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New York State Critical Access Hospital Performance Improvement Network

Leading Change Through Operational Improvement

July 12, 2018

Objectives

- New York State Flex Program Background
- Flex Program Current Activities
- Learning Action Network Concept Overview
  - Performance Improvement Initiative Examples
- Lessons Learned

New York State Critical Access Hospital Performance Improvement Network History

Background

EACH/RPCH State

- Four Rural Primary Care Hospitals
- Network Development

1997 Rural Hospital Flexibility Program

- RPCH's became Critical Access Hospitals
- Awarded exploratory, designation and implementation grant
- Focused on additional hospital conversions, network development, EMS integration and quality assurance

Background, continued

2007

- 13 Critical Access Hospitals
- Changed focus from specific hospital conversion and network development and integration activities
- Began developing the Performance Improvement Network
- Quality Directors had a history of monthly meetings with the Health Care Association of New York State
- CEO's and CFO's began attending meetings

Current

New York State

- 2.4 million people in rural communities, 19.7 million total
- 224 acute care hospitals
- 37 rural/non-metro
  - 17 Critical Access Hospitals
  - 1 waiting survey
  - 16 Sole Community Hospitals

Flex Program

- Focus is on the New York State Critical Access Hospital Performance Improvement Network

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New York State CAH PI Network

- Two Workgroups
  - Finance and Operations
  - Quality

- Consistent collection and analysis of quality measures and financial indicators by hospitals

- Quarterly Meetings
  - Review of market updates
  - State and federal issues
  - Department Productivity
  - Break into workgroups

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New York State Critical Access Hospital Performance Improvement Network – Finance and Operations

Financial and Operational Performance Improvement

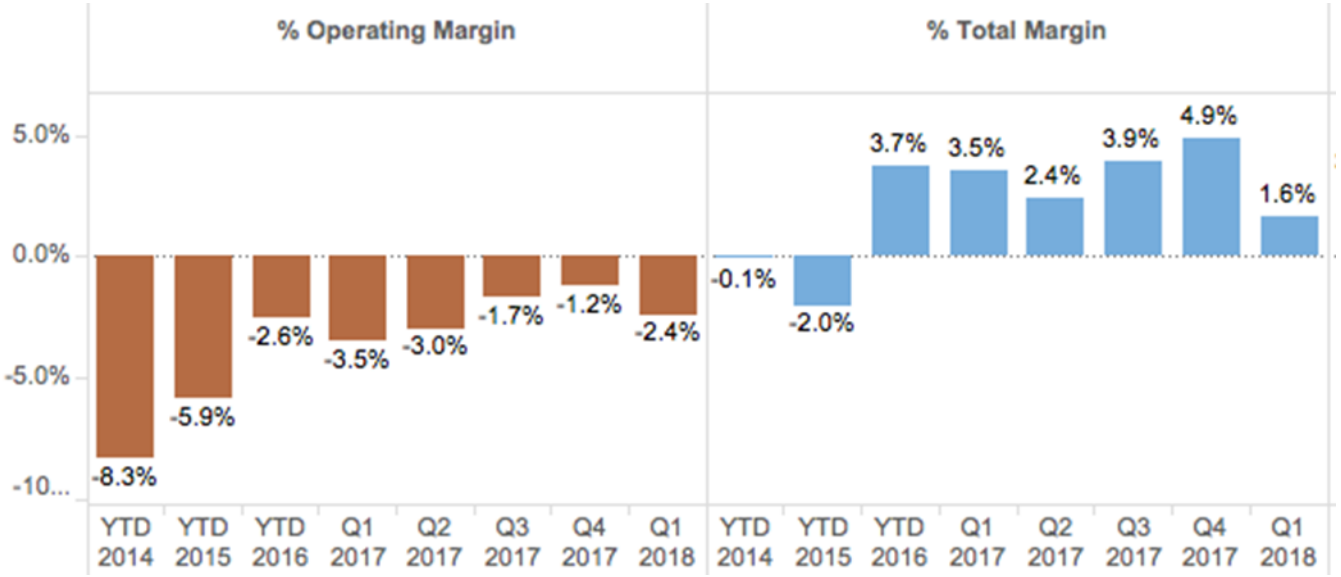
- All hospitals participate and are support other
- Data is unblinded
- Discussion of successful strategies at PI Network meetings
  - Emergency Department throughput
  - Revenue enhancements
  - Maximizing staffing and departmental productivity
  - Payer contracts
  - Primary Care Options, Redesign, and FQHC Collaboration
- Learning Action Network (LAN)

