



Engagement Report

Golden Valley Memorial Hospital

Emergency Department Management
Clinton, Missouri

Engagement Period

July 2023 — June 2026

Prepared by

In-House Medical

May 2026

Foreword

[A foreword from Craig Thompson, Chief Executive Officer of Golden Valley Memorial Hospital, will appear here in the final version of this report.]

Craig Thompson

Chief Executive Officer, Golden Valley Memorial Hospital

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Executive Summary

In July 2023, American Physician Partners, a national emergency medicine contract management company, entered bankruptcy and terminated its management of emergency departments across its portfolio with minimal notice to the hospitals it served. Golden Valley Memorial Hospital, a rural community hospital in Clinton, Missouri, was among the facilities suddenly left without a management partner and at immediate risk of losing its emergency department provider group.

Within twenty-six hours of first contact, In-House Medical executed a management agreement with Golden Valley and began stabilizing the provider group. Every physician and advanced practice provider from the group inherited from the APP-era arrangement was retained through the transition. There was no interruption to patient care, no gap in provider coverage, and no reduction in the hospital's capacity to serve its community.

Over the three years that followed, In-House Medical partnered with Golden Valley to convert what began as a rescue into a sustainably managed, clinically improving emergency department. The engagement concludes on June 30, 2026.

Headline Outcomes

- Provider retention through the July 2023 emergency transition. Zero physician and zero advanced practice provider departures across the 36-month engagement.
- Zero locum tenens days across the three-year engagement. Staffing gaps were filled through direct PRN recruiting and the proactive addition of a third full-time advanced practice provider in July 2025.
- Door-to-needle compliance for stroke patients improved from 20% in Q1 2025 to 100% in Q3 and Q4 2025, sustaining the broader Acute Stroke Ready scorecard performance into 2026.
- Sustained 95% or greater compliance with Joint Commission 12-hour psychiatric reassessment documentation following implementation of the GVMH Behavioral Patient Flowsheet ("pink slip") tool.
- Full provider group adoption of an ambient AI clinical documentation scribe (Heidi Health), identified, evaluated, and rolled out by In-House Medical with negotiated subscription terms on the hospital's behalf.

About This Report

This report documents In-House Medical's three-year engagement at Golden Valley Memorial Hospital, from the circumstances of the July 2023 contract execution through the June 2026 conclusion of the partnership. It serves three purposes simultaneously: as an operational record for Golden Valley's leadership of what was built and what will remain; as a knowledge-transfer document that itemizes the work being absorbed by the hospital's internal administration after the engagement ends; and as a case study for In-House Medical's own learning and for future hospital partners considering the insourcing model.

Background

Golden Valley Memorial Hospital

Golden Valley Memorial Hospital is a rural community hospital serving Clinton, Missouri, and the surrounding communities of Henry County and the adjacent region of west-central Missouri. Like many rural hospitals, Golden Valley operates under the pressures common to its setting and geography: thin margins, workforce scarcity, a patient population that depends on the hospital as the nearest source of emergency care, and limited access to the downstream specialty and psychiatric resources on which larger urban systems routinely rely.

The emergency department is a critical access point for the community. It is staffed by a provider group of five full-time physicians and three full-time advanced practice providers, supplemented by a PRN roster of additional physicians and advanced practice providers, covering the department twenty-four hours a day, seven days a week.

The July 2023 Transition

Prior to July 2023, Golden Valley's emergency department was managed under contract by American Physician Partners (APP), a national emergency medicine contract management company. In the summer of 2023, APP entered bankruptcy proceedings and terminated its management agreements with client hospitals on extremely short timelines. Hospitals across APP's portfolio, including Golden Valley, faced the immediate prospect of losing the management infrastructure that supported their emergency department provider groups.

For a rural hospital, the implications were severe. Provider groups whose management partner disappeared overnight faced uncertainty about compensation, scheduling, credentialing, and the future of their positions. Individual physicians and advanced practice providers, left in this uncertainty, rationally began to consider other opportunities. For the hospital, the risk was not only administrative disruption but the potential departure of the clinical workforce itself, a workforce difficult to recruit in any rural setting and especially difficult to replace on short notice.

In-House Medical was contacted as Golden Valley searched for a new management partner. Within twenty-six hours of first contact, a management agreement was executed and In-House Medical began active work to stabilize the provider group. Attention in those first hours was directed to provider communication, reassurance, and the rapid establishment of the administrative infrastructure (scheduling, credentialing, compensation flow) that a provider group requires in order to continue operating.

Every physician and advanced practice provider from the group Golden Valley had previously employed under the APP arrangement was retained through the transition. The emergency department did not close. There was no provider gap. No patient's care was interrupted by the change in management.

Why the 26-Hour Rescue Matters Beyond July 2023

The speed of the transition was not primarily a story about operational agility, though it was that. It was a demonstration of the thesis of the insourcing model itself: that a management partner whose interests are aligned with the hospital's, rather than with the returns of an outside investor, can act quickly and in the hospital's interest when circumstances demand it.

American Physician Partners' collapse was the kind of event contract management groups backed by private capital are structurally vulnerable to: the management entity is a separate business with its own investors, its own capital structure, and its own failure modes that are independent of the clinical quality of the care being delivered. The hospital's emergency department, and the patients it serves, are exposed to the management company's business risk whether or not they have anything to do with it.

The insourcing model exists, in part, to remove that exposure. Providers are employed by the hospital. Clinical operations belong to the hospital. The management partner's role is to bring the executive function and operational infrastructure the hospital would otherwise have to build itself. When the management partner changes, or, as happened here, is suddenly lost, the hospital's clinical operations can continue because they were never architecturally dependent on the management company's corporate survival.

What follows in the rest of this report is the operational record of the three years that came after the July 2023 rescue: how the engagement was structured, what the partnership did, what was built, what the data shows, and what remains with Golden Valley as the engagement concludes. The chapters are organized to support a reader returning to specific topics over time. The Model & Approach chapter that follows describes the structural mechanics of how In-House Medical operated as the management partner.

