The presentation will begin shortly.

Mary Kitchell, Trustee

Governance for health care transformation, a point of view.

Mary Greeley
MEDICAL CENTER

Mary Greeley Medical Center

Mary Greeley
MEDICAL CENTER

Mary Greeley Medical Center

Overview

- 220-bed hospital serving a 13-county market in central Iowa
- Located in Ames, Iowa – home to Iowa State University
- More than 1,300 employees (second largest employer in Ames)

Patient Care Services

- Cardiovascular care
- Cancer care
- Obstetrics
- Diabetes and nutrition care
- Mental health services
- Surgical services
- Palliative care
- Home medical care
- Public Health

Mary Greeley
MEDICAL CENTER

Mary Greeley Medical Center

- Strong collaborative relationship with McFarland Clinic, a multi-specialty clinic with 220 providers
  - Partners on an advanced EMR system
- $130 million capital project
  - Includes a six-story patient tower with larger patient rooms and an expanded emergency department
- Focus on BSN program has increased BSNs/MSNs on staff by nearly 7% over the last four years

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State & National Recognition

- Highest percentage bonus of any Iowa hospital in CMS Value Based Purchasing program (2nd consecutive year)
- Grade ‘A’ for Patient Safety from Leapfrog Group (2nd consecutive year)
- 2013 Guardian of Excellence Award for Clinical Quality from Press Ganey Associates
- 2013 Top Performer on key quality measures from Joint Commission
- A Top 100 Iowa Workplace

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Independent Community Hospital

- Owned by the city
- Governed by a 5 member publicly elected board of trustees
- Subject to open meetings laws
- Responsible to the community
- Exploring paths to transformation

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Medical Staff

- Physicians are not employed.
- Physician services are contracted.
- Common EHR platform
- Joint strategic planning
- Physician involvement throughout institution
- Board emphasis on positive relationships

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- Majority of physicians, affiliated with a high functioning multi-specialty clinic with a strong primary care base, accustomed to collaboration and peer review.
- Physicians accustomed to evidence based practice.
- Physicians take ownership.

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Foundations

- Culture
- Mission, vision, values
- Physician relationships
- Strategic Plan
- Thoughtful environmental assessment and program design specific to one's circumstances.

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Governance influences culture.

- Lead, through influence, a culture that values the triple aim and is patient centered.
- Develop and support a culture that values education, achievement, and continuous improvement at all levels of the organization.

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Revisit mission, vision, values in light of the new environment of health care.

- Does it include dedication to value?
- Is it patient centered?
- Does it include population health?
- Does it preclude relationships with other entities?

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Physician relationships

- Board recognizes that value is dependent on how medicine is practiced. Physician involvement in planning is key.
- Physicians are partners.
- The board supports leadership development of physicians.

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Effective governance requires constant attention to the strategic plan.

The focus of traditional strategic plans (quality, financial and operational excellence, service, growth) will be necessary but not sufficient for future sustainability.

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New revenue models will emerge.

- Anticipate cuts from Medicare.
- With emphasis on population health, hospitals become cost centers.
- Resource utilization will be altered.
- Uncertainty abounds, urgency is present.

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The board should continually assess the strategic plan.

- Are the underlying assumptions still valid?
- Is it realistic, attainable?
- Is this still the plan we need?
- Does it focus on the future?
- Customize to one's environment

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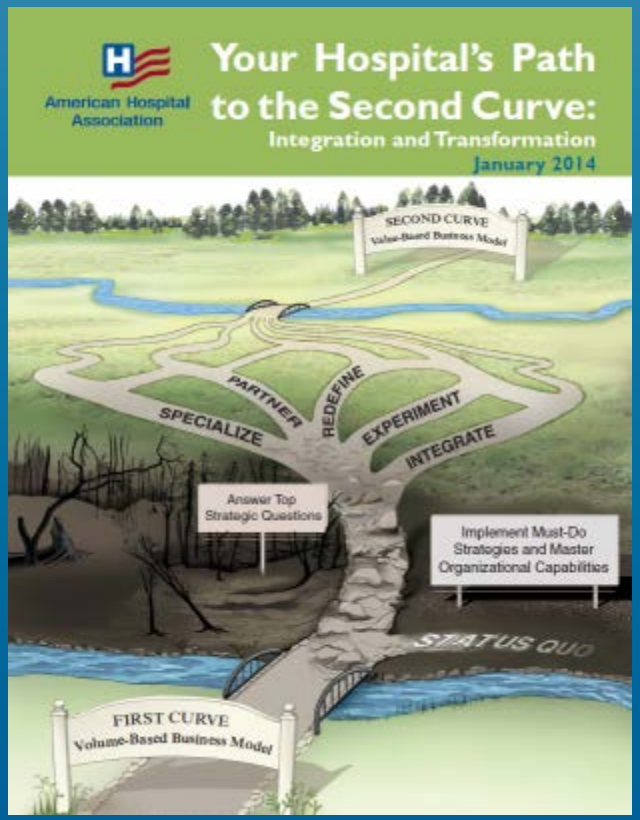
Your Hospital's Path to the Second Curve: Integration and Transformation

Must-Do Strategies for Hospitals of the Future

Top 10 Strategic Questions

Guiding Questions

Characteristics of IDSs



Mary Greeley MEDICAL CENTER

American Hospital Association Webinar

SHARP HEALTHCARE'S INTEGRATION JOURNEY

Dr. Daniel L. Gross, DNSc
Executive Vice President
Sharp HealthCare

Sharp HealthCare Overview

- Not-for-profit serving 3 million residents of San Diego County
- Largest integrated health care system in San Diego
- Largest private employer in San Diego: 17,000 employees, 2,600 affiliated physicians, 2,000 volunteers
- SHC responsible for 300,000 managed care lives
- Integrated Health Care Delivery journey began in the 1980s
- Early adopter of risk based reimbursement philosophy
- Participated in early work with Stephen Shortell-IHDS

Integrated Health Care Delivery

Full continuum of health care services:

- Hospitals: 4 acute and 3 specialty (women's, behavior health, chemical dependency)
- Specialty Services: Trauma/Transplant
- Acute rehabilitation
- Skilled nursing facilities
- Home health, hospice, and home infusion
- Affiliated medical groups: Sharp Rees-Stealy Medical Group (Foundation) and Sharp Community Medical Group (IPA)
- Outpatient clinics: 21 Sharp Rees-Stealy Medical Centers throughout San Diego County