Financial and Operational Performance Improvement, continued

Data review includes:

- Operating Metrics
- Liquidity Metrics
- Capital Metrics

Operating Metrics



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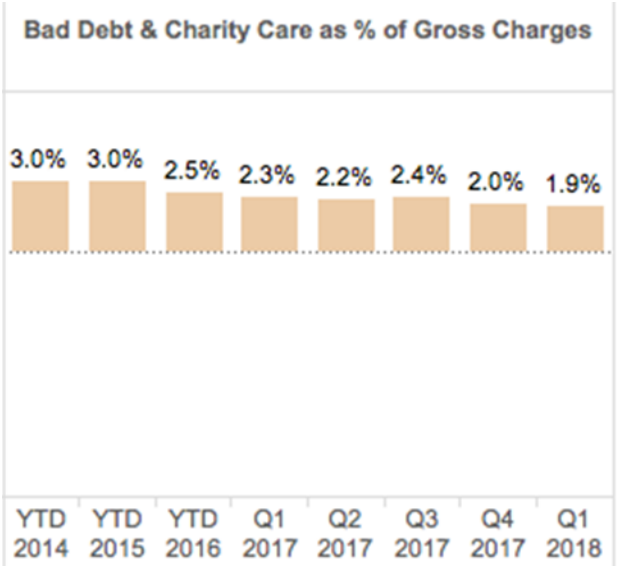
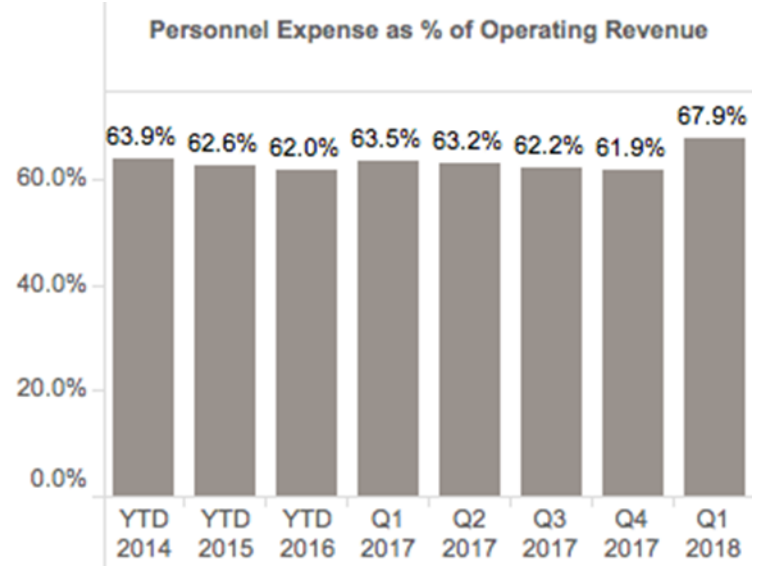
Operating Metrics, continued





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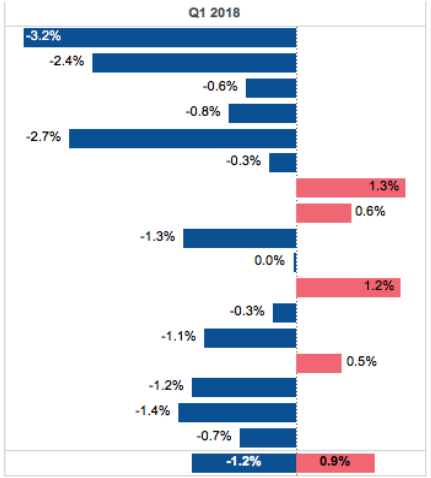
Bad Debt & Charity as Percent of Gross Charges

Select Finance Metric: Bad Debt & Charity Care as % of Gross Charges

Select Benchmark: Regional CAH Benchmark / State Rural Benchmark / Target Benchmark (selected)

