Case Study: Community Memorial Hospital
Flex Conference Webinar Series 2014

Service Area and Population

Community Memorial Hospital (CMH) is a critical access hospital located in a rural area of the United States, 45 minutes from a large urban hospital and 30 minutes from another small rural hospital. One other small hospital is within one hour driving distance.

The community has been steadily losing population during the past two decades as young people often leave to seek employment in larger cities. A factory in town is the largest employer with 248 employees, and Blue Cross and Blue Shield (BCBS) is their insurance company. The insurance company has been relatively aggressive in negotiating hospital discounts.

The area has high rates of diabetes, heart disease, and cancer, all of which are more than 20% higher than the national average.

Of the 7,200 people in the service area, 21% are below the federal poverty level.

Around 62% of CMH’s inpatients and 38% of the outpatients are on Medicare.

Approximately 18% of CMH’s patients are on Medicaid, which has very low payment rates in this state. These Medicaid patients have a high utilization rate of the emergency room (ER), almost 30% of the total ER visits.

Hospital Profile

CMH converted to critical access hospital (CAH) status in late 2004, and now has 15 acute care beds with an average daily census of 3.2, and average length of stay is 2.9 days. CMH has 10 swing beds, but the Chief Financial Officer (CFO) acknowledges that they do not know how to maximize swing bed revenue.

CMH has four primary care physicians and one nurse practitioner on staff, all of whom are part of one independent group practice. Two of the physicians are foreign trained (J-1 visa). One of the physicians, Dr. Larry Holt, age 64, has been practicing in the community for 23 years and has been described by representatives of both staff and board as very outspoken and often difficult to work with. Turnover on the medical staff has been frequent. All of the physicians are independent primary care practitioners, and their clinic is located in an old building three blocks from the hospital.

CMH was built in the late 1950’s, and no renovation has taken place for 11 years. Access to capital for new construction and needed equipment has been difficult to obtain, as their credit rating is relatively low. Although the hospital is city owned, the city lacks resources to help with the current crisis.

CMH is currently not a member of either a large health system or a hospital network. It has an opportunity to join a network of 11 rural hospitals in its state that has been in existence for six years and that includes collaborative programs in quality and finance.
Hospital Leadership

CMH is governed by a board of directors made up of nine local citizens. Three have business experience, including President Bob McGee, who is a local attorney. The board has not had any training in governance and is sometimes unsure of its proper role. Board meetings often last three or more hours, and there has been a tendency for board members to interfere with management and administrative duties.

CMH is currently without a permanent Chief Executive Officer (CEO). The previous administrator was fired two months ago, and 28-year old CFO, Dan Jordan, has been acting as interim CEO as well as CFO. Dan, who has been at the hospital for 18 months, has a degree in accounting but had no previous experience in hospital cost accounting when he assumed the CFO role.

The Director of Nursing (DON) is Diane Sheldon, Registered Nurse (RN), who has been with the hospital for five years. Lately she has been losing nurses to the urban center nearby, which can afford to pay almost 30% more in salary and benefits, and she is having difficulties recruiting a full nursing staff. She has frequently relied on expensive temporary nursing services. The hospital also is short on lab and other technicians as well as various other positions. Low wages and benefits again are cited as factors in the difficulty with recruitment and retention.

CMH has begun implementing electronic health records (EHRs) but has struggled to meet the deadlines to achieve incentives. A number of nursing staff and several physicians have actively opposed EHR adoption and now point to reduced hospital production as the inevitable outcome of this initiative.

Health information technology (HIT) skills of CMH staff are minimal. The hospital employs one full time IT person who graduated from a 6-month training program, and relies on outside IT consulting expertise.

CMH managers generally lack training in leadership, management, and performance improvement. Many of the staff do not have a high school diploma. Most lack college degrees, and it has generally been difficult hiring competent staff.

Hospital Finances

CMH is financially troubled and has historically struggled to survive. Lately, community fundraising events have been unsuccessful and the town seems to have grown complacent about the risk of the hospital’s closure after numerous predictions of closure in the past.

Financial data includes:

- 101 days in accounts receivable (The 2012 US median was 53 days)
- 12 days cash on hand. Most reserves have been exhausted. (The 2012 US median was 77 days)
- -4.5% operating margin (The 2012 US median was 1.6%)
- The hospital charge-master has not been updated in three years
- Preliminary examination of the hospital cost report and revenue cycle management process reveals significant errors and inefficiencies that, if corrected, could capture hundreds of thousands of dollars in additional revenue
- As a CAH, the hospital now receives cost-based reimbursement for both inpatient and outpatient services, but is not using swing beds
• The hospital has a high ratio of inpatient to outpatient days suggesting a lack of emphasis on outpatient business

Hospital Quality

CMH has faced several quality and infection control lapses recently. Several staff have expressed concern about lack of an effective performance improvement program. There have been an increased number of medication errors from the previous year. There have also been a number of patient transfer delays and patients transferred to neighboring facilities without their patient records and care assessment. Families have complained to administration about poor communication between hospital staff and inadequate patient discharge instructions. The Quality Improvement Coordinator, Barb Riley, reports that various quality programs have been attempted to correct these issues at the hospital, but all have lacked top leadership commitment and fizzled when other hospital crises occurred. She feels that hospital leadership has not recognized the importance of continuous quality improvement, and that she may be the only manager that truly cares about this issue. She has applied for a position with one of the neighboring hospitals.

CMH voluntarily participates in the federal Medicare Beneficiary Quality Improvement Program (MBQIP) for quality measure data collection and reporting. However, most hospital staff have minimal skills in data analysis. Information that is gathered is used for compliance purposes, and little time is spent analyzing the data or using it for strategic decision-making on where quality could be improved. The hospital does not currently use evidence-based best practices.

The hospital has a rapidly growing uncompensated care caseload and the state has, to date, refused to accept federal funding to expand Medicaid coverage.

CMH has no formal patient satisfaction program but does have a suggestion box with mostly positive feedback from the patients. The hospital and physicians have been dealing with several malpractice suits.

No formal community survey has ever been conducted to assess health care needs or to obtain community feedback about hospital quality. Reportedly, word on the street is that CMH is fine for emergencies when you can’t go anywhere else, but “we go to the city for our health care.”

Community Health System

An estimated 60% of the population in the local community go to the nearest big city to receive health care. No information exists as to why they do not use the local hospital, but word on the street is that “the hospital has serious quality problems.” Some people have heard this from the hospital employees themselves.

CMH leadership has limited interaction with either public health or mental health providers. There is also little coordination or communication with the independent nursing home and assisted living facility in town, often resulting in readmissions to the hospital within 30 days of discharge. The local ambulance service is staffed by volunteer Emergency Medical Technicians (EMTs) with no advanced life support skills. Hospital transfers are generally to the tertiary care facility 45 minutes away, with no formal relationship and limited communication between the hospital and the referral center.
The referral center is part of a new Accountable Care Organization (ACO), which has recently approached the local independent physicians about participating in their ACO. CMH leaders are concerned that the ACO may attempt to purchase the practice and refer patients away from CMH.