

VIRGINIA REGIONAL MEDICAL CENTER

REPORT PRESENTED TO
VIRGINIA REGIONAL MEDICAL CENTER COMMISSION
AND
VIRGINIA, MINNESOTA CITY COUNCIL
DECEMBER 2009

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PROJECT OVERVIEW

PROJECT OVERVIEW

- The project was defined as an overview that would provide VRMC's Commission with a focused discussion on strategic alternatives.
- The project was also responsible for providing the Commission with recommendations for VRMC future actions.
- Included in the information gathering process were approximately 40 interviews with key stakeholders, including the vast majority of City Council and Commission members.
- A cross section of the medical staff were also included in the project information gathering interviews.
- Most interviews were conducted in person at VRMC.

PROJECT OVERVIEW

- VRMC provided historical financial and operations information for analysis.
- During the project, several unsolicited phone calls were received from physicians and VRMC staff who also provided additional input into the project information gathering.
- Most interviews tended to focus on the challenges VRMC has been facing the past two years.
- Several thoughtful ideas came forth regarding VRMC future options.
- Most interviewees were very candid and open with their input.

PROJECT FINDINGS

PROJECT FINDINGS

INTERVIEWS

- Interview findings grouped into four categories: Strengths; Management; Financial; and Medical Staff.
- VRMC's strengths, based upon the interview input, consisted of long term care (VCC), inpatient rehab, diagnostic imaging, surgery and the bedside/patient care nursing.
- Most interviewees felt that VRMC's senior management had not provided the necessary leadership and skill to make VRMC successful.

PROJECT FINDINGS

INTERVIEWS

- There was extreme concern expressed over VRMC's downward financial spiral that had its origins in 2007 and became highly visible in 2008. Some interviewees voiced concern about VRMC being able to survive and stay open.
- Many interviewees expressed concern that Virginia was unable to attract and retain high quality physicians. Interwoven into this input was a theme expressing the need for more doctors who practice and live in the Virginia service area.

PROJECT FINDINGS

VRMC'S MARKET

- A hospital's primary service area (PSA) is defined by the zip codes that comprise about 80% of the hospital's inpatient admissions. VRMC's PSA consists of 9 zip codes.
- The PSA population in 2009 was 37,907; 2014 projected population is 36,513. This is a loss of 3.7% over the next five years.
- In 2005, VRMC maintained over 51% market share for inpatient services in the PSA. By 2008, that market share was under 42%, a 19% drop (9 market share points) in three years.
- In 2005, Duluth hospitals had 28.3% market share in the PSA. In 2008, that market share was 39.4 %.

PROJECT FINDINGS

VRMC'S MARKET

- Hibbing's market share of PSA hospital admissions grew from 10.4% in 2005 to 13.3% in 2009.
- VRMC had 3,460 inpatient admissions in 2006; in 2009, projecting from 10 months data, the annual admissions will have dropped to 2101. This is a 39% reduction over the past four years.
- This loss of admissions and market share over such a short period (4 years) of time is highly unusual.

PROJECT FINDINGS

FINANCIAL

- In Fiscal Year (FY) 2006, VRMC had a profit of \$507,000. In FY 2007, that was reduced to \$94,000.
- VRMC lost (\$1,967,000) in FY 2008 and, based upon 10 months FY 2009 financial information, VRMC will lose (\$1,520,000) in FY 2009.
- Long term care operations (VCC) are the single largest area of financial challenge for VRMC.
- Days of Cash is a critical barometer of financial well being for hospitals. In 2006, as reported in the Medicare cost report¹, VRMC had 102 days. That total shrunk to 86 days in FY 2007 and 57 days in FY 2008. Days of cash will again be lower for FY 2009

¹As summarized by American Hospital Directory.

PROJECT FINDINGS

FINANCIAL

- All of VRMC's short and long term debt payments are current.
- Because of its shrinking cash position, VRMC has had to delay paying some operating expenses.
- Much of the cash crunch faced by VRMC dates back to their accounts receivable operation falling behind in billing patients and insurance companies. This problem began in FY 2008 and continued into 2009. In FY 2008, days in accounts receivable were 50, but that rose to 71 in 2008 and higher in 2009. This problem is being corrected now.
- An accounts receivable problem this significant rarely happens and was preventable with routine monitoring of financial operations.

