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

STROUDWATER

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

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- 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

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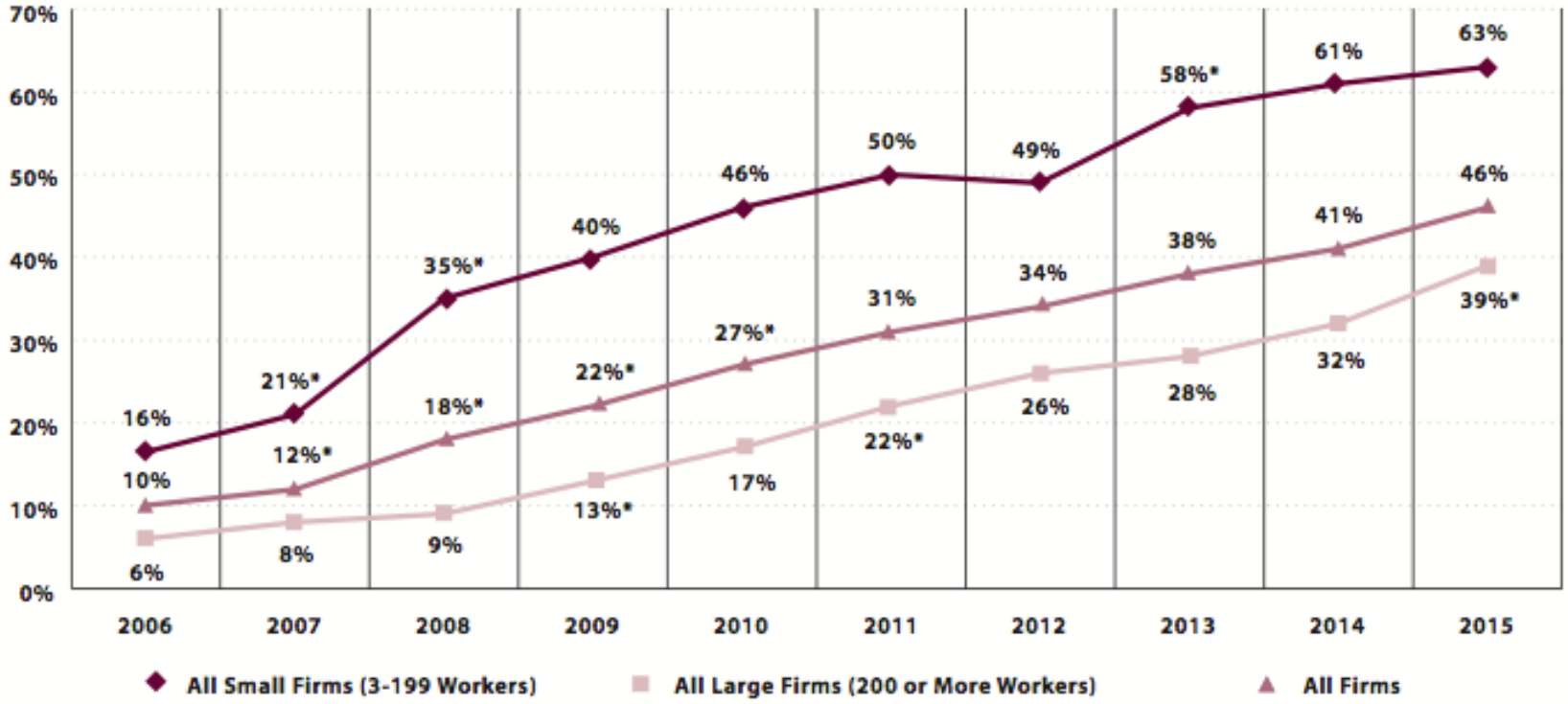
EXHIBIT G

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

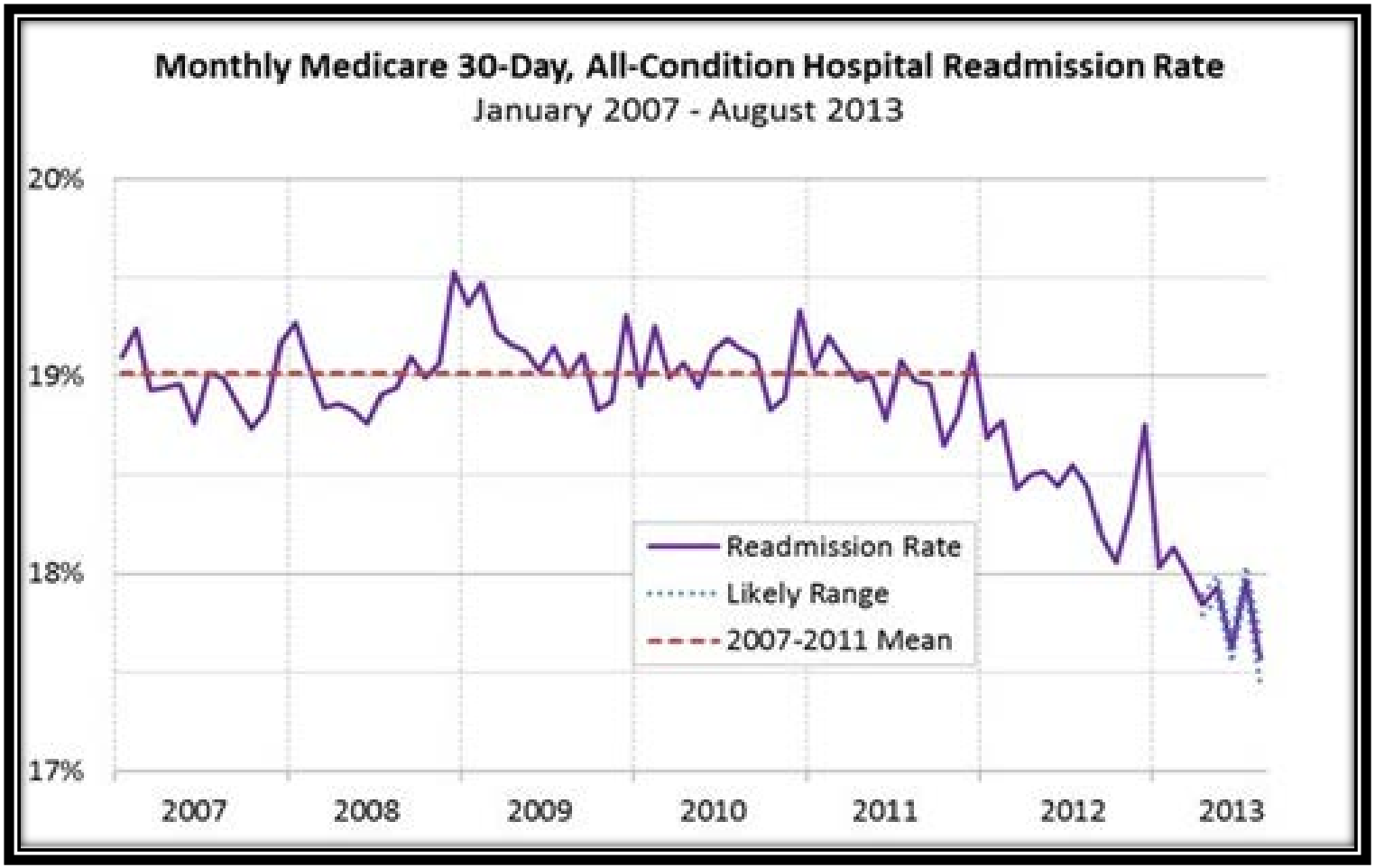


* Estimate is statistically different from estimate for the previous year shown (p<.05).

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.

SOURCE: Kaiser/HRET Survey of Employer-Sponsored Health Benefits, 2006-2015.

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

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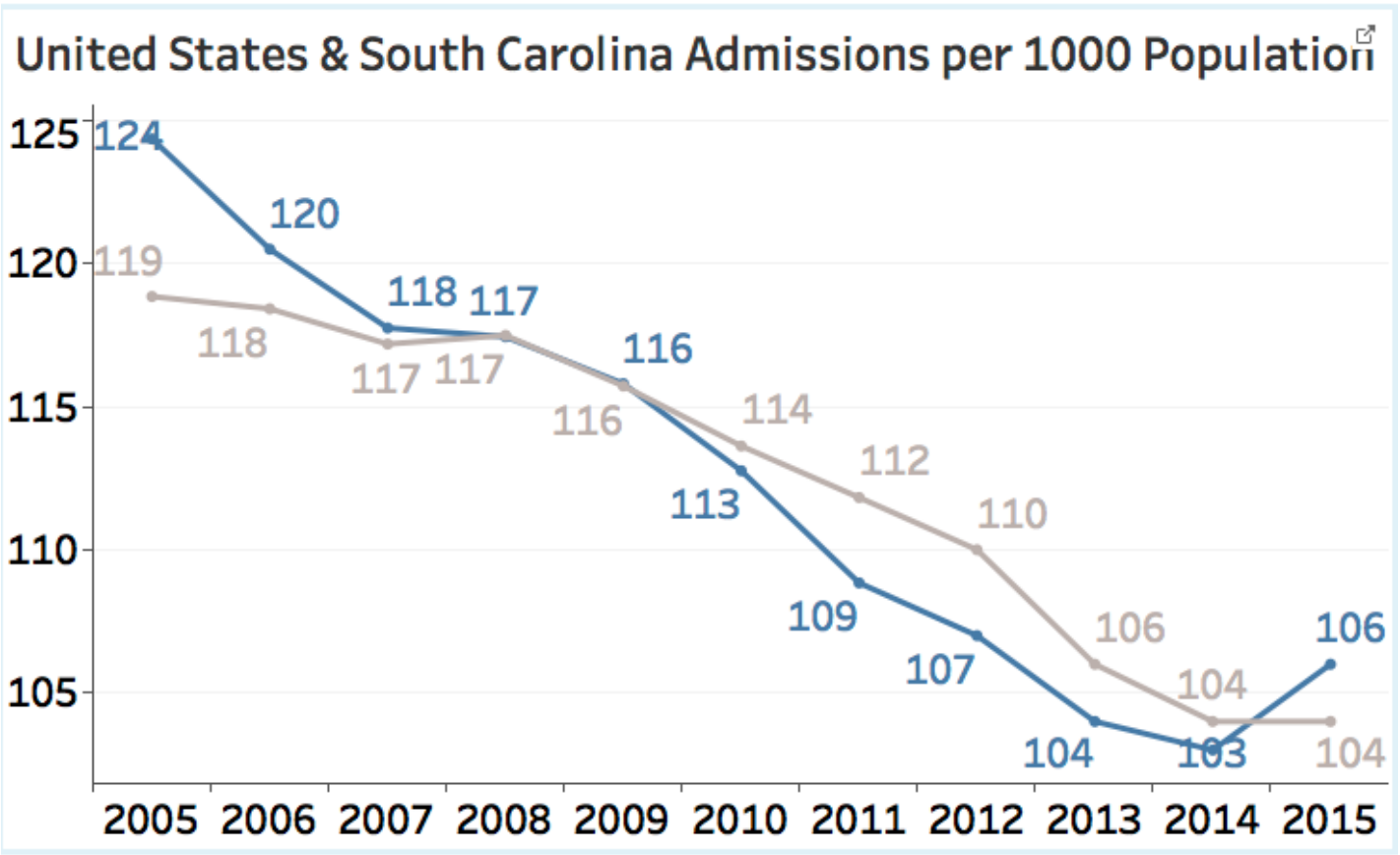

Source:KFF.org

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

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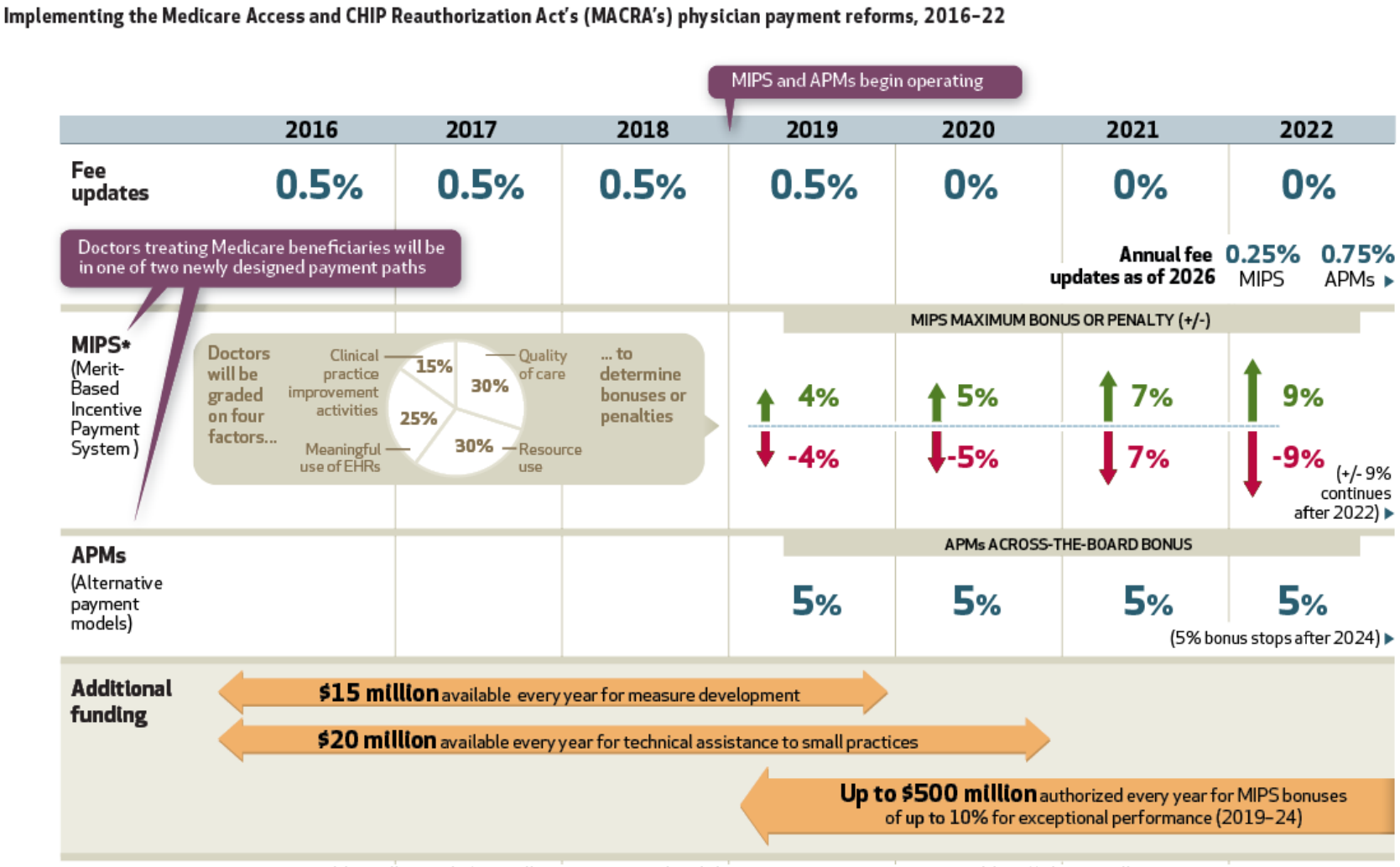

Source: "Health Policy Brief: Medicare's New Physician Payment System," Health Affairs, April 21, 2016. http://www.healthaffairs.org/healthpolicybriefs/

Joint Replacement Comprehensive Pay Model – November 16, 2015

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Comprehensive Care for Joint Replacement Model

Share

The Comprehensive Care for Joint Replacer … aims to support … ficient care for beneficiaries undergoing the mos… urgeries for Medicare … ip and knee replacements (also called low… ments or LEJR). This … bundled payment and quality measurer… sociated with hip an… replacements to encourage hospitals, … and … roviders to work to… improve the quality and coordination … he initia… through recovery…

The proposed rule for the CJR model … ed on July 9, … omment peri… September 8, 2015. After reviewing … mments from the … roposed … major changes were made from the p… including changing … date… 2016. The final rule was placed on dis… nber 16, 2015 and ca… Register.

