2016 Financial Leadership Summit Report

Strategies for Rural Hospitals Transitioning to Value-based Purchasing and Population Health

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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 to assist rural hospital leaders in navigating changes in the new health care environment. This report is designed to help rural hospitals leaders meet these new challenges in three ways. First, the report describes market forces impacting rural hospitals. Second, it provides key operational strategies that providers may deploy to overcome these challenges and be successful in alternative payment models. 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 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 population health. 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 paper 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 particular 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 particular fact situation, and should independently determine the correctness of any particular planning technique before recommending the technique to a client or implementing it on a client's behalf.

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INTRODUCTION

The American health care system is poised to enter a new era of service delivery. This new phase seeks to accomplish what the Institute for Healthcare Improvement (IHI) initiated through the "Triple Aim"[1]. Their approach is intended to optimize health system performance in the following three dimensions:

- Improving the patient experience of care, including quality and satisfaction
- Improving the health of populations
- Reducing the per capita cost of health care

To accomplish these goals, Centers for Medicare and Medicaid Services (CMS) and other insurance carriers are developing new payment methods that incentivize providers to keep their patient populations healthy while phasing out volume-based fee-for-service (FFS) payment models. In January 2015, the Department of Health and Human Services (HHS) announced its "*Better Care, Smarter Spending, Healthier People* initiative to pay providers for value and not volume".[2] The targets set by HHS leave little doubt that CMS is moving forward with the transition to a value-based reimbursement system.[3] "HHS expects to tie 85 percent of all traditional Medicare payments to quality by 2016 and 90 percent by 2018 through programs such as the Hospital Value-Based Purchasing (VBP) and the Hospital Readmissions Reduction Programs."[4] HHS is also using bundled payment plans and encouraging the development of Accountable Care Organizations (ACO) as a way of reducing health care spending while requiring improvements in the quality of care. Through the Centers for Medicare and Medicaid Innovation (CMMI), HHS is developing and testing innovative health care payment and delivery models that improve quality and our health care delivery system.[5][6][7]

[1] Institute for Healthcare Improvement. The IHI Triple Aim Initaitive [webpage].
[2] CMS (2015). Better Care. Smarter Spending. Healthier People: Paying Providers for Value, Not Volume [fact sheet].
[3] iVantage Health Analytics (2016). iVantage Health Analytics Presents New Research on Rural Health Safety Net [press release].
[4] HHS (2015). Better, Smarter, Healthier: In historic announcement, HHS sets clear goals and timeline for shifting Medicare reimbursements from volume to value [press release].
[5] CMS (2016). Better Care. Smarter Spending. Healthier People: Improving Quality and Paying for What Works [press release].
[6] CMS (2015). Better Care, Smarter Spending, Healthier People: Improving Our Health Care Delivery System [press release].
[7] CMS. The CMS Innovation Center [webpage].

The transition from FFS to these other forms of payment creates financial incentives for providers to improve the health of their communities by focusing on preventive care, not sick care. These new payment systems reward providers for doing what they have always wanted to do, keep their patients healthy. While these changes create great opportunities for providers to improve the health of their communities, they are accompanied by great challenges. This is especially true for rural hospitals as they typically lack the resources to successfully negotiate these changes on their own.

Rural Hospitals are facing unprecedented challenges as they struggle to serve their local communities. A recent study by iVantage titled *Rural Relevance: Vulnerability to Value Study,* found that "Since 2010, more than 60 rural communities have experienced a hospital closure. They identified another 673 facilities that are vulnerable or at risk for closure in 2016."[8] According to an article by the North Carolina Research Program, "from 2010 through 2014, 47 rural hospitals ceased providing inpatient services in 23 states across the country. Among the 47 closed hospitals, 26 hospitals no longer provide any health care services, and 21 continue to provide a mix of health services but no inpatient care".[9] As of June 2016, the National Rural Health Association (NRHA) reports that 74 rural hospitals have closed across the country as of June 2016. It is generally accepted within the rural hospital industry that the rate of rural hospital closures is expected to escalate as the industry moves toward higher risk value-based payment models and population health management.

There are numerous factors affecting this trend. According to North Carolina Rural Health Research and Policy Analysis Center. One important factor related to rural hospital closures is the refusal of some states to expand Medicaid. [10] Other factors include declines in inpatient admissions, reductions in reimbursement due to the Federal budget sequestration and from changes in reimbursement due to the implementation of the Affordable Care Act (ACA). The implementation of the ACA has initiated a shift in payment methods from fee-for-service (FFS) to value-based purchasing (VBP) along

[8] iVantage Health Analytics (2016). iVantage Health Analytics Presents New Research on Rural Health Safety Net [press release].
[9] Thomas, Sharita R, Kaufman, Brystana G, Randolph, Randy K et. al. (2015) A Comparison of Closed Rural Hospitals and Perceived Impact. *NC Rural Health Research Program*
[10] Reiter, Kristin L, Noles, Marissa, & Pink, George (2015). Uncompensated Care Burden May Mean Financial Vulnerability For Rural Hospitals In States That Did Not Expand Medicaid. *Health Affairs, 34(10),* 1721-1729. doi: 10.1377/hlthaff.2014.1340

with other innovative payment methods. This shift will test the ability of rural providers to quickly adapt to these changes. They must adapt if they hope to continue serving their communities.

THE FINANCIAL LEADERSHIP SUMMIT (2016)

In response to the numerous challenges facing rural providers, the Federal Office of Rural Health Policy (FORHP) supported the 2016 Financial Leadership Summit, which was convened by The National Rural Health Resource Center (The Center). The summit was mandated to identify strategies and actions that rural hospital leaders should consider as they transition to alternative payment systems and population health management.

The Summit Panelists

The summit panelists consisted of nationally recognized rural hospital field experts, as well as chief executive officers (CEOs) and chief financial officers (CFOs) from top performing critical access hospitals (CAHs) and small rural perspective payment system (PPS) facilities. The panel also included representatives from SORH, Flex program and the NRHA. The 2016 Financial Leadership Summit Panelists include the following field experts (Refer to **Appendix C** for contact information).

