University Medical Center Citizen Task Force Final Report and Recommendations

INTRODUCTION & EXECUTIVE SUMMARY

INTRODUCTION

At the request of the Board of County Commissioners and the County Manager, the University Medical Center (UMC) Citizen Task Force was created in January of 2003. The committee, whose members include representatives from gaming, business, banking, real estate, academia, health care, general labor, community-based health organizations and the law, was asked to assist UMC and County management with an operational review of UMC processes in order to develop a set of consensus-based recommendations for the Board of County Commissioners to consider as they develop future policy for UMC. The Task Force included:

William McBeath, Chairman
President & COO, The Mirage

Robert Forbuss
President, Strategic Alliance

Jeffrey Waddoups, Ph.D.
Associate Professor of Economics, University of Nevada–Las Vegas

William Martin
President & CEO, Nevada State Bank

Patricia Allen
President, Health Strategies, Inc.

Bobbette Bond
Participant Services Manager, Culinary Health Fund

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Owner, Tiberti-Blood Development

Otto Ravenholt, M.D.
Retired Chief Health Officer, Clark County Health Department

Reva Anderson, Ph.D.
Executive Director, SISTA to SISTA

Tony F. Sanchez III
Attorney, Jones Vargas
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Background

University Medical Center of Southern Nevada has served our community for 71 years. In addition to the numerous medical services and programs offered at the hospital, UMC is the state-designated Level I Trauma Center for Southern Nevada, houses the only HIV inpatient unit in Clark County, and is the State's only burn care facility. Additionally, UMC operates a comprehensive freestanding unit solely devoted to physical medicine and rehabilitation that serves as the primary clinical campus for the University of Nevada School of Medicine.

As the only public hospital in Southern Nevada, UMC is the community's medical safety net, treating the vast majority of uninsured patients. As we have seen throughout UMC's history, the fiscal health of the public hospital industry is tied to the buoyancy of the economy. Unreimbursed care costs have skyrocketed during tough economic times, as more uninsured people turn to UMC for care.

The decline of the nation's economy following the events of September 11th affected all of the services provided through local government. Some of those hardest hit were those in the health and social services arena. Locally, layoffs following this tragedy left thousands without jobs or insurance. It is estimated that for every worker laid off, 2.5 individuals lost insurance, creating higher service demands for UMC.

During fiscal year 2002 (July 2001 to June 2002) UMC saw a 28 percent increase in total self/no pay hospital patients, significantly changing the payor mix at UMC. This resulted in a $7.1 million increase in unreimbursed costs.

UMC's financial condition began to cause a direct and significant financial impact to the County. UMC sustained a $22 million operating loss in fiscal year 2002 and incurred a $13 million operating loss through October of 2002. As a result, at the December 17, 2002 Board of County Commissioners meeting, the Board approved an infusion of $38 million to offset the operating losses and to provide funds to reduce outstanding obligations to vendors. This infusion was in addition to the budgeted $30 million for indigent patient claims and $15 million for emergency room admittances paid by the County from specific tax sources for direct patient care services provided at UMC.

In addition to the ongoing cash flow support provided by the County, in December 2002 UMC implemented several cost saving measures including closing two Quick Care centers, reducing marketing costs, transport and pharmaceutical costs, and implementing a freeze on all non-clinical positions and staff travel. In early 2003, UMC implemented layoffs, staff position downgrades and the elimination of open positions including management, supervisory and employed physician positions. This strategic streamlining effort in staffing was aimed at providing an immediate impact on hospital expenses without negatively impacting quality care.

Further measures, however, were needed to address the financial problem, both from an operational and policy standpoint. The County could not afford to continue subsidizing UMC at a rate that jeopardized other critical County services.

Operationally, three consultant firms and the County's Audit Department reviewed several key areas of hospital operations, such as: inpatient and outpatient billing, the viability of UMC's Quick Care system and physicians' contracts (see additional information for a summary review of the consultants' report).

The reviews were a necessary initial step, but the Board of County Commissioners did not want to make decisions regarding UMC in a vacuum. UMC is the community's hospital and therefore the public needed to be involved in policy decisions that would shape the future of UMC.

The Citizen Task Force was a major component of a large public input effort that involved reaching out to a variety of stakeholder focus groups, receiving public comment and developing linkages with community physicians.

Individual stakeholder focus groups were conducted with UMC employees, health care providers, other area hospitals, community physicians, the indigent, the uninsured and Quick Care doctors. These informal round table discussions provided participants with information regarding the consultants' reports as well as gave them an opportunity to share input with the County Technical Team (please see additional information). This information was presented to the Citizen Task Force to incorporate into their discussions, evaluation and recommendation development.

In addition to the focus groups, public comment was solicited via the Internet and time was set aside at each Task Force meeting to receive comments and input. Additionally, the Task Force reserved their last official meeting as an opportunity to receive final public input on the approved recommendations.

As part of the public outreach process and comprehensive operational review, the County believed it was critical to enhance the level of communication and feedback between Clark County administration and the community of doctors affiliated with UMC. In order to do this, a Physician Advisory Group was established that provided input to the Technical Team and the Task Force on a wide range of topics. The information provided was extremely valuable, and the Physician Advisory Group has agreed to provide input and advice to the County and UMC administration on a continuing basis after the culmination of the Task Force.

A County Technical Team, comprised of various representatives from County administration, finance, and auditing departments, along with representatives from UMC, evaluated the results of the consultants' studies, coordinated stakeholder focus groups and presented information to Task Force members and the public on a variety of topics related to the financial viability of UMC. Throughout the course of the UMC Citizen Task Force meetings the Technical Team began working on the suggestions outlined in the consultant's reports. UMC administration developed both a short term and long-range strategic plan, drafted specific action steps/projects and began implementing these initiatives immediately in order to improve the efficiency and financial situation of the hospital.

