Financial and Operational Best Practices

Critical Access Hospital Network Meeting

July 30, 2019

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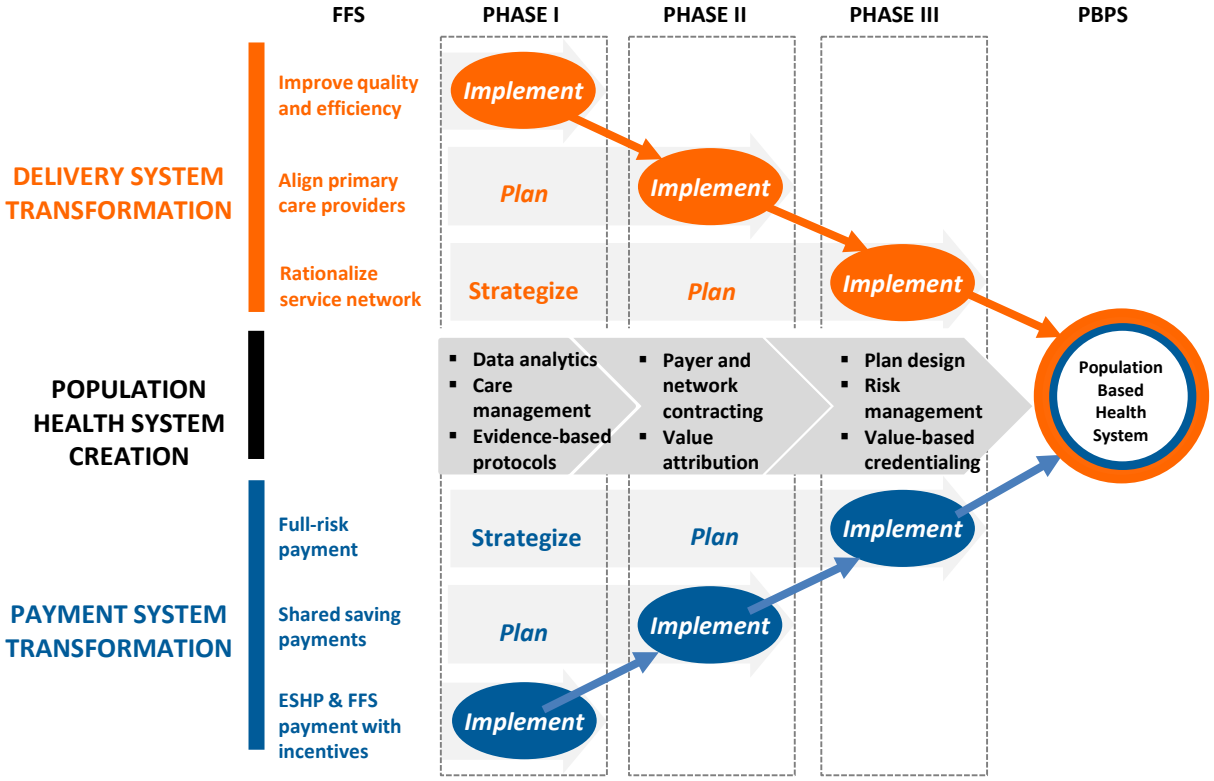
Strategy: Population Health Transition Framework

- 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

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- The following best practice opportunities areas were derived from the 40+ Stroudwater CAH site visits conducted over the last three years
  - ❑ Economic Philosophy
  - ❑ Departmental Profitability
  - ❑ Provider Complement/Practice Management
  - ❑ Inpatient Services
  - ❑ Emergency Services
  - ❑ Clinical Departments
  - ❑ Quality Improvement
  - ❑ Information Technology
  - ❑ Cost Report Improvement
  - ❑ Revenue Cycle
  - ❑ Management Accounting
  - ❑ Staff Benchmark Analysis
  - ❑ Affiliation Strategy
  - ❑ Provider Alignment
  - ❑ Payment System Transformation
  - ❑ Population Health Management
  - ❑ Service Area Rationalization

