2024 Rural Hospital

Virtual Performance Improvement Conferences

FORHP Regions A, B and C: Wednesday, January 31st
FORHP Regions D and E: Thursday, February 1st

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NOSORH

Housekeeping

AGENDA
2024 Rural Hospital and Clinic
Virtual Performance Improvement Conference

Wednesday, January 31st at 11:00 AM Eastern
Register here

Time	Title	Presenter
11:00 AM	**Welcome and Logistics**	**Tammy Norville**
		NOSORH
11:10 AM	**Harsh Realities of Rural Operations**	**Jonathan Pantenburg**
	Healthcare leaders must solidify core operations to ensure financial solvency. This presentation encompasses strategies related to staffing and provider shortages, revenue cycle, growth, reimbursement and stiffening competition.	Wintergreen
11:40 AM	**Federal Office of Rural Health Policy: Updates and Priorities**	**Meredith Anderson**
12:00 PM	**Eliminate the Ego in Rural Recruitment**	**Nicole Barbano**
	Uncover the impact of ego on rural healthcare recruitment and learn to build agile, ego-free strategies with enhanced accountability.	Hunter Ambrose Intl
12:20 PM	**Benefits: Strategic Asset, Not Cost**	**Rob Bloom**
	Staffing drives strategy, operations and patient care. Learn how to rethink benefit programs to address a healthcare organization's most important asset, greatest vulnerability and biggest expense: Its people. **Co-presenter:** Brett Shippee, UPB	Wintergreen
12:50 PM	**Capitalize on the RHC Value Chain**	**Kristen Ogden**
	We're finally here: As payers seek value-based, outcomes-based models, RHCs are positioned for growth and increased relevance – but only if their operations and team are exceptional. **Co-presenter:** Nicole Thorell, Wintergreen	The Compliance Team
1:10 PM	**Harness Technology to Drive Revenue, Compliance and Safety**	**Bryan Knowles**
	Innovation for rural, by rural? Learn how to leverage technology to improve reimbursement, compliance, safety and performance using practical, cost-effective tools designed specifically designed for CAHs and RHCs. **Co-presenter:** John Reagan, Wintergreen	VersaBadge
1:30 PM	**How to Modernize Rural Healthcare**	**Alan Richman**
	Modernization requires access to sufficient financial resources. This presentation demystifies perceived barriers for rural hospitals to fund projects that drive strategic, operational and technology-based innovation.	InnoVative Capital
1:50 PM	**Wait...We Can Get Paid for That?**	**Jonathan Pantenburg**
	Our team will review five novel reimbursement opportunities stimulated by recent industry changes, market dynamics and/or regulatory updates that can be implemented by your hospital or clinic in CY 2024.	Wintergreen

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- Sessions will be recorded
- Recording link and slides will be made available
- Use chat box for questions/comments
- Questions will be answered at end of final session
  - If we don't discuss your question, we will respond directly offline
- Participants will be muted

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NOSORH

NOSORH & SORH:
Things to Know

NOSORH

National Organization of
State Offices of Rural Health

National Organization of State Offices of Rural Health

Promotes the capacity of State Offices of Rural Health and rural stakeholders to improve health in rural America through leadership development, advocacy, education and partnerships.

www.nosorh.org

More simply, we…

Connect, leverage and resource partnerships and communities to improve rural health!

National Organization of State Offices of Rural Health

NOSORH

National Organization of
State Offices of Rural Health

www.nosorh.org

EDUCATE
Webinars; Regional and annual meetings; In-depth institutes

COLLABORATE
Technical Assistance; Listening sessions;
Provide resources: fact sheets, briefs, toolkits, playbooks

COMMUNICATE
Policy and program changes; Resources from partners;
The Power of Rural – all year long!

PowerOfRural.org

- Free resources
- Community Star stories
- Key messages

…and more!

National Rural Health Day®

Celebrating the Power of Rural!

State Offices of Rural Health

3 Core Functions:

- Information Dissemination
- Rural Health Coordination
- Technical Assistance

Other Funding:

- Small Hospital Improvement Program
- Rural Hospital Flexibility Program
- CDC Health Equity

A True Part of the State:

- **37** are in state government
- **10** are within academic institutions
- **3** are independent non-profits

NOSORH Work

Accomplished with partners, the State Offices of Rural Health and their stakeholders…

THANKS!!

Thank you for helping move the Power of Rural forward every day!

Let me know if you have questions or if I may be of assistance.

Tammy Norville
tammyn@nosorh.org
919.689.5110

Harsh Realities of Rural Opportunities

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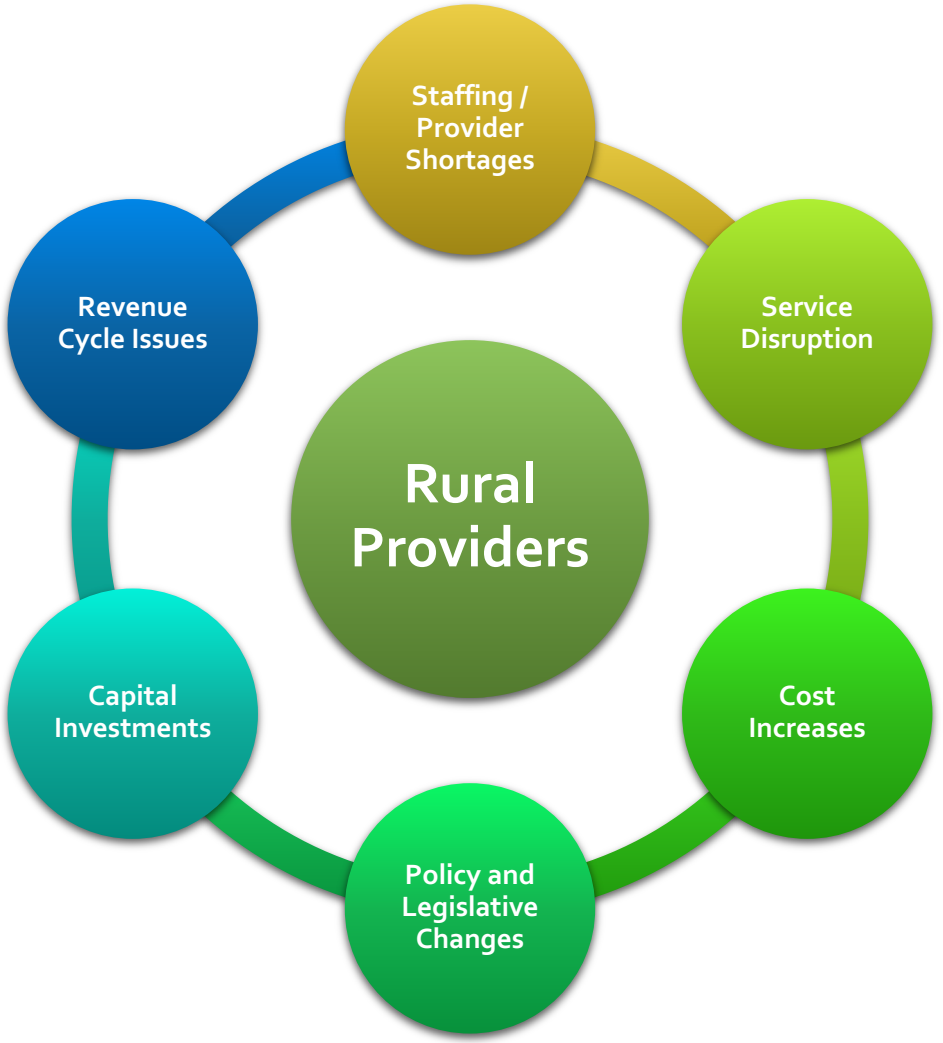
The Harsh Realities

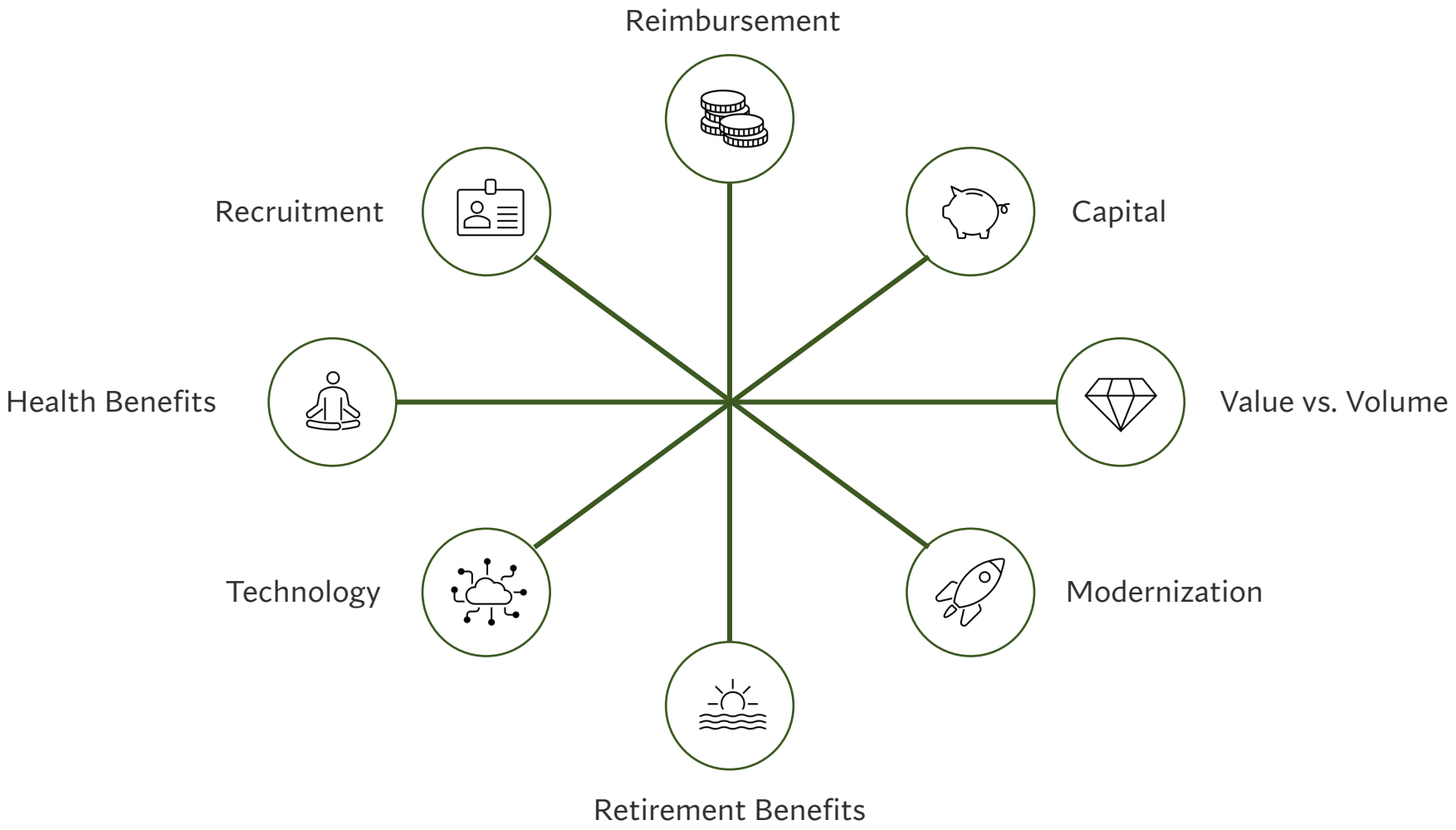
- Rural providers continue to experience cost increases, while having to address staffing shortages, outmigration, and significant policy/legislative changes

- The past few years have fundamentally changed how many patients receive healthcare services
  - Organizations must take a proactive approach to address these changes
  - Population-based initiatives and telehealth continue to gain traction across the industry

CTA Evaluate the current organizational landscape and make necessary changes to improve financial performance



Interdependence of Major Drivers



DOING MORE WITH LESS

Performance Improvement Opportunities

Establish plans for each of the four identified areas to improve the organizational position

- Demand-Based Staffing tools
- Departmental performance improvement
- Revenue cycle and coding
- Cost report optimization
- Practice / clinic designations
- Process improvement
- Supply chain & purchasing

- Define performance gaps
- Integrate department leaders into budgeting process
- Determine cash position and run rates
- Establish actionable metrics
- Pricing transparency and patient engagement

- New market entry and increased competition
- Explore clinically integrated model
- Ambulatory network establishment
- Increase access to care
- Direct contracting
- Improve patient engagement and satisfaction

- Payor contract reviews
- Value-based initiatives
- Population-based strategy
- Self-insured insurance plan offering
- Medicare Advantage negotiations
- Establish payor and provider partners
- Manage overall cost of care

The Integration of Quality and Finance

- To do more with less, organizations must integrate quality and financial initiatives to increase efficiencies, reduce staff waste, and achieve organizational goals
  - This is done through the creation of a Performance Improvement Cooperative (PIC)
- As organizations face staffing shortages, reducing unnecessary meetings and duplication will increase the amount of time employees have to focus on other responsibilities
- Organizations must realize that clinical services has a direct impact on financial performance and financial performance has a direct impact on the abilty to provide financial services

CTA

Integrate quality improvement, performance improvement, and revenue cycle committees into a single multi-disciplinary PIC to improve performance

Benefits of PIC

1. Increases employee engagement and satisfaction
2. Reduces the silo between clinical and finance
3. Removes unnecessary meetings
4. Improves achievement of organizational goals
5. Leverages staff more effectively
6. Increases efficiencies while reducing cost
7. Can more effectively tie goals to strategic plan

Practice Alignment and Designation

- With declining reimbursements, healthcare entities must leverage available reimbursement opportunities to improve financial performance

- The following opportunities are available to hospitals and systems to improve reimbursements when those practices can meet certain eligibility requirements:
  1. Convert eligible practices to a designation that provides the most advantageous reimbursement opportunity
  2. Realign practices within a health system to leverage reimbursement advantages and additional revenue
  3. Integrate specialty practices and providers, when possible, within a PBC or RHC to leverage alternative reimbursement methodologies
  4. Acquire independent practices to leverage provider-based reimbursement opportunities and other additional revenue streams available to hospitals such as 340B
     - This opportunity may not lead to a net positive return; however, will increase in functional, contractual, and governance alignment and increase the attributed lives associated with the hospital / health system
     - **Note:** *An RHC owned and operated by a hospital that qualifies for 340B does not have to meet the provider-based rules at 42 CFR 413.65 to be registered as a child site for 340B purposes*

CTA Evaluate each practice to ensure optimal alignment and designation

Practice Alignment and Designation

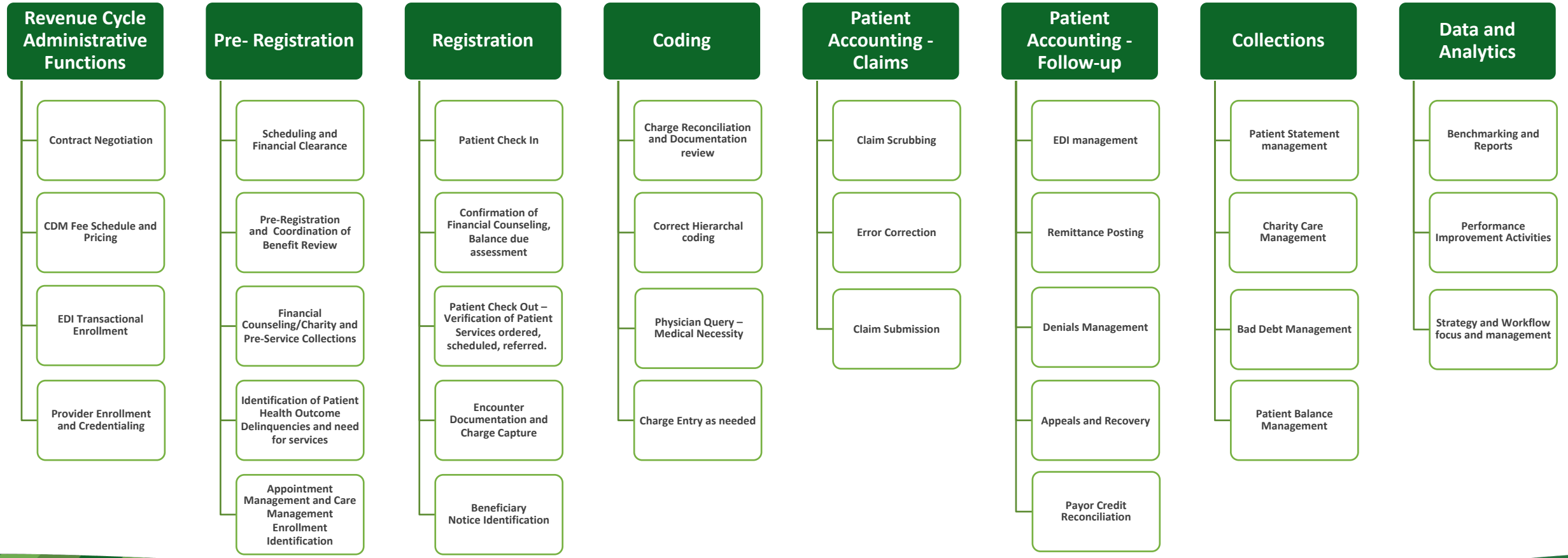
- The following table shows the net financial impact of different designations on a hospital:

			Before Change		After Change
Summary Data	**Scenario #1 PBC**	**After 2019 OPPS Final Rule (PBC)**	**Scenario #2 PB-RHC >50 Beds**	**Scenario #3 PB-RHC <50 Beds**	**Scenario #4 RHC Post 4/1/21**
Medicare / Medicaid Average	$ 149.06	$ 136.86	$ 86.32	$ 187.82	$ 127.92
Annual Visits	28,294	28,294	28,294	28,294	28,294
Reimbursements Received	$ 4,217,643	$ 3,872,319	$ 2,442,338	$ 5,314,296	$ 3,619,368
340B Benefit	n/a	n/a	n/a	n/a	n/a
Variance w/ Before 2019 PBC (Scenario #1)		$ (345,324)	$ (1,775,305)	$ 1,096,653	$ (598,275)
Variance w/ After 2019 PBC (Scenario #1)			$ (1,429,981)	$ 1,441,977	$ (252,951)

- Outcomes:
  - Prior to the change in the RHC reimbursement methodology, the PB-RHC would have been the most advantageous designation; however, under the new reimbursement methodology, the practices would be better served to remain as a PBC until the RHC UPL surpasses the average PBC rate
    - Since the practices were already PBCs, there was no additional 340B benefit by converting the practices to RHCs

High-Functioning Revenue Cycle

- Evaluate and improve revenue cycle functions by ensuring a fair distribution of work, clearly defined roles and task automation or improvement
  - Make sure no matter how tasks are divided among departments, core task elements are incorporated and monitored



Increase Volume and Additional Revenue

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Are our providers "busy"?