The UMC Citizen Task Force was charged with evaluating all the information that was provided from the consultants' reviews, the stakeholder focus groups and public comment. Task Force members became educated on the key issues and challenges facing UMC and synthesized all of the information as they developed the set of consensus-based recommendations for the Board of County Commissioners.

Specifically, the UMC Citizen Task Force was asked to:

- Review input received from the Technical Team from the following sources:
  - Consultant Reviews
  - Stakeholder Focus Groups
  - Public Comment

- Evaluate both quantitative and qualitative information contained within submitted reports and presentations.

- Formulate recommendations on the following:
  - Mission for UMC
  - Vision for UMC
  - Programs and Services
  - Policy Items

EXECUTIVE SUMMARY

Conceptual Summary

Making decisions regarding the operational and fiscal capabilities of a public hospital is an exceedingly complex task. Access to care and financial responsibility to the taxpayers are concepts that are often thought of as diametrically opposed. The Task Force members made great efforts toward balancing these two issues in developing recommendations. It is important to note that Task Force participants believed that the issue of quality of care should not be sacrificed while undertaking measures to improve hospital efficiency.

In order to stay financially healthy, a hospital needs to promote a profitable mix of payers. Being the County's only public hospital, UMC has struggled to maintain this healthy payer mix because of an increasing demand for services by the uninsured. Following deliberations, the Task Force affirmed that addressing the issue of the uninsured was going to require the involvement of the entire community and UMC should not shoulder the majority of this burden.

Task Force efforts culminated in the idea that there is need for a paradigm shift regarding how UMC is perceived by the community and within the organization. As is the case with many public hospitals, UMC has been stereotyped as a "free hospital" or a "hospital of last resort." Implementing the recommendations set forth by the Task Force will assist UMC in becoming the "hospital of choice" by partnering with the entire community to provide accessible, quality health care while remaining fiscally responsible to the citizens.

During the tenure of the UMC Citizen Task Force, a variety of information was presented that focused on developing a common knowledge base among Task Force members. The Task Force developed twelve recommendations under the following five categories:

- Quick Cares
- The Indigent And Uninsured
- Operational Efficiency
- Operational Direction
- Associated Issues

Recommendation Summary

Below is a summary of the UMC Citizen Task Force recommendations, which encompass and reflect the synthesis of public input and information received over the last eight months. The consensus-based recommendations approved by the Task Force were made after extensive education, analysis and debate.

Quick Cares

Recommendation Area 1: Quick Care Primary Care Network Evaluation

- UMC should continue to operate a Quick Care and Primary Care Network.

- UMC should implement a comprehensive evaluation tool that evaluates quality of care, financial and social performance criteria.

- UMC should address underperforming Quick Cares/Primary Cares based on a comprehensive evaluation tool as deemed necessary. In the event the decision is made to close a Quick Care, UMC should examine all opportunities to work with a provider of Federally Qualified Health Clinics (FQHC) and other community health care providers so services are not taken out of the community, but are transferred from UMC control to the FQHC or other community health care provider.

- UMC should develop a clear business plan model (including market analysis using payor data) of Quick Care/Primary Care Network to clearly show health care quality, fiscal and social impact of any expansion, contraction or relocation of the Network, prior to implementation.

- UMC administration should develop and implement a pay for performance program for Quick Care Physicians.

Recommendation Area 2: Referral Process

- UMC should continue to address the suggestions of the Physicians' Advisory Group.

- UMC should continue to monitor the Quick Care Network physicians' compliance with the patient referral process.

Recommendation Area 3: EMTALA/Point of Service Policy

- The UMC Citizen Task Force should support the adoption of the new Point of Service policy for the Quick Care Network and the Emergency Department.

- UMC should evaluate the impact of the current Point of Service Policy and continue to monitor any federal actions regarding the interpretation of EMTALA to ensure compliance.

Recommendation Area 4: Payor Mix

- Maintain, enhance, or develop products, services and facilities designed to attract a favorable payor mix.

- Recognize that in a competitive marketplace, it is appropriate and incumbent upon UMC to compete for a favorable payor mix.

The Indigent and the Uninsured

Recommendation Area 5: Community Partnerships and the Uninsured

- In conjunction with Senate Bill 289, it is recommended that UMC request that the State of Nevada consider a variety of health care related issues during the Interim Study of the Uninsured.

- The Task Force recommends that UMC/County further study and analyze the following issues:

    - Income guidelines for indigency, updated on a regular basis
    - Lack of Mental Health Services
    - Malpractice Issue in relation to UMC
    - Creation of an insurance program for the working poor and uninsured
    - Develop partnerships to address gaps in healthcare (including aftercare)
    - Enhancement of Foundation/Fundraising
    - Exploration of Grant Opportunities to fund programming and services
    - Expansion of Eligibility Outreach
    - Consideration of tax increase to care for the uninsured
    - Maximization of UMC Medical School and expansion of Residency Program (constraints because of new legislation that limits resident's hours)
    - Consideration of a Debt Relief program for new physicians that will decrease student loans but require them to treat uninsured
    - Exploration of linking community health care service to a physician's business license (or provide discount)
    - Discounts for fast-pays paying cash just like insurance companies negotiate a reduced rate upfront for services.

- The Task Force recommends the development of partnerships with the following entities:

    - The Clark County Health District in order to increase access and preventative care
    - Not for Profit Entities in order to increase access and preventative care (i.e., Nevada Cancer Institute, Clinics on Wheels, CCHAC, FQHC)

- The Task Force recommends implementing a community-wide dialogue, including the active participation of other area hospitals, to evaluate and analyze community-wide collection standards, in order to develop a standard for collections.

Operational Efficiency

Recommendation Area 6: Product/Service Line Evaluation

The Task Force recommended that UMC should implement a comprehensive evaluation tool for each lower performing service line area that includes quality of care, financial and social performance criteria.

