RURAL HEALTH WORKSHOP

Rural Provider Strategic Opportunities to Collaborate Regionally

WELL-AHEAD

LOUISIANA RURAL HEALTH ASSOCIATION

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LOUISIANA DEPARTMENT OF HEALTH

STROUDWATER

Regional Collaboration

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Necessity for Interdependency

Partnership Value Curve

Partnership Value Curve & Opportunities for Collaboration

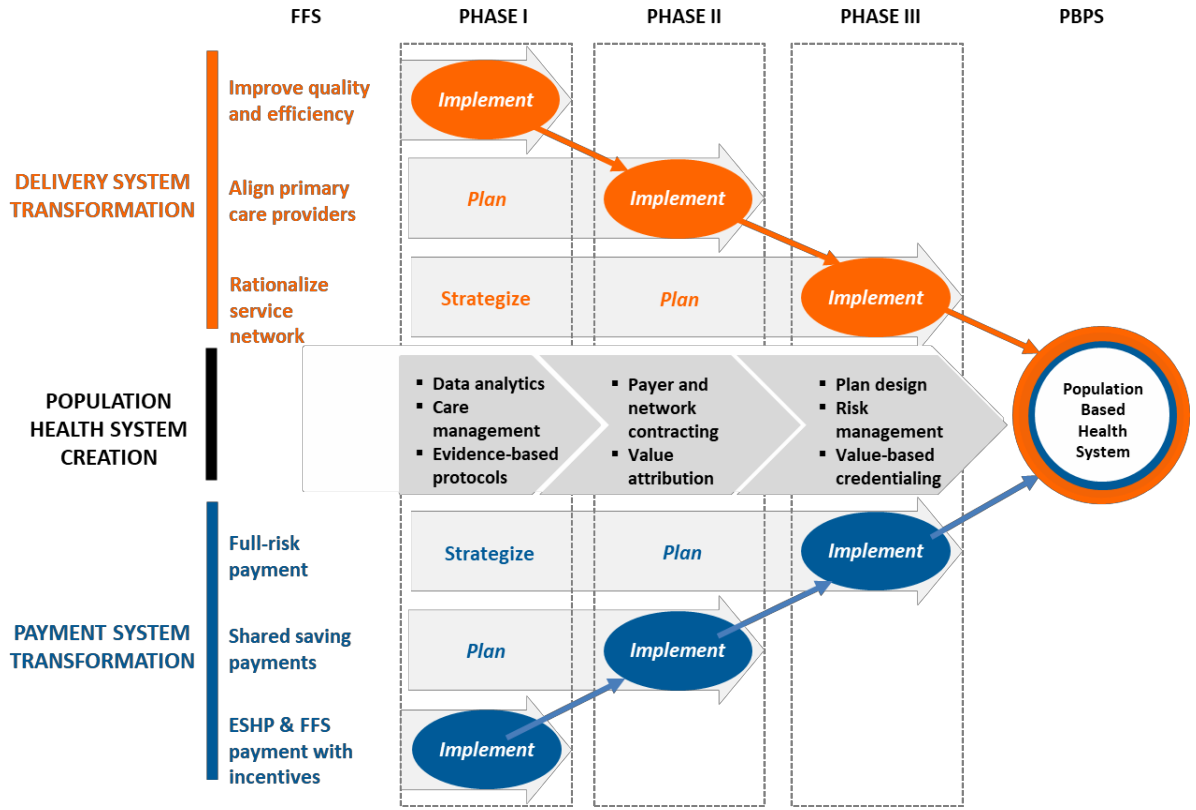
INTRODUCTION

Necessity for Interdependency

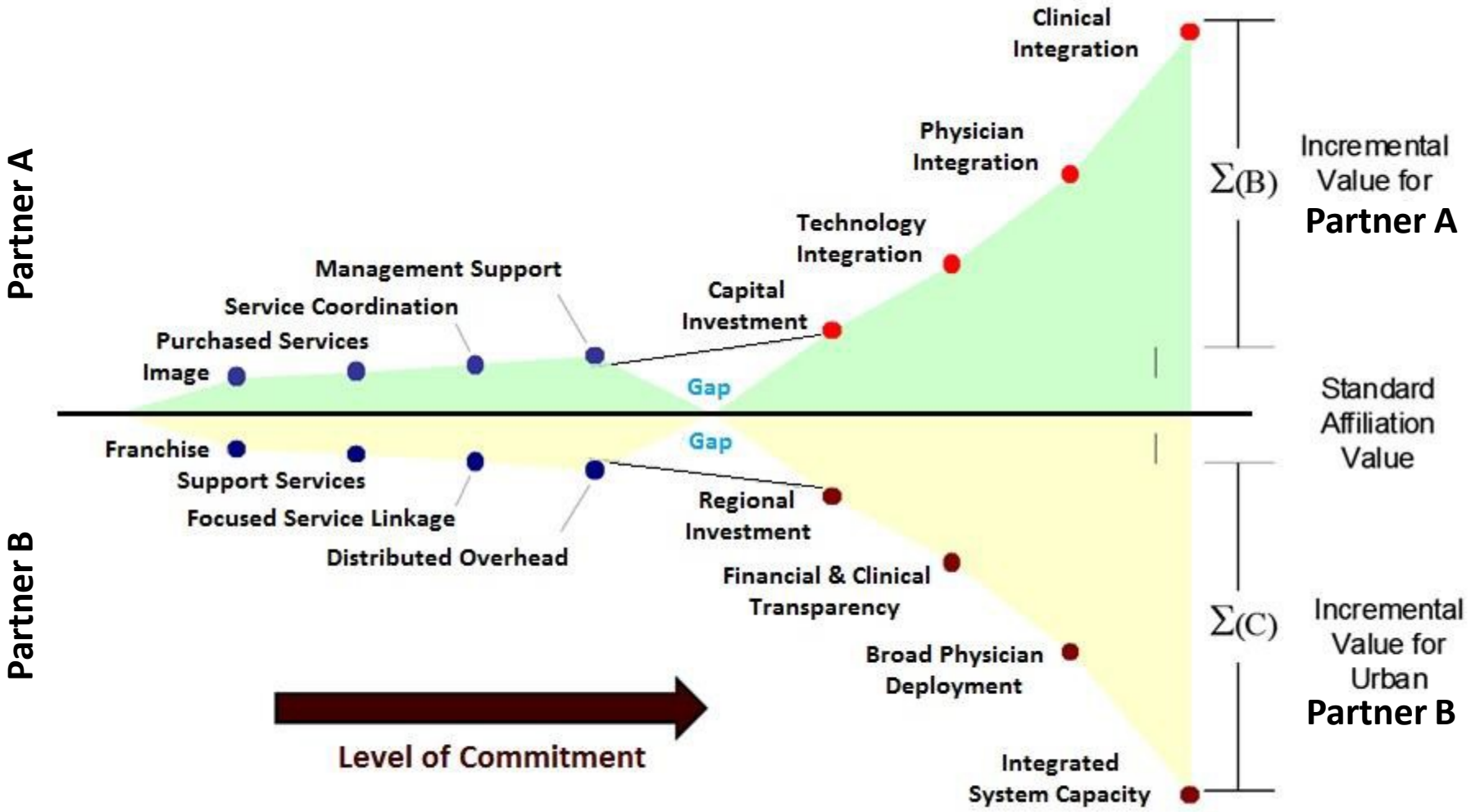
- Health care resources in rural communities are scarce and in jeopardy as rural hospitals struggle to remain financially viable
- Success requires the joining of forces to accomplish partner goals and meet community needs
- Pooling resources allows organizations to create economies of scale and overcome 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



PARNTERSHIP 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

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- **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

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- **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

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- **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

Service Line	Partner A (CAH)	Partner B (PPS)	Partnership Opportunity
Med/Surg	Yes	Yes	
Swing Bed	Yes	No	• Implement active solicitation program with Partner B
ICU	Yes	Yes	• Consider Step Down Unit in CAH • Transfer high acuity patients to Partner B
Labor & Delivery	No	Yes	• Provide pre-natal and post-natal services within community at CAH • Perform deliveries at Partner B
Orthopedic Surgery	No	Yes	• Consider periodic specialty clinic or telehealth at CAH, provided by Partner B • Perform orthopedic surgeries at Partner B
PT, OT, and ST	Yes	Yes	• Provide post-surgical physical therapy in community at CAH
…			

