



Seven Ways to Help Your Hospital Stay in Business

Your inpatient care decisions could make or break your local hospital.

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While many doctors are still of the mind-set that their hospitals have “deep pockets,” the reality today is that many hospitals are having trouble just breaking even. In Illinois, for example, an estimated 53 percent of hospitals are operating at a deficit.¹ According to the American Hospital Association, the comparable national figure was 32 percent in 2000, and this number has surely increased over the past few years.

In the past decade, the pressures by payers to reduce lengths of stay and deny payment for any reason they can find have brought many hospitals to the breaking point.

Added to these pressures are numerous others, including the annual push by doctors for new technologies and nicer facilities to keep up with the changing demands of health care, the rapidly increasing costs of providing health insurance to hospital employees, and the skyrocketing medical malpractice costs being absorbed by many hospitals. What we are left with is a hospital system teetering on the verge of bankruptcy.

In many major cities, if a hospital closes, the negative

impact on the community is absorbable because the next hospital is only a short distance away. But in rural areas, when a hospital has to close its doors because of financial insolvency, the effect on the community is disastrous. It leaves many people unemployed or forces them to commute long distances or move from the community to find employment. For people with life-threatening emergencies, it can mean the difference

between life and death if the closest hospital is a long distance down the road. And for the physicians in these rural communities, the closing of the local hospital may add hours of driving to and from the closest hospital to

do rounds each day, or it may require that the physician turn over inpatient care to another physician.

Misaligned incentives

Most physicians do not see a direct connection between their local hospital’s financial position and their everyday actions as they manage their inpatients. They hear hospital executives fussing about saving money and assume it is an administrative problem. But the nature of our current

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Hospitals are struggling just to break even, and physicians' inpatient care decisions significantly affect their hospital's finances.

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Primary care physicians are usually reimbursed for their hospital work based on the level of services they provide, so their incentive is to take "as long as it takes" to get the patient well.

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When a payer denies a claim for hospital care because it did not meet the payer's criteria for medical necessity, the hospital claim gets denied but the physician gets paid.

reimbursement systems means that physicians' inpatient care decisions have a direct impact on the hospital's bottom line.

Hospital reimbursement. Medicare has been reimbursing hospitals based on diagnosis related groups (DRGs) since the 1980s, and in recent years, Medicaid has followed suit. This means the hospital receives a flat rate of reimbursement to cover the usual costs of working up and treating a patient, based on the patient's main diagnosis. Any services unrelated to the main diagnosis are not reimbursable for the hospital. After the patient is discharged, coders figure out all of the various services and diagnoses related to the patient's stay, which may or may not turn out to be related to the initial reason for the admission, and they assign a DRG. Medicare and Medicaid provide a fixed level of reimbursement to the hospital based on the DRG. (Physicians are paid separately.) If a major surgical procedure is done as part of the hospital stay, that procedure becomes the assignable DRG and dictates the reimbursement level regardless of the length of stay or the other reasons for the patient's hospitalization.

In contrast, most private insurance companies reimburse hospitals on a per diem basis – that is, they contract with the hospital for a flat rate of reimbursement per day no matter how many services the hospital provides to a patient on a given day. The insurance company then monitors the hospital stay closely to verify whether each day was justified. This evaluation is based on criteria that measure both the severity of the patient's illness and the intensity of the services he or she is receiving. If these criteria aren't met, the hospital will receive no payment even though costs were expended for that patient.

Physician reimbursement. In most cases, primary care physicians are reimbursed for their hospital work based on the level of services they provide. The more services and time spent, the greater the physician's reimbursement. The physician's incentive, then, is to take "as long as it takes" to get the patient well, which can result in the ordering of extra tests and procedures unrelated to the original reason for admission and in longer hospital stays. This is directly at odds with the hospital's incentive

KEY POINTS

- Physicians' inpatient care decisions have a direct impact on their hospital's bottom line.
- Under current reimbursement systems, the physician's incentive is to take "as long as it takes" to get the patient well, while the hospital's incentive is to take care of the patient's acute problem only and get the patient out of the facility as quickly as possible.
- Physicians can be part of the solution by making wiser use of hospital resources.

