

## Special Board Meeting

June 15, 2007

A special meeting of the Board of Commissioners of Whidbey Island Public Hospital District was called to order at 9:02 a.m. by Board President, Roger Case, M.D. in Conference Room A at Whidbey General Hospital. Present were Commissioner Case, Commissioner Saugen, Commissioner Miller, Commissioner Zaveruha and Commissioner Schoenknecht. Also present were Chief Executive Officer, Scott Rhine, Chief Financial Officer, Doug Bishop, Chief Operating Officer, Tom Tomasino and Dr. Chris Bibby, Chief of Staff. Judy Moore, Beth Stout, Frank Hemeon, and John Bitting also attended.

It was confirmed that this special meeting was properly noticed to the media, that all commissioners were notified of the meeting, and that a quorum of the Board was present. No other points of order were noted.

### Review and Discussion of District Financial Progress

Doug Bishop, Chief Financial Officer, presented the final financial report for 2006, broken down by major services. After the final cost report submission, the District earned income of \$160,000. Seeing the breakdown by major services was helpful for staff and Board members. The hospital itself earned income in excess of expense of \$4,013,504 or a 9.13% operating margin. In addition, salaries, wages and benefits as a percent of net operating revenue was 56.45%, below the 60% benchmark mentioned by outside auditors as the desirable target. Other services including Emergency Medical Services (EMS); Home Health and Hospice Care; Rural Health Clinics; Hospital owned physician practices; and, Physician Services (hospitalist and on call fees) were also broken out and showed subsidization by the hospital during 2006 (see attached financial report).

The following services are being, or have been, subsidized and Mr. Bishop and the administrative team pointed out the following action that are being taken:

1. **EMS Services** (2006 Subsidy: \$437,000) – New EMS levy will provide additional revenue to cover both operating and overhead costs. In addition, the levy will provide additional capital to assist with equipment and building needs.
2. **Home Health and Hospice Services** (2006 Subsidy: \$667,000) – Outside consultants are looking at the revenue cycle for methods to improve billing and collections. In addition, Home Health management will be looking at ways to modernize scheduling and record-keeping functions and allow providers to be as efficient as possible. The Home Health Care services are covering their direct expenses; but not contributing much to the District hospital overhead expense coverage.
3. **Rural Health Clinics** (2006 Subsidy: \$626,000) Mr. Bishop indicated that due to the income levels of most of the patients, the patients seeing providers at the clinics are being assisted through Medicare, Medicaid and sliding fee schedule arrangements. The target for the rural health clinics (RHCs) was to cover direct expenses. The clinics are covering direct expenses and keeping patients out of the Emergency Department in many cases, and this is felt to be the primary access goal.
4. **Hospital owned physician practices** (2006 Subsidy: \$1,756,000) Mr. Rhine and Mr. Bishop reviewed the status of these practices and indicated that Dr. Becker would be closing his practice later in June. This would eliminate the ENT practice subsidy. In addition, Mr. Rhine indicated that the hospital would no longer be providing medical practice services to Oak Harbor Internal Medicine effective June 30, 2007. Other practices are being reviewed and targets or benchmarks for greater productivity are being considered. Dr. Petrak and Dr. McAnally's practice will be reviewed again later this summer to determine further progress.
5. **Hospitalist Services and On Call physician fees** (2006 Subsidy: \$367,000) With the addition of the full-time core of hospitalists (both physicians and mid-level practitioners) we see the hospitalist program continuing and needing some level of subsidization. It is too early to tell the outcome of the revised hospitalist program, but we feel that will be more consistent and will provide for greater access to outpatient care for community residents (more doctors being able to stay in their offices and see patients). We may also see some decrease in overall cost of inpatient care due to increased continuity in care providers.

In summary, Commissioners, management and medical staff leadership received a better understanding of the major cost issues by service. All agreed that continued effort needed to be undertaken to make sure that each department was working as efficiently as possible (even though the hospital as a division was generating a fair margin).

The question was also raised as to the staffing mix in various clinical departments. Does Whidbey General have more RNs and not enough certified nurses aides? Nursing and hospital management are supportive of the current ratio or mix, and more time will be needed to present the advantages and disadvantages and share management and staff recommendations in this area. It is felt that recruiting nurses has been more favorable at Whidbey General Hospital because of the higher RN ratio and the nurse to patient ratio.

