2023 RURAL HEALTH CARE SYMPOSIUM SACRAMENTO

Rural Health System Financial and Operational Best Practices

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Financial and Operational Best Practices

The following best practice opportunities areas were derived from the 100+ Stroudwater CAH site visits conducted over the last five years

- ❑ Strategy
- ❑ Economic Philosophy
- ❑ Inpatient Services
- ❑ Emergency Services
- ❑ Clinical Departments
- ❑ Departmental Profitability
- ❑ Quality Improvement
- ❑ Information Technology
- ❑ Cost Report Improvement
- ❑ Revenue Cycle
- ❑ Management Accounting
- ❑ Staff Benchmark Analysis
- ❑ Provider Complement/Practice Management
- ❑ Provider Alignment
- ❑ Service Area Rationalization
- ❑ Alignment Strategy
- ❑ Payment System Transformation
- ❑ Population Health Management

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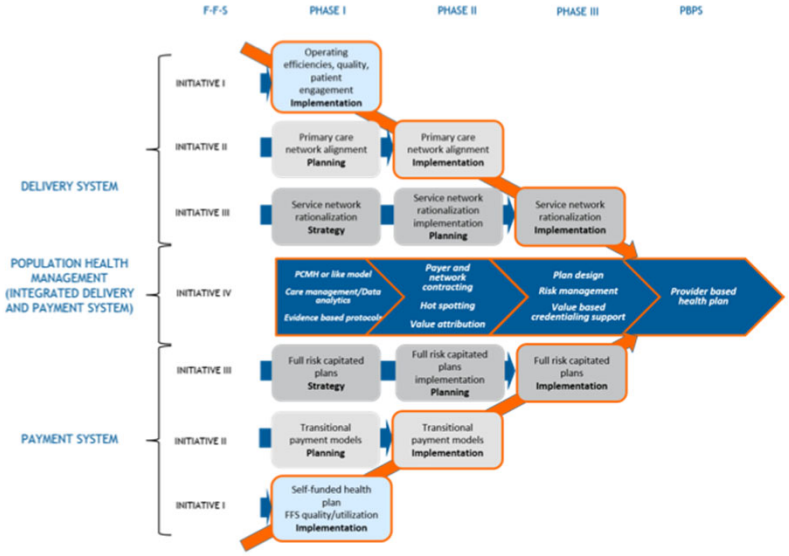
Strategy: Population Health Transition Framework

The Transition Framework helps organizations through the transition from a fee-for-service (FFS) payment system to a population-based payment system

- *Delivery system* addresses strategic imperatives for providers to transform their delivery system
- *Payment system* addresses strategies for providers to influence the evolution of the payment system
- *Population health/care management* requires the creation of an integrating vehicle so that providers can contract for covered lives, create value through active care management, and monetize the creation of that value



Economic Philosophy

The most important performance driver for a rural hospital is the overall mindset of the staff, management team and trustees where their commitment centers on ***abundance, growth*** and ***incremental contribution margin*** gains as opposed to a focus on expense management and cost reductions to the existing care model. Value is unlocked by the marginal revenue gain in a high fixed cost environment.

- Understand the difference between variable costs, fixed costs, and fully allocated costs
- Recognize that nearly all paying services create positive contribution
- Economic imperative is the development of 1,000s of mini "contribution margins" to cover fixed costs of CAH
- Cost-based reimbursement will only cover costs and not generate aggregate profit

Inpatient Services

Target an ED admission rate (acute admissions and observation status) of between 10%-12% by partnering with medical staff to ensure appropriateness of care decisions, as well as to identify opportunities to reduce transfers

Implement systems to ensure all patients who are transferred to other hospitals for health care services are transferred back, when possible, for care delivery

Define the Care Spectrum (those patients able to receive care at your facility) as a collaborative, multi-disciplinary group inclusive of the following categories: Medical Staff, Nursing, Pharmacy, Medical Equipment and Therapists)

Investigate the use of Tele-Intensivist or e-Hospitalist programs with more active Nurse Practitioner as inpatient coverage options

