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Unorthodox Fundamentals

Stepping Back From Financial Dead Ends to See A Better Path

by Jim Burnette, President/CEO, HospitalMD

Small Community Hospitals (SCHs) leave a significant amount of revenue on the table that is equivalent to an average annual net loss per hospital in the range of $1.5 million to $3.0 million. As you would expect, there are many reasons. This issue tackles one of the most subtle and misunderstood sources of lost revenue—the distinction between observation and acute patient status. The good news is that you can capture this lost revenue with more knowledge, not trying harder. How can these losses occur when so many SCHs are in financial distress? In thinking about the answer to this question, I am reminded of the following story.

A small fly is burning out the last of its short life's energies in a futile, life-or-death struggle attempting to fly through the glass of the windowpane. Regardless of how hard it tries, it will die shortly on the windowsill. Ten steps away, the door is open. With ten seconds of flying time it could reach the outside world with only a fraction of the effort. The fly doesn't know this. We do. Regrettably, it's a plan that will kill.

Source: Abridged. You² by Price Pritchett, Founder and CEO of Price Pritchett, LP, Dallas, TX, 1990.

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Obviously, the fly is too close, and cannot see the bigger picture. Like the fly, we continue doing what we are doing and trying harder when we don't see a clearer alternative. We are very reluctant to back off far enough to get a bigger perspective that may include a pathway to success. If we backed away, what might we see?

I believe we would see an "unorthodox" hospital business model that is at the heart of all symptoms and causes of distress. This model seems normal because it's the way it has been done for more than 60 years. The only thing that has changed in a half century is severe price resistance while costs continue to increase every year. Stepping back, we may start to see that this comfortable but radically unorthodox model blurs our thinking for several reasons:

First, we don't see it as a business (and certainly not a conventional business) because for many years there was no restraint on who we served, how much we spent, and how little we collected. I am not judging this, but we were in a "charity mindset". Second, as we attempted traditional business solutions and found that they didn't achieve success, we came to think these techniques do not apply to hospitals. Actually, they work but only if we understand how to apply them to an unorthodox business. Lastly, we thought we could charge as much as we needed to and we were always paid by the payer. It's time to "fly" through the open door so we can begin to see a new pathway.

GENETIC DYSFUNCTIONS

All business models are based on fundamental principles or concepts. Fundamentals are not necessarily right or wrong, but they are the foundation upon which business policies and practices are built. Healthcare is built on three fundamentals that impact every fiber of the business, and either favorably or unfavorably impact success depending on how well we understand them:

1. an artificial third-party market

2. a specialty-driven structure

3. a symbiotic relationship between physicians and hospitals unique to this industry.

The origin of business problems tends to be either *genetic* (intrinsic) or by *design/practice* (we create to operate the business). A "genetic" condition is an intrinsic trait that is inherited and passed from one generation to the next. Some business dysfunctions are genetic as well. These deficiencies have their roots in the fundamentals of the business and perpetuate themselves. Fortunately, business dysfunctions can be corrected and even eradicated.

Most traditional services and products that the public buys are transactions in which the customer choses to buy from a supplier based primarily on the buyer's perception of quality (effectiveness of service) and value (price). Unlike the traditional market, third-party (insurance and government) payers are a form of "broker" that are artificially inserted between the service provider (seller) and the patient-customer (buyer). *Although some patients do not have access to a broker third-party payer, for simplicity, this illustration will assume that all patient are insured by the broker.*

The broker (surrogate **buyer** on behalf of the patient-customer) determines how much money it needs from the business or government (broker's **revenue**) to pay for services (surrogate **payer** on behalf of the insured) for which the same broker also sets the price paid (broker's **cost**) to the service provider. That is, the broker always controls the amount of its revenue and effectively sets the price it will pay to the service provider

on behalf of the patient-customer. In other words, the broker takes with its left hand and gives with the right, and will always be profitable over several years. In any year in which the broker pays more for services than it collects, it simply raises the premiums businesses must pay and/or reduces the price it pays for services.

If you follow this arrangement of the broker playing both sides against the middle, you see how the broker both disrupts the forces of supply and demand while at the same time "fixing" prices so that it doesn't lose. The broker would argue that the equalizer is the risk it takes related to how frequently the patient-customer utilizes services it has to pay for. But, in fact, to mitigate this unfavorable variable, the broker simply raises premiums the next year. Furthermore, the broker can decline to do business in a state that disapproves the broker's premiums. The broker in the long run still has the upper hand because those brokers that stay in the market have greater leverage over future premiums that the state must approve or limit public access to insurance.

SPECIALTY-DRIVEN ORGANIZATION

The second fundamental unique to the hospital is the organizational structure of the hospital's service delivery. This structure produces clusters of service-line related departments and support services around the academic, medical specialty teaching model. Patient care for acute hospital patients can cut across multiple specialties and multiple ancillary services. This delivery model is not designed for efficiency or effectiveness. And possibly more importantly, this model does not lend itself to "team" medical treatment and continuity. Thus, this structure inherently contributes to a dysfunctional workflow impeding high performance from the patient's and provider's point of view. High performance can be achieved but requires specialized application of performance improvement models.

SYMBIOSIS

I am not aware of any other business model in which: (1) a customer of the hospital (physician) earns income from delivery of his services within the hospital and doesn't pay for the hospital's resources used, (2) the hospital earns its revenue independently of the physician by being paid separately for the hospital's services by the same third-party broker, and (3) the actual patient that receives the service has little to say about the treatment or the cost. Also, the physician-customers collectively have authority over the quality of services provided in the hospital and may approve other physician customers to use the hospital's resources and not pay for those resources. This creates a unique, symbiotic relationship in which both hospital and physician are partners and adversaries on any given day which makes it difficult for the parties to trust each other and achieve mutual benefits.

Sadly, the healthcare industry continues to operate under these three unorthodox fundamentals. And sadly, the healthcare industry has not come to understand how to apply performance improvement methods (PIM) to address financial distress. This web of economic interdependencies and regulations have "blinded" the industry to higher performance because of this unique structure.

It seems unlikely that new ACO types of payment models will be effective long-term because

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the physician always has stronger leverage in the relationship because the physician is the only party of the two who has authority to generate or withhold revenue for the hospital.

NEXT

Look for upcoming issues as I will be further illustrating how this unorthodox model has disrupted and continues to disrupt the economics of this market sector that represented 17.8% of the US Gross Domestic Product (GDP) in 2015 and is expected to rise to 19.9% by 2025. We can conclude that no approach to date has proven successful at containing the unbridled cost of this unorthodox model and is not likely to unless new solutions are applied.

What are your thoughts? Email me at **insight@hospitalmd.com** or call me at **877.811.8783** with questions or comments. I want to hear your experiences and your insights as well. See you next issue!

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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