

Garfield County Memorial Hospital

66 North 6th Street Pomeroy, WA 99347-0880

Performance Improvement Assessment



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Garfield County
Hospital District
Caring for Generations 

STROUDWATER ASSOCIATES

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Report Overview

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Executive Summary

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Exec. Summary

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- GCHD is a well-managed organization that has developed an appropriate level of rural health care services in a small market service area
- GCHD is using the Critical Access Hospital status to stabilize and improve its revenues
- Stroudwater's highest priority recommendations are in the following areas:
 - Use interim cost reporting to determine current due to/from Medicare
 - Invest in new chemistry analyzer for the lab and market new services in conjunction with electronic medical record
 - Skilled nursing services ("swing beds") – Develop program that is able to accommodate additional rehab patients and promote program to area hospitals and patients
 - Radiology services – Develop tele-radiology linkages to offset the dependency on one group. Set goal of improved turnaround on stat testing
 - Grow physical therapy department through investment in equipment and staff and promotion of program to area patients, hospitals, and surgical groups
 - Improve performance of Pomeroy Clinic through focused efforts on enhancing patient throughput and provider time seeing patients
 - Renegotiate contracts with third-party payers
 - Improve hospital-wide performance reporting including monthly performance reports to department managers and providers and development of a core set of performance indicators
 - Create linkages between individual performance, hospital performance, and compensation

Purpose of Engagement

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- Two goals:
 - Assess organizational performance improvement opportunities specific to Garfield County Hospital District
 - Areas to review/address include:
 - Market service area
 - Clinical services
 - Physician complement
 - Reimbursement and cash flow
 - Hospital expenses
 - Organizational Architecture and Management Principles
 - Develop a performance improvement framework for other Washington state CAHs
 - This goal is not specifically addressed within this report but will be developed over next 60 days

Approach and Methodology

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- Gather and review pertinent market, clinical service line, and financial data
 - Financial statements and cost reports
 - Current year operating budget
 - Board activity
 - Area demographics
 - Hospital inpatient and outpatient volume
- Conduct an intensive two-day site visit
 - Interview CEO, CFO, Department Managers, Board members, and local primary care provider and nurse practitioner
- Develop Garfield County report and recommendations for validation
 - Review report with CEO and CFO
- Submit final written summary report
- Develop written report to be used as a framework for Washington State CAHs

Background – Financial Status

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• GCHD: Financial Summary

Garfield County Hospital District (Amounts in 000's)

	Year Ended 12/31/1999	Year Ended 12/31/2000	Year Ended 12/31/2001	Unadjusted Year Ended 12/31/2002
Operating Revenue:				
Gross Revenue from ops	\$ 2,146	\$ 2,396	\$ 2,964	\$ 2,989
Less - Deductions from revenue	(290)	(390)	(637)	(134)
Net Patient Revenue	1,856	2,006	2,327	2,855
Plus - Other operating revenue	1,149	813	1,071	405
Hospital Revenue	3,005	2,819	3,398	3,260
Operating Expenses:				
Salaries and wages	1,469	1,589	1,671	-
Pro Fees, Supplies, and other	770	778	778	-
Benefits	311	387	400	-
Depreciation and interest	85	123	108	86
Uncollectible accounts	59	40	70	-
Total Expenses	2,694	2,917	3,027	3,242
Income (loss) from Operations	311	(98)	371	18
Non-Operating Revenue (Expense)	75	106	94	22
Net Surplus (Deficit)	\$ 386	\$ 8	\$ 465	\$ 40
Cash and Investments, End of Period	\$ 401	\$ 203	\$ 714	\$ 914
Accounts Payable & Accrued Liabilities	\$ 493	\$ 456	\$ 642	\$ 309
Days of Operating Cash Available	57.40	26.90	91.47	105.71
Average Payment Period	70.57	60.44	82.25	35.74

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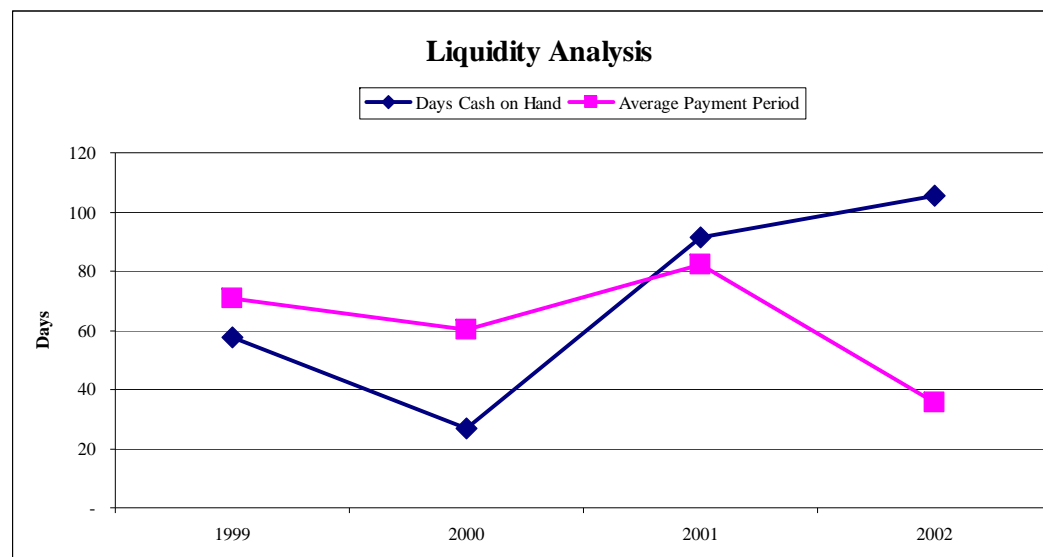
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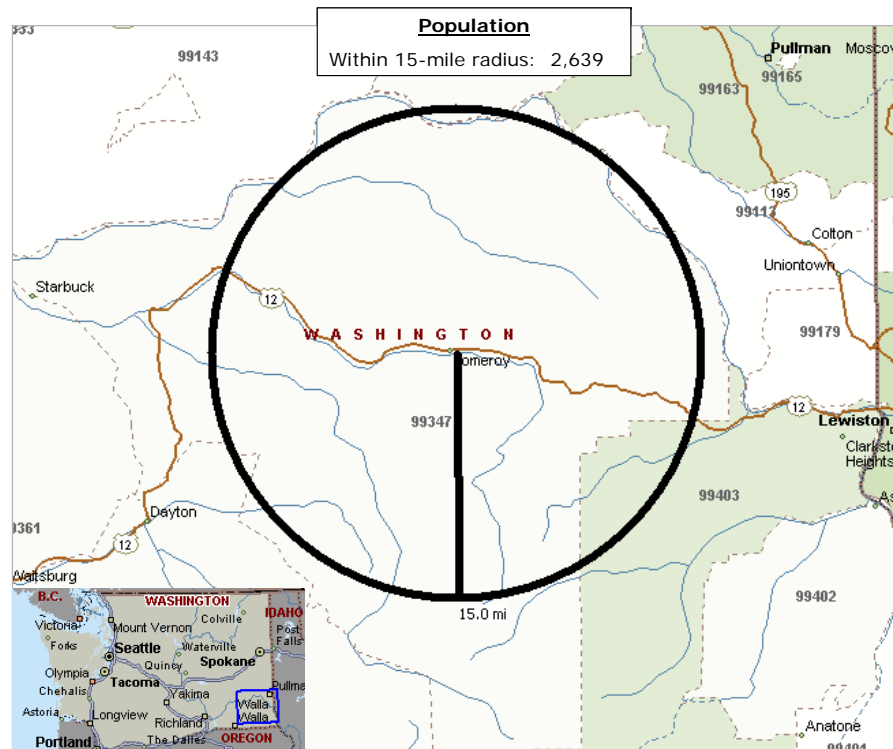
Conclusions

