEOs and other leaders add to the challenge of having a consistent approach. Leadership is critical to helping organizations understand the “why” of needed change.

The top recommended intervention from the applied exercises is to provide CAH leadership development and management education support to improve overall CAH performance at CMH. Leaders need to continually communicate the organization’s vision and strategies but may need training to feel enabled to do so. As one webinar participant mentions, “good leaders can recognize the opportunities available.” It may be that they need the training to build their skill set. Another participant pointed out that many CAH department heads tend to be promoted because they are fantastic front-line workers, but really are not management trained. Such trainings can be eye-opening for the leadership and the board to understand the urgency of needed change. Many state Flex Programs offer CAH leadership and board trainings and have reported qualitative data of those hospitals participating in the trainings performing better than those that have not.

Another highly recommended intervention is to educate CAH leaders, staff and boards regarding health industry trends in reimbursement models, quality, health service delivery, community engagement and their potential impact on the organization. At CMH, there is a lack of expertise to assess appropriate service lines, like swing beds, or explore provider relationships and reimbursement models.

Understanding appropriate services as well as industry trends and quality of care expectations can help improve the facility's bottom line and its relationship with the community. Rural hospital leaders have a unique window of opportunity to understand potential impacts of health reform and work with board trustees to align vision and strategy with local primary care providers.

One other highly recommended intervention, though it did not make it into the top 10, is supporting CMH in a multi-hospital or network quality project focused on leadership and organizational culture. CAH leaders benefit from networking with their peers, sharing best practices and lessons learned. They may even feel more comfortable sharing their challenges and pitfalls among peers who can relate. Multiple tools, resources, frameworks and trainings exist to support CAH leadership and organizational culture development. Hearing stories of successes and challenges from implementing in a peer environment is priceless, and state Flex Programs are developing multi-hospital networks and peer to peer coalitions.

## **Strategic Planning**

In today's rapidly changing environment, regular strategic planning is extremely important. The era of 3 or 5 year strategic plans that gather dust on a shelf has passed. Planning needs to happen more often, be more relevant and include data review. Strategic planning is also a means for working smarter, not harder, which is critical in a rural facility with limited resources. As one webinar participant notes, "the CAH leadership will need to move from putting out fires to strategic planning and board education." Using a systems framework to manage information and strategic knowledge ensures a holistic approach linking strategy to operations. One participant notes that "this case study hospital is like a ship with no captain. Organization-wide data sharing aligned with a well-communicated strategic plan would help them gain buy-in among employees for needed change."

Providing or arranging for direct technical assistance to CMH for a scope of service assessment, physician-hospital alignment or market analysis is a highly recommended intervention. Such technical assistance aids CMH leadership in assessing its current strategy and aligning resources to the needs of its operations, workforce, customers and community. As one participant noted, "big picture thinking will help them be prepared for whatever comes up and a systems framework will provide the hospital a better opportunity for long term success." Another participant notes that as the reimbursement model is changing from volume-based health care to value-based, the CAH needs to get the physicians on board and in alignment with the hospital's strategies and priorities. The physicians are the revenue generators and a voice to the community making a positive working relationship critical.

## **Community, Customers and Population Health**

A focus on building relationships with the community and customers and developing the CAH's role in population health is essential to the growing concept of value in health care. The second highest ranked recommended intervention for CMH is to explore partnerships with larger systems or rural health networks, including care transitions and data sharing. Exploration of partnerships with larger systems, rural health networks and other service providers is an opportunity to coordinate care, share resources and identify strategies to improve chronic disease management and population health. One webinar participant notes that it is important for CMH to have their patients feel safe and well cared for or they will continue to seek health care elsewhere, further jeopardizing the financial livelihood of the CAH. For coordinated care to be efficient, an engaged staff is critical. One state Flex Program shares they have a network of a few CAHs, prospective payment system (PPS) hospitals and a federally qualified health center (FQHC) that is working on an integrated health care model for care coordination seeking to reduce readmission rates and improve quality of care. Another model for coordinated care includes community paramedicine, which many state Flex Programs are implementing.

