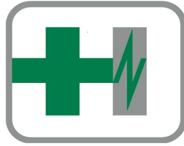

HospitalMD™

Quantum Revenue Growth in the Small Community Hospital

A Case Study

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Executive Summary

A small community hospital with 25 operational beds in a service area with a population of 30,000 was experiencing financial distress. During its most recent 12 months, the hospital had a total of 914 acute inpatient admissions which was equivalent to an acute inpatient average daily census (ADC) of 8.8. Of the 914 admissions, 803 (88%) were admitted through the ED which made the hospital vulnerable. This hospital had a 10 bed geriatric psych service, a modest general surgery service of about 5 cases per week, and no ICU.

A new strategy developed by HospitalMD, LLC (HMD) was implemented. This new strategy is a hospital-based medical practice that concurrently provides a Hospitalist (inpatient) service along with the traditional emergency medical service. The early results of this strategy clearly illustrate its ability to produce dramatic results.

Performance Parameters	Pre-H2MD	First 6 months of H2MD
Inpatient admissions trend	- 31% (prev 3 yrs)	+ 87%
Average inpatient daily census	8.8	14.7 (+ 67%)
ED visit trend	- 22% (prev 2 yrs)	+ 37%
Inpatient service area market share	25%	47%
Inpatient and ED gross revenue (6 months)	$2,594,911	$3,571,140 (+38%)
Total net revenue	-15% (over prior yr)	+16%
Admissions net revenue at 6 months annualized	-	+$2.5M
ROI on admissions growth thru end of 1st yr	-	936%
Incremental Net Revenue 1st six month	-	+ $651,393
ROI for 1st six months	-	552%

The most obvious concerns (or fears) about ED admission growth were that additional admissions through the ED, and most of the patients that primary care physicians (PCPs) handed off to the Hospitalist, would be uninsured. This was not the case. A comparison of payer mix before and after H2MD was implemented is presented below:

Revenue Payer Mix	Inpatient Admissions thru ED in Previous CY	ED Admissions for First 6 months of New Practice
Medicare	76.8%	58.9%
Medicaid	8.4%	5.2%
Blue Cross	3.8%	13.0%
Commercial	3.2%	8.3%
Managed care/PPO	3.9%	6.8%
Self pay	3.9%	7.8%
Total	100.0%	100.0%

The return on investment of 552% and timeliness of results make the decision to implement this new strategy reassuring. The hospital has continued to be profitable each month since implementation.

"Expect quantum results, not incremental change™."

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Detailed Description

Many small community hospitals (SCHs, or hospitals with 100 beds and less) are in financial distress. While it can be due to inefficiency, more often the cause is insufficient revenue consistent with their low market share often in the range of only 15% to 35%. Even if their market share is actually greater than this range, they may still be getting far less inpatient admissions than they could or should get.

The strategy is Hospital MedicineMD™ (H2MD™), a unique hospital-based medical service developed by HospitalMD™ LLC (HMD™) specifically for SCHs. The primary purpose of H2MD is to generate additional revenue and protect against outmigration.

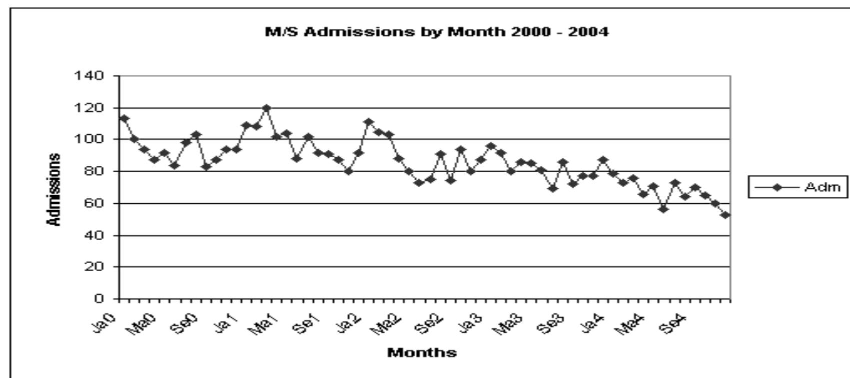
H2MD provides two independent, but concurrent, medical services within the same single practice - inpatient medical services **and** traditional emergency medical services, both typically provided by Internists. It serves as the hospital's primary inpatient admissions "engine" and provides a convenience to PCPs who want to (1) make their office practices more efficient, (2) avoid or eliminate "unattached" call, and (3) suffer no personal patient loss.