- GCHD: Financial Statement Conclusions
 - Financial statements show trend towards improved financial position
 - Keys have been growth in revenue while holding expenses, as a % of revenue, relatively constant
 - Net patient revenue: 54% growth between 1999 and 2002
 - » 2002 reflects \$400K positive prior period settlements
 - Other operating revenue: 65% decrease between 1999 and 2002
 - » 2002 reflects loss of \$300K State Pro Share revenue
 - Expenses: 20% increase between 1999 and 2002
 - Increased level of Cash and Investments directly related to positive Medicare settlements received during 2002 as well as cumulative effect of positive margins



Market/Service Area

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- GCHD Total Service Area
 - Circled area indicates the total service area based on 15 mile radius from GCHD
 - Covers Pomeroy zip code only
- Population
 - Projected Population for 2005

Age	Population	% of Total
0-14	486	18%
15-24	287	11%
25-44	531	20%
45-54	381	14%
55+	954	36%
Total	2,639	100%

Source: Claritas

Market/Service Area

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- Demographics: Age Characteristics
 - GCHD service area population is significantly skewed towards the older age cohorts relative to state and national averages
 - This represents the primary users of hospital services over the next 15-20 years

Total Service Area Population

Population, Projected 2005						
	0-14	15-24	25-44	45-54	55+	Total
99347	486	287	531	381	954	2,639
Total	486	287	531	381	954	2,639

Population, Projected 2005						
	0-14	15-24	25-44	45-54	55+	Total
99347	18%	11%	20%	14%	36%	100%
GCHD	18%	11%	20%	14%	36%	100%
Comparisons:						
Washington	21%	14%	27%	15%	23%	100%
USA	21%	14%	27%	15%	24%	100%

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- GCHD Surrounding Hospitals (continued)
 - There are 3 hospitals near GCHD
 - Dayton General Hospital, Dayton WA 25 miles to the West
 - 61 beds with an acute census of approximately 3
 - Similar size and services as GCHD
 - Designated as CAH in January 2000
 - Little competition for clinical services
 - Tri State Memorial Hospital, Clarkston WA, 25 miles to the East
 - 41 beds with an acute census of approximately 18
 - Full service secondary care hospital
 - GCHD’s CAH network hospital
 - » May be opportunities to further develop network relationship
 - St. Joseph Regional Medical Center, Lewiston ID, 30 miles to the East
 - 189 beds with an acute census of approximately 87
 - Full service hospital
 - Perception that local residents receive a majority of health care services at St. Joe’s

Market/Service Area

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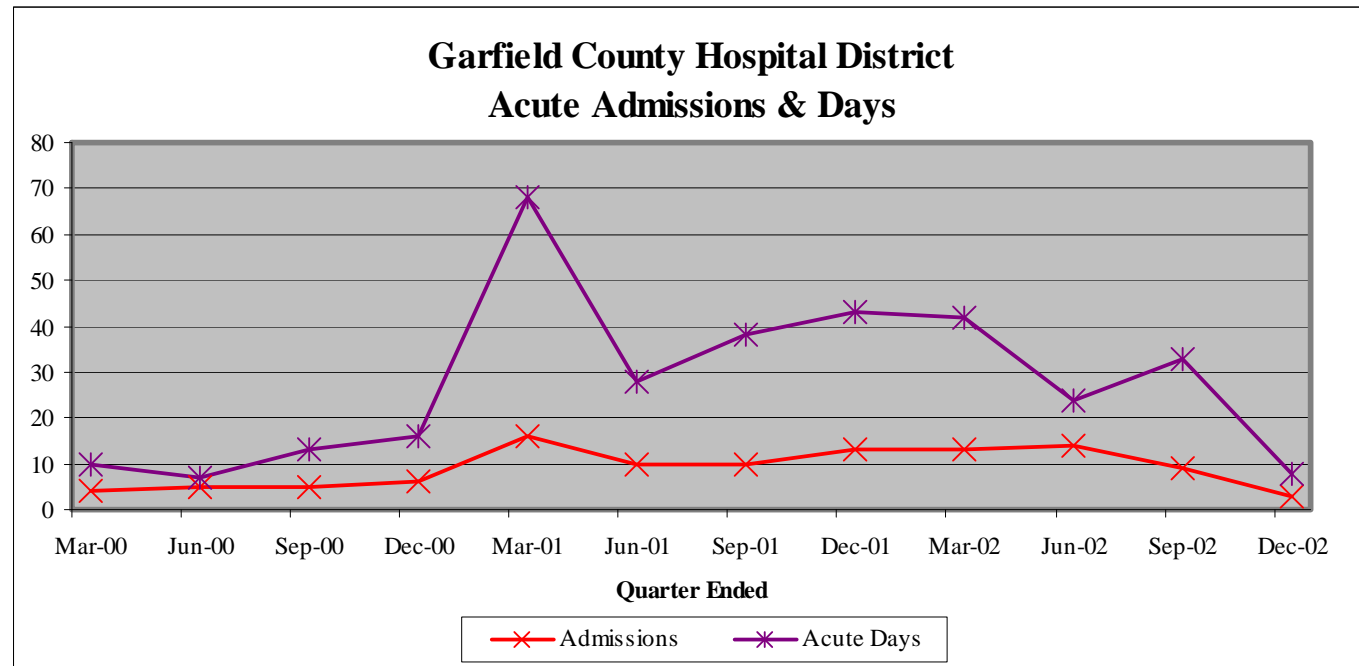
- Conclusions
 - The total service area population of 2,600 provides a very small population base for a small, rural hospital
 - Aged Pomeroy population will require higher level of health care services than average
 - Attracting high % of appropriate health care services to GCHD is essential
 - Although there are other full service hospitals in the surrounding counties, opportunities for growth still remain in the primary service area
 - Further detail in the clinical service section of the report

