Improving Operations: The Toolbox, Part 2

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October 2019

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Agenda

The challenge: significant headwinds are eroding margins while new demands to employ providers and address regulatory, consumer and technology needs pose daunting investment requirements.

- National Trends Overview
- The Operational Tool Box
- Practice Operations Improvement
- The Staffing Efficiency Imperative
- Questions

INDUSTRY TRENDS

Industry Overview: Disruptive Trends

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Affordable Care Act

- More insured
- Reduced FFS price (relative to costs)
- Accountable care payment models

MACRA

- Reduced FFS payment to physicians
- Value based incentives (MIPS)

High Deductible Health Plans

- Increased focus on value with patients becoming consumers
- Value = Quality/Cost

Underinsurance

- Increased bad debt/charity care

Recovery Audit Contractors (RAC)

- Focus on reducing short stay inpatient admissions

Reduced Re-admissions

- Result of Value Based Payment program

Accelerating shift to outpatient care

- Transition from traditional inpatient focused hospital care to outpatient care

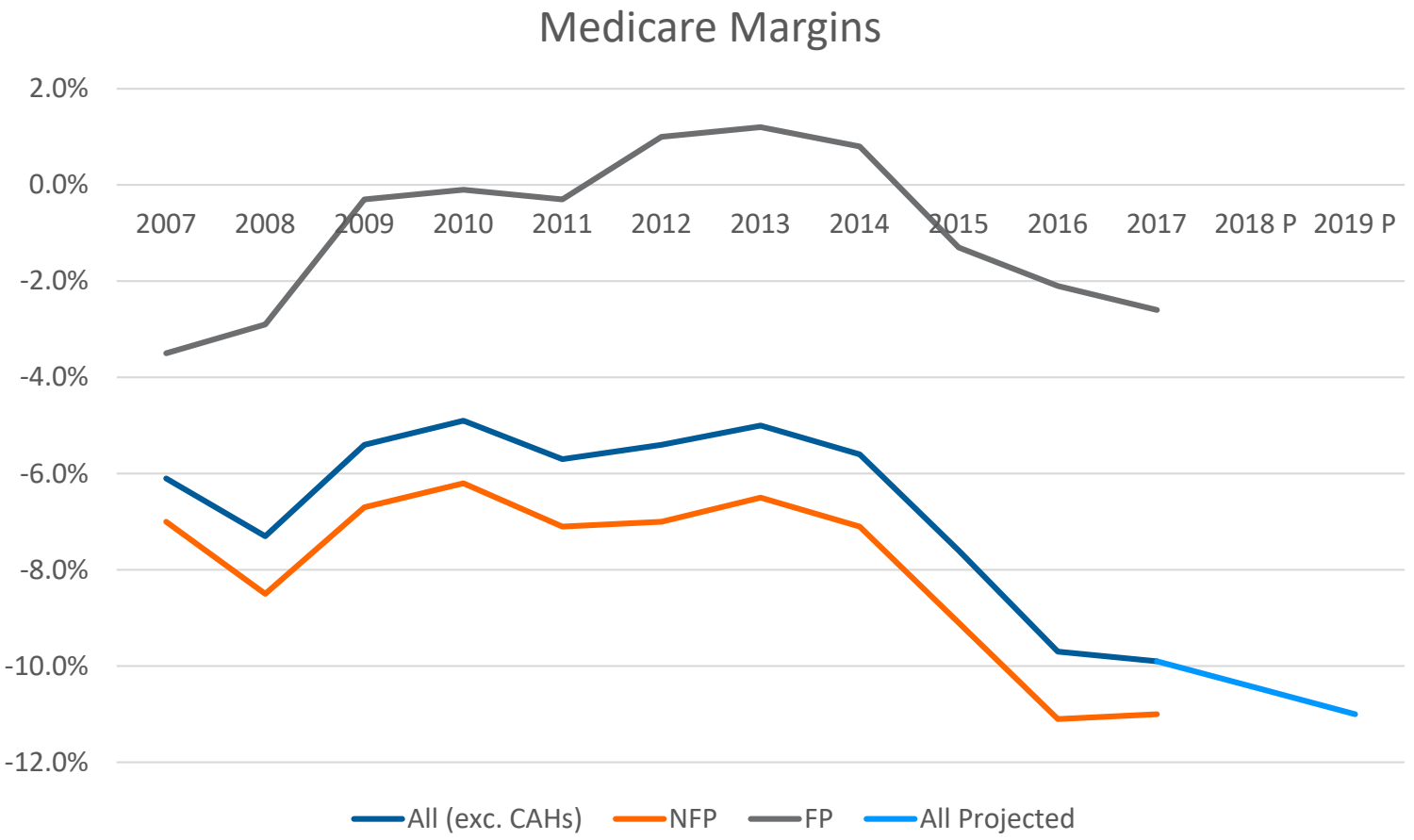
Market Consolidation and New Entrants

- Aetna/CVS
- Walmart/Humana
- Haven (Amazon/Berkshire/JP Morgan)

Consumerism

- Retail mindset
- Convenience
- Transparent pricing

Fee-For-Service Financial Model – Results



