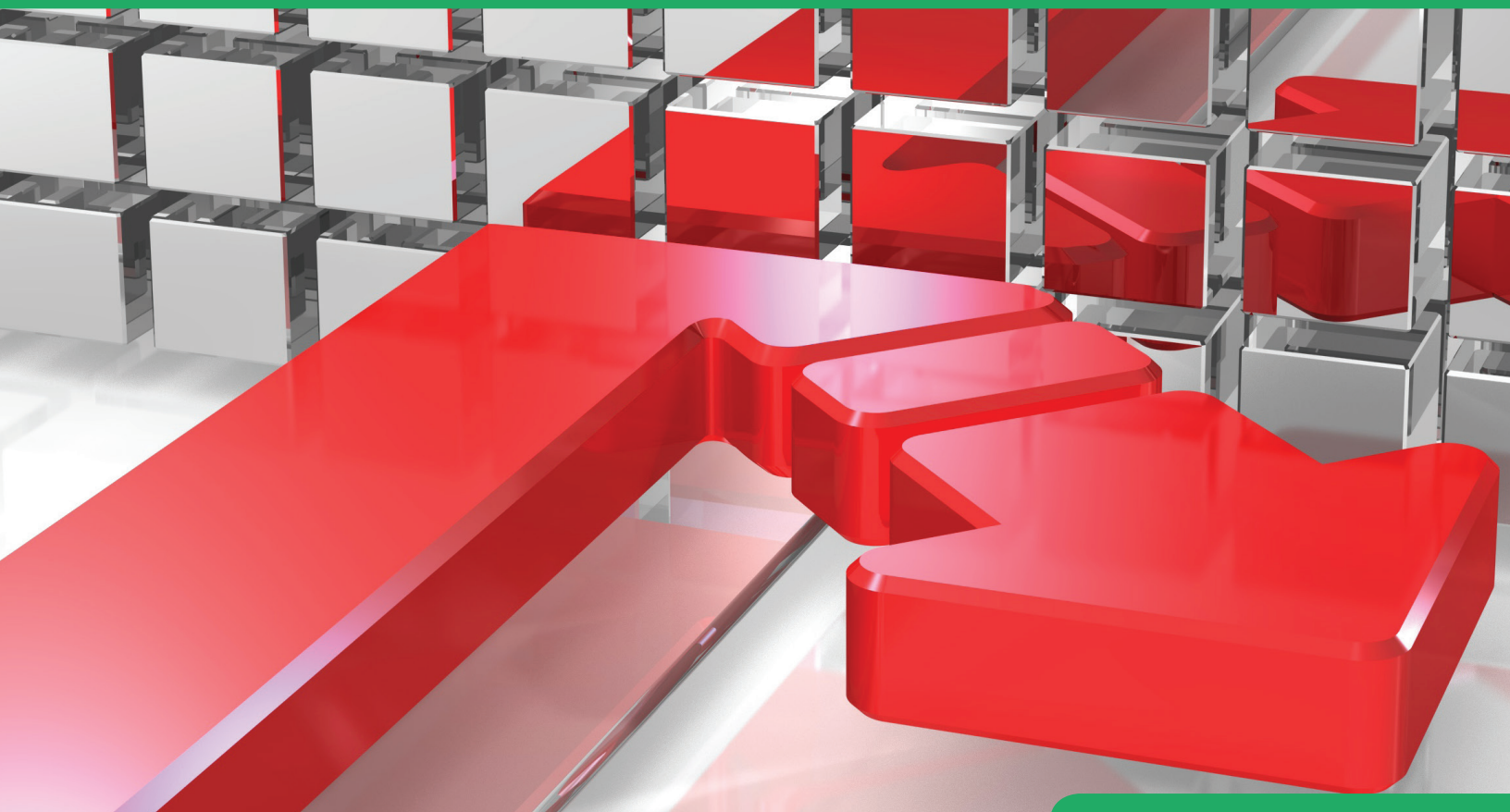


## INSIGHTS AND INNOVATION FOR RURAL HOSPITALS AND PROVIDERS



# *Structural Barriers to Financial Success*

by Jim Burnette, President/CEO, HospitalMD

Historically, most hospitals, large and small, have been organized around patient diagnoses, treatments, procedures, anatomy, diagnostic examination, acuity, and age. Clinical support services that did not fit came to be classified generally as “ancillary” services.

