Rural Provider Strategic Opportunities to Collaborate Regionally
Speakers

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Rural Provider
Strategic Opportunities to Collaborate Regionally

December 7, 2021
Regional Collaboration

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Necessity for Interdependency
Partnership Value Curve
Partnership Value Curve & Opportunities for Collaboration
INTRODUCTION
Necessity for Interdependency

• Health care resources in rural communities are scarce and in jeopardy as rural hospitals struggle to remain financially viable

• Success requires the joining of forces to accomplish partner goals and meet community needs

• Pooling resources allows organizations to create economies of scale and overcome resource constraints
Necessity for Interdependency (cont.)

- In addition, interdependence is required as the health care industry transcends from fee-for-service to value-based payment.
- Organizations that are not fostering such partnerships now will be disadvantaged in future.
Partnership Value Curve
PARTNERSHIP VALUE CURVE
Image & Franchise

• **Partner A: Image**
  - Use of network or system branding and image can increase public opinion about the rural provider
  - Potential increase in patient demand of facility based on combined brand throughout the region

• **Partner B: Franchise**
  - Depending on the level of commitment, expansion of brand to rural communities increases the overall reliance on the brand and patient population served
  - Expands the primary and secondary service areas through the broader regional deployment of the brand into rural communities
    - With the continued push for ACOs and population-based outcomes, the expansion to rural markets increases the attributed lives to the partner(s)
Purchased & Support Services

- **Partner A: Purchased Services**
  - Allows access to group purchasing organizations (“GPO”) and other purchasing agreements that can reduce the cost for the entity
    - Combined scale of partners can secure more advantageous pricing due to the economies of scale associated with the larger entity
    - Can purchase services through the partnership or system OR in collaboration with the partnership or system that would considerably more expensive if secured through a third party

- **Partner B: Purchased or Support Services**
  - In a partnership where Partner A and B are of similar size/scale, Partner B’s benefits are the same as Partner A
  - Where Partner B is a larger system and is providing support services:
    - Can dilute down fixed cost to partners/affiliates and further leverage economies of scale
      - Fixed cost versus variable cost remains material within the healthcare environment and the ability further dilute down fixed costs benefits the collective system
    - Allows for additional revenue streams to the system based on the support services provided
Examples of Group Purchasing & Service Sharing

Supplies

Pharmaceuticals

Specialty services (e.g., radiology group)

Revenue cycle

Employee benefits

- Health plan:
  - Stop loss, third-party administrator, and pharmacy benefit manager under self-insured health plan
  - Risk (and vendor) sharing arrangements under a captive
  - Other programs: life & disability
Service Coordination & Linkage

**Partner A: Service Coordination**
- Creates an environment where patients can easily secure services at other hospitals (or healthcare providers such as Rural Health Clinics) for services not provided in the rural community
- Decreases the number of patients lost to follow-up due to the integrated approach around service coordination
  - Often, patients in rural communities fail to receive follow-up services due to scheduling and coordination of services with providers out of their network

**Partner B: Focused Service Linkage**
- Allows the leveraging of different hospital and practice designations to ensure patients receive appropriate levels of care
  - For example, partnering with a post-acute care facility can reduce the number of waitlisted patients at the larger facility
- Can allow for population-based initiatives where the system can monitor health outcomes among the patient population
# Regional Approach to Care Spectrum Planning

<table>
<thead>
<tr>
<th>Service Line</th>
<th>Partner A (CAH)</th>
<th>Partner B (PPS)</th>
<th>Partnership Opportunity</th>
</tr>
</thead>
<tbody>
<tr>
<td>Med/Surg</td>
<td>Yes</td>
<td>Yes</td>
<td>• Implement active solicitation program with Partner B</td>
</tr>
<tr>
<td>Swing Bed</td>
<td>Yes</td>
<td>No</td>
<td>• Consider Step Down Unit in CAH</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>• Transfer high acuity patients to Partner B</td>
</tr>
<tr>
<td>ICU</td>
<td>Yes</td>
<td>Yes</td>
<td>• Provide pre-natal and post-natal services within community at CAH</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>• Perform deliveries at Partner B</td>
</tr>
<tr>
<td>Labor &amp; Delivery</td>
<td>No</td>
<td>Yes</td>
<td>• Consider periodic specialty clinic or telehealth at CAH, provided by Partner B</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>• Perform orthopedic surgeries at Partner B</td>
</tr>
<tr>
<td>Orthopedic Surgery</td>
<td>No</td>
<td>Yes</td>
<td>• Provide post-surgical physical therapy in community at CAH</td>
</tr>
<tr>
<td>PT, OT, and ST</td>
<td>Yes</td>
<td>Yes</td>
<td></td>
</tr>
<tr>
<td>...</td>
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<td></td>
<td></td>
</tr>
</tbody>
</table>
### Case Study for Service Coordination & Linkage: Swing Bed Program

