RHCs
Creating Stronger Alignment with Hospitals

OVERVIEW

Objectives

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- Understand structural disconnects
  - Financial misalignment (AIR vs cost-based reimbursement not coordinated)
  - Operational silos (scheduling, staffing, workflows)
  - Strategic gaps (growth and service line misalignment)

- Identify key performance gaps
  - Underutilized provider capacity (low visits/provider/day)
  - Inefficient patient flow (clinic not feeding hospital services)
  - Revenue leakage (denials, poor POS collections, incorrect billing)

- Develop actionable alignment strategies
  - Governance redesign
  - Financial integration (cost report + operations)
  - Revenue cycle standardization

Interdependence of Major Drivers

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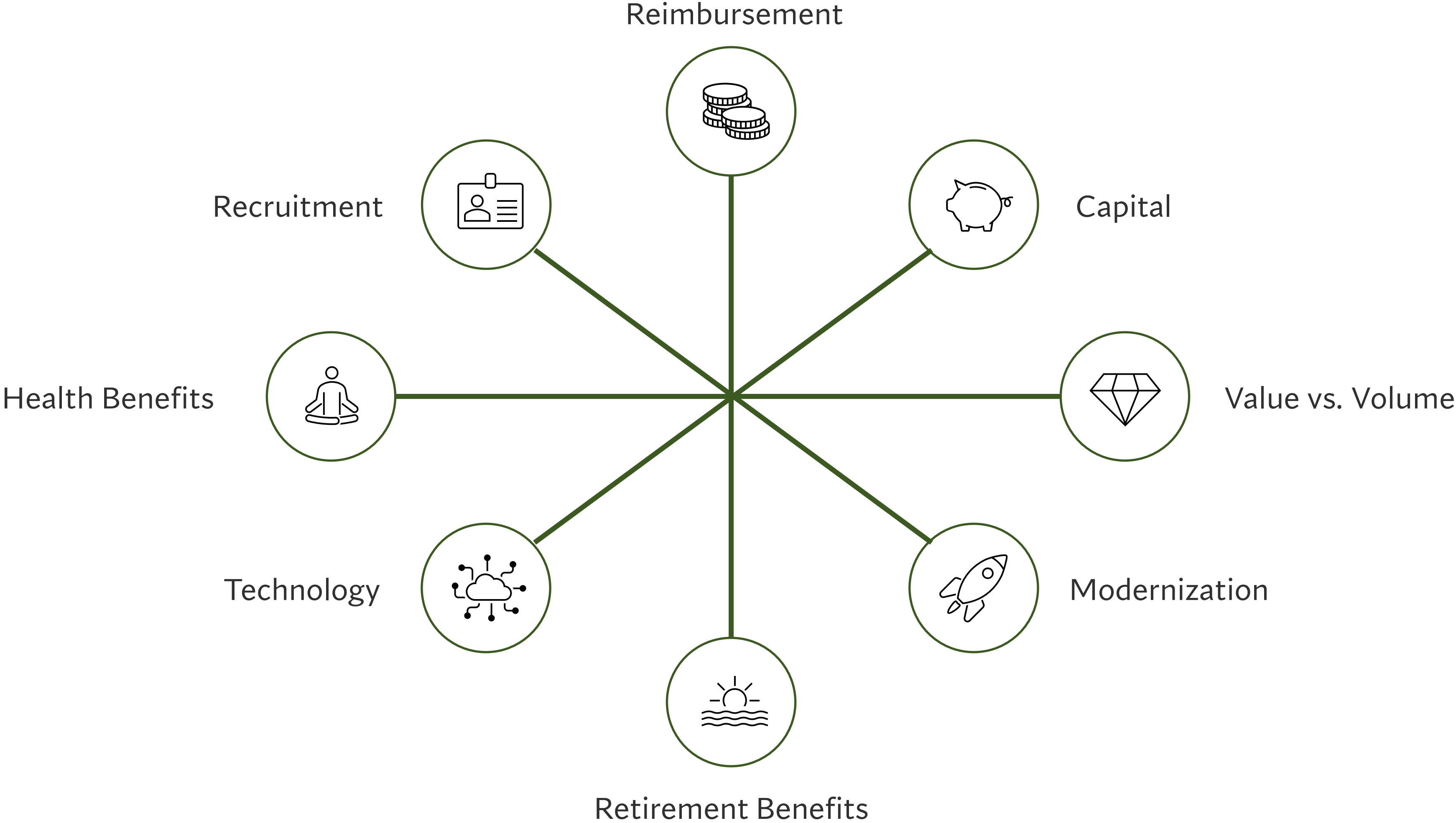