PCP inpatient admissions in the small community are frequently low for an assortment of reasons. For the PCP, inpatient admissions can be financially inefficient and intrusive into their personal life. Older physicians whose practices are mature may be inconvenienced by rounding in light of low reimbursement and the time it takes to round. Younger physicians come to the small community typically for the life style, and for an office practice that permits them to avoid a heavy inpatient practice. In other cases, there are too few PCPs and specialists and hospital find it difficult to recruit.

Pre-H2MD Conditions

Prior to implementing H2MD, total inpatient acute admissions had been in a general decline for 3 years as follows: 3 years prior by 10%, 2 years prior by 7%, and one year prior by 18% for an overall decline of 31% over 3 years. This trend, illustrated below, is not unique. The hospital's inpatient ADC was 8.8 prior to implementation after a two year decline from 11.6. This resulted in a decline in inpatient "net" revenue alone of over $1 million.

Admissions from the ED ranged from 78% to 89% of total admissions. The hospital's average ED customer visits per month was down 22% from the prior year to a low of 605. Thus, the hospital was highly vulnerable to the declining production of the ED and the office-based medical staff.



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During the first two months of this new practice, HMD provided only emergency medical services. After 2 months of the ED medical service only, Hospitalist services began with the formation of the Internist group.

Results of First 9 Months

As this case study illustrates, H2MD can be highly effective at producing increased revenue relatively quickly. Furthermore, its ability to increase volume does not depend on recruiting other PCPs even though this may be possible and needed. At the time of implementation, the average number of monthly inpatient admissions through the ED was 61. At the end of the first 9 months, H2MD had reached 114 admissions. Monthly admissions for the 9th month of 114 were an annualized rate of $2.5 million in additional "net" revenue.

H2MD practice success is measured in terms of its ability to increase (a) ED customer visits, (b) additional inpatient admissions through the ED, (c) inpatient revenue, and (d) total revenue. Each of these parameters is recapped below for this hospital and illustrated in separate sections in the remainder of this case study.

- ED customer visits after the first year increased by 37% over the prior year.
- Inpatient admissions through the ED in the 9th month of 114 were 87% greater than the monthly average for the period of 6 months prior to implementation.
- ED physician professional gross revenue increased by 77% over the first year. (No charge increase.)
- Inpatient gross revenue increased by 38% over the first year. (No charge increase.)
- Total hospital net revenue increased by 16% over the previous year.
- Month 9 admission rate of 114 was an annualized $2.5 million in additional "net" revenue.
- The inpatient ADC grew from 8.8 at the last month of year prior to implementation to 14.7 (67%) by the 9th month.

The Hospitalist model was designed to ensure that PCPs did not lose patients. However, no one expected the benefit of a growth in the practice volume of PCPs and general surgeons. But as reflected in ED patient visit growth and overall improvement in payer mix (both noted later in this case study), a surprising number of customers coming through the ED needed a PCP. Our policy of assigning unattached patients to the current Medical Staff resulted in a growth in PCP practices. Our use of Internists contributed to identifying a rather large number of surgery and procedure opportunities for local surgeons.

ED Customer Visits

The total ED customer visits for several years prior to implementation held steady at an average of 11,200 per year or 933 per month. However, ED customer visits had declined drastically during the immediate year prior to implementation by 22% or an average of 205 per month. ED customer visits for the first 9 months of H2MD increased by 37%.

In light of a favorable payer mix after H2MD was implemented, this suggests improved customer satisfaction and positive public perception in light of the 22% decline prior to implementation. Not only does this ED visit growth generate additional ED revenue but it increases the pool of inpatient admissions prospects.

