STROUDWATER

PERFORMANCE IMPROVEMENT BOOTCAMP – SESSION 1

ERIC K. SHELL, MBA, CHAIRMAN

Overview of Opportunities and Process

PANELIST

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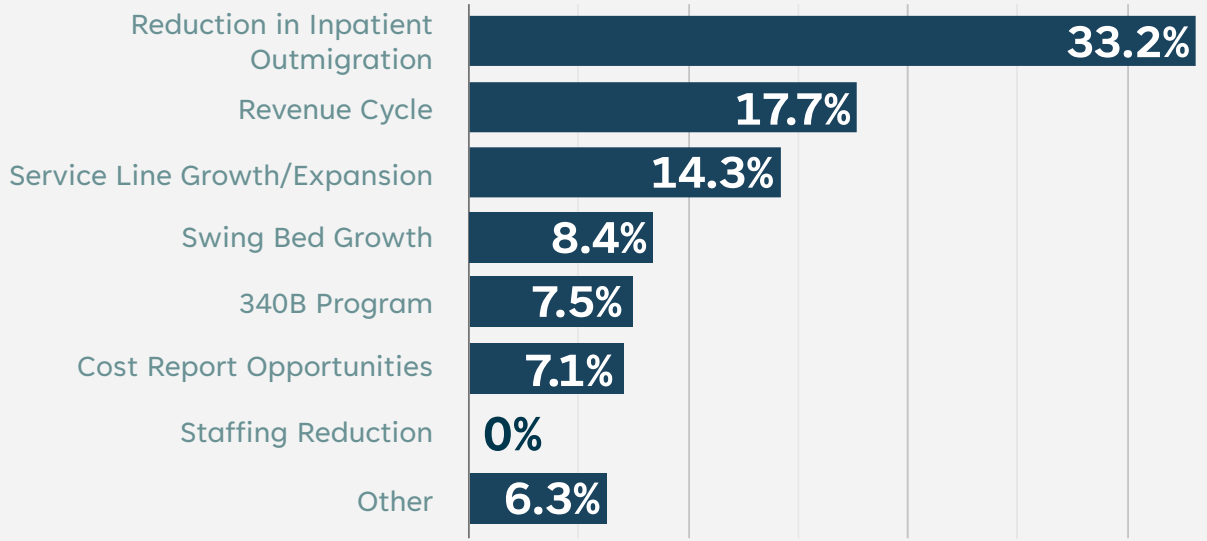
PROVEN RETURN ON INVESTMENT

$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

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

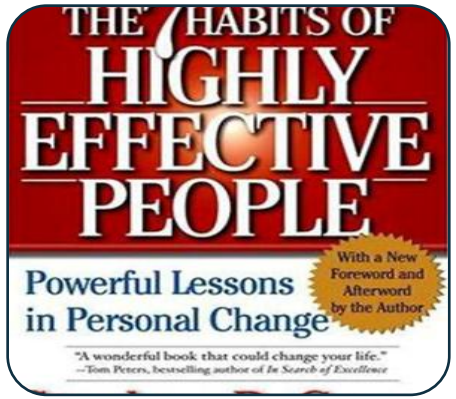
- Strong revenue cycle performance requires intentional strategy, collaboration, and, above all, cross-functional leadership support.
- Identify strategies to engage leaders, align key performance indicators with organizational goals, and apply real-world practices to drive sustainable revenue cycle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

FINANCIAL AND OPERATIONAL BEST PRACTICES

- The following best practice opportunities areas were derived from the 100+ Stroudwater CAH site visits conducted over the last five years

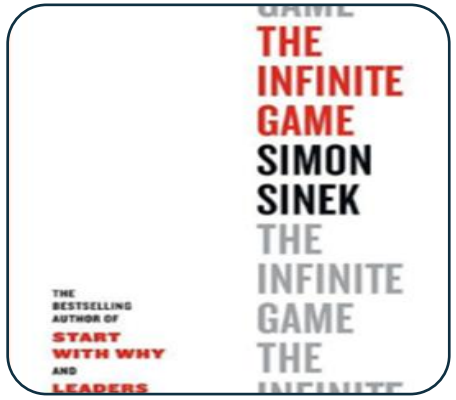
- ❑ Culture (Abundance/Accountability)
- ❑ Economic Philosophy
- ❑ Organizational Strategy
- ❑ Inpatient Services *Session 2 Deep Dive*
- ❑ Emergency Services
- ❑ Clinical Departments
- ❑ Departmental Profitability
- ❑ Quality Improvement
- ❑ Information Technology
- ❑ Cost Report Improvement *Session 3 Deep Dive*
- ❑ Revenue Cycle *Session 6 Deep Dive*
- ❑ Management Accounting
- ❑ Staff Benchmark Analysis
- ❑ Provider Complement/Practice Management
- ❑ Provider Alignment
- ❑ Service Area Rationalization
- ❑ Alignment Strategy
- ❑ Payment System Transformation
- ❑ Population Health Management

ABUNDANCE/INFINITE GAME MINDSET - DEFINED



ABUNDANCE

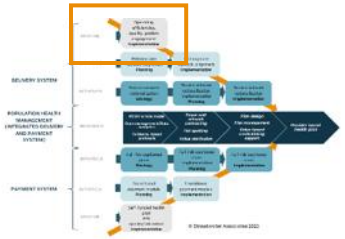
- Stephen Covey coined the idea of *abundance mentality* or *abundance mindset*, a concept in which a person believes there are enough resources and successes to share with others.
- This is contrasted with the *scarcity mindset* (i.e., destructive and unnecessary competition), which is founded on the idea that, if someone else wins or is successful in a situation, that means you lose; not considering the possibility of all parties winning (in some way or another) in each situation (zero-sum game).



INFINITE GAME MINDSET

- Simon Sinek developed the concept of the Infinite Game.
- Infinite Games are played by known and unknown players, with no exact/agreed-upon rules, with the primary objective to perpetuate the game.
  - No such thing as winning or losing.
  - The goal is to advance something bigger than ourselves or our organizations.
- We must stop thinking about who wins or who's the best and start thinking about how to build organizations that are strong/healthy enough to stay in the game for generations.