PROJECT FINDINGS

FINANCIAL

- Bond holders of hospital debt measure the credit worthiness of a borrower by calculating a Debt Service Coverage Ratio. The Minnesota hospital median is a 3.3 ratio (the higher the ratio the happier the bondholder). Bond holders usually set a minimum debt service coverage ratio at the time of lending. A usual minimum threshold ratio is 1.5.
- In FY 2006, VRMC had a debt service coverage ratio of 1.6. That ratio dropped to 1.3 in FY 2007 and 0.5 in FY 2008. It will probably be lower yet in FY 2009.
- Since the City of Virginia guarantees the hospital's debt, VRMC is insulated from their weak debt service coverage position.

PROJECT FINDINGS

FINANCIAL

- In FY 2006, VRMC invested \$4,717,000 of capital; in FY 2007 that investment was \$3,030,000. For FY 2008, capital investment fell to \$2,202,000. In FY 2009, capital investment was \$1,020,000 through August.
- While capital investment usually varies some from year-to-year, this significant 4 year downward trend in VRMC's capital investment should concern the Commission.
- VRMC is likely to have significant Information Technology capital investments over the next 3 – 5 years. In aggregate, this IT investment might be \$4,000,000 to \$6,000,000.

PROJECT FINDINGS

FINANCIAL

- Another indicator of potential capital investment is the average age of plant. For VRMC, that age was 15.9 years at the end of FY 2008. The median average age of plant for Minnesota hospitals is 9.3 years.
- A final ratio comparison is the cushion ratio. This measures the relationship between total debt services and total cash reserves. VRMC's has declined from 3.2 to 2.0 in the past four years. The median Minnesota hospital cushion ratio is 11.0 .
- VRMC will have approximately \$9,000,000 in long term debt after the 2010 debt payments are made.
- As of 8/31 VRMC has used \$270,000 of its \$700,000 line of credit.

PROJECT FINDINGS

GENERAL

- VRMC 's admissions are dependent on physicians who may be nearing the end of their full time practice years. Approximately 18% of admits come from physicians age 60 or over. 34% of admissions are from physicians age 55 or over.
- VRMC is a public hospital (city) but it receives no tax support from Virginia taxpayers. Some interviewees thought that Virginia subsidized VRMC.
- Governmentally owned hospitals are gradually converting to not-for-profit status (IRS Code 501(c)3). VRMC and Virginia looked at this option about 4 years ago and elected not to proceed with conversion.

PROJECT FINDINGS

GENERAL

- Many neighboring hospitals are in collaborative arrangements with larger hospitals and/or are converting to not-for-profit status. This is a trend that is evident throughout much of the United States.
- A cursory review and preliminary estimate of physician need for VRMC's PSA was completed . This is not a physician development plan that would be adopted by the Commission as part of a strategic growth plan. However, this early work suggests that the interview feedback regarding too few primary care physicians in the Virginia market may be accurate. This preliminary information is included in the Attachment to this report.

PROJECT FINDINGS

GENERAL

- A demographically derived physician needs assessment estimates the need for 22.6 primary care physicians to meet 100% of the primary care needs in VRMC's PSA. The current supply is about 12.5. While local doctors will never capture 100% market share, the current supply suggests that 40% - 50% of primary care visits may be occurring at clinic locations outside of Virginia.
- The PSA has a significant shortage of Medical Specialists. This is not uncommon in a rural area, but there seems to be opportunity to grow the medical staff in some Medical areas.
- Surgical Specialties seem to be staffed fairly well.

RECOMMENDATIONS

RECOMMENDATIONS

- The first priority for all involved with VRMC is to focus on the patients and the care that they need to have available to them, both now and in the future. Everyone must work together to maximize the amount of health care services in the community.
- By getting VRMC properly positioned, the community can preserve health care services and local employment.
- However, no one should underestimate the challenging position that VRMC has gotten itself into during the past 3 years. It has depleted most of its cash reserves. While it appears to have enough cash to make the January and February, 2010 bond payments, it is unlikely it will be able to make historically average capital investments in 2010.

