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Back to Basics: A Self-Help Approach to Achieving Financial Success

This project is a collaborative effort by
Navigant Consulting, Inc. and the
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Mary Smith, CFO of Community Memorial Hospital, returned to her office at 5:45 after a lengthy meeting with her CEO. Slumping in her chair, she glumly reviewed the list of the hospital's needs the CEO had presented to her. It was time to replace the hospital's aging main facility, the CEO had said, and information technology upgrades were needed in several administrative departments. Furthermore, the hospital's market position would be compromised if it didn't meet patient (and physician) demands by purchasing two pieces of expensive diagnostic equipment within the next few months.

Mary pondered how Community Memorial would be able to pay for these needed improvements. The hospital had a high debt burden and very limited cash on hand. Mary knew that the key to future success was profitability—"cash is king." For years, she had worked to patch together what proved to be temporary fixes to the hospital's operating efficiency and profitability. It seemed she had presided over one initiative after another, only to realize little lasting benefit to the hospital's bottom line. But clearly, now was the time for lasting operational improvements. She sat up straight in her chair and began to formulate a plan.

More than ever, hospitals need financial leaders who can confront deteriorating financial performance in their hospitals and then redirect their organizational strategy. In many cases, hospitals can achieve financial success by returning to a no-frills, back-to-basics approach.

"We all can do better by attending to basics," says Ronald R. Peterson, president of The Johns Hopkins Hospital and Health System and executive vice president of Johns Hopkins Medicine. "If folks pay attention to issues of clinical process improvement, business process improvement, and matters of safety, a lot can be done on a self-help basis to avoid getting into real trouble."

"Are We Lost?"

Boards of hospitals with waning profitability may ask, "How did we get here?" The answer, of course, is that it's never just one thing. In many cases, volume shrinks and the hospital doesn't manage its expenses to adjust to those lower volumes. Cash dries up, and the ink starts flowing red.

Particularly over the past two years, hospitals have been combating a re-escalation of costs. Chronic labor shortages require hospitals to bear the burden of premium labor costs associated with overtime and agency workers. Malpractice premiums are increasing at rates higher than providers have seen in three decades. Plus, some hospitals' infatuation with bricks and new technology has added to the cost burden. Add to this the sticky issues of underfunded pensions, capacity challenges, and dwindling payment from government and private payers, and the need for financial leadership becomes clear.

Practical indicators such as days cash on hand and balance sheet ratios are a good gauge of an organization's performance. But it's also critical that executives monitor trends and key indicators on a regular basis (*see exhibit*). For example, when overtime climbs to more than 2 percent of productive hours in a community hospital, an organization needs to take action. But it's common for executives to deny the poor performance indicated by such a warning sign and think "it will all turn around next quarter."

CFOs should be a driving force to make the hospital's board and leadership aware of the problems—and get their buy-in on what is an acceptable operating margin. Once this is determined, then executives can develop initiatives and timetables to reach their goal.

Not waiting for the financial "911" call can help an institution identify and solve problems early, when they are easier to correct. Three years ago, the

Virginia Commonwealth University (VCU) Health System in Richmond was among the "worried well" in the hospital arena.

"We weren't in a crisis, but we were nervous about our future," says Dominic J. Puleo, CPA, VCU's executive vice president of finance and CFO. In 2001, the organization barely broke even, with an operating loss of \$300,000. The board and management held monthly meetings and developed several strategic initiatives for the following three years. They also brought in a consultant to help review the internally developed plans and to share national benchmarks for revenues and expenses, as well as best practices from other organizations.

"A lot of times executives want to make excuses for problems," Puleo says. "But at VCU, we decided it was more important to look ahead. We did so, rationally and consciously. And quality was always first on the agenda, not finances." Through revenue-generating and expense-reducing initiatives, VCU went from basically break-even in 2001 to \$19.1 million in 2002, a 2.5 percent operating excess, which the organization will use for capital equipment, maintenance, and other needed renovations.

