



# The ER that Became the Emergency

## *Managing the Double Bind*

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## **FRIDAY SENIOR STAFF MEETING**

"I finally have some good news concerning our marketing activities," Bill Coffman said with a smile at the weekly senior staff meeting. "Our radio advertising and other marketing efforts over the past 5 months seem to be paying off. In the last 2½ months, we've seen a dramatic increase in our emergency room visits, and I feel quite positive about the increase in demand." It was easy to see that Bill, the Chief Financial Officer of Community Memorial Hospital (CMH) was quite pleased about his monthly report.

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From Simendinger, E., Watson, M.A., Jasperson, M., and Boliard, B. (1998). "The ER that became the emergency: Managing the double bind." *Business Case Journal*, 6(2). Used by permission.

Ralph Peterson, Chief Executive Officer of the hospital, returned Bill's grin and responded, "That's great, Bill, especially since 30% of all of our admissions come through our emergency room."

Bill went on to note that admission increases were directly related to the growth in the amount of emergency room visits. He estimated that ER visits were expected to rise 15%–20% next month.

"Do we have enough staff, or should we start looking at hiring more physicians and nurses?" Ralph asked.

Bill promised he would look into the staffing matter before next week's meeting. As Bill continued with his report, Ralph's attention kept drifting back to the new ER figures on the income statement and balance sheet. For some unexplained reason, an uneasy feeling settled in his gut. He couldn't help but think something didn't fit—it seemed too good, too quick, and too lucky that the increase in admissions had occurred almost solely through CMH's marketing efforts. He wondered if the 15%–20% increase in ER visits in such a short time was realistic. The advertising seemed a bit too effective. One of his friend's favorite sayings popped into his head: "If it seems too good to be true, it probably is!"

In an attempt to gain more information from Bill about the emergency room activity, Ralph interrupted Bill's report and asked whether he had analyzed the ER visit numbers, tracking what types of new patients are using the emergency room. He also wanted to know when and from where they had come and what the payer mix was. "I don't have that information right here," Bill answered, "but we assumed that the payer mix was the same as it had been for the past 2 or 3 years. Why would it be any different?" (Payer mix is a term in health care that refers to the fact that different insurers, such as Medicare, Medicaid, HMOs, and PPOs, reimburse the hospital at different rates for the same service to patients.)

"Let's get the numbers. I have an uneasy feeling about this one," Ralph replied with an irritated shake of his head.

After a few minutes, the burn intensified, and Bill, visibly frustrated replied, "Do you realize how much time that analysis would take, and I'm up to my ears right now just trying to get the financials, capital, and operating budgets out on schedule!"

Ralph sat there thinking for a moment, wondering if there was something he was missing. As the senior staff at the meeting paused, Ralph finally answered. "Bill, do the analysis please."

As the Friday senior staff meeting concluded and everybody got ready to go home for the weekend, Ralph caught up with Bill on the way out. "Could you get me that ER information as soon as possible?" he asked.

## **BACKGROUND**

CMH, a 400-bed medical/surgical hospital, is located in Middleville, Ohio, a mid-sized city of about 650,000 residents. It is a private, not-for-profit facility that has been located in the downtown area for 75 years. There has always been strong community support for the hospital. Its medical staff consists of 350 physicians and the hospital employs 1,700 people. The payer mix is typical of many hospitals with 25% private pay, 50% Medicare, 10% Medicaid, and the rest composed of HMO, medically indigent, and self-pay patients. The Medicaid program provides medical aid by the federal government although administered at the state level to provide benefits according to established criteria for the poor, aged, blind, disabled, and dependent children. The hospital's clinical reputation has been positive but community members, the board, and the medical staff have raised some concerns regarding its declining financial situation over the past 5 years.