Clinical Services

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- Inpatient/Long-Term Care Services
 - Findings and Analysis



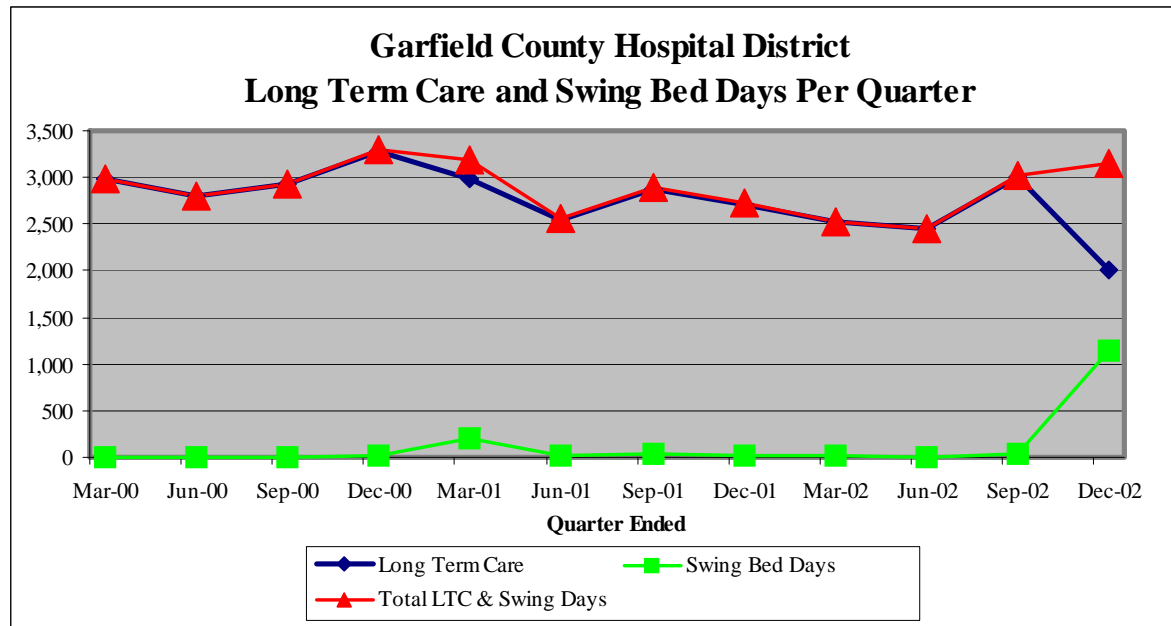
- Inpatient Admissions have not been a focus for GCHD
 - Reported by physician that increasing acute census cannot be supported by current compliment of physician and mid-levels
 - Potential opportunity to discharge sick nursing home patients into acute unit of hospital

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- Inpatient/Long-Term Care Services (continued)
 - Findings and Analysis (continued)



- Long-term care and swing bed services are much more integral to GCHD than acute care and can be supported through current hospital operations
 - Overall census had decreased to approximately 73% before August 2002 prior to a neighboring nursing home closure
 - Since August 2002, census has increased to approximately 97% occupancy
 - Q3 of FY2002, GCHD converted a number of long-term care beds to swing-beds as a means of generating additional Medicare revenue

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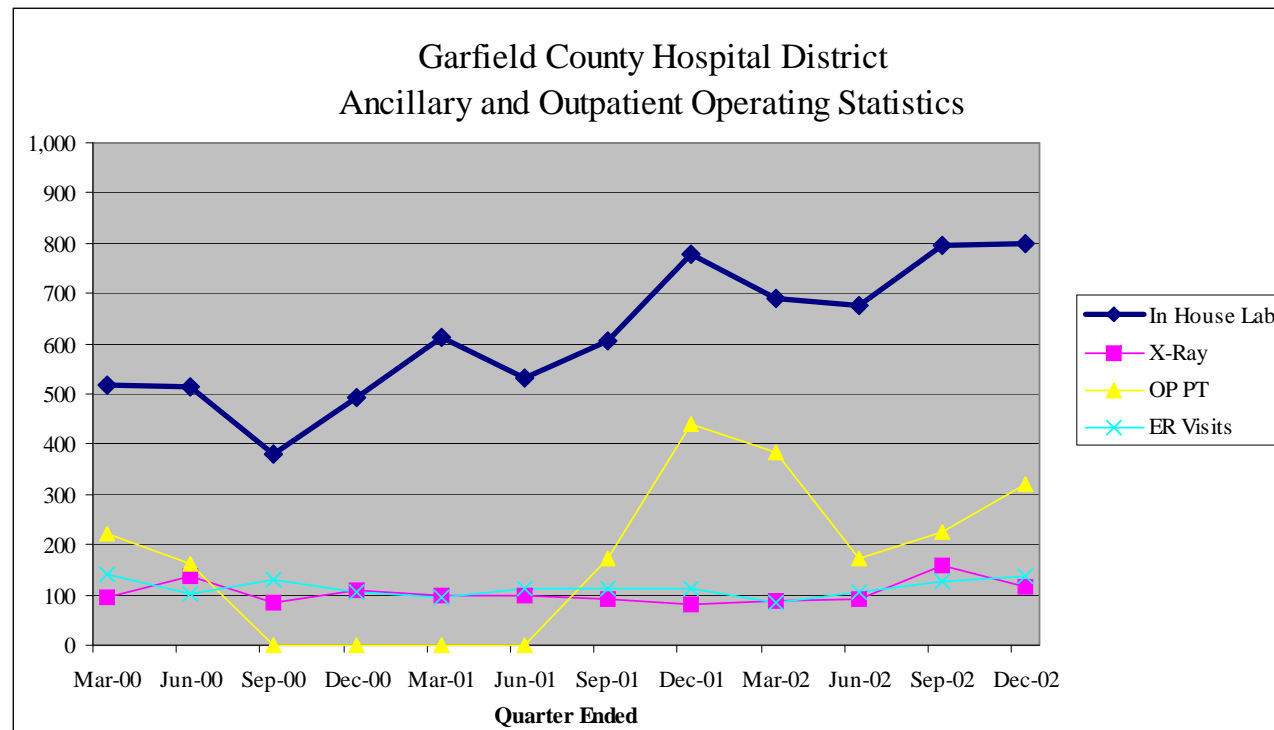
- Inpatient/Long-Term Care Services (continued)
 - Conclusions and Recommendations
 - Develop a clinical process for determining when a nursing home patient should be admitted to the acute unit
 - Continue to develop waiting list of nursing home patients to avoid long-standing vacancies of nursing home beds
 - Work with network hospitals and physicians to refer back to GCHD patients in need of inpatient rehab services

