

OASH Technical Areas Improvement Initiatives Task 2 Planning Tool Demonstration Protocol

Objective: Request feedback on the tool's usability and relevance for hospitals. Feedback will be requested on whether the tool is missing key revenue or expenditure groups, and features of the tool that are most and least valuable or relevant for their hospital. During the demonstration, we will review each section of the tool in detail and summarize the draft users' guide for meeting participants.

Participants: Up to four hospital leaders at each hospital. We anticipate that hospital leaders might include chiefs of staff, chief nurses, executive directors, hospital administrators, and other hospital leadership. We will identify those leaders during the planning tool development stage. Meeting with multiple leaders will help enhance the usability and relevance of the planning tool.

Format: Ideally these will be group meetings but may in some instances need to be one-on-one demonstrations.

Length: 3 hours

Welcome/Introduction

Thank you very much for taking the time to meet with me to go over the Healthcare Services Planning Tool (which I will refer to from here on as the planning tool). As I mentioned, my name is [NAME] and I work for Insight Policy Research, a social science research organization in the Washington, D.C., area. We have been working with the United States Department of Health and Human Services to develop a planning tool that will allow hospital administrators and health leaders in [FAS, RMI, Palau] to easily assess future hospital service and resource needs. Although our team has experience with health care system management, our expertise is not an adequate substitute for your experiences. Today, we would like to carefully go through each aspect of the tool to make sure it meets your needs.

We designed the tool to help hospital leaders in [FAS, RMI, Palau] project revenue, costs, and patient volume through 2035. All projections depend on a set of assumptions that users of the tool can adjust,

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as well as data provided by your hospital for 2016¹. We would like to hear your feedback on the tool's usability and relevance for [hospital name], whether the tool is missing any key revenue or expenditure information, and whether there are other data elements important for managing the hospital. I'd also like to hear your opinion on the features of the tool that are the most and least valuable or relevant for your hospital.

We will go through each section of the tool in detail and I will summarize the draft user's guide for each section. After returning home, I will send a summary of your comments and suggestions to confirm our understanding of the needed refinements to the planning tool. I want to emphasize that all feedback on the tool is welcome. Nothing you say will hurt my or my colleague's feelings. Our only interest is making sure the tool is relevant and useful for you, so we will appreciate your honest responses and reactions, as well as your suggestions on how to improve the tool.

Does anyone have any questions before we begin?

Great! We will start by providing a high-level overview of the tool. The tool is a Microsoft Excel based document that includes 7 tabs:

1. Assumptions
2. Summary
3. Revenue
4. Labor Costs
5. Non-Labor Costs
6. Hospital Capacity
7. 2016 Raw Data

The assumptions and raw data tabs affect the projections in the rest of the document. Tool users can change the projections by adjusting assumptions or changing baseline data. We will demonstrate which portions of these two tabs affect specific projections as we go through the tool. The summary tab, which we will go through at the end of our discussion, should provide hospital leaders with an "at a glance" summary of the most important statistics and information.

Let's start with the revenue tab.

Revenue

This tab projects the hospital's revenue by source until 2035. The revenue sources we identified for this tab are:

- U.S. Department of Health and Human Services (HHS)
- Department of Interior
- Foreign aid sources excluding the United States
- National government sources
- Non-governmental organizations

¹ This assumes we will conduct the data collection prior to the site visit.

- Receipts (e.g., direct payments for service)
- In-kind assistance

Demonstrate how Table 1 in the assumptions tab effects the revenue projections. Be sure to illustrate how users may input any percentage ranging from -100 to 100 percent for each of the revenue streams.

Questions for hospital leaders:

1. Thinking about aggregate revenue sources such as funding from HHS, are there other sources of revenue that should be included on this list?
2. How does the hospital currently track its revenue? If it has an accounting system, do the revenue sources listed align with the revenue codes used in the accounting system? What would need to change to make the listed revenue sources align with the accounting system? Would it be more useful to project revenue using the revenue codes included in the hospital's accounting system?

