

Financial and Operational Best Practices

NC Critical Access Hospital Learning and Action Network

August 23, 2019



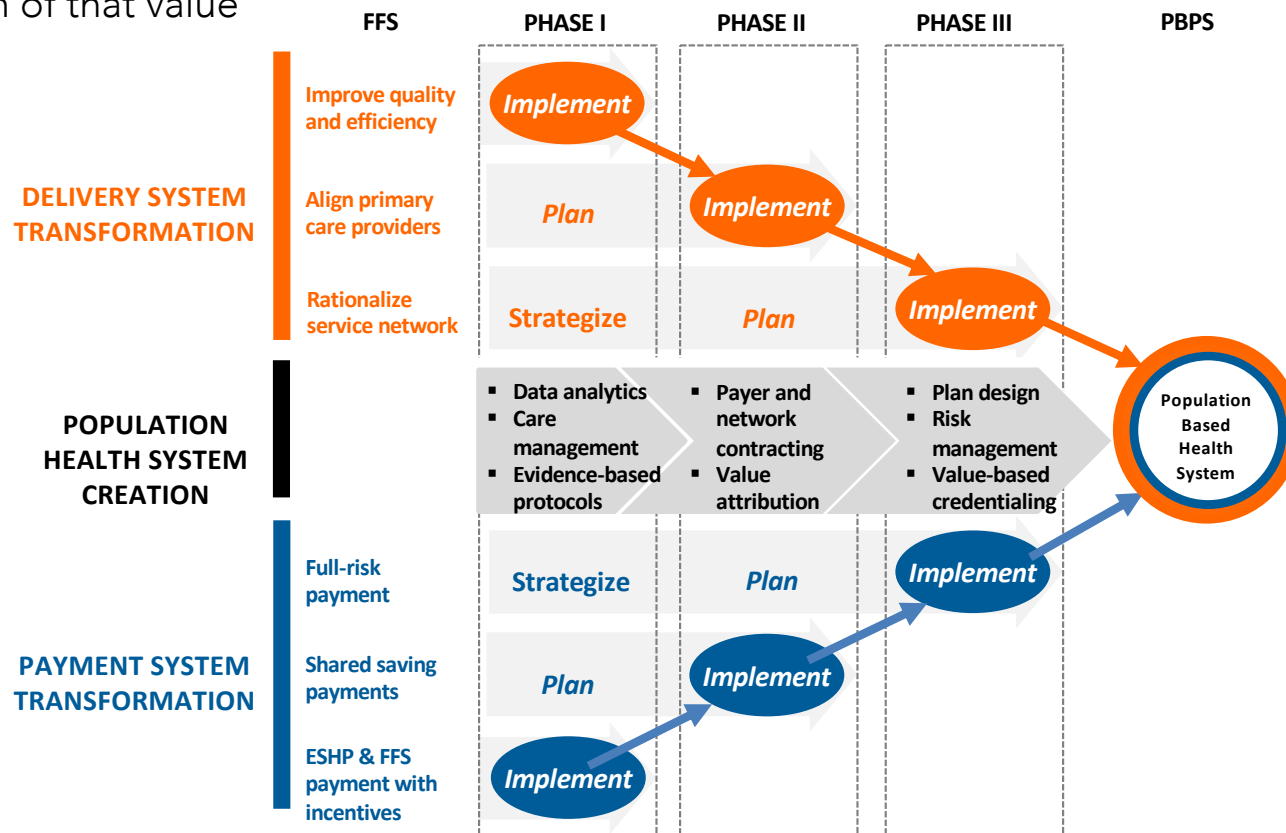
STROUDWATER

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





Financial and Operational Best Practices



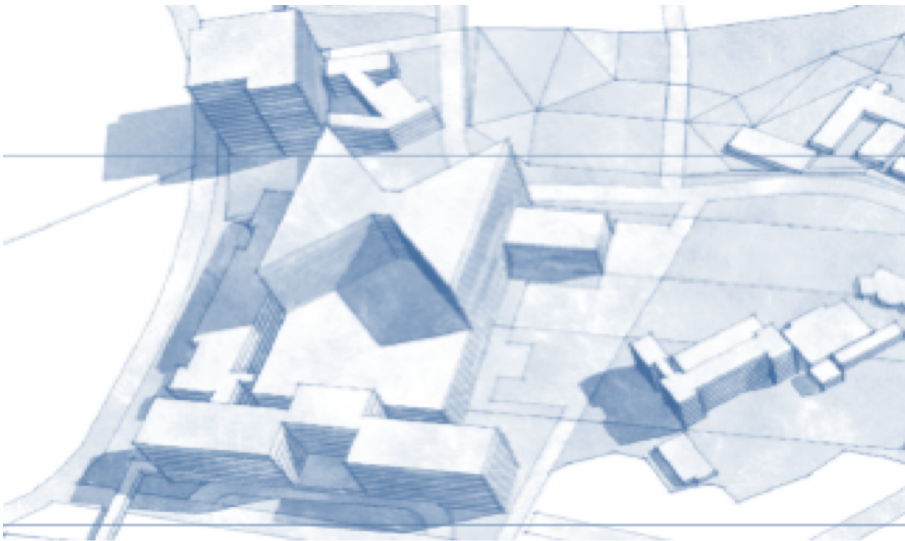
- The following best practice opportunities areas were derived from the 40+ Stroudwater CAH engagements conducted over the last three years
 - ☐ Economic Philosophy
 - ☐ Market Analysis
 - ☐ Departmental Profitability
 - ☐ Provider Complement/ Practice Management
 - ☐ Inpatient Services
 - ☐ Emergency 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



