Institute of Medical Business Advisors, Inc.

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A PROFESSIONAL INTERVIEW WITH
10 QUESTIONS FOR:

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FROM: Steve Brawner [Steve Brawner Communications]
BY: David Edward Marcinko
RE: *Medical Business News, Inc.,* the publisher of *Medical News of Arkansas*

1. How long do you anticipate the recession lasting? (As if anyone knows, but I have to ask).

Well, if you ask the political pundits and macro-economists, their best guess is probably 2012, followed by an inflationary decade. Here in Atlanta, it may be a bit less since we are a corporate town, not a manufacturing one.

But this recession, unlike past recessions, depends less on the industry in which you work and the region in which you live. Moreover, I believe the stock market malaise will last for a decade, or more. Why? US banks just posted their first quarterly loss in 18 years. Health insurers and drug makers also sank after the Obama administration unveiled its' sweeping plans for reform. The domestic economic outlook is far gloomier than expected as unemployment exacerbates, and both credit and housing woes increase. Precious metals, hard assets, and commodity markets will rise with the inflationary uptick; as the equities markets flounder.

There, I made a prediction and although not always right; I am seldom equivocal.

Our sector of healthcare - typically considered recession proof – is not nearly so for doctors or hospitals this time around - the situation is that endemic. Corporate, small business layoffs and the poor employment and housing situation filters down from companies reducing employee numbers and health insurance coverage, to those worrying about same, to a reduction in routine or needed medical office visits, elective procedures, check-ups, etc, all the way down to grass-roots provider level. The situation is not personally good for the MD/DO practitioner, which then is reinforced by this dire macro-economic scene, in a vicious cycle.

Unfortunately, to compensate, some doctors and hospitals view healthcare services as supply driven, rather than need-demand driven. So, they seek to provide excessive and/or unnecessary care, or hospital-admissions, for less than credible reasons. I mean, after two decades of practice, I have never encountered a hospital CEO or administrator not cajoling his/her medical staff members to "admit, test, probe or prod for profit."

As an example, one local hospital administrator confidentially told me that a single hospital bed is currently worth about a million bucks a year to the institution. And, the mantra of this CEO to staff doctors was: "fill the beds"; "schedule the procedures", and "book the operating room." In fact, every lunch or dinner I ever received from a hospital, where I was a staff member, had a "census-sign" in the private physicians' lounge.

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Now, be aware that "profit" has several different definitions. It may be defined as income, but also as other assets like additional patients for internship or residency training programs, drug trials, RD etc, as these may garner additional federal grants or private funding, etc. This later philosophy does seem more independent of economic ecosystem.

2. If you were to list three things that hospitals can do to improve their situation short-term, what would they be?

According to the Dupont Decomposition equation - which involves the conglomeration of net operating income, revenues, expenses and average operating assets - ROI and economic profit is increased in three prioritized ways:

1. Cost and expense reductions.
2. Revenue increases [Rev]
3. Reduced average operating assets [AOO]

Note: ROI = NOI / Rev X Rev / AOO

Although many hospitals have reduced expenses, postponed projects and put clinical and information technology projects on hold, this may be unwise and quality may suffer. And, mental health care programs are almost always the first cost center to be reduced in tough times. Upgrades today, especially with concurrent marketing and advertising promotions, may well be considered a strategic competitive advantage, and at bargain basement prices for those with cash or credit. This cost reduction is easy because it gives the biggest buck-bang in the ROI equation, and is the first line of ROI augmentation by savvy administrators and CEOs. It is also intuitive and wholly "wrung-out" in the marketplace, to date.

On the other hand, revenues can usually be only incrementally increased by improving services like emergency care, urgent care, wellness, out-patient and/or surgical departments. This is the more difficult part of the equation and yields a positive, but lesser return in the ROI equation.

Finally, any delay in updating facilities - while easy and may reduce operating assets - there is little ROI advantage and profit potential. Of course, facility asset upgrades mean borrowing funds through tax-exempt bonds - the main source of debt for most hospitals - and is currently difficult or impossible in this climate. Loans from banks, private investors, angels, venture capitalists or other financial institutions are similarly difficult to obtain. Thus, this part of the equation may often be neglected; as is the case now.

3. When the recession ends, will it also end for hospital providers?

It depends, but it will surely slow and still decline somewhat over the long-term as the financial future of hospitals, and honest medical providers, is not as financially robust as past. The 'golden-age' of medicine [1965-90] is gone forever; demographics and aging populations run against the tide as are the expensive trends of technology, new treatment options and new drugs, etc. And, inner city hospitals and MC/MCD providers are hurt more than the private entities; as always.