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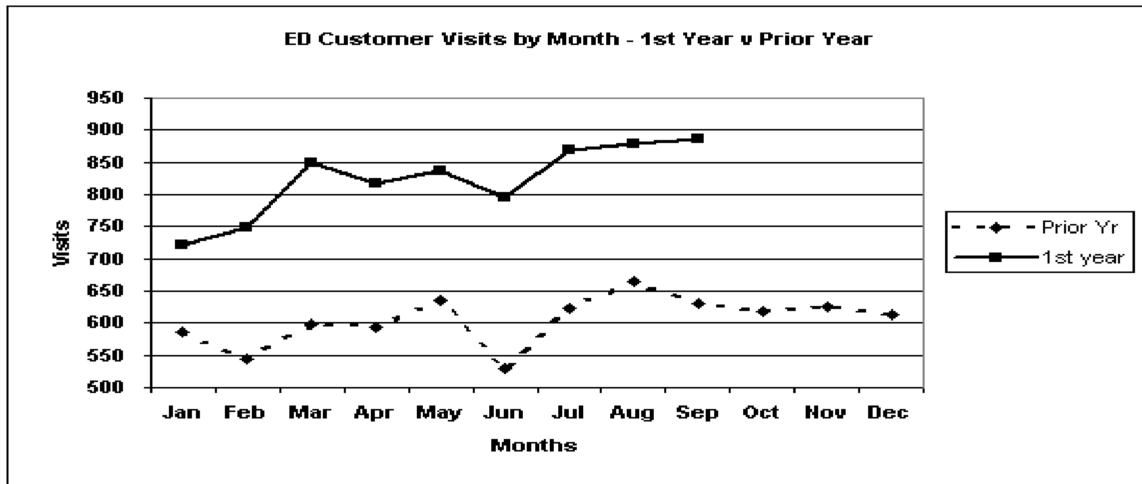
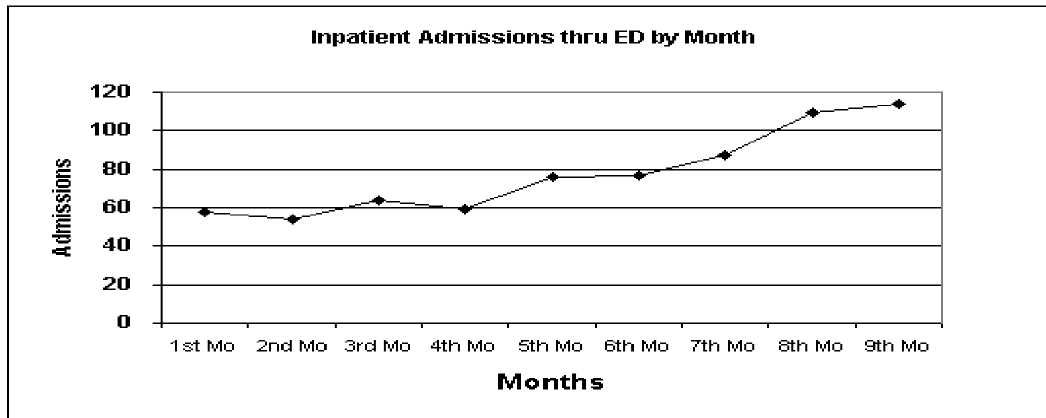


	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec
Prior Yr	585	545	598	594	635	530	623	665	630	618	626	613
1st year	721	748	849	817	838	794	868	879	885			
Incr.	23%	37%	42%	38%	32%	50%	39%	32%	40%			

Inpatient Admissions Through the ED

Inpatient admissions through the ED averaged 61 per month for the last 5 months of the year prior to implementation. Admissions began to increase significantly from 61 to 76 admissions within 5 months and continued to increase to 114 by the 9th month. The admissions rate at the 9th month was an 87% increase over the average monthly admissions of 61.



	3 Prior Months			1st Mo	2nd Mo	3rd Mo	4th Mo	5th Mo	6th Mo	7th Mo	8th Mo	9th Mo
ED Admits	64	69	60	58	54	64	59	76	77	87	109	114

NOTE: This case study was prepared in during the 10th month; and since, inpatient admissions through the ED continued to rise and in the 10th month reached 119 which is a 95% growth in admissions through the ED versus the prior year. The national average for admissions through the ED is 14% of total ED visits with some practices admitting 20% and more without inappropriate admissions. Two of three Internists are admitting at levels of 17% and 20% respectively.

