The Healthcare Environment Has Changed!

- In the past 36 months, the healthcare field has experienced considerable changes with an increased number of rural-urban affiliations, physicians transitioning to hospital employment models, flattening volumes, CEO turnover, etc.

- Federal healthcare reform passed in March 2010 with sweeping changes to healthcare systems, payment models, and insurance benefits/programs
  - Many of the more substantive changes will be implemented over the next two years
  - State Medicaid programs are moving toward managed care models or reduced fee for service payments to balance State budgets
  - Commercial insurers are steering patients to lower cost options

- Thus, providers face new financial uncertainty and challenges and will be required to adapt to the changing market
The Challenge: Crossing the Shaky Bridge
The Premise

Finance

- Macro-economic Payment System
  - Government Payers
    - Changing from F-F-S to PBPS
  - Private Payers
    - Follow Government payers
    - Steerage to lower cost providers

Function

- Provider Imperatives
  - F-F-S
    - Management of price, utilization, and costs
  - PBPS
    - Management of care for defined population
    - Providers assume insurance risk

Form

- Provider organization
  - Evolution from
    - Independent organizations competing with each other for market share based on volume to
    - Aligned organizations competing with other aligned organizations for covered lives based on quality and value

Network and care management organization

- New competencies required
  - Network development
  - Care management
  - Risk contracting
  - Risk management

MARKET OVERVIEW  TRANSITION  FRAMEWORK  STRATEGIES  4
Payment Transition - CMMI

Category 1
Fee for Service – No Link to Quality & Value

Category 2
Fee for Service – Link to Quality & Value

Category 3
APMs Built on Fee-for-Service Architecture

Category 4
Population-Based Payment

A
Foundational Payments for Infrastructure & Operations

B
Pay for Reporting

C
Rewards for Performance

D
Rewards and Penalties for Performance

A
APMs with Upside Gainsharing

B
APMs with Upside Gainsharing/Downside Risk

A
Condition-Specific Population-Based Payment

B
Comprehensive Population-Based Payment
Transition Framework Framework - What Is It?
Delivery System Strategy

• Delivery system must respond to at a similar pace to changing payment models in order to maintain financial viability
  • Getting too far ahead or lagging behind will be hazardous to their health
Initiative I - Operating Efficiencies, Patient Safety and Quality

- Hospitals not operating at efficient levels are currently, or will be, struggling financially

- “Efficient” is defined as
  - Appropriate patient volumes meeting needs of their service area
  - Revenue cycle practices operating with best practice processes
  - Expenses managed aggressively
  - Physician practices managed effectively
  - Effective organizational design

Graphic: National Patient Safety Foundation
Focus on Quality and Patient Safety
- As a strategic imperative
- As a competitive advantage

