ams biweekly report
Applied Management Systems
Dedicated to Excellence in Health Care Management • Trusted in Interim Management

SEPTEMBER 12, 2018 VOLUME 34 NUMBER 11

LABOR BENCHMARKING – GETTING TO THE "RIGHT" NUMBER

If you Google 'labor benchmarking', over 5.75 million results appear in 0.36 seconds, and the first two listings that come up are AMS.

AMS recognizes that no two cost centers of similar name or major function are identical. **Therefore, as part of our in-depth benchmark analysis, we emphasize the functional components of the benchmark productivity ranges and consider many variables including:**

- *Teaching vs. non-teaching hospitals*
- *Overall size of hospital* (helps identify acuity of patient population and degree of specialization)
- *Functions performed within the department* (who orders, registers, schedules)
- *Volume* (important for non-linear department such as laboratory and to deal with minimum staffing issues within small departments)
- *Systems in place* (an example would be nursing patient acuity system vs. no system)
- *Mix of activity* (examples include the mix of echos, stress tests, EKGS, etc. in non-invasive cardiology and the number of admissions, discharges, and transfers on an inpatient unit)
- *Ratios of actual paid hours to worked hours*

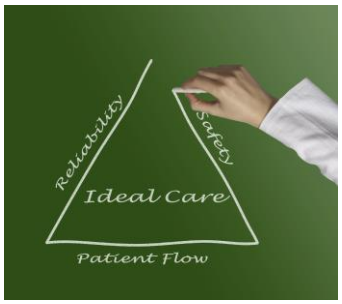
Since the AMS benchmark is not based on "others" or the "competition", the benchmark becomes an achievable performance target for your institution which facilitates efficient performance levels. The benchmark incorporates best practice metrics with unique department functionality and scope of service, to yield a benchmark range that is specific to the cost center's operations.

Hospitals with fiscal years beginning between now and January 1 are planning their budgets for the upcoming fiscal year and accordingly, AMS' recent contracts are from these hospitals. An AMS summary of labor benchmarking is included with this Biweekly, along with who to contact for more information.

NURSE VS NURSE IN MASSACHUSETTS

Around Labor Day is when the November election ads begin everywhere. Besides the candidate ads, an extremely contentious battle is in full force in Massachusetts over Referendum Ballot question number one – "The Patient Safety Act". If passed, this would establish nurse patient staffing ratios which are rigid and fixed at a level that will be an expensive challenge for hospitals to achieve. The nurse to patient ratios mimic what is in place in California, which is the only state with these voter approved, fixed nursing staffing requirements. The referendum is the brainchild of the Mass. Nursing Association (MNA), who provides the most money for the campaign. Other major contributors include the New York State Nurses Association. The hospital industry is backing the vote no campaign, with support from the American Nurses Association (ANA) and Organization of Nurse Leaders (ONL) for Massachusetts, Rhode Island, New Hampshire, Connecticut, and Vermont.

The ads from both sides feature nurses, which has created some confusion for the general public as they hear nurses telling them to vote both yes and no, depending on the ad. Both sides are in blitz advertising mode, and according to the Newburyport MA Daily News (September 11) supporters of Question 1, the Committee to Ensure Safe Patient Care, have raised more than $4.7 million as of Sept. 2 and the Coalition to Protect Patient Safety, which opposes the limits, has raised more than $7.2 million as of that date.



The law would also require hospitals to have patient acuity systems that meet specific guidelines and criteria and be certified by the state prior to implementation. This is an area AMS has helped its clients with for years as part of a sound management and staffing plan. You do not need a law for this.

The election is Tuesday November 6. If you cannot vote in person, be sure to submit an absentee ballot.

SAVE THE DATE: ACHE OF MASSACHUSETTS FALL CONFERENCE, NOVEMBER 1.

Disruptive Technology: Healthcare's Savior? is the conference theme featuring Michael Weissel, Executive Vice President, Optum, and Terri Bresenham, Chief Innovation Officer, GE Healthcare, as the keynote speakers. Panelists are Chris Coburn, Chief Innovation Officer, Partners HealthCare and President, Partners Healthcare International; Patricia Forts, Deputy Chief of Innovation and Strategy, Harvard Pilgrim Health Care; Iyah Romm, Founder and CEO, City Block; and Sarah Sossong, FACHE, Principal, Flare Capital Partners.

The conference will be held at DoubleTree by Hilton, Westborough, MA. For more information, visit www.massache.org/event.

Attached to the Biweekly is the Third Top 10 "Hot Button Issues" in HIM, *TRENDING NOW….* Outpatient Clinical Documentation Specialists (OCDS)

Dedicated to Excellence in Health Care Management

TOP 10 HOT BUTTON ISSUE #3:

Outpatient Clinical Documentation Program - DON'T GET LEFT BEHIND!

ARE YOU

MISSING THE BOAT?

TRENDING NOW….

Out Patient Clinical Documentation Specialists (OCDS)

- 40% increase in OCDS since 2016 (10% to 50%).

WHY OCDS?

- Continued growth in outpatient health care services (ensure proper documentation and coding for optimum reimbursement).
- Continued scrutiny of coding and documentation by third party payers.
- Outpatient reimbursement requires extensive knowledge of additional coding/billing methodologies (i.e. CPT-4, E/M, HCCs) not found in IP CDIS.