Historically rural hospitals have had an advantage when it comes to customer satisfaction, but they need the empirical data to demonstrate their value. With a growing focus on population health management, inpatient volumes will likely decrease. To stay viable, CAHs need to increase market share and engage the community to seek outpatient services locally. The third highest ranked intervention is for the state Flex Programs to facilitate or prioritize community health needs assessments (CHNA) and implementation plans with CMH. CMH needs to become informed of why its patients are seeking care elsewhere, what services the community perceives the hospital as having, and what services the community desires. Finding out the community's perceptions and concerns can establish a commitment with the community and community organizations.. It is important to not only complete the CHNA, but also for the CAH to act on implementing recommendations from the CHNA findings. The state Flex Program can aid in follow-through on the implementation plan by reconnecting with the CAH after the CHNA is completed to identify progress and offer resources. Meaningful engagement in the CHNA process can be a challenge and takes time and resources, but the rewards can greatly impact the hospital's bottom line and reputation within the community.

Rural hospitals, which are inherently linked to the community they serve, are well positioned to thrive in the changing marketplace by developing population health strategies that have both short- and long-term impact on operational viability. The nature of CAHs as a hub for local health care services lends naturally to broader development of partnerships and programs to keep populations healthy and

ultimately reduce overall health care spending. CAHs can begin implementing population health strategies in their facility by building the case for population health and putting population health on the agenda of the facility. One state Flex Program reports that their local health department staff is on the board of almost all of the CAHs in the state, which is a great strategy for getting population health at the table of discussions. CAHs can review their existing data (claims, electronic health records, CHNA) to identify population health needs. CAHs can also look within their own walls to begin to implement population health. Hospitals can begin wellness strategies and a culture of health care, not sick care, among their own employees by promoting employee wellness programs and developing case management or care coordination for employees with chronic health conditions. CAHs can better manage charity care and bad debt policies to support those cases prior to them seeking inappropriate hospital care, impacting the hospitals bottom line. Lastly, CAHs can reach out to the community, as described previously, to partner in the CHNA process and to articulate their role in the community's health.

### **Measurement, Feedback and Knowledge Management**

Many CAHs are overwhelmed by the wide variety of data reporting requests and requirements. Limited staff time and expertise can compound this issue, particularly when there is a lack of understanding of the value of the data being gathered. The ability to gather data and turn it into information is critical and will have growing importance as payment structures start to rely on reporting performance measures.

Although not among the top 10 recommended interventions, supporting CMH in a multi-hospital or network quality project focused on data measurement and benchmarking scored highly in the applied exercises. One webinar participant notes that it could be valuable for CMH to communicate their MBQIP data to their community to demonstrate quality. Sharing this data in a network setting for benchmarking and discussions of lessons learned and best practices among peers is extremely valuable. Because of the case study hospital's seemingly poor reputation in the community, CMH could benefit from communicating and improving their quality scores by working with other hospitals that have credibility and quality improvement experience.

Another optional intervention is for the state Flex Program to support CMH in conducting a hospital economic impact assessment. The measurement, review and regular reference to data and knowledge in the CAH, be it in quality, finances, operations, patient satisfaction or economic impact on the community, can be used to guide strategy, empower employees, inform customers and build market share.

## **Workforce and Culture**

The workforce culture underlies every factor in the performance excellence framework. One webinar participant notes that “introducing a culture of employee engagement, customer satisfaction and leadership development would do a world of good” for the case study hospital. Having an engaged workforce and reducing turnover will increase the ability of CAHs to improve performance and add value. A top recommended intervention for CMH is to develop a workforce that is change-ready and adaptable. Tools and frameworks such as Baldrige, Studer, Lean, Agency for Healthcare Research and Quality (AHRQ) Culture of Patient Safety and TeamSTEPPS are valuable endeavors for CAHs, but leadership needs to be onboard for successful implementation and cultural change organization-wide.