RECOMMENDATIONS

- VRMC's most pressing needs in any collaboration with another provider will be access to capital, ability to grow the medical staff, capabilities to upgrade and support information technology and resources to support VRMC's management needs.
- VRMC's needs, as outlined above, cannot be met by a collaboration with Hibbing and Grand Rapids.
- Once the City Council and Commission have successfully implemented most of the recommended work plan in this section, they could again look at opportunities with Hibbing and Grand Rapids.
- VRMC should explore discussions with St. Luke's (Duluth), SMDC (Duluth), Fairview (Minneapolis) or Allina (Minneapolis) regarding collaboration opportunities.

RECOMMENDATIONS

- This section of the report will focus on recommendations for VRMC 's Commission and Virginia's City Council to implement during the remainder of 2009 and 2010. The fourth and last section of this report is a specific implementation plan that outlines 11 Tasks with their correlating activities.
- **TASK A**—VRMC must immediately engage outside assistance to define and implement a turn-around plan for VRMC operations and financial results. The decline of operational and financial performance during the past three years threatens VRMC's ability to make necessary capital investments and meet future debt payments.

RECOMMENDATIONS

- One option would be for the Commission to hire an interim management group that would be responsible for defining and implementing improved operational performance goals and financial outcomes.
- It is unlikely the management team that has operated VRMC for the past 4 years can now reverse the cash, profitability and financial situation that the Commission must correct.
- Once this is done (about 45-60 days) a new 2010 budget would be presented to the Commission for review and approval.

RECOMMENDATIONS

- **TASK B**—Virginia’s City Council needs to assess and debate if hospital services and long term care are best served in Virginia and its PSA by VRMC remaining city owned and managed.

RECOMMENDATIONS

- To understand their options, the City Council/Commission should prepare an RFP that seeks out potential health care partners to collaborate in the operations/ownership or support of VRMC. The responses to the RFP will provide insight into interested providers and how they would collaborate with VRMC.
- The RFP should focus on **6 areas of support** that are required by VRMC:
 - 1) Quality of care is increasingly challenging for providers and their governing boards. While there are not visible quality concerns at VRMC, the future will demand improved outcomes from both physicians and hospitals.
 - 2) Local governance participation in any future collaboration is important.

RECOMMENDATIONS

- 3) Physician development—growing the medical staff—is important now and in the future for VRMC. It will be impossible to capture lost market share without more doctors who live in and practice in Virginia.
- 4) Service line growth will seek to have VRMC enhance selected clinical areas and focus growth and investment in those areas. VRMC cannot provide all services for all patients.
- 5) VRMC will need outside financial support for growth, capital investment, expanding the medical staff, IT system upgrades, facility redevelopment and securing new debt in the future.
- 6) VRMC's collaboration partner should have management depth to provide long term leadership for delivering health care in Virginia.

RECOMMENDATIONS

- **TASK C**—VRMC should complete a comprehensive medical staff development plan that defines how many (and in what specialties) VRMC wants to recruit during the next 3 years. In addition, establish the budget for recruiting these doctors and supporting their practice start up cash flow (as necessary).
- **TASK D**—Information technology demands in hospitals and clinics continues to increase and VRMC is behind the curve on planning for these new IT demands. Develop, using outside resources, an IT strategic plan and budget. If there is a collaboration partner for VRMC, be sure they can support IT needs.
- **TASK E**—VRMC should conduct a more detailed analysis of the market and define its priority strategies for the next 3 years.

RECOMMENDATIONS

- Task E must carefully integrate the medical staff (Task C) planning work with the strategic recommendations, as well as understanding the operating cost and capital needs of all strategic recommendations.
- **TASK F**—The Health Reform Act currently has language that would expand a small hospital cost-based reimbursement demonstration project that VRMC might be able to apply for. An assessment of this opportunity has been initiated by the Commission.
- **TASK G**—Virginia needs to assess if it should continue to own and operate health care enterprises. This assessment includes understanding the potential for future taxpayer support of VRMC.