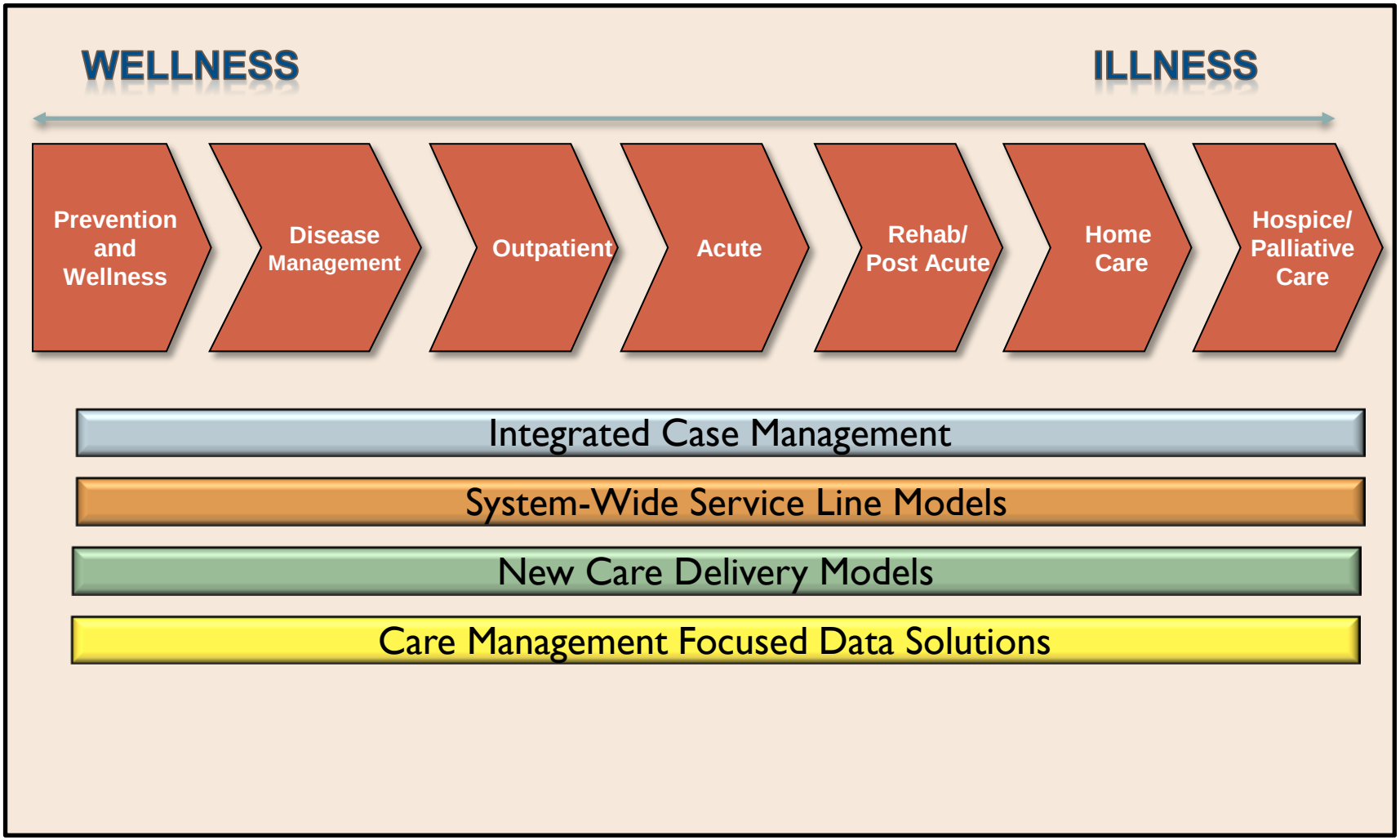
Integrated Health Care Delivery

Full continuum of health care services:

- Emergency/Urgent Care Centers/ Ambulatory
- Retail Pharmacies
- Sharp Health Plan
- Sharp HealthCare ACOs
- Continuous Quality Insurance
- Foundations: Sharp HealthCare, Grossmont, Coronado
- Partnerships: CVS, Imaging, BMT

Care-Continuum Delivery Model

Population Health



SHC: Market Share Position

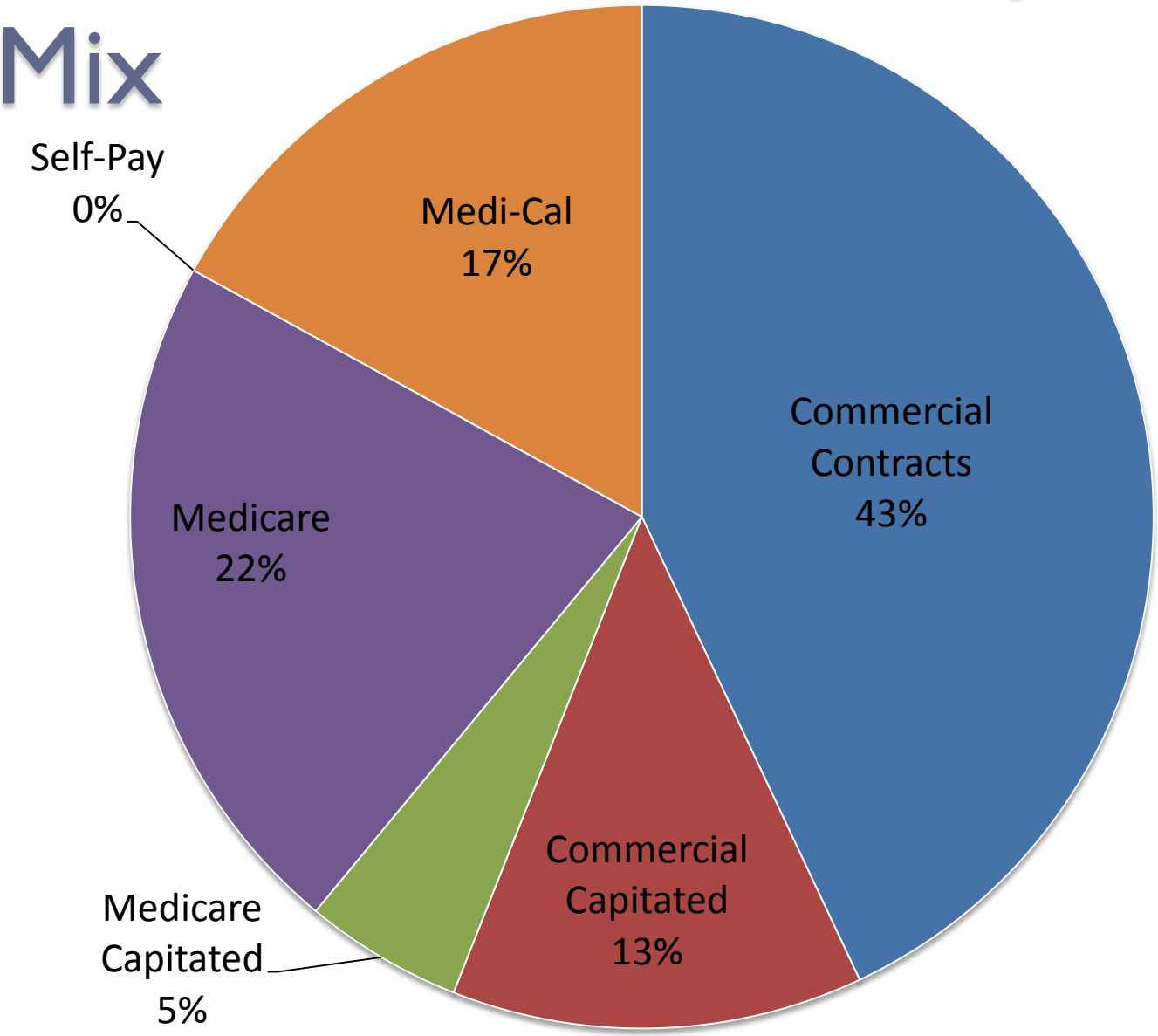
- Sharp HealthCare continues to lead San Diego with 28.6% inpatient market share, with the next closest provider at 22.6%
- 13 consecutive years of growth (23.1% in 1999)
- San Diego's total 2013 population is estimated at 3.2 million and is projected to grow 5.0% from 2013 to 2018
- Sharp HealthCare is identified as a low-cost, high-quality provider and included in all narrow network HMO products offered in San Diego

Growing Utilization

	Fiscal 2011 Audited	Fiscal 2012 Audited	Fiscal 2013 Unaudited
Licensed Beds	2,092	2,097	2,110
Maintained Beds	1,760	1,803	1,792
Average Daily Census	1,266	1,253	1,262
Discharges	83,679	84,793	83,178
Patient Days	462,044	458,485	460,699
Acute Average Length of Stay	4.7	4.6	4.7
Observation Days	14,334	19,121	22,806
Occupancy	71.9%	69.5%	70.4%
Outpatient to Total Revenue	36.0%	38.0%	39.6%

- Continued growth in patient volume – patient days, observation days, outpatient services, and risk-based enrollment

SHC: Net Revenue Payer Mix



Financial Performance: Overview

($ in millions)	Fiscal 2011 Audited	Fiscal 2012 Audited	Fiscal 2013 Audited
Assets	$2,156.5	$2,519.9	$2,827.1
Revenues[1]	$2,314.9	$2,482.6	$2,590.1
Expenses[1]	2,117.4	2,255.5	2,373.0
Income from Operations	$197.5	$227.1	$217.1
Excess of Revenues Over Expenses	$178.0	$300.4	$292.3
Excess Margin	7.7%	12.1%	11.3%
EBITDA	$287.6	$413.6	$411.6

- Sharp HealthCare continues its focus on operations, generating strong and sustainable financial operating performance

SHC: Evolution of Integration

Forming

1950's-1960's

- Health Care Corporation formed
- First hospital
- Comprehensive rehabilitation center

Acquisition/Growth

1970's-1980's

- SHC Foundation
- Three hospitals purchased
- Foundation model medical group
- IPA medical group
- Two convalescent centers
- Senior Center clinic
- Bundled payments for specialty services

