Financial and Operational Best Practices

NC Critical Access Hospital Learning and Action Network

August 23, 2019
Goals for Today

- To provide a high-level introduction to Stroudwater’s catalog of rural hospital best practices
- To describe case study examples of successful peer best performing rural hospitals
- To share common attributes of high performers
Population Health Transition Framework

- This strategic framework is designed to assist organizations in transitioning from a payment system dominated by the FFS payment model to one dominated by population-based payment models.
  - 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 in their market.
  - Population health/care management requires 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.

![Diagram of Population Health Transition Framework]

**FFS**
- Improve quality and efficiency
- Align primary care providers
- Rationalize service network

**PHASE I**
- Implement
- Plan

**PHASE II**
- Plan

**PHASE III**
- Implement
- Plan

**PBPS**
- Implement
- Population Based Health System

**DELIVERY SYSTEM TRANSFORMATION**
- Full-risk payment
- Shared saving payments
- ESHP & FFS payment with incentives

**POPULATION HEALTH SYSTEM CREATION**
- Data analytics
- Care management
- Evidence-based protocols

**PAYMENT SYSTEM TRANSFORMATION**
- Payer and network contracting
- Value attribution
- Plan design
- Risk management
- Value-based credentialing
Financial and Operational Best Practices

- The following best practice opportunities areas were derived from the 40+ Stroudwater CAH engagements conducted over the last three years
  - Economic Philosophy
  - Market Analysis
  - Departmental Profitability
  - Provider Complement/ Practice Management
  - Inpatient Services
  - Emergency Services
  - Ancillary Services
  - Quality Improvement
  - Information Technology
  - Cost Report Improvement
  - Revenue Cycle
  - Management Accounting
  - Staff Benchmark Analysis
  - Affiliation Strategy
  - Provider Alignment
  - Population Health Management
  - Payment System Transformation
  - Service Area Rationalization
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
Case Study: Hospital A
Growth & Primary Care Alignment

- 25-bed not-for-profit CAH located in Virginia
- Owned by 2-state health system
- Completed $18M expansion in summer 2016
- Approximately 300 employees
- 24 employed PCPs
- $134M Gross Revenue / $60M Net Patient Revenue
- Approximately 29% of Primary Service Area Market Share
- Nearest competitor – 40 miles

Service offerings:
- General acute care
- ICU
- Swing bed services
- 24 hour Emergency Department
- Laboratory
- Imaging (X-ray, CT, mobile MRI, 3D Mammography, U/S, nuclear medicine bone densitometry)
- Surgical Services
- Respiratory Therapy
- Speech, Occupational and Physical Therapy
- Primary care through 5 PB-RHCs generating 70K annual visits
Case Study: Hospital A - Growth & Primary Care Alignment

- Highly collaborative team-based culture
- Leveraged shared staffing model and system resources
- Primary Care Focused
  - 70K annual visits through network of 5 PB-RHCs
  - All 5 are PCMH designated
Target an admission rate (acute admissions and observation status) of 10% 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.

Target 20 – 25% of acute days as observation

- Review and educate the medical staff on admission and observation status criteria.
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 2017 cost structure indicates a loss of approximately $2.6M on a fully allocated cost basis.

**Model B** analysis projects the contribution margin opportunity from swing bed census growth:

- Analysis shows a census growth to an ADC of 4 has the potential to yield a contribution margin opportunity estimated at approximately $303K.

### Case Study: Hospital A - Growth & Primary Care Alignment


<table>
<thead>
<tr>
<th></th>
<th>ADC</th>
<th>Total Days</th>
<th>Cost Based Payer Mix</th>
<th>Cost Based Days</th>
<th>Other Days</th>
<th>Payment Per Day</th>
<th>Other Payment</th>
</tr>
</thead>
<tbody>
<tr>
<td>Acute (inc. Observe)</td>
<td>15.0</td>
<td>5,489</td>
<td>72%</td>
<td>3,951</td>
<td>1,538</td>
<td>$ 1,500</td>
<td>$ 2,307,348</td>
</tr>
<tr>
<td>Swing Bed - SNF</td>
<td>1.8</td>
<td>646</td>
<td>94%</td>
<td>604</td>
<td>41</td>
<td>$ 1,200</td>
<td>$ 49,582</td>
</tr>
<tr>
<td>Swing Bed - NF</td>
<td>0.2</td>
<td>57</td>
<td>0%</td>
<td>-</td>
<td>57</td>
<td>$ 250</td>
<td>$ 14,250</td>
</tr>
<tr>
<td><strong>Total Days</strong></td>
<td></td>
<td><strong>6,191</strong></td>
<td></td>
<td><strong>4,555</strong></td>
<td><strong>1,637</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Net Acute/SB SNF/Ob</strong></td>
<td></td>
<td></td>
<td></td>
<td><strong>4,555</strong></td>
<td><strong>1,637</strong></td>
<td><strong>2,371,180</strong></td>
<td></td>
</tr>
</tbody>
</table>