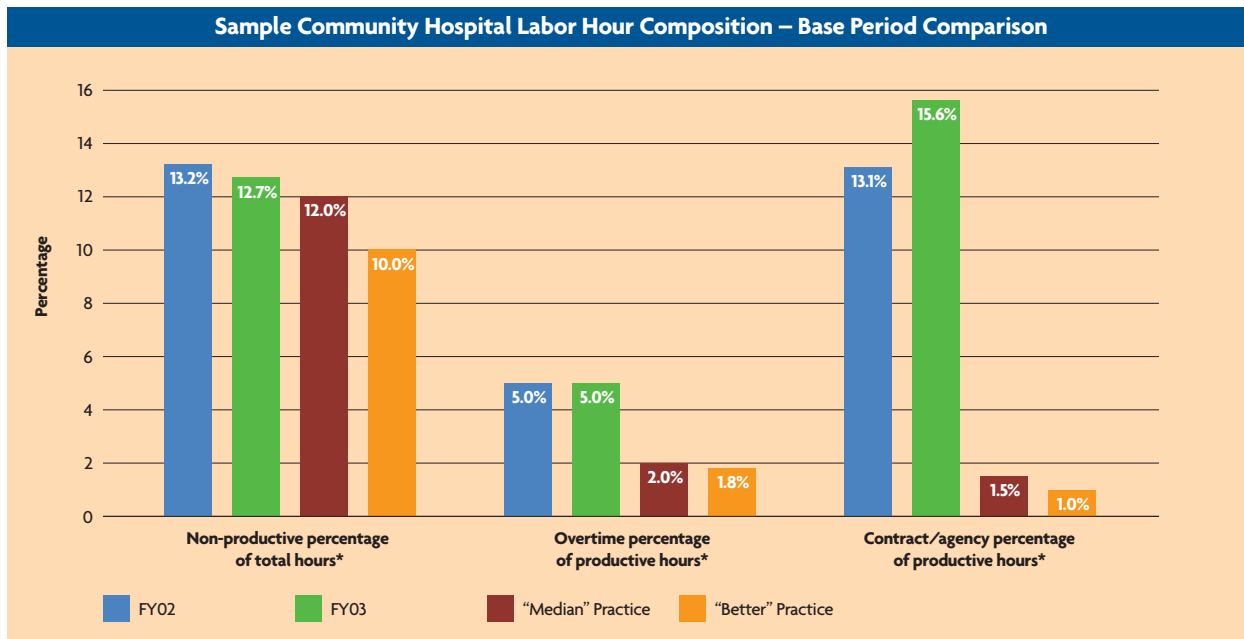
Improving Productivity, Reducing Agency Reliance

One way VCU was able to trim expenses was by reducing positions and using less contract labor. In 2001 and 2002, the system was able to phase out the equivalent of 200 non-nurse FTEs. Combined with a realignment of management, these efforts saved \$9 million annually.

By monitoring labor indicators, such as overtime and agency utilization, executives can "tune in" to some of the variability in labor expenses (*see exhibit, p. 3*).

Labor was also a major focus at Johns Hopkins. The hospital has been able to reduce its dependence on agency nurses, particularly in units where nearly half the staff was temporary. The hospital is now focused more on nurse productivity. An internal study found that direct patient "touch time" amounted to only 35 to 40 percent of nurses' workloads. To help free nurses from non-"touch-time" tasks, the hospital is piloting a program in which college-trained non-nurse professionals—who are more skilled than traditional nursing assistants—support the clinical staff by taking on some of their administrative duties. Johns Hopkins also equipped nurses with cell phones or hands-free phone devices to reduce wasted travel time within and between units.