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The burden of denials. When a payer denies a claim for hospital care because it did not meet the payer's criteria for medical necessity, an odd phenomenon occurs: The hospital claim gets denied, but the physician continues to be paid, even though the physician made the decision to put the patient into the hospital. Few hospitals have developed systems to protect themselves against the admission of patients who do not need to be inpatients or against doctors who enable prolonged hospitalizations of medically stable patients by working up one problem after the next.

As part of the Centers for Medicare & Medicaid Services' (CMS) Payment Error Prevention Program, purportedly developed to prevent billing and coding errors, many of Medicare's Quality Improvement Organizations (QIOs) began to

address the issue of improper admissions. For example, the Illinois Foundation for Quality Medical Care defined criteria for the admission of Medicare patients in three diagnostic categories: chronic obstructive pulmonary disease, pneumonia and congestive heart failure. (To access admission guidelines used in your area, contact either your hospital utilization review department or the QIO that oversees Medicare for your state or region. QIO contact information is available at www.medqic.org/content/qio/qio.jsp?pageID=4.) Although CMS has since moved on to other projects, it correctly identified the problem: Too many patients

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who don't meet admission criteria are getting admitted to hospitals because very few hospitals have any control over whether the patient should be admitted. Once these patients are in the hospital, the doctor has no incentive not to go ahead and work up every little problem.

What can you do?

Whether you work on staff at your local hospital or simply have privileges there, you can be part of the solution. Here's how:

1. Change your mind-set about the use of acute-care hospitals. In 2003, an acute-care hospital is where someone goes to have a baby, to undergo a surgical procedure that will make them so unstable post-operatively that they will need 24-hour-a-day monitoring, or to obtain treatment not available on an outpatient basis.

An acute-care hospital is for patients who are unstable in terms of vital signs or mental status, who might suffer death or severe morbidity without 24-hour-a-day monitoring, or who require a rapid diagnosis to prevent death or severe morbidity and to establish a treatment plan. Establish is the operative word here. Once the treatment plan is established, even if it requires prolonged intravenous therapy, physical therapy or some other type of treatment, the patient can and should be moved elsewhere.

2. Don't include the kitchen sink. When a patient does need to be admitted to the hospital, make every attempt to limit your care to the reason for admission. If another, unexpected problem surfaces while the patient is in the hospital, ask yourself, "Would I admit this patient to the hospital for this problem if I saw him or her in the office?" If the answer is "no," then don't treat the problem while the patient is in the hospital. For example, don't do an inpatient EGD and colonoscopy on a patient who is admitted for an unrelated problem but whose guaiac-positive stool was found on the admission history and physical. If a patient in your office had a guaiac positive stool, you wouldn't admit him or her to the hospital for testing, so do not perform these tests in the hospital now.

3. Break it up into two stays. If, during a patient's hospital stay, a separate medical

problem develops that does not need to be addressed immediately, discharge the patient and bring him or her back to address the new problem. Of course, sometimes this will not be possible, but many times it is. Obviously, a patient who develops chest pain and myocardial infarction while in the hospital for pneumonia needs to have all problems dealt with – even to the point of angioplasty or coronary artery bypass grafting – during the same hospital stay, unless you deem it safe to delay a procedure to a later time. On the other hand, the patient who develops urinary outlet obstruction while in the hospital for pneumonia can safely go home with an in-dwelling catheter and come back at a

subsequent time for the transurethral resection of the prostate.

4. Use other levels of care. Numerous hospital alternatives exist today that did not exist even a decade ago. Patients can receive physical and occupational therapy, get X-rays and lab work, and even receive intravenous (IV) drugs and total parenteral nutrition at home. Skilled-care nursing homes provide high levels of care for long-term ventilator weaning, sophisticated wound care, total parenteral nutrition, and intensive levels of rehabilitation. Nursing homes can provide skilled nursing care for their own custodial patients for the days it takes to finish a course of IV antibiotics.

Once a patient has been stabilized and the physician has established the treatment plan, the patient can be moved out of the acute-care hospital to another place to finish his or her course of treatment. It is simply too expensive today to use acute-care hospitals for this purpose.

5. Bring your costs down. One of the major ways that we, as doctors, can lower our costs is by examining everything we do for a patient. Here are some general rules:

- Put your orders on autopilot. Hospital staff can carry out orders such as advances of diet and decreased frequency of respiratory treatments according to parameters you set rather than waiting for your next rounds. The patient's care will progress faster through the hospital stay.