OUTPATIENT SERVICES THAT MAY BENEFIT MOST FROM OCDS

1. Emergency Department (E/M codes and documentation).
2. Ambulatory Clinics (Review of Local and National Coverage Determinations for medical necessity).
3. Observation.
4. Provider E/M code assignment and documentation.
5. Hierarchal Condition Categories (HCC-provider risk adjustment).

WHERE TO START?

ED DOCUMENTATION/CODING:

- The April (quarterly) Comprehensive Error Rate was 12.1%.
- 10.6% (of the 12.1%) errors were due to inaccurate E/M documentation/coding which resulted in lost revenue to hospitals.
- The OIG announced increased scrutiny of E/M claims in light of these findings.
- These findings are consistent with the 2017 Medicare Fee for Service Supplemental Report, which cited inaccurate E/M coding as the number one reason for Part B overpayments.

SPECIFIC FINDINGS

- Inadequate/incomplete documentation of service.
- Documentation does not support medical necessity of service.
- Improper billing (unauthorized provider or setting).

HOW CAN AMS HELP?

Our consultants have over 35 years' experience in coding/documentation. Their expertise includes auditing, training, interim management of coding services, implantation of coding/billing software and revenue integrity across all heath care spectrums.

OUR CONSULTANTS WILL

- Audit ED coding and documentation to determine risk pertinent to CERT ED findings.
- Audit/Analyze Outpatient Services to determine other services where OCDS may be beneficial.
- Recommendations for Implementation of OCDS.
- Education of pertinent staff (i.e. coders, nursing, providers) in OCDS.
- Perform OCDS services (daily) or on consultative basis to ensure documentation, coding and OCDS program compliant.

TO LEARN MORE PLEASE CONTACT:

- Jeanne Beando, JD, RHIA-Vice President (jbeando@aboutams.com)
- Lynn Mancini, JD, RHIA-General Counsel and Vice President (lmancini@aboutams.com)

Labor Benchmarking

How does your hospital measure up? Benchmarking provides the answers

AMS's hallmark service is labor benchmarking. Only by identifying a hospital's actual staffing levels and comparing it to our proprietary industry labor benchmark database can an institution confidently begin the process of optimizing productivity. We perform both hospital-wide and department-level benchmarks.

Typical initial savings identified is up to 10% of total labor expense

Immediate Benefits

- Identify, by department and cost center, staffing based on AMS work-function level benchmarks
- Identify departments with potential for productivity and operating system improvement
- Provide a focal point for senior management to discuss labor resource issues
- Establish a starting point for improvement efforts
- Assist with development of long-term labor strategies

Recent Results

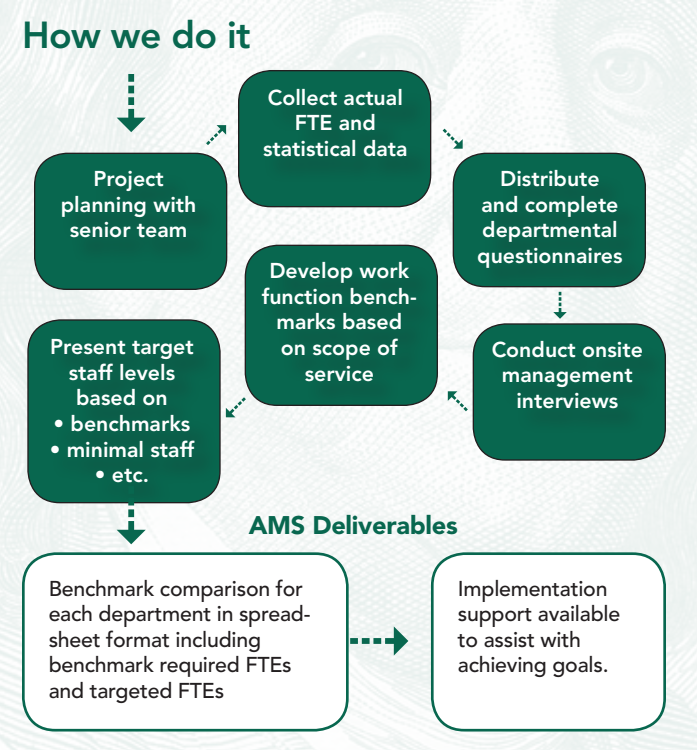
200-bed community hospital: AMS identified a labor improvement opportunity of 108 FTEs of the hospital's 1,250 FTEs. Eight outlier departments accounted for 50% of the opportunity.

3-hospital, 600-bed regional system: AMS identified areas with staffing opportunity equal to 3% (136 FTEs) of the system's 4,500 FTEs.

Critical access hospital: AMS identified an 8% staffing opportunity (48 FTEs) in a system of 600 FTEs comprised of a 25-bed acute care, 25-bed nursing home, 10-bed rehab unit, and support staff for physician practices.

Average ROI = more than 30 times

How we do it



The AMS Benchmarking Advantage

- Hospital-wide benchmarks compare your hospital/health system to similar institutions (size, type, and case mix) on a global basis.
- Department benchmarks are based upon a key volume indicator and paid hours per indicator for each department or area of the hospital.
- AMS's proprietary benchmarking database is based primarily on:
  - Actual studies AMS performs for its clients
  - Best practice targets developed by AMS content experts who specialize in all facets of health care.

Contact AMS: (800) 462-1685

Paul Camara, Principal - pcamara@aboutams.com
Donna Dillon, RN, Principal - dwdillon@aboutams.com
Michael Foley, Principal - mfoley@aboutams.com
Alan Goldberg, Principal - agoldberg@aboutams.com
Jennifer Schuster, RN, Principal - jschuster@aboutams.com