



NATIONAL
RURAL HEALTH
RESOURCE CENTER

600 East Superior Street, Suite 404 | Duluth, MN 55802 | Ph. 800.997.6685 or 218.727.9390 | www.ruralcenter.org

Framing Rural Health Value Webinar Series

Processes for Improved Financial and Quality Outcomes



Terry Hill

Senior Advisor for Rural Health
Leadership and Policy

July 2014



Today's Learning Objectives

- Discover the impact on a critical access hospital (CAH) for value-based reimbursement and its internal processes
- Learn activities a State Flex Program can provide to develop efficient business processes within a CAH
- Understand the value of continuous improvement of CAH operations, quality and patient safety processes using resources such as Lean and Return on Community Investment (ROCI)
- Understand how to maximize information technology to improve both CAH efficiency and quality



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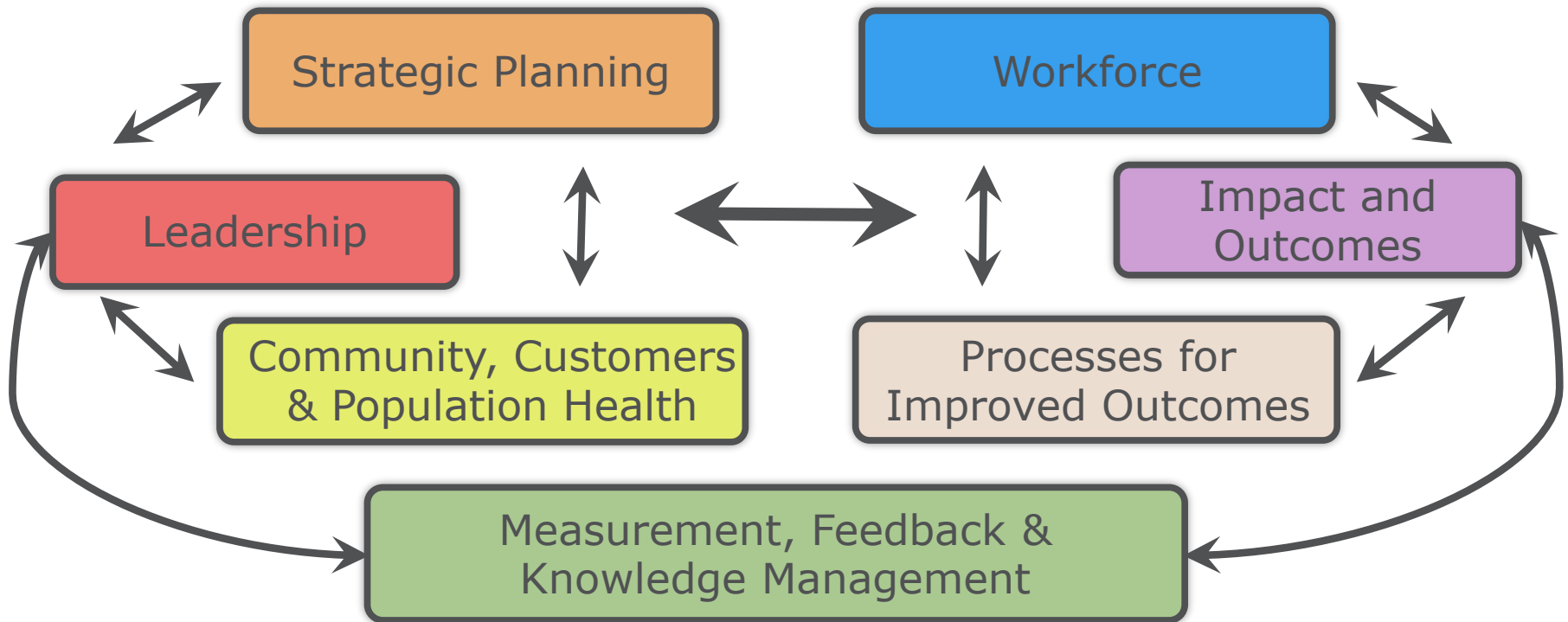
The Challenge: Crossing the Shaky Bridge



