Rural Hospital Performance Improvement

North Sunflower County Hospital

Ruleville, Mississippi

July 2003

What Was Needed

- Business Office Review
- AR Analysis
- Clinical Services Evaluation
- Core Services Planning
- Market Analysis
- Expense Containment
- Service Area Description
- Staff Satisfaction Assessment
- Assessment of Physician's Perspective
- Assessment of Rural Health Clinic Potential

What Was Done

- Applied for and received RHPI Grant
- Initial teleconference screening
- Preliminary (volumes of!) data submitted
- Two-Day Onsite by team of CPA, RN and MBA talents
- Analysis and Summary of Data
- Discussion of Initial Report
- Final Summary Report

The Product

- Presented at the strategic planning retreat in July 2003, the first of its kind in the history of North Sunflower County Hospital

North Sunflower County Hospital

Performance Improvement Report

Conducted: May 30, 2002
Reported: July 17, 2002

FINAL REPORT

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Report Overview

- Purpose of Engagement
- Approach and Methodology
- Themes
- Detailed Analysis, Findings and Recommendations
  - Market/Service Area
  - Programs of Service
  - Financial/Reimbursement
  - Financial/Expense Management
  - Practice Management
  - Organizational Architecture
- Conclusions/Next Steps

Key Findings and Recommendations

Key Findings and Recommendations (1)

- **Market/Service Area**
  - NSCH has a tightly circumscribed market area, with Ruleville contributing a majority of admissions
  - NSCH captures a high market share in Ruleville (49%) but has a dramatically lower market share in all other zip codes in its vicinity
  - Declining population and the potential for declining use rates suggest that inpatient utilization may continue to decline on an overall service area basis
  - In order to increase NSCH utilization, NSCH must recapture market share, with limited opportunities for incremental growth from outside its core market base
- **Programs of Service**
  - Inpatient Services
    - Address issues related to primary care as the basis for addressing community needs and supporting any program development activities that might be considered
    - Invest in hospital staff expertise and equipment to preserve or enhance current levels of inpatient service capabilities (e.g., equipment in lab, radiology, CT Scanner, etc.)
    - Encourage utilization of Swing Bed status for appropriate Medicare patients
    - RECOMMENDATIONS RE: CDU AND SENIOR CARE DEPEND ON CAH FEASIBILITY STUDY (Pending)

Key Findings and Recommendations (2)

- **Programs of Service –continued**
  - **Nursing Facility**
    - Explore opportunities to expand Nursing Facility significantly via the CON process
    - In the more likely case that CON will not be possible, continue to expand incrementally as rapidly as regulation permits
  - **Obstetrics**
    - Regional OB services are in disarray
    - Limited OB access likely to cause women to seek delivery services in Emergency Department setting
      - Assess and address ED obstetric capabilities
    - Efforts related to OB should focus on promoting pre/postnatal care services at the hospital/clinic in conjunction with established area providers (e.g. in Cleveland and/or Indianola, County Health Department, etc.)
  - **Outpatient Services**
    - General
      - Strength in outpatient services is vital to the hospital
      - Focus investment on the enhancement of capabilities, facilities and systems of care which encourage and support the convenient delivery of outpatient services
    - Surgery
      - Support and facilitate enhanced services in endoscopy, minor surgery, surgical consultations and clinic services
      - Do not invest to revitalize broader surgical capabilities in the OR

Key Findings and Recommendations (3)

- **Programs of Service –continued**
  - **Outpatient Services - continued**
    - Rehabilitation Services
      - Actively work with current vendor to expand rehab services
      - Assess vendor contract to optimize incentives to develop the service and share financial benefits
      - Monitor volumes of service for potential to bring service in-house
    - Emergency
      - Rural communities value Emergency services highest of all services offered by small rural hospitals
      - Visits have generally increased over past three years and appear flat in current year to date
      - Provider staffing of ED drawn from hospital's clinic is very disruptive to operations of clinic
        - Enhanced function of clinic should be identified as a priority
      - Seek opportunities to better leverage ED nurse staffing
      - Continued credibility as an Emergency provider likely will require on-site, 24/7 (on-call) access to CT scanning and interpretations
    - Laboratory
      - Laboratory equipment is overdue for replacement, particularly coagulation and hematology instruments
      - Seek opportunities to grow lab volume (e.g., to nursing homes) though aggressive pricing and excellent customer service

Key Findings and Recommendations (4)

- **Programs of Service –continued**
  - **Outpatient Services -continued**
    - Radiology
      - Significant investment in radiology equipment will be required to maintain satisfactory levels of service
      - CT Scanning is increasingly viewed as a basic level of service in the emergency setting and opportunities for providing this service merit focused, near term consideration
      - Mammography represents a new service which, if well implemented, may attract a broader population back to the hospital
      - All radiology equipment acquisitions should be considered in light of the need to be positioned to participate in teleradiology
  - **Physician Complement**
    - Access and stability in primary care services are critical to both meeting the community's needs and enhancing hospital performance, and should be recognized as a high priority
    - The role of hospital sponsored clinics should be re-directed to emphasize development of the primary care practice
    - Clinic operations should be adjusted to appeal to a broader population base, with specific emphasis on more affluent, employed populations
    - Recruitment in primary care should target 1 FTE physician this year

