STROUDWATER

CAH FINANCIAL & OPERATIONAL BEST PRACTICES:

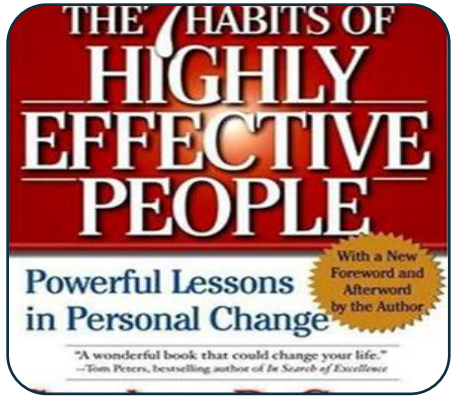
THE HIGH-IMPACT LEVERS THAT MOVE THE NEEDLE

June 11, 2026

3 PILLARS OF FINANCIAL AND OPERATIONAL SUCCESS

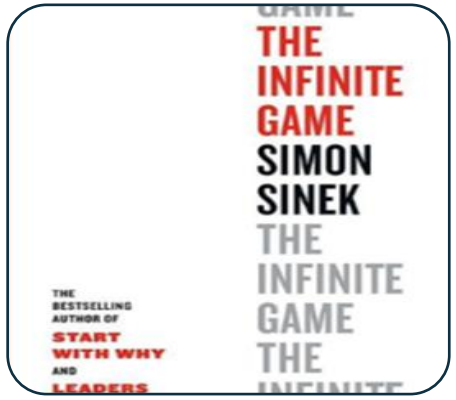
- Possessing an Abundance/Infinite Game Mindset
- Understanding of Hospital Economics
- Establishing a Measurement Culture

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.

HOSPITAL ECONOMICS

- Understand the difference between contribution margin and profit on fully allocated costs
  - Variable Cost
    - Definition: Expenses that change with changes in activity
    - Examples: *Pharmaceuticals, reagents, film, food*
  - Fixed Cost
    - Definition: Expenses that do not change with changes in activity
    - Examples: *Salaries and benefits, rent, utilities*
  - Rural hospitals have inordinately high fixed costs relative to revenue (Examples: 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 1,000s 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 and 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/

HOSPITAL ECONOMICS

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 a 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

MEASUREMENT CULTURE

Have an effective organizational design that drives accountability into the organization.

Decision Rights

- Drive decision rights down to clinical/operation level
- Education to department managers on business of healthcare
  - Avoid separation of clinical and financial functions

