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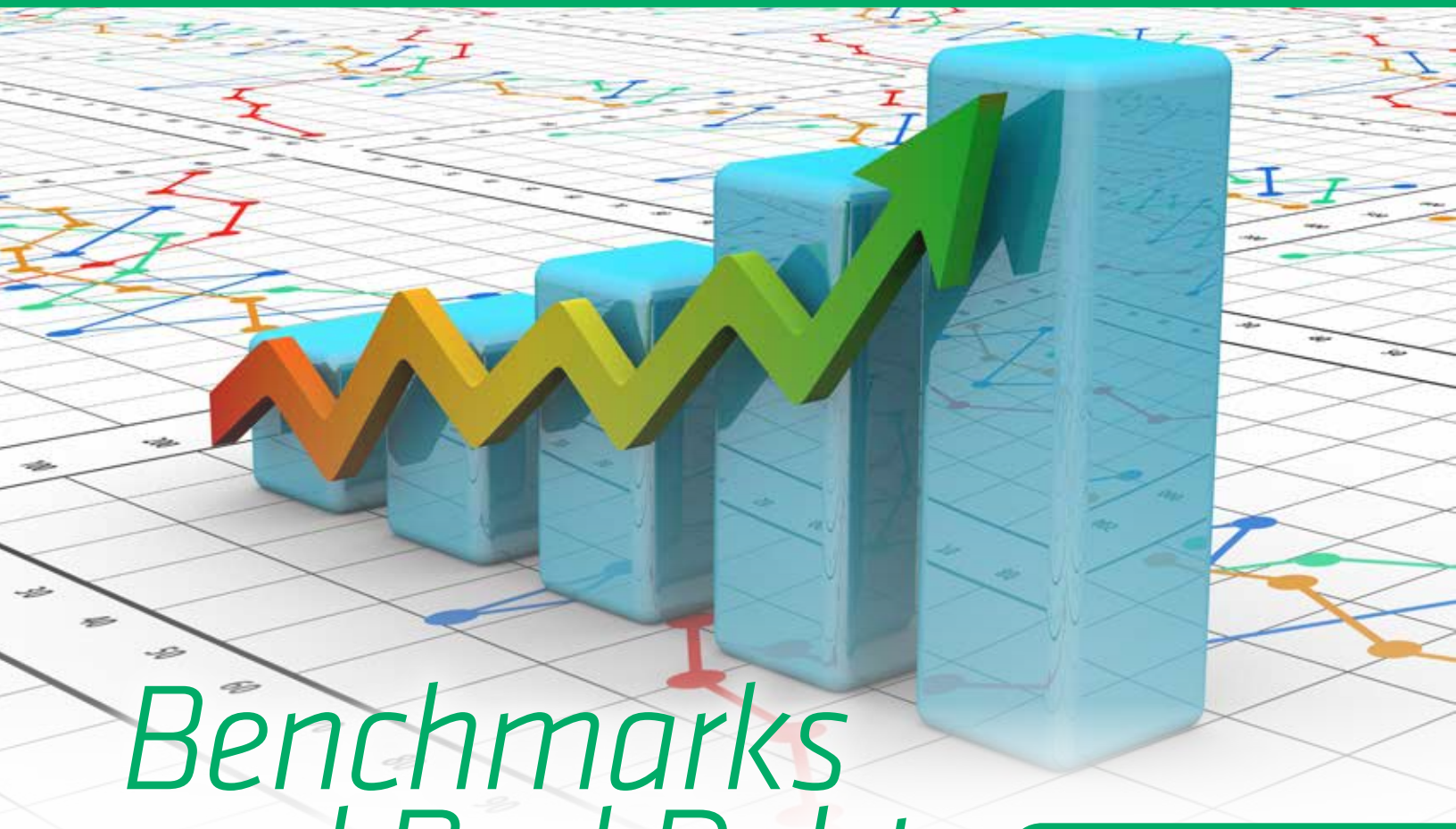

Benchmarks and Bad Debt

by Jim Burnette, President/CEO, HospitalMD

USING BENCHMARKS TO FORECAST NEW REVENUE GROWTH

Historic health utilization data suggest that the probable number of acute inpatient admission is equivalent to about 10% of a service area population. To illustrate, a service area population of 20,000 will generate approximately 2,000 acute admissions. We also know reliably that the number of ED patient visits within a service area are equal to about 40% of the population, and the number of patients admitted to a hospital through the ED is equal to approximately 13% of the total ED patient visits. We refer to these high level utilization rates as benchmarks.