Medicare margins are expected to decline due to a tightening labor market and other sources of cost inflation projected to outpace growth in payment rates.

Private commercial insurers are also applying pressure to control and limit growth in reimbursement.

Source: MedPac Annual Report to Congress, March 2019

Moody's Issues Negative Outlook for Nonprofit Hospitals in 2019

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- Moody's Investors Service has issued a negative outlook on the nonprofit healthcare and hospital sector for 2019, reflecting Moody's expectation that **operating cash flow in the sector will be flat or decline and bad debt will rise**
- Moody's predicts **operating cash flow will either remain flat or decline by up to 1 percent in 2019**, depending how well hospitals manage expense growth
  - The agency expects cost-cutting measures and lower increases in drug prices to cause expense growth to slow, but said **expenses will still outpace revenues** due to several factors, including the ongoing need for temporary nurses and continued recruitment of employed physicians
- Hospital **bad debt is expected to grow 8 to 9 percent in 2019** as health plans place greater financial burden on patients

MOODY'S INVESTORS SERVICE

Source: Becker's Hospital Review, *Outlook is negative for nonprofit hospital sector, Moody's says,* Ayla Ellison, 12/5/18
https://www.beckershospitalreview.com/finance/outlook-is-negative-for-nonprofit-hospital-sector-moody-s-says.html

