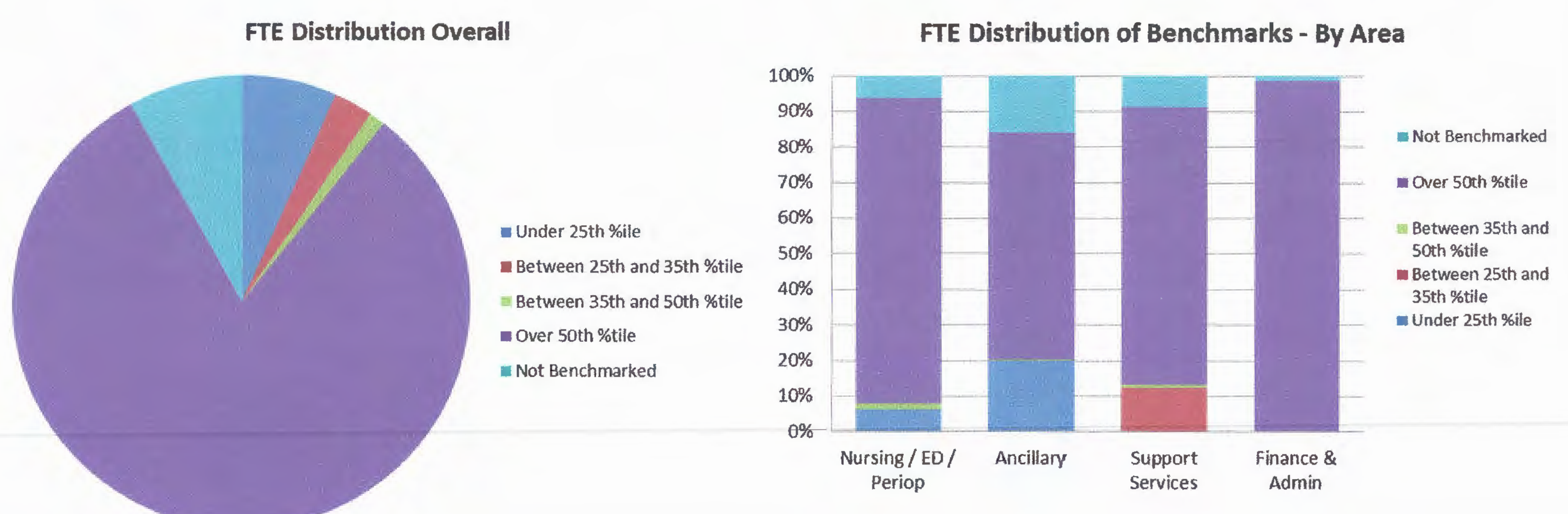
External Comparatives

RIVERSIDE COUNTY REGIONAL MEDICAL CENTER

Distribution of FTEs Based on Peer Comparatives

- 81% of staff are in departments performing above the 50th percentile (unfavorable)



Note: Baseline Period: May, 2012 to April, 2013

Source: L.III.Payroll Data; L.II. Workload Data; ActionOI benchmarks

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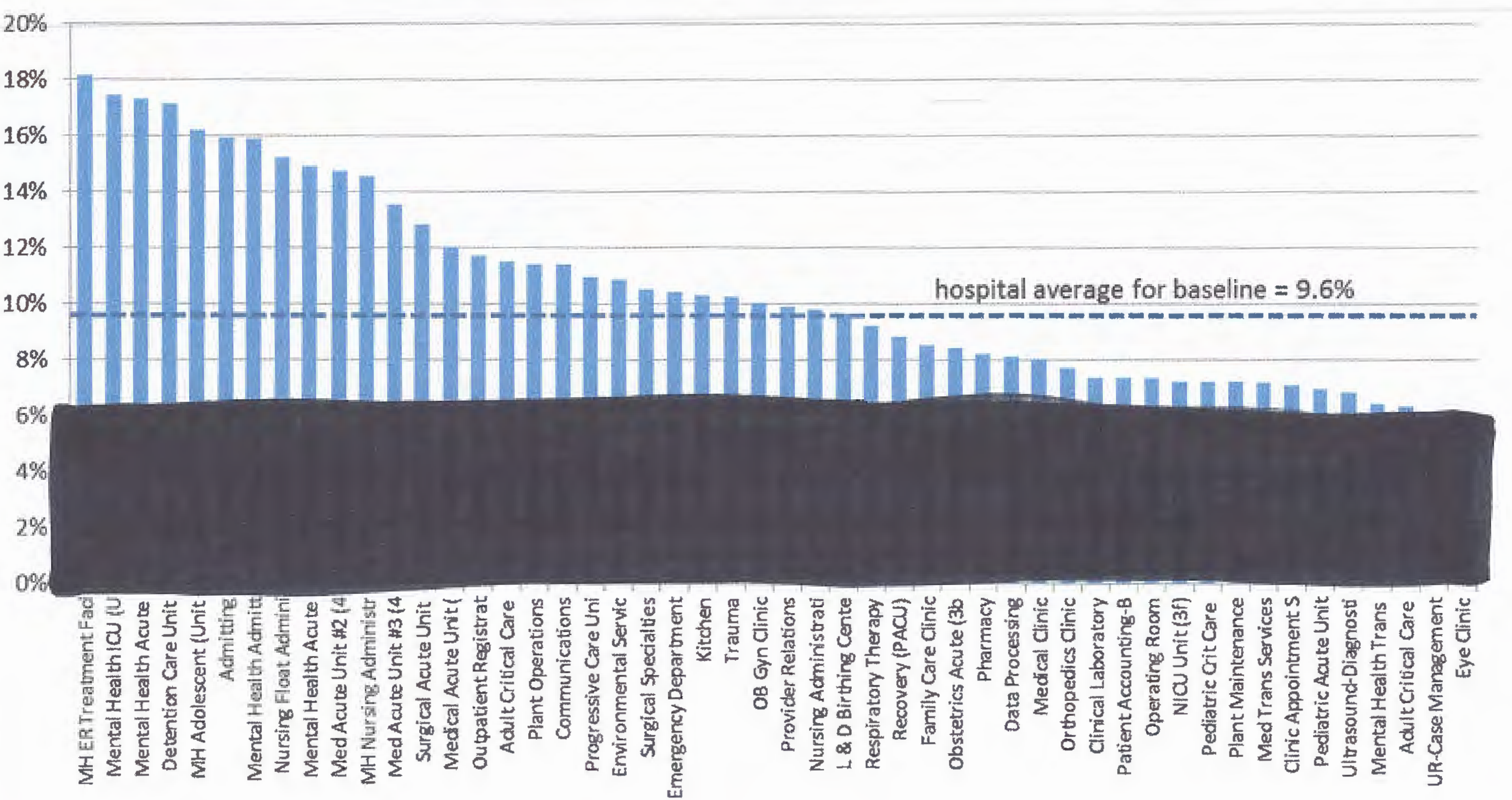
Internal Comparatives

RIVERSIDE COUNTY REGIONAL MEDICAL CENTER



Note: Baseline Period: May, 2012 to April, 2013
Source: L.III.Payroll Data

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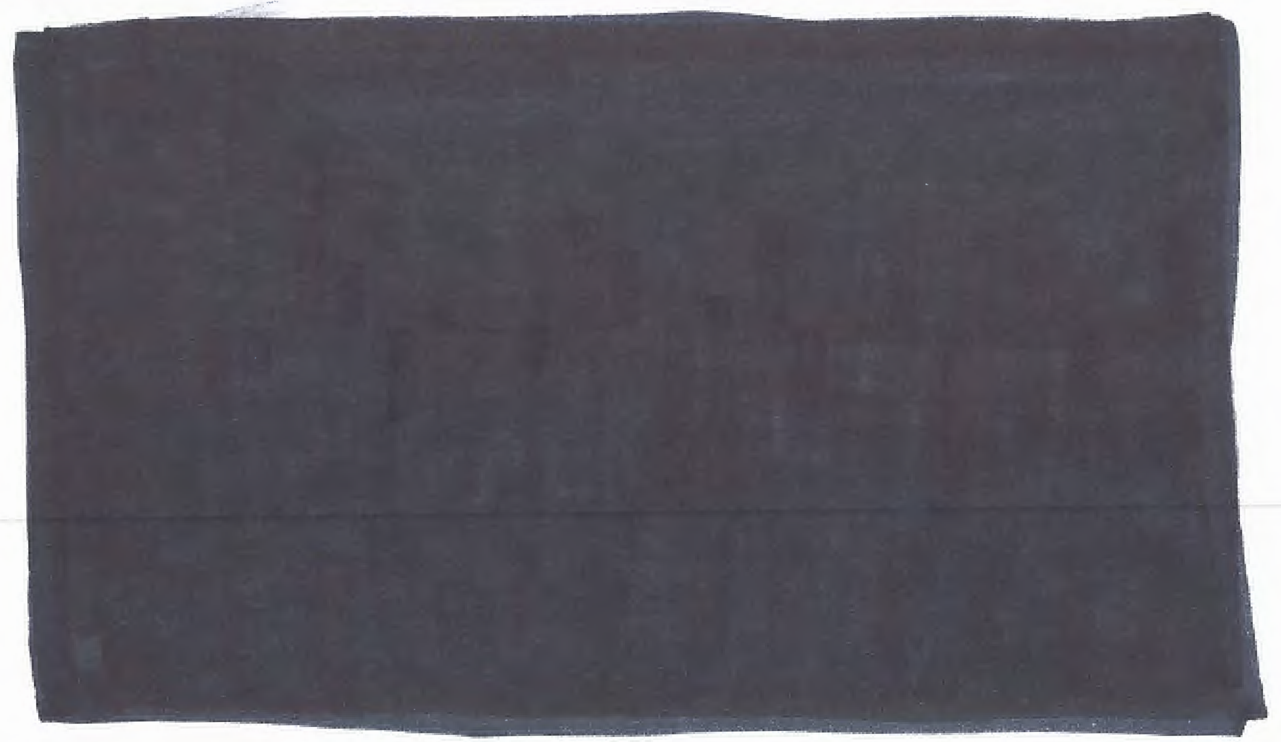
Management Practices

RIVERSIDE COUNTY REGIONAL MEDICAL CENTER

HuronHealthcare

Staffing to Volumes

- Month to month, staffing changes bear little resemblance to patient volume changes



Note: Baseline Period: May, 2012 to April, 2013
Source: L.III.Payroll Data; L.II. Workload Data

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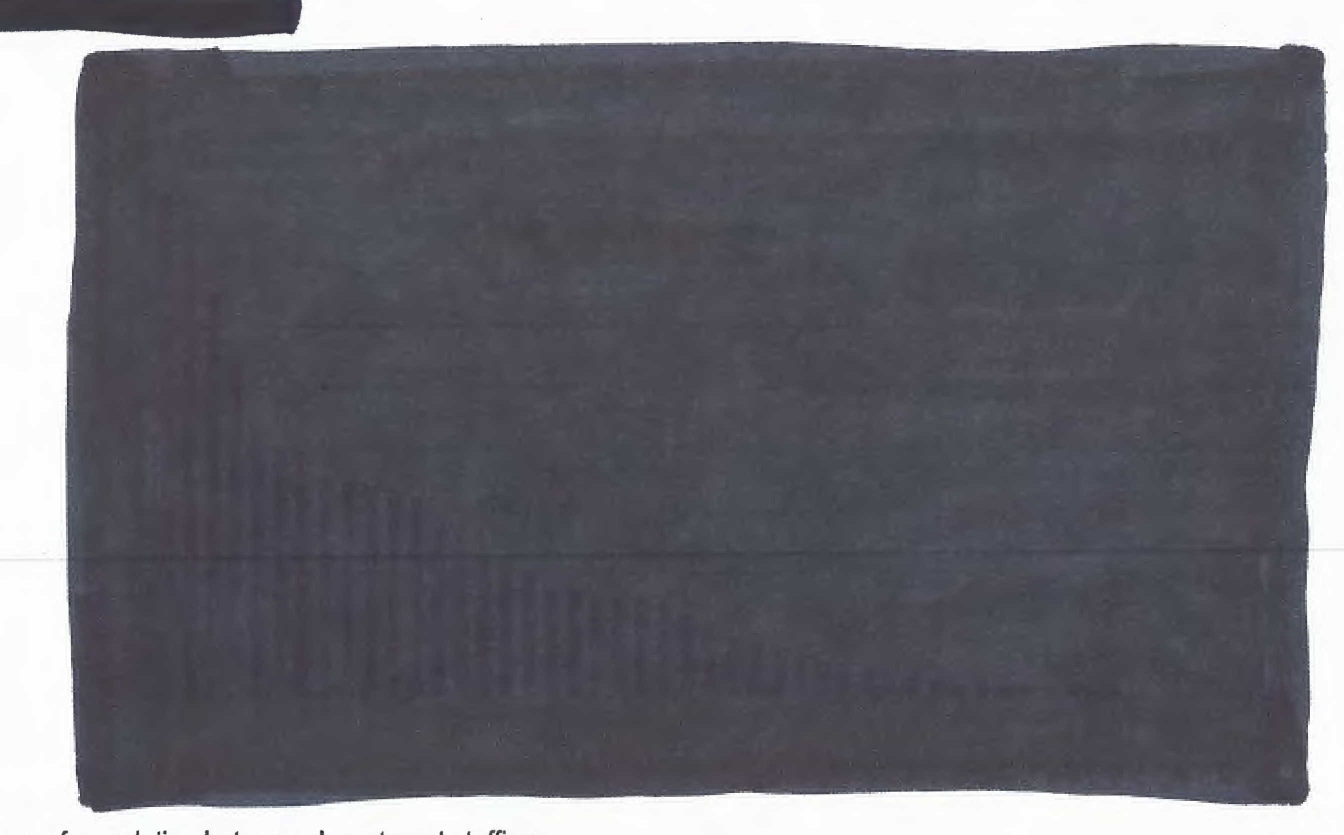
Management Practices

RIVERSIDE COUNTY REGIONAL MEDICAL CENTER

HuronHealthcare

Staffing to Volumes

- R2 is a measure of correlation of department staffing to volumes (1.0 = perfect correlation)
-



Note: R2 is a measure of correlation between department staffing (Worked Hours) to volumes (1.0 = perfect correlation)
Source: L.III.Payroll Data; L.II. Workload Data

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Management Practices

RIVERSIDE COUNTY REGIONAL MEDICAL CENTER

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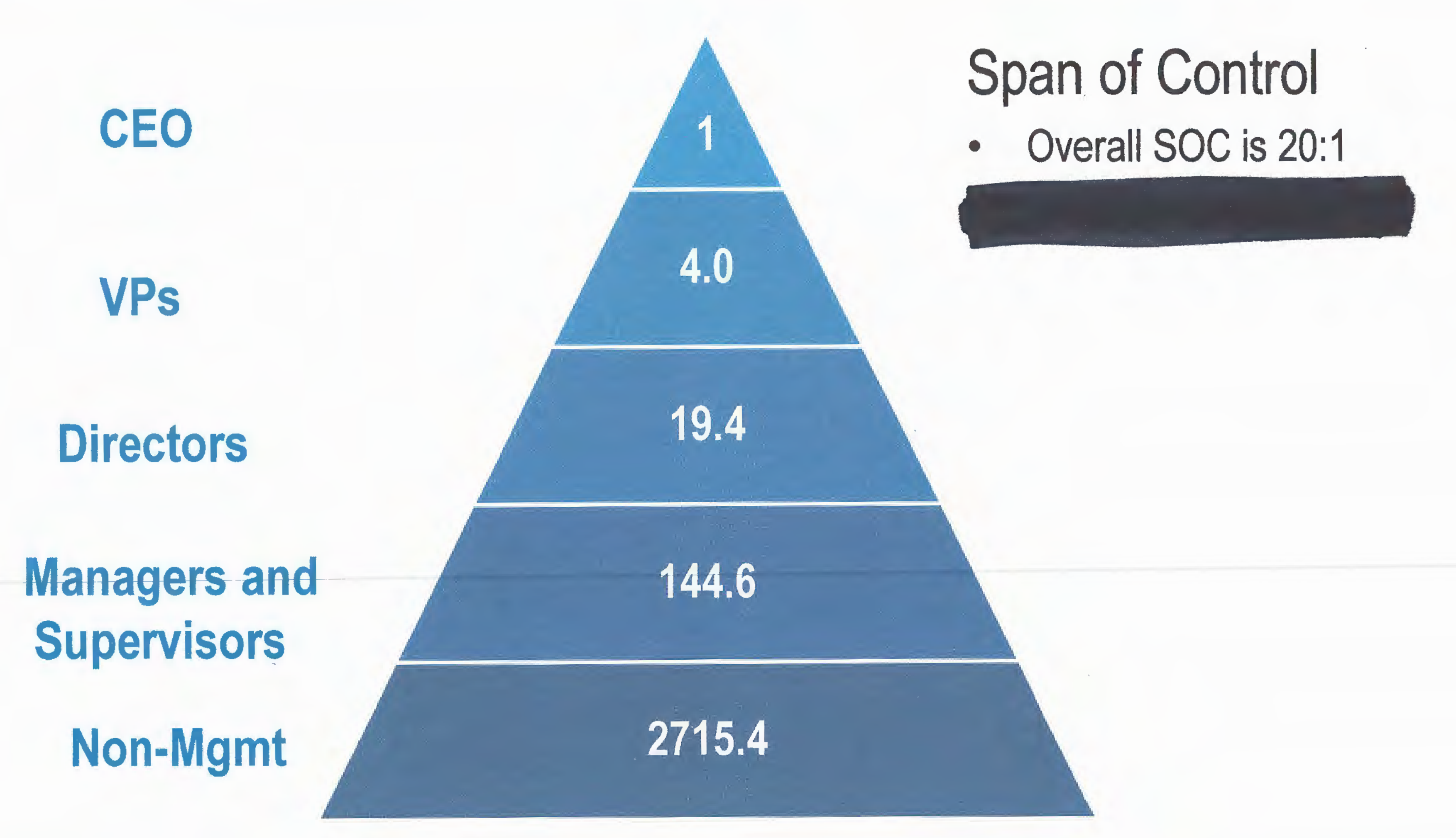

Span of Control

- Overall SOC is 20:1

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What We Reviewed

HuronHealthcare

What We Reviewed

- Organizational structure
- Span of control
- Staffing to demand
- Daily productivity reporting
- Targets and accountability
- Systems and management controls
- Staffing management
- Skill mix
- Economies of scale

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Summary of Findings by Measures

Measures	Rating	Leading Practice	Findings
Benchmarks – External: Productivity	High Opportunity	[redacted]	• Four fifths of FTEs are in departments that are performing above the 50th percentile (unfavorable) of their benchmarked peers for the period reviewed
Benchmarks – Internal: Overtime Use	High Opportunity	[redacted]	• Hospital-wide overtime hours as a percent of total worked (productive) hours totaled 9.6% for the period reviewed • [redacted] • Some managers require that staff document reasons for overtime use - but this is not practiced house-wide
Management: Productivity Tools	Moderate Opportunity	[redacted]	• Meaningful, timely management tools to support managers in managing departmental productivity, are varied in availability, sophistication and use – Labor productivity reports – Monthly budget variance reports – Departmental service volumes – Overtime reports (4-6 weeks retrospective) • Some managers manually collect hours and volume data to create their own retrospective productivity reports • Some departments have productivity standards but do not manage to them

Low Opportunity | Moderate Opportunity | High Opportunity

Note: Baseline Period: May, 2012 to April, 2013

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Summary of Findings by Measures

Measures	Rating	Leading Practice	Findings
Management: Staffing to Volumes	High Opportunity	[redacted]	• Daily management discipline and practices vary • Some managers employ voluntary flexing at low volume/census
Operations: Cross training	Low Opportunity	[redacted]	• Where appropriate, cross-training is employed in most departments reviewed
Operations: Process Improvement	High Opportunity	[redacted]	• Some departments have designed work-arounds to manage key processes such as timekeeping and productivity • Monitoring of key metrics is labor intensive, often through review of paper documents

Note: Baseline Period: May, 2012 to April, 2013

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Summary of Findings

PRODUCTIVE STAFF BREAKDOWN BY AREA

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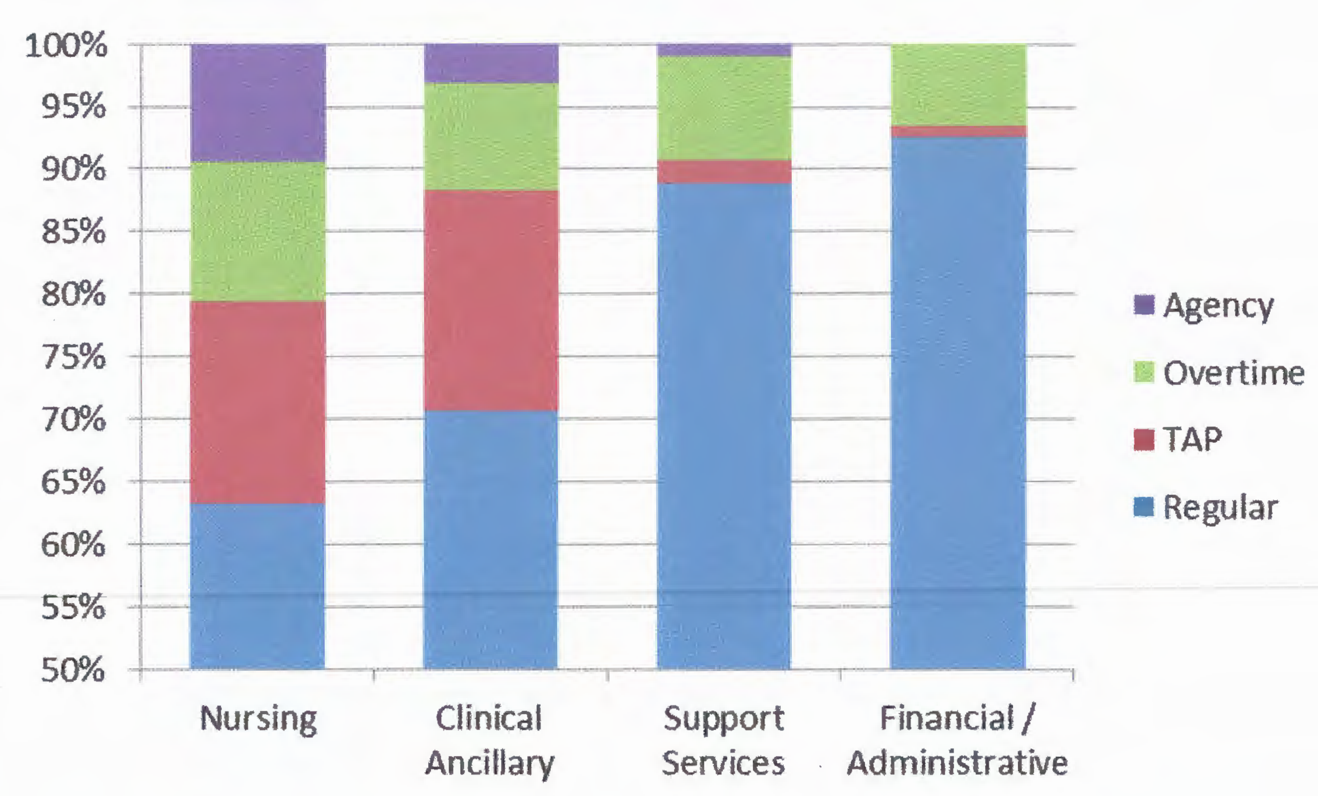

For baseline period: May, 2012 to April 2013. Overtime includes TAP overtime hours

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Labor

FINANCIAL OPPORTUNITY SUMMARY

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Areas	Assessed Recurring Savings			FTEs		
	Low	Mid	High	Low	Mid	High
Nursing	$5,717,000	$7,021,000	$8,325,000	68.8	84.4	100.0
Clinical Ancillary	$1,760,000	$2,222,500	$2,685,000	22.5	28.4	34.3
Support Services	$838,000	$1,050,500	$1,263,000	17.3	21.5	25.8
Financial / Administrative	$633,000	$723,000	$813,000	13.4	15.8	18.1
Total	**$8,948,000**	**$11,017,000**	**$13,086,000**	**122.0**	**150.1**	**178.2**

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Patient Care Units – Med/Surg, ICU, PCU

SUMMARY OF FINDINGS BY MEASURES

Measures	Rating	Leading Practice	Findings
Benchmarks – External: Productivity			• 89% of units are performing above the 50th percentile (unfavorable) of peer departments for the baseline period reviewed
Benchmarks – Internal: Overtime Use			• Overall overtime averaged 12% for the period reviewed • Prior to May 2013 overtime hours were charged to the home cost center and not the cost center where employee worked • Staff working 7 – 12 hour shifts/pay period automatically receive four overtime hours each pay period
Management: Productivity Tools			• Recently initiated a Staffing/Productivity Tracker • Tracker is currently used retrospectively and not for planning, assigning, and follow-up • Staffing matrix and an acuity tool are utilized; however, staffing is assigned based on ratios • Various levels of sophistication among Managers

Baseline date range: 5/1/12-4/30/13

Low Opportunity

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Patient Care Units – Med/Surg, ICU, PCU

SUMMARY OF FINDINGS BY MEASURES

Measures	Rating	Leading Practice	Findings
Management: Staffing to Volumes	High Opportunity	[redacted]	• No specific interval for evaluating staffing resources – Resources are evaluated "throughout the day" • Staff are infrequently flexed down based on census • Regression analysis indicates that some units are flexing; however, there is opportunity to improve staffing to demand on all units
Operations: Cross training	Low Opportunity	[redacted]	• Cross training is systematically employed throughout the units • Med/Surg nurses can work on all Med/Surg units and some are cross trained to work in PCU • PCU nurses are cross trained to work in ICU • Some ICU nurses are cross trained to work in ED • Nursing Assistants are cross trained to some Medical Unit Clerk activities and vice versa
Operations: Process Improvement	Low Opportunity	[redacted]	• Several process improvement initiatives are underway – Supported by Mangers and Assistant Nurse Managers

Low Opportunity | Moderate Opportunity | High Opportunity

Baseline date range: 5/1/12-4/30/13

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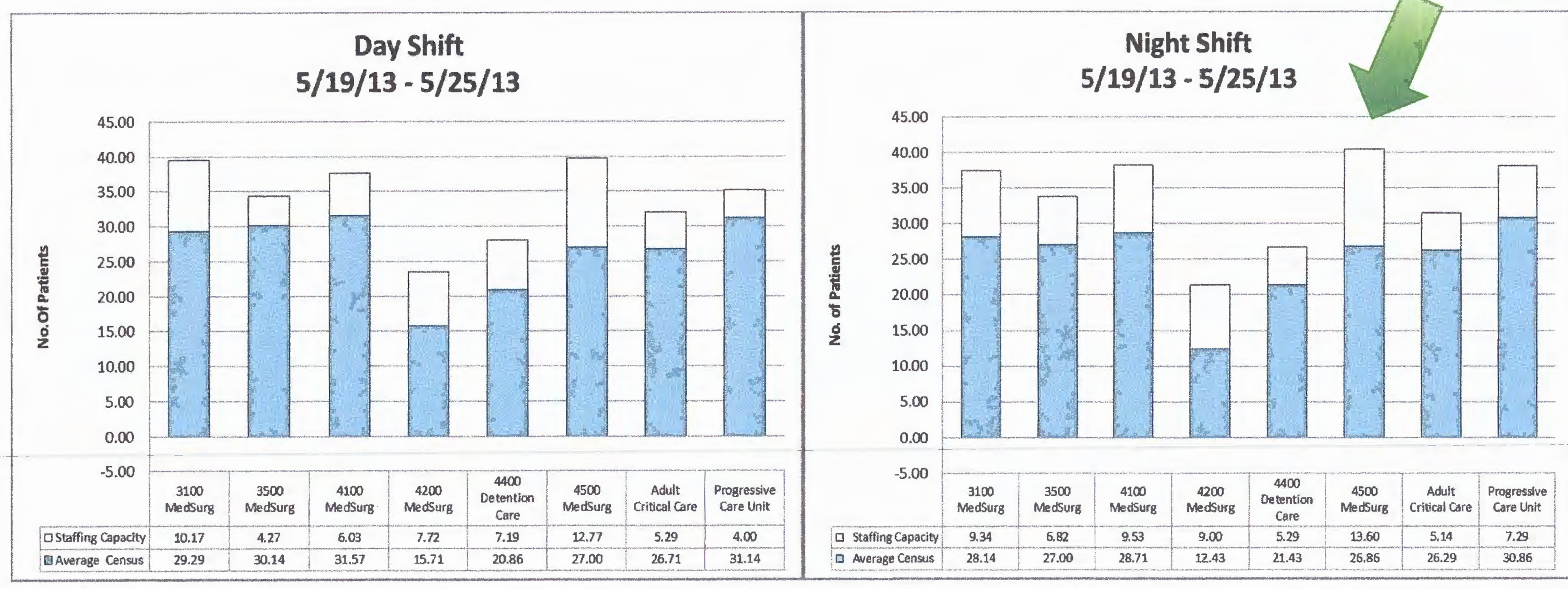
Patient Care Units – Med/Surg, ICU, PCU

