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INSIGHTS AND INNOVATION FOR RURAL HOSPITALS AND PROVIDERS

IN THIS ISSUE

Real Solutions in Changing Times

by Jim Burnette, President/CEO, HospitalMD

Our last issue addressed three economic and social forces that are changing the industry and are challenging the viability of small community hospitals (SCHs). Two of these forces are impacting revenue: more people with access to insurance, and the systematic reduction in the reimbursement insurers pay. The third force is the continuing increases in the costs to provide services. Your hospital may be seeing the chaos of these converging forces in your monthly invoices and financial statements!

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"Being acquired or managed by large urban entities may create short-term prestige; but later, the community feels 'used' and sees their services decline."

SOME NEW "SOLUTIONS" PUT HOSPITALS AT RISK

Remember how increased numbers of people enrolled in new insurance plans sold on public "networks" were hailed nationally as the answer to eliminating billions of dollars in bad debt? The reality? While a few hospitals benefit from the newly insured, the vast majority of SCHs are unable to restructure their business models quickly enough to keep pace with systematic reductions in both coverage and payment. Patients have substantial services that are not covered, leaving large out-of-pocket balances that remain unpaid. The result, new mountains of bad debt!

DIFFICULT CHOICES

The pace of these changes may be putting your hospital under pressure to take action, whether you are ready to or not. Traditional methods of increasing revenue take significant time, and are costly and risky. Innovative methods of increasing revenue quickly and with little risk are not generally available.

In response, some SCHs are opting to give up their autonomy and be acquired or managed by large urban entities. The local community may gain short-term prestige, but later feels "used" and sees their services decline—usually to the benefit of the urban hospital.

Those that "go it" alone have only two choices: increase revenue or cut costs. Choosing between these two "either/or" options can be dangerous. Doing a little of both can also be dangerous. With little time and significant costs, there is very little margin for error.

CEO CONCERNS

In my recent discussions with CEOs, two themes emerged. The first involves the great need for developing ***new revenue sources***. The good news is that these are fairly easy to identify. However, SCHs often lack the analytics and resources to determine the costs necessary to launch new services and calculate profit margins. The second approach involves recruiting one or more new PCPs to the community. One CEO cited his hospital's experience with starting a new office practice. To entice a recent residency grad, they guaranteed his annual salary and pay for all clinical and administrative support services. Eighteen months have passed and the new physician is only seeing about 5 patients per day. It is not an uncommon to take 18 to 24 months to find out if such a costly investment pays off.

WORKING TOGETHER FOR REAL SOLUTIONS

The clinical, financial, regulatory, and process dimensions of health care are very complex. The problems you face are very complex. The best, optimal solutions for complex problems are not "packaged" and ordered from Amazon. The best, optimal solutions are "designed" to meet your specific conditions and requirements. Only you understand your needs. The architect of a solution designed to quickly generate revenue with very little risk requires someone with not only expertise, experience, and insight; but someone that listens very carefully to you. Our structured and objective approach analyzes new and existing service

line growth, creating fairly predictable forecasts. Our proven approach has real world results: ***maximized revenue and market share.*** Secondly, we build successful partnerships aligning physicians and hospital staff around these client-specific solution designs. Contact me at ***insight@hospitalmd.com*** if you would like to learn more about options. It is our mission to help you not just survive, but thrive!

–Jim Burnette

Why Is Your Revenue Declining Year After Year?

Inpatient revenue margins are the most significant part of all of your revenue. And loss of inpatient revenue carries with it a decline in outpatient services including ancillary diagnostic and emergency medicine services. Inpatient revenue suffers from "out migration". This occurs in two places: erosion of direct admits, and admissions "leakage" through the Emergency Department (ED). The primary causes of this erosion are (a) declining pro fee reimbursement for office-based attending physicians; and (b) the inconvenience to the physician of unattached call.

Leakage may be the most vexing and least understood cause. Leakage occurs when patients come through the ED that qualify as inpatient admissions but are not admitted, resulting in low ED admission rates through the ED. These patients fall into the "grey zone". They won't die if you don't admit them, but they don't warrant intensive care. They meet medical necessity but are often discharged instead to home or to the patient's doctor's office.

Low ED admission frequency may sound benign. However, the range of ED admission rates in most SCHs is 3% to 5% compared to the national average of 13%. Large, urban hospitals admitting rates are even higher at 20% to 30%. There is no health utilization data that indicates that the acuity of the SCH ED patient is different than that of the urban ED. We help you identity and establish improved, valid admitting criteria and practices. Many **HospitalMD** (HMD) physicians routinely admit 13% to 18% with no excessive denial rates or compliance deficiencies. Yours can be better as well.

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–Brittany Newberry,
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