Additionally, webinar participants highly recommend the state Flex Program support CMH in creating a culture that is patient-focused and customer driven. Helping employees become aware of the multitude of changes in the health care environment is important in keeping employees engaged. Regular communication that includes a focus on the Triple Aim and the potential impact of health reform at the local hospital can help employees understand the context and urgency of changes that need to be made. Storytelling is another best practice to help employees manage change. Putting information in the context of impact on individual patients can help staff understand how their actions contribute to the overall value of care provided to patients and families. In short, an investment in employees and people pays off.

## **Operation and Processes**

Streamlining operations and continuously improving quality and safety are essential to staying viable in a reformed health care environment, but can be challenging to implement. Three of the top 10 recommended interventions fall into this category of the performance excellence framework. Webinar participants recommend the state Flex Programs assist CMH in identifying potential areas of financial and operational performance improvement. One participant notes the most important thing to do is to “bring in fresh eyes.” Consulting expertise can identify oversights or unintentional omissions in operations and financial processes with recommended improvement strategies. For CMH to remain viable in the changing health care climate, they need to align. With CMH struggling in all areas of operations and services, they cannot implement new programs or service lines without first getting their financial and operational house in order.

It is recommended for the state Flex Program to provide or arrange for direct technical assistance to the CAH for technical experts on finances, business processes, quality of care and patient satisfaction. One webinar participant cautions against dabbling in a variety of methodologies for improvement, but advises rather

to identify a method that staff can understand and incorporate into their daily work. Lean is a cultural transformation supported by many state Flex Programs with the CAHs identifying great savings in revenue and quality from streamlined processes. Participants also highly recommended developing efficient business processes with a particular focus on revenue cycle management. External revenue cycle assessment is specifically cited as important because it may uncover other operational opportunities for improvement.

### **Impact and Outcomes**

Implementation of the performance excellence framework focuses on the goal of improving and documenting outcomes. Now more than ever, CAHs need to demonstrate the value they provide to patients and to their health care systems. As the environment continues to shift toward a focus on measurable outcomes, it is no longer feasible for CAHs to opt out of standard reporting requirements. With the recognition that some quality and safety measures do not adequately reflect the care provided at rural hospitals, high performance on those that are relevant is even more important. Although not scoring in the top 10 recommended interventions, participants note it is important for CMH to document value in terms of cost, efficiency, quality, patient satisfaction and population health. CAHs should take advantage of opportunities to define and promote excellence, both within their community and more broadly in the health system. CAHs need to seize opportunities within the community to share data on performance, and gather information on perceptions and needs as defined locally.

## **OUTCOMES AT THE CASE STUDY HOSPITAL**

\*Note: The CMH hospital story is based partially on a real rural hospital journey from crisis to excellence. Today this hospital is among the top quartile of CAH quality and financial performers in its state. The below outcomes are fictitious and based on the Flex Program recommendations, but many of the Flex recommendations were actually carried out in the real hospital.

The state Flex Program staff scheduled a meeting at CMH and met with hospital leadership, physician leadership and the board. After a lengthy meeting involving discussion and data review, the state Flex Program proposed a multi-faceted plan to turn around the performance of the hospital, and asked for full participation and buy-in from all leaders. After much discussion by group, the board, the medical staff and the hospital leadership team agreed on a multi-faceted strategic approach. The state Flex Program involved CMH in existing activities in their work plan with other CAHs and also dedicated direct funding via a consultant to support CMH in making improvement. Although CMH had limited finances to fund the needed improvements, CMH leadership recognized the gravity of the need and allocated what personnel and financial resources were available to implementing

interventions. The state hospital association was also available with resources to aid CMH. The initiatives executed and the outcome findings after the first year of initiative implementation are outlined below.