Operations Performance Indicators for Community Hospitals	
Performance indicator	Warning signs
Cost per adjusted discharge, case-mix-index and wage-index adjusted	> \$5,000
Supply cost per adjusted discharge, case-mix-index adjusted	> \$900
Overtime as a percentage of productive hours	> 2.0%
Paid hours per adjusted discharge, case-mix-index adjusted	> 110
Benefits as a percentage of total salary and wages	> 22%
FTEs per adjusted occupied bed	> 5.0
Days in accounts receivable	> 65 days
Days cash on hand	< 60 days
Bad debt as percentage of gross revenue	> 4.5%



* Total and productive hours exclude contract/agency hours

In addition, recruitment and retention initiatives have helped at the hospital. As an enticement to full-time staff, Johns Hopkins now offers reimbursement for 50 percent of each dependent child's full undergraduate tuition up to a maximum of 50 percent of The Johns Hopkins University undergraduate tuition. Combined, these efforts have helped the hospital lower its vacancy rate from 15 to 7 percent in the past 18 months.

Hospitals may be able to reduce labor costs by considering these strategies:

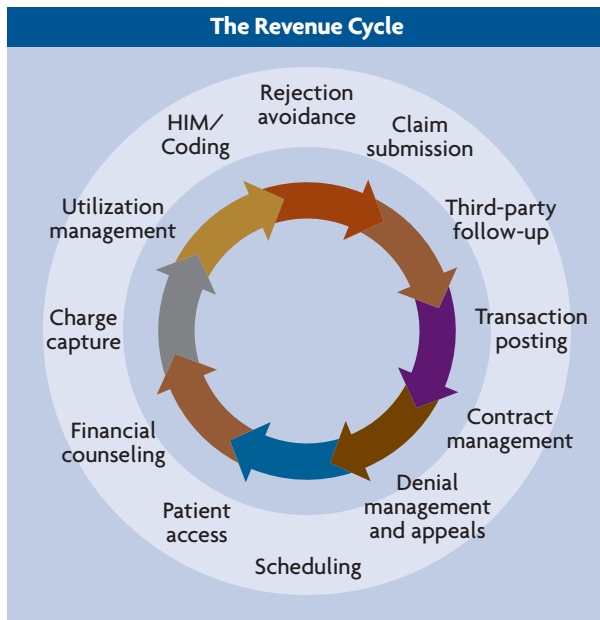
- Recognize that contract labor and overtime can become a crutch for an organization. Agency usage and overtime should be monitored and reported weekly so that managers can work to control it.
- Monitor labor costs at the department or cost center level and track overall labor costs on a case-mix-weighted basis (on as timely a basis as possible, not weeks later).
- Train multidisciplinary teams to look for opportunities to cut costs and improve care. At Johns Hopkins, teams use evidence-based strategies to help prevent central-line infections in the ICU, which can add \$25,000 to the cost of caring for these patients. Solutions include maximizing barrier protections and, where medically indicated, preferentially inserting central lines in the subclavian vein, which presents a lower rate of infection.

- Align staff schedules to patient schedules, especially in outpatient clinics and satellite sites.
- Structure the organization so that no more than three or four reporting relationships separate the frontline employee from the CEO. Too many layers of management can interfere with operational performance.

Reworking the Revenue Cycle

Besides personnel problems, a sputtering revenue cycle cash machine often contributes to lagging financial performance. But by building more efficient revenue and collection processes, hospitals can reverse that trend. It helped at Johns Hopkins, where managers introduced standardized training to their registrars and made significant improvements in the quality of the information captured—thereby limiting rework at the back end of the revenue cycle.

Revamping the front end of the revenue cycle also helped West Suburban Health Care, Oak Park, Ill. The hospital started by closely reviewing the qualifications of its registration staff and comparing them with the job requirements. It also reduced discharged, not final billed days from nearly 10 days to 3.5 days—thanks to the implementation of an automated reporting tool, efforts to reduce coding delays, and an organizational emphasis on accountability.



Greasing the gears of the revenue cycle cash machine can lead to significant results (*see exhibit*). At VCU, nearly one-half of the revenue gain in 2003 resulted from redesigning the revenue cycle. Through better revenue cycle processes, the system increased revenue by 4 percent, or about \$18.3 million.

The Brass Ring: A Favorable MCO Contract

Executives may be hesitant to tell managed care organizations what they are quick to say inside the boardroom: “We can’t survive on these rates.”

