Preparing for Market-Driven Health Care
10:45 a.m. – 12:00 p.m.

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Preparing for Market Driven Healthcare

Rural Health Care Symposium
Brave New World — Transition Strategies for Rural Hospitals
March 14, 2013

Eric K. Shell, CPA, MBA
The Healthcare Environment Has Changed!

- In the past 24 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 three years
  - State Medicaid programs are moving toward managed care models or reduced fee-for-service payments to balance State budgets
- Thus, providers face new financial uncertainty and challenges and will be required to adapt to the changing market
Market Overview — Washington Update

• CBO - January 2011 Report
  • Eliminate the following: Critical Access Hospitals (CAH), Medicare-Dependent Hospital (MDH) and Sole Community Hospital (SCH)
  • Projected Savings over 10 Years, $62.2B

• MedPAC — June 15, 2012 Release
  • MedPAC NOT adopting official recommendations but is prescribing “guiding principles” for future policy
  • CAH conclusions:
    – Keeps hospitals open, but not focused on isolated hospitals
    – Keeps neighboring hospitals open, even if there is excess capacity in the market
    – Cost sharing should be reduced, funded through “focusing” the program
Market Overview — Washington Update

• President’s Proposal — 2011/2012
  • $6 Billion in cuts to rural providers over 10 years

  • Eliminates “higher than necessary reimbursements”
    – Reduce bad debt payments to 25%, down from the current 70%. Save $20 billion over 10 years
    – Reduce CAH reimbursement to 100% of cost, down from the current 101%
    – End CAH reimbursement for facilities located 10 miles or less from another hospital
    – Limit the use of provider taxes beginning in FY 2015, but do not eliminate them entirely
Market Overview — Washington Update

- Stroudwater Analysis — November 7, 2011

Medicare Reimbursement (Parts A and B) (2008)

<table>
<thead>
<tr>
<th>Region</th>
<th>Urban</th>
<th>Rural</th>
</tr>
</thead>
<tbody>
<tr>
<td>New England</td>
<td>$8,889</td>
<td>$7,630</td>
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<tr>
<td>Middle Atlantic</td>
<td>$9,241</td>
<td>$8,459</td>
</tr>
<tr>
<td>South Atlantic</td>
<td>$9,208</td>
<td>$8,730</td>
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<td>East North Central</td>
<td>$9,329</td>
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<td>$10,143</td>
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<tr>
<td>Mountain</td>
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<tr>
<td>Pacific</td>
<td>$8,246</td>
<td>$7,022</td>
</tr>
<tr>
<td>Total</td>
<td>$9,140</td>
<td>$8,730</td>
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</table>

Source: The Dartmouth Atlas (Age, Sex, Race and Price-Adjusted Medicare Reimbursements per Beneficiary), weighted averages by HSA.
Market Overview — Healthcare Reform

• Coverage Expansion
  • By 1/1/14, expand Medicaid to all non-Medicare eligible individuals under age 65 with incomes up to 133% FPL based on modified AGI
    – Currently, Medicaid covers only 45% of poor (≤ 100% FPL)
    – 16 million new Medicaid beneficiaries; mostly “traditional” patients
    – FMAP for newly eligible: 100% in 2014 – 16; 95% in 2017; 94% in 2018; 93% in 2019; 90% in 2020+

• Establishment of State-based Health Insurance Exchanges

• Subsidies for Health Insurance Coverage

• Individual and Employer Mandate

• Provider Implications
  • Insurance coverage will be extended to 32 million additional Americans by 2019
    – Expansion of Medicaid is major vehicle for extending coverage
  • May release pent-up demand and strain system capacity
  • Traditionally underserved areas and populations will have increased provider competition
  • Have insurance, will travel!
Market Overview — Healthcare Reform

• Medicare and Medicaid Payment Policies
  • Medicare Update Factor Reductions
    – Annual updates will be reduced to reflect projected gains in productivity which will produce $895B over 10 years
      – 0.25% in 2010 – 2011; 0.35% in 2012 – 2013; 0.45% in 2014; 0.35% in 2015 – 2016; 1.0% in 2017 – 2019
  • Medicare and Medicaid Disproportionate Share Hospital (DSH) Payment Reductions
  • Medicare Hospital Wage Index
    – Likely redefinition of wage areas — projected savings $2.3B over 10 years
  • Independent Payment Advisory Board (IPAB)
    – Charged with figuring out how to reduce Medicare spending to targets with goal of $13B savings between 2014 and 2020