### **Inpatient Marketshare Review**

Following this question, members present began an overview of current and past market share trends. Mr. Rhine noted that he had presented additional market share data at the February board retreat. Based upon current information for inpatient discharges from January through September of 2006, Whidbey General Hospital is "capturing" approximately 40% of the overall inpatient market share island wide. The market share varies depending on which area of the island one lives on and the proximity of physician providers. Island Hospital in Anacortes and Providence Everett Medical Center are still the leading competitors for Whidbey Island inpatients. Mr. Rhine mentioned that the studies done earlier reflected that the major diagnostic groups going to Anacortes included obstetrical and orthopedic services. Recent reports (that had not yet been summarized) were provided to those present. It was also noted that further discussion would be undertaken regarding obstetrics later in the day.

### **Current Financial Overview**

Doug talked about the May financial statements, noting that two prior settlements were booked in May. Revenues are \$800,000 above budget, contractals above budget due to the settlements booked, operating expenses are below budget by \$26,000 and the bottom line for May is a positive \$168,000 with an operating margin of 3.59%. The average expense per adjusted patient day is \$1,786.00, which is driven by increased volume. **Year to date the bottom line is a positive \$978,000 with a 4.13% operating margin. Cost per adjusted patient day is \$1807.00. Cash, excluding bonds and special funds was \$2.9 million the last day of May.** All present were encouraged by the improvement in the hospital's overall financial performance.

**Recommended Action: Continue efforts to increase cash reserves through increased prices. At the same time make sure that policies and procedures are in place and followed in the areas below still to be discussed.**

### **Billing Cycle/Coding/Bad Debt and Charity Care**

Beth Stout stated that there are basically too many accounts per billing person at this time, which accounts for longer collection periods. The goal is to be at or below an average of 55 days in accounts receivable. In other words, the time from billing a claim to receipt of funds needs to be reduced to an average of 55 days (currently at approximately 59 days). The work being done by HRG (Tom LaPlant's Company) is helping. One of the major recommendations from Mr. LaPlant was that more billing staff (or an ongoing relationship with an outside collector) need to be hired. Patient Accounts is currently recruiting for three FTEs. In addition we are trying to fill a coding position that has been open since last September. Experienced billing and coding personnel are becoming more difficult to find. Beth noted that all avenues are being explored to fill these positions, including creative ways that have not been considered in the past. Commissioner Zaveruha asked what our check and balance system is for coding? Mr. Bishop indicated that there are both internal and external audits that are being performed throughout the year and ongoing education is sought and provided. The hospital presently has four coders. Commissioner Zaveruha observed that HIS (medical records) used to have a lot of questions for the medical staff and now do not. Dr. Bibby wants managers to make sure that staff are comfortable coming to the medical staff with questions.

Beth Stout commented that there are some billing and technology system issues with new Medicare requirements and additional information needed to submit claims. Because the technology has not yet made the changes, we are finding that substantial "re-work" is being done. On the plus side, she stated that the clinical documentation system has been beneficial for nursing notes. Doug noted that we are planning to further centralize physician billing.

Recommended Action Items: 1) Continue recruitment for 3 additional billing FTEs and 1 replacement coder; 2) Reduce Accounts Receivable Days to 55; 3) Continue to plan for centralized physician billing; and, 4) Update billing technology as soon as possible.

### **Bad Debt and Charity Care Policies and Practices**

Beth Stout reported how bad debts are being pursued, and indicated she felt that the hospital needs to be processing more requests for financial assistance (charity care), instead of classifying more unpaid bills as bad debt. The hospital's eligibility threshold for financial assistance has been extended to 300% of poverty level, which will qualify more people for financial assistance. The process and paperwork have also been streamlined. The practice of offering patients without healthcare insurance coverage a 20% discount if the bill is paid within 30 days has also been implemented and it is felt that this is in line with the average discount for patients covered under a health plan agreement.

### **Contracts**

Doug stated that the goal is to continue with percent of charges methodology. Per diem contracts place the hospital at risk and with relatively smaller volumes than larger hospitals, small rural hospitals cannot afford to do so. Contracts on fee schedules are also insufficient to provide adequate reimbursement, especially at the rates that many health plans set. Joint negotiations with other rural district hospitals and the Western Washington Rural Health Care Collaborative have been very helpful, and Doug and Beth work with two western Washington collaborative groups for jointly negotiating insurance contracts. Doug stressed that every contract is different and that data is used off our system to analyze each contract, with numerous variables to consider on each contract. Negotiations continue with Premera and TriCare and a letter is being prepared to send to TriCare to either obtain better reimbursement or consider alternative actions. Recommended Action: Appropriate letters to be sent to health care plans notifying them of the hospital's need for higher reimbursement rates. In essence, failure to negotiate better rates may mean reduction in contract services.