But the reality is, a system needs to use its leverage to negotiate appropriate payment in its contracts. That’s what leaders did at VCU. In fact, better contracts accounted for the other half of their revenue improvements in 2003. Before then, the academic medical center had struggled to get by on the “community rates” that most managed care payers provided. “Contracts were paying us less than cost,” VCU’s Puleo says. “We realized that we could not stay in non-profitable contracts.” By canceling or renegotiating contracts that offered the lowest rates, the system was able to increase its managed care revenue by 3.5 percent from 2002 to 2003.

Contract renegotiation also worked at West Suburban. The hospital eventually decided to outsource its contracting function, says Charles R. Brobst, senior vice president of finance and CFO. By doing so, the organization was able to increase scrutiny of its contracts—

only one FTE had been assigned to the role at the time—as well as gain critical market knowledge. “Without that kind of information, you really are just struggling to do the best that you can,” Brobst says. “You don’t really know what you should be asking for.” The hospital improved its managed care payment by \$5 million by renegotiating four contracts with its larger payers.

In addition, West Suburban implemented a cost-accounting and decision-support system that analyzes profits, losses, and contribution to fixed cost by DRG, physician, and other parameters. The system helps administrators examine the potential profitability and other “what-ifs” of managed care proposals and counterproposals. Being able to examine the profitability of various services is also important as the hospital considers capital improvements, which may follow in light of its pending acquisition by Resurrection Health Care.

Some of these basic strategies may help healthcare executives overseeing managed care contracts:

- Know the competition. Managed care negotiators work on contracts full-time, so go in well armed and well prepared.
- Cancel capitated contracts if the hospital is not in a position to take on risk or if contract profitability is not present.
- Be timely. Don’t let contracts become overdue for renegotiation.
- Take steps to ensure that both managed care organizations and the hospital adhere to the terms in the contract.
- Use your decision-support system to reconcile contract rates with actual collections on a regular basis.

Supplies and Purchased Services: Standardizing, Not Skimping

Hospitals often can make big gains through supply-chain and pharmacy initiatives. If not managed properly, these costs can reach 20 percent or more of total expenses.

At West Suburban, administrators have focused on ways to ensure the appropriate use of medications and reduce pharmacy costs. Efforts have included:

- Limiting pharmaceutical reps’ access to physicians
- Minimizing duplicate drugs on the formulary
- Maximizing use of oral rather than injectable medications
- Empowering the Pharmacy & Therapeutics committee to develop prescribing criteria if there is a potential for overuse or misuse of a medication.

Standardizing products and improving supply-chain processes also can help. The Detroit-based Henry Ford Health System recently sponsored a weeklong “order-to-pay” workshop for its employees in operations, receiving, purchasing, accounts payable, and related areas. The workshop, led by a management-team expert from DaimlerChrysler, addressed ways that employees could streamline the internal supply chain. “The workshop broke down a lot of barriers and improved chemistry across the organization,” says James M. Connelly, CPA, senior vice president and CFO of Henry Ford.

When a hospital needs to do a better job of managing supplies and purchased services, it should consider these simple strategies:

- Remember that medical advances such as drug-eluting stents and automatic implantable cardioverter-defibrillator (AICD) units carry hefty price tags. Review managed care contracts to see if big-ticket technology items are included as carve-outs.
- Make sure contracts for purchased services include performance indicators, if appropriate.
- Review the supply cost per adjusted discharge, case mix-weighted, as well as other key indicators, at least monthly.
- Be patient but persistent. Realize that although pricing issues may be relatively easy to fix, utilization issues requiring clinician buy-in take more time and finesse.

Minding the Medical Staff

Like CFOs, physicians are data people, too. They have been trained to manage patients with data and are facing their own economic pressures. Yet in many hospitals with financial woes, there is frequently a disconnect between physicians and hospital administrators. The root cause is often a simple one: poor communication among the board, medical staff, and management.