ECONOMIC PHILOSOPHY: A MINDSET



The most important performance driver for a rural hospital is the overall mindset of the staff, management team and trustees where their commitment centers on ***abundance, growth*** and ***incremental contribution margin*** gains as opposed to a focus on expense management and cost reductions to the existing care model. Value is unlocked by the marginal revenue gain in a high fixed cost environment.

- Understand the difference between variable costs, fixed costs, and fully allocated costs
- Recognize that nearly all paying services create positive contribution
- Economic imperative is the development of 1,000s of mini “contribution margins” to cover fixed costs of CAH
- Cost-based reimbursement will only cover costs and not generate aggregate profit

ECONOMIC PHILOSOPHY: UNDERSTANDING OF ELEMENTS IS KEY

- Understand the difference between contribution margin and profit on fully allocated costs
  - Variable Cost
    - Definition: Expenses that change with changes in activity
    - E.g.: *Pharmaceuticals, reagents, film, food*
  - Fixed Cost
    - Definition: Expenses that do not change with changes in activity
    - E.g.: *Salaries and benefits (??), rent, utilities*
  - Rural hospitals have inordinately high fixed costs relative to revenue (E.g., ER Standby, acute care nursing costs, etc.)
  - Unit contribution margin
    - The amount from each unit of service available to cover fixed costs and provide operating profits
    - Example - If Department X's unit service price is $200 and its unit variable cost is $30, the unit contribution margin is $170 ($200 – $30)
    - A rural hospital is made up of 1000s of Unit Contribution Margins

THE IMPACT OF HIGH HOSPITAL FIXED-COST RATIOS ON RURAL POPULATIONS

- RUPRI studied the fixed-to-total cost ratios for hospitals of different sizes
  - Study extends a RUPRI analysis from 2023 evaluating whether hospitals in rural areas have higher fixed-to-variable cost ratios
  - Current Study reviewed cost report data between 2011-2020 for 4953 hospitals
  - This model estimated fixed and variable costs using the simple definition of a variable cost as one that varies with volume
    - Costs that tracked with adjusted patient days were considered variable
- Important Findings:
  - The median ratio for all hospitals in metropolitan UICs is 0.733, while the median ratios in all other UICs are markedly higher and increase as hospital locations become more rural
  - CAHs tended to have the highest estimated fixed-to-total-cost ratios, while Low Volume Hospitals (LVHs) tended to have lower ratios, but still higher than those of hospitals with neither designation
- Conclusions:
  - Hospital payment policy and payment model development may benefit from considering hospital fixed-to-total-cost ratios, particularly in places where economies of scale are unattainable

RUPRI Center for Rural Health Policy Analysis
Rural Policy Brief

Brief No. 2025-3 JUNE 2025 http://www.public-health.uiowa.edu/rupri/

The Impact of High Hospital Fixed-Cost Ratios on Rural Populations

by Abigail Barker, PhD; Eliot Jost, MBA, MPH; Timothy McBride, PhD; and Keith Mueller, PhD

Purpose

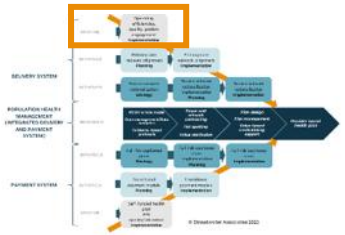
This brief focuses on rural hospitals with high fixed-to-total-cost ratios and describes characteristics of those hospitals and the communities they serve. The brief extends a recent RUPRI Center analysis[1] of whether hospitals in rural areas have higher fixed-to-total-cost ratios, a characteristic that has implications for financial stability under different payment models. We describe how this measure varies across the United States, the demographic characteristics associated with hospitals at different ratio levels, and the share of nonmetropolitan hospitals that have Critical Access Hospital (CAH) or Low-Volume Hospital (LVH) designations.

Table 1. Average County Population Density, Median, 25th and 75th Percentiles of Fixed-to-Total-Cost Ratios for all Hospitals by UIC Group

UIC Group	Number of Hospitals	Average Population Density	Median Ratio of Hospitals in UIC Group	25th percentile	75th percentile
Metropolitan (UIC = 1,2)	2,976	671.7/mi²	0.733	0.602	0.861
Micropolitan (UIC = 3,5,8)	797	69.8/mi²	0.847	0.778	0.895
Noncore adjacent to large metro or with town of 2500+ (UIC = 4,6,9,11)	857	40.1/mi²	0.901	0.866	0.929
Noncore without town of 2500+ (UIC = 7,10,12)	332	13.3/mi²	0.933	0.886	0.957

