
Building Behavioral Health Services As A Strong Contributor To the Bottom Line

by Guy C. Qvistgaard, MS, MFT

Sr. Vice President

St. Helena Hospital and Center for Behavioral Health

Outline

- Successful strategies
 - Lessons learned
 - How we grew the business
 - Manage referral relationships
 - How we achieved a positive bottom Line
 - Controlling expenses
 - Revenue Growth
 - Tools for medical staff
-

Qualifiers

- Not everything I say will apply to every hospital situation
 - It's easy to listen to this presentation and not say "that doesn't apply to us."
 - My experience
 - Clinical Training – MFT
 - Contracting experience – managed care
 - IPA and Risk pool management
 - Hospital management
-

Qualifiers

- I've worked in settings that include:
 - psych units within medical-surgical hospitals
 - free-standing psych hospitals
 - psych hospitals on large multidisciplinary campuses
 - Publicly & privately funded psych clinics
 - Homeless shelters
 - Schools
-

Disclaimer

- The situation at St. Helena Hospital (SHH) does not reflect a psych service that is inundated with behavioral health patients waiting for lengthy periods of time in an urban ED
 - However, I can speak to some of those issues due to previous experience in such a setting
-

Description of Our Hospital

- SHH has 2 campuses –
 - 1 med-surg facility with a 21 bed psych unit for adults only
 - free-standing 61 bed psych hospital for children adolescents and adults
 - Average Daily Census (ADC) for both was 12 at the 21 bed unit and 42 for the 61 bed psych hospital
 - ADC now is 18 at the 21 bed unit and 53 at the 61 bed psych hospital
-

Description of Our Hospital

- Due to the shrinking number of psych beds in CA, referral sources range as far away as 500 miles to the north 250 miles to the south and 120 miles to the east.
-

Successful Strategies

- Expense Management
 - Labor, productivity, supply management
 - Understanding referrals patterns
 - Inheriting and nurturing a supportive medical staff
 - Constant marketing
-

Lessons learned

- We had to build and train a top flight, responsive, self-directed leadership team
 - We had to increase our communication with payers, referral sources and the community
 - Constant watching for business trends
 - It's the small things we do that make the big differences...the devil is in the details
-

How We Grew the Business

- Broke down barriers at our own front door
 - internal reluctance to take on more patients and thus more work
 - Longstanding challenge in psych of “delegating” admission authority (after MD input) to the Charge/Unit Nurse – often because milieu is a factor in unit and thus patient treatment.
 - Issues of “Unit Acuity”, patient safety, lack of staffing, too many 1-1s, too many borderlines, too many bipolars, too many men, too many women
 - Why would Nursing staff want to take on a new admission – typically on the PM shift – if they didn’t have to?
-

How We Grew the Business

- aligned the incentives between the nursing staff and the admission staff
 - Hired an experienced RN with ER/Psych/Med-Surg background as the referral and intake coordinator
 - this individual has experience in unit management and works closely with the DON to ensure that nursing is supported while not allowing nurses to block admissions as a response to real or perceived staffing issues
 - “No excuses” for not taking a qualified patient
 - Educated staff about conditions BH pts & staff face while waiting in EDs, crisis units, etc.
 - Aggressively flexed staff when census dropped to reinforce the status that no patients means no work

How We Grew the Business

- We broke down the barriers between ourselves and our customers/referrals sources
 - developed direct relationship marketing with a designated psych marketing specialist
 - our Intake/Admissions department built phone relationships by:
 - calling out to customers when we had beds available
 - developing first name-type relationships
 - Have intake go out and meet the people they talk to on a daily basis
-

Manage Referral Relationships

- Develop spreadsheets that tracked all admissions and call inquiries.
 - This data included the category of the referral such as other hospitals, county crisis teams, police, physicians, families, walk-ins, yellow pages, internet, schools and self referrals
 - We've identified over 33 different referral categories alone with 122 specific sources
-

Manage Referral Relationships

- After developing the categories in which the referrals fell we then captured the specific source of the referral within that category
 - All of this is designed to hone in on where the referrals are coming from cross referenced with the payers most associated with those referrals and the profitability of each referral source
 - Once ID'd we developed ongoing marketing plans specific to that referral source
-

