The Learning and Action Network: A Collaboration Strategy to Enhance Rural Hospital Performance

Organizing the pack for successful Shaky Bridge Crossing

South Carolina Office of Rural Health Annual Conference
Greenville, SC
October 10, 2017

Matt Mendez, MHA
# About Stroudwater

## Who we are

National healthcare consulting firm founded in 1985 by people with a passion for making a positive difference in healthcare. Our multi-disciplinary team offers deep expertise and perspective across a range of areas including finance, hospital operations, nursing, performance improvement, informatics and business development.

## How we add value

- Affiliations and partnership planning
- Capital planning and access
- Physician-Hospital alignment
- Strategic Master Facility Planning
- Population Health
- Revenue Cycle Management
- Strategic Planning and Operational Improvement
- Rural Practice

## Where we serve

Active projects in all regions of the country serving major academic and tertiary centers, rural providers, physician groups, and government / quasi-government agencies.
Goals for Today

- To stimulate your thinking regarding transformational changes in the healthcare market

- To share our perspective on strategic imperatives rural hospitals must focus on to successfully navigate to the new future state

- To gain an understanding of the Learning and Action Network (LAN) concept and its associated benefits
Part 1 – Healthcare Market Dynamics
• Declining reimbursement
• State Budget Deficits
• Pay For Performance
• Accelerating shift to OP care
• Reduced readmissions
• Recovery Audit Contractors (RAC)
• High Deductible Health Plans
• Declining utilization
• ACOs, bundled payments, medical homes and other payment models

• Attacks on two fronts:
  • Price
  • Utilization

• Emphasis on Value / Health Creation
Growth of High Deductible Plans

EXHIBIT G

Percentage of Covered Workers Enrolled in a Plan with a General Annual Deductible of $1,000 or More for Single Coverage, By Firm Size, 2006-2015

* Estimate is statistically different from estimate for the previous year shown (p<.05).

NOTE: These estimates include workers enrolled in HDHP/SO and other plan types. Average general annual health plan deductibles for PPOs, POS plans, and HDHP/SOs are for in-network services.

Reduced Readmission Rates

CMS: 2,610 PPS hospitals to receive penalties in 2015

Source: Centers for Medicare and Medicaid Services, Offices of Enterprise Management
Declining Admissions

United States & South Carolina Admissions per 1000 Population

Source: KFF.org
Data are for community hospitals, which represent 85% of all hospitals. Federal hospitals, long term care hospitals, psychiatric hospitals, institutions for the mentally retarded, and alcoholism and other chemical dependency hospitals are not included.
### MACRA – Rate Changes Summary

Implementing the Medicare Access and CHIP Reauthorization Act’s (MACRA’s) physician payment reforms, 2016–22

<table>
<thead>
<tr>
<th>Year</th>
<th>Fee updates</th>
<th>MIPS Maximum Bonus or Penalty (+/-)</th>
<th>APMs Across-the-Board Bonus</th>
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<tbody>
<tr>
<td></td>
<td>2016</td>
<td>2017</td>
<td>2018</td>
</tr>
<tr>
<td></td>
<td>0.5%</td>
<td>0.5%</td>
<td>0.5%</td>
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</table>

- **MIPS** (Merit-Based Incentive Payment System)
  - Doctors will be graded on four factors: Meaningful use of EHRs, Clinical practice improvement activities, Resource use, Quality of care
  - 15% for Clinical practice improvement activities
  - 30% for Resource use
  - 30% for Quality of care
  - 15% for ... to determine bonuses or penalties

- **APMs** (Alternative payment models)
  - 5%

- **Additional funding**
  - $15 million available every year for measure development
  - $20 million available every year for technical assistance to small practices
  - Up to $500 million authorized every year for MIPS bonuses of up to 10% for exceptional performance (2019–24)

- Doctors treating Medicare beneficiaries will be in one of two newly designed payment paths

The Comprehensive Care for Joint Replacement Model aims to support better, more efficient care for beneficiaries undergoing the most common surgeries for Medicare, hip and knee replacements (also called lower extremity joint replacements or LEJR). This model uses bundled payment and quality measures to reduce costs associated with hip and knee replacements to encourage hospitals, physicians, and other providers to work together to improve the quality and coordination of care throughout the initial surgery through recovery.

The proposed rule for the CJR model was published on July 9, 2015, allowing 90 days of comments per Medicare.gov. After reviewing more than 3,000 comments from the public, the proposed rule with major changes was made for the publication, including changing the dates of the CJR model. The final rule was placed on display on November 16, 2015 and can be viewed on the Medicare.gov.

Source: CMS
Accountable Care Organizations – Healthcare Reform

- Accountable Care Organizations
  - Each ACO assigned at least 5,000 Medicare beneficiaries
  - Providers continue to receive usual fee-for-service payments
  - Compare expected and actual spend for specified time period
  - If meet specified quality performance standards AND reduce costs, ACO receives portion of savings

- Medicare Accountable Care Organizations
  - 154 ACOs effective August, 2012
  - 287 ACOs effective January, 2013
  - 391 ACOs effective January, 2014
  - 426 ACOs effective January 2015
  - 477 ACOs effective January 2016
  - 8.9 million Medicare beneficiaries, or about 25% of total Medicare fee-for-service beneficiaries, now in Medicare ACOs
  - 64 ACOs are in a risk-bearing track including SSP, Pioneer ACO Model, Next Generation ACO Model, and Comprehensive ESRD Care Model


http://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/sharedsavingsprogram/News.html
Fee-For-Service Financial Model Disruption

Assumptions

• Utilization
  • Inpatient and Outpatient
    • Impact of ACA
    • Impact of Blue Cross steerage initiatives

• Revenue
  • Third party price increases
  • Cost based Medicare revenue
  • DSH payments (Zeroed out in 2014)
  • Bad debt % of patient service revenue (75% reduction in 2014)
    • Impact of ACA
  • Meaningful use incentive payments
  • Other operating revenue
  • Non-operating gains and

• Expenses
  • Salaries, wages and benefits
  • Productivity
  • Supplies and other
When operating income becomes negative in 2016, cash reserves start to decline

- Operational improvement and shared service economies of scale are insufficient to combat declining utilization
- Can’t cut your way to sustainability
Challenges Affecting Rural Hospitals

- Factors that will have a significant impact on rural hospitals over the next 5-10 years
  - Difficulty with recruitment of providers and aging of current medical staff
    - Struggle to pay market rates
  - Increasing competition from other hospitals and physician providers for limited revenue opportunities
  - Small hospital governance members without sophisticated understanding of small hospital strategies, finances, and operations
  - Consumer perception that “bigger is better”
  - Severe limitations on access to capital for necessary investments in infrastructure and provider recruitment
    - Facilities historically built around IP model of care
  - Increased burden of remaining current on onslaught of regulatory changes
    - Regulatory Friction / Overload
  - Payment systems transitioning from volume based to **value based**
  - Increased emphasis of **quality** as payment and market differentiator
  - **Reduced payments** that are “Real this time”
    - 3rd party steerage (surgery, lab, and Imaging), RAC audits
We Have Moved into a New Environment!

- Subset of most recent challenges
  - Payment systems transitioning from volume based to value based
  - Increased emphasis as quality as payment and market differentiator
  - Reduced payments that are “Real this time”

- New environmental challenges are the TRIPLE AIM!!!
- Market Competition on economic driver of healthcare: PATIENT VALUE

Harvard Business Review

Redefining Competition in Health Care

by Michael E. Porter and Elizabeth Olmsted Teisberg

www.hbr.org

Source: IHI
Future Hospital Financial Value Equation

- Definitions
  - Patient Value

\[
\text{Patient Value} = \frac{\text{Quality}}{\text{Cost}} \times \text{Population}
\]

- Accountable Care:
  - A mechanism for *providers to monetize the value derived from increasing quality and reducing costs*
    - Accountable care includes many models including bundled payments, value-based payment program, provider self-insured health plans, Medicare defined ACO, capitated provider sponsored healthcare, etc.
  - Different “this time”
    - Providers monetize value
    - Government “All In”
    - New information systems to manage costs and quality
    - Agreed upon evidence-based protocols
    - Going back is not an option
Future Hospital Financial Value Equation

- Leveraging Primary Care / Small and Rural Hospital Relationship
  - Revenue stream of future tied to Primary Care Physicians (PCP) and their patients
    - Avg. PCP panel of 1,500 people X $9,300 per capita spending = $14M (4 PCPs = $56M)
  - Small and rural hospitals bring value / negotiating power to affiliation relationships as generally PCP based
    - Smaller community hospitals and rural hospitals have value through alignment with revenue drivers (PCPs) rather than cost drivers but must position themselves for new market:
      - Alignment with PCPs in local service area
      - Develop a position of strength by becoming highly efficient
      - Demonstrate high quality through monitoring and actively pursuing quality goals
**Future Hospital Financial Value Equation**

- **Economics**
  - Current economic model of increasing volume to reduce unit costs and generate profit is no longer relevant as payment systems transition away from volume based payment
    - New economic models based on patient value must be developed by hospitals, but not before the payment systems have converted
  - Economic Model: **FFS Rev and Exp VS. Budget Based Payment Rev and Exp**

![Graph showing service volumes vs. dollars with profit and loss zones](image-url)
Future Hospital Financial Value Equation

• Value in Rural Hospitals
  • Lower Per Beneficiary Costs
  • Revenue centers of the future
    • PCP based delivery system
  • CAH cost-based reimbursement
    • Incremental volume drives down unit costs
    • Commitment to community Emergency Department, system incentives to drive low acuity volume to CAH
Cuts threaten rural hospitals 'hanging on by their fingernails'

Story by Michael Nedelman, CNN
Video by Nick Valencia and Meredith Edwards, CNN
Updated 8:34 PM ET, Sat July 1, 2017

Health Care in Rural Communities Uncertain as Medicaid Cuts Loom

by VAUGHN HILLYARD

SAYRE, Okla. — The doctor is in. But he's the only one for miles.

