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Greetings from South Texas! I always look forward to this annual publication and appreciate the hard work done by the people who put it all together. The arrival of said publication means that we are more than half way through our fiscal year and it always seems like an appropriate time to reflect…reflect on what is working and on what we still have time to improve upon.

So that said there continues to be a frenzy of activity in our chapter. Working well is our statewide webinar series, our certification initiative and the introduction of two new programs--the Valley Forum that took place back in September and the Women’s Forum scheduled April 25, 2014.

I reflect also on our theme this year—*Whatever it Takes*--and am proud to be amongst so many friends and colleagues that do so every single day. In a climate where there is so much anxiety and uncertainty I am encouraged by the *opportunity* that always seems to present itself in the wake thereof and encouraged by the number of people who see it that same way. Doing whatever it takes in our own capacity every single day is all that is required.

I look forward to seeing you at an upcoming program and, as usual, appreciate the opportunity to serve the South Texas Chapter.

Tammie Galindez
President, 2013-2014
A Lone Star welcome to you from the Lone Star Chapter, the Texas Voice and hopefully to see you at the Texas State Conference. As we look to another great state conference, we have much to be excited about; both in what we’ve accomplished and in what lies ahead.

We’ve accomplished much in the Lone Star Chapter this year, yet it is but a stepping stone to what is yet to come. We’ve worked collaboratively with the other Texas chapters on a certification program, we’ve expanded our social offerings, we’ve partnered with TAHFA for one of regional meetings, we developed a theme around our educational offerings “REFRESH|RENEWAL|REENERGIZE”, we came into the 21st century with our electronic newsletter, and so many others. Not to spill any secrets of things to come but…we are exploring additional joint offerings, looking to make better use of technology in our educational events, and whatever else our next chapter president, Elizabeth Pulliam, may have up her sleeve.

As I think on National Chair Steve Rose’s theme, the words “Whatever It Takes” seem to ring truer than ever. And, “whatever” in that theme is an ever-evolving thing. Whether it be shrinking reimbursements and thereby shrinking budgets for education and professional association membership, a focus on quality, the move to population health management, there is one thing that is consistent, change. There are many challenges ahead in our industry and our association that will cause us to do “Whatever It Takes”. I am proud and humbled to be part of a group that is willing to step to the plate and do exactly that.

Hope to see you in Austin!

Bill
President’s Corner - Gulf Coast

I am humbled by the opportunity to serve as the Texas Gulf Coast Chapter President for 2013 – 2014. I would like to start by thanking everyone who has been instrumental in our successes. It is indeed an honor to serve our Chapter and it would be unfair if I failed to recognize the leadership team and all our members who make our Chapter successful.

This has been an awesome year so far… we embraced a “pause and reset” concept. Our team has been focusing on a number of innovative initiatives, while keeping the metrics provided by National in the forefront. Some of our successes:

- Introduced a Chapter theme for the first time - “Every 1 Matters”
- Development of a new Chapter organizational structure
- Rebranding of our communication materials
- Inaugural monthly newsletter
- Inaugural women’s breakfast
- Inaugural breakfast for physician alignment special interest committee
- Inaugural event for students and C-Suite / Executives
- Monthly social activities – FUN! FUN! FUN!
- Revamped the certification incentive to provide $600+ incentive for passing the CHFP exam
- Board Challenge for passing the CHFP exam
- Concerted effort to not only recruit volunteers, but also get them plugged-in with committees
- Inviting our generous sponsor partners to introduce speakers and highlight their firms
- Received permission from National HFMA to pilot a student program as full-time members
- Piloting a YouTube channel

Again, I am truly humbled for having given the opportunity to serve you – it has been an absolute pleasure.

Regards, Natasha

Natasha Baria Mehta, FACHE, FHFMA
President 2013 – 2014
HFMA - Texas Gulf Coast Chapter

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As you read this you are probably expecting a story of an exotic destination of a wonderful people, and a story about a team of caring individuals going on a medical mission to Peru. While this is true, it is about much more than that. It is, I hope, as you will soon see, about you. This is not an article about the value of thoughtful, logical deliberation. In fact, it is a celebration of just the opposite.

A few years ago, I was attending church and an announcement was made that a group of college age men were going to go to Joplin, Missouri in the aftermath of the tornado which turned a 2 mile by 7 mile stretch of average American town into something resembling a World War I no-man’s-land. Almost on impulse, I volunteered to go, and by nightfall, I was in Joplin and by morning picking up trash and debris, in awe of the destruction, in awe of the miracles which abounded in such a tragedy, and in awe of how people from all over the country came, pitched in a little bit of their time and went home. That kind of effort happened thousands of times, and is the real way communities re-build; neighbors pitching in and helping do what they can, no matter how big or small it may seem.

