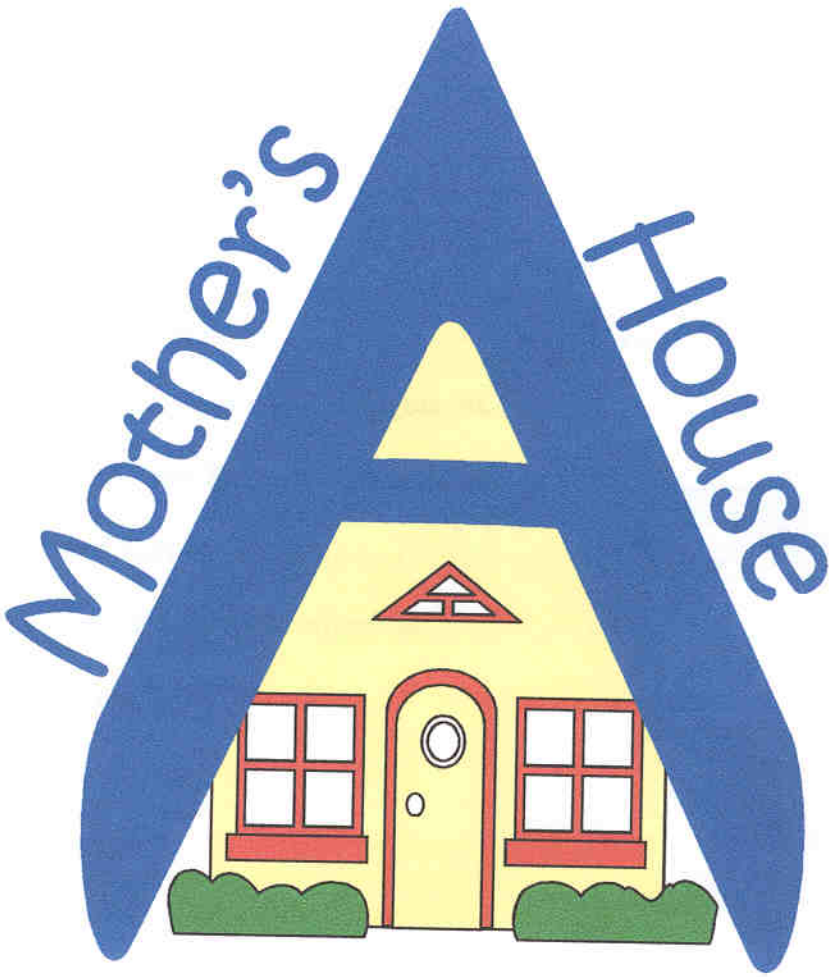
Management Academy Business Plan



A Regional Residential Antepartum Facility

GA12 Team

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I. EXECUTIVE SUMMARY

In 2000, 2,742 pregnant women were admitted as inpatients to Memorial Health University Medical Center for obstetrical services. 1,264 were admitted because of pregnancy-related complications. Of these, 111 met the proposed criteria for management in a residential facility that, if available, could have saved the hospital and the health system approximately $1,000,000. Evidence of the strain on the health care system is the financial burden placed on the hospital and by the limitations of available obstetric hospital beds for laboring women. This project proposes an alternative system of care that is both more cost-effective and more medically appropriate-the establishment of an outpatient residential facility for pregnant women with selected high-risk medical conditions.

Women who experience complications during their pregnancy may require close (daily) monitoring by obstetricians with special skills in caring for high-risk pregnancies to increase the chances of the best possible outcomes for mothers and babies. Nationally, these physicians, Maternal-Fetal Medicine Specialists (MFM) or Perinatologists, are located in close proximity to hospitals that provide the highest level of care for pregnant women and infants (Level III tertiary care centers). Memorial Health University Medical Center in Savannah, Chatham County, Georgia, is a Level III hospital and is the only such facility in this area of the state. Memorial's catchment area covers the southeast corner of the state of Georgia, comprised of 24 counties, divided into three separate public health units.