The Current Landscape

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- 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

DOING MORE WITH LESS

Why This Matters

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- Financial pressure accelerating
  - Labor cost increases outpacing reimbursement growth
  - Rural hospitals operating at <2–3% margins or negative
- RHCs as primary access engine
  - 60–80% of patient entry points originate in clinics
- Misalignment drives measurable losses
  - 1–2 fewer visits/provider/day → 10–20% AIR dilution
  - Poor referral capture → lost inpatient and swing bed revenue
- Strategic implication
  - Without RHC alignment, CAH financial sustainability is not achievable

Fragmentation Between Entities

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- Structural separation
  - Clinics often managed under ambulatory or physician services
  - Hospitals operate under separate executive leadership
- Decision-making disconnect
  - Clinic staffing not tied to hospital census or service demand
  - Growth decisions made independently
- Lack of shared accountability
  - No system-wide KPIs linking clinic and hospital performance

Consideration: Optimization of one area often harms another

Operational Silos

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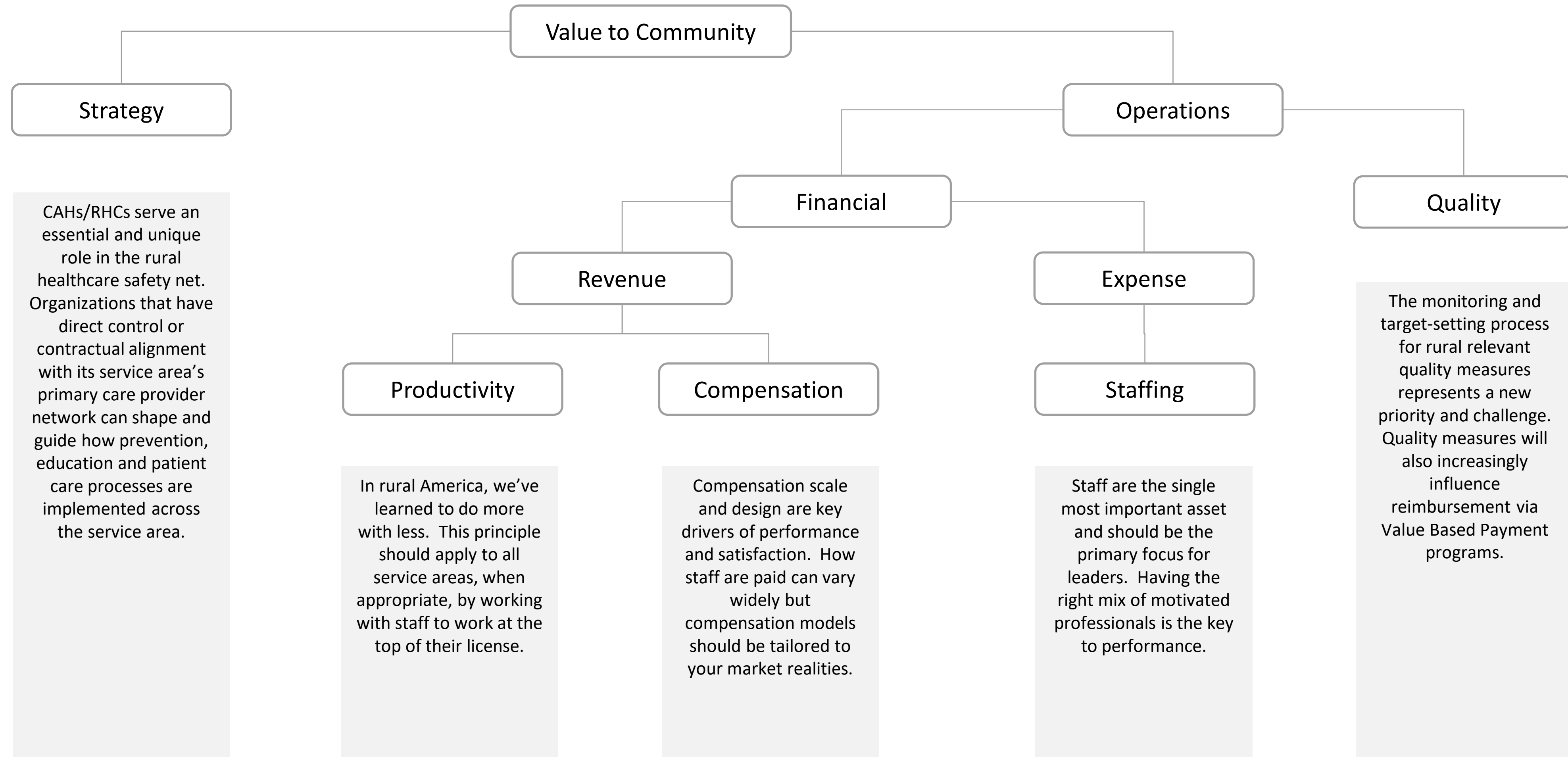
- Scheduling fragmentation
  - Each clinic operates independently with provider-specific templates, resulting in wide variation in visit types, lengths, and capacity
  - Inconsistent use of same-day/acute slots reduces access for high-acuity patients and contributes to inappropriate ED utilization
- Workflow inconsistencies
  - Intake, triage, and rooming processes vary by clinic, staff member, and shift, creating inefficiencies and inconsistent experiences
  - Absence of standardized protocols (e.g., standing orders, triage pathways, documentation workflows) results in avoidable delays and variability in care delivery
- Staffing inefficiencies
  - RNs are routinely performing lower-acuity, task-based activities (e.g., vitals, rooming, intake) that could be more cost-effectively handled by CMAs or LPNs
