Rural Focus

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# Surviving and Thriving in the Post-COVID Era: Five Steps for Reinventing Rural Healthcare

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Rural hospitals and healthcare facilities face unique challenges. There is greater poverty, higher rates of alcohol and nicotine use, higher suicide rates, higher rates of deaths and serious injuries, and fewer physicians and qualified healthcare providers to recruit. Only 10 percent of physicians work in rural areas and almost 500 rural hospitals have closed in the past 40 years. The COVID pandemic has placed an additional strain on this already challenging environment with a decrease of 20–60 percent in operating revenues due to the constriction of routine care, elective procedures, and tests during the height of the pandemic. What are "best practice" and innovative rural healthcare facilities across the country doing to address these unprecedented challenges in order to reinvent the viable rural healthcare systems for the 21st-century post-COVID era?

## Key Board Takeaways: Opportunities for Rural Hospitals and Health Systems

- Look at value-based reimbursement methodologies to see which ones will work best for the organization.
- Work with their clinical staff to reconfigure job descriptions to more efficiently drive high-quality/low-cost care.
- Invest in the same management tools (e.g., clinical and business analytics) utilized by for-profit systems for decades.
- Build virtual healthcare delivery networks to provide low-cost/high-quality routine services.
- Create focused factories that enable them to market services far outside of their regions.

## 1. Change the Business Plan

Most healthcare systems, particularly in rural areas, are still deeply imbedded in a fee-for-service or, in the case of critical access hospitals (CAHs), a cost-based reimbursement system. This is problematic for several reasons. First and most importantly, fee-for-service reimbursement is on the decline and has been for over a decade. Rather than force healthcare organizations to transition into a value-based reimbursement methodology, Medicare and Medicaid are simply squeezing traditional reimbursement to compel this shift. In addition, CAHs realize that so-called "cost-based" reimbursement is not actually based upon true costs but upon fictional costs through its charge master and annual Medicare reports. Cost accounting reveals that this artificial reporting-based methodology has been propping up CAHs for some time and those days are becoming numbered. Therefore, many rural systems are emulating states like Maryland and are seeking a reimbursement system based upon their global budgets.

What are the advantages of such a system?

- First, the hospital will be rewarded (as opposed to penalized) for cutting costs, becoming more efficient, and driving improved outcomes. Ironically, cost-based reimbursement and fee-for-service reward the opposite.
- Second, the organization will not feel compelled to take on high-risk, low-volume patients who are critically ill or injured, often with less than optimal results. Rural hospitals thrive when they do what they do best: take care of high-volume/low-risk individuals with common healthcare problems. Poor outcomes drive lower community confidence and market share and it is essential

for rural communities to have complete confidence in the integrity and competence of their local facility.
- Finally, global payments will enable rural organizations to participate in potentially higher-margin value-based payment models that will reward high quality and lower costs, and lower costs is something that all rural facilities should excel at in comparison with their metropolitan peers.

## 2. Rewrite Job Descriptions So That Everyone Works at the Top of Their License

Rural healthcare facilities lose significant revenues when they assign clerical tasks to physicians and nurses—their most expensive and important resource. According to the American Medical Association, physicians who enter their own clinical data lose their organization up to 50 percent of their potential operating revenues and nurses approximately 70 percent (facility fees). Clinical documentation should be performed by LPN or RN scribes who are certified coders and who can see low-risk/high-volume routine cases under physician-based and supervised algorithms. The same is true for registered nurses who need to supervise LPNs, nurses' aides, and clerical personnel rather than attempt to perform all of these functions both to their and the patients' detriment. The majority of routine clinical care should be provided by nurses under the supervision of advanced practice providers (nurse practitioners and physician assistants) who are in turn supervised by physicians. In this way, rural facilities can leverage the use of fewer physicians and nurses more cost-effectively and drive improved results through the use of evidence-based practices of care.

## 3. Digitize Routine Healthcare Services

Of all healthcare facilities, rural healthcare systems should thrive in telehealth. Around 80 to 90 percent of healthcare services can be safely digitized so that individuals with routine post-operative care, chronic stable medical conditions, and routine healthcare maintenance can receive cost-effective services from the comfort of their homes. This is invaluable when people must drive long distances to a centralized rural facility, and they may not have the financial resources or coverage to pay for more expensive face-to-face experiences.

The ECHO program in New Mexico and Intermountain Healthcare's statewide virtual network are both excellent models that can be emulated anywhere. They provide rural healthcare systems with 24/7 coverage for all major medical and surgical specialties, as well as the ability to deliver routine services anywhere in the country 24/7, which opens up an entirely new revenue stream for rural networks. In addition, when more critically ill or injured patients are in the long recovery and rehabilitation stage, they can be safely transferred home to their rural facility from a tertiary/quaternary medical center, be closer to home, and receive the benefit of a lower-cost/high-quality 24/7 healthcare monitoring experience, which is yet another new source of revenue for rural facilities.

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## 4. Install Clinical and Business Analytics to Manage Proactively

Rural healthcare facilities have long struggled with the timely management of quality and cost of care due to the lack of clinical and business analytics. Most rural organizations have a gap of three months between when care is provided and when managers and clinicians know how well they did and how much it costs. Obviously, we need to stop managing healthcare through the "rearview mirror." Analytics enable managers and clinicians to manage labor, supply chain, and clinical practice in real time and even proactively by anticipating performance and cost, which will enable optimal clinical and business management. Rural facilities need the same management tools that for-profit systems have enjoyed for decades if they are to thrive in the 21st century.

## 5. Create Focused Factories for Direct-to-Employer Contracts

One of the greatest untapped opportunities for rural networks is to excel in the creation of profitable primary care networks. Three major reasons why organizations have traditionally lost money in primary care are:

1. The wrong person (physician) is doing the wrong job.
2. There is no professional clinical documentation (again traditionally performed by physicians).
3. There is inadequate risk and severity adjustment with regards to payers (another consequence of poor clinical documentation).

Best practice rural organizations create primary care-focused factories with LPNs and RNs seeing routine patients for comprehensive wellness visits utilizing algorithms developed by physicians for commonly occurring medical

problems. These individuals are certified coders who utilize software-supported coding algorithms developed and overseen by physicians and management. Nurses are overseen by advanced practice nurses and physician assistants who are overseen in turn by physician managers. Both advanced practice providers and physicians are available to consult for unusual or complex clinical cases and to meet with patients at the conclusion of the visit to collate clinical data and communicate about proposed treatment plans.

These successful programs can then be marketed throughout the region and beyond to large employers as population health programs, which will again create an entirely new profitable revenue stream for rural organizations. For example, SE Georgia Wellness Center in Vidalia, Georgia, two-and-a-half hours south of Atlanta, has a thriving focused factory and markets its services to Emory University in Atlanta, Georgia and Vanderbilt University in Nashville, Tennessee through direct-to-employer contracts.

## Conclusion

Rural healthcare organizations will need to transform themselves into 21st-century healthcare delivery systems that are fully digitized and utilize their scarce clinical resources in clinical management positions to lead high-quality/low-cost services through global budgets or risk-based capitation value-based reimbursement programs. Those that are willing to successfully navigate this transformation will thrive whereas those that cannot will place their organizations at risk. This is the time for governance, management, and clinical leaders to pursue value-based goals in the post-COVID era.

*The Governance Institute thanks Jon Burroughs, M.D., M.B.A., FACHE, FAAPL, President and CEO, The Burroughs Healthcare Consulting Network, Inc., for contributing this article.* *He can be reached at jburroughs@burroughshealthcare.com.*