The primary goal of specialty prenatal care is to help the mother carry the pregnancy as close to term as possible with the least risk to herself and to the infant. The most common result of pregnancy-related complications--social and/or medical--is prematurity (born before 37 weeks of gestation) and low birth weight (born weighing less than 2500 grams). Each year in Southeast Georgia, low birthweight babies (under 5 ½ pounds at birth) account for 7% of all the live births. Additionally, 2% is very low birthweight (VLBW), weighing less than 3 pounds 4½ ounces, many small enough to hold in the palm of your hand.

Currently, women with certain medical risk factors that put them at risk for early delivery are admitted to Memorial as in-patients to receive risk-appropriate medical care or simply because they live too far from the tertiary center to receive the appropriate medical oversight. Women living within the region may have to travel as far 170 miles to reach the tertiary center, making daily trips impossible. Without the close medical supervision, these women are at greater risk for delivering prematurely or for negative outcomes themselves.

The establishment of a residential facility for selected pregnant (antepartum) women at risk for preterm birth will create the mechanism to eliminate the current practice of providing necessary medical management in a setting that does not correspond to the level of risk. A residential facility creates a resource/risk appropriate venue that we expect to decrease the cost of care.

The development of this approach to prenatal specialty care will have two phases; this project addresses Phase I. Named *"**A Mother's House**"*, the proposed site for the Phase I center is a renovated building on the grounds of Memorial Health University Medical Center and will provide a homelike environment for women receiving medical care from the Maternal Fetal Medicine (MFM) specialist. Physicians and nurses will monitor the residents' pregnancies. Perinatal educators, social workers and public health nurses will provide education and counseling. While the measurable

objective of this project is the cost savings to the hospital, we believe that the project will improve pregnancy outcomes, an objective to of Phase II.

II. DEFINITION OF PROJECT

Memorial Health University Medical Center (MHUMC), located in Savannah, Georgia is the regional hospital providing the highest level of care (tertiary care) for the southeast corner of the state. Residents from twenty four (24) counties rely upon Memorial for services ranging from trauma care to perinatal services, which encompass the care of pregnant women, their fetuses and newborn infants. Specialty physicians, nurses, social workers and other allied professions work together to improve outcomes of pregnancy. Maternal-Fetal Medicine specialists, obstetricians with special training in the care of high-risk pregnancies, are a valued resource for the entire region.

To achieve the primary goal of healthy pregnancy outcomes, women with complications of pregnancy receive special care. These women require routine prenatal care but often need close (daily) monitoring Maternal-Fetal Medicine physicians. For those women that live outside of Savannah, many as far as 170 miles away, it is not only impractical but also impossible for them to make daily trips to the physician. For this reason they must be admitted to the hospital as in-patients to receive the monitoring they need.
Care provided in this manner is not cost-effective or appropriate use of medical facilities for the level of risk.

Our plan is to establish a residential facility outside of the hospital but still very close that would provide the level of care these women need but in a more cost-efficient manner.

The strategic plan included research into several options:

- Construction of a free-standing facility (8-10 efficiency units, plus common areas)
- Leasing existing space
- Expansion of the existing Ronald McDonald House located on the Memorial Health campus
- Renovation of an existing facility on the hospital campus

After exploring each possibility the team decided to proceed in phases and selected the option that will allow more immediate implementation in Phase I, renovation of an existing structure previously used to house physician residents and their families. Owned by and located on the campus of MHUMC, the building has four 2-bedroom apartments within 50 yards of the emergency room.

Phase I – ***A Mother's House***
Renovation will not require major structural changes. Inspection of plumbing and electrical services and necessary corrections will assure code compliance and safety. Furnishing each apartment with appliances, furniture and utilities will create a safe, more private home-like environment than a hospital room, a benefit we perceive for the residents.

High-risk prenatal patients are admitted to the hospital for observation and for intervention.
When the acute risk is over, the Maternal-Fetal physician will determine if "discharge" to ***A Mother's House*** is appropriate based on the proposed criteria for admission (**Table 1).**

implementing Right From the Start Medicaid to provide coverage for prenatal care and delivery for pregnant women. Today most women have private insurance or Medicaid. Right From the Start Medicaid provides coverage from the moment of application to pregnant women 200 % of poverty who are otherwise ineligible for Medicaid. Local health departments and hospitals provide information about and complete applications for Presumptive Eligibility. In 1988, Medicaid reimbursed 50% of all deliveries in Georgia and 58% in the Southeast Perinatal Region, decreasing hospital losses. The onset of prenatal care in the first trimester has increased to 84.6%.