SHC: Evolution of Integration

Acquisition, Care Continuum Expansion, and Integration

1990's-2000's

- Two hospitals leased
- Two hospitals purchased
- Two hospitals sold
- New specialty hospital
- TQM/CQI philosophy
- Continuous Quality Insurance Co.
- Foundation medical group purchased/sold
- Sharp Health Plan
- Retail pharmacies
- Hospice and Home Care
- Outpatient Pavilion

2010's-Present

- Pioneer and commercial ACOs
- Three new ambulatory clinic sites
- Statewide health insurance exchange: SHP and commercial carriers
- CVS retail clinic partnership
- Palliative and transitional care
- Residential hospice

SHC: Focus/Priorities

- Capitation Competition/Narrow Networks
- Health Insurance Exchanges
- Business Intelligence-Employment of Technology
- Top Decile Quality Performance
- Capacity Management
- Physician Alignment: Medical Groups and Independents
- Post-Acute Care Management: SNF, Transitions
- Market Consolidation, New Partnerships

Concluding Thoughts: The Integration Journey

- Organizational "must haves" for the Integration Path:
  - Clarity regarding what integration means/looks like
  - Well defined integration goals and outcomes
  - Articulated plan, adequacy of resources, realistic timeline
  - Insight to competitor and community reaction/readiness
  - Board commitment

- Potential Path of Progression:
  - Development of care continuum
  - Physician alignment and commitment
  - Purchaser motivation/readiness
  - Risk based contracts: capitation, bundled payments
  - Health plan development or new relationships

Concluding Thoughts: The Integration Journey

- Creating an IHDS is a "marathon not a sprint"
- Risk-based reimbursement can serve as a vehicle for provider alignment and a volume-to-value transition
- Physician alignment is not optional
- Full care continuum does not necessarily need to be "owned" but must exist with clear care management processes defined
- Acquisition strategies alone do not produce integration
- Health Plan ownership drives new thinking, paradigms, and market opportunities
- Commitment to the integration journey requires tolerance for ambiguity

Bear Valley Community Healthcare District
Our Journey to the Second Curve

Raymond T. Hino, MPA, FACHE
Chief Executive Officer

Our Path to the Second Curve

- Who We Are
- Strategic Plan Driven
- The Rural Hospital Perspective
- Lessons Learned from the Literature
- What's Next
- Reinventing Rural Healthcare
- Questions

About Bear Valley Healthcare District


BIG BEAR LAKE LOCATION MAP
Oregon
Nevada
Utah
Arizona
Eureka
Susanville
Lakeport
Sacramento
Bridgeport
Oakland
Modesto
San Jose
Fresno
Shoshone
California
NORTH PACIFIC OCEAN
Big Bear Lake
Los Angeles
Riverside
Long Beach
Santa Ana
San Diego
Mexico
LEGEND
Intl. Boundary
State Boundary
County Boundary
State Capital
Location
Cities
Miles
0 15 30 60 90 120
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(Updated on 17th May, 2013)

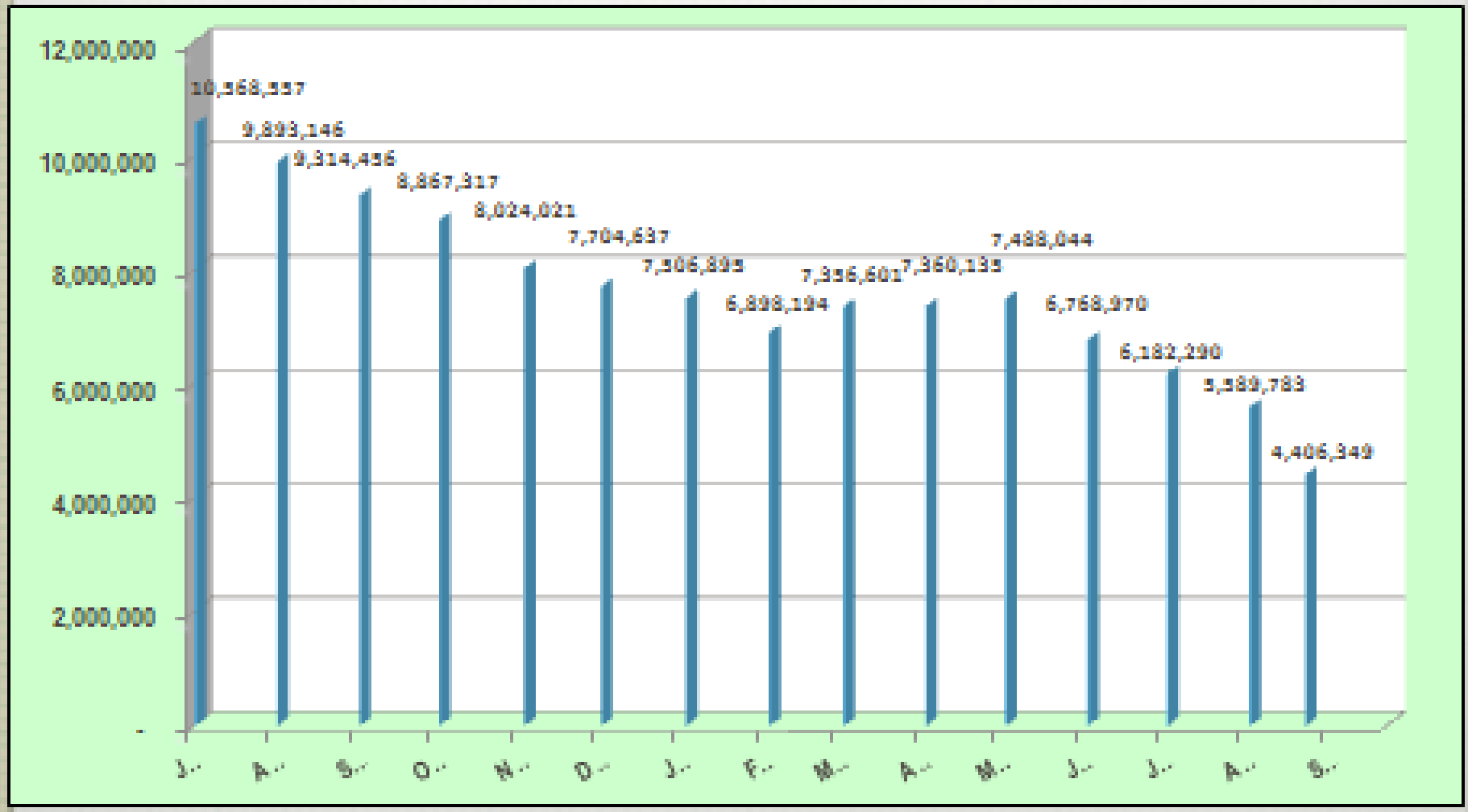
Summer and Winter Activities

Services

- Medical-Surgical Acute
- Skilled Nursing Facility
- Surgery
- Outpatient Surgery
- Emergency Department
- Clinical Laboratory
- Imaging Services
  - CT Scan
  - Ultrasound
  - Mammography
- Physical Therapy
- Family Health Center
- Rural Health Clinic
- The Mom & Dad Project