Personnel Expenses

This tab projects hospital expenditures on clinical staff, non-clinical staff, and professional development. Expenditures on staff are projected by labor category. Our team identified the following labor categories for clinical and non-clinical staff.

Clinical Staff	Non-Clinical Staff
Physician—Primary Care	Administration
Physician--Specialty	Clerical
Dentists	Janitorial
Pharmacists	Security
Nurse Practitioner	Contractors
Nurse/Health Assistant	
Nursing Assistant	
Anesthetists	
Lab Technicians	
Physician's Assistant	

Questions for hospital leaders:

1. Do all of the labor categories for clinical staff apply to your hospital?
2. Are there labor categories for clinical staff that we have left out? If so, what are they?
3. Do all of the labor categories for non-clinical staff apply to your hospital?
4. Are there labor categories for non-clinical staff that we have left out? If so, what are they?

Now let's talk about the factors that influence expenditures on staff. We have identified the following factors for each labor category.

- Number of full time equivalent (or FTE)

- Average salary
- Average bonus amount (e.g., recruitment or retention bonuses)
- Average health insurance contribution in dollars
- Average contribution for employee housing (e.g., a housing stipend)
- Average employer FICA contribution
- Average of other fringe benefits in dollars

We assume that the sum of the average salary, bonus, health insurance contribution, employer FICA contribution, and fringe benefits multiplied by the number of FTE to be the total expenditures on staff for each labor category. The assumptions tab allows users to adjust each of the variables to examine their effect on projected expenditures.

Demonstrate how Table 2 in the assumptions tab affects projected expenditures on clinical and non-clinical staff salaries. Illustrate how users may input any percentages ranging from -100 to 100 for estimated annual changes in salary, bonuses, benefits, and FICA for each labor category. Highlight that the assumption tab asks for annual changes in the number of FTE and not a percentage change. Show how the first table in the labor costs tab summarizes total expenditures on clinical and non-clinical salaries and professional development.

Questions for hospital leaders:

1. Do all of the factors influencing the cost of labor apply to your hospital? For example, do you provide health benefits, housing stipends, or retention bonuses?
2. Are there other factors that influence labor costs for your hospital? If so, what are the costs?

Finally, let's discuss the cost of professional development for clinical staff.

Ask whether hospital provides training for clinical staff. If yes, then proceed. If not, then skip to the Supplies, Materials, and Capital section of the protocol.

We decided on several factors that could influence the cost of professional development, including the:

- Number of professional development activities provided
- Number of participants by labor category
- Number of hours participants devote to professional development
- Costs of delivering the assistance (e.g., hiring of third-party providers or producing materials)
- Costs of travel to and from professional development activities

We assume that the total cost of professional development for each labor category would be the sum of the delivery and travel costs plus the cost of labor for the time staff participate in professional development. We calculate the cost of labor by dividing the number of hours spent on professional development in a given year by the total number of hours in 1 FTE (2020) and then multiplying by the average salary for the labor category. Users can adjust the percentage change of professional development in total in the assumptions tab.

Demonstrate how Table 3 in the assumptions tab affects projected expenditures on professional development.

Questions for hospital leaders:

1. Do the factors affecting the cost of professional development apply to your hospital?
2. What data does the hospital collect on the provision of professional development? For example, does the hospital collect data on:
 - a. The number of professional development activities offered?
 - b. The number of hours by labor category devoted to professional development?
 - c. The costs of delivering professional development?
 - d. The costs of participants' travel to and from professional development activities?
3. Are there other factors that affect the cost of providing professional development that we have not included in the tool?
4. Do you provide training to non-clinical staff? If so, would it be useful to include a projection of those costs in the tool?

Supplies, Materials, and Capital

This tab projects the hospital's expenditures on activities related to patient care and hospital management and operations. We identified the following expense categories for patient care and hospital management and operations.