However, the financial strain on the health care system continues. While unreimbursed normal deliveries have decreased, hospital care for high-risk pregnancies is still very costly for hospitals. The majority of payers, including Medicaid, reimburse hospitals based on Diagnosis Related Groupings (DRG). The payment code for a high-risk woman admitted to the hospital for an extended period of time prior to delivery are the same as that for a woman who comes to the hospital, delivers and goes home all within a 24 hour period. Reimbursement is not related to the length of time a woman's hospitalization prior to or after delivery, but is provided at a fixed rate. **Table 2** details the financial loss Memorial Health University Medical Center incurred in FY 2000 as a result of in-patient antenatal care, representing costs incurred for all patients admitted for antenatal care, a subset of which meet the criteria for residential care. **Table 3** shows the cost savings for the candidates for a residential facility.

Table 2 (see Appendix A)

Cost Analysis by DRG – All Inpatients with Antenatal Care FY2000 Annualized

Case Type	# Cases	Total Cost	Variable Cost	Reimbursement	Variance
Total	1,244	$6,919,279	$3,342,045	$3,842,725	-$3,076,554

Source: MHUMC Decision Support/Trendstar/CCA

Table 3 (see Appendix B)

	Cases	Avg. Length of Stay (ALOS)	Gross Revenue	Est. Net Revenue	Variable Cost	Fixed Cost	Total Cost	Net Income
Total	111	22.92	$ 3,212,881	$1,552,450	$1,070,867	$1,553,876	$2,624,743	($1,072,293)

Source: MHUMC Decision Support/Trendstar/CCA

* Collection percent not factored because reimbursement remains constant regardless of Length of Stay (LOS)

While this proposal seeks to address the costs of antenatal hospitalization, the costs associated with prematurity are not limited to these. The consequences of babies born too early and too little are well documented. In Georgia Perinatal Region 5, the average hospitalization for a VLBW infant in a tertiary level nursery is 51 days and the cost is $156,000. LBW babies are responsible for almost 60% of the infant mortality in our area. Surviving premature infants are more likely to suffer major disabilities such as cerebral palsy, mental retardation and vision and hearing deficits. The costs of disabilities to the community and society are often lifelong-medically, educationally, and functionally. The diagnosis of cerebral palsy among prematures varies according to birth weight from a low of 5/1,000 babies to a high of 250/1,000. The ***Partnership for Health and Accountability*** in Georgia reports that in 1998 in the U.S., the costs of health care, education and child care for

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children born with low birth weight were between $5.5-$6 billion MORE than the costs for normal weight babies.

The principal goal of developing and implementing the residential antepartum facility is to reduce the real cost of high-risk obstetrical care in a defined group of patients. The performance tool used to define success is cost analysis. User satisfaction is a measurable adjunct determined by satisfaction surveys administered to residents and to our project partners.

Because Memorial is the only tertiary center in the region, it is imperative that it continues to provide antenatal care but in a more cost-conscious manner.

III. INDUSTRY ANALYSIS

Georgia's regional perinatal system was created in the early 1970's to assure that the highest level of maternal and neonatal care is available to all Georgians by designating sites fairly evenly distributed throughout the state. Each site serves a designated geographic catchment area and receives supplemental funding from the Georgia Division of Public Health. There are currently six such centers across the state, Memorial Health University Medical Center serving the southeast quarter of the state.

Residential antenatal facilities exist in only one other location in Georgia. The Level III Tertiary Center in Macon, The Medical Center of Central Georgia, has operated a similar facility for four years and reports cost-savings that are comparable to our projections. High-risk women from the Macon catchment area are housed in a renovated Days Inn Motel near the hospital. Staff from the Maternal-Fetal Medicine office were contacted for information as well as counsel as this plan evolved.