  - Lack of clearly defined care team roles and pod structures leads to duplication of effort and inconsistent support for providers
- Patient flow gaps
  - No standardized or formalized pathways for directing patients between clinic, ED, inpatient, and swing bed settings based on acuity and need
  - Limited coordination between clinic and hospital teams (e.g., ED, inpatient, swing bed) results in delays, missed admission opportunities, and suboptimal patient placement

Performance Model



Financial Disconnect

- AIR treated as retrospective
  - Limited real-time management of cost per visit
- Hospital reimbursement disconnected
  - Clinic activity not tied to hospital cost-based revenue streams
- Common inefficiencies
  - Provider underutilization (12–14 visits/day vs target 18–22)
  - Excess staffing relative to volume
  - Misallocation of shared overhead costs
- Financial impact
  - Inflated cost per visit → capped AIR → lost Medicare reimbursement

Alignment and Designation Strategies

- Due to the changing healthcare landscape, healthcare entities must leverage additional revenue opportunities, including reimbursement methodologies, to drive improved financial performance
- Healthcare entities can leverage the following to improve reimbursements when those practices can meet certain eligibility requirements:
  1. Periodically evaluate and convert practices to a designation that will improve the net financial position of that practice
  2. Establish system strategy and realign practices, when possible, to leverage alternative designation types
  3. Consolidate practices by integrating specialty practices and providers, when possible, within a PBC or RHC to realize operational efficiencies and leverage alternative reimbursement methodologies
  4. Pursue acquisition of independent practices to leverage reimbursement and revenue opportunities afforded to rural hospital providers

Practice Approach to Revenue Optimization

- As seen, each of the four clinic types evaluated encompass different reimbursement methodologies that greatly impact reimbursements received from Medicare and Medicaid and must be factored when evaluating primary and specialty providers
  - The table below highlights those differences