As big a moment as my short trip to Joplin was, it was a really just a training ground for what happened next. The lesson of Joplin was this; when the opportunity to volunteer and be of service happens, don’t think too much, make the commitment and just go. Don’t think long about the costs, the reasons volunteering this week might not be a good idea, all the obligations you have at work and at home. Just go. Say yes, commit, oblige yourself, and just go.

Almost a year later, I came to realize that I sat at the crossroads of an opportunity. I had a personal relationship with people who operate the Kausay Wasi Clinic in the Sacred Valley of the Incas in Peru. I also came to realize that I, through my work with other healthcare business professionals with the Lone Star Chapter of the HFMA, knew a lot of service-minded people, who would take this cause to their hearts, create an amazing organization and accomplish some amazing things.

This core group of HFMA volunteers, Phillip McCullough, Chris Joiner and Tammy Walsh and I formed Texas de Peru with the initial target of sending an orthopedic surgical team to treat the poor in the rugged terrain of the Andes of Peru. The space of this article just is not enough to describe all the stories, the miracles we saw. Nor is it enough to describe all of the lives impacted, there, or the impact on the lives of each volunteer who went.

When we arrived at the village of Coya, 9600 feet high and nestled in a tight river valley at the base of some large Andean peaks. We spent most of the afternoon getting ready for the patients which would be at the clinic when we officially opened the mission the next morning. Our doctors and nurses got a feel for the clinic the protocols and how the flow would go the next day. The temperature gets close to freezing sometimes at night, and that night was no exception. Most of the people in the area are heavily bundled most of the time, as there is very little firewood for heating.
I expected we would see about 120 patients during our week-long mission. When our team of 21 orthopedic surgeons, anesthesiologists nurses and volunteer arrived at the clinic there were 120 people lined up outside the clinic. Some, coming from great distances, had been waiting since 2am in the morning. By the time we finished our mission; we saw over 300 patients and performed 43 surgical procedures.

The clinic had been publishing and spreading the word for weeks that an orthopedic foot and ankle specialty clinic was coming. Most of the people in the area are subsistence farmers and the terrain is quite rugged. Naturally, a foot and ankle focused orthopedic mission would be extremely helpful. As subsistence farmers, if a farmer gets injured, the children very often must take up the slack, or the family cannot raise enough to get by.

There were numerous memorable and miraculous stories including one about a 9 year old boy named Jover. Jover was brought to the clinic by former American student named Tyler who had years earlier studied agriculture in the area and learned the local language of Quechua. Tyler met Jover while walking through village and learned he had broken his arm 10 days prior. Jover had lost the use his arm and the Tyler convinced the family to let him take Jover to our clinic. The fact is that if our mission didn’t have orthopedic surgeons on the team, there would not be much that could be done for Jover. Fortunately, the timing was perfect, and our doctors were able to perform a surgery on Jover, and repair his arm. Coincidence? Absolutely not.
As a postscript, Tyler has volunteered and will be joining Texas de Peru on our upcoming August 2014 mission. On that mission we will be conducting a women’s health surgical specialty clinic. We will also be providing logistical support and assisting the doctors who had volunteered last year to make a return trip this May. All of this creates a foundation for the future, to enable ourselves and others to deliver healthcare to the poor, encourage and train leaders to serve and deliver healthcare.

I hope this article has been an encouragement to go. Whether is be as a volunteer with Texas de Peru in the high Andes of Peru, or something more local, I hope when you hear the call, you stand up, and answer loudly, “Yes, I will go!”

**Tips for Volunteer Leaders.**

**Find the Right Attitudes**

Getting the right people and attitudes on the team is critical. Look for the “yes, if…” people and avoid the “no, because” crowd. Find people you can spend a couple of hours in a car with them. All else will follow if you have good people on the team.

**Pack Your Flexibility**

Things will go wrong. Be flexible, expect it, deal with it and everything will be OK. Getting the right people makes this easier too.

**Redefine Victory**

We had accumulated over $250,000 of medical equipment and supplies including arthroscopic gear we purchased for the clinic, which would be a leap forward in the treatments we could do. That was the plan, at least. All that gear was held up in customs and we never got to use it. Being flexible and being able to redefine victory, is particularly easier if you approach the mission with a healthy perspective that this is bigger than us, we are not in charge, that God will perform miracles his way, not necessarily our way.