It is recommended that for each identified lower performing service line UMC Administration do the following:

- Identify and implement opportunities to increase reimbursement
- Identify and implement opportunities to shorten length of stay
- Identify and implement opportunities to manage resources within the length of stay
- In the event all opportunities have been exhausted and the product line continues to under-perform, examine the fit of the service at UMC, taking into account most importantly how many other facilities provide the service and whether the issue is primarily payor mix and unreimbursed cost. If so, evaluate whether UMC should better spend its limited resources elsewhere filling gaps not currently provided in the community.
- In addition to the analysis of the Product/Service Line Matrix, services should be evaluated within the context of their role in the community.

Recommendation Area 7: Information Services Financial Systems Strategy

- Proceed with the implementation of all of the recommendations in the UMC Information Management Short-Term Financial Strategic Plan, over the next year, and evaluate the financial effects of the execution of each component of the plan.

- Concurrent with the short-term plan execution, evaluate the results, and evaluate proceeding with the selection and implementation of a new UMC Hospital Information System, to specifically address a new Patient Accounting System for Patient Billing functions.

Operational Direction

Recommendation Area 8: Continued Public Participation

- The UMC Citizen Task Force should convene semiannually over the next two years to receive progress reports and assist in the evaluation of adopted recommendations.

Recommendation Area 9: Public Image

- UMC should address its image challenges through a sustained marketing and advertising program that provides for a tailored message to be effectively delivered on a consistent basis. The new marketing/advertising efforts will work

to enhance the hospital's existing public relations efforts by promoting the image of UMC as the "hospital of choice."

- UMC should develop an internal educational campaign for hospital employees, which empowers them to reach affected customers with the message that UMC is the "hospital of choice" comprised of a diverse payor mix.

Recommendation Area 10: Mission, Vision, Guiding Principles, Operating Structure

- Vision – Become the model community health care provider and hospital of choice.

- Mission – To provide leadership that ensures safe, high quality, accessible, comprehensive healthcare to our community and visitors while ensuring financial viability and social responsiveness.

- Guiding Principles – Medical Excellence, Responsible Business Practices, Social and Financial Accountability, Community Partnership, Inclusiveness

- Operating Structure – Current operating structure with efficiencies, Tertiary Regional Referral Full-Service Hospital

Associated Issues

Recommendation Area 11: Medical Malpractice

- The County and UMC administration should continue to work with the Physicians'
  Advisory Group in addressing the issue of Medical Malpractice as it relates to community physicians practicing at UMC.

Recommendation Area 12: Trauma System

- It is recommended that the Citizen Task Force request that the State of Nevada Department of Human Resources, Health Division, undertake a community-wide needs assessment of the trauma system and how expansion will affect the cost and quality of care throughout the Las Vegas Valley. The evaluation should focus on assessing the impact of a second trauma center on costs for health care, how other new facilities will affect care and the appropriate separation of facilities to promote the best trauma coverage.

Quick Care/Primary Care Network Evaluation

Issue

Historically, the Quick Care/Primary Care Network was developed using primarily a geographic coverage model. The introduction of EMTALA and the aftermath of 9/11 led to a sharp decrease in the profitability of the Network. At the end of FY02, the Network had a negative Direct Margin and prompted questions about its viability.

Discussion

At the March 18, 2003 UMC Citizen Task Force meeting the Clark County Audit Department provided an update on the consultant reports from the Lewin Group and Deloitte and Touche. Information was presented regarding the Quick Care/Primary Care Network from the Lewin Group Study and included a compensation analysis of UMC Quick Care/Primary Care physicians. The audit report showed that the compensation of UMC employed physicians exceeds national and regional norms. According to the Lewin report, the average salary (with retirement) of UMC Quick Care/Primary Care Physicians was $194,854 compared to a national benchmark average of $168,000.

At the May 20, 2003, Task Force meeting, the members began discussing the viability of the Quick Care/Primary Care Network. The discussion focused on two main issues:

Issue 1: Should UMC continue to operate a Quick Care/Primary Care Network ("Network")?

Presentations on this issue focused on the advantages and disadvantages (both financial and social) of eliminating the Network. Information included:

- UMC Quick Cares service over 400,000 urgent care visits per year, which offloads Community ERs and helps prevent hospitals from going into divert status.
- Extended hours of Quick Cares provide a service for community physicians for after-hours coverage.
- The Las Vegas Valley suffers from a primary care physician shortage; if the Network was eliminated the problem would be exacerbated.
- The Network provides access to the uninsured/underinsured. If the Network was eliminated there is no guarantee that the private sector would treat these patients.
- The Network is a significant contributor to a healthy payor mix for UMC. According to the Lewin Group and Clark County Audit, despite the Network's operational loss it provides a $14.7 to $19.3 million contribution margin for related hospital services.
- Elimination of the Network would limit or decrease UMC's ability to form relationships with physician specialists who admit insured patients and contribute to a healthy payor mix.
- Elimination of the Network would limit or decrease UMC's ability to form a primary care base among community physicians who admit insured patients and contribute to a healthy payor mix.
- Elimination of the Network would decrease UMC's attractiveness to managed care organizations' contracts.

- Elimination of the Network may provide opportunities to private sector providers.

Issue 2: If we continue to operate a Network, what criteria do we utilize to evaluate it?

In order to evaluate the Network for utility, productivity and performance, a request was made to establish specific criteria for evaluation. The Task Force identified two sets of criteria that should be developed: one for the Network as a whole and another for individual clinics. Additionally, it was requested that the evaluative criteria not be based solely on profitability measures but also include social responsibility indicators.

In developing the criteria UMC will be able to:

- Establish best practices
- Model behavior for a consistent delivery system
- Encourage systemic operational improvements
- Identify criteria an individual physician can use to improve his/her clinic
- Make decisions on future changes to the Network

Recommendations/Strategies for Implementation

At the June 17, 2003, UMC Task Force meeting, members made a motion to forward an operating model that includes the Quick Care/Primary Care Network. UMC Administration introduced a draft criteria matrix that incorporated the ideas and comments of the Task Force and Quick Care Doctors.