Source: <http://www.flickr.com/photos/67759198@N00/2974261334/sizes/o/in/photostream/>



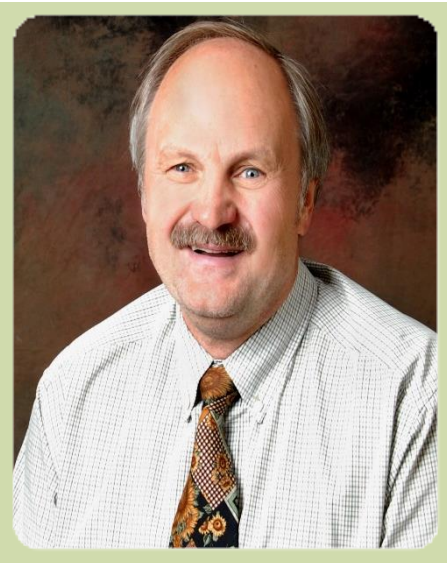
Performance Excellence Framework





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Panel Members



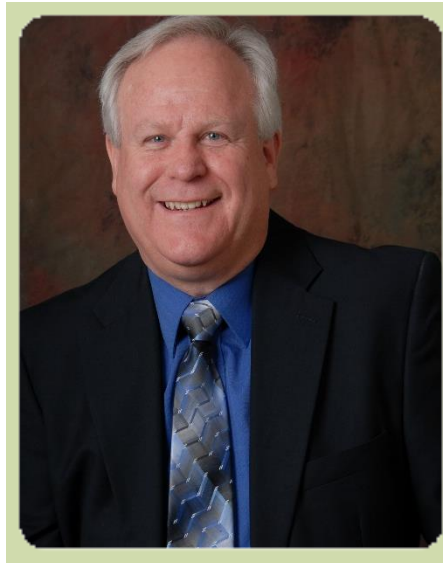
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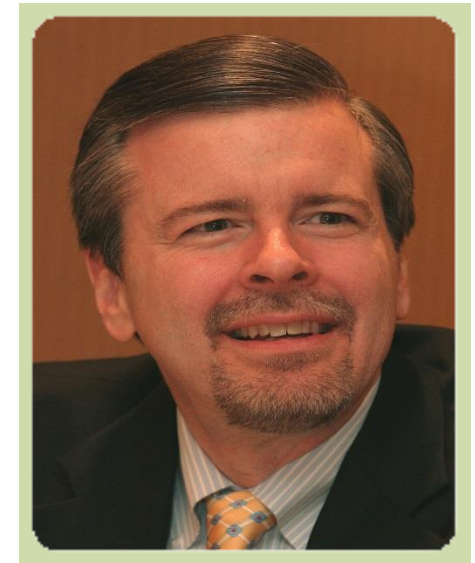
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Moab Regional Hospital

PROCESSES FOR IMPROVED FINANCIAL AND QUALITY OUTCOMES

2014 National Flex
Conference Webinar Series

July 9, 2014

MOAB REGIONAL HOSPITAL



Moab Regional Hospital

- Critical Access Hospital
- 17 Inpatient Beds
- 77% of revenues are Outpatient
- Service population of approx. 12,500
- 2,500,000 annual visitors (2 million at Arches and Canyonlands National Parks)
- Mountain Biking and Jeep Capital of the World
- 160 employees

Board of Directors:

- 7 Members
- 501 © 3 Private Non-Profit
- One physician member

Active Medical Staff Composition

- 3 Family Practice with OB/c-section
- 2 Family Practice, no OB
- 1 General Surgeon
- 2 Orthopedic Surgeons
- 1 MDA + 2 CRNAs
- 4 Emergency Room physicians
- 1 Plastic Surgeon (part-time)

May, 2012



HUD Call

Either:

Make payroll to employees

Or

Default on HUD loan payment

Turnaround Plan - A Call to Action

1. Operational Improvements
2. Operational Improvements – Accounts Receivable
3. Debt Restructuring
4. Governmental Assistance
5. Optimize Reimbursement & Third Party Payor Contracts
6. Pricing Strategies

