



NATIONAL
RURAL HEALTH
RESOURCE CENTER

Transitioning Rural Hospitals To Value-Based Systems

Small Rural Hospital Transition (SRHT) Project

Bethany Adams
Lindsay Corcoran
Melissa Kelly

May 12, 2017

Transitioning Rural Hospitals To Value-Based Systems

Presentation Objectives

- Introduction
- [Small Rural Hospital Transition \(SRHT\) Project](#)
- SRHT Project Outcomes
- Transition Strategies: Position Your Hospital for Value-based Care
- Pender Community Hospital: Preparing for Population Health
- Resources
- Questions & Comments



The Center's Purpose

The National Rural Health Resource Center (The Center) is a nonprofit organization dedicated to sustaining and improving health care in rural communities. As the nation's leading technical assistance and knowledge center in rural health, The Center focuses on five core areas:

- Transition to Value and Population Health
- Collaboration and Partnership
- Performance Improvement
- Health Information Technology
- Workforce



Small Rural Hospital Transition (SRHT) Project

- Supports small rural hospitals nationally in bridging the gaps between the current volume-based health care system and the newly emerging value-based system of health care delivery and payment
- Provides onsite technical assistance to assist selected hospitals in transitioning to value-based care and Alternative Payment Models (APM)
- Disseminates best practices and successful strategies to rural hospital and network leaders

SRHT Eligibility

- Located in a rural community, as defined by FORHP
- Located in a persistent poverty county (PPC) or a rural census tract of a metro PPC
- Have 49 beds or less per most recently filed Medicare Cost Report
- For-Profit and Not-For-Profit CAHs and PPS facilities
- Grantees of Rural Health Network Development Program and the Small Rural Healthcare Quality Improvement Grant Program are encouraged to apply



SRHT Project Core Areas

Financial Operational Assessment (FOA)

- Identifies strategies and develops tactics that improve operational efficiencies, as well as quality and patient satisfaction

Quality Improvement (QI) Project

- Assesses care management and transition of care processes to include utilization review, discharge planning, care coordination and resource utilization to yield cost-effective, quality outcomes that are patient-centric



SRHT Project Expectations

Selected Hospitals must be willing and able to:

- Meet program and readiness requirements
- Track project measures to determine measurable outcomes
- Implement best practices that improve financial performance, operational efficiencies and quality of care
- Adopt key transition strategies to position the hospital for value-based care and prepare for population health
- Complete post-project assessments



SRHT Projects Ask, What...

- Is the current status of the quality of care and financial position of the hospital?
- Are the opportunities for process improvements that enhance performance?
- Best practices should the hospital implement to improve financial performance and quality of care?
- Strategies must be deployed to transition the hospital to a value-based care?
- Does the hospital need to do to prepare for population health management?
- Are the gaps?
- Resources are available to assist the hospitals in closing the gap and meeting their needs?



SRHT Hospital Consultation Process (p1)

Pre-project planning activities

- Complete [transition planning self-assessment](#)
- Participate in kick-off webinar
- Hold pre-project planning calls
- Submit data requests and interview schedule

First onsite consultation

- Interviews with executive and management team members, medical staff and board members
- Discovers opportunities for implementing best practices to increase operational efficiency and adopting transition strategies that position the hospital for the future



SRHT Hospital Consultation Process (p2)

Second onsite consultation

- Report presentation to executive and management teams
 - Focuses on educating team on why consultant recommendations are important to hospital's future
 - Ties department actions with hospital's strategic plans
 - Documents pre-project values for tracking measures
- Action planning with executive and management team to implement hospital wide recommendations
 - Develops action steps at department level to implement best practices and adopt transition strategies
 - Initiates implementation process

Post-project Follow Up Process: Hospitals Are to...

- Hold Recommendation Adoption Progress (RAP) interviews at 6 months and 12 months post-project
- Complete post-project [transition planning self-assessment](#) at 12 months
- Report post-project values at 12 months
 - **QI Project:**
 - CAHs and PPS: Increase HCAHPS composite scores for discharge planning and care transition
 - CAHs: Improve ED Transfer Communication; All EDTC (%)
 - PPS Hospitals: Reduce total readmissions
 - **FOA – CAHs and PPS hospitals:**
 - Increase total margin (net income) by 10% points - annualized basis
 - Increase net patient revenue by 2.5% - annualized basis
 - Increase Days of Cash on Hand by 10 days
 - Improve HCAHPS *overall rating of the hospital and would recommend the hospital*



Post-Project Follow Up: RAP Interview

- Demonstrates a hospital's progress over time by showing the extent to which a facility has implemented consultant recommended best practices and transition strategies
- Focuses on hospital's successes and 'what's going well'
- Gathers both qualitative and quantitative data
- Documents measurable outcomes
- Captures impact of hospital project



