

HFMA'S VALUE PROJECT

The Value Journey

Organizational Road Maps for Value-Driven Health Care

RURAL
HOSPITALS



hfma[®]

healthcare financial management association

ORGANIZATIONS THAT INFORMED THE FINDINGS IN THIS REPORT

HFMA's Value Project research team acknowledges the extensive assistance provided by the following hospitals and health systems. Research for each cohort area—academic medical centers, aligned integrated systems, multihospital systems, rural hospitals, and stand-alone hospitals—was assisted and guided by 35 participating organizations. Researchers for HFMA's Value Project conducted in-depth site visits with two organizations within each cohort and discussed site-visit findings with the broader cohort participants to develop the road maps featured in this report. Participating organizations are featured below.

PARTICIPANTS IN DEVELOPING ROAD MAPS FOR HEALTH SYSTEM CHANGES

Academic Medical Centers	Aligned Integrated Systems	Multihospital Systems	Rural Hospitals	Stand-Alone Hospitals
New York-Presbyterian Hospital	Billings Clinic	Advocate Health Care	Andalusia Regional Hospital	Elmhurst Memorial
Partners HealthCare	Cleveland Clinic	Baptist Health South Florida	Copper Queen Community Hospital	Enloe Medical Center
Rush University Medical Center	Dean Clinic	BJC HealthCare	Crete Area Medical Center	Holy Spirit Health System
University of Alabama at Birmingham (UAB) Hospital	Geisinger Health System	Bon Secours Health System	Franklin Memorial Hospital	Longmont United Hospital
Vanderbilt University Medical Center	Group Health Cooperative	Catholic Health East	New Ulm Medical Center	Platte Valley Medical Center
	Scott & White	CHRISTUS Health	Whitman Hospital and Medical Center	Winona Health
	Spectrum Health	Dignity Health		
		Fairview Health Services		
		OSF HealthCare		
		Novant Health		
		Nebraska Methodist Health System		

RURAL HOSPITALS

Rural hospitals are distinct from other types of providers because they are dominant providers in somewhat isolated markets. What advantages do rural hospitals have as the nation moves toward value-based business models in health care? What are the most important strategies and initiatives for rural hospitals as they position for success in an era of payment reform?

For the purposes of this research, rural hospitals are defined as inpatient and outpatient facilities in a service area with fewer than 50,000 residents. Rural hospitals include critical access hospitals (25 beds or less) and larger, sole community providers.

As part of HFMA's Value Project research, six rural hospitals were studied. The organizations are geographically diverse, and their payment mixes vary. Some receive full cost funding from Medicare. Among the cohort participants, the proportion of Medicare plus Medicaid revenue ranged from 59 to 80 percent. As sole community providers, many of these organizations receive cost-based reimbursement from Medicare. They tend to be more concerned about possible reductions in Medicare rates than value-based payment mechanisms employed by commercial carriers and others.

Two rural hospitals were the subject of site visits: Franklin Memorial Hospital in Farmington, Maine, and Andalusia Regional Hospital in southern Alabama. There are three key distinctions between these hospitals:

- *Physician employment.* Franklin Memorial employs 38 physicians, who comprise nearly all of its medical staff. Andalusia employs one primary care physician and one specialist.
- *Ownership.* Andalusia is owned by a for-profit system, LifePoint Hospitals. Franklin Memorial is a not-for-profit hospital that is owned, in effect, by the community.
- *Cost position.* Andalusia is able to make money from Medicare, its best payer. Franklin Memorial is experiencing strong marketplace pressures to reduce its cost structure.

CHALLENGES AND OPPORTUNITIES

Rural hospitals have several advantages over other healthcare organizations as they prepare for value-based business models of care.

KEY RECOMMENDATIONS

Rural hospitals should consider the following action steps as they position to deliver and demonstrate improved value:

- Position the organization to achieve greater scale.
- Develop financial models and plans that account for reduced revenues, including loss of critical access or sole provider funding.
- Determine the appropriate balance of primary and specialty care services to meet community needs.
- Invest in business intelligence.
- Leverage resources to strengthen community ties.

Rural hospitals are typically the dominant provider in a market area, with strong community loyalty and well-defined service areas. These attributes can help rural hospitals in negotiations with providers in larger market areas, which are likely to be interested in securing rural hospitals as a source of referrals.

