



Engagement Report

Bradley County Medical Center

Hospital Medicine & Emergency Department Management

Warren, Arkansas

Engagement Period:

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Executive Summary

For years, Bradley County Medical Center (BCMC), a critical access hospital in Warren, Arkansas, operated under the instability of a regional outsourced contract management group. By mid-2024 the model had become unsustainable. Marked by incomplete schedules, billing failures, underperforming providers, inflated costs, and community reputational harm. In-House Medical was engaged to replace that model with a true insourcing partnership for Hospital Medicine and Emergency Department services, focused on building a stable, self-sustaining provider group capable of delivering consistent, high-quality care to the communities of Bradley County and surrounding rural areas of south-central Arkansas.

Through deliberate recruitment, intentional cultivation of strong provider relationships, and disciplined management systems, the practice is now stabilized. Provider schedules were consistently published 45–60 days in advance, while all trades, swaps, and coverage gaps were managed internally by In-House Medical without requiring involvement from hospital administration. The department maintained full coverage without open shifts, rarely required additional compensation for last-minute coverage, and never needed to rely on emergency privileges to maintain staffing.

A key leadership transition was successfully executed: the Medical Director, who had been working 12–14 shifts per month in the Emergency Department, moved into a full-time hospitalist role. This change strengthened inpatient continuity while preserving the overall stability of both services. Since the provider group and scheduling system were already mature and reliable, the schedule was not disrupted through the transition. Schedules continued to be released 45–60 days in advance, no open shifts occurred, and all coverage adjustments continued to be handled internally by In-House Medical without involving hospital administration.

Headline Outcomes

- Practice fully stabilized through recruitment and positive working relationships. Staffing gaps were filled through direct PRN recruiting and the proactive addition of a full-time physician in July 2026.
- Schedules released 45–60 days in advance, giving providers meaningful personal and professional planning ability and supporting retention.
- Zero open shifts across the engagement. All coverage needs handled internally by our group.
- No emergency privileges requested and additional compensation for last-minute coverage was limited.
- Trades, swaps, and holes managed entirely by our group — hospital administration was not involved

in day-to-day scheduling resolution.

- Medical Director successfully transitioned to full-time hospitalist after previously working 12–14 ED shifts per month.
- In-House Medical identified and closed Emergency Department operational gaps by implementing sustainable processes and protocols. This created a structure that supports consistent, compliant, and efficient care, as detailed later in this report.

About This Report

This report documents In-House Medical's year and a half engagement at Bradley County Medical Center, from the start of the engagement in January 2025 through the September 2026 conclusion of the partnership. It serves three purposes: an operational record for Bradley County leadership of the critical access hospital's lasting stability; a knowledge-transfer document detailing work absorbed by hospital administration after the engagement; and a case study for In-House Medical's learning and future hospital partners considering the insourcing model.

Background

Bradley County Medical Center

Bradley County Medical Center is a critical access hospital, serving as the primary acute-care and emergency resource for the residents of Bradley County and neighboring rural communities in south-central Arkansas. Like many critical access hospitals, BCMC operates under the structural realities of rural healthcare: limited specialty depth, workforce scarcity, thin operating margins, and a patient population that relies on the hospital as the nearest source of emergency and inpatient care.

The emergency department is a critical access point for the community. It is staffed by a provider group of three full-time physicians and one full-time advanced practice provider, supplemented by a PRN roster of additional physicians, covering the department twenty-four hours a day, seven days a week. The Emergency Department and Hospital Medicine services form the clinical core of the organization's ability to keep care local whenever clinically appropriate.

The Pre-Engagement Landscape: Years Under Outsourced CMG Management

For years, this hospital lived under the instability and unpredictability of a regional outsourced contract management group (CMG). Like most small institutions, the hospital experienced the revolving door of CMGs facing a recurring cycle of poor-quality physician coverage, unreliable scheduling, escalating costs, and daily operational disruptions.

These conditions made clear that continued reliance on a traditional outsourced contract management model was no longer viable. The hospital needed a partner whose interests were aligned with BCMC's clinical and financial stability and a provider group invested in the community for the long term.

In response, Bradley County Medical Center transitioned from its prior regional outsourced contract management arrangement to a true insourcing partnership with In-House Medical. The change was deliberate: to end the cycle of incomplete schedules, provider instability, escalating costs, and to build a sustainable hospital-employed provider group.

Model & Approach

The Insourcing Model

In-House Medical operates a true insourcing model. Providers (physicians and advanced practice providers) are employees of the hospital, not of In-House Medical. They are credentialed through the hospital, compensated by the hospital, and integrated into the hospital's clinical and administrative systems. Their loyalty, their employment, and their future are with the hospital they serve.

