Market Overview

- 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.”
- Underinsurance
- State Budget Deficits
- Recovery Audit Contractors (RAC)
- Reduced Re-admissions
- Accelerating shift to outpatient care
- **MACRA (SGR Fix)**
- Comprehensive Pay Model
- 340B attacks
- New payment models
- Bipartisan Budget Act of 2015
## SGR Fix (MACRA) - Rate Changes Summary

<table>
<thead>
<tr>
<th>Time frame</th>
<th>Rate Increase</th>
</tr>
</thead>
<tbody>
<tr>
<td>2016 – 2019</td>
<td>0.5%</td>
</tr>
</tbody>
</table>
| 2020 – 2025 | 0%. Adjustments made based on physician’s choice to participate in 2 track program of MIPS or APM program  
• APM → 5% bonus (2020 – 2024; fee increase of 0.75%/yr.)  
• MIPS → -4 to +9% | 0.25% for all other physicians |
| 2026+       | • 0.75% for physicians participating in MIPS (Merit-Based Incentive Payment System) or an APM (Alternative Payment Model) program |

Sources: Health Affairs, Modern Healthcare, Congressional Budget Office
MACRA - MIPS

• April 16, 2015 – MACRA becomes law and SGR is out
• Merit-Based Incentive Payment Systems (“MIPS”) and Alternative Payment Systems (“APMs”)
  • Adjustments to FFS payments through MIPS based on:
    • Quality of Care (PQRS)
    • Resource Use (Value-based payment modifiers)
    • Meaningful Use EHR
    • Clinical Practice Improvement Activities
  • Both Positive and Negative Adjustments
    • Negative adjustments of 4% in 2019, 5% in 2020, 7% in 2021, and 9% in 2022
    • Positive adjustments of up to 3X the negative adjustments
  • EXCEPTIONAL performers receive additional incentive payments up to 10% of their FFS Medicare payments per year
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
  • Medicare and Medicaid Disproportionate Share Hospital (DSH) Payment Reductions
• Medicare Hospital Wage Index
• 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
• Summary Impact
### Market Overview - Healthcare Reform

#### ACA Payment Changes for Medicare and Medicaid

<table>
<thead>
<tr>
<th>Payment</th>
<th>Payment Reductions</th>
<th>Potential Offsets</th>
<th>Reduction through 2022</th>
</tr>
</thead>
<tbody>
<tr>
<td>Medicare DSH Payments</td>
<td>$10.2 Billion</td>
<td>$7.3 Billion new uncompensated care pool</td>
<td>$2.9 Billion</td>
</tr>
<tr>
<td>Medicaid DSH payments</td>
<td>$500 Million reduction in FY 2014 rising to $4 Billion/year by 2019</td>
<td>Medicaid expansion</td>
<td>$25 Billion</td>
</tr>
<tr>
<td>EHR Meaningful Use Incentive Payments</td>
<td>$5.5 Billion in 2012 and 2013 to $0 in 2016</td>
<td>None</td>
<td>$5.5 Billion</td>
</tr>
<tr>
<td>PPS Payment Reductions</td>
<td>1.7%</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Readmission Penalties</td>
<td>Increase from 1% to 2% in 2013</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Hospital Acquired Infections</td>
<td>1% penalty beginning in 2015</td>
<td></td>
<td></td>
</tr>
<tr>
<td>DRG Payments</td>
<td>1.25% reduction beginning in 2015 to fund value-based purchasing</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
Market Overview - Healthcare Reform

Payment Update
CMS is updating OPPS rates based on the projected hospital market basket increase of 2.4 percent minus both a 0.5 percentage point adjustment for multi-factor productivity and a 0.2 percentage point adjustment required by law. As described below, there is an additional finalized 2.0 percentage point adjustment to the payment update to redress inflation in the OPPS payment rates resulting from excess packaged payment for laboratory tests that continue to be paid separately outside of the OPPS. The final rate update will be -0.3 percent. After all other policy changes
• Medicare and Medicaid Payment Policies (continued)
• 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)
  • Medicare Accountable Care Organizations (continued)
    • 154 ACOs effective August, 2012
    • 287 ACOs effective January, 2013
    • 391 ACOs effective January, 2014
    • 426 ACOs effective January 2015
    • 477 ACOs effective January 2016

• 8.9 million Medicare beneficiaries, or about 25% of total Medicare fee-for-service beneficiaries, now in Medicare ACOs

• 64 ACOs are in a risk-bearing track including SSP, Pioneer ACO Model, Next Generation ACO Model, and Comprehensive ESRD Care Model


CMS website: http://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/sharedsavingsprogram/News.html
Where Are Medicare ACOs Forming?