**Inpatient Fixed Costs**: $12,428,036

**Inpatient Variable Costs**: $1,495,155

**Net Inpatient Costs**: $13,923,191

**Inpatient Costs Per Day**: $2,270

**Less: Cost-Based Carveouts**: $(1,860,000)

**Cost Based Payment**: $8,957,032

**Total Payment**: $11,328,213

**Inpatient Costs**: $13,923,191

**Net Margin**: $(2,594,979)

---

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 ROEs (WS C)

### Model B: Grow Swing Bed Census to 4

<table>
<thead>
<tr>
<th></th>
<th>ADC</th>
<th>Total Days</th>
<th>Cost Based Payer Mix</th>
<th>Cost Based Days</th>
<th>Other Days</th>
<th>Payment Per Day</th>
<th>Other Payment</th>
</tr>
</thead>
<tbody>
<tr>
<td>Acute (inc. Observe)</td>
<td>15.0</td>
<td>5,489</td>
<td>72%</td>
<td>3,951</td>
<td>1,538</td>
<td>$ 1,500</td>
<td>$ 2,307,348</td>
</tr>
<tr>
<td>Swing Bed - SNF</td>
<td>4.0</td>
<td>1,460</td>
<td>94%</td>
<td>1,367</td>
<td>93</td>
<td>$ 1,200</td>
<td>$ 112,128</td>
</tr>
<tr>
<td>Swing Bed - NF</td>
<td>0.2</td>
<td>57</td>
<td>0%</td>
<td>-</td>
<td>57</td>
<td>$ 250</td>
<td>$ 14,250</td>
</tr>
<tr>
<td><strong>Total Days</strong></td>
<td></td>
<td><strong>7,006</strong></td>
<td></td>
<td><strong>5,317</strong></td>
<td><strong>1,689</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Net Acute/SB SNF/Ob</strong></td>
<td></td>
<td></td>
<td></td>
<td><strong>5,317</strong></td>
<td><strong>1,689</strong></td>
<td><strong>2,433,725</strong></td>
<td></td>
</tr>
</tbody>
</table>

**Inpatient Fixed Costs**: $12,428,036

**Inpatient Variable Costs**: $1,637,675

**Net Inpatient Costs**: $14,065,711

**Inpatient Costs Per Day**: $2,024

**Less: Cost-Based Carveouts**: $(1,860,000)

**Cost Based Payment**: $9,339,645

**Total Payment**: $11,773,372

**Inpatient Costs**: $14,065,711

**Net Margin**: $(2,292,340)

**Difference**: $302,639
Inpatient Services Best Practices

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

Track and monitor Nurse: Patient ratios against industry standards

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

Establish evidence-based standards and educate providers on the benefit of swing bed services

Utilize InterQual-like criteria resources to educate providers and 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
Inpatient Services Best Practices

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

- Implement Active Solicitation model to increase Swing bed census
- Educate the provider community on the benefits of cost-based reimbursement and the appropriate use of swing bed services
- Develop focused swing bed marketing plan, targeting case managers within hospital as well as neighboring hospitals
- Ensure that swing bed utilization is a priority with unit staff, case management staff and physician providers

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
Provider Alignment Best Practices

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

Case Study: Hospital A - Growth & Primary Care Alignment
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.

Leverage 340B Discount Drug Pricing Program by targeting between $350k and $450k per 10k Medicare and third-party payer visits in net proceeds from the 340B program.

---

### Provider Alignment Best Practices

<table>
<thead>
<tr>
<th>Clinic Visits</th>
<th>Est. Medicare and 3rd Party Payer %</th>
<th>340B Eligible Visits</th>
<th>Avg. RX per Visit</th>
<th>Total 340B RXs</th>
<th>Avg. per Rx 340B Increase</th>
<th>340B Incremental Benefit</th>
</tr>
</thead>
<tbody>
<tr>
<td>70K</td>
<td>85%</td>
<td>59K</td>
<td>1.5</td>
<td>89K</td>
<td>$35.00</td>
<td>$3.1M</td>
</tr>
</tbody>
</table>
Case Study: Hospital B
Engagement & Accountability

Service offerings:
- General acute care
- ICU
- Swing bed services
- 24 hour Emergency Department
- Laboratory
- Imaging (X-ray, CT, MRI, Mammography, U/S, nuclear medicine bone densitometry)
- Surgical Services
- Respiratory Therapy
- Speech, Occupational and Physical Therapy
- 1 PB-RHC

- 25-bed not-for-profit CAH located in Kentucky
- Independent organization
- Pursued $10M facility expansion in 2016
- Approximately 130 employees
- 4 employed PCPs
- $64M Gross Revenue / $21M Net Patient Revenue
- Approximately 32% of Primary Service Area Market Share
- 6 competitors within – 50 mile radius
Case Study: Hospital B - Engagement & Accountability

