

THE CAPITAL CONUNDRUM

BALANCING NEEDS UNDER PRESSURE

Many hospital trustees may be feeling better about their institution's future prospects than they did three years ago. Thanks to improved Medicare funding rates, increased private insurance reimbursement, and a lot of hard work on the part of administrators and boards to reduce costs, hospitals' financial performance is on the upswing. And for the first time in more than a generation, many hospitals find themselves needing more beds to

accommodate increased demand. Extrapolating the past two years of increased inpatient utilization over the next decade, the Healthcare Advisory Board, Washington, D.C., recently forecast that hospitals will have to increase their bed capacity by a stunning 40 percent to meet projected demand by 2010. Ambulatory care capacity continues to lag behind demand, while hospitals face insatiable demands from their medical staffs to upgrade radiology and laboratory equipment (major profit sources).

At the same time, it is increasingly clear that needed operational improvements—ranging from better revenue cycle management to improved patient safety—will not be possible without major investments in information technology (IT). Hospitals stand on the brink of being able to eliminate paper records and orders, as well as radiology film and pathology slides. They will also be able to replace telephone-based scheduling and ordering with computerized order entry.

These improvements are vital not only to reducing medical errors, but also to improving working conditions for physicians, nurses and other scarce clinical personnel. Through the Leapfrog Group, businesses have already made it clear that they want their employees to use hospitals that have made the digital "leap." Yet, computerizing hospital operations is very expensive and will draw on the same limited stock of capital as all other improvements.

Trustees thus face a major dilemma: How should they allocate the organization's limited capital between upgrading facilities and information technology? How boards resolve this dilemma may be one of the most difficult challenges they face over the next 10 years—perhaps second only to finding sources of capital in the first place.

Boards need to plan for the next 10 to 20 years, not just address immediate needs. To do this responsibly, trustees should ask some hard questions. One of the toughest: How enduring is the current surge in inpatient utilization likely to be? Is the increased demand of the past two years (against a backdrop of 20 years' decline) the result of relaxed managed care restrictions, or the long-anticipated influx of the aging baby boom population?

A Contrarian View

Contrary to much popular sentiment, this current surge is not about the aging of the baby boomers. Demographics are a glacial force—powerful but *very* slow moving. The modal baby boomer turns 47 this year, and the youngest is in his or her late 30s. The real impact of baby boomers on inpatient demand is at least 10 to 15 years off.

Moreover, the current upswing in inpatient care cannot be traced to new technologies that require a patient's hospitaliza-

BY JEFF C. GOLDSMITH

tion. In fact, the long-term technological trend is toward reduced hospitalization for increasingly complex conditions. Surgery, in particular, continues to migrate into the ambulatory setting.

I believe the current surge of hospitalization stems from the collapse of health plan oversight for physician and hospital use. Not only have managed care restrictions been successfully overridden by state and federal regulatory changes, but many strictures have been abandoned by the plans themselves because their administrative costs outweighed the savings they were intended to create. Physicians, in turn, have reacted to the end of managed care's "gatekeeping" technique by pushing the envelope of the level of care they can provide to patients.

For example, a recent Centers for Disease Control and Prevention (CDC) analysis showed national Caesarean section rates of almost 25 percent, a level not seen in a decade. Federal and state legislative overrides of managed restrictions in the late 1990s sharply increased lengths of stay for obstetrical deliveries. There are also more medical admissions from the emergency department (ED), possibly because physicians are directing more chronically ill patients to the ED rather than treating them in their outpatient settings.

How Will Payers React?

Hospitals can count on a strong payer reaction to this cost surge. Hospital utilization increases, as well as prescription drug spending, are sparking a stunning resurgence in health costs after a decade of relative quiet. Employer health insurance renewal rates have increased 20 percent for large groups, and twice that for smaller groups.

