NEVADA RURAL HOSPITAL BENCHMARKING INITIATIVE AND
NEVADA RURAL HOSPITAL REVENUE CYCLE INITIATIVE

Nevada Rural Hospital Benchmarking

Two core, cross-cutting initiatives undertaken by Nevada Flex Program and its principal subcontractor, Nevada Rural Hospital Partners, are (1) the Nevada Rural Hospital Benchmarking Initiative and (2) the Nevada Rural Hospital Revenue Cycle Initiative. The Nevada Rural Hospital Benchmarking Initiative represents a major set of multi-year activities initiated during previous fiscal periods with the support of the Nevada Flex Program and the pooled resources of the Nevada SHIP Consortium. The current five year goal of the benchmarking initiative is nothing less than the development and utilization of financial, operational, and quality indicators and benchmarks in all rural and frontier hospitals in Nevada.

The Nevada Flex Program and its program partners recognize that accurate data is the key ingredient for evaluating performance and initiating appropriate performance improvement activities. Performance improvement decisions need to be made on the basis of consistent and reliable data – a need which is extremely important in rural settings; but where human and financial resources are limited and comprehensive benchmarking data has been difficult to obtain. In response to the shortcomings of benchmarking data available to rural hospitals, the Nevada Flex Program has established measures (see below) and is developing the means to capture and report benchmarking data. The financial measures will mirror those adopted by the Healthcare Financial Management Association (HFMA) and the operating measures mirror those of the Larson Allen Gold Standard for Critical Access Hospitals. Together they capture the majority of the measures used by the Flex Monitoring Team and all of the required data is available for all Nevada rural and frontier hospitals.

Current and planned benchmarking activities include refinement of the data gathering and reporting process, distributing results to all hospitals, sharing “best practices” among the facilities, and applying the benchmarking data to an individual facility’s Balanced Scorecards or other performance improvement tool. A review by the Nevada Flex Program of the available independent quality measurement tools found the same circumstances as with the financial and operating benchmarking tools – they were designed for larger and urban facilities and were cost prohibitive. To address the need for relevant quality data, Nevada’s rural and frontier hospitals again chose to develop their own unique measures and data reporting tool. This was done in collaboration with the Nevada Flex QI Network and the Nevada Risk Manager Work Group (RMWG). The work group, consisting of risk managers from nine CAH and CAH-eligible hospitals, holds quarterly in-person meetings in conjunction with the Nevada Flex QI Network Committee.

The RMWG has been tracking and reporting their respective hospitals’ risk incidents since 2004 and has used the results of their findings for risk management education programs and QI activities. The group considered incorporating the CMS Hospital Compare measures into their
process, but found the CART tool too difficult to manage and the resource commitment to
 gather the data not feasible; however, some members still chose to participate on their own.
To address this gap in quality reporting, the group developed their own Nevada rural relevant
measures and began compiling and reporting their data.

Upcoming plans include continuing with the above described activities, but to work towards a
consolidated means to report the group’s quality data; both internally and externally. To this
end, the Nevada Flex Program in conjunction with NRHP and the SHIP consortium has begun
development of NRHPI, a web based data management system. This support will continue into
future grant periods.

Nevada Revenue Cycle Activities

The second major initiative underpinning Nevada Flex Program activities is the Nevada Rural
Hospital Revenue Cycle Initiative. The traditional approach to healthcare business operations
has been singularly focused on improving balance sheet performance or accounts receivable
(A/R), reducing A/R days, and increasing cash flow. This approach has typically involved an
ongoing application of human resources, more technology, and special “one-time projects”
that have typically not addressed root-cause process breakdowns and, therefore, have
produced short-lived results for hospitals.

Recognizing the need to create more effective, long-term solutions, healthcare financial leaders
developed a process known as revenue cycle management. The focus of revenue cycle
management is to create a permanent improvement in financial and operational performance.
Through the use of comprehensive measurement and reporting, all hospital processes and
employees are monitored, measured, and altered for optimum performance. Consistent with
revenue cycle management, new tools are implemented to drive work performance, while the
use of existing information technology is optimized. While this approach created a permanent
solution for larger hospitals equipped with the necessary resources, rural providers have been
challenged to achieve the benefits realized by the larger facilities.