**Big Dreams Have Room for Others**

Or, said another way, if your dream has no room for others, it might not be much of a dream. This mission would simply not be the success it was without a lot of people contributing their talents, time and creative enthusiasm. This is real hard to do alone.

**Just Go!**

You will always have incomplete information and incomplete qualification and there are always a hundred rational reasons to say no. Ignore them. Say yes. Go. Volunteer. Serve. You will encounter hardship and setback. But you will also see miracles. I guarantee an adventure, an education and an absolutely rewarding experience.
### Officers

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2013-2014

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Lone Star Chapter Chatter
2013-2014

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SOCIAL EVENTS

MAJOR LEAGUE INSTITUTE

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2013-2014

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South Texas Photos
2013-2014

Above Image:
HFMA ANI 2013 President's Dinner in Orlando
Steve Rose—2013-2014 HFMA National Chair,
Chris Snyder—President Elect, Clint Owen—Vice President,
Tammie Galindez—South Texas President,
Susan Jones—Sponsorship Chair,
John Montain—Region 9 Contact,
Ralph Lawson—2012-2013 HFMA National Chair

Right Image:
Ralph Lawson—2012-2013 HFMA National Chair,
Tammie Galindez—South Texas President,
Steve Rose—2013-2014 HFMA National Chair

Left Image:
HFMA South Texas—Healthcare Landscapes 2014
Richard Rodriguez, CEO - University Health - San Antonio
Tammie Galindez - HFMA South Texas Chapter President
Melinda Hancock - HFMA National Secretary

Left Image:
HFMA South Texas Annual Institute
2013—South Padre Island, TX
Featured Keynote Speaker
Marcus Luttrell

Right Image:
HFMA Leadership Conference—South Texas Outing
Chris Snyder — President Elect, Wes Fountain—Treasurer,
Clint Owens—Vice President, Joseph Topinka—Certification
Chair, Tammie Galindez—President
As new President and Chief Executive Officer Ted Shaw takes the helm of the Texas Hospital Association in February, Texas Hospitals sat down with him for a candid conversation on the importance of listening, the art of collaboration and the tenacity of leadership.

Tell us about yourself.
I was born in Salt Lake City and lived in the upper peninsula of Michigan when I was very young. My parents worked in the copper industry, and we moved around a lot. When I was 8, we moved to El Paso, where my dad ran the world’s largest copper refinery. We lived there until I graduated from high school.

Where did you go to college?
My oldest brother had graduated from Dartmouth, and I loved visiting him there, so I followed in his footsteps. Being at an East Coast Ivy League school in 1969-70 was an interesting experience for a conservative kid from Texas. That year, there were a lot of war protests, the Kent State University shootings happened that spring, and Dartmouth officials closed the school and told us, “You can stay here and take pass/fail, or you can go march on Washington.” I chose to stay and take pass/fail until my dad found out. I then transferred to The University of Texas in Austin, where I graduated three years later in accounting.

What was your first stop out of college?
I joined Ernst & Ernst in San Antonio. It was during the five years there that I met my wife, Josie. She was from San Antonio but going to UT, so I spent a lot of time driving up and down I-35. She graduated with a bachelor’s degree in advertising, and we married in 1979, about the same time I was asked to go to the national office of Ernst & Ernst in Cleveland, where I served as the liaison between that office and the national health care practice.

So what brought you back to Texas?
In 1981, we moved back to the San Antonio Ernst & Ernst office, and in 1984, I was asked to move to Dallas and take over the company’s health care practice. I ran the Southwest region health care practice from 1984-92. It was during that time that Ernst & Ernst transitioned from strictly financial consulting to operational consulting, and I hired the first physicians and nurses into the practice.

You later became a partner with Financial Resource Group in Dallas, where you had a diverse array of consulting engagements. Tell us about that.
Financial Resource Group had five partners, including the former chief financial officer at Baylor Health Care System and another individual I’d met through professional organizations. We were a small boutique consultancy with very specific strategic financial planning and, in my case, interim operational turnarounds. I worked all over the country doing that.
You spent time both before and after Hurricane Katrina at East Jefferson General Hospital in Metairie, just outside New Orleans. That must have been a fascinating time.

Before Katrina, I was at East Jefferson for its original turnaround when they were experiencing significant losses. We stabilized it, I hired my replacement, and then I went off to do other things. Then, Hurricane Katrina came along, and the hospital got in some difficult financial trouble again. They called me to assist in rebuilding systems and processes and helping them deal with some significant changes in demographics.

