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First Management Reports

Monday morning, Emma met with Wes to review the first reports of the new cost information system. From the start, Wes's goal was to empower the department heads by giving them the information they needed to make decisions. He believed that Hap often made decisions that should have been made on a department level.

The meeting was held in the boardroom, where Emma spread the reports on the table, then stepped to the whiteboard. "When we first met with the department heads last September," she said, "they told us they needed information for . . ."

Emma wrote on the board:

Information is needed for:

Pricing
Cost control
Strategic planning
Measurement of the efficiency of our hospital compared with other hospitals

"I think the system we have designed will meet the criteria. For pricing we can find standard costs per procedure, and compare it to the revenues we are getting. For cost control we can compare **actual costs** to **standard costs** or **budgeted costs**. For strategic planning we can see what procedures we earn money on, and which procedures we lose on, and for efficiency we can compare our standard costs to those of other hospitals.

"We can tell how much we earn or lose by DRG, insurance company, doctor, and so on under each of those reimbursement systems." She continued. Her mouth pulled into a frown. "Unfortunately, we're finding that revenue isn't even close to cost in some cases."

"I suspected as much," Wes interjected.

"Let's look at the reports," Emma said, "and I'll show you how they work." The first report shows us profitability by DRG. This report is for DRGs one through 7."

Brannan Community Hospital
Profit or Loss by DRG

DRG	# Cases	Actual Revenue Per Case	Actual Cost Per Case	Profit (Loss)
1	12	$3,240.00	$4,200.00	$ (960.00)
2	45	$1,270.00	$1,200.00	$ 70.00
3	15	$5,680.00	$6,130.00	$ (450.00)
4	67	$3,240.00	$3,100.00	$ 140.00
5	32	$1,200.00	$ 900.00	$ 300.00
6	45	$ 980.00	$1,020.00	$ (40.00)

Definition of Column Headings:

Column 1: The diagnosis related group (DRG).
Column 2: The cases in each group seen by the hospital for the period.
Column 3: The average actual payment received by the hospital for all patients in this DRG category (regardless of their insurer, or the reimbursement system used by their insurer). This is calculated by taking actual reimbursement received and dividing by the number of patients seen.
Column 4: The average cost to the hospital per case.
Column 5: The average actual profit or loss on all patients seen in this DRG category (the difference between Column 3 and Column 4).

"We earn the most money—$300 per case—on DRG 6. We lose the most money—$960 per case—on DRG 2. Strategically we should raise our volume of DRG 6 patients, and either phase out the procedure, or cut the costs of DRG 2."

"The next report," Emma continued, "is an analysis by insurance company for DRG 6—Circulatory Disorders. We'll use this report as we negotiate with insurance companies. Notice that 52% of our contractual adjustments come from Medicare Part A, on which we lose $100 per case on DRG 6. Our total revenue (number of cases x average charge) for Medicare was $38,400, while our total costs were $43,200."

"They're not exactly what you would call a profitable customer, are they?" Wes said.

"Nope."

Insurance Company	# Cases	Actual Revenue Per Case	Standard Cost Per Case	Profit (Loss) Per Case
Blue Cross	13	$1,320	$900	$420
Medicare Part A	48	800	900	($100)
Medicaid	4	750	900	($150)
Aetna	15	1100	900	$200
Western Health	6	1000	900	$100
United	2	1050	900	$150
Security Insurance	5	870	900	($30)

Definition of Column Headings:

Column 1: Name of insurance company.
Column 2: The total cases for the month for this insurance company.
Column 3: The average amount paid per case by the insurance company.
Column 4: The hospital's average standard cost (budgeted cost) per case.
Column 5: The profit or loss per case for this insurance company (revenue minus standard cost).

"The next report compares the average cost of each doctor, compared to standard cost, for DRG 6."
"Remind me once again what standard costs are," said Wes.
"It is what the procedure should cost."
"It's the budget?"
"Right."

Brannan Community Hospital
Physician Based Analysis
DRG 6

Doctor	# Cases	Standard Cost Per Case	Actual Cost Per Case	Variance

Wes studied the report. "Why does Dr. Brannan have such a higher average cost than other doctors?" he asked. "He is $950 over budget per case."

