BEST PRACTICES CHECKLIST – OPERATIONAL PERFORMANCE (PART 2)

June 11, 2025

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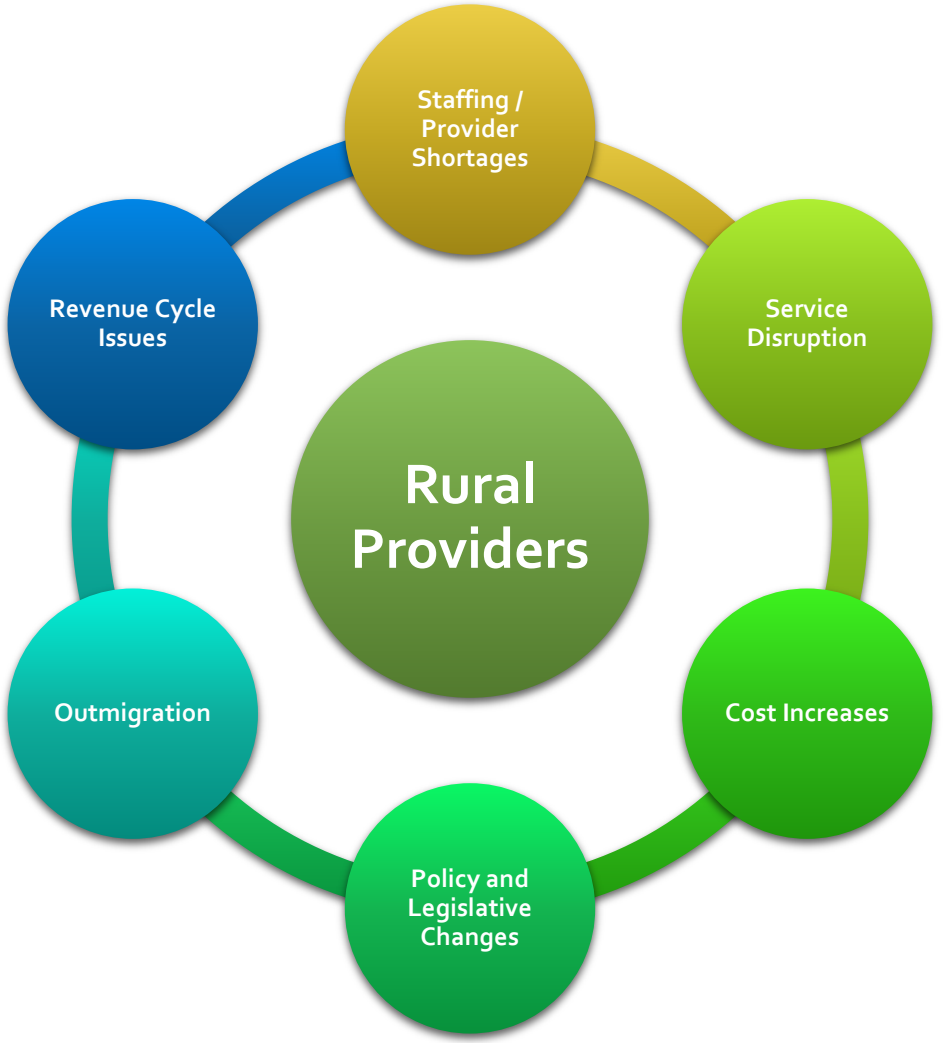
OVERVIEW

The Current Landscape

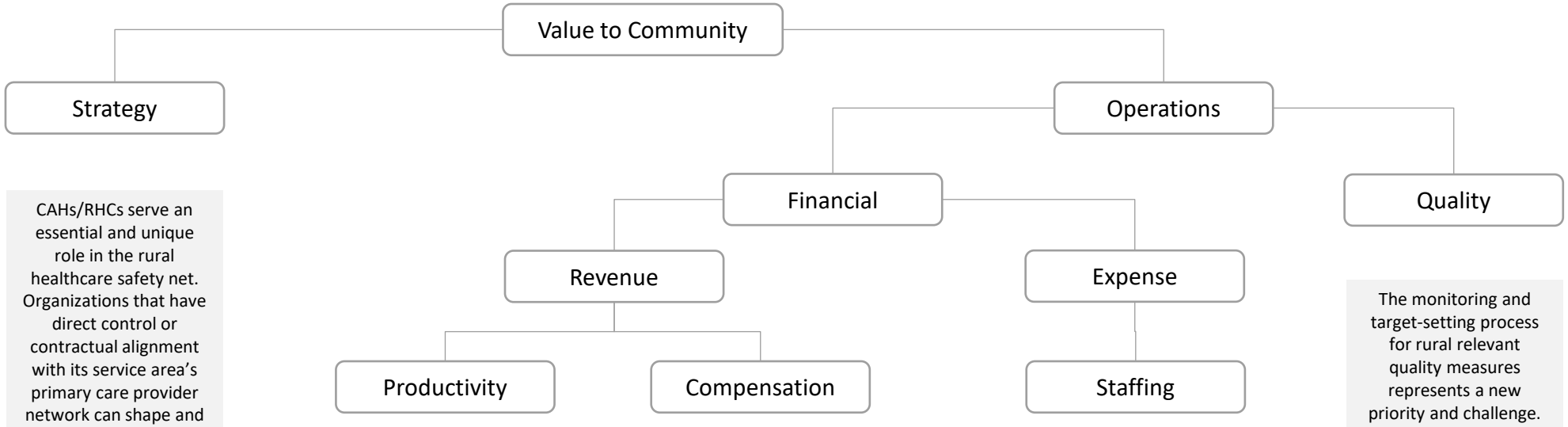
- Rural providers continue to experience cost increases, while having to address staffing shortages, outmigration, and significant policy/legislative changes