Source: CMS

Model Summary

Stage: Announced
Number of Participants: 67 MSAs
Category: Episode-based Payment Initiatives
Authority: Section 3021 of the Affordable Care Act

Milestones & Updates

Nov 17, 2015
Announced: Final rule introductory webinars

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.kaiserhealthnews.org/stories/2011/january/13/aco-accountable-care-organization-faq.aspx
http://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/sharedsavingsprogram/News.html

Source: HHS Press Release, January 11, 2016

Fee-For-Service Financial Model Disruption

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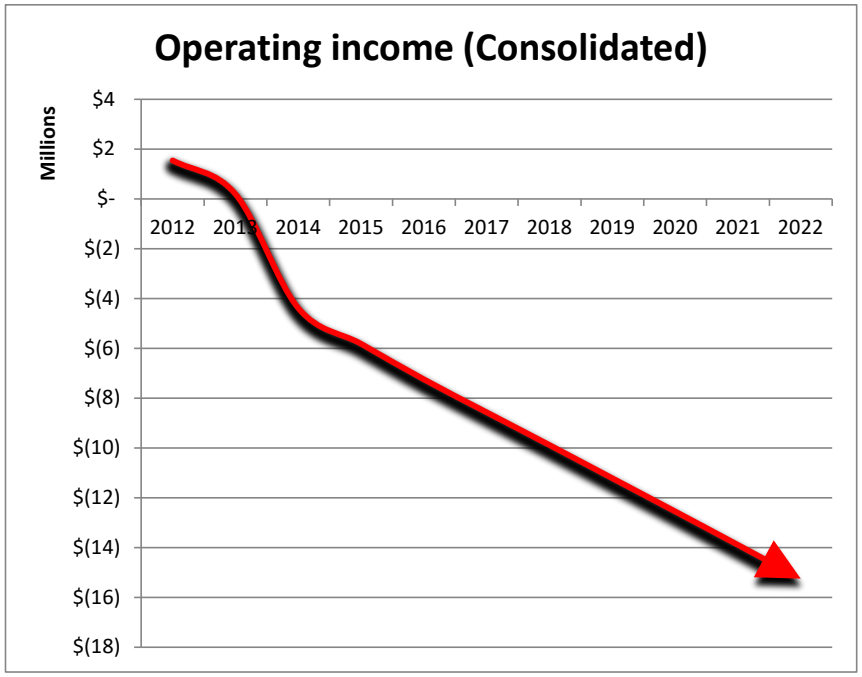
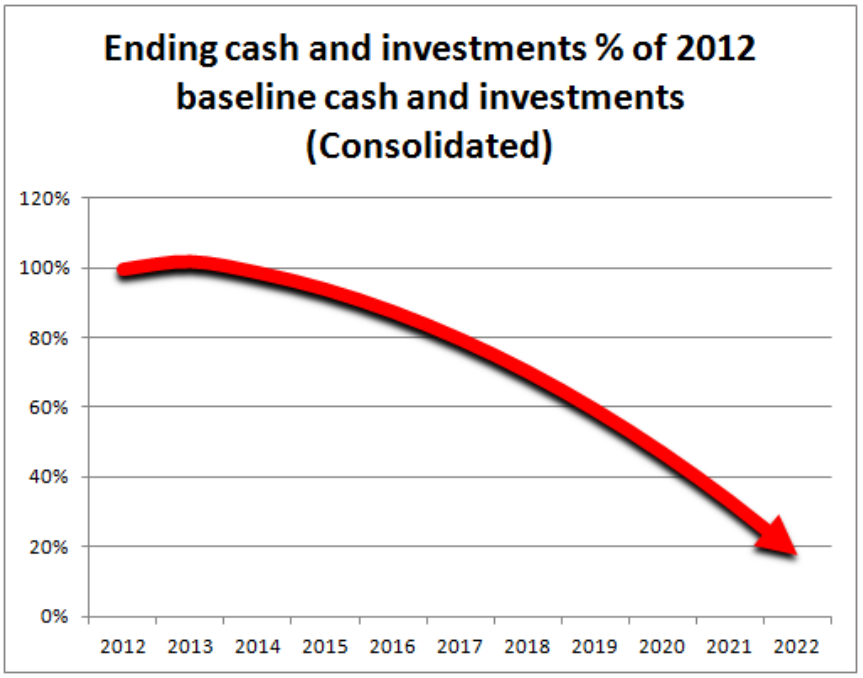
Assumptions

- 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

Fee-For-Service Financial Model – Results

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

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- 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!

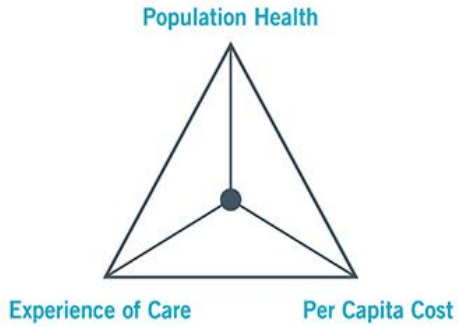
- Subset of most recent challenges
  - Payment systems transitioning from volume based to **value based**
  - Increased emphasis as **quality** as **payment and market differentiator**
  - **Reduced payments** that are "Real this time"
- New environmental challenges are the TRIPLE AIM!!!
- Market Competition on economic driver of healthcare: PATIENT VALUE

Harvard Business Review
www.hbr.org

The wrong kinds of competition have made a mess of the American health care system. The right kinds of competition can straighten it out.

Redefining Competition in Health Care

by Michael E. Porter and Elizabeth Olmsted Teisberg



Source: IHI

Future Hospital Financial Value Equation

- Definitions
  - Patient Value

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

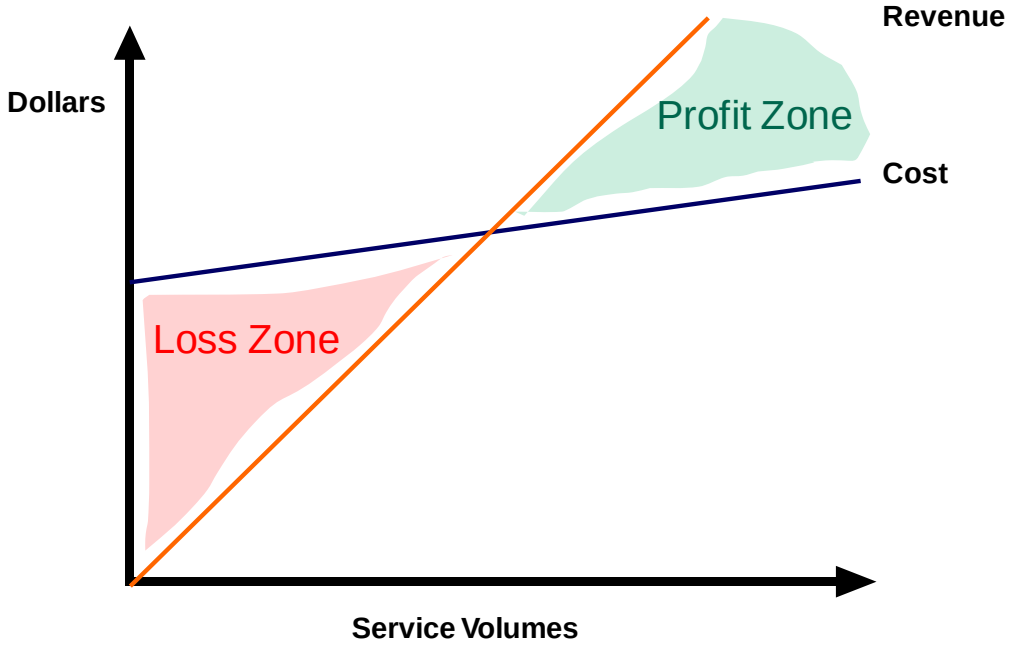
  - Accountable Care:
    - A mechanism for ***providers to monetize the value derived from increasing quality and reducing costs***
      - Accountable care includes many models including bundled payments, value-based payment program, provider self-insured health plans, Medicare defined ACO, capitated 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**



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

CNN Health » Cuts threaten rural hospitals 'hanging on by their fingernails' Live TV U.S. Edition +

Cuts threaten rural hospitals 'hanging on by their fingernails'

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

Sources: www.cnn.com and www.nbcnews.com

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.

Dr. Kenneth Whinery is Sayre, Oklahoma's 87-

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.

HEALTHCARE FINANCE

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REIMBURSEMENT | REVENUE CYCLE MANAGEMENT | STRATEGIC PLANNING | CAPITAL FINANCE | SUPPLY CHAIN

OCT 03 | MORE ON OPERATIONS

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

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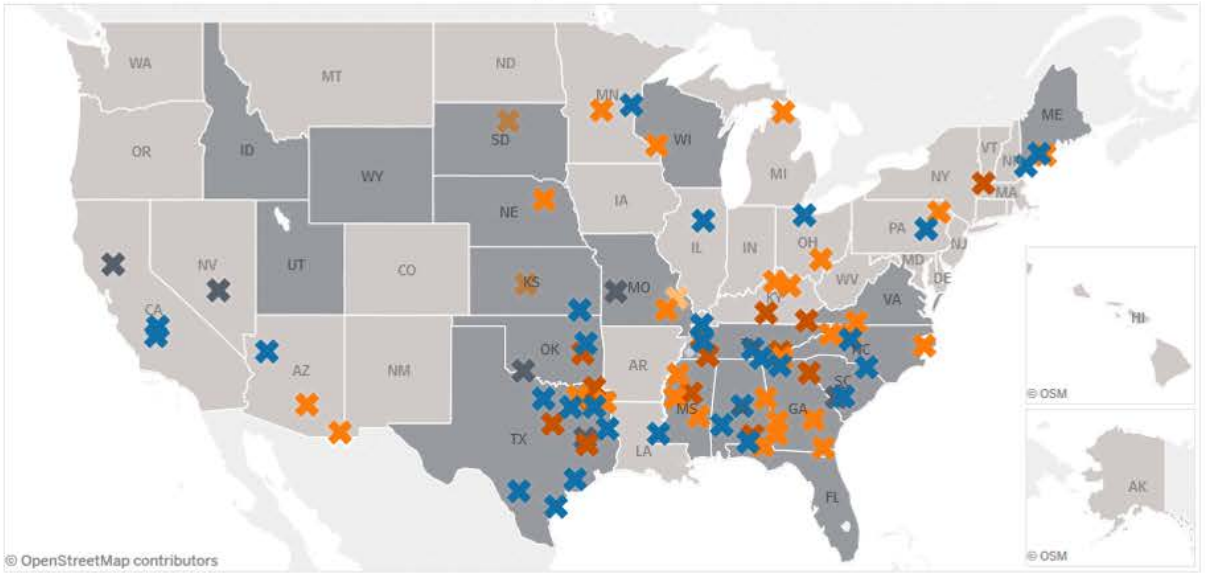
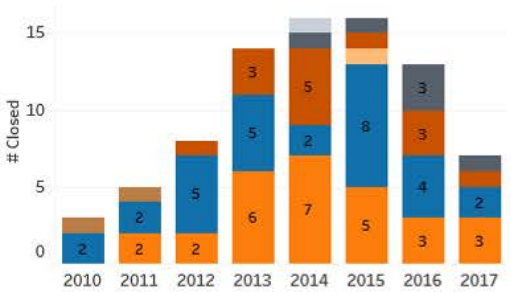
82 Closed Rural Hospitals

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



Closure Year	Hospital
2017	Campbellton-Graceville Hospital
	Care Regional Medical Center
	Copper Basin Medical Center
	Davie Medical Center-Mocksville
	East Texas Medical Center-Trinity
	Pioneer Community Hospital of Patrick County
	Timberlands Hospital
2016	Colusa Regional Medical Center



State..	# Closed
TX	14
TN	8
GA	6
AL	5
MS	5
KY	4
NC	4
AZ	3
CA	3
ME	3
MO	3
OK	3
SC	3
KS	2
MN	2
OH	2
PA	2
VA	2
FL	1
IL	1
MA	1
MI	1
NE	1
NV	1
SD	1
WI	1

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

Closure Year	Prospective Payment System	Critical Access Hospital	Medicare Dependent Hospital	Sole Community Hospital	Re-based Sole Community Hospital	Disproportionate Share Hospital	Rural Referral Center	Total
2010	2				1			3
2011	2	2			1			5
2012	5	2	1					8
2013	5	6	3					14
2014	2	7	5	1		1		16
2015	8	5	1	1			1	16
2016	4	3	3	3				13
2017	2	3	1	1				7
Total	30	28	14	6	2	1	1	82

Updated:9/29/2017

Source:The Cecil G. Sheps Center for Health Services Research & kff.org

Design:Gregg Lathrop

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 i**n 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.

Source: Kaiser Family Foundation http://kff.org/health-reform/issue-brief/where-president-elect-donald-trump-stands-on-six-health-care-issues/

President Trump's Position on Medicaid and Medicare

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- 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**

Source: Kaiser Family Foundation http://kff.org/health-reform/issue-brief/where-president-elect-donald-trump-stands-on-six-health-care-issues/

THE HENRY J. KAISER FAMILY FOUNDATION

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

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- 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**.

Source: Robert Wood Johnson Foundation, "The Cost of ACA Repeal", Matthew Buettgens, Linda J. Blumberg, John Holahan, and Siyabonga Ndwandwe. June 2016.

Robert Wood Johnson Foundation

URBAN INSTITUTE

Numerous attempts to repeal ACA → unsuccessful

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- 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

	Finance (Macro-economic Payment System)	Function (Provider Imperatives)	Form (Provider Organization)

Today (FFS)	• Government Payers
	  • Changing from F-F-S to PBPS
	• Private Payers
	  • Follow Government payers
		• Management of price, utilization and costs	• Independent organizations competing with each other for market share based on volume

The Challenge: Crossing the Shaky Bridge

No Transition

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**.

Full Transition

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.

