Case Analysis of Reading Rehabilitation Hospital

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CASE ANALYSIS OF READING REHABILITATION HOSPITAL

History of Reading Rehabilitation Hospital

Reading Rehabilitation Hospital (RRH) was founded in 1961 as an acute rehab hospital with a capacity of 95 beds. As a subsidiary of Adventist Health Ministries, Inc., RRH is a non-profit organization sponsored by the Seventh Day Adventist churches. As the only acute rehab hospital in Berks County, Pennsylvania, RRH had a monopoly on the acute rehab market and was known for its strong commitment to the well being of residents in Berks County, Pennsylvania.

In 1983, Medicare introduced a Prospective Payment System (PPS), using Diagnosis-related Group (DRG), to rein in escalating health care costs. RRH was mostly protected from this change because acute rehabilitation hospitals were reimbursed for all billable costs up to a limit based on their 1982 costs. As an added protection to the changing environment, Medicare reimbursed the rehabilitation hospital for the difference between the average actual cost and the 1982 limit as an incentive to keep costs low by discharging patients faster. As a result, RRH enjoyed stability without market competition for the time being.

In 1989, Clint Kreitner, a board member for three years, was brought in as the CEO of RRH. Kreitner was known as a successful entrepreneur with four successful start-up companies under his belt. Once on board as president and CEO, Kreitner worried about the future of RRH and foresaw need for change even though RRH was financially sound and without debt at the time. Kreitner believed that rising health care costs in the U.S. would bring difficult times to RRH.
As the new CEO of RRH, Kreitner advocated for a change to prevent future revenue loss. In 1990, Kreitner created the Kaizen Council and implemented a Continuous Improvement (CI) initiative as a part of long-term comprehensive organizational transformation. In 1991, to increase efficiency and continuity of care, Kreitner and Pflum the director of rehab services, reorganized the hospital around service lines and implemented patient-focused care at RRH. Two years later in 1993, clinical pathways were added to RRH as a patient care coordinating tool. Clinical pathways are a set of standard operating procedures that identify a course of care for any hospitalized patient with a diagnosis. In 1994, RRH developed another concept in coordinating patient care, “care coordinators” who conduct utilization reviews as well as managing patient cases through their hospital stay. Despite the implementation of innovative ideas in improving efficiency for patient care, therapist utilization at RRH dropped from 75% to about 50%.

S.W.O.T Analysis

**Strengths**

1. As the only licensed provider of acute rehabilitation services in Berks County, RRH had the monopoly on the market.
2. RRH is capable of meeting demands for patients with a wide range of diagnoses.
3. RRH can supply interdisciplinary care involving a doctor, nurse, social worker, physical and occupational therapists, a psychologist, speech therapist, and cognitive therapist depending upon a patient’s needs.
4. In 1989, a new CEO with a successful track record in business was hired.
5. Under the new CEO’s guidance RRH adopted a patient-focused care through service lines model as a new market strategy.
6. The CEO’s initiatives increased RRH’s reputation for patient care, thus solidifying its brand name in the market.

**Weaknesses**

1. RRH with annual revenues of $20 million is the smallest acute care hospital in the area. As a small hospital, there was no room for cross-subsidizing one discipline from another.
2. RRH did not control its sources for patients; leveling demand for services was difficult.
3. The newly appointed CEO in 1989, Clint Kreitner admitted that he was not knowledgeable in the healthcare industry, which did not foster staff member confidence his ability to lead the organization and the staff did not believe significant change was needed at RRH.
4. The CEO’s CI initiative resulted in improved patient care, but therapist utilization was not maximized in some of the service lines and therefore billable hours dropped to 50% from 75%.

**Opportunities**

1. Acute rehab hospitals were cushioned from the Medicare introduction of Prospective Payment system (PPS) in 1983. Acute rehab hospitals were reimbursed for all billable costs up to a limit based on their 1982 costs, thus allowing stability of revenues at RRH.
2. In 1991, Kreitner reorganized the hospital around service lines to deliver patient focused care aiming for an improved interdisciplinary coordination and efficiency.
3. In 1994, RRH converted 19 beds into a new skilled nursing unit that offered less acute rehab care, thus increasing its chance to remain competitive in the healthcare market by diversifying the services it offered to the community.
4. An acute hospital in the area, RHMC approached RRH about buying RRH’s rehabilitation license which could be a potential contingency bail-out plan for the staff.

**Threats**

1. Annual double-digit increase in healthcare costs started affecting all healthcare facilities in the 1980s and its financial effect on the future of RRH was becoming uncertain.