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- Ancillary and Outpatient Services
 - Findings and Analysis



- Primary services offered include plain film X-Ray, moderate complexity lab, physical therapy (PT), and emergency room (ER) services
 - X-Ray and ER volumes have remained relatively stable
 - 60% growth in Lab in last 3 years
 - PT services have varied based on the ability for GCHD to employ quality therapist but in general have grown

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- Ancillary and Outpatient Services (continued)
 - Findings and Analysis (continued)
 - Radiology
 - Department is staffed primarily by one long-term technologist (who also performs most lab tests)
 - » Part-time assistance from business office employee interested in developing clinical skills
 - » GCHD currently recruiting technologist to perform ancillary services
 - » Significant growth in services currently not feasible due to staffing constraints
 - Physician indicates a need for ultrasound at GCHD
 - GCHD is serviced by radiology group at St. Joe's who will only read actual films
 - » GCHD has capability to create digitized images using a scanner - unfortunately radiology group will not read digitized images
 - Laboratory
 - Department staffed by same technologist who services X-Ray
 - » Again, further growth will be hampered by staffing constraints
 - GCHD has evaluated purchasing a new chemistry analyzer that will enable GCHD to increase scope of tests performed locally
 - » Lab tech has prepared analysis indicated fairly rapid payback period on investment
 - » Physician indicates significant demand for new types of services
 - Primary basis for new Electronic Medical Record (EMR) is lab information
 - » Opportunity to promote local lab services as means of managing community patient health through EMR

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- Ancillary and Outpatient Services (continued)
 - Findings and Analysis (continued)
 - Physical Therapy (PT)
 - Department staffing has fluctuated over the past several years leading to varying degrees of quality and volume of services provided
 - Board member, department managers, and physician all indicate high community demand for PT services
 - Orthopedics group in Lewiston keeps patients for rehab while orthopedics group in Colfax refers rehab patients back to GCHD
 - Emergency Room
 - ER provider coverage provided by employed physician and mid levels
 - ER diagnostic tests provided by lab/X-Ray tech who is on-call 24/7
 - » Reportedly receives approximately 15-20 call backs/month
 - Recommendations
 - Radiology
 - Aggressively recruit or internally train new technologist to reduce reliance on one individual
 - Evaluate the financial feasibility of purchasing/leasing new or used ultrasound equipment
 - » Feasibility to include costs associated with tech training, CAH cost based reimbursement, additional inpatient/outpatient services to be generated by keeping patients local, volume of ultrasound tests, etc.
 - Seek new radiologist willing to read digitized images
 - » If necessary, determine if grants available to improve teleradiology capability

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- Ancillary and Outpatient Services (continued)
 - Recommendations (continued)
 - Laboratory
 - Evaluate feasibility of new chemistry analyzer and purchase if prudent
 - Promote local lab services in conjunction with the EMR as a means of managing patient health
 - Physical Therapy (PT)
 - Stabilize PT department staffing
 - Promote outpatient PT services to orthopedics groups in Lewiston
 - » if unwilling to send patients back to Pomeroy for rehab, consider more extensive use of Colfax surgeons
 - Determine whether additional equipment is necessary to increase appearance and performance of PT department
 - Emergency Room
 - None.

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- Physician Complement
 - Findings and Analysis
 - As identified in the market/service area section of the report, the primary service area is estimated at 2,600
 - The following page shows that the primary service area population of 2.6K supports the following Medical Staff complement (shown in FTEs):
 - Approximately 2 Primary Care Physicians
 - The following medical subspecialties 1/2 day per week: Cardiology, Dermatology, Gastroenterology, Oncology
 - The following surgical subspecialties (as indicated):
 - » ENT (1/2 days per week),
 - » General Surgery (1.5 days per week),
 - » Gynecology (1.5 days per week),
 - » Ophthalmology (1/2 day per week),
 - » Orthopedic Surgery (1/2 to 1 day per week), and
 - » Urology (1/2 day per week)
 - Other specialties including 1.3 days per week of psychiatry

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AREA POPULATION	2,600			
Mkt Share Adj Population	2,600			
SPECIALTY	Demand Indicators			Supply Indicator
	GMENAC	Hicks & Glenn	Group Hlth.	AMA Actual
PRIMARY CARE SPECIALTIES	N	N	N	N
FAMILY/GEN PRACTICE	0.9	0.9	1.1	0.7
INTERNAL MEDICINE	0.8	0.5	0.5	1.1
PEDIATRICS	0.4	0.3	0.4	0.5
SUBTOTAL, PRIMARY CARE	2.0	1.7	2.0	2.3
	GMENAC	Hicks & Glenn	Group Hlth.	AMA Actual
MEDICAL SUBSPECIALTIES				
CARDIOLOGY	0.1	0.1	0.1	0.2
DERMATOLOGY	0.1	0.1	0.1	0.1
GASTROENTEROLOGY	0.1	0.0	0.1	0.1
HEM/ONCOLOGY	0.1	0.1	0.1	0.0
	GMENAC	Hicks & Glenn	Group Hlth.	AMA Actual
SURGICAL SPECIALTIES				
ENT	0.1	0.1	0.1	0.1
GENERAL SURGERY	0.3	0.4	0.2	0.4
OB/GYN	0.3	0.3	0.3	0.4
OPHTHALMOLOGY	0.1	0.1	0.1	0.2
ORTHOPEDIC SURGERY	0.2	0.1	0.2	0.2
UROLOGY	0.1	0.1	0.1	0.1
OTHER SPECIALTIES				
PSYCHIATRY	0.3	0.3	0.2	0.4
TOTAL, ALL SPECIALTIES	3.9	3.5	3.8	4.7