The Risks Are Real: Hospital Closures

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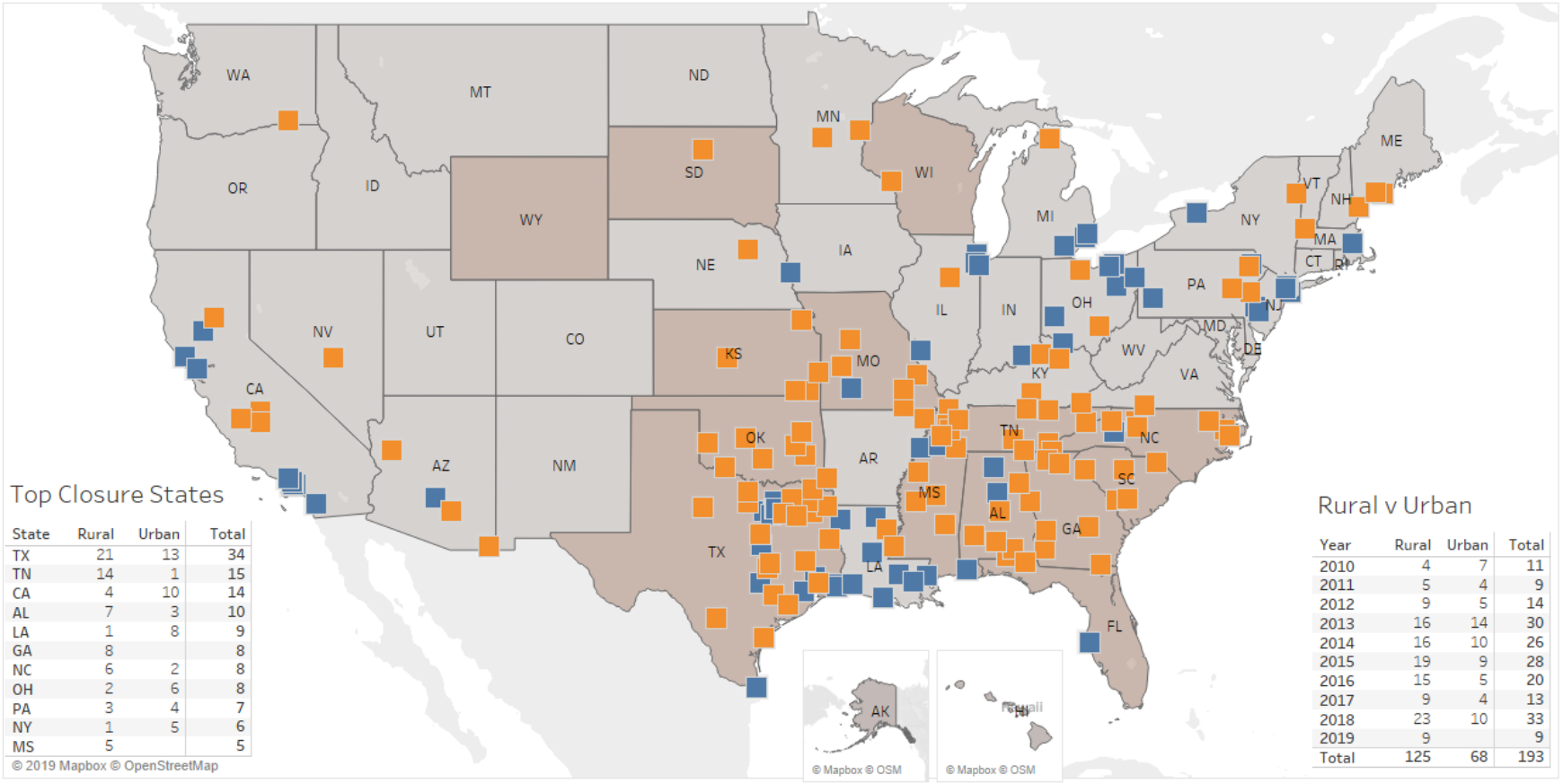
Rural and Urban Hospital Closures since 2010



Top Closure States

State	Rural	Urban	Total
TX	21	13	34
TN	14	1	15
CA	4	10	14
AL	7	3	10
LA	1	8	9
GA	8		8
NC	6	2	8
OH	2	6	8
PA	3	4	7
NY	1	5	6
MS	5		5

Rural v Urban

Year	Rural	Urban	Total
2010	4	7	11
2011	5	4	9
2012	9	5	14
2013	16	14	30
2014	16	10	26
2015	19	9	28
2016	15	5	20
2017	9	4	13
2018	23	10	33
2019	9		9
Total	125	68	193

Current Status of Medicaid Expansion Decision
- Adopted the Medicaid Expansion
- Not Adopting the Medicaid Expansion at this Time

Rural v Urban
- Rural
- Urban

Rural v Urban based on cost report designation

Sources: Cost Report data, The Cecil G. Sheps Center for Health Services Research, KFF.org (Updated 6/4/2019)

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The map above shows closures – it does not show those hospitals that have had to curtail operations or mission driven activities or been forced into bankruptcy.

The Consequences of Failing to Act

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- Researchers examined outcomes in California hospital service areas (HSAs) with and without closure(s) between 1995-2011 both before and after the closure year.
- Adjusted inpatient mortality was studied for time-sensitive conditions: sepsis, stroke, asthma/chronic obstructive pulmonary disease (COPD) and acute myocardial infarction (AMI).
- To the researchers' best knowledge, this is also the first paper explicitly studying patient outcomes of California's rural closures.
- Results suggest that when treatment groups are not differentiated by hospital rurality, closures appear to have no measurable impact.
- However, estimating differential impacts of rural and urban closures shows that rural closures increase inpatient mortality by 0.46% points (an increase of 5.9%), whereas urban closures have no impact.