Reimbursement Options	FQHC	CAH PBC	<50 Beds PB-RHC	FSHC
330 Grant	Yes	No	No	No
340B Pharmacy	Yes	Yes	Yes*	No
Un-Capped Technical Charge	No	Yes	Yes	No
Method II Billing	No	Yes	No	No
Tort Reform - Malpractice Savings	Yes	No	No	No
Enhanced PPS Reimbursement	Yes	Yes	Yes	No

  - * For non-CAHs, Hospital needs to meet DSH % to qualify for 340B

Revenue Cycle Gaps

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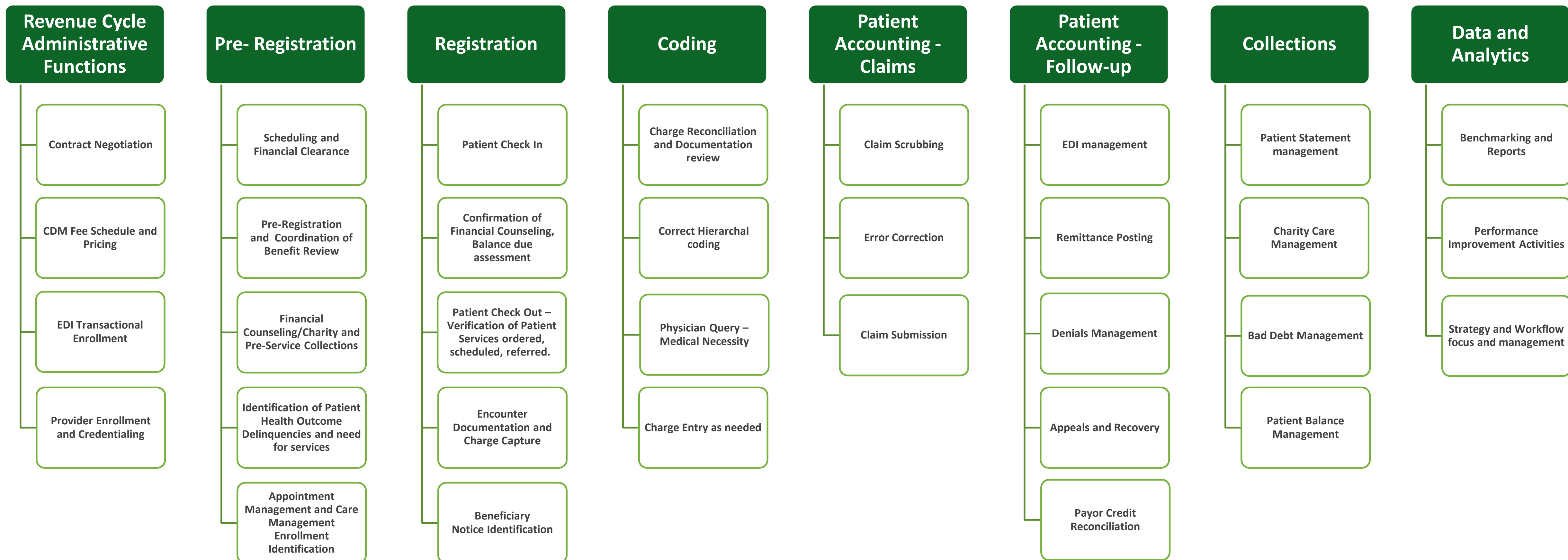
- Front-end issues
  - Inconsistent insurance verification (often same-day vs pre-service)
  - Demographic errors leading to claim rework
- POS collections
  - Often <20–30% of patient responsibility collected
- Back-end issues
  - Denials not tracked at provider or clinic level
  - Limited coding oversight
- Financial impact
  - Increased AR days (>60–80 days)
  - Higher write-offs and avoidable denials

Optimize Revenue Cycle Tasks and Functions

- Evaluate and improve revenue cycle functions by ensuring a fair distribution of work, clearly defined roles and task automation or improvement
  - Make sure no matter how tasks are divided among departments, core task elements are incorporated and monitored