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- Physician Complement (continued)
 - Recommendations:
 - With one full time family physician and two full time mid-levels, additional primary care providers are not warranted based on population indicators
 - Opportunities to explore closer linkages with network hospital around specialty clinics should be explored. Specific opportunities include:
 - Pre-natal OB
 - Pediatrics
 - General surgery
 - Orthopedics

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- Physician Practice Management
 - Findings and Analysis:
 - GCHD currently employs one family physician and two mid-level providers at the Pomeroy Clinic (PC)
 - PC designated as a provider-based Rural Health Clinic (RHC)
 - Second Mid level recently hired by GCHD
 - Providers employed under fixed salary agreements
 - Opportunity to consider productivity incentives in provider contracts
 - Significant discussions regarding moving PC from “in-town” to “up on the hospital campus”
 - Portion of community is opposed to the move as PC would be reportedly more difficult to access as well require capital outlays (renovations)
 - Accounting for the clinic is generally consolidated within the hospital general ledger making performance benchmarking difficult
 - Providers receive no performance information
 - Review of charge master relative to the Medicare Resource Based Relativity Scale (RBRVS) indicates charges are reasonable given market

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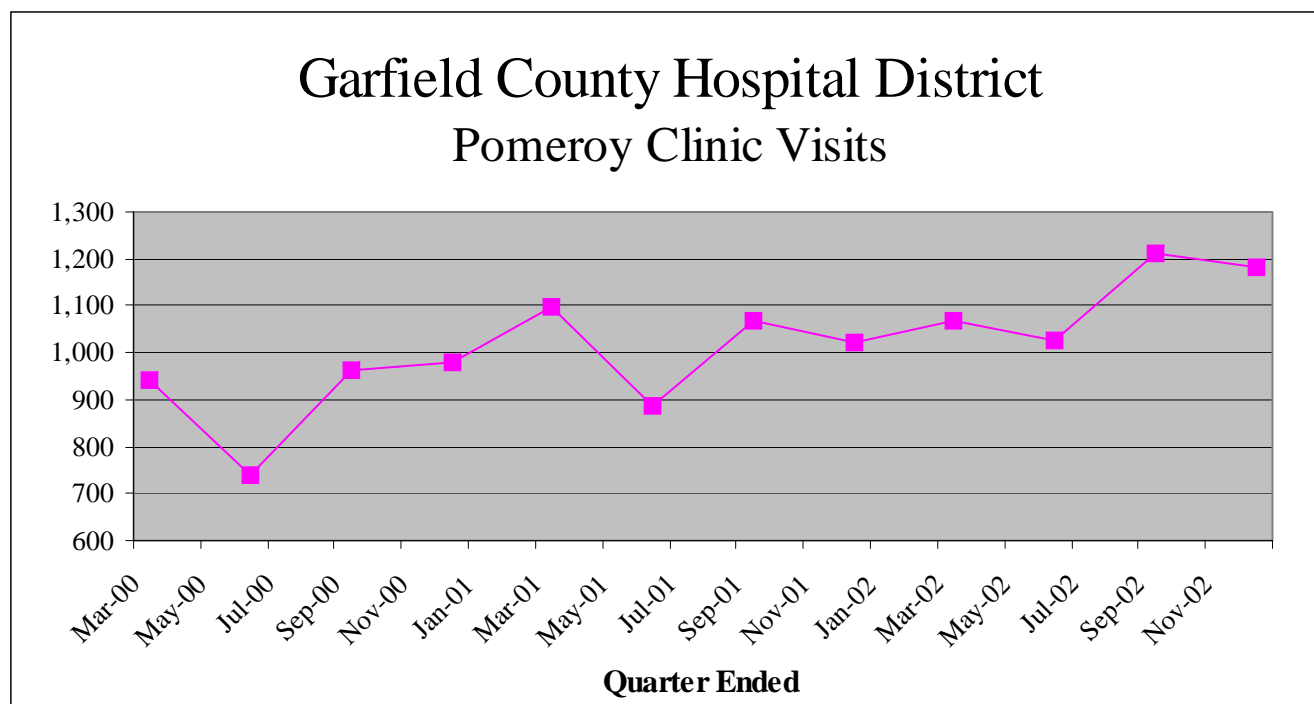
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- Physician Practice Management (continued)
 - Findings and Analysis (continued):



- During FY 2001, PC did not meet RHC productivity standards
 - Overall growth in clinic visits between FY2001 and FY2002
 - As reported by physician, necessary to schedule a minimum of two providers in clinic seeing patients 5 days per week, 8 hours per day

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- Physician Practice Management (continued)
 - Recommendations:
 - Focus PC effort on improving both provider productivity and overall clinic throughput
 - Consider developing productivity incentives for providers based on Relative Value Units (RVUs) generated
 - Create provider schedule that ensures a minimum of 2 providers in the clinic seeing patients 5 days/week, 8 hours/day
 - Provide monthly productivity information to each provider that indicates total visits, RVUs, and charges
 - Maintain PC at its currently location while efforts to improve throughput are going on
 - Consider a move to the hospital campus only if increases in productivity require significant renovations to the current site
 - Breakout the accounting for PC to enable performance benchmarking with other practices
 - Establish the clinic's general ledger considering the generally accepted physician practice general ledger (as used by Medical Group Management Association for practice benchmarking)
 - » See attachment 3 for an example
 - Provide clinic performance information to providers

Financial/Reimbursement

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- Business office functionality
 - Findings and Analysis
 - Performance measures indicate that GCHD has significantly improved performance during the past 12 months, and as of December 31, 2002, is outperforming median performance