### Initiative I - Operating Efficiencies, Patient Safety and Quality

<table>
<thead>
<tr>
<th>Reported Core Measures:</th>
<th>National Avg.</th>
<th>Tennessee Average</th>
<th>Johnson County Community Hospital</th>
<th>Johnson City Medical Center</th>
<th>Sycamore Shoals Hospital</th>
<th>Watauga Medical Center</th>
<th>Johnston Memorial Hospital</th>
<th>Bristol Regional Medical Center</th>
<th>Wake Forest Baptist Medical Center</th>
<th>Franklin Woods Community Hospital</th>
<th>Holston Valley Medical Center</th>
<th>Caldwell Memorial Hospital</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Timely Heart Attack Care</strong></td>
<td>7</td>
<td>6</td>
<td>6</td>
<td>6</td>
<td>8</td>
<td>0</td>
<td>6</td>
<td>6</td>
<td>8</td>
<td>100%</td>
<td>98%</td>
<td>100%</td>
</tr>
<tr>
<td>Avg. # of mins before OPs w/ chest pain or possible heart attack got an ECG</td>
<td>97%</td>
<td>96%</td>
<td>97%</td>
<td>96%</td>
<td>98%</td>
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<td>100%</td>
</tr>
<tr>
<td>OPs w/ chest pain or possible heart attack who got aspirin within 24 hrs of arrival</td>
<td>97%</td>
<td>96%</td>
<td>97%</td>
<td>96%</td>
<td>98%</td>
<td>100%</td>
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<td>100%</td>
</tr>
<tr>
<td><strong>Timely Emergency Department Care</strong></td>
<td>116</td>
<td>114</td>
<td>97</td>
<td>149</td>
<td>125</td>
<td>137</td>
<td>136</td>
<td>149</td>
<td>167</td>
<td>139</td>
<td>154</td>
<td>125</td>
</tr>
<tr>
<td>Avg. time patients spent in ED before being sent home</td>
<td>21</td>
<td>23</td>
<td>15</td>
<td>14</td>
<td>9</td>
<td>19</td>
<td>18</td>
<td>21</td>
<td>22</td>
<td>13</td>
<td>31</td>
<td>29</td>
</tr>
<tr>
<td>Avg. time patients spend in ED before they were seen by a healthcare provider</td>
<td>54</td>
<td>52</td>
<td>40</td>
<td>57</td>
<td>58</td>
<td>50</td>
<td>50</td>
<td>54</td>
<td>32</td>
<td>30</td>
<td>66</td>
<td>57</td>
</tr>
<tr>
<td>Avg. time patients who came to the ED w/ broken bones had to wait for pain meds</td>
<td>2%</td>
<td>2%</td>
<td>1%</td>
<td>2%</td>
<td>0%</td>
<td>2%</td>
<td>0%</td>
<td>2%</td>
<td>3%</td>
<td>1%</td>
<td>2%</td>
<td>4%</td>
</tr>
<tr>
<td>Percentage of patients who left the emergency department before being seen</td>
<td>2%</td>
<td>2%</td>
<td>1%</td>
<td>2%</td>
<td>0%</td>
<td>2%</td>
<td>0%</td>
<td>2%</td>
<td>3%</td>
<td>1%</td>
<td>2%</td>
<td>4%</td>
</tr>
</tbody>
</table>

Source: www.hospitalcompare.hhs.gov
Date: 7/1/2014-6/30/2015
Initiative II - Primary Care Alignment

- Understand that revenue streams of the future will be tied to primary care physicians, which often comprise a majority of the rural and small hospital healthcare delivery network
  - Thus small and rural hospitals, through alignment with PCPs, will have extraordinary value relative to costs

- Physician Relationships
  - Hospital align with employed and independent providers to enable interdependence with medical staff and support clinical integration efforts
    - Contract (e.g., employ, management agreements)
    - Functional (share medical records, joint development of evidence based protocols)
    - Governance (Board, executive leadership, planning committees, etc.)
  - Potential Model for Rural:
    - New PHO
Initiative III - Rationalize Service Network

- Develop system integration strategy
  - Evaluate wide range of affiliation options ranging from network relationships, to interdependence models, to full asset ownership models
    - Interdependence models through alignment on contractual, functional, and governance levels, may be option for rural hospitals that want to remain “independent”
  - Explore / Seek to establish interdependent relationships among small and rural hospitals understanding their unique value relative to future revenue streams
  - Identify the number of providers needed in the service area based on population and the impact of an integrated regional healthcare system
  - Conduct focused analysis of procedures leaving the market
    - Understand real value to hospitals
      - Under F-F-S
      - Under PBPS (Cost of out of network claims)
• Providers have opportunities to “shorten” and “stabilize” the shaky bridge by:
  • Working with payers to create transitional payment models
  • Initiating development with payers of full-capitation payment models
Payment System Strategy - Initiative I

- Develop self-funded employer health plan
  - Hospital is already 100% at risk for medical claims thus no risk for improving health of employee “population”
  - Change benefits to encourage greater “consumerism”
    - Differential premium for elective “risky” behavior
  - “Enroll” employee population in health programs – health coaches, chronic disease programs, etc.