Performance Measurement

- 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

Compensation

- Recognize performance in line with organizational goals

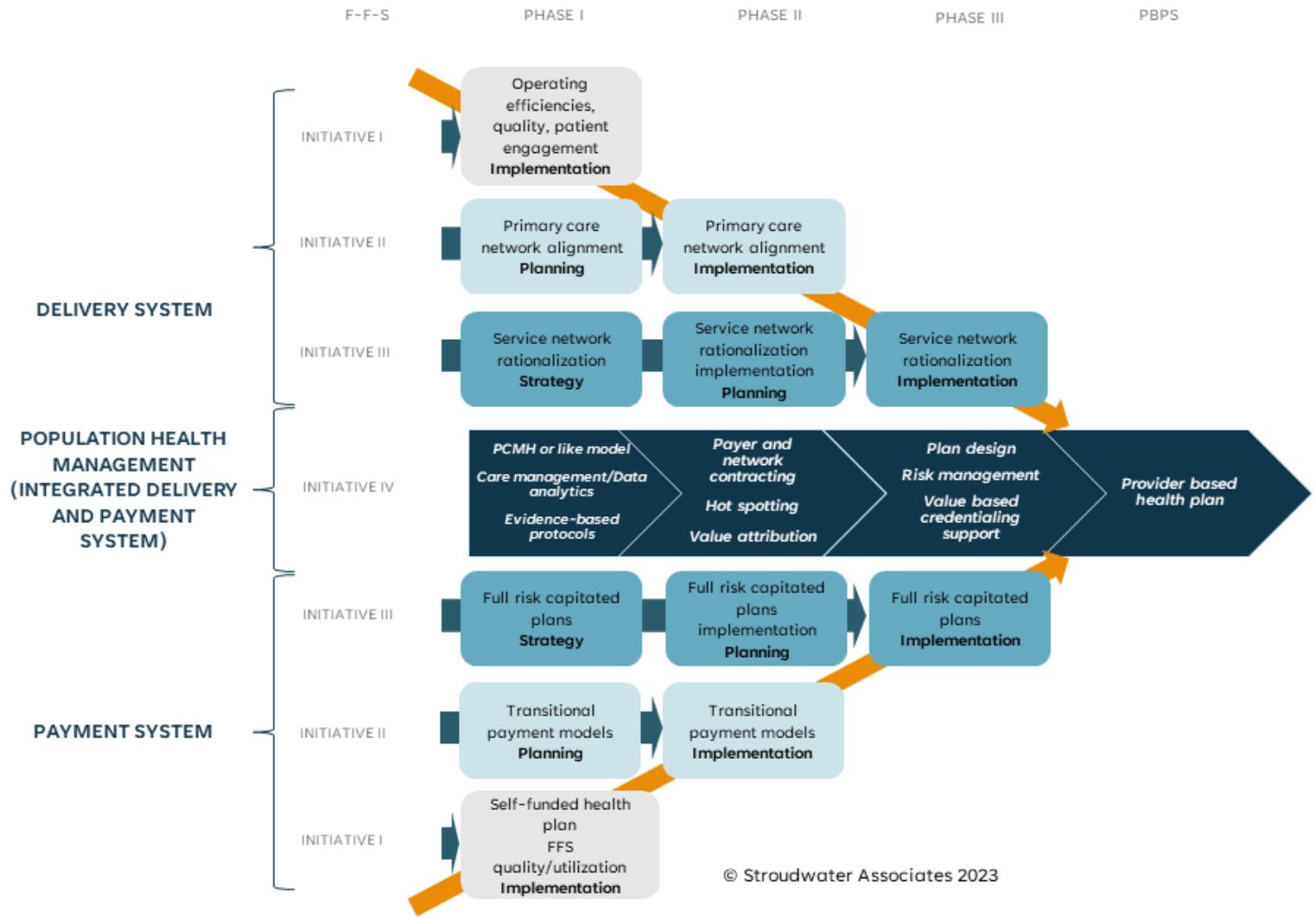
FINANCIAL AND OPERATIONAL BEST PRACTICES

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

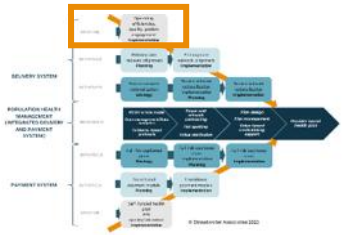
- ❑ Strategy
- ❑ Inpatient Services
- ❑ Emergency Services
- ❑ Clinical Departments
- ❑ Departmental Profitability
- ❑ Quality Improvement
- ❑ Information Technology
- ❑ Cost Report Improvement
- ❑ Revenue Cycle
- ❑ Management Accounting
- ❑ Staff Benchmark Analysis
- ❑ Provider Complement/Practice Management
- ❑ Provider Alignment
- ❑ Service Area Rationalization
- ❑ Alignment Strategy
- ❑ Payment System Transformation
- ❑ Population Health Management

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

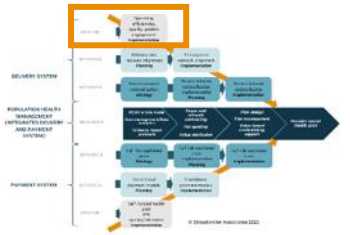


INPATIENT SERVICES: VOLUME GOALS



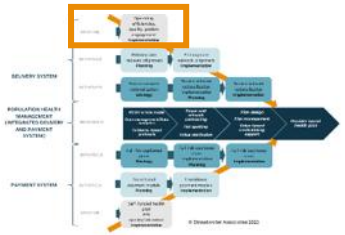
- **Target an ED admission rate (acute admissions and observation status) of between 10%-12% by partnering with medical staff to ensure appropriateness of care decisions, as well as to identify opportunities to reduce transfers**
- Implement systems to ensure all patients who are transferred to other 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 Practitioners 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



