Russell County Hospital: Aligning for Future Success

Small Rural Hospital Transition (SRHT) Project

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Presentation Objectives

• Introduction

• **Small Rural Hospital Transition (SRHT) Project**
  - Program Overview
  - Resources

• Transition Strategies: Position Your Hospital for Value-based Care

• Russell County Hospital: Aligning for Future Success

• Questions & Comments
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 models and preparing for population health
- 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
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 follow up process
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?
- 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 prepare for population health?
- Are the gaps?
- Resources are available to assist the hospitals in closing the gap and meeting their needs?
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
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 Required to...

- Hold 2 Recommendation Adoption Progress (RAP) interviews at 6 months and 12 months post-project to demonstrate project impact
- Complete post-project transition planning self-assessment at 12 months
- Report post-project values for SRHT tracking at 12 months to demonstrate measurable outcomes
The Center’s Resources

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

- **Rural Hospital Transition Toolkit**
- **Population Health Portal**
- **Hospital Spotlights**
- **Performance Management Group (PMG) Calls**
- **HELP webinars**
- **Timely Transitions, SRHT monthly newsletter**
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 payment 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

Watch the webinar recording about the Toolkit content, [SRHT Toolkit Fact Sheet](#) [PDF - 103 KB]

Provide Feedback
The Center’s Population Health Portal

Where are you in the journey towards population health?

What is Population Health?

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 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, helps critical access hospitals, Flex Coordinators and rural health networks navigate the journey towards improved population health.

- **Get Motivated**: To create a movement toward wellness, participate in population health strategies. 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 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 Going**: Acquire tools and resources that inspire staff to effectively demonstrate and communicate wellness with patients, the community and partners for a culture change toward improved population health.
SRHT Hospital Spotlights

• Russell County Hospital Aligning for Future Success
  February, 2017

• Union General Hospital: Showing What's Possible In Population Health
  October, 2016

• North Sunflower Medical Center Successfully Addressing Chronic Care Management
  September, 2016

• Marcum & Wallace Memorial Hospital Successfully Impacts Project Outcomes
  August, 2016

• Chicot Memorial Medical Center Utilizes SRHT Project to Prepare for the Future
  April, 2016

• Spotlight on Richland Parish Hospital
  October, 2015

• Spotlight on Tallahatchie General Hospital
  April, 2015
Transition Strategies:
Position Your Hospital for Value-Based Care

NOW

UNSUSTAINABLE

Transition Strategies

FUTURE

HIGH VALUE
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
## Finance System Driving Transition to Population Based Payment System (PBPS)

<table>
<thead>
<tr>
<th></th>
<th>Finance (Macro-economic Payment System)</th>
<th>Function (Provider Imperatives)</th>
<th>Form (Provider Organization)</th>
</tr>
</thead>
</table>
| **Today (FFS)** | • Government Payers  
• Changing from F-F-S to PBPS  
• Private Payers  
• Follow Government payers | • Management of price, utilization and costs | • Independent organizations competing with each other for market share based on volume |
| **Future (PBPS)** | • Population Based Payment System (PBPS)  
• Steerage to providers with lower costs and better outcomes | • Management of care for defined population  
• Providers assume insurance risk | • Aligned organizations competing with other aligned organizations for covered lives based on quality and value  
• Network and care management organization  
  • New competencies required  
  • Network development  
  • Care management  
  • Risk contracting  
  • Risk management |
The Challenge: Crossing the Shaky Bridge

Fee-for-Service Payment System

Population Based Payment System

2014  2016  2018  2020  2022  2024  2026
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
Operationalizing Transition Strategies

Delivery System
- Operating Efficiencies
- Quality and Engagement
- Business Practices
- Primary Care Networks
- Health System Alignment
- Specialists
- Facilities

Payment System
- Care Management
- Informatics/Analytics
- PCMH
- Employee Health Plans
- Transitional Payment Models
- Physician Leadership
- Governance
- Change Management

Population Health

Culture
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 programs
  ◦ 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
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
Critical Success Factors: #5. Seek solutions outside of healthcare

- Seek solutions from other industries
  - General tendency to believe that the best solutions are those that originate within our walls
- Network professionally with area businesses to share ideas and solutions
- Explore and adopt LEAN as a business model and philosophy that can shift the culture towards a relentless focus on delivering customer value
Critical Success Factors: #4. Cultivate An Entrepreneurial Spirit