Summarized SRHT Outcomes (2014-2015)

- Of 4 FOA Hospitals
 - Three increased net patient revenue by 11% from pre-value average of \$51,850,500 to post-value of \$57,735,100
 - Two improved DCOH on average of 20.7% with pre-values of 55.1 days to post-value of 66.4 days
- Of 3 QI Hospitals:
 - Two decreased total readmission rate averages from 15.8% to 11.45%
 - Three increased HCAHPS discharge planning composite question results from 46.4% to 62.3%



White Mountain Regional Medical Center Springerville, Arizona



"One of the most positive experiences in my 30 plus years of health care. It engaged the board and the hospital"

Greg Was, Chief Executive Officer



NATIONAL
RURAL HEALTH
RESOURCE CENTER

Madison County Memorial Hospital Madison, Florida



"The hospital would not be where we are today financially and/or quality-wise if not for this project. Staff understand how quality impacts reimbursement. There is better communication of quality and HCAHPS scores. We realize the sense of urgency to create the changes to position ourselves for the future."

Tammy Stevens,
Chief Executive Officer



Monroe County Hospital Monroeville, Alabama



"We've implemented everything Carla recommended! (The project) forced us to do things we knew we wanted to do."

Jeffrey Brannon,
Chief Executive Officer



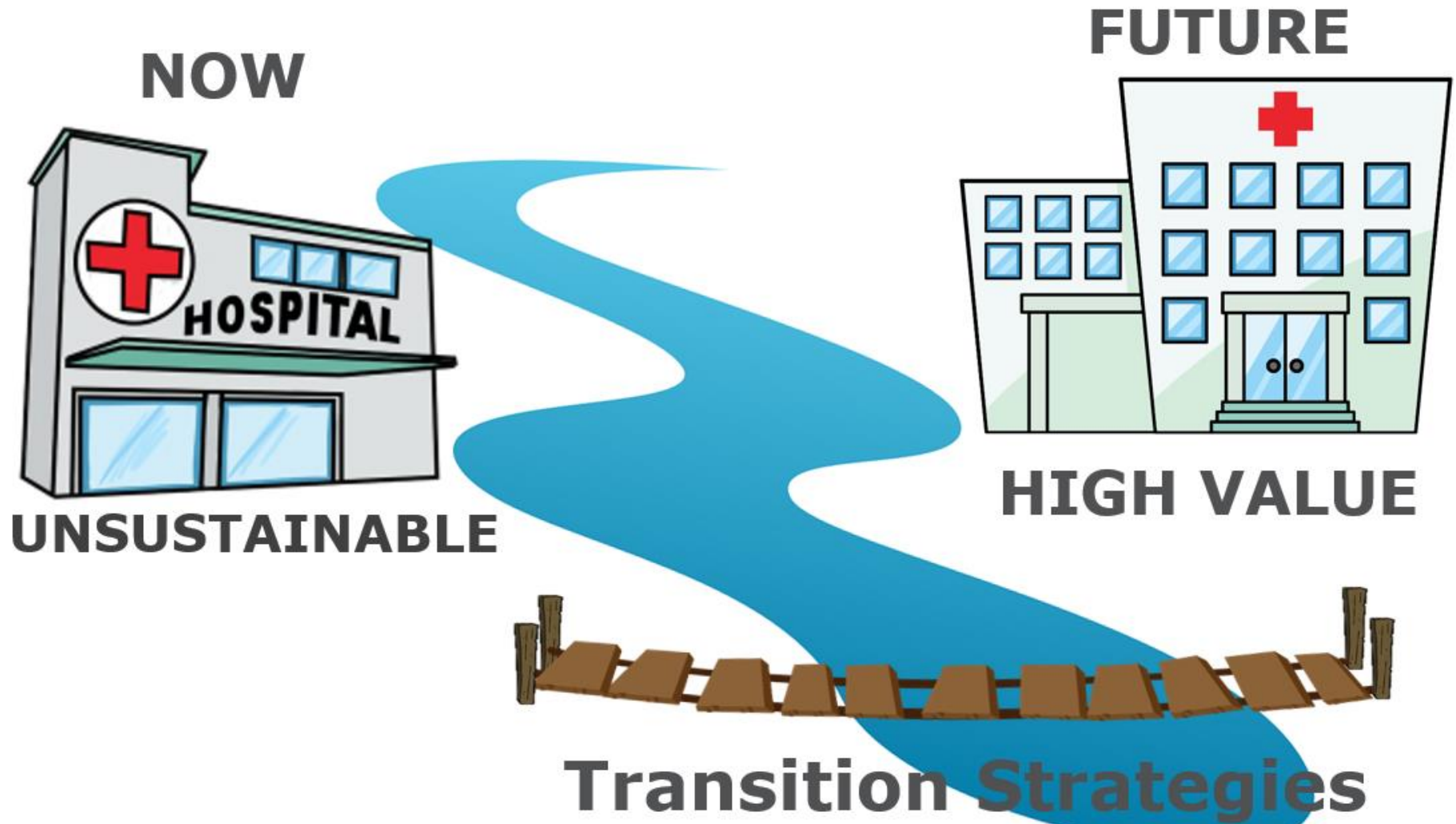
Dissemination of Successful Strategies

Hospital success stories, best practices and transition strategies are shared through:

