

# 2018 Rural Hospital and Clinic Financial Summit Report

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## Key Financial Success Indicators and Strategies

Bloomington, MN

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## PREFACE

With the support of the [Federal Office of Rural Health Policy \(FORHP\)](#), the [National Rural Health Resource Center \(The Center\)](#) developed this report following a summit of key rural hospital and clinic stakeholders to identify the most important financial indicators and strategies to transition to value-based payment. This report is designed to help rural hospitals and clinic leaders meet this transition with financial success. First, the report identifies the indicators of financial success for hospitals and clinics. Second, it provides key strategies that providers may deploy to transition successfully into value-based payment models. Third, the report highlights success stories shared by the Summit participants as well as resources needed by hospitals and clinics. The report is also intended to assist state Medicare Rural Hospital Flexibility (Flex) Programs and state offices of rural health (SORH) by offering timely information to assist them in developing tools and educational resources that support their hospitals and networks as they transition to value-based payment models. This report builds upon the knowledge gained from the [Critical Access Hospital 2012 Financial Leadership Summit](#) and includes key strategies discovered through the [Small Rural Hospital Transition \(SRHT\) Project's Rural Hospital Toolkit for Transitioning to Value-Based Systems](#)

The information presented in this report is intended to provide the reader with general guidance. The materials do not constitute, and should not be treated as, professional advice regarding the use of any technique or the consequences associated with any technique. Every effort has been made to assure the accuracy of these materials. The Center and the authors do not assume responsibility for any individual's reliance upon the written or oral information provided in this guide. Readers and users should independently verify all statements made before applying them to a situation and should independently determine the correctness of any strategy before recommending the technique to a client or implementing it on a client's behalf.

## INTRODUCTION

In 2012, The Center, with funding from the Health Resources and Services Administration's Federal Office of Rural Health Policy, (FORHP) brought a small group of critical access hospital (CAH) financial leaders and experts together to address issues related to CAH financial performance. This first [CAH Financial Summit Meeting](#) produced a list of the key CAH financial indicators and accompanying information about the measures, including definitions, benchmarks, and why these financial measures were more important than others. In May 2018, The Center convened a second Finance Summit to revisit the key indicators for financial success in the transition to value-based payment models.

The findings of the [2012 Finance Summit](#) included the identification of significant financial improvement interventions recommended to optimize the financial performance of CAHs. These included financial and operational assessments, revenue cycle management, physician practice management assessments, and education for hospital boards, department managers, and senior hospital leaders. The CAH Financial Leadership Summit Summary was disseminated to all state Flex programs, many rural hospitals, state rural health organizations, and financial consulting groups. The report became a useful tool and resource over the intervening years and was used by state Flex programs as a supplement to the research information provided by the University of North Carolina's Rural Health Research Center, a partner in the Flex Monitoring Team and was also used by financial consulting groups in their work with rural hospitals. Annually, the Summit Summary was updated with new benchmarks and supplemental information.

Since 2012, a significant shift has occurred in hospital payment programs nationwide, with Medicare, Medicaid, and private insurance payers transitioning from payment for procedures to payment for value and population health management. In these new payment models, high quality outcomes and affordable costs are rewarded with shared savings. In addition, hospitals are given the larger responsibility of helping to manage the general health of their populations. While CAHs have been largely exempt from the requirements of these new value programs, hundreds have become part of the new payment models like Accountable Care Organizations (ACOs), and many others are preparing to be part of value and population health models in the future.

The new payment programs and circumstances prompted The Center to convene a 2018 Summit to reexamine the 2012 financial indicators, assess whether they were still important, and determine whether other rural hospital performance indicators might be identified that would be critical for future rural hospital as well as rural health clinic financial success. This Summit convened in Bloomington on May 22 and 23, 2018, was jointly sponsored by the Center's Technical Assistance and Services Center (TASC) Program and the Small Rural Hospital Transition Program (SRHT), both funded by FORHP.

## Summit Participants

The Summit participants consisted of nationally recognized rural hospital and clinic field experts, including a chief executive officer (CEO) and a hospital network director from critical access hospitals (CAHs), SORH leaders, financial consultants, Flex programs and the Flex Monitoring Team. The 2018 Financial Leadership Summit Participants include the following field experts (Refer to [Appendix A](#) for contact information).