CMS defines a minimum expected number of patient visits for physicians and advanced practice providers (Nurse Practitioners and Physician Assistants)

The goal is always to maximize visit volumes

4,200
Physicians

2,100
APPs

Note: Providers with regular scheduled time are subject to the Minimum Productivity standards
Note: Providers with non-regular scheduled time are not subject to the Minimum Productivity standards
Note: Contracted physician volumes are not included in the calculation
Note: If clinics do not meet productivity standards, the clinic will not get full cost-based reimbursement, subject to CAA provisions

Establishing a Niche Market

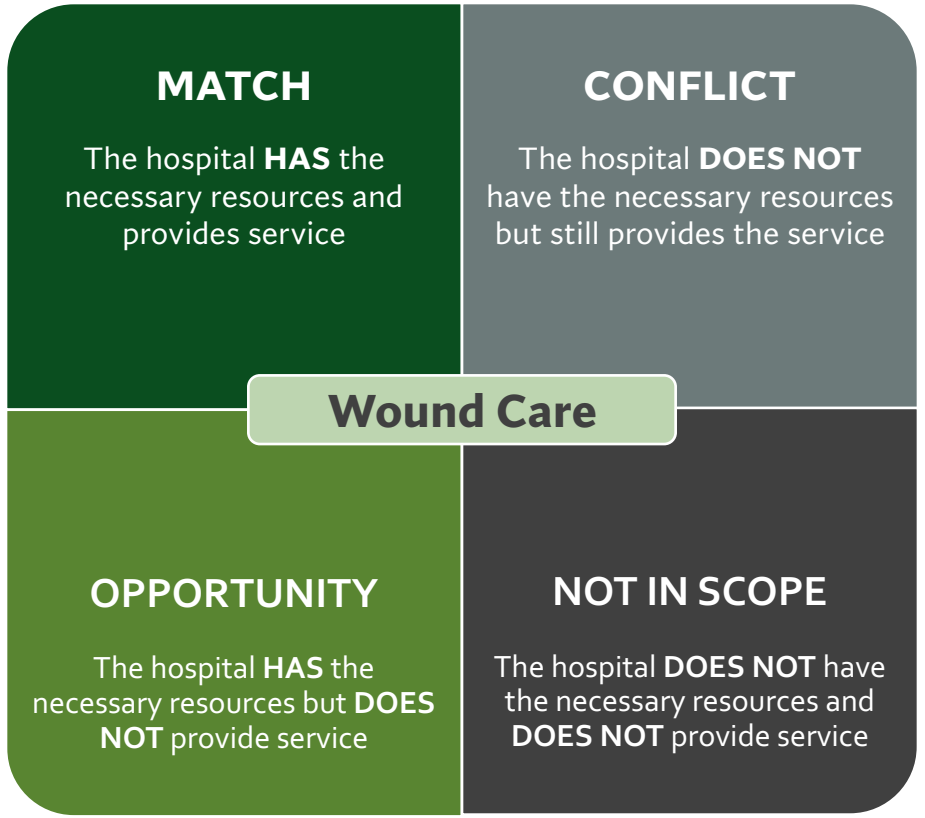
- To effectively position an organization in the current market, each organization must evaluate the current scope of practice and sought opportunities to expand access and reliance on the program to improve financial performance

- Rural hospitals define the Scope of Practice (those patients able to receive care at your facility) across applicable departments (Med/Surg, ED, Rehab, etc.) as a collaborative, multi-disciplinary group inclusive of the following categories:
  - Medical Staff, Nursing, Pharmacy, Medical Equipment, Rehabilitation, and Business Office

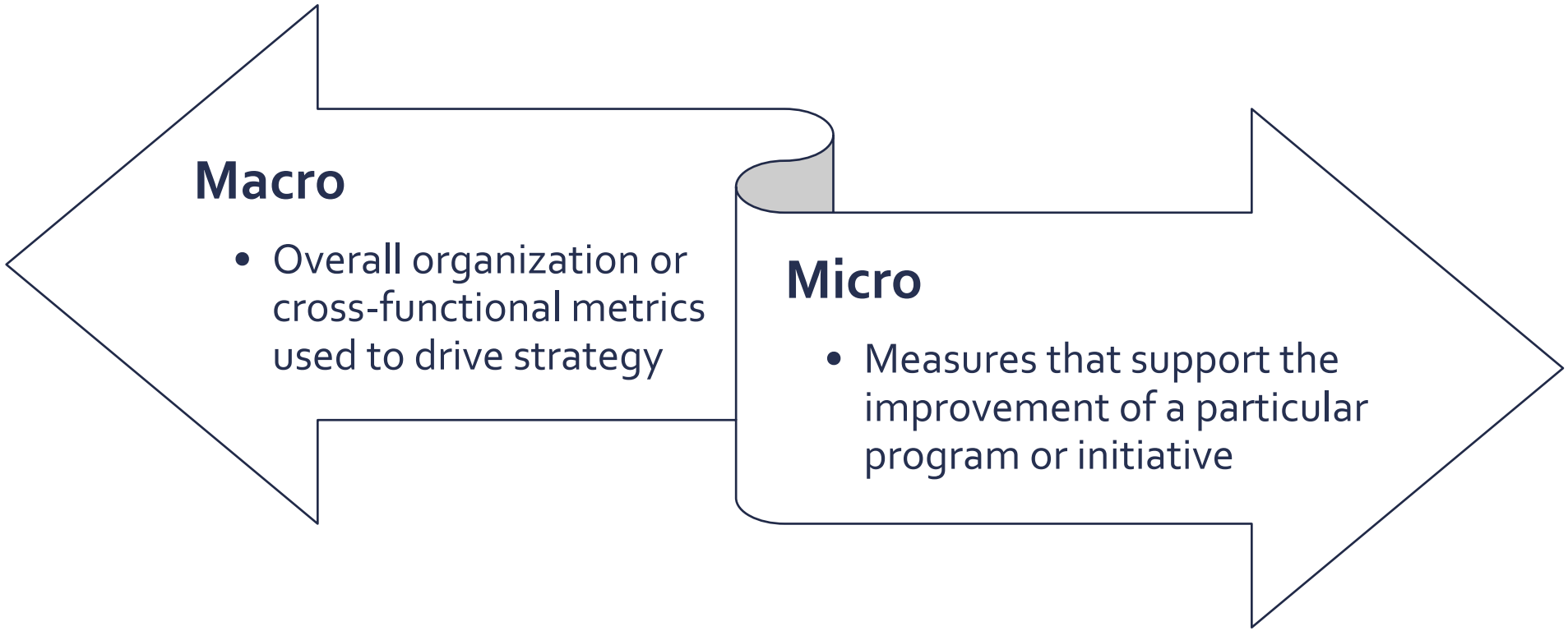
CTA Audit services provided and continue efforts to expand service delivery to increase reliance on the hospital for post-acute care services

CTA Leverage the Swing Bed NF rate

Example: Wound Care Program



Leverage Data to Drive Performance



An error often seen in hospitals is the selection of macro-level metrics to drive specific improvement efforts and micro-level metrics to drive broader

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HRSA
Health Resources & Services Administration

Federal Office of Rural Health Policy Update

2024 Rural Hospital Performance Improvement Conference

January 31, 2024

Meredith Anderson, Hospital State Division
Federal Office of Rural Health Policy

Vision: Healthy Communities, Healthy People

The Federal Office of Rural Health Policy

Established in Section 711 of the Social Security Act

The Federal Office of Rural Health Policy (FORHP) collaborates with rural communities and partners to support community programs and shape policy that will improve health in rural America.

Cross Agency Collaboration

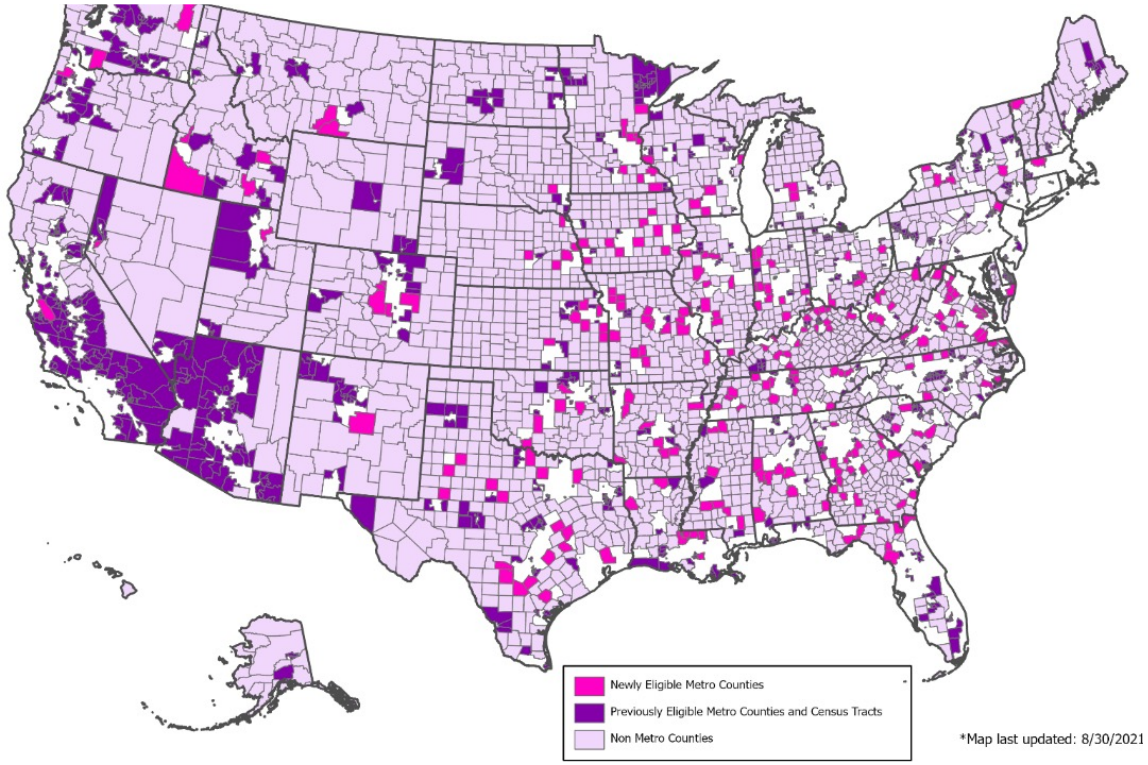
Works across HRSA, HHS, and several other federal partners to accomplish its goals

Capacity Building

Increases access to health care for people in rural communities through grant programs and public partnerships

Voice for Rural

Advises the HHS Secretary on policy and regulation that affect rural areas



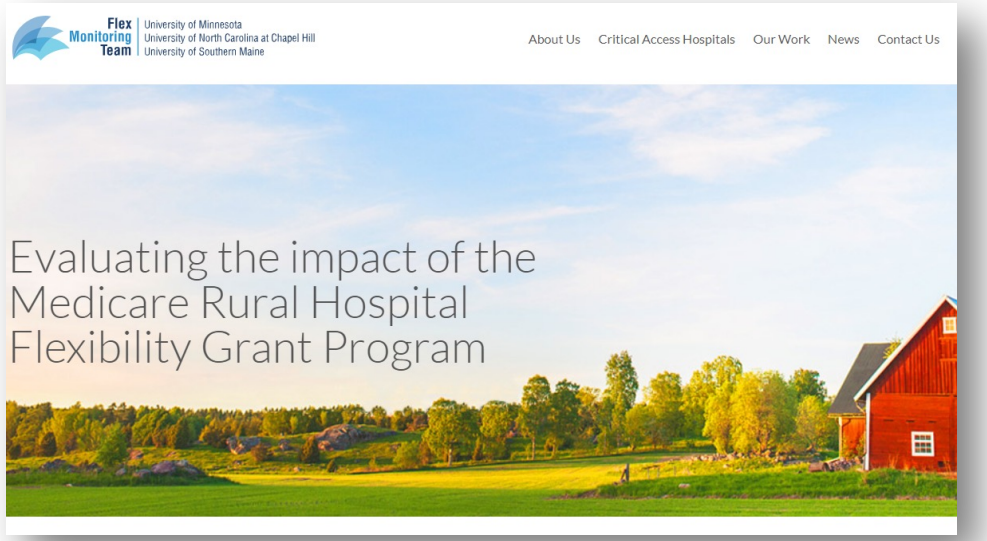
U.S. Department of Health & Human Services
HRSA
Federal Office of Rural Health Policy

Priority Areas

- Supporting Rural Hospitals and Clinics
- Addressing Substance Use Epidemic
- Advancing Rural Community Health
- Addressing Rural Disparities
- Promoting Partnerships to Address Rural Health Workforce

Supporting Rural Hospitals and Rural Health Clinics

Grants and Technical Assistance



Ongoing Support

- Rural Healthcare Provider Transition Project
- State Office of Rural Health
- Rural Hospital Flex Program
- Small Hospital Improvement Program
- Flex Monitoring Team
- Rural Emergency Hospital Technical Assistance Center
- Rural Health Clinic Technical Assistance (NARHC)

Targeted Technical Assistance

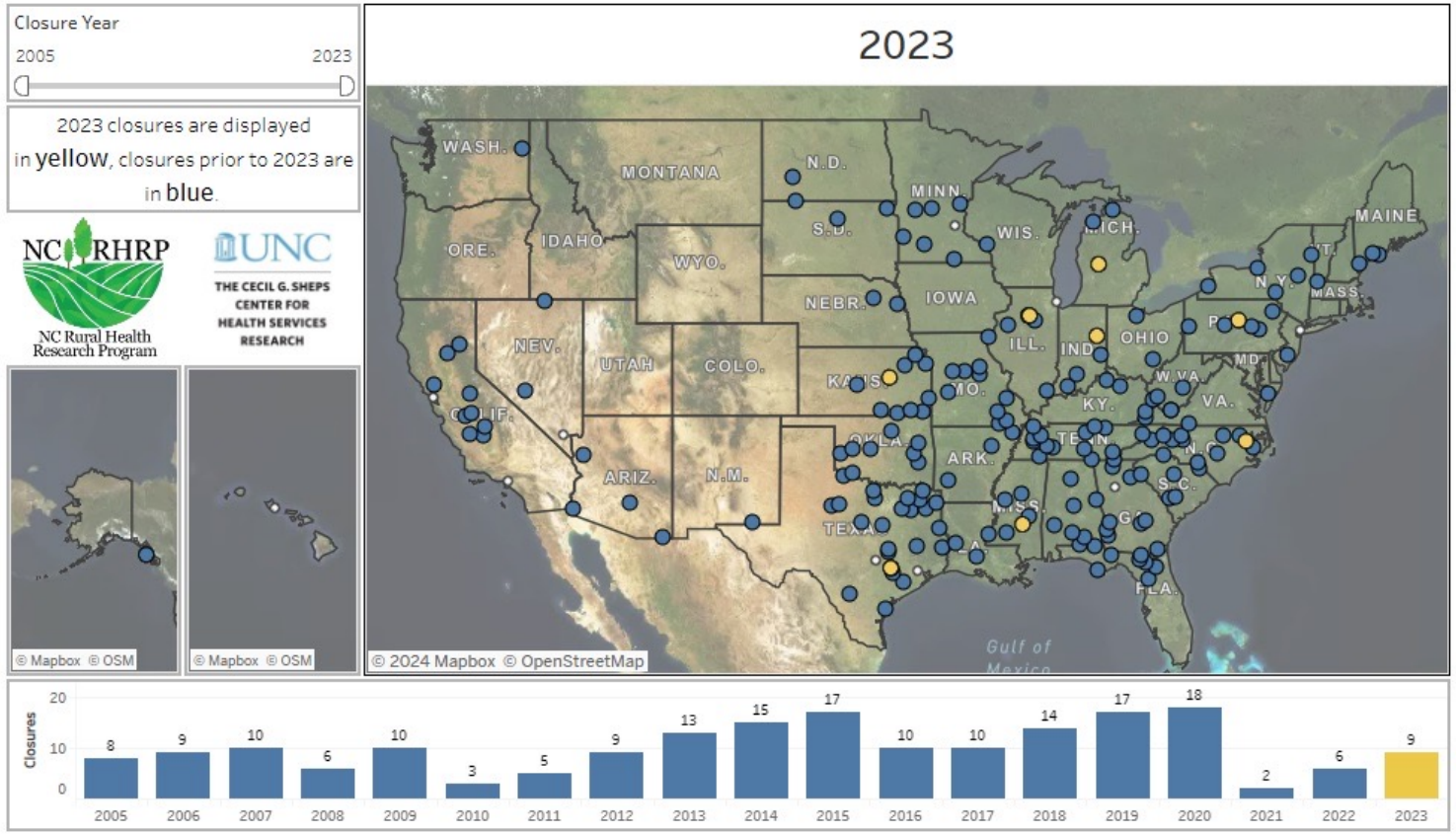
- Focusing on “At-Risk” Facilities
  - ✓ Delta Region Community Health Systems Project
  - ✓ Targeted Technical Assistance for Rural Hospitals Program