Following discussions, the UMC Task Force made the following recommendations for adoption:

1 . UMC should continue to operate a Quick Care and Primary Care Network.

2 . UMC should implement a comprehensive evaluation tool that evaluates quality of care, financial and social performance criteria (see attached example).

3 . UMC should address underperforming Quick Cares/Primary Cares based on a comprehensive evaluation tool as deemed necessary. In the event the decision is made to close a Quick Care, UMC should examine all opportunities to work with a provider of Federally Qualified Health Clinics (FQHC) and other community health care providers so services are not taken out of the community, but are transferred from UMC control to the FQHC or other community health care provider.

4 . UMC should develop a clear business plan model (including market analysis using payor data) of Quick Care/Primary Care Network to clearly show health care quality, fiscal and social impact of any expansion, contraction or relocation of the Network, prior to implementation.

5. UMC administration should develop and implement a pay for performance program for Quick Care Physicians (see attached example).

Attachments:
Example - Quick Care Network Criteria Matrix
Example - Individual Quick Care Matrix
Example – Pay for Performance Program

Referral Process

Issue

The referral of patients from the Quick Care Network and from local physicians helps to foster a healthy payor mix at UMC, which contributes to the financial success of the hospital. Historically, UMC's Quick Care Network has had a patient referral process that has resulted in mixed levels of success in recent years. As a result of the recent financial challenges at UMC, the patient referral process has been evaluated and was brought forth to the Task Force for their consideration.

Discussion

At the May 20, 2003, meeting of the UMC Task Force, a presentation on the referral process was given. Much of this presentation and the ensuing discussion focused on the information compiled at the Physicians' Advisory Group (PAG) meeting held on May 9, 2003.

Among the issues that were raised during the PAG meeting was the management of the processes by which Quick Care Network physicians refer patients to private physicians. The PAG suggested that UMC should:

- Conduct personal visits/phone contact with community doctors
- Create a system for physicians to utilize a blocked surgery schedule
- Enhance relationships with current UMC physicians
- Strengthen relationships with specialists
- Inform physicians on how the referral process works
- Shrink referral list
- Measure Quick Care Network compliance with the referral list

At the Task Force meeting, UMC noted that they had begun to address these suggestions and had been working with the Quick Care Network to ensure adherence to referral process policy.

Recommendations

1. **UMC should continue to address the suggestions of the Physicians' Advisory Group.**

2. **UMC should continue to monitor the Quick Care Network physicians' compliance with the patient referral process.**

EMTALA/Point of Service Policy

Issue

The Federal EMTALA statute was established to prevent hospitals from denying emergency care to patients based on financial status. Further, EMTALA outlines the procedures for gathering financial information from a patient in an emergency situation once a medical screening for an emergent condition has been conducted. The interpretation of these requirements has been a key point of discussion in relation to clients utilizing UMC Quick Cares in non-emergency situations.

In addressing the implementation of EMTALA regulations, UMC Administration adopted an initial Point of Service policy that has subsequently hampered its ability to collect the necessary payment information from Emergency Department and Quick Care patients.

Discussion

At the March 18, 2003, UMC Citizen Task Force meeting, a presentation was made regarding EMTALA regulations and UMC's current Point of Service policy and its proposed revisions to this policy.

Representatives from the District Attorney's Office offered a summary of their recent opinion relating to their interpretation of the EMTALA regulations (see attachment). As a result of this updated interpretation of the EMTALA regulations, UMC provided an overview presentation of the proposed revisions to its Point of Service policy.

The new Point of Service policy creates a process that will allow for UMC staff to collect insurance information, co-pays and/or payments from patients more efficiently. The policy also includes procedures for referral of non-emergent patients who cannot pay for medical treatment (see attached).

Recommendations

1. **The UMC Citizen Task Force supports the adoption of the new Point of Service policy for the Quick Care Network and the Emergency Department. SEE COMMENT**

2. **UMC should evaluate the impact of the current Point of Service Policy and continue to monitor any federal actions regarding the interpretation of EMTALA to ensure compliance.**

Comment

At the March 18, 2003, Task Force meeting, the Task Force took action to support the adoption of the new policy and refer it to the Board of County Commissioners for their consideration. With this in mind, the revised Point of Service policy was presented to and approved by the Board of County Commissioners at its April 1, 2003, meeting and has since been implemented by UMC. While this new policy has not been in place long, it appears that it is already starting to have a positive financial impact for the hospital.

Attachments:
District Attorney's Opinion
UMC Revised Point of Service Policy

Payor Mix

Issue

Maintaining a balance between insured and uninsured patients enables a hospital to sustain financial viability. If the payor mix is not balanced, and there are not enough insured patients to help offset the cost of caring for the uninsured and underinsured, the hospital will not be able to cover its costs unless subsidized. With this in mind, various services offered by UMC have been analyzed with respect to their ability to contribute to a healthy payor mix.

Discussion

Of the total inpatient acute beds available in the Las Vegas service area, three for-profit hospital corporations operate 71% of the beds in six separate facilities. A non-profit organization operates 10% of the beds in two separate facilities. University Medical Center operates the remaining 19% of the available beds.

Historically, UMC has treated a disproportionate share of the uninsured and underinsured patients, as compared to the market share of beds operated. Although UMC operates only 19% of the available beds, UMC treats approximately 50% of all uninsured or underinsured patients who seek hospital services in the Las Vegas service area.

Although there are programs such as the Medicaid Disproportionate Share Hospital (DSH) program that provide reimbursement relief for these patients, the funding for this and similar programs is limited and results in significant un-reimbursed costs incurred by UMC for providing services to these patients.

At the June 17, 2003, UMC Citizen Task Force meeting a presentation was given that described the impact that the Quick Care/Primary Care network has on UMC's operations. This presentation included a comparison of payor mix within services offered at UMC. It also provided data demonstrating a highly desirable, insured payor mix in the Quick Care/Primary Care Network. In addition, the presentation provided data that demonstrated a direct correlation between this highly desirable payor mix and the potential for maintaining ongoing fiscal stability for UMC.

