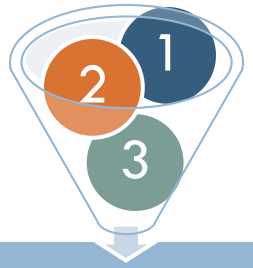
RURAL HEALTH CARE LEADERSHIP CONFERENCE

PHOENIX, AZ

PAUL OSTRANDER • CRAIG CHAPMAN • STORMY BROWN

KPB ASSEMBLY PRESENTATION

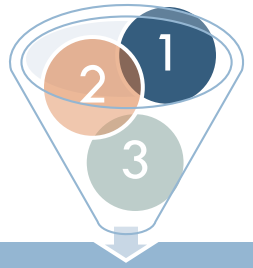
Three Key Learnings



This presentation is an overview of what we feel are the three most significant and relevant key learnings for our team from the conference:

1. It is important to understand the differences between Critical Access Hospitals (CAH) and Acute Care Hospitals (ACH), and how those designations affect our hospitals here in the borough.
2. The future of health care payment models in America is changing. The shift from a fee-for-service model to population-based funding will require us to adjust how we approach health care decisions and spending. We must also prepare to shift from a health care model that rewards volume above all other metrics to one that rewards value and quality.
3. Our health care providers must become part of a clinically integrated network within the borough to remain competitive and successful in the future.

Three Key Learnings



This presentation is an overview of what we feel are the three most significant and relevant key learnings for our team from the conference:

1. It is important to understand the differences between Critical Access Hospitals (CAH) and Acute Care Hospitals (ACH), and how those designations affect our hospitals here in the borough.
2. The future of health care payment models in America is changing. The shift from a fee-for-service model to population-based funding will require us to adjust how we approach health care decisions and spending. We must also prepare to shift from a health care model that rewards volume above all other metrics to one that rewards value and quality.
3. Our health care providers must become part of a clinically integrated network within the borough to remain competitive and successful in the future.

CAH and ACH

Critical Access Hospital (CAH)

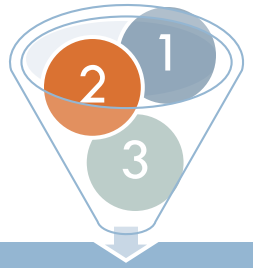
- CAH designation created in 1997 to prevent rural hospital closures
- Must have no more than 25 beds
- Average length of stay of no more than 96 hours for acute inpatient care
- 24 hours / day, 7 days / week emergency care
- At least 35 driving miles away from any other hospital
- Cost reimbursement set at 101% of reasonable costs
- 41% of critical access hospitals operate at a financial loss today
- Proposed federal legislation threatens to remove the reimbursable subsidies
- South Peninsula Hospital is a Critical Access Hospital

CAH and ACH

Acute Care Hospital(ACH)

- Provides short term treatment for injury, illness or surgery
- Typically have 50 or less beds
- Reimbursable rates are set using a complex formula adjusting the cost of an average Medicare case utilizing factors specific to each hospital
- Central Peninsula Hospital is an Acute Care Hospital

Three Key Learnings



This presentation is an overview of what we feel are the three most significant and relevant key learnings for our team from the conference:

1. It is important to understand the differences between Critical Access Hospitals (CAH) and Acute Care Hospitals (ACH), and how those designations affect our hospitals here in the borough.
2. The future of health care payment models in America is changing. The shift from a fee-for-service model to population-based funding will require us to adjust how we approach health care decisions and spending. We must also prepare to shift from a health care model that rewards volume above all other metrics to one that rewards value and quality.
3. Our health care providers must become part of a clinically integrated network within the borough to remain competitive and successful in the future.