Sharing financial data with physicians can help drive clinical resource management initiatives, including those aimed at reducing length of stay and resource consumption. For example, the CFO or chief medical officer might review the cost of procedures with surgeons to determine if they’re getting more in the surgical pack than they truly need. But be warned: If the data is flawed, the hospital risks losing its credibility with the medical staff.

Having the proper physician leadership is also important. Unless hospitals are very small, they should appoint a chief medical officer who has day-to-day responsibility for managing the cost and quality of care. This physician should be the hospital’s leading advocate for effective healthcare delivery.

Some other suggestions for hospital administrators to build better relationships with their medical staff:

- Learn more about your physicians and what motivates them. Physicians are concerned about quality—even though they may talk to administrators about parking spots. They need to have confidence that a hospital has a quality nursing and support staff, as well as the right facilities and equipment, to provide care.

Try These Cost-saving Measures

Labor costs

- Monitor overtime hours and agency use.
- Hire non-nurse professionals to relieve nurses of paperwork.
- Give cell phones to nurses to reduce their inter-unit travel time.
- Align staff schedules to patient schedules.

Revenue cycle

- Review qualifications of staff assigned to revenue cycle processes.
- Emphasize training, and don’t forget accountability after staff is trained.

Clinical costs

- Encourage prescribing of generic medications by limiting pharmaceutical reps’ “face time” with physicians.
- Make services needed by physicians available 24/7 to eliminate delays that can increase length of stay.
- Assign managers to spend time with physicians to determine their concerns and issues.

Overall performance

- Regularly scrutinize IT contracts to make sure the hospital is getting what it’s paying for.
- When considering new projects or programs, think ahead about an exit strategy if the programs don’t succeed.
- Assign an inhouse committee to “own” processes and goals established by consultants.

- Remove physician irritants. Make it easy for physicians to order tests and get results, and do all you can to make sure that services are available around the clock to help reduce length of stay.
- Empower the chief medical officer to standardize care around best practices. Begin with the DRGs that have the highest financial and clinical impact. Share outcomes data with physicians, and call attention to the physicians who are working close to best practice.
- Implement a physician “sales and service” program. Assign managers the task of visiting physicians each month to solicit their feedback on key issues.
- Make sure the hospital is managing its employed physicians. In markets where the employee-physician model is still important, administrators should ensure that the physicians’ compensation contracts are aligned with hospital goals.
- Involve physicians early in risk management cases to reduce malpractice costs.

Information Technology: Get What’s Needed

Hospitals continue to struggle with IT initiatives, which typically range from 2 to 3 percent of total expenses.

As part of the systemwide renewal effort at Henry Ford, executives decided to restructure and outsource the organization’s IT services in late 2000. The IT redesign reflected infrastructure changes in the system, including the complete redesign and integration of its finance, purchasing, and HR functions. “We tried to make our IT infrastructure functional and supportive, not just for the finance area, but also for the business units throughout the organization,” says Connelly of Henry Ford. With these infrastructure changes, the system was able to reduce its 2002 operating costs by \$15 million, compared with 2001, and continues to hold those gains.

When working with technology vendors, financial executives should scrutinize their contracts on a regular basis. Ask:

- Is the hospital getting what it’s paying for?
- Is the system paying for services or modules it doesn’t need?
- Are the contract terms and conditions being realized?

New Programs: To Be or Not to Be?

When the acute census slipped in many hospitals, administrators chose to fill empty space with nonacute programs that would generate additional income, such

as rehabilitation and psychiatry. Before moving or opening new programs, administrators should know which service lines/programs are profitable or have strategic value to their organizations.

Still, when considering new projects, administrators should proceed with caution. It’s important to focus on core services and resist thinking that volume will be the answer to your financial woes. Take it from one financial executive at Henry Mayo Newhall Memorial Hospital, Valencia, Calif.

“The bottom line of any healthcare organization succeeds or fails based on its ability to deliver quality clinical services that are well managed,” says C.R. Hudson, senior vice president and CFO. “If you allow or require your clinical managers to focus on too many additional new programs or projects, it is very easy to lose focus on the day-to-day management, which is, and must be, your No. 1 priority.”