## **Leadership**

Board education became a priority and was included in every board meeting. Physicians were integrated onto the board and into hospital decision-making processes. Rather than hire a new administrator, CMH developed a management agreement with the CEO of the neighboring CAH, and this individual helped to mentor Dan Jordan throughout the year. Hospital leaders were also given leadership training supported by the Flex program, through TASC resources and state hospital association, both on site and at state CAH conferences and hospital network events. At the conclusion of the year, leadership was more stable and more skilled, and the board's self-assessment scores had improved by an average of 37%.

## **Strategic Planning**

Developing a comprehensive business plan became a primary emphasis of the hospital leadership. Dramatic change needed to be outlined to convince a regional economic development authority to loan the hospital \$500,000 to finance their turn around. The authority had been approached previously, but the hospital had not been able to secure a loan without a solid business plan. Through the aid of a Flex-supported consultant, the loan was secured two months after the state Flex Program visit and it helped to finance the subsequent activities and development. The new CMH plan has a compelling vision statement and clear, measurable strategies that are shared with every staff person. Staff are encouraged to identify where they could personally contribute to the vision and strategies, and empowered to be ambassadors for the hospital to the community.

## **Patients, Partners and Population Health**

CMH invested in a community assessment in the first three months after the state Flex Program visit and held a series of community engagement events, including a community forum, focus groups and community education events with the county public health educator. CMH staff visited schools, senior citizen events and opened up an ongoing dialog with other types of providers in the community. Through these community-based initiatives, CMH cut outmigration for care rates by 25% during the first year and significantly increased its volume of outpatient services and inpatient volume by 15%. Patient satisfaction scores were reported through HCAHPS, and customer service training for staff helped bring CMH up to the 50<sup>th</sup> percentile for CAHs by the end of the year. The Flex Coordinator provided support with quality reporting to MBQIP and benchmarking. In preparation for population-

based payments, CMH also began a wellness program for their employees. Although measureable outcomes were not available at the end of Year 1, staff gave the program high marks in their employee satisfaction scores.

### **Measurement, Feedback and Knowledge Management**

CMH not only reported MBQIP data, but also began to participate in a state-wide quality and financial benchmarking program initiated by the state hospital association. They used a Balanced Scorecard to record and communicate their quarterly progress toward strategic goals, and made mid-course corrections as appropriate. Information became closely linked to continuous performance improvement. Education was provided to managers and leaders on how to use data to drive performance, and perhaps, most importantly, hospital staff stopped collecting a great deal of information that seemingly had no purpose. That left most of the remaining information either actionable or data required by the state or federal government for compliance.

### **Workforce and Culture**

Recognizing the need for assistance with culture change and change management, CMH hired a national firm and instituted a prescribed program to build individual accountability, change-readiness and customer service excellence. Included in this program was a staff satisfaction and physician satisfaction survey that provided leaders with crucial information on staff readiness for change, as well as progress to documentation of value. Staff education became a priority. Investment in staff training more than doubled from the prior year as well as accessing state Flex program opportunities. CMH worked hard to launch new partnerships with their physicians and followed up diligently on suggestions from the provider satisfaction scores. The first year scores provided a benchmark for improvement in provider relationships in subsequent years.

### **Operations and Processes**

The state Flex Program provided direct, expert technical assistance to CMH via a consultant to institute a revenue cycle management program that reduced days in Accounts Receivable (AR) from 101 to 53 in the first year. This improvement alone brought in an additional \$1M of revenue. Additional process improvements to the business office brought in additional revenue and, combined with greater volume, allowed the hospital to achieve a positive operating margin by the end of the first year. Quality improvement initiatives were emphasized and the hospital became an active participant in a Flex-sponsored quality network of CAHs. Through network sharing and implementation of patient safety and quality initiatives, as well as full support from CMH leadership, quality scores for CMH improved for most MBQIP measures by at least 10%. Another important initiative that benefitted both quality

and finance was the introduction of Lean methodology. The hospital began slowly with an introduction to the ED staff, but by the end of the first year had spread the training and implementation to a third of the hospital departments. Documentation noted that the ED had reduced patient waiting time by 34% and saved staff time as well.