- The past few years have fundamentally changed how many patients receive healthcare services
  - Organizations must take a proactive approach to address these changes
  - Population-based initiatives and telehealth continue to gain traction across the industry



DOING MORE WITH LESS

Performance Model



CAHs/RHCs serve an essential and unique role in the rural healthcare safety net. Organizations that have direct control or contractual alignment with its service area's primary care provider network can shape and guide how prevention, education and patient care processes are implemented across the service area.

In rural America, we've learned to do more with less. This principle should apply to all service areas, when appropriate, by working with staff to work at the top of their license.

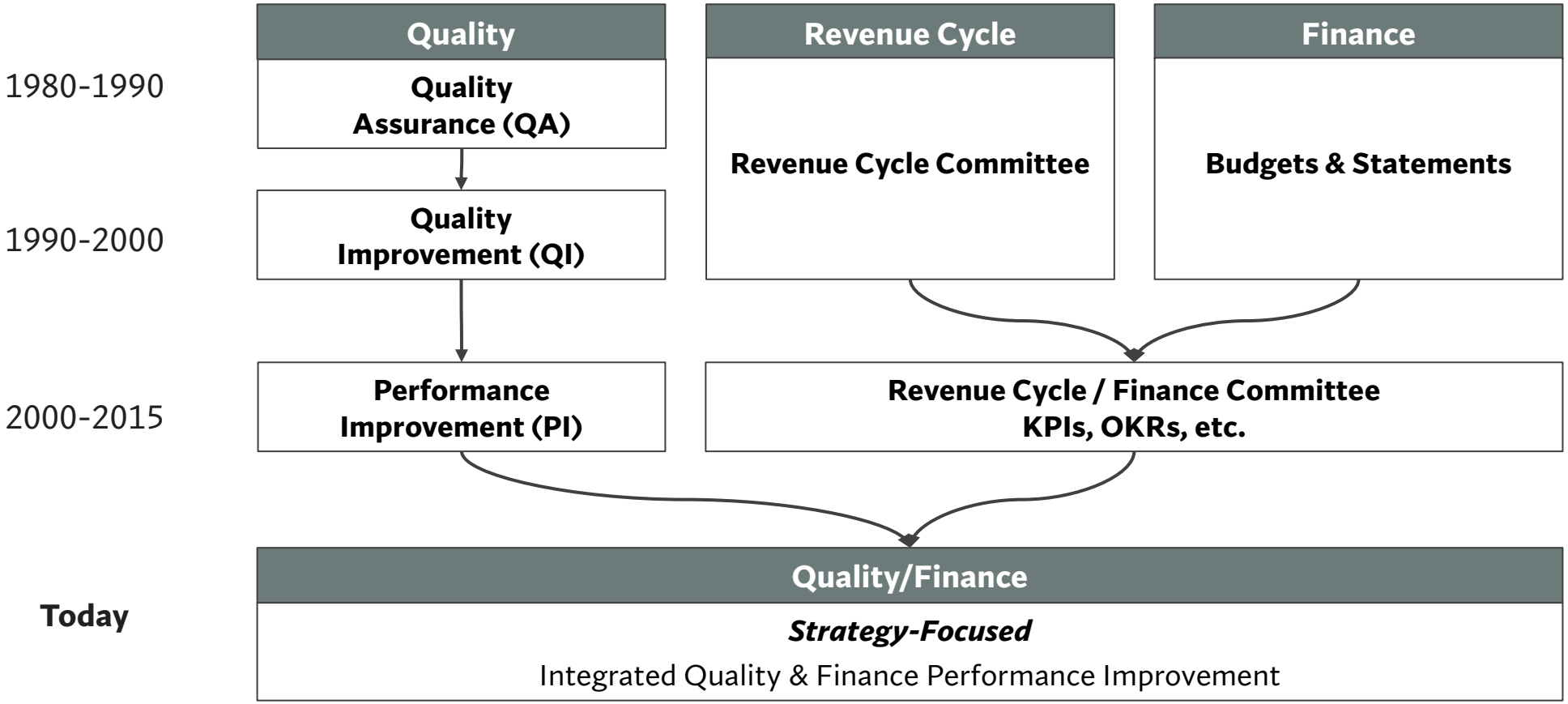
Compensation scale and design are key drivers of performance and satisfaction. How staff are paid can vary widely but compensation models should be tailored to your market realities.