RECOMMENDATIONS

- **TASK H**—VRMC’s 2009 budget missed its net revenue and net expense per adjusted admission targets (through October) by over 22% each. The Commission needs better budgets and precise cash flow numbers given the current financial crisis. MedAssets is the second firm hired by VRMC to solve its accounts receivables problem. They are doing a good job and should be kept in place until longer term issues regarding VRMC are decided. Do not hire new business office staff at this point; contract with MedAssets for the interim needs. VRMC also should delay hiring a new CFO.
- **TASK I**—VCC is a vital asset. Some interviews suggested that closing VCC would solve all financial problems. That is not the case since all costs allocated to VCC would not go away if they closed. Have a third party assess VCC and report back to the Commission.

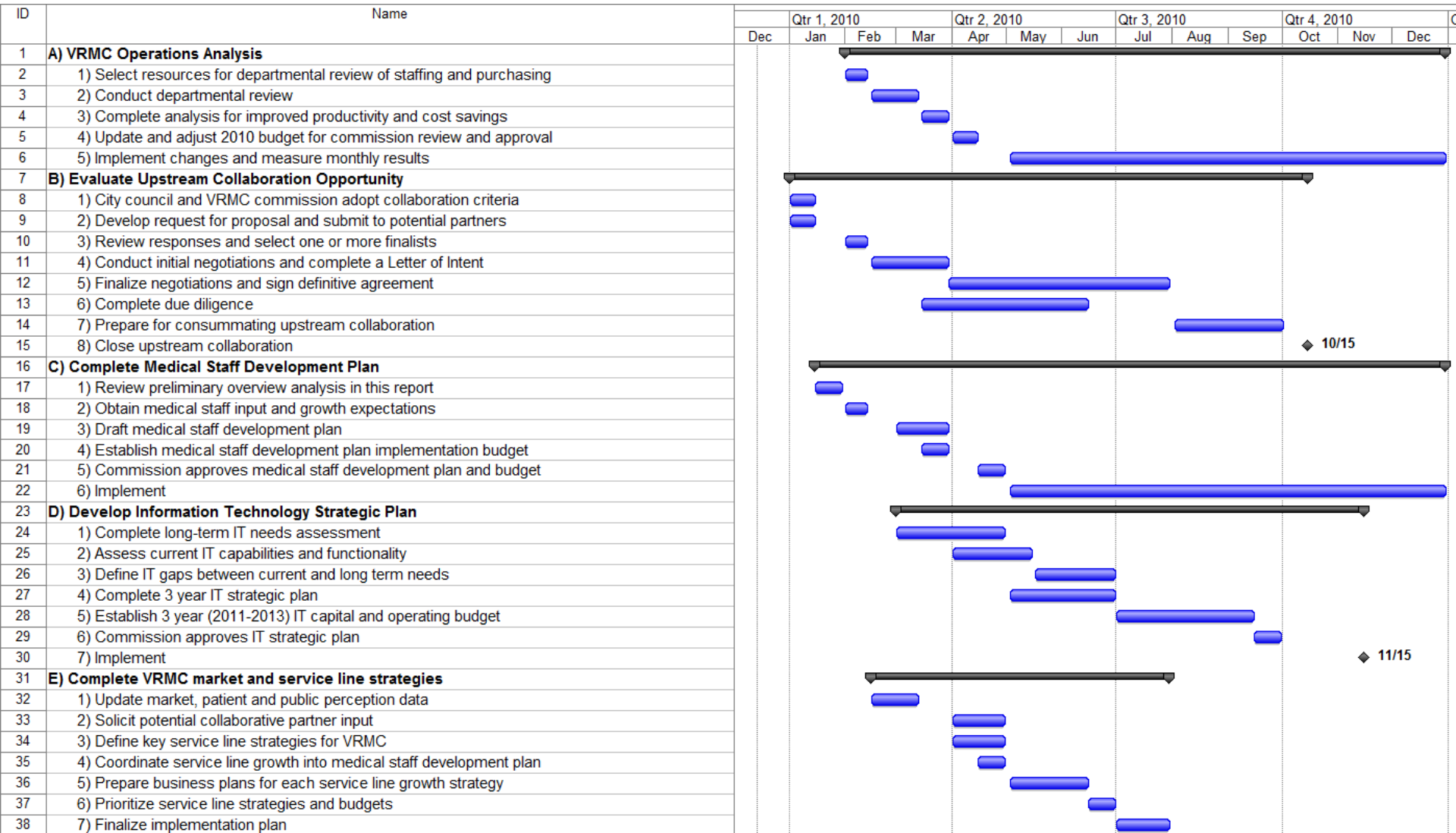
RECOMMENDATIONS

- **TASK J**—The hallway conversations and community discussions carry a significant amount of misinformation. VRMC’s Commission should establish an internal and external communications plan to provide timely and accurate information to all stakeholders.
- **TASK K**—For 2011, VRMC needs to have a better budget process than it did for 2010. This would be a responsibility of management.