- John Barnas, Executive Director at Michigan State Office of Rural Health, Flex Program
- Steve Barnett, President and CEO of McKenzie Health System, Michigan CAH
- Brian Bertsch, Partner at Eide Bailly
- Jane Jerzak, Partner-Health Care Practice at Wipfli
- Jack King, Flex Director of Montana Hospital Association, Flex Program
- Jeanene Meyers, Small Rural Hospital Transitions Project Program Coordinator at Federal Office of Rural Health Policy
- Jonathan Pantenburg, Senior Consultant at Stroudwater
- Kristine Reiter, Professor and Associate Chair of University of North Carolina, Flex Monitoring Team
- Tim Size, Executive Director of Rural Wisconsin Health Cooperative
- Karla Weng, Senior Program Manager at Rural Health Value/Stratis Health
- Sarah Young, Flex Program Coordinator at Federal Office of Rural Health Policy

## SUMMIT PROCEEDINGS AND OUTCOMES

### Key Observations on the Transition to Value for Rural Hospitals and Clinics

The Summit began with a review of the [2016 Rural Hospital Financial Leadership Summit Report](#) convened by The Center through the Small Rural Hospital Transition Program. The participants shared significant rural health care market changes from their perspective.

- The Centers for Medicare and Medicaid (CMS) is moving to value-based programs<sup>1</sup>
- Frameworks, such as the *Blueprint for Performance Excellence* are important in the transition to value for small rural hospitals and clinics
- In the value formula – cost and efficiency are key for rural hospitals and clinics and must be maximized under cost-based reimbursement prior to the move to value-based payment models
- The level of participation in value-based payment models varies across small rural hospitals nationally. The speed of adoption is impacted by state Medicaid programs, system ownership and employment of physicians
- Small rural hospital partners are changing with the transition to population health and now include community agencies, employers, regional provider networks and larger systems
- See Article: [RWHC Commentary: May 2018, Whose Values in the Volume to Value Transition?](#) By Tim Size, Executive Director, Rural Wisconsin Health Cooperative
- Managing to the whole person and providing care with ample support is key. Rural providers, through family medicine, can provide lowest cost and highest quality of care where the patient lives – many rural ACOs don't manage the whole patient in their communities. They don't have the right tools and support
- Economic factors of patients are important for hospitals. Social determinants of health (SDOH) are related to health access and outcomes

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<sup>1</sup> Centers for Medicare and Medicaid (2018). Value-Based Programs. Retrieved from: <https://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/Value-Based-Programs/Value-Based-Programs.html>.

- Population health – need to define who is responsible for the patients – what about those who aren't patients yet attributed to rural hospital/clinic for care
- All patients should receive the same process of care regardless of who is payer
- Rural hospitals may not fully appreciate the significance of attribution or the medical specialty they represent; primary care. The primary care and community need to be supportive of the local hospital
- Provider compensation needs to be aligned with the value care model
- Provider and staff satisfaction is critical and viewed as the 4<sup>th</sup> Aim along with cost, quality and health outcomes
- Rural hospitals need to demonstrate efficiency to the tertiary facilities and determine which ones to work with. Identify indicators that allow us to demonstrate value

The Summit participants confirmed the importance of the original ten financial indicators, identified in 2012, but suggested another 21 measures for rural hospitals to consider in transitioning to value-based payments. They asserted that many of these measures, though not truly financial, would be strongly correlated with financial performance in the future. Many of these new measures were “lead indicators”, predicting future financial success, rather than the “lag indicators”, traditionally associated with financial reports, which describe hospital performance in the immediate past. According to Harvard Business School<sup>2</sup> leaders and other financial experts, successful organizations today need a combination of lead and lag indicators; one set to assess past performance and chart progress toward strategic goals, and another set of indicators to measure the amount of investment into staff, technology, partnerships, education and other intangible assets. Summit participants recommended that rural hospitals need to make substantial investments into these latter types of assets, to successfully navigate the profound changes that are occurring in their environments. Although these investments and measures are not directly associated with costs, they are intended to produce positive financial results in the new value-based payment model.

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<sup>2</sup> Likierman, Andrew, [The Five Traps of Performance Measurement](#), (2009, October), Harvard Business Review.

## Critical Access Hospital Top 10 Financial Indicators Review

Financial indicators closely aligned with financial strength can be used to determine the financial status of a small rural hospital or rural health clinic. Financial indicators, often ratios, combine line items from the balance sheet, statement of operations and/or statement of cash flows in a meaningful way to help interpret strengths or weaknesses in operations or financing activities. Examining these ratios over time can help determine an organization's future trajectory or momentum.