"He has a different practice pattern. He uses more medications, more lab tests, and his patients stay in the hospital longer."

"How come?" Wes asked.

"We're not sure, but we think he has more complications. Whatever he is doing, his patients don't get well as fast as those of other doctors."

"That's interesting," Wes said. "I never thought we could pick out substandard practice through accounting data." He was quiet for a moment as he studied the report. "Let's give this data to the Morbidity and Mortality Committee," he continued. "It looks like Dr. Brannan could benefit from a little peer-review."

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Thursday afternoon, Emma took the data to the University Medical Center where it was reviewed and confirmed. Friday morning, Wes met with Dr. Emil Flagg, Chairperson of the Morbidity and Mortality Committee, to discuss his concerns.

"The quality of Dr. Brannan's care has been a concern since he joined the medical staff," Emil admitted soberly as he reviewed the reports. "I'm not surprised at the data. He has more than his share of complications."

"After reviewing his training, I'm no longer convinced that he's qualified for family practice. As I look at his file, he applied for and got privileges in obstetrics and surgery for which he is marginally qualified. Dr. Brannan finished an internship, but never a residency. He's not board certified in family practice, obstetrics or surgery."

"How did that happen?"

"A rural hospital with a poor history of peer-review, a father who has funded its shortfalls for the past 20 years. It was politics," replied Emil. "Hap should have been more aggressive when Brannan applied for membership on the medical staff, but I think he had his hands full with problems created by managed care, and didn't want to risk his relationship with the Brannans."

"Who grants medical staff privileges?" asked Wes. "The administrator, the medical staff, or the board?"

"The medical staff, through the Credentials Committee, recommends. The final power lies with the board, however."

"After he joined the staff, Brannan ran into complications with several patients. The nursing staff is on record of having complained about him on at least two occasions. Where was the medical staff when this was happening?" Wes asked.

"Brannan's partner visited with Hap off the record, but was unwilling to criticize him openly as he had to practice with him. The doctors in the clinic across town also expressed concern, but felt since Brannan was a new competitor, they might be accused of having ulterior motives. Historically,

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doctors have been reluctant to criticize their peers. It's a brotherhood; there is a tendency to stick together."

"Hap was burned several years ago," Emil continued, "when he took disciplinary action against a radiologist. Everyone on the medical staff complained privately about him. When the administrator took formal action, however, it became '*them against us*.' The staff rallied behind the radiologist."

Wes removed his glasses and stared out the window as he collected his thoughts. "Okay, so what do we do?" he asked.

"Dr. Brannan will meet before the Morbidity and Mortality Committee next week. It will be his second time before that group in less than a year." Flagg was silent as he counted his power chips. The Brannans were no longer funding the hospital. Several members of the medical staff owed him favors. It was time to call in the political IOUs he held.

"With a new administrator," Flagg said, almost as though he were talking to himself, "and a renewed resolve by the board to fix the hospital, this well may be the time for me to push for a resolution." He turned to Wes. "It's not that I've been a laggard, it's just the problem has political ramifications, and the environment wasn't favorable."

"If there's a fight among the medical staff, it won't be pretty," Emil continued. "And you'll be right in the middle, taking sword blows from all sides." He looked Wes straight in the eyes. "When there are problems, the hospital administrator makes a good fall guy. The community can't fire the board, and they don't want to fire the medical staff, and so . . ."

"I get your point," Wes said. "No need to finish the sentence."

"Let's be candid, Wes. When the board went after you they wanted a hired gun. Taking the actions needed to save this place will create enemies. The board would be crazy to stand behind someone as unpopular as you're going to be in certain circles. You're too new to have many allies. Once the dirty work's done, you're expendable."

Wes was quiet while he absorbed the message. "Wish I'd have known this when they offered me the job," Wes said. "I guess I could have figured it out if I'd thought it through."

"Welcome to Politics 101," Emil said. "So, what do you want to do?"

"Let's do what's right," Wes said.