Source: http://www.public-health.uiowa.edu/rupri/

ECONOMIC PHILOSOPHY: MEASUREMENT CULTURE



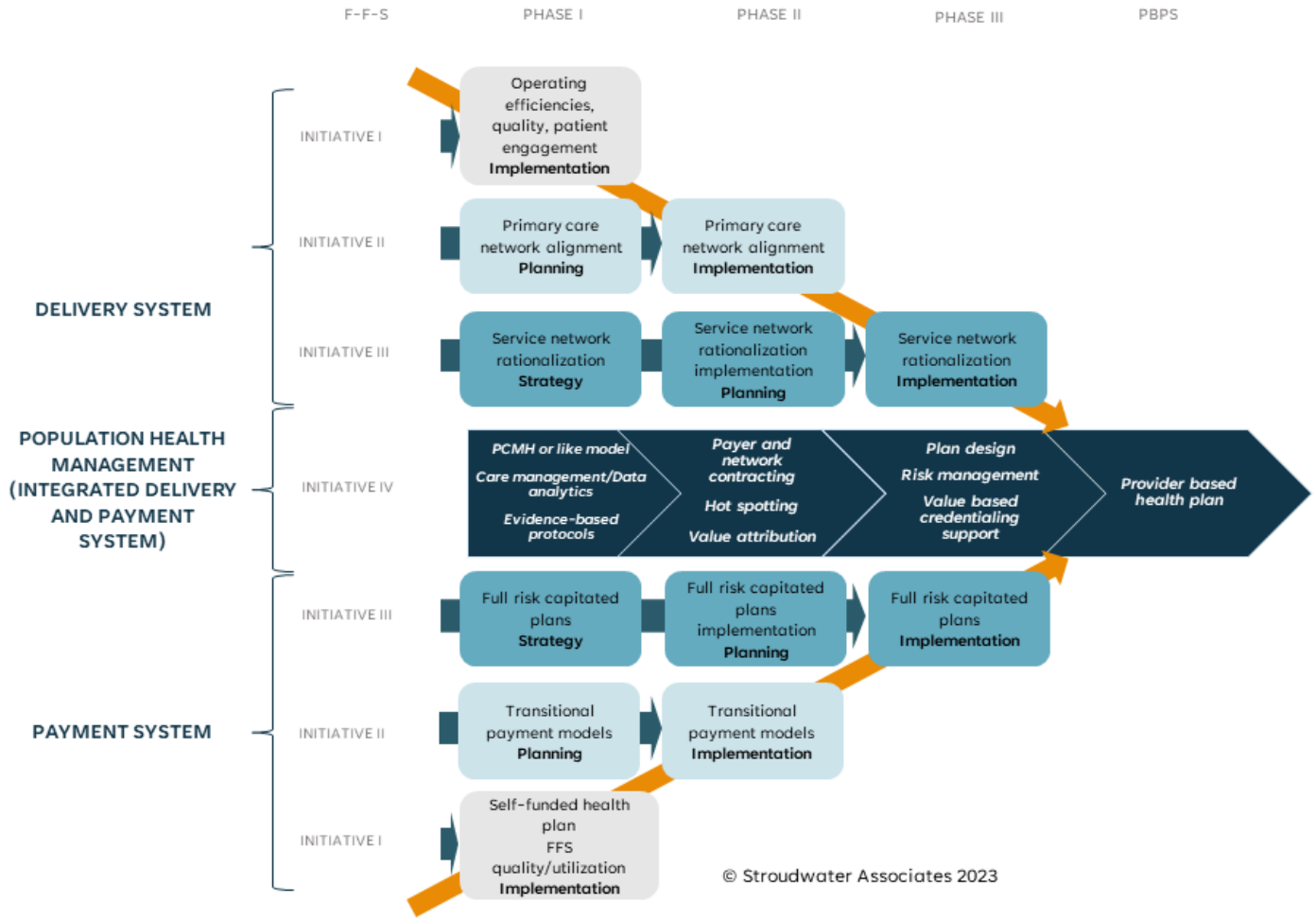
Have an effective organizational design that drives accountability into the organization

Decision Rights	Performance Measurement	Compensation

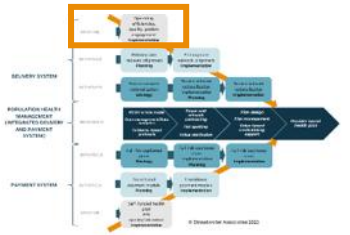
• Drive decision rights down to clinical/operation level
• Education to department managers on business of healthcare
  • Avoid separation of clinical and financial functions
	• Department managers to be involved in developing annual budgets
	• Budget to actual reports to be sent to department managers monthly
	  • Variance analysis to be performed through regularly scheduled meetings between CFO/CEO and department managers
		• Recognize performance in line with organizational goals

STRATEGY: POPULATION HEALTH TRANSITION FRAMEWORK

- The Transition Framework helps organizations through the transition from a fee-for-service (FFS) payment system to a population-based payment system
  - *Delivery system* addresses strategic imperatives for providers to transform their delivery system
  - *Payment system* addresses strategies for providers to influence the evolution of the payment system
  - *Population health/care management* requires the creation of an integrating vehicle so that providers can contract for covered lives, create value through active care management, and monetize the creation of that value

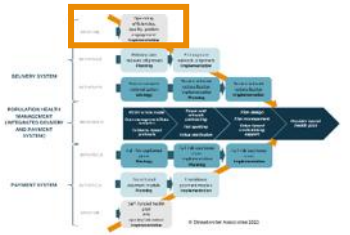


SESSION 2
THURSDAY, 10/9
10AM EDT



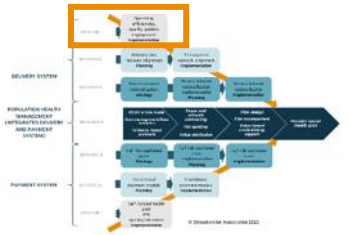
- How Market Insights Drive Rural Hospital Performance
  - Define appropriate service area for your organization
  - Quantify demographic characteristics
  - Identify current and projected service line demand
  - Calculate current “share” and evaluate opportunities for growth
  - Share demand modeling analyses with clinical and operational team
  - Develop strategies to increase local capture

INPATIENT SERVICES: VOLUME GOALS



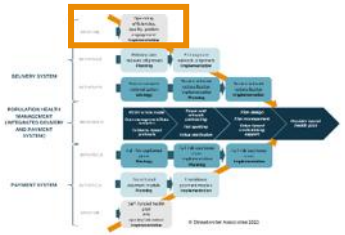
- Target an ED admission rate (acute admissions and observation status) of between 10%-12% by partnering with medical staff to ensure appropriateness of care decisions, as well as to identify opportunities to reduce transfers
- Implement systems to ensure all patients who are transferred to other hospitals for health care services are transferred back, when possible, for care delivery
- Define the Care Spectrum (those patients able to receive care at your facility) as a collaborative, multi-disciplinary group inclusive of the following categories: Medical Staff, Nursing, Pharmacy, Medical Equipment and Therapists)
- Investigate the use of Tele-Intensivist or e-Hospitalist programs with more active Nurse Practitioner as inpatient coverage options
- Reformat a discrete Intensive Care Unit (ICU) into a “High Observation” service and consolidate the ICU costs into the general Med/Surg/Acute cost center
    - Evaluate the operational impact of consolidating the ICU into the Med-Surg department as a high acuity progressive care unit
- Utilize InterQual-like criteria resources to educate providers for proper documentation and determinations of inpatient stays likely to exceed 2-Midnights. Enforce proper usage of observation admission criteria
- Implement Hourly Rounding and Bedside Handoff models for nurses to optimize multidisciplinary communication
- Track and monitor Nurse: Patient ratios against industry standards

