Six Things Every Rural Hospital CEO Must Do

Rural hospitals are closing at a record pace.
Here are many of the reasons why this could have been avoided.

By Robert Thorn, MBA, FACHE
Director, Pinnacle Healthcare Consulting

I have had the good fortune to work in and with hospitals ranging in size and scope, from 25-bed Critical Access Hospitals to regional, tertiary medical centers of more than 500 beds, and one of the nation's top ranked academic medical centers. However, I have an acquired appreciation for small and rural hospitals, both PPS and Critical Access; hospitals that do not always have the same resources available to them as their larger counterparts do. I have often stepped-in as an interim CEO during the middle of an unplanned change in leadership, when people's futures seemed uncertain and morale was low. The reasons for the transitions are varied; however, there are a few common themes that have required these organizations to make a leadership change. As the "fresh set of eyes" coming into the facility, I typically perform a quick assessment to gauge the situation; specifically, how cash levels got to be where they are, how engaged and productive people are, how patients may feel about their providers, or how optimistic people are for the organization's future. This quick assessment is not scientific by any means, but rather a "finger on the pulse," determined primarily as a result of rounding, a lot of listening, and just simply by watching people. As Yogi Berra famously quipped, "You can observe a lot by just watching."

Whether you are an interim CEO or a permanent member of the executive team, you have signed on to serve the organization's best interests. This is not just a contractual agreement between the board and the CEO, this is also a matter of compliance. In this article, which is directed to rural hospital CEOs but applies to CEOs of any size hospital, I will share with you six topics I have learned that can help turn an organization around and keep it moving forward, proactively and deliberately. While there are a million things to keep your eyes on as a rural hospital CEO, it is important to remember that you, among other things, are the organization's lead strategist - its coach, quarterback, and cheerleader all in one. You are setting the course for the organization's growth and future. Although you are ultimately accountable, you direct, lead, work with and trust others in leadership, to ensure cash flow and revenue cycle management are performing optimally, clinical care is consistently high quality, rooms are clean and welcoming, food is warm and appealing, and people are engaged, passionate and productive. Therefore, by paying particular attention to these six areas, you can help keep the organization moving forward. Are these six items easy to implement? No, not necessarily; however, it is far less difficult to implement them proactively rather than reactively before the hospital gets to a "point of no return."

1. Fair Market Value Exercises for Physician Compensation

I am not an attorney, nor am I giving legal advice in any way. However, what I can say is, before you tell yourself, "*I really doubt the Office of Inspector General would ever have our little hospital in its crosshairs*," think about what you are saying, and doing. While it could very well be the case that you are far below OIG's radar, just because you think you will not get caught is not an excuse to operate outside of compliance with Federal Law. Even if unintentional, a "head in the sand" attitude is not serving your hospital's best interests. As a new or interim leader coming into a hospital, before you sign-off on a check request for a physician, you should review the contract to make sure what the physician is getting paid is accurately defined in the contract. Should you see something that could be cause for concern, you have no obligation but to address it. The same applies to anyone, and everyone, but especially the CEO.

Compliance issues with physician contracts are not only a possible legal liability, but they could also be contributing to a hospital's poor financial situation. The best way to stay within the guidelines, and to make sure the contracts are an appropriate exchange of services and compensation, is to adopt a policy for all physician contracts. Contract policy development and review is often most effective when performed through a board committee (with non-physician board members so they can avoid conflicts, legally, politically and other), allowing the organization to speak with one voice. The policy, which should be developed or at least reviewed by a healthcare attorney, should outline compensation levels to coincide with a consistent set of measurements, such as productivity, quality outcomes, medical directorships, hours training residents or a combination of any of these or other measurements, consistent and equitable regardless of the physician, gender, age, race, creed or other factors. For each physician being compensated, the policy should lay out a process for establishing compensation ranges. However, part of the reason many CEOs have elected to forgo a formal Fair Market Value review process has been the cost to undertake such a process. That does not have to be the case, though.