One unique feature of some rural hospitals is that they offer nontraditional medical services to help meet their communities' needs. For example, Franklin Memorial provides both dentistry and mental health services. "If a behavioral issue flares up with a patient, we need the capability to provide mental health services," says Jerry Cayer, executive vice president at Franklin Memorial. "These services are integral to our ability to meet the healthcare needs of the community we serve." If these services were not provided locally, patients' needs might go unmet, or patients might have to drive long distances to larger metropolitan areas for treatment, resulting in a lack of coordinated care for the community's residents. By offering nontraditional medical services of this nature, rural hospitals can help to fill some of the gaps in the continuum of care, which could be helpful as they consider opportunities to improve the health of the populations they serve.

As smaller facilities, largely with local governance, rural hospitals generally have the ability to make informed decisions more quickly than larger systems. This characteristic is likely to be important in light of the dynamic, emerging payment environment.

But rural hospitals also face a number of unique challenges in the move toward improved value. Of all the cohorts, rural providers typically have the least amount of scale, which limits their access to affordable capital. Limited scale also contributes to difficulties in establishing comprehensive population management capabilities. In the absence of offering a continuum of care, for example, it is more challenging for a rural facility to provide all of the necessary components of total health management, from wellness to post-acute services.

Potentially significant reductions in Medicare and Medicaid funding threaten the livelihood of rural facilities. Many rural facilities benefit from critical access or sole community provider payments—Medicare reimbursement at “reasonable cost.” Organizations interviewed by HFMA’s Value Project cited the loss of these reimbursement programs as a key concern, and also expressed concern about the potential erosion of state Medicaid programs.

Key market and organization-specific differences among rural hospitals include the following.

Ownership. Many rural systems are not-for-profit and owned by the community. Some are owned by larger systems, and others have close relationships with regional hospitals.

Physician employment. Employment of physicians varies among rural hospitals. Some are, in effect, small integrated systems, while others operate with a base of independent practitioners.

Service areas. The service areas of rural hospitals vary considerably, from those serving predominantly agricultural areas to those serving small communities heavily dependent on one or two major employers. Income levels of rural households often are below state and national averages.

THE ROAD AHEAD: STRATEGIES AND INITIATIVES

Rural hospital leaders recognize that the emerging payment environment will have a significant impact on their organizations. These leaders are beginning to position for value-based payment by focusing in several key areas. Rural hospital leaders strive to:

- Position their organizations to achieve greater scale, which will improve access to capital and enable the development of capabilities required to better care for the local patient population
- Reduce readmissions to enhance quality of care and avoid financial losses under CMS’s new payment structure
- Broaden quality measurement to enhance performance on dimensions of quality beyond patient satisfaction

UNIQUE CHALLENGES AND OPPORTUNITIES FOR RURAL HOSPITALS

Challenges	Opportunities
<ul style="list-style-type: none"> • Lack of scale economies • Loss of reimbursement advantage for critical access hospitals or sole-community provider status • More limited ability to attract and retain physicians and clinical support staff • Limited access to capital at competitive rates • Need for careful consideration of financial investments • Competition from integrated and multihospital systems • Size (Not large enough to organize an ACO) • Because of infrequency of certain surgical procedures, difficulty in matching quality standards of larger hospitals/health systems or publish accurate data, which may affect payment • Risk of exclusion from insurance plan network (e.g., lab services) • Lack of reimbursement for telehealth 	<ul style="list-style-type: none"> • Take advantage of dominant position in rural market. • Build strategic partnerships or alliances, or seek virtual integration (e.g., position rural facility to offer expanded services). • Strengthen community connections. • Seek ways to benefit from the organization’s size (smaller = more nimble). • Enhance patient experience. • Look for ways to benefit from well defined service areas, which present opportunities for innovative approaches to patient engagement and population health management. • Strengthen financial viability of employed primary care physicians. • Build on strong local governance.

- Invest in business intelligence
- Find and retain physicians and clinicians
- Develop financial models and plans that account for potential reduced revenues, including loss of critical access and sole provider funding
- Leverage boards and local assets to strengthen community ties

Rural hospitals, like other types of providers, should coordinate a number of initiatives to position for success under value-based payment. These initiatives span the four value-driving capabilities of people and culture, business intelligence, performance improvement, and contract and risk management.