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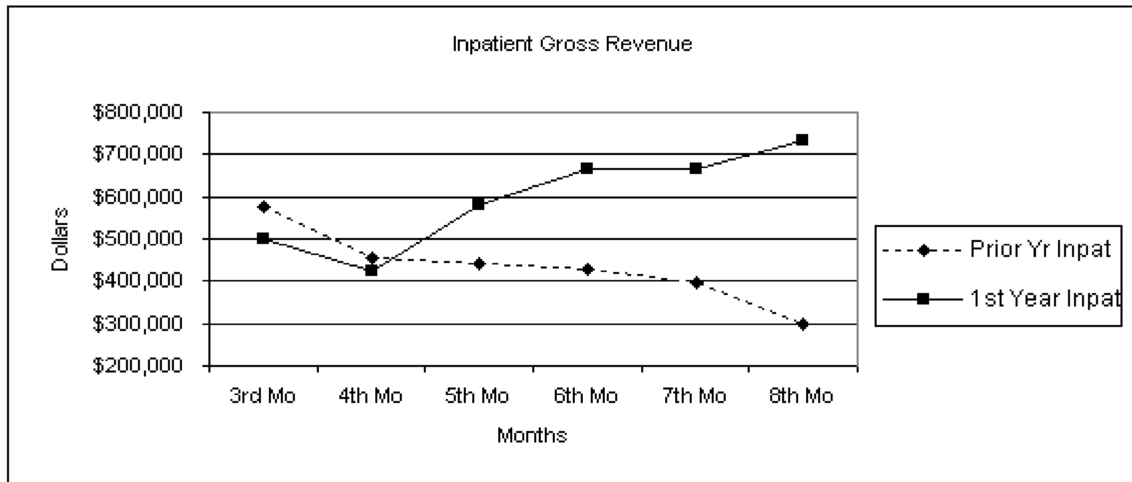
Inpatient Gross Revenue

On a year over year basis, ED physician professional gross revenue grew by 113% for the 6th month, 24% for 7th month, 52% for the 8th month, and 77% overall for the first 6 months. Inpatient gross revenues increased by 38% over the prior year, even though admissions did not begin to increase substantially until the 5th month of the implementation year. To put the increases in perspective of the 4-month growth period, year over year inpatient gross revenue grew by 32%, 56%, 68%, and 145% respectively for the 5th month, 6th month, 7th month, and 8th month.



	3rd Mo	4th Mo	5th Mo	6th Mo	7th Mo	8th Mo
Prior Yr Inpatient	$576,140	$56,744	$439,988	$427,337	$395,515	$299,187
1st Year Inpatient	$500,414	$425,278	$579,935	$667,598	$664,306	$733,609

Total Net Revenue

Gross revenue is tracked separately for inpatient services and ED physician professional revenue. However, inpatient and ED physician "net" revenue is not tracked separately. Therefore, Total "Net" Revenue includes other hospital services in addition to inpatient and ED physician professional revenue. However, note that Total Net Revenue for all services was declining from the year prior to implementing. In fact, net revenue declined in the 3rd month over the same month in the prior year by 15% and in the 4th month over the same month in the prior year by almost 8%. Net revenue began to turn in the 5th month consistent with admissions growth, which was the only material link to growth in net revenue. On a year over year basis, the total net revenue increased at the 6th month by 40%, at the 7th month by 30%, and at the 8th month by 56%.

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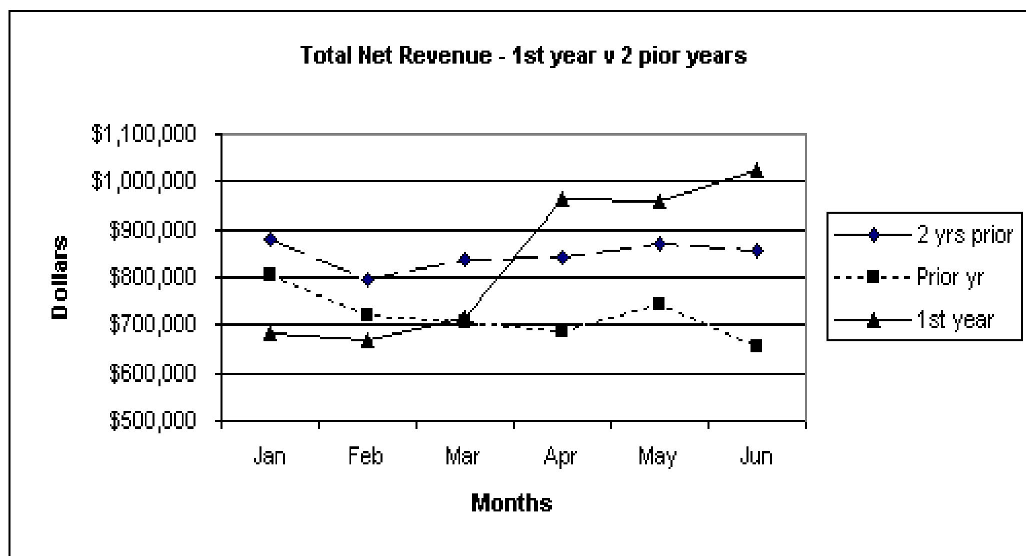

