Small Rural Hospital Transition Project

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Greg Was, CEO
Lindsay Corcoran, MHA
Bethany Adams, MHA, FACHE, MT(ASCP)
Market Overview

• 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
Challenges Affecting Rural Hospitals

• Factors that will have a significant impact on rural hospitals over the next 5-10 years
  • Difficulty with recruitment of providers and aging of current medical staff
    • Struggle to pay market rates
  • Increasing competition from other hospitals and physician providers for limited revenue opportunities
  • Small hospital governance members without sophisticated understanding of small hospital strategies, finances, and operations
  • Consumer perception that “bigger is better”
  • Severe limitations on access to capital for necessary investments in infrastructure and provider recruitment
    • Facilities historically built around IP model of care
  • Increased burden of remaining current on onslaught of regulatory changes
    • Regulatory friction / overload
  • Payment systems transitioning from volume-based to value-based
  • Increased emphasis of quality as payment and market differentiator
  • Reduced payments that are “Real this time”
    • Third-party steerage (surgery, lab, and Imaging), RAC audits
The Transition

- Concern of task force members is that transitioning of the delivery system functions must coincide with transitioning payment system, or rural hospitals, without adequate reserves, will be a financial risk.

- Necessary for hospitals to survive the gap between pay-for-volume and pay-for-performance.

- Delivery system has to remain aligned with current payment system while seeking to implement programs/processes that will allow flexibility to new payment system.

- Delivery system must be ready to jump when new payment systems roll out.
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
Initiative I - Operating Efficiencies, Patient Safety and Quality

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

### Patient survey summary star rating. More stars are better. Learn More

<table>
<thead>
<tr>
<th>U.S. HHS Hospital Compare Measures</th>
<th>National Avg.</th>
<th>Kentucky Avg.</th>
<th>Marcum &amp; Wallace Memorial Hospital</th>
<th>Kentucky River Medical Center</th>
<th>University of Kentucky Hospital</th>
<th>Baptist Health Richmond</th>
<th>St. Joseph Hospital Berea</th>
<th>Clark Regional Medical Center</th>
</tr>
</thead>
<tbody>
<tr>
<td>Patient Satisfaction (HCAHPS) Average:</td>
<td>71%</td>
<td>72%</td>
<td>77%</td>
<td>72%</td>
<td>72%</td>
<td>69%</td>
<td>77%</td>
<td>71%</td>
</tr>
<tr>
<td>Nurses &quot;Always&quot; communicated well:</td>
<td>79%</td>
<td>81%</td>
<td>87%</td>
<td>83%</td>
<td>81%</td>
<td>79%</td>
<td>83%</td>
<td>77%</td>
</tr>
<tr>
<td>Doctors &quot;Always&quot; communicated well:</td>
<td>82%</td>
<td>84%</td>
<td>89%</td>
<td>82%</td>
<td>79%</td>
<td>79%</td>
<td>88%</td>
<td>84%</td>
</tr>
<tr>
<td>&quot;Always&quot; received help when wanted:</td>
<td>68%</td>
<td>69%</td>
<td>76%</td>
<td>72%</td>
<td>70%</td>
<td>63%</td>
<td>74%</td>
<td>66%</td>
</tr>
<tr>
<td>Pain &quot;Always&quot; well controlled:</td>
<td>71%</td>
<td>72%</td>
<td>77%</td>
<td>72%</td>
<td>72%</td>
<td>69%</td>
<td>75%</td>
<td>68%</td>
</tr>
<tr>
<td>Staff &quot;Always&quot; explained med's before administering</td>
<td>64%</td>
<td>66%</td>
<td>69%</td>
<td>68%</td>
<td>64%</td>
<td>59%</td>
<td>72%</td>
<td>64%</td>
</tr>
<tr>
<td>Room and bathroom &quot;Always&quot; clean:</td>
<td>74%</td>
<td>75%</td>
<td>85%</td>
<td>74%</td>
<td>75%</td>
<td>77%</td>
<td>82%</td>
<td>74%</td>
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<tr>
<td>Area around room &quot;Always&quot; quiet at night:</td>
<td>61%</td>
<td>64%</td>
<td>63%</td>
<td>67%</td>
<td>62%</td>
<td>57%</td>
<td>70%</td>
<td>67%</td>
</tr>
<tr>
<td>YES, given at home recovery information:</td>
<td>86%</td>
<td>86%</td>
<td>87%</td>
<td>85%</td>
<td>86%</td>
<td>86%</td>
<td>88%</td>
<td>88%</td>
</tr>
<tr>
<td>&quot;Strongly Agree&quot; they understood care after discharge:</td>
<td>51%</td>
<td>53%</td>
<td>57%</td>
<td>49%</td>
<td>54%</td>
<td>52%</td>
<td>56%</td>
<td>52%</td>
</tr>
<tr>
<td>Gave hospital rating of 9 or 10 (0-10 scale):</td>
<td>71%</td>
<td>71%</td>
<td>78%</td>
<td>73%</td>
<td>72%</td>
<td>68%</td>
<td>78%</td>
<td>73%</td>
</tr>
<tr>
<td>YES, definitely recommend the hospital:</td>
<td>71%</td>
<td>71%</td>
<td>75%</td>
<td>68%</td>
<td>77%</td>
<td>65%</td>
<td>77%</td>
<td>70%</td>
</tr>
</tbody>
</table>