- [Rural Hospital Toolkit for Transitioning to Value-based Systems](#) (Transition Toolkit)
- *Timely Transitions*, SRHT monthly newsletter
- [Hospital Spotlights](#)
- [Performance Management Group \(PMG\) Calls](#)



Transition Strategies: Position Your Hospital for Value-Based Care



Challenges Affecting Rural Hospitals (p1)

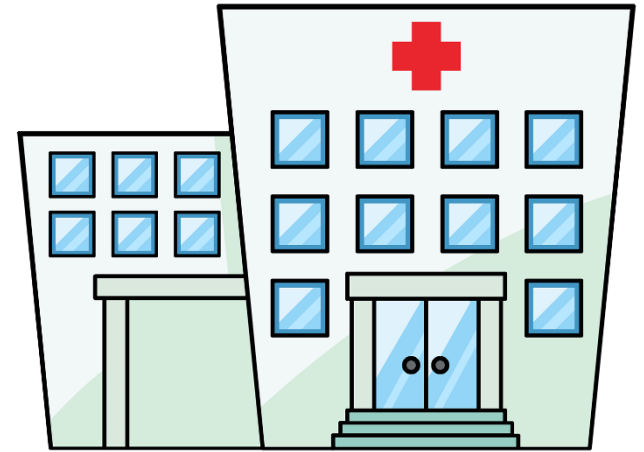
- Difficulty with recruitment of providers and aging of current medical staff
 - Struggle to pay market rates
- Increasing competition from other hospitals and physician providers for limited revenue opportunities
- Small hospital governance members without sophisticated understanding of small hospital strategies, finances, and operations
- Consumer perception that “bigger is better”

Challenges Affecting Rural Hospitals (p2)

- Severe limitations on access to capital for necessary investments in infrastructure and provider recruitment
 - Facilities historically built around IP model of care
- Increased burden of remaining current on onslaught of regulatory changes
 - Regulatory friction / overload
- Payment systems transitioning from volume-based to **value-based**
- Increased emphasis of **quality** as payment and market differentiator
- **Reduced** payments that are “real this time”

Value-based Care of the Future

- New environmental challenges are the TRIPLE AIM!!!
- Triple Aim
 - Better care
 - Smarter spending
 - Healthier people
- Market Competition on economic driver of health care: PATIENT VALUE