Staff are the single most important asset and should be the primary focus for leaders. Having the right mix of motivated professionals is the key to performance.

The monitoring and target-setting process for rural relevant quality measures represents a new priority and challenge. Quality measures will also increasingly influence reimbursement via Value Based Payment programs.

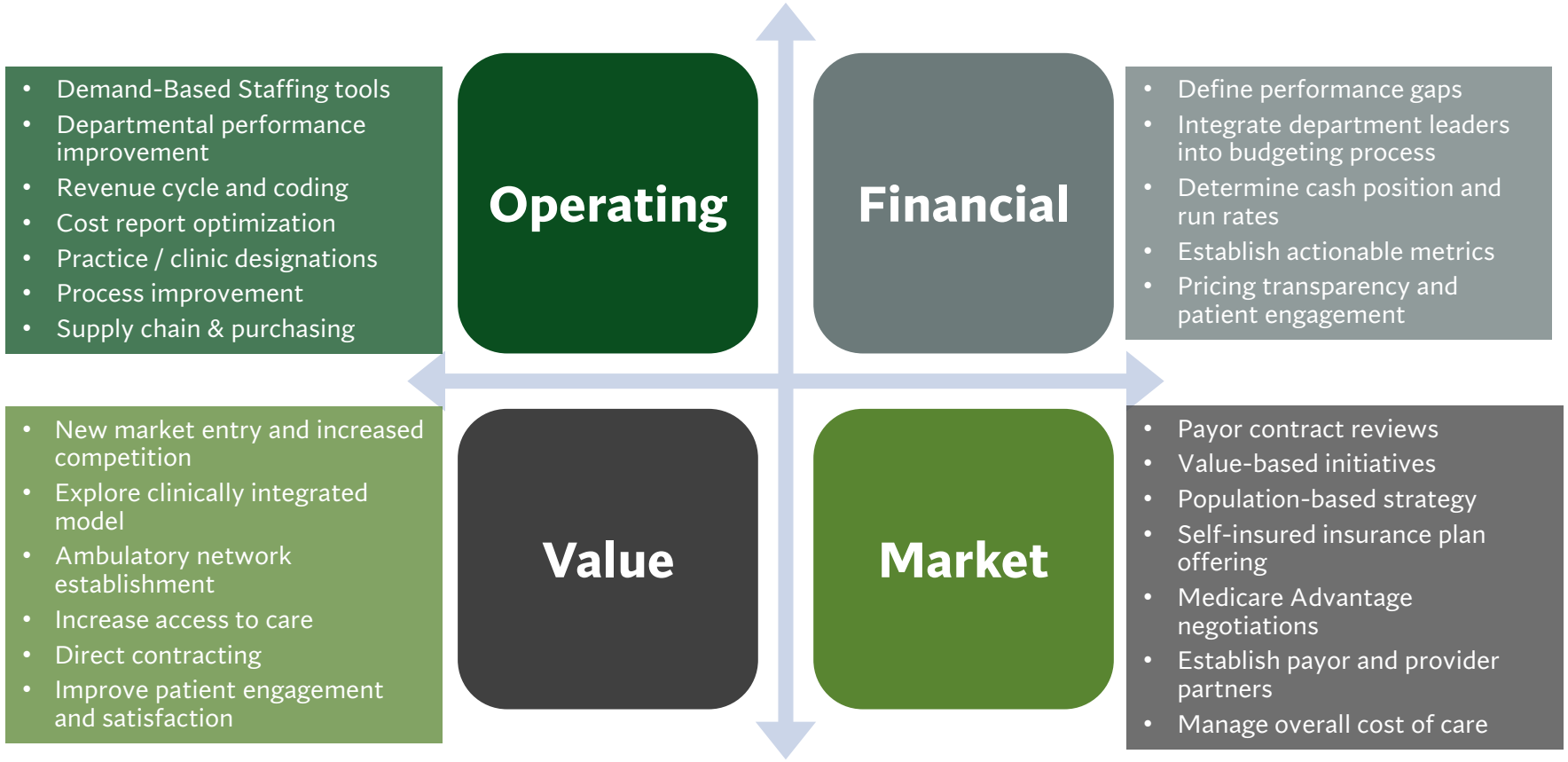
Evolution of Improvement Model

- Healthcare is a segmented industry where quality and finance continue to operate as separate business units with limited integration



Performance Improvement Opportunities

Organizations must focus and establish plans for each of the four identified areas to improve the organizational position



Operational Best Practice Checklist

1. Patient Access and Scheduling

- Timely appointment scheduling
- Reduced patient wait times
- Minimize no-show rates
- Leverage telehealth for access
- Standardized registration process for all providers

CTA **Monitor schedule fill rate and no-show rate**

Common Key Discoveries

- Inefficient scheduling leading to long wait times
- High no-show rate due to lack of reminders
- Inconsistent use of scheduling templates
- Limited telehealth integration
- Understaffed during peak appointment times