Source: www.hospitalcompare.hhs.gov
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
  • Hospitals 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.)
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 Provider Based Payment System (Cost of out-of-network claims)
Payment System Initiatives

- **Initiative I: Develop self-funded employer health plan**
  - Hospital is already 100% at risk for medical claims
  - Change benefits to encourage greater “consumerism”
  - Begin creation of care management infrastructure
  - Begin to move up the learning curve
  - Cost reduction opportunity for the delivery system

- **Initiative II: Begin 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**
Initiative IV - Population Based Payment System

• 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

• Legal entity with corporate powers
  • Governance structure for setting strategy, policy, accountability

• 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
Initiative IV - Population Based Payment System

• Phase I: Develop care management building blocks
  • Goal: Infrastructure to manage self-insured lives
  • Initiatives:
    • PCMH or like model
    • Develop claims analysis capabilities/infrastructure
    • Develop evidence-based protocols
Summary/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.

• Important strategies for providers to consider include:
  • Increase leadership awareness of new environment realities
  • Improve operational efficiency of provider organizations
  • Adapt effective quality measurement and improvement systems as a strategic priority
  • Align/partner with medical staff members contractually, functionally, and through governance where appropriate
  • Seek interdependent relationships with developing regional systems
History of White Mountain Regional Medical Center

February 1995 – Long-standing management relationship with Samaritan Health Services ends. Local Board assumes control.

July 1995 – Voters approve the creation of White Mountain Communities Special Health Care District.
- The District uses a property tax to help fund services for the Medical Center

2000 – Hospital declares bankruptcy

2004 – Hospital emerges from bankruptcy

2008 – WMRMC becomes a Critical Access Hospital
News from the Front Lines

“Fifty-five rural hospitals have closed since 2010, and 283 more are on the brink of closure” -NRHA today

“Community hospital survival guide: Strategies to keep the doors open” -NRHA today

“The shortchanging of rural America” -NRHA today

“Douglas hospital to close after Medicare penalty”
- www.azcentral.com
How the SRHT Project & Stroudwater Assisted WMRMC

• Provided much needed consulting services at no cost to the hospital
• Stroudwater Associates has a great deal of experience with CAHs
• Stroudwater provided excellent data analysis, enhanced the decision-making process
• Eric Shell from Stroudwater was an excellent facilitator in the action planning session and really challenged everyone
• Independence of Stroudwater enhanced the process
• Provided direction and focus throughout the entire process
• Externally driven process with strict timeframes and deliverables. The project never lost energy.
• Board, leadership and staff were highly engaged
• Follow-up is provided after project completion
WMRMC’s Service Area
Service Area Medicare Market Share