Reformat a discrete Intensive Care Unit (ICU) into a "High Observation" service and consolidate the ICU costs into the general Med/Surg/Acute cost center

- Evaluate the operational impact of consolidating the ICU into the Med-Surg department as a high acuity progressive care unit

Utilize InterQual-like criteria resources to educate providers for proper documentation and determinations of inpatient stays likely to exceed 2-Midnights. Enforce proper usage of observation admission criteria

Implement Hourly Rounding and Bedside Handoff models for nurses to optimize multidisciplinary communication

Integrate Pharmacist visit into every patient discharge

Track and monitor Nurse:Patient ratios against industry standards

Inpatient Services

Target 20 – 30% of acute days as observation

- Review and educate the medical staff on admission and observation status criteria

Elevate the development and promotion of the swing bed program as a strategic priority, targeting an Average Daily Census (ADC) of 4 patients per 10,000 population

- Develop an Active Solicitation swing bed marketing plan focused on offered services, targeting employed physicians, area providers, case managers, and area hospitals
  - Actively engage area hospital for swing bed opportunities that may be appropriate for the swing bed program at hospital
  - Access new patients including Medicare Advantage, Medicaid, and commercial payer patients
- Educate the provider community on the benefits of cost-based reimbursement and the appropriate use of swing bed services
- Ensure that swing bed utilization is a priority with unit staff, case management staff and physician providers

Monitor required Swing Bed daily rate -- an amount greater than the Medicaid Nursing Facility (NF) carve-out rate – required to generate a positive contribution margin by pursuing non-traditional arrangements, services and patient types for care in Swing Beds

Inpatient Services

The following financial analysis entails the establishment of a base-case cost structure that is used to project contribution margin impact associated with incremental inpatient swing- bed volume growth

- Model A base case analysis of 2020 cost structure indicates a loss of approximately $304K on a fully allocated cost basis

Model C analysis projects the contribution margin opportunity from swing bed census growth

- Analysis shows a census growth to an ADC of 2 has the potential to yield a contribution margin opportunity estimated at approximately $290K

Model A: Base Case (FY 2020 Cost Report)

	ADC	Total Days	Cost Based Payer Mix	Cost Based Days	Other Days	Payment Per Day	Other Payment
Acute (inc Observ, ICU)	1.1	385	50%	193	192	$ 2,500	$ 480,214
Swing Bed - SNF	0.5	178	100%	178	-	$ 2,000	$ -
Swing Bed - NF	0.0	-	0%	-	-	$ 400	$ -
Total Days	1.5	563		371	192		$ 480,214
Net Acute/SB SNF/Obs		563	66%	371	192		
Inpatient Fixed Costs		$ 1,854,373	[1]				
Inpatient Variable Costs		$ 127,400	[1]				
Total Inpatient Costs		$ 1,981,773	[2]				
Inpatient Costs Per Day		$ 3,520		$ 3,520			
Less: Cost-Based Carveouts		$ (165,000)		$ (293.07)			
Cost Based Payment				$ 1,196,923			$ 1,196,923
Total Payment							$ 1,677,136
Inpatient Costs							$ 1,981,773
Net Margin							$ (304,637)

[1] Assumes $250/day marginal acute costs and $175/day marginal swing bed SNF and NF costs

[2] Nursing costs plus Acute Inpatient departmental inpatient charges times departmental RCCs (WS C)

Model C: Grow Swing Bed Census to ADC of 2

	ADC	Total Days	Cost Based Payer Mix	Cost Based Days	Other Days	Payment Per Day	Other Payment
Acute (inc Observ)	1.1	385	50%	193	192	$ 2,500	$ 480,214
Swing Bed - SNF	2.0	730	100%	730	-	$ 2,000	$ -
Swing Bed - NF	0.0	-	0%	-	-	$ 400	$ -
Total Days	3.1	1,115		923	192		$ 480,214
Net Acute/SB SNF/Obs		1,115	83%	923	192		
Inpatient Fixed Costs		$ 1,854,373	[1]				
Inpatient Variable Costs		$ 224,000	[1]				
Net Inpatient Costs		$ 2,078,373					
Inpatient Costs Per Day		$ 1,864		$ 1,864			
Less: Cost-Based Carveouts		$ (165,000)		$ (147.98)			
Cost Based Payment				$ 1,583,748			$ 1,583,748
Total Payment							$ 2,063,962
Inpatient Costs							$ 2,078,373
Net Margin							$ (14,411)
Difference							$ 290,226