Upon review and discussion, the Citizen Task Force recognized how important it is to make operational decisions with special attention focused on maintaining a healthy payor mix. They also recognized that the Quick Care/Primary Care Network provides a positive, desirable contribution toward the overall payor mix of UMC.

Recommendations

To minimize the fiscal impact on taxpayers and continue to provide a range of services that meet the community's needs, UMC should:

1. **Maintain, enhance, or develop products, services and facilities designed to attract a favorable payor mix.**

2. **Recognize that in a competitive marketplace, it is appropriate and incumbent upon UMC to compete for a favorable payor mix.**

Community Partnerships and the Uninsured

Issue

In fiscal year 2001-02 UMC provided $46.5 million in charity care. Charity care costs include individuals who are not indigent but rather uninsured or underinsured with little ability to pay for their health care needs. Addressing this unreimbursed charity care is pivotal in order for UMC to adequately address their financial challenges.

Discussion

At the May 20, 2003, UMC Citizen Task Force meeting, members received information regarding the uninsured in Clark County.

A representative from the Great Basin Primary Care Association shared with the Task Force the following information:

- 15.9% of the population of Clark County has no form of health insurance.
- Firms that offer health benefits are declining, and high co-payments are decreasing employee participation.
- Small firms are less likely to offer health insurance benefits, and Nevada has a high proportion of small firms.
- As co-pay requirements and premiums increase, more families are unable to afford full health insurance coverage.

Staff conducted brainstorming sessions with the Physician Advisory Group as well as researched possible avenues and opportunities that might be available to address the issues of the uninsured and underinsured. These ideas were presented to the Task Force at the July 29, 2003, meeting.

Task Force members suggested that the following community partners should be invited to the table to address this issue:

- Physicians
- Health Care Providers
- UMC
- Other Area Hospitals
- Businesses/Employers
- State of Nevada
- Not for Profits
- Citizens
- Faith Based Organizations
- Federal Government
- County
- Other Municipalities
- Unions
- Insurance Companies
- Tribal Communities

- School District

Task Force members offered input and suggestions on the array of options presented, and suggested that the items be broken down in four separate recommendation categories:

- Items to recommend for inclusion in the Senate Bill 289 Interim Study
- Items that UMC and the County should further study and analyze
- Items that UMC and the County should enhance or for which partnerships should be developed
- Items that create an opportunity for Community Dialogue and Program Development

Recommendations

1. In conjunction with Senate Bill 289, it is recommended that UMC request that the State of Nevada consider a variety of health care related issues during the Interim Study of the Uninsured (please see attachment for examples).

2. The Task Force recommends that UMC/County further study and analyze the following issues:

- Income guidelines for indigency, updated on a regular basis
- Lack of Mental Health Services
- Malpractice Issue in relation to UMC
- Creation of an insurance program for the working poor and uninsured
- Develop partnerships to address gaps in healthcare (including aftercare)
- Enhancement of Foundation/Fundraising
- Exploration of Grant Opportunities to fund programming and services
- Expansion of Eligibility Outreach
- Consideration of tax increase to care for the uninsured
- Maximization of UMC Medical School and expansion of Residency Program (constraints because of new legislation that limits resident's hours)
- Consideration of a Debt Relief program for new physicians that will decrease student loans but require them to treat uninsured
- Exploration of linking community health care service to a physician's business license (or provide discount)
- Discounts for fast-pays paying cash just like insurance companies negotiate a reduced rate upfront for services.

3 . **The Task Force recommends the development of partnerships with the following entities:**

- The Clark County Health District in order to increase access and preventative care
- Not for Profit Entities in order to increase access and preventative care (i.e., Nevada Cancer Institute, Clinics on Wheels, CCHAC, FQHC)

4 . **The Task Force recommends implementing a community-wide dialogue, including the active participation of other area hospitals, to evaluate and analyze community-wide collection standards, in order to develop a standard for collections.**

Product/Service Line Evaluation

Issue

Based upon UMC's Direct Margin, service lines below the hospital average were separated and identified as areas for improvement. A model was built that takes into account both the financial and social impact of the lower performing service lines.

Discussion

At the August 12, 2003, UMC Task Force Meeting, the Task Force received a presentation on UMC's Product Lines and Services.

Information was received on service lines that currently fall below the average. These services are as follows:

- Burn Care
- Transplant
- OB
- Cardiology
- Oncology
- Med/Surg
- Orthopedics

Each of these service lines was built into the attached grid that identified Direct Margin, FY 02 loss in total and per case basis, number of providers, payor mix, cost drivers, Average Length of Stay (ALOS), and other services requiring the service line as a complement.

- Of the lower performing service lines, only two are not tied to other services and stand alone, Transplant and Oncology.
- Orthopedics and Burn are tied to trauma services; OB, Cardiac, and Med/Surg are essentially core service lines.
- On a per-case basis, Med/Surg is under breakeven by $198, and OB is under by $173.
- Oncology had a loss and is under breakeven by $1,190 per case, while transplant lost $3,380 per case.

Recommendations/Strategies for Implementation

The Task Force recommended that UMC should implement a comprehensive evaluation tool for each lower performing service line area that includes quality of care, financial and social performance criteria.

