Sonoma Valley Hospital

September 17, 2018

Prepared by:

Regulatory, Risk, Compliance Specialists, Inc.

R.R.C.S.

WIPFLI

WIPFLI LLP

CPAs and Consultants

Sonoma Valley Hospital
Skilled Nursing Facility Analysis

Background

On July 25, 2018, senior leadership at Sonoma Valley Hospital (SVH) released a report of the reimbursement, costs of services and recent trends in patient days and volumes of the distinct part skilled nursing facility (SNF). This report revealed a worsening performance with a projected loss for FY 2019 of $879,900. To stabilize the finances of the hospital and restructure for the future, a recommendation was made to close the SNF service line by September 30, 2018. Due to the impact of this important decision on the community, the SVH Board approved at the August 2018 meeting, the formation of a task force that will make a recommendation on the financial viability and future of the hospital's SNF. The mission of the SNF task force was to identify and recommend opportunities to improve the financial performance of the hospital's SNF to the point that it will sustainably be a positive contributor to overhead, or, recommend closure of the unit in a reasonable amount of time. The task force was asked to provide at least an interim report to the Board no later than the October 4th (or, during a special board meeting arranged around that time). Board member, Jane Hirsch and Chief Financial Officer, Ken Jensen notified Regulatory, Risk, Compliance Specialists, Inc. (RRCS) in affiliation with WIPFLI, LLC to assist with a financial and operational information validation and evaluation

Service Scope

The Scope of Service was determined with Jane Hirsch and Ken Jensen to assist the SNF task force to answer the following questions:

- Can the profitability estimates and projections contained in the Closure Recommendation be validated?
- What is causing the decline in patient numbers? Are there sustainable ways to increase the census?
- Are there strong, implementable and sustainable ways to improve occupancy and profitability to the unit?
- Can an evaluation of the SNF alternatives in the Valley be performed? Do they have capacity to absorb our patients? Is their quality similar?

Senior leadership approved the proposal from RRCS Inc. in affiliation with WIPFLI for the submission of a report that contained the following:

- Documentation of the clinical, and reimbursement findings for the SNF, as well as any recommendations addressing identified issues
- Validation of the profitability estimates and projections contained in the Closure Recommendations report
- Contributing factors to the decline in acute and SNF ADC with recommendations for causal findings
- Recommendations for improvement of occupancy and profitability of the SNF
- Demographic analysis on alternative SNF facilities in Sonoma Valley with recommendations for use.

Service Approach

Stakeholder Meetings

Stakeholder meetings were conducted on site and via telephone interviews to assess processes for cost allocation, case management, referrals to and from the hospital and SNF, resource utilization, strategic plan for hospital and SNF, marketing efforts and plan for hospital and SNF. Community member's perspective. The following individuals participated in these meetings.

Kelly Mather, CEO
Jane Hirsch, Chair SNF Task Force- Board Member
Peter Horhorst, Board Member
David Streeter, MD
Sabrina Kidd, MD
Dennis Verducci, MD
Brian Sebastian, MD
Ken Jensen, CFO
Sarah Dungan, SVH Finance
Cynthia L. Denton, Director, Admitting & PFS/admissions
Mike LaMattina, Independent Cost Report Preparer
Mark Kobe, CNO
Michelle Donaldson, SVH Strategy
Leslie Lovejoy, Director of Case Management
Susan Idell and Maggie Haywood, Community Members
Melissa Evans SNF Nursing Director
Lauren Denning MDS Coordinator
Marisol, Intake Coordinator SNF
Bob Kenney, Director of Marketing
Celia Kruse de la Rosa, Community Relations
Chris Gallo, Rehabilitation Therapy Manager
Kimberly Drummond, Director of Facilities/EVS

MDS/RUG Audit

An assessment of SNF billing processes was provided starting with a "probe sample" employing the RATS-STATS statistical methodology to randomly select 15 UB-04s. A sampling of 10 Medicare and 5 Medicaid paid claims for the past 12 months that included July 2017 to June 2018 were selected. The 10 Medicare selected UB-04s were reviewed with corresponding remittance advices, MDS assessments, validation reports along with interviews of SNF Director, MDS Coordinator, and staff from billing, admitting, inpatient and SNF case management.