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Still, we have been contacted by plastic and cosmetic surgeons who are "financially suffering"; as well as internists, anesthesiologists and medical school academic professors. No one, or specialty, seems immune.

Now, although we do face the perceived specter of national healthcare, it is not likely. But, the fear will continue to influence doctors, patients and private third party payers with their related cost reduction strategies and low reimbursements rates based on some percentage of declining Medicare CPT® codes, MS-DRGs payments, etc. Remember, when one considers MC/MCD, the Indian, VA and prison health systems, healthcare is already nationalized to the tune of about 51%. Thus, slow reimbursement erosion will continue; nonetheless. There will be no abrupt dislocation; it will be more insidious; like the "frog-in-hot-water" metaphor.

4. Is there anything "good" about being in a recession? (Professionals get more training; people enter fields like nursing where they are guaranteed to get a job; some items may be less expensive; people will work for less.)

You are correct; classic business theory suggests that two things happen in an economic recession. Folks either re-educate or re-engineer despite the difficulty accomplishing and affording same; or become entrepreneurial and start their own businesses. But, to the extent that these produce positive out-comes is more dependent on the "strivers than the climate." And, outside financing for both endeavors is in short supply. Nevertheless, innovative thinking will continue to thrive in a free market economy.

For example, ASCs, out-patient treatment facilities, physician owned and specialty hospitals, concierge and retail medicine, laborists, officists, ambulists, DNPs, *in-situ* medical providers, aggregated practice models, and e-health etc, will be reinvigorated when the money supply [M1 and M2] again flows. These broadly defined niche providers also include "heart hospitals, orthopedic hospitals, cancer hospitals and centers, dialysis clinics, pain centers, imaging centers, mammography centers, and a host of other narrowly focused providers and spaces.

Just last week, for example, we were contacted by a representative prospect from a 50-physican group interested in developing a financial statement pro-forma for debt funding to establish a private, physician-owned, multi-specialty hospital – very rare to-date.

Although these specialty and niche providers are not new, the increase in their numbers has led to concerns that they will "cherry-pick" and "cream-skim" the most profitable patients and procedures away from community hospitals. Despite studies documenting the benefits of competition in healthcare, hospitals appear to be threatened by specialty and niche providers. This has caused some community hospitals to use their negotiating strength to induce insurance companies to exclude these providers. Additionally, the hospital industry appears to be using the media to add to the public's fears about the closure of local hospitals, often by suggesting that greedy physicians are ordering unnecessary procedures in contrast to community-oriented not-for-profit hospitals.

The current difficulties that patients and consumers have in comparing costs, outcomes, and medical quality in order to choose among these competing niche services will also diminish with technology; over time. But, the AMA's recent lawsuit to keep Medicare claims data private, and their winning appeal to blind Consumers' Checkbook, was appalling IMHO.

"Providing New Era Healthcare Economic Solutions"

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5. If so, what should hospitals do to take advantage of this?

Well, your assumption seems to be that hospitals are always working for advantageous patient or community good; which is not always necessarily true. Regardless of public or private model; hospital and patient interests are not always aligned; nor are physician and insurance company interests.

For example, the doctors need [want] sick folks [real or perceived] to make a living; and the hospitals need [want] sicker folks with insurance in order to survive.

But, as an insurance company or business employer, I would want healthy patients. And, as a middle distance runner for thirty years who watches his weight, I want low insurance or HSA premiums with high-deductibles. I very much want to cherry pick patients and customers for my own interests, and reject those considered morally hazardous. Such divergence is the stuff of business competition.

So, just as the John Maynard Keynes' "paradox-of-financial thrift" may be good for me, it is bad for the economy – and vice versa. The dirty little politico-economic secret we all eschew is that the country needs the demise of its citizen after their productive years are over. Quite frankly, most *cognoscenti* recognize that health is expensive; long-life is really bad for the GDP, and death is good for economy. Except of course - if it is my health - or my death! Nevertheless, you get the point.

This conflicting stakeholder ideology pretty much sums up the current domestic healthcare conundrum; regardless of economic climate.

6. What should hospitals be doing right now to prepare for the end of the recession?

Relative to the above, a deeper cognitive understand of the growing tension in the healthcare services market is a good start. For example, the managed care revolution changed reimbursement for Medicare services through the introduction of prospective payment systems. Cuts have forced healthcare providers to look for more efficient ways to provide services, as well as additional sources of revenue and margin-producing business [See ROI equation above].

With the rise of corporate healthcare provider networks and health systems, together with rising health care costs, competition among providers has become prevalent in the healthcare industry. Strict control of reimbursement costs from payers; reduction in traditional hospital inpatient use; closer regulation from both the state and federal governments; and higher costs of capital have all contributed to the trend for hospitals to form large centralized corporate enterprises.