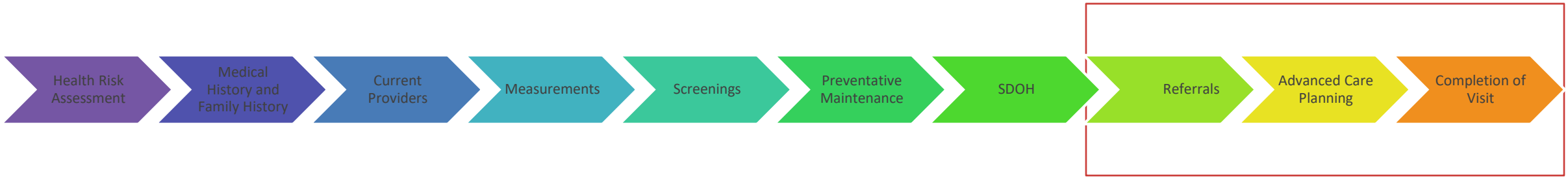
Schedule Fill Rate

	Practice 1	Practice 2	Practice 3
Appointment slots available for scheduling	3200	3200	3200
Appointment slots booked including double booked slots(slots used for double-length appointments)	2400	3040	3040
Appointment slots available but not booked	800	160	160
Fill Rate	75%	95%	95%
Number of missed appointments	100	400	100

Goal Fill rate of 90-95%

Nurse-Driven AWV Workflow

- Assign nurses to lead AWV preparation and patient education
- Schedule provider for a 15-minute review and sign-off slot
- Use pre-visit planning to gather patient data (e.g., screenings, history)
- Implement time-blocked schedules to ensure workflow efficiency



Implement Pre- Visit Planning/Processes

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Team based approach to planning for patient appointments

- Registration
- Nursing
- Care Coordinators

Utilize a checklist to review pre visit tasks:

- Pre-visit labs and other diagnostics arranged and completed
- Review of preventative maintenance measures the patient qualifies for and are due
- Review of immunizations that are due
- Review of necessary screenings to complete

Patient appointment reminder

- Multi different modalities for reminders
- Reminder of appointment time and items to bring with them including:
  - Drivers license
  - Insurance card
  - List of medications
  - Recordings of blood pressures, blood sugars etc..

Care Management Services

Medicare allows care management services that include transitional care management (TCM), chronic care management (CCM), principal care management (PCM), principal illness navigation (PIN), general behavioral health integration (BHI), and psychiatric collaborative care model (CoCM) services

2. Staffing and Workforce Management

- Optimize staffing patterns
- Cross train staff for flexibility
- Reduce turnover for a positive cultures
- Create team-based care models

CTA **Evaluate staffing efficiency and employee satisfaction to ensure a productive workforce**

Common Operational Assessment Key Discoveries

- Understaffing during peak patient hours
- Lack of cross-training for versatile roles
- Lack of standard process and nurse driven workflows
- High turnover due to workplace culture
- Inadequate staff training on RHC operations

