Expanding clinical footprints through partnership with regional hospitals

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Why is my Academic Medical Center Partnering With Regional Hospitals?

Revenue Considerations

Academic Medical Centers generally have fixed margins. Therefore, if the profit margin remains the same, a larger enterprise will have a larger profit that can be reinvested in the core mission.

Current State

After Expansion

Business Development

Creating new referral patterns

Capturing market share

Increasing brand recognition

Health Equity

Regional hospitals likely to serve community with different demographics than main campus

New opportunities for community health improvement

Research

Distinct demographics for clinical trials, population health and bioinformatics research

Why should my department participate?

- ENTERPRISE HEALTH
- BUSINESS DEVELOPMENT
- COMMUNITY HEALTH
- RESEARCH
- FACULTY PREFERENCE

Case Study in regional partnership

- Main Campus- 800 beds, 100% capacity
- Existing regional subscription teleneurology service
- VUMC acquired 3 rural regional hospitals
- Wilson County Hospital in Lebanon
  - 30 miles from Main
  - Community of 40,000
  - 245 beds

Regional EMU?

- Main Campus: Epilepsy surgery program with 10 EMU beds
  - 100% capacity 24/7
  - High Margin and downstream revenue, but no opportunity for expansion on Main Campus
  - 6-8 month wait list for EMU admission

- Challenges to regional EMU Expansion
    - Capital expenditures
    - Staff comfort/skills
    - Faculty resistance to travel
    - Limited Services (no PET or SPECT, 1.5T MRI only, no surgeons)
    - Patient complexity, SUDEP

• EMU Expansion- Structure

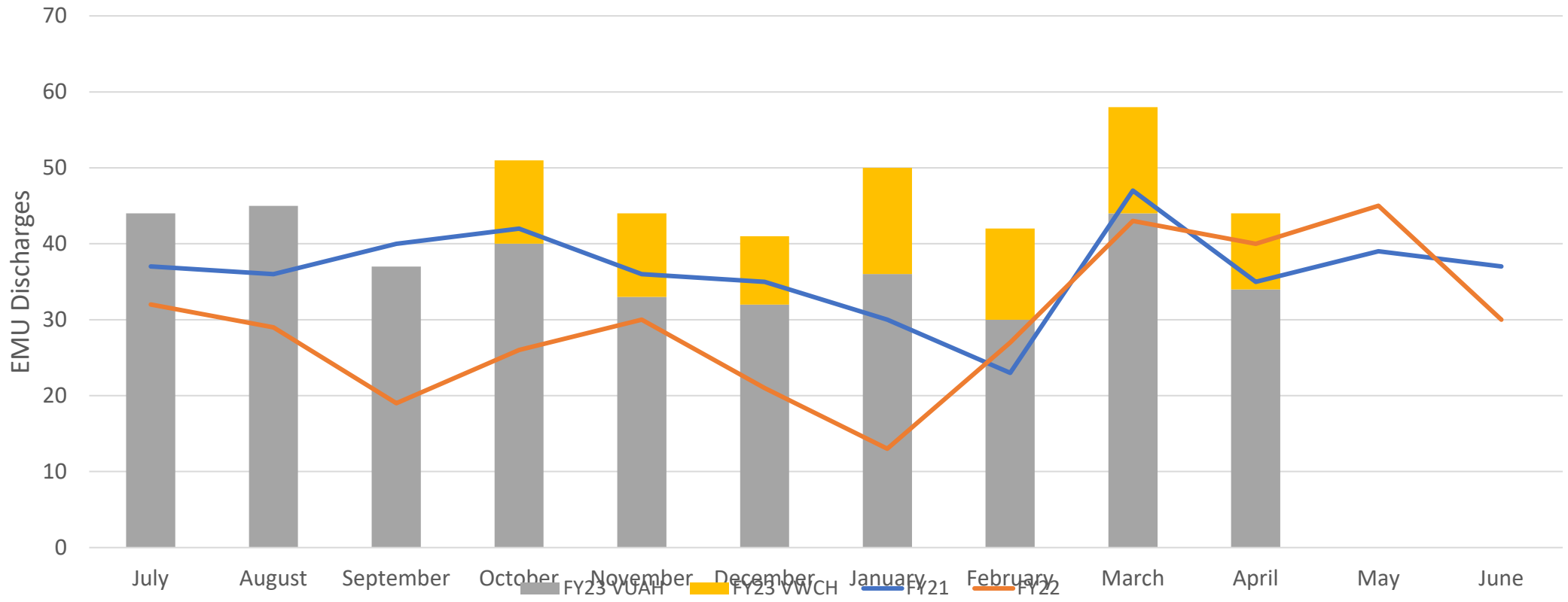
- 4 Beds x 5 days per week
- 2 MDs alternate weeks M-F; See Consults in afternoon
- Conrad 30 Visa Waivers
- Community MD pay scale gap-funded by Hospital
- Patients reviewed by epileptologists for safety before scheduling