Emergency Services

Implement systems to ensure patients who present to the Emergency Department of a non-emergent nature are redirected to the clinics, when open, to receive care

- Recognize that if the CAH does not offer urgent care services, patients with high deductibles will be leaving rural communities for care

Develop strategies to better manage demand for non-emergent care within the community to include the following:

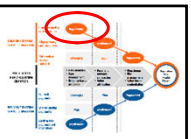
- Expand urgent care clinic to include primary care services
- Explore development of an ED redirect program to the urgent care clinic in partnership with providers
- Evaluate signage to improve patient's ability to self-select the ED versus urgent care clinic
- Educate public on the appropriate use of the ED to reduce the number of non-emergent visits
- Enroll patients with a primary care provider or direct them to a more appropriate level of care setting

Develop ED-hospitalist model coverage capability with ED provider and APP to improve care and admissions capability, and to reduce transfers

Work with medical staff and system partner to review appropriateness of transfers and leverage development of ED-hospitalist coverage model to enable patients to remain at hospital for care when medically appropriate

- Review patient transfers for potential missed opportunities

Emergency Services



Track ED standby time unless contracted Emergency Department providers/contractors bill for professional services; if so, the hospital does not need to track standby time (it is generally 100% of contracted time)

Consider LEAN processes to reduce throughput time in the ED

Engage in EDCAHPS – track and monitor performance

Engage the hospitalists and Emergency Department providers to focus on improved collaboration that results in enhanced patient throughput

Track and monitor KPIs related to the Emergency Department, including:

- ED admissions (acute/observation) as a percentage of ED visits to between 10% and 12%
- Transfer rates as a percentage of Emergency Department visits to below 5% of all ED visits
- Note: Track ED KPIs at the individual provider level
- Throughput measures: Door to MD, Door to Discharge, Door to Admit, Door to Transfer, LWOT, AMA, etc.

Clinical Departments

Conduct outreach to area providers to build awareness of service offerings as well as to foster strong customer service

Advertise/promote services provided to area providers to increase volumes and keep providers informed of the services offered

Maintain reasonably updated equipment/technology which demonstrates quality and promotes patient experience

Track referrals by provider and use information as a means to drive targeted outreach

Conduct ROI analyses to determine feasibility of upgrading and replacing diagnostic (imaging, lab, etc.) equipment

LAB: Conduct strategic pricing reviews to develop outpatient fee schedules that are market competitive

Evaluate community need as part of return on investment (ROI) analyses to determine feasibility of offering or expanding services

Conduct contribution margin analysis to ensure high-cost departments do not return a negative contribution margin

PHARMACY: Target between $350k and $450k per 10k Medicare and third-party payer visits in net proceeds from the 340B program

PHARMACY: Develop strategies to maximize 340B financial opportunities

PHARMACY: Establish channel partnerships with local area retail pharmacies, or develop in-house retail pharmacy operation depending on results of ROI analysis

Evaluate current staffing levels for opportunities to enhance efficiency with a focus on volume growth

Department Profitability

Evaluate opportunities to increase marginal profitability of departments through incentivizing providers and volume growth or evaluate cost structure

Conduct ROI analysis for, at a minimum, all non-cost-based departments to determine whether those programs have a positive contribution margin