• Provider Implications
  • Payment changes will increase pressure on hospital margins and increase competition for patient volume
  • “Do more with less and then less with less”
  • Medicaid pays less than other insurers and will be forced to cut payments further
Market Overview — Healthcare Reform

• Medicare and Medicaid Delivery System Reforms
  • Expansion of Medicare and Medicaid Quality Reporting Programs
  • Medicare and Medicaid Healthcare-Acquired Conditions (HAC) Payment Policy
    – By Oct. 2014, the 25% of hospitals with the highest HAC rates will get a 1% overall payment penalty
  • Medicare Readmission Payment Policy
    – Hospitals with above expected risk-adjusted readmission rates will get reduced Medicare payments
  • Value based purchasing
    – Medicare will reduce DRG payments to create a pool of funds to pay for the VBPP
      ➢ 1% reduction in FFY 2013, Grows to 2% by FFY 2017
  • Bundled Payment Initiative
  • Accountable Care Organizations
    – Each ACO assigned at least 5,000 Medicare beneficiaries
    – Providers continue to receive usual fee-for-service payments
    – Compare expected and actual spend for specified time period
    – If meet specified quality performance standards AND reduce costs, ACO receives portion of savings
Market Overview — Healthcare Reform

• Medicare and Medicaid Delivery System Reforms (continued)
  • Accountable Care Organizations (continued)
    • 154 ACOs effective August, 2012
    • 259 ACOs effective January, 2013
      • 40% increase
    • More than half of the U.S. population now live in localities served by ACOs and almost 30 percent live in areas served by two or more.
    • 4 million Medicare beneficiaries, or about 11 percent of total Medicare fee-for-service beneficiaries, will now receive their healthcare from ACOs
      • The corresponding figures in September were 2.4 million and 6 percent
    • Total number of Medicare and non-Medicare patients served by Medicare-approved ACOs: 29 million

http://www.heraldonline.com/2013/02/19/4630015/accountable-care-organizations.html
Market Overview — Healthcare Reform

• Medicare and Medicaid Delivery System Reforms (continued)

• Provider Implications
  – Hospitals are taking the lead in forming Accountable Care Organizations with physician groups that will share in Medicare savings
  – Value-based purchasing program will shift payments from low performing hospitals to high performing hospitals
  – Acute care hospitals with higher than expected risk-adjusted readmission rates and HAC will receive reduced Medicare payments for every discharge
  – Physician payments will be modified based on performance against quality and cost indicators
  – There are significant opportunities for demonstration project funding
Market Overview — Other

- State Budget Deficits

- High Deductible Health Plans
  - Non Healthcare CEO quote:
    - “We just renewed our High Deductible Plan going into our third year, and guess what ... 5% reduction in premium!!! Needless to say everyone is thrilled. Not sure what the average HSA balance is, but I think it is high. Doing what it is supposed to do, turning health care patients into consumers.”
Challenges Affecting Rural Hospitals

- Factors that will have, or continue to have, a significant impact on rural hospitals over the next 5 – 10 years
  - Continued difficulty with recruitment of providers
  - Increasing competition from other hospitals and physician providers for limited revenue opportunities
  - Requirement that information technology is on par with large hospital systems
  - 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 of necessary investments in infrastructure and provider recruitment
  - Increased burden of remaining current on onslaught of regulatory changes
    - Regulatory Friction/Overload
  - Payment systems transitioning from volume-based to value-based
  - Increased emphasis on Quality as payment and market differentiator
  - Reduced payments that are “Real this time”
We Have Moved Into A New Environment!

- Subset of most recent challenges
  - Payment systems transitioning from volume-based to value-based
  - Increased emphasis as Quality as payment and market differentiator
  - Reduced payments that are “Real this time”

- New environmental challenges are the TRIPLE AIM!!!