- Revenue generation is not just the C-suite’s job
  - Foster entrepreneurial spirit within your management team
  - Develop “Pitchers” instead of “Catchers”
- Set expectation to regularly interface with medical community to:
  - Explore opportunities to better serve their patients
  - Build awareness of new and existing services
  - Seek new partnerships
Critical Success Factors:
#3. Measure what is Actionable (p1)

• Develop dashboard with key performance indicators (KPI) to effectively track and monitor progress
• Identify 1 – 3 metrics per performance category that support actionable steps
• Identify performance metrics on:
  ◦ Macro level for hospital wide initiatives
  ◦ Departmental activities
  ◦ Individual basis to establish alignment of goals
• Communicate widely and frequently to build and hold accountability
# Critical Success Factors: #3. Measure what is Actionable

## Examples of Commonly Used Metrics:

<table>
<thead>
<tr>
<th>Category</th>
<th>Examples</th>
</tr>
</thead>
<tbody>
<tr>
<td>Growth</td>
<td>Emergency Department (ED) volume, Percent admissions, Per center transfers</td>
</tr>
<tr>
<td>People</td>
<td>Employee Turnover, Employee Satisfaction Rate</td>
</tr>
<tr>
<td>Quality and Safety</td>
<td>Core Measures Composite Scores, Hospital- Acquired Conditions (HAC) Score, Medicare Beneficiary Quality Improvement Project (MBQIP) Scores</td>
</tr>
<tr>
<td>Finance</td>
<td>Operating Margin, Days Cash On Hand</td>
</tr>
<tr>
<td>Patient Sat</td>
<td>HCAHPS (<em>Rate 9 or 10 and Willing to recommend</em>)</td>
</tr>
</tbody>
</table>
Effective Planning

- Begins with a solid understanding of your current state and a clearly defined problem
- Develop plan with a focus to 12 – 18 months with annual update
- Establish monthly strategic management review of progress
- Engage all stakeholders (associates, leadership, Board, medical staff, community) in a collaborative manner
Effective Execution

- Develop a formal method for how the organization executes and drives change that utilizes dashboard
  - Action planning that drives accountability though the establishment of specific, time-phased and measurable tasks with defined responsibilities that is monitored on a monthly basis
- Develop cross functional and interdependent teams (e.g. Quality, Satisfaction, Finance)
- Action team charters with clearly defined scope and roles
Critical Success Factors:
#1. Culture Matters

Consciously design and implement a quality focused, performance excellence culture:

• Connect your stakeholders with the mission
• Promote transparency, vision, and accountability
• Convert “renters” into “owners”, and unleash the hidden potential of your associates
• Commit to daily rounding
• Eliminate power gradients
• Adopt a servant leadership style
  ◦ Admit mistakes
  ◦ Seek ideas and solutions from associates
Russell County Hospital
Russell Springs, Kentucky

SERVICES
We’re Here For You

- 24-Hour Emergency Care
- Critical Care
- Inpatient & Outpatient Laboratories
- Inpatient & Outpatient Surgery
- Diagnostic Services
- Dietary Services
- Rehabilitation Services
- Respiratory Therapy
- Specialty Outpatient Clinic
- Woundcare Clinic
- X-Ray Services (Nuclear Medicine and CT Scan Services)
- MRI Services
RCH - 25-bed CAH located in Russell Spring, KY

Our Mission

• To provide quality compassionate healthcare consistent with the trust and support of the communities we serve

Our Vision

• To be the leading provider of quality health care in the communities we serve
• Population: 17,575
  ◦ Increases in summer due to tourism at Lake Cumberland
• Population distribution:
  ◦ Evenly distributed across the age groups
  ◦ 65+ represents 16.5% of population
• Medicaid participants represents 44% of the population
• Median household income: $22,042
• Per capita income: $13,183
Russell County Demographics (p2)

- Percent population below poverty line:
  - 24.3% of the population
  - 20.4% of families
  - 30.8% of under age 18
  - 27.3% of age 65 and older

- Payor Mix:
  - Medicare 47%
  - Medicaid 31%
  - Commercial 17%
  - Worker’s Comp 2%
  - Self Pay 3%
RCH’s Small Rural Hospital Transition Project