Economic Philosophy Best Practices

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:

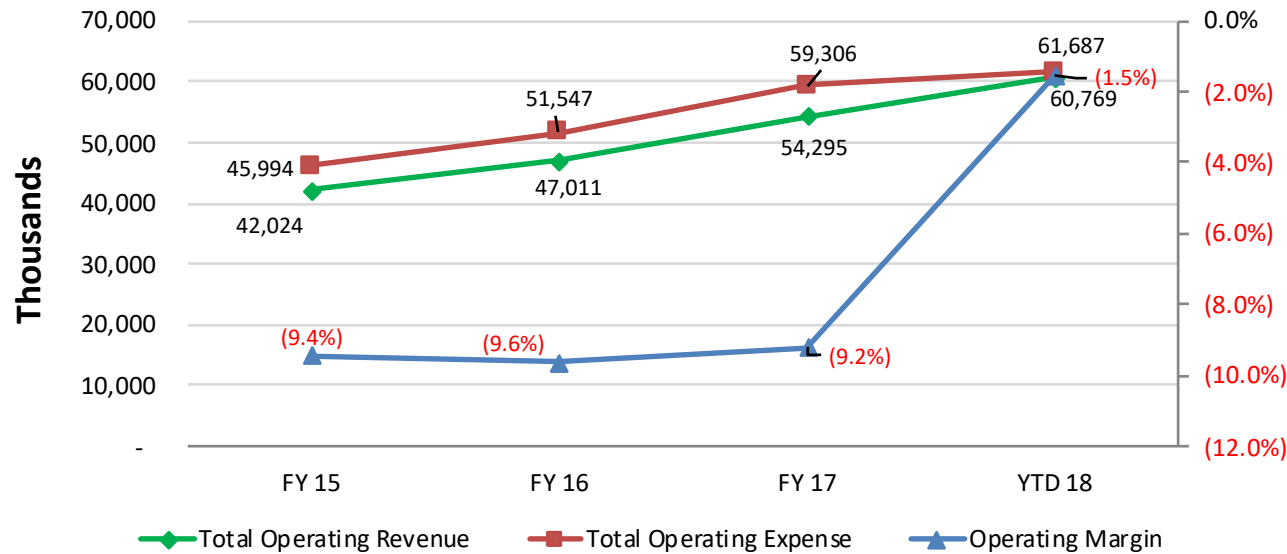
- General acute care
- ICU
- Swing bed services
- 24 hour Emergency Department
- Laboratory
- Imaging (X-ray, CT, mobile MRI, 3D Mammography, U/S, nuclear medicine bone densitometry)
- Surgical Services
- Respiratory Therapy
- Speech, Occupational and Physical Therapy
- Primary care through 5 PB-RHCs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



Case Study: Hospital A - Growth & Primary Care Alignment



Financial Operating Trends (in 000's)



Median CAH Values			
	VA	US	Hospital A
Operating Margin	(9.8%)	.93%	(1.5%)

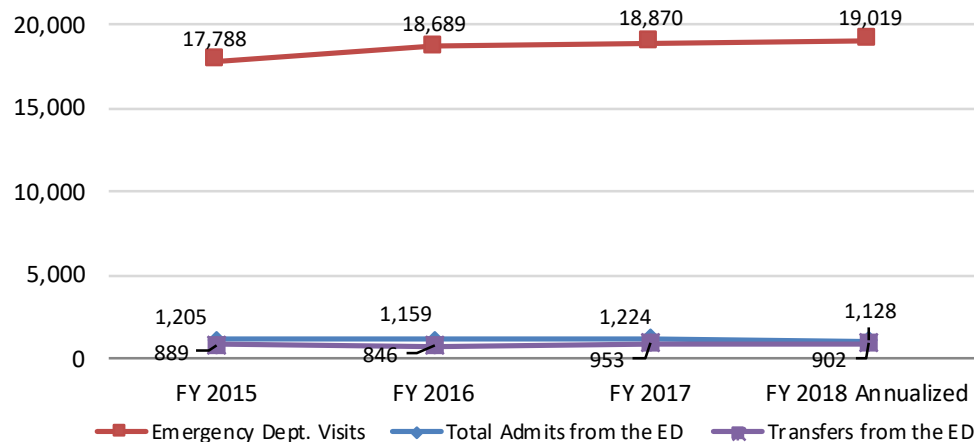
SOURCE: Flex Monitoring Team: CAH Financial Indicators Report – March 2018 (2016 data)