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Monday afternoon, Dr. Emil Flagg reported to Wes. "The committee restricted Dr. Brannan's obstetric and surgical privileges," he said, "but rejected the proposal to suspend him from the medical staff. Their recommendation is that he go back and get a residency."

"What was his response?" asked Wes.

"He'll live with the restricted privileges; he has no choice, although he's angry about it. At this point, he doesn't seem interested in returning to school."

"The problems we are having with Dr. Brannan are raising the issue of quality," Wes said. "I'd like to meet with someone who is doing research in the area to see if there is anything we can do to improve the quality of our product. **Total Quality Management (TQM)** and **Continuous Quality Improvement (CQI)** are big issues in manufacturing, and I think they deserve evaluation in healthcare as well."

"There are continuous studies conducted on those topics at the University of Utah Medical School," Emil said. "If you want, I'll see if I can get someone down here to talk to us."

"Let's do it!" replied Wes.

Discussion Questions

1. What is the difference between standard cost and actual cost? If actual costs are higher than standard costs, is that good or bad from the standpoint of the hospital administrator?

2. Refer to the report entitled "Brannan Community Hospital—Profit or Loss by DRG 6." Calculate the total profit or loss (profit or loss times the number of cases) for each DRG. What is the total profit or loss for the period for DRGs 1 through 7?

3. Brannan Community Hospital loses $30 per case for Blue Cross patients on DRG 6. What choices does Wes have to cut this loss?

4. Why must the Board of Trustees rely on the medical staff to evaluate the quality of healthcare provided by doctors in the hospital?

5. When doctors given the responsibility for reviewing the quality of care of their peers fail in their responsibilities, what impact does it have on the integrity of the healthcare delivery system?

6. Our society has much ambivalence towards "whistleblowers." Many people believe it is wrong to "rat on someone." To whom should healthcare worker feel more responsibility: the welfare of a coworker who is providing substandard practice, or the health and safety of the patient?

7. Why is it important for a healthcare worker to show loyalty to a person? When is this loyalty superseded by "loyalty to principle?"

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Improving Patient Care Decisions

Dr. Tom Woolsey's eyes sparkled with approval. "Your interest in quality is timely," he said. He and Dr. Crystal Hammond were in the office of Wes Douglas at the request of Dr. Emil Flagg. Woolsey and Hammond were professors. Woolsey taught **biostatistics** in the Department of Preventive Medicine at the University of Utah Medical School. Hammond was a professor of business administration at Weber State University. At Wes's invitation, Dr. Emil Flagg and Dr. Ashton Amos were also present.

"I met Hammond at a symposium on marketing sponsored by the Healthcare Marketing Association," Woolsey said. "Much of what she said related to my research on total quality management. Since them, we have coauthored several articles on that topic together." Woolsey turned to Hammond. "Why don't you begin by reviewing your research?"

Crystal Hammond, a stocky woman in her mid-thirties, cleared her throat. "There are four stages in the evolution of markets," she said. "The first stage can be summarized by the phrase *"If you build it, they will come."*[2] In this stage, demand exceeds supply. The power is in the hands of the provider with the greatest assets."

"In the healthcare industry, this occurred in the 1950s," Woolsey added. "The country was concerned about a shortage of hospital beds. The federal government intervened with funds through the **Hill Burton** program for building new hospitals."

"Our 1956 wing was built with Hill Burton money," Dr. Amos volunteered.

Hammond nodded, and then continued. "In the second stage, supply catches and then exceeds demand. Firms begin to compete in the marketplace. This is the stage of selling and competition. In healthcare, this occurred in the early 1970s. Hospital beds alone no longer guaranteed success. Hospitals

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[2] Berkowitz, Eric N., Ph.D. and Robert T. Kauer, Ph.D., "The Strategic Life Cycle," *The Journal of Strategic Performance Measurement*, August/September 1998, Volume 2, Number 4.

started marketing their services, although cost reimbursement softened the impact of oversupply.

"The third evolutionary stage is restructuring. The focus is on ending excess capacity. We have seen this in retailing, banking, and manufacturing."

"And the healthcare industry," Woolsey interjected. "Look at what's happened over the past decade as hospital corporations have bought and downsized competing hospitals. The focus has been on the elimination of duplicate hospitals."