Case Study for Service Coordination & Linkage: Swing Bed Program

	Partner A	Partner B
Background	• 21-bed Critical Access Hospital • 6 beds designated as swing bed • Med/Surg and Swing Bed program operating at a financial loss	• Large PPS facility • Acute beds frequently at capacity; turning away higher acuity patients • Regional proximity to Partner A
Partnership	• Implemented Active Solicitation strategy targeting Partner B for swing bed patients • Daily examination of Partner B's inpatient roster for potentially eligible swing bed patients	• Made available de-identified inpatient roster to Partner A, allowing Partner A to proactively identify potential swing bed patients for transfer
Outcomes	• Efficiency gain in Med/Surg and Swing Bed staffing • Improved financial performance	• Enhanced quality of care • Improved financial performance

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

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- **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

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- **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

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- **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

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- **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

Physician Shortage/Surplus	Adjusted Service Area Population: **16,300**		
Primary Care	**Supply Study Range**	**Existing[1,2]**	**(Shortage)/Surplus Range[2]**
Family Practice	2.2 - 7.7	4.85	(2.8) - 2.6
Internal Medicine	1.9 - 4.5	0.00	(4.5) - (1.9)
Pediatrics	1.3 - 2.0	0.00	(2.0) - (1.3)
Physician Primary Care Range	8.7 - 10.8	**4.85**	**(6.0) - (3.9)**
Non-Phys Providers	1.1 - 3.7	6.40	2.7 - 5.3
TOTAL Primary Care Range	10.8 - 14.6	**11.25**	**(3.3) - 0.4**
Medical Specialties			
Allergy	0.1 - 0.2	0.00	(0.2) - (0.1)
Cardiology	0.5 - 0.6	0.00	(0.6) - (0.5)
Dermatology	0.3 - 0.4	0.00	(0.4) - (0.3)
Endocrinology	0.0 - 0.2	0.00	(0.2) - (0.0)
Gastroenterology	0.3 - 0.4	0.00	(0.4) - (0.3)
Hem/Oncology	0.3 - 0.4	0.00	(0.4) - (0.3)
Infectious Disease	0.1 - 0.2	0.00	(0.2) - (0.1)
Nephrology	0.2 - 0.3	0.00	(0.3) - (0.2)
Neurology	0.3 - 0.4	0.00	(0.4) - (0.3)
Pulmonary	0.2 - 0.4	0.00	(0.4) - (0.2)
Rheumatology	0.2 - 0.2	0.00	(0.2) - (0.2)
Surgical Specialties			
ENT	0.1 - 0.5	0.00	(0.5) - (0.1)
General Surgery	1.0 - 1.2	0.00	(1.2) - (1.0)
Neurosurgery	0.1 - 0.2	0.00	(0.2) - (0.1)
OB/GYN	1.2 - 1.7	0.00	(1.7) - (1.2)
Ophthalmology	0.6 - 0.6	0.00	(0.6) - (0.6)
Orthopedic	0.7 - 1.1	0.00	(1.1) - (0.7)
Plastic Surgery	0.2 - 0.3	0.00	(0.3) - (0.2)
Urology	0.4 - 0.5	0.00	(0.5) - (0.4)

Case Study: Rural Physician Supply & Demand (cont.)

- 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

Primary Service Area							
Specialty	Projected OP Procedure Volume	Assumed % Market Capture	Captured Demand	2020 MGMA Benchmark Encounters	Rural Adjusted Encounters	FTE	Days per Month
Podiatry	1,036	21.5%	223	4,275	3,848	0.06	1.8
ENT	4,330	21.5%	931	3,229	2,906	0.32	9.7
Orthopeadic	3,047	21.5%	655	2,940	2,646	0.25	7.5
Gynecology: Total Non-Invasive	1,574	21.5%	338	2,402	2,162	0.16	4.8
Gastroenterology	572	21.5%	123	2,634	2,371	0.05	1.6
Neurology	2,324	21.5%	500	2,185	1,967	0.25	7.7
Pulmonology	2,133	21.5%	459	3,112	2,801	0.16	5.0

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

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- **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

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Don’t Forget to Join!

- Building a Better Board: Experience in Education
  - December 8
  - 9-10 a.m.

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Thank you for joining us!

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