Table A below displays each of the 2012 Summit Report Top 10 Financial Indicators with the 2019 CAH US medians as listed in the CAH Financial Indicators Report,<sup>3</sup> distributed by the Flex Monitoring Team in April 2020. Each indicator has an indication if favorable values are above or below the median.

**Table A. CAH Financial Indicator Medians, 2019**

CAH Financial Indicator	2019 U.S. Median	Favorable Trending
Days in Net Accounts Receivable	50.54	Down
Days in Gross Accounts Receivable	47.57	Down
Days Cash on Hand	71.23	Up
Total Margin	2.40%	Up
Operating Margin	0.72%	Up
Debt Service Coverage	3.95	Up
Salaries to Net Patient Revenue	45.39%	Down
Medicare Inpatient Payor Mix*	69.80%	Down
Average Age of Plant (years)	12.28	Down
Long Term Debt to Capitalization	29.97%	Down

\* Summit participants agreed Overall Payor Mix was a more comprehensive indicator of financial performance than Medicare Inpatient Payor Mix alone. Source: Flex Monitoring Team CAH Financial Indicators Report, April 2021.

A definition, formula, and benchmarks for each of the 10 most important indicators of small rural hospital and provider-based rural health clinic financial performance is provided in the [Small Rural Hospital and Clinic Finance 101 Guide](#). Each indicator also includes an example data table,

<sup>3</sup> Flex Monitoring Team, University of Minnesota; University of North Carolina at Chapel Hill; University of Southern Maine. <https://www.flexmonitoring.org/publication/cah-financial-indicators-report-summary-2019-indicator-medians-state> (2021, April).

which is meant to be used as a reference when calculating these ratios for a specific hospital or clinic.

## KEY INDICATORS FOR RURAL HOSPITALS AND CLINICS IN VALUE FORMULA

Through a consensus workshop facilitated by Center staff, Summit participants shared key performance indicators (KPI) for small rural hospitals and clinics to achieve successful financial performance while transitioning to value-based payment systems. In addition to the 10 financial indicators, additional factors were revealed, and participants noted that it was critical to have a core set of non-traditional financial metrics. They stated it was important to include the whole community and go upstream to achieve success in a value-based payment system by employing care coordination and medical home models reflective of the population's health. Summit participants grouped the indicators into eight themes, summarized below.

### Performance Indicator Themes

#### Market Indicators

- Market share
- Outmigration rates
- Number of attributed lives
- Number of unique patients
- Level of integration

#### Financial Performance and Conditions

- Liquidity
  - Current ratio or average payment

#### Operational Efficiency

- Average cost per clinic visit
- Productivity rates for primary care practitioners - visits
- Minimum productivity requirements for rural health clinics

#### Workforce

- Provider and staff engagement
- Number of primary care practitioners in service area

- Staff satisfaction scores
- Primary care practitioner information
  - Retention rates to track turnover
  - Provider satisfaction scores
  - New market growth rates

### **Quality Performance**

- Quality core measures and/or HCAHPS

### **Care Management**

- Skilled Nursing Facilities (SNF), Home Health and Durable Medical costs
- Behavioral and mental health screening rates

### **Community health**

- SDOH and County Health Rankings
- Hierarchical Condition Coding score (accounting for chronic conditions)
- Percent of primary care provider contracts containing population health activities
- Patient costs and other factors (time, travel, copay, deductibles, lost wages)

### **Organizational attributes**

- Tertiary provider quality and cost scores (if a choice/health plan ownership); reciprocal relationship with tertiary provider
- System affiliation
- Employed staff and providers vs independent or contracted

These themes are defined in the [Small Rural Hospital and Clinic Finance 101 Guide](#), updated September 2021. Resources are included in Appendix B to identify data sources, benchmarks and examples of implementation. Some of these indicator themes are concepts without precisely defined measures and targets. Others do have precise definitions and national or state level data for benchmarking.

## **STRATEGIES FOR FUTURE FINANCIAL SUCCESS**

The participants were asked to identify strategies within each cluster of indicators that lead to the financial success of rural hospitals and clinics in

the transition to value and population health. These strategies can assist leaders in developing a plan to improve, or at least sustain, the hospital's financial position during the transition between payment systems. Rural health providers and leaders will require a comprehensive strategic plan that would include many if not most of these strategies to guide their hospitals through the transition process. Applications of the financial strategies by the Summit participants are included in Appendix C, as well as identified resources needed for implementation.