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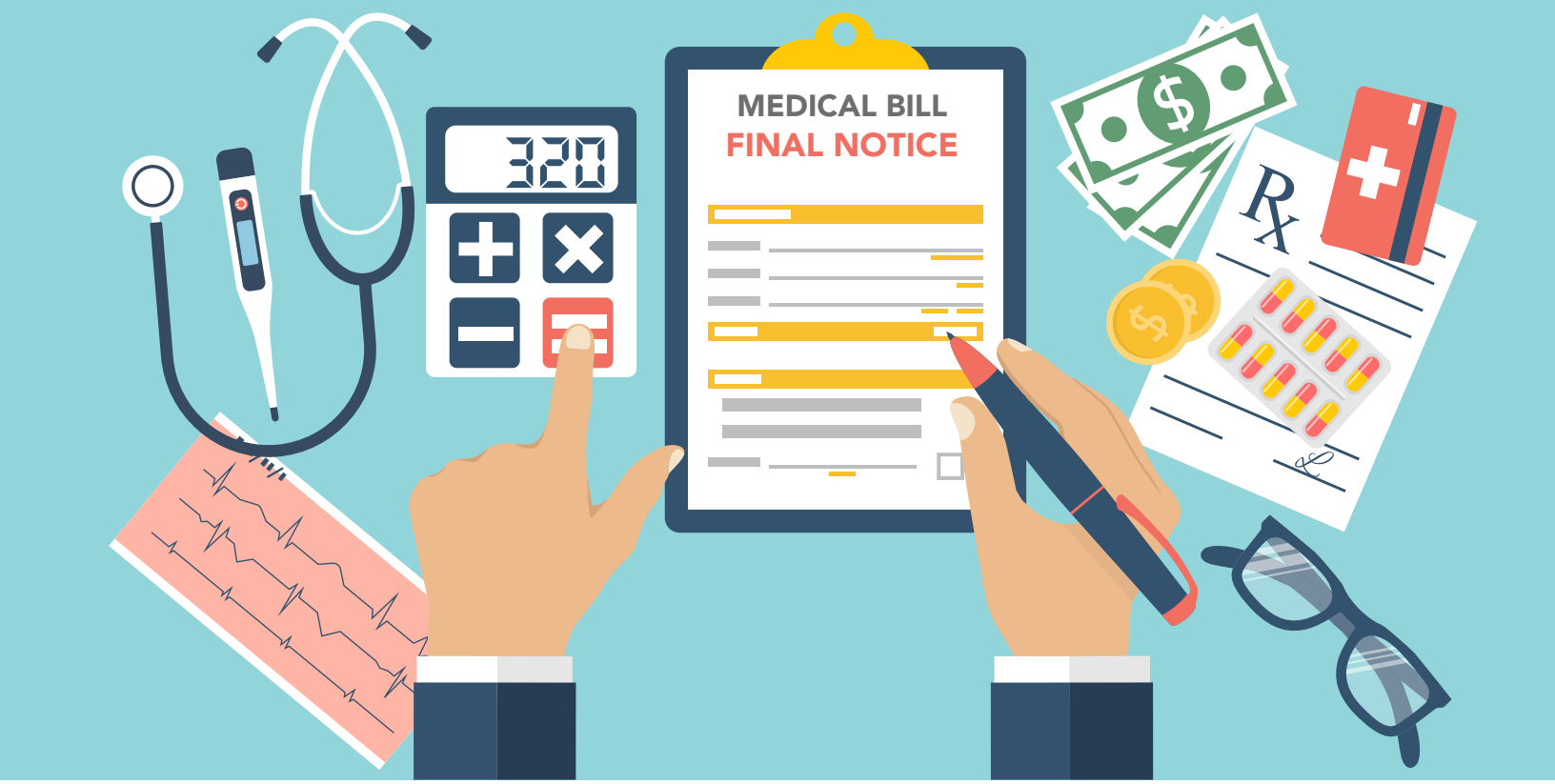