Impact of Rural and Urban Hospital Closures on Inpatient Mortality.
NBER Working Paper No. 26182, Issued in August 2019; Kritee Gujral, Anirban Basu.

Polling Question #1

- What best described your organization?
  - **Healthy**: Adequate cash flow to fund needed investments and initiatives; healthy top line revenue growth and good expense management; positive operating margin; strong and stable market position
  - **Compromised**: Struggling to keep expenses in line with top line revenue; negative operating margin in danger of swamping portfolio returns or tax proceeds; signs of weakness in market position
  - **Stressed**: 2+ years of material deferred investment; 2+ years of top line revenue growth less than 3% annually; negative total margin; market position beginning to erode
  - **Distressed**: 3+ years of material deferred investment; 3+ years of top line revenue growth less than 2% annually; negative cash flow; reserves are being depleted; market position materially eroded; trajectory cannot be sustained

OPERATIONAL PERFORMANCE IMPROVEMENT TOOL BOX

Strategic Risk & Operational Improvement

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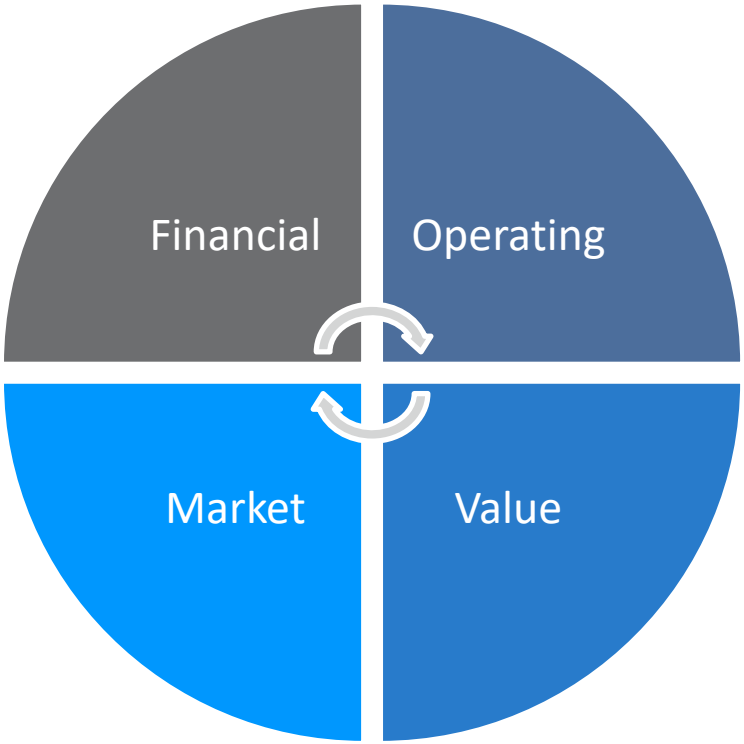
- Define “gaps” in performance
- Develop budget consistent with “sustain” threshold
- Quantify cash “run rate”
- Examine five-year trends at least annually



- **Demand-Based Staffing tools**
- **Provider practice operations improvement**
- **Revenue cycle and coding**
- Cost report reviews (CAHs)
- **Practice / clinic designations**
- Process redesign
- Supply chain & purchasing

- Identify growth opportunities
- Invest in aligned provider base
- Develop ambulatory network
- Address industry disruptors
- Implement retail pricing, access strategy
- Direct contracting
- De-escalate conflict between Boards

- Annual payor contract reviews
- Contracting strategy re: payor products and value-based models
- Value-based payment strategy
- Self-Insured population tools
- Medicare Advantage products
- Define need for payor and provider partners
- Manage total cost of care
- Address industry disruptors

Each of the four strategic and operating risk vectors have potential mitigating management responses. We are going to focus on two powerful performance improvement tools today.