Operational Improvements

(what the staff did)

- 16 Point Action Plan developed within 7 days
- Board Chair became integrally involved in efforts
- Engagement with Consultant–Fresh Eyes! Built Action Plan 2
- CEO communication to Staff, Physicians, Community, Board, HUD, Hospital Association, State of Utah (KEY!)
- Established weekly cash council for cash forecasting
- Reduction in Retirement Contribution 6% to 3% \$ 165,000
- Reduction of CRNA Staff \$ 170,000
- Review of Purchased Services, Maintenance Contracts
- Buyout of Equipment Rental Contracts \$ 260,000

Operational Improvements

- HUD/Board agreement for Management Company-6 months
- Hired Accounting Firm to prepare IRS 990's
- Hired Attorney to Abate IRS penalties \$ 65,000
- Reduction in late payments and interest \$ 19,000
- Reduction in Bank Card Fees
- Accounting Staff to meet reporting requirements
- Changed Charity Policy and Charity Review
- Evaluation of Administrative Write-Offs Authorization \$ 100,000
- Reduced outstanding A/P from \$2m to \$600,000
- Joined Western Healthcare Alliance (WHA) – Association of Rural Hospitals in Colorado (Partnership for education, insurance, GPO, peer groups, collection agency, etc)

Operational Improvements - AR

- Net AR Day Reduction 103 to 51 Days
- Eligibility Software for Deductibles and Co-pays
- Addition of Pre-Authorization Person
- Increased Monthly Time of Service Collections
\$2K to \$85K
- Reduction in Billing Denial Rate from 30% to 2%
- Hospital Wide Expectation -drop a clean bill in 4 Days versus 30+ days
- Went to electronic fund transfers(EFT) with payors

Governmental Assistance

- Regained Medicaid DSH Status via changes to Utah Medicaid State Plan with assistance from Utah Hospital Association, Medicaid, US Senator Hatch, and CMS
- County and City Financial Assistance to pay Medicaid DSH seeding via Healthcare Special Services District
- Increased County Mineral Lease Funds allocated by the County to the Healthcare Special Services District

Debt Restructuring

- Review of Bond Documents to take advantage of new HUD programs
- Review for interest rate relief or reduction
- Discovered 17 year lock on loan to not be able to refinance without penalty
- Borrowed from Mortgage Reserve Fund for Management Company Fees
- Paid off the Mortgage Reserve Fund from excess loan funds built up at the close of the loan

OPTIMIZE REIMBURSEMENT & THIRD PARTY CONTRACTING

- Amended 2011 Cost Report after review by outside consultant
- Worked with Medicare Intermediary to accelerate cost report reviews and rate adjustments
- Prepared interim cost reports to adjust rates and monthly contractual adjustments
- Negotiated 2010 Cost Report Audit Adjustments
- Outsourced capitalization of new hospital project – Decreased average life of project 4 years
- Implemented State Medicaid Worker onsite to increase Medicaid and decrease bad debt
- Rejoined Medicaid DSH program and raised seeding via government funds
- Joined Medicaid Upper Payment Limit (UPL) Hospitals
- Professional component contracting outsourced
- Renegotiated increased rates with 5 payors
- Negotiated with payors that had rate increase caps to allow increases above the caps

PRICING STRATEGIES

- Outside consultant provided Medpar rates and cost report comparisons for 8 non CAH rural hospitals compared to our rates
- Used market based pricing comparisons to non CAH hospitals – Increased non price sensitive rates to Market - Overall rate increase was 44%
- All payors except Medicare in Utah pay rural hospitals percent of charges.