In-House Medical's role is to provide the management infrastructure and executive function that a well-run emergency department and hospital medicine program require. Rural hospitals rarely have the internal resources to build and sustain this model on their own. This includes medical director oversight and physician leadership, scheduling and shift management, recruiting, credentialing, and onboarding of new providers, culture and retention improvement, and the day-to-day problem-solving that keeps an emergency department functioning. The transition from the outsourced CMG arrangement to this insourcing model was designed to reverse the cycle of instability described above and to establish operational and clinical reliability.

Executive-Level Integration: Weekly Leadership Touchpoints

The most consequential aspect of the In-House Medical model at Bradley County is not captured on a project list or quality dashboard. Rather, it is reflected in the consistent, week-to-week engagement with

hospital leaders and providers - In-House Medical functions as an integrated extension of the hospital's administration team.

Throughout the engagement, In-House Medical maintained standing weekly touchpoints: the hospital executive leadership team, hospital nursing and ED leadership, and the Medical Director. These were working meetings covering the full range of responsibilities that fall to executive leadership over Hospital and Emergency Medicine programs: operational issues, clinical quality concerns, provider performance, engagement, and retention, patient experience and feedback and whatever needed immediate attention in any given week.

The weekly touchpoints are the mechanism through which department stability was maintained, but the ability to anticipate staffing needs, resolve coverage challenges internally, and maintain continuous coverage became a defining feature of the partnership and a key measure of its success.

Differentiators

At the time Bradley County Medical Center engaged In-House Medical, the landscape of emergency medicine management was dominated by large contract management groups (many backed by private equity) whose operating models differ from the insourcing approach in several ways.

Lower overhead compared to contract management groups

Contract management groups typically charge fees that cover not only the direct costs of management but also corporate overhead, investor returns, and the infrastructure of a multi-hospital enterprise. The insourcing model is structurally more lean. There are no investor distributions, no layers of regional administration, and no profit center separating the hospital's payments from the services delivered.

Transparent finances

In-House Medical's financial relationship with Bradley County was transparent throughout the engagement. Costs were visible to the hospital, and compensation structures were arranged so that funds flowed to intended recipients without unnecessary markup retention.

Provider recruitment and retention through positive relationships

With an outsourced model, recruitment can become transactional: a shift needs coverage, so the organization finds a provider to fill it. Insourcing allows recruitment to be much more intentional. The goal becomes finding providers who are not only clinically qualified, but who fit the department's culture, work well with the existing team, and are interested in becoming part of the long-term success of the hospital.

Recruitment was approached as a continuous process of relationship-building rather than a response to an immediate staffing vacancy.

Customization to rural and critical-access settings

Rural emergency departments and hospital medicine programs operate differently than urban settings, and management approaches imported from larger systems often fit poorly. Patient volume patterns, staffing constraints, referral networks, specialty access, and the economics of low-volume high-acuity care all differ. In-House Medical's model was built for environments like Bradley County's.

Scheduling Excellence as a Core Differentiator

In rural emergency and hospital medicine, schedule reliability is one of the most powerful levers for provider retention and operational calm. Uncertainty about when a provider will work, how last-minute gaps will be filled, or whether administration will be drawn into coverage disputes creates chronic stress that drives turnover and erodes culture.

At Bradley County Medical Center, In-House Medical made advanced, predictable scheduling a non-negotiable standard. This horizon gives providers the ability to plan family events, personal commitments, continuing education, and rest with real certainty. It signals respect for providers as professionals whose lives extend beyond the shift board. It also reduces the emotional and logistical friction that short-notice schedules create.

Equally important was the method by which coverage gaps, trades, and swaps were handled. All of these were managed internally by In-House Medical. Hospital administration was never required to broker last-minute coverage, approve emergency privileges, or intervene in scheduling disputes. The result was a department that never carried an open shift or activated emergency privileges and rarely paid premium compensation for emergency coverage.

Results & Outcomes

Practice Stabilization Through Recruitment and Positive Relationships

The central operational achievement of the engagement was the stabilization of the Hospital Medicine and Emergency Department programs. Stabilization was achieved through two parallel efforts: disciplined recruitment of providers who fit the rural hospital environment, and deliberate cultivation of positive,

respectful working relationships among providers, nursing leadership, and hospital administration.

Leveraging an existing relationship between the CEO and the regional residency program, IHM created a network of physician connections that helped fuel ongoing interest from the advancing PGY 3 physicians. Recruitment focused on providers who understood and valued rural medicine — the breadth of clinical responsibility, the importance of continuity, and the relationship between the hospital and its surrounding community. Positive relationships were treated as infrastructure, not as soft culture. Providers who feel respected, heard, and supported stay. Providers who experience chronic friction, last-minute schedule chaos, or administrative distance leave.