OPERATIONAL PERFORMANCE IMPROVEMENT TOOLBOX: THE PRACTICE OPERATIONS OPPORTUNITY

Losses in Hospital-Owned Practices

- Hospitals are increasingly concerned with large subsidies paid to cover practice losses – particularly in primary care
- Current average loss across all specialties is $196K per FTE physician
- Most hospitals "host" practices rather than manage them

Infrastructure Change
- Higher benefits
- Staff & management expense
- IT Investment
- **Physician gives up ancillary revenue**
- GPO

Poor Pre-Purchase Due Diligence
- **Understanding culture & operations**
- Payor mix
- Not comparing productivity to salary
- Inaccurate proforma
- Reimbursement

Lack of Consolidation
- Buy and stay
- No network planning for locations

No Standards & Measures
- **Multiple one-off employment contracts**
- **Compensation model**
- Vague work out language
- Inadequate performance standards
- **Poor operations and management**

Revenue Cycle Mismanagement
- **Poor overall RCM performance**
- Poor on-boarding and credentialing
- **No RCM integration with operations**
- **Bad pro fee contracts**
- Change in payor mix

Sources: MGMA 2018 Cost and Revenue Report

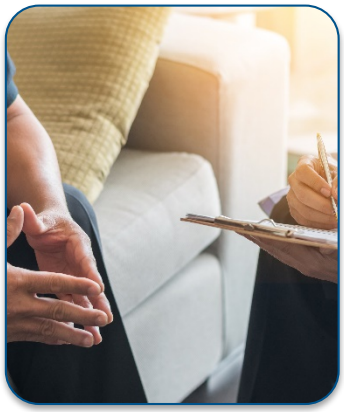
Polling Question #2

- Regarding your physician contracts, which of the following have you applied?

  (Check all that apply)

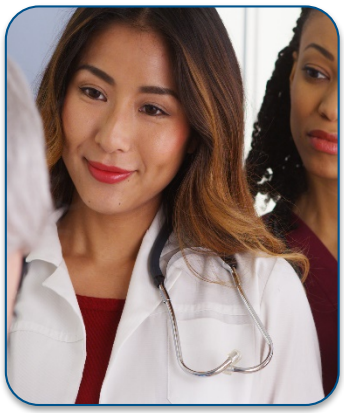
  - Standard contracts amongst all employed physicians
  - Incentive compensation for all physicians employed longer than two years
  - Standard incentive compensation within specialties
  - Fair market valuation report supporting compensation paid for each physician

Standards and Measures – Contracts



Know your physician contract

- Most hospitals have negotiated each physician contract at the individual level; there is no standard contract
- Several hospitals are missing contracts or are operating on expired contracts
- Changes are not reflected in contracts
- Reality does not mirror the contracts
- Contracts do not match fair market valuation reports



Consequences

- Poor contracts with physicians hinder practice management
- Can be costly
  - Example: FMV report put an overall cap on compensation for physician producing at the 90th percentile; report referenced a per WRVU rate that was used in the contract
    - Result: overpaid the physician by $600K; had to self-report; damaged relationship with physician by asking for the money back

Standards and Measures – Practice Management

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- Underperforming practice with budgeted losses of ($731,510), or ($182,877) per physician

	Patient Scheduled Hours						Opportunity based on 47 weeks per year at 32 hours per week					
Provider	Mon	Tues	Wed	Thu	Fri	Total Hours	New Hours	Additional Hrs/Wk	Additional Patients/Wk	Avg. Collections Per Visit X New Pts/Wk	X 47 wks	Opportunity
Dr. A	9:30-12:15	1:30-4:45	9:30-12:15	9:00-12:15	9:00-12:15							
	1:30-3:30		1:30-3:15	1:30-4:45	1:30-4:45	27.25	32	4.75	14.25	$ 1,069	$ 50,231	
Dr. B	Off	8:30-12:15	7:00-12:00									
	(8 hr PCMH Di	1:30-4:45	12:45-3:00	6:000-8:45	1:30-4:45	25.25	32	6.75	20.25	$ 1,777	$ 83,516	
Dr. C	8:00-12:15	OFF	12:30-4:45	8:00-12:15	8:00-12:15							
	1:30-4:45			1:30-4:45	1:30-4:45	29.50	32	2.50	7.5	$ 768	$ 36,096	
Dr. D	12:30-4:45	7:30-12:15	7:30-12:15	OFF	8:00-12:15							
	6:000-8:45	1:30-4:45	1:30-4:45		1:30-4:45	27.50	32	4.50	13.5	$ 1,017	$ 47,797	
NP				8:00-12:00	8:00-12:00							
				1:00-4:00	1:00-4:00	16.00	16	0.00	0	$ -	$ -	
Total Practice Patient Care Hours Per Week:						125.5	**144**				**New Revenue:**	**$ 217,640**