INPATIENT SERVICES: VOLUME GOALS



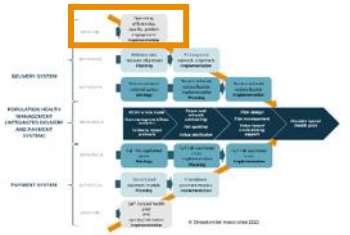
- Target 20 – 30% of acute days as observation
  - Review and educate the medical staff on admission and observation status criteria
- Elevate the development and promotion of the swing bed program as a strategic priority, targeting an Average Daily Census (ADC) of 3 patients per 10,000 population
  - Develop an “Active Pursuit” swing bed marketing plan focused on offered services, targeting employed physicians, area providers, case managers, and area hospitals
    - Actively engage area hospital for swing bed opportunities that may be appropriate for the swing bed program at hospital
    - Access new patients including Medicare Advantage, Medicaid, and commercial payer patients
  - Educate the provider community on the benefits of cost-based reimbursement and the appropriate use of swing bed services
  - Ensure that swing bed utilization is a priority with unit staff, case management staff and physician providers
- Monitor required Swing Bed daily rate -- an amount greater than the Medicaid Nursing Facility (NF) carve-out rate – required to generate a positive contribution margin by pursuing non-traditional arrangements, services and patient types for care in Swing Beds

EMERGENCY SERVICES: CAPTURING APPROPRIATE PATIENTS



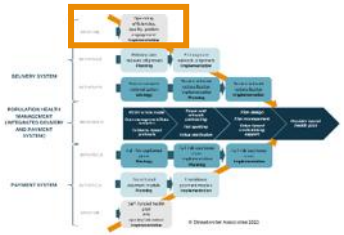
- Implement systems to ensure patients who present to the Emergency Department of a non-emergent nature are redirected to the clinics, when open, to receive care
  - Recognize that if the CAH does not offer urgent care services, patients with high deductibles will be leaving rural communities for care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

EMERGENCY SERVICES: INTERNAL MONITORING



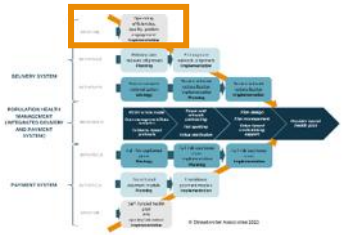
- Track ED standby time unless contracted Emergency Department providers/contractors bill for professional services; if so, the hospital does not need to track standby time (it is generally 100% of contracted time)
- Consider LEAN processes to reduce throughput time in the ED
- Engage in EDCAHPS – track and monitor performance
- Engage the hospitalists and Emergency Department providers to focus on improved collaboration that results in enhanced patient throughput
- Track and monitor KPIs related to the Emergency Department, including:
  - ED admissions (acute/observation) as a percentage of ED visits to between 10% and 12%
  - Transfer rates as a percentage of Emergency Department visits to below 5% of all ED visits
  - Note: Track ED KPIs at the individual provider level
  - Throughput measures: Door to MD, Door to Discharge, Door to Admit, Door to Transfer, LWOT, AMA, etc.

CLINICAL DEPARTMENTS



- Department managers to transition from “catching” to ”pitching” with growth focus
- Conduct outreach to area providers to build awareness of service offerings as well as to foster strong customer service
- Advertise/promote services provided to area providers to increase volumes and keep providers informed of the services offered
- Maintain reasonably updated equipment/technology which demonstrates quality and promotes patient experience
- Track referrals by provider and use information to drive targeted outreach
- Conduct ROI analyses to determine feasibility of upgrading and replacing diagnostic (imaging, lab, etc.) equipment
- LAB: Conduct strategic pricing reviews to develop outpatient fee schedules that are market competitive
- Evaluate community need as part of return on investment (ROI) analyses to determine feasibility of offering or expanding services
- Conduct contribution margin analysis to ensure high-cost departments do not return a negative contribution margin
- PHARMACY: Develop strategies to maximize 340B financial opportunities targeting between $350K and $450K per 10K provider-based clinic visits
- PHARMACY: Establish channel partnerships with local area retail pharmacies, or develop in-house retail pharmacy operation depending on results of ROI analysis
- Evaluate current staffing levels for opportunities to enhance efficiency with a focus on volume growth

DEPARTMENT PROFITABILITY

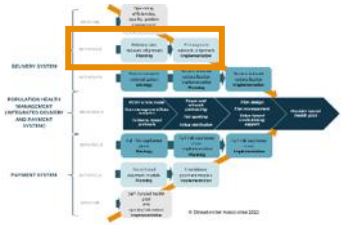


- Evaluate opportunities to increase marginal profitability of departments through incentivizing providers and volume growth or evaluate cost structure
- Conduct ROI analysis for, at a minimum, all non-cost-based departments to determine whether those programs have a positive contribution margin

FY 2020 Home Health Profitabilty Analysis

Revenue:	Visits	Net Rate	Net Revenue
Medicare	2,152	$ 188.56	$ 405,783
Other	608	188.56	$ 114,645
Total	2,760		$ 520,428
Operating Expenses:	**A**		**B**
Direct Expenses (2020 ICR - WS A):			
Salary expense	$ 316,055		$ 316,055
Other	$ 151,492		$ 151,492
Total Direct Expense	$ 467,547		$ 467,547
Allocated Expenses (ICR Stepdown - WS B)			
Capital Costs	$ 15,197	20%	$ 3,039
Cap Movable Equipment	$ 29,735	20%	$ 5,947
Admin and General	$ 71,598	20%	$ 14,320
Employee Benefits	$ 118,326	90%	$ 106,493
Maintenance and Repairs	$ 27,416	50%	$ 13,708
Medical Records & Library	$ 4,316	50%	$ 2,158
Housekeeping	$ 2,820	50%	$ 1,410
Laundry and Linen	$ 43	50%	$ 22
Total Home Health Allocated Expense	$ 269,451		$ 147,097
Total Home Health expenses	$ 736,998		$ 614,644
Home Health Direct Gain (Loss)	$ (216,570)		$ (94,216)
Overhead expenses allocated away from Hospital (a) - (b)			(122,354)
Estimated CAH Cost Based Payer Mix			41%
Cost Based Payer Revenue on Allocated Costs			(50,107)
Net Gain (Loss)			$ (144,323)

