STROUDWATER

PERFORMANCE IMPROVEMENT BOOTCAMP SESSION 2

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How Market Insights Drive Rural Hospital Performance

PANELISTS

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SIX SESSION SERIES

1 Overview

- Highlight the strategic imperative for improvement, identify areas with the most significant opportunity, and deliver an overview of financial and operational best practices.

2 Reducing Outmigration / Growing Volume

- Reducing leakage and outmigration to grow market share and keep care local has been shown to have the highest ROI across more than 30 performance improvement engagements.
- Identify strategies for evaluating demand, engaging with providers and the community, coordinating with external partners.

3 Cost Report Opportunities

- This session will show how CAHs can use the Medicare cost report as a strategic tool to capture missed revenue opportunities and strengthen financial stability.
- Learn how to leverage the Medicare cost report for performance improvement, identify opportunities, mitigate cash flow risk, and apply best practices for interpretation.

SIX SESSION SERIES

4

Swing Bed Bootcamp

- This session provides leaders with a hands-on, interactive overview of swing bed programs, covering compliance, care quality, financial performance, and growth strategies.
- Gain practical insights on regulatory requirements, care planning, program optimization, financial impact, and marketing strategies.

5

340B Programs

- The 340B Drug Pricing Program continues to evolve rapidly, with new manufacturer actions, rebate models, and regulatory changes reshaping how covered entities approach savings and program compliance.
- Identify opportunities to optimize program performance, evaluate pharmacy models, and anticipate emerging trends.

6

Revenue Cycle Deep Dive

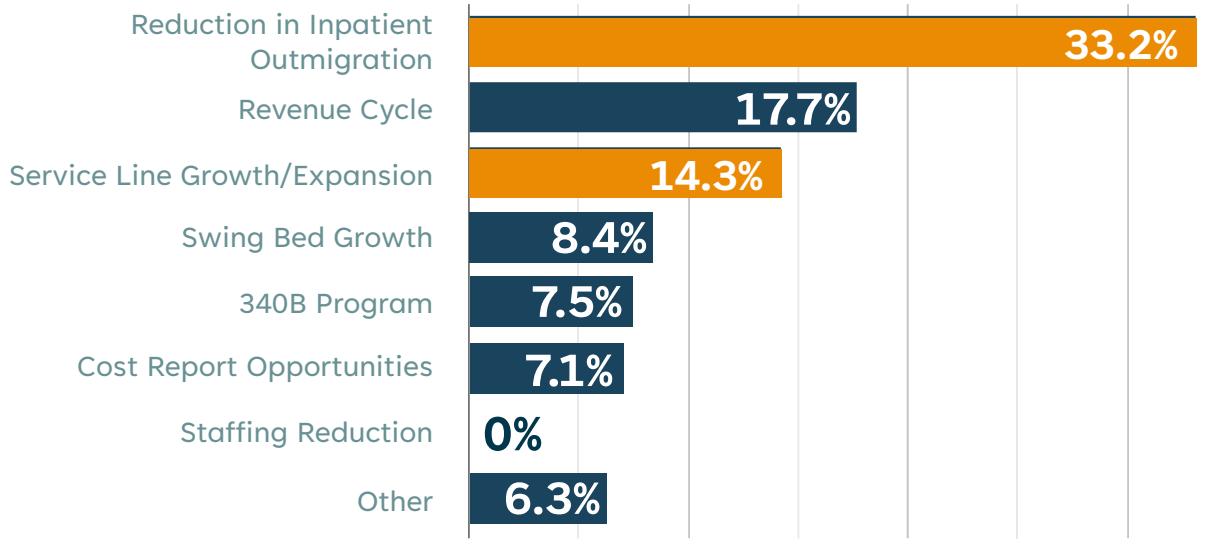
- Strong revenue cycle performance requires intentional strategy, collaboration, and, above all, cross-functional leadership support.
- Identify strategies to engage leaders, align key performance indicators with organizational goals, and apply real-world practices to drive sustainable revenue cycle improvements.

PROVEN RETURN ON INVESTMENT

$1.7M

For nearly 30 hospitals participating in financial and operational assessments, the median value of financial improvement identified was approximately $1.7m, equating to nearly 8% of net patient revenue

The improvements were identified across several functional areas – expressed as a percentage of the total improvements identified:



"Stroudwater's depth of wisdom and genuine passion for rural healthcare made all the difference. Their humility and expertise ensured immediate results but also laid the groundwork for sustained success."

| **Kevin DeRonde,** Mahaska Health CEO

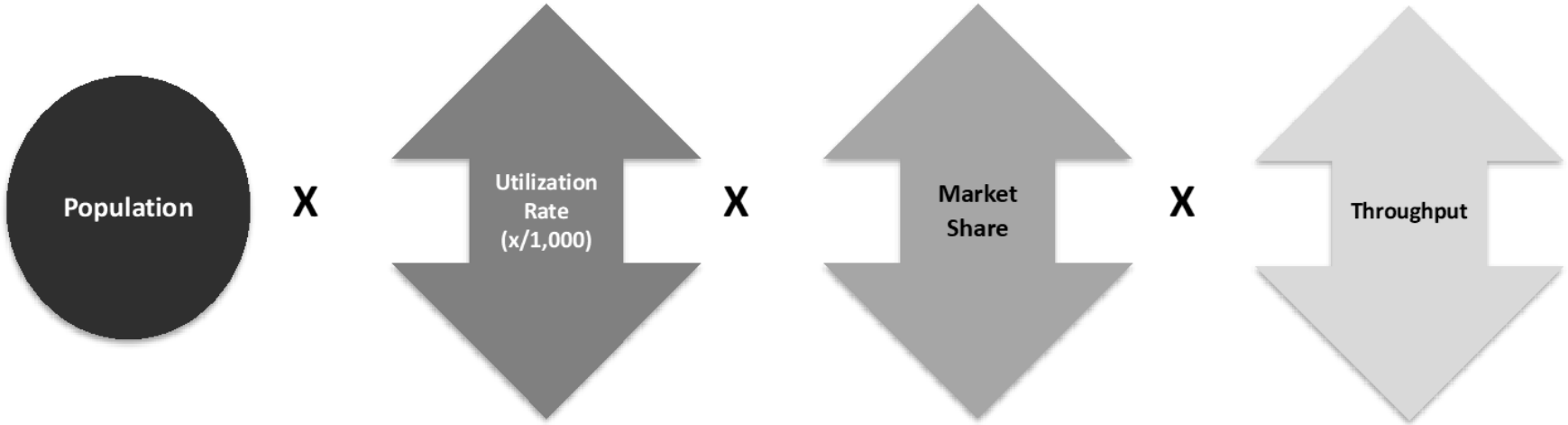
LEARNING OBJECTIVES

- Learn how to evaluate the market opportunity
  - Population
  - Demographics
  - Utilization