- 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

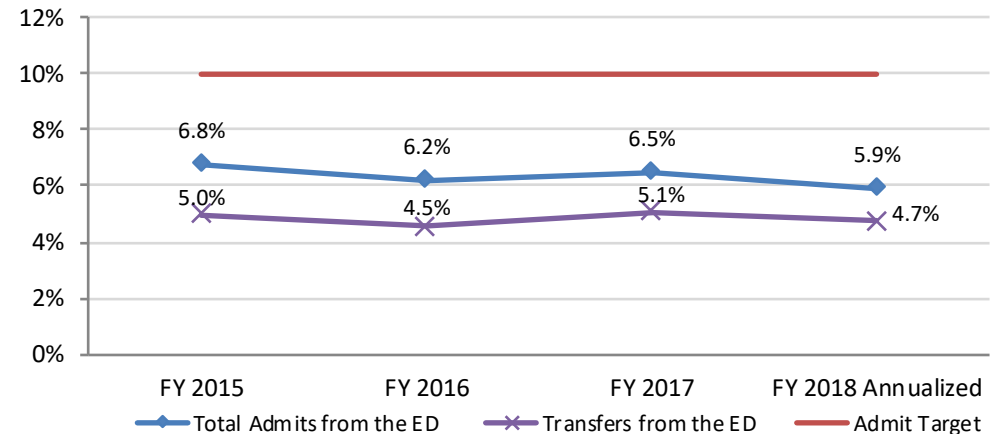
Case Study: Hospital A - Growth & Primary Care Alignment

Inpatient Services Best Practices

Emergency Department Statistics



ED Admissions & Transfers as a % of Visits



- ☐ 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

Case Study: Hospital A - Growth & Primary Care Alignment

- 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 A: Base Case (FY 2017 Cost Report) Cost Structure at FY 2018 Volume

	ADC	Total Days	Cost Based 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	1.8	646	94%	604	41	\$ 1,200	\$ 49,582
Swing Bed - NF	0.2	57	0%	-	57	\$ 250	\$ 14,250
Total Days	17.0	6,191		4,555	1,637		\$ 2,371,180
Net Acute/SB SNF/Obs		6,134	74%	4,555	1,637		
Inpatient Fixed Costs		\$ 12,428,036 ¹					
Inpatient Variable Costs		\$ 1,495,155 ²					
Net Inpatient Costs		\$ 13,923,191					
Inpatient Costs Per Day		\$ 2,270		\$ 2,270			
Less: Cost-Based Carveouts		\$ (1,860,000)		\$ (303.21)			
Cost Based Payment				\$ 8,957,032			\$ 8,957,032
Total Payment							\$ 11,328,213
Inpatient Costs							\$ 13,923,191
Net Margin							\$ (2,594,979)

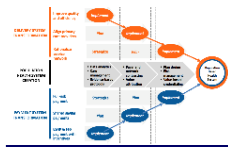
¹ Assumes \$250/day marginal acute costs and \$175/day marginal swing bed SNF and NF costs

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

- 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**

Model B: Grow Swing Bed Census to 4

	ADC	Total Days	Cost Based 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		\$ 2,433,726
Net Acute/SB SNF/Obs		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		\$ 2,024			
Less: Cost-Based Carveouts		\$ (1,860,000)		\$ (267.67)			
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



Case Study: Hospital A - Growth & Primary Care Alignment



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



Case Study: Hospital A - Growth & Primary Care Alignment



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



Case Study: Hospital A - Growth & Primary Care Alignment



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



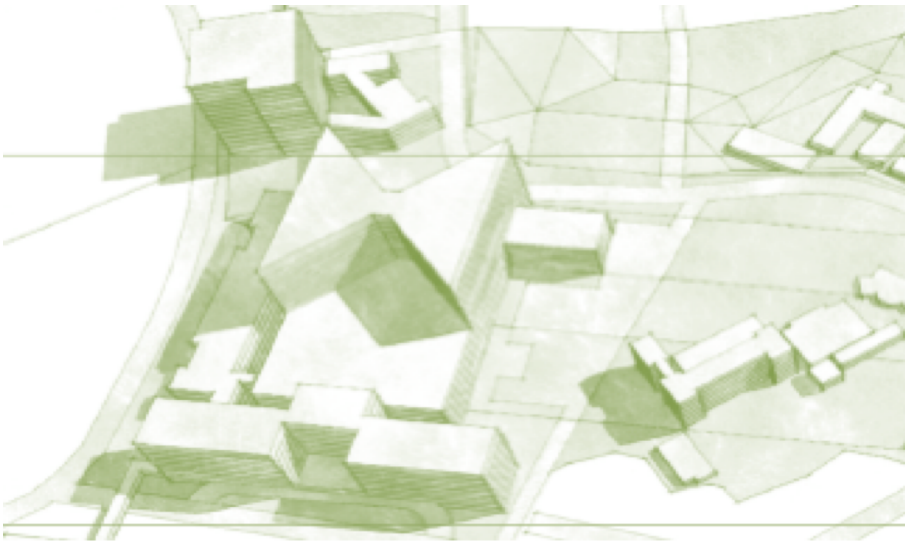
Case Study: Hospital A - Growth & Primary Care Alignment