PROVIDER COMPLEMENT/PRACTICE MANAGEMENT



- Use market-based, population demand studies to evaluate current supply of primary and specialty providers
  - Use information as a basis for recruitment
- Establish a long-term recruitment plan for providers extending beyond 5 years

Physician Shortage/Surplus Adjusted Service Area Population: **19,91**

	Supply Study Existing[1] Range		(Shortage)/Surplu Range[2]
Primary Care			
Family Practice	2.7 - 9.4	5.80	(3.6) - 3.1
Internal Medicine	2.3 - 5.5	0.00	(5.5) - (2.3)
Pediatrics	1.5 - 2.4	1.00	(1.4) - (0.5)
Physician Primary Care Range	10.7 - 13.2	**6.80**	**(6.4) - (3.9)**
Non-Phys Providers	1.4 - 4.5	5.55	1.0 - 4.2
TOTAL Primary Care Range	13.2 - 17.8	**12.35**	**(5.4) - (0.9)**
Medical Specialties			
Allergy	0.2 - 0.3	0.00	(0.3) - (0.2)
Cardiology	0.6 - 0.7	0.40	(0.3) - (0.2)
Dermatology	0.4 - 0.5	0.07	(0.4) - (0.3)
Endocrinology	0.0 - 0.3	0.08	(0.2) - 0.0
Gastroenterology	0.4 - 0.5	0.80	0.3 - 0.4
Hem/Oncology	0.4 - 0.5	0.24	(0.2) - (0.2)
Infectious Disease	0.1 - 0.2	0.05	(0.1) - (0.1)
Nephrology	0.3 - 0.3	0.09	(0.2) - (0.2)
Neurology	0.4 - 0.5	0.20	(0.4) - (0.2)
Pulmonary	0.2 - 0.4	0.18	(0.3) - (0.0)
Rheumatology	0.2 - 0.3	0.28	0.0 - 0.1
Surgical Specialties			
ENT	0.1 - 0.6	0.38	(0.2) - 0.3
General Surgery	1.2 - 1.5	0.54	(0.9) - (0.7)
Neurosurgery	0.2 - 0.2	0.18	(0.0) - 0.0
OB/GYN	1.5 - 2.1	1.00	(1.1) - (0.5)
Ophthalmology	0.7 - 0.8	0.09	(0.7) - (0.6)
Orthopedic	0.9 - 1.4	1.00	(0.4) - 0.1
Plastic Surgery	0.2 - 0.4	0.00	(0.4) - (0.2)
Urology	0.5 - 0.6	0.18	(0.4) - (0.3)

1 Physician FTEs calculated as 5 days per week = 1.0 FTE or 18 days per month = 1.0 FTE

2 See Appendix for detail of Supply Studies.

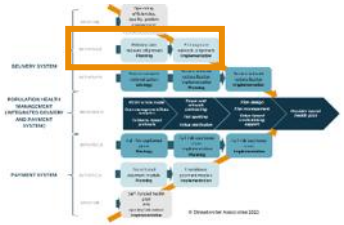
PROVIDER COMPLEMENT/PRACTICE MANAGEMENT

- Pursue increased alignment with regional primary care providers in the service area through functional, contractual and governance alignment strategies given the future importance of primary care network development to developing payment systems

- Given the future importance of primary care network development to developing payment systems, pursue increased interdependence with employed and other primary care providers in the service area through functional, contractual and governance alignment strategies

Specialty	Provider	Ambulatory Encounters	Average Annual Visit per Patient	Patient Estimate	Directed per Capita Cost	Health Based Value
Family Practice	Physician	4,200	3	1,400	9,990	$ 13,986,000
Family Practice	NP / PA	3,000	3	1,000	9,990	$ 9,990,000
				2,400		$ 23,976,000

PROVIDER COMPLEMENT/PRACTICE MANAGEMENT

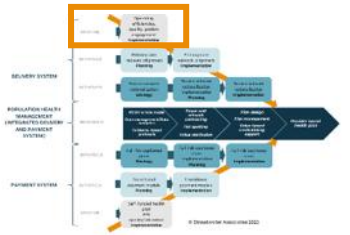


- Create a catalog of all primary care providers with the service area to gain a better understanding of primary care need
- Conduct a primary care options assessment to determine the optimal clinic designation such as Provider-Based Rural Health Clinic (PB-RHC) or Provider-Based Entity (PBE) status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

PROVIDER COMPLEMENT/PRACTICE MANAGEMENT

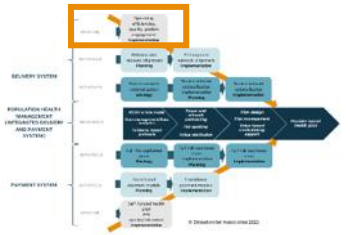
- On a quarterly basis, evaluate Evaluation and Management (E&M) coding relativity, compared to national benchmarks
- Benchmark providers productivity relative to industry benchmarks and share information on a minimum of a quarterly basis (Work Relative Value Units, Visits, Office Hours, etc.)
- Ensure third-party payers are allowing updated (2021) E&M work relative values (e.g., current non-facility, total RVU for 99213 is 2.73 vs. 2.11 in 2020)
- Improve access to primary care providers by allowing open slots in the schedule

QUALITY/PERFORMANCE IMPROVEMENT



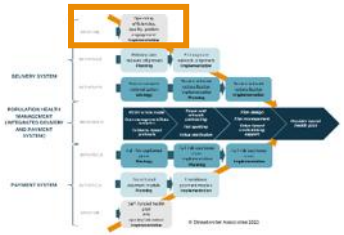
- Establish quality as a strategic priority with the goal of being best in the region within 12 months
- Continue to update the Board and Medical Staff on quality performance and initiative progress on a monthly basis
- Establish a multidisciplinary quality committee that meets on a monthly basis, include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

QUALITY/PERFORMANCE IMPROVEMENT



- Report on public metrics to increase accountability and to compete regionally on quality scores through marketing of public quality and patient safety metrics
- Emphasize importance of quality improvement to staff from the top down
- Ensure that participation in quality metrics measurement and reporting includes Medicare Beneficiary Quality Improvement program (MBQIP) participation for Critical Access Hospitals (CAH)
- Consider dedicating additional staff resources to support quality improvement efforts if necessary
- Convene a Patient Family Advisory Council with community member participation
- Track core measure data and use the information to make systematic and operational changes to improve overall quality and patient outcomes
- Establish specific targets based on Key Performance Indicators (KPI) for the Quality Committee that focus on the entire care continuum then use those KPIs to drive outcomes and improve performance
- Share/post metrics with all staff and utilize performance to drive improvement across the organization