Employment contracts state "reasonable full time hours"

Opportunity based on 47 weeks per year at 40 hours per week					
New Hours	Additional Hrs/Wk	Additional Patients/Wk	Avg. Collections Per Visit X New Pts/Wk	X 47 wks	Opportunity
40	12.75	38.25	$ 2,869	$ 134,831	
40	14.75	44.25	$ 3,883	$ 182,498	
40	10.50	31.5	$ 3,226	$ 151,603	
40	12.50	37.5	$ 2,825	$ 132,769	
16	0.00	0	$ -	$ -	
176				**New Revenue:**	**$ 601,702**

Standards and Measures – Scheduling and Workflow

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- Basic workflow needs policies for effective practice management
- Standardize the patient flow from sign-in to rooming to scheduling the next visit
- Basic checklists will move mountains for hitting quality metrics and moving toward population health
- Policies will make no impact if they are not enforced – perform regular audits to make sure policies are sticking (particularly if turnover is a problem)
- Example: Scheduling
  - Practice manager should work with the providers to have a set scheduling template (number of scheduling blocks dependent on number of rooms and staff per provider)
  - Policy must address the following:
    - Creating an appointment
    - Deleting an appointment – cancellation and no show policies
    - Waiting list
    - Appointment reminders
    - Appointment prep (required signatures, payments, waivers, insurance verification)
    - Delinquent balances
    - Patient wait time monitoring
    - Walk-ins
    - Follow-up appointments
    - Same-day appointments

Revenue Cycle

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Critical components at the macro-level

- Review charge master on annual basis for changes in RVUs
- Review third party contracts on an annual basis taking into account transitioning RVUs
- Target charges being set between 125% and 150% of Medicare fee schedule
- At least quarterly, compare E&M coding distribution for full practice and individual providers
- Know where we each component of revenue cycle is being performed
  - Common mistake is to over-centralize the RCM function for practices into the hospital
  - Timely feedback to physicians about coding and documentation is critical to collections

Common mistakes at the practice level

- Insurance eligibility verification
- Prior authorization process is overly complex
- No one is monitoring the status of submitted claims
- Not collecting co-pays and asking for balance payments at each appointment
  - Hospital with 9 practices in the Midwest has experienced a **51.1% improvement in cash collections** through standardizing collection of co-pays and patient balances

Practice Management To Do List

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- Work with your practice managers and physicians as a team to understand what is happening with:
  - Physician contracts
  - Physician compensation
  - Scheduling
  - Payor contracts
  - Revenue cycle process

- Set up management dashboard that monitors the following:
  - Gross collection rate
  - Net collection rate
  - Overhead ratio
  - Individual category expense ratio
  - Days in accounts receivable
  - WRVUs per provider
  - Accounts receivable per FTE physician
  - Staff ratio
  - Average cost and revenue per patient
  - Aging of accounts receivable by payor
  - Payor mix ratio

Key Takeaways

- Losses on physician practices, while the status quo, are not always necessary
  - Make sure you understand what is generating the losses
  - Identify what factors the physicians can impact and engage them on how to address (do not just tell them to work harder!)
- Monitoring of simple metrics monthly can help the practice get in front of issues and must be an ongoing process
  - Setting up the tools to aid management can take as little as 4 weeks depending on your data system
  - Management tools should be monitored every month
- Typical launching of a new physician action council takes 4-6 months before becoming effective when meeting monthly, but can be the vehicle for improvement to be implemented, to stick and to then focus on strategy

OPERATIONAL PERFORMANCE IMPROVEMENT TOOLBOX: THE STAFFING EFFICIENCY IMPERATIVE

Why the Need for Enhanced Labor Productivity?