Cash and Investments

Monthly Cash & Investments balance for the 15 months ending September 30, 2013



Strategic Plan 2012 - 2014

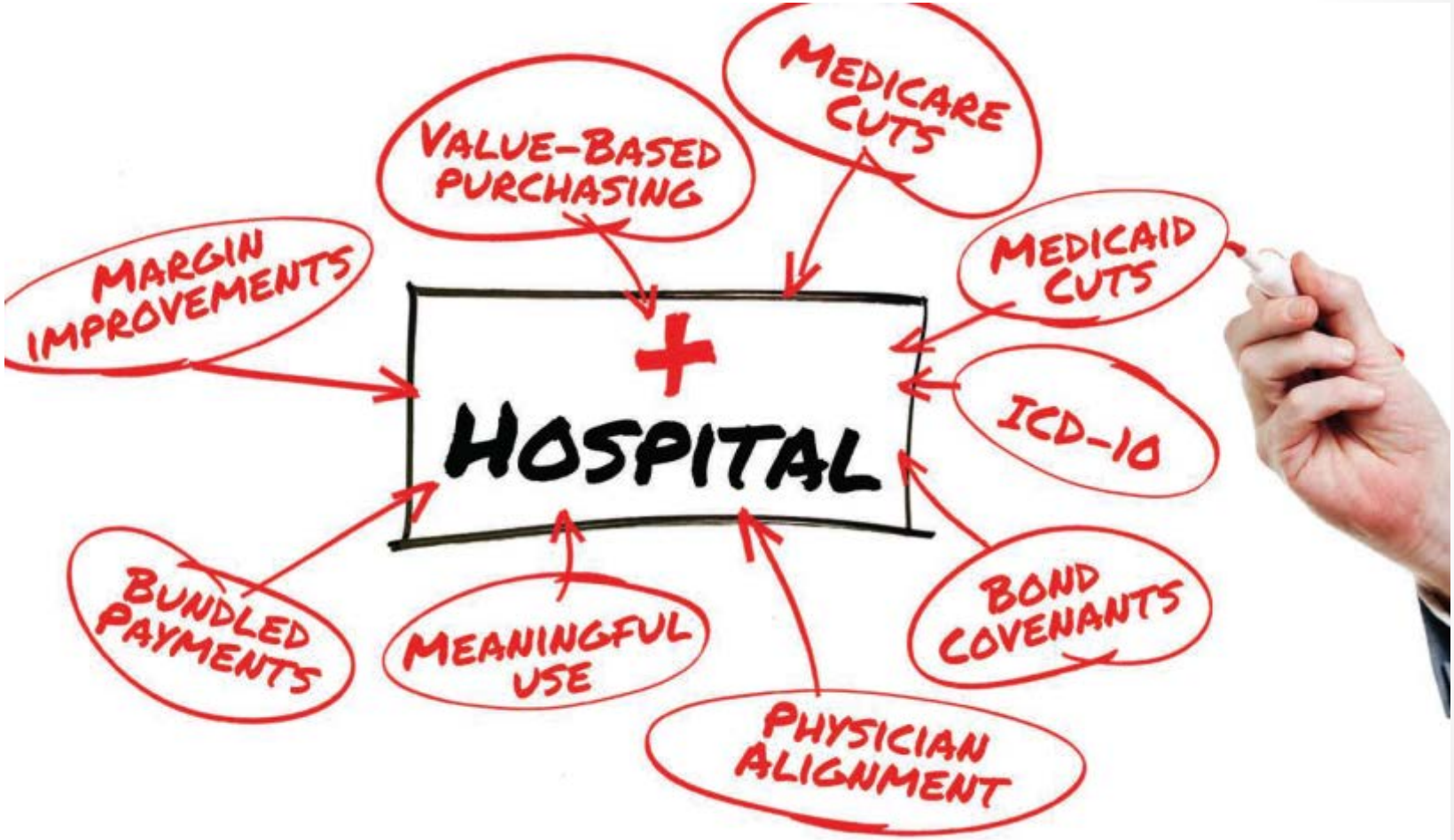
1. Quality
2. Personnel Staffing
3. Market Position
4. Affiliation
5. Physical Plant and Equipment
6. Scope of Services
7. Medical Staff
8. Financial

Review of the Literature

Rural Health Challenges

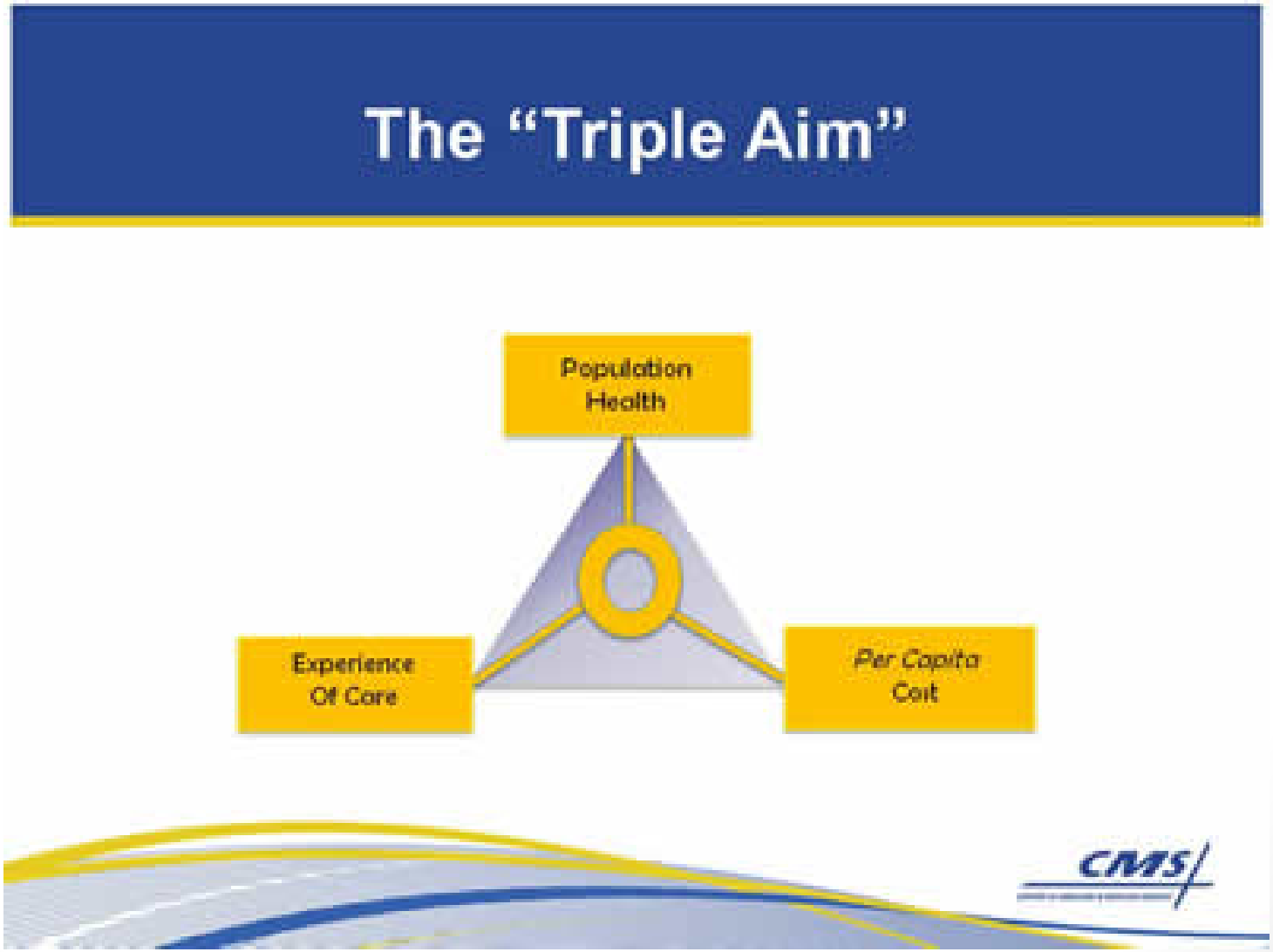
- Dominated by public coverage
- Higher health needs
- Difficulty attracting providers, especially specialists
- Sub-optimal in scale, both clinically and financially
- Quality of care differentials
- Aging plant and equipment
- Measuring Quality with small numbers
- A cost-based system in a value-based world
- Will be subject to the changes in the healthcare environment that surround it

Industry Dynamics



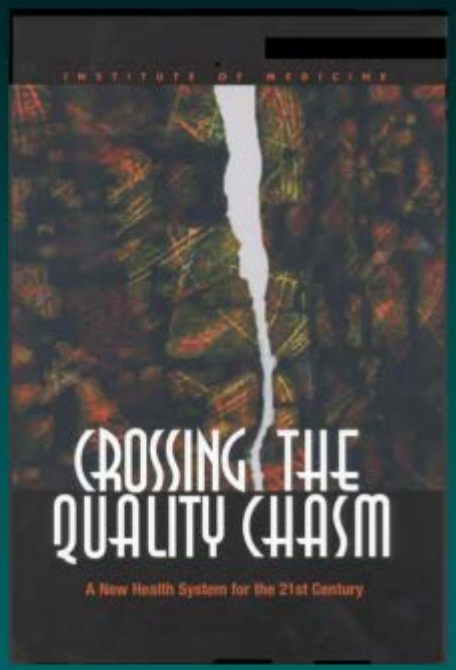
Community Hospitals face daunting industry forces