HuronHealthcare

Management Practices – Nurse Staffing Capacity

Excess Staffing Resources



Day Shift 5/19/13 - 5/25/13

	3100 MedSurg	3500 MedSurg	4100 MedSurg	4200 MedSurg	4400 Detention Care	4500 MedSurg	Adult Critical Care	Progressive Care Unit
Staffing Capacity	10.17	4.27	6.03	7.72	7.19	12.77	5.29	4.00
Average Census	29.29	30.14	31.57	15.71	20.86	27.00	26.71	31.14

Night Shift 5/19/13 - 5/25/13

	3100 MedSurg	3500 MedSurg	4100 MedSurg	4200 MedSurg	4400 Detention Care	4500 MedSurg	Adult Critical Care	Progressive Care Unit
Staffing Capacity	9.34	6.82	9.53	9.00	5.29	13.60	5.14	7.29
Average Census	28.14	27.00	28.71	12.43	21.43	26.86	26.29	30.86

Date range: 5/19/13-5/25/13

Positions include Charge Nurse, RN, LVN; Excludes Nurse Manager, Ass't Nurse Manager (admin time), Nurse on Modified Duty, Nurses performing Chart Audits and Projects

Required staffing was calculated using CA ratios based on the % of patient population by unit, e.g., M/S patients, tele patients, chemo patients

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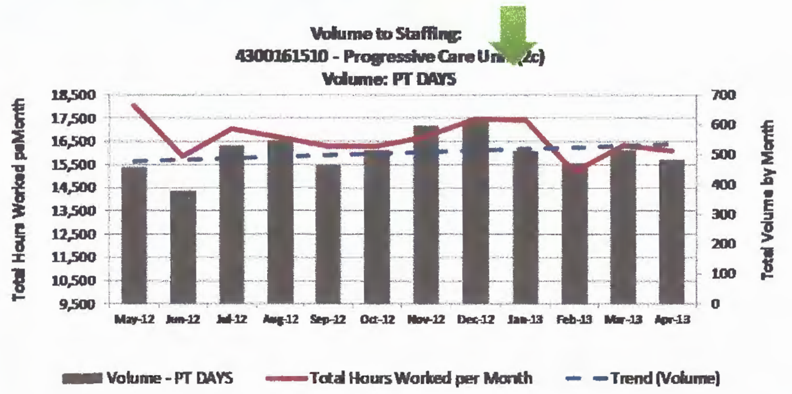
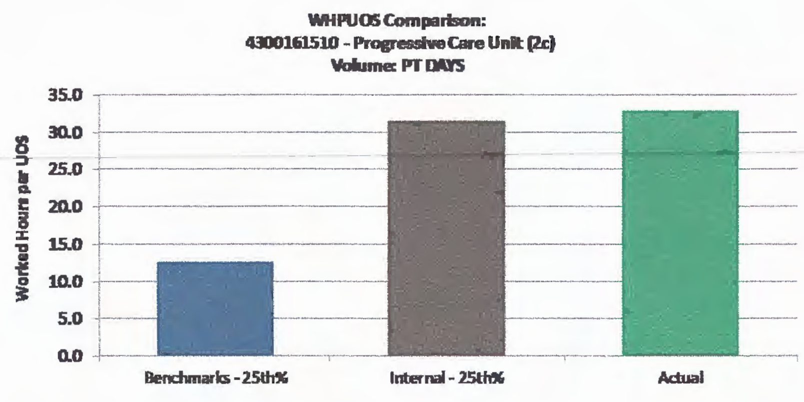
Progressive Care Unit (2c)

HuronHealthcare

Analysis of Staffing to Volumes shows a Low Correlation between Staffing Levels and Demand Volumes





Baseline Period: May, 2012 to April, 2013

Source: L.III.Payroll Data; L.II. Workload Data; ActionOI benchmarks

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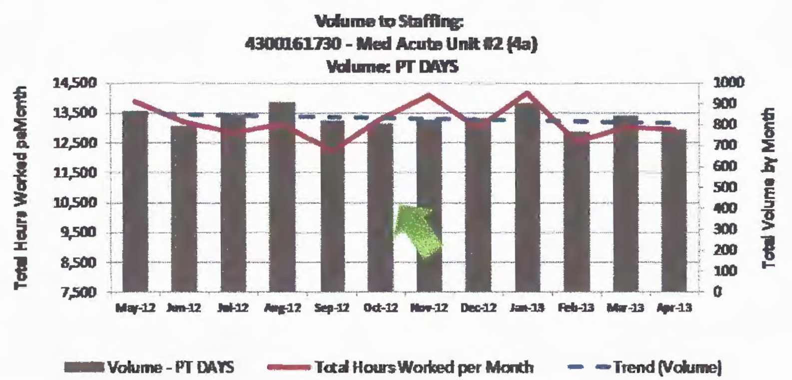
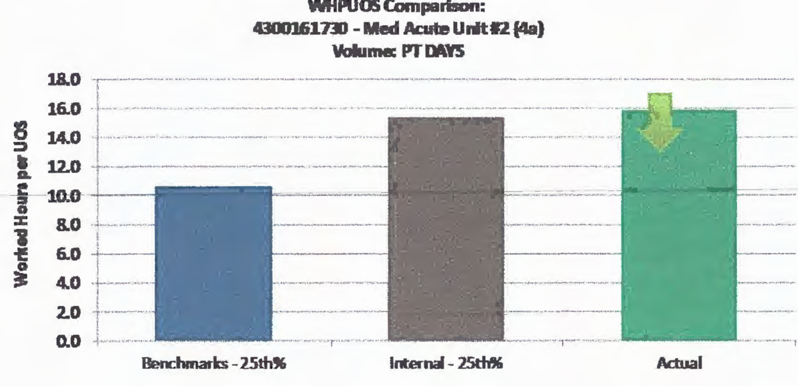
Med Acute Unit #2 (4a)

Huron Healthcare

Analysis of Staffing to Volumes shows a Low Correlation between Staffing Levels and Demand Volumes





Baseline Period: May, 2012 to April, 2013

Source: L.III.Payroll Data; L.II. Workload Data; ActionOI benchmarks

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Patient Care Units – Med/Surg, ICU, PCU

Huron Healthcare

Recommendations

- Develop daily productivity reporting system based on worked hours, and develop management tools for flexing staff to volume every 4 hours
- Begin rigorous training/monitoring of daily worked hours at the Manager, Assistant Nurse Manager, and Charge Nurse level
- Perform volume studies by day of week to identify trends and refine core staffing plan to ensure staff schedules are balanced, and to decrease over-time and TAP and Registry usage
- Utilize Staffing/Productivity Tracker proactively to plan, assign, and follow-up, and for corrective action for worked hours per patient day
- Review hiring hospital per diem staff, for specific units, to decrease/eliminate TAP usage and fees and increase staff buy-in
- Strengthen and enforce policies for utilization of overtime
- Evaluate Assistant Nurse Manager role to determine essential functions and eliminate non-value added activities; develop clearly defined responsibilities and expectations to increase role consistency, reduce supervisory overlap with Nurse Manager, and increase direct patient care resources
- Evaluate roles and responsibilities and establish metrics for nursing support positions, such as Stroke Coordinator, Sepsis Coordinator, Wound Care Nurses, and LVN Liaison; explore potential to consolidate and increase direct patient care resources
- Review, refine and enforce admission/discharge criteria for PCU patients to assist with patient throughput and ensure appropriate staffing ratios

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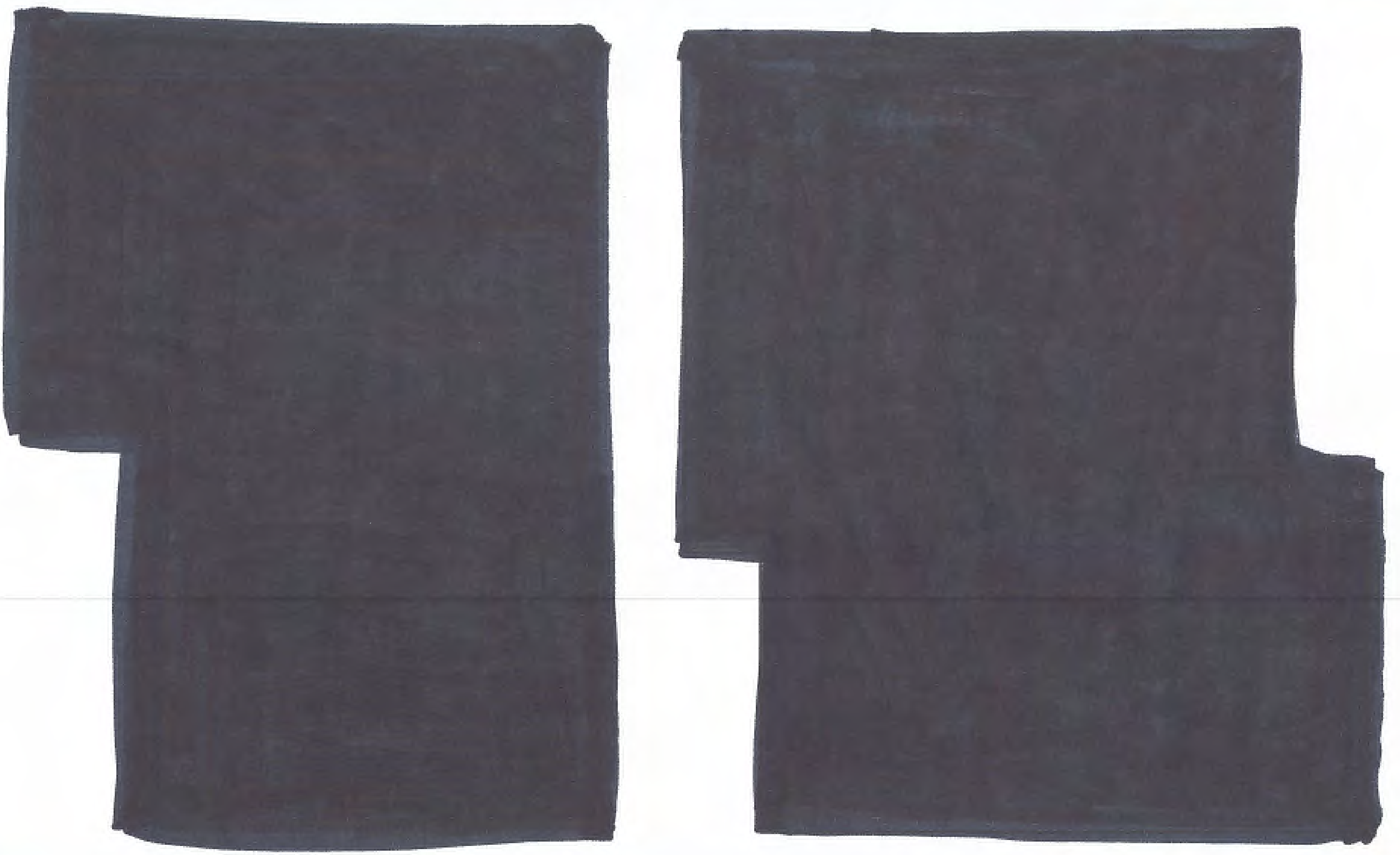
Management Practices

STAFFING / PRODUCTIVITY MANAGEMENT TOOLS

HuronHealthcare



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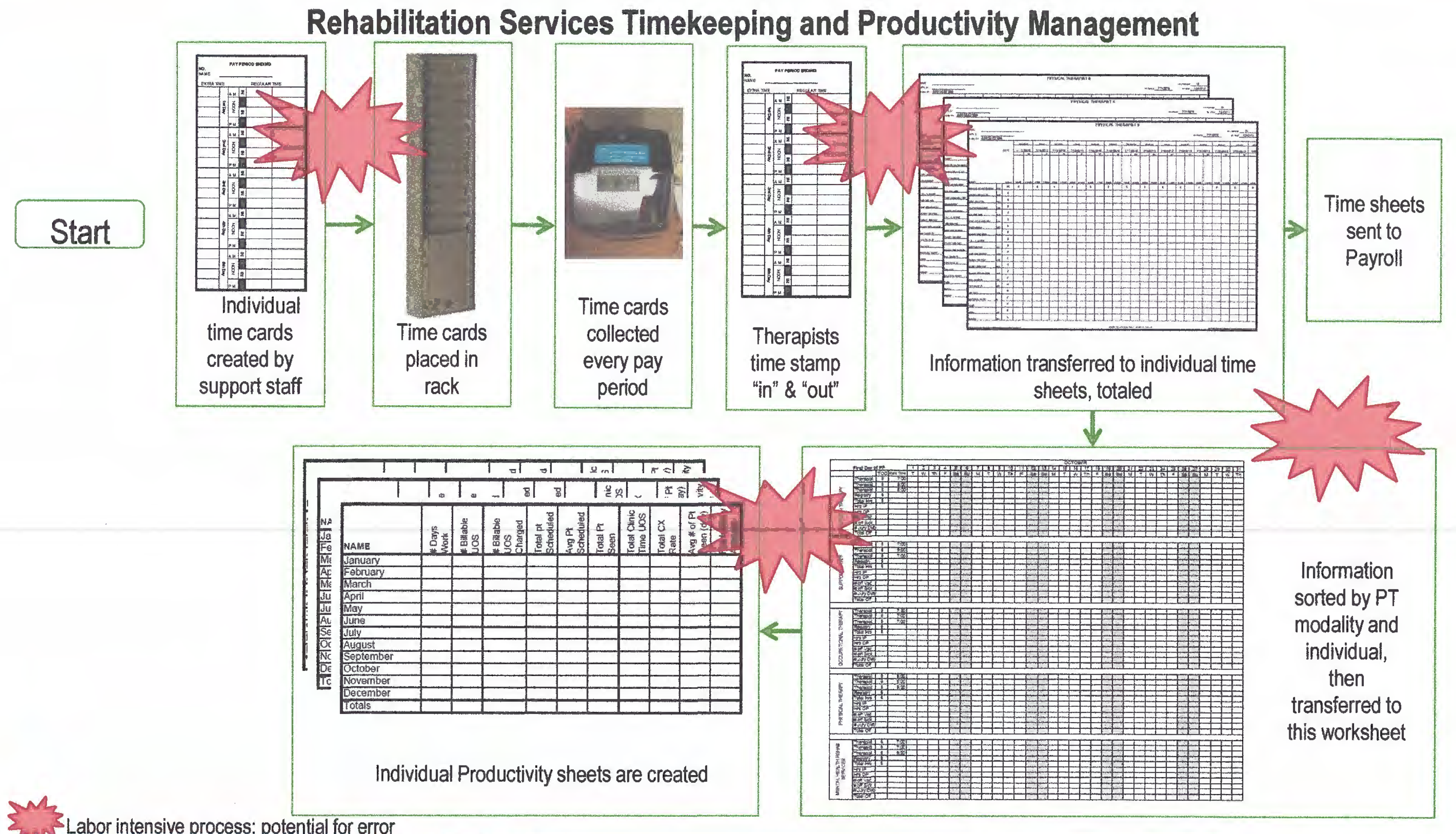
Management Practices

STAFFING / PRODUCTIVITY MANAGEMENT TOOLS

Huron Healthcare

Some departments have designed work-arounds to manage key processes such as timekeeping and productivity.



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Operations: Process Improvement

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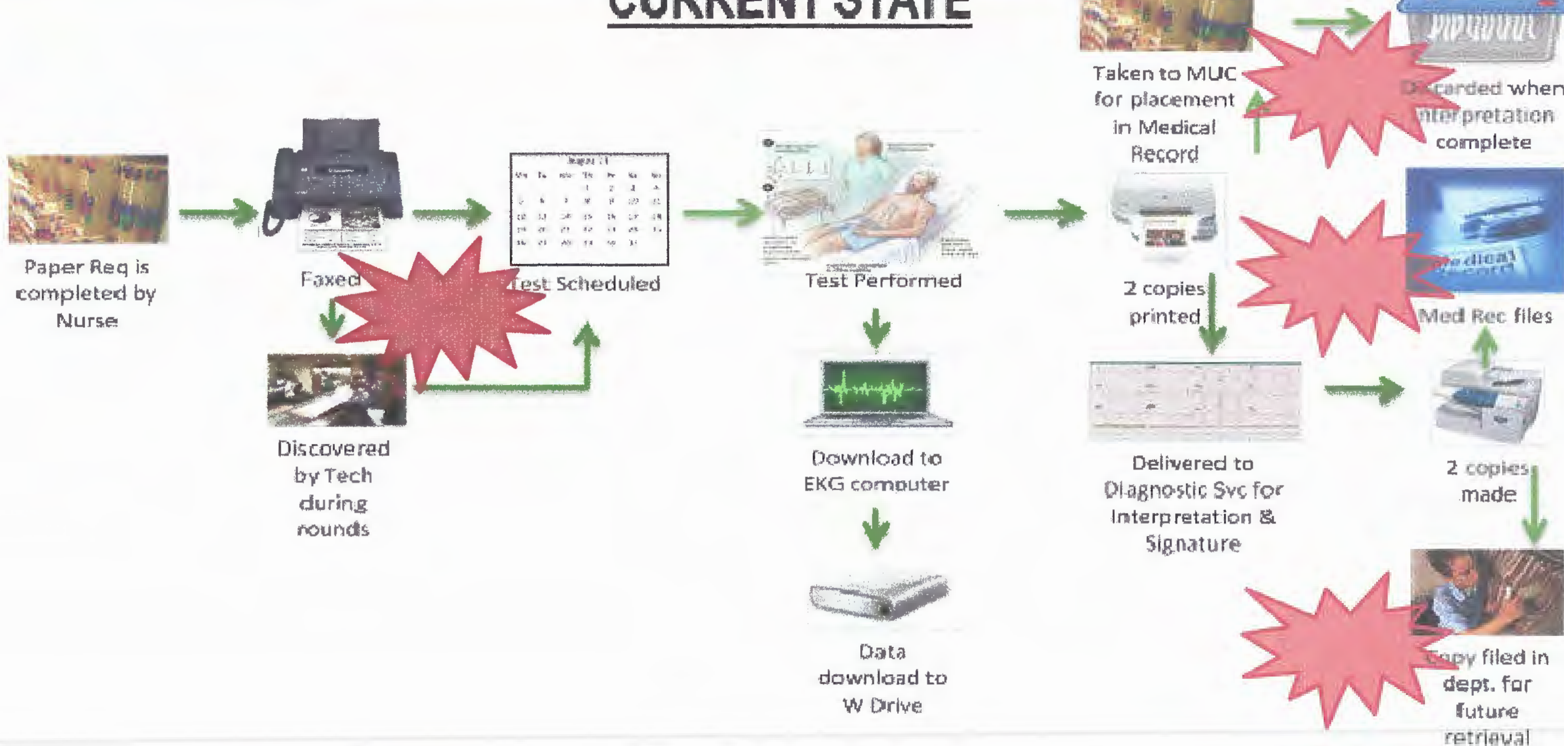
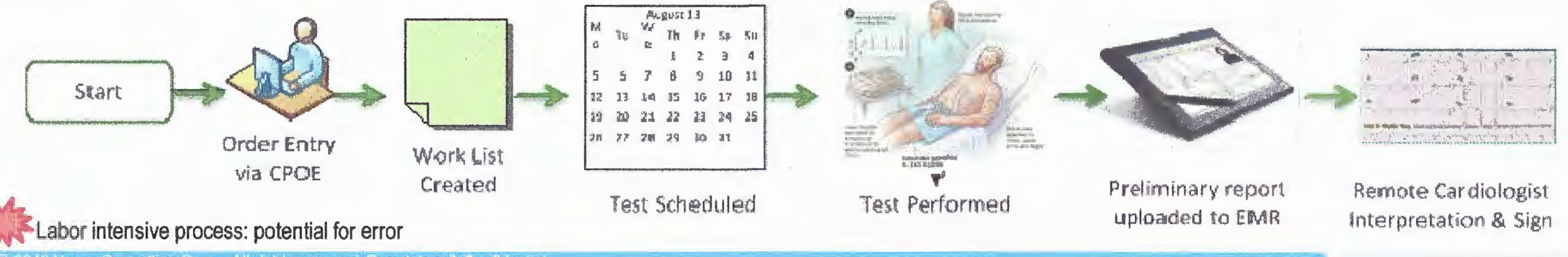
CURRENT STATE



FUTURE STATE



Labor intensive process: potential for error

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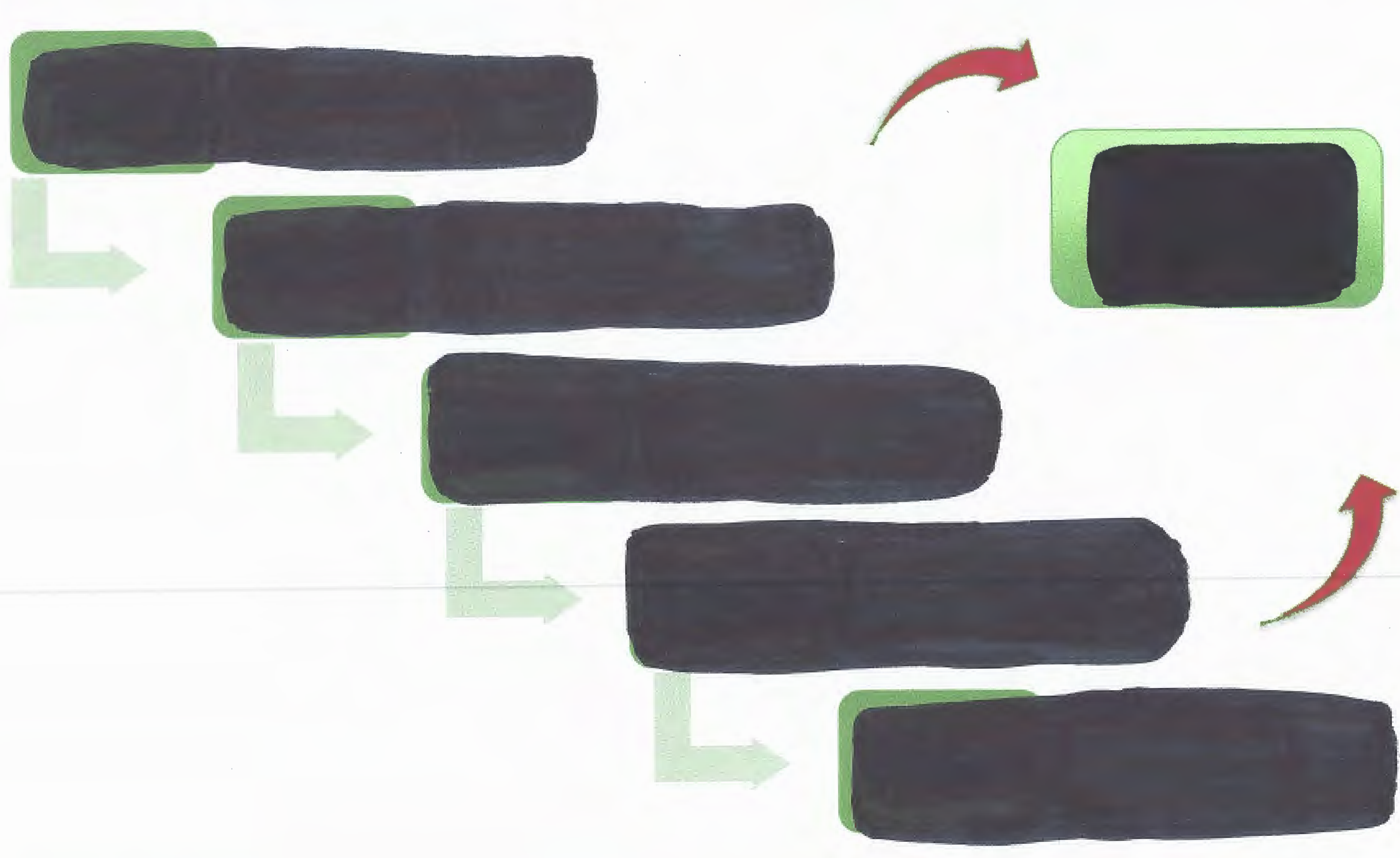
Implementation Progression

HIGH LEVEL PROCESS



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Summary – Recurring Benefits

ALTERNATE LEVELS OF ACHIEVEMENT

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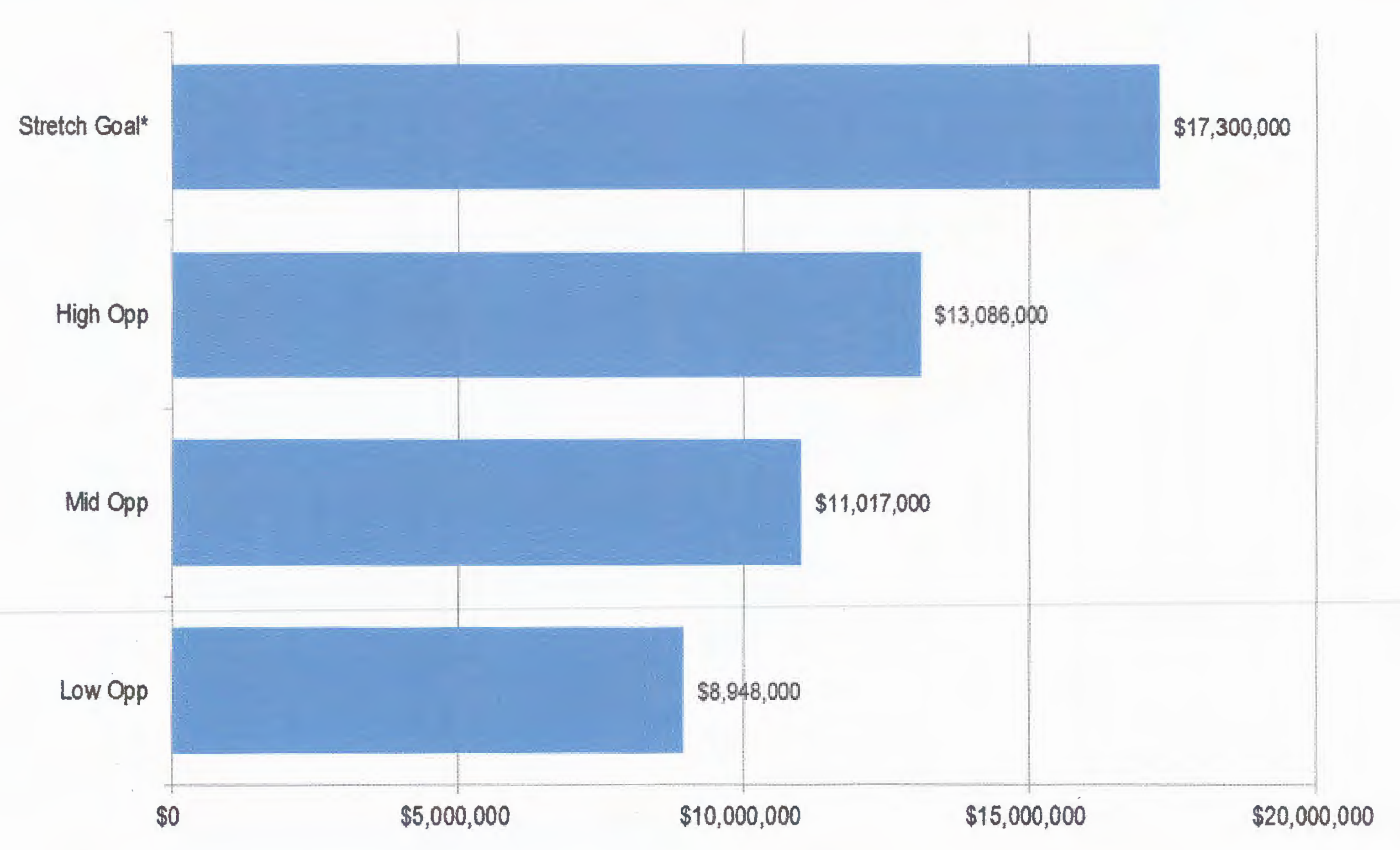