Financial Operating Trends (in 000's)

<table>
<thead>
<tr>
<th></th>
<th>FY 2013</th>
<th>FY 2014</th>
<th>FY 2015</th>
<th>FY 2016</th>
</tr>
</thead>
<tbody>
<tr>
<td>Revenue</td>
<td>19,412</td>
<td>19,844</td>
<td>22,085</td>
<td>21,298</td>
</tr>
<tr>
<td>Expense</td>
<td>18,924</td>
<td>18,933</td>
<td>22,063</td>
<td>21,449</td>
</tr>
<tr>
<td>Margin</td>
<td>0.1%</td>
<td>-0.1%</td>
<td>-0.7%</td>
<td>0.0%</td>
</tr>
</tbody>
</table>

Liquidity Analysis

<table>
<thead>
<tr>
<th></th>
<th>FY 2013</th>
<th>FY 2014</th>
<th>FY 2015</th>
<th>FY 2016</th>
</tr>
</thead>
<tbody>
<tr>
<td>Days</td>
<td>29</td>
<td>41</td>
<td>40</td>
<td>40</td>
</tr>
<tr>
<td>Cash</td>
<td>85</td>
<td>93</td>
<td>97</td>
<td>113</td>
</tr>
<tr>
<td>Pay</td>
<td>59</td>
<td>78</td>
<td>52</td>
<td>50</td>
</tr>
</tbody>
</table>

Median CAH Values

<table>
<thead>
<tr>
<th></th>
<th>KY</th>
<th>US</th>
<th>Hospital B</th>
</tr>
</thead>
<tbody>
<tr>
<td>Operating Margin</td>
<td>0.61</td>
<td>.93%</td>
<td>0.7</td>
</tr>
<tr>
<td>Days in Net A/R</td>
<td>53.8</td>
<td>52.3</td>
<td>50</td>
</tr>
<tr>
<td>Days Cash</td>
<td>24.4</td>
<td>77.7</td>
<td>113</td>
</tr>
</tbody>
</table>


- Healthy team-based performance culture
- New CEO that re-established strong relationship with hospital associates and medical community
- Strong performance improvement focus on revenue cycle
Revenue Cycle Best Practices

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 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

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

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 communication of patient co-payment expectations/estimated costs

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

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

Case Study: Hospital B - Engagement & Accountability (Continued)
### Revenue Cycle Key Performance Indicators (KPIs)