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The work of the expert panel is contained in this report. Their hope is that this report serves as a vital resource when developing an organizational road map to future sustainability.

Summit Goals

The summit's goal was to develop a set of critical strategies that could assist hospital leaders as they transition their organizations from a volume based FFS system to one that focuses on quality of care and value of service. These strategies should help guide leaders in developing a plan that financially stabilizes the hospital during the transition to new alternative payment and care delivery models. Hospitals will require a strong financial position along with a substantial cash reserve to survive the transition

process, as well as competitive quality scores to operate successfully under a value-based system. The objectives of the summit were to:

- Inform rural health care providers and community leaders about the current market changes that are driving rural hospitals to population health;
- Provide critical transition strategies that support hospitals in preparing for population health;
- Create a resource for rural hospitals, networks and other rural providers to use as they develop their own strategic initiatives which will improve the probability their organization will survive the transition to population health; and
- Build awareness of available resources that can assist leaders now, as well as share information on needs with SORH and state Rural Hospital Flexibility (Flex) Programs.

DRIVERS AND CHALLENGES

'In 2008, IHI developed the Triple Aim concept of simultaneously improving population health, improving the patient experience of care, and reducing per capita cost. IHI described the Triple Aim as fundamentally new health systems that contribute to the overall health of populations while reducing costs."[11] IHI created the Triple Aim to refocus the energies of health care providers to improving quality of care, which ignited change in the health care industry. IHI has continued to use the Triple Aim concept to drive changes within the industry and push for greater emphasis on "better care for individuals and health of populations, while lowering per capital costs".[12]

HHS has also long recognized that the current FFS payment method is unsustainable. HHS acknowledges that the current system does not produce the right incentives for providers to deliver efficient and high quality patient care nor improve the health of the general population. "The ACA was passed by Congress and then signed into law by the President on March 23, 2010."[13] ACA is now the major driver of change to improve quality of care,

[11] Stiefel, M & Nolan, K (2012). A Guide to Measuring the Triple Aim: Population Health, Experience of Care, and Per Capita Cost. *Institute for Healthcare Improvement*.
[12] Institute for Healthcare Improvement. The IHI Triple Aim Initaitive [webpage].
[13] HHS (2012). Read the Law: The Affordable Care Act, Section by Section.

prevention of chronic diseases, access to primary care, and efficiency of resources. Under the auspice of HHS, CMS has worked diligently to develop new payment models that incentivize hospitals and clinicians to provide the right level care, improve quality of care and ensure patient access to acute care services. Since 2015 following CMS's announcement for *Better Care, Smarter Spending, Healthier People,* the health care industry has been on a fast track of change. The changes being implemented under the ACA are now making attainment of the goals to improve quality of care for individuals and populations, as well as reducing costs. Through the Innovation Center, CMS has developed various payment models and incentives are that are driving current changes that support providers in moving forward to population health management. For example, "CMS has identified 10 alternative payment models that contribute to progress towards goal of tying 30 percent of traditional, or fee-for-service, Medicare payments to quality or value, which include the following:[14]

- Medicare Shared Savings Program (MSSP)
- Pioneer ACOs
- Next Generation ACOs
- Comprehensive End Stage Renal Disease (ESRD) Care Model
- Comprehensive Primary Care Model
- Multi-Payer Advanced Primary Care Practice
- End Stage Renal Disease Prospective Payment System
- Maryland All-Payer Model
- Medicare Care Choices Model
- Bundled Payment Care Improvement"

Other market forces that are driving the health care industry towards population health includes the list below. These market forces are pressing rural hospitals to transition to VBP, and eventually to population health.

- Commercial insurance plans with large deductibles
- Reductions in Medicare, Medicaid and insurance payments
- Elimination of Disproportionate Share Hospital (DSH) Payments
- Center for Medicare and Medicaid Innovation Model (CMMI) Episode-based payment initiatives ('bundled payments')
- Public reporting requirements that increase transparency of quality indicators

[14] CMS (2016). Overview of Select Alternative Payment Models [factsheet].

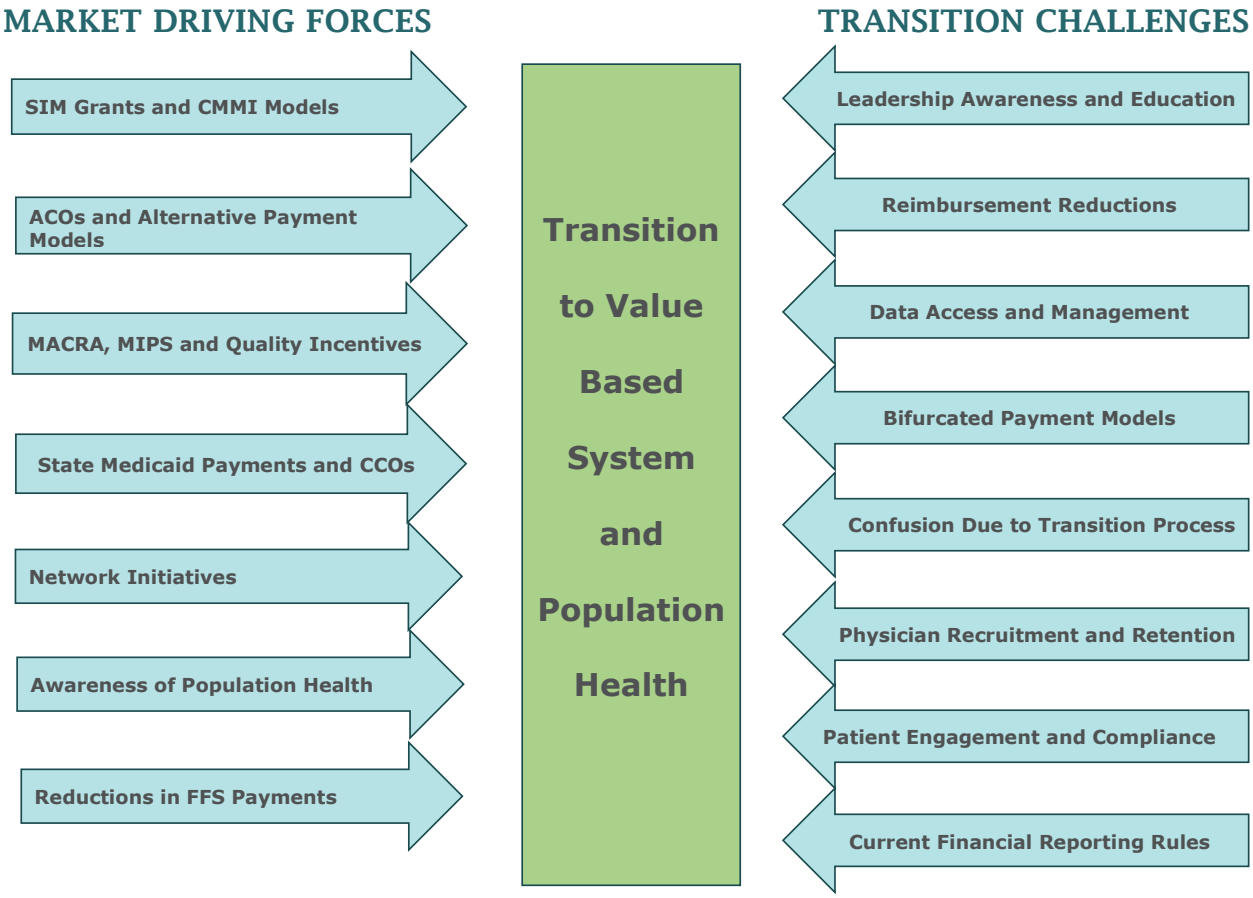
- Incentives and penalties based on quality
- Continued pressure to eliminate CAH status for rural hospitals