• Selected for SRHT Project in October, 2015
• Completed a Financial Operational Assessment (FOA) with Stroudwater Associates in July, 2016
• Submitted data request for bench review
• Hosted 2 onsite consultations:
  1. Interviews and board training
  2. Report presentation and action planning
• Submitted post-project values
• Completed 2 interviews with The Center’s SRHT Team
Consultant Recommendations For RCH

1. Establish urgent care / after hours clinic
2. Align with local providers and expand primary care services
3. Grow surgery program and increase procedures
4. Promote quality scores internally and in community
5. Grow swing bed and inpatient services
6. Grow ancillary services
7. Develop strategic plan to position for the future
8. Improve revenue cycle management
9. Optimize 340B Program
10. Prepare for population health
## RCH Promotes Quality of Care

<table>
<thead>
<tr>
<th>Patients Reported ...</th>
<th>RCH</th>
<th>KY Avg</th>
<th>N’tnl Avg</th>
</tr>
</thead>
<tbody>
<tr>
<td>Nurses &quot;Always&quot; communicated well</td>
<td>88%</td>
<td>82%</td>
<td>80%</td>
</tr>
<tr>
<td>Doctors &quot;Always&quot; communicated well</td>
<td>86%</td>
<td>85%</td>
<td>82%</td>
</tr>
<tr>
<td>&quot;Always&quot; received help as soon as they wanted</td>
<td>79%</td>
<td>70%</td>
<td>69%</td>
</tr>
<tr>
<td>Pain was &quot;Always&quot; well controlled</td>
<td>85%</td>
<td>73%</td>
<td>71%</td>
</tr>
<tr>
<td>&quot;Always&quot; explained meds before giving it</td>
<td>70%</td>
<td>67%</td>
<td>65%</td>
</tr>
<tr>
<td>Room and bathroom were &quot;Always&quot; clean</td>
<td>91%</td>
<td>75%</td>
<td>74%</td>
</tr>
<tr>
<td>Area around their room was &quot;Always&quot; quiet at night</td>
<td>71%</td>
<td>66%</td>
<td>63%</td>
</tr>
<tr>
<td>YES, they were given information about what to do during their recovery at home</td>
<td>86%</td>
<td>87%</td>
<td>87%</td>
</tr>
<tr>
<td>Hospital rating of 9 or 10</td>
<td>77%</td>
<td>73%</td>
<td>72%</td>
</tr>
<tr>
<td>YES, they would definitely recommend the hospital</td>
<td>74%</td>
<td>71%</td>
<td>72%</td>
</tr>
</tbody>
</table>
RCH Advancements on Recommendations: Establishing an Extended Hours Clinic (p1)

• Only one after hours clinic in the county that:
  ◦ Operates during Monday through Friday from 4pm - 7pm and Saturday from 8am to 12pm
  ◦ Is closed on Sunday
  ◦ Is operated by a local primary care physician in community
  ◦ Is staffed with APRNs

• After clinic hours, the RCH’s ED is the only local option for patients to receive healthcare services
RCH Advancements on Recommendations: Establishing an Extended Hours Clinic (p2)

- Acquiring the after hours clinic
- Extending the hours of operation to 11pm on weeknights, 8am until 8pm on Saturday, and 1pm until 5pm on Sunday
- Considering additional hours of operation as required by demand
- Establishing the after hours clinic as an extension of the hospital’s Rural Health Clinic
- Expecting Rural Health Clinic reimbursement for visits
RCH Advancements on Recommendations: Expanding Primary Care Services (p1)

Four primary care practices in Russell County:

- Russell County Medical Associates
  - RCH’s Rural Health Clinic
- Russell County Primary Care (RCPC)
  - Operated by two independent physician practices
- Two Federally Quality Health Centers
  - Russell County Family Medical
  - Jamestown Family Medicine
• Acquiring RCPC from physicians
  ◦ Independent financial analysis indicates that this acquisition will add an additional $500,000 net revenue not considering revenue generated by the after hours clinic’s expanded hours and 340B optimization.