### **Impact and Outcomes**

Thanks to the attention and support from the state Flex Program:

- CMH leadership was stabilized
- A comprehensive strategic plan was developed and implemented
- Bridge financing was accessed
- A change ready, patient-centered culture began to be instilled
- The community was assessed and engaged
- Actionable data was produced, shared with staff and publically reported
- Financial and quality processes were improved
- Lean process improvement approach was implemented

The hospital was well positioned to move forward into an uncertain future, confident that it could provide value and serve its citizens in whatever healthcare environment it faced.

## **APPENDIX:**

### **List of Best Practices and Resources**

#### **Leadership**

A Blueprint for Rural Hospital Performance Excellence – manual

<http://www.ruralcenter.org/tasc/resources/critical-access-hospital-blueprint-performance-excellence>

A Blueprint for Rural Hospital Performance Excellence: One Hospital's Baldrige Experience – webinar <http://www.ruralcenter.org/rhpi/playback/5368>

ACA Marketplace Resources – webinar

<http://www.ruralcenter.org/rhpi/playback/5280>

Board Self-Assessment Guide – document

<http://www.ruralcenter.org/tasc/resources/board-self-assessment-guide>

Building Commitment through Group Decision Making – presentation and document

<http://www.ruralcenter.org/rhitnd/aim-for-impact>

Engaging Stakeholders During Times of Change and Transition – presentation  
<http://www.ruralcenter.org/rhitnd/aim-for-impact>

FAQs regarding Creating a Culture of Safety: A Board Assessment Tool – document  
<http://www.ruralcenter.org/tasc/resources/faqs-regarding-creating-culture-safety-board-self-assessment-tool>

Four Guiding Principles for Healthcare Managers – webinar  
<http://www.ruralcenter.org/rhpi/playback/4927>

Future Hospital Finance Panel – recording  
<http://www.ruralcenter.org/rhpi/pmg/playback/5222>

Leadership During Change – presentation <http://www.ruralcenter.org/rural-hit-network-development/resources/leadership-during-change>

Rural Hospital Quality Leadership Summit: Building and Sustaining Quality Leadership in Rural Hospitals – manual  
<http://www.ruralcenter.org/tasc/resources/rural-hospital-quality-leadership-summit-building-and-sustaining-quality-leadership-r>

Strategies for CAH Success in the New Healthcare Market – recording  
<http://www.ruralcenter.org/rhpi/pmg/playback/4972>

Texas Critical Access Hospital Trustee Resource Manual – manual  
<http://www.ruralcenter.org/tasc/resources/texas-critical-access-hospital-trustee-resource-manual>

The (Rural Hospital) Governance Workbook – document  
<http://www.ruralcenter.org/tasc/resources/rural-hospital-governance-workbook>

Wyoming Healthcare Leadership Training Program – presentation  
<http://www.ruralcenter.org/tasc/resources/healthcare-leadership-training-program>

## **Strategic Planning**

Affiliations: Everyone' doing it, do we? – webinar  
<http://www.ruralcenter.org/rhpi/playback/5098>

Applying Community Health Assessments for Rural Hospital Strategy – presentation  
<http://www.ruralcenter.org/tasc/resources/applying-community-health-assessments-rural-hospital-strategy>

Balanced Scorecards for Small Rural Hospitals: Concept Overview and Implementation Guidance – document  
<http://www.ruralcenter.org/tasc/resources/balanced-scorecards-small-rural-hospitals-concept-overview-and-implementation-guidanc>

Baldrige Framework used to Address Flex Program Challenges – presentation  
<http://www.ruralcenter.org/tasc/resources/baldrige-framework-used-address-flex-program-challenges>

Four Performance Management Tools: An Overview of Balanced Scorecard, Baldrige, Lean and Studer – document  
<http://www.ruralcenter.org/tasc/resources/four-performance-management-tools-overview-balanced-scorecard-baldrige-lean-and-stude>