The panel also developed a list of factors representing a hindrance to the transition from FFS to VBP. These transition challenges inhibit a rural leader's ability to prepare for market changes by limiting the development of internal capacity to position the hospital for population health. These transition challenges include the following:

- Limited internal and financial resources within the hospital to hire consultants
- Lack of board awareness and understanding of population health
- Competition from larger systems that are producing their own insurance product
- Inability to adequately access, manage and share electronic health records (EHR) data
- Unrecognized value of quality of care provided under alternative payments on financial statements due to GAAP (Generally Accepted Accounting Principles) accounting, which is developed to support FFS payment methodology

Figure 1 below illustrates the forces pushing hospitals to a value-based system, as well as demonstrates how resisting pressures are impeding their ability to prepare for the future.

Figure 1: Market Driving Forces and Transition Challenges



The panel realizes that each provider will have differing sets of challenges and opportunities. The following section expands on a number of issues discussed by the panel.

Leadership Awareness

Many rural hospital leaders are excited about their opportunity to be a part of the solution to the current inefficiencies in healthcare. Leaders should appreciate that the coming changes in reimbursement methods will actually support their personal goals for their patients and communities. These changes will improve the quality of care and reduce the overall cost of care while ensuring their patients are happy with the care they receive. To be effective, rural hospital leaders must continue to monitor current operations and maintain an eye to future changes. Developing a high level of knowledge about the types and timing of new reimbursement methods can ensure their organization stays competitive.

Alternative Payment and Demonstration Models

CMS is conducting various demonstration models to test alternative payment and care delivery systems which include ACOs and others, such as episode-based payment initiatives and Primary Care Transformation. Of the ACO demonstration models, the ACO Investment Model is of particular importance to rural hospitals. This model will test the use of pre-paid shared savings to encourage new ACOs to form in rural and underserved areas and to encourage current Medicare Shared Savings Program ACOs to transition to arrangements with greater financial risk.[15] Transforming Clinical Practice Initiatives (TCPI) provide technical assistance to physician groups. The initiative is designed to support more than 140,000 clinician practices over the next four years in sharing, adapting and further developing their comprehensive quality improvement strategies.[16] Refer to Appendix D for more information on The Center for Medicare & Medicaid Innovation (CMMI) Grants and State Innovation Models Initiative (SIM).

Network Initiatives and Outreach

As FFS reimbursement transitions to VBP, rural hospitals will have to become part of a larger network of providers. This must occur for two primary reasons. One, to aggregate scale to diversify insurance risk as providers increasing are taking payment risks. Two, vertical and horizontal integration with other providers will be required to care for the health of an entire population while maintaining access to sick care.

For these networks to be effective, members must be functionally aligned. This alignment might include shared medical records, joint development of evidence-based protocols and coordinated patient outreach. Providers will have to share information and coordinate their care efforts securely and effectively to be successful with providers beyond their hospital and clinics. The open sharing of all this information between network partners will require them to trust each other. Developing high levels of trust will take time but it must happen for these networks to be successful. Panelists noted that some hospitals are very reluctant to share claim data with other providers. Network providers will have to find a way to overcome this issue.

[15] CMS. ACO Investment Model [webpage].
[16] CMS. Transforming Clinical Practice Initiative [webpage].

The nature of VBP models require these networks to increase their efforts in patient outreach. Effective patient outreach reduces avoidable hospital readmissions, improves patient experience and safety while ensuring optimal reimbursement and profitability.

This outreach might include remote home monitoring, follow-up home visits and phone calls from care transition team members. Community education events are another form of community outreach. All efforts designed to engage patients are ways to increase the probability they will remain healthy. Community outreach is a cornerstone of managing population health and keeping patients engaged in their own health care.

Population Health and Patient Engagement

CMS's alternative payment models will drive hospitals and providers into ACOs, shared savings plans and other alternative payment models. Rural providers must plan to participate in these new programs if they hope to remain viable. One key component of these models is the ability of providers to effectively manage population health. Population health can be defined as a "cohesive, integrated and comprehensive approach to health care that considers the distribution of health outcomes with a population, the health determinants that influence distribution of care, and the policies and interventions that impact and are impacted by those determinants."[17] To successfully manage population health, providers must engage their patients in ways that improve compliance with treatment methods for those with chronic conditions and collaborate to address other health outcome factors including housing, transportation, safety, employment and education.