INFORMATION TECHNOLOGY

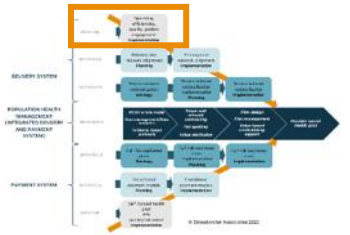


- Create a five-year strategic IT vision that goes beyond meaningful use and leverages IT resources to create a high-quality culture of patient safety through system training and integration into clinical operations
- Recognize IT as a strategic asset, rather than as an expense to be managed
- Schedule and or include IT systems as a part of periodic disaster drills and mitigate single points of failure throughout the system
- Integrate all systems to increase operational efficiencies, access to information, and reduce unnecessary work

SESSION 3
THURSDAY, 10/9
11AM EDT

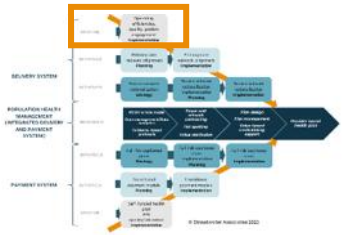
- Practical Cost Report Strategies to Strengthen Financial Health
  - Understand how the Medicare cost report fits within the broader landscape of performance improvement
  - Learn common cost report opportunities
  - Explore cost report strategies to mitigate cash flow risk
  - Understand best practices for interpreting the cost report

COST REPORT IMPROVEMENT BEST PRACTICES



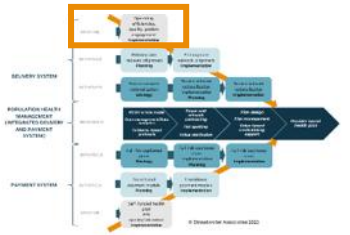
- Evaluate Med-Surg department square footage to incorporate the hallways to ensure accuracy of cost report; Minimum expectation is at least 300 square feet allocated for each inpatient bed
- Utilize best practice time study methodology to ensure physician stand by time is accurate and fairly reflected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

COST REPORT IMPROVEMENT BEST PRACTICES



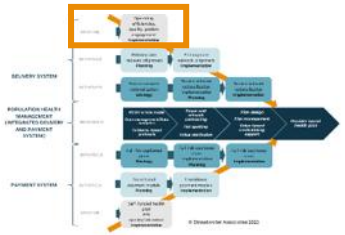
- Evaluate LDRP vs. Med-Surg room usage based on observation status vs. active labor status (Med-Surg) time studies to accurately allocate square footage
  - Ensure costs for Labor and Delivery (LDRP) include only the time assigned to “active” delivery otherwise those costs should be allocated to the Med/Surge cost center
- Continue to monitor departments with low charges relative to cost so they are not missing charge opportunities, as this has a direct impact on ‘bottom line’
- Monitor appropriate assignment of non-Medicare or Medicare Advantage SB patients to Line 6
- Establish a formal Bad Debt policy that pulls claims back from the collection company, after a certain period of inactivity, for inclusion on the cost report
  - Target outpatient Bad Debt 10-20% of patient responsibility
- Work with cost report preparer to determine if investment funds can be designated as funded depreciation to avoid significant offset
- Implement a time study process and conduct medical record time studies to accurately capture true worked time by department for inclusion on the cost report

SESSION 6, THURSDAY, 10/30 11AM EDT



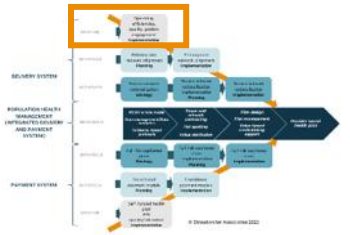
- Leadership and Cross-Functional RCM Champions
  - Understand why cross-functional leadership support is essential for meaningful and sustainable revenue cycle improvement
  - Identify key performance indicators that matter most for financial health
  - Explore strategies to engage cross-functional leadership in revenue cycle goals and performance tracking
  - Apply best practices for aligning teams around shared revenue cycle objectives
  - Recognize how to transform revenue cycle operations through cross-functional leadership-driven accountability and support

REVENUE CYCLE



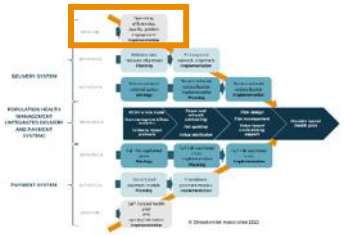
- Establish a Key Performance Indicator (KPI) measurement system and set target for all KPIs and strategies put in place to specifically address improving KPIs to targeted levels
- Establish, target, track, and manage performance indicators, such as the following HFMA best-practice revenue-cycle metrics, in an effort to improve revenue cycle performance: Cash collected and cash percentage of net revenue
  - Gross and Net A/R and A/R days
  - In-house and discharged not-final-billed receivables
  - Cost to collect
  - Bad debt and charity as a percent of gross charges
  - Denials as a fraction of gross charges
  - Point of service collections as a fraction of goal
- Implement a revenue cycle committee that meets at least bi-weekly that includes representatives from clinical, financial, administrative, medical staff, health information management, and the business office to oversee and drive improvements with regard to the revenue cycle process
- Conduct a comprehensive annual review of chargemaster (CDM) to ensure charge level appropriateness and compliance with recent updates
- Catalog and determine profitability of all major commercial payers, comparing payment to Medicare and seek contract increases, if necessary

REVENUE CYCLE (CONTINUED)



