Performance Evaluations

—monitoring organizational health

Part 2

Global Health International
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Scope of this presentation:

1. Governance (Board performance)
2. Trustee evaluation
3. Board meeting evaluation
4. Executive evaluation
5. Management evaluation
6. Professional staff evaluation
7. Employee engagement survey
8. Client satisfaction survey
9. **Programs and operational assessment**
10. **Mission fulfillment**

Objectives:

At the end of this session participants will:

1. Know the 5 five principles of high reliability organizations.
2. Understand the methods used in assessing program and operational efficiency.
3. Have a view on how mission fulfillment can be measured.

Program and operational assessment:

1. Reliability
2. Revenue cycle
3. Right sizing the organization
4. Service line contributions
5. Metrics/dashboard
6. Fraud and cyber security
7. Health care trends

Mission fulfillment:

How can we measure if we are fulfilling our mission?

"The mission of Loma Linda University Health is to continue the teaching and healing ministry of Jesus Christ."

Mission statement: “To reflect Christ”

Based upon three pillars

1. Care for the sick
2. Restore soul, mind, and body
3. Serve the community

Care for the sick:

1. Quality of care and patient safety metrics.
2. Volume of patients.
3. Patient surveys.

Restore soul, mind, and body:

1. Patient surveys.
2. Activities of the Chaplain.
3. Chapel in the hospital.
4. Literature available for patients and visitors.
5. Healthy food service.
6. Appropriate music and TV programming.
7. Time for morning worship for employees.
8. Seminars given to the community on healthy living.

Serve the community:

1. Community activities involving the hospital.
2. Funding support of the community.
3. Seminars given to the community on healthy living.

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What do the following have in common?

1. Nuclear powered aircraft carrier.
2. Air traffic control.
3. Sky diving.
4. Hospital operating room/emergency medical center.

The answer:

Reliability!

What do the following have in common?

1. Nuclear powered aircraft carrier.
2. Air traffic control.
3. Sky diving.
4. Hospital operating room/emergency medical center.

What is reliability?

The consistency and dependability of results or performance over time.

“Do actions agree with words? There's your measure of reliability. Never confine yourself to the words”

—Frank Herbert

5 Principles of High Reliability Orgs:

1. Preoccupation with failure.
2. Reluctance to simplify interpretations.
3. Sensitivity to operations.
4. Commitment to resilience.
5. Deference to expertise.

—Drs. Karl Weick and Kathleen Sutcliffe,
"Managing the Unexpected: Resilient Performance in an Age of Uncertainty"

#1: Preoccupation with failure:

1. Attention on close calls and near misses.
2. Focus more on failures rather than success.
3. Today you had 100 surgeries at your hospital. 99 successful and 1 unsuccessful.

“How can an organization make looking for bad news a good thing”?

—Dr. Karl Weick

“The best measure of success is how you deal with failure.”

—Ronnie Radke


The measure of success is not whether you have a tough problem to deal with, but whether it is the same problem you had last year.
John Foster Dulles
BrainyQuote

#2 Reluctance to simplify interpretations

Solid 'root cause' analysis practices.

1. A method of problem solving to find the cause of a fault or problem.
2. Cause could be bad equipment, poor procedures, poor training, personnel issue, etc.

<u>Examples:</u>

1. Air India 171 crashed on take off resulting in 260 deaths; 150,000 flights per day.
2. Death of man undergoing cataract surgery.

#3 Sensitivity to operations

‘Situation awareness’ and carefully designed change management processes.

Situation awareness: Know what happened, what is happening, and what might happen in the future.

Situation awareness:

The knowledge of current elements and events, the understanding of their meaning, the projection of their future status and impact on the organization.

Outstanding leaders and successful boards have situation awareness?

Situation awareness example:

- Inflation in the country is 5% per year.
- Expenses are increasing by 5% per year but the contracted reimbursement stays the same.

The question that should be asked is:

"What income and expense adjustments have been made in the budget for inflation?"

Sensitivity to operations

- Situation awareness and carefully designed change management processes
- Many models on the internet and in textbooks.
- The “Golden Thread” in all the models is:

Communication

#4 Commitment to resilience:

1. Resources are continually devoted to corrective action plans and training.

2. The capacity to withstand or recover quickly from difficulties.

#5 Deference to expertise:

- Listen to your experts on the front lines.
- Who are the experts in a hospital or a medical clinic?