U.S. Department of Health & Human Services
HRSA
Federal Office of Rural Health Policy

Rural Health Policy Issues

Rural Hospital Landscape

- Rural hospital closures
- Hospital financial situations post COVID-19
- Conversions to Critical Access Hospital and Rural Emergency Hospital



https://www.shepscenter.unc.edu/programs-projects/rural-health/rural-hospital-closures/

U.S. Department of Health & Human Services
HRSA
Federal Office of Rural Health Policy

Program Evaluation

Telling the story of our programs

Feasible data collection

Intentional program measure development

Collaboration

Flexibility

Concise and digestible

Hospital Grants and Resources

Current Opportunities

- **Medicare Rural Hospital Flexibility Program (Flex) Target**
  - ✓ Notice of Funding Opportunity (NOFO) on grants.gov (announcement number: HRSA-24-002) and accepting applications through **April 16, 2024**

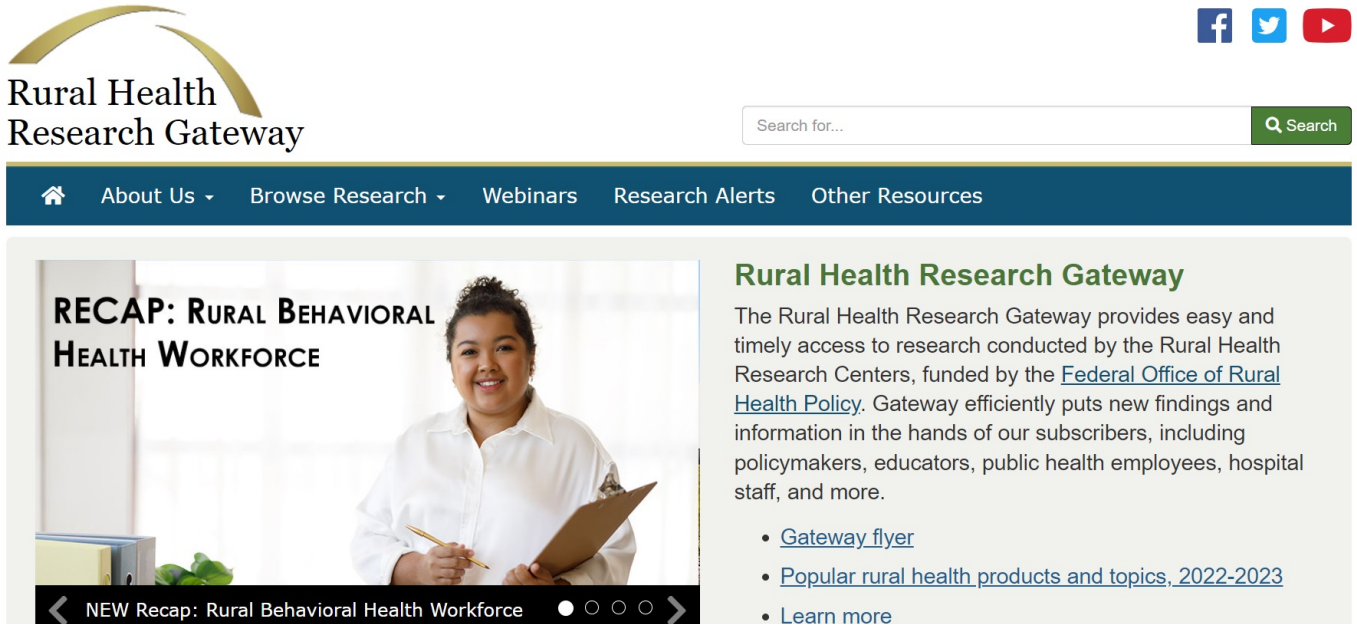
- **Flex EMS: Medicare Rural Hospital Flexibility Program- Emergency Medical Services (EMS) Supplement**
  - ✓ Notice of Funding Opportunity (NOFO) on grants.gov (announcement number: HRSA-24-006) and will be accepting applications through **April 25, 2024**

- **Flex Targeted Technical Assistance for Rural Hospitals (TTAP)**
  - ✓ Two years of technical assistance for rural hospitals seeking to enhance their financial and operational capacity and accepting applications on the TTAP website through **February 7, 2024**

- **Rural Emergency Hospital Technical Assistance Center**
  - ✓ Assistance for rural hospitals exploring REH designation available at https://www.rhrco.org/reh-tac

Health Policy & Research

Accessible and Through a Rural Lens



www.ruralhealthresearch.org

Questions about Policy Updates?

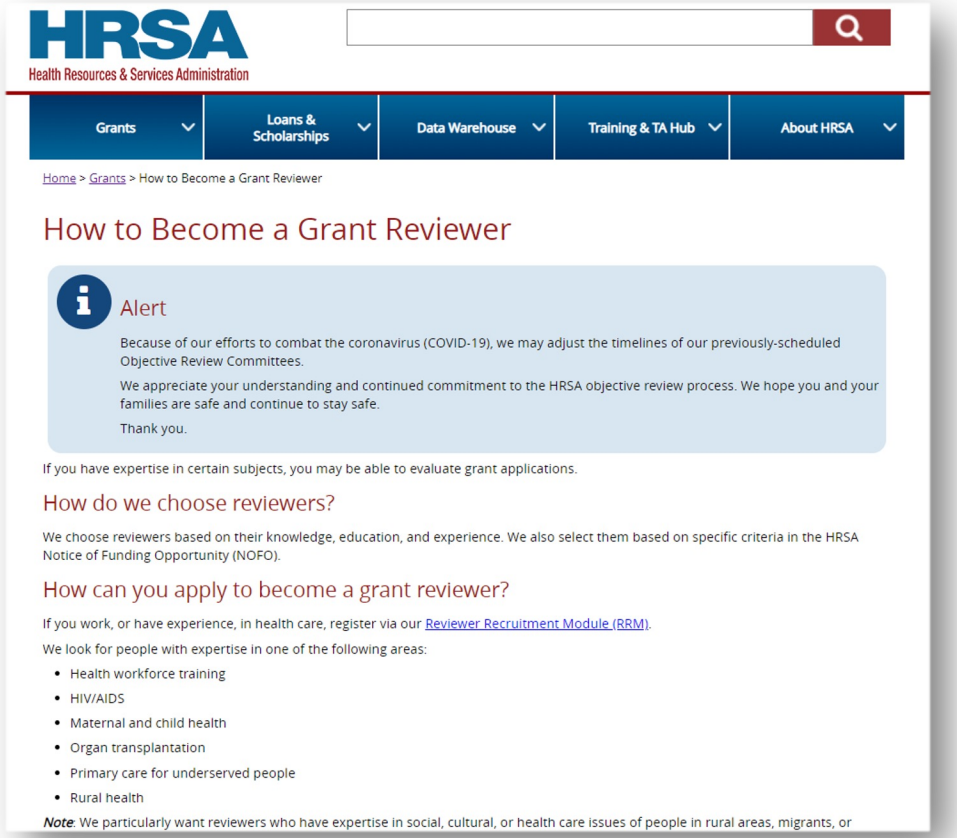
Write to ruralpolicy@hrsa.gov

U.S. Department of Health & Human Services
HRSA
Federal Office of Rural Health Policy

HRSA Needs Your Help!

Consider Being a HRSA Grant Reviewer

- Ensures We Get the Rural Perspective
- Provides a good insight into the grants process
- Key Steps:
  - Once registered note rural as your area of expertise
  - Let us know when you are in the database (so we can select you)
    - ✓ Email Lisa Chechile at lchechile@hrsa.gov



https://www.hrsa.gov/grants/reviewers

U.S. Department of Health & Human Services
HRSA
Federal Office of Rural Health Policy

Contact Information

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FOLLOW US:

Eliminate the Ego in Rural Healthcare Recruitment

2024 Performance Improvement Rural Healthcare Virtual Conference

January 2024
hunterambrose.com

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RECRUITMENT- EXECUTIVE SEARCH - CONSULTING

5 Fast Facts | Rural Healthcare Recruitment Q1 2024

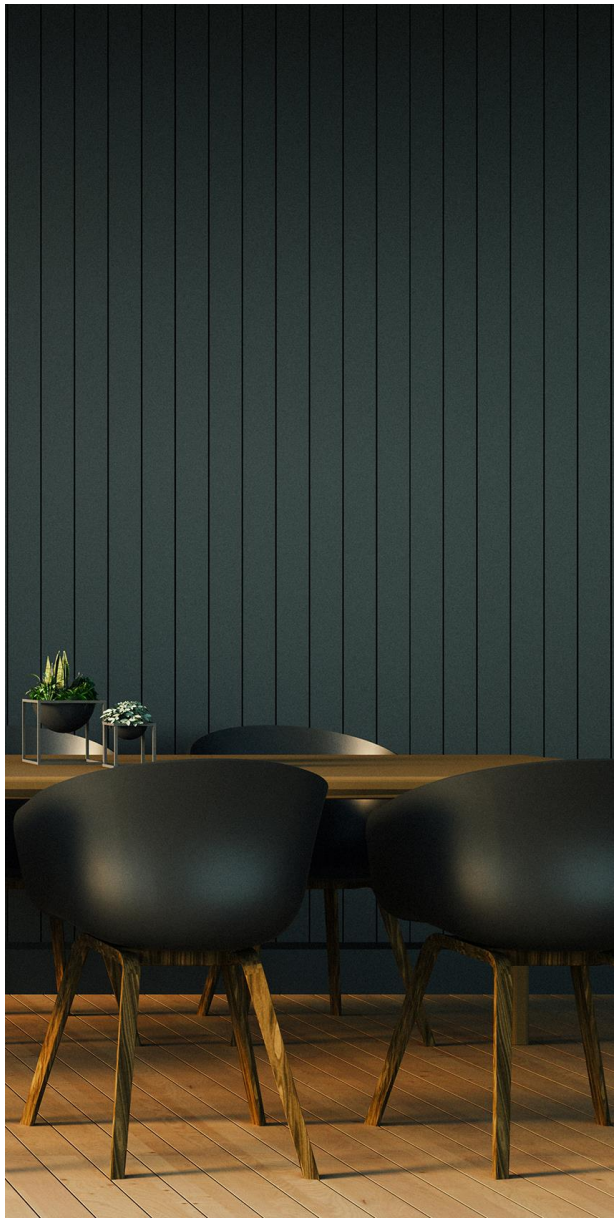
1. While one in three workers plan to leave their position within the next two years, 14 percent of respondents said they planned to leave the healthcare industry entirely within the next year. This extends to non-clinical professionals; specifically, finance, human resources and IT.

2. On average there are 193,000 open Staff RN positions annually. *And, in 2024, there are over 66,000 open healthcare finance jobs paying 75-150k.* Finance is the most in-demand, non-clinical position in healthcare.

3. Fiscal stewardship is the emerging #1 qualification for leadership positions at high-performing Rural Hospitals. Rural Healthcare CEOs are seeking management teams that understand the Revenue Cycle process, Budget Management and Resource Allocation.

4. The most common reason, (beyond compensation) that candidates reject an opportunity in Rural Healthcare is that 30-60 days of temporary housing is not offered and or less than 50% of the cost to relocate is offered in reimbursable expenses.

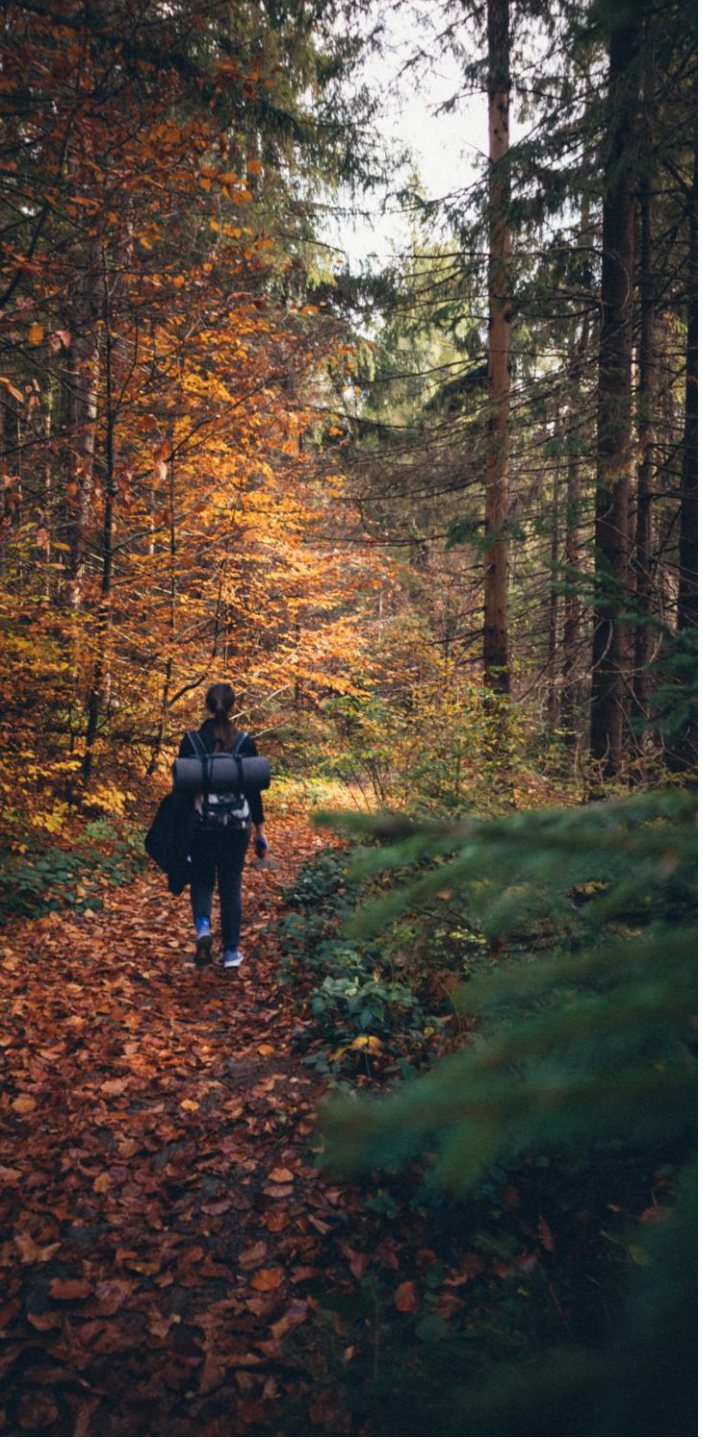
5. According to several surveys, the #1 most ineffective and dreaded interview question a candidate is asked is, “Tell me about a time when….”



Rural Healthcare Recruitment that costs nothing and works.

Be first. Be fast. Be kind.

Drop the Drama. Eliminate the Ego



In a small town, egos at work may manifest in distinctive ways due to the close-knit nature of the community. Here are some ways egos can surface.

1. Local Reputation and Gossip: In smaller communities, professional reputations are often closely tied to personal reputations. Egos may manifest through individuals seeking to enhance their image or maintain a specific reputation. Workplace gossip can be more prevalent, and conflicts might become widely known.

2. Limited Career Opportunities: In smaller towns, there may be fewer job opportunities, leading to increased competition for available positions. Egos might surface as individuals vie for recognition or advancement, potentially leading to unhealthy workplace dynamics.

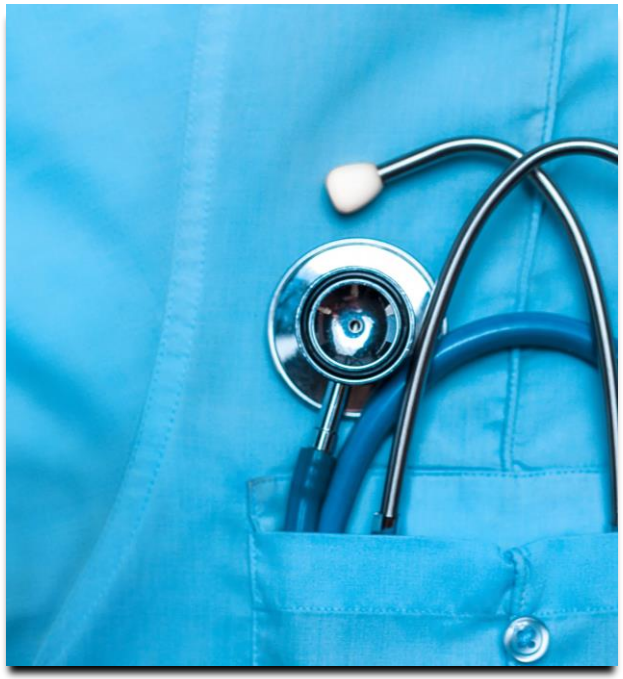
3. Tight Social Networks: Small towns often have tight social networks where professional and personal lives intersect. Egos may manifest in individuals seeking social validation for their professional achievements or asserting dominance within social circles.

4. Resistance to Change: Small towns can sometimes be resistant to change. Egos may surface when individuals resist new ideas or methodologies that challenge established norms. Those with inflated egos may be less open to collaboration or innovation.

5. Public Perception and Status: In a small town, individuals might place a high value on their public image and status within the community. Egos could manifest through displays of superiority or an overemphasis on titles and positions.

6. Lack of Anonymity: In smaller communities, anonymity is rare. Egos may be more pronounced as individuals are acutely aware of their professional standing and how they are perceived by others.

What Causes Ego at Work?



1. **Insecurity:** Individuals with low self-esteem may develop a big ego as a defense mechanism to mask their insecurities. They may feel the need to assert dominance and control to compensate for feelings of inadequacy.