City Hospital, a very well respected, 600-bed health care facility, is located about a quarter mile from CMH. City Hospital has two primary missions: 1) It is a teaching hospital and trains large numbers of residents in conjunction with the local medical school; 2) given its location in the poorest part of the city and its distinction as the city's only publicly funded hospital, it takes care of the city's Medicaid patients as well as other categories of medically indigent patients. A medically indigent patient is one who has insufficient income or savings to pay for medical care without having to sacrifice other essentials for living (i.e., food, clothing, shelter). Treating high numbers of these patients, coupled with the physician training programs, is extremely costly and produces very high operating costs for the City Hospital facility. The Emergency Medical Treatment and Active Labor Act (EMTALA) requires that hospitals receiving federal reimbursement treat, stabilize, and admit (as needed) all patients (regardless of payment) who present at their emergency departments. Patients whose conditions require capability that the hospital lacks may be sent elsewhere after the hospital stabilizes them. City tax funds make up any loss sustained each year by City Hospital for the cost of taking care of this population. The funds transferred to City Hospital have increased to \$10 million over the past few months. Jim Harding, who has been the administrator at the City Hospital for the last five years, has worked with the mayor and other city commissioners to try to reduce City Hospital's high operating expenses. Despite several cost-cutting initiatives and two rounds of layoffs, City Hospital still is predicted to have a loss of \$12 million for the coming year. The city can't cover this loss with its tax funding, and Mr. Harding is feeling a lot of pressure to, as the mayor says, "find a way."

In addition, there are five other hospitals throughout the city that provide medical care to the residents of the area. St. Marks, a 350-bed, religious-based hospital, is located on the north side of town, approximately 12 miles from CMH. OhioCare, a for-profit, 300-bed, medical/surgical hospital, is situated on the south side of the city about eight miles away from CMH. A third facility, Health Associates, is a specialty hospital, concentrating on serving cancer victims. The Ohio Women's Center Hospital, which is located on the east side of town, is a 200-bed facility that provides services primarily to women and children. Finally, Doctor's Hospital, another medical/surgical facility that has been in town for 20 years, is located on the west side of the town and is an osteopathic hospital.

CMH has competed aggressively with the other hospitals in the city through an expensive, active marketing campaign to get its occupancy rate up from 56%. With the recent increase in emergency room visits, CMH's efforts seemed to be paying off. Then, Bill Coffman did the analysis and found some alarming data on the new ER patients.

### **FOLLOW-UP MEETING (RALPH, I HAVE THE INFORMATION YOU ASKED FOR)**

Over the weekend, Bill Coffman went into the office because he couldn't stop thinking about the strained interaction he had with Ralph, his concerns regarding the ER payer mix, and from where the new patients were coming. Sitting at his computer, feeling like Sherlock Holmes, he pored through the ER data with a fine-toothed comb. "From where are they coming? Let's look at the zip codes. When are they coming? How are they paying (type of insurance coverage)—or are they?" The printer was buzzing, pumping out the information. Sipping on his cold coffee and munching a sandwich from the vending machine, Bill began to analyze the stack of computer printouts on his desk. After looking at several sets of data, Bill began to shake his head in amazement and tried to avoid the sinking feeling in the pit of his stomach. "I'm seeing, but I don't believe it!" he said to himself. There was a clear pattern emerging as he looked at the information. Not only were the majority of new ER patients medically indigent patients, but also the zip code analysis showed that they were coming primarily from a high demand area not seen before. They were primarily coming in on the weekends during the busiest times for ERs and the most likely time to draw medically indigent patients. Bill sat back in his chair and thought, "Ralph isn't gonna believe this!" Looking more closely at the figures, he was shocked to learn that the medically indigent patient increases were going to be responsible for CMH losing \$70,000 to \$80,000 this coming month. He groaned and reached for the

phone to call Ralph but changed his mind when he looked at his watch and saw it was 1:30 A.M. He realized that waking Ralph in the middle of the night, combined with delivering the bad news would be an unwise move, especially considering the interaction they had had in the staff meeting.

The following morning, Ralph received a message from Bill Coffman asking if they could get together to discuss the findings that he had come up with concerning the jump in patient activity. At 10 A.M., Ralph popped his head into Bill's office. "So what did you find out, Sherlock?"

"I don't think you're gonna like it—you're not going to believe what's happening and it makes no sense to me. I can't figure it out," Bill said, grimacing. "That jump in emergency room activity was all made up of medically indigent patients coming from one zip code area, and it'll cause a huge ER loss this month."

