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9B21E002

BOMBAY HOSPITAL INDORE: ADMINISTRATION OF PATIENT DISCHARGE SERVICES

Sudipendra Nath Roy and Fredrik Odegaard wrote this case solely to provide material for class discussion. The authors do not intend to illustrate either effective or ineffective handling of a managerial situation. The authors may have disguised certain names and other identifying information to protect confidentiality.

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“Another busy Monday morning for 2016!” thought Firoz Qureshi, senior manager of the health administration department at the Bombay Hospital Indore. Every day, his department saw a high volume of work requiring the completion of payments through medical insurance, which was needed for patients’ administrative discharges from the hospital. Qureshi looked at the lineup of patients’ relatives and friends waiting to make payments and pondered why the hallway was so crowded.

“Roy, you wanted to solve a managerial issue as an intern. Here you go! Why don’t you address this issue?” Firoz asked the summer intern, Sudipendra Nath Roy, as he gestured toward the people waiting.

“There are more cashless patients [patients with medical insurance] these days in the hospital, and as the TPA [third-party administrator] office is closed after 5 p.m., it is creating this influx, Sir,” replied Roy.

For the next few weeks, Roy tried to understand the various tasks and functions of the health administration department and the effects of these tasks and functions on patients waiting for administrative discharge.

BOMBAY HOSPITAL INDORE

Bombay Hospital Indore was a premier private trust hospital serving 21 clinical disciplines and four allied disciplines. The hospital, situated in the vibrant city of Indore in the state of Madhya Pradesh, was an example of India’s state-of-the-art medical care facilities. Since its establishment in October 2003, the 600-bed hospital had relentlessly delivered multi-specialty tertiary care in central India, primarily serving the region’s middle and upper-middle socio-economic classes. Bombay Hospital Indore had established a reliable, quality care brand that served both in-patient departments (IPDs) and out-patient departments 24/7.

The hospital’s “quality care” brand was bolstered by formal recognition from the National Accreditation Board for Hospitals & Healthcare Providers and from various quality recognitions in medical forums: in 2013, it was named the best hospital in the non-metro category, western region in ICICI Lombard, CNBC TV18, and IMRB’s India Healthcare Awards, and, in the same year, it received a Healthcare Excellence Award for the best multi-specialty hospital in Indore from World Wide Achievers.[[1]](#footnote-1) These achievements further reflected the hospital’s quality of health service delivery.

CASHLESS PATIENTS

Before being administratively discharged, IPD patients first needed to clear their hospital bills, either through cash payments or through their medical insurance company. As the medical expenditure borne by patients was mainly an out-of-pocket expense, admitted patients often had medical insurance that could help pay for unforeseen medical expenditures. India had two types of medical insurance: reimbursement and cashless. For the former, patients paid the bills out of pocket and subsequently arranged reimbursement from their medical insurance company. For cashless medical insurance, patients provided their insurance cards and the hospital administration coordinated payments directly from the medical insurance companies through their respective third-party administrators (TPAs). Bombay Hospital Indore facilitated cashless medical insurance claims by coordinating and maintaining ties with various medical insurance companies and their TPAs. Cashless medical insurance was vital for many Indians, as without such insurance a large percentage of Indian patients would be unable to afford quality health care. The hospital’s health administration department personnel colloquially referred to patients covered by cashless medical insurance as “cashless patients.”

The General Insurers’ Public Sector Association (GIPSA), a conglomerate of four major public sector insurance companies, had pre-approved certain medical procedures as special insurance packages. For instance, some of the common insurance packages covered surgery to remove the appendix for the treatment of appendicitis and bypass surgery to treat heart conditions. Nearly 40 per cent of all Bombay Hospital Indore patients underwent treatment that was covered under GIPSA packages.

TPAs were organizations that acted as both intermediators and facilitators for the cashless payment process between the medical insurance companies and hospitals. TPAs functioned under the aegis of the Insurance Regulatory and Development Authority of India and were the points of contact for the health administration departments seeking approval for the medical expenses incurred by the cashless patients.

MEDICAL AND ADMINISTRATIVE DISCHARGE

Roy analyzed the entire patient payment process in an attempt to understand the specifics of how the health administration department coordinated with TPAs for covering the medical expenses of cashless patients. The health administration personnel were involved in two different tasks. First, once a physician announced the medical care of a patient was complete and the patient was ready to leave the hospital, a medical discharge document was created and sent to the health administration department together with the incurred bill. An assistant nurse usually batched the medical discharge documents and delivered them to the health administration desk. The health administration staff, upon receiving the batch of medical discharge files, would send a text message to each patient’s designated contact person (usually a relative or friend) informing them to bring any additional required documents, such as insurance policy documents or ancillary bills incurred during the treatment period. After a patient’s contact person delivered the documents, the administration staff processed the medical discharge files and entered the relevant information on a web portal hosted by the corresponding TPA. This first process was termed the Submission of Documentation to TPA for Final Approval.