Economic Philosophy

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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

Department Profitability

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- 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 Profitabilty Analysis FY 2018

	Days	Rate	Revenue
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 %	
Allocated Expenses (ICR Stepdown - WS B)			
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/Practice Management

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- Create a catalog of all primary care providers with the service area to gain a better understanding of primary care need
- Conduct a primary care options assessment to determine the optimal clinic designation such as Provider-Based Rural Health Clinic (PB-RHC) or Provider-Based Entity (PBE) status
  - Conduct Return on Investment (ROI) analysis on the consolidation and inclusion of the specialty practices into the PB-RHC to leverage cost-based reimbursement opportunities
- Continue to evaluate and explore relationships with specialty providers to increase both the access and number of services offered within the primary service area
- Evaluate revising physician compensation contracts to include production, panel size and quality scores
- Continue to enhance alignment with the area primary care providers that strengthens clinic decisions rights, improves functional alignment and creates partnership opportunities
  - Engage all providers in an effort to ensure balanced participation
  - Review and revise Medical Staff Bylaws as needed to establish clear delineation of responsibilities and accountabilities
- Conduct annual fair market value assessments and Stark Rule analyses for all employed physicians to comply with federal requirements
- Evaluate broad deployment of primary care and specialty providers throughout system

Provider Complement/Practice Management (Cont.)

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Physician Shortage/Surplus

Adjusted Service Area Population: **37,077**

Primary Care	Supply Study Range	Existing[1]	(Shortage)/Surplus Range[2]
Family Practice	5.1 - 17.5	9.00	(8.5) - 3.9
Internal Medicine	4.3 - 10.3	3.50	(6.8) - (0.8)
Pediatrics	2.9 - 4.5	1.00	(3.5) - (1.9)
Physician Primary Care Range	19.8 - 24.7	**13.50**	**(11.2) - (6.3)**
Non-Phys Providers	2.5 - 8.5	14.70	6.2 - 12.2
TOTAL Primary Care Range	24.6 - 33.1	**28.20**	**(4.9) - 3.6**
Medical Specialties			
Allergy	0.3 - 0.5	0.00	(0.5) - (0.3)
Cardiology	1.1 - 1.4	0.20	(1.2) - (0.9)
Dermatology	0.7 - 0.9	0.00	(0.9) - (0.7)
Endocrinology	0.1 - 0.5	0.00	(0.5) - (0.1)
Gastroenterology	0.7 - 0.9	0.00	(0.9) - (0.7)
Hem/Oncology	0.8 - 0.9	0.00	(0.9) - (0.8)
Infectious Disease	0.2 - 0.4	0.00	(0.4) - (0.2)
Nephrology	0.5 - 0.6	0.00	(0.6) - (0.5)
Neurology	0.7 - 1.0	0.00	(1.0) - (0.7)
Pulmonary	0.4 - 0.8	0.00	(0.8) - (0.4)
Rheumatology	0.4 - 0.5	0.00	(0.5) - (0.4)
Surgical Specialties			
ENT	0.2 - 1.1	0.37	(0.7) - 0.2
General Surgery	2.3 - 2.7	2.00	(0.7) - (0.3)
Neurosurgery	0.3 - 0.4	0.00	(0.4) - (0.3)
OB/GYN	2.8 - 3.9	1.00	(2.9) - (1.8)
Ophthalmology	1.4 - 1.4	0.00	(1.4) - (1.4)
Orthopedic	1.6 - 2.6	2.00	(0.6) - 0.4
Plastic Surgery	0.4 - 0.7	0.00	(0.7) - (0.4)
Urology	1.0 - 1.1	0.14	(1.0) - (0.8)

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.