Ongoing declines in reimbursement require organizations to better minimize variable costs and better convert fixed costs (like labor) into variable costs.

On average, labor costs represent anywhere from 50 to 60% of total operating expenses for most healthcare organizations.

Developing systems and tools that allow healthcare organizations to better match staff to demand can reduce labor expenses anywhere from 10 to 15%.

Hospitals and health systems of all sizes have opportunities to better manage staffing levels to demand for services.

Demand-Based Staffing Drives $4.5M Savings in 7 Months

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$100M net-patient revenue hospital in the Southwest that was experiencing **significant financial losses** and needed to **better adjust staffing levels in the face of declining volume**.

Within a **12-week period of time**, Stroudwater performed a **rapid assessment** of labor productivity opportunities **and** assisted hospital leadership in **implementing the tools and resources** to better flex staff to daily fluctuations in volume.

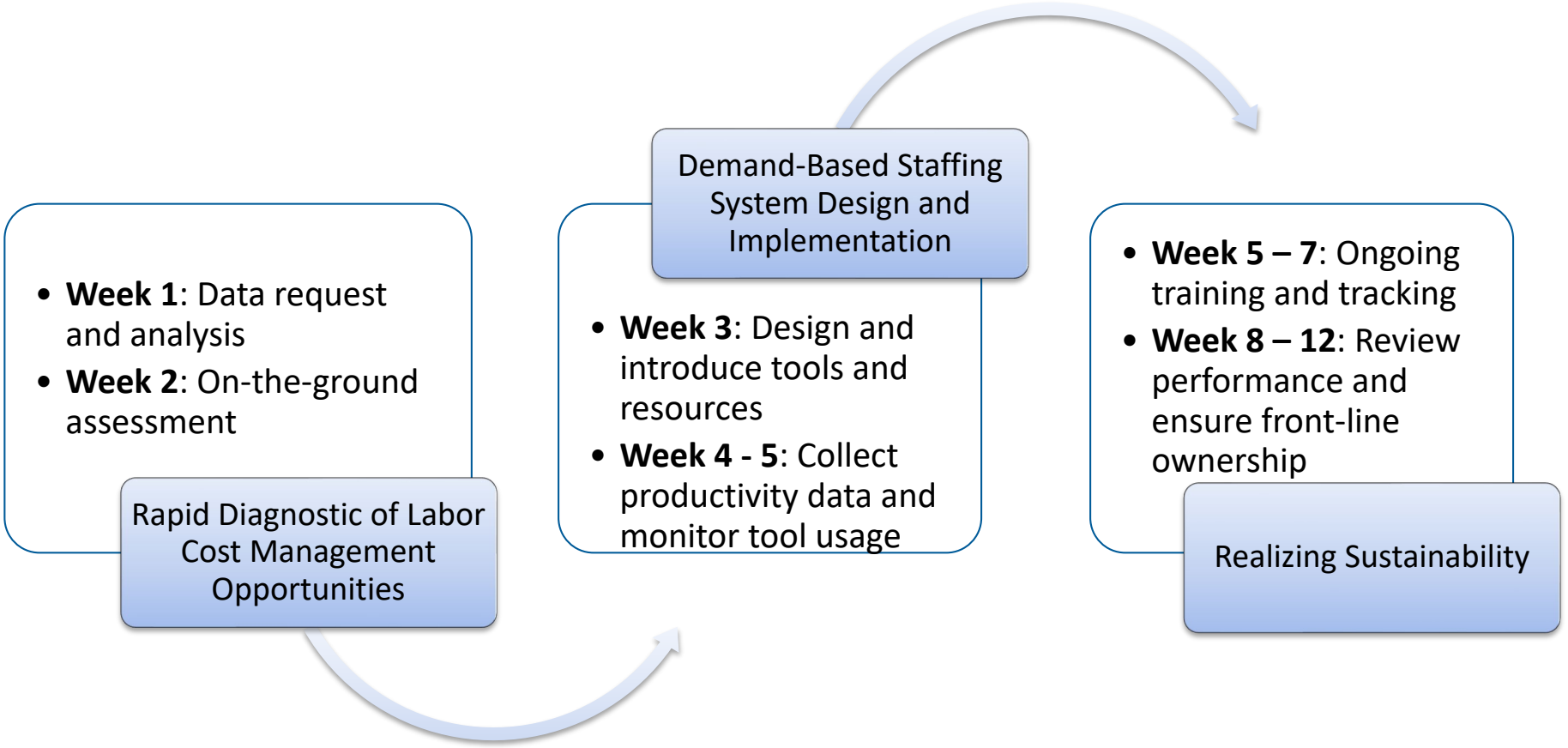
As a result, hospital saved **$4.5M within the first 7-months**.