* Stretch Goal – assumes departments achieve 35th percentile efficiency levels of benchmarked peers (capped at 10%)

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Implementation Structure

LABOR

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Labor Solution Team

Huron Managing Director [redacted]
Huron Lead: TBD
RCRMC Leader: TBD
RCRMC Co-Leader: TBD

Nursing Team
Huron Labor SME / RCRMC Staff

Perioperative Team
Huron Labor SME / RCRMC Staff

Corporate Team
Huron Labor SME / RCRMC Staff

Clinical Ancillary Team
Huron Labor SME / RCRMC Staff

Support Services Team
Huron Labor SME / RCRMC Staff

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Agenda

HuronHealthcare

- Introduction
- Health System Strategic Plan
- Hospital Operational and Financial Performance Review
  - Non-Labor
  - Labor
  - Human Resources
  - Physician Services
  - Revenue Cycle
  - Clinical Documentation Improvement
  - Clinical Operations
- Conclusion

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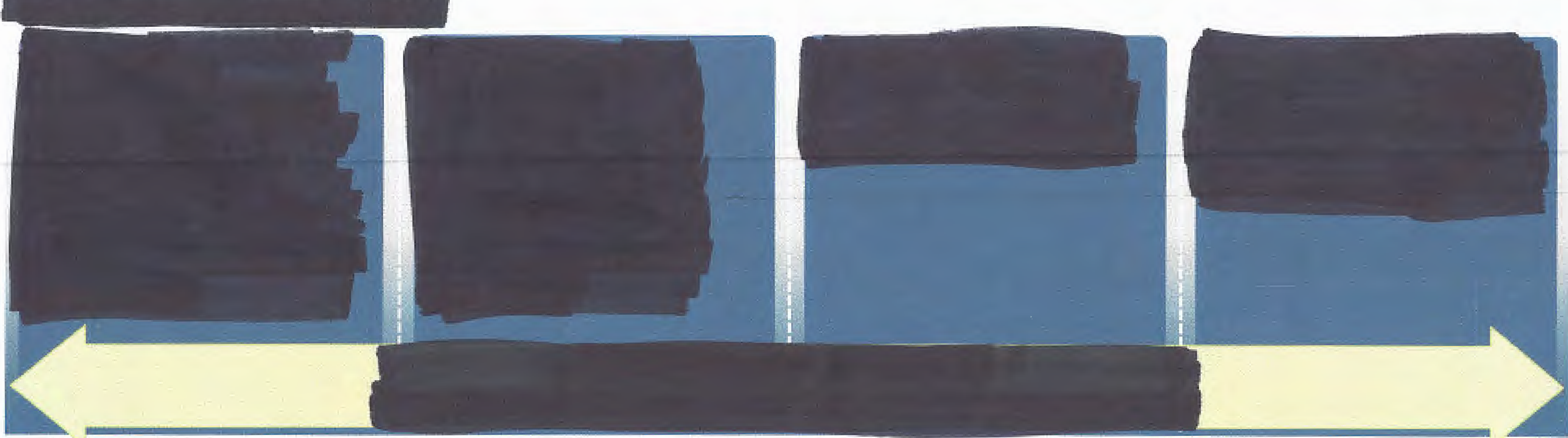
Human Resources Detailed Findings

HURON APPROACH

HuronHealthcare

Huron Addresses the Following Areas:

Employee Benefits	Compensation	Absence	HR-Purchased Services
• Medical • Employee Prescriptions • Retirement • Employee Health Mgmt. • Wellness • Dental • Life	• Salary/Base Pay • Shift Differentials • On Call/Call back • Weekend Options • Non-Exempt Pay • Bonus Programs • Incentive Awards • Performance Based-Pay	• Paid Time Off • Vacation • Sick time • Leaves of Absence • Family Medical Leave • Short Term Disability • Long-term Disability	• Contingent Labor (Agency) • Locum Tenen • Third Party Administrators • HR Service Providers • Brokers • Consultants



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Human Resources

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HuronHealthcare

Interviews	• Organizational culture and challenges • HR strategic alignment • Workforce dynamics • Application of policies and practices
Policy and Practice	• Benefit plan strategy and structure • Compensation and pay policy and practice • Absence/Leave policies and management processes • Vendor utilization and service outsourcing
Benchmarking, Data and Analytics	• Health plan costs and utilization • Payroll and premium pay utilization • Absence/Leave utilization • Vendor expense

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Human Resources Detailed Findings

FINANCIAL BENEFIT – SYSTEM

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- Opportunities below assume:
- Successful negotiations with SEIU and LIUNA to implement changes without grandfathering provisions
- Ability to evaluate and modify health plan and pharmacy vendor partnerships if needed to support changes in care delivery models and medical management programs
- Ability to modify processes, contracts and key provisions for RCRMC to meet financial goals
- Ability to implement changes mid-plan year to realize savings in next Fiscal Year

Area	RCRMC		
	Low	Mid	High
Benefits	$ 1,125,000	$ 1,539,000	$ 1,953,000
Compensation / Premium Pay	$ 1,803,000	$ 2,363,500	$ 2,924,000
Absence	$ 372,000	$ 495,500	$ 619,000
HR Purchased Services	$ 700,000	$ 1,102,000	$ 1,504,000
Total (See Notes)	$ 4,000,000	$ 5,500,000	$ 7,000,000

Notes

- Benefits savings are based on RCRMC employee counts applied to average Riverside County per employee medical costs and plan enrollment distribution
- Pharmacy claim and contract audit savings are not included (need further details on separate contract provisions and available expanded County pharmacy opportunities)
- Process redesign changes in Absence and Return to Work/Workers Compensation are not included
- Process redesign changes in HR functions such as Recruitment and Onboarding are not included

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Human Resources

OVERVIEW

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Strengths

- Riverside County has coordinated programs across the majority of the County departments and employee groups for health and other benefit programs
- Riverside County has implemented their own health plan and network utilizing Riverside Medical Center and select other County health clinics, services and programs for employees that is currently the lowest cost plan available
- Riverside Medical Center is enhancing their overall service delivery models for patients through their physician and integrated services initiatives
- Riverside Medical Center has a dedicated HR Team

Opportunities

- Evaluate the premium pay practices and policies for alignment with the total compensation strategy
- Evaluate HR service delivery model and ability to modify as needed to support ongoing workforce changes and legislative impacts for RCRMC that can possibly be leveraged in other County departments
- Refine benefit plan design and contribution strategies to enhance healthcare accountability, manage chronic conditions and wellness to reduce overall trend increases
- Review absence programs, policies and administration including safety and workers' compensation for further integration opportunities and to align with changing market practices
- Evaluate HR system updates and software program costs to gain additional savings opportunities in premium pay, absence, HR processing and contingent labor

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Human Resources Detailed Findings

OBSERVATIONS – OVERALL

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Area	Rate	Observations
Employee Benefits	High Opportunity	• Health benefits through the County Exclusive Care program have the lowest premium costs of all plan offerings and represent the highest enrollment • Health benefits for RCRMC are not offered through CALIPERS • Retirement benefits and primary administration remain with CALIPERS • Multiple levels of credits towards cost of health coverage are available including Flex credits, dependent credits and wellness credits which are prorated for FT and PT
Premium Pay	High Opportunity	• Multiple premium pay programs exist within RCRMC • Manual recording of time on variable time sheet formats reduces ability to perform detailed verifications
Absence	Moderate Opportunity	• Two paid time off practices are currently being utilized – traditional paid time off including separate banks for vacation, holidays, and sick and annual leave including one bank for vacation and sick • STD and LTD are outsourced, while FMLA is managed in-house • Employee Safety and Workers Compensation are handled separately through the County with limited on-site resources and training for RCRMC staff and contract employees
HR Purchased Services	High Opportunity	• $2.4M+ is spent on County internal per diem shared pool (TAP) • $17M is spent on outside contract labor vendors, on top of what is spent on TAP • Less that 40% of the outside contract labor spend is channeled through the organization's Vendor Management Spend

Low Opportunity | Moderate Opportunity | High Opportunity

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Human Resources Detailed Findings

OBSERVATIONS – EMPLOYEE BENEFITS

Area	Rating	Leading Practice	Observations
Employee Benefits-Medical	[redacted]	[redacted]	• Plan provisions for EPO and HMO programs are rich as compared with emerging regional industry practice; Limited changes can be implemented due to Union contracts in effect until 2016 • Plan designs for 3 EPO/HMO managed care programs are closely aligned and primary variation exists in network and providers • Kaiser and Health Net HMO plan rates are between 35% and 40% higher than Exclusive Care EPO program • PPO plan has highest costs and less than 1% of total County enrollment – monthly premiums are double the Exclusive Care HMO premiums • Plan variations in care delivery and network are reflected in utilization variations - ER utilization is lowest for Health Net HMO at 168.89, Exclusive Care has 188 visits/1000 members while Kaiser has the highest at 231.7 visits/1000 members
Employee Benefits - Pharmacy	[redacted]	[redacted]	• Exclusive Care health plan utilizes RCMC pharmacy resources; Health Net and Kaiser manage the pharmacy benefits for their programs utilizing their own networks and contracts • Variations exist in formulary, delivery (retail and mail) and specialty management utilization and discount and rebate arrangements that drive overall care delivery and cost patterns • Per Member per Month cost for Exclusive Care is is approximately $46 which is right at best-in-class cost of $45 without 340B discount while Health Net HMO has a pharmacy cost of $80 (Kaiser did not provide a PMPM Cost)

Low Opportunity | Moderate Opportunity | High Opportunity

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Human Resources Detailed Findings

OBSERVATIONS – EMPLOYEE BENEFITS

Area	Rating	Leading Practice	Observations
Employee Benefits-Rates and Contributions			• Current credit and contribution strategy has multiple components that are not coordinated to support health care management strategies for employees and dependents • Current SEIU and LIUNA Flex Credit strategy is providing the majority of single employees (63% of County enrollment in medical plans is single coverage) with free medical coverage • Monthly premium equivalents for the County EPO plan is up to 40% below HMO plans for 2013 with plan design differences of less than 10%; network variations and plan services • PPO plan is more than double the EPO rates and has approximately 1% of the total County enrollment
Employee Benefits – Population Management			• Population management is not integrated as a single program throughout the County and is managed by each health plan vendor • The County's Exclusive Care plan' has a dedicated team with programs focused on diabetes and obesity leveraging coaching and County resources • The County's wellness credit program has very limited participation with only approximately 1,350 employees receiving monthly credits in 2013 • Limited reporting and metrics are in place today and vary among plans and vendors • Further development and expansion of targeted case management programs is critical to support management of high cost claimants and cost drivers

Low Opportunity | Moderate Opportunity | High Opportunity

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Human Resources Detailed Findings

SUPPORTING DATA – EMPLOYEE BENEFITS: CONTRIBUTION STRATEGY

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- SEIU and LIUNA represent 93% of employees within RCRMC
- Employee Only contracts represent 63% of the County's medical plan enrollment
- SEIU and LIUNA provide flex credits and dependent subsidies for employee benefits
- SEIU and LIUNA Flex Credits cover between 115% to 169% of monthly EPO/HMO single premium providing employees with free coverage with low out of pocket benefits
- This contribution structure does not provide transparency or accountability for employees to understand healthcare costs and utilization impacts

2013 Monthly Flex Credits			
SEIU		LIUNA	
$	675.43	$	699.33

Monthly Single Medical Premiums for 2013			*Monthly Balance after Flex Credits Applied to Medical Premiums*			
Exlusive Care	$	414.62	$	(260.81)	$	(284.71)
Kaiser HMO	$	558.00	$	(117.43)	$	(141.33)
HealthNet HMO	$	587.78	$	(87.65)	$	(111.55)
HealthNet PPO	$	917.62	$	242.19	$	218.29

*** Flex credits can be used to purchase employee benefits beyond medical including dental and vision**

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Human Resources Detailed Findings

SUPPORTING DATA – EMPLOYEE BENEFITS: CONTRIBUTION STRATEGY

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- Below are estimates based on the county's enrollment ratios applied to RCRMC's population and SEIU and LIUNA ratios
- RCRMC estimated employee contributions are far below the County's average of 23%

	Annual Base Medical/ Pharmacy Premium	Annual Flex Credits and Dependent Subsidy*	Employee Contribution *	Employee Contribution Percentage
SEIU				
Employee Only	$5,321,662.56	$7,112,277.90	-$1,790,615.34	-34%
Employee + 1	$2,633,231.52	$1,845,360.03	$787,871.49	30%
Employee + Family	$4,370,126.88	$2,715,586.38	$1,654,540.50	38%
TOTAL	**$12,325,020.96**	**$11,673,224.31**	**$651,796.65**	**5%**
LIUNA				
Employee Only	$3,587,117.52	$4,958,599.37	-$1,371,481.85	-38%
Employee + 1	$1,764,197.04	$1,282,491.50	$481,705.54	27%
Employee + Family	$2,917,114.08	$1,882,824.15	$1,034,289.93	35%
TOTAL	**$8,268,428.64**	**$8,123,915.02**	**$144,513.62**	**2%**

*** Flex credits can be used to purchase employee benefits beyond medical including dental and vision**

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Human Resources Detailed Findings

SUPPORTING DATA – PHARMACY PROGRAM

HuronHealthcare

- Top 10 medications represent over 20% of total pharmacy costs for Health Net and Exclusive Care
- Key drugs for diagnostic categories of diabetes, cancer, mental health and multiple sclerosis are represented across all 3 vendors
- Each medical program has it's own pharmacy manager and variations in formulary, network and contract provisions are reflected in the utilization statistics

Top 10 Rx Rank by Spend	Health Net - EOA(HMO) 4/1/2012 to 3/30/2013		Exclusive Care 1/1/2012 to 12/31/2012		Kaiser 1/1/2012 to 12/31/12	
1	Copaxone	$ 355,054	Januvia	$ 190,097	Atripla	$ 163,019
2	Enbrel	$ 229,548	Lantius Solostar	$ 185,704	Gleevac	$ 136,703
3	Revlimid	$ 197,689	Accu-CheckAviva Plu	$ 184,648	Copaxone	$ 131,964
4	Aciphex	$ 193,073	Advair	$ 152,026	Zytiga	$ 103,937
5	Humira	$ 142,475	Cymbalta	$ 151,485	Lantus	$ 84,756
6	Abilify	$ 131,231	Novolog Flex Pin	$ 146,675	Novolog	$ 63,153
7	Cymbalta	$ 113,031	Crestor	$ 140,958	Nexavar	$ 53,976
8	Advair Diskus	$ 97,130	Victoza	$ 138,889	Revlimid	$ 52,277
9	Januvia	$ 94,453	Abilify	$ 132,224	Neupogen	$ 47,776
10	Humalog	$ 79,996	Lantus	$ 124,145	Xeloda	$ 46,561
Total top 10 Spend		$ 1,633,680		$ 1,546,851		$ 884,122
Total Rx Spend		$ 5,597,163		$ 7,221,322	Did not Provide Total Rx	
Top 10 as % of Total Paid		29%		21%		

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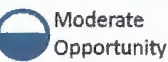
Human Resources Detailed Findings

OBSERVATIONS – PREMIUM PAY

Area	Rating	Leading Practice	Observations
Payroll Processing			• Current use of paper time sheets are labor intensive and may give rise to costly errors or misuse • Time entry is controlled through customization of time sheets by job or job family to reduce error and misuse
Premium Pay Shift Differentials			• Shift differentials are flat dollar amount • Multiple and complex shift differentials exist that may not be market driven • The spend on night differentials is high compared to evening and weekend differentials
Premium and Specialty Pay			• Multiple premium and specialty pay exist that are outside of market or best practice. • The primary incentive for weekend pay is double time for extra weekends rather than a traditional shift differential
Base Compensation			• Participation in surveys has lapsed for several years leaving the market position of jobs and specialty pay unknown • There is a need for robust market data for use in collective bargaining



Moderate Opportunity High Opportunity

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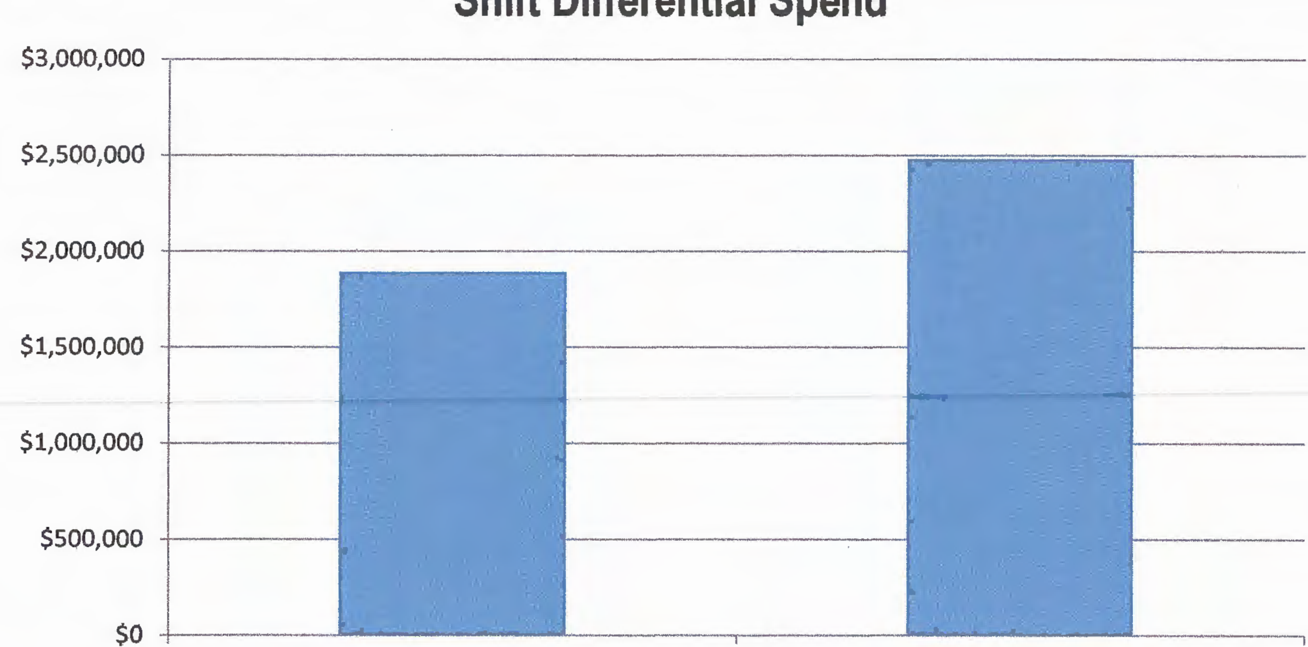
Human Resources Detailed Findings

SUPPORTING DATA – PREMIUM PAY

HuronHealthcare

- Opportunities exist within night differential due to higher share of total differential spend
- Night differential spend is high compared to evening differential



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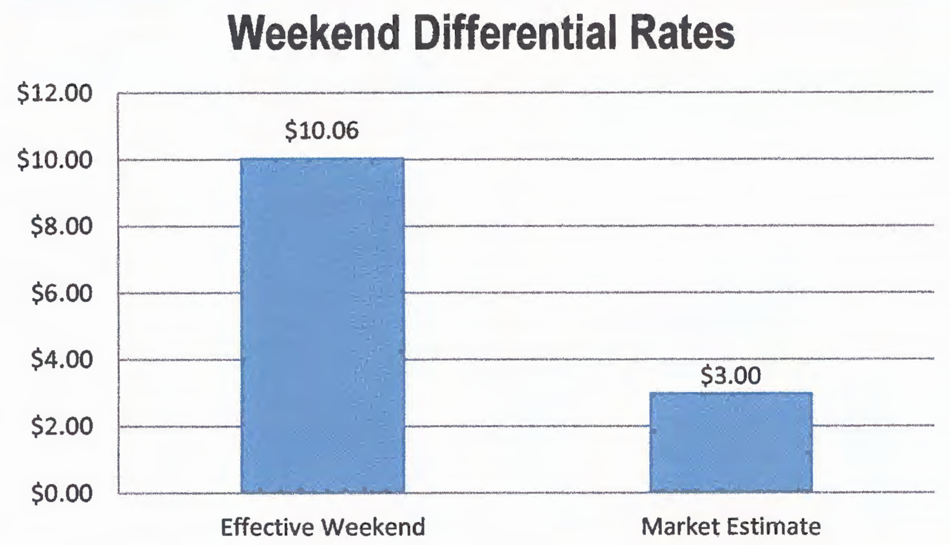
Human Resources Detailed Findings

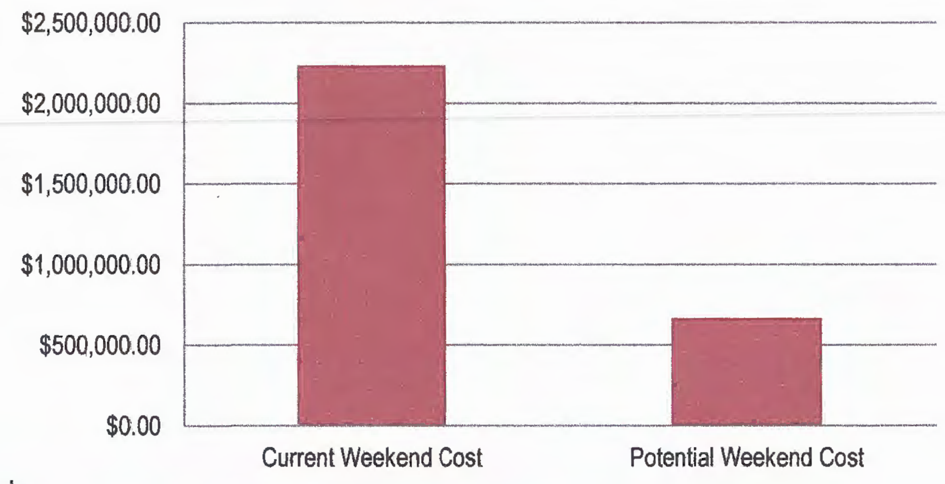
SUPPORTING DATA - PREMIUM PAY

HuronHealthcare



- The double time paid for extra weekend shifts equates to an effective weekend differential of $10.06 compared to a market estimate of $3.00 per hour

- Moving to a standard market rate removes the compounding effect of paying double time and stabilizes costs



Source: 2012 Non-Management Compensation Report Southern California

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Human Resources Detailed Findings

SUPPORTING DATA – PREMIUM PAY

HuronHealthcare

Dept Name	Back Hours	On-Call Hours	Utilization	On Call Cost	Call Back Cost	Total Cost
CLINICAL LABORATORY	2,432	0	0.00%	$0	$41,708	$41,708
CLINICAL LAB - CHEMISTR	1,963	0	0.00%	$0	$34,402	$34,402
PURCHASING & STORES	0	5,602	0.00%	$13,718	$0	$13,718
CLINICAL LAB - MICROBIO	610	0	0.00%	$0	$10,683	$10,683
CLINICAL LAB - IMMUNOL	50	0	0.00%	$0	$874	$874
INFECTION CONTROL	121	0	0.00%	$0	$850	$850
BLOOD BANK	49	0	0.00%	$0	$669	$669
PATHOLOGICAL LAB	35	0	0.00%	$0	$528	$528
PATIENT ACCOUNTING-BI	8	0	0.00%	$0	$78	$78
PATIENT AND FAMILY SER	6	0	0.00%	$0	$77	$77
Grounds	8	0	0.00%	$0	$70	$70
EVS	0	30	0.00%	$53	$0	$53
OUTPATIENT REGISTRATIC	5	0	0.00%	$0	$49	$49
COURIER SERVICES	0	24	0.00%	$41	$0	$41
SURGERY CLINIC	4	0	0.00%	$0	$37	$37
OBSTETRICS ACUTE (3B)	0	8	0.00%	$33	$0	$33
L & D - BIRTHING CENTER	0	5	0.00%	$17	$0	$17
MEDICAL RECORDS	0	5	0.00%	$11	$0	$11
DETENTION CARE UNIT (4I	0	2	0.00%	$10	$0	$10
MEDICAL CLINIC	1	0	0.00%	$0	$6	$6
Kitchen	0	4	0.00%	$5	$0	$5
MEDICAL ACUTE UNIT (4C	0	1	0.00%	$5	$0	$5
NEONATAL ICU (3F)	3	1,418	0.21%	$7,961	$72	$8,032
ANGIOGRAPHY	39	9,830	0.39%	$45,342	$827	$46,168
MENTAL HEALTH PHARMA	26	5,766	0.46%	$41,757	$743	$42,500
DIAGNOSTIC IMAGING	78	14,078	0.55%	$64,231	$1,232	$65,463
PHARMACY	152	26,626	0.57%	$128,627	$2,711	$131,338
RESPIRATORY THERAPY	9	1,241	0.69%	$3,517	$102	$3,620
AD CRIT CARE 1 (2D1)	8	814	0.98%	$4,333	$175	$4,507
CATSCAN-DIAGNOSTIC IM	65	5,916	1.09%	$27,868	$1,191	$29,059
CENTRAL SERVICES & SUP	22	1,698	1.27%	$3,768	$166	$3,934
NUCLEAR MEDICINE	73	5,351	1.37%	$23,062	$1,433	$24,496
IPV/SART-INT PAR VI & SE	19	1,210	1.57%	$5,621	$370	$5,991
AD CRIT CARE 2 (2D2)	29	1,839	1.58%	$9,407	$715	$10,123
MAMMOGRAPHY	105	4,925	2.13%	$26,436	$2,298	$28,734
COMMUNICATIONS	270	11,446	2.35%	$37,911	$5,018	$42,929
PEDIATRICS ACUTE (3D)	6	231	2.60%	$1,050	$113	$1,163
MH SOCIAL SERVICES	20	732	2.73%	$2,101	$230	$2,331
Language & Cultural Servic	228	4,740	4.81%	$10,926	$2,053	$12,978
MH TRANSPORTATION	741	10,183	7.27%	$20,202	$5,548	$25,750
ECHOCARDIOLOGY	429	5,570	7.69%	$22,477	$7,264	$29,741
Totals				**$500,489**	**$122,291**	**$622,781**

Percent Utilization = Call Back Hours/On-Call Hours

- Call Back to On-Call utilization of less than 10% represents a significant cost
- Several departments incur Call-Back cost with no On-Call

	Total	<10% Utilization
On Call Spend	$795,251	$500,489
Call Back Premium	$359,494	$122,291
Total	$1,154,745	$622,781

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Human Resources Detailed Findings

OBSERVATIONS – ABSENCE

Area	Rating	Leading Practice	Observations
Short term disability			• Riverside currently has an effective STD policy in place • Outsourced to Sedgwick • Provided to SEIU (excluding Supervisory Unit) and LIUNA union groups only • STD benefits amount to 60% of base pay • STD elimination period is 7 days
Leave of Absence			• Improving leave management should be part of a total absence strategy and include implementation of proven technology partners to support effective tracking, measurement and regulatory compliance
Paid time off			• Annual leave bank combining vacation and sick provided to Management Resolution staff (excluding Group 4); Traditional paid time off plan offered to union and Mgmt. Resolution Group 4 staff • Annual and max accruals are high in comparison to national and regional benchmark data • An annual cash-out of leave is offered to Management Resolution employees; paid out at 100% base pay and not to exceed 160 hours per calendar year • Sick pay-out in addition to annual leave or vacation pay-out provided upon retirement

Low Opportunity Moderate Opportunity High Opportunity

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Human Resources Detailed Findings

SUPPORTING DATA – ABSENCE

HuronHealthcare

- External benchmarking reveals that modifications could be made to the annual leave and vacation accruals to bring within industry norms
- The highlighted cells reflect where RCRMC exceed the CA Hospital System benchmark

	RCRMC*		Sullivan Cotter**			CA Hospital System***
Completed Years of Service	Management Resolution Employees (except those in Group 4 - Confidential)		National: Total Days Per Year	West Region	2,500-4,999 FTEs	Hospital A Management
	Annual Leave	PTO Equivalent Days	PTO			PTO Equivalent Days
0-3	29	41	27	28	27	43.01
3-9	34	46	31	34	32	43.01-46.01
9+	39	51	31-38	34-40	32-39	49.01
# Holidays		12	7	8	7	13
# Sick		-	7	8	9	12
Max Accrual		225				46-58

	RCRMC*		Sullivan Cotter**			CA Hospital System***	
Completed Years of Service	SEIU Union, LIUNA Union, Management Resolution Employees (Group 4 Only)		National: Total Days Per Year	West Region	2,500-4,999 FTEs	Hospital A Non-Union	Hospital A Union
	Vacation	PTO Equivalent Days	PTO			PTO Equivalent Days	
0-4	10	35	27	28	27	40.02	40
4-10	15	40	31	34	32	40.02	40
10+	20	45	31-38	34-40	32-39	43.01-49.01	43-49
# Holidays		12	7	8	7	13	13
# Sick		13	7	8	9	12	12
Max Accrual		60				40 -58	30-48