Provider Alignment Best Practices

- ☐ 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

Clinic Visits	Est. Medicare and 3 rd Party Payer %	340B Eligible Visits	Avg. RX per Visit	Total 340B RXs	Avg. per Rx 340B Increase	340B Incremental Benefit
70K	85%	59K	1.5	89K	\$35.00	\$3.1M



Case Study: Hospital B

Engagement & Accountability

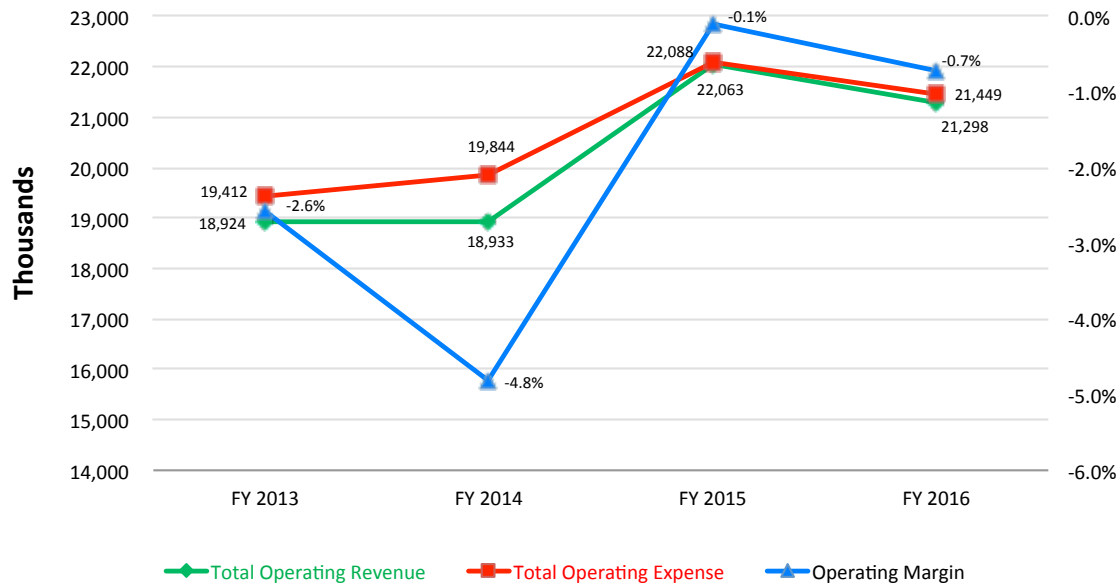
- 25-bed not-for-profit CAH located in Kentucky
- Independent organization
- Pursued \$10M facility expansion in 2016
- Approximately 130 employees
- 4 employed PCPs
- \$64M Gross Revenue / \$21M Net Patient Revenue
- Approximately 32% of Primary Service Area Market Share
- 6 competitors within – 50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

Service offerings:

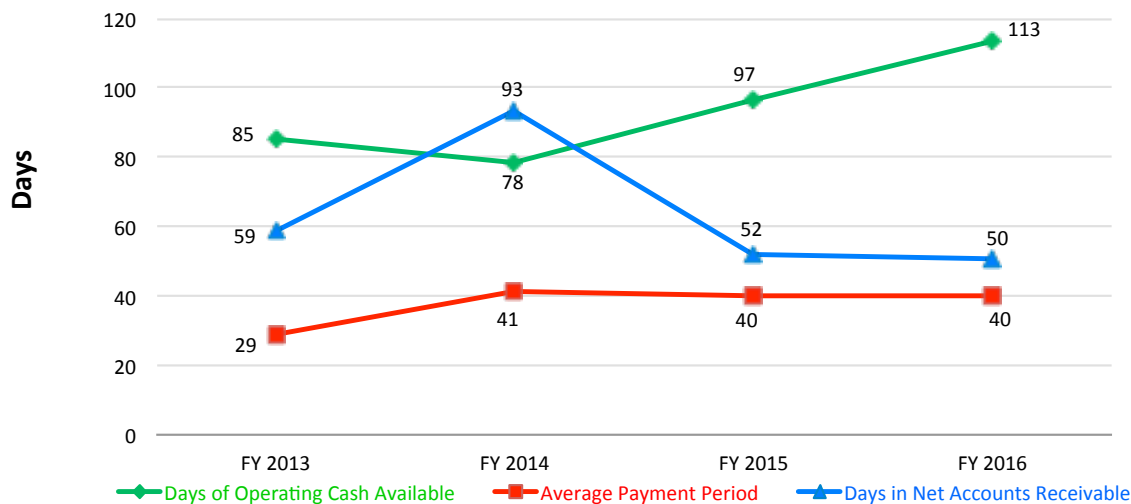
- General acute care
- ICU
- Swing bed services
- 24 hour Emergency Department
- Laboratory
- Imaging (X-ray, CT, MRI, Mammography, U/S, nuclear medicine bone densitometry)
- Surgical Services
- Respiratory Therapy
- Speech, Occupational and Physical Therapy
- 1 PB-RHC