- Calculate the value of capturing the “low hanging fruit”
  - Growing market share of services you’re already providing
  - Differentiating needs versus wants

- Identify when new services make sense to consider
  - Market volumes
  - Staffing requirements
  - Facility requirements

FOUR LEVERS TO CALCULATING MARKET OPPORTUNITY



- Geography
- Total market
- Aging
- Gender
- Special populations

- Population health strategies
- Insurance issues
- Readmission rate
- IP/OP shift
- Technology

- Competition
- Service offerings
- Insurance Steerage
- Primary care alignment
- Affiliation strategy

- IP/OP shift
- Acuity
- Socioeconomic
- Clinical issues

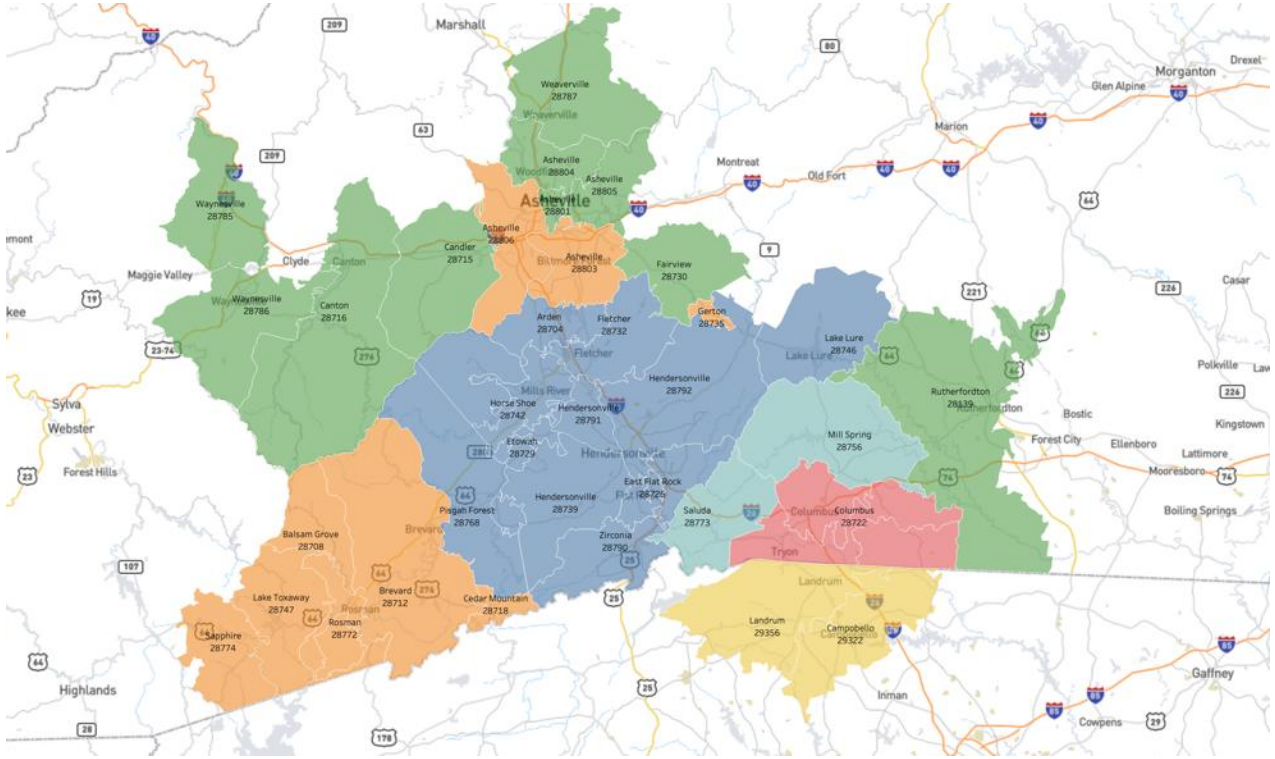
Operating Parameters

Random vs Scheduled | *Confidence Intervals vs Occ %* | *Distinct Unit Types*

Universal vs Specialty | *Observation*

WHAT IS OUR “REAL” SERVICE AREA?

- County vs. district vs. hospital-defined service area
- Are we the dominant provider?
- Should we “subdivide” the service area?
- Who does the project benefit?



DEMOGRAPHICS

- Population projections
- Age distribution
- Special groups
- Market dynamics

UTILIZATION OF HEALTHCARE SERVICES

- Existing volumes
- Inpatient vs outpatient
- Service lines
- Market share

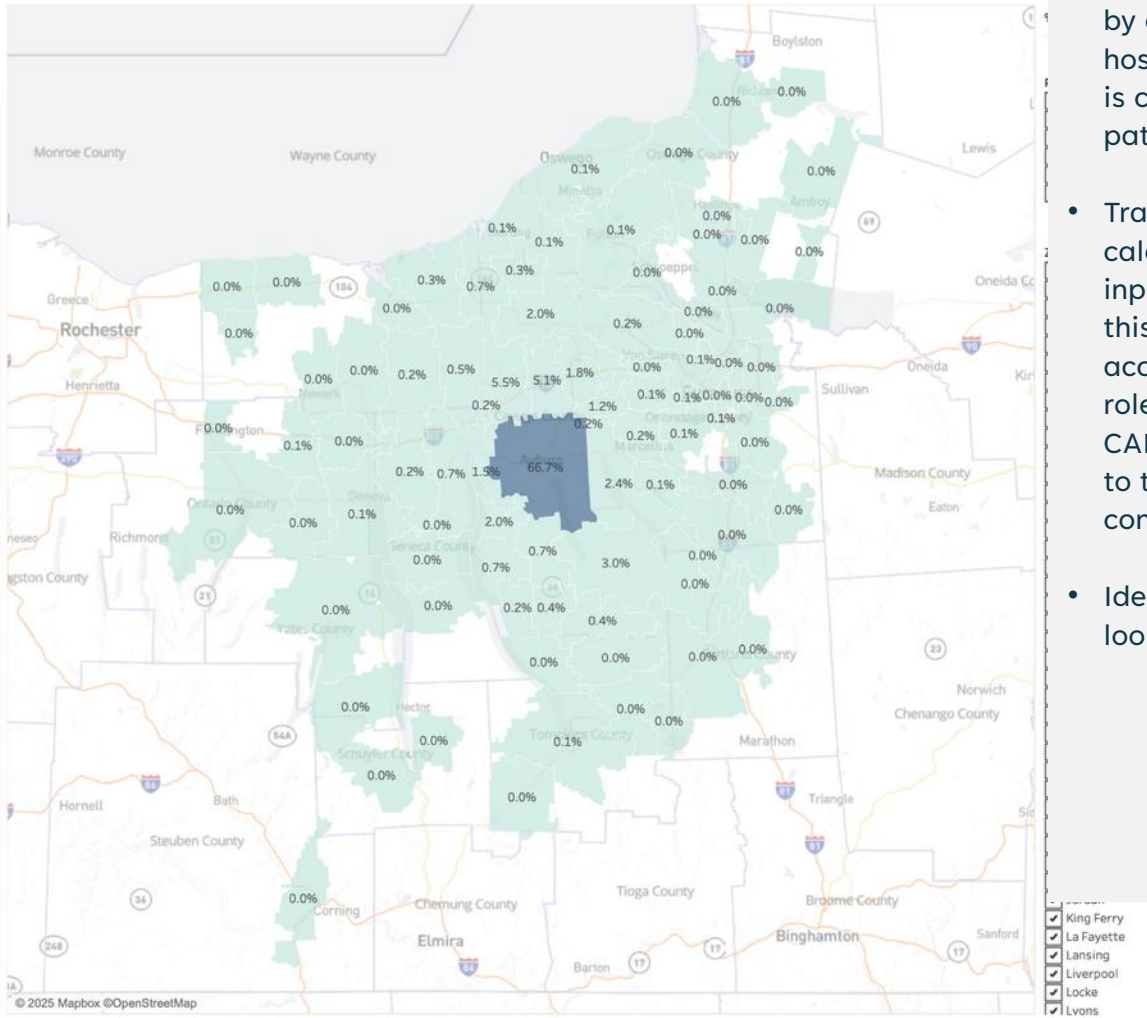
WITH WHOM DO WE COMPETE?