Leadership and Balanced Scorecard Development – presentation  
<http://www.ruralcenter.org/rhci/pmg/playback/5285>

Making Performance Work in Rural Hospitals – presentation  
<http://www.ruralcenter.org/tasc/resources/making-performance-work-rural-hospitals>

Pinckneyville Community Hospital Celebrates Accomplishments from Balanced Scorecard Development – hospital story  
<http://www.ruralcenter.org/rhci/spotlight/5221>

Sample HIT Network Balanced Scorecard – document  
<http://www.ruralcenter.org/rural-hit-network-development/resources/sample-hit-network-balanced-scorecard>

Strategic Planning at North Sunflower Medical Center – webinar  
<http://www.ruralcenter.org/rhci/pmg/playback/5488>

Strategies for CAH Success in the New Healthcare Market – webinar  
<http://www.ruralcenter.org/rhci/playback/5060>

## **Community, Customers and Population Health**

Basics of HCAHPS – webinar <http://www.ruralcenter.org/rhci/playback/basics-hcahps>

Creating Value Through Collaborations – webinar  
<http://www.ruralcenter.org/rhci/playback/4957>

Community Care Coordination – webinar  
<http://www.ruralcenter.org/rhci/playback/community-care-coordination>

Community Health Needs Assessment Toolkit – document  
<http://www.ruralcenter.org/tasc/resources/community-health-needs-assessment-toolkit>

Franklin Medical Center Improves HCAHPS and Core Measures – hospital story  
<http://www.ruralcenter.org/rhpi/spotlight/franklin-medical-center-improves-hcahps-and-core-measures>

Hospital Consumer Assessment of Healthcare Providers and Systems Overview: Vendor Directory – document <http://www.ruralcenter.org/tasc/resources/hospital-consumer-assessment-healthcare-providers-and-systems-overview-vendor-directo>

Hospital Survey on Patient Safety Culture – document  
<http://www.ruralcenter.org/tasc/resources/hospital-survey-patient-safety-culture>

Illinois Critical Access Hospitals: Managing Healthy Communities in Rural Illinois – document <http://www.ruralcenter.org/tasc/resources/illinois-critical-access-hospitals-managing-healthy-communities-rural-illinois>

Implementing Best Practices for Patient Engagement and Satisfaction – document  
<http://www.ruralcenter.org/tasc/resources/implementing-best-practices-patient-engagement-and-satisfaction>

Improving Population Health: A Guide for Critical Access Hospitals – manual  
<http://www.ruralcenter.org/tasc/resources/improving-population-health-guide-critical-access-hospitals>

IRS Compliance: Community Benefits Reporting – presentation and document  
<http://www.ruralcenter.org/rhpi/pmg/playback/4971>

Maintaining Collaboration through Transitions – webinar  
<http://www.ruralcenter.org/rural-hit-network-development/resources/collaboration-series-maintaining-collaboration-through>

Managing Population Health: The Role of the Hospital – document  
<http://www.ruralcenter.org/tasc/resources/managing-population-health-role-hospital>

Methods for Building Effective Community Partnerships - presentation  
<http://www.ruralcenter.org/community-health-assessments/resources/methods-building-effective-community-partnerships>

Moving HCAHPS Into Practice in CAHs – webinar  
<http://www.ruralcenter.org/tasc/events/webinar-moving-hcahps-practice-cahs>

Navigating Community Health Assessments – document  
<http://www.ruralcenter.org/consulting-services/resources/navigating-community-health-assessments>

PPACA Tax Exempt Hospital Status Requirements: 9007- document  
<http://www.ruralcenter.org/tasc/resources/ppaca-tax-exempt-hospital-status-requirements-9007>

Population Health – presentation  
<http://www.ruralcenter.org/rhci/pmg/playback/population-health>

