High-Stakes Changes: The Path to Cost Containment

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In 2012, as South Nassau Communities Hospital in Oceanside, New York, was providing care for residents severely impacted by Hurricane Sandy, another storm was brewing—but this one was on the books. The Affordable Care Act was rolling out, value-based care was taking root, and rising costs were becoming a major challenge for the 455-bed hospital, a key provider of medical services for the nearby barrier island beach communities. The first step? Rein in a big chunk of spending by overhauling inventory management, determined Mark Bogen, CFO and senior vice president of finance.

Bogen engaged a national consulting firm to develop an aggressive supply-chain strategy. The consultants came up with a plan to reduce spending by $5 million to $15 million. “The goal was to go after as much of those savings as was possible,” says Bogen. In fact, leadership spent the next year and a half creating an infrastructure that involved installing a new IT system and automating inventory management. “We wound up identifying and ultimately capturing somewhere north of $7 million,” he says. But that was just the start for Bogen, who has been with South Nassau Communities Hospital for eight years. Moving forward, the hospital would need to make other strategic cost-cutting moves to keep the momentum going. “On an annual $80- or $90-million-dollar controllable spend, there still may be $1 million or $2 million of opportunity,” he says. Phase two of the plan is happening this year, and it largely involves engaging physicians to follow evidence-based guidelines more rigorously. “My big push for all of 2015 is to look at the variation of practice by our medical staff here at the hospital.”

In addition to reducing unnecessary medical tests, the hospital is focusing on boosting quality and shrinking costs by eliminating hospital-acquired conditions and opening up more ambulatory access points to avoid emergency room overuse. For example, the hospital opened an urgent care center at the nearby former Long Beach Medical Center, which was largely destroyed by Hurricane Sandy. The ultimate goal, says Bogen, is to take the savings and invest in a stronger population health management infrastructure for the future.

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Forming a new game plan

Healthcare organizations, such as South Nassau Communities Hospital, are looking beyond one-time cost savings moves, taking on higher risks and investing in long-term strategies to improve their cost structures

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and stay competitive in today’s unpredictable environment. While hospitals are still pruning costs in areas such as materials management, they are also recognizing the need to forge deeper alliances with providers and payers, gather data more strategically, as well as invest in specific technologies to gain deeper understanding and better control of their care delivery costs.

The 2015 HealthLeaders Media Strategic Cost Control Survey, which polled 324 healthcare leaders across the country, found that purchasing and supply-chain efficiencies (64%), process redesign (58%), and business function consolidation/centralization (40%) were the three areas that provided the highest dollar value in cost containment contributions for the fiscal year. The three largest barriers to achieving sustainable cost reductions were not having the right data on the true cost of care (60%); insufficient integration with care partners (41%); and lack of technology in place to achieve goals (40%).

With regard to true cost-of-care data, hospitals and health systems are indeed forming closer relationships with payers through ACOs and other care models. According to the HealthLeaders Media survey, 36% of respondents said they are in or will be in a joint venture within three years with a payer organization as part of a strategic cost control initiative. As such, these partnerships provide unprecedented views of claims, pharmacy, and other previously unavailable utilization data from payers. Having access to claims data in real time—as opposed to one or two years later—enables healthcare organizations to better understand their sickest patients, properly segment them into clinical care categories, and target healthy patients with appropriate wellness services and programs, say hospital leaders.

Organizations also recognize now, more than ever, the key role analytics and predictive modeling play in monitoring expenses and productivity. For example, in the same survey, 28% of respondents said that data sharing and clinical analytics have the biggest economic impact on their organizations’ strategic cost control efforts, followed by care management staffing (23%) and value-based care models (22%). Other areas of cost containment focus include integration of clinical and financial IT systems. In the survey, 55% of respondents said integrating clinical and financial data is the top IT-enabled activity that will deliver cost reductions for their organization over the next three years, followed by analytics support for expense and cost monitoring (53%) and identifying clinical process variation (48%).

