How to Use Benchmarks and Metrics to maintain Quality and Margins

Andrea Devoti, MSN, MBA, CHCE, President & CEO
Neighborhood Health Agencies
&
David Berman, CPA, CVA, Principal
Simione Healthcare Consultants

What is Benchmarking?

- **Benchmarking** is the process of comparing one's business processes and performance metrics to industry bests or best practices from other companies. Dimensions typically measured are quality, time and cost.

- Wikipedia
Why do I care?

- Strategic measurement used to compare business practices within the industry – no matter what that industry does
- Must be careful you are measuring the exact same way as the benchmark to be valid
- Make sure your definitions are the same as the outcome

Neighborhood’s use of Benchmarks

- Always had used a number for case managers, both home care and hospice
- Also had a targeted number of visits per day
- Began looking for a way to compare to our state and regional competitors
- Small groups within the same area had meetings and shared data
Why compare regionally?

- Important to compare like demographics, geography, MSA, economy, and business types.
  - Drive time – mileage and travel time
  - Patient acuity effects time in the home
  - Insurance mix effects time in the home
  - Ability to get supplies and medications timely
  - Communication to prevent visits in error

State Benchmarking

- Started with our state association to participate in a vendor driven benchmarking software May 2011
- Compared all of the business drivers that my board asked for, and the clinical measures my managers needed
- Downloaded data from our systems
How do we use it?

- Cost per visit comparison, and root cause analysis
- Visits per day per discipline – productivity, but analyze beyond the stated norm for your area
  - What part of your territory is easier or harder to traverse?
  - Hospice versus home care
  - Palliative care versus home care

Management Tool

- Review numbers per pay period with managers and look for patterns
- Equate cost per visit with number of visits to see what is lost revenue for poor productivity per clinician
- Use patient satisfaction comments regarding numbers of staff
- Use quality improvement audits about numbers of staff is cases, missed visits and supervision visits for PTA, OTA and CNA
What do managers need to look at?

- Individual clinician productivity
- Team productivity
- Overtime
- Numbers of admissions
- Mileage
- Amount of travel time
- Amount of documentation time

What do I need to look at?

- Overall productivity
- Overall costs per visit per discipline
- Supply costs
- DSO
- Revenue and income
- Overtime and mileage
- EBITDA
- Volume and growth
What do we share with the System C-Suite and Board

Pretty much everything I look at, but at a level higher

Remember

- Be realistic
- Know things fluctuate
- Be able to explain those fluctuations
- Be honest with yourself and your staff
- Find ways to make change easier for them
The Data

► What metrics should you look at that drive both quality and financial results?
► Why are the metrics important?
► How do you present the information in a meaningful way?

The Data

► Metrics tell the story of not just financial performance, but quality and patient care
► The simplest metrics are sometimes overlooked
► Comparison to peers is important to give perspective to your performance
The Data

- LUPA
- Therapy Downcode
- Conversation Rate
- Visits/Patient
- Visits/Day(hospice)
- Ancillary Cost/Day(hospice)
- ALOS

The obvious:
- LUPA episodes generally lose money but are unavoidable at times

The Benchmark
- 11.2%

The Quality Impact
- How many were avoidable?
- Why did we miss visits
LUPA

- How to address the issue:
  - Ordered vs. Actual
  - QI review of all LUPA's
  - Upfront process to avoid the avoidable

Therapy Downcodes

- The obvious:
  - Doing less therapy visits than anticipated and/or order can have a negative financial impact

- The benchmark:
  - 22% of total episodes

- The quality impact
  - Why did we not meet our expected results?
  - Providing fewer visits than needed/ordered can have a direct result on outcomes
Therapy Downcodes

- How to address the issue:
  - Team approach (don’t just talk with PT manager)
  - Overall agency productivity
  - Managing census growth

Conversion Rate

- The Obvious:
  - Admissions = Revenue
  - Note….admissions not referrals
- The Benchmark
  - 81%
- The Quality Impact
  - Time from referral to admission
  - Effective on utilization
Conversion Rate

- How to address the issue
  - Roadblocks to admissions
  - Mystery calls
  - Technology

Visits/Patient

- The Obvious
  - Over or under utilization can effect quality of care
  - Visits = Cost
  - Visits = Revenue
- The benchmark
  - 12 for Medicare 8.2 for Commercial
Visits/Patient

- The Quality Impact
  - Lower utilization, particularly with similar case weight needs should be reviewed by QI
  - When broken down further, by discipline, is there a service not provided that should be
- How to address the issue:
  - Pull sample of records
  - Look at process for scheduling multiple disciplines
  - Look at authorization process

Visits/Day (hospice)

- The obvious
  - Visits = Cost in hospice
  - Visits typically are longer in hospice than homecare
- The benchmark
  - .73 Visits/Day (routine)
- The Quality Impact
  - Are we meeting patient needs
  - Is the care provided meet our standards
Visits/Day (hospice)

- How to address the issue
  - Productivity
  - Manage Case loads
  - Share data by clinician

Ancillary Cost/Day (hospice)

- The Obvious
  - After payroll related, supplies and ancillaries are the largest expense
  - Part D increased expense
- The benchmark
  - $20/Day (routine)
- The quality impact
  - Because drugs and other ancillaries are part of the bundled payment, hospice must provide what the patient needs
Ancillary Cost/Day (hospice)

- How to address the issue
  - Contracts
  - Continually provide the data to the hospice manager
  - Evaluate both positive and negative variances to benchmark
  - Budget

Other Financial/Quality Benchmarks

- ALOS (hospice)
  - 48
- Amount spent on quality and clinical supervision
  - 9.2% of revenue
- Home health supply cost per ADC
  - $29.95
- Amount spent on HR/Recruiting/Education
  - .4% of revenue
Last Thought

- Quality, clinical outcomes and financial outcomes are a team effort and you will struggle to succeed if your entire team is not working toward the same goals.

Questions?

Andrea Devoti  adevoti@nvnacc.com

David Berman  dberman@simione.com