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Revenue cycle:

- "In the United States health care fraud generates close to $100 billion a year."

- "No matter the trial or tribulation, oftentimes the root cause of health care fraud is poor revenue cycle management." —Source: ETACTICS

Revenue cycle:

The processes of:

1. Patient care contracting.
2. Establishing and maintaining prices.
3. Recording patient charges.
4. Payer billing.
5. Entering the bill into the accounting system.
6. Collections.
7. Entering the collections into the accounting system.

Patient care contracts:

When was the last time your patient care contracts were changed?

1. Is there an inflation clause in the contract?
2. Your expenses go up by inflation. Should your income go up accordingly?

Are all services which are provided being properly recorded and billed?

1. Can supplies be billed, and are they?
2. Can the professional fees be billed?

Contract compliance:

- Must list the type and quantity of medicines given.
- Must list the specific laboratory test given.
- The physician must submit the medical summaries with the bill.
- Bills must be submitted within 90 days of the dismissal.
- Readmission for the same medical problem within 30 days of dismissal is not covered by this contract.

Contract compliance: True case…

"The provider may bill against this contract for the following: (See appendix A for rates)

1. Physician services
2. Hospital bed usage
3. Medicines given
4. Meals given to the patient
5. Supplies used in treatment
6. Auxiliary services"

Contract compliance: True case…

"The provider may bill against this contract for the following: (See appendix A for rates)

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Contract compliance: True case…

THE BILL

Physician Services----------	500
Hospital Bed (5 nights)----------	250
Medicines given to the Patient------	100
Meals----------	25
Laboratory ----------	50

- Total---------- 925

Medical supplies??

Payer billing:

1. Are the bills complete and in accordance with the contract?

2. Is there a time limit on the billing?

3. What documentation must go with the bill?

Payer billing:

- Hospital reviewed their payer billing and in the review of the first 4 bills found $400,000 that should have been billed that was not.

- Hospital billed the payer but did not submit the physician notes. When discovered, the physician's notes could not be found. A loss to the hospital of over $1,000,000.

Payer bill into the accounting system…

1. Is there an aging report on payer receivables?

2. Is there a regular review of the receivable and allowance for bad debt recorded?

Payer bill collections:

1. Is there a board approved policy on payer bill collections?

Recording payments in account system:

What is the policy when a patient with a large account comes to hospital/clinic for services?

CHECKLIST
FOR
AUDITING
OF THE
REVENUE CYCLE

A. The revenue cycle is defined as: The processes of patient care contracting, establishing and maintaining the charge master, recording the patient charges, patient billing, entering the bill into the accounting system, collections and entering the collections into the accounting system.

B. THE CHARGE MASTER:

1. Is the charge master readily available?
2. How often is the charge master updated?
3. Does the charge master reflect the cost of the hospital/clinic?
4. Is the charge master automated? If yes, is there a back up in case of computer failure?
5. Is the charge master formatted in a manner to be easily used and updated?
6. Does the charge master properly reflect all of the charges for procedures, supplies, services, drugs, etc.?
7. Who is in charge of the charge master? Who can change the charge master?
8. Is there a periodic audit of the charge master to determine if the changes need to be made?
9. What is the process for the pricing in the charge master to feed into the system of recording of patient charges?

A. **PATIENT CARE CONTRACTS**:

1. Are the contracts filed in a manner that they can be readily accessed?
2. Who is in charge of the patient contracts? Who has the file? Who does the negotiating? Who audits the contract to see if all provisions are being adhered to?
3. Are the contracts current?
4. When were the contracts last renegotiated?
5. Is the pricing in the contracts keeping up with inflation?
6. Is there an inflation clause in the contract? If yes does the billing reflect this?
7. Is there a stop loss clause?
8. Are there provisions for interest charges on late payments?
9. Does the pricing in the contract reflect the true costs of the hospital/clinic?
10. Are there patient co pays and or deductibles in the contract?
11. What is the process for the provisions of the contract to feed into the system of recording of patient charges?