Many of the initiatives that rural hospitals interviewed by HFMA's Value Project are undertaking to prepare for value-based business models are recommended across cohorts, but some are specific to this cohort.

Achieving greater scale. Compared with hospitals and health systems in the other four cohorts, one of the major problems facing many rural hospitals is small volumes: They treat fewer patients and perform fewer surgical and imaging procedures. Their size also is a barrier to financing: They tend to be viewed as riskier credits.

Rural hospitals primarily use three strategies to improve scale:

- Ensuring the right mix of specialists in the community
- Increasing their primary care base
- Networking with larger systems

These strategies can help improve coordination of care, enable the development of foundational population care capabilities such as chronic disease management, and better position rural hospitals for value-based payment.

Right-size specialty services. Rural facilities are reevaluating the need for specialty services in their communities as part of their organization's strategic planning efforts. Franklin Memorial, for example, underwent a strategic planning process through which it recommitted to offering some specialty services. Wayne Bennett, the hospital's CFO, says competitive dynamics, including the emergence of value-based payment, have made it imperative that the hospital deliver these specialty services efficiently and effectively. As a result, Franklin Memorial has engaged

in an intensive effort to bend its cost curve by assessing overhead costs associated with quality management, case management, utilization review, and documentation staff as well as taking another look at vendor contracts and the use of supplies. "We are trying to figure out how to streamline and reengineer our delivery of specialty services," Bennett says. "I think there's a lot of opportunity to improve value in this area.

In addition to determining what level of specialty services is realistic and appropriate for community needs, rural hospitals also are assessing how best to deliver these services. Some organizations have opted to provide certain specialty services through telehealth partnerships. For example, Copper Queen Community Hospital has established telehealth arrangements for cardiology services and strokes and is working on a burn program.

For services provided by specialists in the community, some organizations have established suites where visiting specialists (who usually come from regional tertiary care facilities or larger multispecialty clinics) can see patients when they are in town, making it easier for these specialists to conduct pre- and post-operative patient visits. Franklin Memorial has dozens of physicians—mostly specialists from outside areas—who have admitting privileges. Andalusia has 52 physicians on its courtesy staff, and a number of specialists—representing cardiology, urology, pulmonology, neurology, nephrology, oncology, and ophthalmology—hold periodic clinics at the hospital in a strategic partnership with a neighboring system.

Increase the organization's primary care base. Adding one or two primary care physicians to a rural hospital can significantly affect care delivery, mainly because of their importance in managing patients in a value-based payment environment and the power they hold in coordinating care with specialists. Attracting and using physician extenders also can help rural hospitals bolster their primary care base. Crete Area Medical Center, a 24-bed critical access hospital in Nebraska, has taken the additional step of organizing its four physicians and three midlevel providers into patient-centered medical homes. This strategy will help the facility more effectively address underlying population care issues such as chronic disease management. As Bryce Betke, Crete's CFO, noted, "We are doing this to position for the future."

Network with larger health systems. Rural hospitals may have an opportunity to network with larger, neighboring health systems, many of which are likely to be interested in generating more referrals from rural areas. These types of strategic partnerships could better position the rural facility to gain access to specialists within the community, leverage capabilities of the system, and participate in a broader continuum of care.

For example, Crete Area Medical Center aligned with a larger health system in 2001, leveraging the health system’s expertise in Lean process improvement, PCMHs, and quality performance measurement, including readmissions, infections, medical errors, and harmful events, says CFO Bryce Betke.

Franklin Memorial in Maine has three larger systems nearby. A subcommittee of board members is charged with determining whether Franklin Memorial should align with any of these systems, and, if so, which one. A potential

advantage to Franklin Memorial of this type of alignment is augmenting the availability of specialists from the larger systems in Franklin Memorial’s community.

Networking with a larger health system provides the rural facility with the opportunity to participate in a broader continuum of care. For example, the network could complement the primary and long-term care provided by the rural facility with secondary and tertiary services. This type of affiliation could provide access to longitudinal patient data that enables total health management across the care continuum. It might also present opportunities to participate in population risk-based payment arrangements.