Utilizing the audit tools, RRCS & WIPFLI focused its reviews in the following areas for the Medicare claims: ARD accuracy, using the look-back period, checking the ADL accuracy, special treatments and procedures accuracy, and restorative nursing accuracy;

- Determination of medical necessity for Medicare and Medi-Cal eligibility for services rendered;

- Accuracy of the UB-04 for the coverage period, the revenue codes, and the units of service;
- Review the billing office systems for capturing all data in a timely and efficient manner;
- Review the business office policies and procedures for appropriate guidance with identified practices.

The 5 Medi-Cal claims were reviewed by RRCS/WIPFLI to ensure that processes were in place to attempt to collect the share of cost, and that they had documentation showing there was continued and appropriate follow-up to collect.

Document Review and Analysis

The following documents were requested and provided to the consultant team for review and analysis:

- Cost Report that includes both acute and SNF for prior 4 years 2013-2017
- Profit & Loss Statements for both acute and SNF for prior 4 years 2013-2017 to include payor mix breakdown
- Patient Days for acute for prior 4 years 2013-2017
- RUG's Report for Medicare Reimbursement 2013-2017
- A current Detailed Aged Trial Balance
- Marketing Plan and Materials for SNF
- Staffing Matrix for SNF
- Summary of Commercial Pay Contracts for SNF
- SNF Closure Recommendations Document

Findings

Clinical and Reimbursement Review

The following is a summary of all claims reviewed and attached (Exhibits 1 and 2). It should be noted that many of the recommendations that were provided in our consultation of 2014 had been implemented as evidenced by the discontinuance of the previous practice of many diagnostic services provided in the distinct part SNF on a daily basis (e.g., Lab/Chemistry, Lab/Hematology, Lab/Immunology, Lab/Bact-Micro, Lab/Urology, Pulmonary Function and X-ray).

Only a few of the diagnosis codes on the claims matched on the UB-04 and the MDS, it was noted the MDS Coordinator utilizes the History & Physical, discharge summary and physician progress notes for diagnosis on MDS. She previously did not have access to the *I window* (Medical Records coder's notation of dx codes) until two months ago. The medications that are currently being administered are predominantly antibiotics and normal saline flushes, which is an indicator of inaccuracy. The MDS Coordinator should review the MR MAR and assess the resident along with conversations with caregivers to raise the accuracy of data.

The overall error rate was 6.79%, the OIG recommendation for facilities with a financial error rate of greater that 5% is to conduct a full sample, Stage 2, review. This is accomplished by using the RATS-STATS to ensure that a statistically significant "full sample" of UB-04s is randomly selected from the universe of paid UB-04s. The sample should contain a sufficient number sampling unit to

generate results that provide, at a minimum, a 90 percent confidence interval. Based on the larger, statistical significant full sample analyses, calculate the dollar amounts designated as overpaid relative to the amounts that were actually paid. Improving this error rate would put SVH in line with parameters set by OIG.

The therapy department has experienced continuous turnover, lack of therapy staff experienced in SNF rehabilitation and use of agency staff to fill positions. Examination of a recent Rehab Minutes report provided by the SNF MDS Coordinator reveals numerous gaps in targeted RUG levels and total minutes met. This was also noted in the audit results of the medical records. There are noted inefficiencies in the ability to meet all of the targeted required minutes for rehab and occupational health therapies. Declining LOS can be partially attributed to lack of needed rehab therapies; the lack of required staff often causes a downgrading of the RUG. Only 3 of the 10 claims showed that therapy frequency was provided as ordered by the physician. The 7 claims that did not provide the ordered frequency ended up being paid at a lower RUG rate. The use of a therapy company skilled in understanding and providing the appropriate amount of therapy would improve efficiency and cause the hospital to incur cost only when it will be reimbursed.

