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INSIGHTS AND INNOVATION FOR RURAL HOSPITALS AND PROVIDERS

A $3.5 Million Conversation

by Jim Burnette, President/CEO, HospitalMD

The subject of national intelligence continues to received a great deal of attention and interest. More than fifteen years since the failures that led to 9/11, we have heard about leaked documents and emails, the hacking of the CIA, other intelligence databases, and much more.

Recently, I read an excerpt from a speech given at Hillsdale College in Michigan by Herbert E. Meyer, an intelligence analyst during the Reagan presidency. He stated that ***effective intelligence*** is the combination of information and

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insight. He defines ***information*** as the raw material, and ***insight*** as applying good judgment to human analysis of information. He went on to say that one doesn't collect data and then stare at it in hopes that something important pops up. It is like science. You start by determining what you want to know (thesis).

In the case of national security, Meyer believes intelligence failures are the result of a lack of effective insight, not incomplete or inaccurate information. By this he means that during recent years as terrorism has become the most significant threat, intelligence agencies have been staffed with bureaucratic administrators and managers rather than professional, career intelligence analysts as was the case from the end of World War II to 2000.

As I thought about his comments, I began to compare his description and assessment of the national intelligence model to the hospital "intelligence" model. My first conclusion was that although his model applies to different purposes, the structure and purpose of the two are essentially the same. However, does hospital "intelligence" have the correct thesis? Do we know what data to look for, and how to analyze it in order to achieve desirable outcomes? Or do we collect a lot of data, stare at it, and hope something pops up?

A few days after I read this speech, I visited with the leadership of a hospital that is not profitable and financially fragile, and obviously in need of a change of direction. As we discussed the symptoms of their financial difficulties, the focus turned to a discussion of "data" that they used to measure their performance. These data included the usual ED patient volumes and admissions to the hospital through the ED, both important indicators of financial performance.

They stated that their inpatient admissions rate through the ED is 13%. I was shocked. Hospitals' market share of acute inpatient admissions is always low (often 10% to 20%). This hospital's market share was 14%. Most rural hospitals I encounter have an acute rate in the range of 1.5% to 6%, with an average of about 4%. Benchmarks from the National Center for Health Statistics at the Centers for Disease Control and Prevention (CDC) indicate that the average "acute" admissions rate through the ED for all hospitals of all sizes, urban and rural, is 13%. iVantage reports this rate in rural hospitals at 8%. I could not recall a rural hospital with an acute admission rate of 13%. A rate of 13% is extraordinary and didn't seem to fit comparison. If 13% is correct, surely, their financial difficulties could not be for lack of inpatient revenue.

You may ask yourself, how could anyone make that mistake? It's actually common in rural hospitals.

There seemed to be no explanation. They were as confused and so was I. Neither of us could reconcile their poor financial performance with such a robust admission rate. I asked, "what is the rate of observation (OBS) placements into the Medical Unit from the ED?". The answer was "8.2%". Since they told me that their inpatient admission rate was 13%, I asked if 8.2% is in addition to the 13% rate. The answer was, "no, OBS are included in the 13%". That meant that their acute admission rate was actually only 4.8%.

You may ask, "We know that. How could anyone make that mistake?" Actually, this mistake, and many similar mistakes, are made often. In many rural hospitals, OBS patients (although OBS are outpatients) are placed on the Medical Unit along with acute inpatients and are often provided the same level of patient care as acute patients. First-line supervisors may not be taught to consider the financial implications of their clinical work so they do not see any difference. This is an "intelligence" failure in knowledge.

When nursing staff are asked to report their inpatient census, this error in thinking may cause them to report 10, when 5 of the 10 may be OBS patients. As staff become more accustomed to reporting Medical Unit census as acute and OBS combined, they unintentionally blur the definition of the measure without thinking. With no distinction between acute and OBS, reporting both as inpatient census is reinforced because 13% sounds better than 4.8% and, in time, comes to be viewed as truth.

At this point in the conversation, we appeared to be getting somewhere. We both began to suspect the cause of financial difficulty. We both began to see the gap in perceived and actual revenue. Actually, at a net revenue per OBS and acute patient of $900 and $5,500 respectively, this hospital was actually getting only 50% of the $7,000,000 they imagined.

Although this discovery was discouraging, it is important to learn the truth where you have previously been in error even if it is discouraging. Very often there is a "silver lining" in the midst of dark clouds. I pointed out to them that knowing the acute rate is actually 4.8% could be a significant opportunity to generate more revenue.

Low market share represents great potential. Growth of a high profit margin service is even better. Together, a combination of growth potential with a high profit margin, represents a significant, even extraordinary, revenue growth opportunity. An OBS placement rate of 8.2%, where the benchmark is 2.0%, suggests a high probability of misclassification of acute admissions as OBS and a great opportunity for converting many of these OBS into acute admissions. If this is the case, there is real potential for them to realize an increase in net revenue of over $3,500,000 with patients that are already going through their ED. My final thought was, this was a $3,500,000 conversation. Sadly, "conversations" don't show up on the Income Statement and Balance Sheet. The hospital must use its insight and apply good judgment to human analysis.

There is a real potential for the hospital to realize a net revenue of over $3.5 million with patients that are already going through the ED.

Jim Burnette is the Founder and CEO of **HospitalMD**. Jim has worked in healthcare for more than 20 years. His mission is to strengthen small community hospitals across the nation and help them thrive in today's rapidly changing healthcare climate. Jim is a graduate of Georgia Tech and resides in Peachtree City, a small community right outside Atlanta.

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