What were those initial weeks like?
We had done a lot of disaster planning, but when this particular disaster happened, we found that all those things we’d prepared for didn’t really make a difference when you are running out of fuel and the fuel truck can’t get to you because you are surrounded by water. We borrowed fuel from the U.S. Navy that was flown in by helicopter. The staff had to live in the hospital; their pets were housed in the parking garage. For weeks, that’s how it was – people would be on 10 days and off 10 days. In addition, the demographics changed dramatically post-Katrina. Many of the young professional crowd went to Dallas or Houston or north across Lake Pontchartrain. The people who couldn’t afford to leave – the Medicare and Medicaid population – were the ones who returned. But that was a dark day that turned bright.

You say your next position was your biggest challenge. What was that?
Yes, that was as interim chief financial officer at Jackson Memorial Hospital in Miami, the third-largest public health system in the U.S. The year I was called in, the hospital had lost $350 million and was down to four days cash on hand. I spent every Thursday deciding who got paid. We built cash on hand up to 15 days and went from a $350 million loss to a $65 million loss in the subsequent budget. They made $45 million last year.

What have you’ve learned in working with so many different hospitals that you will be able to apply to your work at THA?
I have learned to be unflappable. I have learned to have patience in understanding and listening to people. And I have learned that you need to have a disciplined, thoughtful, planned approach, not just be reactive.

We have some huge challenges in the next few years, including Medicaid funding and the extension and/or renewal of the 1115 waiver. While those aren’t necessarily operational in nature, they are critical to the operations of the hospital. And we’re in a state where we are particularly challenged in that we rank 48th out of 50 in terms of Medicaid funding. This remains a challenge when we have to deal with a conservative Legislature that may not recognize the need for more funding. We have to leverage as many federal dollars as possible, and we must get all the different constituencies to work together. Texas is a very diverse place with a diverse mix of providers and population needs.

We have to find the balance and maximize the ability to get funds into the state.

You are a self-described data guy who has focused on improving the accuracy and timeliness of data reporting and instilling trust in data. Where can THA add value to its members’ data needs in the years ahead?
One of our problems today is that most data we receive are dated. When we get reports out, the data may be from two years ago. We need to find a way to get better, and more current, data. To maintain reimbursement, we need to put things in place to help our hospitals maximize data through electronic medical records. Large systems have very sophisticated EMRs and may do that on their own, and we can learn from that. But what about all those hospitals that are not able to buy the $100 million system or the $50 million integrated data warehouse? THA can be a focal point for these same types of capabilities and for sharing best practices. I absolutely believe that higher quality doesn’t mean higher costs. Those are the areas where I’ll be challenging the staff to come up with ideas.

You’ve said that the most important decision facing health care is how the industry can change to provide high-quality care in a shrinking funding environment. What is THA’s role in helping Texas hospitals meet that challenge?
First, THA can find ways to assist hospitals in doing things more efficiently. There are many things that all hospitals do that are not their primary business.
Are there things that THA could do for all, or many, hospitals at a substantially lower cost? Second, one of the things that should come out of the 1115 waiver is the opportunity to share best practices and ways to do things more effectively and efficiently. We need for THA to be a conduit for sharing some of that learning in partnership with the Texas Health and Human Services Commission. And third, I see THA playing an important role in making companies and vendors that provide unique services available to the industry.

**What are your primary goals and priorities for the next year?**

The first thing we have to deal with is Medicaid funding. And the second thing we have to deal with is Medicaid funding. That priority will lead to preparing for the next legislative session and whether we can secure support for a major change in the way funding is done in the state. I believe it has to be driven by the industry because a split industry will allow the Legislature to tell us what they want. We need to develop an answer for the Legislature that everybody can get behind. The other thing of almost equal concern to Medicaid funding is the extension or renewal of the 1115 waiver. We need to be actively involved in working with THHSC in determining how we can make that happen. That represents $3 billion a year in transformation dollars that we need to keep coming into the state.

**Where do you see opportunities for THA to add value and be innovative?**

I would like to explore how we can make quality improvement technology available through THA to those who may not be able to access it today. I would like to look at ways we could help members by providing efficient, effective, high-quality services that help them reduce their costs while improving performance. I would love to think that we could do some of those things to reduce the reliance on membership dues while providing additional value. In my 40 years as a consultant, I have found that the best answers are usually ones that we already know; we just have to listen to them. I want to make sure we are being responsive to what members are asking for.