2. **Competitiveness:** A highly competitive work environment can foster egotistical behavior. Employees may feel the need to outshine others, leading to an inflated sense of self-importance.

3. **Excessive Positive Feedback:** If someone receives constant positive feedback without constructive criticism, they might develop an inflated ego. Without corrective input, individuals may become overly confident and less open to improvement.

4. **Poor Leadership:** Leaders who exhibit egotistical behavior can create a culture that encourages similar attitudes among their subordinates. Employees may adopt such behavior as they perceive it to be acceptable or even rewarded.

5. **Failure to Adapt:** People who struggle to adapt to changing circumstances or new information may cling to their existing beliefs and resist feedback. This resistance can contribute to an inflated ego.

6. **Lack of Empathy:** A lack of empathy for others can lead to a self-centered perspective. Individuals who prioritize their own needs and achievements over others may develop a big ego.

Ego Driven Recruitment – Rejection Statements

1. HR- I can't schedule an interview until the Manager looks at the resume
2. I'm too busy to interview until next week
3. This is the way we've always done things
4. I wanted someone with more experience
5. I've heard of this person (not good things)
6. Not a good fit
7. You don't understand
8. That wouldn't work here
9. I know their type
10. Why would they want to work here
11. The team would eat them alive
12. We don't have time to train someone
13. They wouldn't like it here. They don't ski / hike / hunt / fish.
14. You have no idea how hard / bad / wrong things are
15. They don't check the boxes
16. If we're paying more, I want more
17. They won't stay
18. Why are they looking for a new job
19. I didn't like their answers
20. I'm waiting to hear back from everyone
21. I just can't put my finger on it….

Quit the Drama. Lose the Ego. Pivot the conversation.

Let's talk directly about any issues instead of spreading rumors.

If you're worried about something, let's discuss it together or in a meeting, so we keep things respectful.

Venting and gossiping are disrupting an otherwise positive day.

Let’s commit to addressing challenges by sticking to the facts rather than engaging in gossip.

Is what you’re saying, true, kind and necessary to the conversation?

Research has shown that the average employee spends nearly 2.5 hours per day in drama – gossiping, tattling, withholding buy-in, resisting change and stepping down from accountability. Cy Wakeman

The Humble Interview Process (first, fast and kind)

Timely Application Responses - Responding to candidate applications within one business days.HR/Recruitment Team takes the lead in scheduling interviews for a seamless process. Limit the gatekeepers.

Post-Interview Closure - Make timely decisions to move forward or disqualify, discourage negative post-interview discussions. Encourage positive feedback and curiosity. Get back to candidates within 3 business days.

Building a Strong Brand - Ensuring the hiring team and organization present their best foot forward through an updated website and polished online presence, including organization social media pages and a polished LinkedIn profile per stakeholder.

Constant Student - Be ready to discuss the thought leaders, podcasts, or publications that you believe enhance the organization. If you want a Constant Student / Lifelong Learner, showcase that you are one.

Fair Assessment Practices - Avoiding negative assumptions about a candidate's history. Ask stacking-questions to encourage conversation rather than prompting defensive answers.

Candidate-Centric Approach - Recognize that accepting a position with your organization will completely uproot the candidate’s life, it will cost a candidate thousands of dollars to relocate and change their interpersonal relationships.

Professional Boundaries - Refrain from asking personal questions and crossing HR guidelines. Organizations that get too “friendly” in an interview demonstrate to a candidate that accountability may be thin, and boundaries will be crossed, this eroding trust in the interview process.

Interview Questions that work….

- **Seek Fresh Perspectives:** In exploring our department's challenges, what initial ideas might you bring to the table?
- **Open to Mentorship:** In the spirit of growth, are there specific areas where mentorship could help you transition smoothly into this role? Where could we help you get up to speed quickly?
- **Welcome Big-Picture Ideas:** We value innovative thinking. Are there any big-picture concepts you'd like to contribute to our organization or any ideas that you've implemented in the past few years that you'd like to share with us.
- **Address Departmental Challenges:** Recognizing a significant challenge, *(share how bad it is*), what related experiences have you had and what ideas do you have that would help with this issue?
- **Community and Position Interest:** In considering this role, what aspects of our community make it particularly appealing to you or are you concerned about? Share your and your families experience moving to the area.
- **Fiscal Stewardship:** Considering the importance of financial stewardship, can you share instances from your experience where you actively contributed to optimizing the revenue cycle? And how do you instill financial stewardship in your team?

Check your ego at the door

Am I Open to Feedback or Criticism?

Ask yourself if you are genuinely open to receiving constructive feedback. A willingness to listen and learn from others is a key indicator of checking your ego.

Am I Considering Different Perspectives?

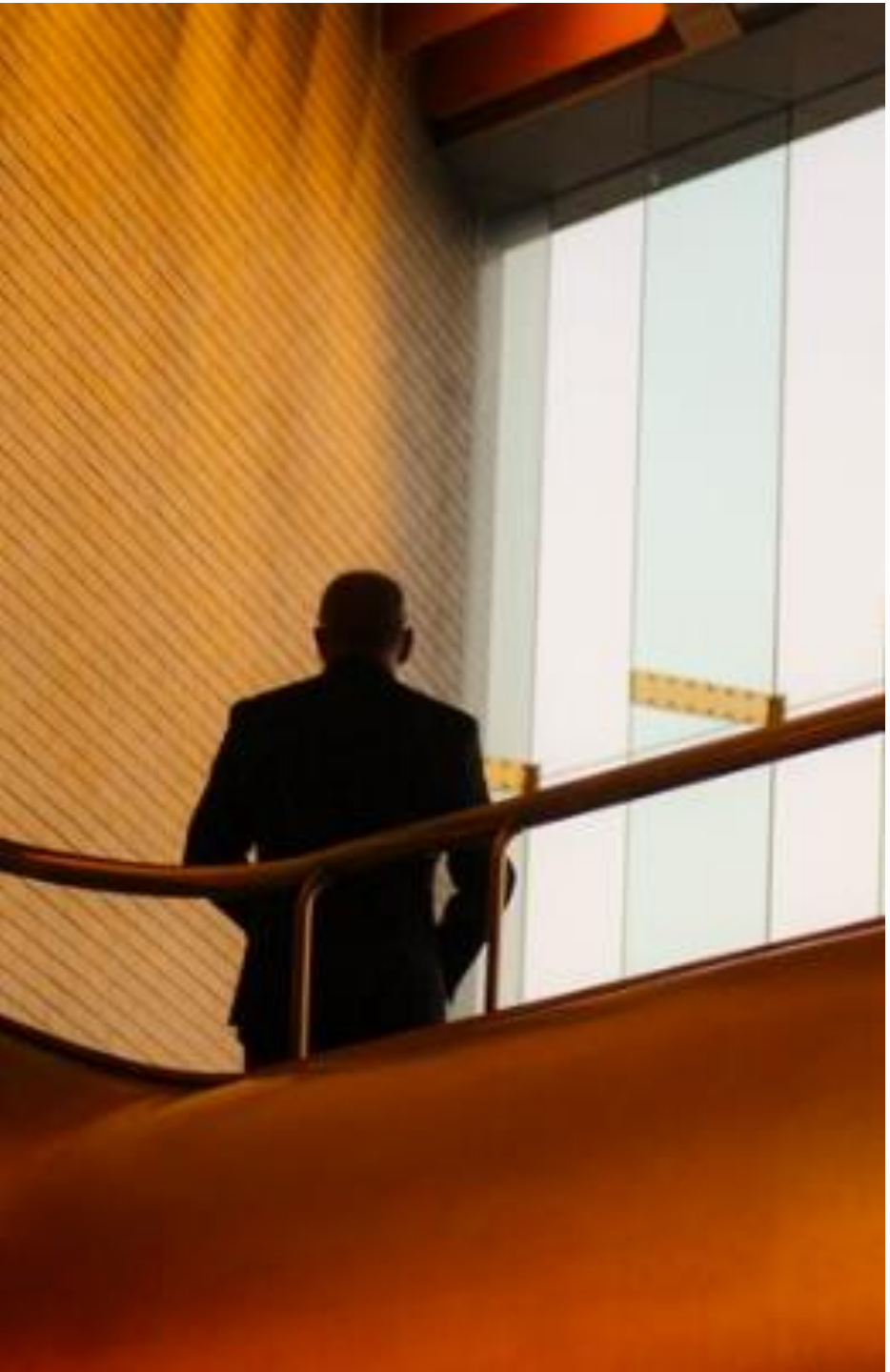
Reflect on whether you actively seek and consider diverse perspectives. Being open-minded and valuing different viewpoints helps in keeping the ego in check.

Is My Decision Based on the Best Outcome for the Team or Organization (or just me)?

Before making decisions, ask if your choices prioritize the best outcome for the team or organization rather than solely serving personal interests.

Am I Overcompensating?

Some individuals respond to insecurity by overcompensating through ego-driven behaviors. This can include withholding information, not being prepared, procrastinating, and or an exaggerated display of achievements as a way to mask underlying feelings of inadequacy.



Homework

1. Examine your current job openings and recognize that filling a position may require approximately 300 hours to fill. Define the team,(internal, external and or vendors) process and benchmarks. Most leadership searches in Rural Healthcare require 159 days, (2 weeks to develop the strategy, 100 days to recruit and 45 days to relocate). If you need positions filled by July, start in February.

2. Evaluate your recruitment-to-hire process, identifying potential obstacles. How long does it take to apply for a job online. If an applicant is using a VPN, can they connect to the website and apply?

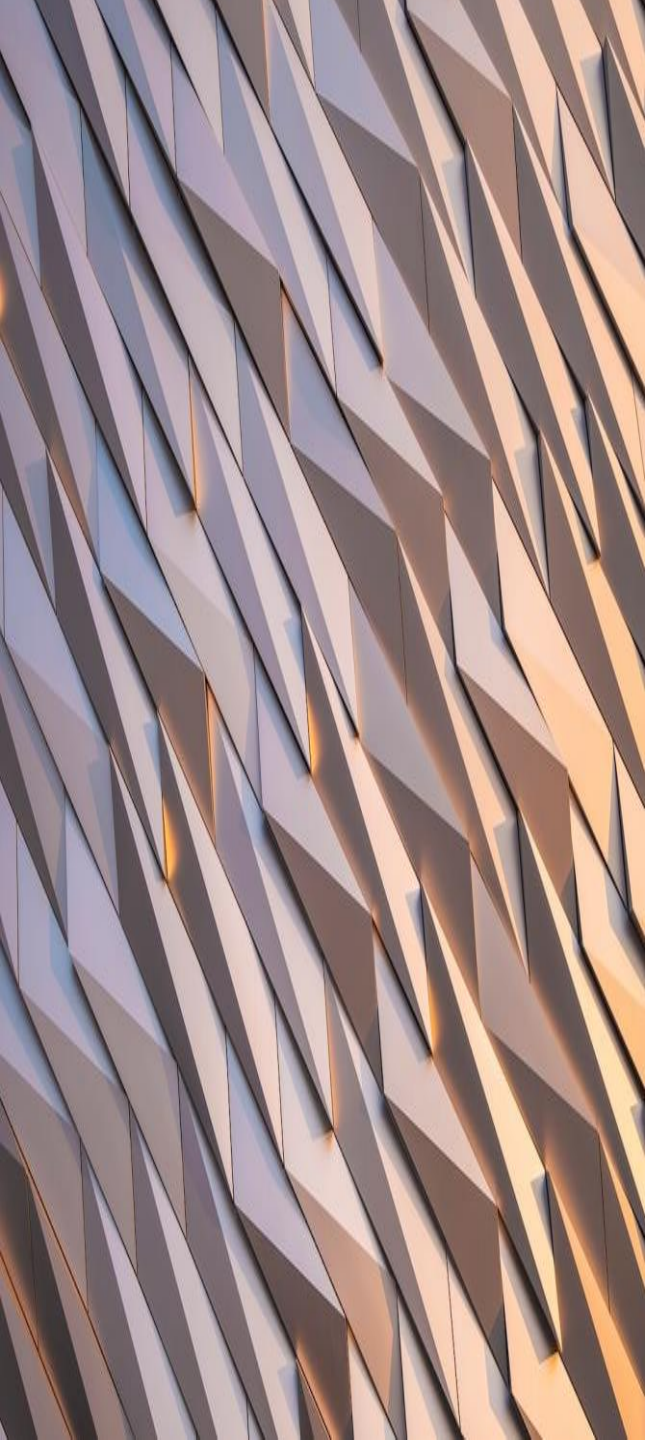
3. Engage in discussions with the last five hires. What worked and what didn’t. Duplicate the conversation with HR and the hiring manager for the last 5 candidates that rejected your offer. The responses and reflections between those two comparisons are your solutions to better, smarter recruitment.

Individuals are yearning for a sense of community.

Rural healthcare is currently in a prime position for growth and success if it can effectively coordinate, establish a strong brand and initiate recruitment efforts.

By understanding and empathizing with the candidate experience, being prompt in responses, conducting swift interviews and consistently demonstrating kindness throughout the process- Rural Healthcare can attract talent and contribute significant value to both the organization and the community.

Be first. Be fast. Be kind.



HUNTER AMBROSE INT.

RECRUITMENT- EXECUTIVE SEARCH - CONSULTING

Nicole Barbano, Founder and Principal

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hunterambrose.com

Benefits: Strategic Asset, Not Cost

Presented by Rob Bloom and Brett Shippee

WINTERGREEN

Let's rethink benefits

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Explicit Problem Statement: Recruiting and retention are ongoing challenges in rural settings that benefit offerings can help address.

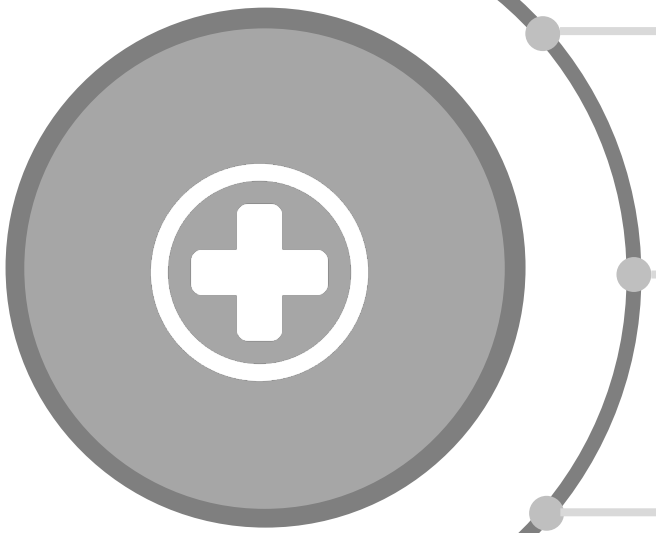
Agonizing Self-assessment

- Healthcare benefits are viewed as a necessary and expensive evil
- Benefits are rarely a part of strategic planning
- Offerings are vanilla
- Benefits are mostly comparative across competitors
- Benefits aren't driving recruiting efforts, salaries are

Why Doesn't Rural Change

- Entrenched incumbents
  - High margins
  - Investment in "education"
- Organizations compare themselves to competitors to evaluate parity
- HR theory taught by professional organizations that don't operate healthcare facilities
- Lack of effort

Environmental Overview



Recruitment Challenges

Hospitals are facing personnel shortages across nearly all positions, not just clinical. This represents an increase in effort and complexity.

New Competitors

Competition is multi dimensional: regional, national, disruptors, and new industries all compete for rural resources.

Changing Workforce

Social evolution and communication platforms are changing the expectations of the existing and potential workforce.

Cost Constraints

Reimbursement pressures and unfunded mandates mean that the issue can't be solved by throwing money at the problem.

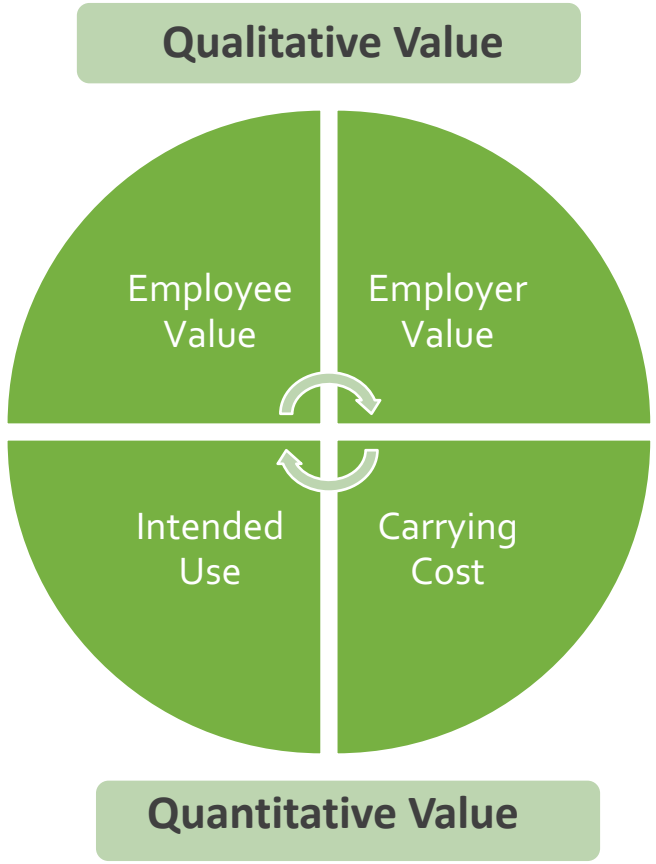
Checking the Box

Historically, most hospitals have a very similar menu of benefit options with little in the way of ingenuity.