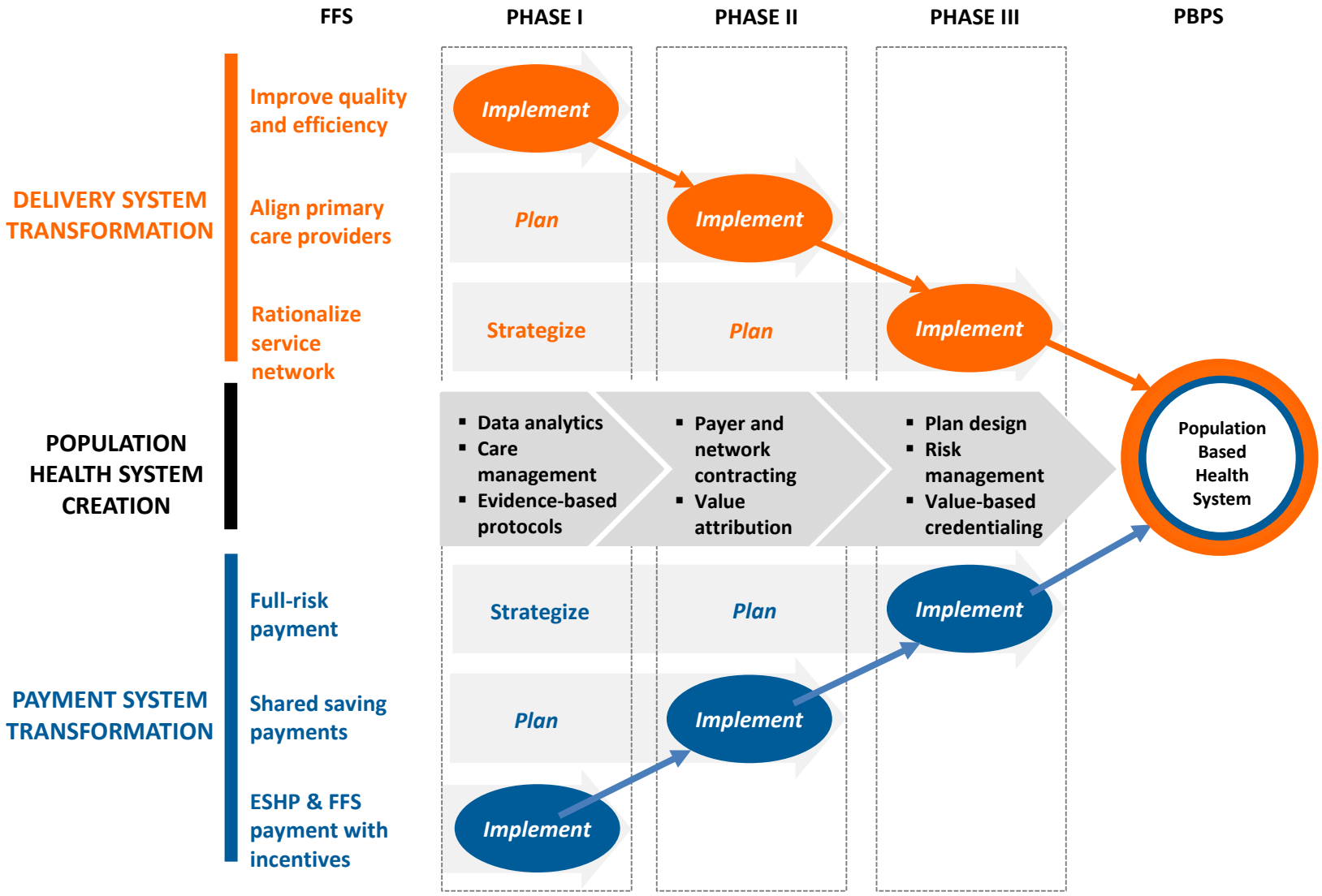
Fundamental Changes

Now

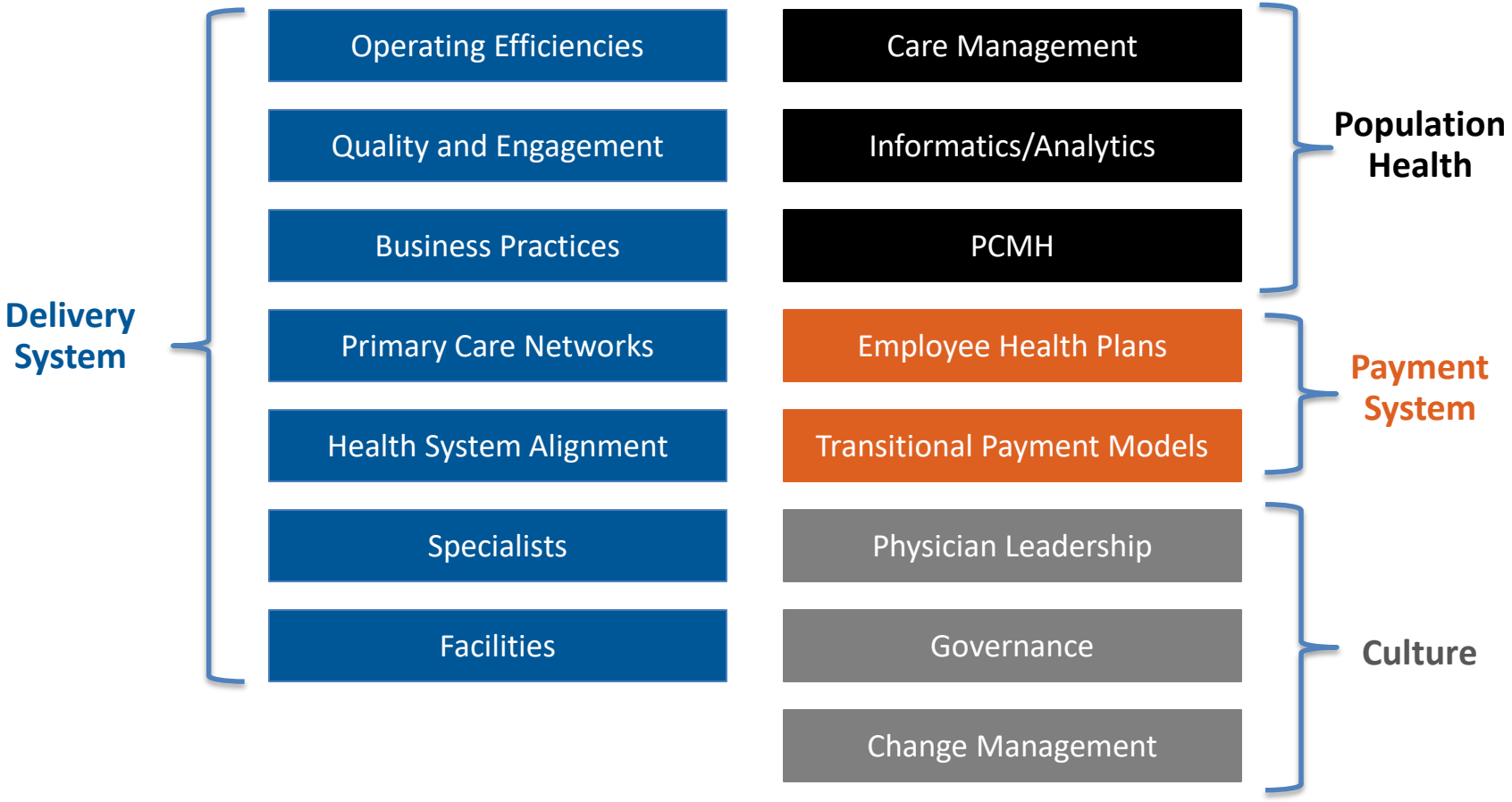
A

- Hospitals and Medical Staffs
- Patients
- Private Payers
- Revenue Centers
- Charge Masters
- Primary Care Providers
- FFS Volume Growth
- Productivity Bonuses

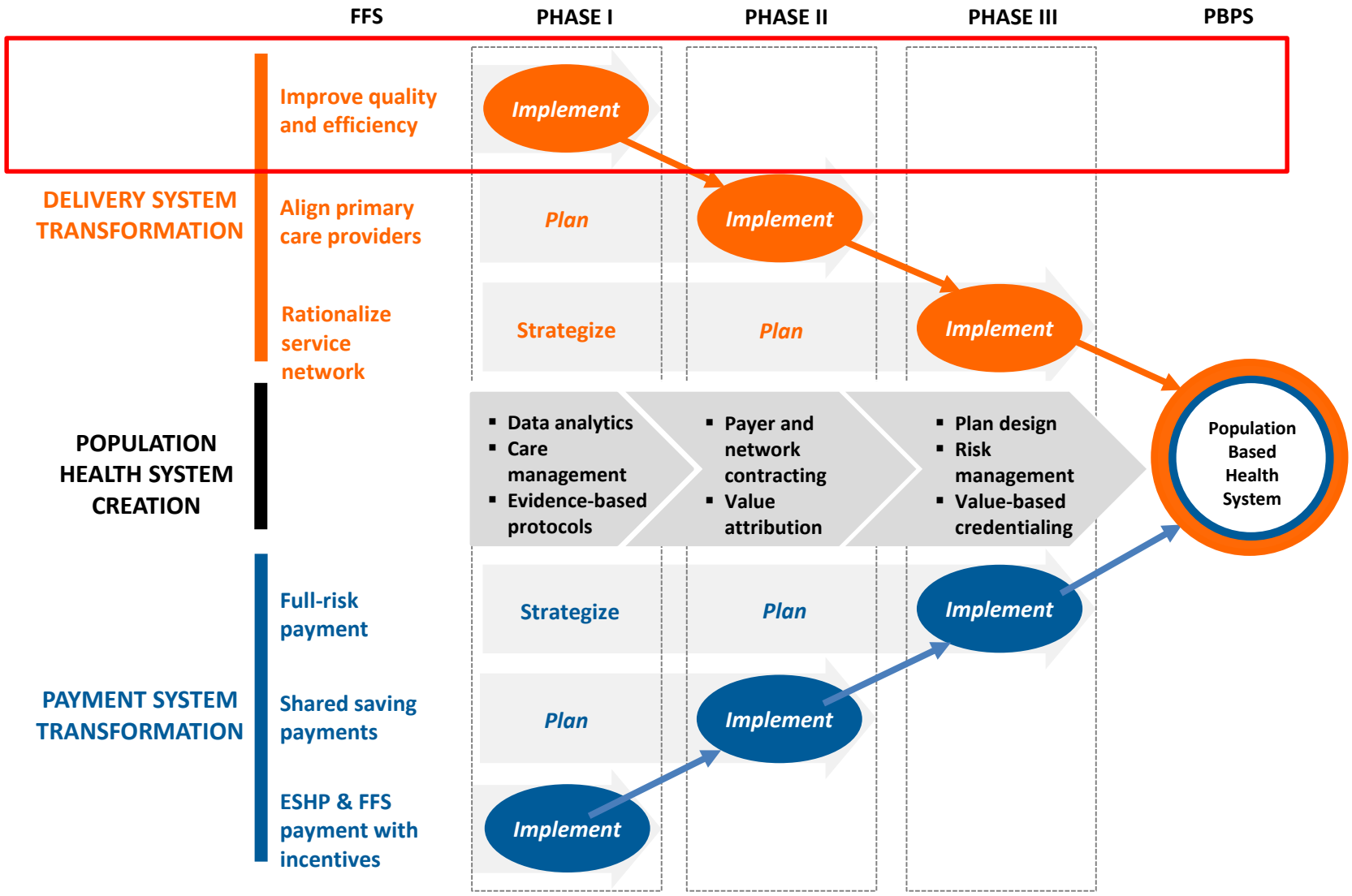
Transition Framework – What Is It?

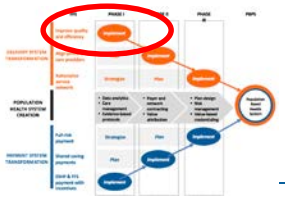


What to change?



Transition Framework





Initiative I – Operating Efficiencies, Patient Safety and Quality

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- 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

Graphic: National Patient Safety Foundation

Delivery System Initiative I – Operating Efficiencies, Patient Safety and Quality

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- **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

Delivery System Initiative I – Operating Efficiencies, Patient Safety and Quality

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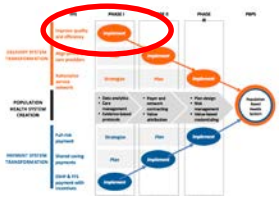
- **Increase departmental staff efficiency**
  - **Monitoring productivity** for all departments
  - Shifting towards **weekly or daily productivity** tracking
  - **Eliminating scheduled OT,** and reliance on agency staff
  - **Staffing education** for DONs/Clinical managers
  - Salary Survey/ Staffing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

Sample of Selected Departments

Department	Performance Indicator	FY 2014 Volume	Hourly Standard[1]	FTEs @ Standard	Actual FTEs[2]	Variance
Nursing - Med Surg	Per Patient Day	2,778	12.00	17.81	27.40	9.59
Nursing - Obstetrical/Postpartum	Per Patient Day		10.00	-	0.30	0.30
Nursing - Nursery	Per Patient Day	188	5.00	0.50	0.24	(0.26)
Nursing - ICU/CCU	Per Patient Day	105	20.75	1.16	0.10	(1.06)
Emergency Room	Per Visit	1,454	2.75	2.14	1.21	(0.93)
Inpatient/ED Subtotal				21.61	29.25	7.64
Nursing - Surgery - Minor	Per Case	226	5.50	0.60	2.40	1.80
Nursing - Endoscopy/GI Lab	Per Case	346	3.60	0.60	-	(0.60)
Nursing - Other OP Proc	Per Case	130	1.60	0.10	-	(0.10)
Nursing - Recovery Room	Per Case	702	3.30	1.11	0.19	(0.92)
Surgery Subtotal				2.41	2.59	0.18
UR/Case Mgr/Soc Ser	Patient Days	2,778	0.75	1.00	1.24	0.24
Nursing Administration	Per Adj. Admissions	2,235	1.75	1.88	1.99	0.11
Subtotal Nursing				26.90	35.08	8.18
Radiology	Per Procedure	3,466	1.41	2.36	4.30	1.95
Lab/Blood Bank	Per Test	28,838	0.25	3.49	4.54	1.05
Physical Therapy	Per Treatment	6,412	0.50	1.54	3.79	2.25
Cardiac Rehab	Per Procedure	221	1.31	0.14	0.15	0.01
Occupational Therapy	Per Treatment	1,833	0.50	0.44	0.99	0.55
Speech Therapy	Per Treatment	351	1.00	0.17	0.20	0.03
Cardio/Pulmonary	Per Procedure	3,358	0.71	1.14	1.57	0.43
Pharmacy	Per Adjusted Day	10,053	0.60	2.90	1.99	(0.91)
Subtotal Ancillary				12.18	17.53	5.35
Subtotal - Clinical				39.08	52.61	13.52
Hospital Administration	Per Adj. Admissions	2,235	1.65	1.77	13.07	11.30
Information Systems	Per Adj. Admissions	2,235	1.00	1.07	-	(1.07)
Human Resources	Per Adj. Admissions	2,235	1.10	1.18	-	(1.18)
Marketing/Planning/Public Rel	Per Adj. Admissions	2,235	0.28	0.30	-	(0.30)
Volunteers	Per Adj. Admissions	2,235	0.75	0.81	-	(0.81)
Telecommunications	Per Adj. Admissions	2,235	0.36	0.39	-	(0.39)
General Accounting	Per Adj. Admissions	2,235	1.23	1.32	-	(1.32)
Security	Gross Square Feet	49,980	0.02	0.48	-	(0.48)
Patient Accounting	Per Adj. Admissions	2,235	3.00	3.22	-	(3.22)
Admitting/Patient Registration	Per Adj. Admissions	2,235	3.75	4.03	-	(4.03)
Medical Records	Per Adj. Admissions	2,235	3.00	3.22	3.10	(0.13)
Cent Supply/Mtl Mgmt/Sterile	Per Adjusted Day	10,053	0.30	1.45	0.04	(1.41)
Housekeeping	Net Square Feet	35,700	0.31	5.36	4.09	(1.27)
Plant Ops/Maintenance	Gross Square Feet	49,980	0.08	1.92	4.15	2.23
Subtotal Support				26.53	24.45	(2.08)
				65.61	77.06	11.45