Before hospital executives launch a new program, they should consider these questions:

- Does the program have physician buy-in? Which physicians will be the clinical champions and refer the patients?
- What is the market potential?
- Does the hospital currently have the resources, including staff, facilities, and technology, to make this work?
- What capital investments will be needed?
- What will be the contribution margin? What kind of bottom line can we expect?
- Does the hospital have realistic, detailed growth plans? Are the growth plans backed up by specific, actionable timetables? When and how will the hospital monitor progress?
- Does the hospital have an exit plan if goals are not met?

Barriers to Operational Performance

While a back-to-basics focus sounds simple enough, a number of factors can interfere with an organization’s efforts to implement corrective initiatives and close its performance gap. The barriers often reflect management’s inability to change. Some of these barriers are listed below:

“**Whose responsibility is this?**” Hospitals that enlist consultants to help launch their turnaround efforts often establish an oversight committee of board members and physicians. Once the consultants go off

the clock, it's the committee's responsibility to monitor the organization's progress toward meeting its goals. Hospitals in which these committees fail to meet regularly and "own" the process may eventually hire a new round of consultants two years down the road to pick up the momentum. Administrators are often reluctant to reverse decisions that they have made, but it's important to find the courage to do so and take on the responsibility for those owned decisions. Thus, ownership is key.

"We don't have the tools." Many hospitals don't provide managers with the information and tools they need to manage their departments. If managers are accountable for productivity, then they need more than just data—they need information. That's why most hospitals benefit from methods for collecting and sharing information, such as a biweekly productivity system that monitors work volumes in each service area. Besides sharing productivity data with managers, hospital administrators also need to make sure that the clinical staff—not just the hospital's managed care staff—understand the provisions of big contracts.

"We may need that empty building someday." Hospitals tend to hang on to old buildings or let offices creep into every square foot of space available. A better rationalization of the use of space can help hospitals unload unnecessary buildings that require costly utilities and upkeep.

"We can't control costs for the whole system." Financial managers of hospitals within a large system must work within certain boundaries and processes set up for the system as a whole. Therefore, financial managers of such hospitals need to concentrate on their hospitals' own operational goals—the goals over which they have control.

"But we benchmark." Benchmarking can help, but it needs to be put in context and modified by the hospital's specific facts and circumstances. Often, industry benchmark data comes from organizations facing their own financial problems. Putting too much trust in cursory benchmarking efforts also can impede financial progress for an organization.

The CFO: The Conscience for Change

Revenue-enhancing and expense-trimming initiatives require a lot of planning, but once implemented, they can deliver results rapidly.

Timeframes for Improvement		
Expense Opportunity/Target	Ability to achieve	
	Difficulty	Years
Labor expense—patient care	High	1–3
Labor expense—support and other	Medium	1–2
Labor expense—management and structure	Medium	1–3
Supply expense—price and utilization	Low	1
Supply expense—clinical practice	High	2–3
Clinical resource management—average length of stay	Medium	1–2
Clinical resource management—resource consumption	High	2–3
Purchased services	Low	1–2
Administrative expenses	Low	1
Program rationalization	High	1–3

Hospitals that take on performance improvement efforts often see results in the first 12 to 18 months, particularly though labor productivity and supply initiatives (see exhibit). But it usually takes two to three years to drive toward the total return. Administrators need this much time to renegotiate contracts, make dents in resource utilization, and evaluate and close any unprofitable programs.

Of course, the quicker an organization accepts that it has a problem, the faster it can be solved. Focusing on operations—and not getting sidetracked by other issues—is crucial. So is following sound management basics, which can help the hospital improve its overall financial and operational performance.

"Oftentimes, healthcare providers find themselves getting into trouble as they attempt to do too much at one time," says Hudson of Henry Mayo. "From the CFO's position, managing cash, controlling payables, and really working to improve the revenue cycle and receivables is critical for your long-term success."



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