1. **It is recommended that for each identified lower performing service line UMC Administration do the following:**

    - **Identify and implement opportunities to increase reimbursement**
    - **Identify and implement opportunities to shorten length of stay**

- **Identify and implement opportunities to manage resources within the length of stay**
- **In the event all opportunities have been exhausted and the product line continues to under-perform, examine the fit of the service at UMC, taking into account most importantly how many other facilities provide the service and whether the issue is primarily payor mix and unreimbursed cost. If so, evaluate whether UMC should better spend its limited resources elsewhere filling gaps not currently provided in the community.**
- **In addition services should be evaluated within the context of their role in the community.**

Attachment
EXAMPLE – Product/Service Line Matrix

UMC Information Services Financial Systems Strategy Evaluation

Issue

As established by the Deloitte and Touche Revenue Cycle Process Review Report, UMC's current Billing System is out-dated, over-stressed, and over-customized, making it difficult to process bills in a timely or efficient manner, which causes problems with revenue and collections. Instead of spending $15 – $20 million to purchase a new system now, and taking 3 – 4 years to implement it, it was deemed fiscally prudent to develop a short-term plan of 1 year, to address immediate deficiencies in the system for approximately $2 million in capital costs. This could potentially generate enough efficiency in the revenue cycle that UMC would be able to fund a new system, when required, instead of obtaining the funding from Clark County.

Discussion

At the August 12, 2003, Task Force Meeting, the members began discussing the challenges that UMC is having with its automated billing system. The discussion focused on the following issue:

Issue 1: What is the best strategy for upgrading our computer system and financial applications?

A presentation was made that reviewed the UMC Information Management Long-Term Strategic Plan, and focused on the specific recommendations for a Short-Term Financial Strategic Plan, to address specific problems in the current Siemens MedSeries4 Patient Accounting applications for Patient Billing and Accounts Receivable functions. Specific recommendations included:

- Negotiate and implement a short-term two-year application software support agreement with Siemens for the MedSeries4 billing system software. This will limit the UMC liability if a satisfactory solution cannot be achieved with the current billing system software. The projected timeframe was completed in May 2003, and the projected operating cost was $240,000 annually for two years.

- Evaluate, plan and implement a remote bill printing function in the business office to replace the regular bill printing process, which resided in the UMC Computer Center. This was done through the existing network and multi-function Xerox Units, and was designed to provide more timely control of the billing and claims processing functions within the Business Office. The projected timeframe was completed in July 2003, and the projected operating cost was $40,000.

- Evaluate, plan and implement an upgrade to our current MedSeries4 billing application for the Automated Collections and Tracking System (ACTS) software to correct certain operational deficiencies in the system and allow it to be used productively by UMC Finance. The projected timeframe for completion is August 2003, and the projected operating cost is $10,000.

- Evaluate, plan and implement the Managed Care Contract Management System from McKessonHBOC to include contract payment monitoring and analysis, and contract modeling for managed care contracts. This system will allow more proactive evaluation of compliance by managed care organizations with negotiated contracts. The projected timeframe for completion is August 2003, and the cost is covered in the previous FY capital budget.

- Evaluate, plan, and implement a two-year interim hardware upgrade to our AS/400 Processor, which will allow us the system capacity to make the required billing application software upgrades, and the capacity to run our current billing application workload in a more timely manner. This will limit the UMC liability of a long-term hardware acquisition. The projected timeframe for completion is September 2003, and the projected capital cost is $980,000.

- Evaluate, plan and execute HIPAA compliance remediation projects with major financial application software vendors for compliance with electronic transaction standards, which require specific transaction data formats and code sets. This includes upgrading and testing the MedSeries4 Patient Accounting applications for HIPAA transaction formats and EDI code sets. The projected timeframe for completion is October 2003, and the cost is covered in the previous FY capital budget.

- Evaluate, plan and implement an interim Document Imaging and Coding System to improve the efficiency of the revenue cycle workflow, patient financial coding, and medical chart document management through the short-term contracting of an Internet Web Coding and Document Scanning and Storage System. The projected timeframe for completion is November 2003, and the projected net capital cost is $382,000.

- Evaluate, plan and implement three projected system software upgrades to the current MedSeries4 billing system software, which will allow us to convert to more efficient application processes, achieve workflow improvements and processing efficiencies, and be compliant with the new HIPAA Transactions and Code Sets Regulations. The projected timeframe for completion is December 2003, and the projected operating cost is $55,000.

- Evaluate, plan and implement the Financial Decision Support System from McKessonHBOC to include revenue analysis, flexible budgeting, and revenue management functions to enable more timely evaluation of financial trends and financial management alternatives. The projected timeframe for completion is December 2003, and the cost is covered in the previous FY capital budget.

- Evaluate, acquire and implement a Physician Practice Management and Outpatient Billing System with an integrated scheduling system for all the hospital outpatient clinics and Quick Cares. This system would allow the transfer of all outpatients billing, receivables, and collection functions from the MedSeries4 system, thereby streamlining the processing of the current system. The projected timeframe for completion is March 2004, and the projected capital cost is $650,000.

- Evaluate, plan and implement the restructuring of the MedSeries4 application functions to focus on the inpatient billing and receivables functions, through the removal of customizations to approximately 1500 application programs, which would significantly improve the efficiency of the processing of the current system workload. The projected timeframe for completion is May 2004, and the projected operating cost is $95,000.

- Continue involvement in Clark County Integrated Financials and Enterprise Resource Planning (ERP) systems project to evaluate UMC General Financial and Human Resource Systems to replace General Ledger, Accounts Payable, Materials Management, Payroll, and Personnel Management Systems. The projected timeframe for completion is FY 2005-2006.

Recommendation/Strategies for Implementation

On August 12, 2003, at the UMC Task Force Meeting, a motion was made after extensive discussion of the pros and cons of each recommendation, that the staff take the following actions:

1. **Proceed with the implementation of all of the recommendations in the UMC Information Management Short-Term Financial Strategic Plan, over the next year, and evaluate the financial effects of the execution of each component of the plan.**

2. **Concurrent with the short-term plan execution, evaluate the results, and evaluate proceeding with the selection and implementation of a new UMC Hospital Information System, to specifically address a new Patient Accounting System for Patient Billing functions.**

Continued Public Participation

Issue

The initial purpose of convening the UMC Citizen Task Force was to provide a forum for community involvement in discussions and decisions regarding the only public hospital in Clark County. The Task Force has provided guidance to UMC and County Management on a number of items over the past eight months. During the discussions of the Task Force, a desire evolved to continue the relationship between the public via this Task Force working with University Medical Center and Board of County Commissioners.