- Hospitals
- Retail marketplace
- Provider groups

IDENTIFY A SERVICE AREA USING PATIENT ORIGIN

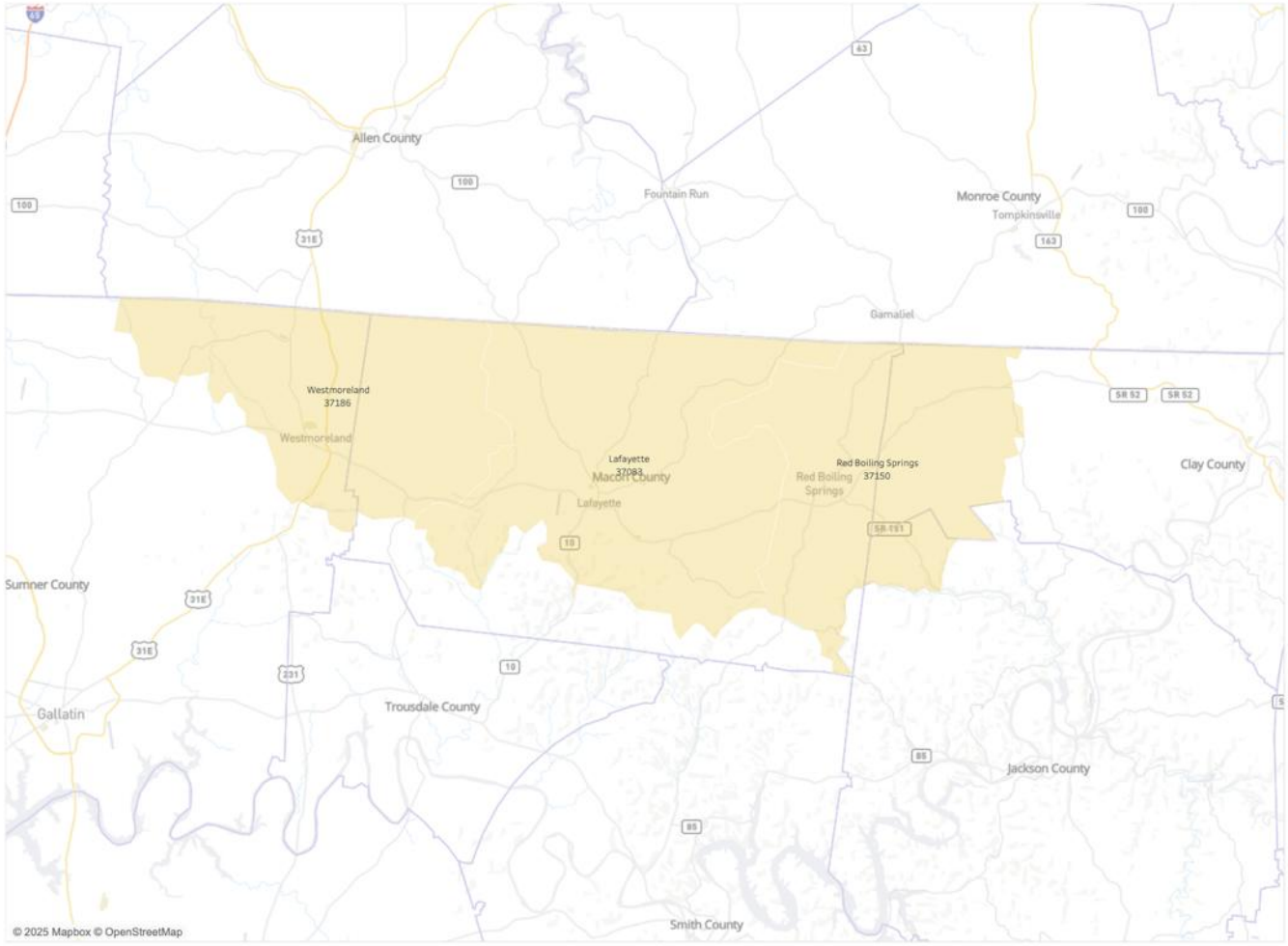
ED Patient Origin

Auburn Service Areas	ZIP Code	ZIP Name	Unit Qty	% of Total	Running Total
Grand Total			24,276	100.0%	100.0%
Primary	Total		20,568	84.7%	84.7%
	13021	Auburn	16,192	66.7%	66.7%
	13140	Port Byron	1,345	5.5%	72.2%
	13166	Weedsport	1,228	5.1%	77.3%
	13118	Moravia	740	3.0%	80.3%
	13152	Skaneateles	574	2.4%	82.7%
	13160	Union Springs	489	2.0%	84.7%
Secondary	Total		2,352	9.7%	94.4%
	13033	Cato	495	2.0%	86.8%
	13080	Jordan	440	1.8%	88.6%
	13034	Cayuga	353	1.5%	90.0%
	13060	Elbridge	280	1.2%	91.2%
	13148	Seneca Falls	181	0.7%	91.9%
	13147	Scipio Center	170	0.7%	92.6%
	13143	Red Creek	166	0.7%	93.3%
	13146	Savannah	133	0.5%	93.9%
	13071	Genoa	86	0.4%	94.2%
	13165	Waterloo	48	0.2%	94.4%
Other	Total		1,356	5.6%	100.0%
	13026	Aurora	178	0.7%	95.1%
	13092	Locke	92	0.4%	95.5%
	14590	Wolcott	83	0.3%	95.9%
	13111	Martville	79	0.3%	96.2%
	13081	King Ferry	58	0.2%	96.4%
	13108	Marcellus	48	0.2%	96.6%
	13153	Skaneateles Falls	45	0.2%	96.8%
	13112	Memphis	42	0.2%	97.0%
	13027	Baldwinsville	41	0.2%	97.2%
	14433	Clyde	39	0.2%	97.3%
	13117	Montezuma	39	0.2%	97.5%
	13126	Oswego	36	0.1%	97.6%
	13110	Marietta	36	0.1%	97.8%
	13069	Fulton	36	0.1%	97.9%
	13156	Sterling	31	0.1%	98.1%
	13031	Camillus	27	0.1%	98.2%
	14456	Geneva	25	0.1%	98.3%
	13074	Hannibal	23	0.1%	98.4%
	13088	Liverpool	18	0.1%	98.4%
	13204	Syracuse	17	0.1%	98.5%
	13215	Syracuse	16	0.1%	98.6%
	13208	Syracuse	16	0.1%	98.6%



- Service area can be defined by others (e.g., county or hospital district), but ideally is calculated using actual patient origin.