**What is your definition of leadership?**

Leadership, for me, is clarifying the vision for where we are going and then having the will to make it happen. Leadership is having the guts to change if you need to change and the perseverance to see it through.

**What are your interests outside of work?**

I enjoy playing golf, although I don’t have much time to do it anymore. We have a small place outside Wimberley, and I love being in the country and working outside. I watch a lot of sports, I cook, and I never go to bed without reading. Among my favorite authors are Brad Thor and David Baldacci. I’ve also been very involved with Leadership Dallas, the Healthcare Financial Management Association, Big Brothers Big Sisters of America and the Visiting Nurse Association in Dallas.

**You have two children. What do they do?**

Jessica, 27, attended Washington and Lee University in Virginia, where I like to say she double majored in poverty and journalism. She now is married and pursuing a master’s degree in nutrition and sports science at the University of Maryland. McLean, 23, graduated in 2013 from Princeton University with a degree in sociology. He lives in New York City, where he works as a strategy consultant.

**What can members and employees expect in President and CEO Ted Shaw?**

A person that is there for them. A person with a lot of energy. And a person that wants to make life better for all of us.

This article originally appeared in the January/February 2014 issue of Texas Hospitals magazine. Reprinted with permission from the Texas Hospital Association.
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Replacing Imprecise Volume Metrics
By William O. Cleverley

Since the 1950s, the hospital industry has used the adjusted discharge or adjusted patient day metrics to define total hospital volumes. Now it’s time to adopt a more precise metric. Here are 10 reasons why finance leaders should use the equivalent discharge metric® instead. The most important: Equivalent discharges is a better predictor of total costs.

Adjusted discharge metrics are still widely used in the industry. For example, most hospitals use cost per adjusted discharge or cost per case-mix-adjusted discharge to assess their relative cost position compared to internal historical values or external benchmarks.

Adjusted discharge and adjusted patient day metrics are very easy to calculate and were reliable when the percentage of outpatient revenue was below 20 percent. However, the present percentage of outpatient revenue is now 50.2 percent, and the figure is higher in smaller hospitals (Cleverley and Associates, State of the Hospital Industry 2013 Edition, page 52).

Most hospital executives understand that adjusted discharges is an imperfect measure but continue to use it in the absence of any better alternative. But that is no longer necessary. Our research shows that an alternative metric of hospital volume—equivalent discharges—is a better predictor of total costs than adjusted discharge.

Formulas and Definitions
First, let’s begin with the actual definition of each metric. The adjusted discharge metric is expressed in the following formula:

\[
\text{Adjusted Discharges} = \frac{\text{Inpatient Discharges} + \left( \frac{\text{Gross Inpatient Revenue}}{\text{Gross Outpatient Revenue}} \right) \times \text{Inpatient Discharges}}{}
\]

We are proposing that adjusted discharges be replaced by equivalent discharges, which is expressed as:

\[
\text{Equivalent Discharges} = \frac{\text{Equivalent Inpatient Discharges} + (\text{Conversion Factor} + \text{Equivalent Outpatient Visits}) \times \text{Inpatient Discharges}}{}
\]

In the equivalent discharge definition, the following formulas are used:

\[
> \text{Equivalent Inpatient Discharges} = \frac{\text{Gross Inpatient Revenue}}{\text{Average Charge per Case-Mix-Adjusted Discharge}}
\]

\[
> \text{Equivalent Outpatient Visits} = \frac{\text{Gross Outpatient Revenue}}{\text{Average Charge per Case-Mix-Adjusted Visit}}
\]

\[
> \text{Conversion Factor} = \frac{\text{Medicare Outpatient Payment per Ambulatory Payment Classification (APC) Weight}}{\text{Medicare Inpatient Payment per MS-DRG Weight}}
\]

To further explain, equivalent inpatient discharges is simply the total of all inpatient cases multiplied by their case weight. In a similar fashion, equivalent outpatient visits is simply the total APC weight of all visits.

The only area left for definition is the conversion factor, which is the ratio of Medicare outpatient payment to Medicare inpatient payment. (For more detailed definitions, see the online version of this article at hfma.org/sfp, Winter 2014 issue.)

10 Reasons to Adopt Equivalent Discharges

The following 10 reasons show why equivalent discharges is superior to adjusted discharges as a metric of hospital volumes.

Pricing changes will not impact the equivalent discharge metric. Most hospital executives understand that pricing decisions can impact the measurement of adjusted discharges. Historically, many hospitals have increased outpatient prices at rates greater than inpatient prices to take advantage of a greater presence of percent-of-charge payment arrangements.