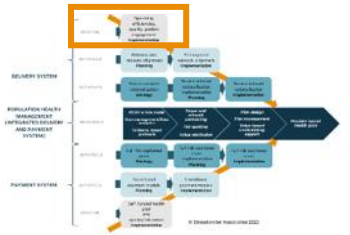
- **Target 20 – 30% of acute days as observation**
  - Review and educate the medical staff on admission and observation status criteria
- **Elevate the development and promotion of the swing bed program as a strategic priority, targeting an Average Daily Census (ADC) of 3 patients per 10,000 population**
  - Develop an “Active Pursuit” swing bed marketing plan focused on offered services, targeting employed physicians, area providers, case managers, and area hospitals
    - Actively engage the area hospital for swing bed opportunities that may be appropriate for the swing bed program at the 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: INTERNAL MONITORING



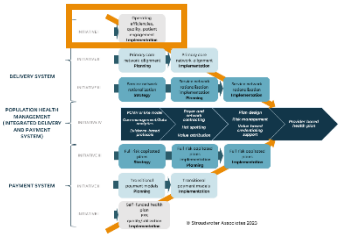
- **Track and monitor KPIs by individual provider related to the Emergency Department, including:**
  - ED admissions (acute/observation) as a percentage of ED visits to between 10% and 12%
  - Transfer rates as a percentage of Emergency Department visits to below 5% of all ED visits
  - Throughput measures: Door to MD, Door to Discharge, Door to Admit, Door to Transfer, LWOT, AMA, etc.
    - Note: Track ED KPIs at the individual provider level
- **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

EMERGENCY SERVICES: CAPTURING APPROPRIATE PATIENTS



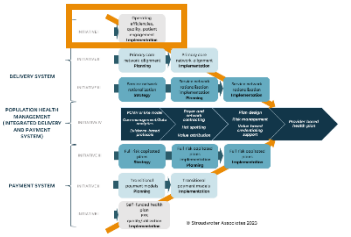
- **Work with medical staff and system partner to review appropriateness of transfers and leverage development of ED-hospitalist coverage model to enable patients to remain at hospital for care when medically appropriate**
  - **Review patient transfers for potential missed opportunities**
- Develop strategies to better manage demand for non-emergent care within the community, to include the following:
  - Establish “levels of care” to be assigned during triaging of non-emergent and emergent patients and compare with billed levels of care to measure accuracy and investigate variance
  - 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

OUTPATIENT/ANCILLARY DEPARTMENTS



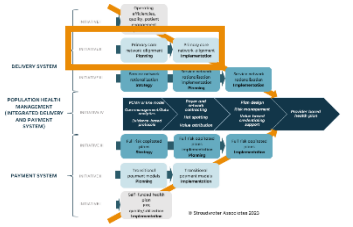
- **Department managers to transition from “catching” to ”pitching” with growth focus**
- **Target growth in surgical volume, using market data to set market share goals by service type, considering opportunities to further partner with tertiary providers to gain access to specialists and improve OR utilization**
- Ensure surgeons and capabilities are promoted to the community
- Develop a report to capture surgical referral patterns by provider, including source, specialty, and conversion to downstream OR volume
- 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**
- Consider additional opportunities to expand access to reduce current scheduling wait times
- Conduct ROI analyses to determine the feasibility of upgrading and replacing diagnostic (imaging, lab, etc.) equipment
- Conduct contribution margin analysis to ensure high-cost departments do not return a negative contribution margin
- **Evaluate current staffing levels for opportunities to enhance efficiency with a focus on volume growth**

OUTPATIENT/ANCILLARY DEPARTMENTS (CONTINUED)