Dr. Kenneth Whinery, an 87-year-old family practitioner, is recovering from a broken back and living with prostate cancer. But he opened his practice here in 1960, and he still sees patients daily.

"I'm the only doctor here through the day," Whinery said. "If they're sick, I take care of them. And through the years, all these years, I think I can say that I didn't turn anybody away that was sick."

The hospital, five minutes from Whinery's office, shuttered 17 months ago, unable to stay afloat in this town of just over 4,000 people on the western edge of Oklahoma. There's no specialty medical care, and the nearest ambulance is based 25 minutes away. Two-thirds of the residents in the town's two nursing homes rely on Medicaid.

As Senate Republicans in Washington continue to wrangle over a bill that would reduce the role of the federal government in health care, rural communities like Sayre are struggling to balance residents' needs in the face of dwindling federal funds and a lack of resources to attract and retain quality providers.

Sources: www.cnn.com and www.nbcnews.com
Tennessee's Copper Basin Medical Center latest rural hospital to shutter

Doctors had only been seeing about 10 patients a day in the emergency room, which is about one-third of what a hospital of that size needs.

Jeff Lagasse, Associate Editor

Credit: Google Earth

The Copperhill and Ducktown communities in Tennessee are now without medical care as the rural area's only hospital, Copper Basin Medical Center, shut its doors for good Sunday.
Closed Rural Hospitals – As of 10/1/17

There have been 82 closures since 2010 and 121 since 2005. These counts do not include those that have closed and re-opened.

MARKET OVERVIEW
TRANSITION FRAMEWORK
LAN STRATEGY

- Medicare Payment Type:
  - Prospective Payment System
  - Critical Access Hospital
  - Medicare Dependent Hospital
  - Sole Community Hospital
  - Re-based Sole Community Hospital
  - Disproportionate Share Hospital
  - Rural Referral Center

- Current Status of Medicaid Expansion Decision:
  - Adopted the Medicaid Expansion
  - Not Adopting the Medicaid Expansion at This Time

- Transition Framework:
  - Marked Rural Hospitals
  - Transition Type

- Strategy:
  - Needs Analysis
  - Implementation Plan

Design: Gregg Latrop
President Trump’s Position on Health Insurance Coverage and Costs

• The Congressional Budget Office (CBO) estimated repeal of the ACA would increase the federal deficit by $137 – $353 billion over 10 years (2016-2025).

• Since enactment, the uninsured rate has fallen to 8.6% and an estimated 20 million Americans have gained coverage, while 27 million remain uninsured.

• President Trump supports complete repeal of the ACA, including the individual mandate to have coverage.
  • He would work with states to create high risk pools for individuals who have not maintained continuous coverage in lieu of requiring insurers to provide coverage to everyone regardless of health status.

• President Trump would provide a tax deduction for the purchase of individual health insurance in place of refundable premium tax credits. He would promote competition between health plans by allowing insurers to sell plans across state lines.

• President Trump would promote the use of Health Savings Accounts (HSA), and specifically would allow tax-free transfer of HSAs to all heirs.

• President Trump would also require price transparency from all hospitals, doctors, clinics and other providers so that consumers can see and shop for the best prices for health care procedures and other services.

President Trump’s Position on Medicaid and Medicare

- Medicaid
  - Donald Trump supports a Medicaid block-grant and a repeal of the ACA (including the Medicaid expansion).
  - President Trump has said he would cover the low-income uninsured through Medicaid after repealing the ACA.
  - The House Republican Plan, which is part of a larger package designed to replace the ACA and reduce federal spending for health care, would offer states a choice between a Medicaid per capita allotment or a block grant.

- Medicare
  - President Trump has stated that his Administration will act to “Modernize Medicare.”
  - President Trump supports repealing and replacing the ACA, which could affect the Medicare provisions included in the law, such as improved preventive and drug benefits and numerous Medicare savings proposals.
  - President Trump previously supported allowing safe importation of prescription drugs from other countries.

What Would a Full Repeal of the ACA Mean for Patients and Providers?

- The number of uninsured people would rise by 24 million by 2021, an increase of 81 percent.
- Eighty-one percent of those losing coverage would be in working families, approximately 66% would have a high school education or less, 40% would be young adults, and about 50% would be non-Hispanic whites.
- There would be 14.5 million fewer people with Medicaid coverage in 2021.
- Approximately 9.4 million people who would have received tax credits for private health coverage would no longer receive assistance.
- State spending would increase by $68.5 billion between 2017 and 2026 as reductions in Medicaid spending would be more than offset by increases in uncompensated care.
- Many states have reported net budget savings as a result of expanding Medicaid and would experience budget shortfalls if the ACA were repealed.
- Significantly less healthcare would be provided to modest- and low-income families.

Numerous attempts to repeal ACA → unsuccessful

- 5/4/17 → AHCA Passage by House
- 6/22/17 → Senate Draft Plan: Better Care Reconciliation Act (BCRA)
- 7/24/17 → BCRA Fails on First Pass
- 7/25/17 → BCRA: Rejected 57-43
- 7/26/17 → Obamacare Repeal and Reconciliation Act: Rejected 55 to 45
- 7/28/17 → “Skinny Repeal”: Rejected 51 to 49
Part 2 – Transition Framework
The Premise – Finance System will drive Transition to PBPS

Today (FFS)
- Government Payers
  - Changing from F-F-S to PBPS
- Private Payers
  - Follow Government payers

Function (Provider Imperatives)
- Management of price, utilization and costs

Form (Provider Organization)
- Independent organizations competing with each other for market share based on volume

Finance (Macro-economic Payment System)
The fundamental role of a hospital is changing rapidly – away from a physical location where patient care is provided to the centerpiece of a highly integrated rural health system for residents of a rural community. To be successful, health systems of the future will assume financial, quality, satisfaction and health status accountability for its community and will take on a new set of strategies, philosophies and performance metrics.

Because of the complexity and uncertainty facing hospitals, for many CEOs the most prudent and comfortable strategy is also the least disruptive and potentially controversial strategy – to resist taking bold steps.

The Challenge: Crossing the Shaky Bridge

Now

No Transition

Future

Full Transition

Reform Shaky Bridge
Fundamental Changes

Now

A

- Hospitals and Medical Staffs
- Patients
- Private Payers
- Revenue Centers
- Charge Masters
- Primary Care Providers
- FFS Volume Growth
- Productivity Bonuses
Transition Framework – What Is It?

**DELIVERY SYSTEM TRANSFORMATION**
- Improve quality and efficiency
- Align primary care providers
- Rationalize service network

**POPULATION HEALTH SYSTEM CREATION**
- Full-risk payment
- Shared saving payments
- ESHP & FFS payment with incentives

**PAYMENT SYSTEM TRANSFORMATION**
- Implement
- Plan
- Strategize

**FFS**
- PHASE I
- PHASE II
- PHASE III
- PBPS

**Population Based Health System**
- Data analytics
- Care management
- Evidence-based protocols
- Payer and network contracting
- Value attribution
- Plan design
- Risk management
- Value-based credentialing

**LAN STRATEGY**
What to change?

Delivery System

- Operating Efficiencies
- Quality and Engagement
- Business Practices
- Primary Care Networks
- Health System Alignment
- Specialists
- Facilities

Population Health

- Care Management
- Informatics/Analytics
- PCMH
- Employee Health Plans
- Transitional Payment Models

Payment System

- Physician Leadership

Culture

- Governance
- Change Management
Transition Framework

DELIVERY SYSTEM TRANSFORMATION

Improve quality and efficiency
Align primary care providers
Rationalize service network

POPULATION HEALTH SYSTEM CREATION

FFS PHASE I PHASE II PHASE III PBPS

Plan
Strategize
Implement

Plan
Strategize
Implement

Plan
Implement

Data analytics
Care management
Evidence-based protocols

Payer and network contracting
Value attribution

Plan design
Risk management
Value-based credentialing

PAYMENT SYSTEM TRANSFORMATION

Full-risk payment
Shared saving payments
ESHP & FFS payment with incentives

Population Based Health System

Implement
Hospitals not operating at efficient levels are currently, or will be, struggling financially.