Note: Based on Full-time status

*RCRMC PTO Equivalent Days includes vacation, holiday, and sick time. Source: Management Resolution Contract

**Sullivan Cotter survey includes vacation, holidays, floating holidays, personal time, and sick leave. Source: Sullivan Cotter Highroads Survey 2012

***CA Hospital System Leave total includes vacation, holiday, and sick

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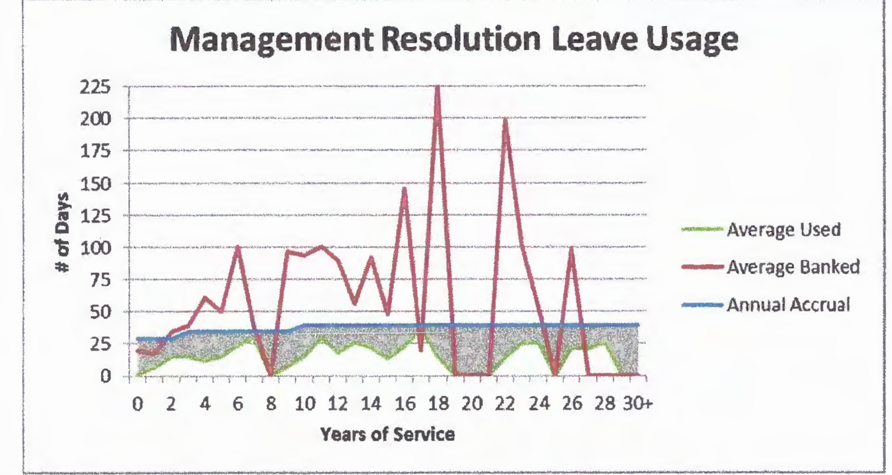
Human Resources Detailed Findings

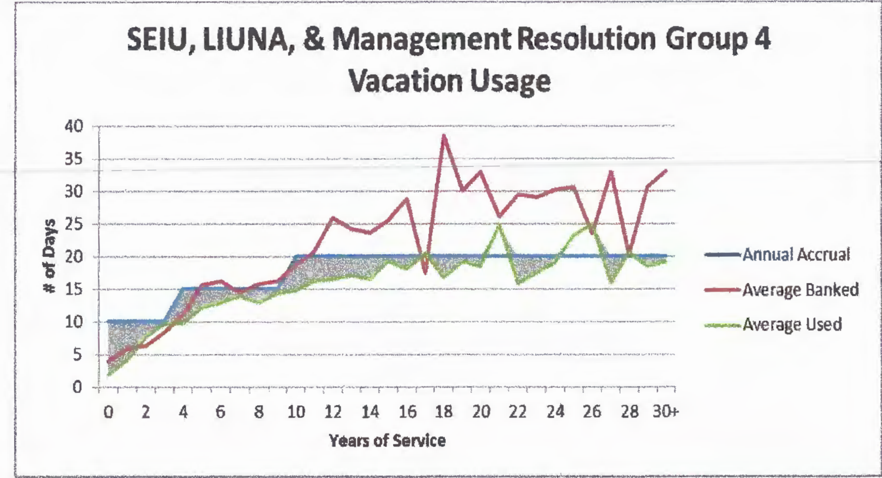
SUPPORTING DATA – ABSENCE

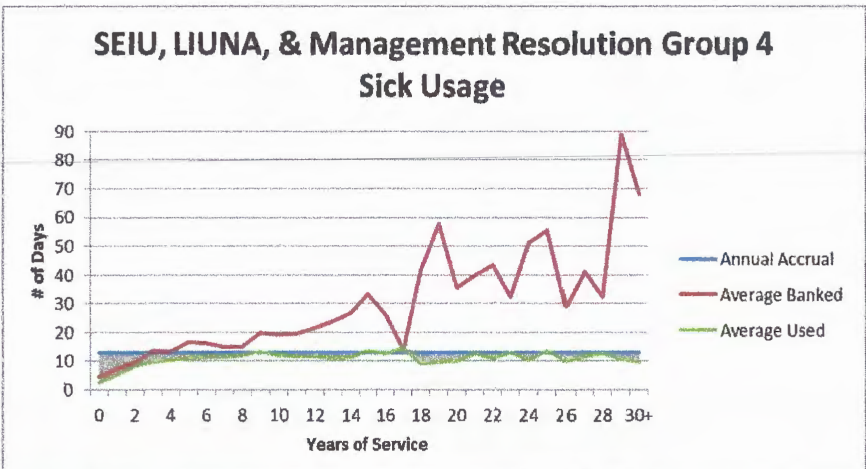
HuronHealthcare

- On average, annual leave, vacation, and sick are not fully utilized by any employee group

- Gray shaded area represents unused days







Source: Based on annual leave, vacation, and sick banks included in calendar year 2012 payroll file; Average days used based on calendar year 2012 payroll file

Note: Annual Leave includes vacation and sick

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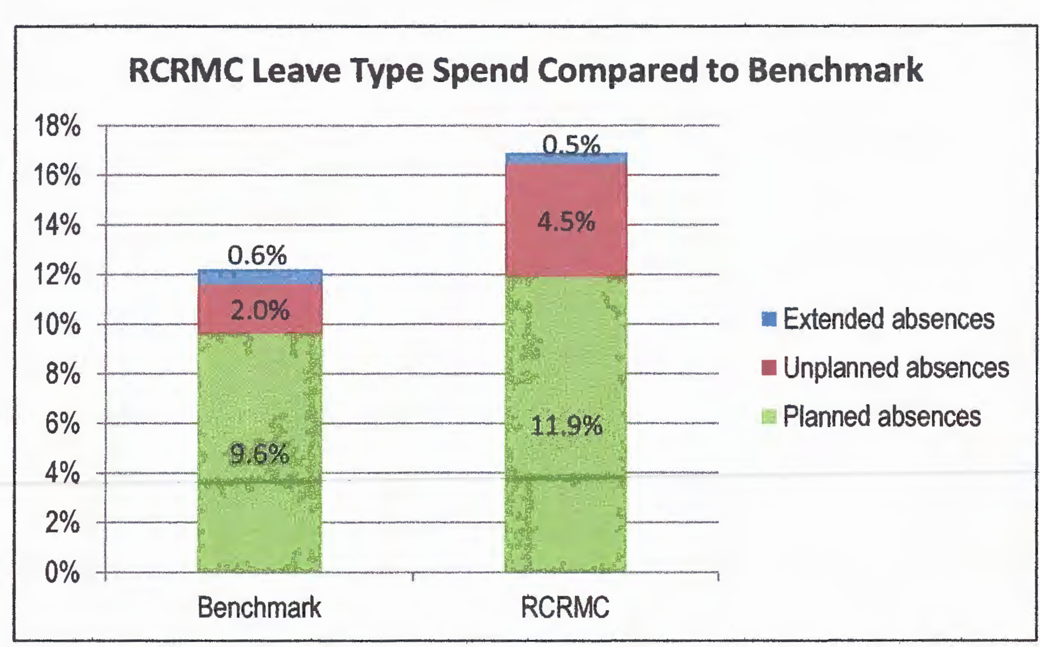
Human Resources Detailed Findings

SUPPORTING DATA – ABSENCE

HuronHealthcare

- Observation: External benchmarking indicates that RCRMC's overall cost of absence is above the 50th percentile (Mercer Survey)
- Achieving the 50th percentile for absence expense as a percent of base payroll is worth $5.4M



Source: January 2012 – December 2012 Compensation File; 2010 Mercer Survey on the Total Financial Impact of Employee Absences.

Leave Type	RCRMC
Vacation	$6,767,952
Sick	$5,265,949
Holiday	$4,418,651
Annual Leave	$1,169,887
Compensatory Leave	$1,038,021
STD	$524,505
Personal Leave	$396,335
Total	$19,581,301

	RCRMC
Regular Pay	$115,936,778
Mercer Survey (50th Percentile)	12.20%
Current % of Payroll	16.89%
Total Absence Spend at 12.2% of Base Payroll	$14,144,287
Savings Opportunity at 12.2% of Base Payroll	$5,437,014

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Human Resources Detailed Findings

OBSERVATIONS – CONTINGENT LABOR

HuronHealthcare

Area	Rating	Leading Practice	Observations
Contingent Labor			• TAP constitutes 19% of temporary services spend (temporary services spend includes TAP and contingent labor) • Nurse Registry constitutes 93% of contingent labor spend; Temporary Help Services (largely attributed to Kitchen and Pharmacy departments) constitutes 5% of contingent Labor spend; Therapy constitutes only 3% of contingent labor spend • A preferred vendor model exists, but is independent of the VMS module • No standardized rates are negotiated amongst contingent labor vendors

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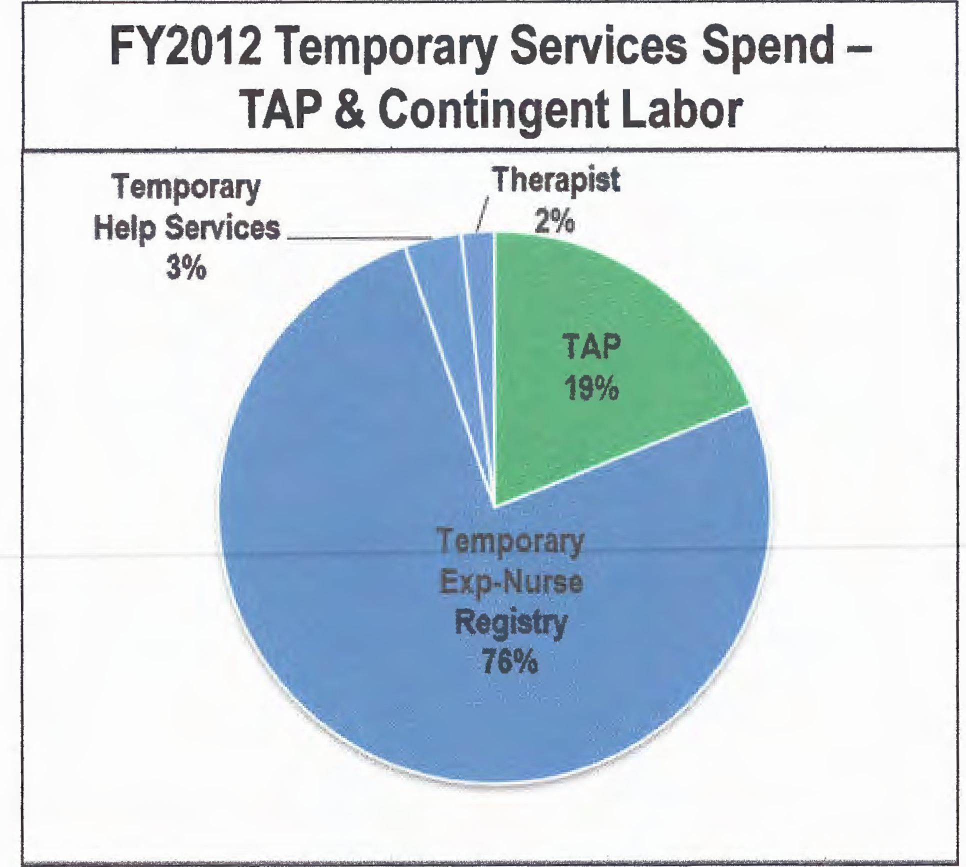
Human Resources Detailed Findings

SUPPORTING DATA – CONTINGENT LABOR

HuronHealthcare

- In FY2012, RCRMC spent $17M on outside contract labor, in addition to the $2.4M spent on the County internal per diem shared pool (TAP)



Source: TAP spend – Annual Budget FY 2012-13; Contingent Labor spend - FY 2012 AP File

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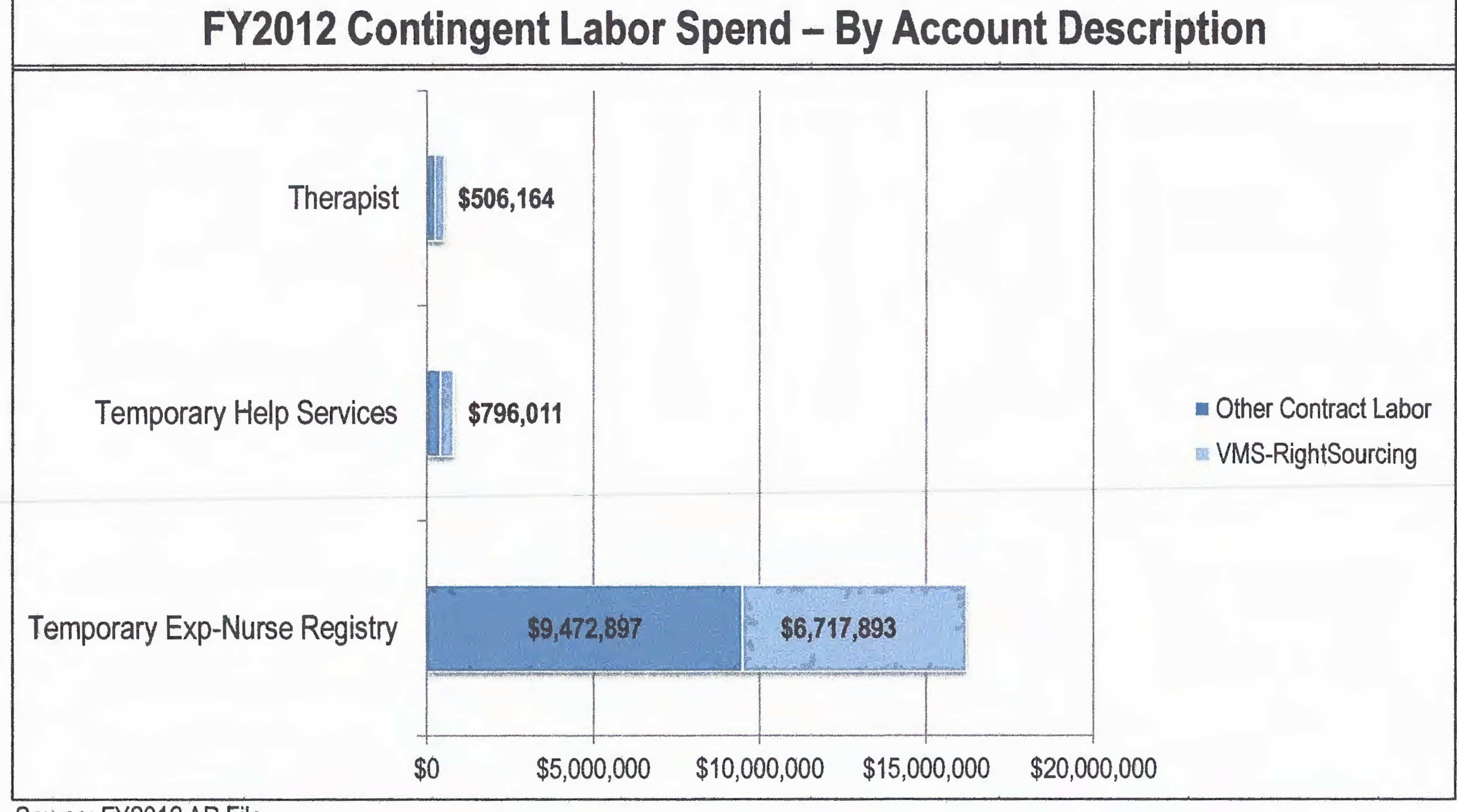
Human Resources Detailed Findings

SUPPORTING DATA – CONTINGENT LABOR

HuronHealthcare

- Less than 40% of RCRMC's contingent labor spend is channeled through the organization's VMS, RightSourcing



Source: FY2012 AP File

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Human Resources Detailed Findings

RECOMMENDATIONS

HuronHealthcare

- **Employee Benefits**
  - Evaluate current programs and vendors to gain coordination and alignment of plan design, contribution/credit, network and care management strategies to facilitate overall healthcare population management, accountability and sustained affordability for the County's employees and dependents
- **Premium Pay**
  - Review premium pay policies for consistency of application, departmental need, equity and resource allocation across the system; revise where appropriate
- **Absence**
  - Evaluate absence management strategy including employee leave, paid time off, policies & practices to ensure that it provides for the employees' needs for time away as well as support the organization's staff management and business objectives
  - Review disability, safety, workers' compensation and return to work policies and programs as part of overall absence strategy
- **HR Purchased Service**
  - Utilize internal staff prior to contracting outsourced labor, but when necessary consolidate utilization of vendors to leverage buying power
  - Process utilization of all vendors through the vendor management system, allowing for enhanced reporting and tracking capabilities

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Human Resources Detailed Findings

IMPLEMENTATION STRUCTURE

HuronHealthcare

Human Resources Solution Team

Huron Managing Director: [redacted]
Huron Lead: [redacted]
RCRMC Leader: TBD
RCRMC Co-Leader: TBD

- Premium Pay — Huron HR SME/RCRMC Staff
- Leave Management/PTO — Huron HR SME/RCRMC Staff
- Benefits — Huron HR SME/RCRMC Staff
- Contingent Labor — Huron HR SME/RCRMC Staff

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Agenda

HuronHealthcare

- Introduction
- Health System Strategic Plan
- Hospital Operational and Financial Performance Review
  - Non-Labor
  - Labor
  - Human Resources
  - Physician Services
  - Revenue Cycle
  - Clinical Documentation Improvement
  - Clinical Operations
- Conclusion

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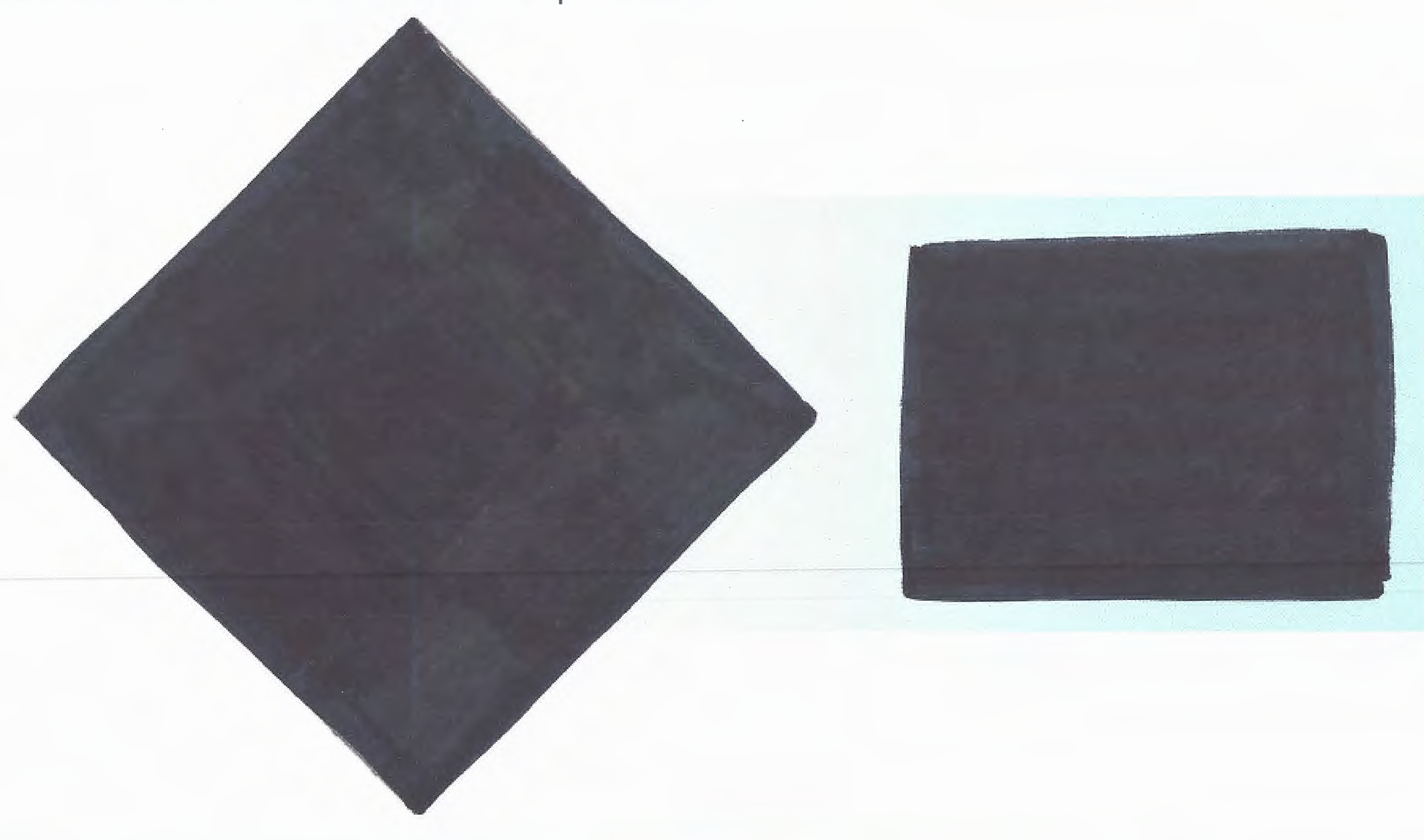
Physician Solution

MANAGEMENT FRAMEWORK

HuronHealthcare

Four Dimensions of a Successful Group Practice



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Physician Solution

SUMMARY OF FINANCIAL OPPORTUNITY

Physician Solution Recurring Benefit			
	Physician Services Recurring Benefit		
	Low	**Mid**	**High**
Non-provider Labor	$1,000,000	$1,500,000	$2,000,000
Span of Control (Ambulatory)	$1,000,000	$1,200,000	$1,400,000
Total Net Revenue Physician Productivity Increase	$1,900,000	$2,150,000	$2,400,000
Projected Associated Additional Downstream Revenue for RHS	$5,700,000	$6,450,000	$7,200,000
Recurring Revenue Benefit Total	**$9,600,000**	**$11,300,000**	**$13,000,000**

Notes: Additional physician compensation was not included; Projected Associated Additional Downstream Revenue was estimated at 3 times Pro-Fee Revenue Increase

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Physician Solution- Detailed Findings

SUMMARY FINDINGS BY FUNCTIONAL AREA

Functional Area	Rating	Leading Practice	Findings
Provider Productivity	Moderate Opportunity	[redacted]	• Lack of data, in general (no data for Hospital-based clinics), and lack of reliable data (hand-keyed data for "FQHCs") makes it difficult to benchmark provider productivity • Of the 24 "FQHC" physicians, 7 (or 30%) are below the MGMA Median for their respective specialties • Physicians and providers are very motivated and committed to RMC's mission; also received positive feedback from many physicians about prospective changes to the organization
Provider Care Model	High Opportunity	[redacted]	• Physicians perform unnecessary and redundant paperwork leading to loss clinical time • Lack of IT resources puts a burden on physician productivity • Physicians spend too much time coordinating referrals • Multiple layers of "hospital bureaucracy" according to physicians • Difficult for the clinics to hire and replace staff often taking an average of 6 months to hire, thereby losing out on candidates

Low Opportunity Moderate Opportunity High Opportunity

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Physician Solution- Detailed Findings

SUMMARY FINDINGS BY FUNCTIONAL AREA

	Rating	Leading Practice	Findings
Patient Access	●	[redacted]	▪ Average patient throughput/cycle time in the clinics ranges from 1.5 hours – 3.5 hours ▪ Physical space constraints are a factor for high-demand specialties such as ophthalmology ▪ High no-show rate/inefficient patient scheduling
Referral Management	●	[redacted]	▪ Referral process has road blocks, and it is difficult for Primary Care Physicians to refer to specialists ▪ No referral reports or tracking to identify and manage out-migration

Low Opportunity

Moderate Opportunity
High Opportunity

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Physician Solution Findings

INTERVIEW SUMMARY

HuronHealthcare

Riverside County Medical Center
Dr. Tabuenca
Dr. Ludi
Dr. Molkara
Dr. Thompson
Dr. Kim
Dr. Faerber
Dr. Siddiqi
Dr. Wong
Dr. Clark
Dr. Leung

Note: Interview list is not exhaustive

Key Interview Themes

- Some clinic employees do not report to the Assistant Nurse Manager (managing the clinic) and makes it difficult to manage these employees
  - HR process is arduous- takes an average of 6 months to replace clinical support staff
- Physicians are dedicated to the system, its mission, and want to be instrumental in improvement
- Systemic breakdowns in office flow creates unnecessarily long patient visit experience
  - Patient check-in process seems unstructured
  - Patient flow is fractured and, at times, incongruent
  - Referral process is broken
  - IT resources are lacking
- Poor data acquisition and management leaves a vacuum of knowledge and tools
  - Difficult to manage physicians and staff with no data or dashboards
- Nurse managers are pulled from management into daily clinical care on a continuous basis
- Due to inefficiencies, physicians are forced into non-clinical and unproductive activities

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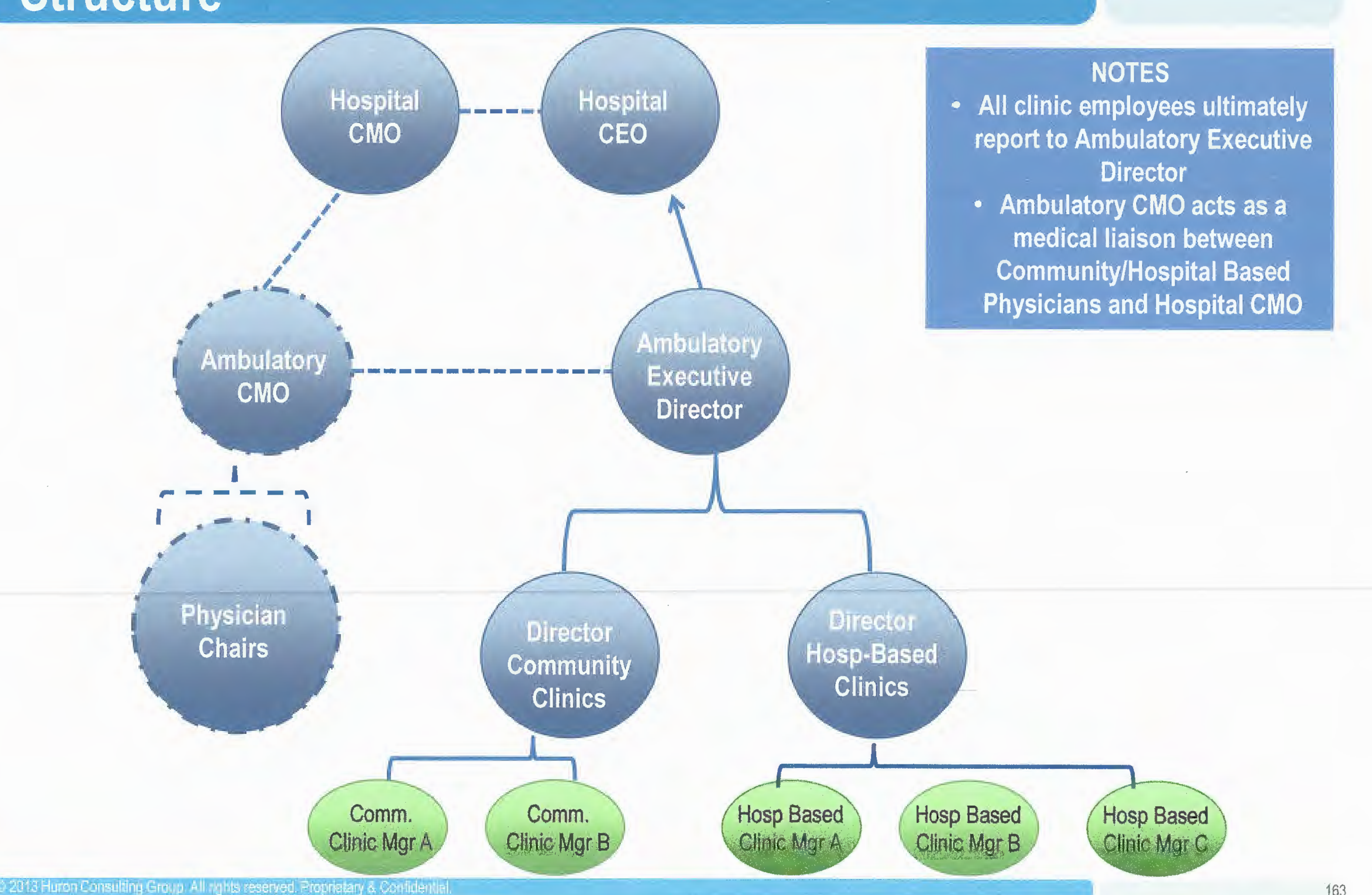
Physician Solution– Proposed Organizational Structure