Ralph sat back in his seat abruptly, and said, "I knew it," and asked for the zip code map. "They're from 00010," Bill stated abruptly. "Get a zip code map, Bill," Ralph commanded.

As soon as Ralph's eyes hit the location on the map, he knew. "These patients are coming from City Hospital's area!" Ralph asked Bill, "What times were the peaks occurring?"

"Peak ER times—the weekends," was the glum reply.

"I think it's time to have a little chat with Jim Harding at City Hospital," Ralph said emphatically, "I'll set up a meeting with him and get to the bottom of this."

## **TUESDAY MEETING WITH MR. HARDING**

Jim Harding, City Hospital's CEO, appeared as scheduled at Ralph's office at 10 A.M. sharp on Tuesday and remarked, "I knew it was just a matter of time before we would be sitting down and discussing this particular issue." He went on to discuss the problems that City Hospital was having with the lack of staffing in its emergency room. Even with the additional government funding, it was unable to afford the number of physicians, residents, and nurses needed to meet the demands of patients coming through its facility. City Hospital's concern for patient's quality of care and lack of staffing, Jim explained to Ralph, was the reason that City Hospital's diversion process had commenced. Diversion is the tactic used by hospital ER administrators to reroute patients to other facilities' emergency rooms when they have reached their capacities. Sometimes this tactic can be used deceptively: A hospital ER may go on diversion to avoid the high costs associated with taking certain types of ER patients, specifically those who provide low reimbursement to the hospital. Jim also admitted that

CMH would be the logical choice for patients diverted from City Hospital based on proximity and patient safety/liability issues. Ralph broke in and said, "I understand your circumstances and why you're going on diversion, but is there any way we can form some kind of financial relationship when you send us your patients? When you go on diversion, can we at least have some kind of a cost-based reimbursement arrangement for the medically indigent patients we take from you?" As the meeting came to a close, Jim agreed that a relationship between the two hospitals would be a good idea and that he would put together a cost-based reimbursement proposal in the next few days for Ralph to consider.

A week later, Ralph received a proposal on his desk from Jim and quickly sent it to Bill Coffman to analyze. Bill quickly ran the numbers and stopped into Ralph's office with the report. After giving Ralph a minute for an initial glance he summed it up, "So. . . the reimbursement of \$100 per visit to CMH that City Hospital is offering us to reduce the expenses isn't even close to covering the losses from the influx of its medically indigent patients. At best they would only reduce our average losses by 20%. In 6 months we will be in serious financial trouble."

Ralph thanked Bill for the fast turnaround on the information as he left the office. Frustrated, he thought to himself, "Okay, I've got an ER that's bleeding us to death. What's my next move?"

Ralph immediately called Jim and told him the proposal was unacceptable based on CMH's financial situation. Jim responded by saying, "I'm not surprised, but that's the best I can do." In the conversation that followed, Jim inadvertently shared the fact that City Hospital received \$550 a visit for medically indigent patients from city funds. Ralph immediately challenged him, "OK, Jim, let me get this straight. If a medically indigent patient in our city walks through your ER doors, the city gives you a visit rate of \$550 as an all-inclusive amount, but if the same patient comes through my doors we will only receive \$100 a visit? How is that fair?!" Jim reiterated, "Like I said, that's the best I can do given our financial situation. Sorry."

### **A WEEK LATER (MEETING WITH COMMISSIONERS)**

Finding no acceptable alternatives in his conversation with Jim, Ralph decided his next step was to call a couple of the city commissioners he knew and ask their advice on the situation. Inasmuch as it had to do with city funds, they suggested that Ralph needed to speak with the mayor. After getting off the phone with the last city commissioner, feeling somewhat like a basketball being tossed around in warm-ups, Ralph finally real-

ized he needed to go to the top. He phoned the mayor's office and was able to get an appointment for the following Friday morning.