- FFS Quality and Utilization Incentives
  - Maximize FFS incentives for improving quality or reducing inappropriate utilization (e.g., inappropriate ER visits, re-admissions, etc.)
Payment System Strategy - Initiatives II and III

**Initiative II: Implementation planning for transitional payment models**

- Transitional payment models include:
  - FFS against capitation benchmark w/ shared savings
  - Shared savings model Medicare ACOs
  - Shared savings models with other governmental and commercial insurers
  - Partial capitation and sub-capitation options with shared savings

- Prioritize insurance market opportunities
- Take the initiative with insurers to gauge interest and opportunities for collaborating on transitional payment models
- Explore direct contracting opportunities with self-funded employers

**Initiative III: Develop strategy for full risk capitated plans**
Population Health Strategies

- A narrow rural/urban provider network focused on patient value
  - Aggregates multiple rural/CAH populations for critical mass
  - Restricted to payers willing to commit to population health and payment
    - On CCO’s terms
    - NOT for existing fee-for-service or cost contracts
- Actively secures and manages risk/reward-based payer contracts
- Supports PCP-focused quality & care coordination across the network
- Retains local hospital independence, but with contractual accountability
- Houses care management infrastructure
Population Health Strategies - Phase I

Phase I: Develop Population Health building blocks

• Goal: Infrastructure to manage self insured lives and maximize FFS Utilization and quality incentives

• Initiatives:
  • PCMH or like structure
  • Care management
    • Discharge planning across the continuum
      • Transportation, PCP, meds, home support, etc.
    • Transitions of care (checking in on treatment plan)
      • Medication reconciliation
      • Post discharge follow-up calls (instructions, teach back, medication check-in)
    • Identifying community resources
    • Maintain patient contact for 30 days
  • Develop claims analysis capabilities/infrastructure
  • Develop evidenced based protocols
Implementation Framework - In Review

F-F-S | PHASE I | PHASE II | PHASE III | PBPS

INITIATIVE I
Operating efficiencies, quality, patient engagement Implementation

INITIATIVE II
Primary care network alignment Planning
Primary care network alignment Implementation

INITIATIVE III
Service network rationalization Strategy
Service network rationalization implementation Planning

INITIATIVE IV
Payer and network contracting
Hot spotting
Value attribution
Plan design
Risk management
Value based credentialing support
Provider based health plan

PCMI or like model
Care management/Data analytics
Evidence based protocols

INITIATIVE III
Full risk capitated plans Strategy
Full risk capitated plans implementation Planning

INITIATIVE II
Transitional payment models Planning
Transitional payment models Implementation

INITIATIVE I
Self-funded health plan FFS quality/utilization Implementation

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Conclusions/Recommendations

• For decades, rural hospitals have dealt with many challenges including low volumes, declining populations, difficulties with provider recruitment, limited capital constraining necessary investments, etc.
  • The current environment driven by healthcare reform and market realities now offers a new set of challenges. Many rural healthcare providers have not yet considered either the magnitude of the changes or the required strategies to appropriately address the changes
• Core set of new challenges represents the Triple Aim being played on in the market
• Locally delivered healthcare (including rural and small community hospitals) has high value in the emerging delivery system
• “Shaky Bridge” crossing will required planned, proactive approach
  • Finance will lead function and form
  • Maintain alignment between delivery system models and payment systems building flexibility into the delivery system model for the changing payment system
Conclusions/Recommendations (continued)

- Important strategies for providers to consider include:
  - Increase leadership awareness of new environment realities
  - Strategic plan to be updated to incorporate new strategic imperatives – “Bridge Strategy”
  - Improve operational efficiency of provider organizations
  - Adapt effective quality measurement and improvement systems as a strategic priority
  - Align/partner with medical staff members contractually, functionally, and through governance where appropriate
  - Seek interdependent relationships with developing regional systems
Discussion

• How can SORHs best support rural hospitals through this transition?