Inpatient Services

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- 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
  - Access new patients including Medicare Advantage, Medicaid, and commercial payer patients

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 for proper documentation and determinations of inpatient stays likely to exceed 2-Midnights. Enforce proper usage of observation admission criteria
- Implement Hourly Rounding and Bedside Handoff models for nurses to optimize multidisciplinary communication
- Integrate Pharmacist visit into every patient discharge

Inpatient Services Best Practices

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- 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** 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

Emergency Services

- Implement systems to ensure patients who present to the Emergency Department of a non-emergent nature are redirected to the clinics, when open, to receive care
  - Recognize that if the CAH does not offer urgent care services, patients with high deductibles will be leaving rural communities for care
- Develop strategies to better manage demand for non-emergent care within the community to include the following:
  - Expand urgent care clinic to include primary care services
  - Explore development of an ED redirect program to the urgent care clinic in partnership with providers
  - Evaluate signage to improve patient's ability to self-select the ED versus urgent care clinic
  - Educate public on the appropriate use of the ED to reduce the number of non-emergent visits
  - Enroll patients with a primary care provider or direct them to a more appropriate level of care setting
- Develop ED-hospitalist model coverage capability with ED provider and APP to improve care and admissions capability, and to reduce transfers
- Work with medical staff and system partner to review appropriateness of transfers and leverage development of ED-hospitalist coverage model to enable patients to remain at hospital for care when medically appropriate
  - Review patient transfers for potential missed opportunities

Emergency Services (cont.)

- 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 in EDCAHPS – track and monitor performance
- Engage the hospitalists and Emergency Department providers to focus on improved collaboration that results in enhanced patient throughput
- Track and monitor KPIs related to the Emergency Department, including:
  - ED admissions (acute/observation) as a percentage of ED visits to between 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
  - Throughput measures: Door to MD, Door to Discharge, Door to Admit, Door to Transfer, LWOT, AMA, etc.

Clinical Departments

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

Quality Improvement

- 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
- Track core measure data and use the information to make systematic and operational changes to improve overall quality and patient outcomes
- Establish specific targets based on Key Performance Indicators (KPI) for the Quality Committee that focus on the entire care continuum then use those KPIs to drive outcomes and improve performance
  - Share/post metrics with all staff and utilize performance to drive improvement across the organization

Quality Improvement (cont.)

- Establish quality as a strategic priority with the goal of being best in the region within 12 months
  - Continue to update the Board and Medical Staff on quality performance and initiative progress on a monthly basis
  - Establish a multidisciplinary quality committee that meets on a monthly basis, include a provider and Board member
  - Identify and partner with medical staff champions to drive improved performance
  - Drive accountability for care quality, outcomes, and patient satisfaction across all staff and providers
  - Leverage quality as a strategic driver of market share and widely promote performance results in outreach and marketing efforts
- Engage in activities to lower their rate of readmissions, such as clarifying patient discharge instructions, initiating follow-up calls, coordinating with post-acute care providers and primary care physicians, and reducing medical complications during patients' initial hospital stays

Information Technology

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- **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

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- Evaluate Med-Surg department square footage to incorporate the hallways to ensure accuracy of cost report; Minimum expectation is at least 300 square feet allocated for each inpatient bed
- Utilize best practice time study methodology to ensure physician stand by time is accurate and fairly reflected on the cost report
  - Evaluate technology-based solutions that automate time tracking functions
- Track Part A time for physicians via Time Studies for Medical Directorships, etc.
- Monitor Ratio of Cost to Charge (RCC) levels to potentially indicate revenue cycle process improvement opportunities such as charge setting and/or charge capture improvement opportunities
- Verify appropriateness of CDM hospital is not at a competitive disadvantage and is not unnecessarily burdening Medicare patients through shifting of co-insurance to patients
- Evaluate the salaries included in Nursing Administration and ensure only the Chief Nursing Officer (CNO) and direct administrative support staff are included in this category
  - Ensure Nursing Administration costs are allocated only to departments that involve nursing functions – exclude departments such as Imaging, Therapy, Laboratory, Pharmacy, etc.
- Establish an internal threshold (such as a due from Medicare in excess of $500K) that would drive the completion and filing of an interim cost report

Cost Report Improvement (Cont.)