The nursing hours per patient days (ppd) are more in alignment with acute staffing needs and not for a skilled nursing unit. This was discussed with the Nursing Director and the Staffing Matrix was reviewed reflecting direct care of 2.0 – 2.5 RNs/12 hour shift for a census between 20-22 patients (Exhibit 3). A comparison of direct care hours ppd to the other two skilled nursing facilities in Sonoma per Medicare Compare is attached (Exhibit 4). Staffing for the weekend of 8/11 – 8/12/18 was randomly selected for review. The census was 24, and there were three (3) RNs and three (3) CNAs and a unit secretary for 6 hours on the day shift. (Secretary only works 6 hours on the weekend days). There were two (2) RNs and three (3) CNAs on the night shift. There is not an Intake coordinator, MDS nurse, or activities person on the weekend. The direct care hours ppd was 5.75 (Exhibit 5) and revealed a flex budget of 5.98. It appears that includes indirect hours for manager, MDS Coordinator and Activity Coordinator. However, per verbal report from manager, this includes the Intake Coordinator, as well. Operating closer to the staffing level of the freestanding facilities would improve efficiency and profitability.

Verbal justification given was requirement for scope of practice coverage for patients in need of IV medication and IV management. A request for pharmacy data showing the frequency of IV medication utilization was made and the Nursing Director followed through with obtaining this data which was presented to RRCS prior to end of the site visit. Findings of this report do not support the need for two direct care RNs on duty at all times. It is noted that the RNs are cross-trained and utilized between the acute care and skilled nursing units. Floating and sharing of staff has an opportunity for further optimization through innovative planning.

Validation of Profitability Projections Contained in the Closure Recommendation

We reviewed the Closure Recommendation report in conjunction with various reports noted above, a phone interview with SVH management and subsequent data sent via email. The reported figures appear accurate, and even somewhat conservative in nature.

To validate revenues, we input the RUG summaries for 2016 through 2018 provided by SVH into the RUG calculator provided by CMS. While 2017 and 2018 were somewhat consistent, there was a significant drop in Medicare patient days from 2016 to 2017 (10%), as well as average Medicare payment per day (10%), which caused a decrease in net revenue of approximately $600k. The primary culprit was the decrease in category "RUC" days (346 to 11) and category "RVC" days (522 to 256). The average payment for these RUG categories is $850 per day. Some other rehab RUG categories increased, but they average $650 per day and most medical RUG days average $500 per day. There was also a decrease in Total patient days of (10%), which caused an additional estimated decrease in net revenue of $100k based on an assumed net revenue of $500 per day.

To validate expenses, we had SVH management provide a detailed breakdown of how expenses were derived. The methodology was clear, and we traced figures back to various source documents. The incorporation of non-nursing costs (e.g., professional fees, rehab services, etc.) was thoughtful as it utilized several different methodologies (e.g., charges, procedure codes, units of services, etc.) depending on services provided to the patient. The Closure Recommendation also acknowledges potential savings of overhead, which we believe are conservative as they only address non-labor portions of Dietary, Laundry, Environmental Services, Pharmacy, various purchased services and licensing. We believe there would also be a labor component to the Dietary, Laundry and Environmental Services departments, as well.

If closing the SNF is the chosen option, then structured referral process for appropriate placement (eg. use of clinical guidelines and formal discharge criteria to appropriate level of service) needs to be achieved. The closure could be messaged as a transition of SNF service to Broadway Villa and/or Sonoma Post-Acute and arrange for a designated number of beds available at all times to SVH at either or both of these facilities. Case management vigilance will be necessary to control the rise of avoidable days. Manage avoidable readmissions to acute; recommend utilizing a transitional care management program, which may include daily rounding by a qualified licensed RN that works in partnership with the Chief Hospitalist. Consider assisting with affiliated facility (eg. Broadway Villa) competency education and use of clinical pathways to ensure early condition change and symptom management. Consider use of the "Interact" Program Tools to assist with this effort.

If SVH's decision is to close the SNF and have predominate operations be emergency and ambulatory services, then it is imperative that a strategic analysis be performed that includes the likelihood of SVH ability to achieve commercial contracts for value-based payments or if survival of the operation can exist on government reimbursement (also becoming value based) moving into the future.