Realizing Rural Care Coordination: Considerations and Action Steps for State Policy-Makers – document <http://www.ruralcenter.org/tasc/resources/realizing-rural-care-coordination-considerations-and-action-steps-state-policy-makers>

Reeves Memorial Medical Center Focusing on Chronic Disease Program to Decrease Readmissions – hospital story <http://www.ruralcenter.org/rhci/spotlight/5218>

Resources for Implementing the Community Health Needs Assessment Process – document <http://www.ruralcenter.org/tasc/resources/resources-implementing-community-health-needs-assessment-process>

Rural Care Coordination Toolkit – document  
<http://www.ruralcenter.org/tasc/resources/rural-care-coordination-toolkit>

Rural Hospital Network Summit Summary – manual  
<http://www.ruralcenter.org/tasc/resources/rural-hospital-network-summit-summary>

Rural Hospitals on the Brink: An Rx for Population Health – webinar  
<http://www.ruralcenter.org/rhci/playback/5284>

Sparta Community Hospital Improves Care Transitions – hospital story  
<http://www.ruralcenter.org/rhci/spotlight/5486>

Union General Hospital Increases Outreach with Community Health Needs Assessment Project – hospital story  
<http://www.ruralcenter.org/rhci/spotlight/5249>

Union General Hospital's Customer Service Training – hospital story  
<http://www.ruralcenter.org/rhci/spotlight/4980>

Using Health IT to Improve Care Transitions – webinar and toolkit  
<http://www.ruralcenter.org/rhci/playback/using-health-it-improve-care-transitions>

Using Hospital Consumer Assessment of Healthcare Providers and Systems (HCAHPS) to Drive Patient and Employee Satisfaction -webinar and document  
<http://www.ruralcenter.org/ship/archive/hospital-webinars>

Utah Rural Hospital and Community Healthcare Needs Assessment Survey – document <http://www.ruralcenter.org/tasc/resources/utah-rural-hospital-community-healthcare-needs-assessment-survey>

## **Measurement, Feedback and Knowledge Management**

Data Analytics: Preparing for Managing Population Health – webinar  
<http://www.ruralcenter.org/rural-hit-network-development/playback/data-analytics-preparing-managing-population-health>

Increasing Patient Satisfaction Scores – webinar  
<http://www.ruralcenter.org/rhpi/playback/4930>

Becoming a Patient Focused but Metrics Driven Revenue Cycle Team – webinar  
<http://www.ruralcenter.org/rhpi/playback/becoming-patient-focused-metrics-driven-revenue-cycle-team>

## **Workforce and Culture**

Conducting Hospital Employee Satisfaction Surveys – document  
<http://www.ruralcenter.org/minnesota-web-recruitment/resources/conducting-hospital-employee-satisfaction-surveys>

Culture Management – webinar and document  
<http://www.ruralcenter.org/rhpi/spotlight/4982>

How to Ensure Departmental Revenue Cycle Accountability and Ownership – webinar <http://www.ruralcenter.org/rhpi/playback/4953>

Improving Hospital Patient Safety Through Teamwork: The Use of TeamSTEPPS in Critical Access Hospitals –document  
<http://www.ruralcenter.org/tasc/resources/improving-hospital-patient-safety-through-teamwork-use-teamstepps-critical-access-hos>

Primary Care Options –recording  
<http://www.ruralcenter.org/rhpi/pmg/playback/4969>

Rural Hospital Change Management – webinar  
<http://www.ruralcenter.org/rhpi/playback/4954>

TeamSTEPPS: National Implementation – website <http://teamstepps.ahrq.gov/>

## **Operations and Processes**

Account Management: Move from Denial Management to Denial Avoidance with Process Improvement – recording

<http://www.ruralcenter.org/rhpi/playback/account-management-move-denial-management-denial-avoidance-process-improvement>

Assessment and Process Improvements for Case Management – presentation  
<http://www.ruralcenter.org/rhpi/playback/4955>

