DESIR GROUP

WHAT DO YOU DO WHEN PATIENT OCCUPANCY ISN'T THE ISSUE AT ALL?

You dig a little deeper.
You find a solution.
You turn things around.

THE SITUATION

The 100+ year-old organization is one of the largest healthcare delivery systems in the state, a Level I trauma tertiary hospital with responsibility for over a million lives within its catchment area. It is located in a large metropolitan city bordering a number of states. The system had over 500 beds, with teaching responsibilities that include taking care of the impoverished/indigent of the community. It supported a large medical school with residencies in all medical and surgical disciplines.

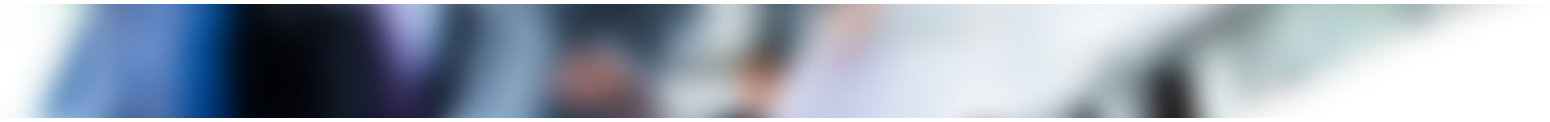
None of the surrounding states from which patients originated were paying for indigent care. Hence, the hospital was losing over $4M per year, exhausting its financial reserves to support daily operations. This hospital was also unionized with a large collective bargaining unit. Case mix of patient population was made up of 20% no pay, 60% Medicare/Medicaid and 20% private pay. The institution was averaging 85% occupancy rate, thus presenting fewer opportunities to increase occupancy and revenue to help improve the bottom line. This also made it tougher to reduce personnel costs. However, our team was able to improve efficiencies through significant reduction of overtime costs and contracted services, and we reduced supply and equipment costs by renegotiating vendor and maintenance contracts.

THERE WERE FOUR SIGNIFICANT JOINT COMMISSION (JC) DEFICIENCIES FROM THE MOST PREVIOUS JC VISIT, AND THE JC PLANNED TO REVISIT THEM WITHIN A YEAR:

1. Delinquent medical records (second time around)
2. Medical staff bylaws were too old or not followed
3. Deficiencies in HIPAA standards
4. Inadequate facilities for detoxification of substance abuse patients and proper evaluation of homeless patients

OUR ANALYSIS FOR HEALTHCARE OPERATIONS IMPROVEMENT

- Evaluated overall operations
- Assessed man hours per adjusted patient day
- Evaluated contracts with insurance companies and state Medicaid programs
- Evaluated days in receivable as well as days in payables
- Assisted with upgrading of the medical records systems and the IT system to accommodate the changes needed in the JC standards.
- Identified other sources of revenue to garner better reimbursement and improve bottom line
- Evaluated prior years' cost reports and reopened them where appropriate
- Assisted in seeking out new sources of capital



OTHER HOSPITALS IN THE COMMUNITY HAD CASE MIX INDEXES OF:

>50% COMMERCIAL PAY

<5% SELF PAY

<5% NO PAY

We also renegotiated insurance contracts and deductibles, and lobbied the bordering states to pay cost-based reimbursement for Medicaid. Our request was supported because our hospital accepted the preponderance of Medicaid and indigent patients. Neighboring hospitals did not want additional Medicaid patients, and did not want to see our hospital damaged or closed because they recognized our viability as important to the community. The originating state increased reimbursement but did not allow cost based reimbursement; the other surrounding states allowed cost-based reimbursement. Other hospitals in the community had case mix indexes of greater than 50% commercial pay, less than 5% self pay, and less than 5% no pay.

Additionally, we lobbied the neighboring hospitals, community leadership and legislative delegations of the surrounding states, which also helped lobby the state legislatures. The combined push resulted in passing of a bill with an annual allocation to our hospital, of $10M - $30M, based on volume of indigent patients.