**Partner A**
- 21-bed Critical Access Hospital
- 6 beds designated as swing bed
- Med/Surg and Swing Bed program operating at a financial loss

**Partner B**
- Large PPS facility
- Acute beds frequently at capacity; turning away higher acuity patients
- Regional proximity to Partner A

<table>
<thead>
<tr>
<th>Background</th>
<th>Partnership</th>
<th>Outcomes</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Implemented Active Solicitation strategy targeting Partner B for swing bed patients</td>
<td>Efficiency gain in Med/Surg and Swing Bed staffing</td>
</tr>
<tr>
<td></td>
<td>Daily examination of Partner B’s inpatient roster for potentially eligible swing bed patients</td>
<td>Improved financial performance</td>
</tr>
<tr>
<td></td>
<td>Made available de-identified inpatient roster to Partner A, allowing Partner A to proactively identify potential swing bed patients for transfer</td>
<td>Enhanced quality of care</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Improved financial performance</td>
</tr>
</tbody>
</table>
Shared Governance

**Partner A: Management Support**
- Access to management and administrative support
  - Positions/areas can include: CIO, Infection Control, Compliance, HIPAA, general counsel, CFO, Medical Directors
  - Hospitals can also gain access to standardized policies, procedures, and processes

**Partner B: Management Support or Distributed Overhead**
- In a partnership where Partner A and B are “peers”, Partner B’s benefits are the same as Partner A
- Where Partner B is a larger system and is providing management services:
  - Large hospitals and systems have a considerable amount of fixed costs that can be distributed to regional partners and affiliates
    - Distributed overhead not only includes staff, but can also include IT systems and other capital components
Capital Investment

- **Partner A: Capital Investment**
  - Potential access to funds for capital initiatives such as facility projects, new service initiatives, and or medical equipment
  - Potential reduced capital cost due to economies of scale and lower borrowing cost
    - Larger systems are often able to fund capital initiatives independently or secure more favorable terms due to the financial position of the system

- **Partner B: Regional Investment**
  - Allows for investment based on the regional needs of a patient population
    - Often, regions experience duplication of services and underutilized staff, which may increase the overall cost of care
  - Can allow for centralization of services at rural hubs based on the collective demand for services within region
Technology Integration

- **Partner A: Technology Integration**
  - Access integrated systems that include an EHR, PACs, Revenue Cycle Tools, Performance Improvement Tools, and other systems
    - Many rural hospitals have these systems in place; however, often deal with interoperability issues that increase inefficiencies and or rely on outdated systems
    - Reduced costs for technological solutions due to the consolidated buying power of the larger group

- **Partner B: Financial & Clinical Transparency**
  - Access to data for patient populations who receive services at the affiliated hospitals or those hospitals which leverage the EHR of a larger hospital/system
    - Data includes services provided, costs of those services, and locations of care
    - Dilution of certain technological fixed overhead that could be shared among all the hospitals on the platform
Physician Enterprise

• **Partner A: Physician Integration**
  • Access to providers, particularly specialists, that may otherwise be unavailable in rural communities due to the cost and demand for services
  • Provider participation in regional performance and growth initiatives
    • For APPs, this can include supervision by other providers within the partnership or system

• **Partner B: Physician Integration or Broad Physician Deployment**
  • In a partnership where Partner A and B are “peers”, Partner B’s benefits are the same as Partner A
  • Where Partner B is a larger system and is providing management services:
    • Decentralization of providers away from urban centers and deployment to rural communities increases access and potential patient referrals back to urban centers
    • Sharing of costs among the affiliated hospitals based on demand for services and deployment of providers
Case Study: Rural Physician Supply & Demand