More acutely, and pragmatically, hospital revenue cycle management must be accelerated. In fact - compared to other industries - healthcare payment processing is extremely inefficient. For example, the retail segment settles payments for less than two percent of revenue, and financial services settles payments for less than one percent. Some health economists even estimate that if health care could settle payments even for 10 percent of revenue, savings would exceed $100 billion.

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Therefore hospitals must begin to financially approve and clear patients, predict payment more accurately, and automate the Medicaid/charity/private insurer approval process. This might include, new-wave procedures, like:

- Real-time access to information that ensures payment sources for services are properly identified prior to, during, and after care delivery.

- Statement processing that can handles documents throughout a city, state, region or national and inter-operable hospital system.

- Insurance claims submissions on a daily or even real-time basis; not at the end of the month, hospital accounting or billing cycle; but on a just-in-time modeled, patient stay basis.

Next up for consideration is length-of-stay [LOS] forecasting. Substantial day-to-day variation in hospital occupancy leads to increases in costs. Hospitals may be able to improve their financial efficiency by preparing more accurate forecasts of length-of-stay, and thus of their utilization of capacity.

For instance, the accuracy of predicted LOS can be improved by using multiple regression analysis. The patient's characteristics (age, gender, ethnicity, marital status, admission type, and admission source) and clinical indicators for their diagnosis-related groups are significant predictors of length of stay. The effectiveness of interventions is often measured by LOS.

However, LOS is a crude measure that is contaminated by the inclusion of all days in the hospital; even if they were not preceded by some type of intervention. An approach that views only the slice of time, after a medical intervention to measure the effect of the intervention on LOS in a more precise manner, can improve the accuracy of forecasting**.**

Hospitals might also embrace alternative medicine. The term "alternative medicine" refers to alternatives to Western medicine, such as herbal medicine or acupuncture. The term "complementary medicine" refers to the use of alternative medicine as supportive therapy in conjunction with traditional medicine. The use of alternative or complementary medicine cannot be dismissed as a fad and is already accounting for a significant volume of healthcare business as well as $20 billion in annual revenues, in the aggregate. Regardless, greater flexibility will be required in all aspects of hospital operations to accommodate different modalities of treatment and thereby increase market share and revenues.

Finally, although CPAs and MBAs may believe that all of the above are desirable business goals – we medical professionals must reinforce our guiding medical principle of *Omnia pro Aegroto* [all for the patient].

7. Are there any historical lessons to be learned from past recessions?

Sure, but memory is poor and no one ever listens.

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Nevertheless, an examination of hospital competition is a repeated take-away object lesson, as many hospital markets are now too small to support more than one hospital (a monopoly), or more than a very few competing healthcare entities or organizations.

We often cite hospital monopolies and "virtual monopolies" as one of the barriers to hospital competition, believing that roughly half of Americans live in markets too small to support medical competition, as for-profit chains have focused acquisitions on these markets.

8. How do hospitals stand to benefit from the federal stimulus?

The Obama stimulus to Congress includes $634 billion for the US health care, including money for the FDA to improve food safety, send visiting nurses to the homes of newborns, improve the American Indian Health System, invest in health information technology [HIT], cancer research and much more.

This includes spending includes $87 billion for Medicaid, $24.7 billion to subsidize private health insurance for people who lose or have lost their jobs, $19.2 billion for health information technology, and $10 billion for the National Institutes of Health (NIH).

So, hospitals should first adopt a patient centered-philosophy as the core of any partnership between a patient and his/her hospital and medical providers and/or government. Yet, just think of the last time you saw your HMO physician-extender, or time-compressed private practitioner, and tried to engage in a collaborative health 2.0 discussion with him/her? Na-Da!

Next, hospitals should prudently begin the transition from paper to electronic records, but not as a first-adopter, in order to:

- Making the business case for ROI funding and profitability.
- Redesigning business processes with HIT implementation.
- Extending the digital footprint to the "medical-home".
- Engaging IT leaders for guidance on prior mistakes.
- Improve workflow - minimize labor intensive activities.

Incidentally, as our private clients, readers and blog subscribers know, I am not a rabid fan of the *Certification Commission for Healthcare Information Technology* [CCHIT], or so-called state-of-art interoperable electronic medical records, at this time. They are an oxymoron.

9. What can they do to get the most possible out of it?

Use stimulus funds to enhance and augment these three initiatives.