Central to this approach is a simple but uncommon posture: In-House Medical treats each provider first as a human being and only then as a clinician. The practical expression of that posture is attentive support through every stage of the relationship — contract negotiation, onboarding, scheduling, and day-to-day practice. When clinicians know that the people managing their practice genuinely care about them as individuals, they experience less background stress, feel safer taking ownership of the department's culture, and are freer to invest their full attention in the patients in front of them. The result is not only higher retention, it is a more sustainable and enjoyable work environment in which providers want to take excellent care of patients because they themselves feel cared for.

The result is a group that is fully stabilized, with a pipeline of additional providers ready to work and care for patients at Bradley County Medical Center. The practice has depth, continuity, and internal capacity to absorb ordinary variation in demand and availability.

Provider Scheduling: 45–60 Days in Advance

Throughout the engagement, provider schedules were published 45 to 60 days ahead of the start of the schedule period. This practice delivered measurable benefits to the providers themselves and to the operational reliability of the department.

Advanced notice allows providers to coordinate childcare, family travel, CME travel, and personal recovery time with confidence. It signals that the organization regards providers as partners whose personal lives matter, not as staffing resources. In a rural setting where recruitment is difficult, this respect directly supports retention. Because schedules were released well in advance, emerging issues could be managed internally by In-House Medical rather than turning into administrative emergencies.

Medical Director Transition to Full-Time Hospitalist

A significant leadership and clinical transition was completed during the engagement. The Medical Director,

who had been working 12 to 14 shifts per month in the Emergency Department, transitioned into a full-time hospitalist role.

This change produced several benefits. Continuity of inpatient care improved because the same physician was present for the majority of each patient's hospital stay rather than rotating through intermittent ED shifts. The Emergency Department retained a stable core of providers and did not experience disruption from the transition. The Medical Director's deep knowledge of both the ED and the inpatient service created a natural bridge between the two services, improving communication, disposition decisions, and overall throughput for patients who move from the Emergency Department to the floor.

The transition was executed within an already-stabilized practice framework. Because the broader provider group was reliable and the scheduling system was mature, the schedule remained fully stabilized through the change. The change in the Medical Director's clinical focus did not create coverage gaps or require emergency recruiting. It was a planned evolution of roles rather than a reactive fix.

ED Process and Protocol Implementation and Management

During our time at Bradley County Medical Center, a few formal processes and protocols were put in place. When issues arose, our team worked side-by-side with hospital leadership, nursing, and clinical staff to design and implement practical improvement strategies that strengthened the department and created streamlined processes intended to last.

Key areas of focus included:

- EMTALA Training — Structured education and ongoing reinforcement to ensure consistent compliance and reduce regulatory risk.
- ED Nurse/Provider Collaboration — Deliberate efforts to improve communication, shared expectations, and teamwork between nursing and providers at the bedside.
- Radiology and Lab Variance Protocol — Clear pathways for identifying, escalating, and resolving turnaround-time or result variances that affect patient flow and disposition.
- Peer-to-Peer Review with Insurance Companies — Active support and coordination of peer-to-peer discussions to protect medically necessary care and reduce unnecessary denials.
- Medical Record Completion and Delinquencies — Systems and accountability measures to improve timely documentation and reduce chart delinquencies.
- Involvement in Time Studies — Participation in operational time studies to identify bottlenecks and support data-driven improvements in throughput and efficiency.

These process and protocol improvements converted recurring operational friction into reliable, repeatable workflows that remain with the department after the engagement.

Voices from the Partnership

The quality of a management partnership is most clearly visible in the experience of the people who work inside it. The relationship with the ED medical director, nurse director and provider group was critical during the engagement.

The Medical Director described the partnership with In-House Medical as a positive experience overall, noting that the organization honored its commitments to maintain physician compensation and prioritize consistent schedule coverage without relying on last-minute staffing solutions. Despite the challenges that often accompany a new contract transition, he credited the In-House Medical team with working diligently to accommodate his scheduling needs during a particularly demanding period of personal and professional responsibilities. He also acknowledged the unique difficulties associated with staffing rural hospitals and expressed appreciation for the team's efforts throughout the engagement. He emphasized his positive experience with both the staff and leadership and conveyed gratitude for the opportunity to work alongside the organization.

Dr. Michael Aziz, a full-time physician with Bradley County Medical Center, also spoke specifically to the advocacy provided during the transition from PRN to a rewarding full-time role:

“Dr. Newquist, IHM President and CMO, was instrumental during contract negotiations with the hospital. His guidance, advocacy, and industry insight helped create a smooth transition into a rewarding full-time position from where I was working PRN.”

— Dr. Michael Aziz

IHM prioritized a partnership-based approach, working alongside nursing leadership to ensure that operational decisions reflected the needs of both clinical staff and patients.