- Traditional origin was calculated using 75% of inpatient discharges, but this often fails to take into account the less significant role inpatient care plays in CAHs, and sometimes fails to take into account contiguity,
- Ideally, organizations will look at:
  - Inpatient origin
  - ED origin
  - Clinic origin
  - Ancillary / procedural origin

DEFINE A SERVICE AREA FOR ANALYSIS



Service Area
Primary
Firm Type
Short Term Acute Care Hospital

Sources: Stroudwater analysis; Definitive Healthcare; HRSA

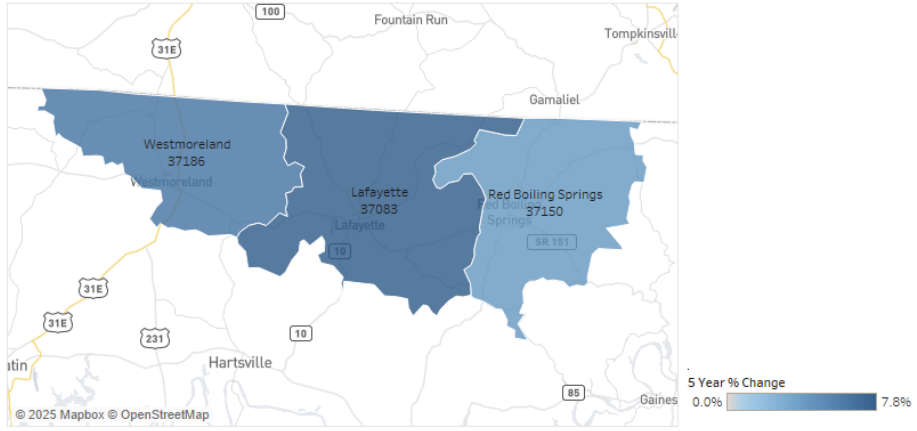
EXAMINE DEMOGRAPHICS

Current	Projected	5 Year Change (#)	5 Year Change (%)
33,451	35,705	2,254	6.7%

Age Group Detail

Age	Current	Projected	5 Year (#)	5 Year (%)
0-17	7,939	8,274	335	4.2%
18-44	11,165	11,924	759	6.8%
45-64	8,402	8,429	27	0.3%
65+	5,945	7,078	1,133	19.1%

5-Year Change (%) by ZIP Code



Source: Claritas 2025

ZIP Code Population Detail

Service Area	ZIP Name	ZIP Code	Current	5yr Est.	# Change	% Change
Primary	Lafayette	37083	17,608	18,978	1,370	7.8%
	Red Boiling Springs	37150	5,019	5,223	204	4.1%
	Westmoreland	37186	10,824	11,504	680	6.3%

- Current and projected population
- Distribution by ZIP code
- Distribution by age cohort
- Additional detail is often helpful:
  - Income
  - Insurance Coverage
  - Health Status

33% OF PERFORMANCE IMPROVEMENT GAINS WERE FROM PREVENTING INPATIENT OUTMIGRATION

- What is the total volume of inpatient discharges / days estimated in the service area?

- What is your hospital able to keep?
  - Service Lines
  - Acuity
  - Staffing competency

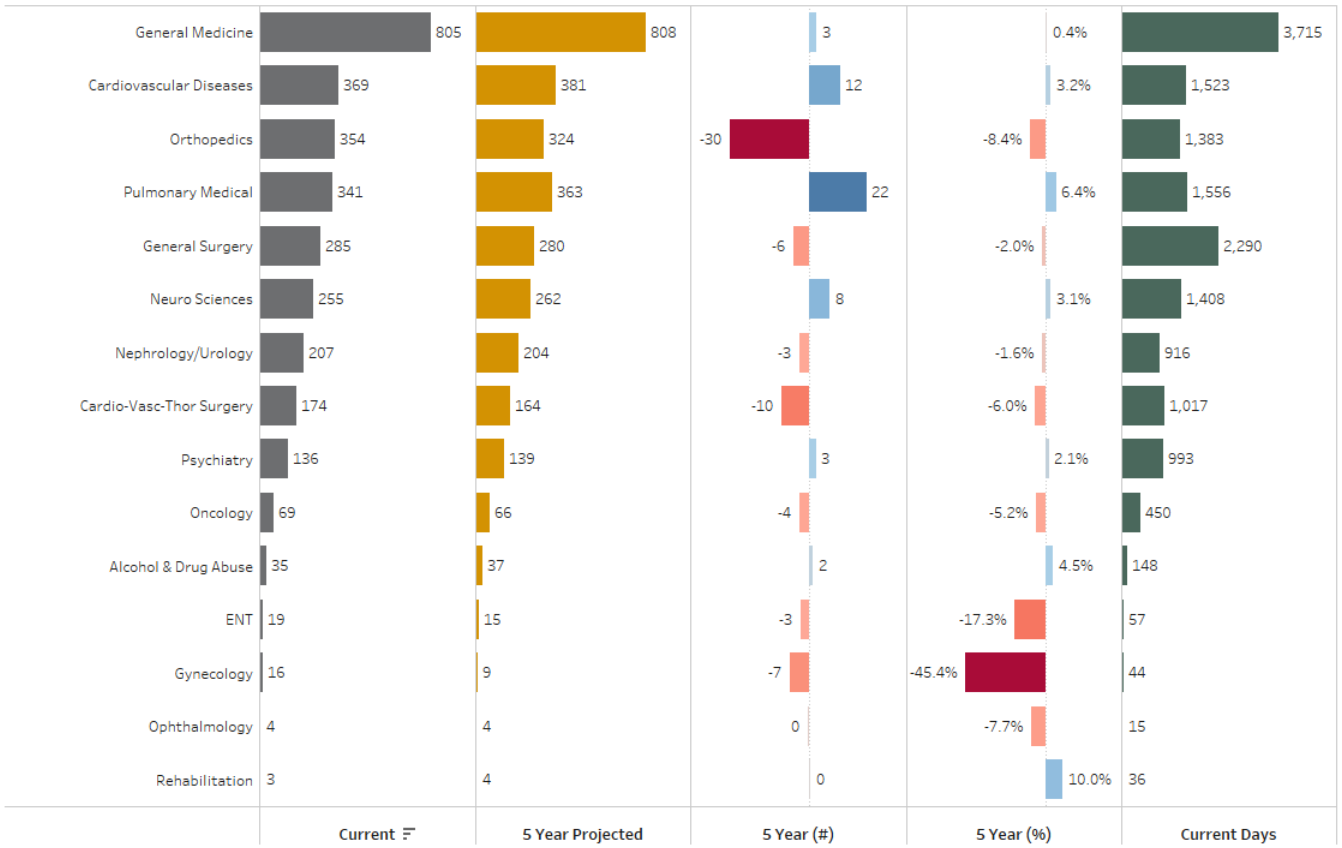
- What is the capacity of your inpatient unit(s)?