FLEX Program Assistance

- Offered a list of available resources
- Paid for our 2013 Community Needs Assessment and provided person to prepare it
- Have sent experienced individuals to facilities as consultants and resource people

Financial Indicators

Moab Regional Hospital

	<u>2011</u>	<u>2012</u>	<u>2013</u>
Days in Net A/R	103	57.3	50.55
Days in Gross A/R	120	79.8	73.4
Days COH	29	49.8	144.3
Total Margin	-5.60%	0.90%	6.70%
Operating Margin	-5.7%	-2.1%	6.0%
Debt Service Ratio (1.5 Required)	1.3	1.8	2.2
Salaries to Net Patient Revenue	41.2%	35.2%	35.1%
Avg. Age of Plant (Years)	1.2	2.0	2.9
LTD to Capitalization	79.40%	70.32%	68.30%

- Source: Critical Access Hospital 2012 Leadership Summit, TASC, National Rural Health Resource Center

Today!!

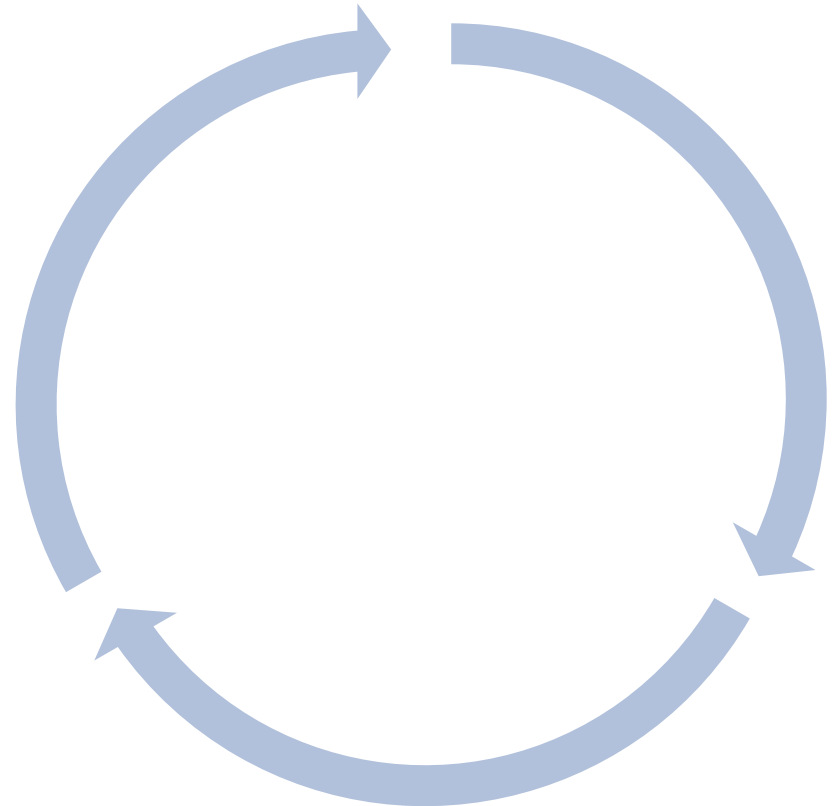




Critical Strategies for CAHs

Optimize fee for service

- Revenue cycle
- Market share
- Payer contracts (skinny networks)





Critical Strategies for CAHs



Drive out inefficiency

- Eliminate waste (Lean)
- Reduce variation (6 Sigma)
- Flatten the organization
- Review bricks & mortar budget



Critical Strategies for CAHs

Engage the medical staff

- Leadership & governance
- Partnerships
- Retention
- Patient-focused, evidence-based





Critical Strategies for CAHs



Preparation for value models

- Medical home
- Care coordination
- Accountable Care Organizations (ACOs)
- Prevention & wellness
- Electronic information



Critical Strategies for CAHs

Engage the Community

- Assessments & dialog
- Long term care & mental health
- Employers and schools
- Population health partnerships





