Tips to Transform the Rural Hospital Business Model

By Marian C. Jennings, M.B.A., M. Jennings Consulting

From volume to value. From fee-for-service to global payment. From episodic care to population health management. These are just a few of the ways the healthcare industry is struggling to transform itself. Perhaps unfairly, rural and critical access hospitals (CAHs) are learning that they need to take giant steps to transform their business model merely to keep their doors open.

Over 60 million Americans live in rural communities.[1] Twenty-one (21) percent of 430 rural hospitals across 43 states are at high risk of closing.[2] While dire, many of these organizations have found ways to rethink how they do business. This article presents tips and takeaways for boards at rural hospitals and health systems to reorient and transform their organizations not only to survive but thrive.

Tip #1: Imagine a 2025 Landscape Very Different from Today

Governance that facilitates transformation anticipates an extremely different future. One way to begin thinking "transformationally" is to answer the question, "Considering trends already underway, if I were going to start from scratch, how would I build this?" If your mission is some variation of "to improve the health of our community," a hospital-centric healthcare model unlikely would be the most effective approach.

Study after study confirms that medical care is but a small factor or "determinant" of health status. There is general agreement that health behaviors (such as exercise, tobacco use, healthy eating, and alcohol and/or substance abuse) and environmental factors (such as adequate housing, access to affordable and nutritious food, and transportation) play greater roles in determining health than does traditional medical care. Because of this, forward-thinking healthcare organizations strive to address social determinants of health while recognizing that no organization can address all of society's ills. You should identify the role your organization can and should play for those issues most affecting your community. For each area, clearly articulate how you should respond: as an advocate? organizer/coordinator of community resources? provider of "seed money"? direct service provider?

Tip #2: Advocate for New Payment Models That Support Transformation

An article in *Modern Healthcare* relays a story about a Southeast Arizona community in which the only area hospital, a CAH, closed. Jim Dickson, the CEO of the nearest hospital, Copper Queen Community Hospital, proposed building a freestanding emergency department there with other essential services such as radiology, a lab, a clinic for visiting specialists, and a physical therapy office. However, Arizona's Medicaid program had lowered the basic fee for freestanding EDs (in response to activity in more urban markets), making his proposed ED financially non-viable.

Instead of giving up, Dickson successfully lobbied state Medicaid officials to make an exception for rural providers, which allowed him to open the freestanding ED staffed by just an emergency physician and nurse practitioner. The facility now sees as many as 1,100 patients a month. About the project, Dickson said, "If you focus a rural hospital on inpatients, you are dead in the water. If you focus on outpatient and primary care, you will be successful."[3]

While admirable, some forward-thinking ideas such as Dickson's are difficult to implement in a fee-for-service payment environment that rewards inpatient hospital care. However, some states such as Maryland already have moved to a global payment model, while Pennsylvania currently has a Medicare demonstration program to pay 30 rural hospitals under a monthly global budget so that members can "retarget their services."[4] Lauren Hughes, M.D., Deputy Secretary for Health Innovation at the Pennsylvania Health Department said, "With a more stable cash flow, rural hospitals can step back and say this service line we rolled out for volume is not aligned with what the community needs, and now we can shift to behavioral health and substance abuse treatment."

While inaugural participants in the program continue to provide inpatient care as they develop population health strategies and reduce costs, some participating hospitals are expected to move away from offering inpatient care altogether. Since the Pennsylvania project launched, 36 other states have expressed interest in launching similar global budgeting demonstrations.[5]

Tip #3: Leverage Telehealth

Telemedicine has come a long way since healthcare's first small-scale dalliances with emerging technologies. Now there is a National Centers of Excellence designation for Telehealth, currently with two centers in the U.S. One of these is the University of Mississippi Medical Center (UMMC), located in a state with the greatest physician shortage in the country and the highest rates of diabetes, low birth weight, and death from heart disease.[6]

Key Board Takeaways

To help steer rural health providers toward transformation, board members can:

- Recognize the risks of not transforming/changing.
- Advocate at the local, state, and federal levels for rural healthcare, including payment changes that will reward transformation.
- Identify which social determinants of health are most critical in your community and articulate the organization's role in helping to address them (you cannot do everything!).
- "Keep an ear to the ground" for demonstration programs like Pennsylvania's that will allow the organization to try out new ideas with less risk.
- Be creative about technology and partnerships.
- Focus investment on the future, not the past, of the organization.

1 United States Census Bureau (available at www.census.gov).
2 David Mosley and Daniel DeBehnke, *Rural Hospital Sustainability: New Analysis Shows Worsening Situation for Rural Hospitals, Residents*, Navigant, February 2019.
3 Harris Meyer, "Reexamining Policy," *Modern Healthcare's* InDepth series, *Rethinking Rural Healthcare*, June 9, 2018.
4 Meyer, June 2018.
5 *Ibid.*
6 Rachel Arndt, "The Growth of Telehealth Improves Continuity of Care in Rural Communities," *Modern Healthcare,* June 9, 2018.

Telehealth care at UMMC includes primary care office visits via computer, tablet, or smartphone; remote patient monitoring; and, most notably, access to 35 kinds of specialty care statewide. The center is connected to over 200 locations across Mississippi, all but six of which are with organizations that are not part of the medical center. Some providers at the center offer only telehealth visits, while most provide a combination of virtual and in-person visits.[7]

Avera Health, in Sioux Falls, South Dakota, has grown eCARE, a suite of telemedicine services, over the last two decades to address some of the challenges of rural healthcare, eventually becoming its own separate revenue source for the health system.[8] Among these telemedicine services is Avera's eCARE ICU, which provides 24/7 ICU monitoring services for rural hospitals by connecting hospitals to intensivists. Avera describes this service as "basically air-traffic control for intensive care patients."[9]

Early telehealth attempts often were hindered by spotty or nonexistent reimbursement by payers. Now, in part due to advocacy from rural health organizations, Medicare is slowly evolving to reimburse for telehealth, including virtual check-ins between patients and clinicians by phone/electronically, remote evaluation of videos or images, standalone telephone consultations with rural health clinics or FQHCs, telehealth wellness visits with additional time for complex patients, and telehealth services as part of a basic benefit for Medicare Advantage plans or Shared Savings Programs.[10]

Conclusion

Transforming the business model of any organization is never easy. Given the challenges unique to rural health, these organizations must be ahead of the curve to keep their doors open. Boards play an essential role in identifying the risks of not changing and showing the courage to innovate and transform to continue their tradition of service to their communities, albeit using new models and approaches.

The Governance Institute thanks Marian C. Jennings, President, M. Jennings Consulting, Inc., and Governance Institute Advisor, for contributing this article. She can be reached at mjennings@mjenningsconsulting.com.

7 The University of Mississippi Medical Center Web site: www.umc.edu.
8 Donna Farris "Forging Rural Health Care Links," Health Progress, January/February 2015.
9 Avera eCARE Web site: www.averaecare.org.
10 Sema Verma, "Putting our Rethinking Rural Health Strategy into Action," CMS blog, May 8, 2019.