These data benchmarks are useful for helping us understand the total potential market size, how we compare to this potential, and our potential revenue growth. How can we translate these benchmarks into tangible solutions outcomes?

First, the Centers for Disease and Control and Prevention (CDC) utilization data is collected by diagnosis code. Thus, the 2,000 acute admissions in the previous example can be further sorted by medical specialty and eventually into relative acuity. Benchmarks from other sources can help us evaluate the need for physicians based on population.

Second, we can analyze charts of all patients transferred from the local ED to other facilities. By examining each transfer chart, we will begin to understand that some patients who were transferred could have been admitted locally without adding greater knowledge, skills, and abilities (KSA) and without additional diagnostic and treatment resources. In addition, some could have been admitted locally with modestly higher levels of KSA and resources. Finally, some could have been kept locally with the addition of specialities.

How do you do this? Your current Medical Staff is a good place to start. Your physicians have all the knowledge you need locally to make the first pass at this assessment. They know what they can and can't do, and whether or not they could acquire the additional knowledge through specific CME.

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white paper that explains
this process in more detail.

CAN BAD DEBT BE GOOD DEBT?

"Bad debt" is a term we try to avoid thinking and talking about about because it implies an assortment of failures, and we may not know how to effectively reduce or eliminate it. It is often treated as a social and economic blight and a cost of doing

business. In other words, "it just is". Often, we confuse bad debt with "charity" and rationalize to ourselves, and to our Governing Boards, that we have to serve every single patient that comes to our hospital because healthcare is an entitlement and it is a "legal" requirement.

This doesn't mean we become insensitive or uncaring. I believe we can be *both* compassionate and strategic. We have moral obligations, but not at the risk of bankrupting and destroying local access to health care for all people because of the economic conditions of a few. My experience, as well as evidence from an analysis of many SCHs, demonstrate that we can be financially responsible and morally responsible at the same time.

Achieving a balance of financial and moral responsibility is often a lack of knowledge and/or lack of discipline. However, regulations are on your side. Furthermore, these regulations actually mandate that SCHs implement responsible policies that collect for services. Not enacting responsible policies and reducing bad debt to become financially viable are clear examples of non-compliance.

Several years ago, I was managing a SCH probably much like yours. I found that some bad debt was actually good debt. Our bad debt had averaged about 30% of net revenue for several years. (Note about net revenue vs. gross revenue: a rate based on net revenue is a better "apples to apples" comparison. Net revenue is based on reimbursement rates, related to acuity, and volume. This is more normalized because all hospitals are paid about the same rate for acuity and the only difference in net revenue is patient volume.)

We initiated five separate projects aimed at five components of the revenue cycle. Targets of improvement of these projects included: medical screening, registration/patient access, insurance follow-up and rework, collections, and accounting.

To ensure that we didn't maximize the outcome of one component at the expense of one or more of the other components, we managed these five under the umbrella of a single management team to balance the various interests.

Within nine months we had reduced bad debt by 50% which translated into $400,000 immediately to the bottom line.

There are several changes in paradigm that are essential to how the SCH views collections (a.k.a bad debt).

- Adopt an attitude that payment for patient services is expected. It is immoral to deny services to the public and to not work with people to pay.
- Expecting to collect charges is counterproductive and unfair.
- Efforts to collect start **before** services are provided and not registration only.
- Methods for managing credit must be taught.

Your registration process is your "cash register." Don't let people walk out without payment.

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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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SUCCESS REQUIRES A PROVEN FORMULA.