<table>
<thead>
<tr>
<th>KPI</th>
<th>Responsible</th>
<th>Benchmark</th>
<th>June</th>
<th>July</th>
<th>August</th>
<th>Sept</th>
<th>October</th>
<th>November</th>
<th>December</th>
</tr>
</thead>
<tbody>
<tr>
<td>Accounts Receivable Days Over 90 &amp; Gross Collections</td>
<td>Trudy Patti</td>
<td>20%</td>
<td>37%</td>
<td>42%</td>
<td>37%</td>
<td>41%</td>
<td>33%</td>
<td>34%</td>
<td>36%</td>
</tr>
<tr>
<td>Bill Hold Days</td>
<td>Patti Sullivan</td>
<td>3 days</td>
<td>4 days</td>
<td>4 days</td>
<td>4 days</td>
<td>4 days</td>
<td>4</td>
<td>4</td>
<td>4</td>
</tr>
<tr>
<td>Percentage of Unbilled Receivable</td>
<td>Patti Sullivan</td>
<td>&lt;10%</td>
<td>13%</td>
<td>10%</td>
<td>12%</td>
<td>13%</td>
<td>12%</td>
<td>12%</td>
<td>12%</td>
</tr>
<tr>
<td>Average Daily Revenue in Held Medical Records</td>
<td>Rhedawn Street</td>
<td>5 days</td>
<td>3.5 days</td>
<td>3.14 days</td>
<td>3 days</td>
<td>2 days</td>
<td>2 days</td>
<td>2 days</td>
<td>3</td>
</tr>
<tr>
<td>Registration Error Rate</td>
<td>Stephanie / Patti</td>
<td>2%</td>
<td>5%</td>
<td>3%</td>
<td>4%</td>
<td>3%</td>
<td>3%</td>
<td>3%</td>
<td>5%</td>
</tr>
<tr>
<td>Percentage of Bad Debt to Gross Revenue</td>
<td>Ann Brown</td>
<td>2.5%</td>
<td>5%</td>
<td>1%</td>
<td>1.96%</td>
<td>1.8</td>
<td>0</td>
<td>1.00%</td>
<td>1%</td>
</tr>
<tr>
<td>Charity Percentage to Gross Revenue</td>
<td>Ann Brown</td>
<td>2.5%</td>
<td>3%</td>
<td>3%</td>
<td>0.03%</td>
<td>2</td>
<td>3%</td>
<td>1.00%</td>
<td>1%</td>
</tr>
<tr>
<td>Days in A/R</td>
<td>Crystal Briner</td>
<td>60 days</td>
<td>68.75</td>
<td>68</td>
<td>84</td>
<td>59.23</td>
<td>52</td>
<td>58.13</td>
<td></td>
</tr>
<tr>
<td>Percentage Clean Claims from Bill Editor</td>
<td>Patti Sullivan</td>
<td>95%</td>
<td>99%</td>
<td>99%</td>
<td>99%</td>
<td>99%</td>
<td>99%</td>
<td>99%</td>
<td>99%</td>
</tr>
<tr>
<td>Return on Worker’s Compensation, Third Party Liability and Auto</td>
<td>Patti Sullivan</td>
<td>85%</td>
<td>85%</td>
<td>85%</td>
<td>85%</td>
<td>85%</td>
<td>85%</td>
<td>85%</td>
<td></td>
</tr>
<tr>
<td>Up-front Deductible and Co-payment Collections</td>
<td>Stephanie Smithson</td>
<td>50%</td>
<td>Unable to track</td>
<td>Unable to track</td>
<td>Unable to track</td>
<td>Unable to track</td>
<td>Unable to track</td>
<td>Unable to track</td>
<td>Unable to track</td>
</tr>
<tr>
<td>Average Daily Revenue in Credit Balances</td>
<td>Patti Sullivan</td>
<td>&gt;1 day</td>
<td>4.54</td>
<td>4.82</td>
<td>5.24</td>
<td>4.49</td>
<td>4.65</td>
<td>4.96</td>
<td>5.55%</td>
</tr>
<tr>
<td>Claim Denial Rate</td>
<td>Patti Sullivan</td>
<td>4%</td>
<td>Unable to track</td>
<td>Unable to track</td>
<td>Unable to track</td>
<td>Unable to track</td>
<td>Unable to track</td>
<td>1%</td>
<td>No way to track yet</td>
</tr>
<tr>
<td>Percentage of Scheduled Services that are Pre-Registered</td>
<td>Stephanie Smithson</td>
<td>95%</td>
<td>52% ancillary</td>
<td>78% OR 65% Angio</td>
<td>Overall avg 86%</td>
<td>86% overall</td>
<td>93% overall</td>
<td>90%</td>
<td>94%</td>
</tr>
<tr>
<td>Percentage of Self-pay Patients that Receive Financial Counseling</td>
<td>Stephanie / Ann</td>
<td>95%</td>
<td>Unable to track</td>
<td>Unable to track</td>
<td>Unable to track</td>
<td>Unable to track</td>
<td>Unable to track</td>
<td>No way to track yet</td>
<td></td>
</tr>
<tr>
<td>Hospital-wide Education Regarding Charity Policy and Payment Options for Patients</td>
<td>Ann Brown</td>
<td>100%</td>
<td>Brochure in process</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

**Purpose of Data**

- Monitor account follow-up processes and practices for extreme efficiencies.
- Time frame that bills are held in order to collect accurate data input, medical record coding and charges.
- Strictly monitor in-house, recurring, and missing diagnosis accounts.
- Total days in revenue that are held for coding delays.
- Registration error rate as a percentage of total registrations.
- Monitor uncollectible accounts to ensure they have been appropriately handled.
- Monitor charity write-off and ensure financial counseling is accomplished.
- Average days to collect the receivable.
- Number of errors on accounts due to data input, charging and coding.
- Effectiveness of third party liability claims collection.
- Improvements to cashflow, by acknowledging the financial obligation with the patient at the time of service.
- Credit balances negatively effect the total A/R.
- Total denied claims as a percentage of total claims.
- Improving patient information data gathering including demographics, medical necessity and insurance eligibility.
- Providing patients with payment options and/or charity consideration.
- Ensuring that Hospital Payment and Charity Care Policies are well understood by all hospital staff.
Revenue Cycle Best Practices

Use current revenues as the basis for establishing POS collection goals for each department

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

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

Report of 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
Quality Improvement Best Practices

Convene a Patient Family Advisory Council with community member participation
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
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
  • Develop an optimal portfolio of members of the Quality Improvement program to include CFO and other key leaders
  • 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

Case Study: Hospital B - Engagement & Accountability (Continued)
Case Study: Hospital C
Alignment & Growth

Service offerings:

- General acute care
- ICU
- Swing bed services
- 24 hour Emergency Department
- Laboratory
- Imaging (X-ray, CT, mobile MRI, 3D Mammography, U/S, nuclear medicine, bone densitometry)
- Surgical Services
- Respiratory Therapy
- Speech, Occupational and Physical Therapy
- Primary care through 3 clinics (2 PB-RHCs)