- Why are patients not being admitted to your hospital?
  - Never had the chance
  - Patient choice
  - Provider choice
  - Capacity constraints

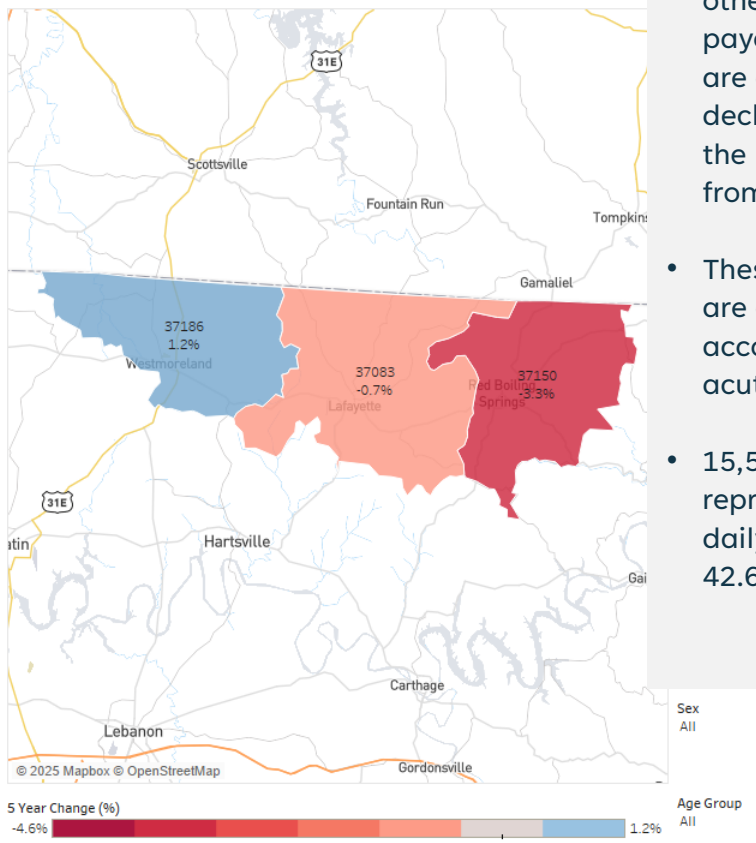
FOR THE PSA…UNDERSTAND THE DEMAND FOR I/P DISCHARGES

Current Discharges	5 Year Projection	5 Year Change (#)	5 Year Change (%)	Current Days
3,073	3,059	-14	-0.5%	15,552

Discharges by Product Line



5-Year Change (%) by ZIP Code



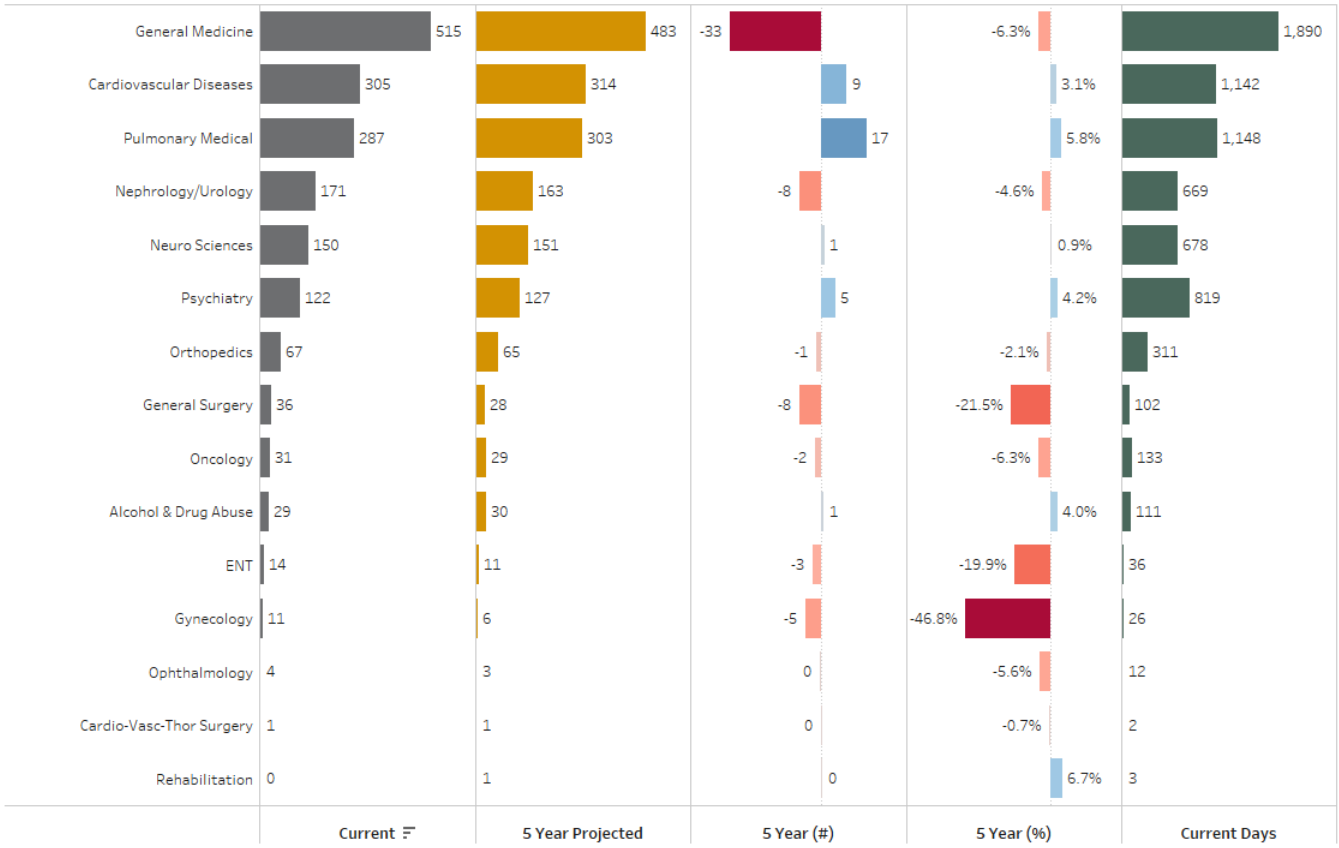
- In the example PSA, excluding OB/Delivery, Newborns and Neonatology, across all other service lines and payers, IP discharges are anticipated to decline by 0.5% over the next five years, from 3,073 to 3,059.
- These acute services are estimated to account for 15,552 acute patient days.
- 15,552 patient days represent an average daily census (ADC) of 42.6.