The Triple Aim



Value – IOM Six Aims

CROSSING THE QUALITY CHASM



"Quality problems occur typically not because of failure of goodwill, knowledge, effort or resources devoted to health care, but because of fundamental shortcomings in the ways care is organized"

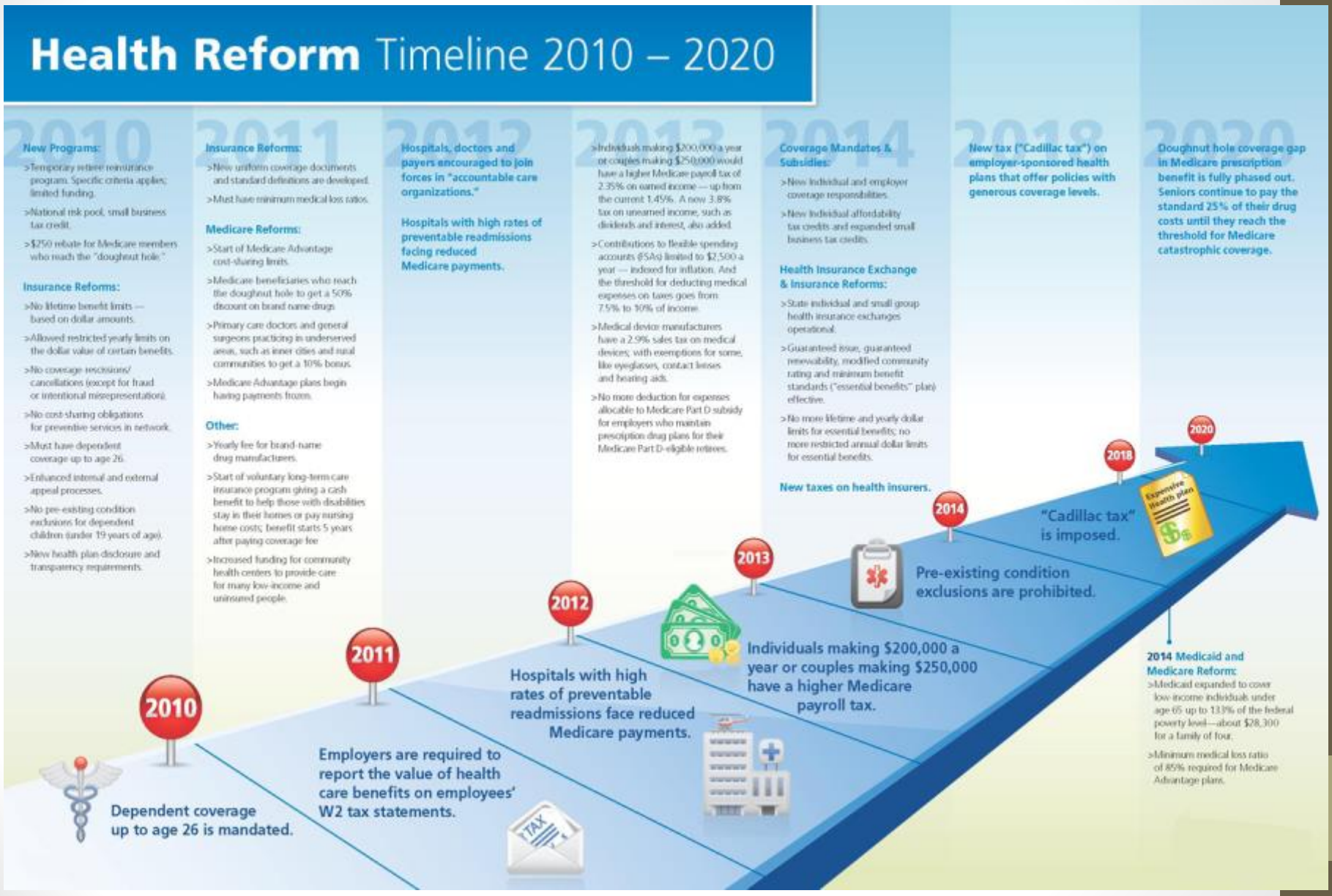
Trying harder will not work: changing systems of care will!

A NEW HEALTH SYSTEM FOR THE 2fST CENTURY (IOM, 2001)

THE NATIONAL ACADEMIES
Advisers to the Nation on Science, Engineering, and Medicine

INSTITUTE OF MEDICINE

Health Reform Timeline 2010 – 2020

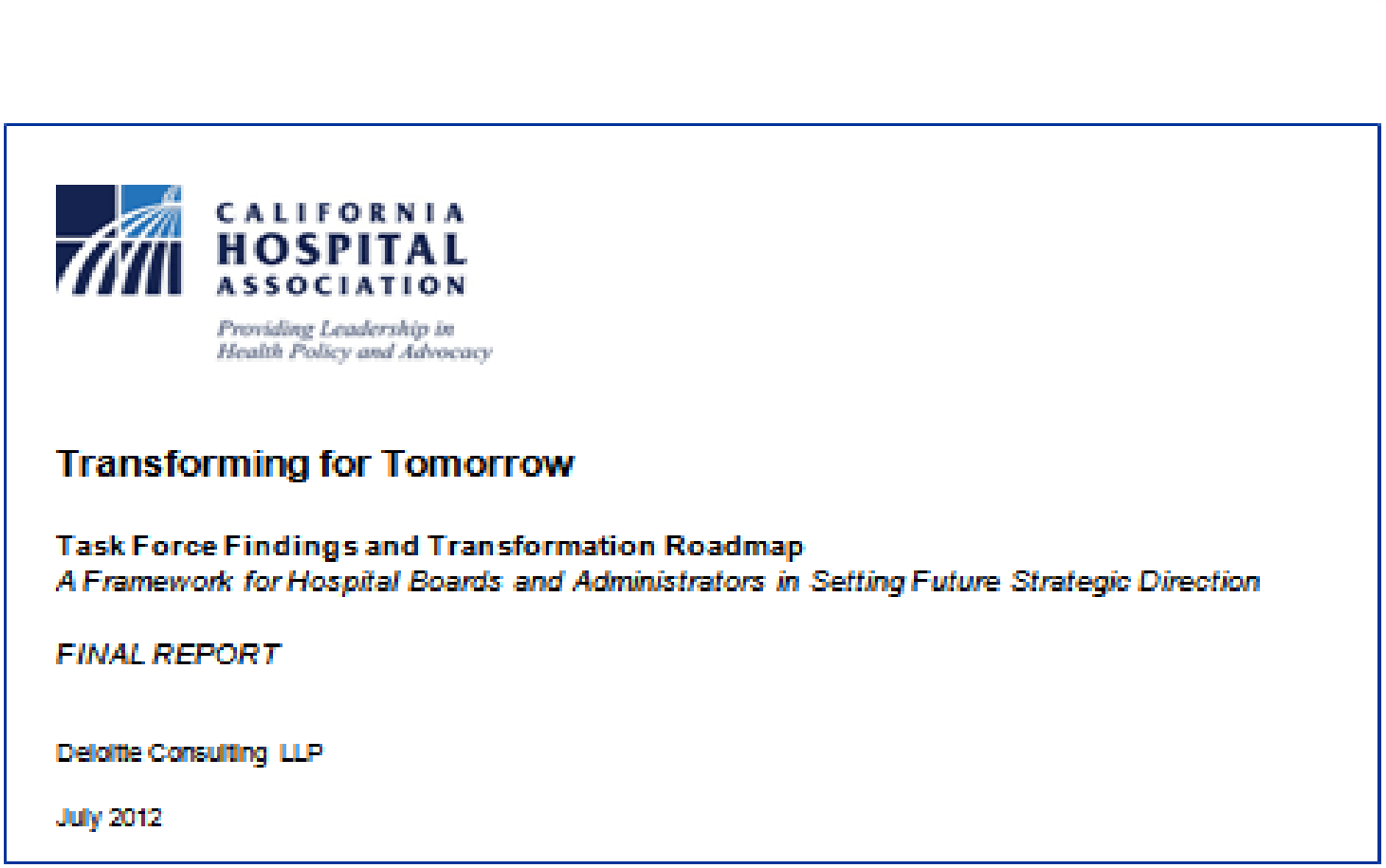


Implications of Health Reform

- Significant downward pressure on reimbursement
  - Mandatory Medicare payment reductions
  - Medicaid payment reductions
  - Potential restructuring of CAH cost-based formula
- Which will result on downward pressure on hospital costs
- Primary care providers will be in huge demand
- Consumers will take more responsibility for their own health care costs
- Market consolidation of providers will occur