- 25-bed not-for-profit, CAH located in West Virginia
- 48,000 sq. ft. replacement facility in 2007
- Owned by academic health system
- Approximately 200 employees
- 4 employed PCPs
- $47M Gross Revenue / $25M Net Patient Revenue
- Approximately 19% of Primary Service Area Market Share
- 2 competitors within 30 miles
Case Study: Hospital C - Alignment & Growth

Financial Operating Trends (in 000's)

- History of strained relationship with medical community
- New CEO brought on in 2017 → improved relationship with medical staff
- Driven growth of services through empowerment of leadership and enhanced provider alignment

Median CAH Values

<table>
<thead>
<tr>
<th></th>
<th>WV</th>
<th>US</th>
<th>Hospital C</th>
</tr>
</thead>
<tbody>
<tr>
<td>Operating Margin</td>
<td>(0.32%)</td>
<td>0.27%</td>
<td>0.1%</td>
</tr>
</tbody>
</table>

### Case Study: Hospital C - Alignment & Growth (Continued)

#### Physician Shortage/Surplus

<table>
<thead>
<tr>
<th>Primary Care</th>
<th>Supply Study Range</th>
<th>Existing</th>
<th>(Shortage)/Surplus Range</th>
</tr>
</thead>
<tbody>
<tr>
<td>Family Practice</td>
<td>2.4 - 8.2</td>
<td>4.00</td>
<td>4.2 - 1.6</td>
</tr>
<tr>
<td>Internal Medicine</td>
<td>2.0 - 4.9</td>
<td>2.00</td>
<td>2.9 - 0.0</td>
</tr>
<tr>
<td>Pediatrics</td>
<td>1.4 - 2.1</td>
<td>1.00</td>
<td>1.1 - 0.4</td>
</tr>
<tr>
<td><strong>Physician Primary Care Range</strong></td>
<td><strong>9.3 - 11.6</strong></td>
<td><strong>7.00</strong></td>
<td><strong>4.6 - 2.3</strong></td>
</tr>
<tr>
<td>Non-Phys Providers</td>
<td>1.2 - 4.0</td>
<td>3.20</td>
<td>0.8 - 2.0</td>
</tr>
<tr>
<td><strong>TOTAL Primary Care Range</strong></td>
<td><strong>11.6 - 15.6</strong></td>
<td><strong>10.20</strong></td>
<td><strong>5.4 - 1.4</strong></td>
</tr>
</tbody>
</table>

#### Medical Specialties

<table>
<thead>
<tr>
<th>Specialties</th>
<th>Supply Study Range</th>
<th>Existing</th>
<th>(Shortage)/Surplus Range</th>
</tr>
</thead>
<tbody>
<tr>
<td>Allergy</td>
<td>0.1 - 0.2</td>
<td>0.00</td>
<td>0.2 - 0.1</td>
</tr>
<tr>
<td>Cardiology</td>
<td>0.5 - 0.6</td>
<td>0.11</td>
<td>0.5 - 0.4</td>
</tr>
<tr>
<td>Dermatology</td>
<td>0.3 - 0.4</td>
<td>0.00</td>
<td>0.4 - 0.3</td>
</tr>
<tr>
<td>Endocrinology</td>
<td>0.0 - 0.2</td>
<td>0.00</td>
<td>0.2 - 0.0</td>
</tr>
<tr>
<td>Gastroenterology</td>
<td>0.3 - 0.4</td>
<td>0.00</td>
<td>0.4 - 0.3</td>
</tr>
<tr>
<td>Hem/Oncology</td>
<td>0.4 - 0.4</td>
<td>0.00</td>
<td>0.4 - 0.4</td>
</tr>
<tr>
<td>Infectious Disease</td>
<td>0.1 - 0.2</td>
<td>0.00</td>
<td>0.2 - 0.1</td>
</tr>
<tr>
<td>Nephrology</td>
<td>0.2 - 0.3</td>
<td>0.00</td>
<td>0.3 - 0.2</td>
</tr>
<tr>
<td>Neurology</td>
<td>0.3 - 0.5</td>
<td>0.00</td>
<td>0.5 - 0.3</td>
</tr>
<tr>
<td>Pulmonary</td>
<td>0.2 - 0.4</td>
<td>1.00</td>
<td>0.6 - 0.8</td>
</tr>
<tr>
<td>Rheumatology</td>
<td>0.2 - 0.2</td>
<td>0.00</td>
<td>0.2 - 0.2</td>
</tr>
</tbody>
</table>