Historically, hospitals have had no financial incentive for improving population health or engaging their patients. The ACA is changing that. Patient engagement is a key component in achieving the "Triple Aim" of improved health outcomes, better patient care and lower costs. It gives patients and their families the opportunity to stay connected with their physicians and become active members of their care team. This care model fits well into the strategies being used by ACOs and other network providers.[18]

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[17] Kindig, Dc & Stoddart, G. (2003). What is population health? *American Journal of Public Health, 93(3),* 380-3.
[18] James, Julia (2013). Health Policy Briefs: Patient Engagement.

Data Access

A significant challenge agreed on by the panelists is that providers are protective of their data and are reluctant to share it for fear other providers might use it to their advantage. Managing population health requires network partners to share and interpret real-time patient data. Ralph Llewellyn reminded the panel members that raw data is much like crude oil; it has little value until it's refined. The ability of providers to turn data into information and information into actions is a crucial step in developing a functional data exchange and managing population health.

Every provider in the network needs data to identify gaps in service, high utilization patients, inefficiencies, community health needs and create solutions that work for the population being served. Therefore, having interoperable Electronic Health Records (EHRs), sharing patient data between providers and access to Health Information Exchanges (HIE) are essential to networks managing population health and needs to be part of a provider's strategic plan.[19]

Insurance Reimbursement and High Deductible Health Plans

The panel noted a number of growing trends in the commercial insurance market place that are having a negative impact on hospital revenues. The first trend is commercial insurance companies that are modeling their reimbursement methods on Medicare's payment models. This trend translates into lower payments for FFS encounters. Many rural hospitals depend on the higher levels of reimbursement they receive from commercial insurance carriers to make a profit.

Commercial insurers are also moving to capitated insurance plans. These plans incentivize providers to reduce utilization while improving the quality of care they provide. This trend is expected to continue and will have a negative impact on the hospital's revenues until providers change the way they provide care.

The trend toward high-deductible insurance plans can also have a negative effect on a hospital's bottom line. As the patient's out of pocket expenses become a larger portion of the bill, hospitals must ensure they collect the

[19] Dichter, Robert (2015). Taking hold of the population health management opportunity. *Healthcare IT News.*

patient's copays and deductibles. If hospitals are unable to collect the patient's portion of the bill, their accounts receivable balances will explode and bad debt will continue to escalate. Higher deductibles may also drive down demand for medical services as patients delay medical care to avoid paying the out of pocket charges. Another concern over higher deductibles is the fear patients will avoid necessary care to manage chronic conditions and eventually need more expensive services when their health needlessly deteriorates.

Medicare Access and CHIP Reauthorization Act (MACRA)

Physician reimbursement is also changing due to the Medicare Access and CHIP Reauthorization Act (MACRA) of 2015. MACRA is designed to drive the health care industry towards VBP and to further support access to better care. "First, MACRA repeals the Sustainable Growth Rate (SGR) Formula, which has historically been used to define how Medicare pays health care providers. Next, it changes the way that Medicare rewards clinicians for value over volume, streamlines multiple quality programs under the new Merit Based Incentive Payments System (MIPS) as well as provides bonus payments for participation in eligible alternative payment models (APMs)". [20] "In addition, MACRA also temporarily extended the Children's Health Insurance Program (CHIP) and increased premiums for Part B and Part D of Medicare for beneficiaries with income above certain levels."[21]

Under MACRA, provider payments are now tied to value and quality. They must choose between two payment models: 1) Merit-Based Incentive Payment System (MIPS) or 2) Alternative Payment Models (APMs).[22] Many rural physicians are unaware of how these new payment models will change and affect their reimbursement. Physicians and hospitals that are educated about the financial impact of these programs are better positioned to enhance their revenue streams. The panel suggested hospitals knowledgeable in this area will improve their revenue streams from employed physicians. They can also assist non-employed physicians as they make decisions about which payment model to choose. Developing

[20] CMS (2015). The Medicare Access & CHIP Reauthorization Act of 2015, Path to Value [Powerpoint slides].
[21] Spitalnic, Paul (2015). Estimated Financial Effects of the Medicare Access and CHIP Reauthorization Act of 2015 (H.R. 2) [press release]. *CMS Dept. of Health & Human Services*.
[22] CMS. The Merit-Based Incentive Payment System (MIPS) & Alternative Payment Models (APMs) [webpage].

transparent and collaborative relationships with area physicians was seen as an essential strategy.

RURAL HOSPITAL TRANSITION STRATEGIES

The summit panel evaluated various financial and operational aspects of the transition to value process. Their goal was to identify key transition strategies that leaders might undertake as they guide their small rural hospitals from FFS to a VBP. These strategies can assist leaders in developing a plan to improve, or at least maintain, the hospital's financial position during the transition between payment systems. Rural health providers and leaders will require a comprehensive strategic plan that guides their hospitals through the transition process. To craft these key transition strategies, the panelists used two frameworks to evaluate various financial, operational and quality issues that leaders should consider when developing a comprehensive plan.

The first framework was The *Performance Excellence (PE) Blueprint framework*, which guided the panel's discussion in relation to the essentials of sound strategic planning. This framework is a systems based management tool used to focus on quality and performance. The PE Blueprint is a modified version of the Baldrige Framework that maps strategies using a system approach to planning and outlines key areas for developing a strategic plan. "The PE Blueprint is a tool for rural hospital leaders to achieve organizational excellence while considering critical success factors relevant to small rural hospitals."[23] Refer to **Appendix A** for more information on the PE Blueprint.