Strategic Misalignment

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- Lack of Integrated Planning
  - Clinics expand without considering hospital capacity or needs
  - Growth decisions are often made at the clinic level without evaluating downstream impact on inpatient capacity, ED throughput, or ancillary services
  - Absence of a system-wide strategic planning process results in misalignment between ambulatory growth and hospital financial and operational priorities
- Service Line Disconnect
  - Specialty services not aligned across system
  - Recruitment and service development efforts occur in silos, leading to gaps in key specialties or duplication of low-demand services
  - Lack of coordinated service line strategy limits the system’s ability to build centers of excellence and capture higher-acuity, higher-margin care locally
- Market Leakage
  - Patients referred outside system due to lack of coordination
  - Referral patterns are not actively managed, resulting in patients being directed to external providers despite internal capabilities
  - Limited visibility into leakage data and absence of physician alignment strategies prevent proactive retention of patient volume within the system

Performance Improvement Opportunities

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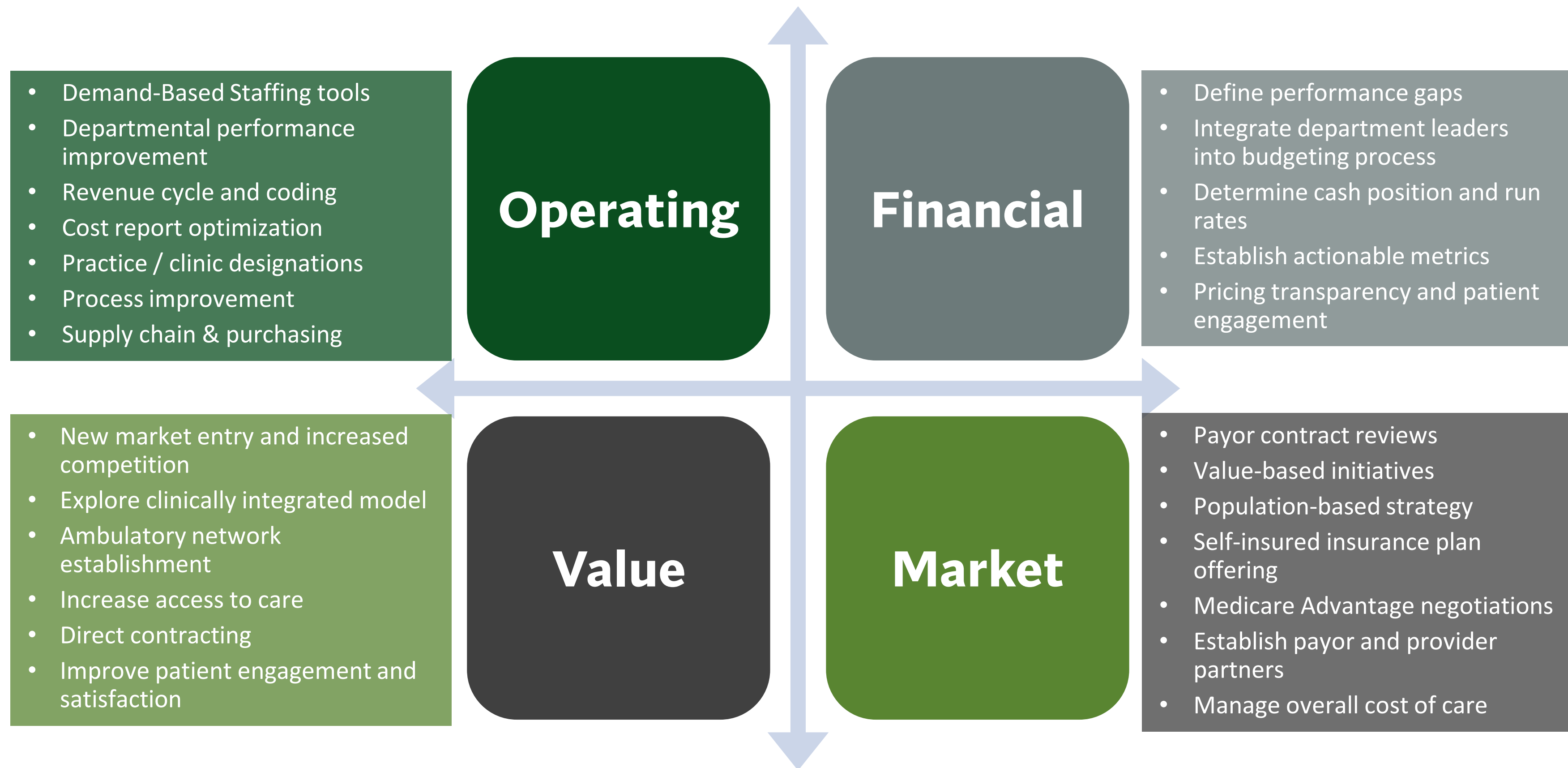
Organizations must focus and establish plans for each of the four identified areas to improve the organizational position