2. The emergence of managed care organizations (MCOs) in the 1980s forced RRH to perform tasks more efficiently to prevent operating costs from exceeding payments, thus reducing revenues overall due to the decreased lengths of patient days.

3. In response to the introduction of Medicare’s prospect payment system in 1983 and new managed care payment systems, acute care hospitals started keeping more patients who needed less intensive rehabilitation services, thus reducing the demand for services at RRH.

4. As the growth in Medicaid per diem rates leveled off, traditional nursing homes also began to integrate vertically and to offer many rehabilitation services, thus adding competition in the market.

5. The CON law up for review at the end of 1996 increased the possibility of CON awards to acute care hospitals and nursing homes. This possible increase in competition could decrease the demand for RRH’s services in the area.

6. The labor market for occupational and physical therapists was highly competitive preventing the hospital from paying therapists on an as needed basis.

7. With the pressure of managed care, it was more difficult to pass along the costs of overstaffing to the payer and therefore equating to less revenue generated for RRH.

**Analysis of RRH’s strategy**
Under the new Medicare policies the average patient stay at RRH was fewer days in length. Because the amount of time the staff spent in weekly interdisciplinary team conferences did not become less along with the shorter patient stays, Kreitner believed the conferences had become inefficient. He reasoned the conferences were delaying the start of a patient’s physical therapy and thus postponing the patient’s discharge, which could lead to unreimbursed costs. With shorter patient stays there was a greater chance that a patient’s treatment would have to start and sometimes end before a weekly interdisciplinary conference occurred. Kreitner knew this could lead to inconsistent treatments across discipline teams because the conference would not establish and update an integrated care plan for patients already discharged or for patients whose treatment had commenced before the occurrence of a weekly interdisciplinary team conference. Kreitner saw this as an impediment to efficiency in care at RRH and therefore a driver of future lower revenues in the competitive market.

As a result, Kreitner brought in the “patient focused care” concept as his CI initiative; staff members were assigned to interdisciplinary service lines, each focusing on patients with a particular diagnosis. This approach put the emphasis on the patient’s needs and convenience rather than the caregivers. Ongoing coordination among staff members resulted in maximizing the experience of patients with a particular diagnosis outside of the weekly team conferences. After implementing service lines, RRH realized its therapist utilization target fell short of 6 hours a day or a 75% billing ratio. Staff idle time rose because with service line specialization management was unable to predict the daily, weekly, and monthly number for each service. As a result, implementing service lines improved patient care but decreased staff utilization at RRH leading to less billable hours.
The emergence of managed care organizations (MCO) and Medicare’s prospective payment system (PPS) cut revenues to acute hospitals and nursing homes driving those organizations to hold onto their patients longer by offering low intensity rehabilitation services, thus squeezing RRH’s market share. Responding to this trend, RRH designated 19 beds to treat less acute rehab patients in a new skilled nursing unit. This diversification of services offered at RRH offer might increase the chance of survival for RRH in the very competitive market.

Pertinent financial analysis

Demand for service in RRH was totally dependant upon referrals by physicians and acute care hospitals. Because RRH could not predict the number of patients per service line, or the length of a patient stay until they received the referral, RRH had to keep excess staff on duty, which kept RRH’s operational costs the same even when the demand for service was low. Nursing staff was managed in a cost efficient manner by part-time contracting and were sent home when the patient census was low, because the supply of nurses was plentiful in the area at the time. Manipulating the nursing labor hours was the only method RRH had for short-term cost reduction. On the other hand, occupational and physical therapists were in short supply in the labor market, making it impossible for RRH to manage them on an as needed basis. The opportunity cost for sending therapists home during periods of low census was too high, thus therapists were left idle about 50% of the time. As a result, RRH was feeling the pain of costly uncertainty (Getzen 2007, p. 208). According to Getzen (2007), uncertainty is expensive because it prevents managers from making effective resource plans (p.208). In this specific case, RRH management was constrained by the unknown supply of patients and the perceived power of the therapists to resist management efforts to reduce their hours when the patient supply was low.
With patient focused care around service lines, the billable therapist hours were about 50%, way below the target of 75%. According to Ward et al. (2006), the performance improvement plans focus on reducing costs without consideration for a hospital’s fixed or variable costs (p.93). At RRH, there was very little room to maneuver variable costs to reduce its marginal loss because the majority of the costs were fixed, such as the facility, equipment, and staff.