Team-Based Care

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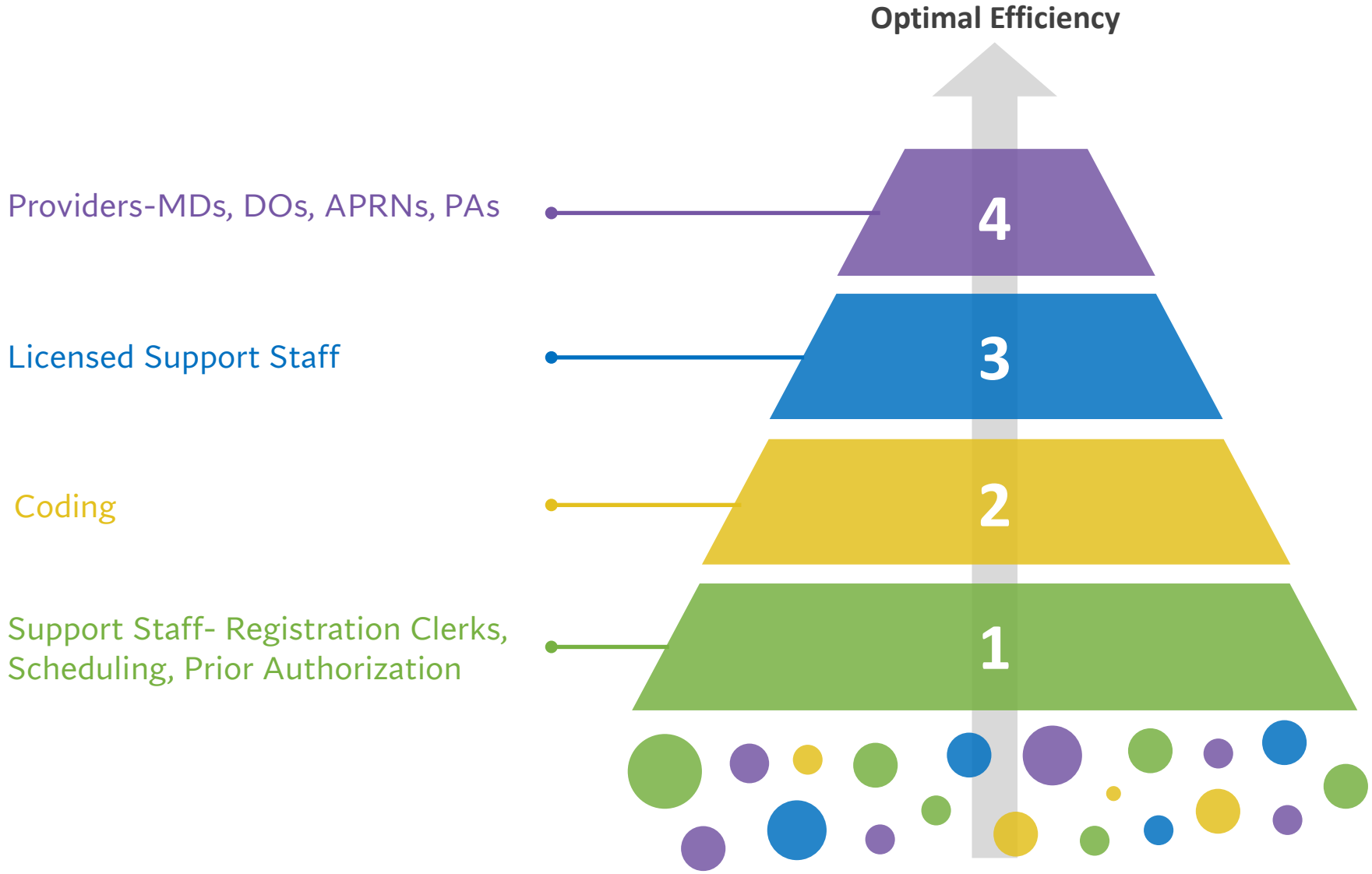
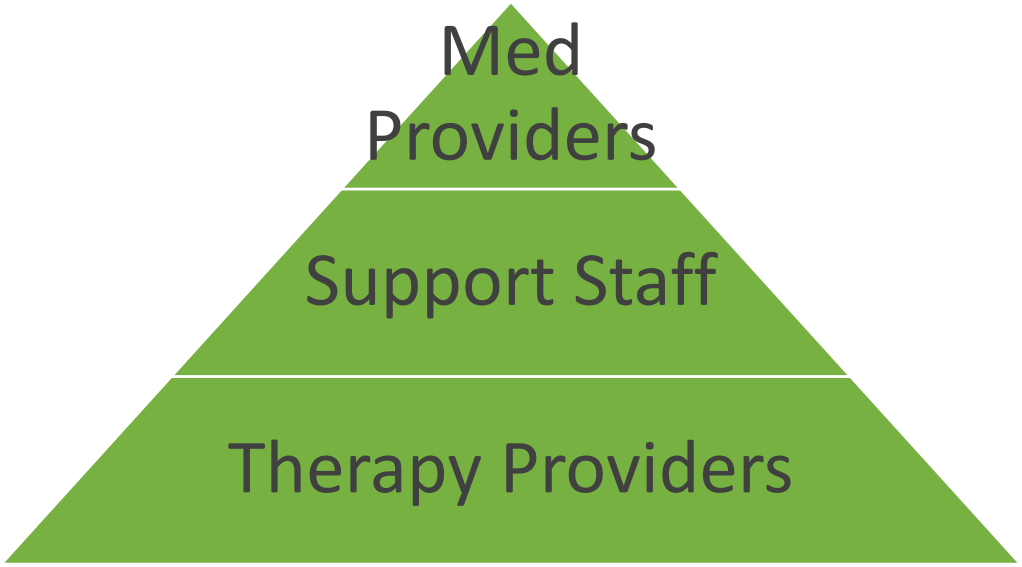