The second model used by the panel is the *Transition Implementation Framework* created by the Stroudwater Associates. [24] This framework pairs vital strategies that should be implemented during each phase of the transition process based on the reimbursement models in use at that time. The framework moves from FFS to VBP in a fluid way through three main transition phases. As the industry moves through each phase, providers and leaders must be ready to implement the actions identified for each phase to sustain the transition process and to ensure that their hospitals remain

[23] National Rural Health Resource Center. Critical Access Hospital Blueprint for Performance Excellence [webpage].
[24] Stroudwater. Future of Rural Healthcare video available! [webpage].

operational under population-based payment system (PBPS). The model emphasizes the importance of hospitals matching current operational strategies with current payment methods while preparing for the next payment method. Refer to **Appendix B** for more information on the Transition Implementation Framework.

Immediate Strategies (In the Next 18 Months)

The panel grouped strategies into three time frames following the Transition Implementation Framework. The first set of strategies are the immediate strategies that should be initiated now. These strategies are designed to position a hospital financially and operationally for the next stage of value based payment methods. Key outcomes include improving operations efficiencies, increasing cash reserves, evaluating unexplored opportunities to increase revenue, educating leadership and exploring opportunities to operate in a small-scale managed care environment.

Improve Financial, Clinical and Operational Efficiency

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 FFS 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 methods. Therefore, it is imperative that leaders begin immediately positioning their hospital to successfully transition into the next phase of value based reimbursement. Rural hospitals that lag in the planning process may become financially unstable. Hospitals 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. Key transition strategies for improving financial and operational efficiency to position the hospital VBP include the following:

- Maximize FFS reimbursement (updating charge master, improving revenue cycle processes, and initiating Point of Care collection processes)

- Identify and eliminate wasted time, materials or redundant actions that add no value – perhaps use LEAN processes other process improvement techniques[25]
- Enroll in a 340 B program. The program requires drug manufacturers to provide outpatient drugs to eligible health care organizations at significantly reduced prices [26]
- Maximize swing bed services by identifying appropriate patients within the network. The Mayo clinic recently created a post-acute care program that transfers patients from its tertiary hospital to twelve area CAHs
- Start transition from traditional employer health plans to self-insured plans, with access to claims data. In addition, redesign the self-insured plan to create incentives for in "network" use as well as health incentives. This can give providers a small-scale experience of what it's like to provide care in a VBP system
- Develop a process for encouraging patients to come to follow up visits and consider using automated calling system to remind patients
- Develop operational and financial forecasting tools

Engage and Educate Leaders and Staff

Another urgency is the need to educate and engage hospital leaders and physicians to build awareness of the importance of preparing for transitioning to value based system. Leaders should recognize that commercial insurance carriers are also developing and implementing incentive payments that reward providers based on quality and tying reimbursement to value. Therefore, it is critical for leaders and physicians to understand that third party payers, which include commercial insurance, are driving market changes towards population health. As the transition continues, these changes will directly impact the hospitals' revenue as well as its future. They must understand the "why" of the impending change, as well as be personally aligned behind strategies that will move the hospital to be successful in value and population health payment systems. At the very least, the change initiatives must be defined in terms that improve patient

[25] Institute for Healthcare Improvement (2005). Going Lean in Health Care.
[26] Medicare Payment Advisory Commission (2015). Report to the Congress: Overview of the 340B Drug Pricing Program.

care, increase affordability and improves access. Immediate action steps to undertake is to:

- Educate the board of directors, executive leadership and the medical and hospital staff about the implications of the transition from FFS and VBP
- Review strategic facility building plans with an emphasis toward VBP by focusing on outpatient services with reduced needs for inpatient beds

Educate and Partner with Physicians and other Primary Care Providers

Primary care providers are at the heart of the new payment systems. In many of the new payment models, primary care physicians are being assigned responsibility for the quality of and the total cost of comprehensive health services for large groups of both Medicare and Medicaid recipients. Private insurance companies are also beginning to use this primary care medical home model. Hospitals that are not aligned with their primary care providers may find these providers recruited into competing ACOs and similar value-based organizations that could potentially alter traditional physician referrals to the local hospital. Immediate actions that support the engagement and alignment with physicians include the following:

- Emphasize with physicians the importance of growing panel size
- Assess providers and staff to identify potential change champions
- Invest in medical staff development with an eye toward leadership
- Develop physician alignment through contractual arrangements using both relative value units (RVU) and quality indicators

Short-term Strategies (In the Next 3 Years)

Short-term strategies are to be implemented over the next 3 years. These strategies will be most effective when payment types are mixed, meaning some are still FFS and others are VBP.

Align Community Health Needs and Identify Population Health Resources

Population health management requires both accurate health information about the service area population and the development of partnerships with other health and social service providers in the area. In addition, community groups such as governmental agencies, schools, civic groups and churches will be key to success in this strategy. Since lifestyle is such an important social determinant of health outcomes, it will also be necessary to engage and enlist the help of family members and the patient themselves. Provider-patient relationships, therefore, must switch from its current patient dependent form to one of patient empowerment and collaboration with the provider. To align community health needs with resources, hospital leaders should begin to:

- Perform community health needs assessment (CHNA) using facilitated deliberation with broad representation beyond hospital
- Utilize CHNA to develop strategic plan that supports community health needs
- Utilize available community health data
- Engage community to reduce out-migration and improve patient retention
- Align services between the hospital, primary care and other community health care organizations including public and mental health providers
- Initiate community health planning and begin to develop a care coordination plan between providers

Develop Care Transition Teams

Patient care management of the future will require multi-disciplinary teams of providers working collaboratively other providers, patients and their families to maximize effectiveness and to ensure continuity of care throughout the delivery system. Physicians, for example, will be asked to "work to the top of their licenses" and rely on nurses, health educators and care coordinators to supplement their efforts. These new team members will need to be educated, processes will have to be modified to reflect the team approach, and care coordinators will need to be hired and given responsibilities for both internal (within hospital) and external (between the

hospital and other service providers) coordination. Key actions to undertake over the next three years is to:

- Develop Patient-Centered Medical Home (PCMH) model
- Implement transitions of care processes
- Develop chronic care management programs
- Develop patient wellness strategies from available services
- Prepare to adopt evidence-based protocols

Collect, Manage and Act on Patient Data

Individual patient data will be an essential resource in population health management. Knowing the cost and quality of care being provided as well as patient medical experience data will help providers improve quality, make better referrals to specialty care and ultimately reduce both cost and wasteful use of medical resources. Top performing hospitals will begin to:

- Identify data partners and create effective and interoperable EHR/IT systems
- Develop data analytics capabilities to better understand claims experience

Long-term Strategies (In the Next 3 – 5 Years)

Long-term strategies are to be initiated and implemented over the next 36 – 60 months. These strategies will become more important as the payment system approaches total VBP and capitated payment plans.