Reimbursement Challenges

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- RHC: AIR Management Challenges
  - Limited real-time visibility and no monthly cost/visit tracking
  - Operational disconnect where staffing decisions made without understanding AIR impact
  - Low visit volumes inflate cost per visit and risks falling below sustainable reimbursement thresholds
  - Inefficient scheduling reduces productivity

- CAH Management Challenges
  - Medicare cost-based reimbursement (101%) creates a lagging payment structure, limiting real-time financial visibility and responsiveness
  - State Medicaid programs and managed care organizations often deviate from Medicare cost-based principles, resulting in inconsistent and reduced reimbursement
  - Low patient volumes make it difficult to absorb fixed costs, creating margin pressure despite cost-based reimbursement methodology
  - Service mix is often not optimized (e.g., limited outpatient procedural volume, underutilized therapy services), reducing overall reimbursement potential
  - Weak front-end processes (eligibility, authorization) and back-end inefficiencies (coding, billing, denials) erode reimbursement despite favorable payment methodology

IMPROVEMENT OPPORTUNITIES

Structural Alignment

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- Governance:
  - Unified leadership
  - Performance Improvement Collaborative
  - KPI accountability tied to compensation
- Technology:
  - EHR alignment
  - Real-time dashboards
  - Data governance
- Implementation:
  - Structured roadmap
  - Continuous monitoring
  - Cultural transformation

Patient Flow Alignment

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- Standardized Care Pathways: Clinic → ED → inpatient → swing bed → follow-up
  - Define clinical criteria, escalation protocols, and standardized handoffs to ensure appropriate level of care and reduce variability
  - Implement real-time communication (provider-to-provider, triage, transfer protocols) to improve coordination and throughput
- Reduce Leakage: Keep patients within system
  - Establish referral management strategies and align providers to prioritize internal care delivery
  - Track leakage by service line and address gaps in access, specialty coverage, and coordination
- Improve Transitions: Faster admission decisions
  - Set clear turnaround expectations (≤60–90 minutes) with defined accountability
  - Utilize standardized criteria and escalation pathways to support timely, accurate decisions
- Coordinated Discharge Planning
  - Initiate discharge planning early with focus on swing bed, home health, and follow-up alignment
  - Use interdisciplinary coordination to ensure seamless transitions and reduce readmissions

Centralized Scheduling

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- Standardize Scheduling Templates: Optimize visit types and durations
  - Implement consistent templates (e.g., 20/45-minute mix, same-day slots) to balance routine and complex visits
  - Align scheduling with provider capacity, panel size, and demand to maximize throughput
- Centralize Scheduling Function: Improve access and utilization
  - Establish a centralized scheduling model to optimize provider availability across clinics
  - Improve access through better slot utilization, reduced gaps, and coordinated system-wide scheduling
- Integrate Nurse Triage: Ensure appropriate care setting
  - Utilize nurse triage protocols to direct patients to the right setting (clinic vs. ED vs. urgent care)
  - Standardize triage workflows to improve access, reduce unnecessary ED utilization, and support care coordination
- Impact
  - Increased visits per provider and improved clinic productivity
  - Reduced no-show rates and improved patient access and satisfaction

