

## American Hospitals – Averting a Crisis in Declining Revenue

by Jan Jennings

The **W.K. Kellogg Foundation** identified in the early 1930s that the management of hospitals needed to be improved and the **American College of Hospital Administrators** (now the **American College of Healthcare Executives**) was formed in 1933. In the period from 1933 to 1954, ten programs in healthcare administration were formed. There is a dispute among alumni programs as to which program was first. My vote goes to the Kellogg School at Northwestern University although people of honest endeavor interest disagree . . . vigorously. I graduated from the Graduate Program in Health Administration at the **University of Pittsburgh**; the first Graduate School of Public Health in the United States.

Over the years, curricula of these programs have changed dramatically. Further, there are many organizations that provide varied and spectacular programs to assist healthcare executives to remain current and relevant. Among these organizations, the **American College of Healthcare Executives** is, far and away, first among equals.

One maxim that has remained unchanged is the following: **The typical hospital CEO or CEO of an Integrated Healthcare Delivery Network (IHDN) is a general manager.** There are, of course, hospital CEOs or IHDN CEOs who understand the engineering of the American hospital at the granular level and have strong control systems that give them control over operating details. I have met five such CEOs in my career spanning over forty years.

Over the last ten years I have learned that hospital and IHDN CEOs sadly (self included) have found it difficult to keep up with the spectacular complexity that has slowly emerged in the American hospital or Integrated Healthcare Delivery Network. This reminds me of baseball, a far less complex organizational framework compared to hospitals. Brian Cashman is the General Manager of the New York Yankees. His impact on the team's win/loss record is highly diffused through a somewhat complex hierarchy of owners and other management layers.

So it is for hospital executives. The impact of the hospital CEO on the financial results of the institution is diffused through organizational designs that ooze with opportunities for failure.

**Hospital executives are deeply deprived of emerging information or solutions to problems they have never considered.** Fear not, I am not a skill for any healthcare consulting firm; however, I have seen healthcare consulting firms, typically small firms where new technology emerges, develop programs and services that really make a difference. This is a glittering generality and without prejudice, but the large, brand name healthcare consulting firms do not have the capital or intellectual curiosity to surface granular solutions to detailed hospital complexities. Without naming names, I will provide several examples in the alternative:

- The standard cost of a single sheet of paper processed (all costs included) in the American hospital is four cents. I have never met a hospital CEO who knew this. There

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is a company who can reduce this cost to 3.4 cents for a single sheet of paper processed (all costs included). For every 250 beds, this company guarantees the hospital a \$300,000 savings. The notion that the American hospital is going paperless is a myth. Why does this company have 90 hospital customers and not 900? The hospital CEO, CFO and COO, understandably, have defense mechanisms in place to protect them for every

salesman calling on the hospital. When this proposition is presented to the person responsible for purchasing for the hospital, well, the proposal just does not get too far. I will leave it to others to explain this lack of empowerment.

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## *Five great reasons why general managers should get more granular:*

:: For every 250 beds, there is a print management company that will guarantee the hospital \$300,000 in savings

:: Guaranteed 10% cost reductions in energy management are available with no capital expenditures

:: There is earned, but not collected, revenue available for capture in every hospital in the country

:: Hospitals typically overspend on labor by \$1.5M for every 50 beds

:: 10-15% savings can be achieved by becoming less dependent on high margin equipment maintenance contracts

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- There is a company in Denver that offers American hospitals, educational institutions and other organizations a ten percent guarantee to reduce energy consumption with no capital expenditure. This company simply fine tunes the equipment the organization owns and are equipment agnostic. Its' track record is unblemished. For the 600 IHDN in the United States, this represents millions of dollars. To the best of my knowledge, this company does not have a single IHDN in its contract portfolio. Really? Really.

- We all like to get paid for what we do so why are hospitals so reluctant to go after their "earned but not collected" revenue? I am familiar with a company that uses proprietary software to find accounts where codes are not "paired" appropriately, therefore, billed incorrectly. Often healthcare executives will assume that they have revenue cycle covered. Why don't more accept the contingency-based challenge of using this company to either validate their current process or to find additional revenue? Arrogance, complacency and lack of understanding are just some of the reasons.

- The average hospital is 20 times more dangerous to the workers, on average, than the work floor adjacent to a 4,000 degree Fahrenheit molten aluminum in an

Alcoa smelting facility. When I heard this from Paul O'Neill, former Chairman of Alcoa, founding Chairman of the Pittsburgh Regional Healthcare Initiative and the first Treasury Secretary under President George W. Bush, I thought he might be slipping just a bit. His staff sent me the data sources and I was empowered to find the truth. He was wrong; the American hospital is **30** times more dangerous than the previously described industrial scenario. Hospitals have a safety officer who writes up injuries, reports these injuries to the carrier of Workers' Compensation and the state and federal government.

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And the beat goes on. I personally remember denying a group of nurses the equipment to lift patients more safely because it did not crawl up my list of capital priorities.