The Challenge: Crossing the Shaky Bridge

**Fee-for-Service
Payment
System**



**Population
Based
Payment
System**

2014

2016

2018

2020

2022

2024

2026

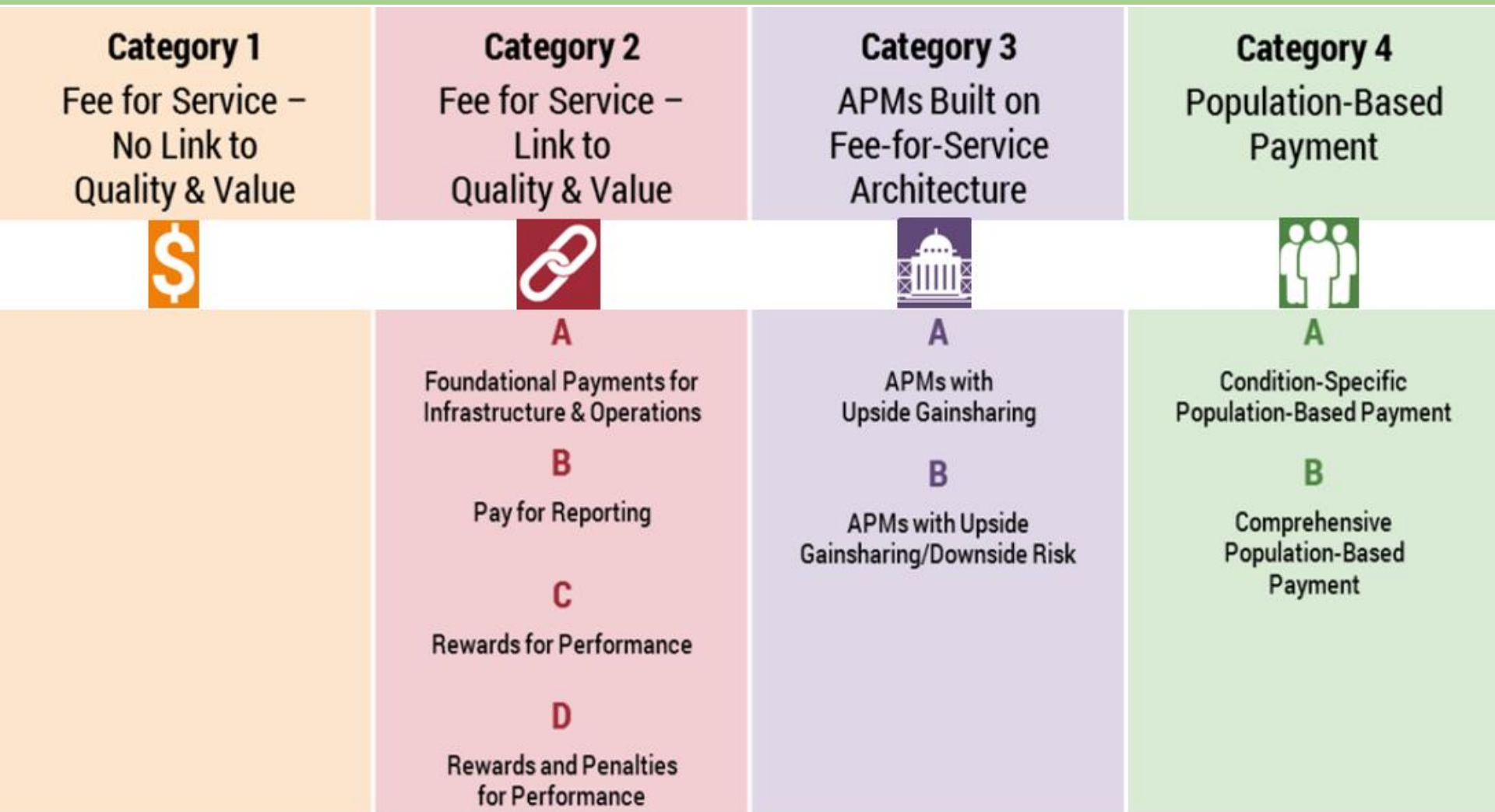


STROUDWATER



NATIONAL
RURAL HEALTH
RESOURCE CENTER

Payment Transition



Source: [DHHS, ARHQ; Alternative Payment Model \(APM\) Framework; January 2016](#)



Key Transition Strategies Targeting Delivery, Payment and Population Health

- **Delivery system** - addresses the imperative to transform the current "sick care" model for optimal fit with population based payment
- **Payment system** - addresses the imperative to proactively transform payment from FFS to population based payment
- **Population health /care management** - requires creation of an integrating vehicle so that providers can contract for covered lives, create value through active care management, and monetize the creation of that value



Key Transition Strategies: Culture

- Increase leadership awareness of new health care environment realities
- Update the strategic plan to incorporate new strategic imperatives – “Bridge Strategy”
- Engage and educate board and medical staff about population health management

Key Transition Strategies: Delivery System

- Maximize financial performance
- Improve operational efficiencies
- Recognize quality and patient safety as a competitive advantage
- Align and partner with medical staff (employed and independent) contractually, functionally, and through governance
- Develop system integration strategy

Key Transition Strategies: Payment System

- Develop self-funded employer health plan
- Participate in transitional payment models that add value and to begin to benefit from available reimbursement options
 - Patient-centered medical homes (PCMH)
 - Shared savings models
 - Accountable Care Organizations (ACOs)
- Begin to develop strategy for managing risk

Key Transition Strategies: Population Health

- Implement care management strategies to position the hospital for population health management
- Develop care transition teams
- Initiate community care coordination planning
- Use self-funded employee health plan to learn how to manage population health interventions
- Use claims data to develop claims analysis capabilities/infrastructure
- Develop evidence-based protocols