Discussion

The UMC Citizen Task Force has spent many months gaining knowledge regarding the operations of hospitals, particularly public hospitals and in particular UMC. The Task Force members came to the Task Force with a variety of educational and experiential backgrounds, and now have a common knowledge base regarding UMC. The combination of these experiences, education and knowledge has provided the basis for sound guidance, recommendations and advice.

As a result of recommendations made by the Task Force, UMC has implemented a variety of measures to improve hospital operations. Some of these efforts are demonstrating early positive effects. The Task Force members realize that time is needed before evaluation of these efforts can be completed. The members voiced a desire to help ensure that UMC stays on track via continued participation on some level.

At the July15, 2003, Task Force meeting, the members suggested providing an avenue for ongoing community involvement via continued citizens' participation in review, discussions and decisions regarding UMC. It was suggested that the Task Force take on this responsibility given that they have had the benefit of many months of education regarding the social and financial aspects of UMC.

Recommendations:

1. **The UMC Citizen Task Force should convene semiannually over the next two years to receive progress reports and assist in the evaluation of adopted recommendations. Issues of particular interest include:**

    - **Quick Care criteria evaluation**
    - **Quick Care Network criteria evaluation**
    - **Product line evaluation**
    - **Social obligations of the hospital**
    - **Future opportunities for expansion**
    - **Opportunities for revenue and positive payer mix**
    - **Information Technology improvements**

Public Image

Issue

County hospitals around the nation, including University Medical Center, face an ongoing image challenge – a stereotype that they are the hospital of last resort because of their responsibility to care for indigent patients. This prejudicial label often includes the misperception that county hospitals provide substandard care.

If UMC is to be successful at attracting more insured patients and promoting a payer mix that is fiscally advantageous to the hospital, its image must be dramatically improved and maintained.

Discussion

Throughout the various discussions that took place during the Task Force meetings, the issue of UMC's public image arose numerous times. These discussions focused on clarifying UMC's mission, providing the public with greater information about the hospital's responsibilities and services, and fostering a positive image. Key among the Task Force concerns is achieving and maintaining a profitable payor mix, helping to ensure the hospital's fiscal stability and its ability to provide access to care.

The following points were made by Task Force members:

- Improving UMC's image in the community and attracting insured patients to its services is essential to the hospital's fiscal well being.

- UMC's communication efforts should strive to address misconceptions about the hospital, including any community misperception that it provides other than top-notch medical care and that it is a "free" hospital or only treats indigent patients.

- UMC should increase its communication efforts in the areas of public relations, marketing and advertising to provide information to the community about the specialized and unique services the hospital provides for our community.

- UMC should develop and implement a multi-media advertising campaign aimed at improving the hospital's image in the community as part of the hospital's efforts to improve the public's perception.

Recommendations:

1. **UMC should address its image challenges through a sustained marketing and advertising program that provides for a tailored message to be effectively delivered on a consistent basis. The new marketing/advertising efforts will work to enhance the hospital's existing public relations efforts by promoting the image of UMC as the "hospital of choice."**

2. **UMC should develop an internal educational campaign for hospital employees, which empowers them to reach affected customers with the message that UMC is the "hospital of choice" comprised of a diverse payor mix.**

Mission, Vision, Guiding Principles and Operating Structure

Issue

The UMC Citizen Task Force was asked to look at the hospital's current programming and service levels as well as investigate a variety of alternative operational scenarios. This evaluation was done in order to ascertain what services should be offered to the community in a fiscally responsible manner.

The Task Force was also asked to develop and recommend a UMC Vision and Mission Statement for the Board of County Commissioners to consider adopting. These statements along with the recommended operating structure will assist in establishing a framework for guiding the future UMC.

Discussion

Over several meetings of the UMC Citizen Task Force, presentations were made regarding the operational mission of UMC. In terms of operational structure the Task Force was presented with the following seven choices:

- Option 1 – No County Hospital: payment to providers for indigent up to available funds based on established tax rate
- Option 2 – Indigent Only Hospital: no emergency department, inpatients by referral only after qualified for indigent assistance
- Option 3 - Community Hospital: an emergency department and minimal outpatient services
- Option 4 – Tertiary Hospital: specialty ICU's, surgical services and provision of complex care
- Option 5 – Tertiary Regional Referral Hospital: specialized services such as trauma, burn, organ transplant, specialized pediatric services to a greater geographic area
- Option 6 – Current Operating Structure: tertiary regional referral hospital with a network of community clinics providing primary, specialty and urgent care
- Option 7 – Current Operating Structure With Additional Services: increased programming provided to extend spectrum of care, possibly the creation of an integrated delivery network that may include services such as a long-term care facility, a skilled nursing facility

Factors considered in choosing an operating option included payor mix and access to care. Information was presented that illustrated the fact that as the services UMC provides become more complex and specialized, the operating costs rise; however, opportunities increase for garnering a more profitable payor mix. Access to care for the

uninsured becomes more limited if the operating structure does not allow for the provision of services.

The Task Force, after some discussion, narrowed their focus to Operating Options 5, 6 and 7. UMC presented information on how each of those options contributed to a healthy payor mix. Option 5, which is the current operating status without the Quick Care/Primary Care Network, was shown to have a negative effect on payor mix. Option 7 presents opportunities for expansion and development that may benefit the payor mix, but considering the current financial climate this option was not chosen.

The Task Force chose Option 6 but emphasized that this operating structure should take into consideration efficiency recommendations made by the Task Force including; Quick Care Network Evaluation, EMTALA/Point of Service Policy, Product Line, Referral Process and Information Technology Improvements. Comments regarding the selection of this option focused on maintaining a healthy payor mix at UMC in order to remain financially viable.