## **FRIDAY MEETING WITH THE MAYOR**

Ralph made his way promptly to his first ever meeting with the mayor. To his surprise, the mayor, Bill Cane, walked in on time despite his very busy schedule and escorted Ralph into his office. Feeling very impressed and a little intimidated by being in the mayor's office, Ralph brought the mayor up to date on the situation. He proposed that the city increase funding to City Hospital to deal with its financial situation. He also suggested that CMH would be willing to help with the diversion problem but it would need reasonable funding from the city for the care of the city's medically indigent patients.

The mayor expressed understanding, "I see your predicament, but right now the city is battling its own health care financial crisis. We're significantly lacking in funding for health care. You may not know that currently the tax funds can only be spent on medically indigent patients that receive care in a city facility. Any changes will take some time to get passed. We could try to change the city code that was passed with the health tax referendum but, as you are well aware, it is a very long, complex process. As you know it typically takes 3 years to complete all the procedural and legal steps, even before it could be put to the voters."

With the meeting coming to an end, it was clear to Ralph that the city's financial problems and the politics behind trying to get something done was digging a financial grave for CMH.

As Ralph drove back to CMH, he started realizing the lack of options and began to contemplate the extent of the double bind he was facing. First, he thought the hospital would reach a serious financial problem within 6 months if the problem weren't resolved quickly. On the other hand, if the hospital took a stance of refusing to accept the city patients coming through the ER doors, CMH could experience severe bad press that would bring a negative image on the facility and him. All Ralph could picture was the front page of the city's newspaper with a cartoon picture of himself holding the ER doors closed, preventing a bleeding, medically indigent patient, on his knees, from getting needed medical care. Ralph trembled to think of the board reaction to that picture.

Observing the traffic jam growing in front of him, Ralph turned to take an alternate route home. As he drove past Doctor's Hospital, it suddenly occurred to him that this issue went beyond CMH. Other hospitals might feel threatened as well, even though they were not currently

affected by an influx of medically indigent patients. He thought a brainstorming session with other hospital administrators might be in order. As Ralph passed by City Hospital en route to his facility, he felt a slow burn across his back thinking about the fact that City Hospital could divert patients with no flack but he shuddered to think what would happen if CMH diverted just one patient. Over time, diversion of medically indigent patients had become an accepted practice from City Hospital. Although infrequent, City Hospital's ER was sometimes understaffed and unable to deal with the incoming patient volume. As a result, the facility went on diversion without notice or criticism. In the past, however, the duration of the diversion was typically short and involved only a few patients. Never had so many patients been diverted for so long!

### **SUGGESTED MEETING WITH OTHER CEOs**

As soon as Ralph returned to the office, he made phone calls to each of the local hospital CEOs asking them to attend a meeting to discuss the situation. He was sure that he would be able to convince the other hospital's administrators, his friends, to take their fair share of medically indigent patients for the city.

As a week passed, Ralph was very frustrated at the lack of response from any of the other hospitals' administrators concerning the proposed meeting. In an attempt to get answers, Ralph called his good friend, Dick Rusk, CEO of Health Associates, to find out why he hadn't heard from him. Dick remarked, "I know what you're going through over at CMH and understand why you called the meeting, but we at Health Associates wouldn't want to change a system that would increase our costs." Dick also added he, as most of the other hospital CEOs, felt that they were already taking their fair share of medically indigent patients! Dick concluded by saying, "City Hospital has the funding support through the local referendum to take responsibility for a larger percentage of the area's medically indigent patients. Let them deal with the problem." As Ralph got off the phone, he realized that if he were one of the other CEOs he would probably do the same thing.

### **MEETING WITH HIMSELF**

Later that afternoon, Ralph sat staring through his window at work. The image of getting doors slammed in his face—first Jim Harding's, the mayor's, the city commissioners', then all those hospital CEOs' who were his supposed friends—kept running through his head. Although Ralph

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realized the problem was complex and had financial, political, and public relations implications, he was humbled by the fact that he had no clear idea what to do next. As he sat perplexed at his desk, the wail of an ambulance siren grew louder, and then passed directly below his window. "Oh great," he thought, "there goes another 550 bucks out the window!"