Everybody Loves Vacation

PTO approaches

- Most Hospitals have fairly comparative PTO features
  - Straight PTO/Holidays
  - Multiple Platform
    - Floating Holidays
    - Vacation
    - Sick
    - Etc.
  - Caps and use or lose
- New competition requires a review of the value proposition
  - Unlimited PTO
  - Flexible work schedule
- Conduct a comprehensive review of time off benefits leveraging both qualitative and quantitative information
  - Balance sheet
  - Survey



Health Insurance=Peace of Mind

Health Insurance Landscape

Fully Insured

Fully insured health insurance follows a traditional model where the employer contracts with an insurance carrier to assume the financial risk of covering employees' health expenses.

Self-Funding

The hospital assumes the financial risk for providing healthcare benefits to its employees. This allows greater flexibility in designing custom benefit plans and controlling costs, as the employer pays for claims directly.

Captive

Captive insurance allows for the creation of a customized insurance program tailored to the specific needs and risks of the parent company, providing more control and flexibility in coverage and cost management but also shared risk.

Hybrid Model

Through combination of the historical insurance offering for healthcare facilities, rural can develop a model that creates savings, enhances employee value and improves employee retention.

Insanity stated clearly

Fully insured plans create high margins for a very large industry

Poorly managed self-funding yields only marginal savings but transfers significant risk

Healthcare captives share risks with homogenous risk pools in the same industry

CTA Leverage status as a healthcare provider to improve offerings while controlling cost and risk

Healthcare has a unique advantage!

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Hospitals provide the very service being purchased. Most CAHs have the capability to provide bread and butter services

Hospitals employ the human resources needed to proactively manage risk while developing population health competencies

Employees can gain real value knowing their families have access to an incredible benefit that limits out of pocket exposure

The better way via a Hybrid model

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Creation of a domestic network controls cost by leveraging available capacity within the Hospital's services, typically between 30-45%

National access to care is maintained through a third-party administrator's network.

Risk is controlled by using a direct contract for each employer with a group trust that includes over 1,500 employers to lower cost and create stability and risk diversity.

The Golden Years

Healthcare Retirement Overview

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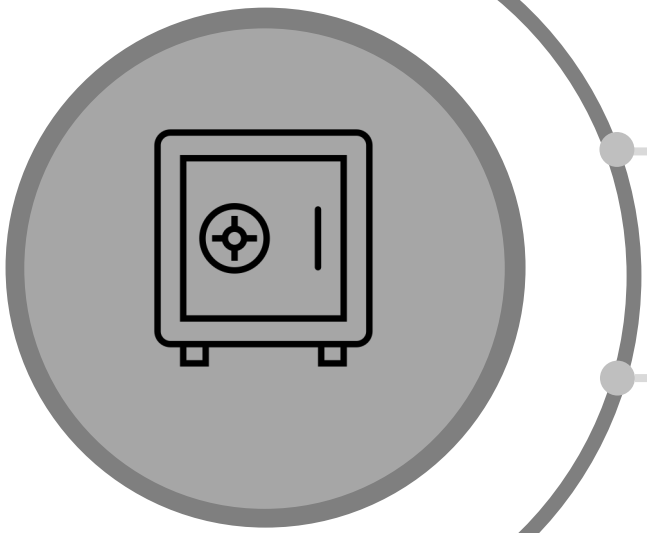


Traditional Retirement Plans

401k and 403b plans are tax-advantaged retirement accounts, allowing employees to save for retirement with pre-tax contributions. Highly compensated employees will struggle with low annual maximum contributions and discrimination testing.

457 Deferred Comp

Employees contribute a portion of their salary to the account, often matched by the employer up to IRS limits for deferred compensation. The employee guides the investments and is responsible for performance.

Defined Benefits

Defined benefit plans offer a fixed retirement income, based on a formula which factors in years of service and average salary. The hospital bares both the funding and investment risks within the defined benefit plan.

Key Employee DER

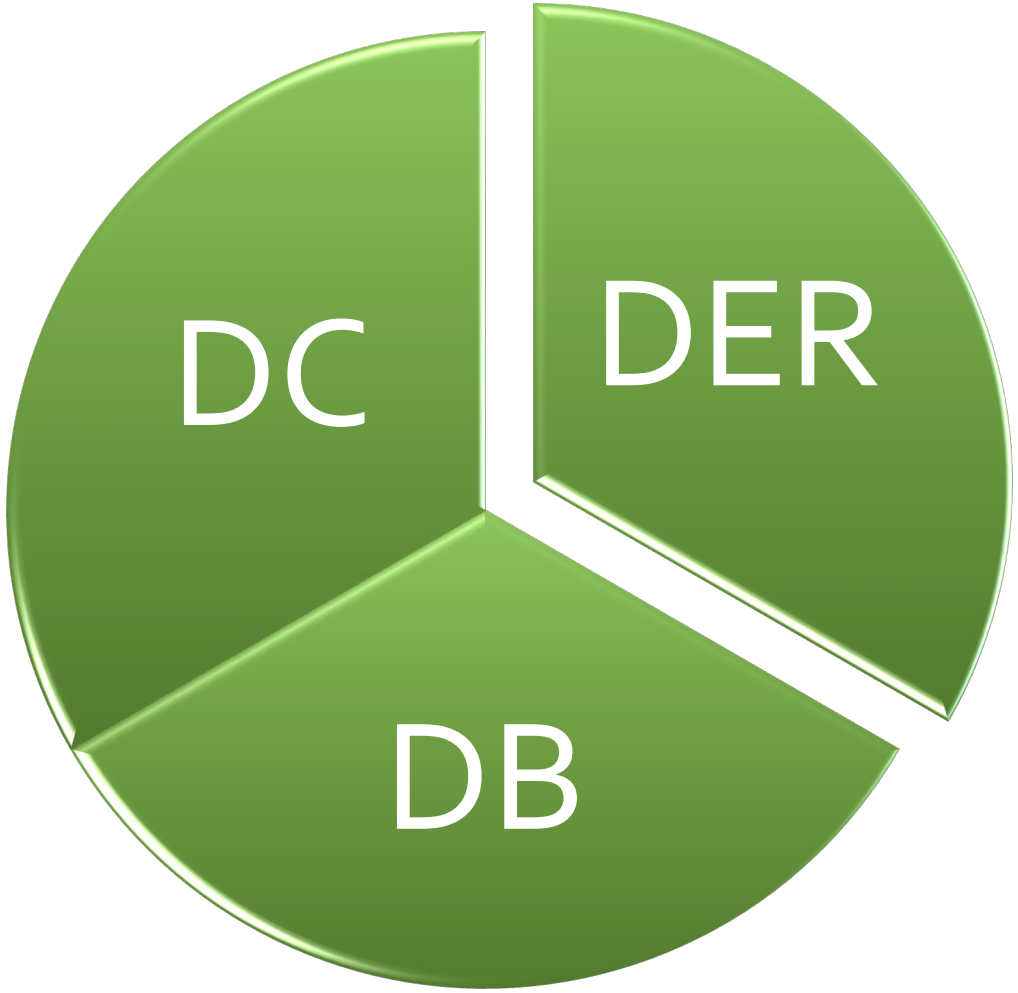
Key Employee DER plans allow hospitals to provide a significant benefit to key employees while avoiding discrimination testing, attached to a vesting schedule that drives retention rates and rewards employees that stay.

Complete the retirement pie

- As defined benefit plans became too expensive, most hospitals have lost a competitive edge in retirement benefits
- Most hospital sponsored programs will not support employees in retirement
- Competition for key employees requires innovation to ensure adequate staffing levels and access to top performers

CTA

Enhance employee retirement benefits to enhance competitive edge for recruiting and retention



Key Employee DER

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DERs provide a solution for each of the four identified areas

- Recruiting/retention asset
- Creates financial incentives for employees to meet 10-year vesting
- Lump sum benefit that transfers upon vesting
- Provides life insurance for employee beneficiaries

- Tax sheltered investment vehicle for highly compensated employees.
- Solves ERISA challenges related to highly compensated employees
- Custom Funding Strategies allow for discrimination

- Can improve financial liquidity of the hospital
- Opportunity to leverage endowed funds of the Hospital/Foundation
- Employer owns and can utilize all funds until vesting is met
- Investment is protected via split of the life benefit

- Turnover during the vesting schedule generates funds available to be reinvested in retention/recruitment
- Sets hospital apart with a unique program designed to solve hospital recruiting challenges
- Keep long-term key employees with flexible vesting schedules

Deeper Dive Presentations Upcoming

- Health Insurance Options: Wednesday April 10, 2024, 1:00 PM EST — Register
- Leveraging DERs for Recruiting and Retention: Wednesday May 1, 2024, 1:00 PM EST — Register

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The Role of Primary Care in Value-Based Models

How RHC's can benefit from improving outcomes

Because every patient deserves exemplary care.

TheComplianceTeam
Accreditation Organization

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Senior Consultant
Wintergreen

Kristen Ogden, RN

Director, Quality Improvement
The Compliance Team

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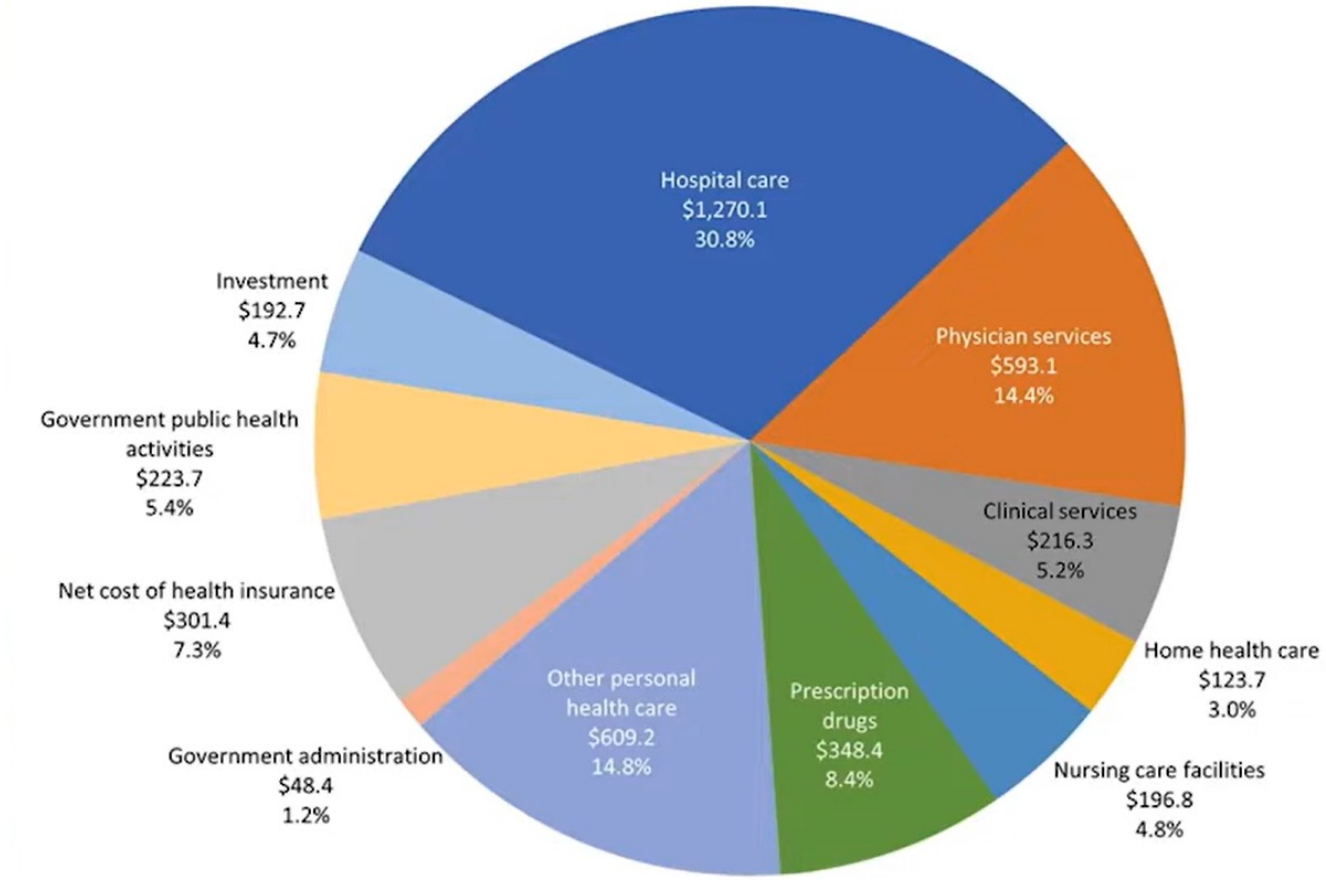
The U.S. spent $4.1 **TRILLION** on health care in 2020



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Importance of Primary Care

Primary care represents the greatest opportunity for improving health care quality and lowering cost.

For Every $100 spent on healthcare in the US, only about $5 is spent on primary care.

Every $1 invested in primary care saves the healthcare system up to $13.

Doubling the nation's current spending on primary care would more than pay for itself in savings.

Beyond the 4 Walls and 15 Minutes

“Ruth”

- 55y/o female w/ COPD
- Monthly ED visits and/or Inpatient stays
- Labeled as “high utilizer”
- Placed with a Care Coordinator
- Collaboration with pharmacy and pulmonologist
- Visit to her apartment revealed mold
- Worked with her family to get her moved into new apartment
- The next quarter she had 2 visits with her PCP, but not acute exacerbations.
- Only one ED visit the next quarter due to influenza.
- No hospitalizations for the year.

Value-Based Care Models

Accountable Care Organizations (ACOs)

- A network of physicians, hospitals and other providers providing coordinated, quality care.
- Eliminate unnecessary treatments and diagnostics focusing on prevention.
- Risk dependent upon agreement raning from no to high downside.
- Savings created through metric performance.

Bundled Payments

- Collective model of care that combines reimbursement for a group providers in a lump sum.
- Incentifized to deliver and coordinate care efficiently during an episode of care.
- If care isn't sufficient/efficient, larger downside risk for providers.
- Predetermined costs for select services.
- Savings based on reduced cost created by providers.

Patient-Centered Medical Homes

- Team managing patient's primary care to increase quality and coordination.
- Coordinate whole-person care.
- Low level of downside risk for providers with high reward based on performance.
- Graded based on patient access, engagement and outcomes.

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Patient-Centered Medical Home Core Principles

- Through this **value-based care model**, a Colorado-based PCMH reported a 15% decrease in emergency department visits, an 18% reduction in inpatient admissions, and a return on investment of $4.50 for every dollar spent. Another Maryland-based PCMH stated that it saved $98 million and increased its quality scores by 10% in one year.

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Impacts for RHCs as of January 1, 2024

General Care Management G0511:

Adding in four new buckets of care management:

- Remote Physiologic Monitoring (RPM)
- Remote Therapeutic Monitoring (RTM)
- Community Health Integration (CHI)
- Principal Illness Navigation (PIN)

$71.68

Allowing multiple G0511s per patient per month

https://www.cms.gov/center/provider-type/rural-health-clinics-center

2024 Care Management Codes (Bold=new)

Physician Fee Schedule Code	Description
G0323	General Behavioral Health Integration (BHI)
99487	Complex CCM (over 60 minutes of care management per month)
99490	Basic CCM (20 minutes of care management)
99491	30 minutes or more of CCM furnished by a physician or other qualified health professional
99424	30 minutes or more of Principal Care Management furnished by physicians or non-physician practitioners
99426	30 minutes or more of PCM services furnished by clinical staff under the supervision of a physician or non-physician practitioner
G3002	Chronic pain management first 30 minutes
G3003	Chronic Pain Management (each additional 15 minutes)
99453	**Remote monitoring of physiologic parameter(s) (eg, weight, blood pressure, pulse oximetry, respiratory flow rate), initial; set-up and patient education on use of equipment**
99454	**Remote monitoring of physiologic parameter(s) (eg, weight, blood pressure, pulse oximetry, respiratory flow rate), initial; device(s) supply with daily recording(s) or programmed alert(s) transmission, each 30 days**
99457	**Remote physiologic monitoring treatment management services, clinical staff/physician/other qualified health care professional time in a calendar month requiring interactive communication with the patient/caregiver during the month; first 20 minutes**
99458	**Remote physiologic monitoring treatment management services, clinical staff/physician/other qualified health care professional time in a calendar month requiring interactive communication with the patient/caregiver during the month; each additional 20 minutes**
99091	**Collection and interpretation of physiologic data (e.g. Blood pressure, glucose monitoring) digitally stored and/or transmitted by the patient and/or caregiver to the physician or other qualified health professional, qualified by education, training, licensure/regulation (when applicable) requiring a minimum of 30 minutes of time, each 30 days**
98975	**Remote therapeutic monitoring (eg, therapy adherence, therapy response); initial set-up and patient education on use of equipment**
98976	**Remote therapeutic monitoring (eg, therapy adherence, therapy response); device(s) supply with scheduled (eg, daily) recording(s) and/or programmed alert(s) transmission to monitor respiratory system, each 30 days**
98977	**Remote therapeutic monitoring (eg, therapy adherence, therapy response); device(s) supply with scheduled (eg, daily) recording(s) and/or programmed alert(s) transmission to monitor musculoskeletal system, each 30 days**
98980	**Remote therapeutic monitoring treatment management services, physician or other qualified health care professional time in a calendar month requiring at least one interactive communication with the patient or caregiver during the calendar month; first 20 minutes**
98981	**Remote therapeutic monitoring treatment management services, physician or other qualified health care professional time in a calendar month requiring at least one interactive communication with the patient or caregiver during the calendar month; each additional 20 minutes**
G0019	**Community health integration services performed by certified or trained auxiliary personnel, including a community health worker, under the direction of a physician or other practitioner; 60 minutes per calendar month, in the following activities to address social determinants of health (SDOH) need(s) that are significantly limiting ability to diagnose or treat problem(s) addressed in an initiating E/M visit**
G0022	**Community health integration services, each additional 30 minutes per calendar month**
G0023	**Principal Illness Navigation services by certified or trained auxiliary personnel under the direction of a physician or other practitioner, including a patient navigator or certified peer specialist; 60 minutes per calendar month,**
G0024	**Principal Illness Navigation services, additional 30 minutes per calendar month**

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Requirements for GCM/CCM

- Verbal or written consent
- Care plan updated at least annually
- 24/7 access to care
- Appropriate documentation

Next Steps

- PCMH=Foundation for successful CCM program
- Care Coordination
- Pull numbers to determine potential for CCM
- Quality Improvement - PDSA

CCM PDSA MODEL

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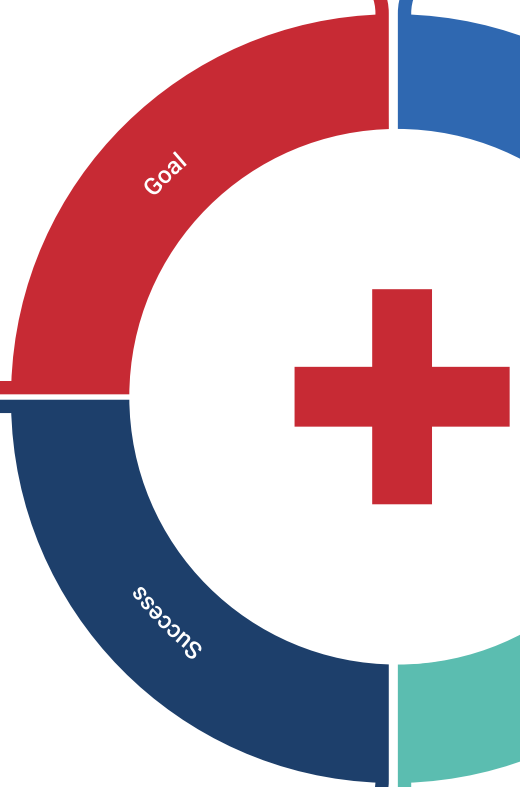
Plan

Background: Chronic Care Management is an organizational approach in primary care that promotes better outcomes, higher patient satisfaction and reducing spend. It consists of care coordination outside the regular office visits for patients with two or more chronic conditions expected to last at least 12 months.