Operationalizing Transition Strategies



Pender Community Hospital (PCH): Preparing for Population Health



NATIONAL
RURAL HEALTH
RESOURCE CENTER

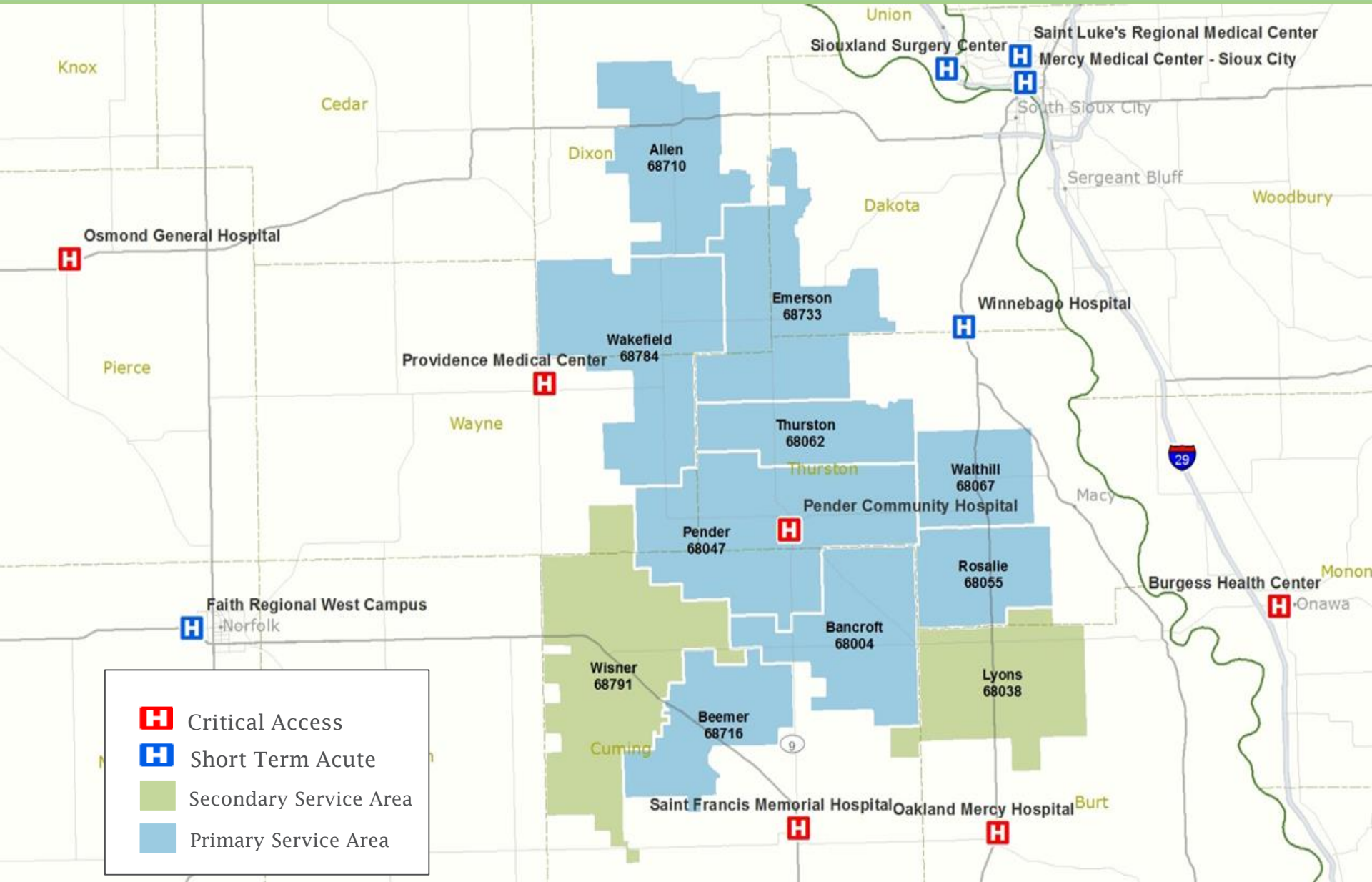
PCH: Vision and Mission

- 21-bed CAH located in Pender, NE
- Vision is to be the best place to get care and the best place to give care
- Mission is to provide a continuum of exceptional healthcare services in a healing environment for everyone

PCH: SRHT Project

- Selected for SRHT Project in October, 2014
- Completed a Financial Operational Assessment (FOA) with Stroudwater Associates in July, 2015
- Submitted data request for bench review
- Hosted 2 onsite consultations with consultants:
 1. Interviews and board training
 2. Report presentation and action planning
- Submitted post-project values and held interview at 9 months with The Center's SRHT Team

PCH: Service Area



PCH: Consultant Recommendations (p1)

1. Relocate clinics to hospital campus
2. Implement 340B Program
3. Market/promote high quality scores
4. Grow services to increase volume and market share
5. Assess feasibility of urgent care or “fast track” ED services
6. Improve revenue cycle processes to reduce AR to 45 days

PCH: Consultant Recommendations (p2)

7. Obtain PCMH certification
8. Redirect Employee Health Plan to focus on improving health to increase wellness visits and include data analytics
9. Evaluate ACO benefits and strategies to move towards population health
10. Update strategic plan to include action steps for transitioning to population health


PCH: Transition To Value Strategies (p1)