- Market Competition on economic driver of healthcare: PATIENT VALUE
Future Hospital Financial Value Equation

- Definitions

- Patient Value

\[
\text{Patient Value} = \frac{\text{Quality}}{\text{Cost}}
\]

- Accountable Care:
  - A mechanism for providers to monetize the value derived from increasing quality and reducing costs
  - Accountable care includes many models including bundled payments, value-based payment program, provider self-insured health plans, Medicare defined ACO, capitated provider-sponsored healthcare, etc.
Future Hospital Financial Value Equation

• Economics

  • As payment systems transition away from volume-based payment, the current economic model of increasing volume to reduce unit costs and generate profit is no longer relevant
    - New economic models based on patient value must be developed by hospitals but not before the payment systems have converted
  • Economic Model: FFS Rev and Exp vs. Budget-Based Payment Rev and Exp
Future Hospital Financial Value Equation

• Value in Rural Hospitals
  • Lower per beneficiary costs
  • Revenue centers of the future
    – PCP-based delivery system
  • CAH cost-based reimbursement
    – Incremental volume drives down unit costs
    – Once commitment to community Emergency Room, system incentives to drive low acuity volume to CAH
    – MedPAC Confusion — Limited incentives to manage costs
Prioritized Challenges — Payment Systems

• Important elements of Volume-Based to Value-Based Payment Challenge
  • Hospital-acquired condition penalties (beginning 2013)
  • 30-day Readmission Penalties (beginning 2013)
    – Readmissions — how does hospital manage behavior of patient population
      ➢ Incentive to affect change now resides with providers
  • Value-Based Purchasing
    – VBP — 2013 withhold for PPS Hospitals
  • Bundled payment initiative
  • Self-funded health plans
    – Efficiencies around self-funded benefit plan to drive savings to hospital bottom line
      ➢ Incent employees to make better choices
        – Ex: Higher premiums for smoking, obesity, etc.
  • Medicare ACOs
Market Symptoms/Response

- Generally agreed that fertile market for ACOs to occur due to relatively low margins and need to transition from volume payment models due to reduced levels of fees
- In 10 years likely that 90% of hospitals will be aligned (10% will be truly independent)
  - Shift at accelerated pace of independent physicians to employed physicians
- Concern of task force members is that transitioning of the delivery system functions must coincide with transitioning payment system of rural hospitals, without adequate reserves, will be a financial risk
  - “Stepping onto the shaky bridge” analogy
- Non-ACO accountable care initiatives will require increased integration between medical staff and smaller hospitals
Prioritized Challenges — Payment Systems

• ACO Relationship to Small and Rural Hospitals

  • Small and rural hospitals bring value/negotiating power to affiliation relationship as generally PCP-based
    – Smaller community hospitals and rural hospitals have value through alignment with revenue drivers (PCPs), rather than cost drivers but must position themselves for new market:
      ➢ Functional alignment with PCPs in local service area
      ➢ Develop a position of strength by becoming highly efficient
      ➢ Demonstrate high quality through monitoring and actively pursuing quality goals
    – Smaller hospitals must better understand their value proposition to forming networks and **NOT** perceive themselves as approaching systems for a “hand out/bailout”
Prioritized Challenges — Payment Systems

• ACO Relationship to Small and Rural Hospitals (continued)

  • Revenue stream of future tied to Primary Care Physicians (PCP) and their patients
    – ACO language: PCP can belong to one ACO. Hospitals and specialists can belong to several
      ➢ Cost centers will become bricks and mortar, technology, and specialists
  • Smaller hospitals will not likely have the scale to form their own ACO and thus must consider their relationship with forming regional ACOs
    – Regional ACOs will look to increase number of covered patients to generate additional “revenue” and dilute fixed costs
Prioritized Challenges — Payment Systems

• Provider Strategies
  • 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
    – Engage commercial payers in conversation about change in payment process
    – Engage all forming regional ACOs in discussions
    – Develop clinical integration strategies with medical staff that increase likelihood of successfully implementing “non-ACO” accountable care programs
    – Evaluate all opportunities to increase efficiency and improve quality
    – Engage employers in wellness programs
Prioritized Challenges — Payment Systems

• Provider Strategies (continued)

• Hospital Affiliation Strategies
  – 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
  – 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
Prioritized Challenges — Payment Systems

• Provider Strategies (continued)
  • 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/Structure
  – Educate Board members about new market realities to both open eyes and influence decision makers in positive direction
    ➢ Goal is to take local politics out of major strategic decisions including affiliation strategies, medical staff alignment, in increasing hospital efficiency

  ➢ [https://secure.ruralcenter.org/help-registration/playbacks](https://secure.ruralcenter.org/help-registration/playbacks); or
Prioritized Challenges — Quality as Differentiator

- Important elements of challenge
  
  - Value-based payment program
    - Hospitals will be scored based on quality measures from three domains compared against peers (outcome score) and yourself (improvement scores)
  
  - Educated Consumers/Transparency
    - Hospital quality data available publicly
      - Hospital Compare
      - Health Leaders
      - Hospital websites
  