Patient Care	Hospital Management and Operation
Medical equipment (e.g., diagnostic and treatment equipment)	Capital improvements (e.g., buildings or vehicles)
Medical supplies (e.g., bandages, syringes, etc.)	Maintenance and repair of capital/equipment
Instruments and devices	Fuel
Pharmaceuticals/immunizations	Furniture
Lab tests	Computer equipment
Travel for the provision of care in remote areas	Communication equipment and service(s)
Patient transportation	Security equipment, supplies, and materials
Office supplies	Janitorial equipment, supplies, and materials
Food and food service supplies	Freight (e.g., transporting supplies/materials to satellite clinics)
Laundry	Utilities
Water supply	Liability costs (e.g., liability insurance, settlements, etc.)
	Books and subscriptions
	Bank service charge
	Non-patient care costs of satellite clinics

Demonstrate how Table 4 in the assumptions tab affects the projected expenditures on patient care and hospital management and operations. Be sure to illustrate how users may input any percentage ranging from -100 to 100 percent for each of the expenditure categories.

Questions for hospital leaders:

1. Do all expenditure categories apply to the hospital?

- a. Are each of the expenditure categories accurately assigned to patient care or hospital management and operations?
2. Are there other expenditure categories that should be included in the tool? If so, what are the categories?
3. [If the hospital has an accounting system] How does the hospital track expenditures (e.g., using fund, organizational, department, grant, project codes)? Do the expense categories align with the hospital's expenditure codes? If not, how could we make the tool more aligned with the accounting system?

Hospital Capacity

The hospital capacity tab projects outpatient volume by location, inpatient admissions by condition, inpatient service days, and the number of available hospital beds. For the outpatient visits, the tool includes the following locations:

- Emergency room
- Hospital clinics
- Dispensaries
- Public health missions

Projecting the inpatient admissions by condition may allow the hospital to better plan its staffing. We included the following conditions in the tool:

- Cancer
- Diabetes
- Heart disease/stroke
- HIV/AIDS
- Hepatitis B
- Pneumonia
- Pulmonary disease and bronchiectasis
- Tuberculosis
- Vitamin A deficiency (VAD)
- Leprosy

Demonstrate how Table 5 in the assumptions tab affects the projected outpatient visits, inpatient visits, inpatient service days, and number of hospital beds. Be sure to illustrate how users may input any percentage ranging from -100 to 100 percent for each variable.

Questions for hospital leaders:

1. To your knowledge, how frequently are data collected on outpatient and inpatient visits?
 - a. [Depending on who is in the group] How are the data collected?
 - b. Where is the data stored after the data are collected?
 - c. What data quality procedures are in place to ensure accuracy? How does the hospital address missing data? Outliers?
 - d. [If not collecting data] What resources would be needed to improve the hospital's capacity to collect and house this type of patient data?

- e. [If collecting data] Does the hospital analyze patient data? If so, how? What does it do with the analysis?
2. How frequently does the total number of beds vary in a year? Would it benefit the hospital for the tool to project the total number of beds?
3. Do the locations of the outpatient visits apply to the hospital? Are there other locations where the hospital treats patients?
4. [if the hospital collects data on admissions by condition] Do all of the listed conditions apply to the hospital? If not, which do not? Are there any other frequently treated conditions not included in the tool? What are those conditions?

Summary Tab

We intend for the summary tab to include an “at a glance” summary of the most important data and information. Currently, the tool includes tables summarizing projected revenue, expenditures, physician FTE to patient ratio, and nurse FTE to patient ratio. These are common metrics for assessing hospital resources and identifying potential shortfalls. However, we would like to hear from you about other summary statistics that will be useful for the hospital.

Write down all other suggestions on a white board or easel paper. Probe participants on how the tool should calculate the statistics, and how the information will benefit the hospital. At this time, if applicable, review all suggested changes to the tool, including new data sources, revenue sources, labor categories, expenditure categories, outpatient visit locations, and patient conditions.

Wrap up and questions

This concludes our demonstration of the planning tool. Thank you all for your feedback and questions. As a reminder, after returning home, I will send a summary of your comments and suggestions to confirm our understanding of the needed refinements to the planning tool. We will make the suggested revisions, populate the tool with data from 2016, and send the final tool to you for review. If you have questions specific to the tool, please do not hesitate to contact me. At this time, I'd like to allow some time for final thoughts and questions.

Thank you again for your time.