The TPA approval process often took a long time, which was outside the hospital administration’s control. Therefore, patients’ contact persons generally left the health administration department and waited outside but near the hospital. Once the TPA approved the expenses, the health administration department staff sent a second automatic text message, through the hospital management information system (HMIS), to the patient’s contact person and included instructions regarding further documents required to complete the payment process. These documents might include the pre-approval of a medical insurance claim or information related to the patient’s medical history. After receiving the requested documents from the patient’s contact person, the health administration staff proceeded to complete the second process, which was termed the Discharge Documentation process. This process included updating the HMIS with payment details regarding the specific TPA-approved amount and generating the administrative discharge permission. If the TPA authorized only a portion of the medical expenditure, the patient’s contact person needed to pay the balance in cash. Although the time for the second process was almost identical for all patients, the processing time for the first process could vary, especially when patients opted for treatment plans listed by the GIPSA.

Processing an average of 30 administrative daily discharges, efficiency in the two administrative processes was crucial, as any delay could lead to a lower bed turnover, and hence lower revenue. Therefore, because delays in the TPA approval were beyond the control of the health administration department, there was great incentive for identifying operational improvements in the medical and administrative discharge process.

GATHERING DATA AND the PROCESS ANALYSIS

Roy had analyzed the process and observed that a patient’s contact person needed to arrive at the health administration department for the two processes at two different times, as the TPA approval was required between the two processes. Roy had also, through screening the medical records and the HMIS, sampled a few consecutive days’ worth of data on the discharge process for the cashless patients. Time-stamps for both process 1 (i.e., the Submission of Documentation to TPA for Final Approval) and process 2 (i.e., the Discharge Documentation) were readily available, enabling Roy to calculate the various processing times.

Roy calculated the average time for the two processes and two types of cashless patients: GIPSA and non-GIPSA patients. The health administration department at Bombay Hospital Indore had two designated staff members who handled the two types of cashless patients; one handled only the GIPSA package patients and the other handled only the non-GIPSA patients. The two employees were efficient and hard-working, and they worked from 9 a.m. to 5 p.m. every weekday. Generally, TPAs also operated during the same office hours. Roy summarized his findings in a process flow diagram that showed the average time required for each process (see Exhibit 1).

Following Qureshi’s suggestion, Roy crunched the numbers to determine whether the current design was sufficient to handle each day’s workload. Astonishingly, he saw that, with the two employees, no one should need to wait for service! This finding was in contrast to the reality of daily hospital operations, where patients were constantly waiting to be processed. Roy thought, “Where did I go wrong? Was it related to the uncertainty in arrivals? For sure we should need a third staff member to reduce the wait or at least not have designated staff.” Looking at his numbers, Roy was convinced that he was on the right track, but he decided to touch base with Qureshi to get some feedback.

PRELIMINARY IDEAS

Roy’s ideas to improve overall operations and in particular patient waiting time focused on (1) pooling the two dedicated staff members—one who handled GIPSA package patients and the other who handled non-GIPSA patients—to have both handle the two types of cashless patients, and (2) adding a third staff member.

He conveyed the first idea to Qureshi, who responded skeptically:

From my experience, when patient parties observe more than 10 people ahead of them, they are very likely to file formal complaints about our service quality! So, at most, 10 per cent of the time, there can be more than 10 people receiving or waiting for service. Therefore, it simply is too risky to merge the two lines.

Roy remained unmoved, as he believed that pooling the resources might help, but he was unsure whether it would be sufficient to ensure the minimal risk of an upset patient party. He moved on to the second idea to which Firoz quickly retorted, “Substantiate your claim if you suggest another recruit!”

Roy knew that he needed to double-check his numbers and rework the analysis because, without a sound analysis and solid numbers, he would never convince Qureshi.

EXHIBIT 1: PROCESS FLOW DIAGRAM FOR bombay hospital indore’s HEALTH ADMINISTRATION DEPARTMENT

Non-GIPSA Patients

GIPSA Package Patients Patients

GIPSA Package Patients Patients

Non-GIPSA Patients

Medical Discharge

Process 1

(16 minutes)

Process 1

(11 minutes)

Process 2

(14 minutes)

Process 2

(14 minutes)

Administrative Discharge

Note: GIPSA = General Insurers’ Public Sector Association, a conglomerate of four major public sector insurance companies that pre-approved coverage for nearly 40 per cent of the medical procedures conducted at Bombay Hospital Indore; TPA = third-part administrator, through which insurance companies covered medical expenses for patients whose medical procedures were paid directly to the hospital.

Source: Created by the case authors.

1. “History: Bombay Hospital Indore,” Bombay Hospital, accessed January 16, 2021, www.bombayhospitalindore.com/history/. [↑](#footnote-ref-1)