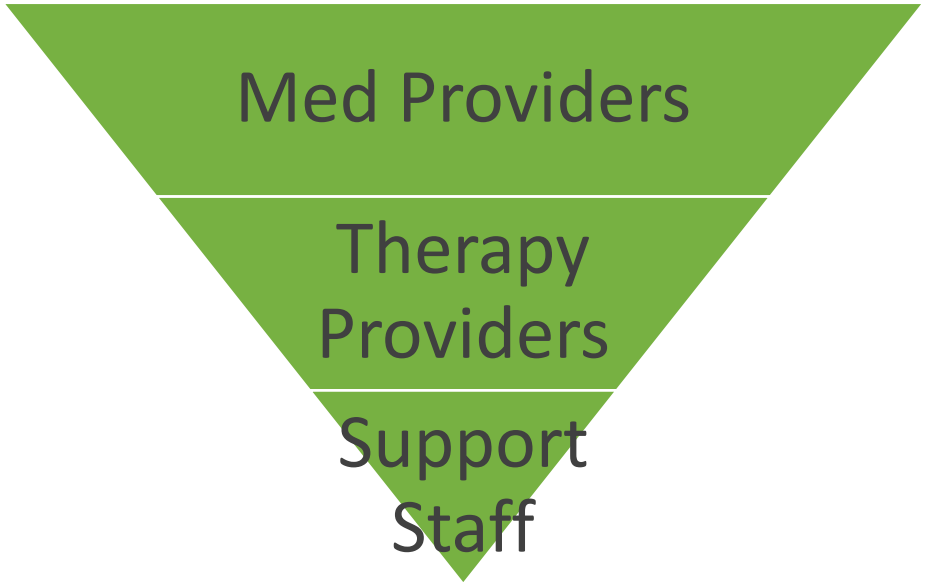
Stratification Matters

Proper staffing models are essential to financial viability. All to often, the model on the right is the norm. This forces medical providers to practice below their license and all licensed professionals to perform clerical work.

Sustainable Staffing Model



Unsustainable Staffing Model



Breaking Down Costs

As verbal therapy providers are added, the verbal therapy burden of prescribers can be decreased to create capacity for medication therapy, driving the cost per visit lower.

Therapist Staffing Calculation					
	Clinical Hours	Avereage visit duration	Total Potential	No Show Rate	Expected Visits
Prescriber	39	30	78	20%	62
Therapist	30	60	30	20%	24
Therapist VT Only (40%)			12		10
Thrapist MT/VT			18		14
Minimum Therapist Requirement					**4**

Staffing Cost					
	Count	Cost Per	Total Cost	Annual Vists	Cost Per Visit
Prescriber	1	$120,000	$120,000	2995	$ 40.06
Therapist	4	$ 70,000	$280,000	4608	$ 60.76
Clerical Staff	1	$ 45,000	$ 45,000		
Total	**6**		**$445,000**	**7603**	**$ 58.53**

Therapist Staffing Calculation					
	Clinical Hours	Avereage visit duration	Total Potential	No Show Rate	Expected Visits
Prescriber	39	15	156	20%	125
Therapist	30	60	30	20%	24
Therapist VT Only (40%)			12		10
Thrapist MT/VT			18		14
Minimum Therapist Requirement					**9**

Staffing Cost					
	Count	Cost Per	Total Cost	Annual Vists	Cost Per Visit
Prescriber	1	$120,000	$120,000	5990	$ 20.03
Therapist	9	$ 70,000	$630,000	10368	$ 60.76
Clerical Staff	1	$ 45,000	$ 45,000		
Total	**11**		**$795,000**	**16358**	**$ 48.60**

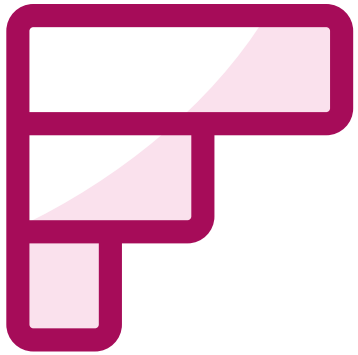
3. Denial Management

- Train staff on accurate coding
- Implement a clinical documentation improvement team
- Identify denial trends early
- Train staff on RHC billing implications and rules

CTA **Establish denial management protocols and staff training to minimize revenue loss**

Common Operational Assessment Key Discoveries

- Inaccurate coding leading to claims rejections
- Lack of documentation to support coding
- Lack of documentation to support medical necessity leading to denials
- Lack of staff understanding of RHC caveats



Rank your provider's level of knowledge related to RHC billing implications and rules?

3. Denial Management

Establish	Establish a Team. Identify Resources to leverage expertise and input.
Organize	Organize Processes – Create an honest environment and routine reporting of denials.
Identify	Identify Trends and root causes. This is not a blame game but rather survival mode.
Implement	Implement solutions, identify clear and concise policies/ protocols to ensure recovery of current denials and prevention of future denials.
Analyze	Establish Analytics. Sometimes what is reported for denials, is not the entire picture. Ensure a standard data method to capture and report denials and internal controls for monitoring..
Act	Act Quickly. Timeliness of denial workflows is extremely important. Expectations should be clearly identified to billing staff and adherence must be monitored.
Celebrate	Celebrate Success and Build Team Confidence. Monitor recoveries and incentive staff. Staff that feel valued and that they are making positive contributions to the organization

Enhance Hierarchical Care Coding

- Document chronic conditions thoroughly for proper HCC capture
- Train staff on HCC coding guidelines and updates
- Use EHR tools to flag uncoded or under-documented conditions
- Conduct regular audits to ensure coding completeness

Common HCC Coding Assessment Key Discoveries

- Incomplete documentation of chronic conditions (e.g., missing diabetes complications)
- Lack of staff training on HCC coding specificity
- Underutilization of EHR alerts for HCC opportunities
- Inconsistent coding audits leading to missed revenue