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 requires but that rural hospitals rarely have the internal resources to build and sustain on their own. This includes medical director oversight and physician leadership; scheduling and shift management; recruiting, credentialing, and onboarding of new providers; quality program design and maintenance; throughput and operational improvement work; culture and retention programs; and the day-to-day problem-solving that keeps an emergency department functioning.

Under this arrangement, the clinical work of the emergency department, and the clinical innovations that emerge from that work, belong to the hospital. Tools, protocols, workflows, and quality programs developed during the engagement are not proprietary In-House Medical assets that leave when the contract ends. They remain with Golden Valley as part of the hospital's operational inheritance from the partnership.

Executive-Level Integration: Weekly Leadership Touchpoints

The most consequential part of the In-House Medical model at Golden Valley is not visible on any project list or quality dashboard. It is the weekly rhythm of executive-level meetings through which In-House Medical operates as a de facto member of the hospital's leadership team.

Throughout the engagement, In-House Medical maintained two standing weekly touchpoints: one with the hospital CEO and one with hospital nursing leadership. Attendance from the In-House Medical side varied by meeting (In-House Medical leadership, the practice manager, or both, depending on what was on the agenda), but the cadence was non-negotiable. These were not status updates or contractual check-ins. They were working meetings covering the full range of responsibilities that fall to executive leadership over an emergency department: operational issues (staffing, schedules, throughput); clinical quality concerns; provider performance, engagement, and retention; patient experience and feedback; cross-department coordination for admissions, consults, and transfers; strategic and long-range planning; and whatever needed immediate attention in any given week.

This is the functional equivalent of a Vice President of Emergency Medicine Management embedded in the hospital's leadership structure: a dedicated executive function focused entirely on the emergency department, reporting into the CEO and operating in lockstep with the Chief Nursing Officer. Rural hospitals rarely have such a role on their organizational charts. Chief Executive Officers oversee too many departments and Chief Nursing Officers oversee too many nurses to give the emergency department the weekly executive bandwidth it requires. In-House Medical filled that specific seat.

The weekly touchpoints are the mechanism through which the projects described elsewhere in this report were surfaced, debated, resourced, and driven to completion. Without them, the psychiatric holds workstream, the advanced practice provider mini-internship program, the patient experience initiatives, and dozens of smaller operational improvements would not have had the forum required to move from idea to implementation. These meetings were not a feature of the partnership. They were the partnership's central operating mechanism.

Differentiators

At the time Golden Valley 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 material ways. The differentiators described here were present throughout the Golden Valley engagement and shape the comparisons a reader should keep in mind when evaluating what was retired at the engagement's end.

Lower overhead compared to contract management groups

Contract management groups typically charge fees that must 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 leaner. 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 Golden Valley 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 retention through culture

Provider retention is the single most financially consequential operational outcome in emergency medicine. Turnover generates locum costs, recruiting costs, onboarding costs, credentialing costs, and, less measurably but no less really, quality and throughput degradation during the period of instability. In-House Medical's approach to retention at Golden Valley emphasized culture over compensation: provider-driven initiatives, respectful operational expectations, and a leadership posture that treated the provider group as long-term partners rather than as a rotating labor input.

Customization to rural and critical-access settings

Rural emergency departments do not operate like urban ones, 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 Golden Valley's, and the projects described in this report reflect the tailored operational work that such environments require.

Results & Outcomes

This chapter summarizes operational and clinical outcomes from the engagement, drawn from data the hospital tracked across the engagement period. Where data is available across the full engagement, it is shown across that span; where data is available only for a subset of the period, the relevant timeframe is identified.

Quality & Patient Satisfaction

Acute Stroke Ready Performance: Door-to-Needle

Beginning in January 2025, the In-House Medical leadership team, the hospital's Time Critical Diagnosis Coordinator, and the Emergency Department Medical Director made a focused effort to improve the department's Acute Stroke Ready performance, with particular attention to door-to-needle time. Door-to-needle measures the elapsed time from a stroke patient's arrival in the emergency department to the administration of thrombolytic therapy in eligible patients. The Joint Commission goal for an Acute Stroke Ready hospital is to achieve this within 45 minutes for at least 85 percent of eligible patients.

At the start of 2025, Golden Valley's door-to-needle compliance was at 20 percent. By the third quarter of 2025, compliance reached 100 percent, and the department sustained 100 percent compliance through the fourth quarter. The improvement was the result of sustained protocol attention, ongoing education for the provider group, and routine performance review built into the department's operational rhythm.

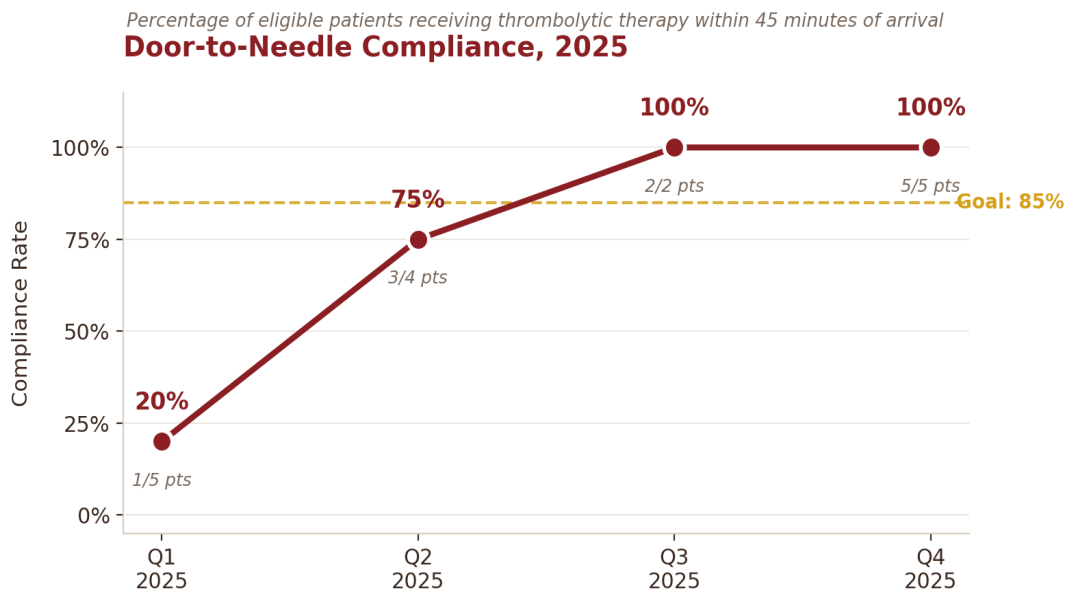


Figure 1. Door-to-Needle Compliance, 2025. Quarterly performance against the 85 percent Joint Commission Acute Stroke Ready goal.