Huron Healthcare



NOTES

- All clinic employees ultimately report to Ambulatory Executive Director
- Ambulatory CMO acts as a medical liaison between Community/Hospital Based Physicians and Hospital CMO

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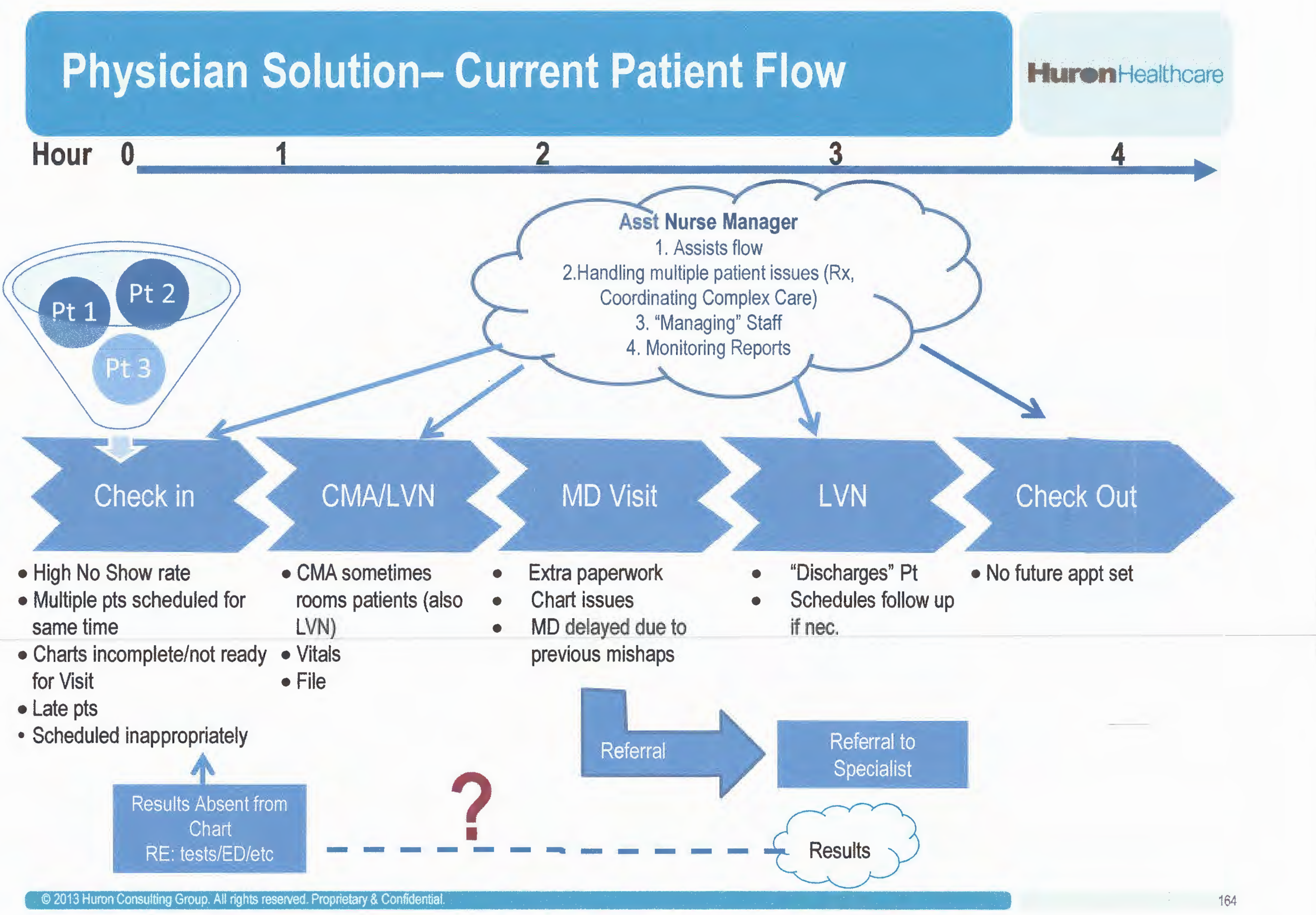

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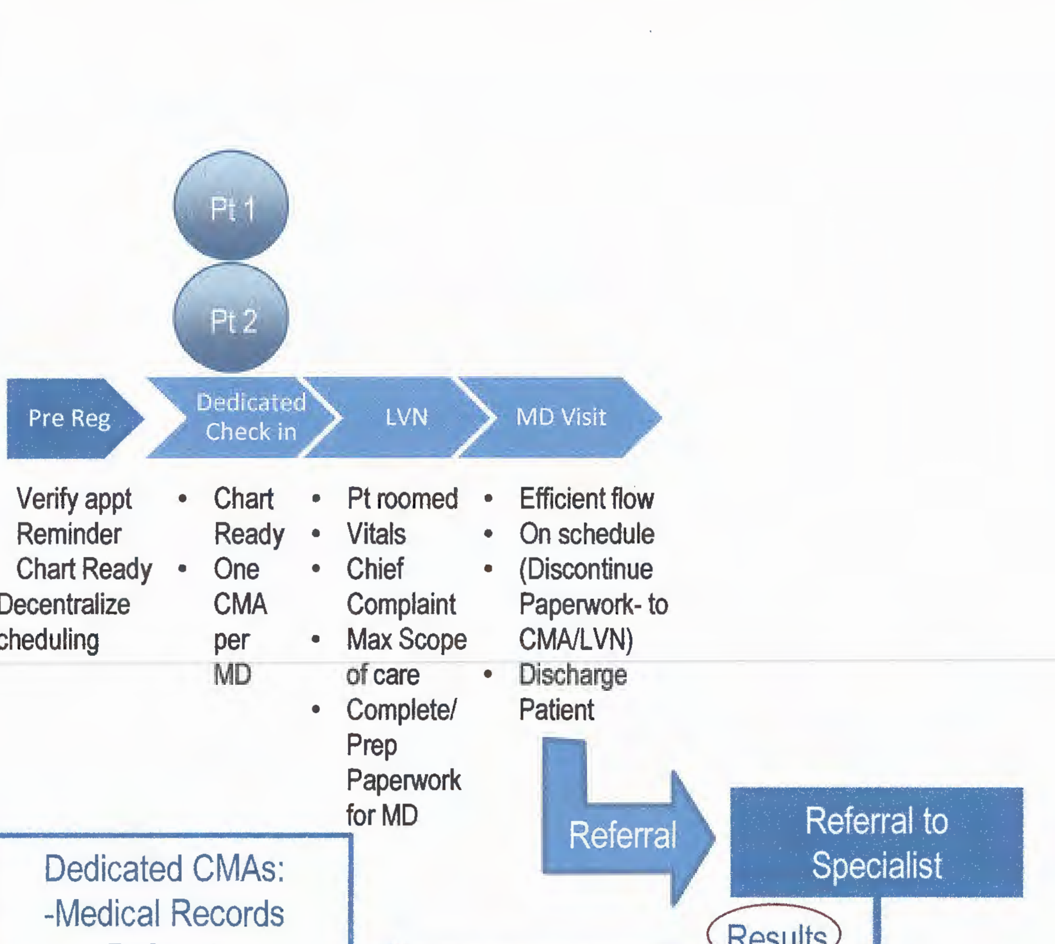
Physician Solution– Proposed Patient Flow

HuronHealthcare

Hour 0 1 2 3 4



Clinic Manager

- Mgt by Data/Reports
- Manages staff and has accountability
- Physician Dashboards
- (Removed from Pt Care)

Standardized clinic processes and procedures will increase efficiency when staff float from one clinic to another

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Physician Solution Findings

CLINIC LABOR AND SPAN OF CONTROL

HuronHealthcare

Observations

- Opportunities exist in current span of control to streamline practice management and operations
- Skill-mix adjustments should be made in order to ensure certain tasks are performed by staff members with the most appropriate skill set

Recommendations

- Institute dyad model and have a strong non-physician lead RHC Ambulatory in conjunction with CMO
- Evaluate span of control (position by position) for all of RHC Ambulatory and determine which positions are appropriate; clarify roles and responsibilities of managers
- Conduct sub-specialty by sub-specialty clinic reviews of current staff and procedures in order to determine best practice; modify other practices as necessary
- Establish a thorough position control process and standardize benchmarking across all positions and departments

Opportunity	
FTEs	($)
0	-
0	-
2	$200k
6	$1M
N/A	-
8	**$1.2M**

Notes: Physicians and Midlevel providers were not included in span of control analysis, FTEs from HR payroll file and only Ambulatory cost centers; benefits were estimated at 15%; average salary for each level used to calculate financial benefit; Executive Directors split time between hospital/ambulatory. Estimation of half-time ambulatory included in above analysis

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Physician Solution Findings

PROVIDER PRODUCTIVITY

Huron Healthcare

Observations

- Lack of data makes it difficult to assess current levels of provider productivity and clinic staffing efficiency
- Based on observations and interviews, there appears to be an estimated opportunity to increase patients seen per day in both the community and hospital-based clinics
- Since patient demand is currently high, physicians are likely below median due to other constraints:
  - No show/cancellation rate
  - Inefficiencies in certain areas such as scheduling, front-desk, or clinical functions

Recommendations

- Achieve FQHC status in order to receive increase reimbursement
- Establish and adhere to benchmarks for a clinical FTE, provider productivity, visits/hour, and resource utilization
- Review and optimize room utilization and provider scheduling; extend patient contact hours in order to meet market needs (e.g., ability to see children after school and extended morning and evening hours
- Develop a monthly dashboard for each physician that reports production, referrals, financial performance, etc. and conduct monthly meetings between RHC administration and physicians basis for all sub-specialties
- Review and monitor 3rd next available appointment for potential patient access issues
- Review use of midlevel providers and determine if additional provider productivity outweighs cost

Physician Productivity Increase	Community Clinics	Hospital Based Clinics
Patients per Day Optimal Target (for Year 1)	22	20
Current Visits per Day*	18	13
Additional Visits per Day	4	7
Number of Physicians	24	8
Estimated Number of Work days	223	223
Reimbursement for Level 3 Established	$71	$71
Projected Pro-Fee Net Revenue	$1,500,000	$900,000
Total Projected Pro-Fee Net Revenue		**$2,400,000**
	Low	**High**
Projected Pro-Fee Net Revenue Opportunity	**$1,900,000**	**$2,400,000**
Projected Associated Downstream Revenue for RHC (estimated 3x Pro-Fee)	**$5,700,000**	**$7,200,000**

(Variable costs were not included in the above analysis; typically about 10% of pro-fee net revenue)

Notes: *Current state of visits is based on limited data provided by the CMO; downstream revenue is estimated at 3 times the pro-fee net revenue

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Physician Solution Findings

CLINIC LABOR

Huron Healthcare

Observations

- There appears to be opportunity to reduce both front office and clinical support staff
- Redundancies and inefficiencies in processes and procedures create the unnecessary need for additional resources
- In some clinics, in order to ameliorate patient flow problem, there seems to be an attitude of "throwing resources at the problem" instead of solving it directly
- Skill mix adjustments should be made in order to ensure certain tasks are performed by staff members with the most appropriate skill set

Recommendations

- Conduct sub-specialty by sub-specialty clinic reviews of current staff and procedures in order to determine best practice; modify other practices as necessary
- Optimize room and staff utilization
- Establish a thorough position control process and standardize benchmarking across all positions and departments

Clinical Staffing Analysis (Community Clinics Only)

Support Staff FTEs Analyzed		
Front Office Support FTEs	89	
Clinical Support FTEs	73	
Total Staff Analyzed	162	
Support Staff FTE Opportunity	**Low**	**High**
Front Office Support FTEs	19	25
Clinical Support FTEs	12	16
Total FTE Opportunity	**31**	**41**
Financial Opportunity	**Low**	**High**
Front Office Financial Opportunity	$500,000	$800,000
Clinical Support Financial Opportunity	$500,000	$1,200,000
Total Potential Opportunity	**$1,000,000**	**$2,000,000**

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Physician Solution

IMPLEMENTATION STRATEGY

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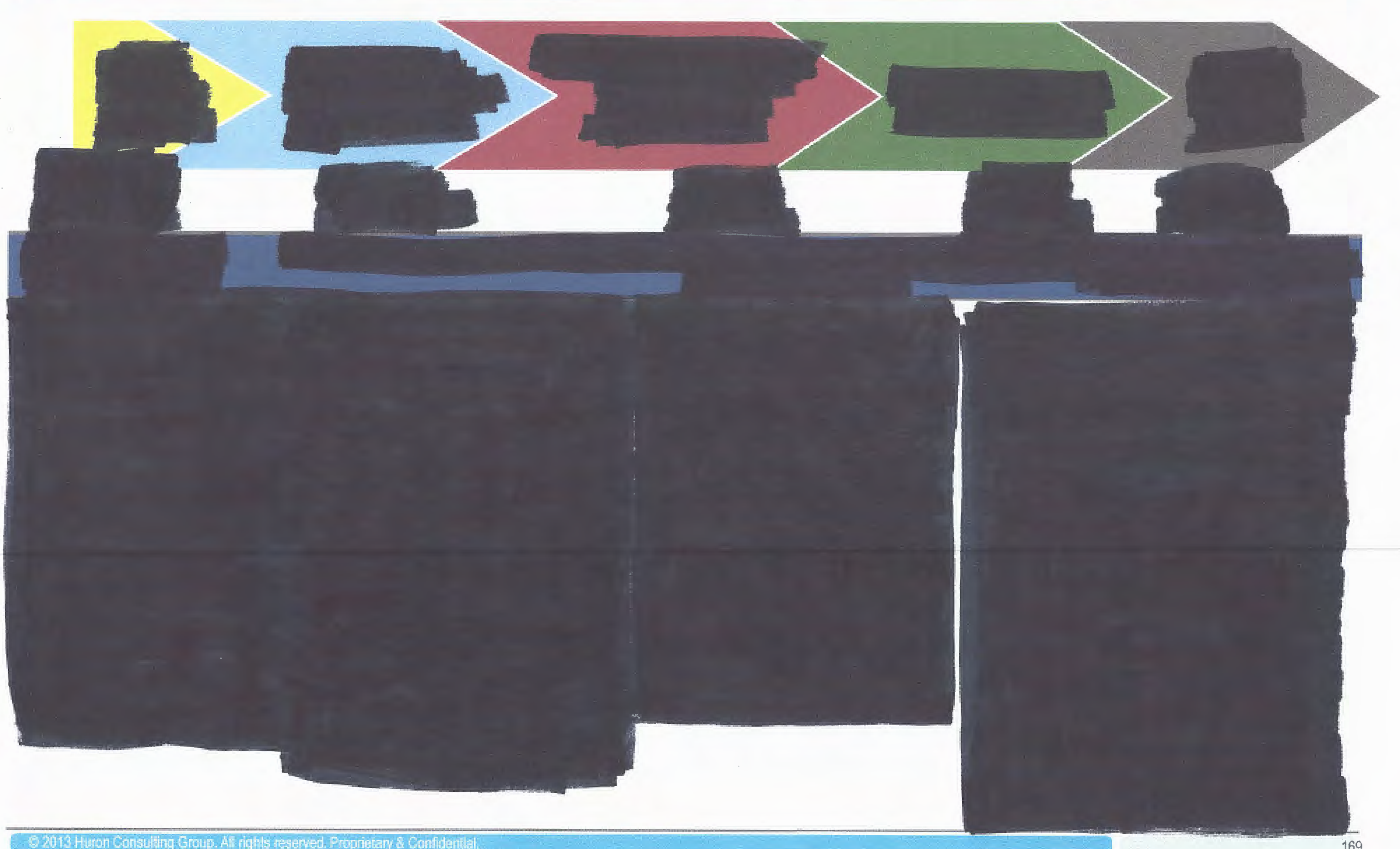

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Physician Solution

SAMPLE PRACTICE MANAGEMENT DASHBOARDS– PRACTICE OPERATIONS METRICS

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Physician Solution

SAMPLE PRODUCTIVITY TRACKER

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Physician Solution

SAMPLE PRODUCTIVTY TOOLS: PATIENTS PER SESSION

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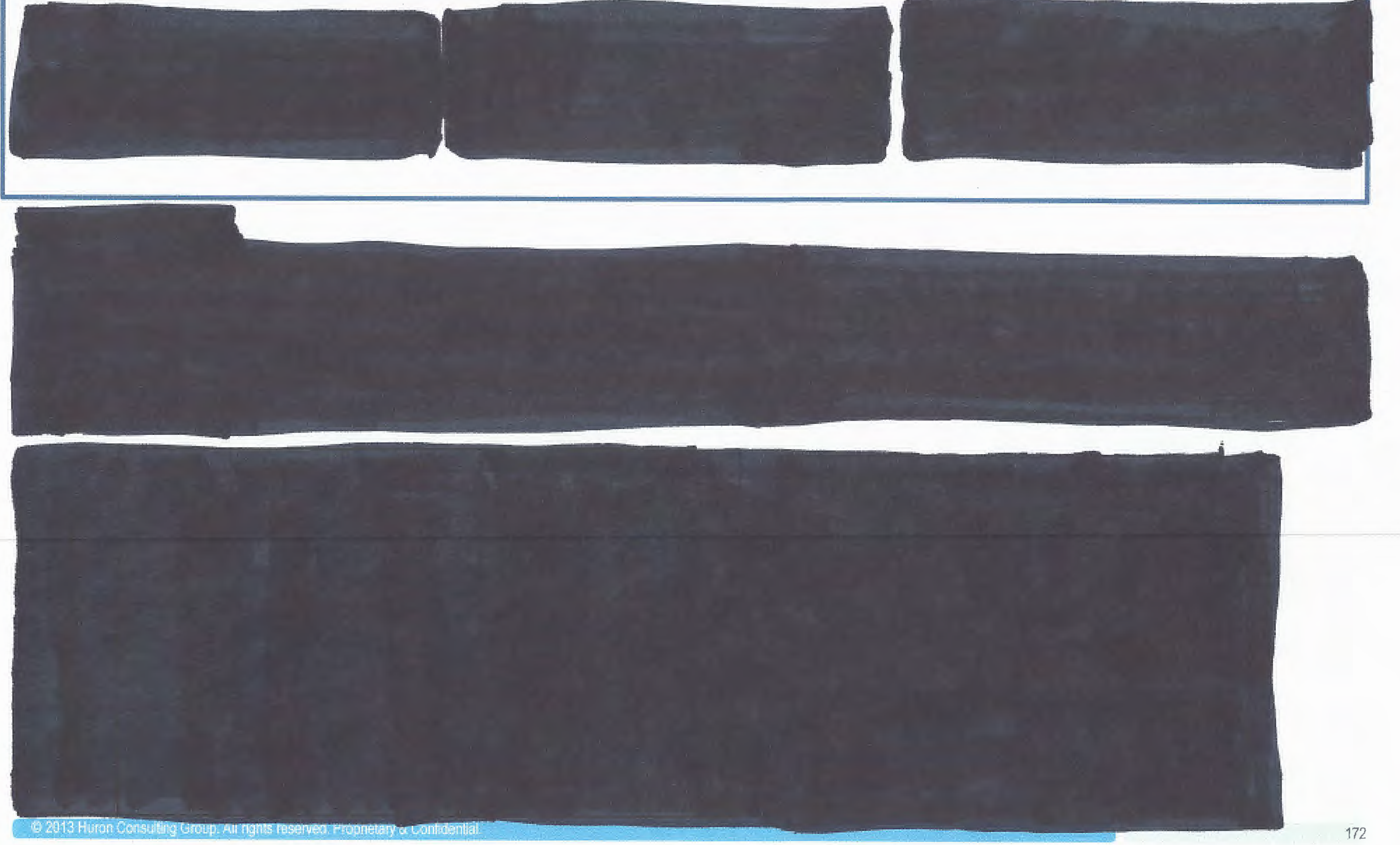

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Agenda

Huron Healthcare

- Introduction
- Health System Strategic Plan
- Hospital Operational and Financial Performance Review
  - Non-Labor
  - Labor
  - Human Resources
  - Physician Services
  - Revenue Cycle
  - Clinical Documentation Improvement
  - Clinical Operations
- Conclusion

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Revenue Cycle Detailed Findings

SUMMARY ASSESSMENT FINDINGS

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The revenue cycle of the Riverside County Regional Medical Center (RCRMC) has significant opportunity to improve workflows and reporting, create more efficient processes, and increase net revenue.

- The revenue cycle management team recognizes the need for pervasive change (currently operating in a reactive mode, focused on A/R clean-up) throughout the revenue cycle and is committed to improving performance
- The Medically Indigent Services Program (MISP) Department is a robust operation that is effectively securing funding for 70% of patients and proactively manages vendor outsourcing and close/return reporting
- Current revenue cycle workflows are dependent upon fragmented systems that require a number of workarounds and manual processes to manage and support
- Lack of automated workdrivers and reporting prevents supervisors and staff from being able to prioritize and stratify AR management in a way which would maximize reimbursement as well as reduce aged receivables and bad debt

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Revenue Cycle Detailed Findings

SUMMARY ASSESSMENT FINDINGS, *CONT'D*

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- Functions across the revenue cycle "pipeline" tend to be managed in silo's; there is a lack of structure and systemic wide thinking about revenue cycle end-to-end processes.
  - There is no mechanism to track and prioritize requests and drive accountability and ownership across the pipeline
- Downstream impacts of broken processes results in significant rework and non-value added activities that limits the Patient Accounts management team ability to focus on core AR management functions
- Backlogs exist in some of the key revenue cycle departments (e.g., HIM and Case Management) which are barriers to getting claims out the door timely and with the proper documentation to ensure maximum reimbursement
- The Treatment Authorization Request (TAR) logs which are Excel based and maintained by Patient Accounts and Case Management are not effective at managing the TAR process

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Revenue Cycle Detailed Findings

SCOPE & APPROACH TAILORED TO THE UNIQUE NEEDS OF OUR CLIENTS

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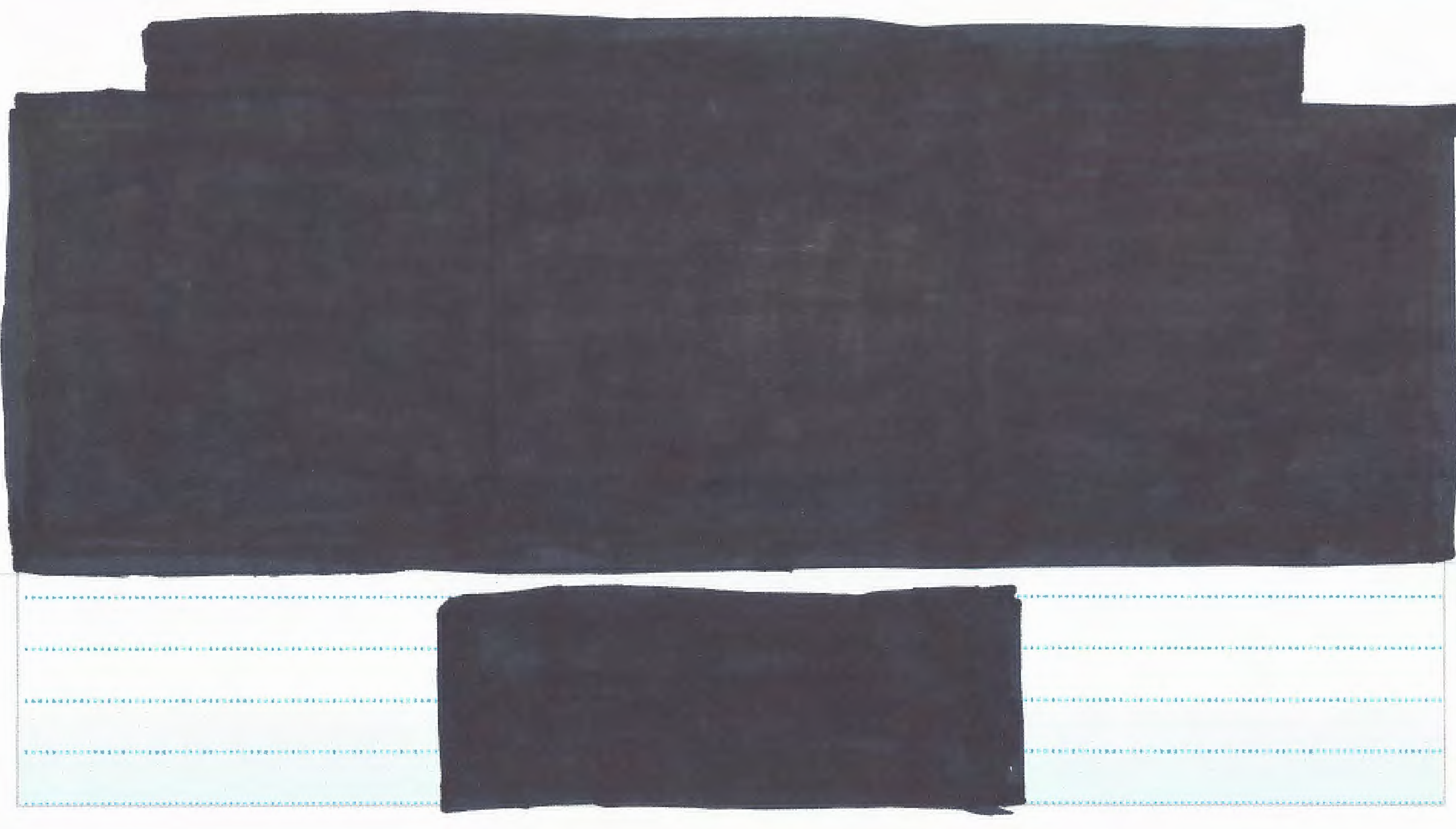

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Revenue Cycle Detailed Findings

KEY ASSESSMENT ACTIVITIES

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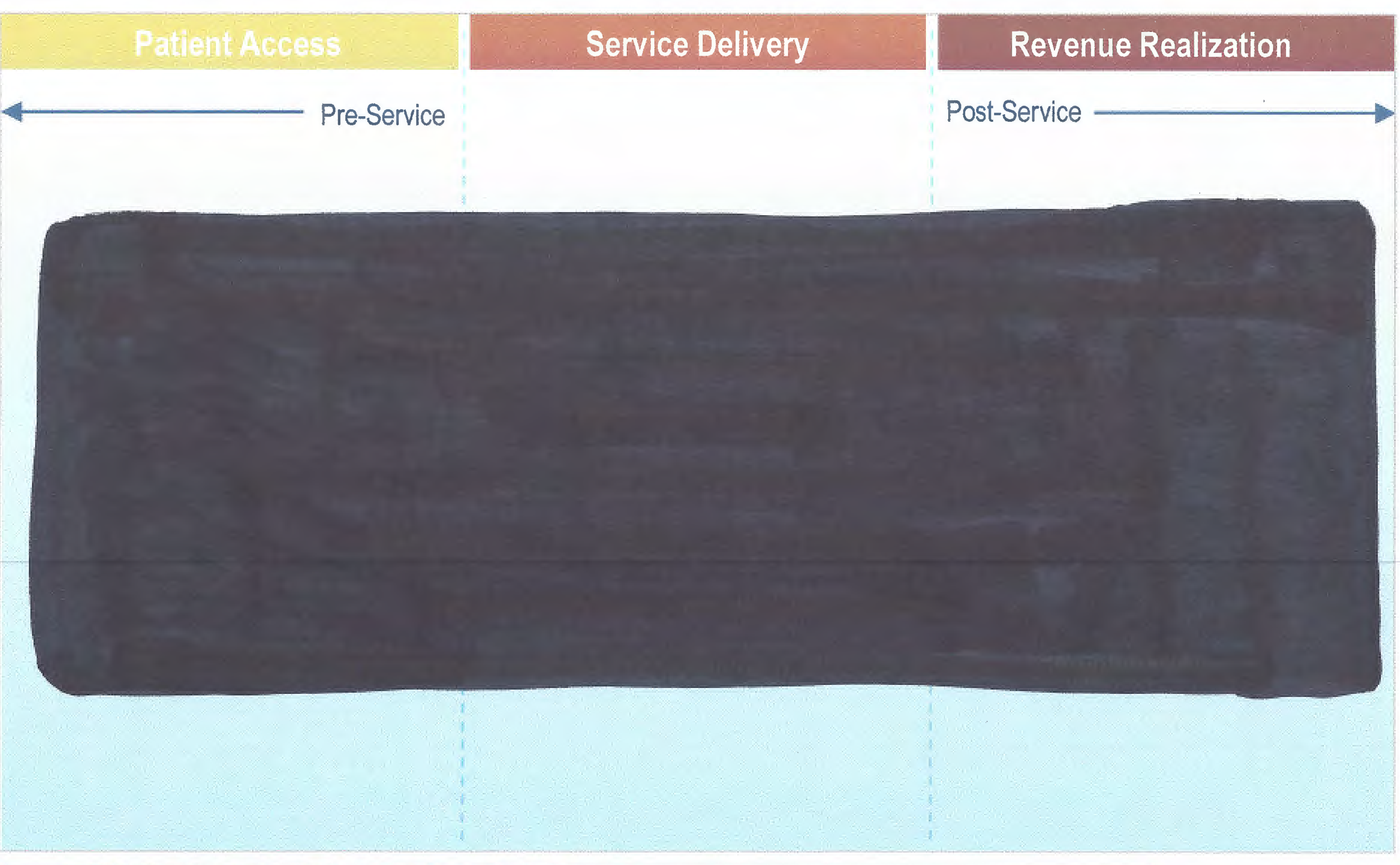