Reduce readmissions. Given CMS’s Hospital Readmissions Reduction Program, reducing readmissions is a matter of financial survival for rural hospitals. Because of their relatively small volume of patients, one or two bad cases

RURAL HOSPITAL ROAD MAP TO VALUE

LOWER ←

ORGANIZATIONAL CAPABILITIES

People/Culture

Governance	Review Governance	Adjust Board Composition
Strategy and Structure	Review Strategy by Segment	
Management	Align Executive Leadership	Develop Common Plans and Goals
Physicians	Educate	Assess Performance
Staffing and Skills	Assess Needs	Plan Attritions
Communication and Culture	Deliver Value Message	Educate

Business Intelligence

Clinical Information Systems	Implement EHR, All Settings	Establish Alerts
Financial Reporting & Costing	Directional, Limited	Precise, All Settings
Performance Reporting	Core, Process Measures	Strategic Measures
Analytics and Warehouses	Review Data Governance	Integrate Clinical, Financial Data

Performance Improvement

Process Engineering	Identify Methodology(ies)	Establish Cross-Functional Forum
Evidence-based Medicine	Patient Safety	Readmissions and Hospital-Acquired Conditions
Care Team Linkages	Measure Primary Care Access	Expand Primary Care
Stakeholder Engagement	Create Transparency	Educate Patients

Contract & Risk Management

Financial Planning	Rolling Calendar	Update Cash Flow Planning
Financial Modeling	Maintain Short-Term View	
Risk Modeling	Analyze Profit/Loss	Estimate Financial Exposure
Contracting	Negotiate Prices	Partner with Quality

in a rural hospital might ruin an otherwise excellent track record in reducing readmissions.

Rural providers are strengthening skills related to measurement, process improvement, and care coordination to reduce readmissions. “We are very aware of our 30-day readmissions,” says Paula Caraway, director of quality at Andalusia. “Our readmission rate had been above average and is now below average. We now conduct post-discharge callbacks with congestive heart failure patients, who have significant rates of noncompliance with post-discharge instructions.” In addition, Andalusia has established relationships with several nursing homes that provide post-acute care. Crete Area Medical Center also has initiated post-discharge phone calls to patients to try to mitigate readmissions. Copper Queen Community Hospital has established a readmissions committee charged with monitoring and reducing readmission rates, and has also established post-discharge follow-up protocols.

Measure quality beyond patient satisfaction. Rural hospitals may have traditionally emphasized patient satisfaction as a predominant indicator of quality. Today, leaders are acknowledging the importance of high performance on other dimensions of quality. Michael Swan, vice president of quality at Franklin Memorial Hospital, said that rural hospitals’ “local touch” is an important but inadequate measure of quality. “There still have to be hard measures of processes and eventually, clinical outcomes.” Expanding the definition of “quality” beyond patient satisfaction to processes of care and outcomes requires underlying business intelligence capabilities including integrated clinical and financial data, as well as analytics.

Invest in business intelligence. Both Andalusia Regional Hospital and Franklin Memorial Hospital have made ongoing investments in inpatient clinical information systems. Franklin Memorial has had a clinical information system in

Degree of Care Transformation & Financial Sustainability				HIGHER
STRATEGIES & INITIATIVES				
Educate Leadership			Augment Governance	
Assess Mergers and Alliances			Bend Cost Curve	
Align Incentives			Manage to Measurement	
Align Compensation	Develop Leaders		Lead Strategies and Initiatives	
Add Staff Strategically	Educate	Align Incentives	Enhance Leadership	
Engage Stakeholders	Experiment with Payment, Care Delivery		Take Risks	
Establish Disease Registries			Develop Data Exchanges	
Longitudinal			Complete Per Member, Per Month Costing	
Outcomes			Population Based	
Develop Analytics			Support Real-Time Decisions	
Initiate Efforts	Utilize Data	Expand Cross-Department	Expand Cross-Continuum	
Standards, Protocols	High-Risk Care	Chronic Conditions	Wellness	
Right-Size Specialty Services		Partner Strategically		Manage Care by Setting
Share Decision Making	Engage the Community		Establish Patient Accountability	
Update Capital Budgeting and Capital Access Planning			Quantify and Allocate Initiatives	
			Conduct Multifactorial Scenario Planning	
Utilize Predictive Modeling			Develop Risk Mitigation Strategy	
Experiment with Value-Based Payment (VBP)	Partner with Payers		Prepare for Second-Generation VBP	

place for 17 years, and has added almost 50 interfaces to keep the system up to date. Andalusia has taken advantage of grant funding available from the state's largest commercial carrier to acquire a system that mines patient data on infection rates and positive cultures and triggers alerts on possible hospital-acquired infections.