Case Study: Hospital B - Engagement & Accountability

Financial Operating Trends (in 000's)



Liquidity Analysis



Median CAH Values

	KY	US	Hospital B
Operating Margin	0.61	.93%	0.7
Days in Net A/R	53.8	52.3	50
Days Cash	24.4	77.7	113

SOURCE: Flex Monitoring Team: CAH Financial Indicators Report – March 2018 (2016 data)

- 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



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



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)

KPI	Responsible	Bench mark	How Do We Rank?							Purpose of Data
			June	July	August	Sept.	October	November	December	
A/R > 90 Days	Trudy / Patti / BO	20%	37%	42%	37%	41%	33%	34%	36%	Monitor account follow-up processes and practices for extreme efficiencies
Gross Cash Collections to Total Revenue	Patti Sullivan	64%	42%	52%	49%	49%	50%	46%	49%	Total revenue being collected
Bill Hold Days	Patti Sullivan	3 days	4 days	4 days	4 days	4 days	4	4	4	Time frame that bills are held in order to collect accurate data input, medical record coding and charges
Percentage of Unbilled Receivable	Patti Sullivan	<10%	13%	10%	12%	13%	12%	12%	12%	Strictly monitor in-house, recurring and missing diagnosis accounts.
Average Daily Revenue in held Medical Records	Rheadawn Street	5 days	3.5 days	3.14 days	3 days	2 days	2 days	2 days	3	Total days in revenue that are held for coding delays.
Registration Error Rate	Stephanie / Patti	2%	5%	3%	4%	3%	3%	3%	5%	Registration error rate as a percentage of total registrations.
Percentage of Bad Debt to Gross Revenue	Ann Brown	2.5%	5%	1%	1.66%	1.8	0	1.00%	1%	Monitor uncollectible accounts to ensure they have been appropriately handled.
Charity Percentage to Gross Revenue	Ann Brown	2.5%	3%	3%	0.03%	2	3%	1.00%	1%	Monitor charity write-off and ensure financial counseling is accomplished.
Days in A/R	Crystal Bruner	60	68.75	68	64	59.23	52	58.13		Average days to collect the receivable.
Percentage Clean Claims from Bill Editor	Patti Sullivan	95%	99%	99%	99%	99%	99%	99%	99%	Number of errors on accounts due to data input, charging and coding
Return on Worker's Compensation, Third Party Liability and Auto Insurance Accounts	Patti Sullivan	85%	85%	85%	85%	85%	85%	85%		Effectiveness of difficult third party liability claims collection.
Up-front Deductible and Co-payment Collections	Stephanie Smithson	50%	Unable to track	Unable to track	unable to track	unable to track	unable to track	unable to track	No way to track yet	Improvements to cashflow, acknowledging the financial obligation with the patient at the time of service.
Average Daily Revenue in Credit Balances	Patti Sullivan	<1 day	4.54	4.82	5.24	4.49 days	4.65	4.96	5.55%	Credit Balances negatively effect the total A/R.
Claim Denial Rate	Patti Sullivan	4%	Unable to track	Unable to track	unable to track	unable to track	1%	unable to track	2%	Total denied claims as a percentage of total claims
Percentage of Scheduled Services that are Pre-Registered	Stephanie Smithson	95%	92% ancillary 78% OR 65% Anglo	Overall avg 88%	88% overall	93% overall	90%	94%	94%	Improving patient information data gathering including demographics, medical necessity and insurance eligibility.
Percentage of Self-pay Patients that Receive Financial Counseling	Stephanie / Ann	95%	Unable to track	Unable to track	unable to track	unable to track	unable to track	unable to track	No way to track yet	Providing patients with payment options and/or charity consideration.
Hospital-wide Education Regarding Charity Policy and Payment Options for Patients	Ann Brown	100%				Brochure in process				Ensuring that Hospital Payment and Charity Care Policies are well understood by all hospital staff.



