The news headlines today are filled with stories about struggling hospitals. Half of the nation’s hospitals are in the red, and many hospitals have laid off personnel, cut services, or closed entirely. While it is unclear if the economic recession has bottomed out, it is likely that most of 2009 will be characterized by softer volumes and suppressed revenue streams.

Here are the top ten practical turnaround strategies that executive teams and front-line managers can implement to influence volume, revenue, and expense to increase income generation.

1. **Invest in physician relations.** Adopt the adage that physician loyalty must be won daily. As layoffs mount and Americans feel the economic pinch, more patients are unable to afford care or are electing to self-ration or defer care. The softening of volume is being compounded by trends in physician employment which are leading to an increasingly captive referral base. Invest resources in physician liaisons and referral tracking mechanisms for independent physicians. Respond to physician needs and perspectives. Manage physician referral relationships with a “Fortune 500 sales force mentality” by implementing simple, yet relatively inexpensive, customer relationship management (CRM) software with the physician relations team.

2. **Address out-of-network referrals.** Entrenched referral patterns are difficult to change even when physicians are employed. However, armed with information about referrals, trends can be observed regarding primary care physicians, specialists, and hospital-owned ancillary services. Through targeted education and relationship building, referral patterns can slowly be influenced. Address the underlying physician concerns about inefficient operations, poor access, service, or quality to keep volume from going to competitors.

3. **Examine pricing strategy.** In an age of increased scrutiny on the provision of charity care and the demonstration of community benefit, this strategy should be executed with precision and delicacy. While raising charges may not be a viable option for every hospital, failing hospitals often charge below market rates and do not receive what they should from paying patients. Critically examine the charge master and identify pricing strategies that will lead to a greater return in the services that are important to the hospital. Review all payer contracts for opportunities to enhance profitability.

4. **Conduct a thorough review of billing/collections.** More than ever, cash is king! Compare the hospital’s revenue cycle performance to common industry benchmarks. Ensure that the billing and collections department has the appropriate leadership, staffing, management reports, and communication processes/relationships with operations to maximize cash collections. Uncover unrealized opportunities, large and small, such as the timeliness of billing and point-of-service collections. Underlying economic forces will continue to increase potential for bad debt, despite the recent government enhancement of COBRA funding. Keep a close eye on the key indicators for bad debt, accounts received, and cash collections.

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1 “Thomson Reuters Study Tracks Impact of Recession on Hospitals: Hospitals’ Median Total Margin and Cash-on-Hand Hit Unprecedented Lows; Approximately Half of Hospitals Unprofitable” 
5. **Assess throughput in revenue generating areas.** Monitor key throughput and utilization indicators in the operating room and procedural areas such as cancellation rates, on-time starts, turnaround time, and block utilization. Poor operating performance in these key areas leads not only to unrealized revenue from additional cases, but underutilized expensive resources. Engage physicians in the improvement process. Physicians not only lose income with idle time, but it creates frustration, and serving the physician customer is extremely important for both growing and retaining business in these times. Undoubtedly, the hospital's competitors.

6. **Examine the business portfolio.** Many hospitals are taking the initial steps to prepare their FY 2010 budgets. While there may be a few places to trim around the edges, most hospital departments are likely already operating on a lean budget. Now is the time to critically examine the business portfolio. Start by evaluating total and per case contribution margin for each service. Next, engage front-line managers and department directors to fundamentally relate their department to the organization's mission and role, in supporting profitable volume growth either directly or indirectly. Identify the services and programs that are losing money and close or scale back marginal programs. Likewise, ensure that profitable services have the appropriate resources to grow. All capital purchases and new positions should be tied to the key strategic directives.

7. **Improve ED access.** Ambulance contracts are usually well established; however, there are practical approaches for influencing them. Territorial adjustments are highly political, so provisions to ensure access and quality are often the best approaches. First, improve throughput to ensure bed availability and avoid ED diversion. Next, consider pursuing stroke or chest pain accreditation as mechanisms for improving relationships and making the hospital a priority with EMS responders.

8. **Reduce staffing appropriately.** At times, staffing reductions cannot be avoided and are vital for the continued well-being of the organization. While certain situations require swift action, avoid “across the board” cuts. Instead, systematically review all management and staff positions compared to standard benchmarks and adjust for nuances of the business operations. Before implementing any staffing reductions, consider the downstream implications of potential cuts on productivity and quality.

9. **Scrutinize staffing effectiveness to volume variations.** In a down economy, responsiveness to even small declines in volume is essential. Conduct a staffing to demand analysis for each major hospital department (e.g. nursing, operating room, radiology, and lab). Compare actual staffing to required staffing using appropriate matrices for skill mix and benchmarks for worked hours per full-time employee (FTE). Arm managers with the tools necessary to monitor performance and hold leadership accountable for results. Encourage the use of part-time and per diem employees in order to respond to volume fluctuations.

10. **Examine the appropriateness of care in the ICU.** The intensive care unit is among the most expensive units to operate. Benchmark ICU average length-of-stay (ALOS) and the number of patients being discharged directly to home from the ICU as an initial indicator of appropriateness of care. Above average measures may indicate opportunities to improve care management through more involved case management or a “closed” intensivist-led ICU. Involve physicians in the effort and review the appropriateness of care in nursing and physician rounds.

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