This is one metric within a broader Acute Stroke Ready scorecard that tracks more than two dozen measures across stroke care delivery. Across the 2025 scorecard, several other emergency department

measures held strong performance throughout the year: door-to-NCCT (head CT) completion within 20 minutes ran at 95 percent for 2025 overall, CT order to CT read within 35 minutes at 98 percent, and door-to-AST member at bedside within 10 minutes at 97 percent. The Acute Stroke Ready focus is one example of the kind of clinical quality work that became part of the department's operational rhythm during the engagement.

Performance on the broader scorecard has held into 2026. Through the first two months of the year, door-to-NCCT (head CT) completion within 20 minutes ran at 100 percent in both January and February, up from the 95 percent achieved across 2025. CT order to CT read within 35 minutes held at 100 percent across both months. Door-to-AST member at bedside within 10 minutes ran at 100 percent in January and 94 percent in February.

Patient Satisfaction — ED Provider

The hospital tracks patient satisfaction across emergency department dimensions on a monthly basis, with quarterly aggregation used for trend evaluation. The ED Provider score reflects patient feedback specifically on the provider portion of the visit and is the dimension within the management partner's direct sphere of influence. Other survey dimensions, including overall ED experience, nursing, and registration, fold in factors that lie largely outside provider group operations and are not reproduced here.

Across calendar years 2023 and 2024, quarterly ED Provider satisfaction at Golden Valley ranged from approximately 61 percent to 72 percent, with no clear directional trend. Beginning in early 2025, a focused patient experience effort, described in Case Study 1, took hold across the provider group as a partnership between In-House Medical and Golden Valley's hospital leadership. The work centered on consistent use of patient care cards introducing care team members by name and a standing expectation that providers return to the room before discharge to answer questions and offer reassurance. From that point forward, quarterly ED Provider satisfaction climbed steadily, reaching 80.2 percent in the third quarter of 2025 and holding above 76 percent through the fourth quarter.

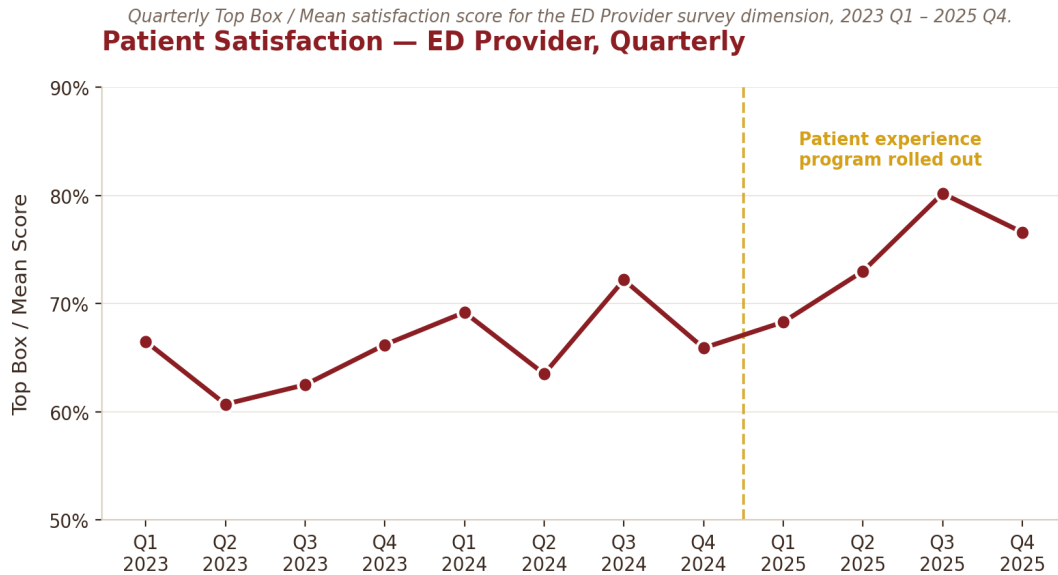


Figure 2. Patient Satisfaction — ED Provider, Quarterly. Top Box / Mean satisfaction score for the ED Provider survey dimension, 2023 Q1 through 2025 Q4.

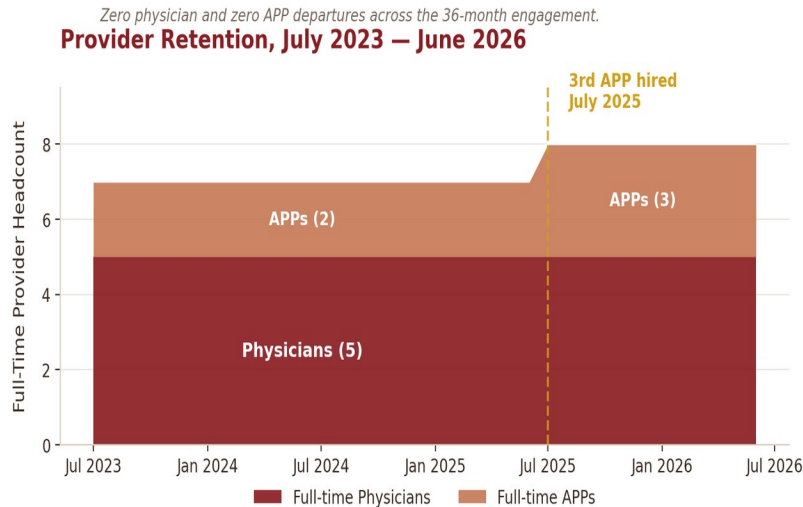
Left Without Being Seen, Across Rising Volume

Left Without Being Seen, or LWBS, is the percentage of patients who arrive at the emergency department but leave before being seen by a provider. It is one of the most direct operational measures of whether a department is appropriately staffed and triaged.