<table>
<thead>
<tr>
<th>Facility</th>
<th>Medicare Market Share</th>
<th>Medicare Cases</th>
</tr>
</thead>
<tbody>
<tr>
<td>Summit Healthcare Regional Medical Center</td>
<td>21% 23% 17% 20% 21%</td>
<td>113 146 98 101 100</td>
</tr>
<tr>
<td>White Mountain Regional Medical Center</td>
<td>21% 17% 20% 21% 20%</td>
<td>115 108 113 108 94</td>
</tr>
<tr>
<td>Phoenix Baptist Hospital</td>
<td>1% 3% 2% 7%</td>
<td>6 16 9 34</td>
</tr>
<tr>
<td>Flagstaff Medical Center</td>
<td>7% 5% 5% 5% 7%</td>
<td>39 33 29 24 33</td>
</tr>
<tr>
<td>Banner Good Samaritan Medical Center</td>
<td>3% 3% 4% 2% 4%</td>
<td>16 19 23 12 20</td>
</tr>
<tr>
<td>Mountain Vista Medical Center</td>
<td>5% 13% 6% 3% 3%</td>
<td>29 82 33 17 16</td>
</tr>
<tr>
<td>Mayo Clinic Hospital</td>
<td>2% 3% 2% 2% 3%</td>
<td>13 20 11 12 12</td>
</tr>
<tr>
<td>Saint Joseph's Hospital and Medical Center</td>
<td>4% 3% 4% 5% 3%</td>
<td>20 22 21 26 12</td>
</tr>
<tr>
<td>Chandler Regional Medical Center</td>
<td>1% 1% 1% 2%</td>
<td>7 9 5 10</td>
</tr>
<tr>
<td>All Other</td>
<td>35% 100% 40% 39% 29%</td>
<td>187 198 227 198 138</td>
</tr>
<tr>
<td>Grand Total</td>
<td>100% 100% 100% 100%</td>
<td>539 643 571 512 469</td>
</tr>
</tbody>
</table>

- WMRMC’s Medicare market share has decreased 1 percentage point from 2009 (21%) to 2013 (20%)
  - Peer rural hospitals generally capture 40% Medicare inpatient market share in their local ZIP code
- Summit Healthcare in Show Low has increased Medicare market share by 4% points since 2011
- Total Medicare market share has decreased 13% from 539 in 2009 to 469 discharges in 2013
  - Decline can be attributed to the transition from less complex inpatient medical care, which has historically supported rural hospitals, to outpatient medical care
WMRMC’s Financial Performance

- **Days Cash on Hand** increased from 8 days in 2012 to 21 days in 2013, declining to 18 days in 2014 as a result of increased net A/R (see below) and is currently at Arizona CAH median levels of 18 days cash on hand, but below US median levels of 69 days
  - Cash increased to 21 days in 2013 due to the receipt of approximately $800k in EHR incentive revenue
- **Days in Net A/R** increased to a high of 49 days in 2014 due to increasing prevalence of high deductible health plans resulting in additional self pay after insurance balances remaining in A/R and payment plans
  - Best practice rural hospitals target maximum of 45 days of both gross and net A/R
- **Average Payment Period** has remained relatively stable over the report period at best practice peer rural hospital standards of 35 days or below
WMRMC’s Financial Performance

- **Operating Revenue** increased approximately 2% between 2011 and 2014
  - Operating revenue has been positively affected by decreasing bad debt and charity care amounts between 2012 and 2014 as a result of newly insured patients obtaining Medicaid and private insurance through the ACA

- **Operating Expenses** decreased from 2013 to 2014 by approximately 3% due to a reduction in force of approximately 9-10 employees
SRHT Tracking Measures

• Tracking measures for project monitoring and post-project follow up:

  ✓ Increase total margin (net income) by 10% (on an annualized basis)
  ✓ Increase net patient revenue by 2.5% (on an annualized basis)
  ✓ Increase days-of-cash and investments on hand by 10 days
Top Initiatives Identified for WMRMC

• Primary care alignment
  • RHC Assessment
  • PCP Recruitment
  • Functional Alignment
  • PHO Development
• Revenue Cycle Management
  • Key Performance Indicators
• Grow outpatient services
  • Develop reference/retail fee schedules
  • Marketing services
• Build our swing bed program
  • Promote rehabilitation and orthopedic services
• Grow surgery services
Top Initiatives Identified for WMRMC

• Review staffing models
  • Utilize benchmarking studies

• Continue to improve and market quality of care
  • Improve hospital exterior (parking lot)
  • Continue to build “A Culture of High Performance” – Studer Group
  • Improve community perception
    • Publicize latest HCAHPS Scores – July 2013 through June 2014
      HCAHPS Composite Score 8th out of 70 Arizona hospitals

• Strategic plan development
  • System alignment
  • Payment transformation
  • Population health management
  • Patient Centered Medical Home

• Develop 340B Drug Pricing Program
Questions?

Thank you.