“Efficient” is defined as:
- Appropriate patient volumes meeting needs of their service area
- Revenue cycle practices operating with best practice processes
- Expenses managed aggressively
- Physician practices managed effectively
- Effective organizational design
Delivery System Initiative I – Operating Efficiencies, Patient Safety and Quality

- Grow FFS patient volume to meet community needs
  - “Catching to pitching”
  - Opportunities often include:
    - ER Admissions
    - Swing bed
    - Ancillary services (imaging, lab, ER, etc.)
- Increase efficiency of revenue cycle function
  - Adopt revenue cycle best practices
    - Effective measurement system
    - “Super charging” front end processes including online insurance verification, point of service collections
    - Education on necessity for upfront collections
    - Ensure chargemaster is up to date and reflects market reality
- Continue to seek additional community funds to support hospital mission
  - Increase millage tax base where appropriate
  - Ensure ad valorem tax renewal
Delivery System Initiative I – Operating Efficiencies, Patient Safety and Quality

• Develop **LEAN production practices** that consider the expenditure of resources for any goal other than the creation of value for the end customer to be wasteful
  • Preserving value / quality with less processes
  • Workflow redesign
  • Inventory Levels / Standardization
  • Response Times
  • Replicating Successes among all hospitals
  • C-Suite training on LEAN / Six Sigma

• Evaluate **340B discount pharmacy program** as an opportunity to both increase profit and reduce costs
  • Often 340B is only looked upon as an opportunity to save costs not considering profit potential
Increase departmental staff efficiency

- Monitoring productivity for all departments
- Shifting towards weekly or daily productivity tracking
- Eliminating scheduled OT, and reliance on agency staff
- Staffing education for DONs/Clinical managers
- Salary Survey/Staffing Levels/Benchmarks that are relevant

**Table: Sample of Selected Departments**

<table>
<thead>
<tr>
<th>Department</th>
<th>Performance FY 2014</th>
<th>Hourly Standard</th>
<th>FTEs @ Standard</th>
<th>Actual FTEs</th>
<th>Variance</th>
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</thead>
<tbody>
<tr>
<td>Nursing - Med Surg</td>
<td>Per Patient Day</td>
<td>2,778</td>
<td>12.00</td>
<td>17.81</td>
<td>27.40</td>
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<tr>
<td>Nursing - Obstetrical/Postpartum</td>
<td>Per Patient Day</td>
<td>10.00</td>
<td>-</td>
<td>0.30</td>
<td>0.30</td>
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<tr>
<td>Nursing - Nursery</td>
<td>Per Patient Day</td>
<td>188</td>
<td>5.00</td>
<td>0.50</td>
<td>0.24</td>
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<tr>
<td>Nursing - ICU/CCU</td>
<td>Per Patient Day</td>
<td>105</td>
<td>20.75</td>
<td>1.16</td>
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<td>Emergency Room</td>
<td>Per Visit</td>
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<td>Inpatient/ED Subtotal</td>
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<td></td>
<td>21.61</td>
<td>29.25</td>
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<tr>
<td>Nursing - Surgery - Minor</td>
<td>Per Case</td>
<td>226</td>
<td>5.50</td>
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<td>Nursing - Endoscopy/GI Lab</td>
<td>Per Case</td>
<td>346</td>
<td>3.60</td>
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<td>Nursing - Other OP Proc</td>
<td>Per Case</td>
<td>130</td>
<td>1.60</td>
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<td>Nursing - Recovery Room</td>
<td>Per Case</td>
<td>702</td>
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<td>1.11</td>
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<td>Surgery Subtotal</td>
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<td></td>
<td>2.41</td>
<td>2.59</td>
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<tr>
<td>UR/Case Mgr/Soc Ser</td>
<td>Patient Days</td>
<td>2,778</td>
<td>0.75</td>
<td>1.00</td>
<td>1.24</td>
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<tr>
<td>Nursing Administration</td>
<td>Per Adj. Admissions</td>
<td>2,235</td>
<td>1.75</td>
<td>1.88</td>
<td>1.99</td>
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<tr>
<td>Subtotal Nursing</td>
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<td>28.90</td>
<td>35.08</td>
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<td>Radiology</td>
<td>Per Procedure</td>
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<td>1.41</td>
<td>2.36</td>
<td>4.30</td>
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<td>Lab/Blood Bank</td>
<td>Per Test</td>
<td>28,838</td>
<td>0.25</td>
<td>3.49</td>
<td>4.54</td>
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<td>Physical Therapy</td>
<td>Per Treatment</td>
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<td>Cardiac Rehab</td>
<td>Per Procedure</td>
<td>221</td>
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<td>Occupational Therapy</td>
<td>Per Treatment</td>
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<td>Speech Therapy</td>
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<td>0.17</td>
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<td>Cardio/Pulmonary</td>
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<td>0.71</td>
<td>1.14</td>
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<td>Pharmacy</td>
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<td>1.99</td>
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<td>Subtotal Ancillary</td>
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<td></td>
<td>12.18</td>
<td>17.53</td>
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<tr>
<td>Subtotal - Clinical</td>
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<td></td>
<td></td>
<td>39.08</td>
<td>52.61</td>
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<td>Hospital Administration</td>
<td>Per Adj. Admissions</td>
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<td>1.65</td>
<td>1.77</td>
<td>13.07</td>
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<td>Information Systems</td>
<td>Per Adj. Admissions</td>
<td>2,235</td>
<td>1.00</td>
<td>1.07</td>
<td>-</td>
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<tr>
<td>Human Resources</td>
<td>Per Adj. Admissions</td>
<td>2,235</td>
<td>1.10</td>
<td>1.18</td>
<td>-</td>
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<tr>
<td>Marketing/Planning/Public Rel</td>
<td>Per Adj. Admissions</td>
<td>2,235</td>
<td>0.28</td>
<td>0.30</td>
<td>-</td>
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<tr>
<td>Volunteers</td>
<td>Per Adj. Admissions</td>
<td>2,235</td>
<td>0.75</td>
<td>0.81</td>
<td>-</td>
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<tr>
<td>Telecommunications</td>
<td>Per Adj. Admissions</td>
<td>2,235</td>
<td>0.36</td>
<td>0.39</td>
<td>-</td>
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<tr>
<td>General Accounting</td>
<td>Per Adj. Admissions</td>
<td>2,235</td>
<td>1.23</td>
<td>1.32</td>
<td>-</td>
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<tr>
<td>Security</td>
<td>Gross Square Feet</td>
<td>49,980</td>
<td>0.02</td>
<td>0.48</td>
<td>-</td>
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<tr>
<td>Patient Accounting</td>
<td>Per Adj. Admissions</td>
<td>2,235</td>
<td>3.00</td>
<td>3.22</td>
<td>-</td>
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<tr>
<td>Admitting/Patient Registration</td>
<td>Per Adj. Admissions</td>
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<td>3.75</td>
<td>4.03</td>
<td>-</td>
</tr>
<tr>
<td>Medical Records</td>
<td>Per Adj. Admissions</td>
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<td>3.00</td>
<td>3.22</td>
<td>3.10</td>
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<tr>
<td>Cent Supply/Mlti Mgmt/Sterile</td>
<td>Per Adjusted Day</td>
<td>10,053</td>
<td>0.30</td>
<td>1.45</td>
<td>0.04</td>
</tr>
<tr>
<td>Housekeeping</td>
<td>Net Square Feet</td>
<td>35,700</td>
<td>0.31</td>
<td>5.36</td>
<td>4.09</td>
</tr>
<tr>
<td>Plant Ops/Maintenance</td>
<td>Gross Square Feet</td>
<td>49,980</td>
<td>0.08</td>
<td>1.92</td>
<td>4.15</td>
</tr>
<tr>
<td>Subtotal Support</td>
<td></td>
<td></td>
<td></td>
<td>26.53</td>
<td>24.45</td>
</tr>
</tbody>
</table>

1 Hourly Standards based on Stroudwater sample of hospitals
2 FY 2014 internal information provided by hospital administration
Delivery System Initiative I – Operating Efficiencies, Patient Safety and Quality

- Focus on Quality and Patient Safety
  - As a strategic imperative
  - As a competitive advantage