Source:Merative. "High Acuity" includes DRGs with a case weight of 1.5 and above

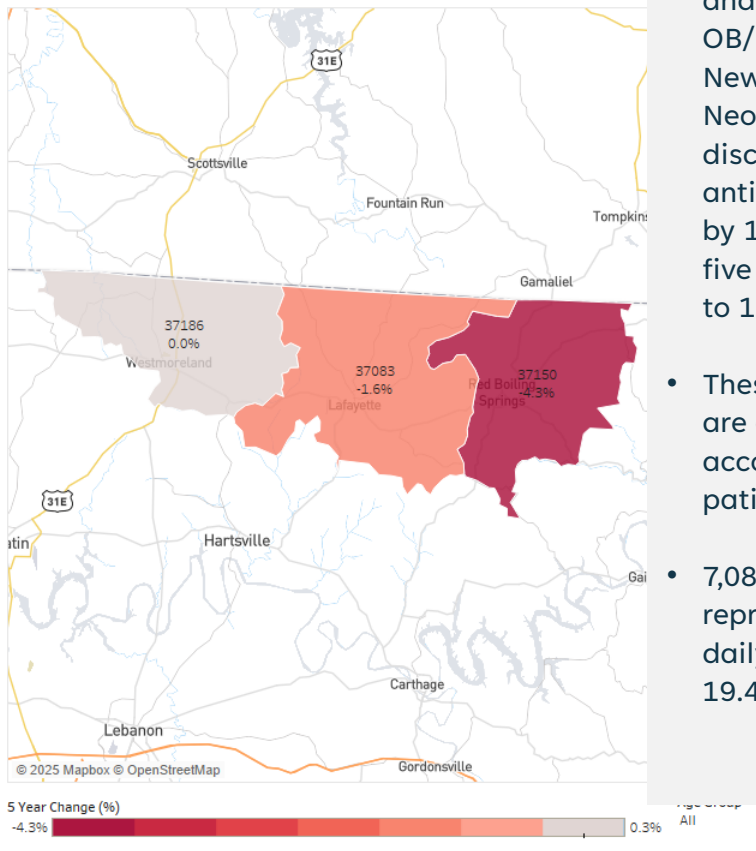
BE REALISTIC ABOUT ACUITY CONSTRAINTS…

Current Discharges	5 Year Projection	5 Year Change (#)	5 Year Change (%)	Current Days
1,743	1,717	-26	-1.5%	7,084

Discharges by Product Line



5-Year Change (%) by ZIP Code



- In the PSA, focusing only on lower acuity discharges with a case mix index below 1.5, and again excluding OB/Delivery, and Newborns Neonatology, IP discharges are anticipated to decline by 1.5% over the next five years, from 1,743 to 1,717.
- These acute services are estimated to account for 7,084 acute patient days.
- 7,084 patient days represent an average daily census (ADC) of 19.4.

Source:Merative. "High Acuity" includes DRGs with a case weight of 1.5 and above

HOW DO WE ADD ACUTE DAYS?

- Grow appropriate ED volume
- Maximize appropriate ED admissions
- Ensure ED staff have comfort with the provider capabilities on the floor
- Consider telemedicine / remote monitoring / support where appropriate to keep patients in house

EVALUATE THE FINANCIAL IMPACT OF ADDING 593 ACUTE DAYS

- Given high-fixed cost, growth in inpatient volumes creates significant margin opportunity
  - Margin opportunity exists for both Acute care growth as well as Swing Bed service growth
  - Oftentimes, dilutive effect on cost-based reimbursement is offset by payment from non-cost-based payers

Model A: Base Case (FY 2024 Cost Report)

	ADC	Total Days	Cost Based Payer Mix	Cost Based Days	Other Days	Payment Per Day	Other Payment
Acute (inc Observ, ICU)	9.4	3,422	49%	1,680	1,742	$ 2,500	$ 4,355,776
Swing Bed - SNF	2.0	733	100%	733	-	$ 1,200	$ -
Swing Bed - NF	0.2	65	0%	-	65	$ 350	$ 22,750
Total Days	11.6	4,220		2,413	1,807		$ 4,378,526
Net Acute/SB SNF/Obs		4,155	58%	2,413	1,807		
Inpatient Fixed Costs		$ 10,894,507					
Inpatient Variable Costs		$ 1,186,200 [1]					
Total Inpatient Costs		$ 12,080,707 [2]					
Inpatient Costs Per Day		$ 2,908		$ 2,908			
Less: Cost-Based Carveouts		$ (583,361)		$ (140.40)			
Cost Based Payment				$ 6,676,180			$ 6,676,180
Total Payment							$ 11,054,706
Inpatient Costs							$ 12,080,707
Net Margin							$ (1,026,001)

[1] Assumes $300/day marginal acute costs and $200/day marginal swing bed SNF and NF costs