<u>Days in Net Accounts Receivable</u>	<u>12/31/2001</u>	<u>12/31/2002</u>
Accounts Receivable, net of Contractual Allowances	\$ 656,458	\$ 468,235
Net Patient Revenue	\$ 2,327,000	\$ 2,855,000
Hospital Rate	102.97	59.86
Benchmark		
75th percentile	81.98	81.98
Median	67.84	67.84
25th percentile	55.26	55.26

- Reported that major “clean-up” began during FY2001 and continued into FY2002
 - » Between 11/99 and 4/00, no bills were sent as GCHD was converting to a new billing system (Dairyland)
 - » 100% turnover of billing/collections staff since FY2000
 - » During FY2002, over \$200K of “administrative” adjustments were necessary to clean-up old A/R that was deemed non-collectable
 - » Self-pay trial balance has been reduced from 300 accounts to 167 accounts

Financial/Reimbursement

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- Billing Office Functionality (continued)
 - Findings and Analysis (continued)
 - Admissions/Registration
 - Patient registration operates with sole focus of registering patient for services
 - » Opportunity to consider adding a “financial counseling” focus to patient registration
 - » 20% of admissions through ER are reported to be missing important information (e.g., copy of driver’s license, etc.)
 - Medical Records
 - Medical records generally codes and preps for MD signature the patient records within 2-3 days
 - » Charges entered into the system by Medical Records
 - » Bi-weekly report run to determine “admissions” without charges
 - » Each morning, “AR Post” loads charges to patient admission
 - Billing
 - Bills dropped twice per week (Tuesday and Friday)
 - » Manual bills used to bill insurance and patients
 - » AR staff print UB92s off of system and manually key into electronic system to bill Medicare
 - » GCHD currently evaluating cost-benefit of electronic clearing house
 - » Denied claims worked 2-3 times per month

Financial/Reimbursement

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- Billing Office Functionality (continued)
 - Findings and Analysis (continued)
 - Collections
 - Written collection policy in place
 - » Patients sent 3 notices approximately 28 days apart prior to being sent to collections
 - » Patient accounts generally written off when sent to collections
 - » Aged Trial Balance worked “when time permits”
 - » No phone call follow-up on aged self-pay balances
 - » No formal policy for establishing “budget” accounts
 - » No sliding fee schedule available for low income patients
 - Recommendations
 - Registration/Admissions
 - Consider combining roles of “Financial Counseling” and “Patient Admissions” with core financial counseling responsibilities including:
 - » Providing information/assistance regarding qualification for public aid
 - » Meeting with customers prior to service to resolve eligibility or non-approved services
 - » Notifying customer of any problems with insurance post-service
 - » Providing information regarding insurance benefits
 - Developing “admissions” training for ER ward clerks

Financial/Reimbursement

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- Billing Office Functionality (continued)
 - Recommendations (continued)
 - Billing
 - Contract with electronic clearing house with ability to bill third parties electronically
 - » Avoidance of manually billing will enable time for working aged trial balance and denied claims on a weekly basis
- Collections
 - Begin tracking and reporting
 - » Bad Debt Expense as a % of Gross Revenue;
 - » Contractual Allowance as a % of Gross Revenue; and
 - » Days Net Revenue in Net Accounts Receivable (Gross A/R less Contractual Allowance reserve)
 - » Days Gross Unbilled Revenue in Gross Accounts Receivable
 - Establish collection policies in line with Medicare guidelines including phone call follow-ups
 - Consider adopting a sliding fee schedule by using cost to benefit analysis (see attachment II for an example)
 - Establish a formal policy for setting up patient “budget” accounts
 - » require \$100 monthly minimum payment and 12-month total time to pay for services

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- 2001 Medicare Cost Report
 - Findings and Analysis
 - A desk review of the FY2001 cost report was completed to look for common errors in preparation or opportunities to enhance revenue or decrease expense. Items requiring follow through were discussed with local CPA and include:
 - Optional Reimbursement Methodology applicability
 - » It is uncertain whether the optional reimbursement methodology could be applicable to GCHD and whether this option would be financially feasibility if it was available
 - Tracking of Swing-Bed SNF days versus NF days
 - » The carve-out methodology for CAHs treats SNF and NF days differently. While it was reported by the CPA that the Washington State FI treats all non-Medicare swing-bed days as NF, GCHD may want to set up a tracking system to ensure accurate accounting for both SNF and NF swing-bed days
 - Physician time allocation to provider-based rural health clinic
 - » Evaluate whether 87% of physician time and salary is appropriately allocated to RHC
 - Accuracy of current interim payment rates
 - » With both current growth in swing-bed usage and reconfiguration in inpatient unit, GCHD may be receiving inaccurate interim payment rates
 - Recommendations
 - Work with local CPA to evaluate each option.

Financial/Reimbursement

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- Third-Party Contracting
 - Findings and Analysis
 - GCHD, with one exception, has not renegotiated contracts with third-party payers
 - Recent negotiations with Blue Cross has enabled GCHD to receive 10% discount off of charges
 - Recommendations
 - Evaluate any significant third-party insurance contract to determine appropriateness of contracted fees
 - Renegotiate any contracts that do not provide fees similar to Blue Cross

Financial/Expense Management

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- Findings and Analysis
 - Benchmark Analysis Comparing Hospital to National Small, Rural Hospital Percentiles (Benchmark Source: The 2001 Source Book, Sachs/HCIA & Deloitte Touche)
 - Uses standardized measures to compare hospitals
 - “Adjusted discharges” is used to transform revenue generating activities into common terms of inpatient activity
 - Hospitals with greater outpatient activity will have higher adjustment

<u>Operating Expense per Adjusted Discharge</u>	<u>2001</u>
Total operating expense	\$ 2,957,000
Adjusted Discharges	486
Hospital Rate	\$ 6,080
Benchmark	
75th percentile	\$ 5,425
Median	\$ 4,541
25th percentile	\$ 3,854

- For FY 2001, GCHD operating expenses are above 75th percentile of “peer” hospitals
 - Likely the result of peer hospitals being much larger than GCHD with the ability to dilute overhead expenses

Financial/Expense Management

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- Findings and Analysis (continued)
 - Benchmark Analysis Comparing Hospital to National Small, Rural Hospital Percentiles (continued)
 - Salary and benefit expense per FTE are slightly above the 25th percentile of peer hospitals