Evaluate community healthcare delivery partners for affiliation opportunities that position SVH for value-based payment success. Downsizing SVH clinical delivery operations alone will not position the organization for survival with future value-based payment models. Though decreasing use of Skilled Level Care and using more cost effective delivery is in CMS's plan, other structure needs to be in place to ensure that overall Medicare costs are reduced. The organizations that will do well into the future will ensure effective/timely primary care access, integrated I.T. platforms that can track the lives of patients within the delivery system of care, effective health management of the populations served, cost-effective continuum of

care management, and real time data analytics. Consideration needs to be made on how SVH can effectively partner vs. remain independent to achieve these metrics moving forward. Further development of ambulatory practice prevention/wellness and other population health management will be essential for future success.

Contributing Factors for Declining Acute and SNF ADC

While we did not see declining ADC, we did see a significant change in patient and RUG mix in the SNF. Beyond the issue of therapy provision noted earlier, examination of the SNF Attending/Dx Report of Jan 2015-June of 2018 (Exhibit 6) reflects a correlative decline in the population mix transferred from acute to skilled level care. There is a notable decline in aftercare for orthopedic type diagnostic patients from 76% of total SNF admission in 2015 to 29% in 2018 thus far. Correlating is a noted drop off of some referring physicians for orthopedic type related patients by 2017. All admissions data reflects a predominance in referrals by hospitalist staff with the Chief Hospitalist, the SNF Hospitalist admitting the highest volume. Current SNF Admission Criteria is very broad and admitting to DRG code 951 (other factors influencing health status) is higher in 2018 compared to previous years. Refer to formulated SNF Admits 4yr Trend Report for added detail (Exhibit 7). Interview with Chief Hospitalist did disclose the desired practice by the hospitalist team to admit the fragile medical patients to the SNF vs. transfer to Broadway Villa.

Also shared was the great concern regarding impact of CMS reimbursement changes for elective orthopedic patients with payment for these cases only as an outpatient status of 23 hour stay. The result being the small number of patients that will stay in the hospital. The hospitalists currently provide critical care to patients to the extent of intubation and central lines, with the more complex patients being admitted to Queen of the Valley, Marin General and the Santa Rosa Sutter Hospitals.

Recommendations of Improved Occupancy and Profitability

Occupancy could be improved with new services at the hospital that naturally require long LOSs and/or rehabilitation. Another option would be to contract with area hospitals that do not have their own SNFs, and promote the fact that SVH's staff is better-trained than local area SNFs.

SVH could consider keeping the SNF open and adjust operating expenses to make it viable. As noted in the Clinical and Reimbursement Findings, SVH could reduce direct patient care and therapy staffing. For instance, using the most recent (2017) Medicare Cost Report, the SNF shows 8.9 nursing hours ppd (WS S-3, Pt II, Ln 9 = 58,166 hours / 365 / ADC of 18 = 8.85). If that were lowered to 4.5, assuming the same mix of RN/LVN/CNA, the cost savings could be $1.2M (4.5 / 8.9 x $2.37M of SNF labor), which does not include benefits. Proximity to acute care staff, union contracts, etc. may all be factors in the achievability of these results.

According to the SNF Financial and Key Therapy Metric report provided by SVH, productive in-house therapy staffing for 2019 is averaging 4.31 FTEs, or 1,494 hours for July and August. Based on the rehab RUG activity for those same months, and assuming max minutes for each category, the overall acuity required 1,033 hours. The 2017 OSHPD report shows an average hourly rate for all therapies is $41 ($1.52M / 37,252 hours), so the reduction in cost could approximate $110k per year, again excluding

benefits.. This staffing level may be difficult with varying occupancy and need, so use of an outside contractor would insure that expense is incurred only when there is the ability to charge for it.

SVH could also consider a designated SNF rehabilitation therapist delivery operation to promote more effective utilization of a team approach to care. Perform real time RUG target minute evaluation using process improvement activities that includes the MDS Coordinator, SNF and Rehab staff. Mobilize needed resources in a timely manner to achieve targeted patient goals for therapy, maximize use of interdisciplinary team. Consider Rehab/Nursing dyad teams to facilitate coordination of rehab care. Utilize existing white boards to communicate scheduled therapy times individualized toward the patient plan of care. Explore unutilized space in close proximity to the SNF unit to relocate rehab equipment such as stairs and other items. As noted in the Clinical and Reimbursement Findings, provision of prescribed therapy minutes could improve revenues, especially if the sample is representative of the whole SNF.