A.RECORDING OF PATIENT CHARGES:

1. Who records the services which are provided to the patient?
2. Do the staff who record the services have the knowledge and understanding of the services to be able to record them correctly?
3. Are services such as the name of the procedure, the supplies, the drugs, the bed, the professional fee, being recorded?
4. Are all services which are being provided properly captured?
5. Are the services being recorded in a format which is understandable and in compliance with contracts and recording standards?
6. Who records the charges that correspond with the services provided?
7. Do the staff who record the charges have the knowledge and understanding of the charges to be able to record the accurate and complete charge for each service?
8. Are the charges being recorded in compliance with the contracts/charge master?
9. Are there spot audits of the recorded patient charge documents?
10. What is the process for the recorded patient charge to feed into the patient billing system?

A.PATIENT BILLING:

1. Are the bills complete and in accordance with the contract?
2. What are the time lags between the services provided, the completed bill and the bill being sent to the payor?
3. Who is in charge of preparing the patient bill?
4. Do the individuals who prepare the patient bill have the knowledge and understanding to complete the bill?
5. Are the patient bills understandable? Are the provided services understandable? Are the charges associated with each service clearly identified? Does the bill have complete and accurate information on where to send the payment, who the patient was. who the provider was, the date when the payment should be paid, etc.?
6. What is the process for getting the patient bill into the accounting system?

A.PATIENT BILL INTO THE ACCOUNTING SYSTEM:

1. Who enters the patient bill into the accounting system or does the information flow electronically?
2. If the information is entered manually, do the individuals who enter the patient bills into the accounting system have the knowledge and understanding to complete to task?
3. Are there periodic audits of the patient bills in the accounting system?
4. Is there an ageing report of the patient receivables?
5. Is there sufficient information in the accounting system to do collections?
6. Is there a process for determining bad debt? Is the bad debt properly recorded in the accounting system?

A.**PATIENT BILL COLLECTONS**:

1. What is the process to identify who is responsible for the patient services bill? i.e. the individual or a third party payor. Is this process accurate?
2. If there are co pays and/or deductibles how are these funds collected and accounted for?
3. If the patient is a self pay patient are up front payments being collected? If no why not? If yes how is it determined how much and how are these fund accounted?
4. Who is charge of collections on patient bills?
5. Do the individuals who do the collections have the knowledge to do the collection?
6. What is the process for collecting patient bills? i.e. The bill is sent out/or delivered, a phone call is made to ensure the bill is received and no additional information is needed, follow up calls and personal visits are made to get payments, after some many attempts the bill is turned over to a collection agency, etc.
7. Is the process which was followed for each bill recorded? i.e. the date a phone call was made, the date a personal visit was made, etc.

A. RECORDING THE PAYMENTS INTO THE ACCOUNTING SYSTEM:

1. Who records the payments into the accounting system?
2. Do the individuals who record the payments have the information and knowledge to properly record the payments?
3. What happens to the patient account when a partial payment is received?
4. What happens to the patient account when a complete payment is received?
5. If a patient has a large unpaid bill and comes to the hospital/clinic for service what is the response of the hospital/clinic? Is this information known at the front of the revenue cycle?

Program and operational assessment:

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Right size the organization:

Where does all the money go?

Wages and Benefits	56%
Supplies	15%
Professional Fees	12%

This financial crisis is forcing companies to make tough decisions;

there is a risk that we might need to lay off Andre....

Fewer might be better:

1. Is your hospital's quality down because of unmotivated and unresponsive staff?

2. Are the staff in the hospital rude to the patients?

3. Is the morale in the hospital down because of some disgruntled staff?

4. Are you losing money because patients and doctors do not want to use the hospital because of 1, 2, and 3 above?

Fewer might be better:

"It is far easier to allow matters in our important institutions to go in a lax, loose way than to weed out that which is offensive, which will corrupt and destroy confidence and faith. But it would be far better to have a smaller number of workers, to accomplish less, and as far as possible to have these who are engaged in the work true hearted, firm as rock in principle, loving the whole truth, obedient to all the commandments of God"

—E G White, *Counsels On Health,* Page 264

Right size the organization:

External benchmarks:

- Commercial Data
- State and Federal Guidelines

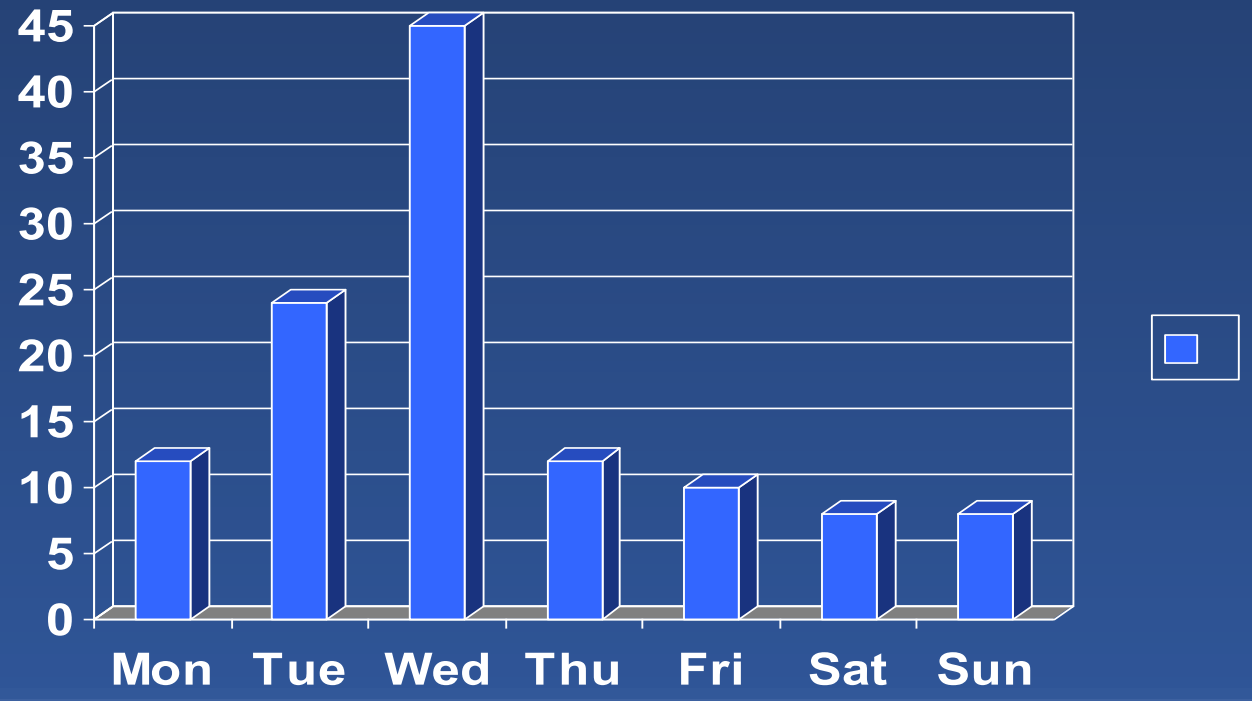
Internal benchmarks:

Where to look:

Over/Under staff review:

- Administration—30 bed hospital with a CEO, CMO, CNO, COO and 10 Department Heads
- Nursing.
- Technicians.
- Support Staff—5 cooks for a hospital that averages 3 patients per day.

How do you deal with this?



Number of patients

What nursing staff do you need?

Assume 1 to 5 nurse to patient ratio.
However, there will never be less than 2 nurses.

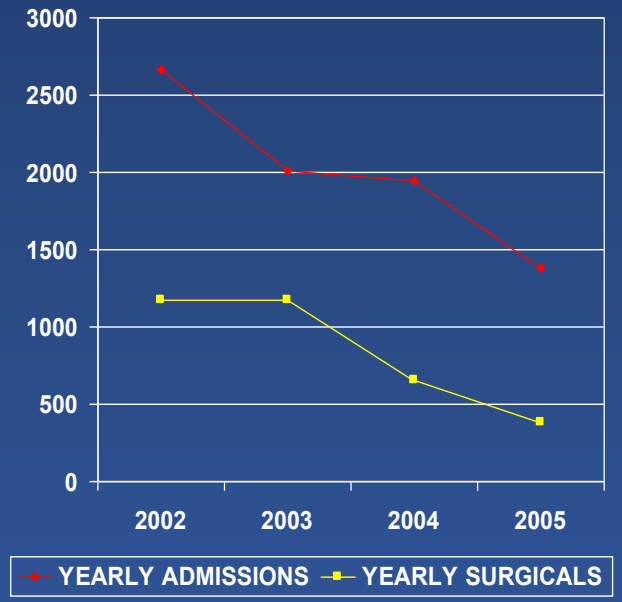
Patients	5	10	15	20	25	30	35	40	45	50	55
Number Of Nurses	2	2	3	4	5	6	7	8	9	10	11