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Revenue Cycle Detailed Findings

FINANCIAL OPPORTUNITY SOURCES

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Key Benefit Source	Annual, Recurring Benefit		
	Low	Mid	High
Net Revenue Recovery [redacted]	$5M	$6M	$7M
Total Annual, Recurring Benefit	$5M	$6M	$7M

Key Benefit Source	One-Time Benefit		
	Low	Mid	High
One-Time Cash Flow Opportunity [redacted]	$6M	$7M	$8M
Total One-Time Benefit	$6M	$7M	$8M

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Revenue Cycle Detailed Findings

SUMMARY FINDINGS BY FUNCTIONAL AREA

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Revenue Cycle Function	Rating	Leading Practice Performance Indicator	Summary Performance Assessment
Revenue Cycle-wide		[illegible]	▪Productivity standards exist, however the tracking against these standards is manual and unreliable as the data is difficult to obtain in a timely manner ▪Most standards deviate from best practice, generally on the higher side, which is preventing necessary work from being completed in an acceptable fashion
Revenue Cycle-wide		[illegible]	▪Reliable data and reporting is one of the key challenges across the entire revenue cycle ▪Reporting was cited as a key barrier in achieving ideal performance at each department ▪Data, reports, and systems that are being utilized are outdated and retro-fit to suit the area's needs but are below industry standards
Revenue Cycle-wide		[illegible]	▪Registration staff within hospital based clinics report up through Revenue Cycle, but this has not been fully accepted and is currently being reviewed ▪Referral process reports up through Case Management

Low Opportunity | Moderate Opportunity | High Opportunity

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Revenue Cycle Detailed Findings

SUMMARY FINDINGS BY FUNCTIONAL AREA, *CONT'D*

HuronHealthcare

Revenue Cycle Function	Rating	Leading Practice	Summary Performance Assessment
Scheduling & Pre-Registration			▪ Centralized scheduling exists but is not being used to its full capacity; clinics have control of templates which causes disconnects with centralized scheduling ▪ Lack of communication between clinics and centralized team prevents effective pre-registration of patients and days out being achieved
Insurance Eligibility, Authorizations & Referrals			▪ Responsibility for obtaining referrals/authorizations is decentralized and requires back-forth contact between registration team, provider relations, and clinics ▪ Ineffective enforcement of hospital protocols allows patients to be seen without an established funding source
Admitting and Registration			▪ Admitting department is bypassed when patients are admitted through urgent clinical determination at a clinic, which prevents effective registrations ▪ Paper reports prevent full efficiency of Admitting staff to ensure funding has been secured and documentation has been completed

Low Opportunity Moderate Opportunity High Opportunity

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Revenue Cycle Detailed Findings

SUMMARY FINDINGS BY FUNCTIONAL AREA, *CONT'D*

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Revenue Cycle Function	Rating	Leading Practice	Summary Performance Assessment
MISP Department	○ (Low)	[redacted]	▪ MISP Department is a robust operation that effectively is securing funding for 70% of patients ▪ Tools have been adapted to best available means, but improved tools would allow for more efficient workflows and staff productivity
Billing	● (High)	[redacted]	▪ Clean claim rate for both billing systems is consistently less than 40%, significantly lower than industry standard 70+%
Bill Hold Resolution	● (High)	[redacted]	▪ Billing WIP across all departments is managed via spreadsheet processes which causes delays in resolution and inefficient tracking/communication ▪ Billing and follow-up functions are shared across representatives, which can lead to issues with daily prioritization and prevent effective timely touches on all outstanding accounts

Low Opportunity | Moderate Opportunity | High Opportunity

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Revenue Cycle Detailed Findings

SUMMARY FINDINGS BY FUNCTIONAL AREA, *CONT'D*

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Revenue Cycle Function	Rating	Leading Practice	Summary Performance Assessment
HIM / Medical Records	●		▪ Coding backlogs are tracked daily, ▪ Despite goals and recent improvements to achieve <9 days of backlog, current backlogs are ~15 days with staffing issues causing ebbs and flows ▪ There are coding delays due to various clinical holds and requests
Receivable Management	●		▪ Staff are divided by government funding sources and commercial payers, predominantly working by dollar tiers, though staff have final discretion on which account to work ▪ Portfolio sizes are well above the expected amount to be completed by an individual in a timely manner
Receivable Management	◒		▪ Staff are expected to work ~75 accounts/days, which aligns with the over-sized portfolios and will lead to ineffective overall receivable management ▪ Lack of automated workdrivers creates lack of control with staff prioritization and quality

Low Opportunity | Moderate Opportunity | High Opportunity

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Revenue Cycle Detailed Findings

SUMMARY FINDINGS BY FUNCTIONAL AREA, *CONT'D*

HuronHealthcare

Revenue Cycle Function	Rating	Leading Practice Performance Indicator	Summary Performance Assessment
Transaction Posting			▪Limited write-off requests are reviewed by supervisor; elevation of review was not witnessed in account sampling ▪Write-offs are inserted into an Excel spreadsheet for IT to script write-offs; ▪Administrative write offs (timely filing) are mis-classified as contractual allowances
Transaction Posting			▪Cash receipts are expected to be posted daily, however suspense is not (goal is not to exceed $5K by end of month) ▪Delays exist in receiving mail in a timely fashion from the RCRMC hospital and cashier
Denials Management			▪Denials spreadsheets exist, but management of specific root cause denials is not a focus area ▪Specifically, clinical denials are expected to be worked by Case Management, but the responsiveness to these requests is not timely

Low Opportunity Moderate Opportunity High Opportunity

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Revenue Cycle Detailed Findings

RECOMMENDATIONS

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RCRMC is in need of end-to-end revenue cycle processes that promote effective communication, collaboration, and accountability. A comprehensive implementation of process improvements, staff skill development, and more effective tools and reporting will produce substantial benefits and establish a durable operation that will sustain performance for the long term and allow for continued growth.

- Implement **focused work drivers** to effectively manage and consolidate tasks, establish priorities, allow staff to work proactively, and support accountability
  - Work drivers with clear prioritization are needed to ensure accounts are worked consistently and timely
  - Automated workflows related to account exceptions that may arise during the care process (e.g., financial class or patient type changes) are needed to alert staff of additional work that may be required to mitigate financial risk
  - Streamline interdepartmental communication (e.g. HIM and Case Management) and manage outstanding requests by utilizing a work driver to ensure timely resolutions and eliminate backlogs and black holes
- Create **management reporting** to support effective prioritization of process improvements and cash flow opportunities at a revenue cycle-wide level. A comprehensive view of the revenue cycle performance will enable management to track key metrics, promote ownership, and proactively identify financial and performance risks to the organization.

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Revenue Cycle Detailed Findings

RECOMMENDATIONS, *CONT'D*

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- Establish a **formal tracking and trending of denials** to proactively identify root causes, ensure the resolution of time-sensitive appeals, and facilitate necessary process improvements
- **Create a centralized front-end registration team** (or at a minimum standardized processes with appropriate accountability) that has clear responsibility for activities ranging from scheduling through referral/authorization obtainment
- **Define realistic productivity standards** and **establish a formalized quality review process** for staff that maximizes quality and performance as well as creates a strong culture of accountability. These will also assist in identifying performance concerns and training needs.
- **Complete streamlined conversion to TAR free process,** including the timely and consistent adoption of the use of InterQual measures, **and enhance the submission and monitoring of TARs** in an effort to eliminate backlogged populations
- **Assess staffing levels across all departments** based on best practice productivity standards to achieve best practice performance on front-end and back-end functions
- **Analyze receivables** to ensure appropriate prioritization is in place and **evaluate outsourcing protocols** where appropriate to improve overall efficiency and effectiveness (e.g., resolution of unnecessary aged receivables, system clean-up, low dollar)

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Revenue Cycle Solution

THE PROVEN SOLUTION FOR SUSTAINABLE PERFORMANCE IMPROVEMENT

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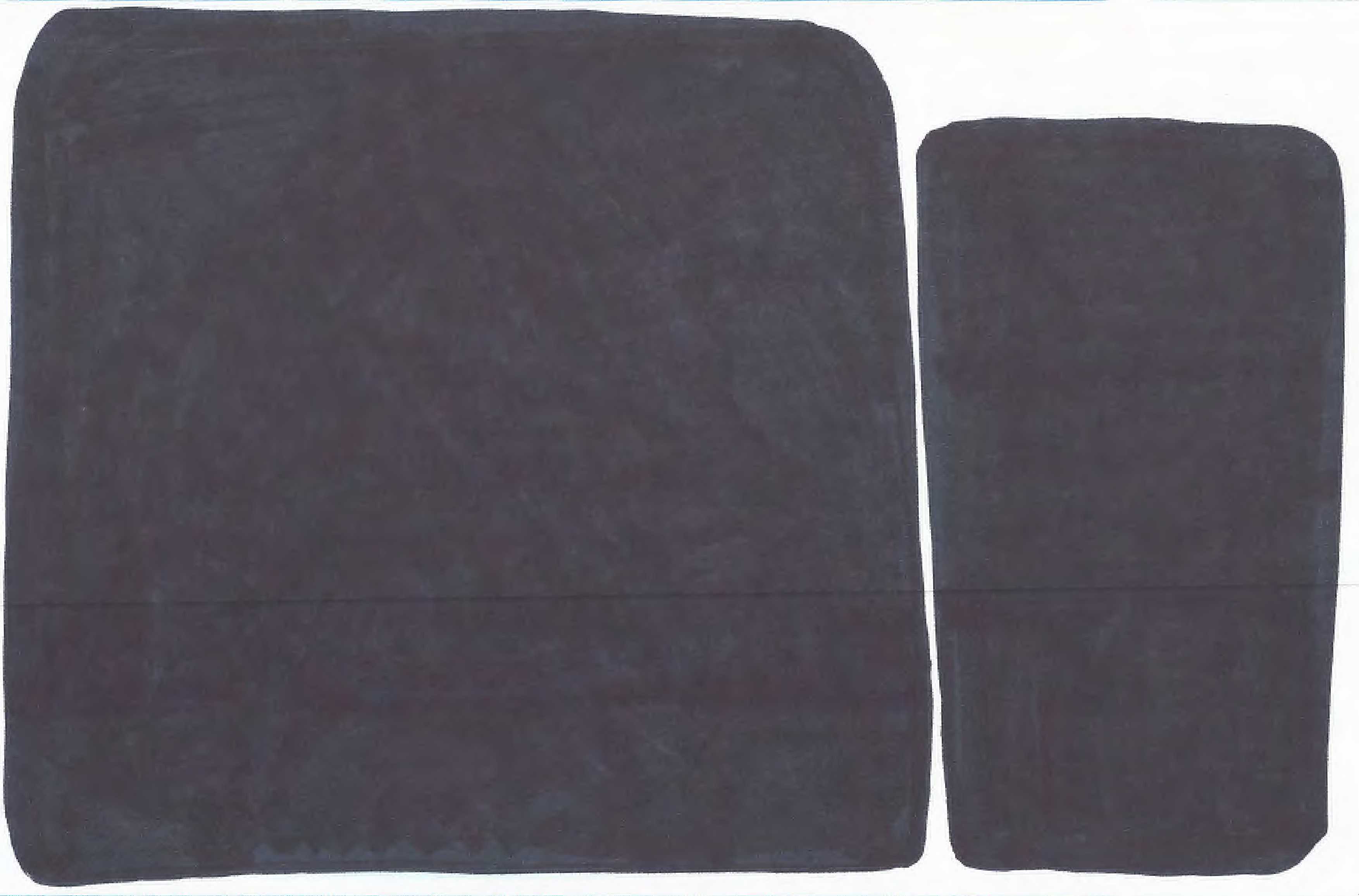

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Revenue Cycle Detailed Findings

SCOPE & APPROACH TAILORED TO THE UNIQUE NEEDS OF OUR CLIENTS

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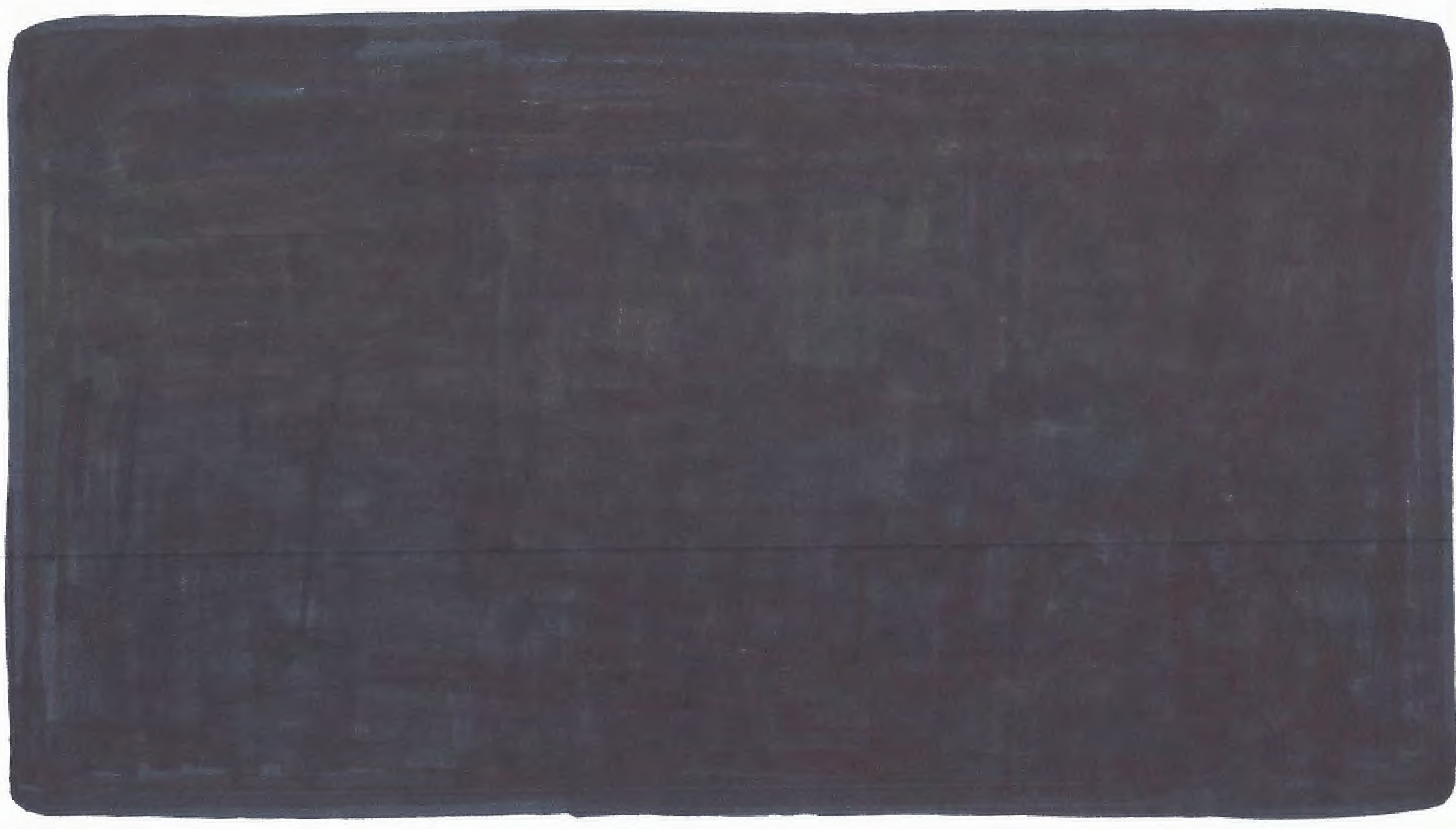

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Essential Elements of Our Tools

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Typical Implementation Approach and Timeline

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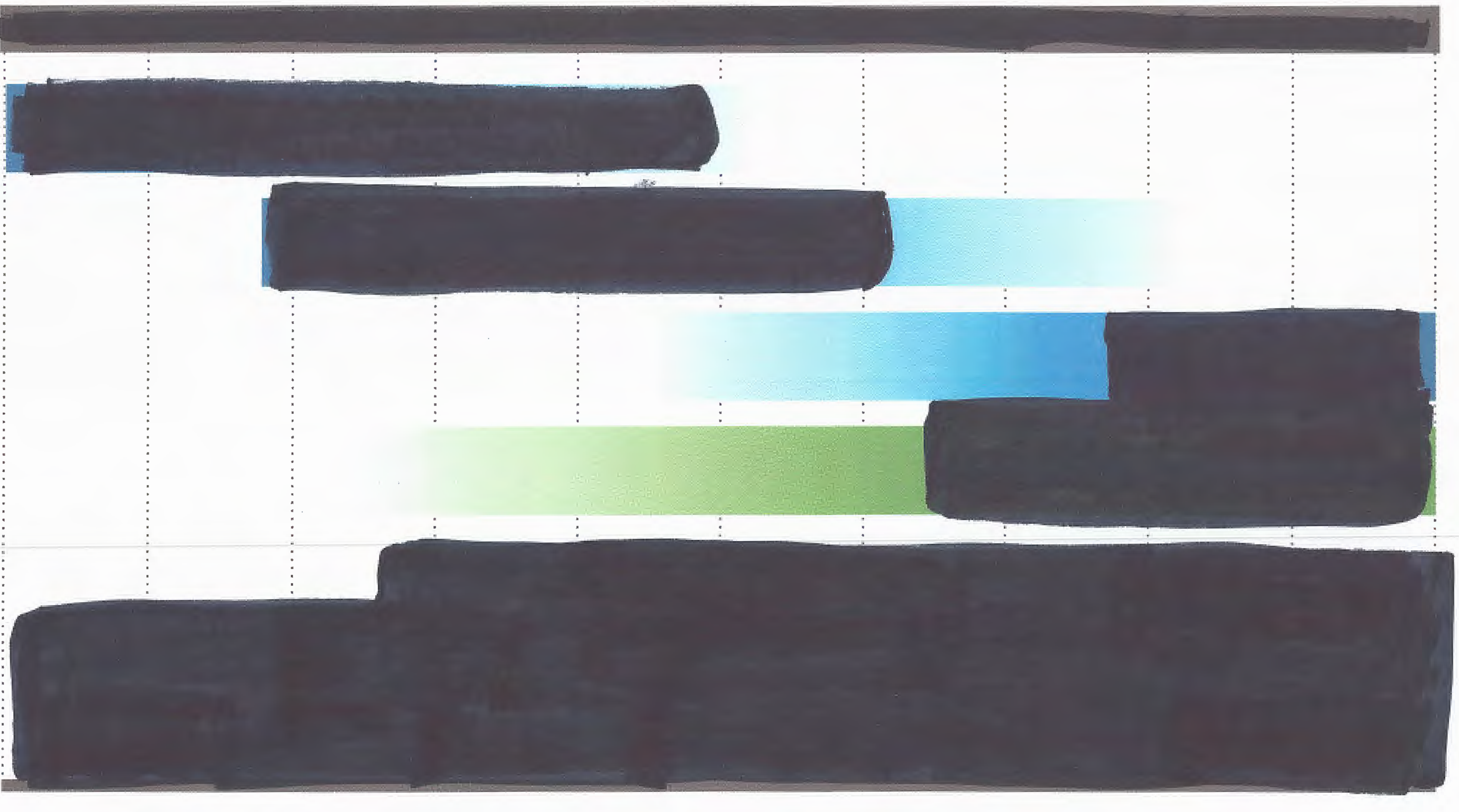

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Revenue Cycle

IMPLEMENTATION STRUCTURE

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Revenue Cycle Solution Team

Huron Managing Director: [redacted]
Huron Lead: TBD
RCRMC Leader: Theresa Deem

Net Revenue Recovery Implementation Team
Huron RC SME/RCRMC Staff

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Recap of Assessment Conclusions & Next Steps

RECOMMENDED APPROACH TO CHANGE

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Agenda

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CDI Detailed Findings

EFFECTS OF CLINICAL DOCUMENTATION IMPROVEMENT

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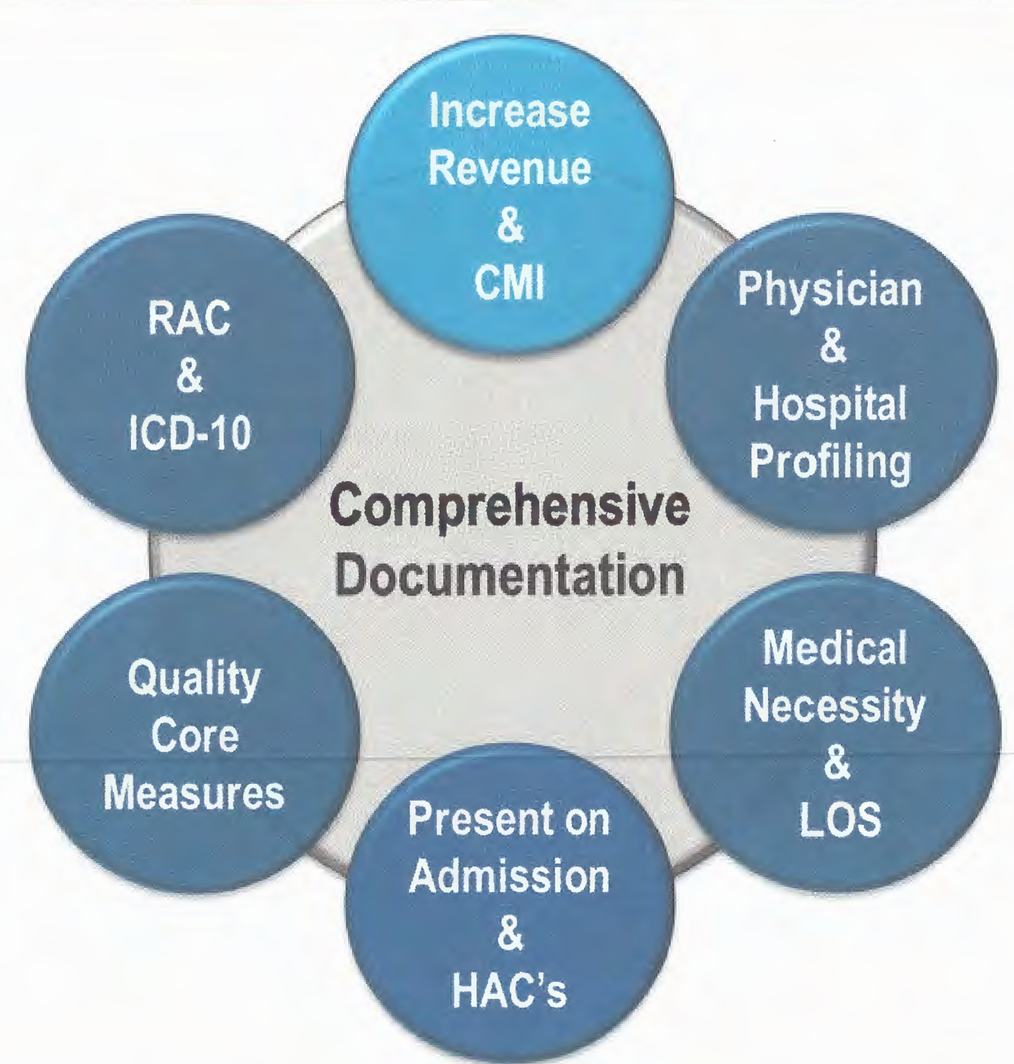

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Clinical Documentation Improvement

RIVERSIDE COUNTY REGIONAL MEDICAL CENTER DATA ANALYSIS

HuronHealthcare

Desktop Review

- A desktop analysis of inpatient Medicare discharges was conducted.
- Timeframe of the analysis: May 2012-April 2013
- The organization's data was compared to MedPar National benchmark data.

Hospital	RCRMC
Medicare Discharges for the timeframe of (May 2012-April 2013) Annualized	1,303
Current CMI	1.5324
Projected CMI	1.6280
Projected CMI Change	0.0956
Financial Impact Range*	$650-000- $700,000

**The opportunity has been annualized. A Medicare blended rate of $6,188.52, was utilized to determine the benefit.*

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Clinical Documentation Improvement (CDI)

EXECUTIVE SUMMARY

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Area	Rating	Leading Practice	Observations
Scope and Staffing	High Opportunity	[redacted]	• A CDS structured program is in the process of being implemented • A CDS with a nursing background has been hired to conduct reviews • There are 6 inpatient coders that send retrospective queries to the physician
Training and Development	High Opportunity	[redacted]	• The CDS has been hired to perform retrospective reviews, minimal CDI training has been provided at this time • Physician documentation is reflective of a low severity of illness and CDI educational needs for the medical staff • Missed coding opportunities identified in CDI assessment indicated a need to provide the Coding Professionals with clinical and coding education
Leadership and Governance	High Opportunity	[redacted]	• The leadership structure of the CDI department is through the HIM Department • Physician advisors are actively involved in implementation of a CDI program; they both acknowledged the need for improvement in the documentation from a severity of illness and reimbursement perspective
Tools and Reporting	High Opportunity	[redacted]	• There is no CDI tracking tool in place at this time. • The leadership recognizes the need for a tracking tool to be utilized • A tracking mechanism to identify which charts have been reviewed by the CDS team does not exist.