Regional CAH Benchmark	State Rural Benchmark	Target Benchmark
0.0%	3.9%	2.5%

Hospital Name	Bad Debt & Charity Care as % of Gross Charges								Variance from Target Benchmark
	YTD 2014	YTD 2015	YTD 2016	Q1 2017	Q2 2017	Q3 2017	Q4 2017	Q1 2018	Q1 2018
	1.7%	2.8%	1.0%	1.6%	1.5%	0.8%	0.3%	-0.7%	-3.2%
	2.3%	2.3%	2.1%	2.2%	2.2%	2.2%	2.1%	0.1%	-2.4%
	2.9%	6.8%	4.2%	4.1%	1.9%	2.2%	2.2%	1.9%	-0.6%
	1.8%	2.1%	1.3%	2.5%	1.8%	1.7%	1.7%	1.7%	-0.8%
	3.5%	2.2%	1.6%	1.3%	2.2%	3.2%	1.3%	-0.2%	-2.7%
	2.8%	2.6%	2.0%	1.7%	1.9%	2.5%	2.6%	2.2%	-0.3%
	3.7%	3.4%	3.2%	3.5%	3.9%	3.8%	1.0%	3.8%	1.3%
	3.5%	3.4%	2.9%	3.4%	3.1%	2.8%	2.7%	3.1%	0.6%
	2.6%	2.1%	1.3%	1.4%	1.2%	1.2%	1.2%	1.2%	-1.3%
	3.5%	2.9%	3.1%	2.4%	2.4%	2.6%	2.5%	2.5%	0.0%
	1.2%	2.5%	2.5%	1.4%	1.8%	3.4%	3.0%	3.7%	1.2%
	4.1%	2.4%	3.5%	2.0%	2.0%	2.3%	2.3%	2.2%	-0.3%
	2.0%	1.8%	1.9%	1.2%	1.4%	1.4%	1.4%	1.4%	-1.1%
	4.0%	3.6%	3.5%	4.0%	3.2%	3.1%	2.9%	3.0%	0.5%
	2.9%	3.0%	1.4%	1.9%	0.8%	1.2%	1.3%	1.3%	-1.2%
	1.6%	1.6%	1.2%	1.4%	1.6%	1.6%	1.5%	1.1%	-1.4%
	3.1%	2.4%	2.2%	1.6%	2.0%	2.2%	2.0%	1.8%	-0.7%
Average	2.8%	2.8%	2.3%	2.2%	2.1%	2.2%	1.9%	1.8%	-0.7%



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Learning Action Network (LAN)

- Team-Based Performance Improvement introduced in October 2015
- Over 20 ppriority areas chosen for discussion
- Consensus exercise to choose priority areas each year
- PI Network members work in small groups to develop assessment and action plans
- Meeting via conference call and during the PI Network quarterly meetings

Learning Action Network (LAN), continued

Timeframe:	Pre LAN Meeting	Q1	Q2	Q3	Q4	Q1 – Q4
Phase:	Identification and selection of Priority Opportunity Area(s)	Team formation / initiative kickoff	Team Progress Review and Sharing	Team Progress Review and Sharing	Final Team Reports and Progress Review	
CAH Key Tasks / Activities:	• Selection of 1 – 2 Priority Opportunity Areas	• Formation of initiative teams to focus on identified priority areas (subject matter experts – SME's are expected to attend) • Metrics identified • Baseline scores identified • Improvement Target identified • Dashboard development • Initial project plans identified	• All teams share key learnings and progress • Dashboard review • CAHs and Stroudwater SMEs present on related topics • Project plans refined via breakout groups • Best practice play books are developed	• All teams share key learnings and progress • Dashboard review • CAHs and Stroudwater SMEs present on related topics • Project plans refined via breakout groups • Best practice play books are developed	• All teams report year one results • Dashboard review • Best practice play books synthesized for group use and distribution • Identification of future priority initiatives	Process repeats
Stroudwater Activities:	• Survey and selection process administration	• Coaching sessions offered to teams • Dashboard management	• Coaching sessions offered to teams • Dashboard management	• Coaching sessions offered to teams • Dashboard management	• Coaching sessions offered to teams • Dashboard management	