Staffing Optimization

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- Team-Based Care Model: Provider + CMA/LPN + RN support
    - Establish pod-based teams to ensure consistent support, improve workflow efficiency, and enhance patient experience
    - Clearly define roles across team members to eliminate duplication and ensure top-of-license practice
- Top-of-License Utilization: Shift tasks to lowest appropriate license level
    - Transition routine tasks (rooming, vitals, intake, screenings) to CMAs/LPNs, reserving RNs for triage and care coordination
    - Implement standing orders and protocols to enable staff to act independently within defined clinical guidelines
- Operational Efficiency: Reduce cost per visit
    - Align staffing models to visit volume and acuity, reducing reliance on higher-cost resources for routine care
    - Improve clinic flow and reduce bottlenecks through standardized workflows and role clarity
- Productivity Impact: Improve provider productivity
    - Increase visits per provider through better support, reduced downtime, and optimized patient flow
    - Enhance access and capacity without adding provider FTEs, supporting overall system growth

Clinic Throughput

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- Target Productivity Benchmarks: 18–22 visits/provider/day (adjusted for complexity)
  - Establish benchmark-driven expectations aligned to MGMA rural standards and provider specialty mix
  - Monitor productivity through dashboards (visits/day, cycle time, no-shows) and adjust scheduling templates accordingly
- Optimize Room Utilization: Minimum of two rooms per provider
  - Implement a two-room (or more, where feasible) model to minimize provider idle time and enable continuous patient flow
  - Ensure adequate staffing (CMA/LPN support) to room patients, prep charts, and manage turnover between visits
- Reduce Cycle Time: Intake → provider → discharge
  - Standardize intake, rooming, and discharge workflows to eliminate delays and reduce variability across clinics
  - Track and manage cycle time metrics to identify bottlenecks and improve overall clinic efficiency
- Impact
  - Increased provider capacity without adding FTEs and improved patient access
  - Reduced wait times, improved patient experience, and stronger financial performance

Shared Resources

- Centralize Non-Clinical Functions: Billing | Scheduling | Patient Access
  - Consolidate core functions into a centralized model to standardize workflows, improve oversight, and reduce duplication across clinics
  - Enhance revenue cycle performance through consistent processes in eligibility, registration, charge capture, and billing
- Cross-Train Staff Across Locations
  - Develop a flexible workforce capable of supporting multiple clinics to address volume fluctuations, staffing gaps, and coverage needs
  - Standardize training and competencies to ensure consistent patient experience and operational performance across sites
- Operational Benefits: Lower overhead | Improved consistency
  - Reduce administrative costs through economies of scale and more efficient staffing models
  - Improve process consistency, data accuracy, and patient access, leading to stronger financial and operational outcomes

After Hours Alignment

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- Align Clinic and ED Services: Redirect non-emergent cases
  - Implement clear triage and redirection protocols to route low-acuity patients from the ED to appropriate clinic settings
  - Train front-line staff to consistently identify and redirect non-emergent cases while maintaining EMTALA compliance
- Implement Urgent Care Protocols
  - Standardize same-day access and walk-in capabilities within clinics to absorb urgent, lower-acuity demand
  - Utilize nurse triage and clinical protocols to ensure patients are treated in the most appropriate setting
- Extend Clinic Hours Strategically
  - Expand evening and weekend hours based on peak demand patterns to reduce avoidable ED visits
  - Align staffing and scheduling to support extended access without significantly increasing cost structure
- Impact
  - Reduced ED overutilization and improved throughput for true emergent cases
  - Enhanced patient access, reduced wait times, and improved overall patient experience

Clinical Protocols

- Chronic disease management / Preventive care
  - Develop evidence-based protocols for high-volume conditions (e.g., diabetes, hypertension, COPD) to ensure consistent, high-quality care delivery
  - Embed preventive care workflows (AWVs, screenings, immunizations) into routine visits to improve population health outcomes
- Reduce Variation in Care Delivery
  - Implement standardized clinical guidelines, standing orders, and documentation templates across providers and locations
  - Utilize care teams and decision support tools to ensure adherence to best practices and minimize provider-to-provider variability
- Performance Optimization
  - Track key quality and utilization metrics (e.g., HEDIS measures, readmissions, gap closure rates) to monitor adherence and outcomes
  - Leverage data to identify gaps in care and continuously refine pathways and workflows
- Impact
  - Improved clinical outcomes and patient satisfaction through consistent, proactive care
  - Enhanced operational efficiency and reduced cost of care through standardized, streamlined processes