Hammond nodded. "The final stage is customer value," she said. "Finally, the seller focuses on quality. That's where the health industry is today."

"How does one raise quality in a hospital setting?" Wes asked.

"One area that has received great attention is **outcomes management**."

"What's that?" Wes asked.

"Outcomes management focuses on measurable improvements of patient health because of specific procedures or treatments."

Wes shook his head. "That doesn't sound innovative to me."

"It's not; the idea has been around for a long time. It just hasn't always been applied. The approach was first proposed in 1913 by a Harvard surgeon named Emery Codman. He called it the *end results idea*. It consisted of tracking surgical patients for a year to see how their treatment turned out. The goal was to discover the most likely cause of success or failure. Codman planned to collect the information into a **database** to improve treatment profiles. Unfortunately, his proposal to the American Medical Association was essentially ignored—it got only $500 in funding. More important to Codman, other doctors stopped sending patients to him, his practice suffered, and he abandoned the idea. [3]

"In 1919, the concept was resurrected by the American College of Surgeons that performed a study of 692 hospitals with 100 beds or more. The study showed that only 89 met the minimum standards. The response of The Board of Regents to the report was swift and uncompromising. They collected all the copies, carried them to the basement of the hotel, and burned them."

"The regents were men of action," Flagg said with a sarcastic laugh.

"Despite its rocky start," Woolsey continued, "outcomes management is receiving attention again because of pressures of employers and consumers who would like to be able to judge the quality of the healthcare services they are receiving. One approach is to build **clinical pathways**, doctor guidelines, and **treatment protocols**. Though this approach has its critics, it also has its supporters.

"Research conducted by several medical schools has shown there is a large geographical variation in treatment patterns among doctors. Patients like to think their doctor's approach is based on research, but unfortunately that isn't true. Doctors don't always follow the best practices. The result is that

[3] Many of the concepts in this section are drawn from an excellent article by Joey Flower entitled "Measuring Health," which appeared in the *Journal of Strategic Performance Measurement*, August/September 1998, Volume 2, Number 4.

Double-blind peer-reviewed scientific study. A double-blind study is a study that uses a placebo (harmless substance) as well as the drug being tested on separate patients to compare outcomes. Neither the researcher nor the patients getting the drugs know which is being administered. The objective is to distinguish between the actual action of a drug and the psychological effect taking a drug might have on a patient. Peer-reviewed means that the methodology and results are reviewed by scientists with similar qualifications.

Retrospective statistical analysis. Statistical analysis that occurs after an event, such as the treatment of patients.

resources are wasted, and, in some situations, patients die. A 1992 Harvard study estimates that as many as 180,000 patients die each year from medical mistakes.[4] A 1997 Rand Corporation study of autopsies shows a 35 to 40% error rate in diagnoses."[5]

"Why don't doctors follow the best practices?" Wes asked.

"There are two schools of thought on that one," Woolsey said. He wrote the following on the chalkboard:

Doctors don't know what the best approaches are.

Doctors get bogged down in dealing with the huge volume of information needed to make decisions.

"Let's address the first possibility," Woolsey said as he retrieved a professional journal from his briefcase. "Part of the problem is that we don't know what the best practices are."

"That's hard to believe," said Wes.

"Let me read from an article in the August/September *Journal of Strategic Performance Measurement*," replied Woolsey. "Most practices in clinical medicine have never been tested in **double-blind peer-reviewed scientific studies**, or even through **retrospective statistical analysis**. When practice techniques have been firmly established or debunked in such studies, the knowledge often does not affect clinical practice. Many doctors fail to hear of the new knowledge; others routinely ignore it, preferring to continue to practice the way they were taught in medical school.[6]

"The first problem can be solved through research and education," Woolsey continued. "The second problem is caused by limits in human memory."

Hammond spoke. "Studies on human information processing shows that we have two types of memory. Long-term memory is almost unlimited in its capacity, while short-term memory is limited to six or seven chunks of data. Unless a doctor follows a decision tree when making decisions that involve many variables, it is easy to get confused."