Additional perinatal centers across the South were surveyed to identify other antenatal residential facilities. A summary of the findings is in **Table 4.**

Table 4

Perinatal Center	Location	Arrangements for High-risk antenatal patients
Memorial Health University Medical Center (MHUMC)	Savannah	Admitted as in-patients
Carolinas Medical Center	Charlotte, NC	Admitted as in-patients. System identical to current MHUMC system
Medical Center of Central Georgia (MCCG)	Macon, GA	Outpatient residential facility, *Orange Terrace*
Medical University of South Carolina	Charleston, SC	Admitted as in-patients then administratively changed to outpatient status while occupying the same bed but at an outpatient rate. *"PASS Program" (Perinatal Access Support Services)*
Shands University Medical Center	Jacksonville, FL	Admitted as in-patients. System identical to current MHUMC system

IV. TARGET MARKET

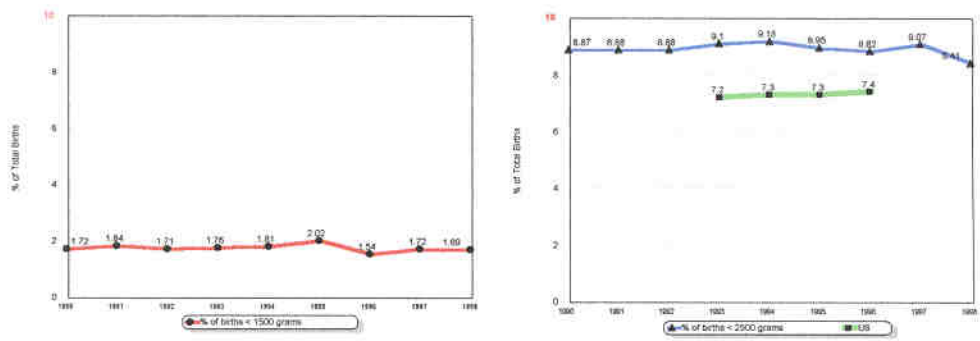
State health data and regional (tertiary) hospital admission data were also reviewed to determine the scope c the need.

- Data from Georgia Vital Records reveals that for the past five years, seven (7) percent of all births in the region resulted in an infant weighing less than 5 ½ pounds (2500 grams).
- In 1999 there were 2,742 pregnant women admitted to Memorial Health for obstetrical care. A review of these patient records revealed that of these women, 111 met the proposed criteria (**Table 1**) for management in a residential facility.

Nationally, little change has occurred over the past thirty years in the percentage of births that are low birth weight (LBW), despite many and varied interventions. 1990-1998 rates are depicted in **Figure 1.**

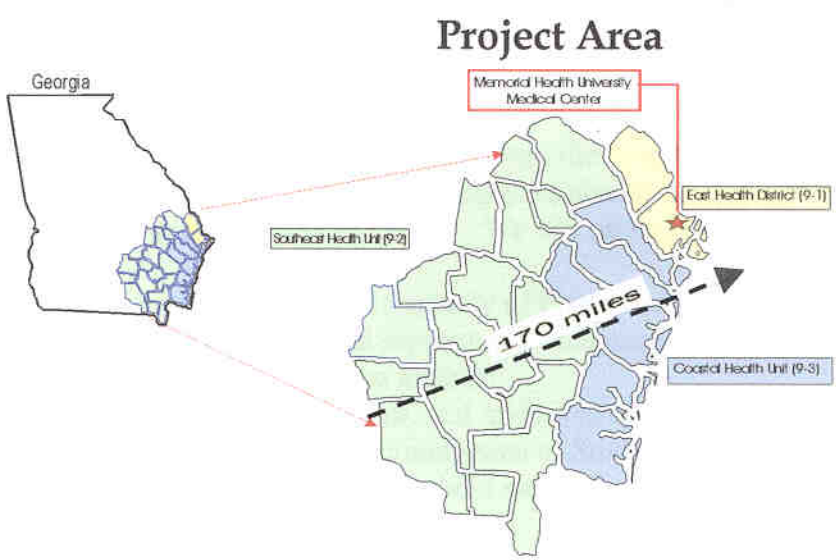
Figure 1

Very Low Birthweight & Low Birthweight Rates
Southeast Perinatal Region 5
1990-1998



Memorial Health University Medical Center is in Savannah, Georgia in the most eastern county of the state. It is the designated Level III tertiary care center serving 24 surrounding Georgia counties, as well as some counties in South Carolina (**Figure 2**).