The changing pay model

CURRENT STATE…

Treatment-Based pay model

- Fee for service
- Volume-driven
- Encourages max use of clinical resources (keep the beds/labs full)
- Risk is held largely by the consumer

Pay for performance measures begin:

- *Cost*
- *Quality*
- *Access*
- *Services (Medicare)*

COMING…

Episode-Based pay model

- Bundled payments
- Paid for an individual's care throughout an episode or event
- Beginning of intended integration
- Risk begins to shift toward provider(s)

Global payments: payment for discreet populations

FUTURE STATE…

Population-Based pay model

- Payment for population
- "Own the lives"
- Moves toward full capitation
- Shared savings
- Risk held largely by the provider system

The changing pay model

What is driving the move from a fee-based to a population-based pay model?

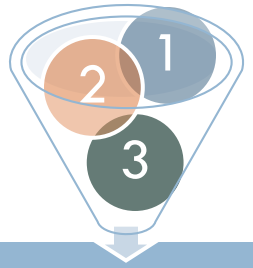
- The need to reduce overutilization
- The need to incorporate care coordination which will focus on the those patients who require the greater percentage of health care
  - Top 1% of patients account for 20% of spending
  - Top 5% of patients account for 50% of spending
  - Bottom 50% of patients account for 2% of spending
- The need to reduce overall costs for payers and the system

And the changing value model

What is driving the move from a *volume*-based system to a *value*-based system?

- The need for improved patient outcomes and reduced costs for the community
- The need to include the patient experience rating as a measurement of success
- The need to reduce strain on limited health care resources: provide the *right* services at the *right* time to the *right* patients
- The need for compliance with changing regulations: Affordable Care Act requirements

Three Key Learnings



This presentation is an overview of what we feel are the three most significant and relevant key learnings for our team from the conference:

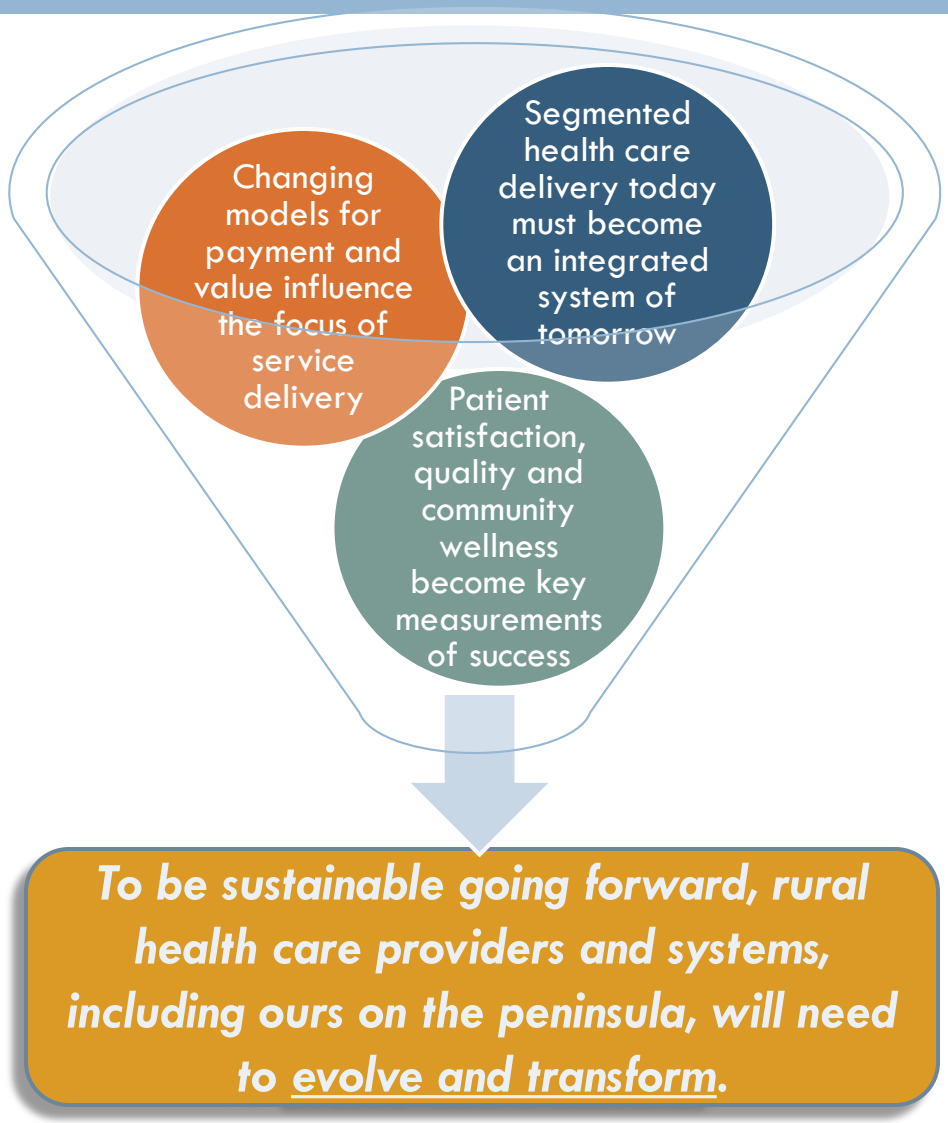
1. It is important to understand the differences between Critical Access Hospitals (CAH) and Acute Care Hospitals (ACH), and how those designations affect our hospitals here in the borough.
2. The future of health care payment models in America is changing. The shift from a fee-for-service model to population-based funding will require us to adjust how we approach health care decisions and spending. We must also prepare to shift from a health care model that rewards volume above all other metrics to one that rewards value and quality.
3. Our health care providers must become part of a clinically integrated network within the borough to remain competitive and successful in the future.