Across the three years measured, Golden Valley's emergency department absorbed meaningful growth in patient volume. Annual visits rose year over year, reflecting the department's expanding role as a regional access point for emergency care. Across this same period, the department's monthly LWBS rate ran between approximately 0.5 percent and 3.6 percent, with a three-year average of approximately 1.9 percent, within typical ranges for community emergency departments. The rate held steady year over year, with no deterioration as volume grew. The department took on additional patient demand without compromising the speed at which arriving patients were seen.

Provider Retention & Staffing

Provider retention is the most financially and operationally consequential variable in emergency medicine staffing. Each departure produces direct replacement costs, locum bridge costs while the position is filled, and indirect costs in continuity, quality, and the morale of the providers who remain. Across the 36-month engagement at Golden Valley, the department experienced zero physician departures and zero advanced practice provider departures.



Full-time providers shown. The department was additionally supported by a PRN roster of physicians and advanced practice providers throughout the engagement.

Figure 3. Provider Retention, July 2023 — June 2026. Full-time physician and advanced practice provider headcount across the engagement period.

The full-time provider group inherited from the prior contract management arrangement in July 2023, comprising five physicians and two advanced practice providers, remained intact across the entire engagement period. In July 2025, a third full-time advanced practice provider was added to bring the department to its full intended staffing model. The decision to add the third APP was made proactively, before any attrition had occurred among the existing two, with the explicit intent of reducing burnout risk and creating sustainable schedule depth.

This level of stability was supported throughout by a PRN roster of physicians and advanced practice providers who provided coverage flexibility and absorbed the schedule variability that would otherwise have fallen on the full-time group. The engagement concludes with the same provider group that arrived to it, expanded rather than depleted.

A direct consequence of this staffing stability was that the emergency department never required locum tenens coverage during the engagement. In rural emergency medicine, locum coverage is the ordinary fallback for schedule gaps and short-term vacancies, and three locum-free years is an uncommon result. Schedule gaps that did appear were filled through direct PRN recruiting and flexible coverage arrangements within the existing group rather than through outside contract labor.

Financial Snapshot

A financial view of the partnership is worth including here, in plain terms, because management service costs are easy to see on a budget while the operational costs that good management prevents are not. The aim of this section is simply to put both on the same page.

This section does not reproduce the hospital's accounting or In-House Medical's management fee schedule. Those line items are straightforward and visible on both parties' books. What this section does instead is quantify the financial value of two specific operational outcomes described elsewhere in this report whose dollar signatures are not visible on any budget line, because the costs were never incurred. These are the outcomes that cost-pressure conversations frequently miss.

The Staffing Outcome

Golden Valley's emergency department was staffed during the engagement by five full-time physicians, each working twelve 12-hour shifts per month, and three full-time advanced practice providers, each working ten 12-hour shifts per month. A PRN bench of physicians and advanced practice providers provided supplemental coverage flexibility.

Across the three-year engagement, the department experienced zero physician turnover and zero advanced practice provider turnover. The provider group retained through the July 2023 APP transition remained intact and was expanded, not reduced, over the course of the partnership.

The deliberate addition of a third full-time advanced practice provider mid-engagement was undertaken specifically to reduce burnout risk on the two existing full-time APPs, a proactive retention decision rather than a response to attrition that had already occurred. The addition was financially neutral: the all-in cost of a W-2 full-time advanced practice provider with benefits is comparable to the equivalent hourly cost of the PRN coverage the hospital would otherwise have been purchasing.

What Industry Benchmarks Would Have Predicted

Published industry data places emergency medicine physician voluntary turnover at approximately 7 percent annually and emergency medicine advanced practice provider turnover at approximately 14 percent annually¹. Applied to a provider group of Golden Valley's size over three years, statistical expectation would have predicted approximately one to two physician departures and one to two advanced practice provider departures, roughly three to four turnover events across the engagement.

The Dollar Signature of Zero Turnover

Conservative industry estimates of emergency medicine provider turnover costs, accounting for recruiting, credentialing, onboarding, and productivity ramp-up, range from \$250,000 to \$400,000 per physician departure² and \$150,000 to \$250,000 per advanced practice provider departure³. Higher estimates reach well above these figures for rural and hard-to-fill settings.

Separately, when a rural emergency department experiences a physician vacancy, the bridge to a permanent replacement is typically filled with locum tenens coverage. Locum emergency medicine bill rates currently run approximately \$350 to \$450 per hour all-in, including provider pay, agency, travel, housing, and malpractice costs⁴. Rural emergency medicine recruitment timelines commonly span five to ten months². A single physician vacancy bridged by locum coverage during an average search typically incurs an additional \$300,000 to \$500,000 in locum costs beyond the direct turnover cost itself.

Statistical Expectation vs. Actual Outcome

Statistical expectation, 3-year engagement:

- Approximately 3–4 turnover events across physicians and APPs
- Approximately \$1.5–2.5 million in combined turnover and locum bridge costs at industry midpoints
- Higher-end estimates for rural settings extend the range meaningfully further

Actual outcome at Golden Valley:

- Zero physician turnover
- Zero advanced practice provider turnover
- Zero locum tenens days across the full engagement
- Provider group retained and expanded rather than reduced

The costs listed above do not appear on any budget line at Golden Valley because the events that would have triggered them did not occur. They are, in that sense, invisible, but no less real for being invisible.

What This Means for the Cost-Pressure Conversation

Management service costs are visible. They appear as a recurring line item, they are priced in advance, and they are straightforward to compare against alternatives. Turnover costs and locum bridge costs are comparatively less visible, because they arrive intermittently and get absorbed across multiple line items: recruiting expenses, provider compensation variability, contract labor, lost revenue during vacancies, and the softer costs of temporary coverage (variable quality, reduced continuity, strain on the remaining provider group). A cost-pressure analysis that considers only the first category without the second produces an incomplete picture.