4. Clinical and Financial Collaboration

- Collaboration is a must and communication is key
- Align clinical workflows with billing
- Share data for better decision making
- Monitor quality and cost metrics

Foster teamwork between clinical and financial teams to optimize care and revenue

Common Operational Assessment Key Discoveries

- Siloed clinical and financial operations
- Poor documentation affecting reimbursement
- Lack of share goals and shared language
- Inadequate training on financial impacts

5. Clinical Operations and Quality Care

- Map Current State
- Standardize evidence-based protocols
- Optimize EHR efficiency
- Monitor quality metrics regularly
- Focus on patient centered outcomes

CTA **Track quality metrics and streamline workflows to support enhance patient care**

Common Operation Assessment Key Discoveries

- Providers influence templates based on preference.
- EHR inefficiencies slowing down workflows
- Data validation issues with reporting
- Gaps in quality metric reporting-CPTII codes
- Limited focus on patient outcomes

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Hierarchy of Quality Measurement (QM)

- **Structural measures**
  - The foundation of QM - evaluates infrastructure/capacity of health care organizations to provide care (e.g., equipment, personnel, or policies)
  - Examples - % of providers using an electronic health record, % of diabetics tracked in a patient registry, staff to patient ratio

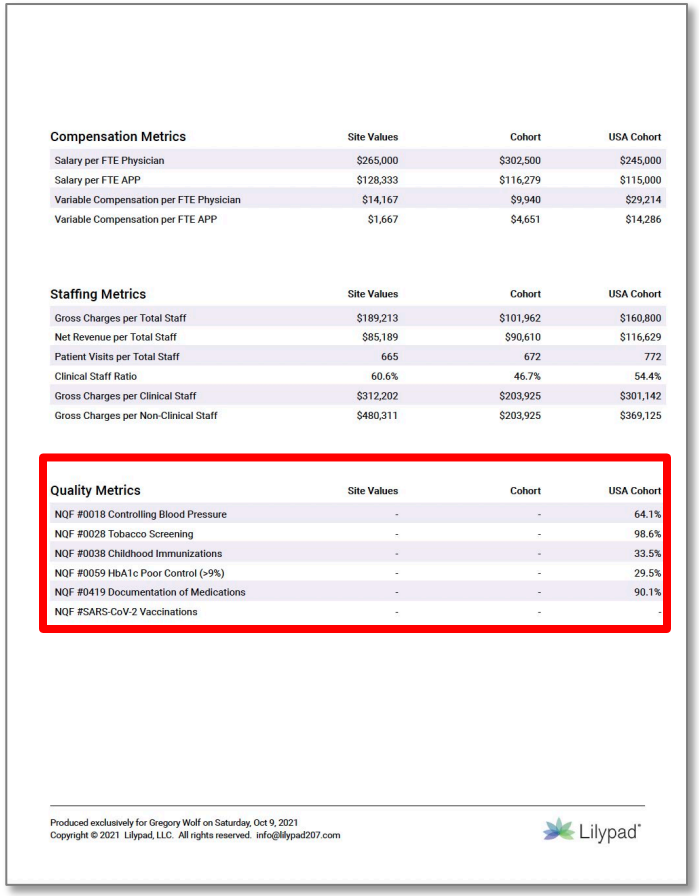
- **Process measures**
  - The building blocks of QM that focus on evidence-based steps that should be followed to provide good care
  - When executed well, increases the likelihood of a desired outcome
  - Examples – medication reconciliation, colorectal cancer screening, use of aspirin for patients presenting with ischemic vascular disease

Hierarchy of Quality Measurement (QM)

- **Outcome measures**
  - Evaluate/assess the results of care on a patient's health, such as clinical events, recovery, or health status
  - Outcome measures are slots into which process blocks fit
  - Process and outcome measures go hand in hand as improving a process can result in an improved outcome
  - Examples: optimal asthma control, long-term complications of diabetes, controlling high blood pressure

- **Composite measures**
  - Combines individual measures to produce one result that gives a more complete picture of quality for a specific area or disease
  - Examples – comprehensive diabetes care, substance use screening and intervention, optimal vascular care

What Quality Measures Should We Track?



Compensation Metrics	Site Values	Cohort	USA Cohort
Salary per FTE Physician	$265,000	$302,500	$245,000
Salary per FTE APP	$128,333	$116,279	$115,000
Variable Compensation per FTE Physician	$14,167	$9,940	$29,214
Variable Compensation per FTE APP	$1,667	$4,651	$14,286

Staffing Metrics	Site Values	Cohort	USA Cohort
Gross Charges per Total Staff	$189,213	$101,962	$160,800
Net Revenue per Total Staff	$85,189	$90,610	$116,629
Patient Visits per Total Staff	665	672	772
Clinical Staff Ratio	60.6%	46.7%	54.4%
Gross Charges per Clinical Staff	$312,202	$203,925	$301,142
Gross Charges per Non-Clinical Staff	$480,311	$203,925	$369,125

Quality Metrics	Site Values	Cohort	USA Cohort
NQF #0018 Controlling Blood Pressure	-	-	64.1%
NQF #0028 Tobacco Screening	-	-	98.6%
NQF #0038 Childhood Immunizations	-	-	33.5%
NQF #0059 HbA1c Poor Control (>9%)	-	-	29.5%
NQF #0419 Documentation of Medications	-	-	90.1%
NQF #SARS-CoV-2 Vaccinations	-	-	-

The **National Quality Forum** is responsible for coordinating the development and ratification of clinical quality measures. The following five NQF metrics have been identified via research by John Gale from the Maine Rural Health Research Center as the most rural relevant.