Collaborate with Regional Rural Hospitals and Larger Health Systems

Many rural hospitals fiercely protect their independence and are reluctant to diminish local control. Rural hospitals, however, lack the patient volume or the resources to participate fully in a population health payment system. They will be compelled to seek partners, either with other small hospitals or with larger health systems. As the evolution to value develops, partnerships will be essential. But, partnerships do not have to mean giving up all local control. Achieving and documenting value-based outcomes in the immediate future will ensure that rural hospitals can create win-win partnerships with

other providers' long-term. Strategies that support and enhance collaborative efforts include the following:

- Affiliate with larger health care systems, ACOs or Rural Hospital Networks
- Forge new partnerships by collaborating with other hospitals, networks, community providers, public health departments and mental health providers
- Share services with other hospitals to increase efficiencies
- Strategize the local rural health system by not competing with other area providers to the detriment of both – "rural shouldn't compete with rural"
- Partner with local self-insured employers
- Address social determinants of health with community partners (housing, transportation, education, employment)

Document Hospital Outcomes and Demonstrate Value

Hospitals must document their value in terms that will be required in the Value and population health payment systems. They will then have to find a way to communicate their value to both their local communities and to other providers. Leaders should begin demonstrating the value of their hospitals by undertaking the following strategies.

- Quantify the value attributed by each participant in the network, Coordinated Care Organization or ACO to ensure compensation matches contributions.
- Align payment and delivery models
- Develop impact and outcome studies for every strategy to confirm their effectiveness
- Create value statement which can be used to forge partnerships with larger health systems or payers

RURAL HOSPITAL EXAMPLES:

Success Stories and Lessons Learned Shared by Summit Panelists

Rebecca, Care Transition Teams

Developed an internal care transition team with the intention to reduce readmissions and assure compliance with follow-up care. Worked closely with the tertiary facility who sometimes would admit patients to other area rehab hospitals or refer them to other home health agencies without the patient's or the primary care provider's knowledge. The key to successful implementation is receiving real-time data on patients, not monthly reports. Having a robust HIE will be imperative to long-term success.

Larry, Community Needs Assessment

Provider discovered through community needs assessment that community wanted physician clinics to be open after hours and weekends. Both requests were honored and patient encounters grew by 340 per month and physician panel size grew by ten new patients per month.

Susie, Executive Team Morning Huddles

The staff huddles last 10-15 minutes. Offsite clinics attended huddle via conference call. Reviewed any activities impacting income or quality of care. Items reviewed included left without being seen ER visits, number of no shows in the clinics, hospital readmissions, the destination of hospital discharges and patient or family complaints and others.

Jim, Focus on Community Wellness and Population Health

The hospital used county health rankings to drive strategic initiatives. Their goal is to be the healthiest community in Wisconsin. They have collaborated with many grass roots community organizations, municipalities and the county to improve their ranking from 28 of 72 to 8 of 72 in the past 4 years. They are piloting hospital based registries for adult wellness and senior wellness as well was developing registries for diabetes, pediatric wellness and other services. Creation of registries required working with payers to

obtain necessary data. They learned that data elements must be discrete and well defined and available before patients return to physician office for follow-up visits for data to be useful.

Greg, Network with Other Providers

Our state had a large number of standalone hospitals with no system support. Using a network planning grant, the hospitals created a network of standalone rural hospitals that invited University of Utah and Intermountain Healthcare System into their network. The network was able to get better pricing from vendors and educational resources from the larger systems.

Brian, Collaborate with Networks

The Rural Wisconsin Health Cooperative invited hospitals to participate in a project to prepare for value-based payment. After a series of education and priority identification sessions, the network is now focusing on facilitating participation in the CMS Transforming Clinical Practice Initiative, forming a captive to share risk in self-insured plans and developing a population health analytics resource to support disease management.

Rebecca, Collaboration with Area Providers

A hospital needed community health workers to support discharged patients. The hospital used first responders as community health workers. Lesson learned, network with EMS, Police and Fire departments to use their staff during down times.

Ralph, Improve Efficiencies

Improve Charge Capture and Labor – Management. Labor management involves holding staff accountable and moving out poor performers. Consultants found significant opportunities to improve revenue by improving charge capture, updating charge master and improving documentation.

Lance, LEAN Implementation

Provided an example of one hospital that implemented LEAN processes. Staff identified $240,000 in annual savings.

Greg, Collaboration with State Office of Rural Health

State Offices are able to help increase efficiency by educating Rural Hospital Networks about Studer Group model.

Eric, Network Development and Leadership Education

Align with local primary care providers (PCPs) through functional, contractual, and governance mechanisms. Consider a Physician Hospital Organization (PHO) as a vehicle for alignment when local community includes independent and/or FQHC employed PCPs. Rural Hospitals must have a seat at the table when value attribution formulas are set up. Use auditors to educate Board and C-Suite before the annual report.

Jodi, Quality Improvement

Established a team of physicians and hospital staff to review patient treatment protocols. The goal was to ensure the consistent application of evidence-based care for all patients within the delivery of care process. To assist in monitoring, the quality reporting structure was reorganized to ensure that decisions were made based on data and were consistent with the Quality Assessment and Performance Improvement (QAPI) initiatives.

RESOURCES NEEDED TO TRANSITION TO VALUE-BASED SYSTEM

The panelists considered each strategy and identified the resources available now for rural hospitals to deploy to support the implementation of these strategies and the resources needed to support long-term success. 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 so that they can successful implement these key financial strategies.