- Expand primary care network
- Develop a marketing plan to educate the community about quality of care
- Create incentives around quality and clinic panel size into all provider arrangements
- Redesign employee health plan to incorporate population health interventions such as disease management programs to manage overall benefits costs, and learn how to provide high-quality, low-cost health care to sell to external markets

PCH: Transition To Value Strategies (p2)

- Determine system-wide strategic priorities for the ACO
- Determine ACO value attribution model and financial impact to PCH for local population health initiatives
- Increase care coordination by enrolling current employees and dependents into clinic care management (PCMH) and leveraging historical claims data for developing system strategies around population health

PCH: Promote Quality of Care

Patients... 	PCH	NE Avg	N'tnl Avg
Reported their nurses "Always" communicated well	86%	83%	80%
Reported their doctors "Always" communicated well	87%	86%	82%
Reported "Always" received help as soon as they wanted	80%	75%	69%
Reported staff "Always" explained meds before giving it	78%	68%	65%
Reported their room and bathroom were "Always" clean	92%	81%	74%
Reported area around their room was "Always" quiet at night	74%	69%	62%
Reported YES, they were given information about what to do during their recovery at home	90%	89%	87%
Gave their hospital a rating of 9 or 10	86%	78%	72%
Reported YES, they would definitely recommend the hospital	88%	78%	72%

PCH Outcomes (p1)

- Relocated clinics to hospital campus:
 - Impacted physician recruitment
 - Incentivized physicians to join
 - Improved staff morale and community perception
- Grew services and increased volume:
 - Grew rehab revenue by \$400K over a year
 - Increased swing bed ADC to 7
 - Moved MRI in-house and averaging ~14 / month
 - Upgraded digital mammography
 - Used information technology as a strategic driver

PCH Outcomes (p2)

- 340B Program
 - Since implementation and over two-year period, net revenue is now nearly \$2.1 Million
- Developed committee and initiated PCMH documentation
- Completed strategic planning for the organization
 - Set 12 action plans based on consultant and board recommendations

PCH: Outcomes (p3)

- Implemented ACO strategy to increase the panel size in RHCs and position hospital for future
 - Focused on reductions in readmissions
 - Implemented health coaching
 - Communicated preventive care to community
 - Established goals for preventative care services
 - Experienced increase in preventive care
- Identified questions about how the ACO benefits the hospital
 - Hospital has large value - ACO needs to create value for hospital

PCH: Next Steps In Transitioning to Population Health

- Take advantage of fee for service
- Partner and align with physicians
- Build partnerships with other regional providers and local non-traditional care providers
- Develop care transition teams
- Coordinate community care planning
- Develop chronic care management programs

PCH: To Learn More About SRHT Project Experience

- [Preparing to Jump to the Future: Chicot Memorial and Pender Community Hospital Share Their Transition Strategies](#), July 8, 2016
- [Pender Community Hospital Surpassing Project Goals](#), May, 2016

Resources and Tools

- Financial and quality performance improvement and transition to value resources are available for rural hospitals, networks and providers to include:
 - [Rural Hospital Toolkit for Transitioning to Value-based Systems](#) (Transition Toolkit)
 - [Population Health Portal](#)
 - [Financial Leadership Summit Report](#)
 - [Rural Provider Leadership Summit Reports](#)
 - [HELP webinars](#)



Transition Toolkit

Rural Hospital Toolkit for Transitioning to Value-based Systems

[SRHT](#) > Rural Hospital Toolkit for Transitioning to Value-based Systems

With the support of the Federal Office of Rural Health Policy, The Rural Hospital Toolkit for Transitioning to Value-based Systems (Toolkit) was developed to disseminate consultant recommended best practices and transition strategies identified through the [Small Rural Hospital Transition \(SRHT\) Project](#). The Toolkit shares best practices for improving financial, operational and quality performance that position rural hospitals and networks for the future, as well as outlines strategies for transitioning to value-based purchasing and population health. Rural providers and leaders should use the Toolkit to identify performance improvement opportunities for their hospitals and networks, and develop strategies for successfully transitioning to population health.

- [Self-assessment for Transition Planning](#)
- [Strategic Planning](#)
- [Leadership: Board, Employee and Community Engagement](#)
- [Physician and Provider Engagement and Alignment](#)
- [Population Health Management](#)
- [Financial and Operational Strategies](#)
- [Revenue Cycle Management and Business Office \(BO\) Processes](#)
- [Quality Improvement](#)
- [Community Care Coordination and Chronic Disease Management](#)

Provide Feedback

If you have suggestions that would make this toolkit a more useful resource, please share them by completing our [website feedback form](#). You may also email srht@ruralcenter.org.