Moving toward clinical integration

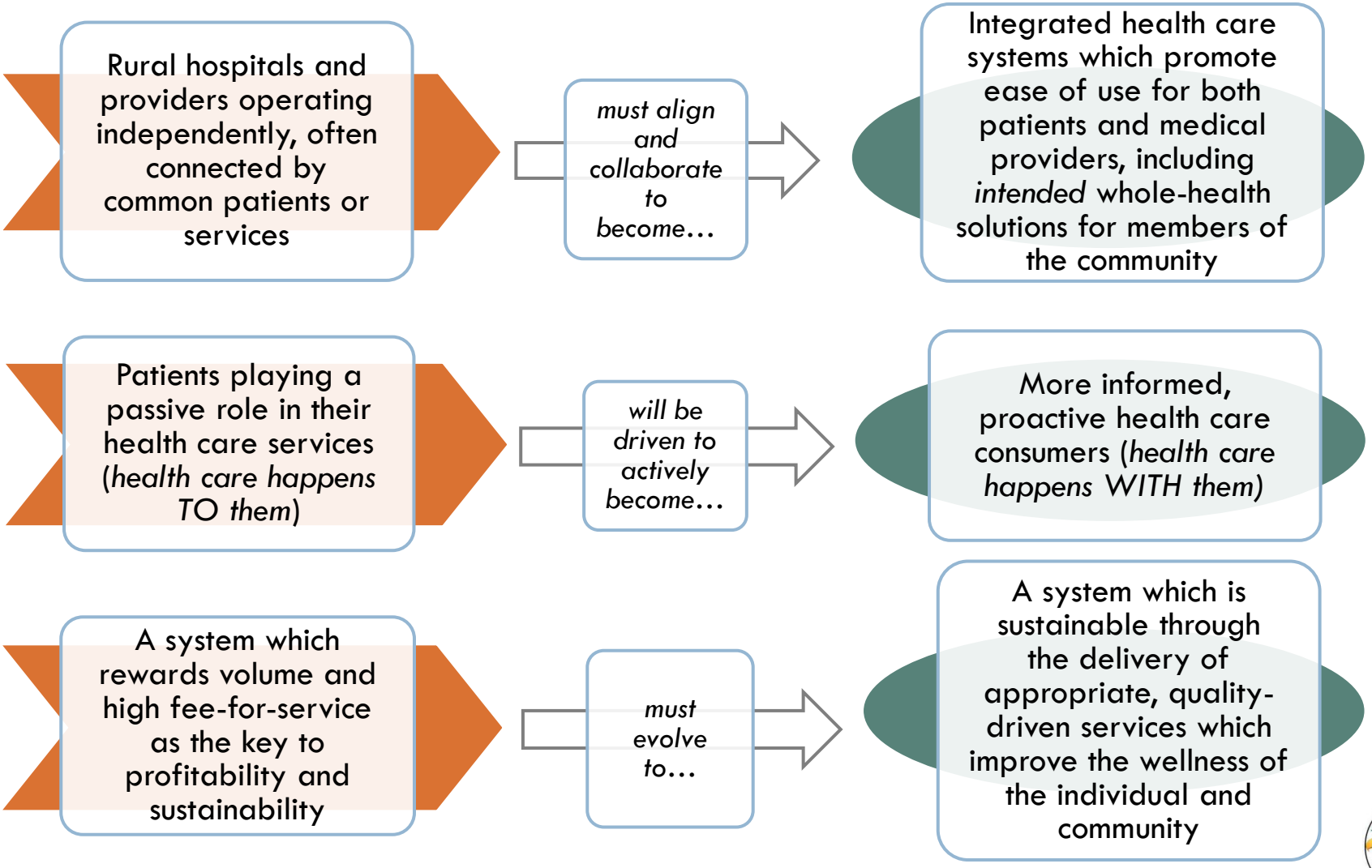
Rural health care models in the future will be dependent upon clinical integration of providers: hospitals, physicians, and the medical community.