IMPLEMENTATION PLAN

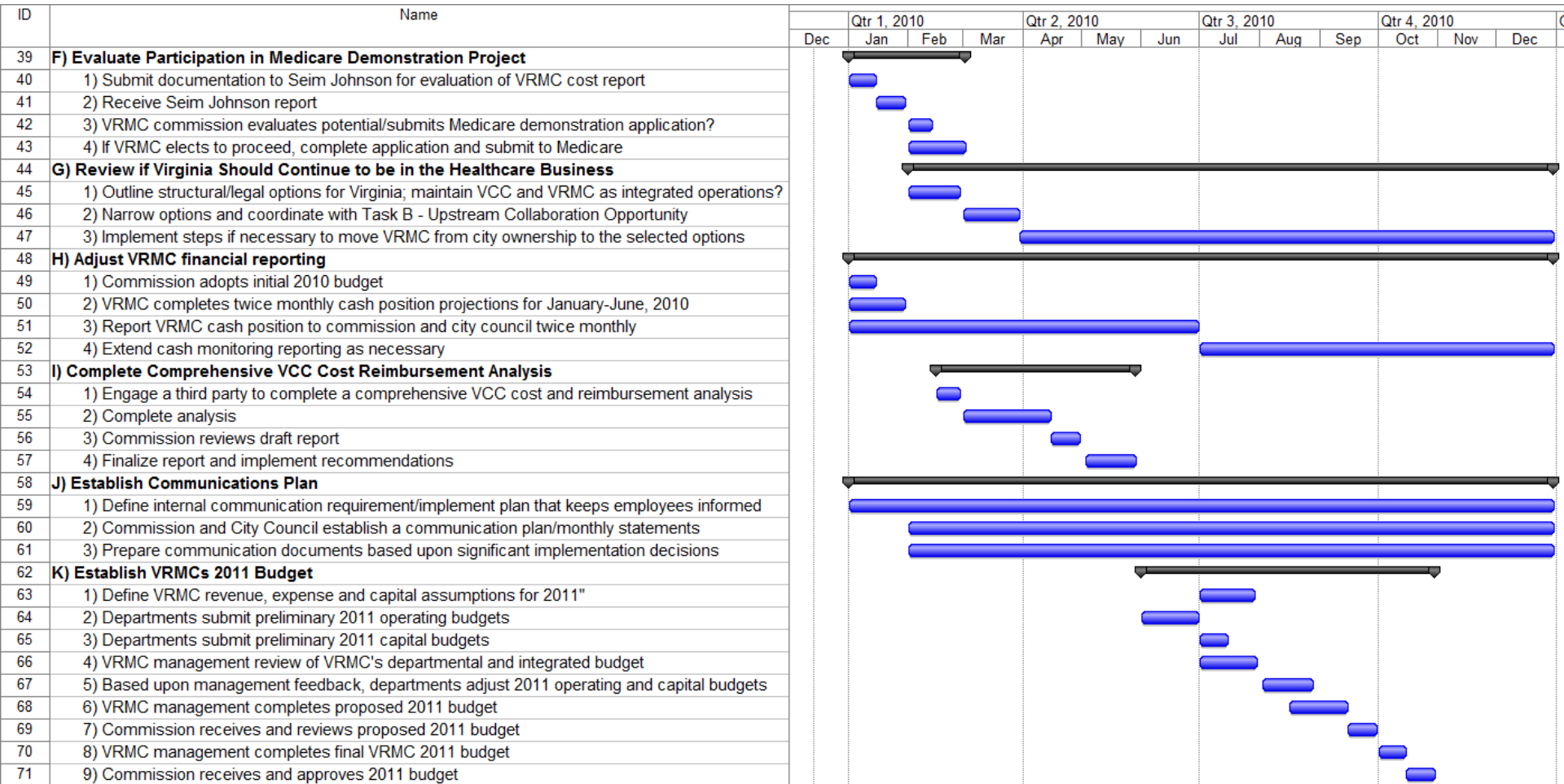
- The following Implementation Plan is a comprehensive work scope that should be completed in 2010. The Plan covers all the tasks discussed in the RECOMMENDATIONS section.
- This scope of work has tasks that will required the use of outside resources (non-VRMC or Virginia City staff) to successfully complete.
- The highest priorities are preparing and sending an RFP to potential collaboration partners and hiring a firm or individuals that can define and implement a turn-around plan for VRMC.