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



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

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

U.S. HHS Hospital Compare Measures	National Avg.	Kentucky Avg.	Hospital B						
Patient Survey Summary Star Rating:			5	4	3	3	3	4	3
Patient Satisfaction (HCAHPS) Average:	71%	73%	78%	72%	66%	67%	69%	73%	71%
Nurses "Always" communicated well:	79%	81%	87%	81%	78%	76%	78%	82%	80%
Doctors "Always" communicated well:	82%	85%	89%	81%	79%	77%	78%	87%	79%
"Always" received help when wanted:	68%	70%	81%	67%	58%	67%	62%	65%	70%
Pain "Always" well controlled:	71%	73%	71%	71%	69%	69%	69%	72%	71%
Staff "Always" explained med's before administering:	65%	67%	75%	66%	62%	60%	62%	68%	65%
Room and bathroom "Always" clean:	74%	75%	86%	74%	65%	69%	67%	80%	74%
Area around room "Always" quiet at night:	62%	66%	69%	55%	60%	61%	59%	61%	59%
YES, given at home recovery information:	86%	87%	91%	88%	84%	86%	86%	86%	87%
"Strongly Agree" they understood care after discharge:	52%	53%	52%	54%	48%	48%	51%	55%	54%
Gave hospital rating of 9 or 10 (0-10 scale):	71%	73%	81%	77%	64%	65%	70%	72%	71%
YES, definitely recommend the hospital:	71%	71%	76%	83%	63%	57%	72%	73%	75%

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

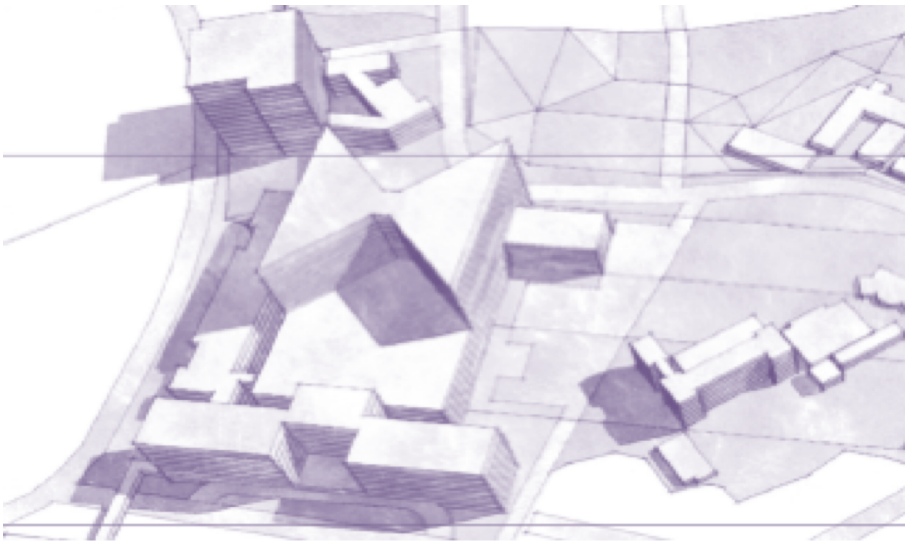


Case Study: Hospital B - Engagement & Accountability (Continued)



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 C

Alignment & Growth

- 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

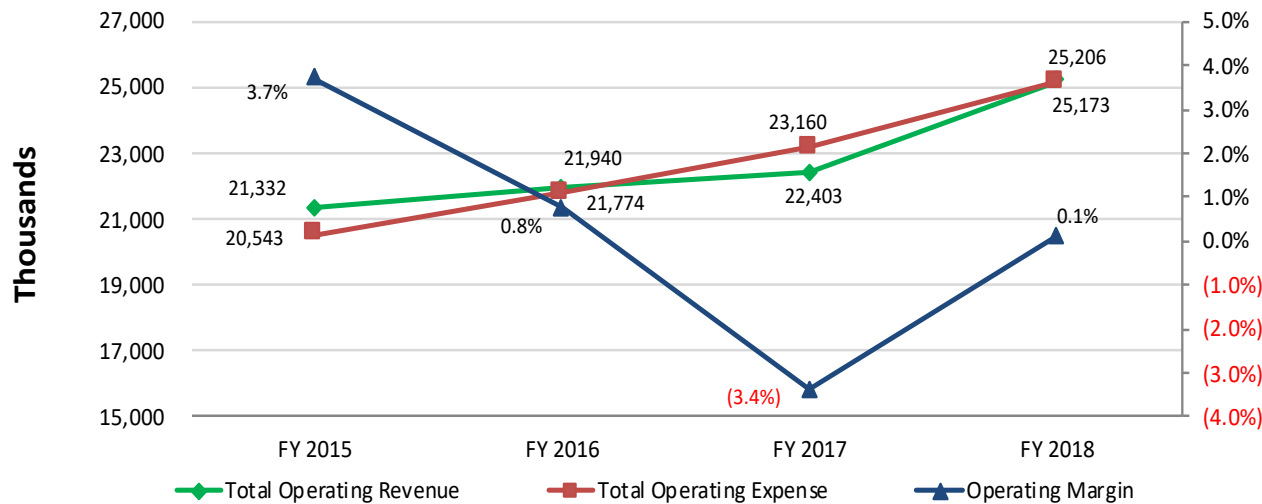
Service offerings:

- 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)

Case Study: Hospital C - Alignment & Growth



Financial Operating Trends (in 000's)



Median CAH Values			
	WV	US	Hospital C
Operating Margin	(0.32%)	.27%	0.1%

SOURCE: Flex Monitoring Team: CAH Financial Indicators Report – April 2019 (2017 data)

- 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

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

Physician Shortage/Surplus

Adjusted Service Area Population: 17,409

Primary Care	Supply Study Range	Existing ¹	(Shortage)/Surplus Range ²
Family Practice	2.4 - 8.2	4.00	(4.2) - 1.6
Internal Medicine	2.0 - 4.9	2.00	(2.9) - (0.0)
Pediatrics	1.4 - 2.1	1.00	(1.1) - (0.4)
Physician Primary Care Range	9.3 - 11.6	7.00	(4.6) - (2.3)
Non-Phys Providers	1.2 - 4.0	3.20	(0.8) - 2.0
TOTAL Primary Care Range	11.6 - 15.6	10.20	(5.4) - (1.4)

Medical Specialties

Allergy	0.1 - 0.2	0.00	(0.2) - (0.1)
Cardiology	0.5 - 0.6	0.11	(0.5) - (0.4)
Dermatology	0.3 - 0.4	0.00	(0.4) - (0.3)
Endocrinology	0.0 - 0.2	0.00	(0.2) - (0.0)
Gastroenterology	0.3 - 0.4	0.00	(0.4) - (0.3)
Hem/Oncology	0.4 - 0.4	0.00	(0.4) - (0.4)
Infectious Disease	0.1 - 0.2	0.00	(0.2) - (0.1)
Nephrology	0.2 - 0.3	0.00	(0.3) - (0.2)
Neurology	0.3 - 0.5	0.00	(0.5) - (0.3)
Pulmonary	0.2 - 0.4	1.00	0.6 - 0.8
Rheumatology	0.2 - 0.2	0.00	(0.2) - (0.2)

Surgical Specialties

ENT	0.1 - 0.5	0.00	(0.5) - (0.1)
General Surgery	1.1 - 1.3	2.00	0.7 - 0.9
Neurosurgery	0.1 - 0.2	0.00	(0.2) - (0.1)
OB/GYN	1.3 - 1.8	0.06	(1.8) - (1.3)
Ophthalmology	0.6 - 0.7	0.00	(0.7) - (0.6)
Orthopedic	0.7 - 1.2	2.00	0.8 - 1.3
Plastic Surgery	0.2 - 0.3	0.00	(0.3) - (0.2)
Urology	0.5 - 0.5	0.00	(0.5) - (0.5)

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 Best Practices

- 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
- Establish multi-year provider development plan with an emphasis on recruitment / succession planning



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

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

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

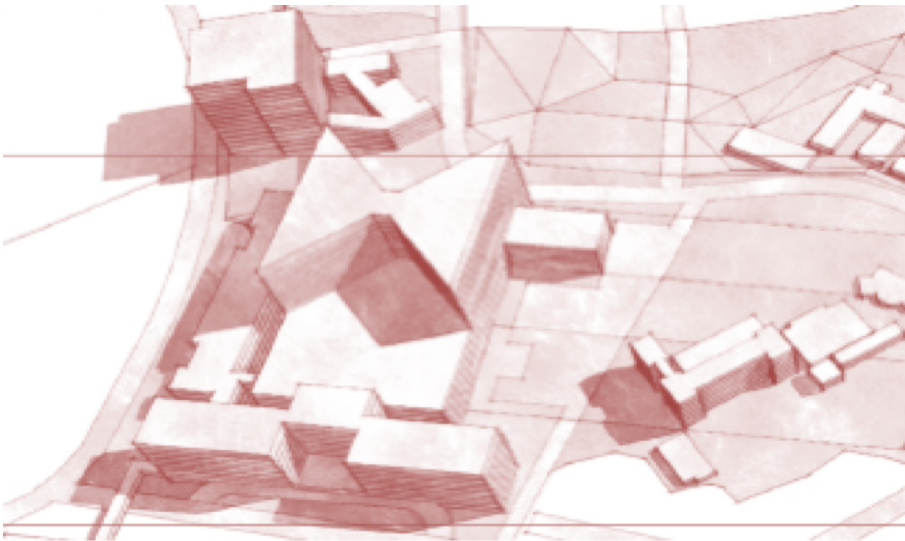


Case Study: Hospital C - Alignment & Growth (Continued)