Low Opportunity | Moderate Opportunity | High Opportunity

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Income Statement Opportunity

CLINICAL DOCUMENTATION IMPROVEMENT REVIEW

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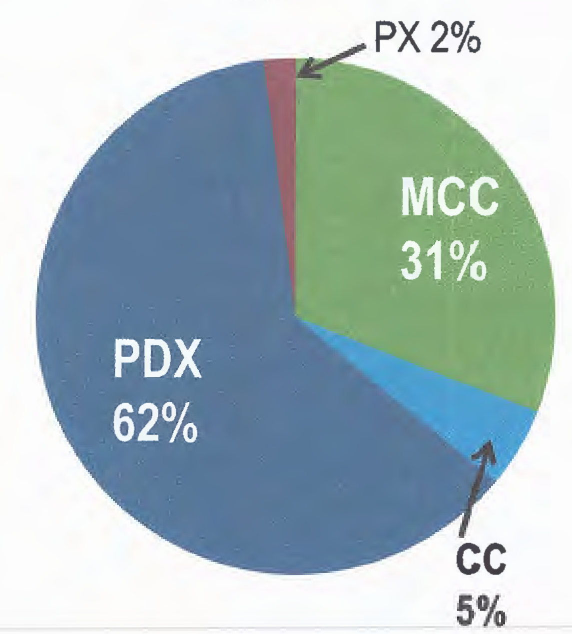
- **Objective:** Evaluate the need for a CDI program at **Riverside County Regional Medical Center**
-
- **Opportunity Exists for Improvement:**
  - **35** of the reviewed medical records indicate that concurrent clinical evaluation would have produced an increase in the severity of illness and Risk of Mortality ***with*** physician clarification. The following are some examples of those cases:
  - Clarification for *Metabolic Encephalopathy* is indicated when a patient presents with increased confusion secondary to an underlying condition which resolves when the underlying condition is treated. (e.g.. pneumonia, hyponatremia)
  - Clarification for catheter related UTI is indicated when a patient is known to have a chronic foley catheter in place or performs self-catheterizations
  - Missed coding opportunities was found that resulted in a lower reimbursement
-

Summary of Charts with Opportunity 46.7%



*PDX: Principal Diagnosis
*MCC: Major Co-Morbid Condition
*CC : Comorbidities
* PX: Procedure

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CDI Detailed Findings

RECORD REVIEW – CASE EXAMPLE #1 PRINCIPAL DIAGNOSIS OPPORTUNITY

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CDI Detailed Findings

RECORD REVIEW – CASE EXAMPLE #2 MAJOR COMORBIDITY OPPORTUNITY

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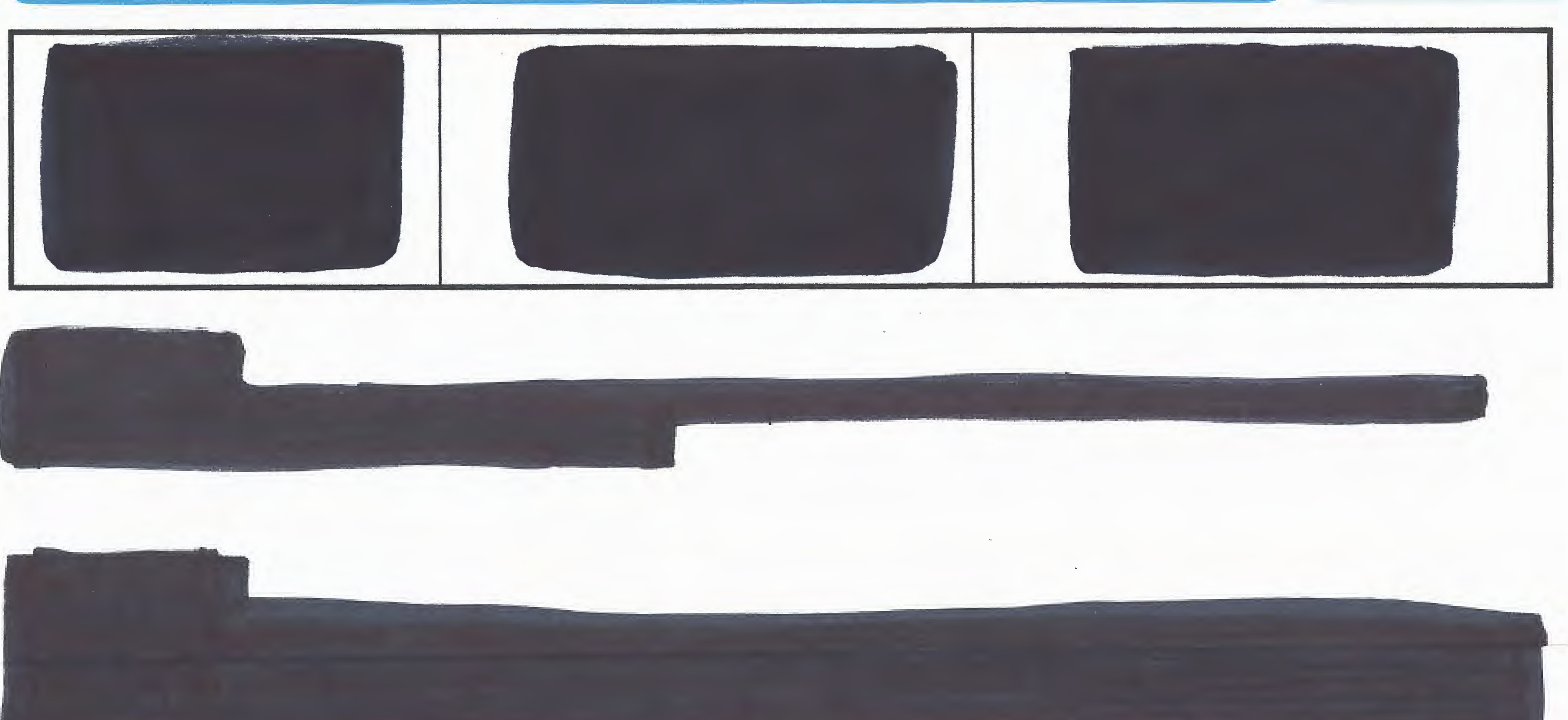

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CDI Detailed Findings

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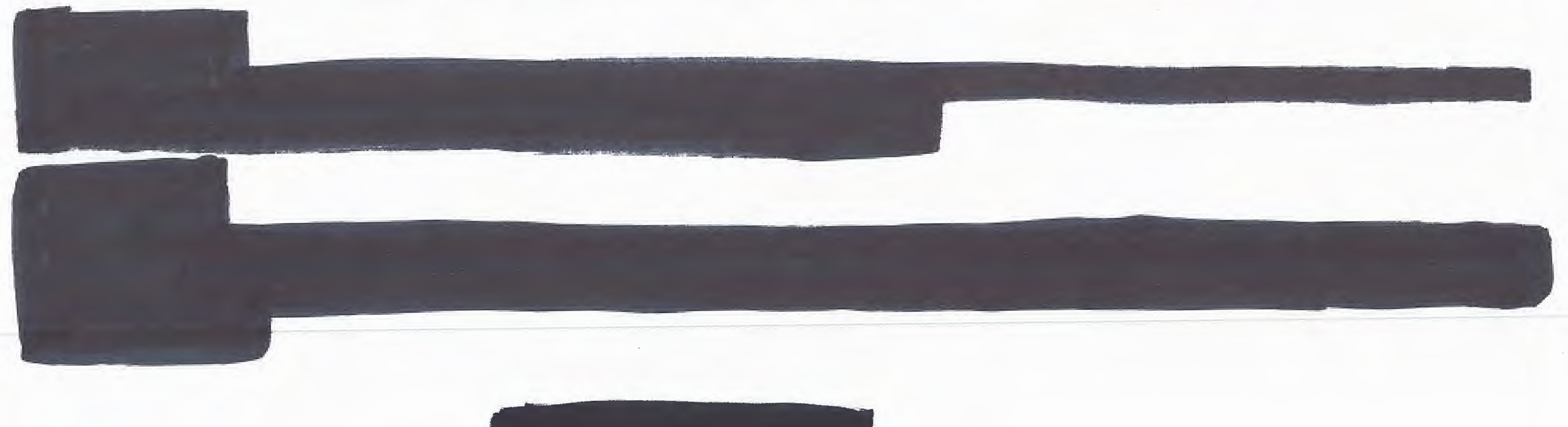
RECORD REVIEW – CASE EXAMPLE #3 COMORBIDITY OPPORTUNITY



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Recommendations

CLINICAL DOCUMENTATION

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- Implement a structured, standardized CDI program that reflects the accurately severity of illness, risk of mortality and complexity of care
- Support additional time for the physician leadership to devote to the CDI initiative
- Provide support and education for the physician leadership to assist in engaging the medical staff in the CDI initiative
- Perform a comprehensive staffing analysis to maintain a "dedicated" CDI program to review all identified payors
- Engage the medical staff by providing "peer-to-peer" education to the physician population on documentation improvement to accurately reflect the severity of illness and complexity of care
- Provide coding education to the CDS and coding professionals on documentation opportunities, clinical signs, symptoms, risk factors and treatment coding guidelines
- Ensure the tracking tool identifies financial benefit and progress of the CDI program
- Implement a methodology which demonstrates the programs effectiveness, through a structured reconciliation process
- Establish benchmarks to hold all key stakeholders accountable

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Phases of CDI

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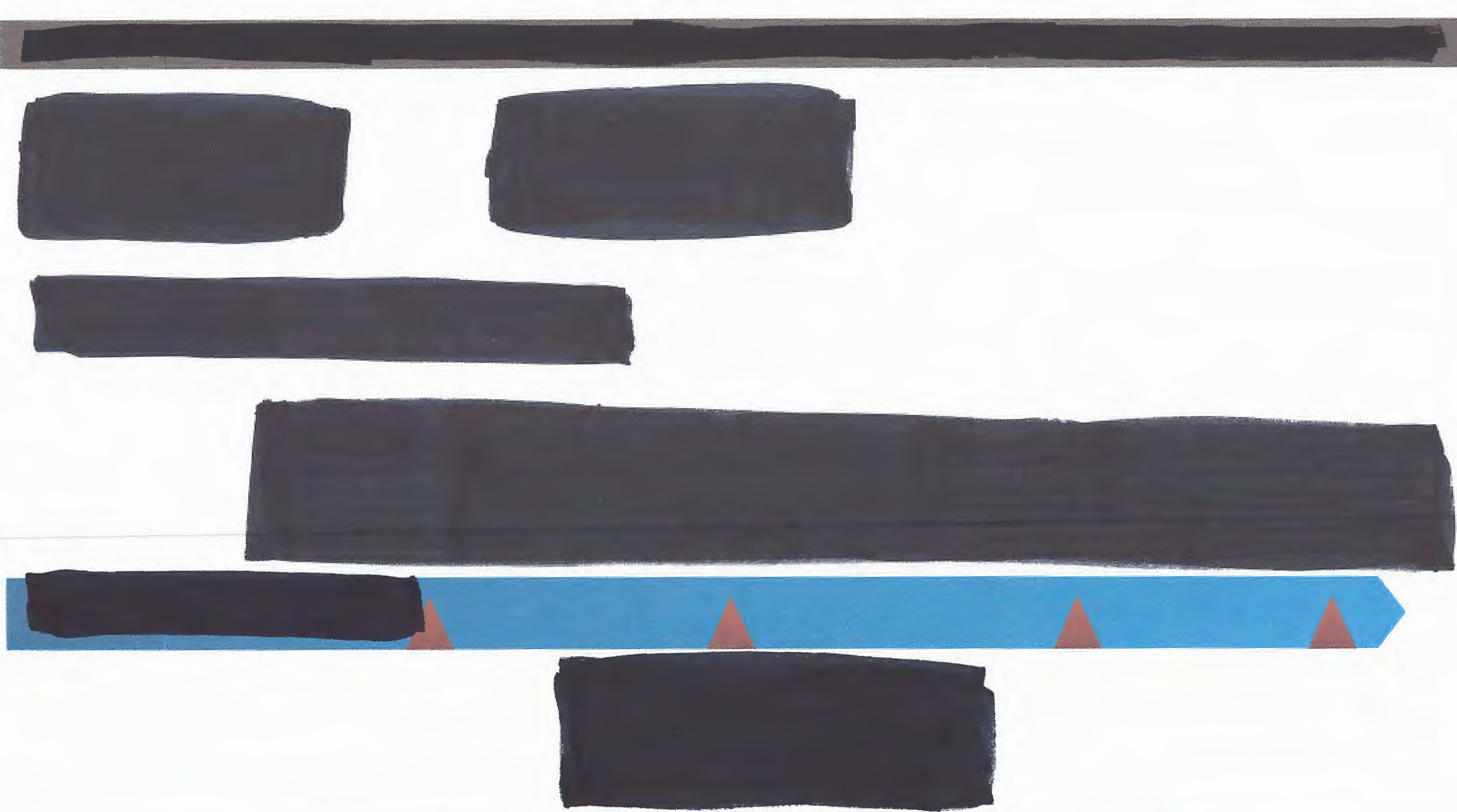

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Clinical Operations Detailed Findings

OBSERVED SUCCESSES

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- Physicians, leaders, and care team members are engaged and interested in making positive improvements to patient flow and clinical care and are passionate about their hospital
- Leadership has identified the need for and is moving forward with several key tools required to support patient flow
  - Bed Board
  - CERME (online version of InterQual)
  - UHC Database (Clinical Database portion in use; Resource Management piece not contracted)
- Recent clinical equipment purchases are advancing patient care technology
- RCRMC has made efforts to implement infrastructure to improve clinical operations
  - Recommended a new Case Management model to address the unique needs of the complex payer environment
  - Added a Case Manager position to the Emergency Department
  - Recently began reviewing select, key patient throughput metrics in the Bed Throughput Committee
- Physicians are adopting the Heart Failure order set and pathway, which creates a framework for implementing additional order sets and pathways as well as refining those currently being used

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Clinical Operations Assessment Approach

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Clinical Operations Detailed Findings

FINANCIAL BENEFIT

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Clinical Financial Benefit	
Length of Stay Opportunity	**$1.6M to $3.2M**
• Average Length of Stay Reduction (days)	0.41 to 0.59
• Annual Patient Day Reduction	5,600 to 8,100
• Percentage of Current Patient Days Reduced	7.5% to 11%
• Capacity for Additional Patients	1,100 to 1,700
• Virtual Beds	15 to 22
Write Off Reduction Opportunity	**$2.0M**
Total Financial Opportunity	**$3.6M to $5.2M**

Notes:
Benefit model vetted with Dave Runke and Annette Greenwood
Financial opportunity does not take into account impact to DSH and SNCP payments
Benefit model takes into account lost revenue associated with per diem and percent of charges payers
LOS benefit is based on medical/surgical patients with a standard discharge (excludes OB, newborn, rehabilitation, psychiatry, expired, and AMA)

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Clinical Operations Detailed Findings

LEVERAGING CHANGE ACROSS THE CONTINUUM

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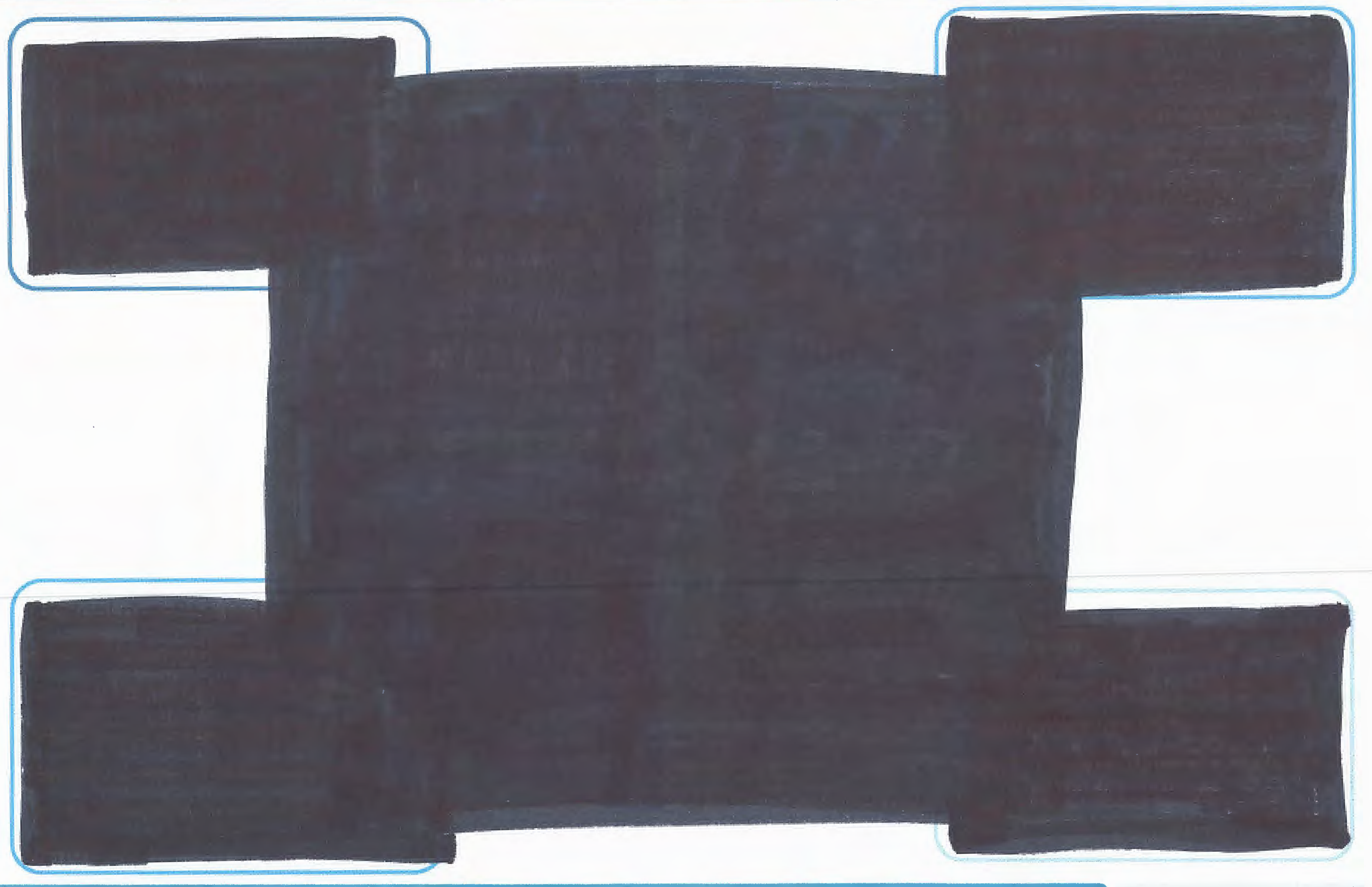

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Clinical Operations Detailed Findings

SUMMARY OF FINDINGS BY FUNCTIONAL AREA

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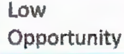
Functional Area	Process	Tools	Org/ Culture	Findings
Patient Placement	●	●	●	• Full bed board has not been implemented to facilitate patient placement and provide a house-wide view of bed availability, so true bed status is not known • Placement process is manual and involves considerable time rounding to discuss discharges and assign beds • Significant admission delays exist in placing patients from all admission sources: ED, PACU, direct admissions, and transfers despite beds being available • No clear criteria is available to guide the placements of patients in the appropriate level of care and unit (based on service)
Case Management	●	●	◒	• Case Management (CM) is moving to a triad model, but case loads are not aligned with best practices • Patients are not consistently screened for level of care and patient status prior to admission • CMs do not consistently facilitate care progression by reviewing level of care and continued stay appropriateness daily • Although CMs appropriately escalate cases to the Physician Advisor (PA), PA coverage is limited to two hours per day


Low Opportunity

Moderate Opportunity
High Opportunity

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Clinical Operations Detailed Findings

SUMMARY OF FINDINGS BY FUNCTIONAL AREA

Functional Area	Process	Tools	Org/ Culture	Findings
Care Coordination	●	●	●	• Select units have interdisciplinary rounds, but they occur weekly, may include only a subset of the care team, and vary in which patients are discussed • Follow-up items are not clearly identified or documented for review later in the day • While night Charge Nurses anticipate which patients will leave the next day, LOS estimation does not begin upon admission and is not used to drive the plan of care
Care Variation Management	◒	◒	◒	• Heart Failure order set and pathway are utilized, but pathway is not organized by day of stay and does not include medical milestones; other order sets and pathways are still in development • Limited guidelines are available for the appropriate use and clinical setting (e.g., inpatient or outpatient) of over-utilized tests/treatments • Monthly rotations present challenges in orienting residents to proper resource utilization and order sets • Quality Department and physicians leverage UHC to identify physician-level opportunities, but opportunities exist to further leverage the tool

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Clinical Operations Detailed Findings

SUMMARY OF FINDINGS BY FUNCTIONAL AREA

HuronHealthcare

Functional Area	Process	Tools	Org/ Culture	Findings
Tools and Accountability	High Opportunity	High Opportunity	Moderate Opportunity	• Key support tools are being evaluated or have been selected for implementation (e.g., bed board and online InterQual tool) but are not yet available for use • Other key tools such as a Case Management system and the Resource Management module of UHC are not available • Most existing reporting is compiled manually, which limits the breadth of reports available for managers to make decisions and drive accountability • Staff circumvent existing tools such as BedTracker and continue to use manual processes

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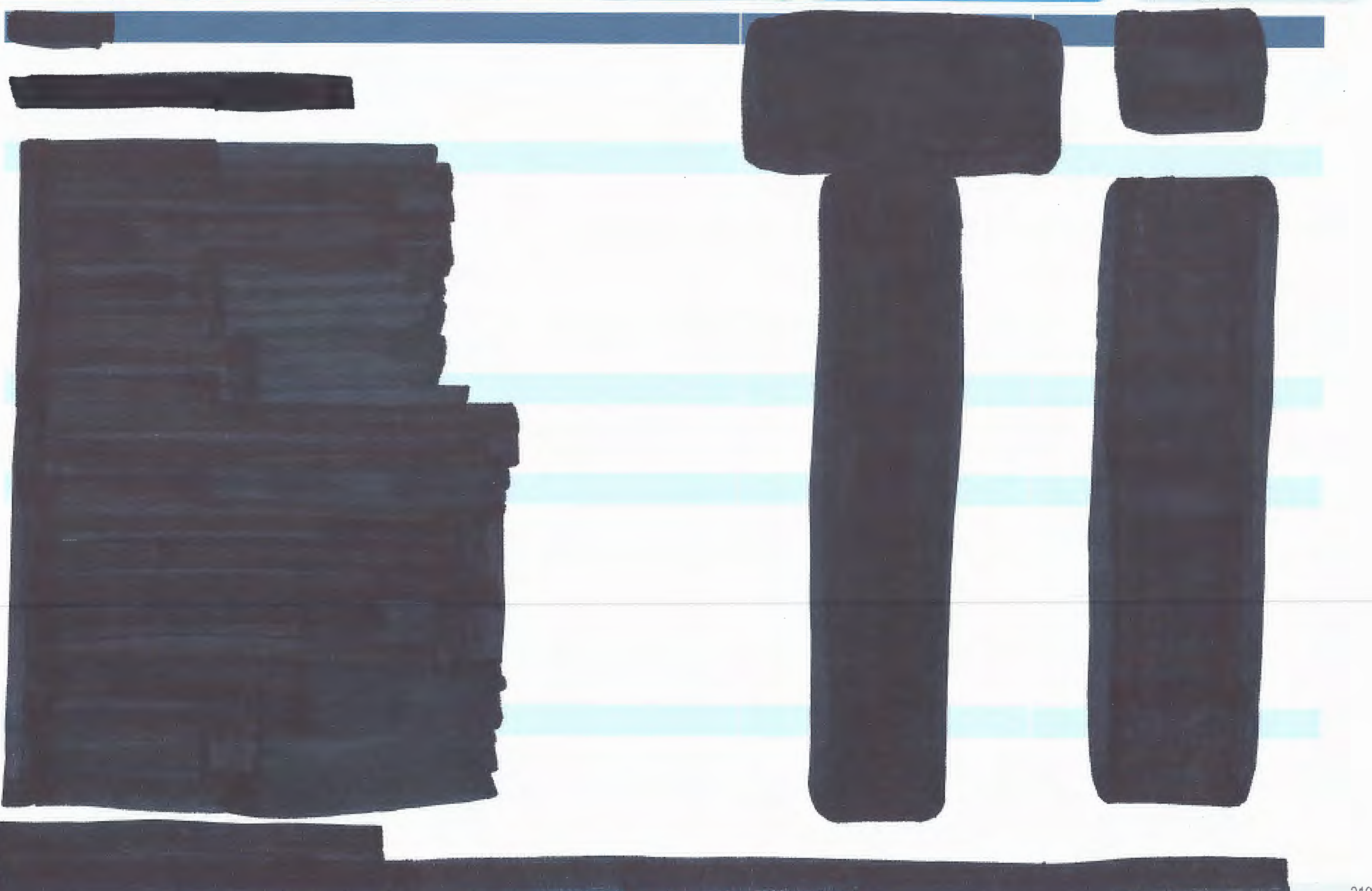
Clinical Operations Detailed Findings

KEY PERFORMANCE INDICATORS



Clinical Operations Detailed Findings

CHART REVIEW FINDINGS

- Focused review of random Heart Failure charts
- Findings included:
  - General compliance with established use of order sets and pathways
  - Lack of pathways around expected LOS targets and medical milestone formats, but evidence-based practice was present in the pathways
  - Inconsistent nursing care documentation (daily weights, I&O, oxygen weaning, and activity)
  - Prolonged Foley catheter use on multiple patients, leading to UTI complications
  - Test and treatment ordering patterns inconsistent with the primary medical condition for which the patient was hospitalized
  - Multiple days where patients did not appear to meet criteria for continued stay in the hospital; no tests, treatments, or interventions were performed

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ANECDOTES

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- From January to March 2013, over 230 patients boarded in the PACU beyond their required recovery time because of inpatient bed availability, and the average boarding time was nearly 5 hours
- “About 35% to 40% of the admitted ED patients hold in the ED for a lengthy period of time.” – ED Leader
- “Most of our discharges occur between 5pm and 9pm.” – House Supervisor
- “I identify open beds by talking to units or rounding; BedTracker isn’t always reliable for me to know which beds are available.” – House Supervisor
- "We have our share of inappropriate admissions. For example, the orthopedics patients who come to a bed for 30 minutes, go to the OR, and then discharge from the PACU. The doctor just wanted the patient to get the OR spot.“ – Physician
- “75% of the internal medicine denials are from lack of documentation of inpatient medical necessity.” – Physician
- “Social admissions increase on the evening/night shift when we are not here to provide adequate screening and alternate placement options.” – ED Case Manager
- "I know I am behind on this patient's reviews by at least a week." – Case Manager
- “I’m responsible for updating Soarian when the patient discharges, which alerts Housekeeping and the House Supervisor that the bed is empty. I wait to enter the discharge so that nurses have more time to chart…even though nurses can still chart after the patient is discharged from the system.” – Charge Nurse
- “I like to work as a Charge Nurse on Thursdays because our interdisciplinary meeting is on Wednesday, so everything is organized the day after.” – Charge Nurse
- “We have a significant problem with over-utilizing resources.” – Physician

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Clinical Operations Detailed Findings

MEDICARE OPPORTUNITY REPORT

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Metric	Percentile	Quartile	Opportunity Measure
Severity-Adjusted LOS Index (excluding outliers)	23rd	4th	Excess Days of Care
Severity-Adjusted Critical and Intermediate Care Index (excluding outliers)	33rd	3rd	Excess Critical and Intermediate Days
Quality Composite Score	73rd	2nd	CMS Core Measures
Risk-Adjusted Mortality Index	43rd	3rd	Potentially Avoidable Deaths
Hospital Acquired Conditions (HACs)	22nd	4th	Potentially Avoidable HACs
Readmission Rate	58th	2nd	Potentially Avoidable Hospital Readmissions

Notes:
Timeframe: April 1, 2011 to March 31, 2012
Population: Medicare patients
Benchmark: Medicare fiscal year 2011

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ANALYSIS: EXCESS DAYS

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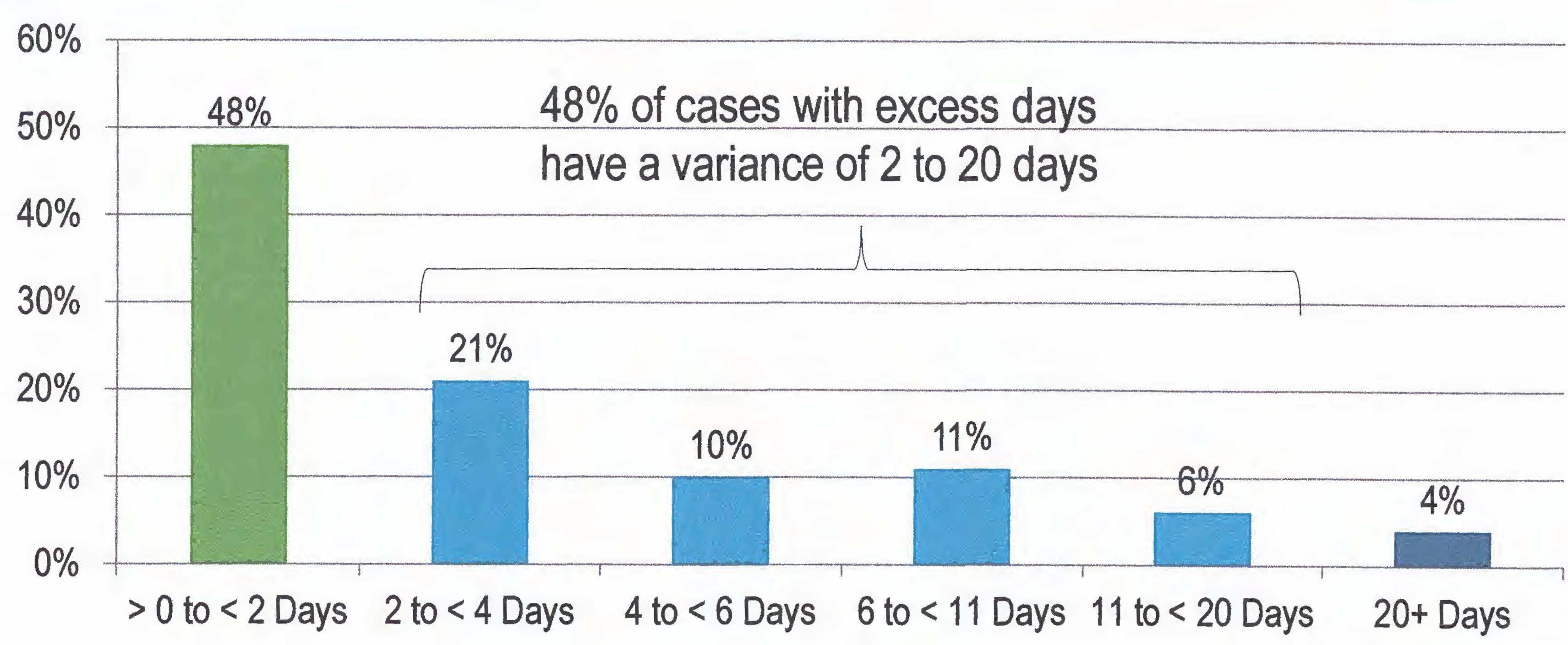

- 51% of RCRMC patients have a LOS greater than the Medicare geometric mean LOS. The distribution of those patients is highlighted above.