Pinnacle Healthcare Consulting produces an annual Fair Market Value Consulting Guide that states the Fair Market Value compensation ranges (hourly, annually, on-call, independent or employed) and production at the 25th, 50th, 75th and 90th percentile levels for different regions in the US for 102 physician and APC specialties. While there are other guides available, the Pinnacle FMV Consulting Guide sources multiple surveys in the formulation of its ranges. Pinnacle offers small and rural hospitals the tools to conduct their own analyses using Pinnacle's FMV guide, and will review work and attest to its reasonableness in writing, at very affordable rates. Therefore, the cost to conduct a FMV exercise is no longer a reason for any small or rural hospital to place itself at increased risk of a compliance issue when negotiating and executing physician compensation agreements.

2. Physician Demand Analysis

Many leaders in rural communities do not bother conducting a physician demand analysis since the populations are so small and the supply of physicians so lean, that they feel they already know the needs. While they may need "all specialties," they may only need a piece of each and could never really justify a full-time presence of a particular specialty in their communities. That being said, it is best to be proactive in knowing the needs of your community so you have some direction. Also, as I referenced in my previous section on physician compensation, knowing how much of a physician's time you may need can influence the compensation you plan to pay. You should have a range in mind that falls within Fair Market Value *before* you enter into discussions. You are doing this for your protection as well as the physician's.

So, where do you start? Whether it is part of your strategic planning process, Community Health Needs Assessment or just in response to some of your PCPs telling you about the number of patients they are referring to specialists in other communities, you need data. The more accurate the data, the better your response to needs. Some leaders use rough ratios to gain an idea of need; however, these ratios are often outdated and loosely applied without regard to market variables. A more accurate means of assessing needs should take a number of variables into consideration, including market demographics and population trends, current and anticipated medical staff succession, patient access issues, open versus closed practices, wait times for an appointment, referral and outmigration patterns, and other factors. Such an analysis should be conducted at least every three years, with annual adjustments, so that a three-year forecast and medical staff development plan, prioritized by specialty demand, may be created and followed. This plan may also be used to create a compelling argument to convince specialists to work with your community; and, it can be used, along with your anticipated Fair Market Value compensation ranges, to create a realistic budget for compensation of a "fractional-presence" of specialists in your community. Such plans are also considered a best practice for demonstrating responsiveness to community needs. And, in the event you are asked to assist an independent provider in the recruitment of an associate, such a plan is the most compliant means to show you exercised proper due diligence in meeting OIG and IRS requirements for community need.

Sound daunting? It is not, especially when you consider the alternative of "flying blind."

3. Strategic Planning

One of the most common practices I see in rural hospitals is using the budget as the organization's strategic plan, whether intentionally or by default. However, for a budget to be truly effective, it should be based on strategies, which drive goals and tactics, and the resources to support them. Planning assumptions, or premises, should be reviewed at least annually to drive each year's budgets; and, if not annually, at least every two years a rural hospital should undergo a formal strategic planning process. In today's rapidly changing healthcare environment, other than planning for major capital expenditures, strategic planning windows of more than two years could result in missed opportunities, changes in the market and the need to respond to new payment models. As an interim CEO who prepares an organization for its permanent leader, it is my job to walk the new leader, board, medical staff leaders and others through a post-leadership transition strategic planning process. It serves as an excellent opportunity for the new CEO to get an overview of both internal and external factors, how well the organization is positioning itself and performing, and to confirm the strategies already in place are sound. When a budget drives strategy, this opportunity does not exist.

Regardless of whether your organization has conducted a strategic planning process in the past, has used the budgeting process to drive strategies, or is transitioning to a new leader, Pinnacle Healthcare Consulting can provide a strategic planning solution that both drives your budget as well as fits within it.

4. Telehealth

With the introduction of COVID-19 into our world, providers have been scrambling to develop alternatives to people coming into the office to be seen. The government cleared a lot of hurdles to allow providers and patients to see one another via video platforms. Medicare even changed its restrictions for reimbursement; state licensure has at least been temporarily waived, as well. Regardless of whether these changes are temporary or permanent, having a solid plan to provide safe alternatives for patients and doctors to use in getting together will be required to navigate the "new normal." Moving forward, it is the patients' expectation that providers offer convenient, effective and secure telehealth options. So, where do you start?