- Rural communities cannot always support physician employment, particularly for specialties
- Market assessment is critical in identifying the:
  - Current supply of providers within the service area;
  - Projected needed supply range;
  - Resultant shortage or surplus of providers by specialty type
- Example right demonstrates characteristic outcome in rural communities
  - Often there’s a projected shortage in primary care and specialty care
  - Specialty care needs within the service area reflect <1 FTE for many specialties

<table>
<thead>
<tr>
<th>Primary Care</th>
<th>Supply Study Range</th>
<th>Existing 1,2</th>
<th>(Shortage)/Surplus Range³</th>
</tr>
</thead>
<tbody>
<tr>
<td>Family Practice</td>
<td>2.2 - 7.7</td>
<td>4.85</td>
<td>(2.8) - 2.6</td>
</tr>
<tr>
<td>Internal Medicine</td>
<td>1.9 - 4.5</td>
<td>0.00</td>
<td>(4.5) - (1.9)</td>
</tr>
<tr>
<td>Pediatrics</td>
<td>1.3 - 2.0</td>
<td>0.00</td>
<td>(2.0) - (1.3)</td>
</tr>
<tr>
<td>Physician Primary Care Range</td>
<td>8.7 - 10.8</td>
<td>4.85</td>
<td>(6.0) - (3.9)</td>
</tr>
<tr>
<td>Non-Phys Providers</td>
<td>1.1 - 3.7</td>
<td>6.40</td>
<td>2.7 - 5.3</td>
</tr>
<tr>
<td>TOTAL Primary Care Range</td>
<td>10.8 - 14.6</td>
<td>11.25</td>
<td>(3.3) - 0.4</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Medical Specialties</th>
<th>Supply Study Range</th>
<th>Existing 1,2</th>
<th>(Shortage)/Surplus Range³</th>
</tr>
</thead>
<tbody>
<tr>
<td>Allergy</td>
<td>0.1 - 0.2</td>
<td>0.00</td>
<td>(0.2) - (0.1)</td>
</tr>
<tr>
<td>Cardiology</td>
<td>0.5 - 0.6</td>
<td>0.00</td>
<td>(0.6) - (0.5)</td>
</tr>
<tr>
<td>Dermatology</td>
<td>0.3 - 0.4</td>
<td>0.00</td>
<td>(0.4) - (0.3)</td>
</tr>
<tr>
<td>Endocrinology</td>
<td>0.0 - 0.2</td>
<td>0.00</td>
<td>(0.2) - (0.0)</td>
</tr>
<tr>
<td>Gastroenterology</td>
<td>0.3 - 0.4</td>
<td>0.00</td>
<td>(0.4) - (0.3)</td>
</tr>
<tr>
<td>Hem/Oncology</td>
<td>0.3 - 0.4</td>
<td>0.00</td>
<td>(0.4) - (0.3)</td>
</tr>
<tr>
<td>Infectious Disease</td>
<td>0.1 - 0.2</td>
<td>0.00</td>
<td>(0.2) - (0.1)</td>
</tr>
<tr>
<td>Nephrology</td>
<td>0.2 - 0.3</td>
<td>0.00</td>
<td>(0.3) - (0.2)</td>
</tr>
<tr>
<td>Neurology</td>
<td>0.3 - 0.4</td>
<td>0.00</td>
<td>(0.4) - (0.3)</td>
</tr>
<tr>
<td>Pulmonary</td>
<td>0.2 - 0.4</td>
<td>0.00</td>
<td>(0.4) - (0.2)</td>
</tr>
<tr>
<td>Rheumatology</td>
<td>0.2 - 0.2</td>
<td>0.00</td>
<td>(0.2) - (0.2)</td>
</tr>
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</table>