<u>Salary and Benefit per FTE</u>		<u>2001</u>
Salary and Benefits	\$	2,071,000
Full Time Equivalents		63.0
Hospital Rate	\$	32,873
Benchmark		
75th percentile	\$	41,742.00
Median	\$	36,674.00
25th percentile	\$	31,974.00

- FTEs per adjusted discharges are above the 75th percentile of peer hospitals
 - As previously discussed, is likely the result of larger peer hospitals being able to dilute overhead FTEs over greater revenue base

<u>FTEs per Adjusted ADC</u>		<u>2001</u>
Number of FTEs		63.0
Adjusted ADC		9.9
Hospital rate		6.3
Benchmark		
75th percentile		6.0
Median		4.8
25th percentile		4.0

Financial/Expense Management

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- Findings and Analysis (continued)
 - Benchmark Analysis Comparing Hospital to National Small, Rural Hospital Percentiles (continued)
 - Salary and benefits as a % of total operating expenses are also in excess of the 75th percentile of peer hospitals
 - Result of both higher FTE count than peers as discussed previously which inflates “salary expense” and well managed non-salary costs

<i>Salary and Benefit as a Percentage of Total Operating Expenses</i>	
	<u>2001</u>
Salary and Benefits	\$ 2,071,000
Total operating expense	\$ 2,957,000
Hospital Rate	70%
Benchmark	
75th percentile	56%
Median	51%
25th percentile	46%

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- Findings and Analysis (continued)
 - Benchmark Analysis Comparing Hospital to National Small, Rural Hospital Percentiles (continued)
 - Capital costs as a % of operating costs are significantly below the 25th percentile for peer hospitals
 - Reflects level of investment in plant and equipment (including capital leases)

<i>Capital Costs as a % of Operating Expense</i>		<u>2001</u>
Total Operating Expense	\$	2,957,000
Capital Costs		108,000
Hospital Rate		3.65
Benchmark		
75th percentile		8.24
Median		6.54
25th percentile		5.12

- GCHD's capital cost ratio below the 25th percentile indicates long-term lack of investment in technology, equipment, and plant

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- Recommendations
 - Based on benchmarks with peer hospitals, improved financial performance, and overall observations during the site visit, expense management is appropriately balanced with revenue generation
 - Low capital cost ratios suggest a need to reinvest in plant and equipment

Organizational Architecture

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- Theoretical Overview
 - An effective organization, through sound leadership, will enable its employees to make decisions taking into account relevant data and hold employees accountable for these decisions. The key elements of this OA are as follows:
 - Governance/Leadership
 - Maintaining visionary leadership while giving managers the tools to make effective decisions and holding accountable managers to improve the performance and value of the organization
 - Decision Making/Accountability
 - The goal within an organization is to place decision making at a level that leverages local information while improving overall hospital value
 - » In a competitive and consumer oriented organization, decision making should be as close to the consumer as practical
 - Compensation
 - Compensation must be set at market rates and reward risk taking by managers and other employees
 - Performance Reporting
 - Provides regular and timely information to managers to use in effective decision making as well as to provide administrator with organizational results

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- Findings and Analysis
 - Decision Making and Responsibility
 - Overall perception by managers interviewed is that there is an adequate process for decisions being pushed down to departmental levels and increased accountability for meeting goals and objectives
 - “Open-door” leadership-style by administrator provides an excellent opportunity for department managers to seek input from senior management
 - Board members have expressed confidence in current administrative team and to a large degree, maintained appropriate levels of leadership without becoming overly involved in operations
 - Compensation
 - Wages are set based on a wage surveys at comparable facilities and State data and account for job position, years of service and achievement (defined by level of leadership and training)
 - Benefits package is average with partial medical and dental for the employee, as well as short-term disability
 - No retirement plan in place for employees
 - With some exceptions, limited job vacancies at GCHD indicates market-based wage and benefits package as well as decent work environment
 - Managers are not eligible to participate in a formal or informal productivity or performance incentive plan

Organizational Architecture

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- Findings and Analysis (continued)
 - Performance Measurement
 - Timely communication to front line managers of key operating performance measures which contribute to financial performance does not occurs on a systematic and regular basis
 - CFO is currently in process of cleaning up the general ledger to ensure accuracy in reporting and has expressed an interest to creating monthly performance reports for department managers
 - Annual budget developed by Administrator

Organizational Architecture

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- Recommendations:
 - Decision making and Responsibility
 - None.
 - Compensation
 - Consider adopting variable pay methodologies for managers and staff that reward exceptional behavior
 - These can be annual bonuses or annual pay increases that vary based on performance to goals/objectives
 - Create defined contribution for employees that has a profit sharing component in which the hospital can agree to voluntarily match some portion of the employees contributions
 - Performance Reporting
 - Consider creating charts of key departmental performance indicators
 - Indicators may include: monthly charges, expenses, volume, staffing to volume ratios, combined with clinical indicators etc.
 - Develop “dashboard” set of performance indicators for which the hospital is to be managed with
 - Attachment 4 provides the set of indicators currently being used to develop national database on rural hospital performance improvement

Summary of Recommendations

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Clinical Services

- Develop a clinical process for determining when a nursing home patient should be admitted to the acute unit
- Continue to develop waiting list of nursing home patients to avoid long-standing vacancies of nursing home beds
- Work with network hospitals and physicians to refer back to GCHD patients in need of inpatient rehab services
- Evaluate feasibility of new chemistry analyzer and purchase if prudent
- Promote local lab services in conjunction with the EMR as a means of managing patient health
- Stabilize PT department staffing
- Promote outpatient PT services to orthopedics groups in Lewiston
- Determine whether additional equipment is necessary to increase appearance and performance of PT department
- Focus Pomeroy Clinic effort on improving both provider productivity and overall clinic throughput
- Maintain PC at its currently location while efforts to improve throughput are main focus
- Breakout the accounting for PC to enable performance benchmarking with other practices

Summary of Recommendations

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Financial/Reimbursement

- Contract with electronic clearing house with ability to bill third parties electronically
- Begin tracking and reporting
 - Bad Debt Expense as a % of Gross Revenue;
 - Contractual Allowance as a % of Gross Revenue; and
 - Days Net Revenue in Net Accounts Receivable (Gross A/R less Contractual Allowance reserve)
 - Days Gross Unbilled Revenue in Gross Accounts Receivable
- Establish collection policies in line with Medicare guidelines including phone call follow-ups
- Consider adopting a sliding fee schedule by using cost to benefit analysis (see attachment II for an example)
- Establish a formal policy for setting up patient “budget” accounts
- Identified cost report opportunities to be evaluated with local CPA
- Evaluate all significant third-party insurance contracts to determine appropriateness of contracted fees and renegotiate if necessary