MARCH 4, 2013
SPECIAL REPORT
TIME
ONE ACETAMINOPHEN TABLET COSTS 1.5¢. YOUR HOSPITAL MARKS IT UP 10,000%
BITTER PILL
WHY MEDICAL BILLS ARE KILLING US
BY STEVEN BRILL
www.time.com

California Hospital Association

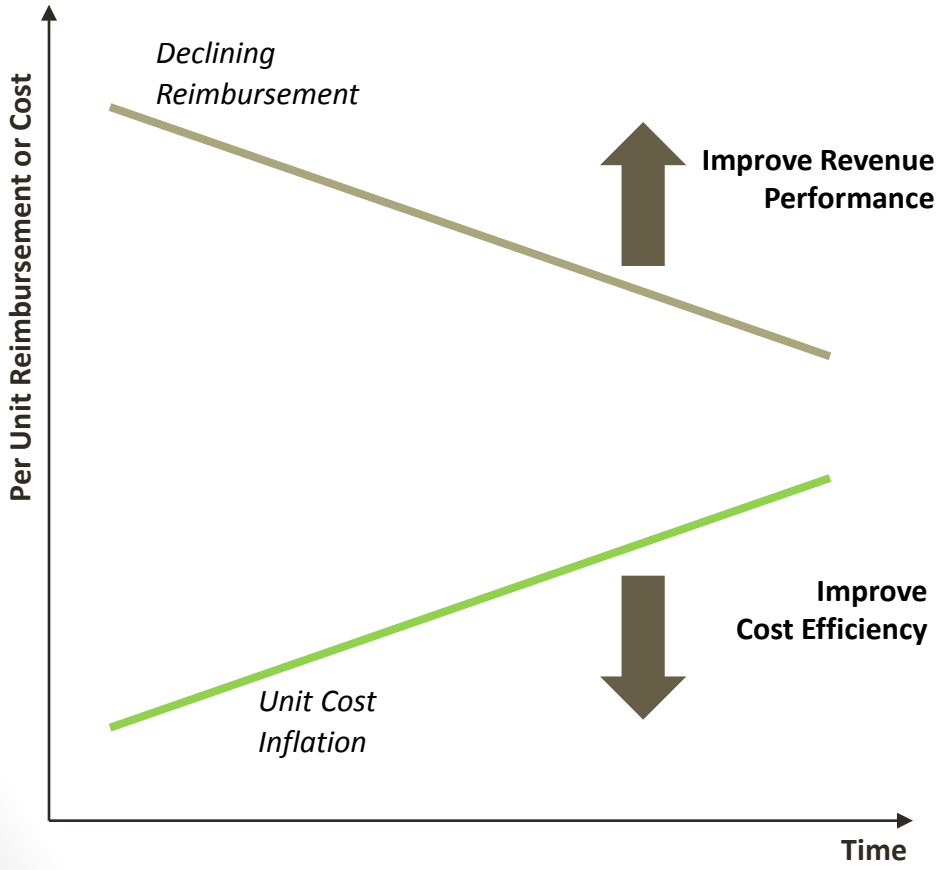


Deloitte.

Durable Paths to

Profitability Levers

Strategic Destinations



The Innovator
Deliver superior outcomes/service to realize superior reimbursement

The Diversifier
Extend consumer relationships to achieve a greater 'share of wallet'

The Aggregator
Use actual and virtual scale to drive a sustainable unit cost advantage

The Health Manager
Integrate care across the continuum to decrease utilization and total cost

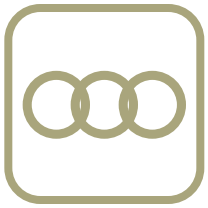
The Connector
Focus service mix and direct extended care to other high value providers

Destination Selection – Leading Characteristics

Each Destination's unique characteristics should be considered in the evaluation of strategic fit

	Aggregator	Health Manager	Connector	Innovator	Diversifier
Focus	Cost			Revenue	
Leadership Role	Leading acquisitions to develop critical mass / scale economies	Integrating the system of care to prevent the prevalence and progression of disease	Assembling value-added network of secondary and tertiary providers	Leading the research, design, and introduction of best in class methods	Using brand loyalty, consumer insight, and trusted partners to monetize relationships
Leverage Point	Scale	Utilization Management	Focus	Leading Products	Relationships
Key Enabler	Efficiency and Standardization	Physician and Continuum Alignment	Efficient and Effective Transitions	Continuous Disruption	Commercialization
Success Measure	Cost per Service	Utilization per Member	"Directed" Outmigration	Quality and Outcomes	Share of Consumer Discretionary Spend
Required Capital	High	Medium	Low	High	Medium

The Connector: Detailed Description



The Connector delivers a very narrow set of facility-based services and directs patients to the most appropriate site of care for other services through a network of affiliated high-value providers

Focus: Cost

Destination Strategies

- Narrow service mix to high frequency community-based ambulatory and acute care services
- For all other services, develop a regional delivery network of ambulatory, tertiary, quaternary and post-acute care partners based on quality, cost, and proximity
- Work with preferred network partners to create 'frictionless' connections
  - Develop virtual care collaborations where possible (e.g., administration of TPA for stroke, neuro telemedicine consults, etc.)
  - For all others, develop expedited transfers (to/from partners) with appropriate health information
- Leverage regional network partners to maximize access to resources such as technology, purchasing, and performance improvement

Illustrative Metrics

- Performs only 50% of the services of a typical California medical center, and uses partnerships for remaining 50%
- 50% of patients triaged are referred to lower- or higher-acuity network partners without receiving care
- 50% of admitted patients receive a 'virtual' consult in collaboration with a regional network partner

- Competency in virtual collaboration and related technology
- Proficient in team-based care, leveraging non-physician providers and collaboration across organizations
- Active network management function:
  - Screens potential network partners based on value
  - Negotiates support from network partners (e.g., equipment to support remote monitoring and virtual consultations)

Key Hypotheses Arising from the Data

- Competition is fierce in most counties, and a focus on value proposition will be essential to long-term relevance / viability
- California's high proportion of small business and active legislature will likely result in a more active health insurance exchange, which will be the key driver of financial risk between now and 2020
- Primary care supply will require organizations to innovate the care model, and in particular the role of non-physician providers to successfully address the incoming wave of utilization due to aging and the newly insured
- While risk for most organizations is more heavily weighted toward short-term factors, the impact of coverage shifts will be extremely damaging to many organizations and especially the state's safety net
- California hospitals show early signs of readiness for the future, but face significant near-term challenges to sustainability
- The state's rural and critical access hospitals are acutely vulnerable, and without additional support could create access issues for patients and dilute the margins of surrounding facilities
- Integration will become more important than scale in driving revenue and cost leadership
- Diversification will be a key lever in addressing expected challenges in profitability and access to capital

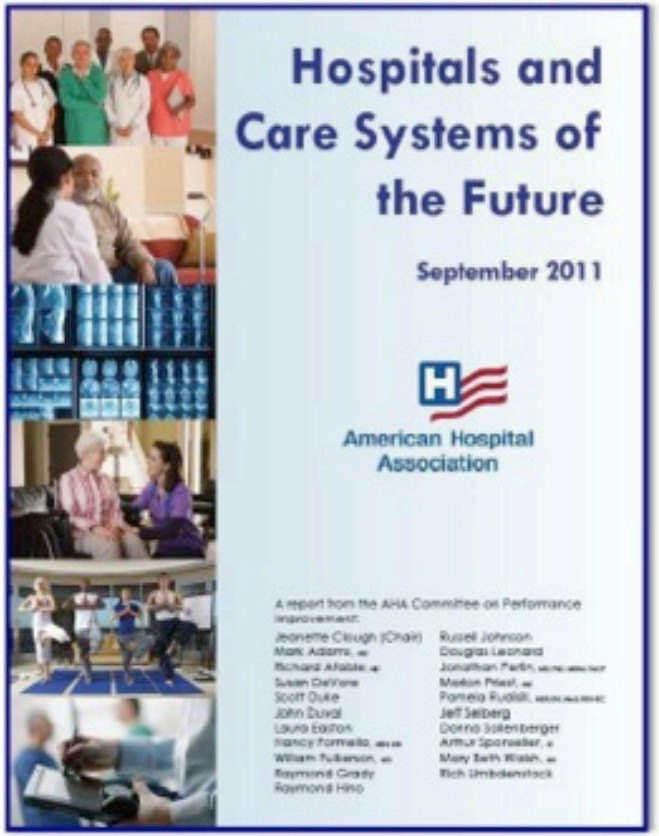
Critical Success Factors

California's hospitals and health systems should consider the following guiding principles as they develop their own Transformation plans