The net effect of this differential pricing (per our observations of 300-plus clients per year) is an increase in the level of reported adjusted discharges, making it appear as if volumes were increasing more than they actually were. As a result, cost per adjusted discharge would be understated when compared to prior time periods, or when compared to other hospitals with a different pricing policy.

A recent trend in hospital pricing reduces outpatient prices to levels more competitive with free-standing imaging and surgery centers. The exhibit below illustrates the impact of a reduction in outpatient pricing on adjusted discharges and equivalent discharges. A 20 percent reduction in outpatient pricing will reduce adjusted discharges by 10 percent, but has no effect on equivalent discharges. Thus, cost or revenue metrics based on equivalent discharges are more comparable across time and across other hospitals.

Equivalent discharges are not biased by case mix. In most cases, when adjusted discharges are computed, the metric is further refined by multiplying adjusted discharges by the inpatient case mix index (CMI). For example, in the exhibit at left, the adjusted discharges of 1,200 are multiplied by the CMI of 2.0 to yield 2,400 adjusted discharges-CMI adjusted. The primary purpose of the adjustment is to account for changes in case mix complexity over time and across comparative hospitals.

For this case mix adjustment to be valid for adjusted discharges, there must be a correlation between inpatient and outpatient case mix complexity. Outpatient complexity can be assessed by defining the average APC weight for a visit. For example, a diagnostic cardiac cath will have an APC weight of 39.59 while a colonoscopy will have an APC weight of 9.34.

Actual national Medicare claims data suggest that, while there is some correlation between inpatient and outpatient case mix, it is not that perfect. There are many hospitals with high inpatient CMIs that have low outpatient...
CMIs, and vice versa. The average inpatient CMI for the highest quartile of acute care hospitals was 1.881 in 2011, and the average outpatient CMI for those hospitals was 13.782, a ratio of 7.33.

In contrast, the average inpatient CMI for the lowest quartile of acute care hospitals was 1.098 in 2011 and the average outpatient CMI for those hospitals was 7.027 (a ratio of 6.40). Significant bias can be introduced when inpatient CMIs are applied to adjusted discharges. The greater the percentage of outpatient revenue, the worse the bias can become.

Equivalent discharges are not subject to this bias. Inpatient discharges are multiplied by the inpatient CMI to yield equivalent inpatient discharges, and outpatient visits are multiplied by the outpatient CMI to yield equivalent outpatient visits. Those equivalent outpatient visits are then converted to equivalent outpatient discharges through the multiplication of the Medicare payment conversion factor.

Equivalent discharges can be easily defined. One argument often advanced for the retention of adjusted discharges is that the measure can be easily defined. This is an argument that cannot be taken lightly because there will never be a perfect measure of overall hospital volume. And ease of computation is and should be an important concern.

However, while ease of computation is important, it needs to be offset by the validity of the measure. Significant decisions are often based on metrics such as cost per adjusted discharge. Management may decide that sizable cost reductions are in order because the hospital has an unfavorable cost per adjusted discharge compared to other hospitals. If this unfavorable comparison is the result of low outpatient pricing, decisions can be made that will harm the quality of patient services.

While adjusted discharges are easy to compute, equivalent discharges are also easy to define. At the facility level, you need to add the number of case-mix-adjusted discharges in the period and the number of case-mix-adjusted outpatient visits. You would then convert the case-mix-adjusted outpatient visits to equivalent discharges by multiplying that value by the Medicare payment conversion factor.

Equivalent discharges can be verified. Verification of the values for both adjusted discharges and equivalent discharges is very important, especially in a multi-hospital system setting where comparisons across other system hospitals are being made. One hospital may be told to reduce its cost by 10 percent because its cost per adjusted discharge or cost per equivalent discharge is 10 percent above the system average. Hospital executives will want to ensure that values for either adjusted discharges or equivalent discharges can be verified because their organizations can be dramatically affected by these values. The adjusted discharge metric can be verified by simply identifying gross inpatient revenue, gross outpatient revenue, and case-mix-adjusted discharges. The equivalent discharge metric does not require either gross inpatient revenue or gross outpatient revenue but uses case-mix-adjusted discharges and case-mix-adjusted outpatient visits in cases where all payer claims data is available. In addition, the conversion factor—Medicare payment ratio—must also be defined. Because charges are not used, pricing changes will not impact equivalent discharge calculations.