- Reorient the overall managerial focus on the revenue cycle process to the “front end” of the value chain (e.g. pre-authorizations, scheduling, registration, etc.) and a measurement culture
  - Establish workflow to pre-register all scheduled services including appointment verification, insurance verification, and a co-insurance discussion with patient
  - Ensure 100% of outpatient procedures are scheduled and pre-registered with proactive discussion of estimated costs. Collection of patient co-payment, deductible and coinsurance should be requested based on verified information
- Prioritize improvement of Point of Service (POS) cash collection amounts, with particular focus in all outpatient departments, and hold staff accountable through the creation of POS collection goals
  - Establish similar POS cash collections in hospital owned physician practices
- Use current revenues as the basis for establishing POS collection goals for each department
- Implement a bad debt policy that establishes when claims will be deemed worthless and uncollectable for inclusion on the cost report
- Implement a quick pay discount that matches the average commercial discount to increase cash flow and reduce bad debt
- Target Days in DNFB to 5 days
- With aggressiveness of Medicare Advantage and commercial payer related to denial, ensure an effective denial management system in place
- Develop process to ensure third-party payers are paying accurately based on contracted rates

MANAGEMENT ACCOUNTING



- Engage managers in the process of developing operating and capital budgets to foster ownership and accountability
  - Educate all managers on the budget process and basic financial management principles
  - Manager involvement in both department revenue and expenses
- Consistently hold managers accountable for monthly variance reporting by requiring rationale and actions related to positive/negative budget variances
- Establish performance monitoring dashboards for all managers
- Provide monthly budget to actual reports to all department managers and mentor them to improve financial understanding and commitment to accountability
  - Develop process where department managers are required to prepare variance reporting for pre-determine variances from budget and plan monthly DOR meetings with CFO/CEO for overall financial/business mentoring

STAFFING

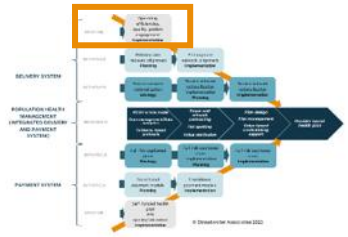
- Use volume-based staffing benchmarks to evaluate departmental staffing levels for possible inefficiencies
  - Continue to monitor departments/units, recognizing that staffing maybe already be at a minimum threshold
- Ensure balanced effort on managing staff and growing services
- Establish a long-term recruitment plan that involves sponsoring additional H1B Visa employees and aggressively recruiting new nurses and techs from local colleges

Sample of Selected Departments

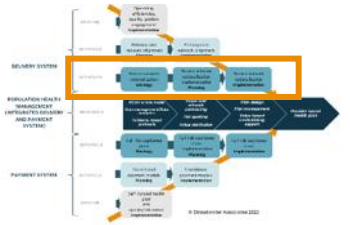
Department	Performance Indicator	FY 2020 Volume	Hourly Standard[1]	FTEs @ Standard	Actual FTEs[2]	Varian
Nursing - Med Surg	Per Patient Day	4,525	12.00	26.11	33.89	7.7
Nursing - Obstetrical/Postpartum L	Per Patient Day	289	10.00	1.39	7.44	6.(
Nursing - Nursery	Per Patient Day	260	5.00	0.63	-	(0.63)
Inpatient Subtotal				28.12	41.33	13.21
Nursing - Surgery - Major	Per Case	250	11.00	1.32	16.32	15.00
Nursing - Surgery - Minor	Per Case	1,918	5.50	5.07	-	(5.07)
Nursing - Recovery Room	Per Case	2,168	3.30	3.44	-	(3.44)
Surgery Subtotal				9.83	16.32	6.49
Emergency Room	Per Visit	7,718	2.75	10.20	14.54	4.34
UR/Case Mgr/Soc Ser	Patient Days	5,074	0.75	1.83	6.60	4.77
Nursing Administration	Per Adj. Admissions	6,988	1.75	5.88	4.08	(1.80)
Subtotal Nursing				55.87	82.87	27.01
Radiology	Per Procedure	35,451	1.36	23.22	14.88	(8.34)
Lab/Blood Bank	Per Test	202,460	0.25	24.33	16.62	(7.71)
Occupational Therapy	Per Treatment	23,763	0.50	5.71	7.29	1.58
Speech Therapy	Per Treatment	2,902	1.00	1.40	1.55	0.16
Cardio/Pulmonary	Per Procedure	25,810	0.71	8.84	14.36	5.52
Pharmacy	Per Adjusted Day	22,854	0.60	6.59	16.41	9.82
Subtotal Ancillary				70.09	71.11	1.02
Subtotal - Clinical				125.96	153.98	28.02
Hospital Administration	Per Adj. Admissions	6,988	1.65	5.54	7.56	2.01
Information Systems / Telecom	Per Adj. Admissions	6,988	1.36	4.57	4.31	(0.26)
Human Resources	Per Adj. Admissions	6,988	1.10	3.70	-	(3.70)
Marketing/Public Rel/Volunteers	Per Adj. Admissions	6,988	1.03	3.46	-	(3.46)
General Accounting	Per Adj. Admissions	6,988	1.23	4.13	2.15	(1.98)
Security	Gross Square Feet	181,263	0.02	1.74	0.63	(1.11)
Patient Accounting	Per Adj. Admissions	6,988	3.00	10.08	10.57	0.49
Admitting/Patient Registration	Per Adj. Admissions	6,988	3.79	12.72	13.95	1.23
Medical Records	Per Adj. Admissions	6,988	3.00	10.08	7.30	(2.78)
Cent Supply/Mtl Mgmt/Sterile	Per Adjusted Day	22,854	0.20	2.20	6.07	3.87
Housekeeping	Net Square Feet	108,758	0.25	13.07	15.61	2.54
Dietary	Meals Served	46,377	0.20	4.46	10.20	5.74
Plant Ops/Maintenance	Gross Square Feet	181,263	0.08	6.97	5.61	(1.36)
Laundry and Linen	Lbs of Laundry	186,232	0.02	1.79	1.77	(0.02)
Subtotal Support				84.51	85.74	1.23
				210.47	239.72	29.26