### **Hospital Services Discussion**

**Rural Health Clinics** – Doug stated that the goal when starting the rural health clinics was to break even and perhaps recover some direct expenses. Both the north and south rural health clinics have grown in volumes and outgrown their spaces, with North Whidbey moving to a new clinic in Oak Harbor two years ago, and South Whidbey to hopefully have a new space in the coming year. Contribution margins for North Whidbey Community Clinic are slightly positive and for South Whidbey Community Clinic slightly negative. Doug is hoping that both clinics will continue to break even for direct expenses. Frank Hemeon noted that the business model for the rural health clinics has changed, and that this is the first year of those changes. Judy Moore reported that the case mix for the clinics has shifted, and that they do a lot of prevention work. The clinics must demonstrate that they serve mostly low income patients for DSHA, Medicare, Medicaid and Medicare/Medicaid. They do take some private insurance, but not all – Group Health and Champus being two that they do not take. Judy stated that the hospital is a member of the Rural Health Association, which is federal and also the State Rural Health Organization.

**Obstetrics** - One of the services that seems to be under scrutiny periodically is the service of obstetrics. This is probably due to the relative low number of births and the high costs associated with the service including call coverage and epidural anesthesia. Mr. Rhine stated that letters from Dr. Barrio and Dr. Burnett in support of the OB services at Whidbey General Hospital were in today's packets. Management also recommends continuing this service even though it is costly for the hospital and ultimately for the community. Mr. Rhine stated that the total number of births for 2006 were down; however, births in June and July look strong. Board Commissioners were pleased that Dr. Burnett indicated a willingness to stay on the island and continue to provide obstetrical services. As the topic of epidurals were discussed, it was felt by most present that these were needed as an alternative in order to provide a service that is up-to-date and current. It was also felt that mothers would further leave the island if this service was not available. The question was raised as to the possibility of integrating obstetrical anesthesia with other anesthesia physicians. Dr. Zaveruha felt that this might be a possibility and felt that the current Chief of Surgery (Dr. Chris Outlund) will be working on it. Ideas were generated and a suggestion was made to have an OB/GYN physician or nurse practitioner on the north end. Another suggestion was to hire a women's health coordinator. After much discussion, the Board unanimously indicated their support for continuing OB services with epidurals.

Recommended Actions: The hospital needs to find a way to offset fixed costs for this service. It was felt that a meeting is needed with the people doing the epidurals to further analyze efficiencies and other ideas. It was expressed that better marketing may also be needed on an ongoing basis. One idea was to have a women's health week, with tours of the birth center. It was noted that the right people need to get involved. Volumes have to be carefully monitored because of critical access, and internal efficiencies should be strived for.

#### **Plastic Surgery**

Issues have been identified for this area and are being looked at. A form will be developed for quoting prices for these services to patients to help with consistency in this area. Block times for surgery and improved efficiencies are being discussed with Katie Carr, Dr. Slepian and Dr. Outlund, Chief of Surgery. Doug Bishop is working on charges for these services.

#### **Physician Services**

Mr. Rhine reported that in looking at the comparisons, all of the contribution margins for this service are negative. There is a possibility of getting part time ENT services, Mr. Rhine has meetings in July to explore these opportunities. Dr. Outlund, Chief of Surgery, feels that we should have at least part time ENT services available. There was discussion about the practices the hospital is subsidizing, and most are doing well. Goals have been discussed with them. Referral numbers will be brought to a future meeting. There was speculation that an operating bond may be needed in the future. It was noted that the hospital has had to use a lot of locum tenens services over the last months, which are costly.

#### **Sleep Disorder Center**

Tom Tomasino, Chief Operating Officer, has made changes to this service. There is a new manager, more days that sleep studies are being done, and work being done on becoming accredited, which will bring better reimbursement. Tom indicated that there is a waiting list of 60 patients for sleep studies. Dr. Nikomboriak has been asked to increase his time at the Sleep Center, and now comes three days per month. There is another physician interested in helping part time. It is anticipated that he can start in July after his credentialing is completed. Expenses have been reduced by using an outside reading service for the studies. Charges were increased in March, 2007. Tom also reported that to increase efficiency, the Sleep Center will take over part of the office that was built for Dr. Eggers. Tom noted that we probably should have started with four beds instead of two.

There being no further business, the meeting was adjourned at 3:28 p.m.