Figure 2



These 24 counties represent the entire southeast quarter of the state. Savannah is the county seat of Chatham County, the most populous and wealthy county in the region. There are approximately 44,000 females of childbearing age living in these counties, delivering 12,574 liveborn babies each year. Obstetricians, two family physicians and 3 midwives provide prenatal care and delivery at 15 hospitals and one birthing center. Mostly rural, the only public transportation system is in Savannah, making transportation expensive and difficult. Per capita incomes range from $13,245 to $26,384 (Chatham), averaging $18, 672 (**Table 5**). By comparison, the wealthiest county in the state, Atlanta's Fulton County, had a per capita income of $41,325 in 1998.

Table 5

1998	Total
Total Population	2,795,191
Average per capita income	$18, 672
Population of Women of Childbearing age	44,000
Number of Pregnancies	14,968
Number of Live Births	12,574
Number of Fetal Deaths	746
Pregnancy Terminations	1,648
% Of LBW infants	8.4%
% Of VLBW infants	1.7%

VI. COMPETITION

Because no such facility exists in the area and because of the regionalized system of maternal care in Georgia, there is no competition.

VII. MARKETING STRATEGY

The initial emphasis for marketing ***A Mother's House*** is to move from an "idea" to an actual "entity". The best way to sell a new entity to a community or target audience is to develop a unique name with a logo that conveys your concept. We selected a name and logo to establish the legitimacy of this entity. Once ***A Mother's House*** is open, we will develop public awareness materials and distribute them to spread the word of this new resource that assists in the care of women at risk for pre-term delivery.

The marketing strategy is two-pronged.

- First, we must secure the authority and support from the hospital to implement the project. As we gathered information to complete this plan, we shared the concept with some individuals on the hospital management team. We will make a formal presentation to the management team.
- Once operational, we will focus on sustainability of Phase I and expansion to Phase II. Sustainability is dependent on financial support and acceptance by stakeholders, namely physicians and residents. Target groups include:
    - Obstetricians, family physicians, and midwives that provide prenatal care and delivery to women in our 24 county area of Southeast Georgia
    - Women's groups with concerns about women's health issues (i.e. civic clubs, sororities, church groups, etc.)

The development of the public awareness materials for use throughout the region will begin immediately upon opening ***A Mother's House***. Representatives from the medical, consumer, and charitable sectors will review the proposed materials to offer ideas for improvement and advice on dissemination of such information. Materials presented to physicians & women's groups will focus on the risk-appropriateness of care provided to women at ***A Mother's House*** with the goal of a better pregnancy outcome for mothers and babies. A three-month advertising campaign will initiate public awareness of the project. Six months after the initial ad campaign, the Project Coordinator will conduct a survey of physicians in the region to see if we reached one of our target audiences for marketing. Future considerations for marketing *A Mother's House* include annual ad campaigns, a quarterly newsletter for stakeholders, and "spotlights" for local newspapers to use that highlight moms in their communities who have stayed at ***A Mother's House***.

VIII. PROJECT OPERATIONS

Phase 1

A. Preparation of facility

1) Identification of site & authority to proceed

2) Renovation of facility
   - Structural renovation
   - Assurance of code compliance-plumbing, electrical, fire
   - Pest extermination

3) Purchase and installation of
   - Furnishings
   - Carpet
   - Appliances

4) Arrangements for utilities not currently available
   - Telephone services
   - Television cable services

5) Operations
   - Food
   - Security
   - Housekeeping
   - Diversion/recreation activities
   - Prenatal education
   - Health counseling (nutrition, lactation, family planning, etc.)
   - Care coordination/Case Management
   - Social services
   - Transportation to MFM
   - Emergency plan