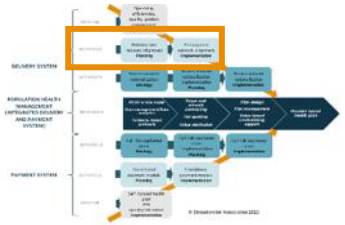
- Imaging: Replace equipment that has extended beyond useful life and consider additional investment in equipment that is nearing the end of life.
- **PT: Reduce 8-10 week wait-times for therapy services to best practice of less than 3 days by re-evaluating staffing model and implementing efficiency metrics per therapist**
- **PT: Decrease the existing no-show and cancellation rates of 15-17% and target a wait time of 3 days or less for appointments**
- PT: Continue to evaluate new programs or services that could be offered through certified therapists and implement those programs if there is a clear ROI
- Lab: Partner with local nursing homes and attend community health fairs, serving as a brand leader
- **Lab: Ensure the lab compendium of services is updated on an annual basis, with the goal to maintain the best practice of 90% of tests kept in-house versus reference lab**
- Lab: Conduct strategic pricing reviews to develop outpatient fee schedules that are market competitive
- **Pharmacy: Develop strategies to maximize 340B financial opportunities targeting between $400K and $450K per 10K provider-based clinic visits**
  - Consider Alternative distribution model to address manufacturers restricting deliveries to one pharmacy
  - Ensure referred specialty services are included as eligible 340B visits
- Pharmacy: Establish channel partnerships with local area retail pharmacies, or develop in-house retail pharmacy operation depending on results of ROI analysis

PROVIDER COMPLEMENT/PRACTICE MANAGEMENT



- **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
- Evaluate and explore relationships with specialty providers to increase both the access and the number of services offered within the primary service area
- **Evaluate revising physician compensation contracts to include production (WRVUs), panel size and quality scores**
- **Continue to enhance alignment with the area primary care providers that strengthens clinic decision rights, improves functional alignment and creates partnership opportunities**
    - Engage all providers in an effort to ensure balanced participation
- **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.)**
    - **Provide providers with quarterly production reports benchmarked to MGMA standards**
- Evaluate E&M coding relatively by provider to ensure it is reasonably distributed among the different levels
- Ensure practice CDM is updated to reflect current Relative Value Unit weighting at a % of Medicare

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**

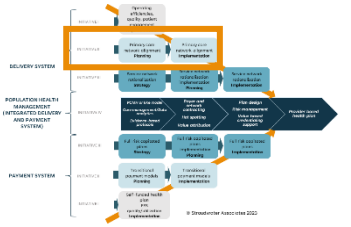
Physician Shortage/Surplus Adjusted Service Area Population: **19,913**

	Supply Study Range	Existing[1]	(Shortage)/Surplus 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

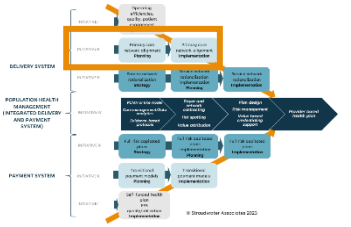


- Pursue increased alignment with regional primary care providers in the service area through functional, contractual and governance alignment strategies given the future importance of primary care network development to developing payment systems

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

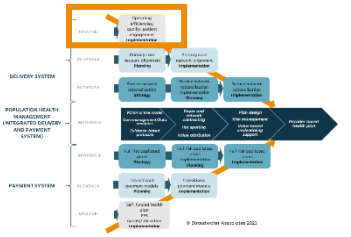
- **Refine and expand the provider compensation strategy to better align with organizational goals and improve provider productivity and financial performance, with consideration to the following:**
  - **Productivity incentives**
  - **Quality incentives**
  - **Patient panel growth and maintenance**
  - **Compliance (chart completion, meeting attendance, etc.) incentives**
- Evaluate opportunities to engage medical staff in leadership and decision-making, such as Board involvement or executive committees
- Assess the communication channels between the administration and the medical staff
  - Ensure adequately scheduled meetings in which admin/medical staff can share updates and discuss operational, clinical, and strategic needs of the organization

PROVIDER COMPLEMENT/PRACTICE MANAGEMENT



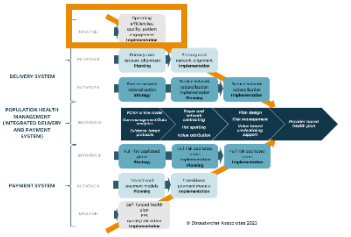
- **Ensure third-party payers are allowing updated (2021) E&M work relative values (e.g., current non-facility, total RVU for 99213 is 2.73 vs. 2.11 in 2020)**
- Conduct annual fair market value assessments and Stark Rule analyses for all employed physicians to comply with federal requirements
- Use MGMA benchmarks for both production and staffing to ensure practices run efficiently
- **Target POS collections, managed based on expected patient responsibility**