Demographic Analysis of Alternative SNF Facilities

If SVH's decision is to close the SNF, there would be available beds at other SNFs within the community. We used the OSHPD financial data pivot because the agency requires consistent reporting by all facilities. We isolated all facilities in the town of Sonoma, then downloaded their report full reports and input the data into our report (Exhibit 8). Some of the numbers are reported in a per patient day (ppd) format to allow for comparisons between facilities with different counts.

There were three facilities in Sonoma, and they varied in number of beds (32, 83 and 144) and patient mix (mostly Medi-Cal, mostly Managed Care and all Private Pay). There were many more comparable facilities in towns like Petaluma and Santa Rosa, but the scope of this analysis was specific to Sonoma. They were only compared to each other because they are self-contained facilities, while SVH's SNF is a department of the hospital and shares overhead costs with other departments. Below are some observations on statistics that were able to be compared:

- While the number of beds is dramatically different (27 at SVH vs 83 avg), the occupancy was fairly close at 85%, which correlates to at least 40 open beds at any given time. SVH averages about 18 patients at any given time, so these facilities could absorb the additional patients from the SVH SNF closure.
- SVH's Medicare utilization in the SNF is approximately 60%, which correlates to approximately 12 patients per day, and would effectively double the Medicare patients at other local SNFs. This would likely represent a positive impact for those SNFs as Medicare often reimburses higher than every other payer.

Though quality of care appears acceptable at the other SNFs (no recent citations), physician visits would be limited to once/weekly and risk of acute readmission would be high. Additional opinions were expressed regarding the quality of care at the outside skilled nursing facilities as poor and very concerned and opposed to closure of the SNF. By transferring this patient population to the SNF the physicians are able to assess patients daily and be close to respond to any subtle change in patient condition. This practice has led to the decrease of avoidable days and rehospitalization rates.

Other Considerations

Meetings were also conducted to clarify the seismic requirements for the hospital and its potential impact on the decision to close the SNF, upon confirmation with the Director of Facilities/EVS, the East Wing which includes the SNF, Rehab area, IT, Medical Records, Dietary departments meets the 2030 SPC (structural) codes however does not meet the non-structural codes that are the requirements for bracing of equipment. The West Wing will not meet structural requirements, however, it was noted this would be in effect until 2040 with the current regulatory enforcement environment.

Results of interviews revealed community members and physician's great concern and understanding of the parcel tax was to support all the hospital services to include the SNF with the priority being to maintain the emergency department. Verification of the Board's rationale for the parcel tax was noted in the minutes of the Sonoma Valley Health Care District Board of Directors special session meeting on March 9, 2017 (Exhibit 9). The Board voted the parcel tax measure to be placed on the ballot for the election of June 6, 2017. The purpose of the parcel tax of $250 per parcel for five (5) years is

> "*to supplement State and Federal insurance payments which are below the cost of providing hospital services in order to ensure continued local access to hospital emergency room care, acute hospital care, and other hospital services for residents of the District and visitors to the area. The parcel tax will not be used for capital improvements other than improvements made in connection with the day-to-day operational needs of the District.*"

It would appear as in other District Parcel Tax allocations that SVH has discretion on how to spend the monies, however, the decision to keep the emergency department is a key strategy for providing a vital service to the community. The continuance of the SNF would be a strategic public relations benefit.

Conclusion

The goal of this project was to assist SVH senior leadership in making an informed decision regarding the closure of the SNF. We have addressed the questions posed by the SNF task force with findings and possible corrective actions where appropriate. Closure of the SNF as it currently operates appears to remove more cost than revenue, thereby saving SVH money. However, operating the SNF differently (e.g., correcting error rates, billing issues and staffing for nursing and therapies) has the potential of making the SNF profitable. Closure is more expeditious and conclusive in its benefits, while changing SNF operations would take time and success is not guaranteed. We hope you find this report helpful in your decision-making process.