6) Program Coordination
   - Definition of responsibilities of program coordinator
   - Selection of or assignment of coordinator
   - Negotiation with partners and definition of roles and responsibilities
   - Development of policies and procedures

C. Evaluation

- Patient & family satisfaction
- Medical provider satisfaction
- Cost analysis

IX. IMPLEMENTATION PLAN AND TIMELINE

6/1/01 Obtain authority from management leadership at Memorial Health, Inc. for implementation
6/30/01 Assure funding for Phase I
6/30/01 Assign a project manager for Phase I
8/1/01 Develop written policies & guidelines for to "A Mother's House"
- Admission policies
- House rules
- Nursing guidelines

8/1/01 Complete renovation
9/1/01 Admit first resident
9/1/01 Begin public awareness campaign
Begin Business Plan for Phase II
3/1/02 Complete 6-month evaluation
- Provider satisfaction survey
- Client satisfaction survey

10/1/02 Complete 1-year fiscal analysis
Complete 1-year customer satisfaction survey

X. POTENTIAL RISKS

A. Failure to implement plan Phase I

- Insufficient funding
- Lack of support by Memorial Health University Medical Center administration
- Renovations more involved than predicted
- Safety not assured
- Inability to arrange meals, diversion

Contingency Plan

Continue to provide in-patient antenatal care to high-risk prenatals and to incur increasing unreimbursed costs. The negative impact is financial.

B. Inability to sustain facility after opening

- Lack of patients' acceptance; preference for hospital care
- Lack of resources for continued operation

Contingency Plan

A return to the current admission practice of in-patient care for this population of high-risk will increase the financial burden on the hospital. Once operational, the residential facilities will free-up hospital beds for use by an increasing number of normal obstetric patients. The negative impact is two-fold—financial (**Table 3**) and outcome-based. A problem with the current system is the use of hospital beds originally intended for non high-risk patients. Failure to sustain the facility would result in limited beds for very high-risk women, requiring

them to stay in their home communities which are too far from the specialty medical care they need. This situation could result in unfavorable pregnancy outcomes.

Long-term plans are to expand to Phase II, utilizing the same concepts to provide a free-standing, newly built facility with the capacity to house an increasing number of residents. Building on the success of Phase I, we will solicit community volunteers to provide support and diversion for the residents.

XI. FINANCIAL PROJECTIONS

A Mother's House will save approximately $1,000,000 in unreimbursed health care costs for Memorial Health, Inc. and for the health care system. In 2000, 111 high-risk prenatals met the proposed criteria for admission to *A Mother's House* and remained hospitalized an average of 23 days at a cost of $2,624,742 (**Appendix B**). Third-party payers do not reimburse the hospital based on the length of stay in the hospital but on fixed rates determined by delivery type only. In the same year, actual reimbursement for these 111 patients was $1,552,450.

Currently, no payer reimburses residential outpatient antenatal care; therefore, this project will not generate income. The first year's projected cost to establish A *Mother's House* is $150,692 and include:

- Renovation of a facility
- Daily operating expenses
- Staffing

Re-direction of existing funds and in-kind contributions by the hospital and the health department are adequate to cover the first year expenses. Expenses in the second year of Phase I will not include renovation and will decrease considerably.

Phase II requires a separate business plan.

Operations Budget

(see Appendix C)

	2001
Revenue	
State of Georgia Perinatal Grant	$20,000
Indigent Care Trust Funds	$150,000
Total Revenue	**$170,000**
Operating Expenses	
Start-up Costs	$104,595
Supplies	$2,445
Food @ $20/day/resident	$28,500
Administrative and General Expenses	
Utilities	$10,510
Housekeeping	$4,202
Security System & monitoring	$240
Public Awareness Material Printing	$200
Total Operating Expenses	**$150,692**
Excess of Revenues over Expenses	**$19,308**