A. Supply-chain Management

Improved management of the supply chain has long been a focus in many industries; it is now having an impact on the healthcare industry. For instance, one study has shown that hospitals in the United States have been more successful than hospitals in France in reducing levels of supplies inventory.

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RFID, bar-coding and just-in-time [JIT] approaches to inventory management can improve financial performance. Improved supply chain management can reduce costs by eliminating unnecessary delays and eliminating defects in healthcare supplies.

Current competitive trends will likely make supply chain management more important. The emergence of complementary medicine has implications for the supply function in hospitals, as these therapies require supplies of rather exotic items such as acupuncture needles, herbs, beads, and so on. Thus, improvements in patient care often require concomitant improvements in operations management processes. Improving the quality of care using patient-focused care can also improve the financial performance of a facility. Patient-focused care not only refers to a holistic approach to care, but it also refers to the re-engineering of processes to facilitate patient care. This re-engineering may lead to increased efficiency of healthcare providers that result in lower costs.

For example, in an effort to provide patient-focused care, a hospital may conduct job analyses leading to cross-training of personnel and the elimination of the duplication of performance of tasks.

B. Operations Management

The implementation of patient-focused care has implications for hospital operations management. For example, patient-focused care may require adjustments in materials management. The storage of more supplies and equipment in the rooms of patients might require the maintenance of higher levels of inventory and assets, and necessitate ordering supplies and equipment in different sizes.

Further, some alterations in hospital design might have to be made to accommodate patient-focused care [i.e., Japanese *kahn-bahn* engineering]. For example, rooms for patients may need to be larger to accommodate more cabinets and drawers for storage of supplies and equipment. Once again, improvements in patient care often require concomitant improvements in operations management processes.

C. Access and Scheduling Management

Better management of hospital access and scheduling can improve financial performance. There is some evidence that scheduling can be improved by giving schedulers more latitude to use their professional judgment and thereby avoid bottlenecks that occur over the use of critical resources. Also, improvements in outpatient scheduling can decrease patient waiting times, nurse staffing, and physician overtime.

Hospitals should also take a comprehensive approach to scheduling and consider how each component fits in with overall optimization. In short, scheduling systems that provide flexibility and simplify decision making are likely to confer strategic advantage in the current competitive environment.

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10. What resources are available for hospital administrators to get more information?

Hospital administrators and institutional CEOs, CXOs, CFOs, medical or clinic managers and health economists should subscribe to our 2-volume, 1,200 pages, quarterly, print journal*:* Healthcare Organizations *[Financials Management Strategies].*

Web link: www.HealthcareFinancials.com

Private practitioners, physicians and nurse executives should read our text books and hand books on medical practice management, financial planning and risk management for physicians and their advisors.

Web Link: www.MedicalBusinessAdvisors.com

Stakeholders should access our rating and ranking blog forum for daily alerts and current information in the ever changing healthcare milieu.

Web Link: www.HealthcareFinancials.wordpress.com

All patients should become informed about the current healthcare scene by leaning something about definitions, abbreviations and new terms of healthcare administration art and health 2.0

Web Link: www.HealthDictionarySeries.com

Conclusion

Tom - many thanks again for the opportunity to be of service. Let's remain in touch going forward, to explore mutual health economic, financial and managerial opportunities.

Fraternally,

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Full disclosure: Dr. David Edward Marcinko; MBA, CMP™ is a former insurance agent, registered investment advisor and Certified Financial Planner™. As a clinician and past president of a privately held regional physician practice management corporation in the Midwest, he helped consolidate 95 solo medical practices, with $50 million in revenues as the company's IPO roll-up attempt was aborted due to adverse market conditions, in 1999. He was also managing partner of a successful ambulatory surgery center that was sold to a publicly traded company in 1998. Dr. Marcinko holds general securities (Series # 7), uniform securities state law (Series # 63) and registered investment advisory representative (Series # 65) licenses from the National Association of Securities Dealers (NASD-FINRA). He is a member of the American Society of Health Economists (ASHE), the International Health Economics Association (iHEA), the American Health Information Management Association (AHIMA), the Healthcare Information and Management Systems Society (HIMSS), the Microsoft Professional Accountant's Network (MPAN) and US Microsoft Partner's Program (MPP), the Microsoft Health User's Group (MS-HUG), the Sun Executive Boardroom program sponsored by CEO Jonathan Schwartz, and SUNSHINE [Solutions for Healthcare Information, Networking and Education]. Dr. Marcinko is Founder and Chief Executive Office of the Institute of Medical Business Advisors Inc. www.MedicalBusinessAdvisors.com

Disclaimer: All opinions expressed herein all those of the interviewed, and not necessarily iMBA Inc., or its affiliates.

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