Critical Strategies for CAHs

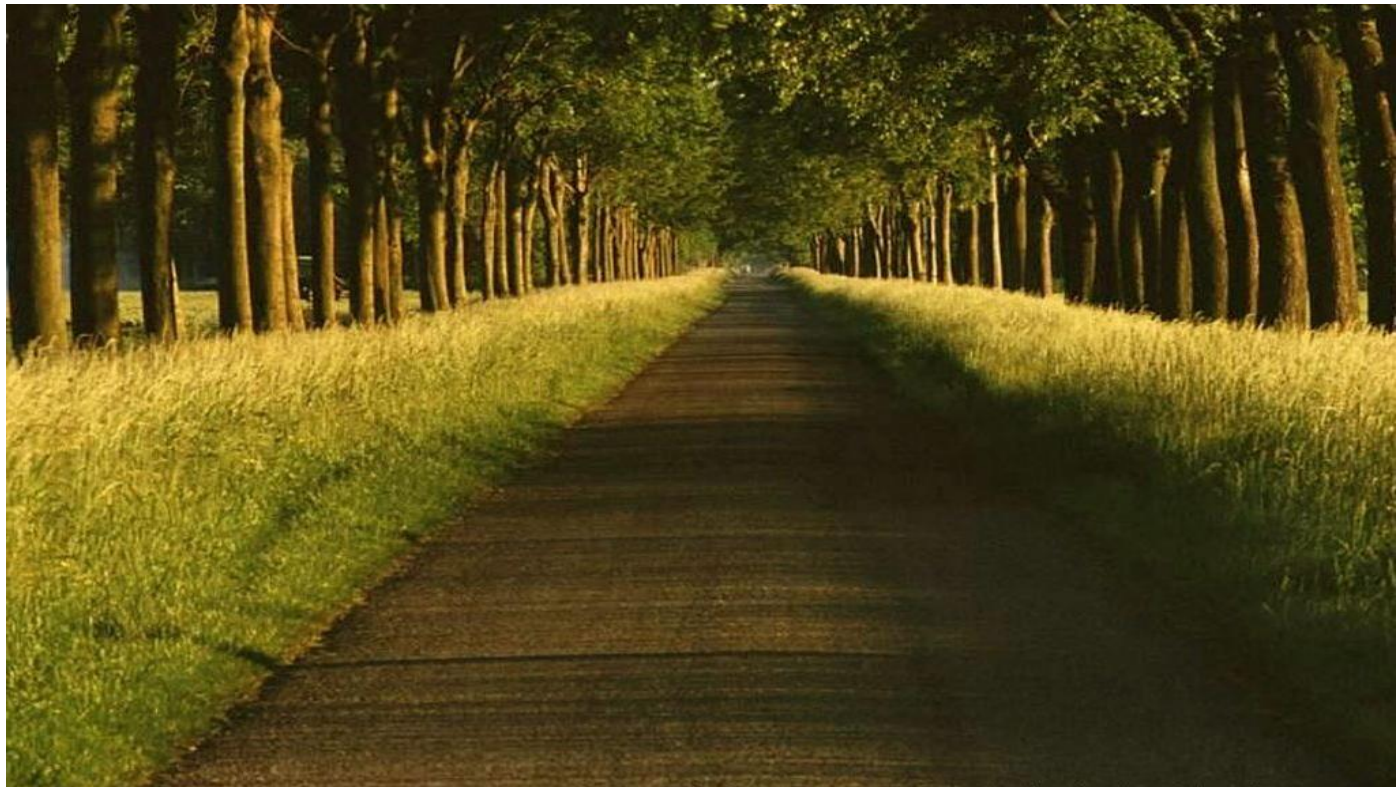


Document and promote hospital value

- Public reporting
- Marketing
- Feedback for improvement
- Participate in value models



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A journey of a thousand miles begins
with a single step.
- Lao-tzu

Source: <http://seidoryu.com/journeyi.HTM>



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“Even if you’re on the right track,
you’ll get run over if you just sit there.”
-Will Rogers



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Panel Q&A



Next Event

- Wednesday, July 16, 2:00 – 3:00 pm CDT
- Plenary #5: Data Measurement Outcomes and Impact
- Speakers:
 - Kami Norland, National Rural Health Resource Center
 - Melissa Van Dyne, Missouri Office of Primary Care and Rural Health;
 - Sue Dietz, Critical Access Hospital Network (Eastern Washington)



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