Strong data bridges the gulf between physicians and business leaders

While materials management has been a major coup for reducing costs over a two-year period, at South Nassau Communities Hospital, Bogen also is also intensely focused on forming deeper clinical partnerships to improve quality and further reduce costs. “Historically, the CFO and the CMO, as recently as five years ago, would generally be at loggerheads because the CFO was always worried about the money and the CMO was always worried about representing the medical staff at the hospital,” says Bogen. This dynamic is changing, he adds, thanks to the advent of federal and state initiatives, the move from volume-based to value-based payments, and the public reporting of hospital quality data. “I’ve always been able to establish a good working relationship with each of the CMOs with whom I have worked,” says Bogen, noting that one of the most important roles of the CMO/CFO partnership is establishing benchmarks and ongoing measurements for particular investments.

To that end, he is working with clinical leaders to look at the clinical data and make changes around radiology testing guidelines. During preparation for the 2015 budget, Bogen says he was shocked to learn that radiologists were predicting they would perform more than 30,000 CT scans that year, a number representing close to half of the patients the hospital treated the year before. “In 2014, we treated about 65,000 patients, which means the 30,000 CT scans translated to someone having a CT scan 45% of the time. I am now working with our quality folks and clinical leadership in the ED to peel back the generic statistical numbers to try to understand what...
is going on,” says Bogen. Today, the group is looking closely at the clinical data, matching it up with additional care that a particular patient was given (or not given) and then reviewing the overall cost of care to develop better protocols, he explains.

For example, he says, in partnership with the imaging chairman, the team is looking at the necessity of the host of tests that patients are given, in which results come back days and weeks after the patient is discharged. “If the tests are ordered as an inpatient, they will be bundled into the DRG payment. Can they have it done in an outpatient setting so that the hospital can bill and get paid for it?” questions Bogen. While he agrees that not every physician order can be examined, the team is reviewing evidence-based medicine protocols to determine the various risk factors and the real needs for specific patient types. “Rather than simply running through the checklist and ordering a battery of tests because that’s the way we’ve always done it, we take a better look at providing better care with better outcomes, and there’s nothing wrong with saving unnecessary dollars along the way.” It’s still early days, but “the entire organization has been invigorated,” says Bogen. “It’s really as much about quality of care, outcomes, and patient satisfaction as it is about simply the cost of care being rendered.”

South Nassau is also looking ahead to even more changes. “I think we’re going to continue to expand out to not only the rest of imaging, but to a lot of the services that we provide, both diagnostic and otherwise,” says Bogen. At the same time, he says, “we are looking into our own ACO, both at the federal and at the Medicaid level.” A readiness assessment has been performed to look at whether the organization has enough physicians to make such an arrangement work. “We are leaning towards something; it will likely be a 2017 implementation.”

Cutting costs through technology and proactive patient care

Eyal Zimlichman, MD, a practicing physician and research associate at the Center for Patient Safety Research and Practice in Boston’s Brigham and Women’s Hospital, and former lead researcher for the clinical affairs department at Partners Healthcare, says the next wave of cost savings will come, in large part, from improved proactive patient care. “As we tie payments more to performance and outcomes and become more patient-centered, providers will need to embrace and adopt interventions for which we have sound or emerging evidence—both for clinical value, and also for cost reductions and financial return on investment,” says Zimlichman. “With technology, and specifically information technology growing in all healthcare settings, we are seeing—and will see—technology-driven proactive patient care become more widespread.”

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Some examples of technology for which healthcare is seeing more evidence emerge, and which supports widespread adoption for both clinical value as well as cost containment, are using electronic medical records (EMR), computerized physician order entry with decision support for clinicians, barcoding for medication administration, and continuous monitoring of patients in non-ICU settings, he notes. Regarding the latter, Zimlichman says, new technology is enabling clinicians to better monitor patients, predict adverse events, and detect patient deterioration.

“Early detection of patient deterioration and allowing for early intervention has the potential to tackle the challenge of avoidable mortality in hospitals—also named ‘failure to rescue’—now considered a major adverse event,” explains Zimlichman. “New technologies, as well as the rapid adoption of electronic medical records, which make available huge sets of clinical data, are converging finally to allow the development of solutions.” For example, he says, there is new sensor technology that allows for both contactless as well as wearable sensors, along with “big data” streams that collect continuously from monitors, EMRs, and other clinical systems. “In the near future, we will see the convergence of continuous monitoring with predictive analytics engines able to alert us with much more accuracy and minimal noise [to avoid alert fatigue] ahead of patients who are about to deteriorate.”
REVENUE CYCLE TRANSFORMATION

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