Manage Referral Relationships

- We then narrowed our focus on those referrers whose clinical needs we could meet while identifying those relationships that would best contribute to our financial viability.
 - Turn-around-time (TAT) for admission (just like in EDs) was the biggest customer satisfier.
 - Developed clinical screens that are fast, efficient and minimize our exposure to accepting patients that are not suited for treatment in an inpatient psych setting.
 - TAT went from 4 hours to 30 minutes
-

A Positive Bottom Line

- Controlling Expenses
 - Key to expense management is to hire a leadership team that takes personal pride and accountability in meeting budgeted expenses while at the same time delivering quality and customer friendly services.
 - Revenue Growth
-

A Positive Bottom Line

- Daily Leadership Huddles
 - 15 minutes
 - Hot Topics Only
 - Admissions, DCs, Heads-up
 - Review of Data with Established & Critical Tools
 - All Team Leaders (TLs) are expected to be skilled in understanding, speaking about and developing action plans around the data that are revealed with these data
-

A Positive Bottom Line

- Review of Data with Established Tools (Financial, Daily, Weekly and Monthly Dashboards and Reports)
 - Daily Tools
 - Daily Census Report 17/21 beds + hot issues no roommate orders/high # of 1-1s
 - Daily Census against MTD census and where we are against budgeted census
 - Unit productivity spreadsheets
 - Registry Use Tracking tool – Reg hrs AND \$
 - Premium Time Use (OT, Callback, missed meal breaks, etc.)
 - Denial Tracking
-

A Positive Bottom Line

- Review of Data with Established Tools
 - Financial Tools
 - Monthly Income statement review with TLS
 - Monthly Tools
 - Pt Financial Services Critical Indicators
 - LOS Stats
 - Census Review
 - Weekly Tools
 - Weekly Referral Report
 - Targeted Marketing Report
-

Controlling Expenses

- Huge focus on labor management
 - Managed to a reasonable budget developed within community standards
 - 100% productivity is the expectation not the goal.
 - Goal is actually 100% - 105%
 - Negative variances to productivity resulted in leaders needing to develop viable action plans (not “variance reports”) that are reported on as frequently as daily
 - If action plans are not working then Senior Administration is involved and directly assists in modifying the plan
 - If that is not successful then positions are reduced until productivity comes into line
 - It’s all about accountability – one of our core values
-

Controlling Expenses

- Identifying and eliminating high wage dollars
 - 1st we eliminated registry use
 - 2nd we managed OT to within 2% of total hours
 - 3rd we reduced PRN use
 - ALL WHILE increasing our hiring focus with our HR dept
 - We monitor this on a weekly basis with automatically generated reports that we discuss each week
-

Controlling Expenses

- Every invoice is signed by the dept director and reviewed and countersigned by the vice president before submission to accounts payable
 - You can't expect what you don't inspect
- Strict inventory control of pharmacy supplies food, nursing and office supplies
 - Agreed upon effective formulary with obvious exceptions
- ~~Managing patient discharge time~~

Revenue Growth

- Meet census goals
 - Aggressive contracting in a seller's market
 - Manage the payer mix
 - know your best payers and market to them
 - establish personal relationships
 - develop strategic marketing tactics and plans
 - Ensure capture of step down service lines such as PHP and IOP
 - working with the MDs, case managers and nurses
-

Tools for Medical Staff

- Assigned a Nursing liaison (LPT/LVN) for MDs with heavy patient loads
 - Relied heavily on expert Social Services staff to expedite patient discharge / disposition
 - Establish lead MD role in the Intake/Admission process. Reduces admission TAT, works closely with rest of the MD staff, pt assignments are distributed fairly and equitably
 - Increased communication between Senior Admin and Medical staff around issues such as hospital's financial condition, vision, education re details of referral relationship management
-

Tools for Medical Staff

- Data about ADC, LOS, referral trends, staffing limitations, “heads-up” issues
 - History taught us to develop a Behavioral Health Nurse Liaison position within the ED
 - This was a critical factor in addressing the assessment and disposition issues of behavioral health pts in the ED
 - TAT in that ED went from 12 hrs and higher to under 3 hours
-

QUESTIONS