Equivalent discharges cannot be manipulated. Many executives understand how adjusted discharges can be manipulated through pricing and do not want to switch to an alternative volume metric that can be influenced by pricing.
The initial formulas presented to define equivalent inpatient discharges and equivalent outpatient visits appear to be influenced by prices because an average charge metric is used in the denominator of each equation.

However, both of the average charge terms cancel when the equation is expanded as shown below:

\[
\text{Equivalent Inpatient Discharges} = \frac{\text{Gross Inpatient Revenue} \div \text{Average Charge per Case-Mix-Adjusted Discharge}}{\text{Gross Inpatient Revenue} \div \text{Average Charge per Case-Mix-Adjusted Discharge}} = \text{Equivalent Inpatient Discharges}
\]

\[
\text{Equivalent Outpatient Visits} = \frac{\text{Gross Outpatient Revenue} \div \text{Average Charge per Case-Mix-Adjusted Visit}}{\text{Gross Outpatient Revenue} \div \text{Average Charge per Case-Mix-Adjusted Visit}} = \text{Equivalent Outpatient Visits}
\]

Changes in prices will not affect the overall equivalent discharge volume metric as shown above. This can be further seen in the exhibit on the previous page.

The equivalent discharge metric is intuitive. In many respects, the equivalent discharge metric is more intuitive than the adjusted discharge metric. The equivalent discharge metric starts by actually defining the case-mix-adjusted volumes for inpatient discharges and outpatient visits.

The adjusted discharge metric does not measure outpatient volume in any way and merely assigns a value based on total charges of outpatient volume in relation to inpatient total charges. In short, equivalent discharge counts actual volumes in both inpatient and outpatient areas while adjusted discharge only counts inpatient volume.

The equivalent discharge metric can be expanded to other areas. The nature of hospital business is changing as many hospitals diversify into other patient service areas, such as direct employment of physicians and the operation of freestanding surgery centers and independent laboratory centers. Inclusion of these ancillary operations can complicate assessment of facility-level cost effectiveness. Oftentimes, the costs associated with these ancillary operations will be removed from total costs to derive a more traditional measure of acute care hospital costs. However, many cost elements, such as administrative overhead, cannot be cleanly allocated to these ancillary areas.

The equivalent discharge metric can incorporate these ancillary service areas easily if Medicare prospective payment exists. For example, physician areas may use relative value units (RVUs) as the volume metric. To convert RVUs to equivalent discharge, we would apply the Medicare payment conversion ratio for RVUs and inpatient payment to derive equivalent discharges.

The equivalent discharge metric can be calculated on any time period. The length of the time period to be used can often vary. In some cases, monthly or quarterly data may be sufficient and, in other cases, daily activity volume may be required. The equivalent discharge metric can easily accommodate any time interval because it is based on simple counts of case-mix-adjusted discharges and case-mix-adjusted outpatient visits. The Medicare payment conversion factor most likely will not change over short time periods (see the exhibit above).

The equivalent discharge metric is a better predictor of cost. A standard assumption in economic theory is that cost is a function of volume, and thus, greater volume requires more costs. The most important question to answer is which metric—adjusted discharges or equivalent discharges—explains a greater percentage of cost variation.

To answer this question, we pulled data in 2012 for all acute care hospitals that were not critical access designated. We next computed adjusted discharges and equivalent discharges for all 3,000 hospitals with complete data sets. We then ran simple regressions using total hospital expenses adjusted for cost-of-living differences against case-mix-adjusted discharges and against equivalent discharges. We would expect that each metric would be able to explain a large percentage of the total cost variance because volume is the single most important predictor of cost.

The adjusted discharges metric explained 83 percent of the total cost variance but the equivalent discharge metric explained 95 percent of total cost variance. This represents a sizable improvement in cost explanation and is a direct result of an absence of bias in the definition of equivalent discharges when compared to adjusted discharges.

The Better Metric

As shown, the adjusted discharge metric is usually biased when used as a measure of total hospital volume. The equivalent discharge metric is a far better measure of overall hospital volume and is a much better predictor of total costs (i.e., 95 percent of variance compared to 83 percent).

Assessing costs across different hospitals or across time periods within the same hospital will be more valid when equivalent discharges is used as the volume measure rather than adjusted discharges. The only reason for using adjusted discharges would be computational ease. However, we have shown here that equivalent discharges can be calculated as easily as adjusted discharges.
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In early 2013, the South Texas Chapter sponsored certification training through the use of “Go To Meeting” (See https://www3.gotomeeting.com/m/g2mab_49sideLMlp.tmpl.) and the use of Christopher Stauder, the individual who has conducted HFMA Certification Candidate Practicums across the country for years. The classes were held once every two weeks from late February to early April on Friday afternoons and included a free webinar guide to be used along with the training. In total, four, two-hour classes were held covering four core areas.