QUALITY/PERFORMANCE IMPROVEMENT



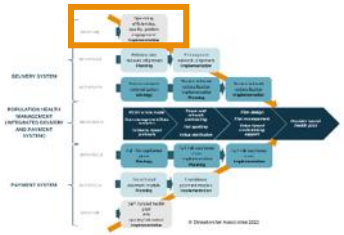
- **Establish quality as a strategic priority with the goal of being the best in the region within 12 months**
- Continue to update the Board and Medical Staff on quality performance and initiative progress every month
- **Establish a multidisciplinary quality committee that meets monthly, include a 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



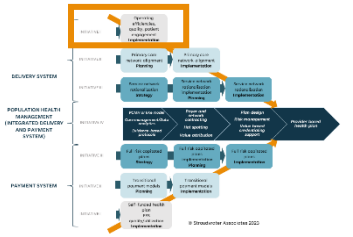
- **Report on public metrics to increase accountability and to compete regionally on quality scores through marketing of public quality and patient safety metrics**
- Emphasize the importance of quality improvement to staff from the top down
- Ensure that participation in quality metrics measurement 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



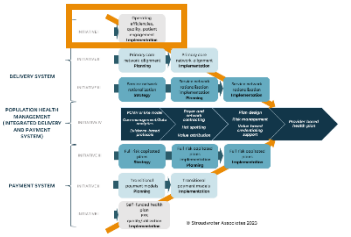
- **Recognize IT as a strategic asset, rather than as an expense to be managed**
- **Develop a structured, multi-year IT strategy and roadmap to harness technology for operational efficiencies, data-driven insights, enhanced cybersecurity, and executive oversight with the purpose of transforming IT from a cost center into a strategic enabler via:**
  - Governance and Leadership: Form an IT Steering Committee with C-level executives, clinicians, and a dedicated CIO or interim consultant that will meet quarterly to align IT with clinical and financial goals
  - Infrastructure Assessment and Modernization: Evaluate aging hardware and software (e.g., WiFi, email, scanning systems) to pinpoint vulnerabilities, then execute phased upgrades via grants and managed services for a reliable IT foundation
  - Security and Compliance Foundation: Implement robust cybersecurity frameworks, HIPAA-compliant tools, and regular audits (e.g., SOC 2) through external firms to protect against breaches and meet regulations, reducing risks without relying on limited internal capabilities
  - EMR Standardization and Interoperability: Pursue migration to a single EMR platform to improve medical record access and quality, cut costs, and streamline workflows
- **Schedule and or include IT systems as a part of periodic disaster drills and mitigate single points of failure throughout the system**

COST REPORT IMPROVEMENT BEST PRACTICES



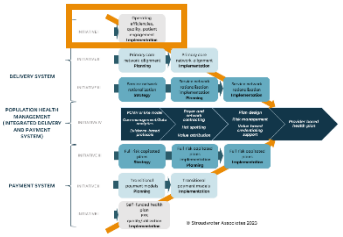
- Evaluate Med-Surg department square footage to incorporate the hallways to ensure accuracy of cost report; Minimum expectation is at least 300 square feet allocated for each inpatient bed
- **Utilize best practice time study methodology to ensure the physician stand-by time is accurate and fairly reflected 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 the 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



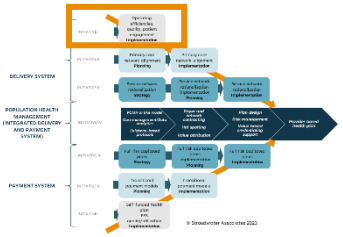
- **Evaluate LDRP vs. Med-Surg room usage based on observation status vs. active labor status (Med-Surg) time studies to accurately allocate square footage**
  - **Ensure costs for Labor and Delivery (LDRP) include only the time assigned to “active” delivery; otherwise, those costs should be allocated 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 the ‘bottom line’
- Monitor appropriate assignment of non-Medicare/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 the cost report preparer to determine if investment funds can be designated as funded depreciation to avoid a significant offset
- Implement a time study process and conduct medical record time studies to accurately capture true worked time by department for inclusion on the cost report