Rural Hospital Toolkit for Transitioning to Value-based Systems

Self-assessment for Transition Planning

Strategic Planning

Leadership: Board, Employee and Community Engagement

Physician and Provider Engagement and Alignment

Population Health Management

Financial and Operational Strategies

Revenue Cycle Management and Business Office (BO) Processes

Quality Improvement

Community Care Coordination and Chronic Disease Management

Transition Toolkit

- Provides hospitals and networks with access to tools and resources that support the:
 - Implementation of best practices that improve financial, operational and quality performance
 - Adoption of strategies that help rural hospitals successfully transition to a value-based care
 - Preparation of population health management

"I Just took a look through the Rural Hospital Toolkit – some very powerful stuff in there – I look forward to using it!"

David Usher, Chief Financial Officer
Coteau des Prairies Health Care System, South Dakota



NATIONAL
RURAL HEALTH
RESOURCE CENTER

Population Health Portal



NATIONAL
RURAL HEALTH
RESOURCE CENTER

[Feedback](#) [Login](#)

[Facebook](#) | [On Center Blog](#) | [Twitter](#) | [LinkedIn](#)

[Search](#)

[ABOUT](#)

[PROGRAMS](#)

[SERVICES](#)

[RESOURCE LIBRARY](#)

[RHI >](#)



Population Health Portal

Population health is defined as the health outcomes of a group of individuals, including the distribution of such outcomes within the group. These groups are often either geographically defined or defined as a specific group of individuals. The successful health and health care organizations of the future will be those who simultaneously deliver excellent quality of care, at lower total costs, while improving the health of both the geographic and targeted populations.

This Population Health Portal, created in cooperation with the Federal Office of Rural Health Policy, is designed to help critical access hospitals, Flex Coordinators and rural health networks navigate the journey towards improved population health.

Readiness Assessment

Where are you in the journey towards population health? Complete the Critical Access Hospital Population Health Readiness Assessment to connect with tools and resources targeted towards rural health organizations' unique strengths and needs for transitioning towards population health. These tools and resources are targeted at each milestone of the journey: Get Motivated, Get Informed and Get Going.

[COMPLETE THE ASSESSMENT >](#)

Get Motivated



By participating in population health strategies, a movement towards wellness is created. Become a movement leader and learn how to enhance the board, leadership team and community awareness, understanding and planning for the transition towards population health.

[GET MOTIVATED >](#)

Get Informed



Access tools, resources and case studies on collecting data, assessing information and establishing workflow and communication processes designed to deliver excellent quality of care, at lower total costs, while improving health outcomes in the journey towards population health.

[GET INFORMED >](#)

Get Going



Acquire tools and resources that inspire staff in demonstrating and communicating wellness effectively with patients, the community and partners in creating the necessary culture change towards improved population health outcomes.

[GET GOING >](#)

Put Data to Use



Learn how to effectively conduct population health analytics with access to a web-based database for acquiring geographic health data specific to your location. This tool also consists of educational modules offering step-by-step instructions of common population health analytical procedures.

[EXPLORE THE DATA >](#)

Financial Leadership Summit Report



NATIONAL
RURAL HEALTH
RESOURCE CENTER

[Feedback](#) [Login](#)

[Facebook](#) | [On Center Blog](#) | [Twitter](#) | [LinkedIn](#)

[ABOUT](#)

[PROGRAMS](#)

[SERVICES](#)

[RESOURCE LIBRARY](#)

[RHI >](#)

2016 Financial Leadership Summit Report: Strategies for Rural Hospitals Transitioning to Value-based Purchasing and Population Health

Author: The Center and Mark Chustz

July 12, 2016

[Download the 2016 Financial Leadership Summit Report: Strategies for Rural Hospitals Transitioning to Value-based Purchasing and Population Health](#) [PDF - 810 KB]

[View the HELP Webinar Playback](#) [FLASH]

With the support of the [Federal Office of Rural Health Policy](#) (FORHP), the National Rural Health Resource Center (The Center) developed this report to assist rural hospital leaders in navigating changes in the new health care environment. 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](#).

2016 Financial Leadership Summit Report: Strategies for Rural Hospitals Transitioning to Value-based Purchasing and Population Health

Rural Provider Leadership Summit



NATIONAL
RURAL HEALTH
RESOURCE CENTER

[Job Postings](#) [Feedback](#) [Login](#)

[Facebook](#) | [On Center Blog](#) | [Twitter](#) | [LinkedIn](#)

[ABOUT](#)

[PROGRAMS](#)

[SERVICES](#)

[RESOURCE LIBRARY](#)

[RHI >](#)

Rural Provider Leadership Summit Findings

Author: National Rural Health Resource Center

With the support of the Federal Office of Rural Health Policy (FORHP), the National Rural Health Resource Center (The Center) hosted a Rural Provider Leadership Summit in Bloomington, Minnesota on May 23 – 24, 2016. The purpose of the Summit was to identify strategies for rural provider engagement in transitioning to value-based reimbursement systems. The Summit participants included representatives of critical access hospitals, rural accountable care organizations (ACOs), physicians, state Flex Programs, state offices of rural health (SORHs), universities, quality and rural health network leaders. The panel also included representatives from FORHP, a rural foundation, emergency medical services and community paramedics.