Financial/Expense Management

- Low capital cost ratios suggest a need to reinvest in plant and equipment

Summary of Recommendations

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- Consider adopting variable pay methodologies for managers and staff that reward exceptional behavior
- Create defined contribution for employees that has a profit sharing component in which the hospital can agree to voluntarily match some portion of the employees contributions
- Create charts of key departmental performance indicators and provide to department managers on a monthly basis
- Develop “dashboard” set of performance indicators for which the hospital is to be managed with

Attachment 1: Provider Demand/Supply Sources

Notes to the Physician Need Calculations

Standards cited are drawn from the following sources and represent varying points-of-view regarding physician need:

- GMENAC (Graduate Medical Education National Advisory Committee) Population based standards are derived from epidemiological information as well as consensus panels of physicians. Estimates were developed in the early 1980s for 1990 needs. This was a large, highly respected study, which stimulated much of the discussion of potential excesses in certain specialties.
- Hicks & Glenn These represent the estimates of a health services research team that used measures of physician productivity such as office visits, consultations, etc. to project physician demand for a population. Source: Hicks and Glenn, "Too Many Physicians in the Wrong Places and Specialties? Populations and Physicians from a Market Perspective" Journal of Health Care Marketing, December, 1989.

Group Health Inclusive These represent the combination of internal provider staffing and externally accessed provider resources used by two large, well established staff model HMOs. This research differs from earlier work in so far as it carefully accounts for purchased services, with the implication that some of the earlier studies likely undercounted physician demand in HMOs. Midlevel practitioners are accounted separately in this study. Due to the widely differing patterns of utilizing midlevels, actual midlevel complement was adjusted to reflect "physician equivalents." Source: Hart, et. al, "Physician Staffing Ratios in Staff-Model HMOs," Health Affairs, Jan-Feb, 1997.

- AMA (American Medical Association) "Standards" represent the actual population to physician ratios for active physicians in the identified specialties in the United States in 1993. Source: Physician Characteristics and Distribution in the U.S., 1994 Edition. In effect, this represents more of a measure of "supply" than of "need" or "demand."

As presented, the "standards" project the estimated size of the population required to support a full time physician in the identified specialty. Calculations of expected complement are made by dividing market share adjusted population by the "standard."

Attachment 2: Sliding Fee Schedule

- Sliding Fee Schedule Example

Sliding fee schedule guideline 2001

family size	100% reduction	75% reduction	50% reduction	25% reduction
1	\$7,820.00	\$10,590.00	\$13,238.00	\$15,888.00
2	\$10,656.00	\$14,208.00	\$17,760.00	\$21,312.00
3	\$13,368.00	\$17,823.00	\$22,278.00	\$26,736.00
4	\$16,080.00	\$21,438.00	\$26,798.00	\$32,156.00
5	\$18,792.00	\$25,056.00	\$31,320.00	\$37,584.00
6	\$21,504.00	\$28,676.00	\$35,838.00	\$43,005.00
7	\$24,216.00	\$32,286.00	\$40,358.00	\$48,428.00
8	\$26,928.00	\$35,904.00	\$44,880.00	\$53,856.00

Attachment 3: Clinic Accounting Example

Clinic Example:

	Dollars	% of Net Rev	MGMA**	
			Median %	Diff
Clinic Revenue	275,000	100%	100%	0%
Non-Provider Payroll Costs:				
Non-Provider Salary	70,000	25%		
Non-Provider Benefits	30,000	11%		
Total Non-Provider Payroll Costs	100,000	36%	31%	-5%
Operating Expenses:				
Building and occupancy	15,000	5%	8%	3%
Professional liability insurance	5,000	2%	1%	-1%
Telephone/information systems	5,000	2%	2%	0%
Medical supplies	10,000	4%	4%	0%
Administrative supplies	2,500	1%		
Miscellaneous operating cost	10,000	4%		
Total Operating Expenses	47,500	17%	28%	11%
Total Non-Provider Expenses	147,500	54%	60%	6%
Net Income before Provider Comp	127,500	46%	40%	14%
Provider Compensation and Benefits:				
Physician compensation	130,000	47%		
Physician benefits	15,000	5%		
Total Physician Expense	145,000	53%	46%	-7%
Net Practice Income (Deficit)	\$ (17,500)	-6%	-6%	0%

** MGMA Family Practice-All, Median Information (2002 Report)

Attachment 4: Performance Measures

Core Measures

Business and Development

- Operating Profit Margin
- Days Cash on Hand
- Net Patient Revenue Increase
- Commercial Mix %
- Salary and Benefits Expense
- Cost per Discharge
- Nursing Staff Productivity

Patients and Community

- Patient Satisfaction (Emergency Department)
- Patient Satisfaction (Inpatient Unit)
- Time to Treating Physician
- Patient Satisfaction (Q8 "Understand discharge...")
- Quality of Care Index
- Patient Engagement Index
- Patient Satisfaction (Q2 "Access to services...")
- Patient Satisfaction (Q4 "Services up to date...")

Hospital wide Quality and Safety

- Unplanned Admit Rate
- Time to Transfer
- Medication Error Rate
- Medication Error Reporting
- Patient Falls
- ER Wait Time (Time to Triage)
- ALOS for specified DRGs
- Contractual Allowances
- Bad Debt Expense
- Net Days in Accounts Receivable

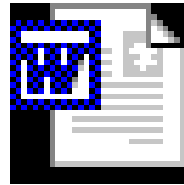
Staff and Clinicians

- Staff Engagement Index
- Nursing Staff Turnover
- Staff Satisfaction (Q4 "Support the goals...")
- Staff Satisfaction Index
- Staff Satisfaction (Q3 "Aware of goals...")
- Staff Satisfaction (Non-punitive Reporting Policy)
- Staff Satisfaction (% Reporting Medication Errors)
- External Staff Training Dollars
- Staff Satisfaction (Q2 "Receive training...")
- Staff Turnover
- Physician Engagement Index

Attachment 4: Performance Measures

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The attached document provides instructions on calculating each of the performance measures as presented on previous slide



Microsoft Word
Document