The intent of this section is not to second-guess any management decision. It is to ensure that the full picture of what emergency department management involves, both the visible line items and the operational costs that good management prevents, is part of the record this report leaves behind.

Sources

1. SullivanCotter, *Advanced Practice Provider Turnover: A Costly Reality*, 2025.
2. Becker's Hospital Review, *The Cost of Physician Turnover*, 2023 (citing NEJM / Jackson Physician Search data); Pappas et al., *Estimating the Costs of Physician Turnover in Hospital Medicine*, *Journal of Hospital Medicine*, 2022.
3. SullivanCotter, *2024 Advanced Practice Provider Organizational and Leadership Survey*.
4. LocumStory, *Locum Tenens Pay Trends by Specialty*, 2025; AMN Healthcare, *Cost of Locum Tenens Physicians*; Marit Health locum compensation data, 2026.

Case Studies

The projects described in this chapter illustrate how In-House Medical's model produced concrete operational improvements at Golden Valley. They are drawn from the many initiatives undertaken during the engagement and represent a range of work types: clinical compliance, patient experience, workforce development, and cross-functional operational problem-solving. Additional projects may be added to this chapter as the engagement's final documentation is completed.

Case Study 1: Humanizing the ED Experience

Patient Care Cards and Provider End-of-Visit Engagement

Patient care cards, physical cards given to patients listing the names of the clinicians who cared for them, are a longstanding practice in emergency medicine. Golden Valley was using them before In-House Medical's engagement began. What changed in 2025 was a focused, shared effort between In-House Medical and the hospital to take two patient experience initiatives, the consistent use of the patient care cards within the provider group and a standing expectation that providers return to the room at the end of each visit, and operationalize them into durable provider-group practice. The decision to prioritize this work, and the rollout that followed, was a partnership between In-House Medical and Golden Valley's hospital leadership.

The first initiative was the patient care card: a physical card given to each patient by the nursing team that lists, by name, the physician or advanced practice provider, nurse, and technicians who cared for them during their visit. The card's purpose is simple. It ensures that the patient leaves the emergency department knowing who took care of them as people, with names, not as the processing stations in a clinical workflow. In-House Medical's role with the cards was to work with the providers and hospital administration to ensure the cards were used appropriately and consistently across the provider group.

The second initiative was an expectation that the provider, physician or advanced practice provider, would return to the room at the end of the visit. The purpose of this return is not clinical. Clinical discharge instructions are handled separately. The purpose is human: to answer lingering questions, to offer reassurance, and to close the encounter personally for patients being discharged home. In a busy emergency department, this is a behaviorally demanding ask, and turning that expectation into a durable provider-group practice was a meaningful piece of the partnership work.

The provider group's initial response to the end-of-visit expectation was neutral compliance. They did it because it was asked of them. Over the months that followed, as they observed how patients responded and as the tone of patient interactions changed, their investment in the practice grew. This arc, from compliance to ownership, is how genuine culture change happens in clinical settings. It is worth naming honestly rather than describing the rollout as if everyone embraced it enthusiastically from day one.

The initiatives produced a measurable improvement in patient satisfaction scores. Beyond the scores, they reframed the identity of the emergency department from a place patients pass through to a place they are cared for. The trajectory of ED Provider satisfaction across the engagement is shown in the Results & Outcomes chapter.

Case Study 2: The APP Mini-Internship Program

Growing a Provider Pipeline in a Rural Setting

In a rural emergency department, recruiting advanced practice providers is a perennial challenge. Experienced APPs with emergency medicine backgrounds are scarce in rural Missouri, and the new-graduate APPs who might be willing to relocate face a familiar catch-22: they cannot get hired for emergency department work without emergency department experience, and they cannot get emergency department experience without being hired. Golden Valley's emergency department felt this constraint directly, and In-House Medical responded by building a pipeline rather than continuing to rely only on external recruiting.

The APP Mini-Internship Program was a structured, approximately six-month, non-accredited training program designed to take a new-graduate physician assistant or nurse practitioner and develop them into a clinically independent emergency department provider. The curriculum was adapted from existing training templates and tailored to Golden Valley's specific patient population, staffing model, and case mix.

Curriculum Domains

1. Clinical Foundations — BLS/ACLS/PALS, ESI triage, core ED presentations, differential diagnosis, labs and imaging interpretation, procedural sedation familiarity.
2. Procedural Skills — suturing (15 repairs with documented case types including multi-layer, staples, and adhesive closures), wound debridement, incision and drainage, splinting, foreign body removal, airway basics, POCUS basics.
3. Critical Decision-Making — structured communication (SOAP, SBAR), red-flag recognition, clinical decision rules (Ottawa, PERC, NEXUS, Wells), escalation practice.
4. Communication & Teamwork — handoffs, attending communication, interdisciplinary collaboration, patient-centered communication under stress.
5. Documentation & Risk Management — medical decision-making rationale, discharge clarity, EMR mastery, radiology review practice including watching for findings-impression mismatches.
6. Workflow & Time Management — prioritization, task stacking, ownership mindset for patient disposition.
7. Professional Development — simulation labs, CME, punctuality, timely charting, alignment with hospital mission and culture.

The program's structure paired rigor with flexibility. The intern was scheduled as a supplemental provider on the emergency department's busier days, working alongside the physician and advanced practice provider on shift without displacing existing staffing. She began by shadowing physicians across the provider group (meaning every physician in the department participated in her mentoring) and progressively graduated to independent patient pickup under physician oversight. Sign-off on checklist

items was distributed across the physician team rather than resting on a single mentor, giving the intern exposure to a broader range of clinical styles and judgment patterns.

During the training period, the intern was compensated at a reduced training rate, reflecting the realities of a provider still in development and producing meaningful cost savings for the hospital relative to hiring a fully-credentialed advanced practice provider from day one.

Outcome

The intern completed the program and emerged as a clinically strong, independently functioning provider. Upon program completion, the emergency department did not have the patient volume to support an additional full-time equivalent, but Golden Valley Memorial Hospital recognized her capability and hired her into its urgent care clinic, where she continued to serve the same community before later relocating to a position closer to her home.