- Evaluate LDRP vs. Med-Surg room usage based on observation status vs. active labor status (Med-Surg) time studies to accurately allocate square footage
  - Ensure costs for Labor and Delivery (LDRP) include only the time assigned to “active” delivery otherwise those costs should be allocated to the Med/Surge cost center
- Continue to monitor departments with low charges relative to cost so they are not missing charge opportunities, as this has a direct impact on ‘bottom line’
- Monitor appropriate assignment of non-Medicare or Medicare Advantage SB patients to Line 6
- Consider consolidating RHC for cost report purposes to reduce variation and remove reimbursement variances
- Conduct time studies of physicians and APPs to assess the amount of time providing care or scheduled care to patients while removing time for administrative duties, vacation, sick time, and other non-patient centered items to ensure the accurate statement of FTE information on Worksheet M-2
- Establish a formal Bad Debt policy that pulls claims back from the collection company, after a certain period of inactivity, for inclusion on the cost report
  - Target outpatient Bad Debt 10-20% of patient responsibility
- Work with cost report preparer to determine if investment funds can be designated as funded depreciation to avoid significant offset
- Implement a time study process and conduct medical record time studies to accurately capture true worked time by department for inclusion on the cost report

Revenue Cycle

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- 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
- Establish, target, track, and manage performance indicators, such as the following HFMA best-practice revenue-cycle metrics, in an effort to improve revenue cycle performance: Cash collected and cash percentage of net revenue
  - Gross and Net A/R and A/R days
  - In-house and discharged not-final-billed receivables
  - Cost to collect
  - Bad debt and charity as a percent of gross charges
  - Denials as a fraction of gross charges
  - Point of service collections as a fraction of goal
- Implement a revenue cycle committee that meets at least bi-weekly that includes representatives from clinical, financial, administrative, medical staff, health information management, and the business office to oversee and drive improvements with regard to the revenue cycle process

Revenue Cycle (Cont.)

- Establish workflow to pre-register all scheduled services including appointment verification, insurance verification, and a co-insurance discussion with patient
- Ensure 100% of outpatient procedures are scheduled and pre-registered with proactive discussion of estimated costs. Collection of patient co-payment, deductible and coinsurance should be requested based on verified information
- 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
- 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
- Catalog and determine profitability of all major commercial payers, comparing payment to Medicare and seek contract increases, if necessary
- Target Days in DNFB to 5 days

Management Accounting

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- 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
- Establish performance monitoring dashboards for all managers
- Provide monthly budget to actual reports to all department managers and mentor them to improve financial understanding and commitment to accountability
  - Develop process where department managers are required to prepare variance reporting for pre-determine variances from budget and plan monthly DOR meetings with CFO/CEO for overall financial/business mentoring

Staffing Benchmarks

- 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

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- Independent peer rural hospitals will evaluate partnership and affiliation opportunities based on the needs of the organization to solidify their position within the market
- Evaluate strategic partnership options using the Affiliation Value Curve to guide the determination of mutual opportunities with an emphasis on the following priorities:
  - 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
  - Technological integration and support
  - Capital investments
  - Expense reductions through administrative integration and group purchasing

Provider Alignment Best Practices

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- 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