"But we have the technology to supplement short-term memory," said Wes. "Computers can store, organize, and retrieve an almost unlimited amount of information."

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4 Allen, Jane E. "Doctors, Insurers Meet to Highlight Ways to Reduce Medical Errors," Associated Press, October 14, 1996.

5 "U.S. Healthcare Can Kill, Study Says," San Francisco Chronicle, October 21, 1997.

6 Flower, Joe. "Measuring Health," The Journal of Strategic Performance Measurement, August/September 1998, Volume 2, Number 4.

"That's right," Hammond replied. "And some teaching hospitals have developed **decision-tree** software programs for use by doctors in diagnosing. Unfortunately, not all doctors have embraced that technology. Many still rely on memory."

"I think we have pretty well covered the theory," Flagg said. "Now let's be more specific. What can the medical director of a small hospital like ours do to improve the quality of its doctor decisions?"

"There are several actions you can take," replied Woolsey. "Your Quality Control Committee can start performing **outcome audits**.

"You can encourage members of the medical staff to adopt **practice protocols** that have been shown to have the best outcomes. These are essentially pathway guidelines, as opposed to **boundary guidelines** that define medical practices beyond which doctors incur penalties. You can also encourage doctors to use computer technology to store, organize, and retrieve these protocols. The use of computers to retrieve and execute decision trees can cut errors resulting from omissions of memory."

"What can hospital administration do?" asked Wes.

"You have installed a cost accounting system that will identify the medical resources used to treat patients. You might consider including outcomes data in your database."

Wes nodded as he took notes.

"You can also adopt many recent innovations of manufacturers in the areas of continuous quality improvement (CQI) and total quality management (TQM)," offered Hammond.

"Your first focus," she continued, "should be on improving customer satisfaction, market share, and profitability. It should also focus on ending waste and rework and on improving productivity. The most important part of this program will be managing the core processes in the hospital—processes that clinical trials have shown improve outcomes."

"To work," Flagg said, "the system will have to be clinically meaningful. That means we will have to gather and report clinical data."

"That's correct," said Woolsey. "One community hospital I'm consulting with has begun by identifying four high-volume critical medical conditions for outcomes assessment." He walked to the board and wrote the following:

Pediatric asthma
Pregnancy
Cardiovascular disease
Acute myocardial infarction

"Could we hire you to help us do the same?" Flagg asked.

"Dr. Hammond and I would be happy to help you in any way we can," Woolsey replied.

"Where will we get the money?" Wes asked.

"That's your assignment," said Flagg.

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The Competition

With the successful completion of the first module of the information system, Wes turned his attention to the competition. One of the obvious reasons for the decline in patient volume was Snowline Medical Center, ten miles to the south. From visiting with Madeline McMillan of the Utah Healthcare Association, he learned Consolidated Healthcare of Arizona, a for-profit hospital corporation formed in 1985, built the hospital.

Madeline told Wes the company was well capitalized and that most of its hospitals were new. The company boasted saving from centralizing the purchasing, housekeeping, financial, and dietary functions. Its charges were slightly higher than many **nonprofit hospitals** in the state—not including Brannan Memorial Hospital, which raised prices in its struggle to remain solvent.

Madeline reported the company was **vertically integrated**, owning hospitals, nursing homes, and a health insurance company that served as the nucleus for its managed-care program. The corporation recently started an aggressive program of doctor practice buyouts in an attempt to control doctor referrals.

Although some criticized the company for its aggressive marketing practices, Madeline was impressed by its efficiency and financial strength. She suggested that Wes meet Jon Einarson, the local hospital administrator. At Wes's request, she called Einarson and set up the appointment.

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"Today's hospital employees are too expensive," Jon Einarson snarled. At age 35, he stood six foot three and tipped the scales at a muscular 220 pounds. His closely cropped beard accentuated the rawboned features he inherited from his Icelandic ancestors, and his sea green eyes could pierce an opponent like a Viking pikestaff.