By the measure that matters most for a pipeline program, did the program take a new graduate and produce a provider strong enough to be retained by the hospital system and later recruited elsewhere, the program succeeded. The training was of sufficient quality that the hospital chose to retain her in a different clinical setting rather than lose her to the broader job market.

A second cycle of the program was discussed but not formally launched before the engagement's conclusion. The curriculum, checklist, and mentoring model remain with Golden Valley as part of the operational inheritance from the partnership. The full curriculum checklist is included as an appendix to this report.

Case Study 3: The Psychiatric Holds Workstream

Cross-Functional Operational Problem-Solving Over a Fourteen-Month Arc

Psychiatric holds are among the most operationally complex patients any emergency department manages, and in rural emergency departments the challenges compound. Limited inpatient psychiatric placement options produce long boarding times. Safety concerns demand dedicated staffing that rural hospitals struggle to provide. Joint Commission documentation requirements govern reassessment cadence. Legal pathways for involuntary holds intersect with law enforcement, the courts, and community mental health resources. Billing for the work is often unclear. And the patients themselves are among the most vulnerable people the emergency department serves.

Beginning in the spring of 2024, In-House Medical leadership convened a stakeholder group at Golden Valley to address the full landscape of psychiatric hold management in the emergency department. The effort was not a single initiative but a sustained, multi-front workstream that continued for more than a year. It produced process changes, policy changes, a new staff position, and coordination with external stakeholders including the courts and the local jail.

Scope of Work

- Distinct hold processes developed for adult and pediatric patients.
- A physical accommodation (a designated smoking area) to reduce against-medical-advice departures among voluntary psychiatric patients whose primary reason for leaving was nicotine withdrawal. A small intervention addressing a real and persistent disposition problem.
- A weapons-screening protocol (“wandering”) for psychiatric patients not in paper gowns.
- Coordination with the court and local jail on a new process allowing medically cleared patients on 96-hour holds to be held at the jail rather than occupy an emergency department bed.
- Clarification of billing and coding practices for emergency department reassessments on held patients.
- Advocacy for and eventual approval (September 2025) of a dedicated Psych Sitter position to relieve the technicians and nurses who had been absorbing that work.

Headline Outcome: The 12-Hour Reassessment Tool (“Pink Slip”)

Joint Commission standards require provider reassessment of psychiatric hold patients every twelve hours. Before the workstream’s intervention, compliance with this standard at Golden Valley was inconsistent, not from clinical inattention, but because the workflow contained no mechanism designed specifically to cue and document the reassessment at the right moment in a busy emergency department. The problem was operational, not clinical, and it required an operational solution.

The workstream produced one. The GVMH Behavioral Patient Flowsheet, referred to internally as the “pink slip,” was designed by Golden Valley’s Emergency Department Medical Director, a hospital-employed physician working within the In-House Medical-managed group. The flowsheet consolidates onto a single document the elements that matter for a psychiatric hold: the Columbia-Suicide Severity Rating captured on arrival; the mental health assessment status; the disposition recommendation (inpatient placement or discharge with safety plan); and a standing grid of date, time, and provider-initials rows for each twelve-hour reassessment throughout the duration of the hold.

The tool’s effectiveness comes from its workflow, not from its design alone. Nursing staff track the reassessment cadence and cue the provider when each twelve-hour window is approaching; the provider completes the reassessment and initials the grid. The slip creates a single, legible audit trail visible to any clinician picking up the chart.

Following implementation in 2025, compliance with 12-hour reassessment documentation climbed from an inconsistent baseline to a sustained rate of 95 percent or greater, month over month. This is not the signature of a one-time fix. It is the signature of a durable process change. A tool like the pink slip succeeds because it turns a compliance obligation into a shared, low-friction routine between nurse and provider, which is exactly the kind of operational design work that In-House Medical brought to the psychiatric holds workstream as a whole.

Workstream Outcome

The workstream's results are visible in the cumulative effect: a documented, legally defensible, Joint Commission-compliant psychiatric hold process where previously there was ambiguity; a new staff position where previously there was strain; external coordination that freed emergency department capacity that had been consumed by patients who no longer clinically required it; and a sustained 95 percent or greater compliance rate on a core Joint Commission reassessment requirement. These outcomes address a cluster of operational challenges that are well documented in rural emergency medicine.

The workstream was led by In-House Medical leadership, working alongside hospital clinical and administrative stakeholders over more than a year of sustained meeting discipline, follow-through, and advocacy. A sample of the Behavioral Patient Flowsheet ("pink slip") is included as an appendix to this report.

Case Study 4: Bringing Ambient AI Documentation to a Rural ED

The Heidi Health Rollout at Golden Valley

Documentation burden is one of the unglamorous engines of clinician dissatisfaction in emergency medicine. A single shift can produce dozens of patient encounters, each requiring its own note, disposition, and discharge documentation. The work falls to the same providers who are simultaneously triaging, treating, and positioning patients in real time. When documentation runs behind, it follows providers home; when providers chart at the bedside, they spend less time looking at the patient. The trade-off is constant, and in a rural emergency department where each provider carries broader responsibilities than in higher-volume settings, the costs of either side of the trade-off compound.

In-House Medical identified ambient artificial intelligence scribing as a category of tool with the potential to ease that trade-off. Ambient AI scribes listen to the clinical encounter, transcribe the conversation, and produce structured documentation that the provider reviews and signs rather than writes from scratch. Published pilots of the technology in emergency settings, including at hospitals in New Zealand and Australia, have reported meaningful time savings, earlier completion of documentation, and increased face time between providers and patients. Bringing this kind of forward-looking technology evaluation into a rural hospital is itself a form of executive function that rural emergency departments rarely have the bandwidth to do for themselves.

The Choice

After evaluation, In-House Medical recommended Heidi Health, a clinical AI scribe used at scale across emergency departments, primary care, and specialty practice. Heidi was selected for its emergency department track record, its compliance posture, its ability to function in noisy clinical environments, and its fit with the workflow the Golden Valley provider group already used. As part of the rollout, In-House Medical negotiated favorable subscription terms on behalf of the hospital, securing a discount off the

standard per-provider rate. The hospital agreed to fund the subscription as a department-wide budget item, and the rollout extended to every full-time physician and every full-time advanced practice provider in the group.