FY 2020 Home Health Profitabilty Analysis

	Visits	Net Rate	Net Revenue
Revenue:			
Medicare	2,152	$ 188.56	$ 405,783
Other	608	188.56	$ 114,645
Total	2,760		$ 520,428
Operating Expenses:	**A**		**B**
Direct Expenses (2020 ICR - WS A):			
Salary expense	$ 316,055		$ 316,055
Other	$ 151,492		$ 151,492
Total Direct Expense	$ 467,547		$ 467,547
Allocated Expenses (ICR Stepdown - WS B)			
Capital Costs	$ 15,197	20%	$ 3,039
Cap Movable Equipment	$ 29,735	20%	$ 5,947
Admin and General	$ 71,598	20%	$ 14,320
Employee Benefits	$ 118,326	90%	$ 106,493
Maintenance and Repairs	$ 27,416	50%	$ 13,708
Medical Records & Library	$ 4,316	50%	$ 2,158
Housekeeping	$ 2,820	50%	$ 1,410
Laundry and Linen	$ 43	50%	$ 22
Total Home Health Allocated Expense	$ 269,451		$ 147,097
Total Home Health expenses	$ 736,998		$ 614,644
Home Health Direct Gain (Loss)	$ (216,570)		$ (94,216)
Overhead expenses allocated away from Hospital (a) - (b)			(122,354)
Estimated CAH Cost Based Payer Mix			41%
Cost Based Payer Revenue on Allocated Costs			(50,107)
Net Gain (Loss)			$ (144,323)

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Quality/Performance Improvement

Establish quality as a strategic priority with the goal of being best in the region within 12 months

- Continue to update the Board and Medical Staff on quality performance and initiative progress on a monthly basis
- Establish a multidisciplinary quality committee that meets on a monthly basis, include a provider and Board member
- Identify and partner with medical staff champions to drive improved performance
- Drive accountability for care quality, outcomes, and patient satisfaction across all staff and providers
- Leverage quality as a strategic driver of market share and widely promote performance results in outreach and marketing efforts

Engage in activities to lower their rate of readmissions, such as clarifying patient discharge instructions, initiating follow-up calls, coordinating with post-acute care providers and primary care physicians, and reducing medical complications during patients' initial hospital stays

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Quality/Performance Improvement (cont.)

Report on public metrics to increase accountability and to compete regionally on quality scores through marketing of public quality and patient safety metrics

- Emphasize importance of quality improvement to staff from the top down
- Ensure that participation in quality metrics measurement and reporting includes Medicare Beneficiary Quality Improvement program (MBQIP) participation for Critical Access Hospitals (CAH)
- Consider dedicating additional staff resources to support quality improvement efforts if necessary

Convene a Patient Family Advisory Council with community member participation

Track core measure data and use the information to make systematic and operational changes to improve overall quality and patient outcomes

Establish specific targets based on Key Performance Indicators (KPI) for the Quality Committee that focus on the entire care continuum then use those KPIs to drive outcomes and improve performance

- Share/post metrics with all staff and utilize performance to drive improvement across the organization

Information Technology

Create a five-year strategic IT vision that goes beyond meaningful use and leverages IT resources to create a high-quality culture of patient safety through system training and integration into clinical operations

Recognize IT as a strategic asset, rather than as an expense to be managed

Schedule and or include IT systems as a part of periodic disaster drills and mitigate single points of failure throughout the system

Integrate all systems to increase operational efficiencies, access to information, and reduce unnecessary work

Cost Report Improvement Best Practices

Evaluate Med-Surg department square footage to incorporate the hallways to ensure accuracy of cost report; Minimum expectation is at least 300 square feet allocated for each inpatient bed

Utilize best practice time study methodology to ensure physician stand by time is accurate and fairly reflected on the cost report

- Evaluate technology-based solutions that automate time tracking functions

Track Part A time for physicians via Time Studies for Medical Directorships, etc.

Monitor Ratio of Cost to Charge (RCC) levels to potentially indicate revenue cycle process improvement opportunities such as charge setting and/or charge capture improvement opportunities

Verify appropriateness of CDM hospital is not at a competitive disadvantage and is not unnecessarily burdening Medicare patients through shifting of co-insurance to patients

Evaluate the salaries included in Nursing Administration and ensure only the Chief Nursing Officer (CNO) and direct administrative support staff are included in this category

- Ensure Nursing Administration costs are allocated only to departments that involve nursing functions – exclude departments such as Imaging, Therapy, Laboratory, Pharmacy, etc.