  - Small hospitals that lack sophisticated technology must combat negative market perceptions
  
  - Federal Office of Rural Health Policy initiatives MB-QIP program encouraging CAHs to report rural relevant quality measures
Prioritized Challenges — Quality as Differentiator

• Market Symptoms/Response
  • Rural hospitals have varying degree of acceptance as to rural relevant measures
    – Often unwilling to report (CAHs) as measures “not relevant to us”
    – Hospitals that have accepted measures are aggressively seeking to improve scores
  • Increasingly, patients have easy access through internet to hospital quality information (Healthgrades.com; Hospital Compare)
    – Hospital administration often not aware of their scores or do not believe their scores reflect the quality provided in their institutions
  • Rural hospitals that have performed well on quality scores are beginning to promote quality and safety of their hospitals
  • Loss of market share due to perceived or real quality deficiencies is much more serious threat to rural hospitals that potential loss of 1 – 3% Medicare inpatient reimbursement
  • Increasingly, quality will be differentiator in future provider recruitment
Prioritized Challenges — Quality as Differentiator

• Provider Strategies (continued)

  • Publicly report quality measures
    – All CAHs to begin reporting to Medicare Beneficiary Quality Improvement Program (MBQIP)
    – Increase internal awareness of internet based, publicly available, quality scores
    – Develop internal monitor systems to “move the needle”
    – Monitor data submissions to ensure reflect true operations
    – Consider reporting quality information on hospital website or direct patient to LA Hospital Compare
    – Staying current with industry trends and future measures
    – Educate staff on impact of how actual or perceived quality affects the hospital image
    – Must develop paradigm shift from quality being something in an office down the hall to something all hospital staff responsible for
      ➢ Shift from being busy work to being integrated in business plan
Prioritized Challenges — Quality as Differentiator

• Provider Strategies (continued)

  • Partner with Medical Staff to improve quality
    – Restructure physician compensation agreements to build quality measures into incentive-based contracts
    – Modify Medical Staff bylaws tying incentives around quality and outcomes into them

  • Ensure most appropriate methods are used to capture HCAHPS survey data
    – Consider transitioning from paper survey to phone call survey to ensure that method has increased statistical validity

  • Electronic Health Record (EHR) to be used as backbone of quality improvement initiative
    – Meaningful Use — Should not be the end rather the means to improving performance

  • Increase Board members understanding of quality as a market differentiator
    – Move from reporting to Board to engaging them (i.e., placing board member on Hospital Based Quality Council)
    – Quality = Performance Excellence
Prioritized Challenges — Cuts Are Real This Time!

• Important elements of challenge
  • Failure of Super Committee to reach agreement thus possible -2% sequestration impact beginning in 2013
  • Uncertainty related to future of state UPL and DSH programs
  • Value-Based Payment Program with 1% maximum cuts beginning in 2013 and 2% in 2017 and after
  • Re-admission payment with max. reduction of 1% in 2013 and 3% 2015 and after
  • RACs, MICs, etc.
  • High deductible commercial health plans (e.g., HSAs)
  • Commercial contract with insurers (not willing to cost share)
  • Healthcare Reform
    – Cuts in update factors for PPS
    – ACOs — potential reduction in volume
    – DSH dollars/UPL
  • Potential physician pay cuts
Prioritized Challenges — Cuts Are Real This Time!

• Market Symptoms/Response

  • Hospitals not operating at efficient levels are currently or will be struggling financially
    – Efficient being 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
  • Resources available for necessary investments in plant, technology, and recruitment are becoming increasingly scarce when required the most
  • Providers hospitals increasingly seeking affiliations primarily as a safety net strategy
Prioritized Challenges — Cuts Are Real This Time!

• Increase efficiency of revenue cycle function
  • Adopt revenue cycle best practices
    – Effective measurement system
    – “Super charging” front end processes including online insurance verification, point of service collections
    – Education on necessity for upfront collections
    – Ensure chargemaster is up to date and reflects market reality

• CAHs to ensure accuracy of the Medicare cost reports
  • Improving accuracy of Medicare cost reports often results in incremental Medicare and Medicaid revenue to CAHs

• Review profitable/non-profitable service lines to determine fit with mission and financial contribution to viability of organization
  • Define who you are and be good at it

• Continue to seek additional community funds to support hospital mission
  • Increase millage tax base where appropriate
  • Ensure ad valorem tax renewal
Prioritized Challenges — Provider Strategies

