HospitalMD®
EMERGENCY | HOSPITALIST | HYBRID

Executive in·sight™
OCTOBER 2018

INSIGHTS AND INNOVATION FOR RURAL HOSPITALS AND PROVIDERS

Blind Spots

Part One

Are You Missing Acres of Diamonds in Your Backyard?

You may have heard the expression "If we had perfect information, we could make perfect decisions." Well, we don't have perfect information. In some cases, we have too little information, sometimes too much, and sometimes the wrong information. I call these conditions "blind spots". Regardless of these conditions, we have enough adequate information to make substantive decisions. We just need to know where to look and how to use it. It's like finding acres of diamonds in your back yard! I propose we change our perspective and shine light on these information "blind" spots so we can see clearly and begin harvesting this resource for success.

THE TRENDS
Industry Trends

Reuters (news agency) reported recently that Moody's (a financial services firm) expects the 2017 trend of median operating margin and cash flow margin declines of 1.6% and 8.1% respectively to continue well beyond 2018. Separately, Morgan Stanley (an investment

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 3.4

bank) reported that an analysis of over 6,000 US hospitals indicates that nearly 20% were either weak or at risk of closure. Highly popular industry mergers and acquisitions (M&A) may be no savior for financially weak hospitals, especially in hard-to-reach areas, as the pace of hospital closures accelerates.

Local Impact

About 70% of all patient volume comes from patients that are 60 years of age and older. This translates into a significant portion of Medicare (MC) volume. This should be good news if you are a rural market, and a PPS hospital. But, the regulatory "design" of the Critical Access Hospital program limits a CAH hospital from making more than an abysmal 1% gross profit margin (101% of cost) on MC patients. ***And you may want to sit down for this***—in 2011, the Office of Management and Budget (OMB) proposed that both the 2011 and 2014 federal budgets reduce payment to 100% of cost (from 101%) yielding a 0% profit margin for hospitals but saving CMS $1.4 billion. This pressure is not going away.

You may be even more surprised that in 2013, the HHS OIG reported to the US Congress that 64 % of rural CAH hospitals would not meet CAH regulatory requirements today if they had to recertify, and CMS and beneficiaries would save $700 million if this same 64% were re-designated PPS hospitals. HospitalMD's internal studies indicate that many CAHs would be better off as a PPS hospital because their actual cost-based CAH reimbursement per inpatient discharge is less than the PPS baseline reimbursement rate.

THE FORECAST

Revenues are decreasing, and costs are increasing. This is an economic reality and not likely to change. This forecast isn't pretty. Hospitals have been closing at a rate of about 30 a year according to the American Hospital Association, and patients living in rural areas outside major cities may be left with few, or no, hospital choices. The next 12 to 18 months should see the rate of closures increase.

SO WHAT'S NEW?

You say, give me some good news. Tell me something I don't know. What can work that hasn't been done before? A book titled ***Acres of Diamonds*** was written in 1890 by Russell Conwell who is best known for founding Temple University in Philadelphia. It is about a man that set out on a journey to search for the largest and most precious diamond on earth. His search took him a lifetime but without success. Ironically, after his death, this rare and precious stone that he had pursued was actually discovered in his backyard.

THE OPPORTUNITY (REALLY)

Only 12% of all hospital patient visits at rural hospitals are inpatients (IPs) compared to 33% at urban hospitals. Over 90% of all rural hospitals achieve a very low average market share of between 15% and 20% **AND** utilize only 12% of their available beds compared to 65% utilization for urban hospitals.

It is ironic that often the cause of a problem can also be the cure. Vaccinations for

various diseases (e.g., polio, flu, pneumonia, shingles, etc.) are a cure (or protection). In 1800 in England, doctors experienced an unexplained epidemic number of deaths during C-sections. It was common practice to perform C-sections in the afternoon after they spent the morning in the (cadaver) lab.

The breakthrough occurred when they realized that if they washed their hands after leaving the lab and before performing C-sections, the death rate declined dramatically. We look at this illustration today and marvel at how they could be so ignorant. But they were. Today, the only difference may be that we have different blind spots. The irony is that anything that can be a cause of financial distress can at the same time be the cure.

If this is true, it must mean that we don't understand something about the cause of financial distress. And if we come to understand the cause, we may come to understand the solution. We refer to the ED as the front door (or gateway) of the hospital. When someone says this we typically agree. But do we really know what this means? The ED is the mouth of the funnel through which the largest number of patient population enter the hospital. The ED feeds the inpatient medicine service. So if we don't get enough acute inpatient admissions, we need to understand why.

Generally, the county population is a good proxy for the number of patients that use the local hospital. So, let's stop to rethink this with an illustration using a county with a population of 20,000 which represents all possible sources of patient care. About 40% (8,000) of any population will use the ED at least once a year. Of these ED patient visits, about 15% (1,200) will consist of observation placements and acute inpatient admissions admitted locally and transferred.

Our research indicates that the sum of acute admissions and observation patients is almost always within +/- 2% of 15%. This is consistent with CDC health utilization data which is the longest running (25 years) utilization study in history. Observations should be about 2% (160), and transfers should be about 3% (240), leaving 10% (800) that are local acute admissions.

If a hospital doesn't fit this profile, it is experiencing outmigration "leakage" and is not keeping as many acute admissions local as it could and should.

Our first "blind spot" may be not understanding admission regulations well, and what it takes to keep 10% local. The next several issues of **insight™** will shine a light on the reason(s) and what we can do about it.

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.

Get all the issues FREE

at HospitalMD.com/resources

Clinical in•sight

FREE AND NOW AVAILABLE! INSIGHTS AND INNOVATION FOR PROVIDERS AND CLINICIANS

Blind Spots

Part One

PH: 1(877) 881.8783
E: insight@hospitalMD.com

HospitalMD.com
Delivering Excellence. Every Time.

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

PRESORTED
STD RATE
US POSTAGE PAID
PEACHTREE CITY, GA
PERMIT NO 1