Establish an internal threshold (such as a due from Medicare in excess of $500K) that would drive the completion and filing of an interim cost report

Cost Report Improvement Best Practices (cont.)

Evaluate LDRP vs. Med-Surg room usage based on observation status vs. active labor status (Med-Surg) time studies to accurately allocate square footage

- Ensure costs for Labor and Delivery (LDRP) include only the time assigned to “active” delivery otherwise those costs should be allocated to the Med/Surge cost center

Continue to monitor departments with low charges relative to cost so they are not missing charge opportunities, as this has a direct impact on ‘bottom line’

Monitor appropriate assignment of non-Medicare or Medicare Advantage SB patients to Line 6

Consider consolidating RHC for cost report purposes to reduce variation and remove reimbursement variances

Conduct time studies of physicians and APPs to assess the amount of time providing care or scheduled care to patients while removing time for administrative duties, vacation, sick time, and other non-patient centered items to ensure the accurate statement of FTE information on Worksheet M-2

Establish a formal Bad Debt policy that pulls claims back from the collection company, after a certain period of inactivity, for inclusion on the cost report

- Target outpatient Bad Debt 10-20% of patient responsibility

Work with cost report preparer to determine if investment funds can be designated as funded depreciation to avoid significant offset

Implement a time study process and conduct medical record time studies to accurately capture true worked time by department for inclusion on the cost report

Revenue Cycle

Establish a Key Performance Indicator (KPI) measurement system and set target for all KPIs and strategies put in place to specifically address improving KPIs to targeted levels

Establish, target, track, and manage performance indicators, such as the following HFMA best-practice revenue-cycle metrics, in an effort to improve revenue cycle performance: Cash collected and cash percentage of net revenue

- Gross and Net A/R and A/R days
- In-house and discharged not-final-billed receivables
- Cost to collect
- Bad debt and charity as a percent of gross charges
- Denials as a fraction of gross charges
- Point of service collections as a fraction of goal

Implement a revenue cycle committee that meets at least bi-weekly that includes representatives from clinical, financial, administrative, medical staff, health information management, and the business office to oversee and drive improvements with regard to the revenue cycle process

Conduct a comprehensive annual review of chargemaster (CDM) to ensure charge level appropriateness and compliance with recent updates

Catalog and determine profitability of all major commercial payers, comparing payment to Medicare and seek contract increases, if necessary

Revenue Cycle (cont.)

Reorient the overall managerial focus on the revenue cycle process to the "front end" of the value chain (e.g. pre-authorizations, scheduling, registration, etc.) and a measurement culture

Establish workflow to pre-register all scheduled services including appointment verification, insurance verification, and a co-insurance discussion with patient

Ensure 100% of outpatient procedures are scheduled and pre-registered with proactive discussion of estimated costs. Collection of patient co-payment, deductible and coinsurance should be requested based on verified information

Prioritize improvement of Point of Service (POS) cash collection amounts, with particular focus in all outpatient departments, and hold staff accountable through the creation of POS collection goals

- Establish similar POS cash collections in hospital owned physician practices
- Use current revenues as the basis for establishing POS collection goals for each department

Implement a bad debt policy that establishes when claims will be deemed worthless and uncollectable for inclusion on the cost report

Implement a quick pay discount that matches the average commercial discount to increase cash flow and reduce bad debt

Target Days in DNFB to 5 days

Management Accounting

Engage managers in the process of developing operating and capital budgets to foster ownership and accountability

- Educate all managers on the budget process and basic financial management principles
- Manager involvement in both department revenue and expenses

Consistently hold managers accountable for monthly variance reporting by requiring rationale and actions related to positive/negative budget variances

Establish performance monitoring dashboards for all managers

Provide monthly budget to actual reports to all department managers and mentor them to improve financial understanding and commitment to accountability