A report with the findings of the Summit has been developed to assist rural hospital leaders in engaging rural health providers in the transition to value-based purchasing and population health. This report is designed to help rural hospitals leaders and providers during the transition.

First, the report describes issues and opportunities related to engaging rural providers in value models. Second, it provides key strategies that rural hospitals may deploy to overcome challenges and engage providers in value-based models and enhance medical staff collaboration. Third, the report highlights success stories and lessons learned that were shared by the panelists during the summit. The report is also intended to assist state Medicare Rural Hospital Flexibility (Flex) Programs and SORHs by offering timely information to develop tools and educational resources that support their hospitals and networks as they transition to population health.

**Rural Provider Leadership Summit
Findings**

A Resource For You



NATIONAL
RURAL HEALTH
RESOURCE CENTER

[Job Postings](#)

[Feedback](#)

[Login](#)

[Facebook](#) | [On Center Blog](#) | [Twitter](#) | [LinkedIn](#)

[ABOUT](#)

[PROGRAMS](#)

[SERVICES](#)

[RESOURCE LIBRARY](#)

[RHI >](#)

The National Rural Health Resource Center is a nonprofit organization dedicated to sustaining and improving health care in rural communities.

As the nation's leading technical assistance and knowledge center in rural health, The Center focuses on five core areas:

- Transition to Value and Population Health
- Collaboration and Partnership
- Performance Improvement
- Health Information Technology
- Workforce

[Learn more about The Center >](#)

[Programs](#)

[Services](#)

[Resource Library](#)

Questions & Comments





NATIONAL
RURAL HEALTH
RESOURCE CENTER

Contact Information

Jeanene Meyers

Public Health Analyst
DHHS, HRSA, FORHP
jmeyers@hrsa.gov

Bethany Adams

Senior Program Manager
National Rural Health Resource Center
badams@ruralcenter.org

Get to know us better:
<http://www.ruralcenter.org>





NATIONAL
RURAL HEALTH
RESOURCE CENTER

Contact Information

Melissa Kelly

Chief Executive Officer

Pender Community Hospital

kellyma@mercyhealth.com

Lindsay Corcoran

Consultant

Stroudwater Associates

LCorcoran@stroudwater.com

Get to know us better:

<http://www.ruralcenter.org>



Speaker Bio: Bethany Adams

Bethany Adams, MHA, FACHE

Senior Program Manager

National Rural Health Resource Center



Bethany has over fifteen years of experience in rural health and serves as Program Manager for the SRHT project, and previously managed the Rural Hospital Performance Improvement project. Bethany served as the Assistant Program Manager for the KY Rural Health Works Program, and worked for the KY State Office of Rural Health as a Program Coordinator. Bethany holds a double Bachelor of Science in Clinical Laboratory Science and Biology from the University of KY. She also obtained a Master of Health Administration from the University of KY and is a fellow with the American College of Healthcare Executives.

Speaker Bio: Lindsay Corcoran

Lindsay Corcoran, MHA

Consultant

Stroudwater Associates



Lindsay has over ten years of healthcare consulting and medical office experience. Lindsay focuses on supporting and sustaining healthcare access for rural communities through hospital operational improvement and affiliation strategies, and has assisted rural and community hospitals and clinics across the country to improve operational and financial performance. Before joining Stroudwater, Lindsay worked in an outpatient physical therapy setting as a practice administrator for three clinics in southern Maine. Lindsay is a graduate of the University of Southern Maine, and earned her Masters of Healthcare Administration in August 2013 from Seton Hall University. She is a member of the American College of Healthcare Executives.

Speaker Bio: Melissa Kelly

Melissa Kelly, CPA

Chief Executive Officer
Pender Community Hospital



Melissa Kelly has been with the PCH for eleven years, eight as the Chief Financial Officer and three as the Chief Executive Officer. Melissa attended the University of Nebraska-Lincoln and attained her Bachelor of Science Degree in 2002, as well as her Master's of Professional Accountancy in 2003. She obtained her Certified Public Accountant status in 2006. Melissa resides with her husband, Jeff, and their five children in rural Thurston, Nebraska. She has been instrumental in numerous advancement projects at PCH, which have allowed the facility to maintain its continued excellent care to its patients, as well as continuous advancement in the medical field.