Source: CMS 1/20/15- Mapped from address of parent ACO
FOR IMMEDIATE RELEASE
March 3, 2016

HHS.reaches goal of tying 30 percent of Medicare payments to quality ahead of schedule

A major milestone in the effort to improve quality and pay providers for what works

Thanks to tools provided by the Affordable Care Act, an estimated 30 percent of Medicare payments are now tied to alternative payment models that reward the quality of care over quantity of services provided to beneficiaries, HHS announced today. Today’s announcement means that over 10 million Medicare patients are getting improved quality of care by having more time with their doctors and better coordinated care – nearly a year ahead of schedule.
Fee-For-Service Financial Model Assumptions

• Utilization
  • Inpatient and Outpatient
    • Impact of ACA
    • Impact of Blue Cross steerage initiatives
• Revenue
  • Third party price increases
  • Cost based Medicare revenue
  • DSH payments (Zeroed out in 2014)
  • Bad debt % of patient service revenue (75% reduction in 2014)
    • Impact of ACA
    • Meaningful use incentive payments
  • Other operating revenue
  • Non-operating gains and
• Expenses
  • Salaries, wages and benefits
  • Productivity
  • Supplies and other
When operating income becomes negative in 2016, cash reserves start to decline.

- Can’t cut your way to sustainability
- Operational improvement and shared service economies of scale are insufficient to combat declining utilization
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
Closed Rural Hospitals Since the Beginning of 2010

Sources:
- Kaiser Commission on Medicaid and the Uninsured (Medicaid Expansion)
- The North Carolina Rural Health Research Program (Closures) - 3/23/2016

MAP OF THE UNITED STATES OF AMERICA

<table>
<thead>
<tr>
<th>State</th>
<th># Closed</th>
</tr>
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<tbody>
<tr>
<td>TX</td>
<td>10</td>
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<tr>
<td>TN</td>
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<tr>
<td>AL</td>
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<td>GA</td>
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<td>KY</td>
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<td>SD</td>
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<tr>
<td>VA</td>
<td>1</td>
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<td>1</td>
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</tbody>
</table>
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

- 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.
  - Different “this time”
    - Providers monetize value
    - Government “All In”
    - New information systems to manage costs and quality
    - Agreed upon evidence-based protocols
    - Going back is not an option
Future Hospital Financial Value Equation

- ACO Relationship to Small and Rural Hospitals
  - Revenue stream of future tied to Primary Care Physicians (PCP) and their patients
  - Small and rural hospitals bring value / negotiating power to affiliation relationships 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
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
The Challenge: Crossing the Shaky Bridge

Fee for Service Payment System

Population Based Payment System

MARKET OVERVIEW  TRANSITION  FRAMEWORK  STRATEGIES
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
Implementation Framework – What is it?

© Stroudwater Associates 2015
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
Operating Efficiencies, Patient Safety and Quality

- Grow FFS patient volume to meet community needs
  - “Catching to pitching”
  - Opportunities often include:
    - ER Admissions
    - Swing bed
    - Ancillary services (imaging, lab, ER, etc.)
- 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
  - Continue to seek additional community funds to support hospital mission
    - Increase millage tax base where appropriate
    - Ensure ad valorem tax renewal
Operating Efficiencies, Patient Safety and Quality

• 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 is only looked upon as an opportunity to save costs not considering profit potential
Operating Efficiencies, Patient Safety and Quality