• Seeking a APRN-GYN for operation

• Applied to license RCPC as RCH’s second provider-based Rural Health Clinic
Recruited General Surgeons

• In January 2016, RCH’s only general surgeon left
• By March 2016, RCH recruited:
  ◦ A full-time general surgeon
  ◦ Two part-time general surgeons for one day per week
• Surgical cases increased monthly by an average of 23%
RCH Advancements on Recommendations: Increased Surgical Procedures

• Performing a small number of orthopedic and urology cases, and will continue to grow services
• Providing cataract surgery
  ◦ Collaborating with a second ophthalmologist that is interested in working at RCH
• Seeking a GYN surgeon for our community
RCH Advancements on Recommendations: Growth In Ancillary Services (p1)

- Opened MRI Center with a new Hitachi Oval MRI in March, 2016
  - Older mobile unit was not well received by physicians
  - Increased scans on average of 51%
  - From 74 per month to 112 per month, on average
RCH Advancements on Recommendations: Growth In Ancillary Services (p2)

• Brought sleep study services in house in March 2017 after working with three contract services in 24 months
  ◦ Hired a double registered sleep technician
  ◦ Contracted with boarded sleep physician
  ◦ Purchased the most current equipment
  ◦ Increased in referrals and the quality of studies
  ◦ Seeking accreditation for sleep lab
• Converted a wing of the hospital for a Women’s Health Center

• Women’s health services include:
  ◦ Digital mammography
  ◦ Ultrasound
  ◦ Stereotactic breast biopsy
  ◦ DEXA bone density
  ◦ Molecular breast imaging
    ✓ Our MBI is currently the only one in the Commonwealth of Kentucky
RCH Advancements on Recommendations: Increased Swing Bed and Inpatient Services

- Aggressive marketing with referral hospitals

  Increased:
  
  - Swing bed average daily census (ADC) by 2 patients from 4 patients in FY16 to 6 patients in FY17
  - Total ADC (inpatient plus swing) by 3.2 from 9.3 patients per day in FY16 to 11.5 per day in FY17
  - Case Mix Index from 0.905 to 1.01

- Hospitalists now accepting patients of higher acuity

- ED accounts for approximately 60% of admissions, which relates to 3% of all ED patients
RCH Advancements on Recommendations: Optimized 340B Program (p1)

- Initiated Specialty Drug Program within 340B
- Created a Provider/Patient relationship:
  - When a specialty consult is needed, we work with the specialty physician and the primary care physician writes the prescription for the medication under our 340B program.
RCH Advancements on Recommendations: Optimized 340B Program (p2)

- Benefit to Patients
  - Co-pay is only out of pocket cost for specialty drugs
  - Uninsured patients pays only a maximum of $15
- Underinsured to pay maximum of $15
  - Developing program for the working poor that do not have insurance with an employer or have an income level that disqualifies them for medical assistance
RCH’s Next Steps

• Implement PCMH
• Outreach to area systems to explore potential strategic partnerships
• Develop value-based health plan design
  ◦ Transition to high deductible, self-insured health plan to gain access to claims data for improving health of employee base
  ◦ Create incentives to move employees to high deductible plan and increase employer HSA portion
  ◦ Establish incentives to encourage employees to utilize RCH for services
SRHT Application Period

• SRHT application period for program 2017 – 2018 to open in fall 2017
  ◦ Watch for announcements
  ◦ More information to follow
Collaborating and innovating to improve the health of rural communities.

Upcoming Events

**Critical Access Hospital Pro Forma for Shared Savings**
- **July 26, 2017**
  Explore a new Excel-based tool developed by the Rural Health Value team and Premier, Inc. The CAH Pro Forma for Shared Savings assesses the financial implications of joining an ACO.

Upcoming Network Development Webinar

**Network Development TA Welcome Webinar 2017**
- **August 1, 2017**
  RHI is the technical assistance provider for the 2017 cohort of Rural Health Network Development grantees. In this introductory webinar, grantees will learn about the goals, expectations, and resources available to them.

News

**SRHT Hospital Spotlight**

**Magnolia Regional Medical Center Exceals as a Hospital in Transition**
- **July 2017**
  By staying focused on implementation of recommendations from their SRHT FOA, MRMC increased net income, net patient revenue and days cash on hand, even during a transition in senior leadership.

**Network Spotlight**

**Network Spotlight: Southeast Texas Health System**
- **July 2017**
  SETHS integrates health care locally and regionally in responding to the needs of the community.
Questions and Comments
Contact Information

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