In ambulatory settings, Andalusia and Franklin Memorial are proceeding at different rates. Franklin Memorial, which employs nearly all of its physicians, has all of the physicians on EHRs. Andalusia, with a predominantly independent medical staff, has approximately half of its physicians on an EHR. The hospital is converting to a new clinical information system over the coming year and hopes that many of the physicians not currently on EHRs will implement them after the hospital's new system is in place.

As payment methodologies increasingly require providers to capture costs across a continuum of care, rural hospitals will also need to invest in cost accounting capabilities. Both Franklin Memorial and Andalusia are making additional investments in cost accounting in consideration of emerging payment policies.

Ultimately, the investments that rural hospitals are making in their underlying clinical and cost accounting systems should enable integration of clinical and financial data to inform organizational decision making. Attracting skilled analysts who can cross-walk clinical and financial information may be a particular challenge for rural providers: In a Value Project survey of HFMA members, only 38 percent of respondents from rural hospitals were confident that they could find a sufficient number of appropriately trained data analysts within the next three years, as opposed to 73 percent of respondents from urban organizations. Information officers at hospitals interviewed for this report are focused on growing their own talent, identifying or hiring staff with promising skills that can be cultivated to meet future analytics needs.

Find and retain physicians and clinicians. This is often a serious challenge for rural providers. Both of the organizations that were the subject of site visits offer physicians the opportunity for salaried employment.

At Franklin Memorial, offering salaries to physicians has proven effective in attracting a physician base. "The hospital got into employing physicians by accident. As

practices started to go under, we had no choice but to employ key physicians," says Jay Naliboff, MD, director of medical practices for Franklin Community Health Network. "This leaves us with a big hurdle: How do you make the practices financially viable? ACOs, with better payment for primary care, would help."

For Andalusia and its predominantly independent medical community, medical practice independence and the attractiveness of the community as a place to live and raise children are especially important. However, CFO Shirley Smith notes that it is sometimes necessary to offer a salary guarantee, and this is a financial liability for the hospital.

Develop long-range financial plans. The potential loss of special treatment—specifically, reimbursement for reasonable costs by Medicare—is of significant concern to many rural providers. Both Franklin Memorial and Crete Area Medical Center leaders indicated that the loss of this funding source represents millions in lost revenue dollars.

If critical access and sole provider funding sources were removed from the federal budget, it is likely that the arrangements would be phased out over several years. Rural hospitals are beginning to undertake multifactorial scenario planning and augment their longer-range financial plans in consideration of the possibility that these funding sources go away. Franklin Memorial, for example, has begun to quantify this impact. Crete Area Medical Center has taken the next step of discussing immediate, intermediate, and long-range steps that the organization could take if it lost its funding.

Leverage boards and community assets. It is imperative that rural hospitals compose boards of local community leaders capable of understanding the complexities of the emerging payment environment and of making tough decisions in light of this new future.

Both Andalusia and Franklin Memorial have been strategic in the ways in which they have composed the membership of their boards. The CFO of a national flooring company's local plant (1,400 employees) is the chairman of the board of Andalusia Regional Hospital. The board chair of Franklin Memorial and two additional board members are associated with a local paper mill (800 employees). Board members and the companies they are associated with

are vitally interested in the quality of care provided by the hospitals and physicians in each community and the future economic viability of the rural facilities they are serving.

Rural hospitals should provide board members with a thorough education about the potential implications of reduced revenue and shifting payment methodologies. Both Andalusia and Franklin Memorial have strong governing boards that are well-versed on value-based payment and its implications for their hospitals. Franklin Memorial's leaders have spent a significant amount of time educating hospital board members about the emerging payment environment, competitive dynamics, and internal performance drivers. Wayne Bennett, the hospital's CFO, described board members as providing "strong board leadership at the appropriate level of governance. They are proactive, not reactive."

At many rural hospitals, becoming better positioned to respond to changes in payment and care delivery, particularly on the cost side, remains a major challenge for governing boards, management teams, and physician leaders.