Therefore, while it is good news in the short term for hospitals, the current surge in hospital utilization has sown the seeds for a powerful health insurance counterreaction. As employers tire of large premium rate increases, they will place tremendous pressure on health plans to rein in health costs.

Health plans have already begun to respond—by significantly increasing employee cost sharing as well as by moving to multi-tiered provider networks, with higher cost sharing for patients who use more expensive facilities and services. This will have the immediate effect of increasing hospitals' bad debts and encouraging patients to postpone or avoid hospitalization.

In the likely event that these efforts fail to slow the cost surge sufficiently, health plans will return with a vengeance to the provider bargaining table and demand significant price concessions from hospitals. Such concessions will not be achieved easily, particularly in highly consolidated hospital markets. Like many hospitals in the western states today, their beds will be full, but they will not be able to generate an operating margin.

Will the Current Demands Continue?

How sustainable current inpatient demand is may depend on the individual institution and its market position. For some dominant institutions, such as major teaching hospitals and regional refer-

ral centers, current utilization growth is probably attributable, at least in part, to market share gains (measured by growth in hospital admissions and procedures). These gains may well endure.

On the other hand, some hospitals' utilization increases may be the result of deteriorating internal controls. This is particularly true for ICU beds, where lengths of stay (and resource use) may vary by as much as three times for patients with the same severity of illness, depending on their physician. This variability, as well as many questionable ICU admissions, often disappears once ICUs become staffed by intensivists (another of the Leapfrog Group's primary criteria).

There is also significant variability in how operating suites and procedure rooms are used, as well as the rate of bed turnover. Bed shortages may be a result of deteriorating scheduling, poor internal communications and poor information systems support. If hospitals are experiencing LOS increases (in addition to admission increases), trustees and management may be able to trace

them to reduced clinical discipline and poor communication or coordination of services inside the hospital.

It is also important for trustees to ask how much of current inpatient pressure for beds is driven by "outliers"—preventable infections, readmissions and other quality problems. Recent CDC analyses found that hospital-acquired septic infections are growing annually by 17 percent, resulting in almost 100,000 deaths (many of which are preventable) and billions of dollars in avoidable medical costs.

Analytic tools exist to help hospitals examine variations in clinical resource

use and to determine if they have a basis in clinical severity. These tools enable management to determine how much capacity could be freed by more effective internal utilization systems.

Good analysis, however, requires good clinical data and reporting systems. As long as clinical records remain in paper form, it will be difficult to evaluate and control variations in hospital usage. There may be a direct trade-off between clinical IT spending and expanding the physical plant.

Precisely to avoid unnecessary operational spending, hospital trustees should have as great an interest as health plans in reducing variation or clinically questionable use of their hospital's resources. Trustees should satisfy themselves that the hospital is making the most effective use of its existing capacity before adding new beds.

Can the Hospital Staff More Beds?

Many hospitals are unable to fill all their licensed beds because of nursing shortages. It is a questionable use of scarce capital to build additional capacity you cannot staff, or can staff only by driving up operating costs, thereby cutting into operating profits.

Nationally, hospitals are experiencing a nurse vacancy rate of more than 12 percent and have resorted to mandatory overtime, as well as engaging expensive temporary agencies to fill the gap. Reasons for the shortage are complex and will likely endure for many years. (See "Nurses Needed STAT!" in the June

THE CURRENT
UPSWING IN
INPATIENT CARE
CANNOT BE
TRACED TO NEW
TECHNOLOGIES.

2000 *Trustee*, and "In Our Hands," an AHA report available on the AHA's Web site, www.aha.org. Click on "Workforce," in the center column, first page.)

Although many hospitals have stepped up recruitment efforts, adequate staffing ultimately depends on improved retention and job satisfaction among current skilled workers.

Can the Information System Support Capacity?

As suggested previously, capacity use and information systems are intimately linked. Information technology, particularly the electronic record, as well as supporting scheduling systems, can play a major role here. Automating clinical systems may markedly improve productivity while reducing medical errors and facilitate higher clinical personnel retention rates.