[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

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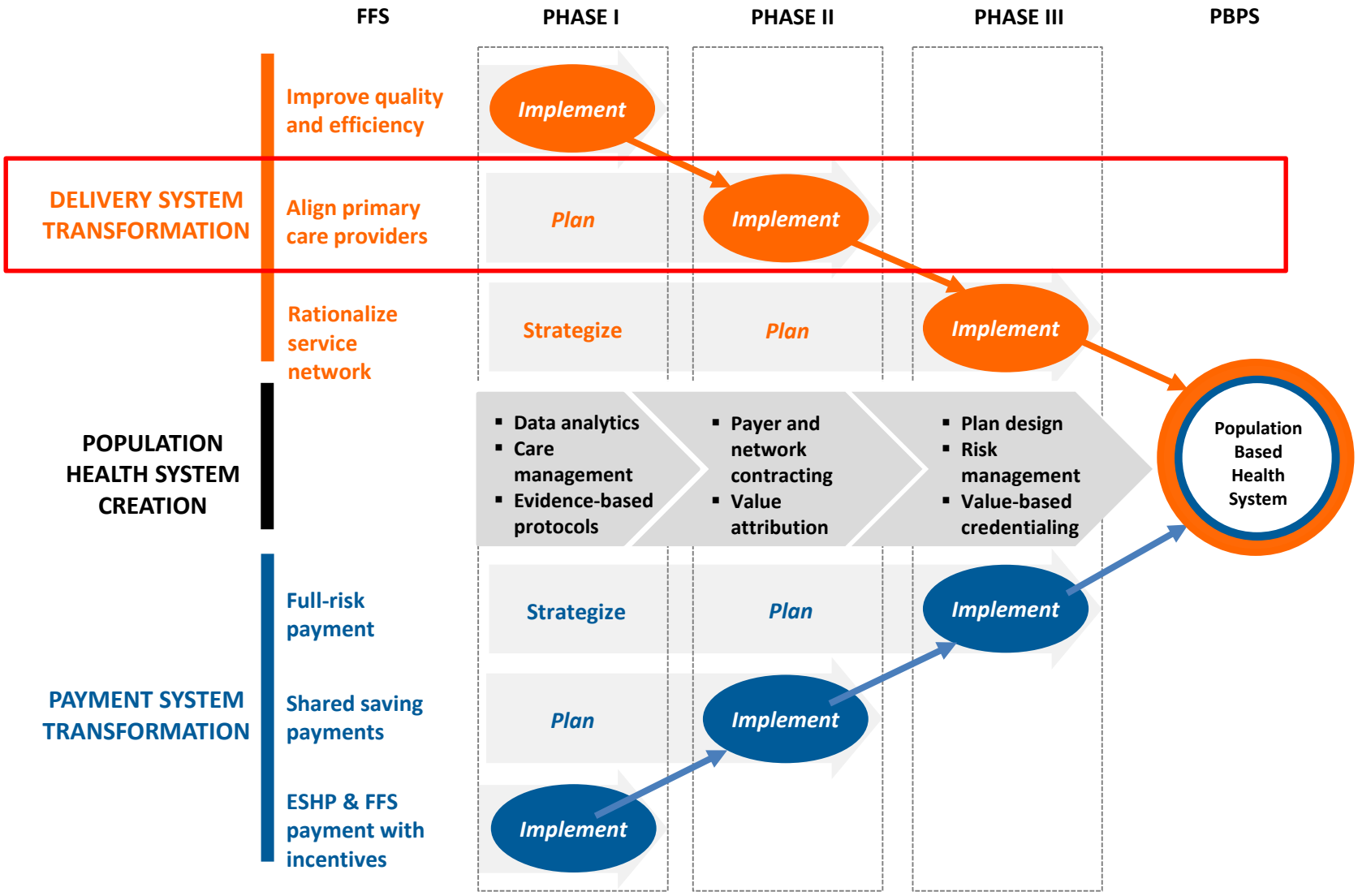
- Focus on Quality and Patient Safety
  - As a strategic imperative
  - As a competitive advantage

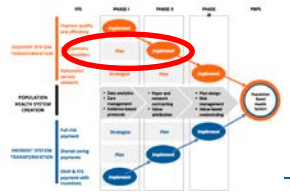
	National Avg.	IL Average	Midwest Medical Center	Mercy Medical Center-Dubuque	UnityPoint Health-Finley	University of Iowa Hospitals & Clinics	University of Wisconsin Hospital and Clinics	FHN Memorial Hospital	OSF Saint Anthony Medical Center
Patient Survey Summary Star Rating:				4	4	3	4	4	3
Patient Satisfaction (HCAHPS) Average:	**71%**	**72%**	**78%**	**76%**	**73%**	**70%**	**76%**	**70%**	**68%**
Nurses "Always" communicated well:	80%	81%	77%	85%	82%	79%	83%	79%	78%
Doctors "Always" communicated well:	82%	82%	87%	82%	82%	77%	84%	81%	80%
"Always" received help when wanted:	69%	69%	75%	75%	67%	59%	65%	66%	60%
Pain "Always" well controlled:	71%	72%	71%	74%	69%	65%	72%	74%	70%
Staff "Always" explained med's before administering:	65%	65%	65%	69%	64%	62%	69%	66%	63%
Room and bathroom "Always" clean:	74%	75%	88%	77%	78%	74%	78%	72%	69%
Area around room "Always" quiet at night:	62%	62%	73%	63%	59%	51%	66%	65%	46%
YES, given at home recovery information:	87%	87%	94%	90%	92%	92%	91%	91%	87%
"Strongly Agree" they understood care after discharge:	52%	53%	62%	59%	56%	53%	57%	48%	52%
Gave hospital rating of 9 or 10 (0-10 scale):	72%	72%	80%	80%	74%	73%	82%	71%	69%
YES, definitely recommend the hospital:	72%	71%	86%	84%	77%	80%	84%	61%	73%

Best Score
Better than State
Worse than State
Worst Score

Source: www.hospitalcompare.hhs.gov

Transition Framework



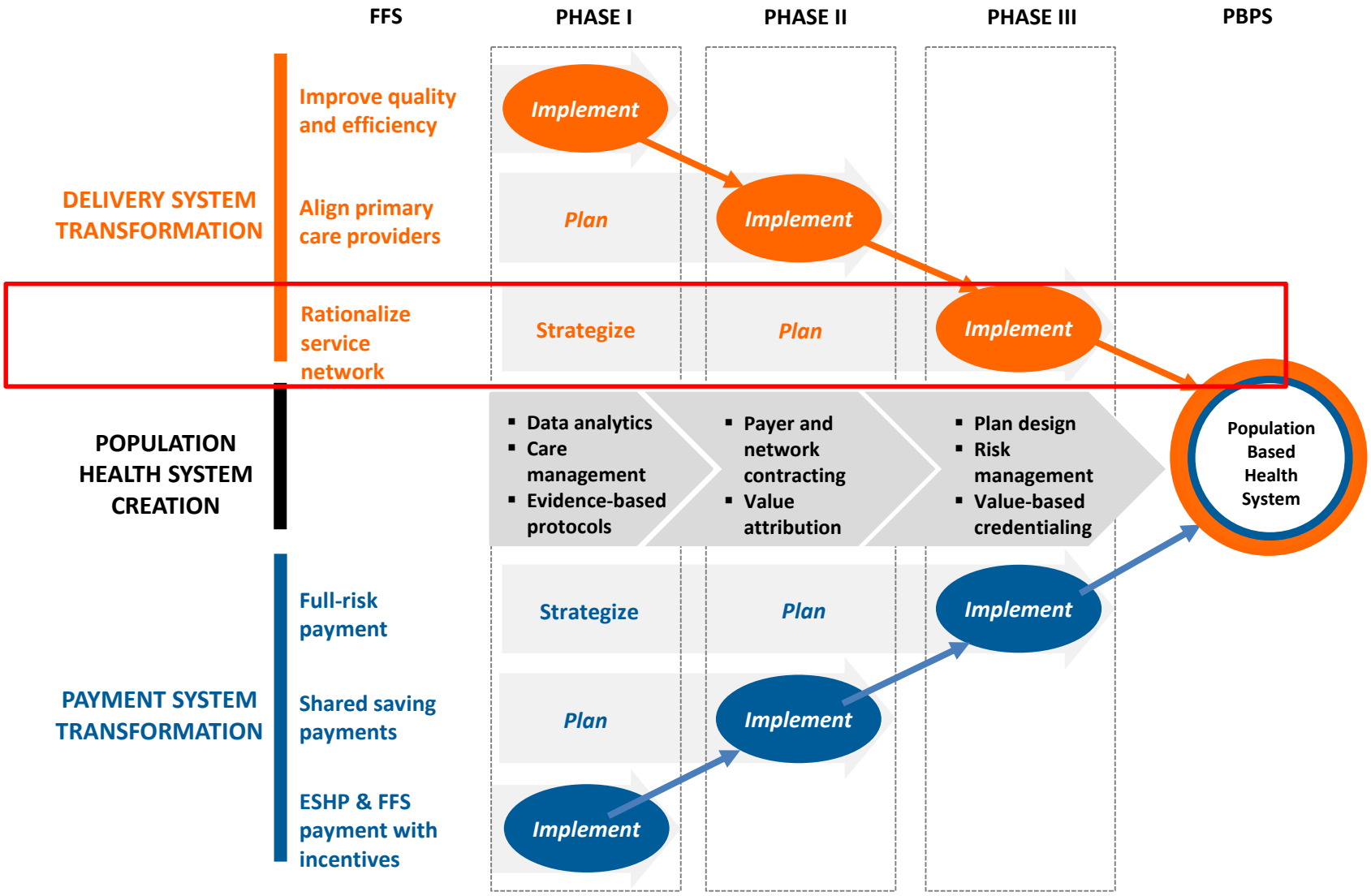


Delivery System Initiative II - Primary Care Alignment

- **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 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

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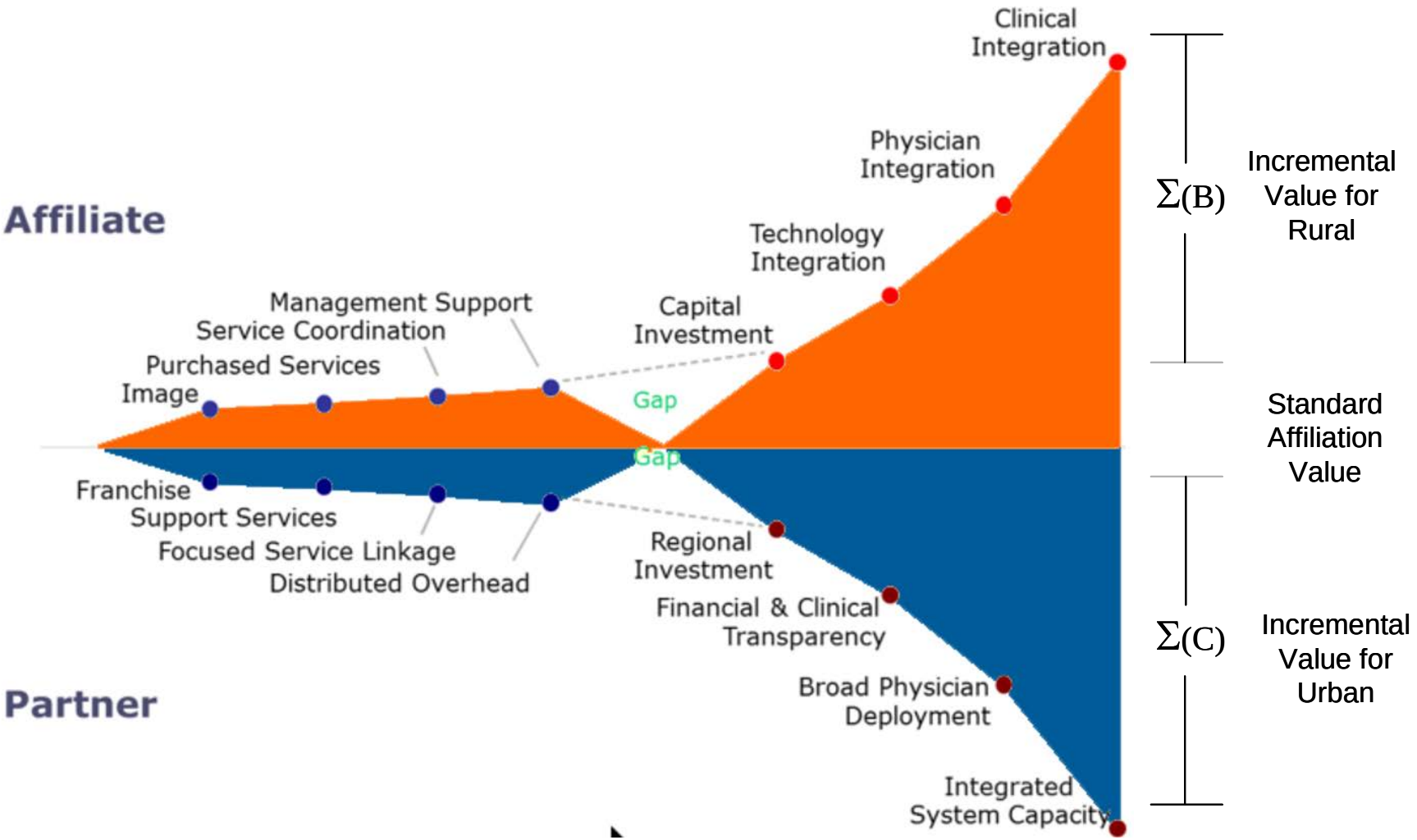
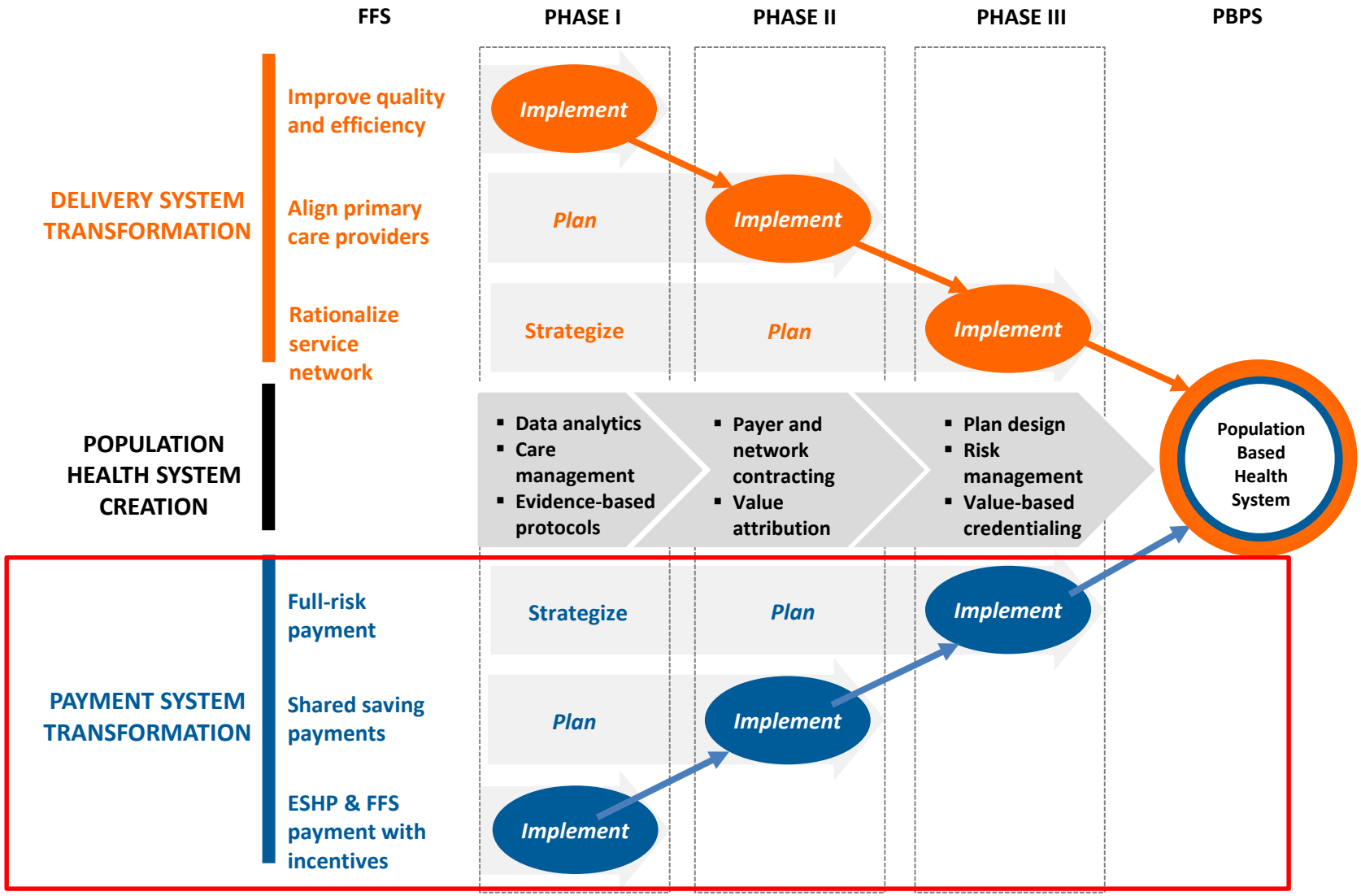
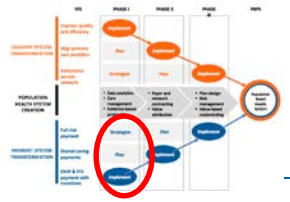
- Affiliation Value Curve