#### Surgical Specialties

<table>
<thead>
<tr>
<th>Specialties</th>
<th>Supply Study Range</th>
<th>Existing</th>
<th>(Shortage)/Surplus Range</th>
</tr>
</thead>
<tbody>
<tr>
<td>ENT</td>
<td>0.1 - 0.5</td>
<td>0.00</td>
<td>0.5 - 0.1</td>
</tr>
<tr>
<td>General Surgery</td>
<td>1.1 - 1.3</td>
<td>2.00</td>
<td>0.7 - 0.9</td>
</tr>
<tr>
<td>Neurosurgery</td>
<td>0.1 - 0.2</td>
<td>0.00</td>
<td>0.2 - 0.1</td>
</tr>
<tr>
<td>OB/GYN</td>
<td>1.3 - 1.8</td>
<td>0.00</td>
<td>1.8 - 1.3</td>
</tr>
<tr>
<td>Ophthalmology</td>
<td>0.6 - 0.7</td>
<td>0.00</td>
<td>0.7 - 0.6</td>
</tr>
<tr>
<td>Orthopedic</td>
<td>0.7 - 1.2</td>
<td>2.00</td>
<td>0.8 - 1.3</td>
</tr>
<tr>
<td>Plastic Surgery</td>
<td>0.2 - 0.3</td>
<td>0.00</td>
<td>0.3 - 0.2</td>
</tr>
<tr>
<td>Urology</td>
<td>0.5 - 0.5</td>
<td>0.00</td>
<td>0.5 - 0.5</td>
</tr>
</tbody>
</table>

---

### Provider Complement Best Practices

1. Create a catalog of all primary / specialty care providers with the service area to gain a better understanding of how current and future need is being addressed.
2. Establish multi-year provider development plan with an emphasis on recruitment / succession planning.

---

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 Alignment Best Practices

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.

<table>
<thead>
<tr>
<th>Specialty</th>
<th>Provider</th>
<th>Ambulatory Encounters</th>
<th>Average Annual Visit per Patient</th>
<th>Patient Estimate</th>
<th>Directed per Capita Cost</th>
<th>Health Based Value</th>
</tr>
</thead>
<tbody>
<tr>
<td>Family Practice</td>
<td>Physician</td>
<td>4,200</td>
<td>3</td>
<td>1,400</td>
<td>9,990</td>
<td>$13,986,000</td>
</tr>
<tr>
<td>Family Practice</td>
<td>NP / PA</td>
<td>3,000</td>
<td>3</td>
<td>1,000</td>
<td>9,990</td>
<td>$9,990,000</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td>2,400</td>
<td></td>
<td>$23,976,000</td>
</tr>
</tbody>
</table>
Emergency Services Best Practices

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

Work with 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

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)

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 8% and 10%
• 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
56-bed not-for-profit, general acute care hospital located in Alabama
- Approximately 192 employees
- Significant deficit of primary care providers → 0 employed providers as of Sept. ‘14
- $38M Gross Revenue
- Management agreement with area system that expired in Fall ’14
- Approximately 29% of Primary Service Area Market Share
- 5 competitors within 30 miles

Service offerings:
- General acute care
- Swing bed services
- Geriatric psychiatry services
- 24 hour Emergency Department
- Laboratory
- Imaging (X-ray, CT, MRI, Mammography, U/S, bone densitometry)
- Surgical Services
- Respiratory Therapy
- Speech, Occupational and Physical Therapy
- Attached wellness center
- Primary care through 2 clinics – PCP exodus
Performance Snapshot - Hospital D

Operational Performance

<table>
<thead>
<tr>
<th>Area</th>
<th>Metric</th>
<th>Result</th>
</tr>
</thead>
<tbody>
<tr>
<td>Finance</td>
<td>Operating Margin</td>
<td>-18%</td>
</tr>
<tr>
<td></td>
<td>Net Income (Loss)</td>
<td>($2,545M)</td>
</tr>
<tr>
<td></td>
<td>Days Operating Cash</td>
<td>12</td>
</tr>
<tr>
<td>Growth</td>
<td>IP (4 yr. trend)</td>
<td>11% decline</td>
</tr>
<tr>
<td></td>
<td>Ancillary Services (4 yr. trend)</td>
<td>28% decline</td>
</tr>
<tr>
<td>Quality</td>
<td>Core Measures Avg.</td>
<td>93%</td>
</tr>
<tr>
<td>Patient Satisfaction</td>
<td>HCAHPS Average</td>
<td>76%</td>
</tr>
<tr>
<td></td>
<td>HCAHPS Likely to Recommend</td>
<td>62%</td>
</tr>
</tbody>
</table>

(lower than state and peers)

Transition Readiness

<table>
<thead>
<tr>
<th>Ops Efficiency &amp; Quality</th>
<th>Physician Alignment</th>
<th>Service Area Rationalization</th>
<th>Payment System</th>
</tr>
</thead>
<tbody>
<tr>
<td>Yellow</td>
<td>Red</td>
<td>Red</td>
<td>Red</td>
</tr>
</tbody>
</table>
5 Key Attributes of High Performers

1. Establish **well-defined strategic objectives** for how they serve their communities / market

2. Create a **focused plan** and leverage a **disciplined approach** to achieving the strategic Objectives and Key Results

3. Cultivate **entrepreneurial mindset** → Growth focus as opposed to expense focus

4. Seek **solutions outside of healthcare** → “what got us here is not going to get us out of here”
5 Key Attributes of High Performers