<table>
<thead>
<tr>
<th>Patient Survey Summary Star Rating:</th>
<th>National Avg.</th>
<th>IL Average</th>
<th>Midwest Medical Center</th>
<th>Mercy Medical Center-Dubuque</th>
<th>UnityPoint Health-Finley</th>
<th>University of Iowa Hospitals &amp; Clinics</th>
<th>University of Wisconsin Hospital and Clinics</th>
<th>FHN Memorial Hospital</th>
<th>OSF Saint Anthony Medical Center</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Patient Satisfaction (HCAHPS) Average:</strong></td>
<td>71%</td>
<td>72%</td>
<td>78%</td>
<td>76%</td>
<td>73%</td>
<td>70%</td>
<td>76%</td>
<td>73%</td>
<td>70%</td>
</tr>
<tr>
<td>Nurses &quot;Always&quot; communicated well:</td>
<td>80%</td>
<td>81%</td>
<td>77%</td>
<td>85%</td>
<td>82%</td>
<td>79%</td>
<td>83%</td>
<td>79%</td>
<td>79%</td>
</tr>
<tr>
<td>Doctors &quot;Always&quot; communicated well:</td>
<td>82%</td>
<td>82%</td>
<td>87%</td>
<td>82%</td>
<td>82%</td>
<td>77%</td>
<td>84%</td>
<td>81%</td>
<td>81%</td>
</tr>
<tr>
<td>&quot;Always&quot; received help when wanted:</td>
<td>69%</td>
<td>69%</td>
<td>75%</td>
<td>75%</td>
<td>67%</td>
<td>59%</td>
<td>65%</td>
<td>66%</td>
<td>66%</td>
</tr>
<tr>
<td>Pain &quot;Always&quot; well controlled:</td>
<td>71%</td>
<td>72%</td>
<td>71%</td>
<td>74%</td>
<td>69%</td>
<td>65%</td>
<td>72%</td>
<td>74%</td>
<td>74%</td>
</tr>
<tr>
<td>Staff &quot;Always&quot; explained med's before administering:</td>
<td>65%</td>
<td>65%</td>
<td>65%</td>
<td>69%</td>
<td>64%</td>
<td>62%</td>
<td>69%</td>
<td>66%</td>
<td>66%</td>
</tr>
<tr>
<td>Room and bathroom &quot;Always&quot; clean:</td>
<td>74%</td>
<td>75%</td>
<td>88%</td>
<td>77%</td>
<td>78%</td>
<td>74%</td>
<td>78%</td>
<td>72%</td>
<td>72%</td>
</tr>
<tr>
<td>Area around room &quot;Always&quot; quiet at night:</td>
<td>62%</td>
<td>62%</td>
<td>73%</td>
<td>63%</td>
<td>59%</td>
<td>51%</td>
<td>66%</td>
<td>65%</td>
<td>65%</td>
</tr>
<tr>
<td>YES, given at home recovery information:</td>
<td>87%</td>
<td>87%</td>
<td>94%</td>
<td>90%</td>
<td>92%</td>
<td>92%</td>
<td>91%</td>
<td>91%</td>
<td>91%</td>
</tr>
<tr>
<td>&quot;Strongly Agree&quot; they understood care after discharge:</td>
<td>52%</td>
<td>53%</td>
<td>62%</td>
<td>59%</td>
<td>56%</td>
<td>53%</td>
<td>57%</td>
<td>48%</td>
<td>48%</td>
</tr>
<tr>
<td>Gave hospital rating of 9 or 10 (0-10 scale):</td>
<td>72%</td>
<td>72%</td>
<td>80%</td>
<td>80%</td>
<td>74%</td>
<td>73%</td>
<td>82%</td>
<td>71%</td>
<td>71%</td>
</tr>
<tr>
<td>YES, definitely recommend the hospital:</td>
<td>72%</td>
<td>71%</td>
<td>86%</td>
<td>84%</td>
<td>77%</td>
<td>80%</td>
<td>84%</td>
<td>61%</td>
<td>61%</td>
</tr>
</tbody>
</table>

Best Score
Better than State
Worse than State
Worst Score

Source: www.hospitalcompare.hhs.gov
Transition Framework

**DELIVERY SYSTEM TRANSFORMATION**
- Improve quality and efficiency
- Align primary care providers
- Rationalize service network

**POPULATION HEALTH SYSTEM CREATION**
- Full-risk payment
- Shared saving payments
- ESHP & FFS payment with incentives

**PAYMENT SYSTEM TRANSFORMATION**
- Shared saving payments
- ESHP & FFS payment with incentives

**MARKET OVERVIEW**

**TRANSITION FRAMEWORK**

**PHASE I**
- Implement
- Plan
- Strategize
- Data analytics
- Care management
- Evidence-based protocols

**PHASE II**
- Implement
- Plan
- Strategize
- Payer and network contracting
- Value attribution

**PHASE III**
- Implement
- Plan
- Strategize
- Plan design
- Risk management
- Value-based credentialing

**PBPS**
- Population Based Health System
Delivery System Initiative II - Primary Care Alignment

- **Revenue streams of the future** → tied to **primary care physicians**, which often comprise a majority of the rural and small hospital healthcare delivery network
  - Small and rural hospitals, through alignment with PCPs, will have extraordinary value relative to costs

- **Physician Relationships**
  - Hospital aligns with employed and independent providers to enable interdependence with medical staff and support clinical integration efforts
    - **Contractual alignment** (e.g., employ, management agreements)
    - **Functional alignment** (share medical records, joint development of evidence based protocols)
    - **Governance alignment** (Board, executive leadership, planning committees, etc.)
  - Potential Model for Rural:
    - New PHO
Transition Framework

**Delivery System Transformation**
- Improve quality and efficiency
- Align primary care providers
- Rationalize service network

**Population Health System Creation**
- Full-risk payment
- Shared saving payments
- ESHP & FFS payment with incentives

**Payment System Transformation**
- Implement
- Plan
- Strategize

**Phase I**
- Implement
- Plan
- Strategize

**Phase II**
- Implement
- Plan

**Phase III**
- Implement
- Plan

**Population Based Health System**

**Key Strategies**
- Data analytics
- Care management
- Evidence-based protocols
- Payer and network contracting
- Value attribution
- Plan design
- Risk management
- Value-based credentialing
Delivery System Initiative III - Rationalize Service Network

- Develop system integration strategy
  - Evaluate wide range of affiliation options ranging from network relationships, to interdependence models, to full asset ownership models
    - Interdependence models through alignment on contractual, functional, and governance levels, may be option for rural hospitals that want to remain “independent”
  - Explore / Seek to establish interdependent relationships among small and rural hospitals understanding their unique value relative to future revenue streams
- Identify the number of providers needed in the service area based on population and the impact of an integrated regional healthcare system
- Conduct focused analysis of procedures leaving the market
  - Understand real value to hospitals
    - Under F-F-S
    - Under PBPS (Cost of out of network claims)
Delivery System Initiative III - Rationalize Service Network

- Affiliation Value Curve
Transition Framework – What Is It?

DELIVERY SYSTEM TRANSFORMATION

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

POPULATION HEALTH SYSTEM CREATION

- Data analytics
- Care management
- Evidence-based protocols

PAYMENT SYSTEM TRANSFORMATION

- Full-risk payment
- Shared saving payments
- ESHP & FFS payment with incentives

MARKET OVERVIEW

TRANSITION FRAMEWORK

LAN STRATEGY
Payment System Strategy Initiative I

- Develop self-funded employer health plan
  - Evaluate self funded health insurance plans for optimal plan design
    - Self funded health insurance plans offer often overlooked opportunity to develop accountable care strategies for a defined patient base through aligning employee incentives through improved benefits design and more effective care management processes
  - Hospital is already 100% at risk for medical claims thus no risk for improving health of employee “population”
  - Change benefits to encourage greater “consumerism”
    - Differential premium for elective “risky” behavior
    - “Enroll” employee population in health programs – health coaches, chronic disease programs, etc.

- FFS Quality and Utilization Incentives
  - Maximize FFS incentives for improving quality or reducing inappropriate utilization (e.g., inappropriate ER visits, re-admissions, etc.)
Initiative II: Implementation planning for transitional payment models

- Transitional payment models include:
  - FFS against capitation benchmark w/ shared savings
  - Shared savings model Medicare ACOs
  - Shared savings models with other governmental and commercial insurers
  - Partial capitation and sub-capitation options with shared savings

- Prioritize insurance market opportunities
- Take the initiative with insurers to gauge interest and opportunities for collaborating on transitional payment models
- Explore direct contracting opportunities with self-funded employers

Initiative III: Develop strategy for full risk capitated plans
Transition Framework

**DELIVERY SYSTEM TRANSFORMATION**
- Improve quality and efficiency
- Align primary care providers
- Rationalize service network

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

**POPULATION HEALTH SYSTEM CREATION**
- Data analytics
- Care management
- Evidence-based protocols
- Payer and network contracting
- Value attribution
- Plan design
- Risk management
- Value-based credentialing

**MARKET OVERVIEW**

**TRANSITION FRAMEWORK**

- **FFS**
  - PHASE I: Plan
  - PHASE II: Strategy
  - PHASE III: Implement

- **PBPS**
  - Population Based Health System

**LAN STRATEGY**
Phase I: Develop Population Health building blocks

• Goal: Infrastructure to manage self insured lives and maximize FFS Utilization and quality incentives

• Initiatives:
  • PCMH or like structure
  • Care management
    • Discharge planning across the continuum
      • Transportation, PCP, meds, home support, etc.
    • Transitions of care (checking in on treatment plan)
      • Medication reconciliation
      • Post discharge follow-up calls (instructions, teach back, medication check-in)
    • Identifying community resources
    • Maintain patient contact for 30 days
  • Develop claims analysis capabilities/infrastructure
  • Develop evidenced based protocols
Conclusions/Recommendations

• For decades, rural hospitals have dealt with many challenges including low volumes, declining populations, difficulties with provider recruitment, limited capital constraining necessary investments, etc.