Transition Framework – What Is It?





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.)

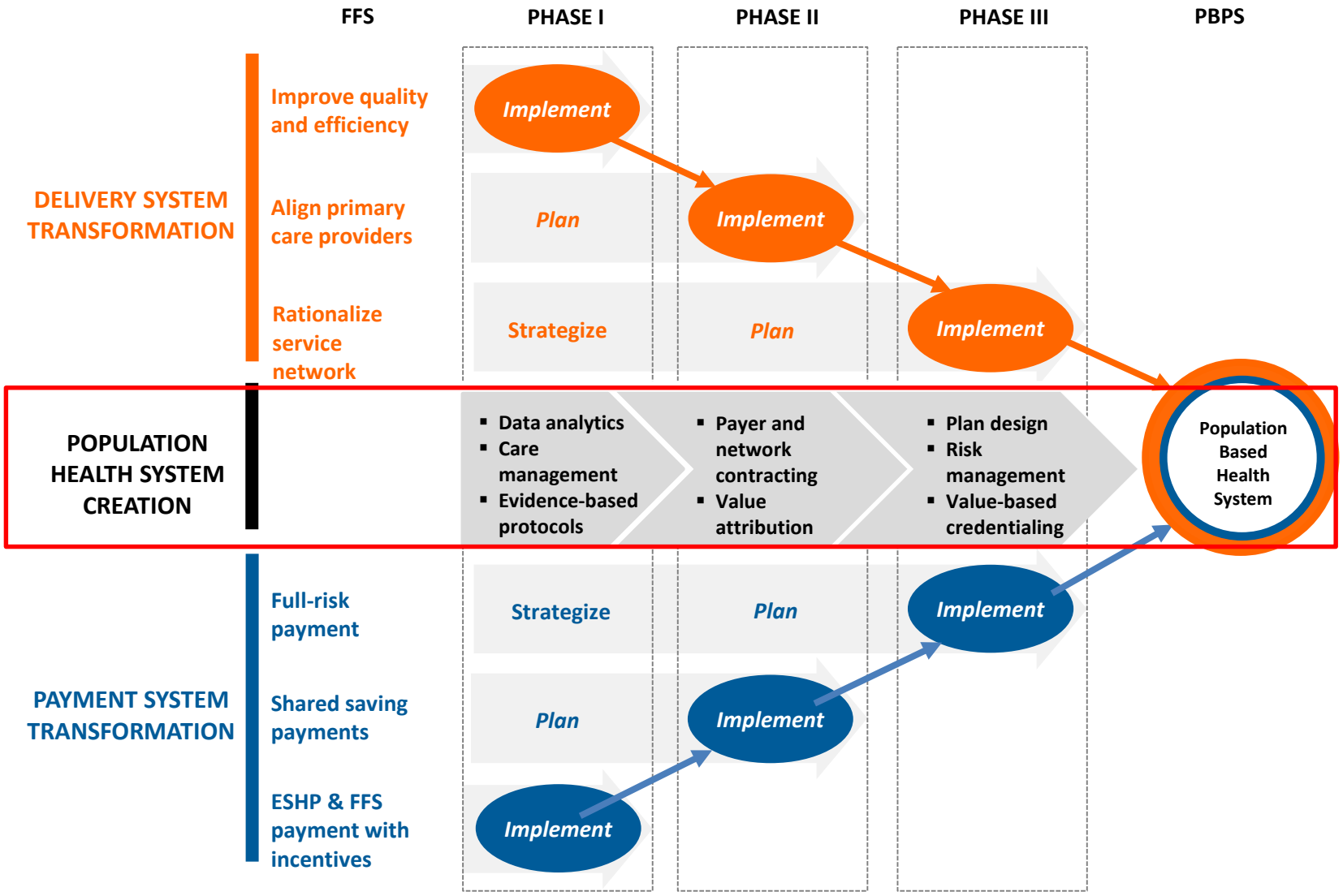
Payment System Strategy Initiatives II &III

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



Population Health Strategies – Phase I

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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

	CAH Meetings	LAN
Learning and Education	• Major focus on State updates • Education provided by State and external presenters	• State and national market updates shared • Education provided by State and external presenters
Networking and information sharing	• Professional networking is key component to foster information sharing	• Professional networking is key component to foster information sharing
Performance Benchmarking	• *Not traditionally supported*	• Performance benchmarking used to harvest best / leading practices
Collaborative Problem Solving	• *Not traditionally supported*	• Team-based performance improvement focused on shared core priority areas
Analytics	• *Not traditionally supported*	• Support of specific analytics-driven projects

LAN Concept

Learning and Action Network (LAN)
The Group of CAHs and their Curriculum and Activities

Learning

Sharing of operational best practices and improvement outcomes

Monitoring of state and national rural trends

Action

Hospital-level performance improvement action plans

Improvement concepts spread across the CAH

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

	Learning	Action
CAHs	• Sharing of best practices • Initiative presentations	• Participation in Initiative(s) • Initiative measurement
Stroudwater	• Didactic presentations • Sharing of best practices • Benchmarking	• Expert technical assistance • LAN Initiative facilitation
State Partner	• Onsite meeting logistics • Onsite meeting facilitation	• LAN Initiative monitoring • Measurement development

PDSA Methodology

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1

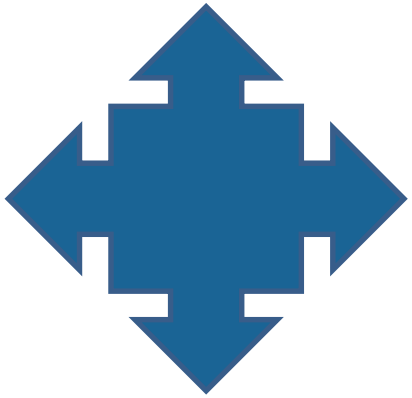
Plan

What are the initiative objectives, predictions and plan for the cycle?

4

Act

How can the cycle be spread, and what are the outcomes?



2

Do

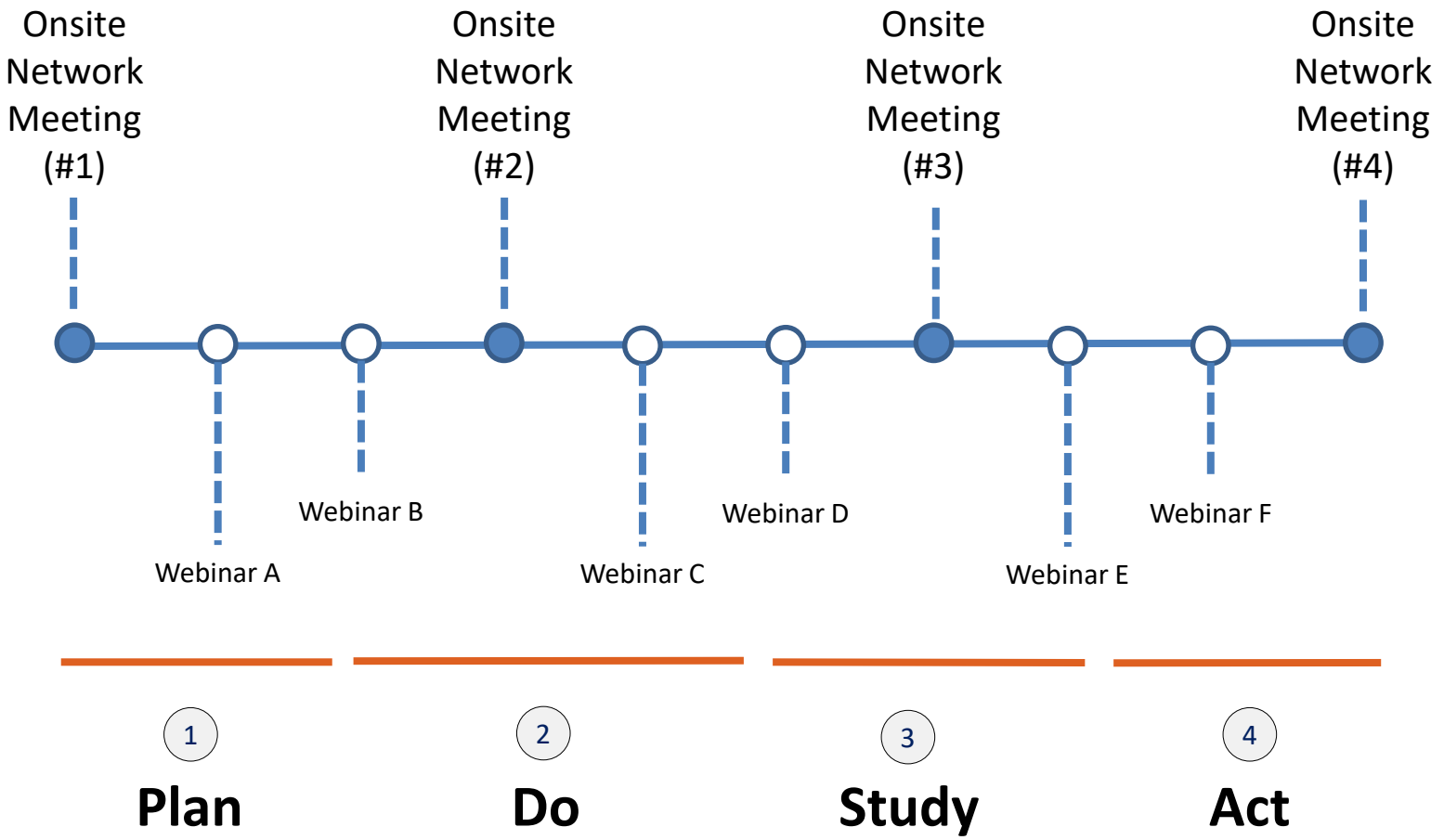
Carry out the plan, start data analysis, test predictions and sharing of best practices

3

Study

Summarize learnings, complete analysis and test predictions

PDSA Sample Timeline (9 months)



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

TASK FORCE NAME	Swing Bed
CO – LEADERS	Theresa Aversano & Nate Smith
PURPOSE *(Overall charge, purpose, or focus)*	Elevate quality and cost effectiveness of the swing bed program to position CAHs as the subacute provider of choice
DELIVERABLES *(Products the Task Force is asked to produce.)*	• 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 *(Meeting frequency and attendance, promote NY LAN activities, review meeting materials, time commitments)*	• 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

	October '16	November '16	December '16	January '17
LAN Activities	10/14 Service Line & Rev Cycle Finance & Productivity	**11/18**		Service Line, Rev Cycle & Provider Alignment TBD Finance, Productivity & ED Rev Cycle, POND?

Activities:
Actions and Meetings

Key	LAN Meeting	Advisory Council Call	Task Force Call/ Meeting	Data Submission

2 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

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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)

Action Plan 1				
Issue				
Goal				
#	What is the Action Step?	Who is the Driver?	By When?	Follow-Up and Next Steps
1.				
2.				
3.				
4.				
5.				

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

Act: Capstone Presentation

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

	Quality	Finance / Operations	# CAHs
Alabama	X		4
Hawaii	X	X	9
Massachusetts		X	3
Mississippi		X	32
New York	X	X	18
North Carolina	X_1	X	21
Tennessee	X	X	14
Virginia	X	X	7

Notes:

- LANs are supported through the Medicare Rural Hospital Flexibility (Flex) Program
- $_1$ Stroudwater supports only the Finance / Operations LAN

LAN Benefits

What are the Benefits of a LAN?