Implement a chronic care management program serving the practice Medicare beneficiaries

- Measurement Description:
- Numerator Statement:: Total number of patients enrolled in CCM
- Denominator Statement: Total number of the Medicare beneficiaries in the primary care practices with two or more chronic conditions



Fully implement a chronic care management program with successful reimbursement

4 PDSA cycles

1. Chartering
2. Training
3. Outreach
4. Intervention

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Initiative: Chronic Care Management

Do & Study

CHARTERING

- Convene multidisciplinary team.
- Acquire executive sponsorship.
- Identify target patient populations. Assess electronic health records capability for reporting of Medicare beneficiaries with two or more chronic conditions
- Validate baseline data integrity.
- Identify a provider champion
- Assess EHR documentation fields
- Assess staffing needs

TRAINING

- Staff training
- Provider education
- EHR training
- Ensure staff proficiency.
- Develop standing orders and processes and care coordination practices
- Develop comprehensive care plans interventions and list of suggested community resources and services

OUTREACH

- Develop and distribute marketing materials.
- Identify CCM eligible patients through internal referral patterns.
- Determine the reimbursement of chronic care management and billing structure.

INTERVENTION

- Launch CCM with the provider champion patient population
- Collect and monitor data and required metrics for each patient
- Evaluate reimbursement integrity

Act

Test Metric(s) to Act:
1. # of potential eligible patients identified, staffing needs addressed

Test Metric(s) to Act:
1. % staff trained

Test Metric(s) to Act:
1. # of eligible participants identified
2. Detailed plan for reimbursement for CCM

Test Metric(s) to Act:
1. Enroll eligible patients into CCM
2. Reimbursement obtained for patients who have received CCM services

Questions

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Harness Technology to Drive Revenue, Compliance & Safety

VersaBadge

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Innovation for Rural, by Rural

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Innovation can't be an afterthought and access to essential technology should not be a luxury that is only accessible to large health systems.

- For too long, healthcare technology has been developed exclusively for large, urban hospitals. Rural hospitals and clinics that have found ways to make technology investments often find that these systems don't meet their unique needs and are poorly supported by vendors.
- This session will highlight real-time location technology developed by rural, for rural; with practical, cost-conscious applications that improve reimbursement accuracy, compliance, safety and quality.
- We will discuss the importance of accurately calculating ED standby time (Part A) for the cost report and how you can leverage technology to automate time studies while improving staff safety and satisfaction.

Understating ER Standby Time Reduces Reimbursement

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CMS Regulation

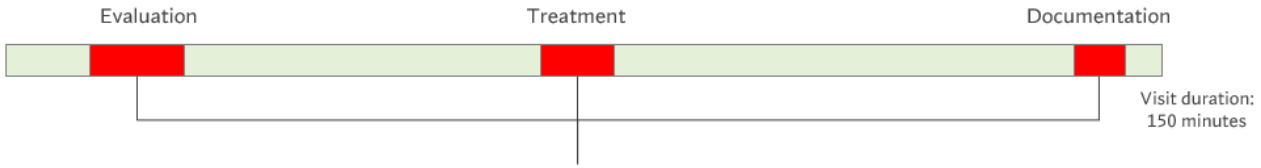
To ensure that Critical Access Hospitals can provide emergency services 24/7, regardless of low patient volumes, CMS reimburses for Emergency Department provider stand-by time

Cost Report

A critical access hospital (CAH) may be reimbursed through its cost report for the reasonable cost it incurs compensating a physician for the time the physician spends in the emergency room (ER) awaiting the arrival of patients and furnishing other services to the provider (provider component). Before this cost may be claimed, the CAH must determine the amount of time the ER physician spends with patients (professional component) vs. the time spent furnishing otherwise allowable services that do not directly relate to the care of one individual patient (provider component.)

Provider Time

Providers furnish services to patients during an ED visit but not for the entire duration



Target = 20 minutes per ED visit

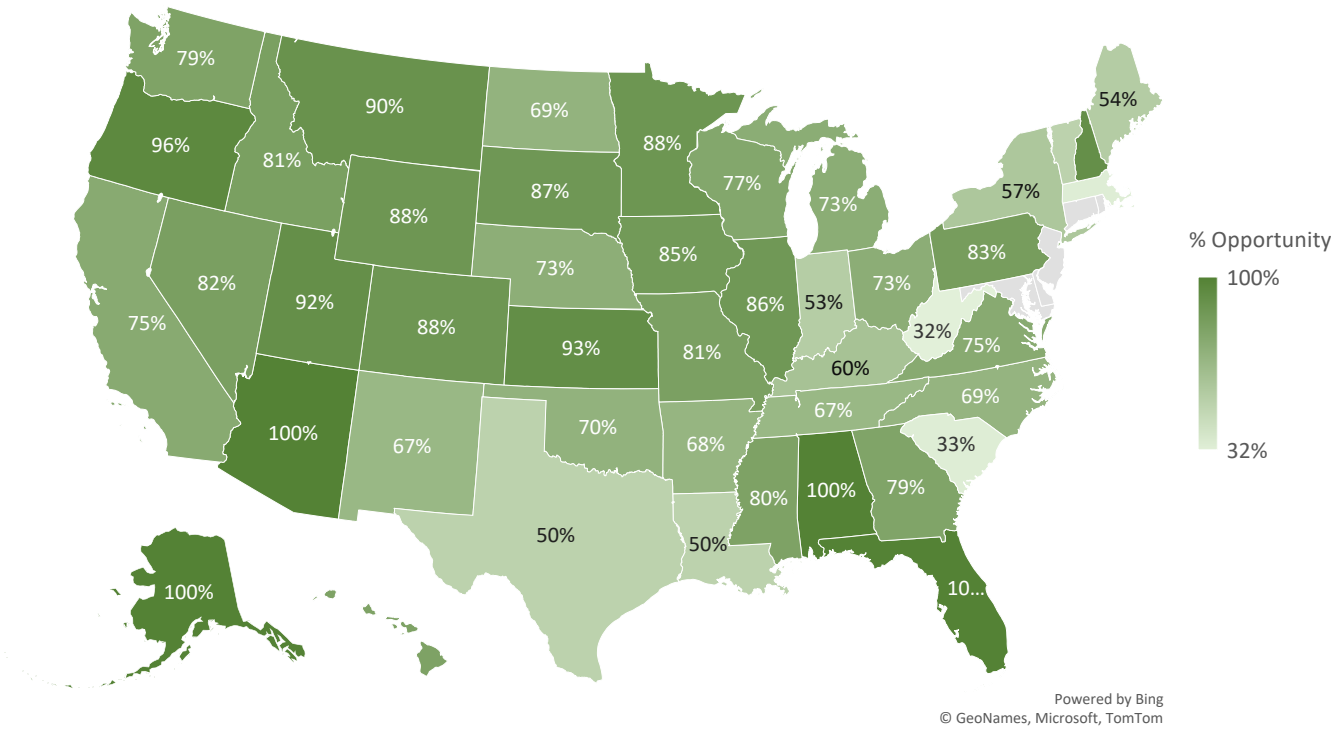
Our Study

We identified which CAHs failed to meet the 20-minute target and then quantified the financial impact

The full national study will be available next week on www.wintergreenme.com
and we will make available your CAH's specific analysis upon request

All 45 States With CAHs Have Opportunity

Map A: Percentage of CAHs with Reimbursement Opportunity by State (FY 2022)



Highest Percentage States

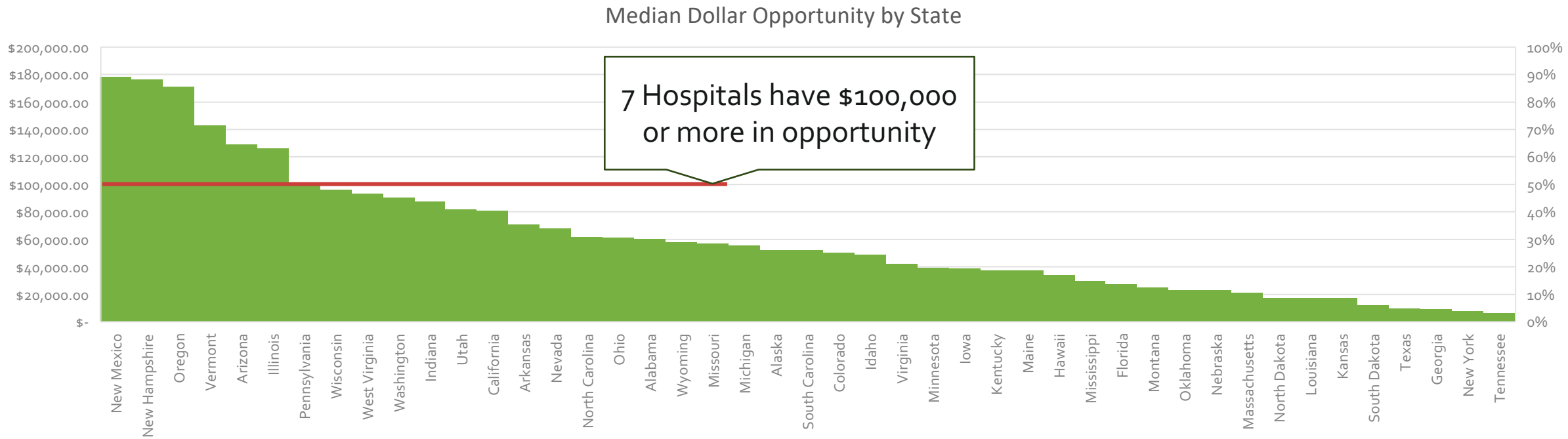
Alabama: 2 of 2 CAHs or 100%
Alaska: 8 of 8 CAHs or 100%
Arizona: 12 of 12 CAHs or 100%
Florida: 8 of 8 CAHs or 100%

Lowest Percentage States

West Virginia: 6 of 19 CAHs or 32%
South Carolina: 1 of 3 CAHs or 33%
Massachusetts: 1 of 3 CAHs or 33%

Note: Data set includes 1,186 of 1,360 critical access hospitals
Data Source: December 2023 Medicare Cost Report release for CAH fiscal year 2022
Additional Analysis: Refer to the ED Standby Time study published at www.wintergreenme.com

What is the Median Opportunity?

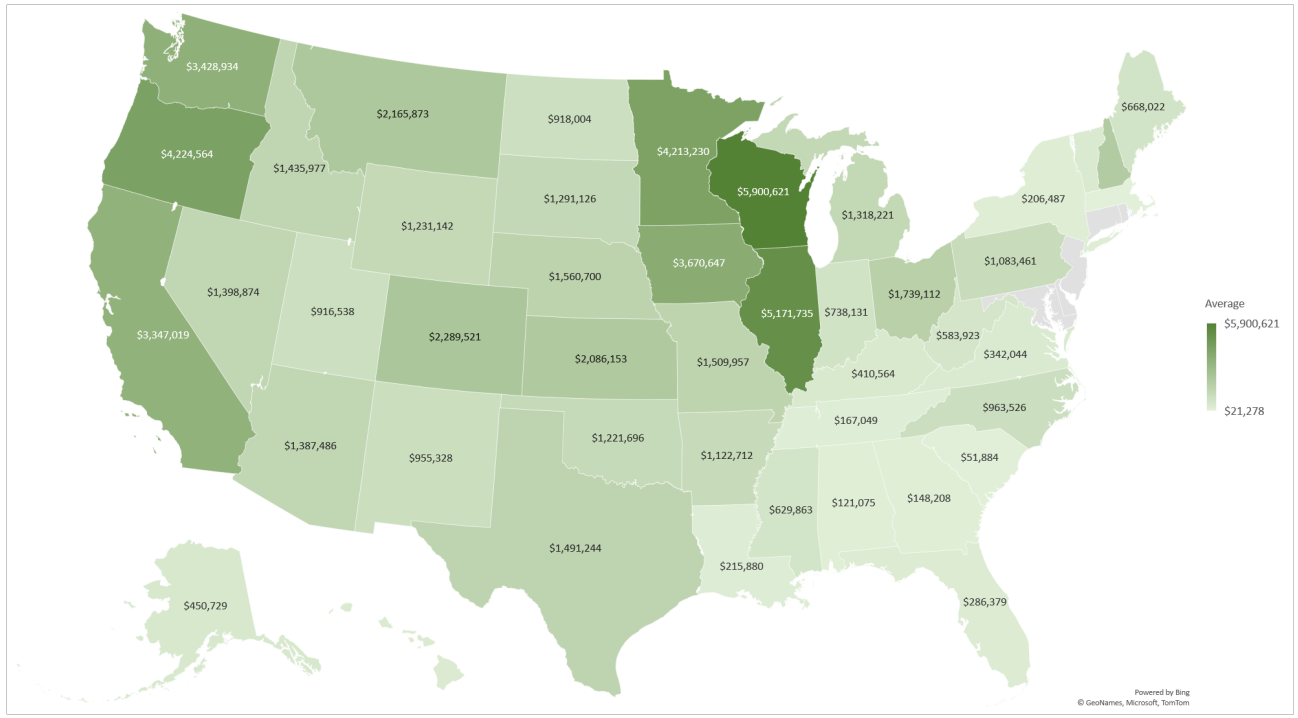


$178,000 ⟸ The range among the state median opportunity values is significant ⟹ **$6,000**

Note: Data set includes 1,186 of 1,360 critical access hospitals
Data Source: December 2023 Medicare Cost Report release for CAH fiscal year 2022.
Additional Analysis: Refer to the ED Standby Time study published at www.wintergreenme.com.

What is the Total Opportunity?

Map C: Total Reimbursement Opportunity by State (FY 2022)



$66 million

If every CAH met the 20-minute target, the aggregate national opportunity is **$66 million** annually

The **top seven states** account for **over 50 percent** of the total reimbursement opportunity

Traditional Medicare is the focus of this study, however there is additional dollar opportunities from Medicare Advantage plans and Medicaid (State depending)

Note: Data set includes 1,186 of 1,360 critical access hospitals
Data Source: December 2023 Medicare Cost Report release for CAH fiscal year 2022
Additional Analysis: Refer to the ED Standby Time study published at www.wintergreenme.com

Case Study: Operational Opportunity

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Education

We noticed that most physicians don't like to report stand by time as they believe it reflects poorly on them

Do your physicians know what is included in stand by time?

Schedule

Do you roll out a schedule for when time studies will be conducted on alternating weeks per CMS regulation?

Operational Support

Do you have leaders or managers to support the completion and review of physician time studies?

Will your time studies stand up against a CMS Medicare audit?