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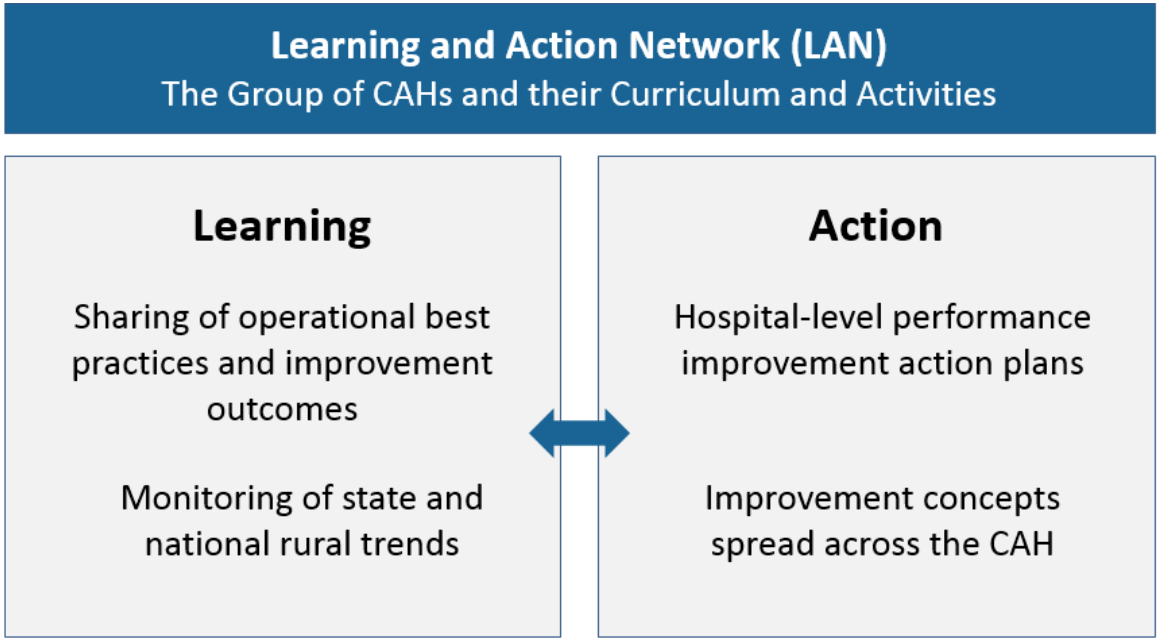
LAN Concept



The purpose of the LAN is to **demonstrate** performance improvement

LAN Initiatives Overview

Definition

A Critical Access Hospital Learning and Action (LAN) **Initiative** is a highly-structured, rapid-cycle project that **demonstrates improvement** in a defined performance area.

Design Specifications

- An Initiative does not exceed 9 months
- Initiative activities use the Plan-Do-Study-Act (PDSA) methodology
- Every LAN Initiative has one to two lead “champion” CAHs
- LAN Initiatives incorporate PROCESS and OUTCOME metrics
- Outcome metrics can be monitored over multi-year periods

PDSA Methodology

1

Plan

What are the initiative objectives, predictions and plan for the cycle?

2

Do

Carry out the plan, start data analysis, test predictions and sharing of best practices

3

Study

Summarize learnings, complete analysis and test predictions

4

Act

How can the cycle be spread, and what are the outcomes?