  • The current environment driven by healthcare reform and market realities now offers a **new set of challenges**. Many rural healthcare providers have not yet considered either the magnitude of the changes or the required strategies to appropriately address the changes

• Core set of new challenges represents the **Triple Aim being played on in the market**

• Locally delivered healthcare (including rural and small community hospitals) has **high value in the emerging delivery system**

• “Shaky Bridge” crossing will required planned, proactive approach
  
  • Finance will lead function and form  
  
  • Maintain alignment between delivery system models and payment systems building flexibility into the delivery system model for the changing payment system
Conclusions/Recommendations (continued)

- Important strategies for providers to consider include:
  - **Increase leadership awareness** of new environment realities
  - **Improve operational efficiency** of provider organizations
  - **Adapt effective quality measurement** and improvement systems as a strategic priority
  - **Align/partner with medical staff** members contractually, functionally, and through governance where appropriate
  - **Seek interdependent relationships** with developing regional systems
  - **Incorporate new strategic imperatives** – “Bridge Strategy” into Strategic plan
  - **Establish Learning and Action Networks** – as a mechanism to leverage shared ideas and collaborative problem solving
Part 3 – Learning and Action Network (LAN) Concept
# Evolution of the Learning and Action Network

<table>
<thead>
<tr>
<th>CAH Meetings</th>
<th>LAN</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Learning and Education</strong></td>
<td><strong>Major focus on State updates</strong></td>
</tr>
<tr>
<td></td>
<td><strong>Education provided by State and external presenters</strong></td>
</tr>
<tr>
<td><strong>Networking and information sharing</strong></td>
<td><strong>State and national market updates shared</strong></td>
</tr>
<tr>
<td></td>
<td><strong>Education provided by State and external presenters</strong></td>
</tr>
<tr>
<td><strong>Performance Benchmarking</strong></td>
<td><strong>Professional networking is key component to foster information sharing</strong></td>
</tr>
<tr>
<td></td>
<td><strong>Not traditionally supported</strong></td>
</tr>
<tr>
<td><strong>Collaborative Problem Solving</strong></td>
<td><strong>Performance benchmarking used to harvest best / leading practices</strong></td>
</tr>
<tr>
<td></td>
<td><strong>Not traditionally supported</strong></td>
</tr>
<tr>
<td><strong>Analytics</strong></td>
<td><strong>Team-based performance improvement focused on shared core priority areas</strong></td>
</tr>
<tr>
<td></td>
<td><strong>Not traditionally supported</strong></td>
</tr>
<tr>
<td></td>
<td><strong>Support of specific analytics-driven projects</strong></td>
</tr>
</tbody>
</table>
The purpose of the LAN is to **demonstrate** performance improvement.
LAN Initiatives Overview

Definition

A Critical Access Hospital Learning and Action (LAN) Initiative is a highly-structured, rapid-cycle project that demonstrates improvement in a defined performance area.

Design Specifications

- An Initiative does not exceed 9 months
- Initiative activities use the Plan-Do-Study-Act (PDSA) methodology
- Every LAN Initiative has one lead “champion” CAH
- LAN Initiatives incorporate PROCESS and OUTCOME metrics
- Outcome metrics can be monitored over multi-year periods
- Stroudwater will visit the lead CAH facility during the Initiative
# Accountability Matrix

<table>
<thead>
<tr>
<th>CAHs</th>
<th>Learning</th>
<th>Action</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>• Sharing of best practices</td>
<td>• Participation in Initiative(s)</td>
</tr>
<tr>
<td></td>
<td>• Initiative presentations</td>
<td>• Initiative measurement</td>
</tr>
<tr>
<td>Stroudwater</td>
<td>• Didactic presentations</td>
<td>• Expert technical assistance</td>
</tr>
<tr>
<td></td>
<td>• Sharing of best practices</td>
<td>• LAN Initiative facilitation</td>
</tr>
<tr>
<td></td>
<td>• Benchmarking</td>
<td></td>
</tr>
<tr>
<td>State Partner</td>
<td>• Onsite meeting logistics</td>
<td>• LAN Initiative monitoring</td>
</tr>
<tr>
<td></td>
<td>• Onsite meeting facilitation</td>
<td>• Measurement development</td>
</tr>
</tbody>
</table>
PDSA Methodology

1. **Plan**
   What are the initiative objectives, predictions and plan for the cycle?

2. **Do**
   Carry out the plan, start data analysis, test predictions and sharing of best practices

3. **Study**
   Summarize learnings, complete analysis and test predictions

4. **Act**
   How can the cycle be spread, and what are the outcomes?
PDSA Sample Timeline (9 months)

1. Plan
2. Do
3. Study
4. Act

Onsite Network Meeting (#1)
Onsite Network Meeting (#2)
Onsite Network Meeting (#3)
Onsite Network Meeting (#4)

Webinar A
Webinar B
Webinar C
Webinar D
Webinar E
Webinar F
LAN Initiative Bundle
Document Bundle Components

1. **Plan**  
   - Objectives, predictions and plan
   - Initiative Charter & Roadmap

2. **Do**  
   - CAH-Specific Tasks & Due Dates
   - Action Plan Template

3. **Study**  
   - Process and Outcome Metrics
   - Data Collection Tool

4. **Act**  
   - Findings and Spread Strategies
   - Capstone Presentation

---

Debrief and Evaluation

- Post-Initiative Survey
Plan: Initiative Charter & Roadmap

Project Planning Documents

- Developed by: Stroudwater during onsite Network Meeting #1
- Purpose: To organize the Initiative and document commitments from the participating CAHs

Components

- Project Plan including Deliverables and Metric Design
- Initiative membership and Contact information
- Initiative Timeline (Teleconferences and Webinars)
- Identification of Lead/Champion CAH(s)
## Charter Overview

<table>
<thead>
<tr>
<th>TASK FORCE NAME</th>
<th>Swing Bed</th>
</tr>
</thead>
<tbody>
<tr>
<td>CO – LEADERS</td>
<td>Theresa Aversano &amp; Nate Smith</td>
</tr>
<tr>
<td>PURPOSE</td>
<td>Elevate quality and cost effectiveness of the swing bed program to position CAHs as the subacute provider of choice</td>
</tr>
</tbody>
</table>
| DELIVERABLES    | Identify and bring forward education material and best practices  
|                 | Develop understanding of how to best manage the SB patient population  
|                 | Identify and share best practices for developing and marketing the SB program  
|                 | Conduct research to determine if available comparative data for nursing homes and other long term care providers exists  
|                 | Create a Dashboard that captures both outcomes and cost which can be used as a communication / promotion tool |
| EXPECTATIONS OF MEMBERS | Attend regularly scheduled task force calls / meetings.  
|                 | Respond to adhoc requests for feedback.  
|                 | Be prepared to participate in the task force meetings. |
| COMPOSITION     | CEOs, CFOs, CNOs, Quality |
# Roadmap Overview – Begin with End in Mind

## Activities:

### LAN Activities

<table>
<thead>
<tr>
<th>October ‘16</th>
<th>November ‘16</th>
<th>December ‘16</th>
<th>January ‘17</th>
</tr>
</thead>
<tbody>
<tr>
<td>10/14</td>
<td>11/18</td>
<td></td>
<td>Service Line, Rev Cycle &amp; Provider Alignment, TBD, Finance, Productivity &amp; ED Rev Cycle, POND?</td>
</tr>
<tr>
<td>Service Line &amp; Rev Cycle</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Finance &amp; Productivity</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

### Deliverables:
- Tangible work products of activities

### Desired Outcomes:
- Goals and tasks related to activities

### Key:
- LAN Meeting
- Advisory Council Call
- Task Force Call/ Meeting
- Data Submission
Do: Action Planning Template

Document for LAN Initiative Action Plans

- Developed by: Stroudwater and Initiative Team
- Purpose: To breakdown the Initiative Plan into discrete, CAH-specific Action Steps/Tasks

Components

- Action Plan/Initiative Issue and Goal
- Schedule of Tasks with Accountabilities and Due Dates
- List of CAH-specific Team Members
## Action Plan Overview