For example, the board of Franklin Memorial was recently surprised by a financial downturn that was attributed to reductions in average length of stay and emergency department visits, which were the result of quality improvement efforts focused on reducing readmissions. This example illustrates the complexity of understanding and navigating the steps required to be successful under value-based payment while ensuring ongoing financial viability. Ongoing education of board members and hospital leaders, as well as superior financial planning, is vital to a successful journey toward improved value.

Rural hospitals have a competitive advantage in their ability to engage the communities they serve more broadly and to foster loyalty to their facilities. Most rural organizations are viewed as valuable community assets and have unique opportunities to leverage their strong community ties as they develop capabilities to improve the health of the local patient population.

Franklin Memorial has a particularly rich history of community engagement. In the late 1960s and early 1970s, a group of physicians associated with Franklin Memorial formed Rural Health Associates, an early HMO focused on disease prevention and community health. Ultimately,

Rural Health Associates had to disband because the model needed more members to sustain the financial risks involved. Bennett noted that having a larger system partner will help Franklin Memorial as it reconsiders a population health management strategy today. Meanwhile, Franklin Memorial is beginning to develop population health capabilities such as PCMHs and chronic disease registries.

OTHER STRATEGIES AND INITIATIVES

For rural hospitals to be successful under value-based business models, there are a number of additional initiatives, as described in the common road map, that should be undertaken to support the strategies above. Two are highlighted below.

Foster a more nimble culture. The ability to make informed decisions fairly quickly was cited as a competitive advantage by nearly every board member, executive, and physician interviewed in this cohort. The relatively small number of individuals involved in the decision-making process in rural hospitals, and their strong and unified commitment to doing what is best for both the community and organization, is typically viewed as a significant advantage. For example, Franklin Memorial was able to quickly consolidate two physician practices in a new building in Livermore Falls, about half an hour south of Farmington. "It's an effective model," says Jerry Cayer, executive vice president for Franklin Memorial. "We got rid of two buildings and kept our costs down. Plus, this protects our market to the south."

Rural hospitals are aiming to create cultures that embrace change. Bennett of Franklin Memorial shared that hospital leaders are emphasizing the importance of being nimble regardless of the future: "The message is, we need to be prepared for change." Crete Area Medical Center has made an effort over the last several years to engage its workforce in process improvement. Leaders are on message that "we are not cutting jobs" through process improvement efforts. Further, employees contribute to idea logs that are considered by management. Employees' performance evaluations consider the degree to which they generate ideas and participate in performance improvement. Crete's Betke noted that the hospital's employee survey indicates 99 percent engagement.

Invest in process improvement. Jim Heilsberg, Whitman Hospital and Medical Center’s CFO, described that facility’s investments in rapid process improvement as an effort to “see care delivery through a new lens. We are beginning to measure what we do, and looking for opportunities to reduce inefficiencies. We are beginning to change the mindset of how we deliver value, by changing systems of care.” Many of the hospitals interviewed for this report are focusing on chronic conditions for their care delivery reform efforts, investing in chronic disease registries to drive quality improvement in a manner that positions the organization for a population health management role.

Other rural hospitals are similarly leveraging process engineering as a means to improve financial and clinical performance. Diane Moore, CFO of Copper Queen Community Hospital, commented that process

improvement efforts are helping the hospital staff to function better as a team, and noted that process improvement efforts in 2011 resulted in \$800,000 in savings. Crete Area Medical Center uses Lean methodology to drive process improvement. Bryce Betke, Crete’s CFO, noted, “We are tackling process engineering to work smarter, not harder.”

RECOMMENDATIONS

Like the other provider cohorts, rural hospitals face the challenge of undertaking many strategies and initiatives simultaneously to prepare for emerging payment models. Rural hospitals have unique advantages to leverage, including relatively nimble decision-making processes and strong community affiliations. Recommendations for the rural cohort include the following.