For the past two hours Einarson had given Wes a tour of his building, highlighting efficiencies in design that allowed the hospital to cut staffing by

20%. Now both dined in the private dining room next to Einarson's office. Einarson reached for his steak knife. "A good administrator knows how to slash labor costs," he said cutting the rim of gristle and fat from his thick steak. "That's why we ax old hospitals. We design our buildings to save labor. In five years we can pay for a new building in payroll savings alone.

"Before entering the market," he continued, "I approached your board with a purchase offer. Your Finance Committee chair, Edward Wycoff, killed it." Einarson took his first bite and nodded approvingly as he savored the flavor. "It was a mistake," Einarson continued. "Park City would have been a better location for us, but your board resisted our for-profit ownership. In the long run, the decision will hurt us both."

"Why?" asked Wes.

"Because there isn't a big enough population to support two new hospitals. That's why I was pleased when I heard you wanted to meet with me. I hope you've come to the same conclusion," said Einarson.

"The board will never support a consolidation," said Wes. "The community tradition is too strong."

"The tradition is wrong," Einarson retorted angrily. "Hospitals are too expensive to plop in every community along the Wasatch Front. What your board is doing is a disservice to the community. If you want to do what's right for Park City and yourself, you'll work with us. We can make it worth your time."

"What do you have in mind?"

Einarson swallowed, then wiped his face with his napkin. He leaned forward conspiratorially, dropping his voice to a whisper. "You don't have to take direct steps to sabotage the operations. Your hospital's a sick patient, Wes. Remove the life-support systems, and it will die on its own."

"What specifically are you suggesting?" asked Wes.

"We've heard about your efforts with budgeting, cost accounting, and so on. Don't waste your efforts. Let nature take its course."

"And if I do as you suggest?" Wes asked.

"When the hospital closes, there will be a position for you with Consolidated Health Systems, at a generous salary. We'll give you a two-year contract at $150,000 a year. You won't have to do anything; use the time to rest, or find a new job."

"Three-hundred-thousand dollars to close the hospital," Wes mused. "What you're talking about sounds like a bribe."

"Don't get caught up in semantics, Wes. When the place falls apart, you'll need a new job. Wycoff's not going to take responsibility for the stupid decisions the board has made. When he gets done with you, you won't be able to get a job in Park City waiting tables."

Wes was surprised at the boldness of Einarson's offer. Jon Einarson hadn't risen to the top of his profession by being timid. Wes believed that what Einarson was proposing was a conflict of interest. Wes paused in mock

seriousness as though considering the offer. "You don't mind if I discuss your generous offer with my board?" he asked.

Einarson saw through the sarcasm and was offended. "Don't be stupid, Wes. We must be discreet. I'm doing my best to save your hide, and you're insulting me."

Wes Douglas folded his napkin and placed it on the table. "Thanks," he said as he rose to leave, "but I'm not interested."

"You'll be sorry," Einarson said.

"Perhaps."

"Quote me, and I'll deny it," Einarson said as Wes left the room. Wes closed the door behind him.

Thayne Ford swore—not a soft, mealy mouth cuss like his grandmother used when she burned the rolls or dropped a stitch in her knitting, but a blaspheming profanity that fermented angrily in his guts and exploded with the violence of an Irish pipe bomb. Slightly ashamed, he glanced over his shoulder to see if anyone was listening. That wasn't probable since the newspaper office was empty. It was 4:00 a.m. He was about to miss the deadline for the Wednesday edition of the *Park City Sentinel*. The press was broken—*again.*

He grabbed a rag from the table and wiped his hands. It wouldn't be easy to fix this time. Made in 1952, parts were hard to get, and money was tight. Subscriptions were down. It wasn't enough that national papers like *USA Today* targeted rural markets. Even the statewide newspapers like the *Salt Lake Tribune* had online editions that stole readers from the smaller biweekly rural newspapers.

At 6:00 a.m., he'd call Edward Wycoff, his silent partner. Wycoff would write a check to fix the press—but not to replace it. Ford doubted he would ever get that commitment. There would be a price, of course—not just the verbal abuse. Ford could take that, but Wycoff would require more. Ford would agree. If it were a question of ethics or of feeding his family, he would choose the latter. There weren't other options at his age.

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