Many hospitals continue to support clinical care with information technologies more appropriate to the pre-computer era than to a modern enterprise. Paper records, curly fax paper, telephone message slips, paper scheduling systems—all are incontrovertible evidence of an early 1970s information environment. Effective internal scheduling, care coordination, clinical profiling and utilization control, patient safety, and improved efficiency and morale on nursing units all depend on the quality of clinical and administrative information.

If overutilization can be attributed to clinical variation, poor scheduling, and coordination and quality problems, rather than sustainable gains in market share, then the board should give funding priority to IT for clinical and administrative programs rather than to new construction.

But IT that enables these programs to function at maximum efficiency first requires a willingness to re-examine care processes and workflow. However, such re-examination will likely expose clinicians and administrators to countless "Who Moved My Cheese?" (in the words of bestselling author Spencer Johnson, when referring to the resistance to changing comfortable routines) moments. Trustees must insist that improving care and service go hand in hand with IT investment.

Ask the Tough Questions

Trustees should consider the following before they approve a major capital spending plan, either for the physical plant or for IT:

• What is the return on proposed capital investments?

Trustees should insist on a rigorous analysis of the investment return on their limited capital dollars. These analyses should apply to all forms of capital investment—plant, equipment and IT infrastructure. While some essential capital investments may not generate identifiable returns (e.g., replacing existing beds; correcting building code problems), they may be unavoidable if the hospital is to remain in business.

However, for major capital expenditures, all other things being equal, trustees must be willing to give higher priority to capital expenditures that can generate higher rates of return. If operat-

ing savings are projected from a capital investment (facilities or IT), there should be an explicit responsibility assigned for realizing them, and trustees must be willing to hold management accountable.

• How sustainable is demand and financial performance?

The strong likelihood of health plan and employer reaction to the present cost explosion makes it dangerous for hospital managers and boards to assume both continued volume growth and continued robust operating margins. One or the other will probably suffer within the next 18 months to two years as payers respond to employer outrage over rising costs. For this reason, simply projecting today's demand and payment rates over the next 10 years on a straight line is not prudent planning.

• **What is the quality of increased demand?** One advantage of being at full capacity is the opportunity/necessity of making choices about who uses the hospital and for what purposes. Trustees should ask management whether bed requests are coming from market share gains, or from slackening clinical discipline and resource use variation. Trustees should also ask if increased utilization is coming from the hospital's leading clinicians and clinical programs, or from its marginal practitioners and programs. Are the clinicians who are creating utilization pressures the same physicians trustees and their families are likely to use for their own medical problems? Building new capacity to accommodate physicians or programs that trustees do not have complete confidence in is not responsible investment strategy.

• **How ready is the hospital to use clinical IT?** Some hospitals that need modern clinical information systems do not possess the management depth or physician support to manage the installation effectively. Does the hospital have the managerial and medical staff commitment and understanding to actually change clinical care processes? Can its IT staff ride herd on the vendors and ensure "value for money" in the IT installation process? Getting the return on an IT installation is a complex, demanding task—one which trustees should not take for granted.

Hospital and system trustees face difficult challenges in the coming years to make the best use of limited capital. Setting the right balance between investments in the physical plant and in IT infrastructure may be their most difficult challenge. There is no magic formula that will work for every institution. To find the right balance will require not only rigorous analysis, but sound, prudent judgment by trustees and managers. **T**

JEFF C. GOLDSMITH is president of Health Futures, Charlottesville, Va. He can be reached at (434) 979-9524 or www.healthfutures.net.

The author wishes to thank Tony Speranzo, CFO of Ascension Health, St. Louis, and Don Ammon, CEO of Adventist Health System West, Roseville, Calif., for their comments and advice on this article.

THE SURGE IN
INPATIENT
DEMAND IS NOT
ABOUT THE
AGING OF THE
BABY BOOMERS.