STRATEGIC OUTCOMES

- Within 18 – 24 months realized costs reductions and improved operational efficiencies, eliminating the $4M deficit and yielding a $6M positive bottom line for a total of $10M swing, that included the reinstatement of the hospital's reserve funds.
- Reduced days in receivables from 90 to 40 and days in payables from 120 to 60 days.
- Corrected current and anticipate JC issues and subsequently received a "no deficiency" JC visit that led to a three-year accreditation – with accommodations.

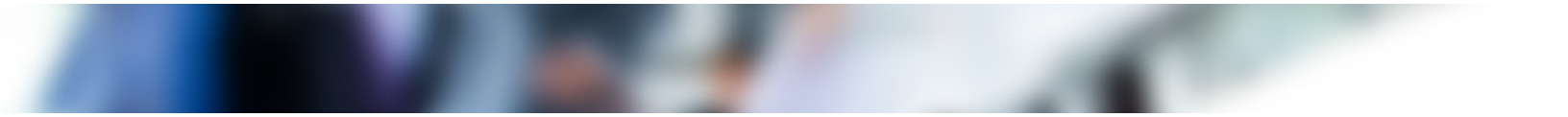
While most other organizations need to increase their occupancy rate and reduce cost, the issues here were different for us because of this hospital's high occupancy rate of uninsured and indigents patients. We leveraged the experience of the turnaround team to influence the relationship with the legislatures, a lesson for hospitals in large metropolitan areas, and achieved what the leadership of the previous 30 years could not. When signed into law, the indigent trauma bill guaranteed this hospital's mission to serve the community in perpetuity.

$4M

DEFICIT ELIMINATED WITHIN **18-24 MONTHS** YIELDING A

$6M

POSITIVE BOTTOM LINE



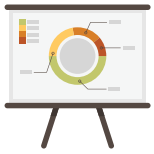
SOME OF THE OTHER GREAT RESULTS INCLUDED:

MEDICAL RECORDS DEFICIENCY

We approached and collaborated with the dean of the local school of medicine, as the residents and attending physician had majority of delinquent records. We also jointly approached chairs of the various clinical divisions and established new standards requiring all discharged summaries to be completed within 24 hours after discharge. After 48 hours, the physician's privileges would be suspended. Upon the next JC visit, there were no deficient records.

MANAGEMENT TURNOVER

Our management consulting firm replaced C-suite and middle-level executives, with the CEO leading the entire turnaround.

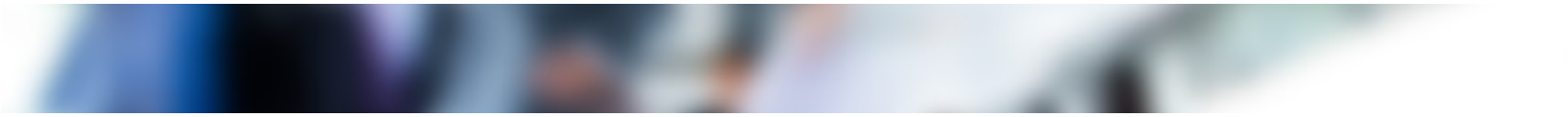


LEADERSHIP DEVELOPMENT AND WORKFORCE DEVELOPMENT

In preparation for the JC visit, our management consulting firm deployed our JC consulting team to assist in a comprehensive training program in JC standards, from front-line employees to the manager level.

STAFFING

We temporarily brought in qualified traveling nurses to help augment the shortages within the tertiary nursing ratios to meet JC standards.



A POLITICAL SOLUTION CHANGED EVERYTHING

Typically, hospitals seeking turnaround assistance are small 100-250-bed facilities suffering from low occupancy, poor or inadequate physician composition, old equipment and/or a poor patient mix, all of which present significant opportunities for cost reductions through improved operational efficiency, increased volume and improvement in revenue cycles.

By contrast, this case involved a large, tertiary care organization known for quality care and with all physician specialties represented. It had the right patient/nurse ratios and its man hour/patient day ratios were right on target. In order to identify solutions to improve bottom line, we had to dig deeper, going back years to examine the organization's historical context to better understand the root cause of the existing fiscal deficits.

Our in-depth analysis led to the discovery that the primary corrective actions required a political solution. We were successful whereas the previous leadership had failed in garnering the proper level of support from the surrounding state and legislative bodies to find a political solution.

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