• EMU Expansion-Outcomes

- 20% reduction in EMU wait times
- 20% increase in volume
- Patient Acuity Improvement
  - Previously: 35% of EMU discharges were PNES
  - Now: 90/10% (regional) and 10/90% (Main)

- ICU Video/EEG availability has reduced transfers to Main

- EMU Expansion- Volume Impact



• EMU Expansion-Outcomes

- Regional hospital leadership pleased with service
  - EMU margin
  - In-house neurology expertise and ICU-EEG service
- Patients pleased with reduced wait times
- Surgeons pleased with increased volumes
- Community pleased with addition of services, travel to region and inclusion in regional marketing

Regional Partnerships- Conclusions

- While there may be some challenges to overcome, regional partnerships can have significant positive impact for a neurology department, enterprise, and partner hospital and its surrounding community

AUPN Spring Chairs Session

Navigating and Interacting with Hospital Partners/Large Healthcare Systems: private main teaching hospitals

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Kaleida Health

Largest hospital system by market share in WNY

- Non-profit, no religious affiliation
- Owns Univ. at Buffalo's two main teaching hospitals and a handful of community hospitals
  1. Buffalo General Medical Center: 484 beds, tertiary referral center, top 20 hospital in NYS, aging facility
  2. Oishei Children's Hospital: 185 beds including L&D, 12 EMU beds, relatively new facility
- Unlike other 3 SUNY medical schools, UB has no university hospital to cost share, backstop academic practice plans (UBMD)
  - Tough environment for revenue-poor practice plans which include dermatology, nuclear medicine, general surgery in addition to usual E/M dominated specialties like neurology

Relationship pre and post-pandemic

- Buffalo environment
  - 4th poorest large city in US
  - Outlying Western NY is not wealthy, rural with segments of poverty including smaller urban pockets (Niagara Falls, Lockport, Jamestown, Salamanca, etc.)
  - 65% of neurology business is CMS driven
  - Hospital system suffered large losses driven by pandemic
    - $300 million over 2020-22
    - 2023 will likely post small loss
    - NY State covering only $30 million of loss so far
  - Financial pressure due to labor union contracts and need to be on par or exceed recent contract in Catholic Health System
    - Region is susceptible to labor strikes of healthcare workers

Negotiations with private partner

- Financial benefit>>academic/investigational benefit
- Sources of leverage
  - Improved patient flow to reduce ED burden
  - Reduce LOS
  - Services that feed into/support larger revenue/profit centers
    - Orthopedics
    - Cardiology
    - Bariatric surgery
    - Stroke
      - Successful in negotiating a 1.5%/yr bump in 2022 for stroke contract vs. no increase for general neurology/child neurology/LTM & EMU services
- Contracts are for 3 years; system threatens non-payment if agreement not signed
- Hospital system will use a variety of salary databases that best serve their interests
- GME standoff for 6th adult neurology resident
    - Provided data on increased encounters compared to pre-pandemic
    - Educational vs. clinical balance
    - Had support of neurosurgery and GME office

Strategies (worked better pre-pandemic)

- Volunteer to serve on hospital committees
  - P&T committee
- Aging Physician Exams (>70 yo)
  - Chair/COS performs all of them; facilitates scheduling; completes paperwork right away
- Timely reporting of hours for administrative roles (by 5th day of following month) and quality assurance reports
- Team up with neurosurgery
- Threats (last resort)
  - Used effectively by psychiatry chair with our county hospital
  - Need to be responsible to patient care issues/housestaff coverage
    - Refused to read EEGs after hours; no ED consults after 9 pm

Quality input metrics

- We met 3/5 below for 2022
  - >95% consults called in by 2 pm seen the same business day
  - >95% consults called after 2 pm seen the next business day
  - >95% consults called in by 10 am with staffed note within 4 hours
  - >90% LTM reads within 4 hours of study with preliminary report called into service; final report within 48 hours
  - 23% decrease of ICU admissions for patients with severity level 1

Joint ventures

- Hospital system resistant to joint promotions/advertising/fundraising
  - BGMC and OCH are not “closed shops.”
  - Non-UBMD affiliated physicians work at both; some services primarily driven by non-university providers (physiatry, GI, until recently radiology)
  - Neurology/neurosurgery services are exclusively UBMD providers
  - Hospital system has its own foundations and fundraising events