The discussions regarding operating structure combined with input received throughout the tenure of the Task Force brought to the forefront many ideas that were utilized to compose draft statements for UMC's Vision, Mission and Guiding Principles. These ideas included:

- Payor Mix
- Profitability and Competition
- Financial Viability
- Accountability
- "Not trying to be all things to all people"
- Access
- Social Responsibility
- Community Partnership
- The County's Responsibility to Provide Indigent Care
- Quality Health Care
- Evaluative Criteria and Benchmarking for Hospital Programming
- "Hospital of Choice" instead of "Hospital of Last Resort"

On August 28, 2003, the UMC Citizen Task Force considered the draft Vision, Mission, Guiding Principles and Operating Structure. There was some discussion over whether the Task Force should be recommending a Mission and Vision for UMC, and members questioned if it was in their scope of responsibility. After reviewing the purpose document for the Task Force and obtaining feedback from the entire group, the Task Force decided to proceed and began fine-tuning the draft statements. The final document the Task Force developed is included in the recommendation.

Recommendation

At the August 28, 2003, UMC Citizen Task Force Meeting, the Task Force recommended and adopted the following as their Mission, Vision, Guiding Principles and Operating Structure statements:

Vision

Become the model community health care provider and hospital of choice.

Mission

To provide leadership that ensures safe, high quality, accessible, comprehensive healthcare to our community and visitors while ensuring financial viability and social responsiveness.

Guiding Principles

Medical Excellence

Leading the community in the delivery of high quality health care while supporting necessary medical research and education.

Responsible Business Practices

Creatively formulate and implement new concepts, approaches and methodologies in providing medical care to maintain a profitable payer mix and generate enough revenue to cover operating expenses and remain financially viable.

Social and Financial Accountability

- Fulfill the County's obligation to medically treat the indigent.
- Provide medical assistance to the uninsured and underinsured to the extent of our financial ability, making us fiscally accountable to tax payers.
- Utilize both social and financial criteria to evaluate hospital services.
- Protect unique community medical services.

Community Partnership

Provide leadership in addressing the needs of the underserved by actively pursuing partnerships with the entire community, both public and private, in order to encourage the development of programs and services to address the medical needs of the indigent, uninsured and underinsured.

Inclusiveness – with the Community and our Employees

Including the community and employees in the decision-making process to find solutions and identify opportunities.

OPERATING STRUCTURE

Current operating structure with efficiencies

Tertiary Regional Referral Full-Service Hospital
Including:

Emergency Room
Specialty ICUs
Surgical Services
Inpatient and Outpatient Services
Specialty Services (i.e. Trauma and Burn)
Community clinic network providing primary, specialty, and urgent care.

Medical Malpractice

Issue

The escalating cost of obtaining medical malpractice insurance is a significant concern among physicians nationwide. Community physicians practicing at UMC also are feeling the effects of this cost increase, which is complicated further by the County's sovereign immunity, which places a cap on liability.

Discussion

At the UMC Citizen Task Force meeting held on August 28, 2003, Dr. Jerry Cade gave a presentation on the malpractice issue. Much of this presentation and the ensuing discussion focused on the information compiled at the Physicians' Advisory Group (PAG) meeting held on August 8, 2003.

The presentation detailed the issue of the County's sovereign immunity in relation to UMC. If a malpractice suit is filed against UMC its liability is capped at $50,000. Due to Joint and Several Liability laws in Nevada, the County's sovereign immunity has the unintended effect of making community physicians the "deep pockets" in any medical malpractice litigation that may arise involving physicians practicing at UMC.

The PAG suggested that the UMC Task Force should:

- Recommend the development of a Malpractice Working Group
- Support the Initiative Petition

The Task Force thought the Medical Malpractice issue was important and needed to be addressed. Task Force members commented that retention of Community Physicians is essential in bringing insured patients into the hospital. If the malpractice issue does not get resolved it could have a negative effect on the hospital's payor mix.

The Task Force had some reservations about making specific recommendations regarding malpractice, commenting that it may be beyond the Task Force's scope. Further, it was suggested that the Physicians' Advisory Group might be the more appropriate venue for leadership on this issue.

Recommendation

1. The County and UMC administration should continue to work with the Physicians' Advisory Group in addressing the issue of Medical Malpractice as it relates to community physicians practicing at UM

Trauma System

Issue

UMC operates the only level one Trauma Center in Clark County. As the population of the Valley increases there has been interest by other area hospitals in exploring the development of offering trauma services. Due to the fact that trauma services and the infrastructure needed to support them are very costly, an overlap in service area is concerning. Additionally, a second trauma center in the same geographic area would not best serve the expanding community.

Discussion

At the September 16, 2003 UMC Citizen Task Force meeting Dr. Fildes presented the following information on the development of a trauma system in Clark County:

- A Trauma Center is a hospital that provides acute care for severely injured patients.
- UMC is currently the only freestanding trauma center in the western USA
- A Trauma System is an organized system encompassing all phases of care from pre-hospital through acute care and rehabilitation.
- All hospitals that are not trauma centers will participate in the trauma system by caring for patients with mild to moderate injuries.
- The general rule is that a trauma center should service an area that can be accessed by vehicle in less than 30 minutes.
- Clark County's population is increasing rapidly and there may be a need for another trauma center, but it should be planned and built in a way that makes sense for the community and not for competitiveness.
- If another trauma center is built it should not be within the 30-minute access area of the current Trauma Center at UMC.
- The framework of an ideal trauma system as described in NRS and Nevada Administrative Code 450B.772 should be tiered, contiguous, free of duplication and developed though a public planning process.
- Trauma Centers must be added to a Trauma System the same way that new Fire Stations are added to the community.
- This is a public health issue that must be addressed through a public process.

Recommendation

1 . It is recommended that the Citizen Task Force request that the State of Nevada Department of Human Resources, Health Division, undertake a community-wide needs assessment of the trauma system and how expansion will affect the cost and quality of care throughout the Las Vegas Valley. The evaluation should focus on assessing the impact of a second trauma center on costs for health care, how other new facilities will affect care and the appropriate separation of facilities to promote the best trauma coverage.