REVENUE CYCLE



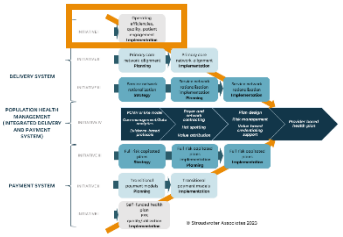
- **Establish a Key Performance Indicator (KPI) measurement system and set targets for all KPIs and strategies put in place to specifically address improving KPIs to targeted levels**
- Establish, target, track, and manage performance indicators, such as the following HFMA best-practice revenue-cycle metrics, in an effort to improve revenue cycle performance:
  - Cash collected and cash percentage of net revenue
  - Gross and Net A/R 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, which 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 the chargemaster (CDM) to ensure charge level appropriateness and compliance with recent updates
- Catalog and determine the profitability of all major commercial payers, comparing payments 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 the 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 on 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 Discharged Not Final Billed (DNFB) to 5 days
- With the aggressiveness of Medicare Advantage and commercial payers related to denial, ensure an effective denial management system is in place

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 a process where department managers are required to prepare variance reporting for pre-determined variances from budget, and plan monthly DOR meetings with the CFO/CEO for overall financial/business mentoring

STAFFING

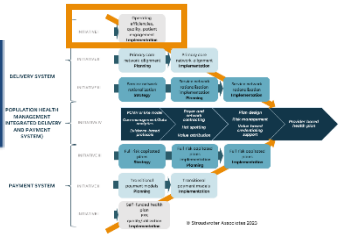
- Use volume-based staffing benchmarks to evaluate departmental staffing levels for possible inefficiencies
  - Continue to monitor departments/units, recognizing that staffing may already be at a minimum threshold
- Ensure balanced effort on managing staff and growing services
- Establish a long-term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

Sample of Selected Departments

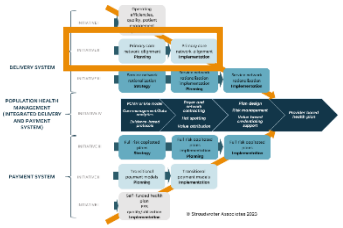
Department	Performance Indicator	FY 2024 Volume	Hourly Standard[1]	FTEs @ Standard	Actual FTEs[2]	Variance
Nursing - Med Surg	Per Patient Day	2,706	12.00	15.61	13.13	(2.48)
Nursing - Obstetrical/Postpartum Unit	Per Patient Day	408	10.00	1.96	9.17	7.21
Nursing - Nursery	Per Patient Day	316	5.00	0.76	0.50	(0.26)
Nursing - ICU/CCU	Patient Day	440	20.75	4.39	6.79	2.40
Inpatient Subtotal				22.72	29.60	6.88
Nursing - Surgery - Major	Per Case	3,231	11.00	17.09	19.26	2.17
Nursing - Endoscopy/GI Lab	Per Case	1,203	3.60	2.08	3.00	0.92
Nursing - Other OP Proc	Per Case	3,645	1.60	2.80	2.29	(0.51)
Nursing - Recovery Room	Per Case	4,435	3.30	7.04	3.25	(3.78)
Surgery Subtotal				29.01	27.80	(1.21)
Emergency Room	Per Visit	5,352	2.75	7.08	14.94	7.86
UR/Case Mgr/Soc Ser	Patient Days	3,430	0.75	1.24	4.48	3.24
Nursing Administration	Per Adj. Admissions	7,750	1.75	6.52	9.53	3.00
Subtotal Nursing				66.57	86.34	19.77
Radiology	Per Procedure	22,410	1.37	14.74	14.64	(0.10)
Lab/Blood Bank	Per Test	168,002	0.25	20.19	17.03	(3.16)
Physical Therapy	Per Treatment	19,975	0.50	4.80	7.47	2.67
Occupational Therapy	Per Treatment	11,244	0.50	2.70	1.68	(1.02)
Speech Therapy	Per Treatment	450	1.00	0.22	0.65	0.44
Pharmacy	Per Adjusted Day	17,108	0.60	4.94	5.74	0.81
Subtotal Ancillary				47.59	47.21	(0.38)
Subtotal - Clinical				114.15	133.55	19.40
Hospital Administration	Per Adj. Admissions	7,750	1.65	6.15	8.14	1.99
Information Systems / Telecom	Per Adj. Admissions	7,750	1.36	5.07	6.64	1.57
Human Resources	Per Adj. Admissions	7,750	1.10	4.10	3.82	(0.28)
Marketing/Public Rel/Volunteers	Per Adj. Admissions	7,750	1.03	3.84	5.12	1.29
General Accounting	Per Adj. Admissions	7,750	1.23	4.58	3.04	(1.55)
Security	Gross Square Feet	290,244	0.02	2.79	-	(2.79)
Patient Accounting	Per Adj. Admissions	7,750	3.00	11.18	10.21	(0.96)
Admitting/Patient Registration	Per Adj. Admissions	7,750	3.79	14.10	8.31	(5.79)
Medical Records	Per Adj. Admissions	7,750	3.00	11.18	7.03	(4.15)
Cent Supply/Mtl Mgmt/Sterile	Per Adjusted Day	17,108	0.20	1.65	4.70	3.05
Plant Ops/Maintenance	Gross Square Feet	290,244	0.08	11.16	3.39	(7.78)
Subtotal Support				75.79	60.38	(15.42)
Total				**189.95**	**193.93**	**3.98**