- CTA Review time studies for accuracy and educate physicians on what is included and excluded from stand by time
- CTA Develop a schedule before the year begins and pass that along to managers and physicians
- CTA Identify operational managers/leaders to support and guide physicians on monthly time studies

A Technology Solution for CAHs:

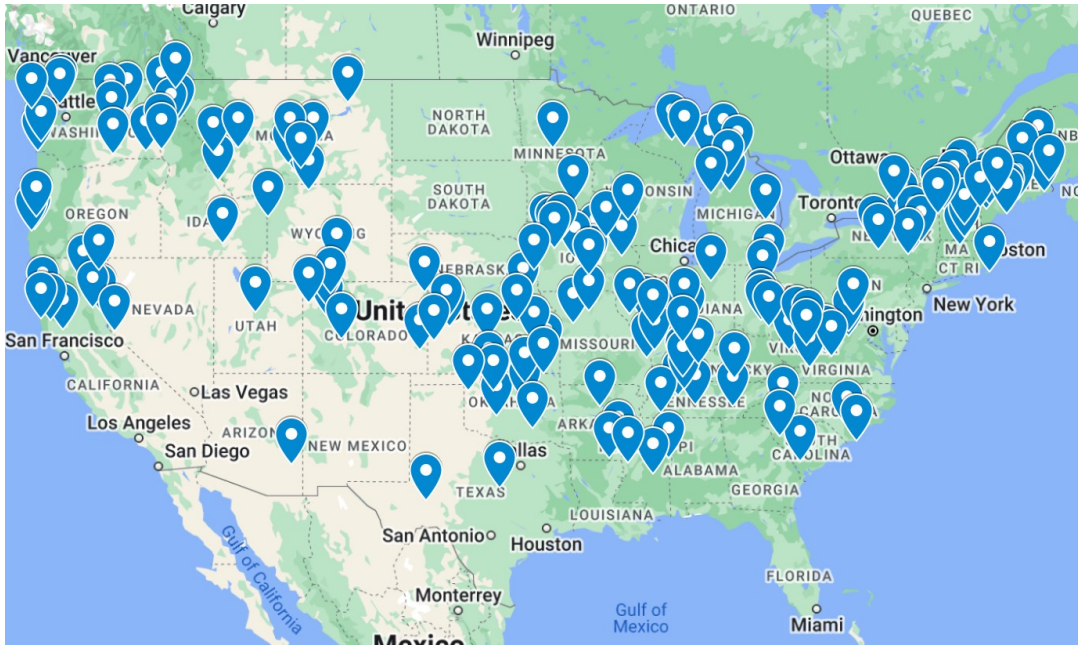
- The VersaBadge technology was **co-developed with (and specifically for) Critical Access Hospitals, with the initial goal of automating the tedious and often inaccurate time study process** required by CMS to receive reimbursement for ED clinician stand-by time (Part A)

- VersaBadge now serves more than **175 CAHs and numerous RHCs nationwide**, delivering a range of location-based use cases that help clients improve their **financial health, compliance, caregiver safety and workforce efficiency**

On average, VersaBadge clients see the following estimated impact (2023):

- **Emergency Department Part A increase by 28 percentage points**
- **$110,000 increase in Emergency Department Part A reimbursement**
- **296% ROI**

VersaBadge data has withstood numerous detailed audits and to our knowledge it has been accepted by CMS without changes in every instance.



Issues With Traditional Time Studies

- **Observe & Record (time-in-motion)**
  - Expensive, invasive, inaccurate, resource-intensive
- **EHR & Timesheet Data**
  - Provides only an inference about the actual Part A time involved and often allocates the full amount of time that a patient is present in the ED as Part B
- **Clinician Estimates**
  - Highly inaccurate, subject to substantial human error and inherent bias with frequent compliance/defensibility issues under audit
- **Traditional RTLS**
  - Only provides location data, lacks crucial documentation/charting time details

Using traditional methods, CAHs tend to be very conservative and often under-report Part A time to avoid penalty, reducing overall reimbursement.

VersaBadge Automated Time Studies

VERSABADGE CAH SUMMARY: QE & YTD (In Hours)
Example Community Hospital
Current Report Period 11/01/20 11/30/20

	VersaBadge				
Weighted Averages	Total Q1	Total Q2	Total Q3	Total Q4	TL YTD
TSB (Availability)	79.2%	79.2%			79.2%
DOCUMENTATION	13.6%	13.7%	0.0%	0.0%	13.7%
ED PATIENT	7.2%	7.1%	0.0%	0.0%	7.1%
NON-ED PC	0.0%	0.0%	0.0%	0.0%	0.0%

CLIENT FYE
6/30/21
Pre-VB TSB%
2016: 56.38%

Time Class Color Code:	Badge Use & Shifts	Availability (TSB)	Documenta-tion	Non-ED Patient Care	BeaconBox (Badge Storage)

*Data in Hours

				Travel Standby Time (Availability Time)					VB Documentation & EMR Time						ED Patient Care Time		Non-ED Patient Care Time				
Time Period	Valid Shift %	# Shifts	Badge Compliance %	ED TSB	TL Standby Adj.	VBDS TSB Adj	Total TSB (Availabilit	%	VB Doc.	%	VBDS	%	Applied Doc.	%	ED Patient	%	Acute	Total Non-ED PC	% TL ST	Badge Storage	%
Q1 07/01 - 09/30	82%	92	72%	339.5	420.0	144	903.1	79.2%	299.2	26.2%	138.2	12.1%	155.6	13.6%	81.9	7.2%	-	-	0.0%	11.4	1.0%
Q2 10/01 - 12/31	89%	70	89%	607.2	409.9	162	1,178.8	79.2%	365.4	24.6%	211.0	14.2%	203.7	13.7%	105.5	7.1%	-	-	0.0%	-	0.0%
Q3 01/01 - 03/31	-	-	-	-	-	0	-	0.0%	-	0.0%	-	0.0%	-	0.0%	-	0.0%	-	-	0.0%	-	0.0%
Q4 04/01 - 06/30	-	-	-	-	-	0	-	0.0%	-	0.0%	-	0.0%	-	0.0%	-	0.0%	-	-	0.0%	-	0.0%
YTD	68%	162	80%	946.8	829.9	305	2,081.9	79.2%	664.6	25.3%	349.2	13.3%	359.4	13.7%	187.3	7.1%	-	-	0.0%	11.4	0.4%
# Shift Exclusions YTD:		52		36.0%	31.6%	11.6%															
Q1 07/01 - 09/30	Σ:	92	71.6%	339.5	420.0	144	903.1	79.2%	299.2	26.2%	138.2	12.1%	155.6	13.6%	81.9	7.2%	-	-	0.0%	11.4	1.0%
Clinician	Valid Shift %	# Shifts	Badge Compliance %	ED TSB	TL Standby Adj.	VBDS TSB Adj	Total TSB (Availability)	%	VB Doc.	%	VBDS	%	Applied Doc.	%	ED Patient	%	Acute	Total Non-ED PC	%	Badge Storage	%
Dr. Meredith Grey	100%	13	100%	18.8	22.3	10	50.8	74.0%	20.2	29.5%	10.6	15.4%	10.6	15.4%	7.3	10.7%	-	-	0.0%	3.3	4.8%
Dr. Alex Karev	63%	19	86%	65.1	130.5	39	234.9	81.6%	72.4	25.1%	27.7	9.6%	33.1	11.5%	19.9	6.9%	-	-	0.0%	0.1	0.0%
Dr. Derek Shepherd	63%	24	100%	183.1	105.0	21	309.4	86.0%	53.6	14.9%	36.0	10.0%	32.2	9.0%	18.3	5.1%	-	-	0.0%	0.0	0.0%
Dr. Christina Yang	100%	1	100%	4.5	7.0	9	20.0	83.5%	8.7	36.5%	0.2	0.9%	0.2	0.9%	3.7	15.6%	-	-	0.0%	0.0	0.1%
Dr. Izzie Stevens	100%	1	100%	0.4	4.9	5	10.6	56.9%	10.8	57.5%	5.4	29.0%	5.4	29.0%	2.6	14.1%	-	-	0.0%	5.3	28.4%
Dr. Jackson Avery	50%	6	60%	9.0	21.6	19	49.5	68.7%	35.2	48.9%	9.3	13.0%	16.3	22.7%	6.2	8.7%	-	-	0.0%	-	0.0%
Dr. George O'Malley	54%	24	81%	58.6	128.8	40	227.8	73.6%	98.2	31.8%	48.9	15.8%	57.8	18.7%	23.7	7.7%	-	-	0.0%	2.7	0.9%

Provider Compliance
Total number of valid shifts per provider for reporting period

Standby Time (TSB)
Travel/Standby Time for both Receiver-captured and VBDS-captured time

Documentation/VBDS
Documentation time on computer via VersaBadge Desktop Software (VBDS)

ED Patient Care
Total time in ED patient rooms (based on room receivers)

Non-ED Patient Care
Receiver-based time captured in non-ED areas of the hospital where VersaBadge is installed (optional)

Badge Storage
Time where badge is detected in BeaconBox (optional)

Badges are assigned to and worn by providers. Each badge broadcasts a unique Bluetooth Low Energy (BLE) signal

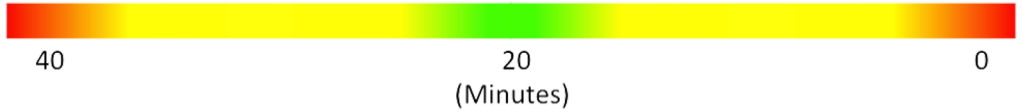
Receivers are installed throughout the department(s) and scan for badge signals. Each receiver's coverage area is mapped and designated as either patient care, standby, or documentation/dual-purpose

VersaBadge's proprietary desktop software separates documentation/charting time from dual-purpose areas. Time is allocated to the designated modality for each provider and the hospital receives detailed reporting on a monthly basis

Stop Leaving Reimbursement on the Table

The industry gold standard for professional time per emergency department encounter is

20 minutes per patient.



CAHs averaging **significantly more** than 20 minutes per patient may be missing substantial reimbursement

CAHs averaging **significantly less** than 20 minutes per patient may have difficulty substantiating their position upon audit

CTA

Perform your own minutes per patient test:

_____ ÷ _____

(ED patient care minutes) (total ED visits)

= _____

(minutes per patient)

CTA Evaluate the professional time per patient encounter to determine if hospital performs at the gold standard and if not, implement systems to ensure hospital is not leaving money on the table

Violence against healthcare workers is a national crisis

RURAL IS NOT IMMUNE

- **6x** more likely for violence to occur in healthcare settings than other sectors
- **66%** of ER providers report being assaulted in the past year alone
- **57** nurses are assaulted each day
- **89%** of ER providers believe that violence in the hospital has harmed patient care

The Joint Commission

New and Revised Workplace Violence Prevention Requirements

It's apparent that the time is right to develop new requirements addressing workplace violence. After an extensive literature and public field review, we are pleased to announce that The Joint Commission is introducing new workplace violence requirements, effective January 1, 2022. They will be applicable to hospitals and critical access hospitals.

The requirements will provide a framework to guide hospitals and critical access hospitals in:

- *Developing strong workplace violence prevention systems*
- *Defining workplace violence*
- *Establishing leadership oversight for the program*
- *Fine-tuning policies and procedures*
- *Creating easy and accessible reporting systems*
- *Analyzing, tracking and trending data*
- *Crafting post-incident strategies*
- *Staff training and education to decrease workplace violence*

Doing “The Right Thing” Pays

As compared with other security measures, **discreet, wearable duress alerting technology is often more affordable and effective at early intervention and proactively deescalating situations, before they get out of hand.**

Invest in Safety

- Create a culture of safety among care teams
- Improve morale, retention, recruitment and relationships between leadership and staff
- Decrease likelihood of workers’ comp claims, fines, and litigation costs related to staff harm due to workplace violence
- Address expanded legislative and regulatory workplace violence prevention requirements from governmental and accrediting bodies
- Reduce likelihood of missed workdays associated with workplace violence

Be Strategic

- Explore grant options to offset duress alerting system costs
- Determine reimbursement of system costs based on Medicare mix across deployed cost centers to calculate net annual costs
- Identify risk areas on campus and control infrastructure costs by defining appropriate location granularity (room level vs. unit level)
- Engage care teams in vendor selection process
- Evaluate additional time study, cost allocation and other use case opportunities that a hospital-wide location infrastructure could deliver to improve reimbursement, quality and performance

Innovation by Rural, for Rural

We are incredibly fortunate to work with many of the most innovative thought leaders in rural health. Through our close client partnerships, we have expanded our suite of services to address a wide range of highly impactful use cases for CAHs and RHCs

Financial Health & Compliance

Emergency Department Part-A (Standby)
Capture ED Provider Part-A standby time more accurately and efficiently, while improving audit defensibility.

Administrative Time Studies
Capture reimbursable administrative time for hospitalists, medical directors, primary care and specialty providers.

Inter-Departmental Cost Allocation
Accurately allocate clinician time and salary costs across various departments such as acute, emergency, surgery, OB/nursery or clinics.

EMS/Ambulance Cost Allocation
Accurately allocate personnel time to realize cost reimbursement opportunities for EMS.

Support Personnel Cost Allocation
Accurately allocate time to realize cost reimbursement opportunity for support personnel such as EVS, facilities, dietary and security.

Safety, Quality & Workforce Efficiency

Staff Duress Alerting
Improve caregiver safety with a wearable badge that allows staff to discreetly summon assistance to their specific location to promote prompt de-escalation.

Asset Tracking and Inventory Management
Instantly locate key assets to save time, reduce inventory loss, improve utilization and streamline maintenance efforts.

Rounding Reporting and Interaction Alerting
Monitor caregiver contact with patients and leverage data to substantiate those interactions with detailed rounding and interaction reports.

Infection Control and Contact Tracing
Aid infection control and contact tracing efforts with the ability to access reports that show who came into contact with specific contamination areas.

Hand Hygiene Compliance
Monitor handwashing events, frequency and trends. Leverage handwashing data insights to reduce the spread of germs and prevent infections.

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WINTERGREEN

How to Modernize Rural Healthcare

Alan Richman

President & CEO

InnoVative Capital LLC

The Imperative to Modernize Rural America's Healthcare Facilities

- In short, rural healthcare matters. 46 million U.S. residents live in rural areas.
  - Extensive efforts must be made to preserve and enhance rural healthcare.
- Rural healthcare providers remain a top 5 employer in their communities, rivaling only the local school district in most communities.
  - Properly-sized stable modern healthcare enhances local economies and attracts new companies and residents.
- Rural America has documented higher rates of morbidity, lower quality of life scores, and less opportunities to improve health outcomes.
  - Disparities in physician and facility access, as well as quality of care continue to grow between rural and urban areas. This must be addressed immediately before rural healthcare degrades entirely.

The Imperative to Modernize Rural America's Healthcare Facilities (cont.)

- Many rural healthcare facilities remain outdated. This restricts service realignment, quality assurance, and recruitment efforts, which exacerbates financial instability.
  - Modernization offers healthcare providers the opportunity to expand healthcare services tailored to their communities.
- A modernized facility improves physician recruitment attraction, as well as attracts health system affiliation and partnerships.
  - Strategic collaborations with tertiary care facilities can: a) increase local health service utilization, b) enable enhanced physician recruitment capabilities, c) optimize service line offerings, and d) provide administration support functions (i.e., marketing, group purchasing options, and accounting / collections assistance).
- Even in today's higher interest rate and unstable capital markets, affordable financing programs for rural providers exist through the USDA Community Facilities Loan Program.
  - Due to cost-based reimbursement and enhanced revenue, most CAHs can afford hospital projects that will transform their communities.

Overview

- Where to Start?
- Upfront Strategic Reports Provide Direction for Modernization
- The Importance of Stakeholder Support
- Assembling a Team, Aligning Roles and Responsibilities
  - Administration
  - Finance
  - Construction
- The USDA Community Facilities Program
- The Road Map for a Successful USDA Transaction
- Healthcare Financing Alternatives: Limited Options in Today's Market
- Final Thoughts

“The unprepared mind cannot see the outstretched hand of opportunity.”

- Alexander Fleming

Bacteriologist and Discoverer of Penicillin

Where to Start?

- Review your mission statement, vision and organizational goals.
  - How is your current facility meeting your corporate objectives and serving the interests of your community?
- Based on your legal structure, what consents do you need to commence a project?
  - A 501(c), a government owned entity (District, Hospital Authority or City/County) or for-profit?
  - An affiliate of a health system with an independent board, health system-owned or independent entity?
  - Are you a Critical Access Hospital, or pursing a CAH designation?
  - Will any encumbrance of debt require modifying corporate bylaws or structures?
- Identifying your core team members and stakeholders.
- What contributed capital does your organization and community have available for support?
  - Cash Reserves
  - Foundation Fundraising
  - Taxes
  - Grants

Upfront Strategic Reports Provide Direction for Modernization

Operational Reports:

- A Community Health Needs Assessment identifies health factors and outcomes.
- An independent Market Study details utilization, outmigration, and service areas.
- A Physician Needs Report reviews the sufficiency of doctors serving your community.

When overlaying these operational reports, healthcare providers can start to plan service line changes and organizational modifications which may include staff reallocation or pursuing a strategic collaboration.

Facility Report:

- A Facility Master Plan evaluates your current facility's condition, identifies any deficiencies, and presents facility modernization options.

Financial Reports:

- Enterprise Evaluation
- Preliminary Financial Forecast
- Debt Capacity Study
- Project Sources and Uses (based off Masterplan) with Gap Financial Evaluation

The Financial Report package provides leadership and decision-making stakeholders with a Project Viability Assessment and Capital Financing Strategy.

Obtaining Stakeholder Support

- Present the rationale for a hospital modernization project.
- Explain the project options and operational impacts of each.
  - Renovation versus replacement
  - Onsite or relocation
  - Service line modifications
- Discuss options for the debt financing and the project costs.
- Generate and distribute a debt capacity analysis and initial financial forecast detailing financial viability for a debt financed project under different scenarios, a) self supporting, b) with tax support, and/or c) with the need of a health system partner.
- Articulate any need for gap funding and best method of building equity.
  - Fundraising
  - Tax Support
  - Enhance Revenue Cycling
  - Conducting Chargemaster Review
- Allay concerns by explaining the merits of the undertaking, project affordable, impact and outcomes.