<table>
<thead>
<tr>
<th>Knowledge domain</th>
<th>Financial reporting</th>
<th>Budgeting &amp; forecasting</th>
<th>Revenue cycle</th>
<th>Internal controls, managed care, contracts and disbursements</th>
</tr>
</thead>
<tbody>
<tr>
<td>Topics covered</td>
<td>Financial statements, ratio analysis</td>
<td>Variance analysis, breakeven/CVP, capital budgeting</td>
<td>Revenue cycle process, IPPS, OPPS, MPFS, Medicare billing fundamentals</td>
<td>Various, incl. cost reporting</td>
</tr>
<tr>
<td>Outline of webinar</td>
<td>Financial reporting overview; ratio case studies; sharing and discussion of findings</td>
<td>Budgeting &amp; forecasting overview; variance, CVP &amp; capital budgeting case studies; sharing and discussion of findings</td>
<td>Revenue cycle overview; revenue cycle process case studies; sharing and discussion of findings</td>
<td>IC and compliance; contract mgmt; disbursements; case studies; wrap-up</td>
</tr>
<tr>
<td>Learning objectives</td>
<td>Calculate financial ratios and operating indicators; analyze financial statements</td>
<td>Calculate variances and breakeven; determine profitability of capital projects</td>
<td>Calculate reimbursement under IPPS, OPPS and MPFS; design a best-practice revenue cycle; design a fee schedule; calculate revenue cycle KPIs</td>
<td>Draft a compliance plan; calculate Medicare margins from a cost report; analyze a managed care contract; analyze clinical quality indicators</td>
</tr>
<tr>
<td>% of exam</td>
<td>16-20%</td>
<td>18-22%</td>
<td>21-25%</td>
<td>33-45%</td>
</tr>
</tbody>
</table>

In addition, Mr. Stauder conducted three additional classes for students that wanted personalized teaching. As a result of the training, one of the chapter members passed the CHFP exam and others indicated a desire to get further training. Lone Star and Gulf Coast Chapters asked to be part of the effort and bring this to the state level. The Texas Stagecoach was ready to depart for a long trip!

The Texas-sized certification effort began in August 2013. It was a similar program to that developed by the South Texas Chapter but only over a longer period of time. Specifically, Mr. Stauder taught one core webinar a month in August, September, October, and then in November so students had the holidays to review their notes and study for the exam.
Additional speakers were invited to teach topics that complimented the core courses taught by Mr. Stauder. Those additional presentations brought an experienced perspective on the subjects presented in the core classes but were designed to help chapter members who did not have a background in particular areas:

September: Wayne Martin, Budgeting and Forecasting.
October: Gordon Edwards, “Enhance Performance, Eliminate the Budget.”
January: Ellen Stewart, Internal Control, Contract Management, and Disbursements.
January: Suzanne Lestina, Critical Data and Revenue Cycle.

Collaboration between the three chapters was incredible and literally students from all over the state had access to the best classes and preparation materials needed to give them the confidence to take and pass the CHFP exam.

Texas is truly leading the way and now Region 9 is looking to have a region-wide program later this year. So….come on Arkansas, Louisiana, Mississippi, and Oklahoma and get on the Texas stage coach of certification! YA-HOO! Let’s get certified!!!!

PS. For all those behind the stage coach (which is a dusty place to be), visit the South Texas Chapter’s certification webinars from early last year at http://www.stxhfma.org/pages/certification. The most recent webinars and materials will be posted in the coming weeks. Those interested in viewing the webinars and doing a self-study should contact their respective chapter certification committee chairs or the South Texas Chapter Certification Committee Chair about acquiring a copy of the webinar guide to be used with the recordings. The certification chairs are there to help chapter members get on the Texas stage coach for certification success!

Joseph Topinka

THANK YOU

Joseph, Elizabeth, Beverly, for coordinating and all the work you did to get this together.
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HFMA Texas Gulf Coast Chapter Annual Meeting and Conference

Save the Date
May 16, 2014—Friday

The Houstonian
111 N Post Oak Ln
Houston TX 77024

HFMA Monthly Luncheon Meeting
March 21, 2014
11:15 am - 1:30 pm

Perspectives on Optimizing Use of Mobile Health Solutions

Speaker- David Allen — Director — PwC