- In 1989 the Institute of Medicine demonstrated its research in a book entitled ***“To Err Is Human . . .”*** that the universe of American hospitals accidentally kills 98,000 patients annually to which the hospital industry stood up and took notice. The ***American Hospital Association*** mounted an enormous awareness campaign to bring attention to this subject and save 98,000 lives. Last year, a study was published from research done in North Carolina and it demonstrated clearly that the American hospital has made absolutely no progress. Why? I know of one corporation, if taken seriously, can reduce hospital-acquired errors as well as hospital-acquired infections to zero or near zero. Why is this firm not hiring professional staff at a record clip to keep up with demand? There is little demand. Our findings are that hospitals all have quality management departments with one interesting name and approach or another. When I discussed this subject with a CEO of an IHDN, even though my firm has nothing to do with this subject, he said that “he was comfortable with his approach to improving hospital care.” I did not have the nerve to ask him why he was “comfortable.” The publically available data suggests he should not be able to sleep at night.
- Ironically, the majority of American hospitals do not have the right person in the right place at the right time for the right clinical outcome. Equally serious, these hospitals tend to overspend for W-2 related costs by \$1,500,000 for every 50 beds of inpatient occupancy. Why? Well, show me one healthcare executive in the United States who was educated, dare I say it trained, to know the detailed requirements of staffing the American hospital. There are firms that can improve patient care and save millions of dollars for the American hospital, but they are in nominal demand. Why? Here is what we observe: every three years, the American hospital becomes more efficient through legitimate hard work, lays off employees and within three years, 50 to 100 percent of the employees are back through insidious “job creep.” Is it any wonder that two-thirds of American hospitals lose money or just barely breakeven? By the way, if you are just breaking even, you are falling behind in the maintenance of existing plant and equipment, replacing old technology and acquiring needed new technology. Breaking even is the same thing as losing money . . . just less.
- With respect to non-W-2 related expenses, or supply chain management, the typical hospital loses millions of dollars through inefficient purchasing and distribution throughout the hospital without regard to how many GPOs it may have in its portfolio.



I know nothing about this subject and most of my peers know just as much as I do. There are firms that specialize in tuning up the supply chain to yield millions of dollars to

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fund many needed priorities of the institution. I would not describe these firms as overwhelmed with work. By the way, these firms are GPO agnostic.

- One firm that focuses on IHDNs has about fifteen of 600 in its portfolio. The firm engages in supply chain management with technologies well-known in private industry; GE and others. He presented his program with guaranteed annual savings of approximately \$10,000,000 to a former financial executive of GE of one large IHDN. The response went something like this, “You do not understand, one of our key goals is to be the largest private employer in this state and your program does not feed into this corporate goal.”
- The federal government has offered extraordinary strides to incentivize U.S. hospitals to deploy an electronic medical record. This all falls under the rubric of meaningful use. Very few hospitals met the first round with the highest incentives. Why? That is way over my pay grade. There is an extremely well-funded IT firm that will do a turnkey operation for even the smallest critical access hospital in the United States for an extremely low monthly fee (all costs included). Most IT directors are successful in keeping this firm at bay. It might be good for the hospital, but it may or may not be good for the existing IT director.
- Biomedical engineering is the black hole of the hospital’s operating statement. A recent study of American hospitals demonstrated that the biomedical engineering department responds within 30 minutes to a major equipment breakdown. Then, the biomedical engineer calls the Original Equipment Manufacturer (OEM) or the OEM biomedical engineers under an overpriced service agreement. The margins in this business are so wide that firms have emerged to assume all of the risk through secondary insurance markets and offer wall-to-wall replacement for all service agreements with improved service and millions of dollars of savings. Why don’t hospitals do this in droves? Who in the hospital will listen to them?
- In the last two decades hospitals have, out of necessity, hired physicians at a record pace; the reasons are legitimate and varied. It is a completely different business from running a hospital and most hospitals have lost money at the operating line for these hospital-based physician groups. There is a lot of rhetoric about how these physician operating losses are more than justified by the physicians’ “contribution” to the overall enterprise - *nonsense*. There are multiple firms that now guarantee breakeven status or operating surpluses within three years or forego consulting fees. This is where the larger hospital-based physician groups in the largest healthcare IHDNs will become almost hostile. They know better or, do they?

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The impact of healthcare reform will make it essential that hospitals become much more profitable now, because they are going to be less profitable in the future. At the current rate of growth in the Medicare and Medicaid programs, at a date certain, the only two items in the gross national product will be the Medicare and Medicaid programs. You will not have a car, you will not be able to pay for groceries, and you will not be able to purchase water or pay your mortgage payment because every U.S. dollar will be spent on the Medicare and Medicaid programs. Here is a tip. Despite all of the banter between the two major political parties, there is bipartisan support to remove \$531 billion from the Medicare program without regard to changes to the Medicaid program.



In addition, there are currently ten million Americans covered by the Medicaid program. This is estimated to grow by 29 million additional Americans over the next ten years. Where do you think the needed savings from Medicare and Medicaid are going to be derived . . . you got it, the American hospital. Here is one small example. A hospital our firm recently served experienced one patient that was admitted and re-admitted so many times under DRG 291; the most complicated DRG for congestive heart failure, and received approximately \$1,000,000 in net patient revenue from the Medicare program. Effective October, 1, 2011, the new Medicare reimbursement rules will treat this hospital somewhat differently. At most, the same care will yield in Fiscal Year 2012 . . . \$50,000. What is the plan to improve the continuum of care to prevent this enormous loss in patient care revenue? There is no plan. Does your hospital have a plan for the readmission rule effective October 1, 2011?

There is so much more to say and the real challenge is that *hospital CEOs need to be much more involved in the granular operations of their hospital or hospitals*. Failing to do so will place that CEO at his/her own peril. As I said at the outset, I am no shill for healthcare consulting firms. On the other hand, it would be reckless and irresponsible to not call to your attention an organization that can direct you to solutions that might benefit your organization. You are not a victim even though you may not know where to turn.

I would direct you to an organization known as **MD Resources, Inc.** and its brand of “**Optimizing Healthcare Delivery through Operational Integrity & Best Practice Solutions.**” It is led by a



former HCA executive, Greg Eisele. He has been on a quest for the last fifteen years finding new and emerging solutions to old and new hospital operational challenges. He can be reached at [GregEisele@MDResources.net](mailto:GregEisele@MDResources.net) or 559-447-4488. If you believe you have every one of these issues completely under your control, I am willing to bet that MD Resources can offer you solutions that will significantly improve your bottom line.

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