APPENDICES

Cost Analysis by DRG – All inpatients with Antenatal Care **FY2000 Annualized**

Case Type	# Cases	Total Cost	Variable Cost	Reimbursement	Variance
C-Section with complications	212	$2,301,048	$1,175,871	$951,244	-$1,349,804
C-Section without complications	79	$576,384	$320,405	$298,541	-$277,843
Vaginal Delivery with complications	289	$1,719,839	$763,457	$923,644	-$796,195
Vaginal Delivery without complications	664	$2,322,008	$1,082,312	$1,669,296	-$652,712
Total	**1,244**	**$6,919,279**	**$3,342,045**	**$3,842,725**	**-$3,076,554**

Source: MHUMC Decision Support/Trendstar/CCA

Women Who Could Have Been Managed in a Facility Like *A Mother's House*

Memorial Health University Medical Center
Feasibility Study of High-risk Prenatal In-patients
Calendar Years 2000 AND 1999

	CASES	Avg Length of Stay (ALOS)	GROSS REVENUE	EST. NET REVENUE	DIRECT VARIABLE COST	INDIRECT VARIABLE COST	DIRECT FIXED COST	INDIRECT FIXED COST	TOTAL COST	NET INCOME
Calendar Year 2000										
Placental Abnormalities	1	21.00	41,745	26,726	5,576	5,373	3,607	12,576	27,132	(406)
Pre-eclampsia	22	21.09	733,371	357,549	114,485	122,397	67,496	245,132	549,510	(191,961)
Incompetent Cervix	3	9.00	41,160	24,115	6,465	7,307	3,944	14,764	32,480	(8,365)
Pre-Term labor	33	20.54	854,792	380,453	128,545	157,951	86,928	347,355	720,779	(340,326)
Non- Reassuring Fetal Status	14	31.40	485,626	229,146	73,007	101,245	51,276	218,168	443,696	(214,550)
PROM	35	18.08	929,121	468,837	142,832	158,467	88,794	340,823	730,916	(262,079)
Twin Complications	3	39.33	127,066	65,624	19,064	28,153	13,453	59,560	120,230	(54,606)
Total For 2000	111	22.92	$ 3,212,881	$1,552,450	$489,974	$580,893	$315,498	$1,238,378	$2,624,743	**($1,072,293)**
Calendar Year 1999										
Placental Abnormalities	9	24.88	278,758	138,489	48,697	54,584	31,362	97,945	232,588	(94,099)
Pre-eclampsia	8	16.87	194,174	91,931	32,136	33,520	19,823	59,971	145,450	(53,519)
Incompetent Cervix	9	17.11	220,562	99,103	37,255	36,264	23,572	67,788	164,879	(65,776)
Pre-Term labor	41	14.41	860,863	383,371	138,968	134,524	90,315	257,573	621,380	(238,009)
Non- Reassuring Fetal Status	17	19.00	383,828	170,175	62,921	74,512	43,582	138,775	319,790	(149,615)
PROM	26	17.19	631,208	284,712	100,046	103,250	64,170	197,942	465,408	(180,696)
Twin Complications	6	18.16	180,209	96,387	31,007	26,601	17,946	48,305	123,859	(27,472)
Total For 1999	116	18.23	$2,749,602	$1,264,168	$451,030	$463,255	$290,770	$868,299	$2,073,354	($809,186)

ITEMIZED EXPENSE BUDGET

Renovation of facility	
Installation of new blinds Patching & painting Replacement of tiles in bathrooms, kitchen floors Handrails Front doors with lock sets Appliances where needed Carpet-installation of new or cleaning of old Counter tops & Cabinets Dedicated electrical circuit for washer/dryer Refrigerators Miscellaneous Furniture **SUBTOTAL**	$104,595
Operations	
▪ Utilities & Maintenance	
Telephone services	$1,450
Television cable services	$1,200
Electric bill	$4,800
Natural gas bill	$1,200
Water	$480
Garbage collection	$480
Pest control	$900
▪ Security System	$240
▪ Food @ $20.00/day/resident	$28,500
▪ Housekeeping	$4,202
▪ Hospitality packets-bath items	$780
▪ Recreation & diversion activity supplies	$1,665
▪ Printing of brochures	$200
▪ Nutrition Education & Case Management	$12,807
TOTAL	**$150,692**