EDs Bring Profits, Not Just Patients, to Hospitals

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SAN FRANCISCO — Patients admitted to the hospital through the emergency department generated significant profit and produced double the relative profitability of patients admitted directly to the hospital, Brian J. Browne, M.D., reported at the annual meeting of the American College of Emergency Physicians.

The results of his retrospective analysis debunk the image of the emergency department (ED) as a "cost center" or "loss leader"—in other words, a necessary expense supported by the rest of the hospital's clinical services, said Dr. Browne, chief of emergency medicine at the University of Maryland, Baltimore, and director of emergency medical services at the University of Maryland Medical Center.

The findings should be useful to ED administrators when they need to lobby for institutional support, he said.

The investigators defined the direct margin as the amount by which net revenue exceeded the sum of direct fixed and variable components. Out of the margin, the hospital pays overhead expenses, and what remains is profit. Net profit was the amount by which net revenue exceeded the sum of all costs, both direct and indirect.

In the study of 89,757 discharges during July 2000-June 2003, patients admitted to the ED generated 19% of the hospital revenue, 20% of the direct margin, and 33% of profits from all hospital admissions, said Dr. Browne and coinvestigator, Dick Kuo, M.D., also of the medical center.

Patients who were admitted directly to the hospital produced higher totals for net revenue, costs, direct margin, and profit because more patients entered the hospital directly rather than through the ED—73% vs. 27%, respectively. However, it's notable that patients admitted through the ED generated profit—totaling a third of all profits—despite inclusion of ED costs, Dr. Browne said.

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DR. BROWNE

Patients admitted directly to the hospital generated about 81% of revenues, 80% of the direct margin, and 67% of total profits. (Percentages may not add up because of rounding.)

The ED patient group, however, had a higher direct margin (expressed as a percentage of net revenue), compared with the direct-admission group—40% vs. 37%. And ED admissions were twice as efficient when comparing profit as a percent of the revenue—10% vs. 5% in the direct-admission group, Dr. Browne said.

The analysis looked at direct and indirect costs. Data for the ED patient group included all costs generated both in the ED and in the hospital for patients admitted through the ED. The analysis included only revenues actually collected, not charges that were never collected. "Many previous papers looked at charges, which is not real," Dr. Browne said.

The direct-admission group included both elective admissions and transfers into the hospital that did not go through the ED, including 21,223 admissions to the trauma center.

The Case Mix Index and average length of stay were comparable between groups. The Case Mix Index is a measure of case severity (complexity and acuity), so the ED patients were slightly less severe cases than direct-admit patients. The Case Mix Index was 1.10 in the ED group and 1.28 in the direct-admit group. The length of stay after admission (not including time in the ED) averaged 5.8 days in the ED group and 6 days in the direct-admit group.

Under traditional cost accounting practices, the ED is seen only as a source of admissions, with associated costs. "That model is unfair, and doesn't recognize the full impact of the ED and those patients for the finances of the hospital accurately," Dr. Browne said.

Hopefully, the data will help change the traditional view of the ED, Dr. Browne said, so that "when I ask for something for the common good of the ED—like an information system update, or ultrasound equipment, or a lab—the administration should recognize that the ED is a major player in profitability." ■