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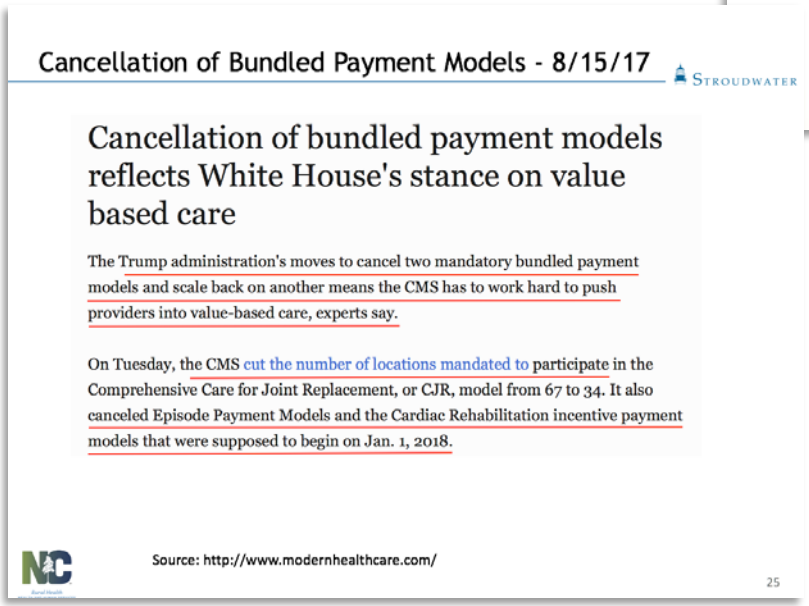
1. Learning and Education
2. Networking and information sharing
3. Performance Benchmarking
4. Collaborative Problem Solving
5. Analytics

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

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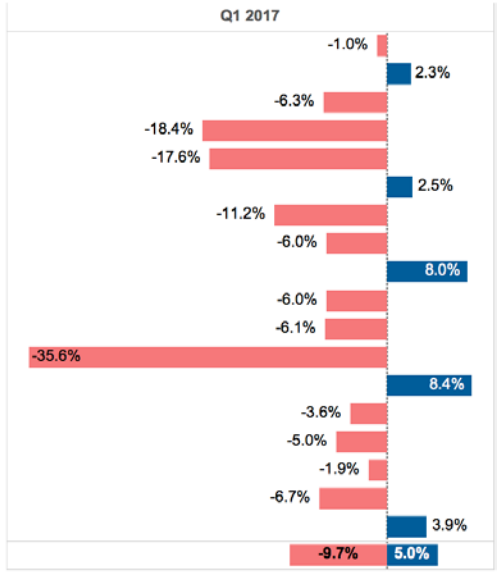
Percent Operating Margin

Select Finance Metric: % Operating Margin

Select Benchmark:
- Regional CAH Benchmark
- State Rural Benchmark
- (•) Target Benchmark

Regional CAH Benchmark	State Rural Benchmark	Target Benchmark
0.5%	-0.4%	2.0%

	% Operating Margin								Variance from Target Benchmark
	YTD 2014	YTD 2015	YTD 2016	Q1 2016	Q2 2016	Q3 2016	Q4 2016	Q1 2017	Q1 2017
Hospital A	-29.2%	-11.8%	-3.8%	3.1%	-0.9%	-2.3%	-3.8%	1.0%	-1.0%
•	-0.2%	4.4%	4.3%	5.4%	4.3%	4.3%	4.3%	4.3%	2.3%
	-6.6%	-7.1%	4.2%	-12.0%	-21.9%	-8.1%	4.2%	-4.3%	-6.3%
•	-6.4%	0.9%	-10.4%	0.6%	-6.2%	-6.3%	-10.4%	-16.4%	-18.4%
	-27.4%	-12.8%	-15.6%	-7.8%	-9.7%	-15.6%	-15.6%	-15.6%	-17.6%
•	4.2%	5.8%	8.1%	5.0%	7.0%	9.8%	8.1%	4.5%	2.5%
	1.7%	7.5%	-3.1%	-7.1%	-8.5%	-3.4%	-3.1%	-9.2%	-11.2%
•	-16.4%	-5.6%	-4.0%	-6.1%	-3.5%	-4.0%	-4.0%	-4.0%	-6.0%
	-8.3%	-6.7%	-8.1%	-15.0%	-11.3%	-11.1%	-8.1%	10.0%	8.0%
•	-0.1%	-3.8%	-3.8%	-3.2%	-2.5%	-3.2%	-3.8%	-4.0%	-6.0%
	-10.1%	-20.2%	-1.2%	6.9%	1.6%	-1.4%	-1.2%	-4.1%	-6.1%
•	-10.0%	-25.0%	-40.5%	-13.9%	-23.6%	-29.8%	-40.5%	-33.6%	-35.6%
	-17.2%	-20.7%	25.5%	100.0%	52.3%	37.3%	25.5%	10.4%	8.4%
•	1.9%	6.9%	5.2%	9.8%	5.0%	5.2%	5.2%	-1.6%	-3.6%
	-21.3%	-6.1%	-13.0%	-24.8%	-18.6%	-16.1%	-13.0%	-3.0%	-5.0%
	-1.2%	-11.2%	2.6%	-8.5%	4.4%	3.0%	2.6%	0.1%	-1.9%
	-3.2%	-4.9%	-4.7%	-9.1%	-7.5%	-4.7%	-4.7%	-4.7%	-6.7%
UHS Delaware Valley Hospital	-0.4%	4.4%	6.3%	8.6%	6.8%	6.2%	6.3%	5.9%	3.9%
Average	-8.3%	-5.9%	-2.9%	1.8%	-1.8%	-2.2%	-2.9%	-3.6%	-5.6%



Blue bar is desired variance

Performance Benchmarking: Staff Efficiency

Inpatient Nursing

Select Productivity Metric

Paid IP Nursing Hours per Day

Hospital A

-
-
-
-
-
-
-
-

Target Benchmark

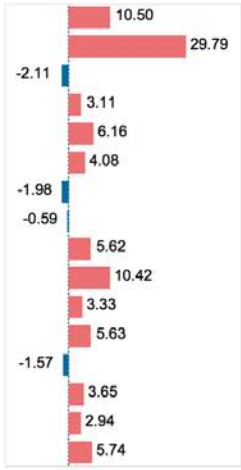
12.00

Paid IP Nursing Hours per Day

2016												2017		
Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar
19.94	15.59	16.11	18.49	20.20	18.92	26.89	28.60	27.23	24.13	27.30	27.26	25.43	22.24	19.82
19.16	29.09	45.96	25.39	75.09	24.91	25.39	75.09	24.91	25.39	75.09	24.91	25.39	75.09	24.91
10.11	9.46	9.08	9.83	9.44	15.05	9.32	10.17	11.25	10.24	9.84	11.76	8.55	11.43	9.69
15.19	15.56	14.39	21.72	21.95	16.66	18.56	16.93	14.72	23.46	16.71	20.59	13.68	14.76	16.88
19.61	25.77	26.96	12.46	13.71	14.61	14.26	17.19	23.02	14.26	17.19	23.02	14.26	17.19	23.02
19.38	20.61	22.11	20.72	20.99	28.96	17.99	19.96	26.17	17.99	19.96	26.17	16.16	12.58	19.49
8.22	7.42	9.82	10.04	13.04	12.37	10.93	8.53	9.90	8.91	7.85	11.21	11.55	9.33	9.17
11.76	13.19	16.99	13.60	9.89	16.04	13.24	10.96	10.04	13.24	10.96	10.04	13.24	10.96	10.04
24.60	13.13	13.22	13.98	13.43	14.97	24.85	17.13	14.57	13.41	16.91	14.95	20.52	17.85	14.49
19.75	15.90	16.67	21.51	24.71	19.98	23.30	17.66	20.64	23.30	17.66	20.64	21.32	20.24	25.72
8.61	13.25	10.36	12.36	15.23	12.22	13.57	12.35	15.32	15.82	17.87	16.11	11.34	18.28	16.36
24.50	25.98	17.21	30.10	18.35	46.89	39.62	19.03	16.51	39.62	19.03	16.51	17.63	19.75	15.49
8.73	9.75	9.31	9.50	11.43	16.88	11.36	10.74	12.27	15.70	16.34	16.89	13.44	9.52	8.31
10.19	12.67	16.88	10.96	10.22	12.28	13.83	17.48	15.79	11.93	14.70	17.86	16.82	14.23	15.91
18.63	21.34	12.29	18.16	12.80	16.91	17.96	13.53	13.34	17.96	13.53	13.34	17.96	13.53	13.34
16.98	16.21	18.87	28.66	28.43	23.01	21.16	24.28	22.33	21.16	24.28	22.33	15.94	17.70	19.58

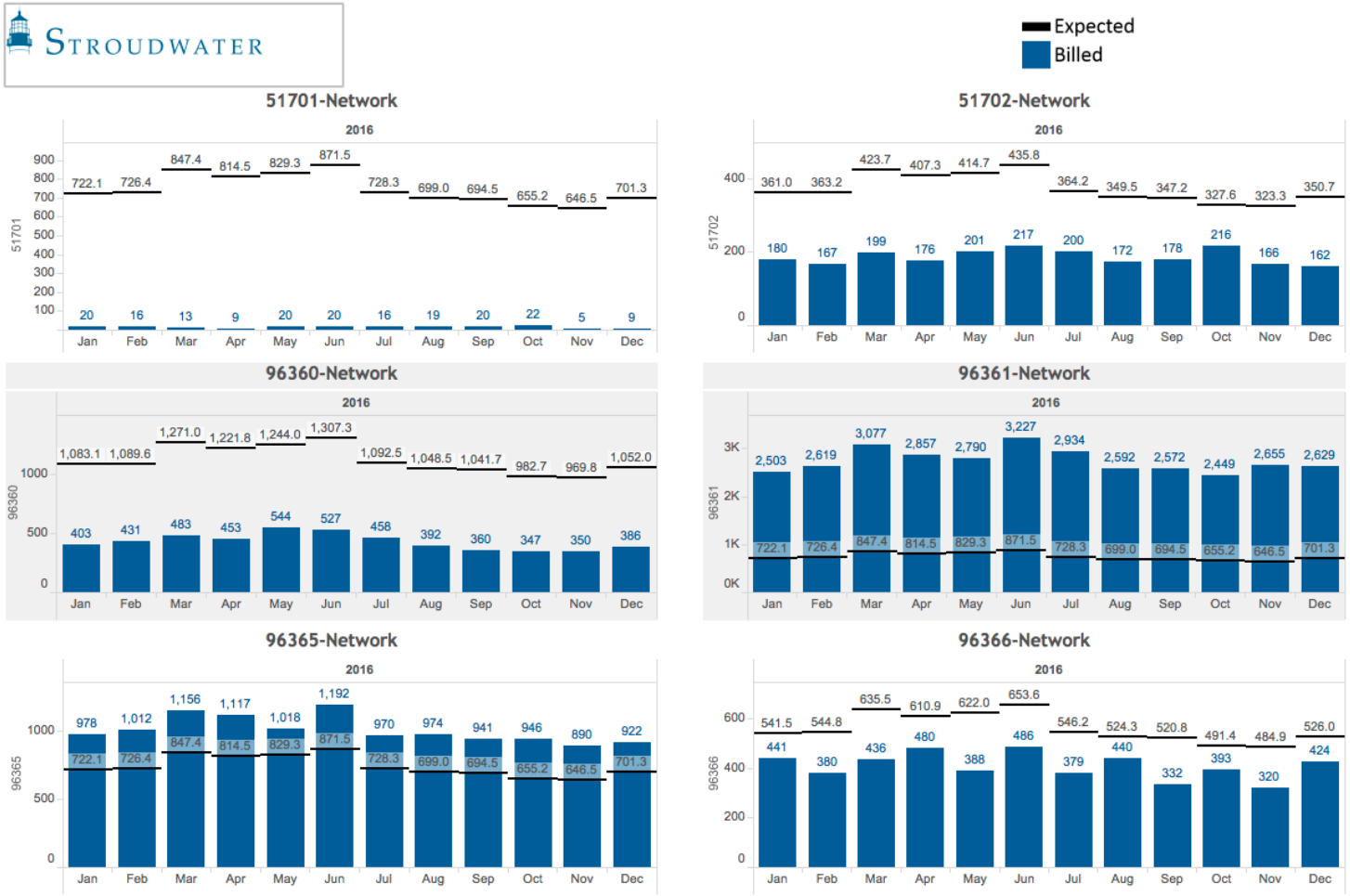
3 Month Avg & Variance From Target Benchmark

3 Month Avg	3 Month Variance
22.50	10.50
41.79	29.79
9.89	-2.11
15.11	3.11
18.16	6.16
16.08	4.08
10.02	-1.98
11.41	-0.59
17.62	5.62
22.42	10.42
15.33	3.33
17.63	5.63
10.43	-1.57
15.65	3.65
14.94	2.94
17.74	5.74



Blue bar is desired variance

Performance Benchmarking: ED Revenue Cycle



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

				NYS Critical Access Hospital			Key
	KPI	Calculation	Bench Mark Target				
				Comments	Jan	Feb	Mar
Financial/Outcome Measures							
	A/R > 90 Days	$ Value of AR >90 / Total Gross AR	20%				
	Gross Cash Collections to Total Revenue	Total Cash Collected / Total Revenue	Facilty Specific				
	Bill Hold Days	Days bill are held until sent on complete	3 days				
	Percentage of unbilled receivables	Gross Unbilled Accounts Receivable / Total Gross AR	< 10%				
	Average Daily Revenue in Held Medical Records	Did Not Final Bill AR / (Total Gross Rvenue / Days in Period)	5 days				
	Registration error Rate	# of registation errors / # of patients registered	2%				
	Bad Debt % to Gross Revenue	Bad Debt Expense / Gross Patient Revenue	2.50%				
	Charity % to Gross Revenue	Charity Care Write-offs / Gross Patient Revenue	2.50%				
	Days in Gross Accounts Receivable	(Gross Patient Accounts Receivable / Gross Patient Revenue) / # of days in period	45				
	Days in Net Accounts Receivable	(Net Patient Accounts Receivable / Net Patient Revenue) / # of days in period	45				
Process Measures							
	Percentage of clean claims from bill editor	# of clean billed claims / # of total billed claims	95%	3rd party system to scrub claims			
YES	Up-front Deductible and Co-payment collections	Point of Service Collections (for patient care services) / Net Patient Revenue	Facility Specific	Point of Service Collection - $ or % What would the total deductable been - high deductable insurance issue			

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CAH Swing Bed Program Best Practices Checklist

PROGRAM DEVELOPMENT

- ☐ Dedicated Swing Bed coordinator
- ☐ Dedicated contact number, email and fax
- ☐ Create pre- admissions screening form and admission checklist including DME needs, discharge plan and insurance verification process
- ☐ Create basic admission order sets
- ☐ Education on teach back and AskMe 3
- ☐ Develop activities program
- ☐ Education on Effective Coding and Documentation

MARKETING and PROMOTION

- ☐ Referral source data collection
- ☐ Develop brochure, advertise open house, in person visits
- ☐ Track all transfers from IP and ED for potential SB admission
- ☐ Ensure employed and/or local PCPs understand the value of the CAH Swing Bed program
- ☐ Transitional Care Management coding for Swing Bed discharges
- ☐ Relationship with local tertiary facility for daily lists of patients ready for discharge (BAA)

CLINICAL PROCESSES and OUTCOMES

- ☐ Interdisciplinary team review
- ☐ Interdisciplinary huddles at least twice a week and at discharge
- ☐ Pharmacist at bedside for med teaching
- ☐ Meds to Bed
- ☐ Follow-up appointments made at discharge
- ☐ Discharge Follow-up calls 24-48 hours after discharge
- ☐ Family and patient part of discharge planning

PERFORMANCE MONITORING

- ☐ Barthel index on admission, weekly and at discharge
- ☐ Utilize readmission risk assessment
- ☐ Develop dashboard to include at a minimum: ALOS, ADC, Cost per episode, Readmissions within 30 days

LEADERSHIP DEVELOPMENT and ACCOUNTABILITY

- ☐ Hospital management has explicitly established Swing Beds as a strategic priority
- ☐ Establish Swing Beds as a formal Department for performance measurement and accountability
- ☐ Provide ongoing leadership development training to Swing Bed manager

Swing Bed Performance Improvement Initiative

Swing Bed Performance Improvement Goals

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- 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.