## Market Indicators

Maximizing market share is an essential component of the transition to a value strategic framework. With an industry wide reduction of inpatient census, rural hospitals must maximize their outpatient activities to maintain a positive margin. This generally requires minimizing the out-migration for services of potential customers and patients for health services that could otherwise be done locally. Assessment of reasons for out-migration will suggest appropriate initiatives. Strategies also include obtaining claims data from major payers and conducting data analysis to identify population health needs and provider costs. These strategies are particularly important in value-based payment models, where providers take on the responsibility for cost and quality of the patients, also referred to as 'attributed lives'. It is important to assess the services and costs within the preferred tertiary network.

## Financial Performance and Conditions (liquidity)

One of the most urgent strategies for rural hospitals preparing for the transition to value and population-based payment systems is to maximize the efficiency of their current hospital processes and operations in their fee for service or cost-based reimbursement systems. Eliminating waste, maximizing quality and patient satisfaction, and generally being as efficient as possible are critical success factors in emerging alternative payment models. Therefore, it is imperative that leaders begin immediately to position their hospital to successfully transition into the next phase of value-based reimbursement. Rural hospitals that lag in the planning process may eventually become financially unstable. Hospitals and clinics that do not have a cash reserve may lack the resources to invest in the various strategies needed to successfully transition into the new payment systems

and care delivery models. Initiatives for financial strategies include implementing a revenue cycle committee, establishing a management reporting system, and increasing financial education to hospital department leads.

## Operational Efficiency

Maximizing the efficiency of business, clinical, and operational processes is a prerequisite for successful value payment. Using Lean and other process improvement and tracking tools, rural hospitals can reduce the waste of resources, produce optimal business office performance, streamline patient flow through the entire care delivery system, introduce new medical and information technology, and quantify both cost savings and quality improvements. An important operational component for value-based payment is accurate risk scoring which occurs from the hierarchical condition coding (HCC) to identify patient conditions. Rural providers have often failed to document all the patient's conditions, therefore generating lower HCC scores which give the impression to payers that the patients are healthier than they are.

## Workforce

The historic workforce challenge for rural hospitals takes on new urgency in the value-based payment systems. Hospitals and clinics are increasingly challenged to recruit and retain needed providers, nurses, therapists, and technicians and, in addition, they now face the task of preparing this workforce for major changes in service delivery that accompanies the changes in payment. New types of service providers are also needed for information management, care coordination, chronic illness management, telehealth, and population health management. Moreover, the workforce available to provide health care will shrink within the next 10 years in proportion to the population over age 65 which puts a stronger reliance on family caregivers. Strategies for strong workforce performance include ensuring staff engagement into care coordination while maintaining staff satisfaction. Rural facilities benefit from early recruitment to "grow your own" by providing experience and education in local schools for information technology, emergency medical services, and nursing.

## Quality Performance

Providing excellent quality health care has always been the right thing to do for patients, but now it is also a requirement for excellent financial performance in value-based payment models. With quality outcomes and patient satisfaction being a significant factor in the formula for health services, continuous quality improvement, effective transitions of care, and patient safety become major drivers of hospital financial performance. Publicly reporting quality data and promoting quality scores are key value-based strategies. Successful rural facilities will build value-based performance into provider contracts and integrate evidence-based medicine.

## Care Management

Since providers in value-based payment models now have a responsibility for the comprehensive care and cost of their patients, care management becomes an essential component of new service delivery models. These models include not only traditional in-patient and out-patient care, but also bring in rehabilitation, long term care, home care, hospice, behavioral health care, and even prevention and wellness activities. Managing the transitions of care between these various services and partners becomes an important responsibility of the hospitals and providers (the entity being paid), and generally results in lower costs and improved quality, especially for patients with chronic diseases through care redesign and/or Patient Centered Medical Home (PCMH) certification. Education and training are needed for the board, providers and staff

## Community Health

Hospitals and clinics play an important role in a value-based payment system by pro-actively working on measurably improving the health of their community. This new responsibility is usually shared with public health providers but is most effective when it also includes working with other types of community providers and community leaders. Keeping patients well and keeping their care local therefore becomes an important strategy for rural providers and hospitals in the new value-based payment systems. Strategies may include a defined set of the population based on location or condition. In both scenarios, prevention through multi-sector collaboration is also key to reduce the need for high-cost care. Hospitals can be the

convener and therefore the coordinator of all the care rather than just a contributor.