[1] Hourly Standards based on Stroudwater sample of hospitals

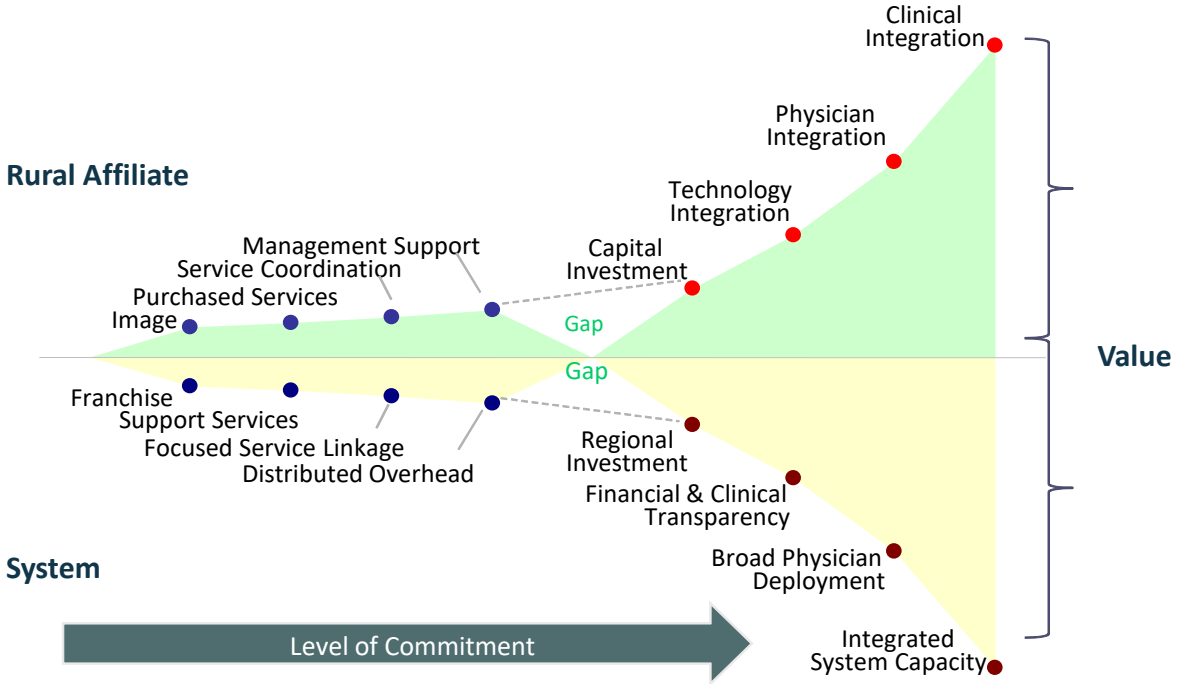
[2] FY 2018 internal information provided by hospital administration



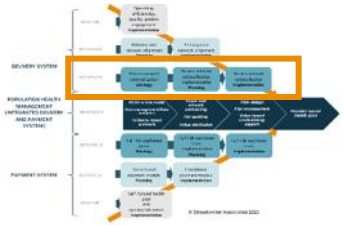
SERVICE AREA RATIONALIZATION



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

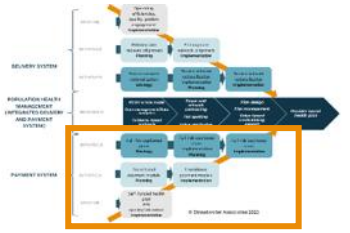


ALIGNMENT BEST PRACTICES



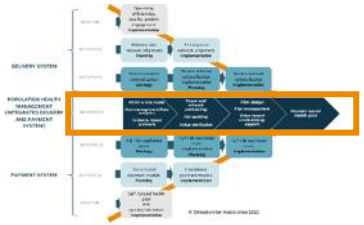
- Independent peer rural hospitals will evaluate partnership and affiliation opportunities based on the needs of the organization to solidify their position within the market
- Evaluate strategic partnership options using the Affiliation Value Curve to guide the determination of mutual opportunities with an emphasis on the following priorities:
  - Improve physician and clinical integration throughout the service area and region
  - Increase access to network specialists
  - Expand integrated and coordinate care management capabilities while establishing best practice, evidence-based medical protocols
  - Capital investments
  - Expense reductions through administrative integration and group purchasing
  - Technological integration and support

PAYMENT SYSTEM TRANSFORMATION



- Increase use of FFS payment systems that pay for health-related activity such as annual wellness visits, chronic care management, commercial insurance quality incentive programs, etc.
  - Implement Chronic Care Management (CCM), Transitional Care Management (TCM) and Behavioral Health Intervention (BHI) programs and billing codes to generate incremental revenue and build greater loyalty among primary care patients
    - Explore strategies to improve patient compliance through the use of health coaches and health navigator roles
- Incorporate population health interventions, such as disease management programs to manage overall benefits costs, into the employee health plan and learn how to provide high-quality, low-cost health care to sell to external markets
- Consider a self-insured health plan as an opportunity to better understand population health management of a defined, at-risk population
  - Redesign plan benefits to provide incentives for healthy behavior, disincentives for unhealthy behavior, and that maximize use of your health system for services through co-pay differentials
  - Partner with TPA/Broker to manage claims targeting reduced out-migration and more effective spending
- Proactively develop a strategy to participate in a population health payment mechanisms, and consider an ACO model or alternative payment system option that meets the needs of the hospital
  - Leverage Accountable Care Organization (ACO) to improve health outcomes, improve the continuity of care, and transition organization towards a value-based reimbursement model
- Consider benefit of converting coverage to a pilot population health intervention (such as disease management programs) to manage overall benefits costs and test providing high-quality, low-cost health care to sell to external markets, beginning with the hospital's self-insured population, if indicated
- Look to maximize commercial incentives through the development and application of population health management practices

POPULATION HEALTH



- Implement the use of evidence-based protocols and care management processes in conjunction with the medical staff to ensure seamless and efficient quality care for all patients
- Evaluate claims data (self-insured plan, ACO, etc.) to better understand opportunities for improved health of the workforce/community and better efficiencies in plan design, including reducing outmigration
    - Implement a data analytics platform and use employee claims data, once received, as a proxy for a regional care plan to improve outcomes throughout the community
- Evaluate the Patient Centered Medical Home (PCMH) certification through NCQA or a PCMH-like structure as a key strategy for future population health positioning
    - Consider incorporating team-base care features into PCMH
    - Ensure that all third-party payers recognize Patient Centered Medical Home (PCMH) status, and that hospital is to be reimbursed for per member per month case management fees

QUESTIONS?

COMING UP...

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.

October 9th at 10am EDT

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.

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

STROUDWATER

THANK YOU

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