1. **Improve Financial, Clinical and Operational Efficiency**
    - Build greater awareness of available resources
    - Hospital grant resources such as Small Rural Hospital Improvement Program and Health Center Control Network Grants (created by HRSA to fund development of Health Information Exchange Networks to link FQHCs, Community Health Centers and area hospitals so they can exchange patient data)
    - Regional, state and national financial benchmarks available through Healthcare Financial Management Association to build accountability within hospital
    - Automated calling for outreach services to target populations
    - Leverage incentives for hospitals with match from state program
    - Directory of rural hospital vendors' services and resources
    - Training for rural hospitals to build capacity
    - Case studies to share impact of strategies
    - Skills for data / excel pivot tables
    - Benchmarking in finances and operations
    - Addressing cost transparency

2. **Engage and educate leaders and staff**
    - Materials and best practices on change processes
    - Effective communication methods
        - *Future of Rural Health Care video*
        - *Transition to Value video and tools from Rural Health Value*
        - Utilize small group discussions on value with staff and Board with repetition

- Targeted 10 to 15 minute videos for boards and medical staff or 90 second videos (YouTube clips) on transition to value
- Small group discussions guides for hospital leaders
- Multiple messages and repetition with board

3. **Align Community Health Needs and Identify Available Population Health Resources**
   - Education on Community Health Needs Assessment and meaningful information and process
   - Research on community
   - Tools for conducting community health needs assessments
   - Rural community facilitation resources
   - Short board and staff education on hospital messaging
   - Press release templates for small hospitals and communities; social media templates and tools

4. **Educate and Partner with Physicians and other Primary Care Providers**
   - Methods to partner with physician leadership (physician champions)
   - Recommendations on partnering with medical associations
   - Education on transition to value for providers
   - Examples of physician contracts, incentives with relative value units (RVUs) plus quality indicators, and explanation of current importance as related to future of health care
   - Guide on why physician contracts with incentives are important
   - Address medical / osteopathic education on value
   - Utilize technical assistance through CMMI initiatives:
     - Transforming Clinical Practice Initiative (TCPI)
     - Practice Transformation Network (PTN)
     - Medicare Access and CHIP Reauthorization Act of 2015 (MACRA)
     - Merit-Based Incentive Payment System (MIPS)

5. **Develop Care Transition Teams**
   - Education through networks

- Follow-up support after workshops – example, Small Rural Hospital Transitions (SRHT) Project
- Reimbursement for care coordination benefits
- CMMI Transforming Clinical Practice Initiatives - technical assistance
- Caravan (NRACO) and other ACOs

6. Manage Data

- Access to data and ability to mine health care data (claims, quality, costs and community health status)
- Technical assistance to work with commercial payers for data
- Consistency in data format
- Interoperability tools
- Grant funding for HIE connectivity
- Interoperability legislation
- Tools to navigate HIPAA

7. Collaborate with Other Rural Hospitals and Larger and Regional Health Networks

- Identifying local social determinants of health
- Network development
- Grant funding
- Technical assistance for other community partners and providers
- Negotiation skills to demonstrate value
- Understand the why of transition to value
- Examples from states / networks

8. Document Hospital Outcomes and Demonstrate Value

- National Quality Forum
- SRHT outcomes
- Key performance indicators
- Understanding true costs
- Flex needs assessments for population health

CONCLUSION

The time for paying for sick care is coming to a close. The Triple Aim of improving the patient experience of care, improving the health of populations and reducing the per capita cost of health care is forcing the coming wave of payment reform. Many providers still hope the wave will dissipate before it arrives. Their hope is in vain. The relevant question is how will providers survive and prosper in this new environment.

The panelists hope the information and strategies presented in this document help providers prepare for both the challenges and opportunities created by the ACA. The challenges are not insurmountable. Providers will find ways to survive the transition from FFS to VBP. To do so, they must create networks of shared information and care that ensure their sustainability and produces significantly improved outcomes for their patients.

APPENDICES

Appendix A: Performance Excellence (PE) Blueprint

The *Performance Excellence (PE) Blueprint* assists rural health care providers and leaders in mapping strategies using a system approach to planning. It provides leaders with a methodology to ensure that they prepare for changes in the care delivery and payment systems from an organizational perspective. The PE Blueprint outlines seven key areas for rural providers to consider when developing a strategic plan. The seven categories include the following.

- Leadership
- Strategic planning
- Community, customers and population health
- Workforce
- Impact and outcomes
- Processes for improved
- Measurement, feedback and knowledge management

The seven categories in the Blueprint are not separate, but rather are interdependent. Success or failure in one will have an impact, either positively or negatively, on the others. Figure 2 below illustrates how the seven components are intertwined to impact the quality of care, financial performance and overall operations.

The PE Blueprint provides rural hospital leaders a framework to effectively coordinate and manage various activities that will be necessary to successfully transition to integrated health delivery system of the future. The PE Blueprint enables organizations to measure predicted outcomes. Results in all seven categories are measured regularly, and the information is fed back to hospital leaders for ongoing improvement. Rural hospitals generally are not short of information; rather they have so much information they often struggle to sort the important strategic information from the less important. The PE Blueprint helps to sort the hospital information to answer the questions: Are we making progress toward this important goal?; and, what can we do now to improve the performance of any strategy that is producing results that are under target?