- Develop process where department managers are required to prepare variance reporting for pre-determine variances from budget and plan monthly DOR meetings with CFO/CEO for overall financial/business mentoring

Staffing

Use volume-based staffing benchmarks to evaluate departmental staffing levels for possible inefficiencies

- Continue to monitor departments/units, recognizing that staffing maybe already be at a minimum threshold

Ensure balanced effort on managing staff and growing services

Establish a long-term recruitment plan that involves sponsoring additional H1B Visa employees and aggressively recruiting new nurses and techs from local colleges

Sample of Selected Departments

Department	Performance Indicator	FY 2020 Volume	Hourly Standard[1]	FTEs @ Standard	Actual FTEs[2]	Variance
Nursing - Med Surg	Per Patient Day	4,525	12.00	26.11	33.89	7.78
Nursing - Obstetrical/Postpartum L	Per Patient Day	289	10.00	1.39	7.44	6.05
Nursing - Nursery	Per Patient Day	260	5.00	0.63	-	(0.63)
Inpatient Subtotal				28.12	41.33	13.21
Nursing - Surgery - Major	Per Case	250	11.00	1.32	16.32	15.00
Nursing - Surgery - Minor	Per Case	1,918	5.50	5.07	-	(5.07)
Nursing - Recovery Room	Per Case	2,168	3.30	3.44	-	(3.44)
Surgery Subtotal				9.83	16.32	6.49
Emergency Room	Per Visit	7,718	2.75	10.20	14.54	4.34
UR/Case Mgr/Soc Ser	Patient Days	5,074	0.75	1.83	6.60	4.77
Nursing Administration	Per Adj. Admissions	6,988	1.75	5.88	4.08	(1.80)
Subtotal Nursing				55.87	82.87	27.01
Radiology	Per Procedure	35,451	1.36	23.22	14.88	(8.34)
Lab/Blood Bank	Per Test	202,460	0.25	24.33	16.62	(7.71)
Occupational Therapy	Per Treatment	23,763	0.50	5.71	7.29	1.58
Speech Therapy	Per Treatment	2,902	1.00	1.40	1.55	0.16
Cardio/Pulmonary	Per Procedure	25,810	0.71	8.84	14.36	5.52
Pharmacy	Per Adjusted Day	22,854	0.60	6.59	16.41	9.82
Subtotal Ancillary				70.09	71.11	1.02
Subtotal - Clinical				125.96	153.98	28.02
Hospital Administration	Per Adj. Admissions	6,988	1.65	5.54	7.56	2.01
Information Systems / Telecom	Per Adj. Admissions	6,988	1.36	4.57	4.31	(0.26)
Human Resources	Per Adj. Admissions	6,988	1.10	3.70	-	(3.70)
Marketing/Public Rel/Volunteers	Per Adj. Admissions	6,988	1.03	3.46	-	(3.46)
General Accounting	Per Adj. Admissions	6,988	1.23	4.13	2.15	(1.98)
Security	Gross Square Feet	181,263	0.02	1.74	0.63	(1.11)
Patient Accounting	Per Adj. Admissions	6,988	3.00	10.08	10.57	0.49
Admitting/Patient Registration	Per Adj. Admissions	6,988	3.79	12.72	13.95	1.23
Medical Records	Per Adj. Admissions	6,988	3.00	10.08	7.30	(2.78)
Cent Supply/Mtl Mgmt/Sterile	Per Adjusted Day	22,854	0.20	2.20	6.07	3.87
Housekeeping	Net Square Feet	108,758	0.25	13.07	15.61	2.54
Dietary	Meals Served	46,377	0.20	4.46	10.20	5.74
Plant Ops/Maintenance	Gross Square Feet	181,263	0.08	6.97	5.61	(1.36)
Laundry and Linen	Lbs of Laundry	186,232	0.02	1.79	1.77	(0.02)
Subtotal Support				84.51	85.74	1.23
				210.47	239.72	29.26