- 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
  - CAHs – Cost report becomes a significant driver of reimbursement
    - Top Cost Report Errors
      - Medicare Bad Debts
      - Nursing Administration
      - RHC Provider FTE Count
      - Double Counting of Expenses
      - RCC inconsistencies
      - Statistical Allocation of Costs
      - Physician Stand-by Costs in EDs
      - Related Party Cost Allocations
      - LDRP Allocations
Increase monitoring of staffing levels staffing to the “sweet spot”

- Staffing education for DONs/Clinical managers
- Salary Survey / Staffing Levels / Benchmarks that are relevant
Operating Efficiencies, Patient Safety and Quality

- Develop physician practice expertise
Operating Efficiencies, Patient Safety and Quality

• 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
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>University of Kentucky Medical Center</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>69%</td>
<td>77%</td>
<td>71%</td>
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<tr>
<td>Nurses &quot;Always&quot; communicated well:</td>
<td>79%</td>
<td>81%</td>
<td>87%</td>
<td>83%</td>
<td>79%</td>
<td>79%</td>
<td>83%</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>
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<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>
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<td>Pain &quot;Always&quot; well controlled:</td>
<td>71%</td>
<td>72%</td>
<td>77%</td>
<td>72%</td>
<td>69%</td>
<td>69%</td>
<td>75%</td>
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<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>
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<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>
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<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>
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<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>
</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>
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<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>
</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>
</tr>
</tbody>
</table>

Source: www.hospitalcompare.hhs.gov
Operating Efficiencies, Patient Safety and Quality

- 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
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
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)
Payment System Strategy

• **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 - 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
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
• Important strategies for providers to consider include:
  • Increase leadership awareness of new environment realities
    • Access resources to support key transitional strategies
      • Rural Hospital Toolkit for Transitioning to Value-Based Systems
  • 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
The Rural Bridge to Value and Population Health

Terry Hill
Senior Advisor of The Center and Executive Director of RHI
April 8, 2016
Triple Aim

- Better health
- Better care
- Lower cost

- Better Care
- Smarter Spending
- Healthier People
Understanding the Social Determinants of Health

![Factors Influencing Health and Well-Being](image)

- **Social and Economic Factors**: 40%
- **Health Behaviors**: 30%
- **Clinical Care**: 10%
- **Physical Environment**: 10%
- **Genes and Biology**: 10%

Framework for the Bridge to Value
Leadership

• Education and support of:
  – Boards of Directors
  – Medical Staff
  – Hospital leaders, managers and coordinators

• Creation of a compelling strategic plan
• Primary care providers
• Other area service providers—long term care, mental health, public health, social services
• Businesses, churches and government
• Payers?
Population Health has Many Partners

- Hospitals
- Clinics
- Mental Health
- Schools
- Government
- Businesses
- Long-Term Care
- Housing
- Public Health
- Faith-based Organizations
A Collaborative Effort
Quality, Operational and Financial Efficiency

• Customer service excellence
• Clinical quality excellence
• Highly efficient clinical, business and operational processes
• Measured in documented value
Care Management

• Patient-centered, multi-disciplinary care coordination teams working to the top of their licenses
• Coordination, both internally and externally, with other community service providers
• Focus on managing the care of specific patient populations, which requires collaboration and patient empowerment
Information Management

- Access to easily accessible, comprehensive patient information
- In depth IT, data analysis and actuarial expertise
- Ability to use information to improve patient quality and cost outcomes
Mobile and Telehealth Technology

• Access to effective telehealth services
• Patient portals to gain access to health records and health information
• Effective hospital websites and social technology
• Access to online and distance education
Workforce Preparation

• Staff understands the “why” of change
• Staff acquires new value-based and population health skills and knowledge
• Staff exhibits positive health behaviors
• Staff is customer focused and team oriented
Community and Population Health Management

• Effective wellness and prevention services, perhaps beginning with hospital employees
• Ongoing patient education and support
• Providers are part of community-wide efforts to address population health problems
• Providers partner with local businesses
A health system that links health care with community stakeholders to create a network of organizations working together to improve population health
Get Moving!

Use the Population Health Portal

Use the Rural Hospital Toolkit for Transitioning to Value-Based Systems

“Even if you’re on the right track, you’ll get run over if you just sit there.”
-Will Rogers
Terry Hill

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