The Rollout

The introduction of Heidi to the Golden Valley provider group was deliberately structured to give clinicians room to form their own judgments before any commitment was made. Heidi offered a free trial period for interested providers, and In-House Medical encouraged voluntary participation rather than imposing the tool top-down. Curious providers tried it on their own terms; skeptical providers waited and watched. The early adopters became the internal evidence base for the broader group.

Initial response from the provider group was mixed. Some clinicians were enthusiastic about reducing their documentation load. Others were skeptical, citing two reasonable concerns: the possibility of artificial intelligence inaccuracies or hallucinated content in the generated notes, and the time investment required to learn a new tool while continuing to carry full clinical responsibilities. Both concerns were legitimate, and both were taken seriously. Provider review of every Heidi-generated note remained the standard, addressing the accuracy concern directly. Training and onboarding were paced to the comfort of individual providers, and those who needed more time to adapt were given it.

Over the trial period, providers who had been skeptical observed colleagues finishing documentation earlier in the shift, leaving on time at the end, and spending visibly more of their bedside time looking at the patient rather than at the screen. As that evidence accumulated, the case for broader adoption made itself. The hospital committed to the full subscription, and the rollout extended to every full-time provider in the group.

Outcomes

The outcomes observed since the rollout have been qualitative rather than measured against a formal data collection. Within that limitation, the pattern has been consistent across the provider group. Documentation that used to require sustained attention during and after each encounter is now largely complete by the time the encounter ends, requiring only review and finalization rather than composition from scratch. Providers report less after-shift charting and a more sustainable end of shift. Cognitive load during shifts has decreased; the constant background task of remembering what needs to be charted later has eased. Provider satisfaction in the group has improved, and burnout indicators have softened in the same period.

Most consequentially for the patient experience, providers now have meaningfully more face time with the patients in front of them. Time previously spent typing into the electronic health record during the encounter is now spent in conversation with the patient. This effect has compounded with the patient experience program described in Case Study 1, in which providers return to the room before discharge to answer questions and offer reassurance. Heidi reduced the documentation cost of doing that, which made the practice easier to sustain. The two interventions reinforce each other: the patient experience program created the expectation of presence, and Heidi created the operational space for it.

Continuation

The Heidi subscription is paid by the hospital as a budget line item and continues with Golden Valley after the engagement's conclusion. Ongoing administration of the tool, including license management, onboarding of any new providers, and the relationship with Heidi Health's support team, will transfer to the hospital alongside the broader management responsibilities described in the Transition & Handoff chapter.

What This Case Reflects About the Insourcing Model

The decision to bring an ambient AI scribe into a rural emergency department was not initiated by the hospital. It was identified, evaluated, negotiated, and implemented by In-House Medical, with the hospital agreeing to fund the subscription once the case had been made. This is the kind of work that rural emergency departments do not typically generate from within. Tracking emerging clinical technology, evaluating it against the operational realities of the department, negotiating commercial terms on the hospital's behalf, navigating the change management of provider adoption, and seeing the rollout through to durable group-wide use is sustained executive work. It is the kind of work that, in larger health systems, might fall to a Vice President of Emergency Medicine or a Chief Clinical Officer. At Golden Valley during the engagement, it fell to In-House Medical.

Voices from the Partnership

The testimonials below were collected from hospital leadership and staff during the engagement. Staff feedback was gathered in February 2026 as part of the hospital's ordinary feedback collection.

Operational Perspective

"The partnership is very valuable because communication is strong and support is readily available. When issues come up, responses are prompt and help keep the Emergency Department running smoothly. In-House Medical has been very effective in supporting day-to-day ED operations by ensuring appropriate staffing and maintaining clear communication. They are responsive to issues and follow through quickly to resolve concerns. In-House Medical has had a positive impact on physician engagement and overall stability in the Emergency Department. When provider issues are raised, they are addressed appropriately and in a timely manner."

— Golden Valley Memorial Hospital staff, feedback survey (February 2026)

Accessibility and Professionalism

"Accessibility, top down: I have never had a situation where I needed to reach out to anybody at IHM and not been able to get hold of someone, get a phone call back, or a prompt email. They are always succinct and on time. It is just a pleasure to work with them."

— Executive Director of Emergency Services, Golden Valley Memorial Hospital

Breadth of Value

"Provider scheduling, provider recruitment, communication, support, and responsiveness are good. Day-to-day operations flow smoothly and communication and follow-through are good. Physician engagement, stability, and performance are good. We have a stable team of providers who are engaged. Our providers have made considerable improvements in patient experience and continue to perform well."

— Golden Valley Memorial Hospital staff, feedback survey (February 2026)

Transition & Handoff

The engagement between In-House Medical and Golden Valley Memorial Hospital concludes on June 30, 2026. Golden Valley's plan is to absorb the emergency department management function into its existing hospital administration. This chapter is written to support that transition. Its purpose is to leave a clean record of what was in place during the engagement so that the people taking it forward have the information they need, in one place, when they need it.

What Remains with Golden Valley

Under the insourcing model, most of what was built during the engagement stays with the hospital. The provider group is employed by Golden Valley and continues in place. The clinical tools, protocols, and workflows developed during the engagement, including the Behavioral Patient Flowsheet (the pink slip) and the APP Mini-Internship curriculum, belong to the hospital. The patient care card program, which In-House Medical and the hospital operationalized together within the provider group, continues. The Psych Sitter position approved in September 2025 continues. The physical and procedural interventions from the psychiatric hold workstream, the designated smoking area, the weapons-screening protocol, and the court-approved 96-hour hold process, continue. The cross-department working relationships that support emergency department operations continue as well.

This is a meaningful inheritance, and it is a direct consequence of how the insourcing model is designed. The hospital keeps what was built together.