- Pay attention to medication costs. If a medication can be given by mouth (e.g., it is formulated that way and the patient has a

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Once a physician establishes a treatment plan for a patient, the patient can and should be moved out of the hospital and into another setting.



When a patient does need to be admitted to the hospital, make every attempt to limit your care to the reason for admission.



If a separate, non-urgent medical problem develops during the patient's hospital stay, consider discharging the patient for the current problem and then bring him or her back to address the new problem, if needed.



Putting your orders on autopilot can help your patients' care progress faster through their hospital stays.



When you admit a patient to the hospital, consider whether the patient is likely to need short- or long-term care upon discharge and get those plans underway immediately.



Most hospitals count their census at midnight, so if you know you will be sending the patient home in the morning, consider sending the patient home tonight.



Before you admit a patient, identify what services the patient will receive that he or she could not get elsewhere and what outcomes will define when the patient is ready for discharge.



Include your patients and their caregivers in the decision-making process and present them with evidence-based facts and realistic probabilities of the outcomes.

functional gastrointestinal tract), then give it by mouth as soon as possible. Many drugs work as well or better that way (histamine blockers and fluoroquinolones, for example). Intravenous drugs are expensive, so change from IV to oral as soon as possible, but don't simply choose the cheapest drug on the market. An expensive once-a-day IV antibiotic may end up being less expensive than a cheaper twice-a-day antibiotic once you factor in the staff costs involved in administering the drugs. Also, discontinue oxygen

as soon as it is not needed, and don't keep IVs going beyond the time they are needed.

- Make discharge planning a standard part of admitting a patient to the hospital. Ask yourself whether the patient is likely to need short- or long-term placement. If post-hospital care will be necessary, get the social workers and the family into that mind-set and working on it as early as possible – days before the discharge.

- Get your patients moving as soon as they are able. Too often, elderly patients are admitted for an illness or surgery and we forget to get them up, out of bed and ambulating as soon as possible. Just a few days of bed rest can debilitate an elderly person and dramatically lengthen his or her hospital stay.

- Don't order equipment you don't need. For example, don't ask for a higher-level bed (e.g., step-down or telemetry) unless it is absolutely critical to the patient's care. Your hospital's utilization management department should have criteria to help you determine this. And don't put patients on Holter monitors while they are on telemetry.

- Don't do a test in the hospital that will not be used to make decisions about the rest of the patient's stay. If a test is not directly related to the reason for admission and it will not change the course of the hospital diagnosis and treatment plan, don't do it in the hospital. You are in essence giving it away for free.

- Remember, most hospitals count their census at midnight. If the patient is in that bed at midnight, you have just added another day to the length of stay. If you know you will be sending the patient home in the morning, consider sending the patient home tonight unless there is something critical to be done in the morning.

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6. Avoid the clinical cascade. The clinical cascade occurs when you see something that may or may not be wrong that provokes you to order another test, where you additionally find something that may or may not be wrong, which provokes another test, and so on. Many doctors fall into the trap of admitting patients “because they are sick”

without first answering two critical questions:

1) What care will the patient receive in the hospital that cannot be provided elsewhere?

and 2) What outcome

will define when this patient is ready for discharge? If you put sick patients into the hospital without first clearly defining what you expect to accomplish and when you plan for them to go home, you will fall into the clinical cascade trap.

7. Just because you can do something, doesn't mean you should. It is incumbent upon us as physicians to include our patients and their caregivers in the decision-making process, to make realistic presentations of evidence-based facts and to give realistic probabilities of the outcomes upon which to base decisions. We should not intervene simply because we can. Consider the case of feeding tubes being placed in patients with advanced dementia.² If physicians were really keeping up with the evidence and having realistic discussions with their patients (or their families) about the benefits, risks and probable outcomes of this intervention, we probably wouldn't do it nearly as often.

Our bedside decisions can make or break our hospitals. Applying even one of the lessons above to your practice situation can have an enormous impact on the bottom line of your local hospital. Perhaps the hospital will even be able to afford that new-fangled technology you have been pushing for! **FPM**

Send comments to fpm@afp.org.

1. Robbins K. Illinois hospitals and the financial environment: a plea to strengthen the hospital/state government partnership. Illinois Hospital Association. Available online at: www.ihatoday.org/public/medicaid/bobpres.htm.

2. Gillick MR. Rethinking the role of tube feeding in patients with advanced dementia. *N Engl J Med*. 2000;342:206-210.