- ***Engagement*** – Engaging key stakeholders early should increase adoption / success, consider including a limited number of key Physician and Board representatives to assist in strategy formulation
- ***Unambiguous Differentiation*** – Avoiding commoditization is dependent on avoiding the "stampede"
- ***Focus*** – Similarly, organizations who avoid "being all things to all people" will have a higher chance of achieving success
- ***Flexibility*** – Hospitals and health systems should avoid developing "linear" strategies; strategic flexibility will allow organizations to successfully adjust as the market evolves
- ***Non-Traditional Solutions*** – Many hospitals and health systems are exploring non-merger collaborations with peers and creative alignment strategies with employers / purchasers

American Hospital Association

Hospitals and Care Systems of the Future



Engage senior leadership in planning for the hospital of the future

- **Must-do strategies to be adopted by all hospitals**

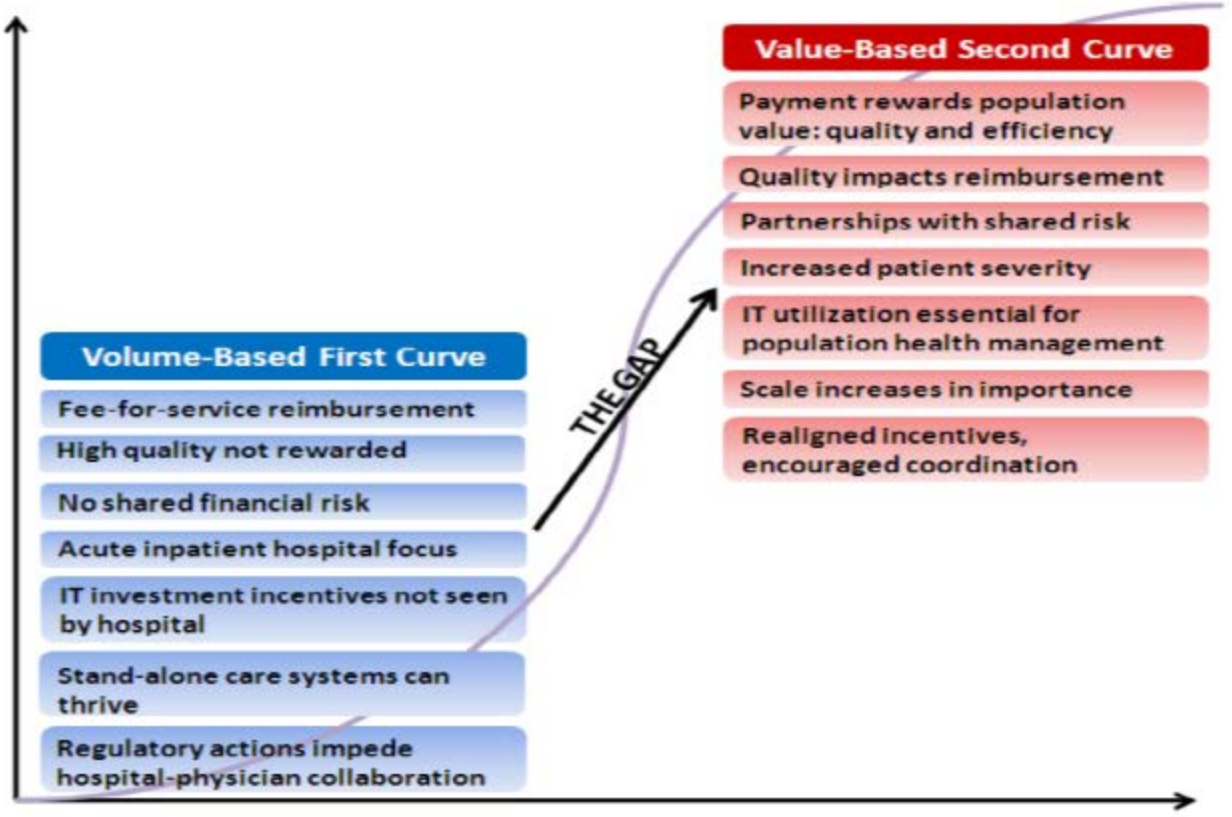
  Second curve metrics measure success of the implemented strategies

- **Organizational core competencies that should be mastered**

  Self-assessment questions to understand how well the competencies have been achieved

First–Curve to Second-Curve Markets

How will hospitals successfully navigate the shift from first-curve to second-curve economics?



Strategy Implementation Leads to Core Competency Development

Adoption of Must-Do Strategies

1. ***Clinician-hospital alignment***
2. ***Quality and patient safety***
3. ***Efficiency through productivity and financial management***
4. ***Integrated information systems***
5. Integrated provider networks
6. Engaged employees & physicians
7. Strengthening finances
8. Payer-provider partnerships
9. Scenario-based planning
10. Population health improvement

Organizational culture enables strategy

Metrics to Evaluate Progress

Development of Core Competencies

1. Design and implementation of patient-centered, integrated care
2. Creation of accountable governance & leadership
3. Strategic planning in an unstable environment
4. Internal & external collaboration
5. Financial stewardship and enterprise risk management
6. Engagement of employees' full potential
7. Utilization of electronic data for performance improvement

Self-Assessment Questions

St. Joseph Health - Hoag

ST. JOSEPH
HEALTH SYSTEM


BEAR VALLEY
COMMUNITY HEALTHCARE DISTRICT
LIFE-SAVING EMERGENCY CARE ON THE MOUNTAIN
1974
40
YEARS
2014

BVCHD's Path

Step 1:
Establish a Set of Guiding Principles

- Maintain Local Control
- Provide High Quality Care Close to Home
- Easy Access to Specialty Care in our Mountain region
- BVCHD to maintain it's own identity
- Both systems to maintain their independence
- Cultural Fit
- Revenue enhance/ resource availability

Step 2:
Identify Needs in Specific Areas

- Physician Recruitment
- Provider Alignment
- Quality/ Risk Management
- Enhanced Clinical Services
- Financial Resources
- Staff Sharing/ Education & Training
- Marketing

Step 3:
Prioritize and Rank Needs

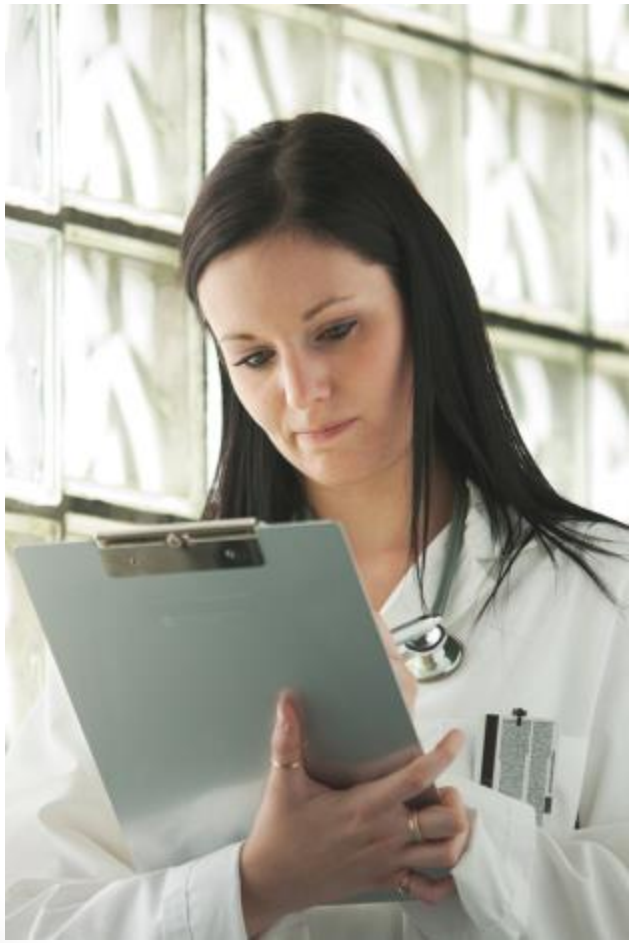
- Priority 5
  - Physician Recruitment/ Alignment
  - Quality/Risk Management
  - Clinical Services
  - Financial Resources
  - Staff Sharing
- Priority 4
  - Human Rescources
  - Marketing
- Priority 3
  - Accreditation
  - Staff Education/ Training