Barthel Index Classification System

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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**

Swing Bed Average Change in Score

Category: Deconditioned / Disposition: Home

Top #: Score
Bottom #: # of Cases

Average Change in Score by Quarter

Hospital	Deconditioned 2016 Q2	2016 Q3	2016 Q4	2017 Q1
	10.00 1	30.77 13	28.75 12	34.92 14
		1	2	
	33.33 3	19.44 9	16.25 4	27.73 11
	20.00 1	37.50 4		35.20 25
	28.33 3	30.00 8		12.65 17
	33.89 9	37.92 24	25.00 6	
	45.00 3	38.13 8	40.00 9	38.46 13
		7.14 7	21.33 6	
	-15.00 2	36.00 5	33.57 7	32.14 7
			21.67 10	-13.00 5

Difference from Target Score of 15

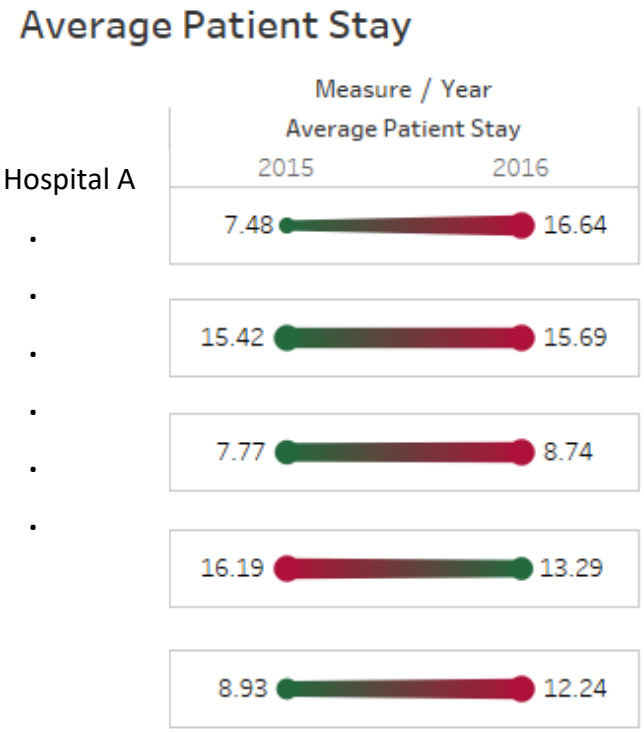
Hospital	Deconditioned 2016 Q2	2016 Q3	2016 Q4	2017 Q1
	-5.00	15.77	13.75	19.92
	18.33	4.44	1.25	12.73
	5.00	22.50		20.20
	13.33	15.00		-2.35
	18.89	22.92	10.00	
	30.00	23.13	25.00	23.46
		-7.86	6.33	
	-30.00	21.00	18.57	17.14
			6.67	-28.00

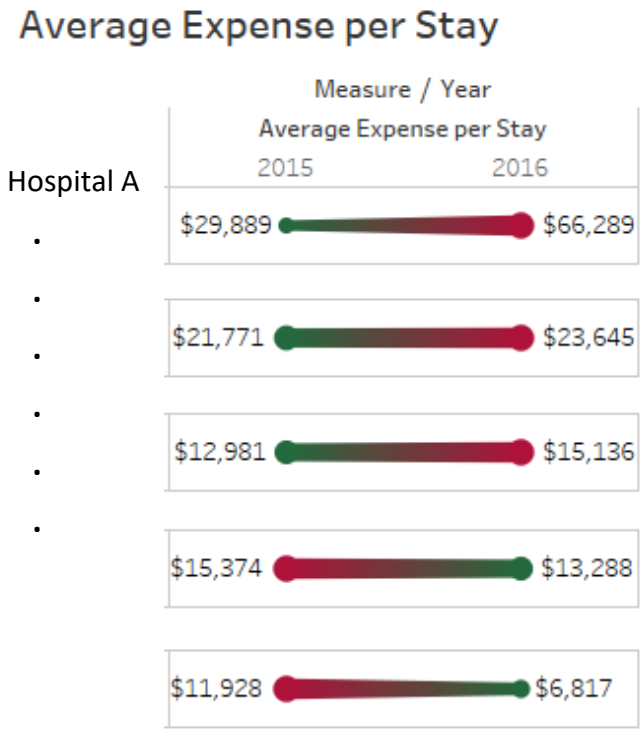
Difference between Change in Score & Target

Target Score = improvement of 15+ points

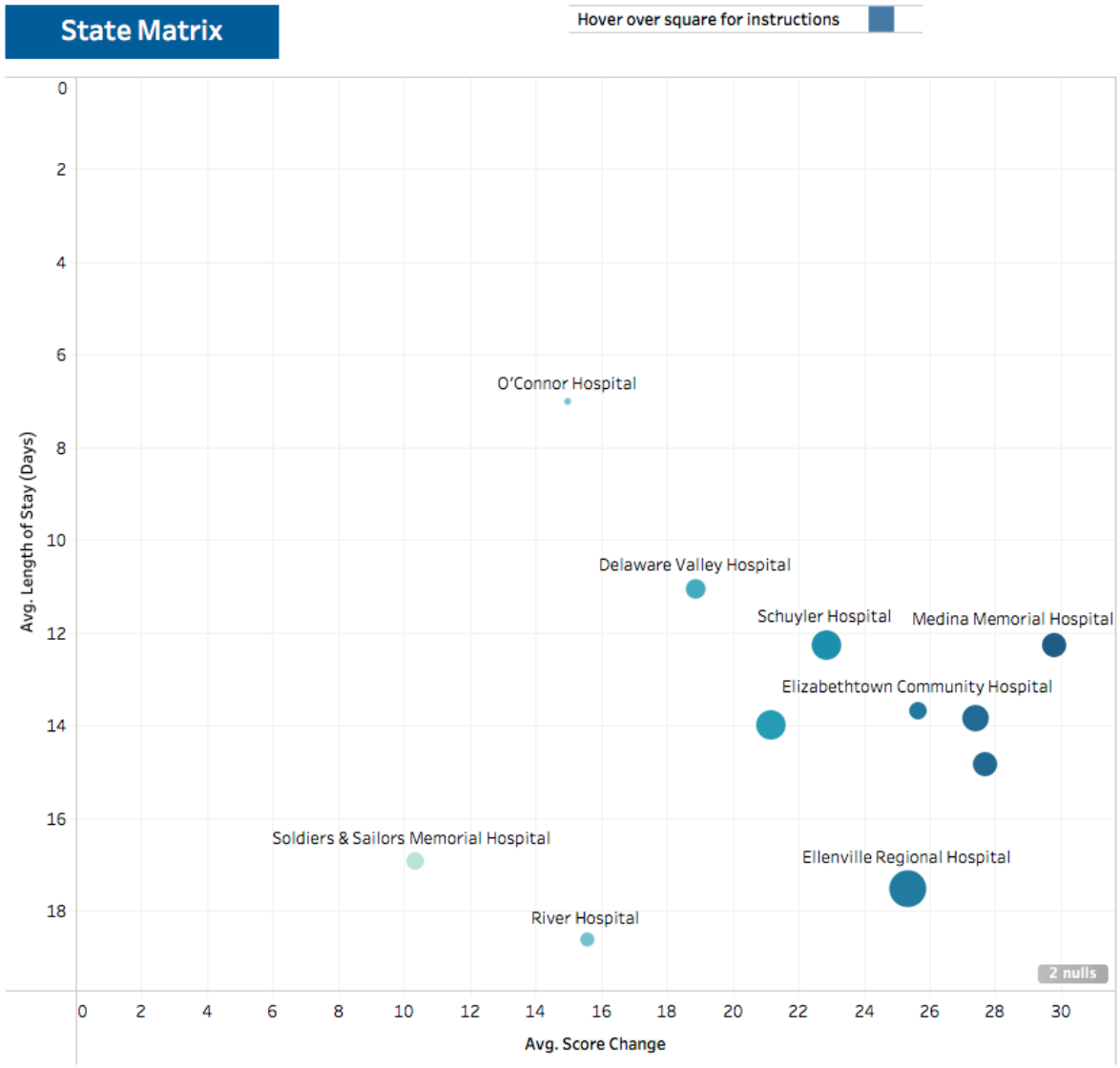
Low — High

Swing Bed Average Stay and Expense per Stay





State Comparative Matrix Example



Individual Hospital Dashboard Example

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Swing Bed Dashboard

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Avg Change in Score

Disposition	Diagnosis Cate..	2016 Q2	2016 Q3	2016 Q4	2017 Q1	2017 Q2
AMA	Deconditioned				0.0	
Deceased	Deconditioned					-25.0
	Neuro					0.0
	Ortho					-35.0
Home	Deconditioned	33.9	37.9	25.7	23.8	25.3
	Neuro	60.0	47.5	20.0	30.0	10.0
	Ortho	55.0	39.0	34.7	30.0	33.3
Transferred to Higher Level Care	Deconditioned	-40.0		2.5	5.6	-3.6
	Neuro			0.0	-5.0	
	Ortho	-30.0				5.0
Transferred to LTC/SNF	Deconditioned	-50.0	12.5	5.0	2.5	5.0
	Neuro				-5.0	
	Ortho					

Difference from Target Score of 15

Hospital	Disposition	Diagnosis Cate..	2016 Q2	2016 Q3	2016 Q4	2017 Q1	2017 Q2
	AMA	Deconditioned				-15.0	
	Deceased	Deconditioned					-40.0
		Neuro					-15.0
		Ortho					-50.0
	Home	Deconditioned	18.9	22.9	10.7	8.8	10.3
		Neuro	45.0	32.5	5.0	15.0	-5.0
		Ortho	40.0	24.0	19.7	15.0	18.3
	Transferred to Higher Level Care	Deconditioned	-55.0		-12.5	-9.4	-18.6
		Neuro			-15.0	-20.0	
		Ortho	-45.0				-10.0
	Transferred to LTC/SNF	Deconditioned	-65.0	-2.5	-10.0	-12.5	-10.0
		Neuro				-20.0	
		Ortho					

Number of Cases

Hospital	Disposition	Diagnosis Ca..	2016 Q2	2016 Q3	2016 Q4	2017 Q1	2017 Q2
	AMA	Deconditio..				1	
	Deceased	Deconditio..					1
		Neuro					1
		Ortho					1
	Home	Deconditio..	9	24	22	25	20
		Neuro	1	4	2	2	1
		Ortho	3	21	19	5	9
	Transferred to Higher Level Care	Deconditio..	1	2	5	8	7
		Neuro			1	1	
		Ortho	1	3			4
	Transferred to LTC/SNF	Deconditio..	1	5	3	2	3
		Neuro		2		1	
		Ortho		1			

Network Average

Disposition	Diagnosis C..	2016 Q2	2016 Q3	2016 Q4	2017 Q1	2017 Q2
AMA	Deconditio..				0.0	
Deceased	Deconditio..					-25.0
	Neuro					0.0
	Ortho					-35.0
Home	Deconditio..	33.9	37.9	25.7	23.8	25.3
	Neuro	60.0	47.5	20.0	30.0	10.0
	Ortho	55.0	39.0	34.7	30.0	33.3
Transferred to Higher Level Care	Deconditio..	-40.0		2.5	5.6	-3.6
	Neuro			0.0	-5.0	
	Ortho	-30.0				5.0
Transferred to LTC/SNF	Deconditio..	-50.0	12.5	5.0	2.5	5.0
	Neuro				-5.0	
	Ortho					

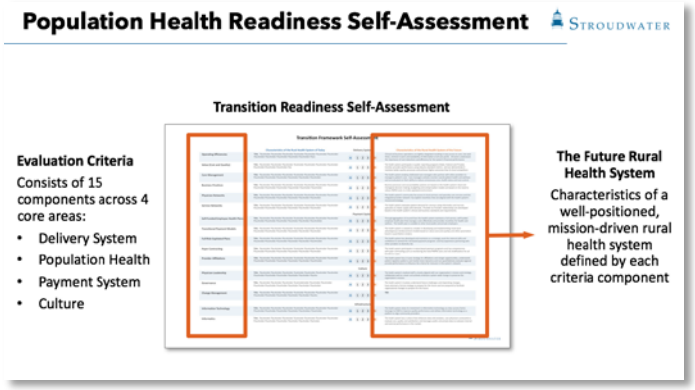
Average Expense per Stay

2015	2016
$21,771	$23,645

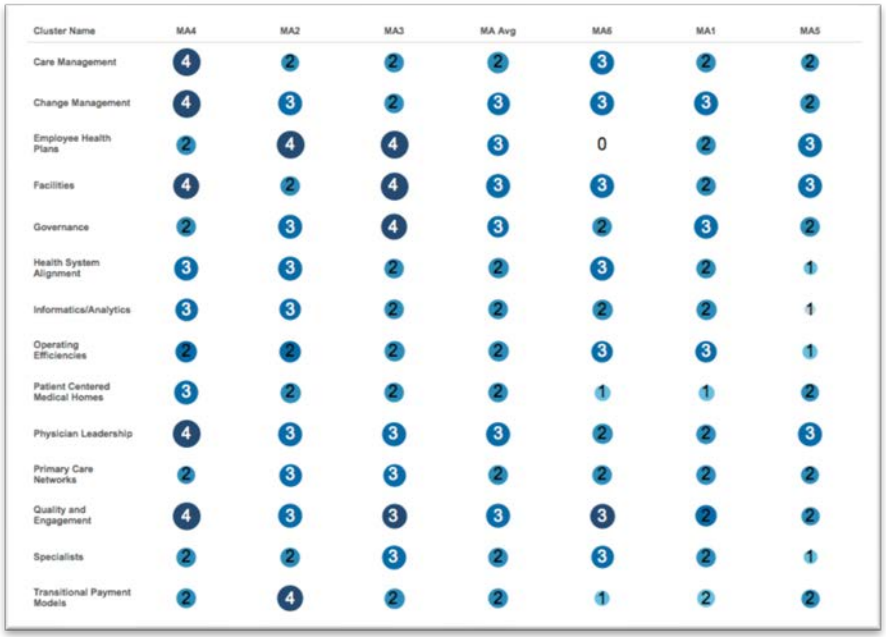
Average LOS

2015	2016
15.42	15.69

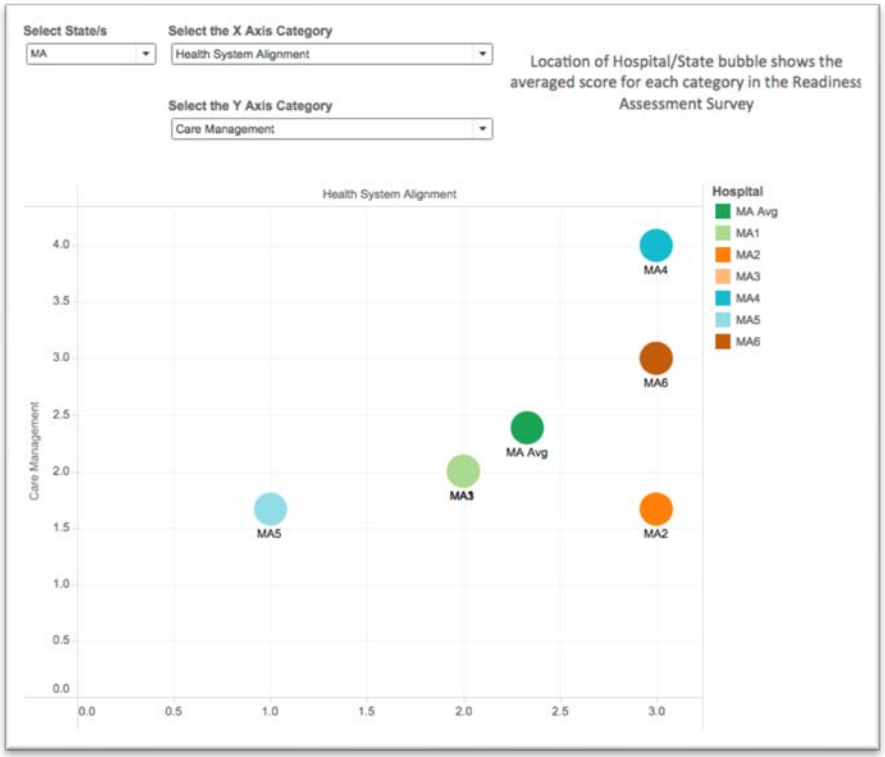
5. Benefits: Analytics



- Population Health Transition Readiness Self-Assessment
- Comparative Services Matrix
- CAH Value to System