To **ensure sustainability**, Stroudwater **embedded the tools and resources** that allowed the hospital's front-line managers to maintain a demand-based staffing system and **continue to drive bottom-line results**.

Polling Question #3

- Poll Question: Do your front-line managers have the tools and processes to forward-manage and staff their units based on anticipated volume?
  - A. Yes
  - B. Yes, but we still experience issues in flexing staff on/off as volume changes
  - C. No
  - D. Unsure

Stroudwater Demand-Based Staffing System



Rapid Diagnostic: Identify and Quantify the Opportunity

- **Week 1**: Data request and analysis
- **Week 2**: On-the-ground assessment

Rapid Diagnostic of Labor Cost Management Opportunities

Key Objectives

Translate actual historical data into **productivity data that front-line managers can understand and impact**.

Understand current-state of labor management processes, work load assignments, and existing reporting and control tools.

Identify and quantify opportunities from enhancing productivity in individual departments.

DBS System Design and Implementation

- **Week 3**: Design and introduce tools and resources
- **Week 4 - 5**: Collect productivity data and monitor tool usage

Demand-Based Staffing System Design and Implementation

Key Objectives

Create a **common understanding** around productivity metrics, goals, and objectives.

Collaborate with managers to choose and understand initial performance goals that will **enhance each department's productivity**.

Begin to **implement and monitor a work force that flexes** and responds **to demand for services**.

Realizing Sustainability

- **Week 5 – 7**: Ongoing training and tracking
- **Week 8 – 12**: Review performance and ensure front-line ownership

Realizing Sustainability

Key Objectives

Identify barriers to greater efficiency and productivity.

Form Productivity Improvement Team tasked with addressing and removing those barriers.

Empower "PI Team" with processes, tools, and authority to monitor performance, impact change, and measure progress.

Demand-Based Staffing Provides 11% Improvement in Staffing Expenses in 6 Weeks

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$40M net-patient revenue hospital in the Northeast that needed **better labor cost reporting and control tools** to control labor costs and ensure that staffing levels adjusted based on volume.

After quantifying the DBS opportunity, Stroudwater worked with hospital leadership and managers to **develop and deploy shift management tools and a performance tracker** to monitor and adjust staffing levels **across specific cost centers on a shift-by-shift basis**.

Within the third pay period (6 weeks), the **hospital realized an 11% improvement in labor expenses**.

Since the end of the engagement, Stroudwater has worked with hospital leadership to provide **training to new managers** in the use of these DBS tools **so that additional cost centers can introduce these tools within their units**.

Best Practices for Enhancing Staffing Productivity

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Enhancing staffing productivity is **won or lost with your front-line managers**.

Equipping and empowering front-line managers **with** the necessary **tools and resources** to track and enhance productivity is **central to developing a demand-based staffing system**.

Creating and leveraging **open communications to share challenges or barriers** to enhancing productivity within and across departments is **crucial to moving the organization forward**.

Providing **transparent information** about the identified productivity goals and the financial impact from reaching those goals **better motivates teams and positively impacts behaviors**.

Questions & Thank You

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