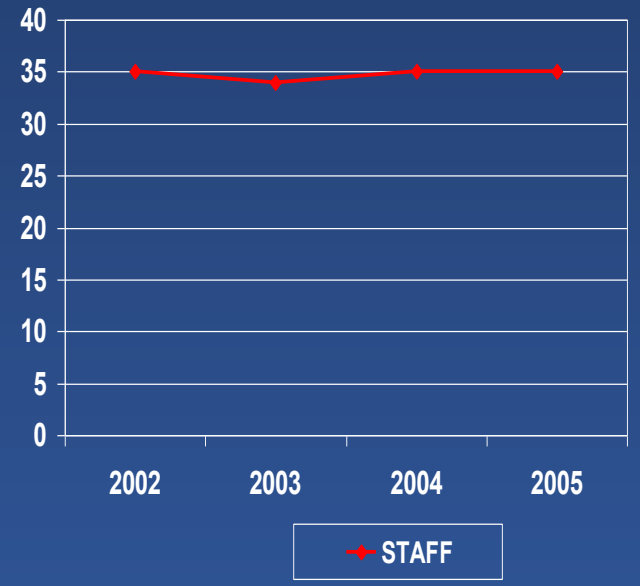
State and Federal guidelines:

Nurse Staffing in California:

OPERATING ROOM	1-1
STEPDOWN	1-3
PEDIATRIC	1-4
PSYCHIATRIC	1-6
LABOR AND DELIVERY	1-2
INTENSIVE CARE	1-2

What are these charts telling us?





Use flex staffing:

- Send employees home.
- Use an on-call system.
- Use an employee contracting agency.
- Have part-time employees who can be called.

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Contribution margin:

In finances there are two types of costs:

- Direct costs:
  - Supplies used by a particular service:
  - Personnel costs to deliver the service:

- Indirect costs:
  - Cost of insurance:
  - Cost of house keeping:

Contribution margin:

Does a medical service (laboratory, imaging, operating room etc.) cover all of the direct costs and contribute to the indirect costs (insurance, administration, maintenance, etc.)?

Contribution margin for the laboratory:

Income			100,000	
Direct Expenses				
	Supplies	30,000		
	Personnel	65,500		
Total Direct Expenses			95,000	
Contribution			5,000	

Contribution margin for the laboratory:

Income			90,000	
Direct Expenses				
	Supplies	30,000		
	Personnel	65,500		
Total Direct Expenses			95,000	
Contribution			-5,000	

Contribution margin:

If you know the financial performance of each of the service lines, you will be able to:

- Make better decisions.
- Understand the problem.
- Solve the problem.
- Improve the processes.
- Better service the customer.

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How important is information?

1. Decision making.
2. Understanding.
3. Problem solving.
4. Improving processes.
5. Understanding customers.

Knowledge and Wisdom:

Wisdom is defined as having information and knowing what to do with it.

Example:

Knowledge is knowing that a tomato is a fruit.
Wisdom is knowing not to use tomatoes in a fruit salad.

Dashboard or metrics:

Key Performance Indicator (KPI) / Metric

1. Financial. Net profit.
2. Customer. Customer retention rate.
3. Operational. Length of stay.
4. Employee. Employee satisfaction.

Operational KPIs:

There are hundreds of hospital KPIs.

1. Staffing efficiency:
   - FTE per occupied bed.
   - Overtime and agency hours.
   - Shift gaps and turnover rates.
2. Length of stay:
   - LOS by diagnosis or department.
   - LOS trends over time.
   - Discharge delays and bottlenecks,

—Source: Dimensional Insight

Operational KPIs:

There are hundreds of hospital KPIs.

3. Readmission rates:
   - 30 day readmission rates.
   - Cause-specific readmission.
   - Readmission by provider or care plan.
4. Patient satisfaction & experience:
   - Patient wait times and discharge efficiency.
   - Follow-up and communication ratings.

—Source: Dimensional Insight

Operational KPIs:

There are hundreds of hospital KPIs.
5. Operating margin by service line

—Source: Dimensional Insight

Key Performance Indicators:

1. Must be measurable and collectible.
2. Do trend analysis.
3. Have a goal.
4. You now have information, key performance indicators, what are you going to do with them, you now need wisdom.