Dollars of Total Net Revenue

	Jan	Feb	Mar	Apr	May	Jun	Total
2 yrs prior	$ 878,229	$ 796,841	$ 835,572	$ 844,482	$ 870,247	$ 855,046	$ 5,080,417
Prior yr	$ 806,183	$ 722,599	$ 708,459	$ 689,307	$ 742,605	$ 656,969	$ 4,326,122
1st year	$ 683,110	$ 666,621	$ 713,419	$ 963,642	$ 961,661	$ 1,023,365	$ 5,011,818
1st year over prior year	-15.3%	-7.7%	0.7%	39.8%	29.5%	55.8%	15.9%

Summary

Total Incremental Inpatient and ED Net Revenue for months 3 through 8 (3rd month beginning calendar year) was $651,393 for a return on investment of 552%. These results are taken from the hospital's internal financial statements for the period. These results, extended through the end of the first full calendar year on a continuation of activity levels at the end of the 6th month of the calendar year, would yield Annual Net Revenue of $2,500,000 and a return on investment of 936%.

Low Admission Frequency

There are several general reasons SCHs do not get an appropriate market share. The size and specialty mix of the Medical Staff can be insufficient. In other cases, the Medical Staff (primarily PCPs) do not admit in favor of treating patients on an outpatient basis. When asked about their admission volume and patterns, physicians commonly reply that they just don't have a lot of admissions in their practices. And while this may be true in some cases, it represents a physician-specific philosophical practice perspective and may not be appropriate in all cases. Otherwise, their practices are unique, and don't follow the general utilization patterns experienced elsewhere. It is unlikely that their patients are a unique population in which the frequency of illness is statistically different than all other populations and demographics. Furthermore, these general utilizations patterns have been tracked by the Centers for Disease Control for 25 years and utilization patterns have been relatively constant for the last 10 years.

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Actually, there are more fundamental reasons that PCPs are often not willing to express. ED physicians report that it is common to not admit some patients because of reimbursement disincentives relative to the time required to admit, time limitations within the ED, avoidance of PCPs who don't want to bothered after normal office hours, nurses that discourage admissions because they don't want more work, and the ease of referring the patient to his/her PCP to avoid additional work themselves. These reasons are most common where ED physicians are paid by the hour to provide ED medical care.

ED physicians and nursing homes also report that often senior citizens who present to the ED are not admitted upon initial onset of illness but are later admitted in more serious condition, with additional complications, and at a far higher cost to the payer. In the SCH setting, these patients, now more seriously ill, must be admitted to other larger hospitals due to acuity limitations of the SCH. A customer that meets admission criteria and is admitted sooner based on a "preventive" mindset could and would have a far less serious subsequent illness which would be far less adverse and far less costly to treat. This philosophy is consistent with pharmacological studies that indicate illness is easier to treat, has faster recovery, and less costly when treated at the earliest onset.

Typical reasons for low PCP admission frequency can broadly be summarized as follows:

- Inpatient care can be a higher risk to the PCP than outpatient care in one's office.
- As physicians' office practices develop and mature over time, "unattached" call and rounding become an undesirable interference. Physicians may come to provide just enough inpatient care to meet either (1) the privilege requirements of the Medical Staff By-Laws, (2) what they perceive as their moral obligations to the hospital and their patients, or (3) what their more demanding patients insist upon.
- With the decline in reimbursement, inpatient care can reduce their efficiency (effective hourly income), or they have to provide inpatient care either before or after normal office hours extends their work day and interferes with their limited personal time.
- Even to most young physicians who come to a small community to practice, a hospital practice is not desirable or a high priority. If he/she wanted a hospital practice they would have practiced medicine in a larger urban area.
- Adversarial relationships with the hospital or members of the Medical Staff.
- A lack of sub-specialists or of mutually motivated PCPs and sub-specialists.
- Hospitals' inability to provide appropriate quality clinical skills, equipment, or facility.

The unfortunate conclusion is that many physicians of any age in the small community do not admit at the level of their peers in urban settings. And this is not due to fewer admissions per capita in small communities. The good news is, in spite of these causes of low market share, there is generally sufficient overall inpatient volume within most hospital's geographic service area for success.

More information about Hospital MedicineMD may be obtained by contacting HospitalMD, toll free at 877.881.8783. **Hospital MedicineMD (H2MD)** is a hospital-based medical service of Hospital**MD**. Hospital**MD** is one of a family of companies operated by **Hospitalogic (HLG)** who specialized in the small community hospital market**.** Learn more about **HMD and HLG** by visiting our web site at www.hospitalogic.us or call toll free 877.881.8785.

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