As stated previously in section 2, "Physician Demand Analysis," I mentioned the need to assess your medical community and identify where there may be opportunities for an increased presence of specialists. While there can be an argument made that nothing is better than for a doctor and a patient to be in the same room at the same time, there is also an argument that can be made as to whether having a doctor and a patient in the same room is always a good idea. Besides the COVID-19 pandemic, patients living in rural communities have other factors to consider, such as driving long distances, sometimes in questionable weather, and often having multiple appointments requiring multiple trips. Therefore, if you have not done so already, it is time to assess your community's medical staffing needs; and, based on these needs, determine which physician specialties are needed, and if they can they be supported through a virtual presence. Do they need a face-to-face exam, or will data (medical test results, remote patient monitoring, images, etc.) prove to be more meaningful to the physician? Furthermore, where do opportunities lie for recurring treatments, such as dialysis? Can they be coordinated and safely offered in a setting previously considered unacceptable because the specialist is not routinely physically present? Telehealth has opened the door for rural hospitals to provide diagnostic and therapeutic services that could both benefit the patient through increased local access, and the hospital through an ability to offer services and retain the revenues that were going to another community. It can also help position the hospital for value-based models of care, allowing the hospital to better manage its risk by addressing chronic conditions proactively and cost-effectively, rather than reactively and costly. After all, telehealth is more than two-way video that has come into the limelight as a result of the COVID-19 pandemic. It is yet another tool providing valuable information that providers can use to assess conditions, treat and manage care, driving a more responsive approach and, in many cases, a higher quality outcome for the patient. If you have not considered telehealth as a viable option for you community, or if the specialists to whom your physicians refer patients have not, please contact me and I would be glad to discuss options with you.

5. Telepharmacy

As I travel to rural communities and learn more about how they operate, one constant challenge I see is related to in-house pharmacies for Critical Access Hospitals (CAHs). Many of these CAHs are too small to justify having a pharmacist on staff; rather, dispensing of medications is often left to one or two well-trusted nurses. These nurses are sometimes supported by a traveling pharmacist or retail pharmacist in the community, who ensures medication inventories are monitored and that everything is properly accounted for. However, while these pharmacists provide a valuable and much needed service to their community hospitals, the number of rural pharmacists is declining. Consequently, many of them do not consult with physicians prospectively and review and verify orders prior to dispensing, as they commonly do in larger hospitals that have pharmacists in-house.

Just as primary care physicians may send EKGs to a cardiologist or images to a radiologist, medication orders can be securely sent electronically to a remotely-located clinical pharmacist for review. When done properly, the improvement in coordination of care can be felt very early on. Specifically, when one particular telepharmacy program was started by a regional tertiary medical center with five Critical Access Hospitals, every time a new hospital was brought on-line, there was a pharmacist-initiated intervention within the first two weeks. These were all good, quality rural hospitals with quality physicians and staff. However, when orders were passed in front of the knowing eyes of a clinical pharmacist for review, in real-time prior to dispensing, things were seen that may have been previously missed. And, once you go to that level of care, you will wonder why you had not done it sooner (and possibly, shudder…). Besides patient safety, the improvements you will see with the involvement of a clinical pharmacist in real-time consultations, review and verification of orders, include the possibility of less waste from use of lesser-effective medications.

If you would like to consider setting up a telepharmacy program in your hospital, Pinnacle Healthcare Consulting is ready to help.

6. Board Education

I once had the opportunity to hear a legendary, now since-retired hospital CEO-turned-university professor give a presentation to a group of Critical Access Hospital boards with whom I was working. Once each year, at the least, I would bring rural hospital boards together for an educational summit where they could put community differences aside (who won the most recent football game could be cause for some very hard feelings), to learn about their roles and responsibilities as board members. This guest lecturer started his presentation with a simple question: “Who is responsible for the care provided in your community?” He went around the room to hear the different answers. Most people said it was the doctors, thinking that was the obvious answer. Some said it was the nurses, who “really do the work” prescribed by the doctors. And, others gave answers ranging from the CEO, who brings all the “moving parts” together, to the EVS staff, who keep the environment clean and warm-looking, thus reassuring patients they came to the right place for their care. While the guest lecturer agreed with all these answers, that each was responsible for their pieces of the puzzle, he asked again which one position, out of all the people in the organization, was responsible for the care provided in the community. The consensus went to the doctors.

