HospitalMD®
EMERGENCY | HOSPITALIST | HYBRID

in•sight™
JUNE 2017

INSIGHTS AND INNOVATION FOR RURAL HOSPITALS AND PROVIDERS

Revenue Growth²

by Jim Burnette, President/CEO, HospitalMD

AS YOU PURSUE DELIVERING EXCELLENCE IN PATIENT CARE, how are you addressing improvements in your profit margin? Revenue without profit margin is not good. Variations in daily inpatient census due to the random frequency of daily inpatient admissions are difficult to staff efficiently, and often impose the need for minimum staffing levels in order to provide safe patient care. Minimum staffing at low levels of census often yields costs per discharge that exceed revenues per discharge.

Previous issues of **in•sight**™ have presented the case for significant revenue growth in most rural hospitals where the hospital's market share is low. But as volume begins to grow, expenses tend to grow in proportion to revenue because we simply overlay growth onto underlying staffing methods and work processes designed for low volume. We are

CALL US AT:
1.877.881.8783

EMAIL US AT:
insight@HospitalMD.com

**400 Westpark Court,
Suite 230
Peachtree City, GA 30269**

HospitalMD.com

VOL 2.3

familiar with the axiom that you should not expect a better outcome without a using a better method. Therefore, we should not be surprised when financial losses continue to occur even when significant revenue growth occurs.

Let's look at an example. If your net revenue is $4,000 per discharge and your cost is $4,200 per discharge, you are losing $200 per inpatient admission. Modest increases in inpatient revenue can absorb some of the expense of minimum staffing. But, at some point as revenue grows, the admission of one additional inpatient at $4,000 now results in a $400 loss if your cost per discharge remains at $4,200. The impact of changes in cost and volume for a Critical Access Hospital has very risky consequences that are difficult to predict. Continuing revenue growth in this situation is worse than not increasing any revenue.

WHAT TO EXPECT?

We shouldn't expect to depend only on volume-based monthly reports and traditional monthly income statements and budget reports to guide improvement decisions. Such reports are not designed to provide insight into the relationship between revenues and expenses at an operational level of detail, and on a frequency, that permit daily and weekly operational interventions and adjustments. Furthermore, traditional income statements and budget reports that do not usually report "net revenue" at the service level and department level can "blur" analysis.

AVOID PROBLEMS. DON'T KEEP FIXING THEM.

Just as there are systematic methods for revenue growth, there are systematic methods for optimizing profit margin. With this issue, I will begin a series of articles that outline how to achieve this improvement in profit margin.

I am sure your Performance Improvement (PI) reports tell you when Emergency Department (ED) patient visits increase or decrease. Likewise, your reports also indicate when LWOTs (or LWBSs) are increasing. You may assume that your staff needs to create more positive patient encounters, or perform more timely patient treatments. You may be right. You also may be wrong.

You may have worked with your staff on ways to get better patient satisfaction scores, but the results remain unchanged. Or, your satisfaction scores are better than ever. You congratulate your staff and tell them to "keep up the good work". Well, they kept up the good work. But the following month your scores fall back to previous low levels. Now you really don't know why you had either good or bad scores. Do you know how to link satisfaction with patient care in a more predictable way? Is another pep rally in order? Even if you are right about the causes of either high or low satisfaction, are you able to replicate better scores consistently? Our ultimate goal is to avoid deficiencies, not keep correcting a mistake over and over.

PERFORMANCE IMPROVEMENT (PI) OVERVIEW (PI 101)

Performance Improvement is a broad, "catch-all" term associated with many different analytic tools and techniques designed to achieve organizational performance improvement; and it means many different things to many different people.

HospitalMD™ has developed a PI methodology that integrates (1) improvements within individual service lines and across all services lines, (2) monitors and reports performance outcomes that point to improvement opportunities, and (3) provides a way to change organizational behavior necessitated by service line improvements. Its essential characteristics are:

- Improvement is its purpose.
- Management is its method (how).
- Incorporates improving efficiency (reduce cost) *and* effectiveness (quality of service).
- PI is not an organizational unit.

INTEGRATED PERFORMANCE IMPROVEMENT SYSTEM

- PI is intrinsic to every manager's job, not a regulatory requirement that we have to do in addition to managing.
- PI must first be adopted as a philosophy and culture before one can expect to see results from use of the tools.

Many tools and techniques have evolved out of "performance-mature" industries such as manufacturing for over 50 years. These have become complex and serve specific purposes (but not all purposes). Tools and techniques are designed to point to a solution or remedy, not only to report outcome.

Healthcare is in its relative infancy in adopting and implementing PI compared to manufacturing. Many of these "industrial" tools and techniques have been adopted and used by hospitals without understanding how to apply the tool or technique. This has created frustration. If we don't see results, we come to question the value of PI and just go through the motions.

HospitalMD's experience in performance improvement, and systems and process engineering has enabled us to better know which techniques apply and how to apply them to healthcare. Much about PI is quite simple. From this experience, we have adopted an approach to PI of "simplifying complexity" which helps us to assist hospitals to cut through hours of rigor (and frustration) and achieve results quickly. Effective PI follows the "80/20" rule. We can achieve 80% of improvements (i.e., low hanging fruit) by use of only 20% or less complexity.

PI is a methodology for managing business, process, and clinical improvement. Therefore, your PI methodology should incorporate Peer Review (PR) and Risk Management (RM) in the same way PI addresses financial and operational improvement. PR and RM are simply two different organizational purposes of the same methodology. PI is analogous to the human body's central nervous system. It sends signals and prompts activity.

A diagram of a "best practice" PI function is shown above.

PI is much too broad and deep to adequately address in multiple issues of this newsletter. However, I will provide an overview of PI in future issues, and post more details of the methodology at **hospitalmd.com**. I believe you will find these newsletter articles, case studies, and methodologies useful.

I welcome your questions and comments about your experiences with PI, and what does and doesn't work for you. If you would like more information, please contact me anytime at *insight@HospitalMD.com*.

Get in•sight™ via email as well as access to other FREE leadership resources to help your hospital thrive. There are no strings. Email us to sign up and follow us:

Facebook.com/HospitalMD

Linkedin/HospitalMD

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.

CARE.
QUALITY.
PERFORMANCE.
PROFITS.

UP.

EXECUTIVE INSIGHTS AT:

Facebook.com/HospitalMD

Linkedin/HospitalMD

in•sight™

HospitalMD®

EMERGENCY | HOSPITALIST | HYBRID

IN THIS ISSUE:

Revenue Growth?

CALL US AT: 1(877) 881.8783

OR EMAIL US AT: insight@hospitalMD.com

HospitalMD.com®

Delivering Excellence. Every Time.