Maine Rural Health Research Center

John Gale, Director of Policy Engagement
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The PQRS and then MIPS public reporting programs for physician practices included 100+ potential measures, most of which were relevant to large urban practices and multi-specialty practices. Few of the metrics were rural relevant and/or valid for small volume clinics.

6. Identify Duplication and Redundancy

- Audit workflows for overlapping tasks
- Consolidate redundant processes
- Standardize documentation practices
- Eliminate unnecessary resource use

Review operations to identify and remove duplication for improved efficiency

Common Operations Assessment Key Discoveries

- Overlapping tasks across departments
- Redundant documentation requirements
- Lack of standardized workflows
- Failure to track resource utilization

7. Risk Management

- Compare reported data with patient feedback
- Address gaps in care perception
- Train staff on patient communication
- Address metrics and processes based on patient input

Complete regular charge reconciliation.

Common Operational Assessment Key Discoveries

- Misalignment between measured data and patient reports
- Lack of patient feedback integration
- Inadequate staff training on addressing concerns

Patient Satisfaction Data

3.2 106 reviews

5 months ago

2 months ago

Amazing staff, very dedicated to quality service.

a month ago

I was a patient at this hospital. I stayed over night after my surgery.
Nurses don't listen to there patients when the age introduced to.
When a patient stayed over night. Thet still need there morning meds.
In my case, they didn't think that my blood pressure medication are not important.

I hate to tell you.

Don't stay at this hospital.

5 months ago

1 star is generous. I went in October and thought I was having an allergic reaction as my tonsils were swelling quickly and I was very scared. I went to the ER in the middle of the night and the doctor on that night was the worst doctor ... More

a month ago

8. Revenue Cycle and Billing Optimization

- Conduct charge capture reviews
- Review RHC billing methodologies to ensure services are billed correctly
- Educate staff on RHC-specific billing, including split/shared visits and G-codes.

Optimize processes for efficiency.

Common Operational Assessment Key Discoveries

- Unbalanced workloads create overreliance on individuals and limit efficiency.
- Automation is underutilized.
- Workarounds take the place of corrective action
- Lack of frontline staff/clinical team knowledge to support revenue cycle operations

9. Invest in staff training

- Enhance skills to streamline workflows
- Reduce errors through better process understanding
- Promote cross-functional knowledge sharing
- Improve resource utilization with trained staff

Equip teams with the tools and knowledge to drive efficiency and innovation

Common Operational Assessment Key Discoveries

- Insufficient training on new tools or processes
- Lack of awareness of best practices
- Inconsistent skill levels across teams

10. Monitor Performance

- Drive improvement culture
- Celebrate wins
- Make changes!

Monitor and adjust accordingly.

Common Operational Assessment Key Discoveries

- Staff fear identifying problems.
- Staff lacks awareness of goals.
- Failed processes are not adjusted

Additional Opportunities

- Leverage data to better understand opportunities for improved patient outcomes, the demand for additional service providers, and revenue capture opportunities
  - Data remains one of the valuable, but underutilized, resources available to RHCs that can drive strategy and performance improvement efforts
- Pursue the Patient Centered Medical Home (PCMH) model to drive patient outcomes
  - Negotiate with third-party payors to ensure the clinic receives PMPM payments
- Explore the expansion of services to include Behavioral Health
- If eligible, pursue the 340B program to drive additional revenue

Patient Centered Medical Home (PCMH)

Patient-centered medical home is a model of care where patients have a direct relationship with a provider who coordinates a cooperative team of healthcare, whether you're being seen at the doctor's office, if you become hospitalized or recuperating at home, through ongoing preventative care

Why become a PCMH as a value-based strategy	Medicare has moved to change how it structures payment from a quantity to a quality approach Medicare will provide incentives for better processes and outcomes Medicaid programs have made enhanced payments to providers who achieved certain distinctions or process measures
Benefits of a PCMH strategy	Make primary care more accessible, comprehensive and coordinated. Provides better support and communication Creates stronger relationships with your providers Improves patient outcomes Lowers overall healthcare costs
Benefits of a PCMH to the Bottom Line	A more efficient use of practice resources, resulting in cost savings A practice equipped to take advantage of payment incentives for adopting medical home functions A practice is better prepared for enhanced payment under MIPS or Alternative Payment Models, to participate in an ACO, and provide chronic care management services

QUESTIONS

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