5. Foster a **healthy culture**
   - Empowerment of most important resource → people
   - Transparent sharing of information
   - High engagement of staff and medical community
   - Collaborative, team-based problem solving
   - Performance measurement and accountability
   - Trust and mutual respect
   - Deep and personal connection to Mission
   - Ownership v. Rentership
   - Accessible and authentic leadership
Organizational Real-time Self-Assessment
# High Performance Self-Assessment

<table>
<thead>
<tr>
<th>Attribute</th>
<th>1</th>
<th>2</th>
<th>3</th>
<th>4</th>
<th>5</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Attribute</strong></td>
<td><strong>Strongly Disagree</strong></td>
<td><strong>Disagree</strong></td>
<td><strong>Neutral</strong></td>
<td><strong>Agree</strong></td>
<td><strong>Strongly Agree</strong></td>
</tr>
<tr>
<td>1  Our organization has <strong>well-defined strategic objectives</strong> that are known and supported by all stakeholders</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>2  We have a <strong>focused plan</strong> that clearly defines objectives and key results</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>3  We have a <strong>disciplined approach to driving change</strong> that seeks to engage all stakeholders</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>4  We <strong>empower our associates</strong> to act like &quot;owners&quot;</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>5  We <strong>encourage innovation</strong> and look to outside industries and sources for solutions</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>6  Leadership fosters a <strong>healthy culture</strong> characterized by a foundation of trust, transparency, engagement and collaborative problem solving</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Range</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>5 - 14</td>
<td>Straggler</td>
</tr>
<tr>
<td>15 - 24</td>
<td>Pace Setter</td>
</tr>
<tr>
<td>25 - 30</td>
<td>Rock Star</td>
</tr>
</tbody>
</table>
Thanks for listening!
Appendix
Department Profitability Best Practices

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.

Nursing Home/SNF Profitability Analysis FY 2018

<table>
<thead>
<tr>
<th>Revenue:</th>
<th>Days</th>
<th>Rate</th>
<th>Revenue</th>
</tr>
</thead>
<tbody>
<tr>
<td>Medicaid Revenue</td>
<td>15,391</td>
<td>$169.00</td>
<td>$2,601,079</td>
</tr>
<tr>
<td>Self Pay Revenue</td>
<td>1,654</td>
<td>$169.00</td>
<td>$279,526</td>
</tr>
<tr>
<td>Medicare Revenue</td>
<td>891</td>
<td>$169.00</td>
<td>$2,374</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td>17,936</td>
<td></td>
<td><strong>$2,882,979</strong></td>
</tr>
</tbody>
</table>

Operating Expenses:

*Direct Expenses (2018 ICR - WS A):*

<table>
<thead>
<tr>
<th>Item</th>
<th>Allocation</th>
<th>Nursing Home</th>
</tr>
</thead>
<tbody>
<tr>
<td>Salary expense</td>
<td>$1,362,187</td>
<td>$1,362,187</td>
</tr>
<tr>
<td>Other</td>
<td>$361,255</td>
<td>$361,255</td>
</tr>
<tr>
<td><strong>Total Direct Expense</strong></td>
<td><strong>$1,723,442</strong></td>
<td><strong>$1,723,442</strong></td>
</tr>
</tbody>
</table>

*Allocated Expenses (ICR Stepdown - WS B)*

<table>
<thead>
<tr>
<th>Item</th>
<th>Allocation</th>
<th>Nursing Home Variable %</th>
</tr>
</thead>
<tbody>
<tr>
<td>Capital Costs</td>
<td>$109,645</td>
<td>90%</td>
</tr>
<tr>
<td>Admin and General</td>
<td>$494,735</td>
<td>50%</td>
</tr>
<tr>
<td>Employee Benefits</td>
<td>$191,284</td>
<td>90%</td>
</tr>
<tr>
<td>Operation of Plant</td>
<td>$273,827</td>
<td>50%</td>
</tr>
<tr>
<td>Dietary</td>
<td>$621,848</td>
<td>50%</td>
</tr>
<tr>
<td>Medical Records &amp; Library</td>
<td>$7,106</td>
<td>50%</td>
</tr>
<tr>
<td>Nursing Admin</td>
<td>$69,060</td>
<td>50%</td>
</tr>
<tr>
<td>Housekeeping</td>
<td>$150,735</td>
<td>50%</td>
</tr>
<tr>
<td>Laundry and Linen</td>
<td>$51,228</td>
<td>50%</td>
</tr>
<tr>
<td><strong>Total Nursing Home Allocated Expense</strong></td>
<td><strong>$1,969,468</strong></td>
<td><strong>$1,105,106</strong></td>
</tr>
<tr>
<td><strong>Total Nursing Home expenses</strong></td>
<td><strong>$3,692,910</strong></td>
<td><strong>$2,828,548</strong></td>
</tr>
</tbody>
</table>

**Nursing Home Direct Gain (Loss)**

$-(809,931)$ $54,431$
Provider Complement Best Practices

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
Inpatient Services Best Practices

Target an admission rate (acute admissions and observation status) of 10% 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.