RURAL HOSPITAL RESEARCH PARTICIPANTS

Participating Organization	No. of Beds	No. of Employed Physicians	Critical Access Hospital?	Payer Mix*	Geography
Andalusia Regional Hospital	88	2	No	58% Medicare 18% Medicaid 19% Managed Care/Commercial 5% Self-Pay	Andalusia, Ala.
Copper Queen Community Hospital	14	13	Yes	27% Medicare 32% Medicaid 35% Commercial	Bisbee, Ariz.
Crete Area Medical Center	24	9	Yes	43% Medicare 27% Medicaid 26% Managed Care/Commercial 4% Self-Pay	Crete, Neb.
Franklin Memorial Hospital	43	38	No	60% Medicare 20% Medicaid 18% Managed Care/Commercial 2% Self-Pay	Central Maine
New Ulm Medical Center	35	39	Yes	44% Medicare 17% Medicaid 38% Commercial 1% Self-Pay	New Ulm, Minn.
Whitman Hospital and Medical Center	25	0	Yes	75% Medicare/Medicaid 20% Commercial 5% Self-Pay	Colfax, Wash.

*Payer mix is based on inpatient discharges including normal newborns.

Position the organization to achieve greater scale. Rural hospitals would be well-served to improve scale to better position for coordinated care delivery and enhanced population care management from preventive care and wellness to end-of-life care. Strategies include expanding primary care and strategic partnerships with other providers, including aligning with a larger, neighboring system.

Plan for a future of reduced revenue. Today, many hospitals rely on critical access and sole provider funding and would suffer financially if that type of payment arrangement was discontinued. Given the risk associated with such change, and the extreme financial pressures that payers and employers are under, rural hospitals should conduct multiyear, multifaceted scenario planning that informs near-term, intermediate, and longer-term strategies to remain financially viable in an environment of extremely constrained revenue.

Determine the appropriate balance of primary and specialty care services to meet community needs. Primary care, including a focus on chronic disease management, should be a priority for rural providers and will help position their organization for a role in population health management. The prevalence of chronic diseases within the community should also help determine specialty care needs, such as cardiology, neurology, pulmonology, nephrology, podiatry, and ophthalmology. Factors including the size of the population served, its demographics, and the distance to larger facilities should help determine the

need for additional specialty services such as obstetrics or behavioral health. These factors will also aid decisions on whether specialty needs require a full-time physician on staff or can instead be met with visiting specialists, telehealth arrangements, or physician extenders.

Invest in business intelligence. The research suggests that rural hospitals lag other cohorts in their investment in business intelligence. Some facilities lack EHRs in outpatient settings, for example, and many are deficient in their costing capabilities. However, in light of emerging payment models, business intelligence is a sound investment. Like other types of providers, rural hospitals will need actionable information to cost effectively manage the health of a population and to identify areas of opportunity for improved quality at a reduced cost.

Leverage resources to strengthen community ties. One of a rural hospital's greatest assets is the loyalty of the local community. Leaders of rural facilities should be savvy in building boards with strong area business leaders with the acumen and fortitude to make tough decisions in a dynamic environment. Hospital leaders should seek opportunities to leverage board members' ties to the community, and exploit other points of local leverage to shore up a community's loyalty. More solid footing within the community can bolster opportunities for population health management, including creative, personal approaches to care delivery, from wellness to chronic disease management.

RESEARCH SPONSORS

Research for this report was sponsored by the 16 hospitals and health systems represented on HFMA's Value Steering Group:



HFMA's research was conducted with the assistance of McManis Consulting.



Special thanks to Terry Allison Rappuhn for her assistance with the project.

PUBLISHED BY



hfma[™]

healthcare financial management association

The Healthcare Financial Management Association (HFMA) provides the resources healthcare organizations need to achieve sound fiscal health in order to provide excellent patient care. With more than 39,000 members, HFMA is the nation's leading membership organization of healthcare finance executives and leaders. We provide education, analysis, and guidance; we lead change and innovative thinking; and we create practical tools and solutions that help our members get results. Addressing capital access to improved patient care to technology advancement, HFMA is an indispensable resource on healthcare finance issues.

**HFMA'S VALUE PROJECT: PHASE 2
THE VALUE JOURNEY
ORGANIZATIONAL ROAD MAPS FOR
VALUE-DRIVEN HEALTH CARE**

October 2012

Copyright 2012

**Healthcare Financial Management Association
3 Westbrook Corporate Center, Suite 600
Westchester, IL 60154-5732**

All rights reserved.

Correspondence: resourcecenter@hfma.org

SPONSORED BY

Med**Q**Assets