- Increase monitoring of staffing levels to reach the “sweet spot”
- Staffing education for DONs/Clinical managers
- Salary Survey/Staffing Levels/Benchmarks that are relevant

### Sample of Selected Departments

<table>
<thead>
<tr>
<th>Department</th>
<th>Performance Indicator</th>
<th>FY 2012 Volume</th>
<th>Hourly FTEs @ Standard</th>
<th>Actual FTEs</th>
<th>Variance</th>
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<tbody>
<tr>
<td>Nursing - Med Surg</td>
<td>Per Patient Day</td>
<td>3,263</td>
<td>12.00</td>
<td>18.82</td>
<td>36.82</td>
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<td>Nursing - Endoscopy/GI Lab</td>
<td>Per Case</td>
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<tr>
<td>Emergency Room</td>
<td>Per Case</td>
<td>2,672</td>
<td>2.40</td>
<td>3.08</td>
<td>-</td>
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<tr>
<td>UR/Case Mgr/Soc Ser</td>
<td>Patient Days</td>
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<td>0.75</td>
<td>1.18</td>
<td>-</td>
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<td>Nursing Administration</td>
<td>Per Adj. Admissions</td>
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<td>1.75</td>
<td>1.54</td>
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<td><strong>Subtotal Nursing</strong></td>
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<td>Radiology</td>
<td>Per Procedure</td>
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<td>Lab/Blood Bank</td>
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<td>Physical Therapy</td>
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<td>Cardiac Rehab</td>
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<tr>
<td>Speech Therapy</td>
<td>Per Treatment</td>
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<td>1.00</td>
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<tr>
<td>Cardio/Pulmonary</td>
<td>Per Procedure</td>
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<td>Pharmacy</td>
<td>Per Adjusted Day</td>
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<td><strong>Subtotal Ancillary</strong></td>
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<td><strong>Subtotal - Clinical</strong></td>
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<td>Hospital Administration</td>
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<td>1.46</td>
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<td>Information Systems</td>
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<td>Human Resources</td>
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<td>0.97</td>
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<td>Marketing/Planning/Public Re</td>
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<td>Volunteers</td>
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<td>Telecommunications</td>
<td>Per Adj. Admissions</td>
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<td>0.36</td>
<td>0.32</td>
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<td>General Accounting (5)</td>
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<td>1.23</td>
<td>1.09</td>
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<tr>
<td>Security</td>
<td>Gross Square Feet</td>
<td>-</td>
<td>0.02</td>
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<tr>
<td>Patient Accounting</td>
<td>Per Adj. Admissions</td>
<td>1,835</td>
<td>3.00</td>
<td>2.65</td>
<td>5.03</td>
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<td>Admitting/Patient Registration</td>
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<td>2.00</td>
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<td>Medical Records</td>
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<td>Cent Supply/Mt Mgmt/Sterile</td>
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<td>Housekeeping</td>
<td>Net Square Feet</td>
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<td>Dietary</td>
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<td>Plant Ops/ Maintenance</td>
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<tr>
<td>Laundry and Linen</td>
<td>Lbs of Laundry</td>
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<td>0.02</td>
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<td><strong>Subtotal Support</strong></td>
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<td>31.37</td>
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<td>73.52</td>
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</tbody>
</table>

1 Hourly Standards based on Stroudwater sample of hospitals
2 FY 2012 information provided by hospital administration (average of last three payrolls ending 2/4/2012)
Prioritized Challenges — Provider Strategies

• Develop LEAN production practices that consider the expenditure of resources for any goal other than the creation of value for the end customer to be wasteful
  • Preserving value/quality with less processes
  • Workflow redesign
  • Inventory levels/standardization
  • Response times
  • Replicating Successes among all hospitals
  • C-Suite training on LEAN/Six Sigma

• Evaluate self-funded health insurance plans for optimal plan design
  • Self-funded health insurance plans offer often overlooked opportunity to develop accountable care strategies for a defined patient base through aligning employee incentives through improved benefits design and more effective care management processes

• Evaluate 340B discount pharmacy program as an opportunity to both increase profit and reduce costs
  • Often 340B only looked upon as an opportunity to save costs not considering profit potential
Prioritized Challenges — Provider Strategies

- Develop physician practice expertise
Prioritized Challenges — Provider Strategies

• 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
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
• 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
  – Maintain alignment between delivery system models and payment systems building flexibility into the delivery system model for the changing payment system
Questions
Thank You

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