CASE STUDY

# Helping Rural Hospitals Manage Costs & Provide Quality Care

Preston Memorial Hospital was **awarded a five-star rating by CMS** for its effort in delivering high-quality care

"We want to take care of our patients in the best way we know how. We're all about community and taking care of our community. Collective helps us increase the quality of care we're giving."

**- Kris Kark**
Director of Case Management,
Preston Memorial Hospital

## Preston Memorial Hospital

Mon Health Preston Memorial Hospital is a 25-bed critical access hospital in Kingwood, West Virginia. The rural hospital participates in the Caravan Health accountable care organization, intending to close as many care gaps as possible while reducing costs.

### The Challenge: Delivering Effective & Cost-Efficient Care in Rural Areas

Since 2005, over 160 rural hospitals have closed, with more than 60 percent of those closing since 2012.[1] Additionally, over 450 rural hospitals are vulnerable to closure based on performance levels.[2] Of the rural hospitals in business today, most survive on slim operating margins, with many operating in the red.

Those living in rural America experience significant health disparities when compared to the overall population, which can increase the total cost of caring for these patients. Mortality rates for heart disease, cancer, unintentional injury, chronic lower respiratory disease, and stroke—the five leading causes of death—are higher in rural areas.[3] Suicide rates and drug overdose deaths involving natural and semisynthetic opioids are also higher.[4,5]

Finding efficient ways to improve care delivery, keep patients as healthy as possible, and reduce costs are critical for rural hospitals to stay afloat.

### The Solution: Coordinating & Managing Care for Vulnerable Patients

A few years ago, Preston Memorial Hospital (PMH) committed to working toward better quality care by putting processes into place that held physicians accountable for keeping patients as healthy as possible, focusing first on improving both continuity of care and transitions of care.

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Staff began looking for ways to better merge inpatient, outpatient, and emergency department (ED) care together. PMH implemented Collective Medical—a real-time, ADT-based event notification and care coordination platform—to achieve this level of collaboration and serve as the technical backbone for programs designed to better track, manage, and support complex patients.

**Value-Based Payment Programs**

The commitment towards quality care led PMH to value-based payment programs and participation in an accountable care organization (ACO) to better manage the care of the 664 Medicare patients on its primary care list of approximately 3,000 patients total. Kris Kark, Director of Case Management at Preston Memorial Hospital explains:

"Preston Memorial Hospital is part of an accountable care organization. As part of our value-based payment program through Medicare, we make sure patients are getting quality care by closing as many care gaps as possible and taking care of their needs. Ultimately, we're decreasing cost by reducing unnecessary admissions—especially for those with chronic illnesses. So, we're spending less money by taking better care of these people."

## Addressing High Utilization

In July 2019, staff at PMH took the 20 patients with the most ED visits and created care guidelines, housed them in the Collective platform, and talked to patients about what they could do to help. Since this intervention, 53 percent of these patients have had a decrease in visits and several haven't been back to the ED at all. By redirecting care to more appropriate settings and decreasing utilization, PMH cut down on care costs.

In one case, PMH staff noticed a patient that had been to the ED four times in two weeks. At registration, Collective's technology identified the patient and sent a real-time notification with easy-to-digest, relevant information to a printer in the hospital. Kark was able to call the patient's primary care physician, explain the situation, and help get an appointment set up. Kark explains, "I didn't have to look for any information; it was right there on that paper. It was quick and easy. I saw where he'd been, how many times he'd been there, and who he normally sees."

**Care Management for Complex Patients**

PMH has 62 patients enrolled in a chronic care management (CCM) program. Patients in this program have two or more chronic illnesses—such as COPD, diabetes, renal failure, and heart failure—conditions that historically cost the Centers for Medicare & Medicaid Services (CMS) more in care due to multiple readmissions.

To help manage the care of CCM patients, PMH has one nurse case manager that covers inpatient care, a population health nurse who helps coordinate annual wellness visits, and a population health coordinator that ensures everyone is meeting established quality measures. Kark explains: "We have somebody in every avenue, at every point of entry into our organization, to help watch these patients."

Each CCM patient is tagged in Collective's care coordination platform to help staff quickly identify them as they move through the care continuum. Real-time identification and notification of these complex patients helps staff manage their care and address any issues that arise in a timely and efficient manner. Additionally, care plans are created for these vulnerable patients and housed in the platform. That way, every provider that cares for a CCM patient is operating from the same playbook.

Staff touch base with CCM patients at least once per week to check on medications, blood sugar, and blood

pressure metrics—depending on the patient's needs. The case manager and nurse can adjust medications, set up appointments with specialists, and ensure patients have transportation to help keep these patients healthy and out of the hospital.

When a patient does present to the ED, case management staff are notified immediately and can visit the patient while in the ED to go over care plans and coordinate with ED staff to avoid readmissions when possible. For patients that present at other hospitals—PMH staff calls the patient post-discharge to check-in, go over medications, and discuss follow-up care.

## The Outcomes: Achieving a 5-Star CMS Rating

With insights from Collective and the commitment to providing quality care to patients, PMH has been able to improve operational efficiency and be recognized for its efforts. In 2020, CMS awarded the hospital a five-star rating, one of only three in West Virginia, for meeting or exceeding quality measures across the following seven areas: mortality, safety of care, readmissions, patient experience, effectiveness of care, timeliness of care, and efficient use of medical imaging.

In addition to the five-star rating from CMS, PMH has also seen a decrease in ED visits by focusing on chronic care management and patients with high-utilization patterns. In the last 12 months, PMH has had approximately 10,000 ED visits—which is about a 3 percent decrease over the course of two years.

The efforts of case management and hospital staff, aided by the support of Collective's streamlined care collaboration technology, have helped PMH manage ED utilization, prevent unnecessary readmissions, and hone in on providing both practical and timely care. By focusing on taking better care of vulnerable patients, PMH has kept costs down while continuing to provide valuable healthcare services to the rural community.


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2. Ellison, A. (2020, February 11). 453 rural hospitals vulnerable to closure: 6 things to know. Retrieved from https://www.beckershospitalreview.com/finance/453-rural-hospitals-vulnerable-to-closure-6-things-to-know.html?utm_medium=email

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4. CDC. (2017, October 5). Americans in rural areas more likely to die by suicide. Retrieved from https://www.cdc.gov/media/releases/2017/p1005-rural-suicide-rates.html

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## About Collective Medical

Collective Medical provides the nation's largest and most effective ADT-based network for care collaboration. Our risk-adjusted event notification and care collaboration platform spans across all points of care—including hospitals, payers, behavioral and physical ambulatory, and post-acute settings.

Collective's platform helps identify at-risk, complex patients and share actionable, real-time information with diverse care teams across the network, leading to better care decisions.