Payment System Transformation

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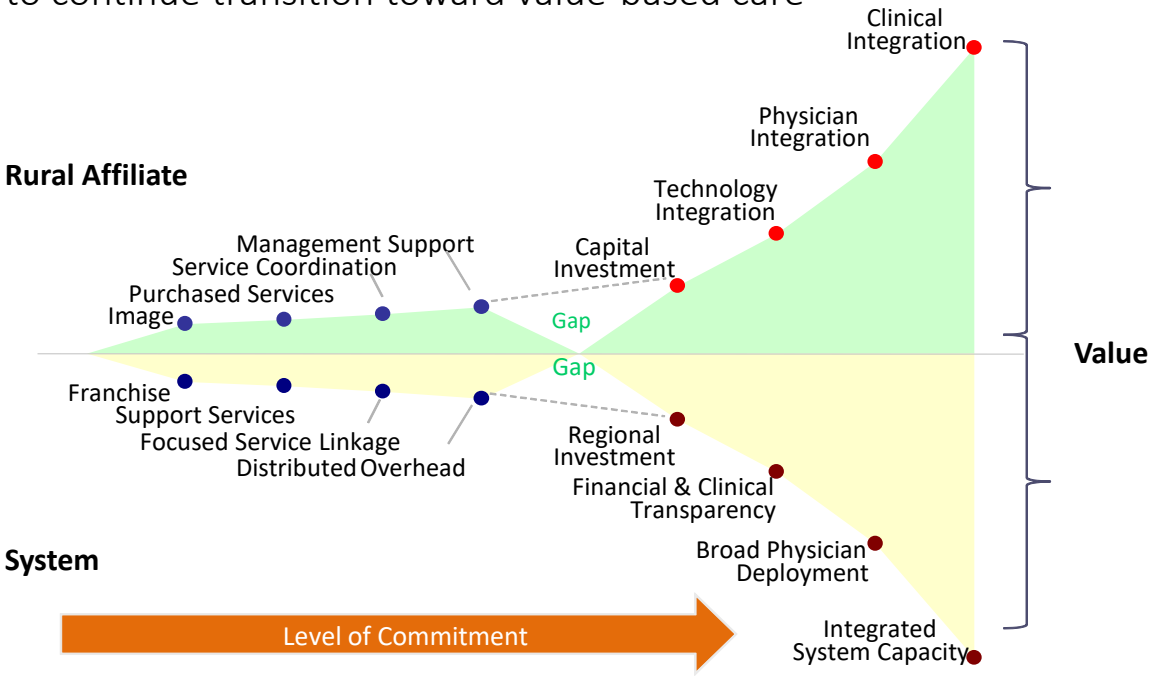
- Incorporate population health interventions, such as disease management programs to manage overall benefits costs, into the employee health plan and learn how to provide high-quality, low-cost health care to sell to external markets
- Evaluate addition of incentives and disincentives for employees 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
- Consider benefit of converting coverage to a pilot population health intervention (such as disease management programs) to manage overall benefits costs and test providing high-quality, low-cost health care to sell to external markets, beginning with the hospital's self-insured population, if indicated
- Proactively develop a strategy to participate in a population health payment mechanisms, and consider an ACO model or alternative payment system option that meets the needs of the hospital
- Look to maximize commercial incentives through the development and application of population health management practices

Population Health

- Implement the use of evidence-based protocols and care management processes in conjunction with the medical staff to ensure seamless and efficient quality care for all patients
- Evaluate claims data to better understand opportunities for improved health of the workforce and better efficiencies in plan design
  - Implement a data analytics platform and use employee claims data, once received, as a proxy for a regional care plan to improve outcomes throughout the community
- Ensure that all third-party payers recognize Patient Centered Medical Home (PCMH) status and that hospital is to be reimbursed for per member per month case management fees
- Implement Chronic Care Management (CCM), Transitional Care Management (TCM) and Behavioral Health Intervention (BHI) programs and billing codes to generate incremental revenue and build greater loyalty among primary care patients
  - Explore strategies to improve patient compliance through the use of health coaches and health navigator roles

Service Area Rationalization

- Using the Affiliation Value Curve, evaluate partnership opportunities with regional providers that effectively position for population health by focusing on the following areas:
  - *Delivery System*: Assess specialty care needs of the service area and develop specialty care network to meet demands
  - *Population Health Management*: Use consolidated employee claims data to drive healthcare initiatives throughout the region
  - *Payment System*: Further relationship with ACO and use ACO as a basis to continue transition toward value-based care



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