Step 4:
Identify Resources to Be Requested

- Physician Recruitment
- Shared Medical Staff
- Telemedicine Specialists
- Quality Program Resources
- Reimbursement Enhancement
- Preferred Pricing Agreements
- Collaboration to keep health care local in the mountains
- Access to Capital
- Staff Education Programs

Step 5:

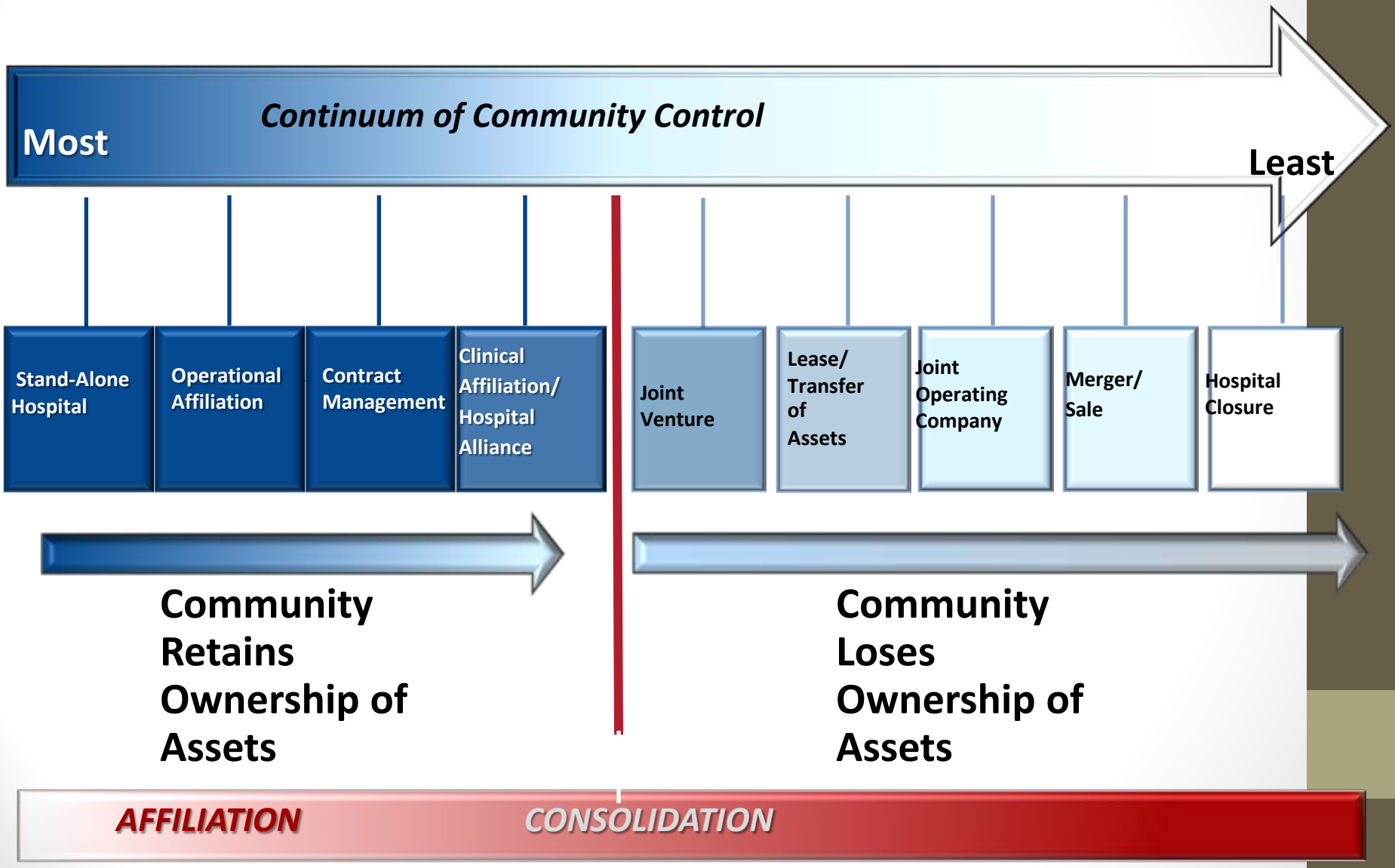
Evaluate the Gap Between Needs and Partner Capabilities



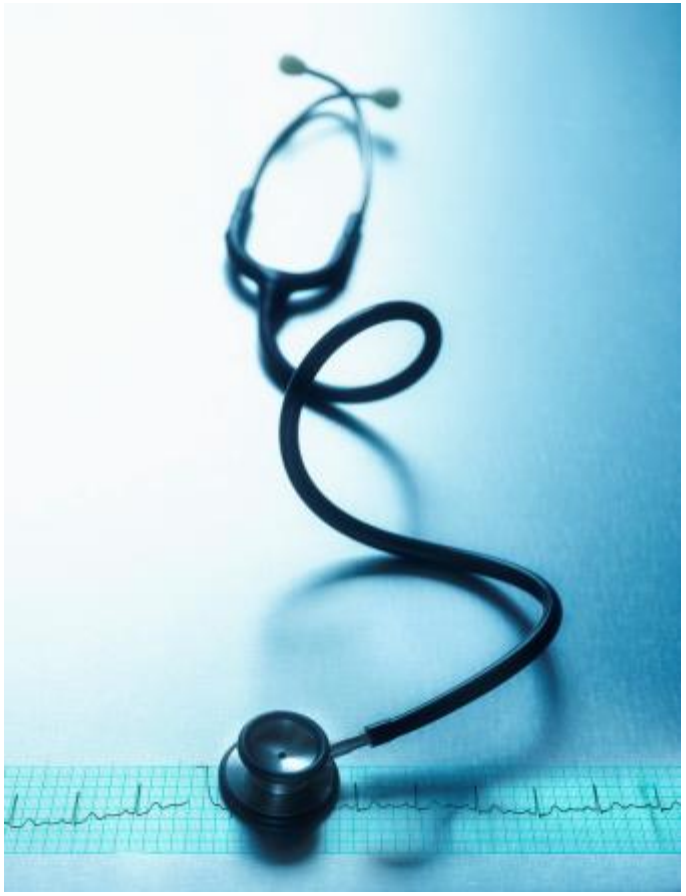
Step 6:
Identify Preferred Partnership/ Affiliation Model

- Brand Sharing
- Telemedicine
- Clinical Integration
- Electronic Health Record Interoperability
- Practice Standards and Protocols
- Physician Aligment
- Program Affiliation

Ownership & Governance Continuum



Step 7:
Assemble An Information Packet for Potential Partners



- Financial Performance
- Identified Needs
- Identified Resources to be Requested
- Hospital Utilization Data
- Non-disclosure agreement

Step 8:
Request for Proposals

- Make contact with potential partners to determine level of initial interest
- Distribute RFP documentation packet to those determined to be best fit
- Create a weighting system for responses
- Rank order each response according to needs and resources offered

Step 9:
Make Final Selection and Negotiate a Contract

Lessons Learned

- This may be the biggest single decision that our current Board of Directors will ever make
- Buy-in from all key stakeholders is key
  - Medical Staff
  - Board of Directors
  - Community Served
  - Labor organizations
- Professional Help from a firm experienced in all aspects of affiliation, particularly with small public hospitals, is essential
- Think in terms of regionalized systems of care

Reinventing Rural Healthcare

“By failing to prepare, you are preparing to fail.”…….Benjamin Franklin

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Accelerating Performance Improvement

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- Strategies for health care transformation
- Reducing health care disparities
- Reducing avoidable readmissions
- Managing variation in care
- Implementing electronic health records
- Improving quality and efficiency
- Bundled payment and ACOs
- Others

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