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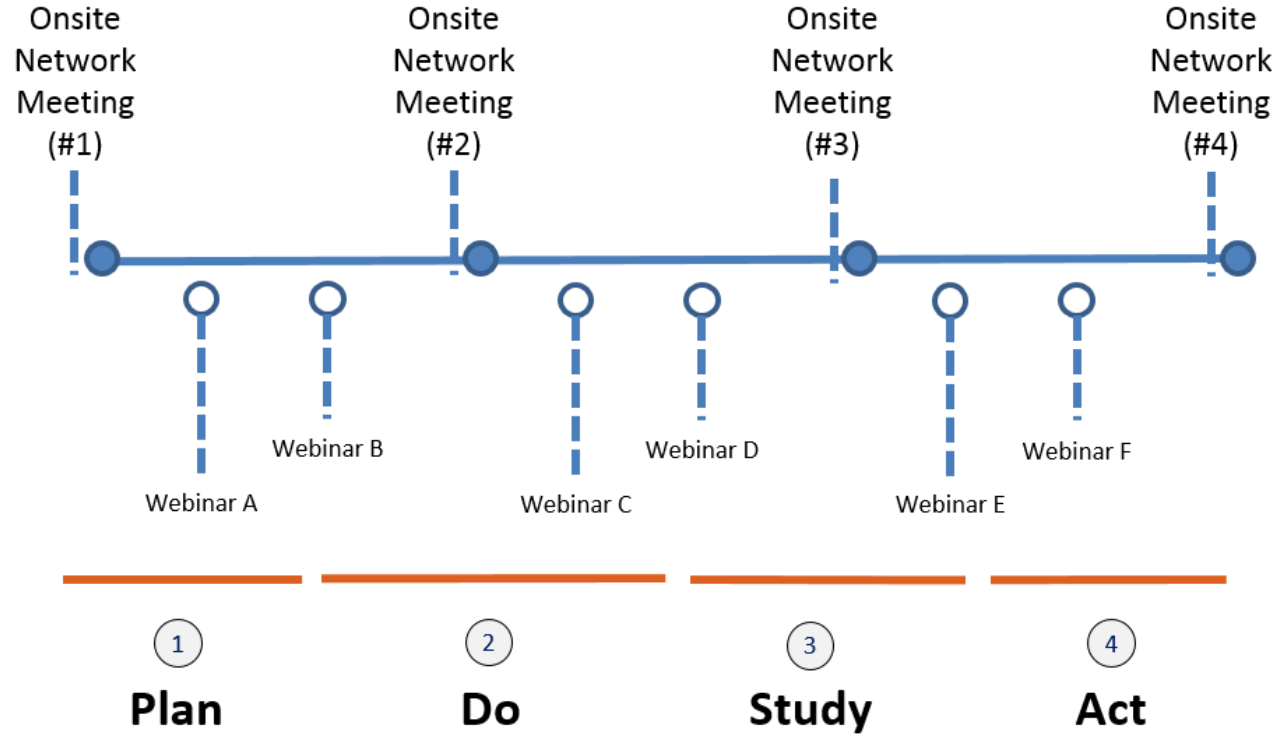
PDSA Sample Timeline (6 - 9 months)



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LAN Priority Areas Considerations

A. Physician Alignment / contracting strategies / Physician practice management (8)
B. Affiliation discussions → key learnings for independent CAHs /Maximizing affiliation relations (7)
C. Swing Bed program (7)
D. Staffing levels / productivity – comparing staffing models (6)
E. 340B strategies (6)
F. Service Rationalization / Geographical opportunities (5)
G. Revenue cycle/ ICD-10 / Self Pay → in house / out source (4)
H. Pricing – how to position for being paid on a value basis (4)
I. Physician recruitment (4)
J. Sharing resources: best practices for rad report turnaround, group purchasing, etc. (3)
J. Market share (3)
K. Telehealth (3)
L. DSRP – what are other regions experiencing? (3)
M. Contracting (2)
N. Quality measures (1)
O. 6056 & 1094 ACA filing (1)
P. Staff recruitment (1)
Q. Organizing against Locum tenens (1)
R. Surgical Services - improving performance and outcomes (0)
S. IT solutions and pricing (0)
T. Outsourcing/ Insourcing (0)
U. Political lobbying (0)
V. Managing no shows (0)

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LAN Priority Areas

Long –term – Task Force 1:

- Physician Alignment / contracting strategies / Physician practice management (8)
- Alternate Payment Models

Intermediate – Task Force 2:

- Affiliation discussions (7)

Short Term – Task Force 3:

- Swing Bed program (7)
- 340B strategies (6)

Ongoing:

- Staffing levels / productivity – comparing staffing models (6)

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LAN Priority Areas, short term

TASK FORCE NAME	340B / Swing Bed
CO – LEADERS	Terry Lang & Nate Smith
CHARTER EFFECTIVE DATE and DURATION	December 2015 – December 2016
PURPOSE *(Overall charge, purpose, or focus)*	Provide guidance, expert opinion, voice of customer, and perspective to the programs and services we develop for our customers. Maximizing reimbursements related to 340B & Optimal Swing Bed program management

DELIVERABLES *(Products the Task Force is asked to produce.)*	• 340B – assessment of participation & reassessment of current participation
	  ○ What is the assessment process?
	  ○ How do we assess / evaluate effectiveness of program?
	  ○ Identify 340B program key speakers/ subject matter experts → 3rd party administrators, pharmacy benefits managers, etc. (Hudson Headwaters)
	• Swing Bed program
	  ○ Identify and bring forward education material and best practices (Elizabethtown presentation)
	  ○ Understanding how to best manage the SB patient population
	  ○ How to develop and market the program

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LAN Priority Areas, intermediate