<table>
<thead>
<tr>
<th>Surgical Specialties</th>
<th>Supply Study Range</th>
<th>Existing 1,2</th>
<th>(Shortage)/Surplus Range³</th>
</tr>
</thead>
<tbody>
<tr>
<td>ENT</td>
<td>0.1 - 0.5</td>
<td>0.00</td>
<td>(0.5) - (0.1)</td>
</tr>
<tr>
<td>General Surgery</td>
<td>1.0 - 1.2</td>
<td>0.00</td>
<td>(1.2) - (1.0)</td>
</tr>
<tr>
<td>Neurosurgery</td>
<td>0.1 - 0.2</td>
<td>0.00</td>
<td>(0.2) - (0.1)</td>
</tr>
<tr>
<td>OB/GYN</td>
<td>1.2 - 1.7</td>
<td>0.00</td>
<td>(1.7) - (1.2)</td>
</tr>
<tr>
<td>Ophthalmology</td>
<td>0.6 - 0.6</td>
<td>0.00</td>
<td>(0.6) - (0.6)</td>
</tr>
<tr>
<td>Orthopedic</td>
<td>0.7 - 1.1</td>
<td>0.00</td>
<td>(1.1) - (0.7)</td>
</tr>
<tr>
<td>Plastic Surgery</td>
<td>0.2 - 0.3</td>
<td>0.00</td>
<td>(0.3) - (0.2)</td>
</tr>
<tr>
<td>Urology</td>
<td>0.4 - 0.5</td>
<td>0.00</td>
<td>(0.5) - (0.4)</td>
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</tbody>
</table>
• Market assessment provides a high-level indication of service area need
• Refined physician planning involves examining the service area’s projected procedural volumes and the hospital’s market share to understand potential demand captured by the hospital
• Comparison of potential demand to survey data benchmark encounters refines the projected FTE need within the client’s service area based on their market share
• The hospital developed Professional Services Agreements and Billing/Lease Services Agreements with physicians in the community
  • Specialty services were offered monthly

<table>
<thead>
<tr>
<th>Specialty</th>
<th>Projected OP Procedure Volume</th>
<th>Assumed % Market Capture</th>
<th>Captured Demand</th>
<th>2020 MGMA Benchmark Encounters</th>
<th>Rural Adjusted Encounters</th>
<th>FTE</th>
<th>Days per Month</th>
</tr>
</thead>
<tbody>
<tr>
<td>Podiatry</td>
<td>1,036</td>
<td>21.5%</td>
<td>223</td>
<td>4,275</td>
<td>3,848</td>
<td>0.06</td>
<td>1.8</td>
</tr>
<tr>
<td>ENT</td>
<td>4,330</td>
<td>21.5%</td>
<td>931</td>
<td>3,229</td>
<td>2,906</td>
<td>0.32</td>
<td>9.7</td>
</tr>
<tr>
<td>Orthopedic</td>
<td>3,047</td>
<td>21.5%</td>
<td>655</td>
<td>2,940</td>
<td>2,646</td>
<td>0.25</td>
<td>7.5</td>
</tr>
<tr>
<td>Gynecology: Total Non-Invasive</td>
<td>1,574</td>
<td>21.5%</td>
<td>338</td>
<td>2,402</td>
<td>2,162</td>
<td>0.16</td>
<td>4.8</td>
</tr>
<tr>
<td>Gastroenterology</td>
<td>572</td>
<td>21.5%</td>
<td>123</td>
<td>2,634</td>
<td>2,371</td>
<td>0.05</td>
<td>1.6</td>
</tr>
<tr>
<td>Neurology</td>
<td>2,324</td>
<td>21.5%</td>
<td>500</td>
<td>2,185</td>
<td>1,967</td>
<td>0.25</td>
<td>7.7</td>
</tr>
<tr>
<td>Pulmonology</td>
<td>2,133</td>
<td>21.5%</td>
<td>459</td>
<td>3,112</td>
<td>2,801</td>
<td>0.16</td>
<td>5.0</td>
</tr>
</tbody>
</table>
Clinical Integration & Integrated System Capacity

**Partner A: Clinical Integration**
- Provides access to processes and evidence-based standards implemented within larger hospitals and system
  - Many smaller hospitals do not have the staff available to constantly monitor and maintain systems and processes as seen at larger hospitals
- Can rotate staff through larger hospitals to maintain/increase clinical competencies
- May provide access to float pools and additional staff to meet patient demand

**Partner B: Integrated System Capacity**
- Allows for the creation of staffing pools and the regional deployment and flexing of staff based on specific needs of an entity at any given time
  - As seen with COVID, hospitals continue to experience staff shortages which can often be addressed more easily in a system environment than at an individual hospital
QUESTIONS
Don’t Forget to Join!

• Building a Better Board: Experience in Education
  • December 8
  • 9-10 a.m.
Thank you for joining us!