- Achieves savings through economies of scale
- Allows adoption of standards of practice
- Allows sharing of best practices
- Builds sustainability through collaborated strategic planning
- Promotes a whole-health approach for individuals and the community
- Promotes the capture of lost market share due to outmigration

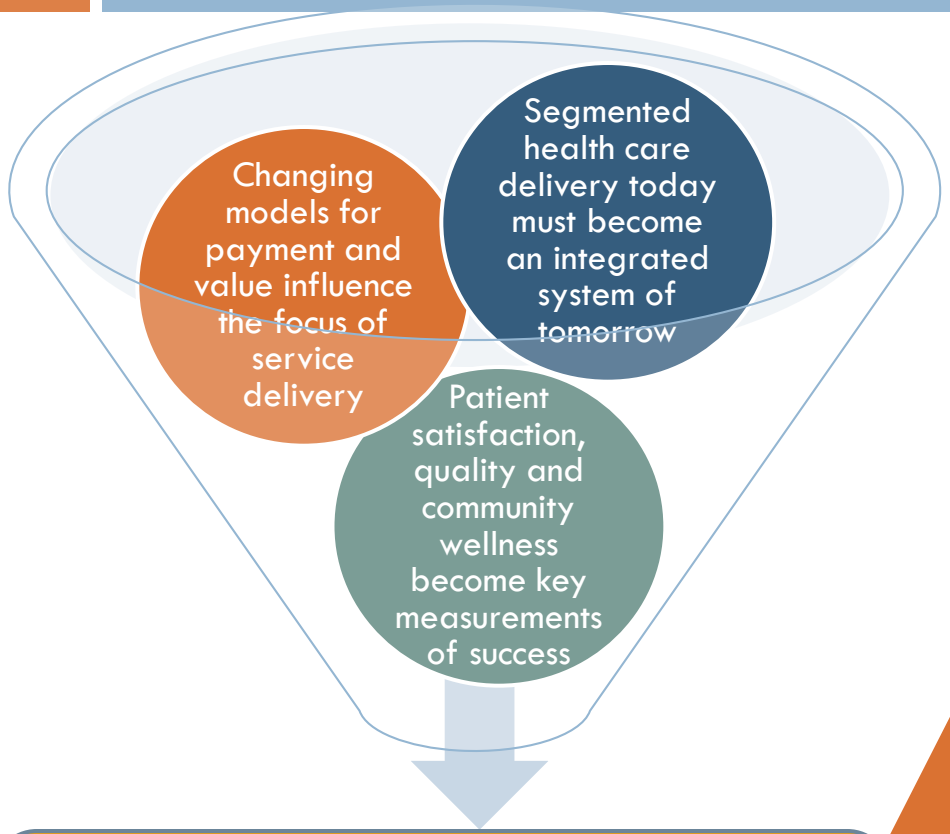
Three Key Learnings…what's next?