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



Case Study: Hospital D

Culture Disconnect

- 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

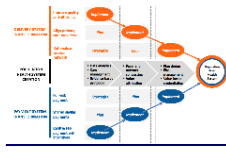
Performance Snapshot - Hospital D

Operational Performance

Area	Metric	Result
Finance	Operating Margin	-18%
	Net Income (Loss)	(\$2,545M)
	Days Operating Cash	12
Growth	IP (4 yr. trend)	11% decline
	Ancillary Services (4 yr. trend)	28% decline
Quality	Core Measures Avg.	93%
Patient Satisfaction	HCAHPS Average	76%
	HCAHPS Likely to Recommend	62% (lower than state and peers)

Transition Readiness

Ops Efficiency & Quality	Physician Alignment	Service Area Rationalization	Payment System



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

		1	2	3	4	5
	Attribute	Strongly Disagree	Disagree	Neutral	Agree	Strongly Agree
1	Our organization has well-defined strategic objectives that are known and supported by all stakeholders					
2	We have a focused plan that clearly defines objectives and key results					
3	We have a disciplined approach to driving change that seeks to engage all stakeholders					
4	We empower our associates to act like "owners"					
5	We encourage innovation and look to outside industries and sources for solutions					
6	Leadership fosters a healthy culture characterized by a foundation of trust, transparency, engagement and collaborative problem solving					
		0	0	0	0	0

Range	Description
5 - 14	Straggler
15 - 24	Pace Setter
25 - 30	Rock Star

Thanks for listening!



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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

Revenue:	Days	Rate	Revenue
Medicaid Revenue	15,391	\$ 169.00	\$ 2,601,079
Self Pay Revenue	1,654	\$ 169.00	\$ 279,526
Medicare Revenue	891	\$ 169.00	\$ 2,374
Total	17,936		\$ 2,882,979

Operating Expenses:

Direct Expenses (2018 ICR - WS A):

Salary expense	\$ 1,362,187	\$ 1,362,187
Other	\$ 361,255	\$ 361,255
Total Direct Expense	\$ 1,723,442	\$ 1,723,442

	Total Allocation	Nursing Home Variable %	
<i>Allocated Expenses (ICR Stepdown - WS B)</i>			
Capital Costs	\$ 109,645	90%	\$ 98,681
Admin and General	\$ 494,735	50%	\$ 247,368
Employee Benefits	\$ 191,284	90%	\$ 172,156
Operation of Plant	\$ 273,827	50%	\$ 136,914
Dietary	\$ 621,848	50%	\$ 310,924
Medical Records & Library	\$ 7,106	50%	\$ 3,553
Nursing Admin	\$ 69,060	50%	\$ 34,530
Housekeeping	\$ 150,735	50%	\$ 75,368
Laundry and Linen	\$ 51,228	50%	\$ 25,614
Total Nursing Home Allocated Expense	\$ 1,969,468		\$ 1,105,106
Total Nursing Home expenses	\$ 3,692,910		\$ 2,828,548
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 A: Base Case (FY 2017 Cost Report) Cost Structure at FY 2018 Volume

	ADC	Total Days	Cost Based 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	1.8	646	94%	604	41	\$ 1,200	\$ 49,582
Swing Bed - NF	0.2	57	0%	-	57	\$ 250	\$ 14,250
Total Days	17.0	6,191		4,555	1,637		\$ 2,371,180
Net Acute/SB SNF/Obs		6,134	74%	4,555	1,637		
Inpatient Fixed Costs		\$ 12,428,036 ¹					
Inpatient Variable Costs		\$ 1,495,155 ²					
Net Inpatient Costs		\$ 13,923,191					
Inpatient Costs Per Day		\$ 2,270		\$ 2,270			
Less: Cost-Based Carveouts		\$ (1,860,000)		\$ (303.21)			
Cost Based Payment				\$ 8,957,032			\$ 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 RCCs (WS C)

Model B: Grow Swing Bed Census to 4

	ADC	Total Days	Cost Based 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		\$ 2,433,726
Net Acute/SB SNF/Obs		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		\$ 2,024			
Less: Cost-Based Carveouts		\$ (1,860,000)		\$ (267.67)			
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

- **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**



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



Management Accounting Best Practices

- ☐ 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



Staff Benchmark Best Practices

- ☐ 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



Affiliation Strategy Best Practices

- 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



Population Health Best Practices

- ☐ 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



Payment System Transformation Best Practices



- ☐ 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

Service Area Rationalization Best Practices

- 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