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

Model B: Grow Acute Census to ADC of 11

	ADC	Total Days	Cost Based Payer Mix	Cost Based Days	Other Days	Payment Per Day	Other Payment
Acute (inc Observ, ICU)	11.0	4,015	49%	1,971	2,044	$ 2,500	$ 5,110,590
Swing Bed - SNF	2.0	733	100%	733	-	$ 1,200	$ -
Swing Bed - NF	0.2	65	0%	-	65	$ 350	$ 22,750
Total Days	13.2	4,813		2,704	2,109		$ 5,133,340
Net Acute/SB SNF/Obs		4,748	57%	2,704	2,109		
Inpatient Fixed Costs		$ 10,894,507 [1]					
Inpatient Variable Costs		$ 1,364,100 [2]					
Net Inpatient Costs		$ 12,258,607					
Inpatient Costs Per Day		$ 2,582		$ 2,582			
Cost Based Payment		$ (583,361)		$ (122.86)			
Total Payment				$ 6,648,507			$ 6,648,507
Total Payment							$ 11,781,847
Inpatient Costs							$ 12,258,607
Net Margin							$ (476,760)
Difference							$ 549,241

[1] Assumes $300/day marginal acute costs and $200/day marginal swing bed SNF and NF costs

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

EVALUATE THE IMPACT OF ADDING 657 ACUTE DAYS AT NON-CAH

- Given high-fixed cost, growth in inpatient volumes creates significant margin opportunity
  - PPS Hospitals don't face the same dilutive effect on Medicare rates as CAHs do

Contribution Margin Impact of Incremental Acute Volume				
		Low Growth		High Growth
Average Daily Census (M/S ADC)		1.2		1.2
Targeted Acute ADC		2.0		3.0
Incremental Acute ADC		0.8		1.8
Incremental Acute Days		292		657
Estimated Revenue per Acute Day	$	1,500	$	1,500
Estimated Incremental Daily Expense	$	(500)	$	(500)
Estimated Daily Acute Profit	$	1,000	$	1,000
Estimated Incremental Acute Contribution Margin	$	292,000	$	657,000

14% OF PERFORMANCE IMPROVEMENT GAINS WERE FROM GROWING / EXPANDING SERVICE LINES

- Understand what OP volumes exist in the market today
  - Do we offer the service?
  - What is our market share?
  - Is the service offered nearby?
  - Do we have the facilities to accommodate growth?
  - Do we have the providers to deliver the care?

- #1 opportunity is to do more of what we are already doing
  - Capture appropriate ED patient volumes – if emergency patients CHOOSE to leave the community, ask ourselves why?
  - Growing ED volumes also helps to grow inpatient volumes
  - Ancillary services where we don't have high market share…what are the reasons?
    - Schedule availability / convenience?
    - Cost?
    - Provider referral streams?

FOR THE PSA…UNDERSTAND THE DEMAND FOR OP SERVICES

Current Procedures	5 Year Projection	5 Year Change (#)	5 Year Change (%)
904,689	1,052,230	147,540	16.3%

Volumes by Stroudwater Procedure Group

	Current	Projected	5 Year (#)	5 Year (%)
Labs	313,123	360,085	46,962	15.0%
Medical Exams	176,345	201,702	25,357	14.4%
Medicine Other	84,857	100,378	15,521	18.3%
Injections	67,924	75,492	7,568	11.1%
Physical Therapy	63,618	75,726	12,108	19.0%
X-Ray/Fluoroscopy	25,478	27,571	2,093	8.2%
Psychiatric Therapy	17,641	29,138	11,498	65.2%
Chiropractic Spinal Manipulation	15,169	16,065	897	5.9%
Cardiology Analysis	14,603	19,893	5,289	36.2%
ED Visits	14,052	14,663	611	4.4%
Misc	13,215	15,759	2,544	19.3%
Ultrasound	10,810	11,996	1,185	11.0%
Ophthal Office	10,225	11,999	1,774	17.3%
CT Scans	9,333	14,266	4,933	52.9%
Hemonc	5,595	6,106	511	9.1%
Allergy	5,361	5,736	375	7.0%
Dermatology Procedures	5,016	5,944	928	18.5%
Breast Imaging	4,578	6,020	1,443	31.5%
Nephrology	3,918	4,565	647	16.5%
Neurology Testing	3,359	3,709	350	10.4%
MRI	3,096	3,494	398	12.9%
Audiologic Testing & Therapy	3,084	3,487	403	13.1%

Site of Service

	Current	% of Total
Emergency Department	74,623	8.2%
Hospital Outpatient	133,246	14.7%
Independent Ambulatory Surgery Center	3,922	0.4%
Independent Laboratory	143,408	15.9%
Non-Hospital Facility	55,281	6.1%
Private Office	473,357	52.3%
Telemedicine	13,225	1.5%
Urgent Care Center	7,627	0.8%

Service Area
Primary

ZIP Name
Multiple values

ZIP Code
All

ATG
All

CSC
All

SA Procedure Group Filte
Stroudwater Procedure G

SA Procedure Group Deta
All

Procedure
All

Payer
All

Site_Of_Service
All

Age Group
All

Sex
All

Source: Merative. "Stroudwater Procedure Group" is Merative procedures grouped by Stroudwater to better reflect hospital facility demand. Detail available on request.

- Adjusted PSA outpatient volumes are anticipated to grow by 16.3% over 5 Years.
- 52.3% of all outpatient volumes occur at the physician office site of service.
- The PSA is anticipated to generate:
  - 176k office visits
  - 25.4k x-rays
  - 14k ED visits
  - 10.8k ultrasounds
  - 9.3k CT scans
  - 4.5k mammograms

WHAT ARE WE DOING TODAY AND WHERE ARE THE OPPORTUNITIES?

	PSA Estimate	FY 2025A Volume	Share of PSA (using 25A)
ED Visits	14,052	10,500	74.7%
X-Ray	25,478	9,938	39.0%
CT Scans	9,333	5,835	62.5%
MRI	3,096	792	25.6%
Ultrasound	10,810	3,227	29.8%
Mammography	4,578	3,042	66.4%
Dexa	809	365	45.1%
OP Lab	313,123	142,580	45.5%

- For things we're already doing, what prevents us from capturing more volume?
- Common issues include:
  - Throughput…"The wait was too long so I went elsewhere"
  - Price…"You're too expensive. My insurer sent me elsewhere."
  - Referral patterns…"My PCP sent me to XYZ location for lab work, etc."
- Identify the barriers and look to remove them.
- If we already capture close to 100% share…then perhaps we can learn "why" some services are capturing more than others.

IF WE CAPTURE MORE ED VOLUME...WHAT MIGHT IT MEAN?