[1] Hourly Standards based on Stroudwater sample of hospitals

[2] FY2024 internal information provided by hospital administration



STAFF/HUMAN RESOURCES

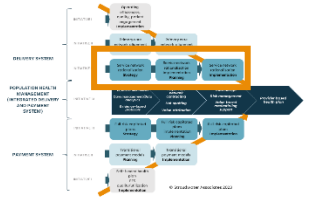


- Leverage compensation surveys from local associations to benchmark and reset employee compensation, ensuring wage competitiveness and supporting recruitment and retention
  - “My employer does not set payment rates. The market does.”
- Implement a standardized annual performance evaluation process and incorporate performance-based incentives to support merit-based compensation.
  - Align organizational goals (e.g., financial performance, quality, and employee engagement) with incentive structures to drive accountability and performance.
- **Self-Insured Health Plan: Ensure that the TPA can provide claims data on a routine basis to help address outmigration and inform plan design**
  - **Strategically use claims data to manage outmigration, with the goal of increasing market share and keeping care local, while targeting a reduction in outmigration**

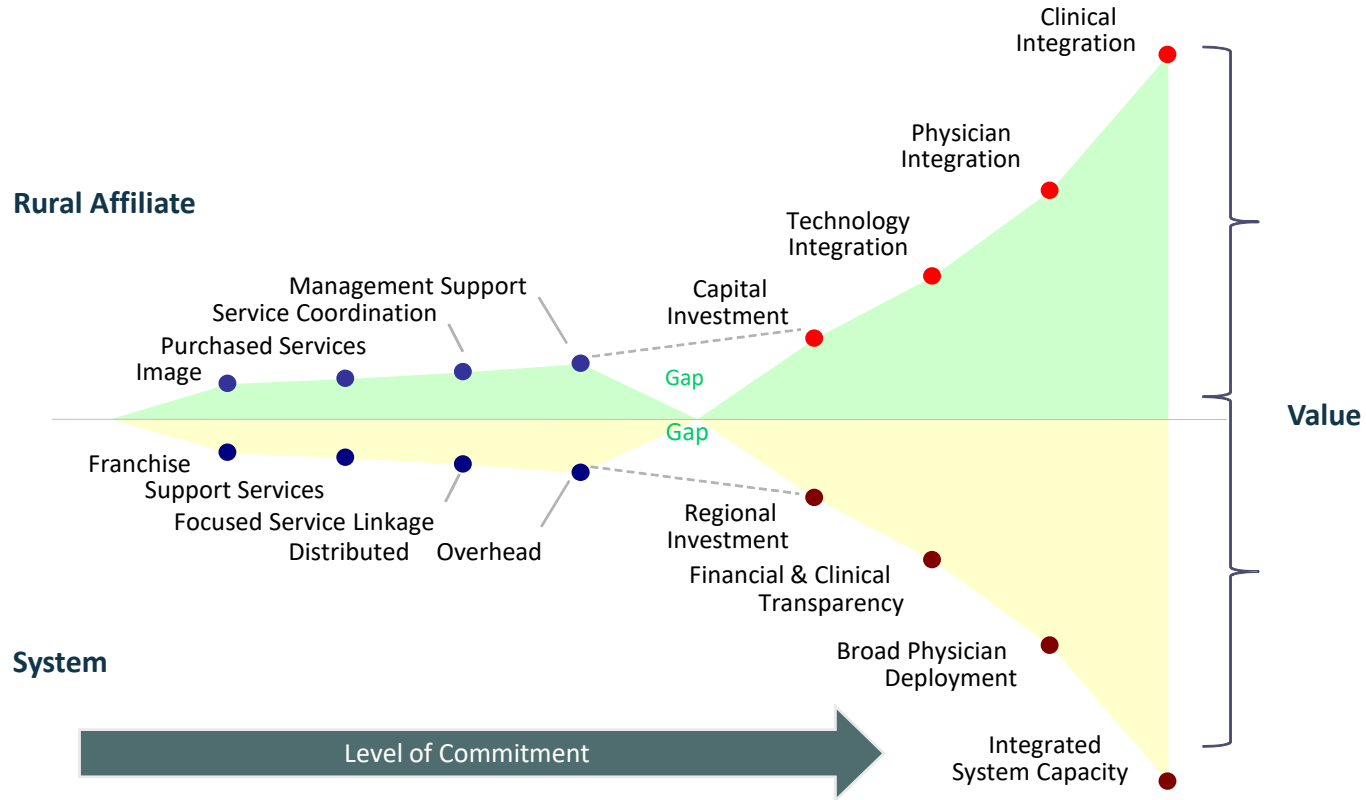
Self-Insured Health Plan: Include incentives for health behavior and disincentives for poor health choices (e.g., smoking) into self-insured plan design, creating opportunities for a healthier workforce