1. Choose initiative from list of priority recommendations identified by your hospital

2. Define the issue or problem you are trying to solve. What is Current State vs. desired Future State?

3. Define the Goal in terms of SMART (Specific, Measurable, Attainable, Realistic, Time-phased)

<table>
<thead>
<tr>
<th>Action Plan 1</th>
<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Issue</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Goal</strong></td>
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<td></td>
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</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>#</th>
<th>What is the Action Step?</th>
<th>Who is the Driver?</th>
<th>By When?</th>
<th>Follow-Up and Next Steps</th>
</tr>
</thead>
<tbody>
<tr>
<td>1.</td>
<td></td>
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<tr>
<td>2.</td>
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<td>3.</td>
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<tr>
<td>4.</td>
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<tr>
<td>5.</td>
<td></td>
<td></td>
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<td></td>
</tr>
</tbody>
</table>

4. Identify specific action steps with defined accountabilities, target dates, resources, etc.
Study: Data Collection Tool

Excel Worksheet for Initiative Metric(s)

- **Developed by**: Stroudwater with input from Grantee/Members
- **Purpose**: To identify relevant and effective PROCESS and OUTCOME metrics tied to LAN Initiative

**Components**

- PROCESS Metric specifications
- OUTCOME Metric specifications
- Data collection tool (Excel) for both Metrics
Slide Deck Summary of Initiative

- **Developed by:** Lead “Champion” CAH and Stroudwater
- **Purpose:** To organize and document the Initiative background, purpose, CAH-specific action plans, Initiative Metrics and Spread strategies

**Capstone Slide Deck Components**

- Initiative Background, Summary and Rationale
- Initiative Prediction and expected outcomes
- Results expressed via trended Outcome metrics
- CAH-specific strategies for Initiative Spread
Post-Initiative Survey

Web-Based Survey to Evaluate Effectiveness

- **Developed by**: Stroudwater with input from Grantee
- **Purpose**: To evaluate the relevance and effectiveness of the LAN Initiative from a CAH end user perspective

SurveyMonkey Assessment Components

- CAH-specific feedback on the LAN Initiative
  - Relevance and utility of the Initiative
  - Caliber of project management and engagement
  - Self-assessment on participation and performance
  - Overall satisfaction and effectiveness
Project Management and Resources
Roles and Expectations

Hospital Participants
• To provide full, active participation in the LAN Initiative
  - Consistent meeting attendance
  - Free exchange of ideas and best practices
  - Implementation of Action Plan(s)
  - Prompt and accurate data collection
  - Volunteer to be a “Lead/Champion” CAH periodically
    - Change agent for Initiative team; Presenter

Stroudwater
• To provide technical assistance and project management
  - Appropriate research and best practice recommendations
  - Access to expert, consultant-level technical support
  - Effective, reliable project management (Paula Knowlton)
  - Coordination with grantee to ensure linkage with grant
  - Data processing and interpretation of findings
LAN Initiative Document Management

DropBox (https://www.dropbox.com)
A free file management system that securely stores and provides access to shared documents

DropBox Details

- Stroudwater will create and activate a shared DropBox folder
  - Each LAN Initiative will have a dedicated folder
  - Every CAH and staff member will have access to the folder
  - Stroudwater will curate the data files in the folder
  - Upon completion of the initiative, the folder will contain all supporting documents comprising the “Initiative Bundle”
## Current State LANs

<table>
<thead>
<tr>
<th></th>
<th>Quality</th>
<th>Finance / Operations</th>
<th># CAHs</th>
</tr>
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<tbody>
<tr>
<td>Alabama</td>
<td>X</td>
<td></td>
<td>4</td>
</tr>
<tr>
<td>Hawaii</td>
<td>X</td>
<td>X</td>
<td>9</td>
</tr>
<tr>
<td>Massachusetts</td>
<td></td>
<td>X</td>
<td>3</td>
</tr>
<tr>
<td>Mississippi</td>
<td></td>
<td>X</td>
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</tr>
<tr>
<td>New York</td>
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<td>X</td>
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<tr>
<td>North Carolina</td>
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<td>X</td>
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<tr>
<td>Tennessee</td>
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<td>14</td>
</tr>
<tr>
<td>Virginia</td>
<td>X</td>
<td>X</td>
<td>7</td>
</tr>
</tbody>
</table>

**Notes:**
- LANs are supported through the Medicare Rural Hospital Flexibility (Flex) Program
- $X_1$ Stroudwater supports only the Finance / Operations LAN
LAN Benefits
What are the Benefits of a LAN?

1. Learning and Education
2. Networking and information sharing
3. Performance Benchmarking
4. Collaborative Problem Solving
5. Analytics
1. Benefits: Learning and Education

- Productivity Strategies and Daily Monitoring Tools
- Swing Bed Promotion
- 340B Retail Drug Pricing Program
- Virtual Hospitalist Program
- Behavioral Health Care Coordination
- Rehabilitation Services Growth
- Urgent Care Strategies
- Provider Alignment Strategies
- MACRA Readiness
2. Benefits: Networking and Information Sharing

- State Updates
- National Trends
- CAH Sharing and updates
3. Benefits: Performance Benchmarking

• Finance and Operations
  • 15 – 50+ indicators
• Department Staff Efficiency
  • IP Nursing
  • Rehabilitation Therapy Services
  • ED Nursing
  • Imaging
• Emergency Department Revenue Cycle Coding
• Revenue Cycle Function
• Swing Bed
# Performance Benchmarking: Finance

## Percent Operating Margin

<table>
<thead>
<tr>
<th>Hospital</th>
<th>% Operating Margin</th>
<th>Variance from Target Benchmark</th>
</tr>
</thead>
<tbody>
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<tr>
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</tr>
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</tr>
<tr>
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<td>-6.3%</td>
</tr>
<tr>
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<td>-4.3%</td>
<td>-18.4%</td>
</tr>
<tr>
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<td>Q1 2017</td>
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<td>-6.0%</td>
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<table>
<thead>
<tr>
<th></th>
<th>Q1 2017</th>
<th></th>
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<td>% Operating Margin</td>
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<td>YTD 2014</td>
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<tr>
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<tr>
<td>Q2 2016</td>
<td>-12.0%</td>
<td>-17.6%</td>
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<tr>
<td>Q3 2016</td>
<td>-8.1%</td>
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<tr>
<td>Q4 2016</td>
<td>-2.3%</td>
<td>-6.0%</td>
</tr>
<tr>
<td>Q1 2017</td>
<td>-3.4%</td>
<td>-6.0%</td>
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</table>

**Blue bar is desired variance**
Performance Benchmarking: Staff Efficiency

Inpatient Nursing

Paid IP Nursing Hours per Day

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<tr>
<th></th>
<th>Jan</th>
<th>Feb</th>
<th>Mar</th>
<th>Apr</th>
<th>May</th>
<th>Jun</th>
<th>Jul</th>
<th>Aug</th>
<th>Sep</th>
<th>Oct</th>
<th>Nov</th>
<th>Dec</th>
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<td>24.91</td>
<td>25.39</td>
<td>75.09</td>
<td>24.91</td>
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Target Benchmark

12.00

3 Month Avg & Variance From Target Benchmark

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<th>3 Month Variance</th>
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<tr>
<td>17.74</td>
<td>5.74</td>
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</table>

Blue bar is desired variance
Performance Benchmarking: ED Revenue Cycle

MARKET OVERVIEW

TRANSITION FRAMEWORK

LAN STRATEGY
4. Benefits: Collaborative Problem Solving

Key Steps:

• Identification of challenges
• Prioritization and selection of shared initiatives
• Task Force Chartering
• Roadmap Design
4. Benefits: Collaborative Problem Solving

Initiative Prioritization and Selection

A. Revenue cycle/ ICD-10 / Self Pay → in house / out source (12)
   • Pricing – how to position for being paid on a value basis ()
B. Service Line (IP & OP) optimization → conduct analysis to identify opportunities to increase local utilization & decompress tertiary (11)
C. Sharing resources / collaboration across CAHs (rural hospital alliance model) → e.g. MSO creation, best practices for rad report turnaround, staffing services, group purchasing, etc. (9)
D. Service Rationalization / Geographical opportunities (2)
E. Physician recruitment (4)
F. Market share (3)
G. Telehealth (4)
H. DSRP – what are other regions experiencing? (0)
I. Contracting (1)
J. Staff recruitment (0)
K. Organizing against Locum tenens (0)
L. Surgical Services - improving performance and outcomes (2)
M. IT solutions and pricing (2)
N. Outsourcing/ Insourcing (1)
O. Managing no shows (2)
4. Benefits: Collaborative Problem Solving

Task Force Supported Initiatives

• 340B Retail Drug Pricing
• Affiliation Strategies
• MACRA Readiness
• Provider Alignment
• Revenue Cycle
• Service Line Growth
• Swing Bed Outcomes
4. Benefits: Collaborative Problem Solving

Example Deliverables

- Swing Bed Best Practices Checklist
- Revenue Cycle Performance Dashboard
Swing Bed Performance Improvement Initiative
Swing Bed Performance Improvement Goals

- To improve the **functional outcomes** of our swing bed patients.
- To maximize our monthly percentage of swing bed patients that **return home** or to their prior level of residence.
- To **improve our communication** among the rehabilitation team and **increase our efficiency** in working together.
- To be able to educate the patient’s family and caregivers to **ensure a safe discharge** was established.
Swing Bed Performance Improvement Background

- **Barthel Index**
  - a tool to assess self care and mobility activities of daily living
  - used to predict length of stay and to indicate the amount of nursing care needed
  - widely used in geriatric assessment settings
  - measure of what patient can do – not what they could do

- **Process**
  - initial score is assessed at the beginning of patient care
  - patient is observed for improvement in scoring
  - end score is assessed prior to patient’s discharge

- **Goals**
  - to establish a degree of independence
  - to improve functional outcomes → strive for end score to be higher than initial score. The higher the score the more likely the patient is discharged to home or prior level of residence.