[1] Hourly Standards based on Stroudwater sample of hospitals

[2] FY 2018 internal information provided by hospital administration

Provider Complement/Practice Management

Create a catalog of all primary care providers with the service area to gain a better understanding of primary care need

Conduct a primary care options assessment to determine the optimal clinic designation such as Provider-Based Rural Health Clinic (PB-RHC) or Provider-Based Entity (PBE) status

- Conduct Return on Investment (ROI) analysis on the consolidation and inclusion of the specialty practices into the PB-RHC to leverage cost-based reimbursement opportunities

Continue to evaluate and explore relationships with specialty providers to increase both the access and number of services offered within the primary service area

Evaluate revising physician compensation contracts to include production, panel size and quality scores

Continue to enhance alignment with the area primary care providers that strengthens clinic decisions rights, improves functional alignment and creates partnership opportunities

- Engage all providers in an effort to ensure balanced participation
- Review and revise Medical Staff Bylaws as needed to establish clear delineation of responsibilities and accountabilities

Conduct annual fair market value assessments and Stark Rule analyses for all employed physicians to comply with federal requirements

Evaluate broad deployment of primary care and specialty providers throughout system

Provider Complement/Practice Management

Physician Shortage/Surplus Adjusted Service Area Population: **19,913**

	Supply Study Range	Existing[1]	Shortage)/Surplu Range[2]
Primary Care			
Family Practice	2.7 - 9.4	5.80	(3.6) - 3.1
Internal Medicine	2.3 - 5.5	0.00	(5.5) - (2.3)
Pediatrics	1.5 - 2.4	1.00	(1.4) - (0.5)
Physician Primary Care Range	10.7 - 13.2	**6.80**	**(6.4) - (3.9)**
Non-Phys Providers	1.4 - 4.5	5.55	1.0 - 4.2
TOTAL Primary Care Range	13.2 - 17.8	**12.35**	**(5.4) - (0.9)**
Medical Specialties			
Allergy	0.2 - 0.3	0.00	(0.3) - (0.2)
Cardiology	0.6 - 0.7	0.40	(0.3) - (0.2)
Dermatology	0.4 - 0.5	0.07	(0.4) - (0.3)
Endocrinology	0.0 - 0.3	0.08	(0.2) - 0.0
Gastroenterology	0.4 - 0.5	0.80	0.3 - 0.4
Hem/Oncology	0.4 - 0.5	0.24	(0.2) - (0.2)
Infectious Disease	0.1 - 0.2	0.05	(0.1) - (0.1)
Nephrology	0.3 - 0.3	0.09	(0.2) - (0.2)
Neurology	0.4 - 0.5	0.20	(0.4) - (0.2)
Pulmonary	0.2 - 0.4	0.18	(0.3) - (0.0)
Rheumatology	0.2 - 0.3	0.28	0.0 - 0.1
Surgical Specialties			
ENT	0.1 - 0.6	0.38	(0.2) - 0.3
General Surgery	1.2 - 1.5	0.54	(0.9) - (0.7)
Neurosurgery	0.2 - 0.2	0.18	(0.0) - 0.0
OB/GYN	1.5 - 2.1	1.00	(1.1) - (0.5)
Ophthalmology	0.7 - 0.8	0.09	(0.7) - (0.6)
Orthopedic	0.9 - 1.4	1.00	(0.4) - 0.1
Plastic Surgery	0.2 - 0.4	0.00	(0.4) - (0.2)
Urology	0.5 - 0.6	0.18	(0.4) - (0.3)

1 Physician FTEs calculated as 5 days per week = 1.0 FTE or 18 days per month = 1.0 FTE

2 See Appendix for detail of Supply Studies.

Provider Complement/Practice Management

Pursue increased alignment with regional primary care providers in the service area through functional, contractual and governance alignment strategies given the future importance of primary care network development to developing payment systems

Given the future importance of primary care network development to developing payment systems, pursue increased interdependence with employed and other primary care providers in the service area through functional, contractual and governance alignment strategies