These organizational structures derive primarily from large teaching hospitals where these structures work well for teaching specialized medicine. Thus, it seems natural to organize and manage Emergency Medicine (EM) and inpatient medicine, or Hospital Medicine (HM), in the small community

### IN THIS ISSUE

- Structural Barriers to Financial Success
- ZIKA FREE RESOURCES for providers and patients

CALL US AT:

**1.877.881.8783**

EMAIL US AT:

[insight@hospitalMD.com](mailto:insight@hospitalMD.com)

400 Westpark Court,  
Suite 230  
Peachtree City, GA 30269

**HospitalMD.com**

*The bottom line is that on any given day, keeping patients local is limited by the lowest clinical capability and risk threshold of all EM or HM physicians.*



hospital (SCH) as two separate services, two separate specialties, and two separate hospital departments.

But this structure is ineffective for managing the **BUSINESS** of EM and HM. Why?

## FINANCIAL IMPACT

To understand the financial impact, let's look at what could be expected. Approximately 80% to 85% of all ED patients do not qualify as inpatient admission candidates. Observation patients should not exceed 2% and transfers should not exceed 2%.

SCHs transfer more than 2%, and classify more than 2% of their patients as observation.

For a SCH that has 8,000 ED patient visits per year, this "grey zone" represents the potential to admit 880 (8,000 x 11%) to 1,280 (8,000 x 16%) patients per year. At a modest \$5,000 in net revenue per discharge, the total revenue potential is \$4,400,000 and \$6,400,000 respectively. **The difference between 880 to 1,280, and your actual acute admissions, represents your revenue growth potential.** If the sum of your admissions is 600 per year, your potential net revenue is approximately \$1,400,000 to \$3,400,000.

believes is an admission prospect according to his EM assessment and risk threshold. Even where the EM physician has attending experience from the past, he still makes his medical decisions from the "silo" perspective. The attending (or HM) physician usually doesn't know this patient well and therefore must perform an assessment of medical necessity and "can I take care of this particular patient?" This assessment takes time and involves risk.

## SO WHAT DOES THIS HAVE TO DO WITH FINANCIAL SUCCESS? EVERYTHING.

### Revenue Improvement Potential

	Range	
Percent ED Patient Visits	100%	100%
ED Non-Acute Admission Prospects	- 85%	- 80%
Total Potential Admission Prospects	15%	20%
Transfer Benchmark	- 2%	- 2%
Observation Benchmark	- 2%	- 2%
Candidates for Admission ("Grey Zone")	11%	16%

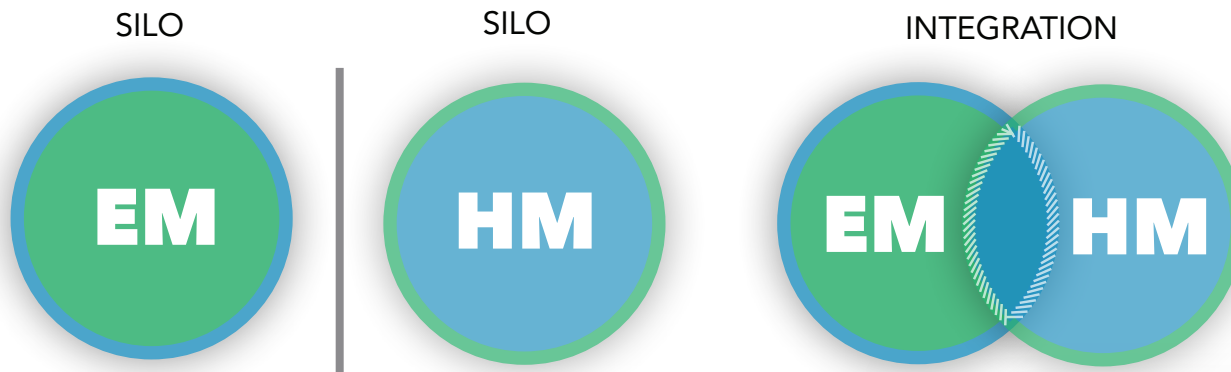
This leaves a "grey zone" of about 11% to 16% that are potential candidates for admission. National acute admission rates through the ED are 13%. As a concession for SCHs (and low expectations), some people suggest that 8% is a more reasonable target. Many