Notes:
Timeframe: May 1, 2012 to April 30, 2013
Population: Medical/surgical patients with a standard discharge (excludes OB, newborn, rehabilitation, psychiatry, expired, and AMA)
Source: Client provided data, Medicare GMLOS

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AVERAGE LENGTH OF STAY BY TOP OPPORTUNITY SERVICES

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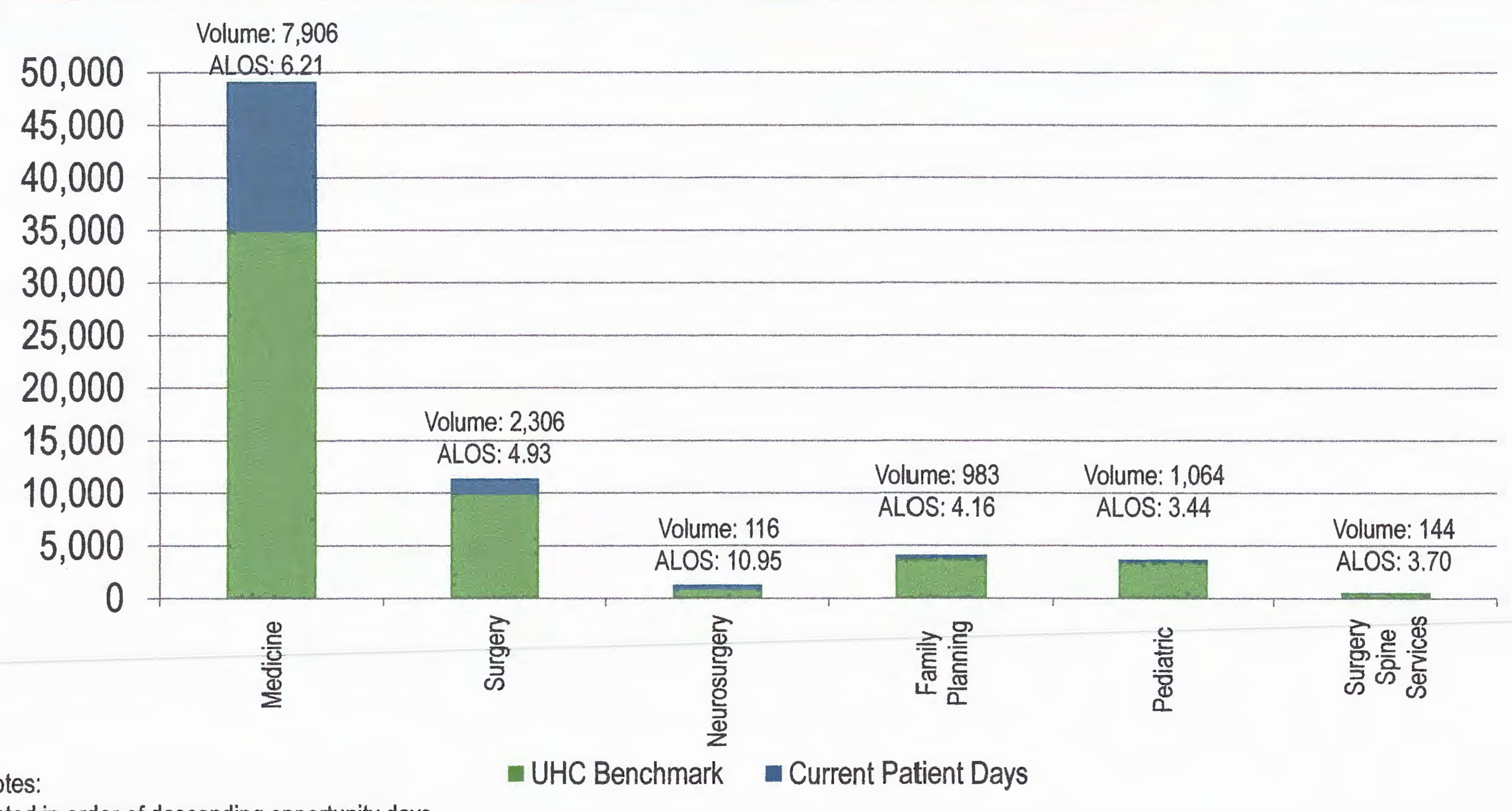

Notes:
Listed in order of descending opportunity days
Timeframe: May 1, 2012 to April 30, 2013
Population: Medical/surgical patients with a standard discharge (excludes OB, newborn, rehabilitation, psychiatry, expired, and AMA)
Benchmark: UHC LOS
Source: Client provided data

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LENGTH OF STAY OPPORTUNITY BY SERVICE - MEDICINE

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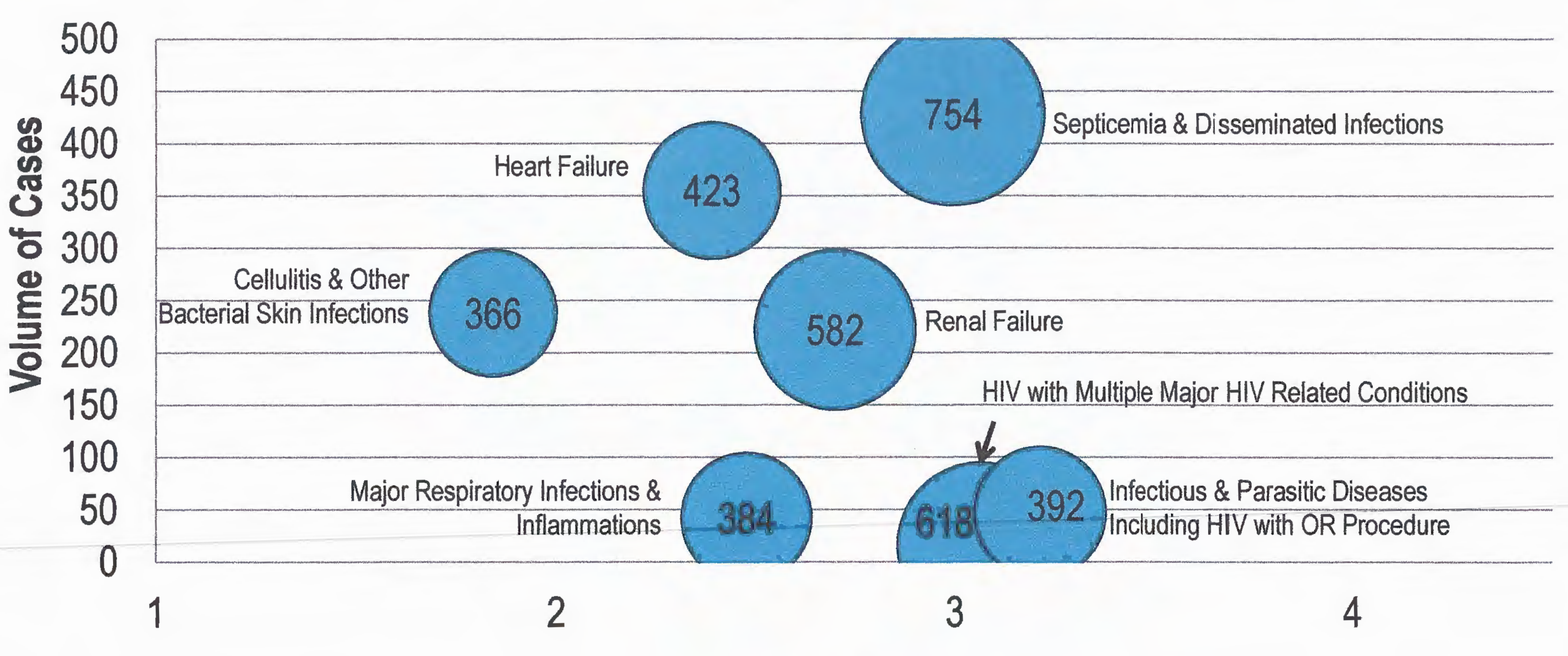

Notes:
Timeframe: 5/1/2012 to 4/30/2013
Population: Medicine patients with a standard discharge (excludes expired and AMA)
Benchmark: Riverside UHC Benchmark (LOS Expected - 2012 Risk Model)
DRGs: APR-DRGs – Size of the Bubble as well as the Data Labels Show Opportunity Days

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LENGTH OF STAY OPPORTUNITY BY SERVICE – SURGERY

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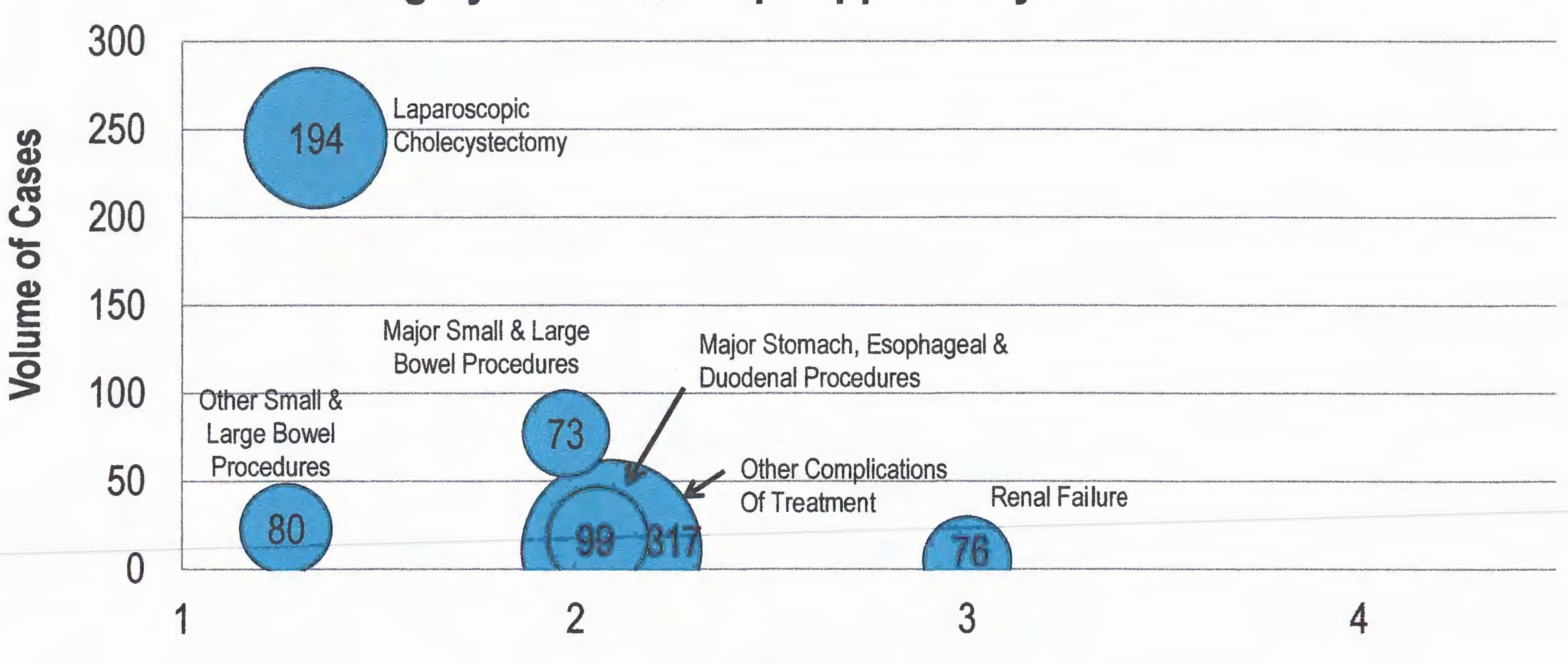

Notes:
Timeframe: 5/1/2012 to 4/30/2013
Population: Surgery patients with a standard discharge (excludes expired and AMA)
Benchmark: Riverside UHC Benchmark (LOS Expected - 2012 Risk Model)
DRGs: APR-DRGs – Size of the Bubble as well as the Data Labels Show Opportunity Days

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CHART REVIEWS

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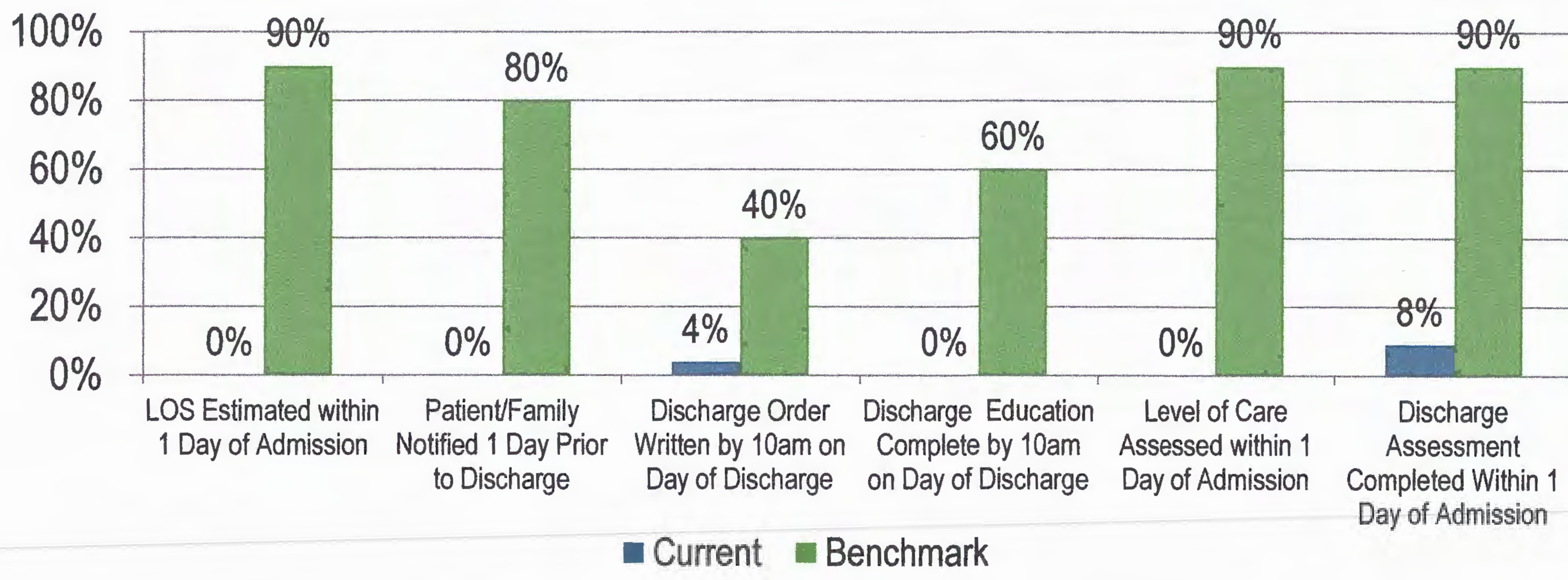

- Delayed length of stay discussions, patient and family communication, and late discharge order times leads to breakdowns in care coordination as well as discharge delays

Notes:
Timeframe: Sampled patients discharged from 1/2/13 to 3/29/13
Population: Medical/surgical patients with a standard discharge (excludes OB, newborn, rehabilitation, psychiatry, expired, and AMA)
Source: Chart review

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RECOMMENDATIONS: PATIENT PLACEMENT

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Implement best practice patient placement processes supported by an electronic bed board

# of Staff/Physicians Impacted	Required Change in Physician Behavior	Current Variation	Technology Change Required
High	Moderate	Limited	High

- Implement a bed board system that clearly displays bed availability
  - Set up user access appropriately to provide key information to users while limiting each unit's view of other unit availability, which will reduce pushback on bed requests
  - Develop process on inpatient units to utilize the system as their primary communication tool for pending admissions, potential and actual discharges, and blocked rooms for maintenance or other reasons
- Support the Admissions House Supervisor with a Patient Placement department
  - Utilize clerical resources for the majority of patient placements
  - Empower House Supervisors to manage difficult patient placements, intervene when patients are not moving to the units in a timely manner, and continue to manage patient flow throughout the house
- Create a placement matrix to support clerical resources in identifying the best unit and bed for each patient
- Review bed allocation to ensure an appropriate number and type (acute, PCU, etc.) of beds are available
- Reduce ED holding time for admitted patients by using holding orders and staffing a Hospitalist in the ED
- Implement a capacity alert policy to facilitate patient flow as the inpatient units become more full and the ED and PACU become capacity constrained
- Utilize expected discharge dates to anticipate next day patient discharges and plan for future bed availability

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RECOMMENDATIONS: CASE MANAGEMENT

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Clearly define roles between all CM disciplines to promote better integration with the care team and ensure accurate reimbursement, appropriate patient status, LOS, and accountability within the department

# of Staff/Physicians Influenced	Required Change in Physician Behavior	Current Variation	Technology Change Required
High	Moderate	High	High

- Empower the CM team to actively manage the plan of care
  - Incorporate CMs, Social Workers (SWs) and Discharge Planners (DCPs) in to regular interdisciplinary meetings
  - Maximize the effectiveness of the weekly Long Term Case meeting by interactively problem solving high risk and long LOS patients. Reduce threshold of which to patients to include to less than 20 days.
  - Coach them to dialogue with physicians about appropriate patient status, level of care, and discharge readiness
- Complete a detailed CM department staffing analysis to confirm inpatient, portal, and weekend staffing levels and case loads are appropriate
- Ensure CMs are facilitating the patient's care progression by reviewing level of care and continued stay appropriateness daily and by dialoging with physicians
- Install and standardize the use of a CM tool to monitor clinical reviews, discharge planning activities, and avoidable delays
- Employ a full time Physician Advisor and create an escalation process to support CMs; use this physician to facilitate conversations with physicians as appropriate
- Better engage the CM team in the denial and appeal process

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RECOMMENDATIONS: CARE COORDINATION

Develop a consistent interdisciplinary meeting structure where care team members discuss each patient daily and proactively plan for their transition

# of Staff/Physicians Impacted	Required Change in Physician Behavior	Current Variation	Technology Change Required
High	High	Moderate	Moderate

- Structure interdisciplinary meetings to include the following:
  - Focus discussion to an average of one minute per patient focusing on medical milestones and discharge barriers to progress each patient through the care setting
  - Involve key care team members: Charge Nurse or Nurse Manager, bedside nurses, physician or extender, Case Manager, Social Worker, and, as needed, ancillary services
  - Select an appropriate nursing leader to facilitate each unit's meetings and follow up on action items
  - Develop or refine standard talking points to focus the discussion on progress to discharge
  - Design and implement a training plan that prepares care team members to interactively discuss the plan of care and facilitate interactions to maximize meeting effectiveness
- Implement processes to predict and document expected discharge dates upon arrival to help the care team proactively manage patients throughout their stay and plan for discharge; review and update the anticipated discharge date during the daily interdisciplinary meetings
- Communicate how Accreditation Council for Graduate Medical Education (ACGME) competencies are met through Care Coordination meetings to increase resident physician participation
- Establish a reporting and review process to monitor the effectiveness of interdisciplinary rounds

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RECOMMENDATIONS: CARE VARIATION MANAGEMENT

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Institutionalize the process for identifying resource consumption opportunity, developing order sets and care pathways, and monitoring performance

# of Staff/Physicians Impacted	Required Change in Physician Behavior	Current Variation	Technology Change Required
High	High	Limited	Moderate

- Update and operationalize order sets and pathways for select high-opportunity APR-DRGs
  - Include latest evidence-based multi-disciplinary interventions, target LOS, and expected medical milestones
  - Actively use the pathways to further manage both delivery and progression of care at the bedside and during daily multidisciplinary meetings
- Track utilization of care pathways and order sets, incorporate confirmation of pathway and order set use into interdisciplinary rounds, and outline a concurrent escalation process to drive accountability for pathway and order set utilization
- Develop guidelines for frequently over-utilized tests and treatments; include recommendations for ordering protocols as well as appropriate service location (inpatient or outpatient)
- Maximize investment in existing benchmarking database (Clinical Database module of UHC)
  - Increase frequency of physician dashboard publication and review
  - Develop and regularly review scorecards at the department and hospital level
- Implement resource utilization system (such as Resource Management module of UHC) to track and benchmark utilization review

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RECOMMENDATIONS: TOOLS AND ACCOUNTABILITY

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Create an accountable organization by developing an automated, consistent reporting system and training end users to drive performance improvement using the data

# of Staff/Physicians Impacted	Required Change in Physician Behavior	Current Variation	Technology Change Required
High	Moderate	Moderate	High

- Implement a comprehensive patient flow reporting tool to bridge information from disparate inpatient and outpatient systems and provide daily, weekly, and monthly patient flow metrics
  - Develop reporting hierarchies to empower key users across the system (e.g., service line leaders, Nurse Managers, etc.)
  - Train department leaders to use patient flow data to engage physicians and improve patient flow within their units
- Develop a weekly patient flow meeting at each facility to review key patient flow metrics and drive accountability
- Implement key tools necessary for managing patient flow and decision making: bed board, Case Management system, and a resource utilization benchmarking system
- Retrain staff to use existing tools to facilitate their work and drive efficiency

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Clinical Operations Detailed Findings

IMPLEMENTATION STRUCTURE

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Clinical Operations Solution Team

Huron Managing Director: [redacted]
Huron Lead: TBD
RCRMC Leader: TBD
Physician Leader: TBD

Workstream 1

- Patient Placement Work Team — Huron Clin Ops/RCRMC Staff
- Patient Flow Analytics Work Team — Huron Clin Ops/RCRMC Staff
- Interdisciplinary Care Coordination Work Team — Huron Clin Ops/RCRMC Staff
- Case Management Work Team — Huron Clin Ops/RCRMC Staff

Workstream 2

- Care Variance Management Work Team — Huron Clin Ops/RCRMC Staff

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IMPLEMENTATION APPROACH

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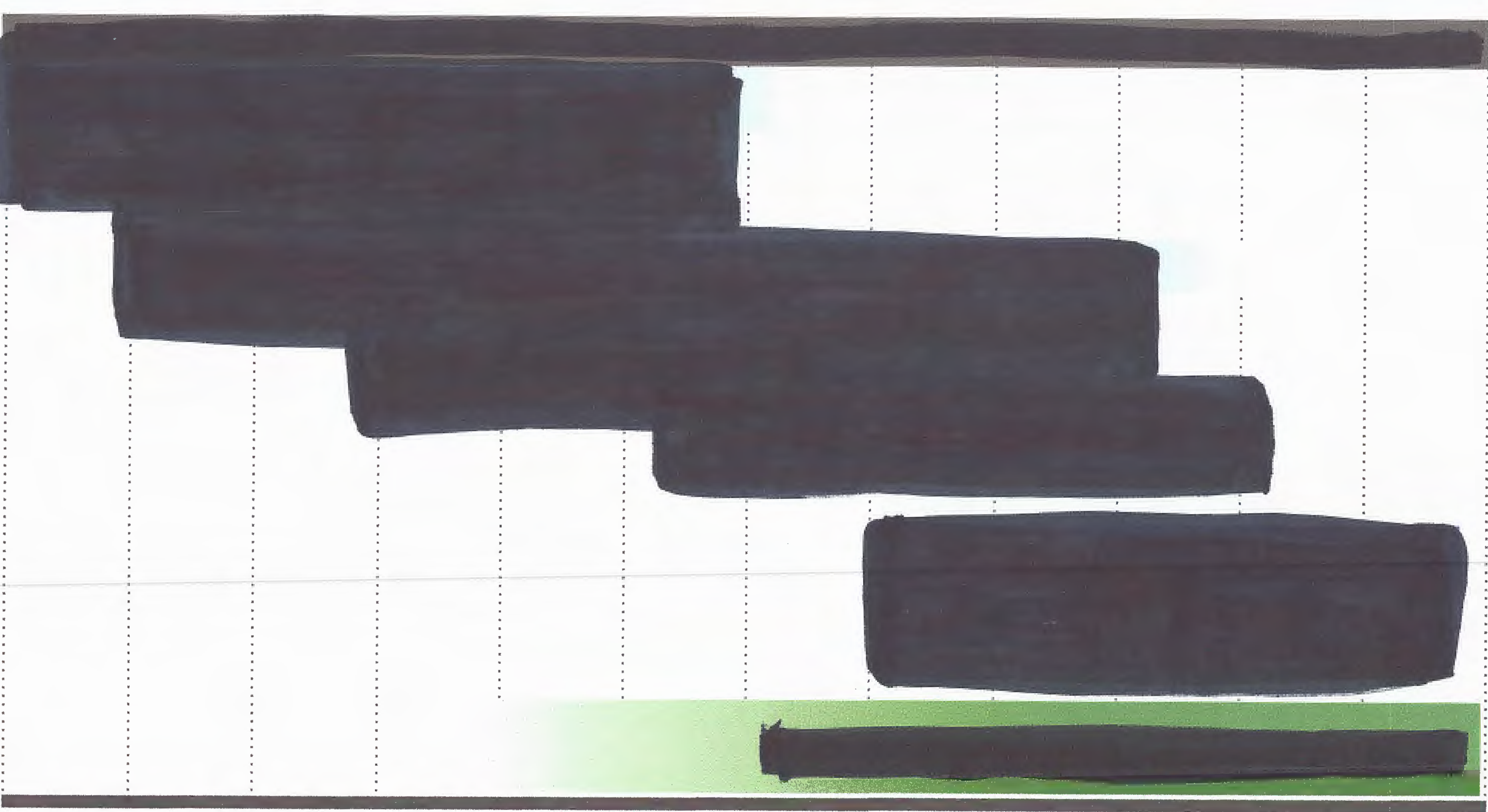

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Agenda

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- Introduction
- Health System Strategic Plan
- Hospital Operational and Financial Performance Review
  - Non-Labor
  - Labor
  - Human Resources
  - Physician Services
  - Revenue Cycle
  - Clinical Documentation Improvement
  - Clinical Operations
- Conclusion

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Transition to Implementation

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Implementation Deliverables - Example

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Results:

- Significant cost savings and revenue benefits
- Speed to implementation
- Sustainable results

People:

Education and coaching of front-line staff

Staff and physician involvement in improvement process

Stakeholder buy-in into the changes

Knowledge transfer from specialists

Many "feet on the ground" to support front-line management team

Process:

- Establishment of disciplined process environment throughout the entire organization
- Organizational alignment
- Process improvement throughout the entire organization
- Culture change toward accountability
- Improved decision support systems
- More formalized and standardized approach to decision-making
- Engagement project management
- Access to proprietary data bases and benchmarks
- Implementation of numerous management tools that complement current tools, e.g., balanced scorecard
- Adoption of common performance improvement language
- Integrated/holistic performance improvement approach to complex areas
- Rigorous and granular benefit measurement
- Various reduction and standardization

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Next Steps

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- [redacted]
- [redacted]
- [redacted]
- [redacted]
- [redacted]
- [redacted]
- [redacted]
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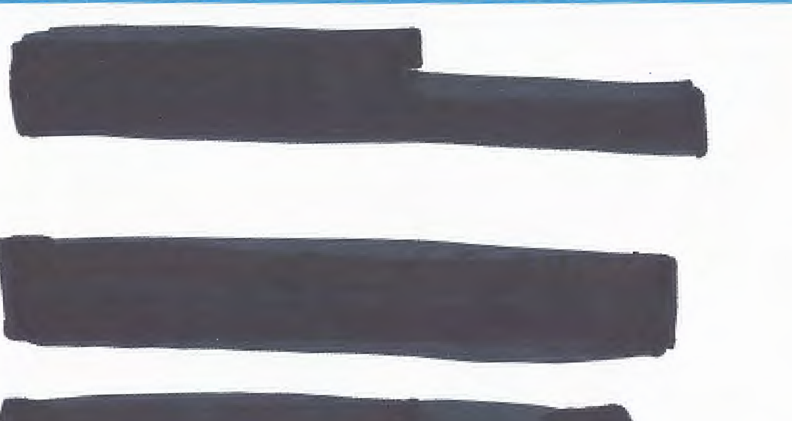
Huron Contact Information

HuronHealthcare



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