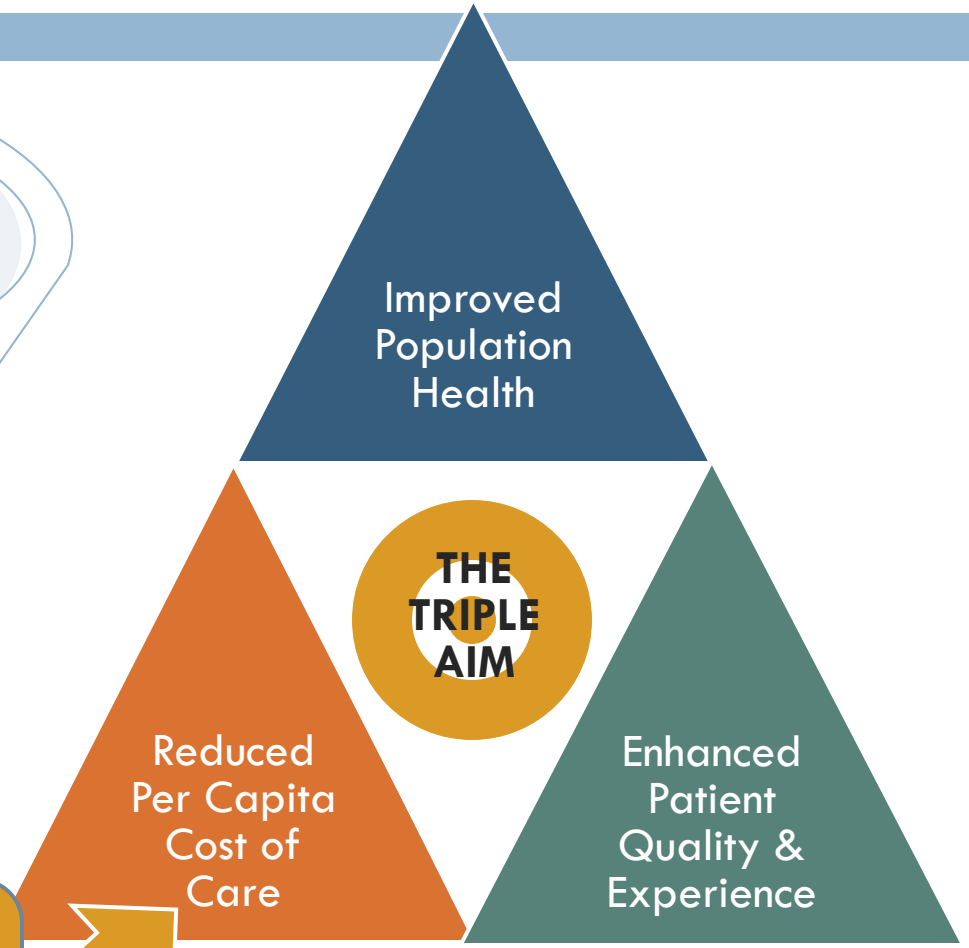


Transforming rural health care



Transforming rural health care



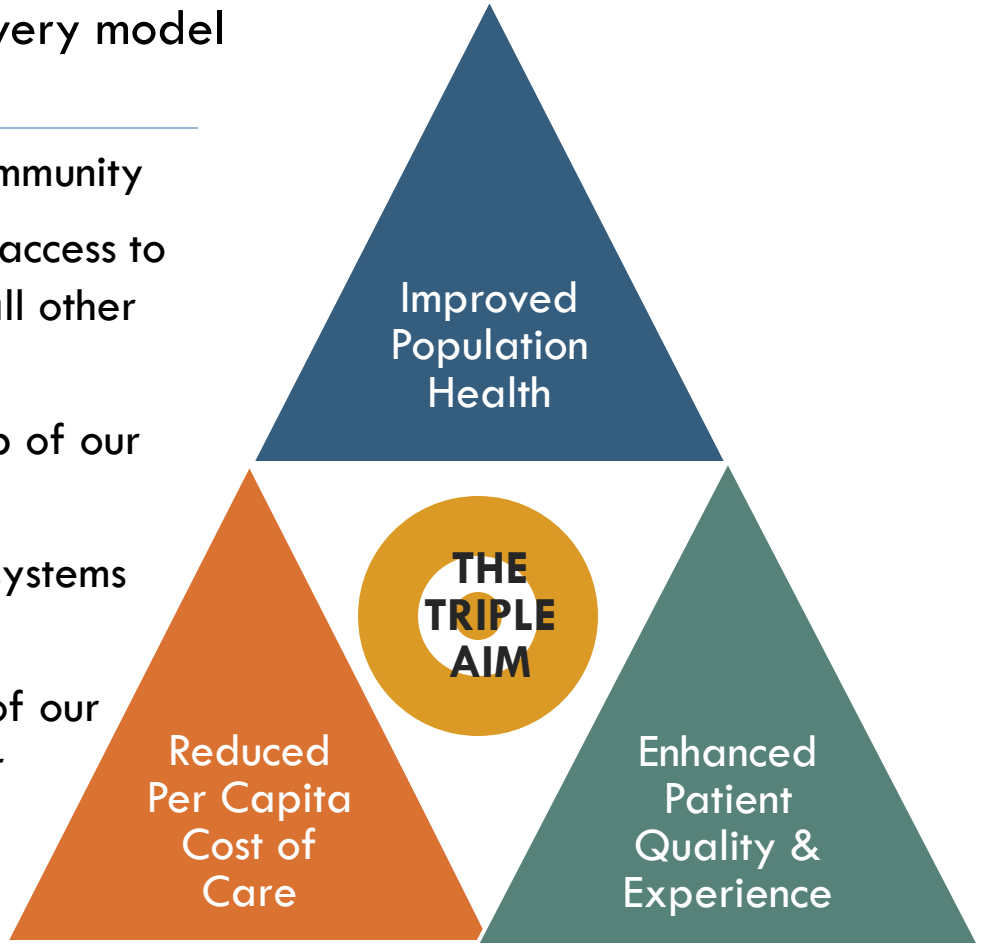


To be sustainable going forward, rural health care providers and systems, including ours on the peninsula, will need to evolve and transform.

Hitting the target: the "Triple Aim"

A sustainable, integrated health care delivery model must offer care which is:

- **Affordable**: to patients, payers and the community
- **Accessible**: provides local and near-home access to essential services, which are connected to all other services across the continuum
- **High Quality**: ensures we deliver at the top of our ability, every experience, every time
- **Integrated:** Values medical providers and systems working together to serve the community
- **Community-based:** focuses on the needs of our communities, both individually and together
- **Patient-centered:** keeps patients at the core of our delivery model, and engages them about their care



Summing it up

The experts and peer organizations attending the conference had clear messages about the future of rural healthcare delivery.

While no two rural health systems are the same, many of the case studies and examples shared at the conference had significant relevance to our health care environment on the peninsula.

Summing it up

"True heath care reform cannot happen in Washington. It has to happen in our kitchens, in our homes, in our communities. All health care is personal."

-Dr. Mehmet Oz

Questions?