The gentleman chuckled and smiled, and slowly walked to a front row table, slamming his hand down, jolting even those in the back row. "WRONG!," he exclaimed. "Look around. Who do you see? A Board member. The answer lies in this room. Board members are ultimately responsible for the care. After all, do they not sign-off on every member of the medical staff, attesting to the skills and education of each? Do they not set strategy, instruct the CEO on identifying the most existential matters, and approve budgets from which to operate, provide services and ensure new equipment can be purchased? Yes, each one of you has the ultimate responsibility for the care provided in your community; and, the accountability and legal responsibility that goes with it."

The room went silent. I was starting to wonder what I had done, inviting the board members into their own private episode of "Scared Straight." However, it was a very effective reminder, almost a re-booting of these boards, to understand what their individual and collective purposes were. He now had their attention, and they spent the day learning about topics before which many had no knowledge, and to whet their appetite for learning more.

This one education session hit me like a ton of bricks. For most people in the room, this one day was their only real education as board members. Compare that one day to the education efforts of the organizations these board members govern, where licensed professionals are required to maintain skills and demonstrate competencies. However, board members, who are often lay people, serve on their boards for a variety of reasons. Some are elected, others appointed, but rarely are they required to demonstrate industry knowledge or preparedness. Rather, by design, they represent all walks of life, and often join and start serving without much more than a brief orientation. According to a survey by the American Hospital Association (2019), only 29% of hospitals and health systems said they required continuing education for board members in the last year. Some states, such as Georgia, now require board members, CEOs and CFOs to receive continuing education in Healthcare Finance. While one could argue that the subject of Finance is only one aspect of healthcare, an often complex and confusing one at that, it is a start. Compliance, Quality and other important subjects will hopefully follow; but starting with Finance is certainly understandable, as it has been the one area where rural hospitals have been struggling, and a leading cause of rural hospital closures. Researchers at the University of Washington (2019) examined rural hospitals and found that while the closings of urban hospitals had no impact on their surrounding communities, rural hospital closings caused their populations to see mortality rates rise 5.9 percent. In the case of the State of Georgia, it has recognized that in order to hold a fiduciary responsibility to an organization, and an accountability for the care provided in their communities, board members must have an understanding of how its system works. Board education is the way that State plans to address it.

To those serving rural and Critical Access Hospitals outside of Georgia, we can raise the bar from the 29% of organizations that require board education. It does not take a lot of money to bring in an expert such as the guest lecturer used in this example. State hospital associations and other groups offer sessions for boards regularly. Yet, before COVID, when I attended these conferences, most of the participants I saw were hospital executives and possibly a small delegation of board members, usually those whose turn it was to attend a conference that year. Now, with the pandemic upon us, more and more of these educational conferences are being offered virtually. Even if the registration cost is the same as it had been for in-person conferences, there is no travel, lodging or meals out with a virtual conference. It does not get much simpler, or cheaper, than this. As board members often serve as unpaid volunteers, virtual conferences can help keep them from missing work, which may have been a reason why so many hospitals have not required continuing board education.

I am not suggesting a board become more educated to manage the hospital and possibly assume responsibilities of the CEO; rather, just the opposite, to support the CEO in collectively making informed, well-educated decisions. A strong and well-educated board will know the difference between governance and management. As challenges continue to face rural and Critical Access Hospitals, which are closing at a record pace, now more than ever is the time to invest in board education. By educating boards, the people at the tip of the accountability spear, the stage is set that the right decisions are being made for the right reasons by the right people at the right time.

If your organization would benefit from Board Education, Pinnacle Healthcare Consulting has speakers to cover all major topics, including Governance, Compliance, Quality, Strategy and Value-based Care models.

About the Author

Robert Thorn, MBA, FACHE, is a Director at Pinnacle Healthcare Consulting, where he serves in interim CEO roles for rural and Critical Access Hospitals and as a strategic advisor to Boards for healthcare organizations of all sizes. Robert has held C-suite and other operational and strategic positions on the east and west coasts, and in the Rocky Mountain region, for both large and small healthcare organizations and networks. Robert has also led the development of several "first-to-market" programs, including a Program of All-inclusive Care for the Elderly (PACE) in Boulder County (Colorado), telehealth programs that became national models while at Banner Health, and the tobacco "Quitline" cessation programs for the States of Colorado, Idaho, Montana, and Ohio while at National Jewish Health. He is a Fellow of the American College of Healthcare Executives (FACHE).