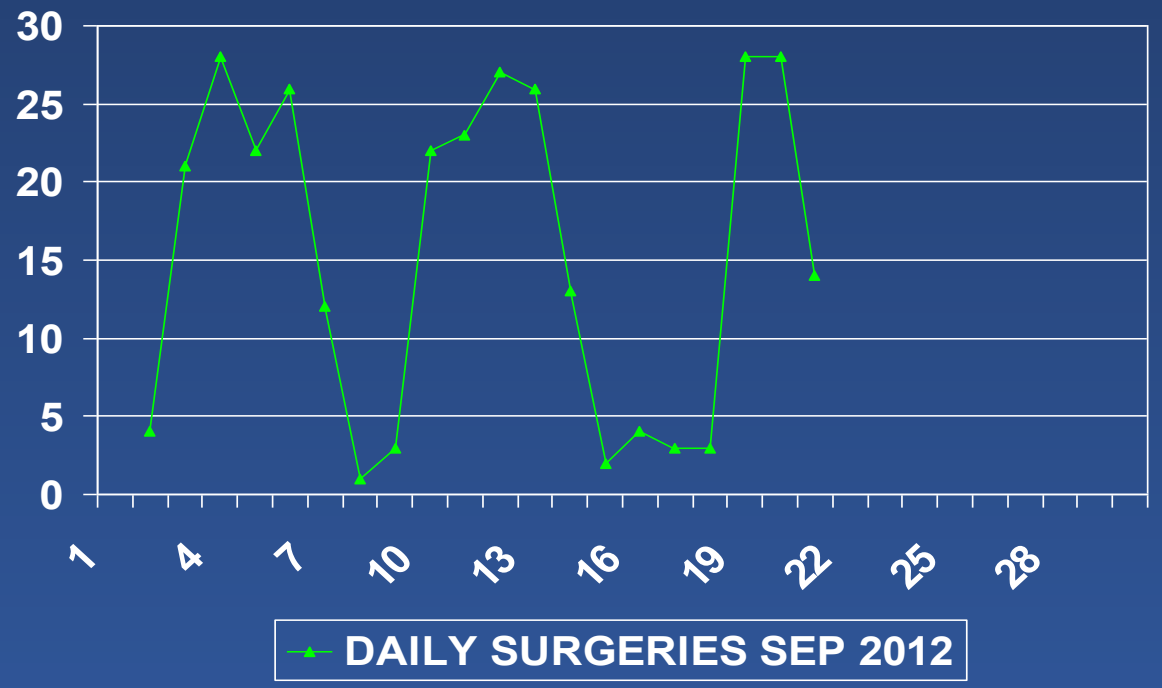
What are you watching?

MEDICAL DASHBOARDS

I cannot watch everything! What should I watch?

- DAILY
  - Number of surgeries
  - Occupancy
  - Number in NICU
  - Charges posted by department

Do trend analysis…



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Fraud and abuse:

- Medical identity theft.
- Billing for unnecessary service or items.
- Billing for services or items not furnished.
- Up coding.
- Kickbacks.

—Center for Medicare and Medical Services

Purchase Order

For Hart Hospital
11560 Elm Street
New York City NY. 25680

Purchased from

Vege Links Inc.
2531 Oak Avenue
New York City NY. 25681

5 Cases of Vege Links @ $10/case
Total cost $50.00

Should you pay this bill?

Bill:

Pay to
Vege Links Inc.
2581 Oak Avenue
New York City NY. 25681

For 5 Cases of Vege Links @ $10/case
Total Payment due $50.00

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VIDA
Surgical System

Healthcare trends #1: Artificial Intelligence

Projected reduction in treatment cost when using AI for diagnosis.	50%
Projected improvement in health outcomes when using AI for diagnosis.	40%
The estimated market value for AI in health care in 2030.	$187 Billion

—Harvard School of Public Health

Healthcare trend #2: Customer experience

1. Appointment scheduling.
2. Medication reminder.
3. Remote monitoring.
4. Preventive recommendation.
5. Virtual care.

—CIGNA

Healthcare trend #3: Behavioral health

In the US, 59.3 million adults have mental health issues. This is 23.1% of all adults.

—National Institute of Mental Health

—CIGNA

Healthcare trend #4: Cancer healthcare

Better outcomes for cancer health care.

—CIGNA

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Case studies.