## Organizational Attributes

As the health care industry changes and becomes more complex, it is important for rural hospitals to collaborate with other organizations in various types of formal and informal partnerships. These partners may include larger tertiary centers or other rural hospitals, but the goals are to maximize efficiency, gain access to needed expertise, and produce value in the new payment systems. Two key items overarching all strategies for rural health organizations are understanding 'my' data and making it actionable, as well as advocating for rural policies.

## CONCLUSION

Small rural hospitals and clinics must address current financial challenges while transitioning to the value-based payment and population health care models. This Report, a product of the 2018 Finance Summit meeting, has suggested a comprehensive list of indicators, strategies, applications and resources that are beneficial to hospitals, provider-based rural health clinics, payers, networks and state Flex Programs. It will be important to closely monitor the financial performance of hospitals and clinics to document the outcomes of specific financial improvement interventions with varying participation in value-based payment systems. State Flex Programs will be an important resource to support rural hospitals in the anticipated transition to a value-based health system.

## APPENDIX A

### Participant Contact List

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## APPENDIX B

### Key Performance Indicator Resources

- [2017 Rural Hospital Value-Based Strategic Summit: BSC & Strategy Map Templates](#). The Summit was held to provide leaders with templates that improve organizational planning, strengthen actionable steps and operationalize key strategies to effectively transition to value
- [Flex Monitoring Team](#). Assesses the impact of the Flex Program on rural hospitals and communities and the role of the states in achieving overall program objectives
- [Transition Toolkit: Financial and Operational Strategies](#) for best practice tools and key performance indicators (KPI) to increase operational efficiencies and improve financial stability, and resources to minimize risk or optimize benefit relative to VBM
- [Transition Toolkit: Revenue Cycle Management \(RCM\) and Business Office \(BO\) Best Practice](#) tools and KPI to improve RCM performance and BO processes
- [Transition Toolkit: Quality Improvement](#) for best practice tools on care management, HCAHPS, and patient and family engagement
- [Quality Improvement Implementation Guide and Toolkit for CAHs](#) offers strategies and resources to help CAH staff organize and support efforts to implement best practices for quality improvement
- [Transition Toolkit: Physician and Provider Engagement and Alignment](#) resources support participation in Accountable Care Organizations (ACO) and Shared Saving (SS) Programs
- [Rural Health Value \(RHV\)](#) for resources on rural health transformation
- [Population Health Portal Readiness Assessment](#) for resources and educational modules to support population health planning
- [Rural Health Information Hub \(RHIHub\) Evidence-Based Toolkits for Rural Community Health](#) for step-by-step guides to effective community health planning to include resources and examples that are drawn from evidence-based and promising programs

## APPENDIX C

### Applications of Financial Strategies

Each participant shared how his/her organization would execute an intervention strategy and/or action for one of the top financial indicators.

### Financial Performance and Conditions

#### **Leverage reimbursement advantage available to rural providers**

- Improve financial solvency using Health Professional Shortage Area (HPSA) scores, cost-based method II billing for rural health clinics, with high efficiency.
- Understand data and leverage reimbursements. Rural health clinics need to be strategically located with CAHs. Implement board education. Tracking provider productivity and rural health clinic locations. Look at swing bed census data.

### Market Indicators

#### **Network adequacy standards for health plans**

- The Rural Wisconsin Health Cooperative (RWHC), brought together providers, specialists and hospitals. They also created an adequacy council and developed a set of market principles including choice and affordability
- RWHC proposed a draft for health plans and facilitated consumers sharing stories with health commissioner
- Look at essential community providers to ensure local rural communities are represented. Address outmigration in rural communities for health care. Wisconsin has many provider-owned health plans, more Medicare Advantage and less ACOs.
- Systems are asking for help to understand rural sites

## Quality, Care management, Workforce

### **Stakeholder engagement, care redesign**

- Communities can bring together partners to develop palliative care services in rural communities to help address care for those with complex care needs.
- Educate board and staff to address financial issues and leverage reimbursement advantages available to rural providers.
- Establish culture open to change management for improvement. Physician champions are needed with allocated time for workflow redesign, care teams and electronic health records (EHR)
- Explore value-based care and payment options and models, which often is a difficult conversation with boards

## Financial Performance

### **Leverage reimbursement advantages**

- To address reimbursement inadequacy, the Michigan Hospital Association Board Task Force developed a recommendation that corrects an average CAH payment to cost ratio of 72 percent while rural and urban hospitals enjoy an average payment to cost ratio of 95 percent for Medicaid
- Locally inventory payer contract value-based payments and determine what data needs to be collected that so that no money is left on the table