To address the problems faced by rural hospitals in Nevada, the Nevada Flex Program, through
their subcontract with NRHP, has supported the development and implementation of the
Nevada Rural Hospital Revenue Cycle Initiative. The program involves a complete review of the
flow of patient financial information (PFI), the functions involved in the processing of PFI, and
the identification of needed revisions. To assist in the monitoring of the effectiveness of the
program, five specific reports (listed below) to review the results of accounts receivable (A/R)
and to identify key trends assessing the effectiveness of rural hospital business offices have
been developed.

The reports include:

- A/R Days, Hospital-wide and by payer class
- A/R over 90 Days, Hospital-wide and by payer class
- Cash Collected as a Percent of Net Revenue
• Net Revenue as a Percent of Gross Revenue  
• Bad Debt Expense as a Percent of Gross Revenue

To date, the revenue cycle initiative has been implemented in one Nevada rural hospital and has led to reductions in A/R days, reductions in bad debt write offs, and increases in patient revenue collections. The program was subsequently expanded to include performance measurements for areas such as registration errors, unbilled revenue, charge capture, and claims denial, thus providing a complete measure of a facility’s revenue cycle performance. The Nevada Flex Program is committed to providing the measures template and data gathering assistance to other Nevada CAH and CAH-eligible facilities as requested.

In summary, the Nevada Rural Hospital Benchmarking Initiative and the Nevada Rural Hospital Revenue Cycle Initiative represent ongoing, cross-cutting work undertaken by the Nevada Flex Program and program partners to support and extend technical assistance provided to Nevada’s Critical Access Hospitals and CAH-eligible small rural hospitals.

CORE MEASURES

Nevada Rural Hospital Benchmarking Initiative Core Measures

Financial Measures (HFMA Core Measures)

1. Average Length of Stay  
2. Maintained Bed Occupancy  
3. Operating Margin  
4. Excess Margin  
5. Debt Service Coverage  
6. Current Ratio  
7. Days of Cash on Hand  
8. Cushion Ratio  
9. Days in Accounts Receivable  
10. Average Payment Period  
11. Average Age of Plant  
12. Debt to Capitalization  
13. Capital Expense %

Operating Measures (Larson Allen Gold Standard)

1. Medicare Cost Based Utilization  
2. Medicare Inpatient %  
3. Medicare Outpatient %  
4. Average Charge per Inpatient Day  
5. Medicare Allowances and Discounts  
6. Overall Mark Up %
7. Non-CAH Collection %
8. FTEs per Adjusted Occupied Bed
9. Acute Nursing Cost per Adjusted Patient Day
10. Surgery Cost per Adjusted Patient Day
11. Emergency Room Cost per Adjusted Patient Day
12. All Other Ancillaries Cost per Adjusted Patient Day
13. Support and Administration Cost per Adjusted Patient Day
14. Capital Expense Cost per Adjusted Patient Day
15. All Other Services and Costs per Adjusted Patient Day
16. Medicare Inpatient Surgery Cost per Patient Day
17. Medicare Emergency Room Cost per Patient Day
18. Medicare All Other Ancillaries Cost per Patient Day

Quality Measures Developed by LiCON Risk Managers Work Group

1. Aspirin for Chest Pain
2. CHF Patients Given Dx Instructions
3. CHF Patients Giving Smoking Cessation Advice or Counseling
4. PN Patients Assessed and Given PN Vaccine
5. PN Patients given Smoking Cessation Advice or Counseling
6. PN Patients Assessed and Given Influenza Vaccine
7. Age Appropriate Vital Signs w/in 20 minutes of Discharge from ED
8. Weight of Pediatric ED Patients

Nevada Rural Hospital Revenue Cycle Initiative Core Measures

1. Point of Service (POS) Collections
2. Registration Accuracy
3. Denial Management
4. Net Revenue per Patient Encounter
5. Net Patient Revenue as a Percentage of Gross Patient Revenue
6. Cash Collected as a Percentage of Net Patient Revenue
7. Bad Debt Expense as a Percentage of Gross Patient Revenue
8. Gross A/R days
9. % of A/R Greater than 90 Days
10. Discharged Not Final Billed (DNFB)
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