As ED Nurse Manager, Paige Stell, stated:

"I think working together made everything better for our patients, doctors, and nursing staff. We all have a common goal of caring for the patients we encounter daily. I tell my crew all the

time that teamwork makes the dream work. I truly appreciate you both listening to me and my staff's concerns. I know we can work through anything together."

This sentiment exemplifies the collaborative philosophy that guided the engagement. By partnering closely with nursing leadership and maintaining open lines of communication, In-House Medical helped create a cohesive, team-oriented environment focused on delivering high-quality patient care while supporting the needs of providers and hospital staff.

These comments reflect a consistent pattern across the engagement. Providers were treated as individuals whose personal and professional well-being mattered. The same partnership extended to hospital staff and administration, who worked alongside In-House Medical as true collaborators rather than as parties to be managed.

Transition & Handoff

The engagement between In-House Medical and Bradley County Medical Center will conclude on September 30, 2026. Bradley County's plan is to absorb the emergency department and hospital medicine management functions into its existing hospital administration. This chapter is written to support that transition.

Areas of Ongoing Work

The categories below describe the routine, ongoing work of managing a hybrid emergency department and hospital medicine provider group. They are presented here as a reference and checklist of areas where a designated owner at the hospital will be helpful. These are the things a well-run ED and HM program tends to require.

Provider Recruiting, Credentialing, and Onboarding

Rural emergency medicine recruiting has its own rhythm. Candidates are scarce, credentialing timelines are long, and the first several months of a new provider's tenure shape how well they settle in for the long term. Bradley County will want a designated person or team to carry recruiting, credentialing coordination, and onboarding forward.

Provider Scheduling and Shift Management

A twenty-four-hour-a-day emergency department requires continuous scheduling work: initial shift

construction, personal time-off coordination, shift swaps, and the daily small negotiations that keep a schedule functioning for a provider group whose lives change. During the engagement, the emergency department operated without any locum tenens coverage, and gaps were handled through direct PRN recruiting and flexible coverage arrangements. Continuing that approach is worth prioritizing, as locum-free staffing contributes to the financial health of the department.

Provider Performance Management and Engagement

Physicians and advanced practice providers are highly trained professionals. The ongoing work of keeping a group aligned—regular check-ins, performance feedback, and support through difficult conversations—benefits from a designated owner to lead it well. This is routine management, not crisis response, and it strengthens the group over time.

Retention and Culture

The provider group is stable at the engagement's close. Retention in a rural emergency department benefits from attention to the small things that make providers feel valued: being heard on operational concerns, having clear leadership, knowing their feedback produces change. These are habits rather than programs, and they carry forward naturally in a department that has already developed them.

Day-to-Day Operational Response

Most of the work of an emergency department management function is responsiveness: answering the nurse manager's question, returning the CEO's call, troubleshooting the schedule problem, sitting down with the physician who has a concern. The weekly leadership touchpoints described earlier in this report were the structural mechanism for this kind of responsiveness. The hospital will want to consider what cadence and mechanism work best for it going forward.

The Value of Quiet Stability

There is a particular kind of management work whose signature is its own invisibility. When it succeeds, the thing it produces is not a dramatic announcement but the absence of problems. The shift that was always covered. The provider who stayed rather than left. The schedule that appeared 50 days in advance and simply worked. The trade that was handled internally without a single email to administration. The

Medical Director who moved into a new role without creating a coverage crisis.

This kind of work is easy to undervalue precisely because it looks like normalcy. A smoothly running ED and HM program at a critical access hospital does not announce the reasons it is running smoothly. It simply runs. The people inside it experience it as the ordinary state of the department, because that is how they have come to know it.

At Bradley County Medical Center, the engagement produced that quiet consistency. Schedules were published far in advance. Coverage never failed. Providers experienced a professional environment built on respect and predictability. The group that remains is stable, has depth, and has a pipeline ready to care for the patients of Warren and Bradley County.

These outcomes did not occur by accident. They were the result of sustained attention to relationships, to the mechanics of advanced scheduling, and to the daily discipline of solving small problems before they became large ones. They are the result of a management model that treated the provider group as long-term partners rather than as a rotating labor input, and that treated the hospital's leadership as collaborators rather than as customers to be managed.

This is what effective work looks like when it succeeds: quiet consistency of ordinary months in which serious problems never materialized, because people were working every day to keep them from occurring.

Closing & Acknowledgments

In-House Medical is grateful for the opportunity to have managed the Hospital Medicine and Emergency Department services at Bradley County Medical Center. The work described in this report was possible because of the partnership of hospital leadership, the dedication of the nursing and clinical staff, and the professionalism of the provider group that cared for the people of Warren and the surrounding communities through every shift.

The tools, relationships, scheduling discipline, and provider stability built during the engagement remain with Bradley County Medical Center, where they belong. We wish the hospital, its leadership, its staff, and its providers continued success in serving the rural communities that depend on them.

Thank you, Bradley County Medical Center.