Best Practice Business Office Policies and Procedures – webinar  
<http://www.ruralcenter.org/rhpi/playback/4951>

Building Your Quality Program – webinar  
<http://www.ruralcenter.org/rhpi/playback/5537>

CAH Financial Management – webinar  
<http://www.ruralcenter.org/rhpi/playback/5463>

Care Management and Transitions of Care Process Improvement – presentation  
<http://www.ruralcenter.org/rhpi/pmg/playback/5108>

Chargemaster Fundamentals for a Solid Revenue Cycle Foundation – webinar  
<http://www.ruralcenter.org/rhpi/playback/4950>

Critical Access Hospital 2012 Financial Leadership Summit Summary – document  
<http://www.ruralcenter.org/tasc/resources/critical-access-hospital-2012-financial-leadership-summit-summary>

Critical Access Hospital Finance 101 Manual – document  
<http://www.ruralcenter.org/tasc/resources/critical-access-hospital-finance-101-manual>

Critical Access Hospital Financial Performance Indicators – document  
<http://www.ruralcenter.org/tasc/resources/critical-access-hospital-financial-performance-indicators>

Financial and Operational Assessments – webinar  
<http://www.ruralcenter.org/rhpi/pmg/playback/4973>

Flex Financial and Quality Reports: Making Sense for CAHs – presentation  
<http://www.ruralcenter.org/tasc/resources/flex-financial-and-quality-reports-making-sense-cahs>

Holmes County Hospital and Clinics Uses Lean to Improve Emergency Department – hospital story <http://www.ruralcenter.org/rhpi/spotlight/5219>

How to Create a Defensible Pricing Strategy –webinar  
<http://www.ruralcenter.org/rhpi/playback/4952>

LaSalle General Hospital's Strategic, Financial and Operational Assessment – hospital story <http://www.ruralcenter.org/rhci/spotlight/4978>

Madison Medical Center's Strategic, Financial and Operational Assessment – hospital story <http://www.ruralcenter.org/rhci/spotlight/4981>

Medical Center Barbour Prepares for the Future with Financial and Operational Assessment – hospital story <http://www.ruralcenter.org/rhci/spotlight/medical-center-barbour-prepares-future-financial-and-operational-assessment>

Methodist Hospital Union County Seeking to "Super Satisfy" Patients with Emergency Department Operations Assessment Project – hospital story <http://www.ruralcenter.org/rhci/spotlight/5331>

Keeping your Patient at the Heart of your Revenue Cycle – webinar  
<http://www.ruralcenter.org/rhci/playback/keeping-your-patient-heart-your-revenue-cycle>

Muhlenberg Community Hospital's ED Operational Assessment – hospital story <http://www.ruralcenter.org/rhci/spotlight/4977>

Nevada Rural Hospital Revenue Cycle Initiative – document  
<http://www.ruralcenter.org/tasc/resources/nevada-rural-hospital-revenue-cycle-initiative>

Overview of Lean - webinar and document  
<http://www.ruralcenter.org/ship/archive/hospital-webinars>

Pennsylvania's Lean Outreach – document  
<http://www.ruralcenter.org/tasc/resources/pennsylvanias-lean-outreach>

Revenue Cycle Management in a Critical Access or Small Rural Hospital – presentation <http://www.ruralcenter.org/tasc/resources/revenue-cycle-management-critical-access-or-small-rural-hospital>

Richland Parish Hospital Experiencing Important Outcomes from a Business Office Assessment Project – hospital story  
<http://www.ruralcenter.org/rhci/spotlight/5217>

St. James Parish Hospital's Lean Project a Success – hospital story  
<http://www.ruralcenter.org/rhci/spotlight/5403>

Top 10 Cost Reporting Errors – document  
<http://www.ruralcenter.org/tasc/resources/top-10-cost-reporting-errors>

## **Website of all Recorded Events and Materials**

<http://www.ruralcenter.org/tasc/content/2014-flex-conference-webinar-series-recordings-and-materials>