Kreitner had accurately predicted that rising health care costs and managed care would bring changes to the industry. However, his initiative to change the company strategy was incomplete; it lacked a cost benefit analysis. He did not calculate that the efficiency of the patient focused care would bring shortened lengths of stay, and thus a decrease in revenue. Ward et al (2006) assess the situation; by improving the efficiency in patient care, the true benefactors of the improvements are the health plans or the government that pay the hospital bills in the managed care reimbursement system (p.93). Patient focused care at RRH was working out well for the patients and to the satisfaction of therapists, but the initiative was losing money for RRH.

Strategic recommendations

The first priority of RRH is to increase the therapist staff utilization in order to increase billable hours. RRH should reorganize the disciplines and cross train staff members to work across multiple service lines to reduce therapist down time. As can be seen in figure 1, there are big differences in the number of patient days in RRH depending on service lines. Disparities for staff utilization across service lines exist from just 206 patient days for arthritic patients to 6198 patient days for orthopedic patients. RRH must implement a more efficient way to utilize the therapist staff in order to stay viable in the market. Prior to the CI initiative RRH staff members
were used to working with patients with a variety of diagnosis, thus this should be an easy change to RRH’s patient care practice. RRH should continue with service line oriented interdisciplinary conferences as needed when patients arrive at RRH to facilitate patient focused care.

Secondly, to increase demand for its services, RRH should look for ways to use the staff for other than inpatient referrals. For example, adding outpatient/ambulatory rehab care to the repertoire of services RRH offer in the area might be a great opportunity for RRH to stay afloat in the market. RRH’s established reputation as a good rehab hospital will make it easy for RRH to obtain regulatory approval and start accepting referrals for ambulatory services. The trend to shorter patient hospital stays will increase the need for outpatient rehab services. Offering outpatient services will increase the patient load for RRH and will provide the hospital administrators with the ability to predict the demand for its services easier than other acute rehab patient referrals. With increased demand for services, RRH management will find it easier to balance the staff population with the hospitals revenue.

Thirdly, manipulating the labor force by putting staff off-duty when the census goes down can lead to low morale and high turn over so it should be avoided. Staff members are a primary asset in the health care industry and should be treated accordingly. What RRH administrators should recognize is that manipulating the labor force in this way will reduce the
quality of care and increase staff dissatisfaction of nurses followed by therapists, doctors, and patients and ultimate underutilization of hospital services (Ward et al, 2006, p.95). One way to maximize staff utilization and prevent manipulation of staff time would be to become more flexible in the bed designation in patient acuity levels. RRH should stop limiting just 19 beds to be the skilled nursing unit for less acute patients, but increase or decrease the acuity-designated beds count according to the census demand. This way, the nursing and the therapist utilization will maximize yielding higher revenues for RRH.

Lastly, RRH must vigorously defend its license to remain as the only acute rehab hospital in Berks County, Pennsylvania when the law for CON review comes due in 1996. RRH should argue that another acute rehab hospital is not necessary in the area by demonstrating RRH’s track record, solid reputation in the community as an institution dedicated to the well being of residents in Berks County for the past 35 years, and by presenting statistical figures derived from “Patient Statistics and functional Independence Measures (FIM)” in 1994:

- Shorter LOS at RRH, 18.2 days compared to national average of 21 days
- Higher FIM of 1.18 than national average of 1.10 points per day
- Higher patient satisfaction than the national average

At the same time, RRH can demonstrate that there is not a need for another acute rehab hospital in Berks County because RRH is struggling to fill its beds with acute rehab patients currently. Another competitor in the market will force RRH to reduce its labor force and as a result, displacing the laid off RRH staff to look for employment elsewhere. This will reduce the tax base for the county and therefore, the county will be worse off than if it only had one acute rehab hospital with a good reputation and a proven track record.
The recommendations listed above should bring increased revenue to RRH and ensure its solid footing in Berks County as the only reputable acute rehab hospital. Providing interdisciplinary patient care across service lines should improve staff utilization, thus reducing staff idle time and increase therapist billable hours. Diversifying the services offered should also reduce RRH’s dependence on referrals from other hospitals. By flexing the number of beds according to the acuity of patients on hand, RRH will be able to increase patient days. Securing RRH’s place as the only acute rehab hospital in the county will enable RRH to hold onto its niche market in the community, thus RRH will be able to provide services to the residents of Berks County now and beyond 1996.
References


## Appendix 1

### Reading Rehabilitation Hospital

#### Table of Events

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