Key Findings and Recommendations (5)

- **Programs of Service –continued**
  - **Physician Complement -continued**
    - Near term initiatives geared toward addressing specialty needs should be secondary to efforts to enhance primary care
    - Specific opportunities to develop consultant clinics that may arise merit consideration but should not divert a focus on primary care
- Financial Reimbursement
  - Benchmarking
    - Target a reduction in "Days Revenue in Accounts Receivable" from 126 to 68 and begin tracking and charting performance in 2-week intervals
  - Admissions and Collections
    - Assess and reinforce polices and procedures related to point of service collections
    - Consider expanding the hours that business office representatives staff the admissions desk
    - For Medicare patients, front-end collection of 20% co-pay and deductibles must become a priority even if it means subsequently refunding deductible amounts
    - NSCH should develop and take ownership of a policy for writing off accounts and use it to create a more focused and patient friendly means of collecting accounts
    - Begin tracking bad debt write offs as a % of gross charges should immediately
    - Identify multiple collections agencies and request bids from each agency, with an eye toward establishing minimum requirements and intent to contract with multiple agencies

Key Findings and Recommendations (6)

- Financial Reimbursement - continued
  - Admissions and Collections - continued
    - Reprogram the billing system to allow bills to be worked "in-house" for at least 90 days
    - Consider having business office staff more actively involved in billing and collections of the Clinic
    - Begin the process of integrating the business office staff into the billing and collections process of the Home Health service line
    - Separately track Clinic and Home Health Days Revenue in A/R and bad debt expense as a % of gross charges
  - Critical Access Hospital (CAH) Designation
    - Study pending
- Expense Management
  - Expense management is not the number one priority – focus should be on volume growth, revenue generation and improved collection efforts
  - Low capital cost ratios suggest a need to reinvest in plant and equipment
- Practice Management
  - Rural Health Clinic does not maximize its potential value, primarily because it is not managed with the type of expectations, policies and accountabilities generally associated with a privately-owned physician practice
  - Among the chief limitations at the Clinic:
    - Lack of incentives to grow the practice and respond to community needs
    - Low patient visit volumes

Key Findings and Recommendations (7)

- Practice Management – continued
  - Rural Health Clinic is subordinate to NSCH Emergency Department responsibilities for the two NSCH employed physicians
  - Focus priorities and incentives on growing primary care volume, shifting away from provider focus on Emergency and inpatient care
  - Actively promote the clinic to increase awareness of its availability
  - With increased promotion, determine need to increase clinical staffing
  - Begin to schedule and track a maximum number of clinic visits to prepare for increased volumes
  - Encourage hospital business office to provide a more active oversight role over the clinic billing and collection functions
  - Develop and enforce a clearly articulated collections policy that is consistently applied for all patients
  - Institute a sliding fee schedule (see Appendix II)
  - Develop a standardized conversion factor for E&M codes (between $45-$48)
  - Develop a Clinic-specific monthly reporting system that tracks:
    - Expenses
    - Gross Charges and Net patient Revenues
    - Accounts Receivable and Bad Debt
    - Physician Productivity
    - Volume Growth integrating Payer Mix

Key Findings and Recommendations (8)

- Organizational Architecture
  - Decisionmaking and Responsibility
    - NSCH should create a senior management team that is both **held accountable** and **rewarded** for driving improved organizational results
    - Develop departmental operating/financial reports that integrate revenues, expenses and volumes
    - Goal is to use a senior management team effectively and drive accountability down in the organization to the department manager level
    - Restructure Business Office Organizational Chart to bring Business Office manager and CFO onto equal footing
    - Develop monthly departmental and overall organizational performance reports that indicate and chart the direction of the organization. Examples of indicators may include Average Daily Acute Census, Outpatient Visits, ED Visits, Procedure Volumes, etc.
      - An organization measures what it values
      - NSCH should value appropriate volumes of service
    - Use the budget process to create a sense of ownership at the departmental level for both revenue and expense as well as the overall business of the hospital

What We Have Done

- The Final Report serves as a core document for the execution of the Strategic Plan developed at the retreat.
- The Report contains data, assumptions and analyses of dynamic systems and therefore lends itself to ongoing relevance via periodic review
- Several key strategies already implemented

As We Go Forward

- Benchmarks have been established in key areas
- Points of reference serve to anchor future performance measures
- A map is now available to orient and provide context for planning future programs and services
- Synthesis of information heretofore seen as independent