## OPERATIONAL AND FINANCIAL INSIGHT INTO THESE NUMBERS

Under the traditional "silo" organizational and specialty structure, the EM physician identifies and refers to the attending physician what he

The EM's willingness to refer to the attending is his perception of the risk threshold and clinical capability of the HM physician. This perception influences his willingness to even refer current and future admissions. Likewise, the willingness of the HM physician, who is the only physician in the hospital on any day, depends on his risk threshold and clinical capability to take care of the patient locally.

The bottom line is that on any given day, the SCH's capacity to keep patients local is limited by the



lowest clinical capability and risk threshold of all EM or HM physicians. This is true because on any given day, the "weakest link" physician will be working. This does not mean any such physician is a bad physician. It means he may not be well suited to be the sole EM or HM physician working at a SCH. In other words, it is essential that EM and HM physicians that work at a SCH must have the highest clinical capabilities and take appropriate risk, and possess a team-oriented mentality suited to full and seamless integration.

In most cases, the EM and HM physicians are paid whether or not they admit and attend any patients. So there is also a real barrier of "human nature" and "personal and organizational motivation". Therefore, insight into EM and HM candidate selection is essential.


## NOW THAT WE HAVE INSIGHT INTO HOW THESE ADMISSION DECISIONS ARE TYPICALLY MADE, WHAT INSIGHT DO WE NEED TO SOLVE THE PROBLEM?

The solution is a practice model

that is designed to effectively overcome these barriers. The design elements of this model include:

- An integrated EM and HM service.
- A single Medical Director responsible and accountable for **both** services.
- An agreement among the physician regarding the highest scope (and appropriate risk) of medical conditions that can be managed and treated locally based on the SCH's available services.
- EM and HM providers each of which have the same clinical capability and risk threshold (and know when they can pass the baton without stopping to ask, "Who is working tomorrow?").
- Providers who are both challenged and motivated by their authority and responsibility to make the SCH financially viable.

Lastly, this model needs leadership and management that is committed and accountable for success, supported by hospital

leadership, and a medical staff that is aligned. This is not a staffing or coverage solution, it is a revenue solution that takes bold vision and implementation. 

—Jim Burnette



## STAYING AHEAD OF ZIKA VIRUS WITH HELPFUL RESOURCES

HospitalMD is committed to assisting hospitals disseminate provider and patient education. This month we focus on distributing up-to-date information on Zika virus to both providers and patients. These can be printed, posted or emailed.

*For providers*

[www.hospitalMD.com/resources/zikaMD](http://www.hospitalMD.com/resources/zikaMD)

*For patients*

[www.hospitalMD.com/resources/zikapatient](http://www.hospitalMD.com/resources/zikapatient)





How effective are  
your EM and  
HM services at  
*passing the baton?*  
**We can help.**

**in·sight**<sup>TM</sup>



**HospitalMD**<sup>®</sup>

EMERGENCY | HOSPITALIST | HYBRID

**HospitalMD in·sight**<sup>TM</sup> is published by HospitalMD. All rights reserved. ©Copyright 2016 HospitalMD. Printed in the U.S.A.

IN THIS ISSUE:  
*Structural Barriers  
to Financial Success*

CALL US AT: **1(877) 881.8783**  
OR EMAIL US AT: **insight@hospitalMD.com**

**HospitalMD**<sup>®</sup>.com  
Delivering Excellence. Every Time.



400 Westpark Court, Suite 230  
Peachtree City, GA 30269  
Direct 770.631.8478