Specialty	Provider	Ambulatory Encounters	Average Annual Visit per Patient	Patient Estimate	Directed per Capita Cost	Health Based Value
Family Practice	Physician	4,200	3	1,400	9,990	$ 13,986,000
Family Practice	NP / PA	3,000	3	1,000	9,990	$ 9,990,000
				2,400		$ 23,976,000

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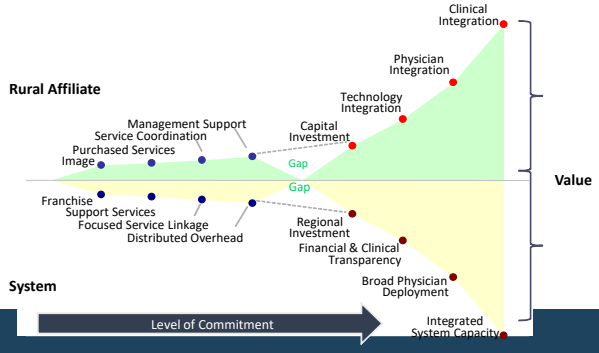
Service Area Rationalization

Using the Affiliation Value Curve, evaluate partnership opportunities with regional providers that effectively position for population health by focusing on the following areas:

- *Delivery System*: Assess specialty care needs of the service area and develop specialty care network to meet demands
- *Population Health Management*: Use consolidated employee claims data to drive healthcare initiatives throughout the region
- *Payment System*: Further relationship with ACO and use ACO as a basis to continue transition toward value-based care



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Alignment Best Practices

Independent peer rural hospitals will evaluate partnership and affiliation opportunities based on the needs of the organization to solidify their position within the market

Evaluate strategic partnership options using the Affiliation Value Curve to guide the determination of mutual opportunities with an emphasis on the following priorities:

- Improve physician and clinical integration throughout the service area and region
- Increase access to network specialists
- Expand integrated and coordinate care management capabilities while establishing best practice, evidence-based medical protocols
- Capital investments
- Expense reductions through administrative integration and group purchasing
- Technological integration and support

Payment System Transformation

Increase use of FFS payment systems that pay for health-related activity such as annual wellness visits, chronic care management, commercial insurance quality incentive programs, etc.

Incorporate population health interventions, such as disease management programs to manage overall benefits costs, into the employee health plan and learn how to provide high-quality, low-cost health care to sell to external markets

Evaluate addition of incentives and disincentives for employees in an effort to improve outcomes and further transition towards a population health model

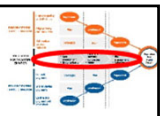
Proactively develop a strategy to participate in a population health payment mechanisms, and consider an ACO model or alternative payment system option that meets the needs of the hospital

> Leverage Accountable Care Organization (ACO) to improve health outcomes, improve the continuity of care, and transition organization towards a value-based reimbursement model

Consider benefit of converting coverage to a pilot population health intervention (such as disease management programs) to manage overall benefits costs and test providing high-quality, low-cost health care to sell to external markets, beginning with the hospital's self-insured population, if indicated

Look to maximize commercial incentives through the development and application of population health management practices

Population Health



Implement the use of evidence-based protocols and care management processes in conjunction with the medical staff to ensure seamless and efficient quality care for all patients

Evaluate claims data to better understand opportunities for improved health of the workforce and better efficiencies in plan design

- Implement a data analytics platform and use employee claims data, once received, as a proxy for a regional care plan to improve outcomes throughout the community

Evaluate the Patient Centered Medical Home (PCMH) certification through NCQA or a PCMH-like structure as a key strategy for future population health positioning

Consider incorporating team-base care features into PCMH

Ensure that all third-party payers recognize Patient Centered Medical Home (PCMH) status and that hospital is to be reimbursed for per member per month case management fees

Implement Chronic Care Management (CCM), Transitional Care Management (TCM) and Behavioral Health Intervention (BHI) programs and billing codes to generate incremental revenue and build greater loyalty among primary care patients

- Explore strategies to improve patient compliance through the use of health coaches and health navigator roles

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Questions?

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Thank you

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