IMPLEMENTATION SCHEDULE



*Some tasks titles have been shortened due to chart space considerations. For full text description please refer to slides 32 &33

IMPLEMENTATION SCHEDULE



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IMPLEMENTATION SCHEDULE FULL TEXT

A) VRMC Operations Analysis	Begin	End
1) Select resources for departmental review of staffing and purchasing	2/1/10	2/15/10
2) Conduct departmental review	2/15/10	3/15/10
3) Complete analysis for improved productivity and cost savings	3/15/10	3/30/10
4) Update and adjust 2010 budget for commission review and approval	4/1/10	4/15/10
5) Implement changes and measure monthly results	5/1/10	12/30/10
B) Evaluate Upstream Collaboration Opportunity	Begin	End
1) City council and VRMC commission adopt collaboration criteria	1/1/10	1/15/10
2) Develop request for proposal and submit to potential partners	1/1/10	1/15/10
3) Review responses and select one or more finalists	2/1/10	2/15/10
4) Conduct initial negotiations and complete a Letter of Intent	2/15/10	3/30/10
5) Finalize negotiations and sign definitive agreement	3/30/10	7/30/10
6) Complete due diligence	3/15/30	6/15/10
7) Prepare for consummating upstream collaboration	8/1/10	10/1/10
8) Close upstream collaboration	10/15/10	
C) Complete Medical Staff Development Plan	Begin	End
1) Review preliminary overview analysis in this report	1/15/10	1/30/10
2) Obtain medical staff input and growth expectations	2/1/10	2/15/10
3) Draft medical staff development plan	3/1/10	3/30/10
4) Establish medical staff development plan implementation budget	3/15/10	3/30/10
5) Commission approves medical staff development plan and budget	4/15/10	4/30/10
6) Implement	5/1/10	12/30/10

D) Develop Information Technology Strategic Plan	Begin	End
1) Complete long-term IT needs assessment	3/1/10	4/30/10
2) Assess current IT capabilities and functionality	4/1/10	5/15/10
3) Define IT gaps between current and long term needs	5/15/10	6/30/10
4) Complete 3 year IT strategic plan	5/1/10	6/30/10
5) Establish 3 year (2011-2013) IT capital and operating budget	7/1/10	9/15/10
6) Commission approves IT strategic plan	9/15/10	9/30/10
7) Implement	11/15/10	Ongoing
E) Complete VRMC Market and Service Line Strategies	Begin	End
1) Update market, patient and public perception data	2/15/10	3/15/10
2) Solicit potential collaborative partner input	4/1/10	4/30/10
3) Define key service line strategies for VRMC	4/1/10	4/30/10
4) Coordinate service line growth into medical staff development plan	4/15/10	4/30/10
5) Prepare business plans for each service line growth strategy	5/1/10	6/15/10
6) Prioritize service line strategies and budgets	6/15/10	6/30/10
7) Finalize implementation plan	7/1/10	7/30/10
F) Evaluate Participation in Medicare Demonstration Project	Begin	End
1) Submit documentation to Seim Johnson for evaluation of VRMC cost report	1/1/10	1/15/10
2) Receive Seim Johnson report	1/15/10	1/30/10
3) VRMC commission evaluates potential and decides on submitting Medicare demonstration application	2/1/10	2/15/10
4) If VRMC elects to proceed, complete application and submit to Medicare	2/1/10	2/28/10