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Barthel Index Classification System

**Levels of Care**

- 0 - 14 points → Patient requires a Long Term Care facility
- 15 - 60 points → Patient requires a Skilled Nursing facility
- 61 - 80 points → Patient may return home, but will require at least 4 hours of assistance within the home daily
- 81-100 points → Patient will require fewer than 2 hours of care within the home

*For a score less than 60, recommend patient to be in a Long Term Care setting or will require 24 hour care within the home

**Levels of Dependence**

- 80 - 95 → mildly dependent
- 60 - 79 → moderately dependent
- 40 - 59 → markedly dependent
- 20 - 39 → severely dependent
- 0 - 19 → total dependence

The total score is **100 points**

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## Swing Bed Average Change in Score

**Category:** Deconditioned / **Disposition:** Home

### Average Change in Score by Quarter

<table>
<thead>
<tr>
<th>Hospital</th>
<th>Q2 2016</th>
<th>Q3 2016</th>
<th>Q4 2016</th>
<th>Q1 2017</th>
<th>Q2 2017</th>
<th>Q3 2017</th>
<th>Q4 2017</th>
<th>Q1 2018</th>
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<td>13.00</td>
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<td>4.25</td>
<td>12.75</td>
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<td>28.00</td>
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### Difference from Target Score of 15

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<th>Q3 2017</th>
<th>Q4 2017</th>
<th>Q1 2018</th>
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Swing Bed Average Stay and Expense per Stay

### Average Patient Stay

<table>
<thead>
<tr>
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<th>2016</th>
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<td>7.48</td>
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<td>8.74</td>
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<td>16.19</td>
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<td>8.93</td>
<td>12.24</td>
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### Average Expense per Stay

<table>
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State Comparative Matrix Example
### Individual Hospital Dashboard Example

#### Swing Bed Dashboard

**Avg Change in Score**

<table>
<thead>
<tr>
<th>Disposition</th>
<th>Diagnosis Category</th>
<th>Q2</th>
<th>Q3</th>
<th>Q4</th>
<th>Q1</th>
<th>Q2</th>
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<td>Deconditioned</td>
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<tr>
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<td>Neuro</td>
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<tr>
<td></td>
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<tr>
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<td>37.9</td>
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**Difference from Target Score of 15**

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<th>Hospital</th>
<th>Disposition</th>
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</tr>
<tr>
<td></td>
<td>Neuro</td>
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</tbody>
</table>

**Number of Cases**

<table>
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<tr>
<th>Hospital</th>
<th>Disposition</th>
<th>Diagnosis Category</th>
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<th>Q3</th>
<th>Q4</th>
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<th>Q2</th>
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<tr>
<td></td>
<td>Ortho</td>
<td>19</td>
<td>19</td>
<td>5</td>
<td>9</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Transferred to Higher Level Care</td>
<td>Deconditioned</td>
<td>1</td>
<td>2</td>
<td>5</td>
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<td></td>
</tr>
<tr>
<td></td>
<td>Neuro</td>
<td>1</td>
<td>1</td>
<td>1</td>
<td>1</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
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<td>3</td>
<td>3</td>
<td>4</td>
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<tr>
<td>Transferred to LTC/SNF</td>
<td>Deconditioned</td>
<td>1</td>
<td>5</td>
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<td>2</td>
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<tr>
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<td>1</td>
<td>2</td>
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<td>1</td>
<td></td>
<td></td>
</tr>
<tr>
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<td>1</td>
<td>1</td>
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**Network Average**

<table>
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<th>Q2</th>
<th>Q3</th>
<th>Q4</th>
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<th>Q2</th>
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<tr>
<td>AMA</td>
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<td>0.0</td>
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<td></td>
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</tr>
<tr>
<td>Deceased</td>
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<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Ortho</td>
<td>-35.0</td>
<td></td>
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<tr>
<td>Home</td>
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<tr>
<td></td>
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<td>20.0</td>
<td>10.0</td>
<td>10.0</td>
</tr>
<tr>
<td></td>
<td>Ortho</td>
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<td>39.0</td>
<td>34.7</td>
<td>34.7</td>
<td>33.3</td>
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<tr>
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<td>2.5</td>
<td>5.6</td>
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</tr>
<tr>
<td></td>
<td>Neuro</td>
<td>-15.0</td>
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<td></td>
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<tr>
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</tr>
<tr>
<td>Transferred to LTC/SNF</td>
<td>Deconditioned</td>
<td>-65.0</td>
<td>-2.5</td>
<td>-10.0</td>
<td>-12.5</td>
<td>-20.0</td>
</tr>
<tr>
<td></td>
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<td>-5.0</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Ortho</td>
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**Average Expense per Stay**

<table>
<thead>
<tr>
<th>Year</th>
<th>2015</th>
<th>2016</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>$21,771</td>
<td>$23,645</td>
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</table>

**Average LOS**

<table>
<thead>
<tr>
<th>Year</th>
<th>2015</th>
<th>2016</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>15.42</td>
<td>15.69</td>
</tr>
</tbody>
</table>
5. Benefits: Analytics

- Population Health Transition Readiness Self-Assessment
- Comparative Services Matrix
- CAH Value to System
CAH Value to Systems Analysis
Delivery System Initiative III - Rationalize Service Network

- Affiliation Value Curve
Transition Framework

**DELIVERY SYSTEM TRANSFORMATION**
- Improve quality and efficiency
- Align primary care providers
- Rationalize service network

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

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

**MARKET OVERVIEW**
- TRANSITION FRAMEWORK
- LAN STRATEGY
Value Categories

**ECONOMIC**
- Financial Performance
- Indirect Cost Allocations
- Transfer Benefits
- Transfer Opportunity Costs

**STRATEGIC**
- Scale/Attributed Lives
- Clinical Integration
- Human Capital

**INTANGIBLE**
- Branding/Reputation
- Goodwill

**Primary Care**

*Our Study*
System Relationship to Small and Rural Hospitals

Revenue stream of future tied to Primary Care Physicians (PCP) and their patients

Small and rural hospitals bring value / negotiating power to affiliation relationships as generally PCP based
Smaller community/rural hospitals have value through alignment with revenue drivers (PCPs) rather than cost drivers but must position themselves for new market:

- Functional alignment with PCPs in local service area
- Develop a position of strength by becoming highly efficient
- Demonstrate high quality through monitoring and actively pursuing quality goals
Contribution Margin Analysis Concepts

- **How well does the CAH perform financially? Profit or loss?**
  - Financial Performance

- **What are the accounting-based efficiencies from the affiliation?**
  - Indirect Cost Allocations

- **What services currently migrate from the CAH market to the Partner?**
  - Transfer Benefits
    - CMS, Truven, AHD

- **What services from the CAH market would the Partner likely sacrifice?**
  - Transfer Opportunity Costs
    - CMS, Truven, AHD
Contribution Margin Analysis Model

- **Financial Performance**
  - CAH Revenue less Expenses from Medicare Cost Report Schedule G
  - Net Income (less Depreciation and non-Operating Expense)

- **Indirect Cost Allocations**
  - Administrative and General Costs; Cost-Based reimbursement based on Payer Mix
  - Fixed Allocated Costs

- **Transfer Benefits**
  - CAH Service Area Discharges; IP Market Share; Per Discharge Payments; OP Percentage
  - Net Transfer/Referral Contribution Margin (Current)

- **Transfer Opportunity Costs**
  - Estimated Contribution Margin; Assumption of 10% change in Market Share due to Competition
  - Transfer Contribution Margin (Competition)
Contribution Margin Analysis Model Assumptions

Contribution the CAH provides to a system’s annual cash position by adjusting Operating Income through:

1. Non-cash related expenses (CAH specific depreciation)
2. Addition of non-operating revenue
3. Cost-based revenue on Partner overhead allocated to CAH
4. Incremental inpatient and outpatient services referred from the CAH service area to Partner
5. 10% market share shift is assumed
## South Carolina Rural Affiliate Contribution Margin Analysis