Figure 2: Performance Excellence Framework

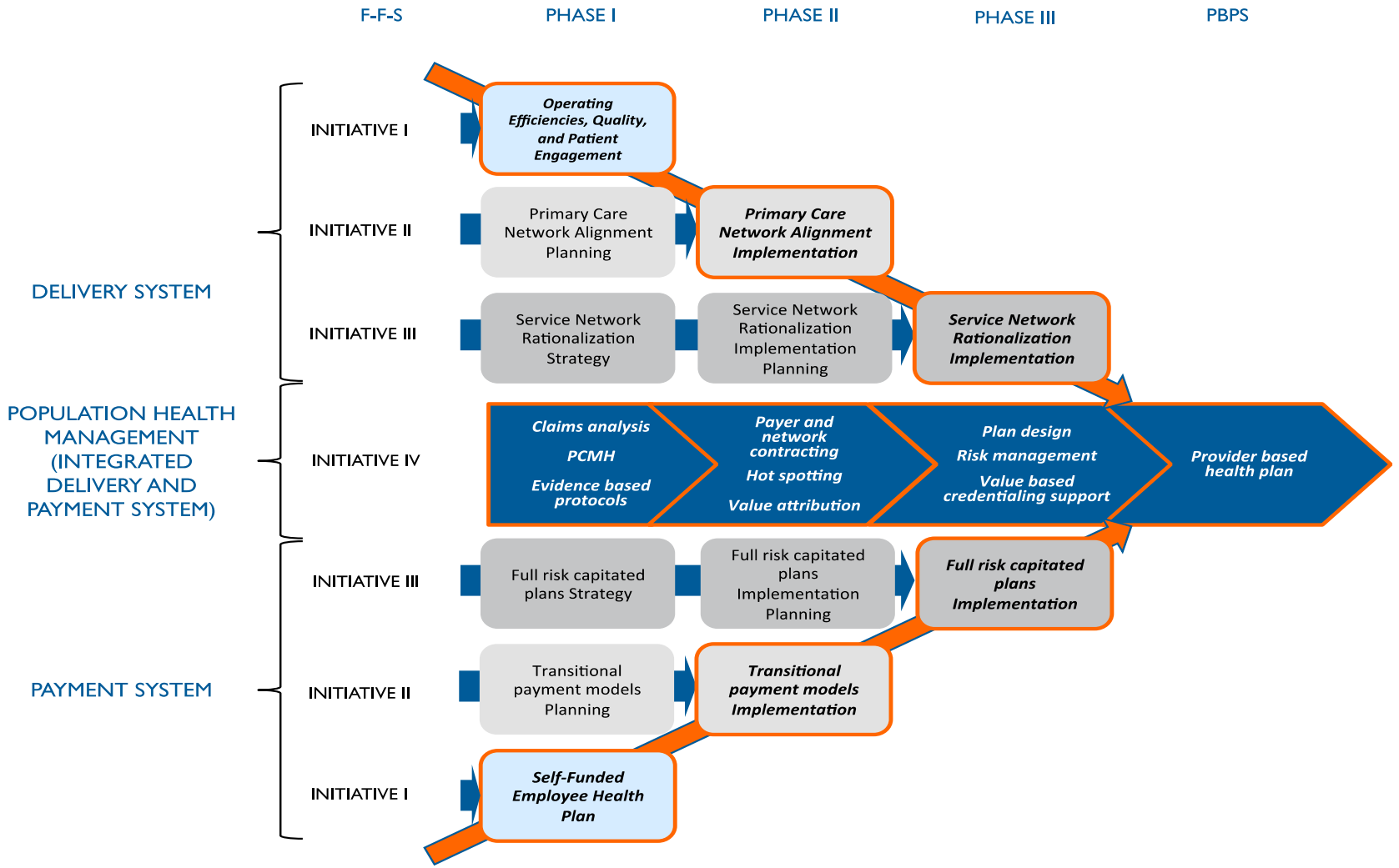
Modified from *Baldrige Framework*

Appendix B: Transition Implementation Framework[27]

The *Transition Implementation Framework* outlines key activities that rural health providers and leaders should target and complete to successfully transition to a value-based payment system of the future (see Figure 3 below). Theoretically, the framework moves from fee-for-service (FFS) to population based payment system (PBPS) through three transition phases. Currently, the health care industry is in phase I of the transition process. As the industry moves through each phase, providers and leaders must be ready to implement the actions identified for that phase to sustain the transition process, as well as to ensure that their organizations will operational under PBPS. These key actions are highlighted in orange boxes under each phase. In addition, the graph divides these activities into three categories that consist of the delivery system, population health management and payment system. The framework illustrates that the transition process must be a system approach to ensure that the care delivery and payment systems are developed and implemented simultaneously, and thus, become operationalized within the organization. As the care delivery and payment systems are being implemented over time through each phase, the infrastructure for an integrated delivery system will begin to emerge, which will then allow population health activities to be managed as normal operational procedures. Eventually, an integrated population health system that is supported by a capitated reimbursement methodology under PBPS will replace the old fee-for-service health care system.

[27] Framework obtained from Stroudwater Associates through the Small Rural Hospital Transition (SRHT) Projects

Figure 3: Transition Implementation Framework



Appendix C: Financial Leadership Summit Panelists

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Appendix D: Glossary

Value-based purchasing: Medicare's payment system that links to a value to improve healthcare quality, including the quality of care provided in the inpatient hospital setting.[28][29]

State Innovation Models Initiative (SIM): "The purpose of the SIM initiative is to test whether new models with potential to improve care and lower costs in Medicare, Medicaid and Children's Health Insurance Program (CHIP) will produce better results when implemented in the context of a state-sponsored plan that involves multiple payers, broader state innovation and larger health system transformations to improve population health."[30][31]

The Center for Medicare & Medicaid Innovation (CMMI) Grants: "The Innovation Center develops new payment and service delivery models in accordance with the requirements of section 1115A of the Social Security Act. Additionally, Congress has defined – both through the Affordable Care Act and previous legislation – a number of specific demonstrations to be conducted by CMS. CMMI Models are organized into seven categories".[32]

- Accountable Care Organizations
- Episode-based Payment Initiatives
- Primary Care Transformation
- Initiatives Focused on the Medicaid and CHIP Population
- Initiatives Focused on the Medicare-Medicaid Enrollees
- Initiatives to Accelerate the Development and Testing of New Payment and Service Delivery Models
- Initiatives to Speed the Adoption of Best Practices

[28] CMS. Hospital Value-Based Purchasing [webpage].
[29] CMS DH&HS (2015). Hospital Value-Based Purchasing.
[30] CMMI (2012). State Innovation Models: Funding for Model Design and Testing Assistance.
[31] CMS. State Innovation Models Initiative: General Information [webpage].
[32] CMS. Innovation Models [webpage].