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

- Implement Active Solicitation model to increase Swing bed census
- Educate the provider community on the benefits of cost-based reimbursement and the appropriate use of swing bed services
- Develop focused swing bed marketing plan, targeting case managers within hospital as well as neighboring hospitals
- Ensure that swing bed utilization is a priority with unit staff, case management staff and physician providers

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
Inpatient Services Best Practices

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

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

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

Establish evidence-based standards and educate providers on the benefit of swing bed services

Utilize InterQual-like criteria resources to educate providers and 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
Inpatient Services Best Practices

Track and monitor Nurse:Patient ratios against industry standards

Target 20 – 25% of acute days as observation

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

- 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 2017 cost structure indicates a loss of approximately **$2.6M** on a fully allocated cost basis

- **Model B** analysis projects the contribution margin opportunity from swing-bed census growth
  - Analysis shows a census growth to an ADC of 4 has the potential to yield a contribution margin opportunity estimated at approximately **$303K**

<table>
<thead>
<tr>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>ADC Total Days Base Case Payer Mix Cost Based Days Other Days Payment Per Day Other Payment</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Acute (inc. Observ) 15.0 5,489 72% 3,951 1,538 $1,500 $2,307,348</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Swing Bed - SNF 1.8 646 94% 604 41 $1,200 $49,582</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Swing Bed - NF 0.2 57 0% - 57 $250 $14,250</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Total Days 17.0 6,191 4,555 1,637</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Net Acute/SB SNF/Ob 6,134 74% 4,555 1,637</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Inpatient Fixed Costs $12,428,036</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Inpatient Variable Costs $1,495,155</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Net Inpatient Costs $13,923,191</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Inpatient Costs Per Day $2,270</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Less: Cost-Based Carveouts $(1,850,000) $(307,271)</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Cost Based Payment $8,957,032 $8,957,032</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Total Payment $11,328,213</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Inpatient Costs $13,923,191</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Net Margin $2,594,979</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

* Assumes $350/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 ROIs (WS C)

| Model B: Grow Swing Bed Census to 4 |
|---------------------------------|----------------|----------------|----------------|---------------|---------------|
| ADC Total Days Base Case Payer Mix Cost Based Days Other Days Payment Per Day Other Payment |
| Acute (inc. Observ) 15.0 5,489 72% 3,951 1,538 $1,500 $2,307,348 |
| Swing Bed - SNF 4.0 1,460 94% 1,367 93 $1,200 $112,128 |
| Swing Bed - NF 0.2 57 0% - 57 $250 $14,250 |
| Total Days 19.2 7,006 5,317 1,689 6,949 74% 5,317 1,689 |
| Net Acute/SB SNF/Ob 6,949 74% 5,317 1,689 |
| Inpatient Fixed Costs $12,428,036 1 |
| Inpatient Variable Costs $1,637,675 2 |
| Net Inpatient Costs $14,065,711 |
| Inpatient Costs Per Day $2,024 |
| Less: Cost-Based Carveouts $(1,850,000) $(267,671) |
| Cost Based Payment $9,339,645 $9,339,645 |
| Total Payment $11,773,372 |
| Inpatient Costs $14,065,711 |
| Net Margin $(2,292,340) |
| Difference $302,639 |
Emergency Services Best Practices

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

Work with 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

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)

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 8% and 10%
  • 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
Ancillary Services Best Practices

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

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

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.

PHARMACY: Evaluate 340B financial impact in conjunction with clinic expansion and provider recruitment decisions.

Evaluate current staffing levels for opportunities to enhance efficiency with a focus on volume growth.
Quality Improvement Best Practices

Report of 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

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

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
• Develop an optimal portfolio of members of the Quality Improvement program to include CFO and EVS
• 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
Information Technology Best Practices

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

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 Swing Bed patients to Line 6

Consider consolidating Rural Health Clinics (RHC) for cost report purposes to reduce variation and remove reimbursement variances

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 Best Practices

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 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

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

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 communication of patient co-payment expectations/estimated costs

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

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
Revenue Cycle Best Practices (Cont.)

Use current revenues as the basis for establishing POS collection goals for each department.

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

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

Consistently hold managers accountable for monthly variance reporting by requiring rationale and actions related to positive/negative budget variances
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
Evaluate strategic partnership options using the Affiliation Value Curve to guide the determination of mutual opportunities with an emphasis on the following priorities:

• Development of primary care and sustainable specialty care resources in the region

• Expansion of outpatient services, as well as clinical integration with regional partners to enable seamless coordination of care

• Negotiating leverage with third party payers
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

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
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.

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