### 2016 Financial Performance

<table>
<thead>
<tr>
<th></th>
<th>A</th>
<th>B</th>
<th>C</th>
<th>D</th>
<th>E</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Total Operating Revenue</strong></td>
<td>39,737,221</td>
<td>13,635,103</td>
<td>12,343,984</td>
<td>13,030,807</td>
<td>21,451,598</td>
</tr>
<tr>
<td><strong>Total Operating Expense</strong></td>
<td>42,735,138</td>
<td>14,455,788</td>
<td>14,174,360</td>
<td>16,066,226</td>
<td>22,658,749</td>
</tr>
<tr>
<td><strong>Operating Income (Loss)</strong></td>
<td>(2,997,917)</td>
<td>(820,685)</td>
<td>(1,830,376)</td>
<td>(3,035,419)</td>
<td>(1,207,151)</td>
</tr>
<tr>
<td><strong>Depreciation Expense</strong></td>
<td>1,946,750</td>
<td>405,496</td>
<td>429,637</td>
<td>550,486</td>
<td>871,772</td>
</tr>
<tr>
<td><strong>Non Operating Income</strong></td>
<td>1,834,999</td>
<td>904,109</td>
<td>1,407,192</td>
<td>2,652,099</td>
<td>2,211,203</td>
</tr>
<tr>
<td><strong>Net Income Less Depreciation Expense</strong></td>
<td>783,832</td>
<td>488,920</td>
<td>6,453</td>
<td>167,166</td>
<td>1,875,824</td>
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</tbody>
</table>

### Indirect Cost Allocations to CAH Affiliates:

- **Estimated Administrative and General Costs**: $6,272,971 A, $1,941,620 B, $1,790,760 C, $1,508,320 D, $2,928,385 E
- **Cost-Based Payer Mix**: 45.00% A, 45.00% B, 45.00% C, 45.00% D, 45.00% E
- **Net Increase in CAH Cost Based Reimbursement**: 2,822,837 A, 873,729 B, 805,842 C, 678,744 D, 1,317,773 E

### Net Income Less Depreciation Expense Plus Fixed Allocated Costs

<table>
<thead>
<tr>
<th></th>
<th>A</th>
<th>B</th>
<th>C</th>
<th>D</th>
<th>E</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Total 2016 Est. Discharges for Rural Affiliate Service Area</strong></td>
<td>1,659</td>
<td>1,055</td>
<td>1,030</td>
<td>1,539</td>
<td>1,736</td>
</tr>
<tr>
<td><strong>Current Partner Medicare Market Share (Source: 2016 CMS Data)</strong></td>
<td>58%</td>
<td>22%</td>
<td>38%</td>
<td>42%</td>
<td>38%</td>
</tr>
<tr>
<td><strong>Estimated Partner Discharges from Rural Affiliate Service Area</strong></td>
<td>969</td>
<td>231</td>
<td>397</td>
<td>641</td>
<td>655</td>
</tr>
<tr>
<td><strong>Estimated Partner Net Revenue Per Discharge (Source: AHDI.com; 2017 Data)</strong></td>
<td>13,711</td>
<td>8,556</td>
<td>11,160</td>
<td>14,941</td>
<td>11,406</td>
</tr>
<tr>
<td><strong>Estimated Partner Net Inpatient Revenue from Rural Affiliate Service Area</strong></td>
<td>13,283,151</td>
<td>1,979,283</td>
<td>4,424,960</td>
<td>9,577,146</td>
<td>7,465,424</td>
</tr>
<tr>
<td><strong>Partner OP Rev relative to IP Revenue (2015 Cost Report WS G-2)</strong></td>
<td>191%</td>
<td>109%</td>
<td>162%</td>
<td>64%</td>
<td>109%</td>
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<tr>
<td><strong>Estimated Net OP Rev From Rural Affiliate Service Area</strong></td>
<td>25,409,038</td>
<td>2,159,766</td>
<td>7,178,618</td>
<td>6,088,494</td>
<td>8,146,167</td>
</tr>
<tr>
<td><strong>Total Net Transfer / Referral Dollars to Partner from Rural Affiliates</strong></td>
<td>38,692,189</td>
<td>4,139,049</td>
<td>11,603,578</td>
<td>15,665,640</td>
<td>15,611,591</td>
</tr>
<tr>
<td><strong>Estimated Contribution Margin % (Source: Estimated)</strong></td>
<td>80%</td>
<td>80%</td>
<td>80%</td>
<td>80%</td>
<td>80%</td>
</tr>
<tr>
<td><strong>Estimated Contribution Margin on Net Revenue from Rural Affiliate Service Area</strong></td>
<td>30,953,751</td>
<td>3,311,239</td>
<td>9,282,862</td>
<td>12,532,512</td>
<td>12,489,272</td>
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<tr>
<td><strong>Contribution Margin Per 1% of Inpatient Market Share</strong></td>
<td>530,121</td>
<td>151,060</td>
<td>241,239</td>
<td>300,901</td>
<td>331,280</td>
</tr>
<tr>
<td><strong>Estimated Change in Market Share % with Competitive Entry into Rural Affiliate Market</strong></td>
<td>10%</td>
<td>10%</td>
<td>10%</td>
<td>10%</td>
<td>10%</td>
</tr>
</tbody>
</table>

### CM from Loss of existing or potential gain of Rural Affiliate SA Market Share

<table>
<thead>
<tr>
<th></th>
<th>A</th>
<th>B</th>
<th>C</th>
<th>D</th>
<th>E</th>
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<tbody>
<tr>
<td><strong>CM from Loss of existing or potential gain of Rural Affiliate SA Market Share</strong></td>
<td>5,301,208</td>
<td>1,510,602</td>
<td>2,412,386</td>
<td>3,009,007</td>
<td>3,312,804</td>
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### Total Benefit / (Cost) to Partner for Rural Affiliates

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<tr>
<th></th>
<th>A</th>
<th>B</th>
<th>C</th>
<th>D</th>
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<tbody>
<tr>
<td><strong>Total Benefit / (Cost) to Partner for Rural Affiliates</strong></td>
<td>8,907,876</td>
<td>2,873,251</td>
<td>3,224,681</td>
<td>3,854,916</td>
<td>6,506,402</td>
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Lessons Learned

• Establish an Advisory Council comprised of CAH executives to provide input into curriculum and network focus

• Strive for data transparency and sharing to foster trust

• Establish a Roadmap to frame LAN goals achieved through specific activities, outcomes and deliverables

• Develop task force initiative charters that are narrowly focused and well-defined

• Limit performance improvement initiatives to 6 to 9 months

• Harvest learnings through the use of data to identify outliers

• Encourage discussion of strategies that worked and didn’t
“The New York State Critical Access Hospital (CAH) Network has been critical to Schuyler Hospital’s success over the past seven years. As a new CFO, and also new to CAHs, the quarterly meetings are extremely beneficial and I have tried not to miss many since I came to Schuyler in 2010. The sharing of ideas and information from other CAH CEOs and CFOs, guidance and resources from NYS, and Stroudwater’s rural healthcare expertise has been invaluable. The NYS CAH Network is well attended and very valuable to all NYS CAHs regardless of their financial and affiliation situations. Everyone leaves the meeting with at least one actionable item that will be positive to their organization.”

Amy Castle, CFO
Schuyler Hospital
“The New York State Hospital Quarterly Flex meetings have resulted in substantially better financial performance for the CAHS in New York State. In 2014, the New York State CAHs had a negative net gain of -8.3%. In 2015, it was -5.9% and in 2016, -2.2%. There have also been substantial gains in quality and outcomes that are continuing – for example, the Swing Bed Outcome Improvement project has substantially improved outcomes at Ellenville Regional Hospital. In addition, the Flex meetings have provided a valuable forum for exchange of ideas and information among the 18 NYS CAHs.”

Steven Kelley, CEO
Ellenville Regional Hospital
What your peers are saying...

North Carolina LAN

“Two things that have always struck me have been the value and importance of hospitals networking to discuss and solve problems together, but some of the challenges continue to be just who is the convener and defining the objectives that will keep the groups together and getting results from the efforts. I am pleased that the North Carolina Office of Rural Health along with Stroudwater have been the catalysts to be the convener and leader for our rural hospitals.

The benefits of the LAN concept are more than just data sharing. They include a forum whereby like hospitals from different systems who ordinarily would not be talking with each other actually network about numerous common problems, solutions and opportunities for us all to be more successful. It is always a work in progress but the results are in the efforts invested by all. I appreciate the leadership of the Office of Rural Health and Stroudwater in being the glue for our efforts.”

Mike Stevenson, CEO
Murphy Medical Center
What your peers are saying...

North Carolina LAN

“I have found the LAN initiative to be an excellent resource for benchmarking/best practice data for critical access hospitals in North Carolina. This collaborative between the NCORH and Stroudwater Associates provides ongoing opportunities for all participating hospitals to engage in active dialogue and potential solutions to challenges that each of us have in managing our day-to-day operations. I enthusiastically support this ongoing initiative and the results that are being realized for our CAH colleagues.”

Craig James, President
Alleghany Memorial Hospital
Matt Mendez, MHA
mmendez@stroudwater.com
(910) 508-7672

www.stroudwater.com