Areas of Ongoing Work

The categories below describe the routine, ongoing work of managing an emergency department provider group. They are presented here as a simple reference, a checklist of areas where a designated owner at the hospital will be helpful, rather than as a warning or a cautionary tale. These are the things a well-run emergency department management function tends to attend to. Golden Valley may find some of these straightforward to continue, may adjust others to fit its own approach, and may discover better ways of doing some of them than In-House Medical did.

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. Throughout the engagement, In-House Medical recruited multiple PRN physicians, a full-time advanced practice provider, and additional PRN advanced practice providers, and also developed the APP Mini-Internship Program as a pipeline-building approach. Golden Valley 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, PTO coordination, call coverage, 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 materially to continuity of care and to the financial health of the department.

Provider Performance Management and Engagement

Physicians and advanced practice providers are highly trained professionals, and the ordinary work of keeping a group aligned, including regular check-ins, feedback on performance, and support through the occasional difficult conversation, benefits from having a designated owner with the experience and standing to do it well. This is normal management work, not crisis management, and it pays off gradually over time as the group feels supported.

Quality Program Stewardship

The quality programs that took shape during the engagement, including sepsis, stroke, and chest pain protocols, the 12-hour psychiatric reassessment process supported by the pink slip, and the patient experience initiatives, are all in working order as of the engagement's conclusion. They benefit from periodic review: a look at the data, a check on adherence, occasional reinforcement when drift appears. The pink slip's 95 percent-plus compliance is the result of a simple, well-designed workflow that Golden Valley can continue to audit on a cadence that works for the department.

Retention and Culture

The provider group is stable and engaged 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 Invisibility of Good Work

There is a particular kind of management work whose signature is its own invisibility. When it succeeds, the thing it produces is not a visible output but the absence of a problem. The shift that was always covered. The provider who stayed rather than left. The compliance rate that held. The audit that passed. The crisis that did not arrive, because the conditions that would have produced it were attended to before they compounded.

This kind of work is difficult to value, not because it is not valuable, but because it shows up in the world as normalcy. A smoothly running emergency department does not announce the reasons it is running smoothly. It simply runs. The people inside it experience it as the natural state of the department, because that is how they have always known it to be.

We are proud of the work we did at Golden Valley. Over three years, an emergency department that began the engagement in crisis became one that operated with quiet consistency. Every shift was covered. Every provider who joined the group at the start remained part of it. Every question, every concern, every crisis that walked through the department's doors was attended to. And the tools, programs, and workflows built along the way became part of how the department simply functions now.

These outcomes did not happen by themselves. They were the result of the weekly leadership rhythms, the cross-department advocacy, the sustained attention to provider culture and retention, the willingness to do the unglamorous work of recruiting, credentialing, scheduling, and problem-solving on a continuous basis. They were the result of a management model that treated the emergency department as a partnership rather than as a line item.

A reader encountering this report years from now, or a future hospital evaluating the insourcing model, may find it useful to know that this is what the work looks like when it works. Not in the form of dramatic rescues or headline-grabbing interventions, though the July 2023 rescue was dramatic enough. But in the form of three quiet years in which nothing went badly wrong, because people were working to make sure it did not.

We take pride in that kind of quiet. It is what we came to Golden Valley to build.

Closing & Acknowledgments

In-House Medical is grateful for the three years it was entrusted with the management of the Golden Valley Memorial Hospital emergency department. The work described in this report was possible only because of the partnership of the hospital's leadership, the dedication of its clinical staff, and the engagement of the provider group who cared for Clinton and the surrounding community through every shift of the engagement.

We came into this engagement under unusual circumstances. Within twenty-six hours of a phone call, we took on responsibility for stabilizing a provider group whose management partner had just collapsed. Three years later, we depart an emergency department that is stable, clinically improving, and staffed by a group of people, clinicians, nurses, technicians, and administrators, whose commitment to their patients is evident in the daily work that continues.

As Golden Valley moves forward under a different management structure, we wish the hospital and its team every success. The tools, protocols, programs, and, above all, the people who made this engagement worthwhile remain with Golden Valley, where they belong.

Thank you, Golden Valley.

Appendices

Appendix A: APP Mini-Internship Program Curriculum Checklist

The Emergency Department Advanced Practice Provider Readiness Checklist developed during the engagement is the curriculum referenced in Case Study 2. It covers seven curriculum domains spanning clinical foundations, procedural skills, critical decision-making, communication and teamwork, documentation and risk management, workflow and time management, and professional development. Each domain is structured around specific, observable skills and sign-off criteria distributed across the physician mentoring team. The full checklist is provided as a companion document to this report.

Appendix B: Methodology

This report draws on three categories of source material. First, operational records generated during the engagement, including meeting notes, project tracking documents, and program artifacts such as the APP Mini-Internship curriculum and the Behavioral Patient Flowsheet. Second, quantitative data provided by Golden Valley Memorial Hospital covering the engagement period, including monthly Key Performance Indicator scorecards and the hospital's Acute Stroke Ready scorecards. Third, qualitative feedback from Golden Valley hospital leadership and staff, including an attributed testimonial from the Executive Director of Emergency Services and anonymous responses from a hospital feedback survey collected in February 2026.

Where attributions are provided to title rather than name, this reflects the preference of the individual being quoted. Where responses are anonymous, this reflects the anonymous nature of the feedback instrument. No attribution has been made in this report that was not verified against the source.

Appendix C: Full Testimonial (Executive Director of Emergency Services)

“For me, I think some of the benefits of working with IHM — first and foremost — is collaboration. They are a great team. They work to identify performance metrics and really how we wish to direct care in our organization, rather than coming in with something pre-packaged. They work with you to make certain that the care you are providing and the standard to which the providers work is aligned with your organizational mission, vision, and values. There is a high degree of professionalism. Everybody on their team is easy to work with and accountable. We get what we say we will get, when we are told we will get it. It just makes it an easy process and an easy team to work with. Accessibility, top down: I have never had a situation where I needed to reach out to anybody at IHM and not been able to get hold of someone, get a phone call back, or a prompt email. They are always succinct and on time. It is just a pleasure to work with them.”

— Executive Director of Emergency Services, Golden Valley Memorial Hospital