Cluster Name	MA4	MA2	MA3	MA Avg	MA6	MA1	MA5
Care Management	4	2	2	2	3	2	2
Change Management	4	3	2	3	3	3	2
Employee Health Plans	2	4	4	3	0	2	3
Facilities	4	2	4	3	3	2	3
Governance	2	3	4	3	2	3	2
Health System Alignment	3	3	2	2	3	2	1
Informatics/Analytics	3	3	2	2	2	2	1
Operating Efficiencies	2	2	2	2	3	3	1
Patient Centered Medical Homes	3	2	2	2	1	1	2
Physician Leadership	4	3	3	3	2	2	3
Primary Care Networks	2	3	3	2	2	2	2
Quality and Engagement	4	3	3	3	3	2	2
Specialists	2	2	3	2	3	2	1
Transitional Payment Models	2	4	2	2	1	2	2



CAH Value to Systems Analysis

Delivery System Initiative III - Rationalize Service Network

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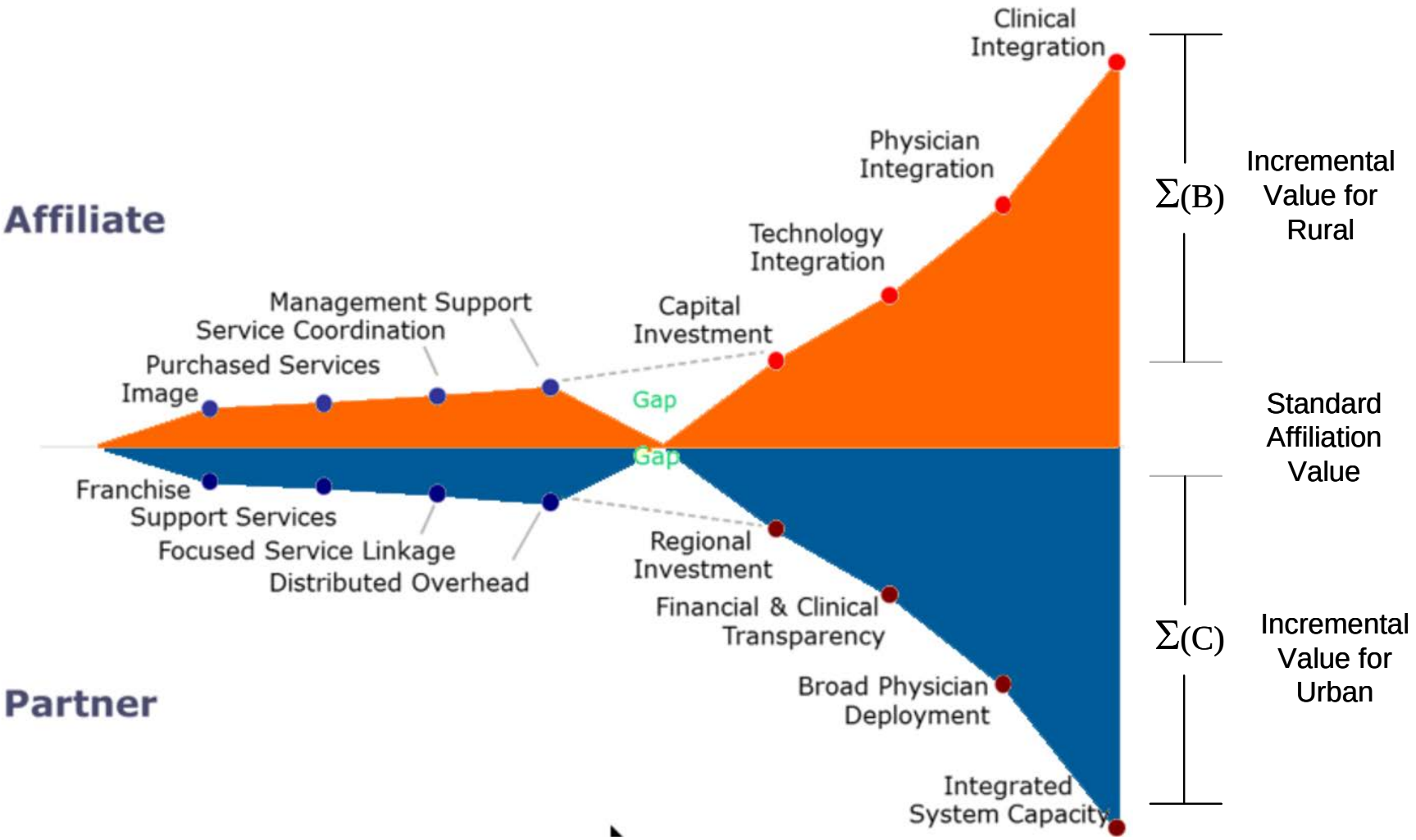
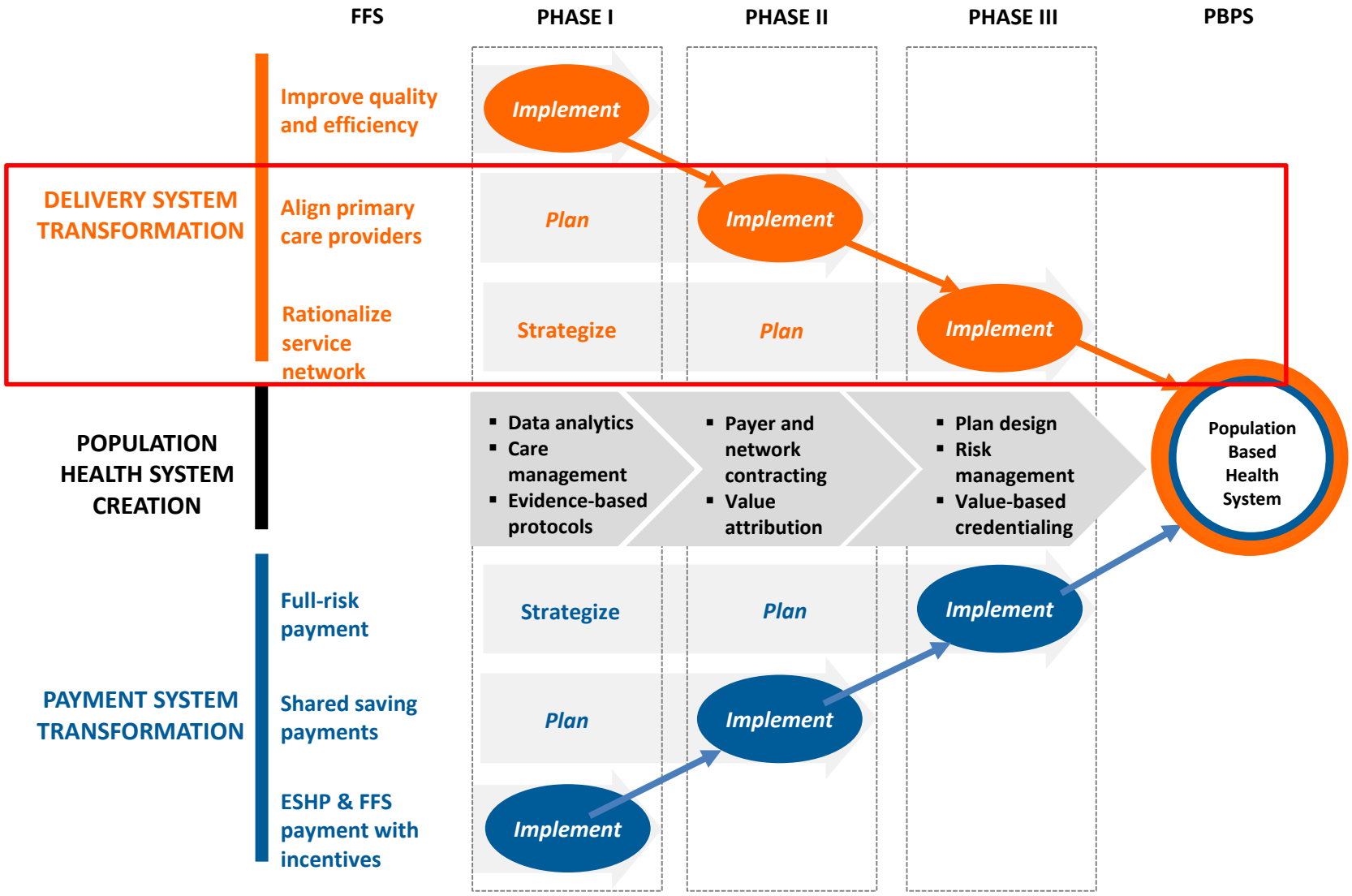
- Affiliation Value Curve



Transition Framework



Value Categories

ECONOMIC	STRATEGIC	INTANGIBLE
Financial Performance	Scale/Attributed Lives	Branding/Reputation
Indirect Cost Allocations	**Primary Care**	Goodwill
Transfer Benefits	Clinical Integration	
Transfer Opportunity Costs	Human Capital	

Our Study

Future Hospital Financial Value Equation

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Primary Care

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

Future Hospital Financial Value Equation

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Primary Care

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	*Medicare Cost Report (2016)*
What are the accounting-based efficiencies from the affiliation?	Indirect Cost Allocations	*Medicare Cost Report (2016)*
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

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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

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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

Contribution Margin Analysis

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South Carolina Rural Affiliate Contribution Margin Analysis

2016 Financial performance	SC A	SC B	SC C	SC D	SC E
Rural Affiliate Statement of Operations (Source: KH Analysis)					
Total Operating Revenue	$ 39,737,221	$ 13,635,103	$ 12,343,984	$ 13,030,807	$ 21,451,598
Total Operating Expense	42,735,138	14,455,788	14,174,360	16,066,226	22,658,749
Operating Income (Loss)	**(2,997,917)**	**(820,685)**	**(1,830,376)**	**(3,035,419)**	**(1,207,151)**
Depreciation Expense	1,946,750	405,496	429,637	550,486	871,772
Non Operating Income	1,834,999	904,109	1,407,192	2,652,099	2,211,203
Net Income Less Depreciation Expense	**$ 783,832**	**$ 488,920**	**$ 6,453**	**$ 167,166**	**$ 1,875,824**
Indirect Cost Allocations to CAH Affiliates:					
Estimated Administrative and General Costs	$ 6,272,971	$ 1,941,620	$ 1,790,760	$ 1,508,320	$ 2,928,385
Cost-Based Payer Mix	45.00%	45.00%	45.00%	45.00%	45.00%
Net Increase in CAH Cost Based Reimbursement	**2,822,837**	**873,729**	**805,842**	**678,744**	**1,317,773**
Net Income Less Depreciation Expense Plus Fixed Allocated Costs	**$ 3,606,669**	**$ 1,362,649**	**$ 812,295**	**$ 845,910**	**$ 3,193,597**
Transfer Benefits					
Total 2016 Est. Discharges for Rural Affiliate Service Area (Source: Truven Health)	1,659	1,055	1,030	1,539	1,736
Current Partner Medicare Market Share (Source: 2016 CMS Data)	58%	22%	38%	42%	38%
Estimated Partner Discharges from Rural Affiliate Service Area	969	231	397	641	655
Estimated Partner Net Revenue Per Discharge (Source: AHD.com; 2017 Data)	$ 13,711	$ 8,556	$ 11,160	$ 14,941	$ 11,406
Estimated Partner Net Inpatient Revenue from Rural Affiliate Service Area	$ 13,283,151	$ 1,979,283	$ 4,424,960	$ 9,577,146	$ 7,465,424
Partner OP Rev relative to IP Revenue (2015 Cost Report WS G-2)	191%	109%	162%	64%	109%
Estimated Net OP Rev From Rural Affiliate Service Area	$ 25,409,038	$ 2,159,766	$ 7,178,618	$ 6,088,494	$ 8,146,167
Total Net Transfer / Referral Dollars to Partner from Rural Affiliates	$ 38,692,189	$ 4,139,049	$ 11,603,578	$ 15,665,640	$ 15,611,591
Estimated Contribution Margin % (Source: Estimated)	80%	80%	80%	80%	80%
Estimated Contribution Margin on Net Revenue from Rural Affiliate Service Area	$ 30,953,751	$ 3,311,239	$ 9,282,862	$ 12,532,512	$ 12,489,272
Contribution Margin Per 1% of Inpatient Market Share	$ 530,121	$ 151,060	$ 241,239	$ 300,901	$ 331,280
Estimated Change in Market Share % with Competitive Entry into Rural Affiliate Market	**10%**	**10%**	**10%**	**10%**	**10%**
CM from Loss of existing or potential gain of Rural Affiliate SA Market Share	**$ 5,301,208**	**$ 1,510,602**	**$ 2,412,386**	**$ 3,009,007**	**$ 3,312,804**
Total Benefit / (Cost) to Partner for Rural Affiliates	**$ 8,907,876**	**$ 2,873,251**	**$ 3,224,681**	**$ 3,854,916**	**$ 6,506,402**

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

What your peers are saying…

New York State CAH PI Network

"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

What your peers are saying…

New York State CAH PI Network

"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

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