Assembling a Team, Aligning Roles and Responsibilities

Administration – Determine your corporate mandate and provide final decision-making

- C-Suite and Board of Directors
- Finance Committee and Facility Sub Committee Members
- Facility Manager
- CNO and Chief of Medical Staff
- Foundation Chairperson

Supporting Parties

- Legal Counsel
- Independent Financial Advisor
- Local Government Liaisons
- County Commissioners
- Economic Development Executive

Roles & Responsibilities

- Identify initial market, facility and staffing needs
- Develop mission and goal driven board consensus of project development
- Conduct solicitation of Project Team Members
- Address Community Stakeholders, with Project Team Member Assistance

Assembling a Team, Aligning Roles and Responsibilities

Finance – Determine financial feasibility, debt capacity, funding options and execute the chosen financial transaction

- Independent Financial Advisor – Leads finance team, provides construction budget input, and hiring third-parties
- CPA Firm – Develops Lender Mandated Feasibility Study
- Appraiser
- Lenders
  - Construction Lender
  - Permanent Lender (USDA)
  - Respective Lender's Counsel

Supporting Parties

- Borrower Counsel
- Bond Issuing Authority
- Foundation Chairperson
- County Commissioners
- Economic Development Executive

Roles & Responsibilities

- Initial Assessment
  - Organization: Strategic Plan Review and Market Analysis
  - Finance: Financial Reports
- Determine if the Project increases: a) revenue, b) efficiencies, and c) service quality.
- Review Capital Markets and Economic Factors
- Explore Collaboration Opportunities
- Finalize the Capital Stack
- Pursue and Execute the Financial Transaction

Assembling a Team, Aligning Roles & Responsibilities

Construction – Determine facility reuse, site options, project budget/outlays and provide pre-construction services

- Project Manager (Owner's Representative)
- Architect
- Construction Manager
- Facility Manager
- Independent Financial Advisor

Supporting Parties

- Environmental Consultant
- City/County Planners
- Facility Manager
- Equipment Planner

Roles & Responsibilities

- Master planning
- Identify any potential environmental or historic preservation concerns
- Generate construction budget
- Proceed with Pre-Construction Development Process
  - Schematic Design
  - Design Development
  - Construction Documents

What is the USDA Community Facilities Program?

Summary

- The USDA CF Program identifies “essential healthcare community facilities” as hospitals, medical and dental clinics, rehab centers, nursing homes and assisted living facilities.
- Funding levels are subject to annual federal appropriation for new construction, expansion, modernization and acquisition in the form of low-cost long-term loans and/or grants.
- CF eligible applicants must be either nonprofit or governmental institutions.

* For-profit providers are ineligible for the CF Program but may borrow through the USDA Business Industry Program.

CF Program Loans for Healthcare Institutions

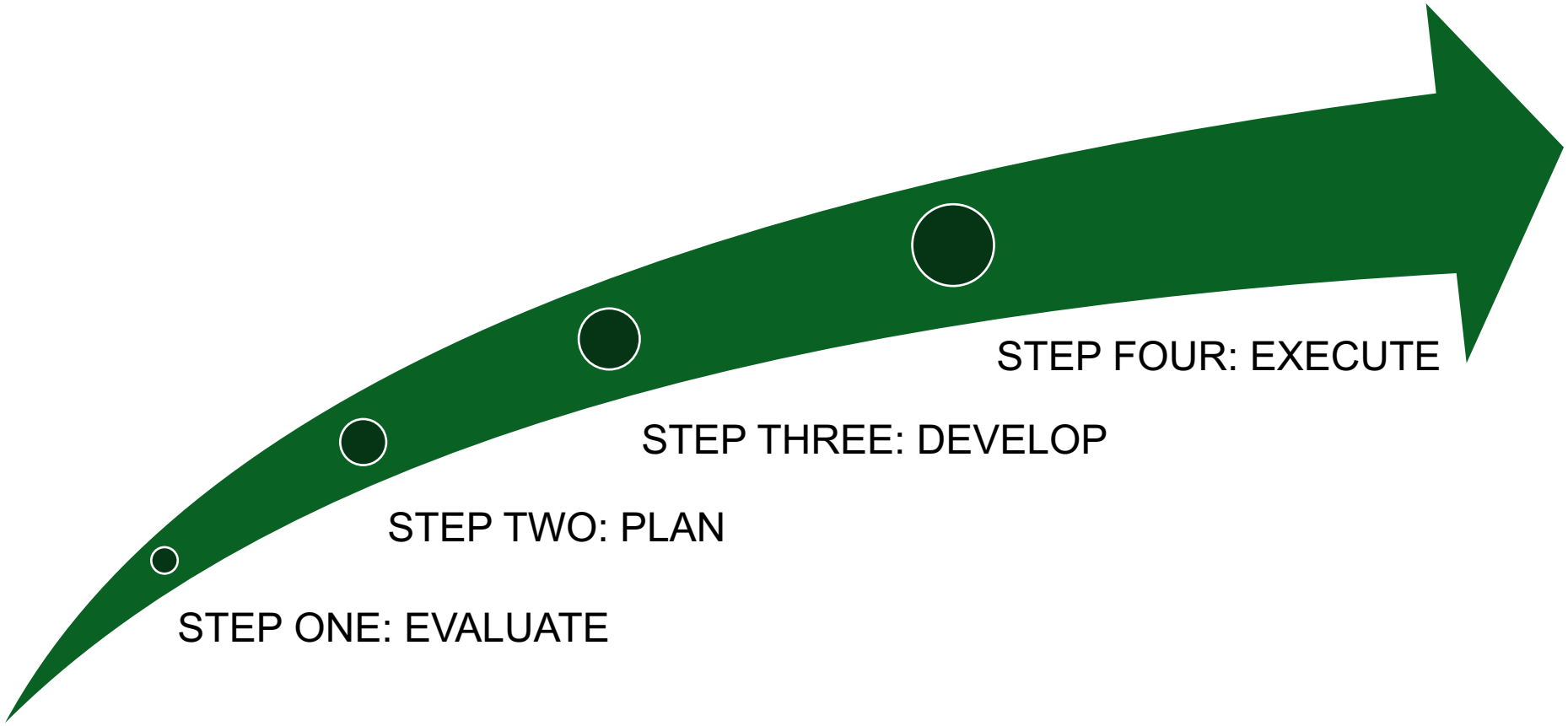
- Direct Loans (rates set by USDA).
- Guaranteed Loans (rates set by independent lender).

The USDA CF Program: The Direct Loan is the Optimal Financing Vehicle for CAHs.

An Overview of Terms and Conditions

Eligible Projects	• Must be a governmental, community-based non-profit, or federally-recognized tribal entity • Located in a community with a population less than 20,000.
Uses	• At least 50% of proceeds must be for new construction or renovations. • Funds can be used for equipment.
Loan Sizing	• May not exceed 100% LTV with value determined with an independent appraisal.
Loan Term & Amortization	• Standard term is 30-35 years or the expected life of the PPE. • Term and Amortization may extend to 40 years.
Interest Rate	• Direct Loan Rates are reset quarterly by USDA. • **The Q1 2024 USDA Direct Loan Rate is 3.75%.**
USDA Loan Processing Timeline	• From Pre-Application submission to loan closing, without interruptions the process should take approximately 8 months.
Other Considerations	• Each state USDA RD office has its own Pre-Application process that may vary. • USDA customarily does not provide construction financing, which would necessitate an independent commercial bank loan or municipal bond issuance. • Public meetings are required. • A mortgage is a USDA requirement, however, in certain cases a long-term lease may suffice.

The Road Map For a Successful USDA Transaction



The Road Map For a Successful USDA Transaction

Step One: Evaluate

- Engage Consultants for Operational, Facility and Financial Reports.
- Benchmark performance against comparable healthcare providers.
- Review current service lines and utilization in relation to forecasted population trends.
- Identify community stakeholders.

Step Two: Plan

- Reconfigure service lines and adjust staffing levels.
- Select capital funding method(s).
- Issue Requests for Proposals and begin working with contracted professionals.
- Focus on revenue cycling and instituting a plan of cash accumulation.
- If requested, discuss and evaluate possible collaborations or affiliation opportunities.
- Obtain final board approvals.

The Road Map For a Successful USDA Transaction

Step Three: Develop

- Start construction development process.
- Submit Pre-Application packages to USDA.
- Conduct final community outreach.
- Assemble construction loan team
- Submit final financial feasibility forecast and appraisals.
- Start Certificate of Need Process (if required).
- Negotiate any government financial support.
- Review possible collaboration partners (if necessary).

Step Four: Execute

- Procure supplemental funding guarantees and fundraising (if needed).
- Obtain USDA loan underwriting commitment.
- Receive the Guaranteed Maximum Price contract for the project.
- Close the construction loan and USDA transaction.

Healthcare Financing Alternatives: Limited Options in Today's Market

- **USDA Guaranteed Loans Program:** Requires a bank lender. Guaranteed loans have higher interest rates with more extensive financial covenants and upfront fees.
- **HUD 242 Mortgage Insurance:** HUD is disinclined to underwrite CAH loans. HUD has greater upfront fees, an annual Mortgage Insurance Premium and higher borrowing rates.
- **Municipal Bonds:** Have higher interest rates with minimal buyer interest for CAH nonrated debt unless secured by a local government tax pledge.
- **Commercial Bank Loans:** Long-term bank loans are unlikely except in rare circumstances. Current banking conditions make the availability of willing and able lenders sparse and loan rates high.
- **Local Tax Referendums:** A full G.O. pledge or limited tax pledge requires a voter tax referendum to secure a municipal bond issue for a CAH project.

Final Thoughts

- Focus on practicality first, then aesthetics.
  - Drawings are only good if you can afford the project.
- Identify regulatory approvals early in the development process.
  - Certificate of Need, easements, mortgage requirements.
- Remain updated on market conditions.
  - Inflation, change orders and interest rate fluctuations require maintenance of contingencies.
- A key to a successful project is community participation.
  - Stay connection with local stakeholders.
- The Loan closing is not the transaction closing.
  - Construction Draw Compliance and Cost Certification is required.

For Any Questions

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Wait...We Can Get Paid for That?

Five Reimbursement Opportunities That Can Be Implemented In Your Hospital or Clinic in 2024

January 31, 2024

WINTERGREEN

New Billable RHC Providers

- The Consolidated Appropriations Act of 2023 included provisions allowing RHCs to bill for Marriage and Family Therapists (MFTs) and Mental Health Counselors (MHCs) beginning January 1, 2024
- MFTs and MHCs becoming qualified RHC providers means they can generate a Medicare encounter that is reimbursable at the RHC's All-Inclusive Rate (AIR). MFTs and MHCs are subject to the same policies and supervision requirements as other non-physician RHC providers
- Mental health practitioners who meet all of the applicable statutory qualifications for the mental health counselor benefit category but are licensed by their State under a different title, are eligible to enroll in Medicare under the "Mental Health Counselor" category
- MFTs and MHCs will not be subject to a productivity standard in RHCs
- MFTs and MHCs were added to the regulations 491.8(a)(3) and 481.8(a)(6), allowing these provider types to serve as the RHC owner or an employee, or be under contract
- Additionally, MFTs and MHCs can fulfill the requirement that a provider must be available to furnish care at all times the clinic is open

Telehealth Services

- Pandemic-era telehealth flexibilities have only gained momentum in the past few years
- Starting in 2022, RHCs could bill and be reimbursed by Medicare for mental health services provided via telehealth and receive the RHC All-Inclusive Rate (AIR) on a permanent basis
- Permanent Medicare Changes:
  - RHCs can serve as a distant site provider for behavioral/mental telehealth services
  - There are no geographic restrictions for originating site for behavioral/mental telehealth services, including the home
  - Behavioral/mental telehealth services can be delivered using audio-only communication platforms
  - Expansion of telehealth practitioners to include Marriage and Family Therapists (MFTs) and Mental Health Counselors (MHCs)
  - Social Determinants of Health Risk Assessments added to Medicare Telehealth Services List
- CY2024 Temporary Changes (through 12/31/24):
  - RHCs can serve as a distant site provider and there are no geographic restrictions for originating site for non-behavioral/mental telehealth services, allowing patients to be located at anywhere in the US during the telehealth service, including a patient's home
  - Delays the in-person requirement for mental health visits furnished via telehealth (within 6 months prior and annually thereafter)
  - Physician or practitioner "direct supervision" of incident-to services to be performed via two-way, real time-audio visual technology, as opposed to immediately available in the physical space of the RHC
  - Added health and well-being coaching services to the Medicare Telehealth Services List

Impacts of Primary Road Definition Change

- Starting last calendar year, CMS changed the definition of a “primary road” stating that Federal highways with only one lane each way were removed from the definition of primary roads

- Primary roads are now defined in §485.610(c)(2) to include a numbered federal highway, including interstates, intrastates, expressways or any other numbered federal highway with two or more lanes each way; or a numbered state highway with two or more lanes each way

- CAHs can continue to meet Conditions of Participation (CoP) via “secondary roads” criterion (i.e., not a primary road) if there is a combination of primary and secondary roads between it and any hospital or other CAH, so long as more than 15 of the total miles from the hospital or other CAH consists of areas in which only secondary roads are available

- Since provider-based clinics (non-RHCs) and other hospital outpatient departments (HOPDs) extend the distance of a CAH to the site of service, CAHs have historically experienced limitations on their ability to expand services off-campus

- With the relaxed definition of a primary road, CAHs can seek opportunities to expand services off-campus so long as it continues to meet the distance requirements of the new distance definitions

Expansion of RHC Care Management Services

- Historically, RHCs have only been allowed to bill and be reimbursed for Care Management Services, including Remote Patient Monitoring, Remote Therapeutic Monitoring, or using CPT code G0511 or G0512 **once per month** per beneficiary

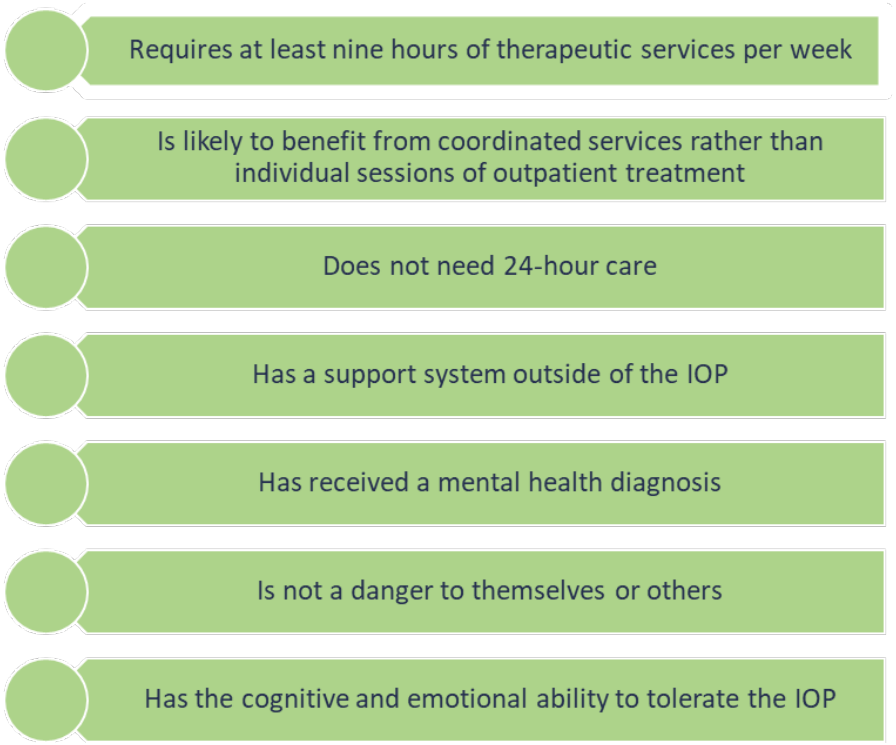
- Starting January 1, 2024, **an RHC may bill code G0511 multiple times in a calendar month** as long as all requirements are met and services are not double counted. In addition, G0511 will include coverage for the following service areas:
  - Behavioral Health Integration (BHI)
  - Chronic Care Management (CCM)
  - Remote Patient Monitoring (RPM)
  - Remote Therapeutic Monitoring (RTM)
  - Community Health Integration (CHI)
  - Principal Illness Navigation (PIN)

Intensive Outpatient Program (IOP)

- Services eligible to be provided and reimbursed under an IOP may include:
  - Individual and group therapy with physicians, psychologists, and other mental health professionals as available under state law
  - Occupational therapy
  - Furnishing of drugs and biologicals for therapeutic purposes that are not self-administered
  - Family counseling (as part of treatment of the patient's condition)
  - Patient training and education
  - Individualized activity therapies
  - Diagnostic services
  - Other related services for diagnosis and active treatment intended to improve or maintain the patient's condition and function

Intensive Outpatient Program (IOP)

- Qualifications for IOP Services
  - To quality a patient for IOP services, a physician is required to certify that a patient needs behavioral health services for at least nine, but no more than 19 hours per week
  - That certification must be completed by a physician at least once every other month for the patient to continue to qualify for services and the plan of care must demonstrate that the patient:



Intensive Outpatient Program (IOP)

- IOP services are not reimbursed at the RHC's AIR, but rather under a special rule that would allow for a flat payment

- RHCs are allowed to perform up to three services per day and, to qualify for the special payment, at least one of the three services must be from the Partial Hospitalization and Intensive Outpatient Primary Services table shown at right

HCPCS/CPT	Short Descriptor	Proposed Action
90832	Psytx pt&/family 30 minutes	
90834	Psytx pt&/family 45 minutes	
90837	Psytx pt&/family 60 minutes	
90845	Psychoanalysis	Add
90846	Family psytx w/o patient	
90847	Family psytx w/patient	
90853	Group psychotherapy	Add
90865	Narcosynthesis	Remove
90880	Hypnotherapy	
96112	Devel tst phys/qhp 1st hr	Add
96116	Neurobehavioral status exam	Add
96130	Psychological testing evaluation by physician/qualified health care professional; first hour	Add
96132	Neuropsychological testing evaluation by physician/qualified health care professional; first hour	Add
96136	Psychological/neuropsychological testing by physician/qualified health care professional; first 30 minutes	Add
96138	Psychological/neuropsychological testing by technician; first 30 minutes	Add
G0410	Grp psych partial hosp/IOP 45-50	Update
G0411	Inter active grp psych PHP/IOP	Update

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