TASK FORCE NAME	Affiliation Strategies
CO – LEADERS	Jack Ormond and Amy Castle
CHARTER EFFECTIVE DATE and DURATION	December 2015 – December 2016
PURPOSE *(Overall charge, purpose, or focus)*	• Gain insight from other CAHs that are currently affiliated • How to leverage affiliations to maximize for positive financial gain and operating efficiencies
DELIVERABLES *(Products the Task Force is asked to produce.)*	• Inventory of affiliation types / models (structure) and partners for all CAH members • List of documented/ quantifiable benefits derived from affiliation • Best practice playbook → lessons learned, key steps / sequence → Centralization core pillars: Finance, IT, HR

LAN Priority Areas, long-term

TASK FORCE NAME	Physician Alignment
CO – LEADERS	Steve Kelley and Wendy Jacobson
CHARTER EFFECTIVE DATE and DURATION	December 2015 – December 2016
PURPOSE *(Overall charge, purpose, or focus)*	Provide guidance on benefits/ disadvantages of different physician alignment models (independent v. employed).
DELIVERABLES *(Products the Task Force is asked to produce.)*	• Comparative matrix documenting pros / cons of alternate alignment models • Documented best practices of CAHs participating in ACO and alternate payment models • Evaluation of how various alignment models fit within DSRP

LAN Priority Areas Considerations

A. *Political lobbying / Advocacy (13)
B. Revenue cycle/ ICD-10 / Self Pay → in house / out source (12)
   - Pricing – how to position for being paid on a value basis ()
C. Service Line (IP & OP) optimization → conduct analysis to identify opportunities to increase local utilization & decompress tertiary (11)
D. Sharing resources / collaboration across CAHs (rural hospital alliance model)→ e.g. MSO creation, best practices for rad report turnaround, staffing services, group purchasing, etc. (9)
E. Service Rationalization / Geographical opportunities (2)
F. Physician recruitment (4)
G. Telehealth (4)
H. DSRIP – what are other regions experiencing? (0)
I. Contracting (1)
J. Staff recruitment (0)
K. Organizing against Locum tenens (0)
L. Surgical Services - improving performance and outcomes (2)
M. IT solutions and pricing (2)
N. Outsourcing/ Insourcing (1)
O. Managing no shows (2)

**Out of scope of NY LAN*

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LAN Current Priority Areas

TASK FORCE NAME	Physician Practice
CO – LEADERS	TBD
CHARTER EFFECTIVE DATE and DURATION	
PURPOSE *(Overall charge, purpose, or focus)*	TBD
DELIVERABLES *(Products the Task Force is asked to produce.)*	• TBD

TASK FORCE NAME	Revenue Cycle
CO – LEADERS	Chris Graham and Mark Pohar
CHARTER EFFECTIVE DATE and DURATION	May 2017 – June 2018
PURPOSE *(Overall charge, purpose, or focus)*	• Define performance measures for industry and tools • Use initial dashboard to help understand where the potential areas of focus • Focus on reducing registration errors and denials • If error prior to reaching insurance company then registration error. If declined by insurance then claims error.
DELIVERABLES *(Products the Task Force is asked to produce.)*	• Global dashboard for all CAHs for comparison – micro management each month • Defining best practice work flow standards for denial management and registration • Co-create dashboard

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What's working well with the LAN?

- Foundation of trust – safe environment
- Sharing data
- Peer presentations
- Idea exchange
- Networking and collegial environment
- Positive relationships
- Problem solving on shared issues

What can be improved with the LAN?

- Strive to send data in advance of meeting so hospitals can review and share with team
- Schedule task force meetings in advance by choosing specific date / time

LAN Next Steps

- Complete the current work
  - Determine if time should be extended
- Choose new groups
- Survey CAHs to determine impact

PI Network Lessons Learned

- Strive for data transparency and sharing to foster trust
- Encourage discussion of strategies that worked and didn't
- Establish an Advisory Council comprised of CAH executives to provide input into curriculum and network focus
- Develop task force initiative charters that are narrowly focused and well-defined
- Limit performance improvement initiatives to 6 to 9 months

New York State CAH PI Network

"There are not enough words to describe what we continue to gain from this collaboration."

Jennifer Shaver, DNP, MSN, RN
Former Director of Nursing, Gouverneur Hospital
June 2018

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Contact Information

Karen Madden
518-402-0102
karen.madden@health.ny.gov

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