Referral Management

- Develop Internal Referral Networks
  - Establish clear referral pathways and preferred provider networks to keep patients within the system for specialty, diagnostic, and post-acute services
  - Align providers through education, performance expectations, and streamlined scheduling to support internal referrals
- Track Referral Leakage Rates
  - Implement analytics to monitor leakage by service line, diagnosis, and referring provider to identify gaps and opportunities
  - Use data-driven insights to address access issues, specialty gaps, and operational barriers driving outmigration
- Strengthen Relationships with Regional Partners
  - Build strategic partnerships with regional hospitals, specialists, and post-acute providers to create coordinated care pathways
  - Formalize agreements and communication channels to improve referral alignment and patient transitions

Goal: Maximize in-system care delivery

Care Coordination

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- RN-Led Coordination Programs
  - Deploy RNs in dedicated care coordination roles to manage complex patients across settings (clinic, inpatient, swing bed, post-acute)
  - Utilize structured workflows for outreach, follow-up, medication reconciliation, and care plan management
- Focus on High-Risk Populations
  - Identify high-risk patients (e.g., chronic conditions, frequent ED utilizers, recent discharges) using data analytics and risk stratification tools
  - Prioritize proactive engagement, chronic disease management, and gap closure for these populations
- Improve Transitions of Care
  - Standardize discharge follow-up processes (e.g., 24–72 hour calls, timely PCP follow-up appointments) to ensure continuity
  - Coordinate across providers, settings, and services to reduce fragmentation and avoid unnecessary utilization
- Impact
  - Reduced readmissions and avoidable ED visits through proactive, coordinated care
  - Improved patient retention, satisfaction, and long-term engagement within the system

Service Line Alignment

- Strategic Service Line Alignment
  - Align clinic offerings with hospital capabilities to create a coordinated, system-wide approach to care delivery
  - Ensure clinic services actively support downstream hospital utilization (inpatient, outpatient procedures, swing bed)

- Focus on High-Demand Specialties: Ortho | Cardiology | Wound Care
  - Prioritize recruitment, access, and program development in specialties with high volume and revenue potential
  - Build targeted programs (e.g., joint rehab, cardiac management, advanced wound care) to establish centers of excellence

- Improve Access and Integration
  - Expand clinic capacity, streamline referrals, and reduce wait times to keep patients within the system
  - Integrate specialty services with diagnostics, therapy, and post-acute care to create a seamless patient experience

- Impact
  - Reduce outmigration
  - Retain higher-acuity, higher-margin services and strengthen system financial performance

Revenue Cycle Alignment

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- Front-End Optimization: Eligibility / Registration / POS Collections
  - Standardize pre-registration (48–72 hours prior), eligibility verification, and financial counseling to reduce downstream denials
  - Implement point-of-service collection protocols with scripting, accountability, and daily performance tracking
- Mid-Cycle Integrity: Coding Accuracy / Documentation Integrity
  - Enhance provider documentation and coding accuracy through education, audits, and real-time feedback loops
  - Ensure complete and accurate charge capture to fully reflect services rendered and support compliant reimbursement
- Back-End Performance: Denial Management / AR Follow-Up
  - Implement structured denial tracking, root cause analysis, and rapid resolution workflows to prevent recurring issues
  - Strengthen AR follow-up processes with clear ownership, aging targets, and escalation protocols
- KPIs: Clean Claim Rate >95% / Denial Rate <5% / Days in AR <45
  - Monitor performance through standardized dashboards with routine review and accountability across departments
- Integration: Standard workflows across clinics and hospital
  - Align revenue cycle processes across all care settings to ensure consistency, transparency, and optimal financial outcomes

QUESTIONS

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