IMPLEMENTATION SCHEDULE FULL TEXT

G) Review if Virginia Should continue to be in the Healthcare Busin	Begin	End
1) Outline the structural and legal options for Virginia and if maintaining VCC and VRMC as integrated operations is the best model (Governmental, Not-For-Profit, For-Profit, Hospital District, etc.)	2/1/10	2/28/10
2) Narrow options and coordinate with Task B - Upstream Collaboration Opportunity	3/1/10	3/30/10
3) Implement steps if necessary to move VRMC from city ownership to the selected options (The details of this activity will vary based upon the decisions of G-2)	3/30/10	12/30/10
H) Adjust VRMC financial reporting	Begin	End
1) Commission adopts initial 2010 budget	1/1/10	1/15/10
2) VRMC completes twice monthly cash position projections for January-June, 2010	1/1/10	1/30/10
3) Report VRMC cash position to commission and city council twice monthly	1/1/10	6/30/10
4) Extend cash monitoring reporting as necessary	7/1/10	12/30/10
I) Complete Comprehensive VCC Cost Reimbursement Analysis		
1) Engage a third party to complete a comprehensive VCC cost and reimbursement analysis	2/15/10	2/30/10
2) Complete analysis	3/1/10	4/15/10
3) Commission reviews draft report	4/15/10	4/30/10
4) Finalize report and implement recommendations	5/1/10	5/30/10

J) Establish Communications Plan	Begin	End
1) Define internal communication requirement and implement a plan that keeps all employees informed about operational issues, commission issues and discussions etc.	1/1/10	12/30/10
2) Commission and City Council establish a communication plan and issues comprehensive monthly statements about VRMC's operations and strategic options that are being evaluated	2/1/10	12/30/10
3) Prepare specific communication documents for employees of the public based upon significant implementation decisions (if any)	2/1/10	12/30/10
K) Establish VRMCs 2011 Budget	Begin	End
1) Define VRMC revenue, expense and capital assumptions for 2011	5/1/10	5/30/10
2) Departments submit preliminary 2011 operating budgets	6/1/10	6/30/10
3) Departments submit preliminary 2011 capital budgets	7/1/10	7/15/10
4) VRMC management review of VRMC's departmental and integrated budget	7/1/10	7/30/10
5) Based upon management feedback, departments adjust 2011 operating and capital budgets	8/1/10	8/30/10
6) VRMC management completes proposed 2011 budget	8/15/10	9/15/10
7) Commission receives and reviews proposed 2011 budget	9/15/10	9/30/10
8) VRMC management completes final VRMC 2011 budget	10/1/10	10/15/10
9) Commission receives and approves 2011 budget	10/15/10	10/30/10

Estimated 2013 VRMC Market Area FTE Physician Needs

Primary Care	Demand 2013	Current Supply	2013 Surplus (Deficit)
Family Medicine	10.3	5.0	(5.3)
Internal Medicine	9.4	4.5	(4.9)
Pediatrics	2.9	3.0	0.1
SubTotal	22.6	12.5	(10.1)

Surgical Specialty	Demand 2013	Current Supply	2013 Surplus (Deficit)
General Surgery	2.6	2.0	(0.6)
OB/Gyn	3.9	4.5	0.6
Ophthalmology	2.6	4.0	1.4
Orthopedics	2.8	1.0	(1.8)
Otolaryngology	1.1	1.0	(0.1)
Plastic Surgery	0.7	0.0	(0.7)
Urology	1.5	1.0	(0.5)
Subtotal	15.2	13.5	(1.7)

Medical Specialty	Demand 2013	Current Supply	2013 Surplus (Deficit)
Allergy	0.7	0.0	(0.7)
Cardiology	2.7	0.4	(2.3)
Dermatology	1.4	1.0	(0.4)
Gastroenterology	2.1	0.0	(2.1)
Hematology/Oncology	0.8	0.4	(0.4)
Nephrology	0.5	0.0	(0.5)
Neurology	1.0	1.0	0.0
Psychiatry	2.0	0.0	(2.0)
Pulmonary	0.8	0.5	(0.3)
Rheumatology	0.5	0.0	(0.5)
Other	1.5	0.5	(1.0)
Subtotal	14	3.8	(10.2)

Total	51.8	29.8	(22.0)
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*Hospital based physicians in Emergency, Radiology, Pathology and Anesthesiology are not assessed in this chart

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