### **Share actionable data**

- Establish peer sharing of CAHs for financial data to share best practices. For example, CAHS agreed to share data unblinded through a finance network in the North Carolina Flex Program. They share ideas across lessons learned and best practices
- Technical assistance providers can identify lead indicators for CAH financial performance and recommend earlier interventions for performance improvement
- Conduct research to demonstrate where current policies aren't working

- Educate larger health systems about rural reimbursement, quality and finance data when exploring networks and affiliations
- Address market strategies for each state

### **Educate providers, board**

- Physician education is important as well as communication with hospital leadership
- Implement Small Rural Hospital Transition (SRHT) recommendations and action planning that incorporate board and provider education. Leadership of CAH is so important for an implementation

## Efficiency of Operations

### **Implement operations to turnaround financial distress**

- One participant offered a demonstration of the importance of financial and operational data. Addressed staffing ratios in CAH and using contract staff in SNF. Made tough changes in workforce structure to improve expenses and it improved staff satisfaction.

## Workforce

### **Staff engagement and satisfaction**

- Redesigned the primary care clinics to *advanced team-based care*. Medical assistants and others took ownership of care and manage chronic care with follow-up emails, tracking tests and referrals. Nurses are doing wellness visits. Patients are happier, and the incentives are coming in

### **Educate CAH boards in transition to value**

- At a state CAH meeting, a panel of board chairs and CEOs from four CAHs shared their stories regarding 'going to the brink and back'. Stories were complex covering CEO turnover, loss of a rural health clinic and other examples, but was a good opportunity to for peer sharing relating to CAH governance

## **Integrate Lean**

- CAHs proposed operational projects for a two-week period then teamed with an engineering student for an immersion in a Lean process. Projects included: inventory control, operating room work flow, claim denials and cost to redo claims. One intern was hired by a CAH and is coaching others

## Care Management

### **Improve Partnerships**

- The rural ACOs in Michigan achieved improvement in 34 indicators and achieved a 1.5 percent reduction in Medicare spending. ACO support from Advanced Investment Model (AIM ACO) is ending in 2018. These ACOs are currently developing a rural Clinically Integrated Network (CIN). Some members of the previous ACOs were lost by affiliation and finances. Seven original and three new participants in the CIN. Next steps: to move forward and assimilate new members into ACO and achieve shared savings. They need to achieve these strategies and use this as a guide for Greater MI ACO and help recruit other communities into the MI Rural ACO. Next move is to include a rural federally qualified health centers (FQHCs)

## APPENDIX D

### Resources Needed to Support Strategies

The Summit participants considered the strategies and identified the resources needed for communities, rural hospitals, clinics, networks and states to deploy to support implementation. Some of these recommended resources are available or could be supported or created by state Flex programs, state offices of rural health, rural health networks, policy makers and funding agencies to provide better support to rural hospitals and clinics so that they can successfully implement these key financial strategies.

### Hospitals and Networks

#### Operational Efficiency

- Best practices around public data (state variation today) to be used for organizational design – understanding market share
- Hospital focus – access to claims data for self-insured (plans) risk to understand care and cost
- Demonstrating rural value (roles) in relationships to tertiary provider (direct and indirect)

#### Care Management

- Resource directories for patients such as "[Where is Care](#)" in Wisconsin

#### Workforce

- Action planning to review state level workforce needs vs supply of providers
- Staffing ranges by department for sharing and learning (Roundtable)
- Productivity measures

#### Quality Performance

- National conversation on rural relevant measures and how they are being incorporated into incentives are needed

### Flex, SORH, SHIP, and Network Programs

#### Quality Performance

- Funding through Flex innovation – Balanced Scorecard cohort

- Balanced Scorecard – incorporating lead measures with quality reporting lag measures in four quadrants
- Rural health clinic quality measures

### **Financial**

- Strategies to reach the hospitals that are the low performers. They don't know how to implement when there is so much going on in high – risk and not engaged. High performers self-select technical assistance and resources. It is important to reach the majority to make change

## Research and Technical Assistance Programs

### **Market Indicators**

- Assistance with collecting and analyzing local data

### **Financial Performance and Conditions**

- Developing a claims data warehouse
- Standardizing risk scoring formula

### **Workforce**

- Steps to implement evidence-based practice

### **Quality Performance**

- Utilizing state-based initiatives such as MN Community measurement to increase reporting and benchmarking

### **Community Health**

- Creating and using readiness tools in many areas