- **Establish the best practice of $0 copays for insured employees and dependents receiving care “in-house”**

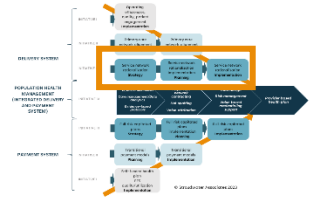
SERVICE AREA RATIONALIZATION



- 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

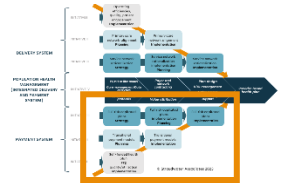


ALIGNMENT BEST PRACTICES



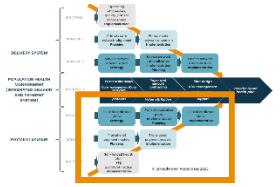
- Independent peer rural hospitals will evaluate partnership and affiliation opportunities based on the needs of the organization to solidify their position within the market
- Evaluate strategic partnership options using the Affiliation Value Curve to guide the determination of mutual opportunities 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



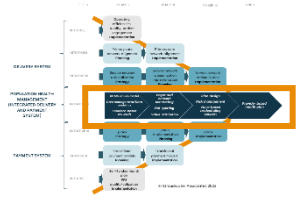
- **Increase use of FFS payment systems that pay for health-related activity such as annual wellness visits, chronic care management, commercial insurance quality incentive programs, etc.**
  - Implement Chronic Care Management (CCM), Transitional Care Management (TCM), and Behavioral Health Intervention (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 to 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 mechanism, 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 the organization towards a value-based reimbursement model

PAYMENT SYSTEM TRANSFORMATION (CONT.)



- Consider the 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
- Maximize commercial incentives through the development and application of population health management practices

POPULATION HEALTH



- Implement the use of evidence-based protocols and care management processes in conjunction with the medical staff to ensure seamless and efficient quality care for all patients
- **Evaluate claims data to better understand opportunities for improved health of the workforce and better efficiencies in plan design**
  - Implement a data analytics platform and use employee claims data, once received, as a proxy for a regional care plan to improve outcomes throughout the community
- 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-based care features into PCMH
  - Ensure that all third-party payers recognize PCMH status, and that the hospital is to be reimbursed for per-member-per-month case management fees
- **Develop claims analysis capabilities for available claims (ACO, self-insured health plan, etc.) and use them to reduce outmigration and spend**

QUESTIONS?

STROUDWATER

COMMITTED TO INCREASING THE IMPACT OF RURAL AND COMMUNITY HEALTHCARE.

Our team of rural and community healthcare experts support the leadership of hospitals, health systems with a rural footprint, and the groups and clinics that form an essential care network across the 97% of the US that is defined as rural.

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