	Example CAH
Assumptions:	
Annual ED Arrivals	10,500
% Growth in ED Visits with Decreased Outmigration / Performance Improvement	10.00%
Current LWBS Rate	3.00%
Improved LWBS Rate	1.00%
Current ED Admission Rate (acute and Observation)	9.00%
Improved ED Admission Rate	12.00%
Estimated ED Technical Charge (WS C Charges divided by visits)	$ 1,526
Estimated ED Ancillary Charges (estimated based on avail. Services	$ 1,500
Estimated ED Admission Charge (avg estimated IP / admission charges)	$ 13,624
Payment to Charge Ratio (WS G-3, NPSR / Gross Revenue)	31.32%
Variable Cost Ratio (estimated)	20.00%
Current ED Contribution Margin:	
Current ED Arrivals	10,500
Current LWBS Rate	3.00%
Net ED Visits	10,185
ED Technical Charge (Avg per visit)	$ 1,526
ED Ancillary Charge (Avg per visit)	$ 1,500
Total ED related charges (Avg per visit)	$ 3,026
ED Charges (Total Annual)	$ 30,819,810
Current Inpatient / Observation Admissions %	9.00%
ED Related Inpatient / Observation Admissions	917
Estimated ED Admission Charge (avg estimated IP / admission charges)	$ 13,624
ED related Acute/Observation Charges	$ 12,488,440
Total ED IP and OP related charges	$ 43,308,250
Payment to Charge Ratio (WS G-3, NPSR / Gross Revenue)	31.32%
Estimated ED IP and OP Net Patient Revenue	$ 13,564,144
Estimated Variable Cost Ratio	20.00%
Estimated Variable Costs	$ 2,712,829
Estimated Current ED Contribution Margin	$ 10,851,315

- Increased ED volume can contribute to the bottom line in the following ways:
  - Direct reimbursement for ED visit
  - Ancillary revenue associated with ED visit (e.g., imaging, lab, etc.)
  - Greater inpatient admissions (Acute & Observation)

IF WE CAPTURE MORE ED VOLUME...WHAT MIGHT IT MEAN?

	Example CAH
Improved ED Contribution Margin:	
Current ED Visits	10,500
Growth in ED visits with Decreased Outmigration	10.00%
Improved ED Arrivals	11,550
Improved LWBS Rate	1.00%
Net ED Visits	11,435
Total ED related charges (Avg per visit)	$ 3,026
ED Charges (Total Annual)	$ 34,600,797
Improved Inpatient/Observation Admissions %	12.00%
ED Related Inpatient/Observation Admissions	1,372
Estimated ED Admission Charge (avg estimated IP / admission charges)	$ 13,624
Improved ED related Acute/Observation Charges	$ 18,694,035
Total Improved ED IP and OP related charges	$ 53,294,832
Payment to Charge Ratio (WS G-3, NPSR / Gross Revenue)	31.32%
Improved Estimated ED IP and OP Net Patient Revenue	$ 16,691,941
Estimated Variable Cost Ratio	20.00%
Estimated Variable Costs	$ 3,338,388
Estimated Improved ED Contribution Margin	$ 13,353,553
Net Impact of ED Improvement	$ 2,502,238
% Contribution Margin Improvement	23.06%

- When considering direct reimbursement, additional ancillaries, and potential inpatient admission growth, growth in ED volumes are potentially significant

IF WE CAPTURE MORE LAB VOLUME...WHAT MIGHT IT MEAN?

Lab Tests Fully Allocated Costs vs. Relevant Costs	Total Costs	Relevant Costs	
Direct Costs:			
Salary	$ 326,632	$ -	
Supplies	$ 581,708	$ 145,427	*
Total Direct Costs	$ 908,340	$ 145,427	
Allocated Costs:			
Variable	$ 217,297	$ 50,000	**
Overhead	$ 366,143	$ -	
Total Allocated	$ 583,440	$ 50,000	
Fully Allocated Costs	$ 1,491,780	$ 195,427	
Number of Tests	102,057	102,057	
Cost Per Test	$ 14.62	$ 1.91	
Revenue Per Test	$ 7.89	$ 7.89	
Gain (Loss) Per Test	**$ (6.73)**	**$ 5.98**	

* Estimated at total supplies times 25%

** Represents miscellaneous costs of billing paper and supplies, etc.

- Given very low variable cost, lab services create opportunity for additional contribution margin in a hospital

COMMON PITFALLS WHEN CONSIDERING ADDING NEW SERVICES

- What we often hear…
  - “We have a donor that has pledged to give us $X to put in _____ service, so we should proceed.”
  - “Our last CHNA told us that the community wants _____ service, so we need to do this.”
  - “At my last facility, we provided _____ service and it did really well, so we should do it here.”
  - “Our biggest competitor recently started providing _____ service, and we need to be able to stay competitive.”
  - “I attended a presentation on _____ service, and it seems like a really good idea.”

WHAT ABOUT ADDING NEW SERVICES?

- Complete a market assessment to understand the total estimated market volume for the service
    - What share would we need to make it viable financially, clinically and operationally?
        - Example:
        - A community generates an estimated 2,200 GI procedures (e.g., colonoscopies, upper GI, etc.)
        - At 100% share, this would likely require 1-2 GI procedure rooms
        - At 25% share, with only 550 procedures this wouldn't "fill" a room but could be enough to justify a part time provider…and the space could be used for other minor procedures when not being used for GI.
        - This may make sense
        - For a smaller community that generates only an estimated 500 GI procedures, a 25% share would be 125 procedures, and this may be more challenging to justify bringing someone onsite to perform the service.

WHAT ABOUT ADDING NEW SERVICES?

- Develop a pro-forma for the service offering, considering:
  - Anticipated volumes
    - Often helpful to model multiple volume scenarios
  - Payer Mix
  - Service Location
    - Hospital
    - Provider-based Clinic
    - Rural Health Clinic
    - Freestanding Clinic
  - Supplemental revenue
  - Expenses
    - Fixed vs variable
    - Staffing, capital, supplies, etc.
  - Medicare Cost Report impact

QUESTIONS?

COMING UP...

3

Cost Report Opportunities

- This session will show how CAHs can use the Medicare cost report as a strategic tool to capture missed revenue opportunities and strengthen financial stability.
- Learn how to leverage the Medicare cost report for performance improvement, identify opportunities, mitigate cash flow risk, and apply best practices for interpretation.

In just a few minutes
October 9th at 11am EDT

4

Swing Bed Bootcamp

- This session provides leaders with a hands-on, interactive overview of swing bed programs, covering compliance, care quality, financial performance, and growth strategies.
- Gain practical insights on regulatory requirements, care planning, program optimization, financial impact, and marketing strategies.

October 16th at 11am EDT

COMING UP...

5

340B Programs

- The 340B Drug Pricing Program continues to evolve rapidly, with new manufacturer actions, rebate models, and regulatory changes reshaping how covered entities approach savings and program compliance.
- Identify opportunities to optimize program performance, evaluate pharmacy models, and anticipate emerging trends.

October 23rd at 11am EDT

6

Revenue Cycle Deep Dive

- Strong revenue cycle performance requires intentional strategy, collaboration, and, above all, cross-functional leadership support.
- Identify strategies to engage leaders, align key performance indicators with organizational goals, and apply real-world practices to drive sustainable revenue cycle improvements.

October 30th at 11am EDT

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