The Powers Report Podcast

Episode 9:

Let's Find Out about the Hospital, Part II

Welcome to The Powers Report Podcast. I am your host, Janis Powers. The show brings you candid, unique and data-driven perspectives on the health care industry. I believe that any solution that is going to positively impact the American health care system has to satisfy two major criteria: financial viability and behavioral incentive alignment. In other words, access to high quality care can only be achieved if we can afford it, and if we behave in ways that optimize our health. Please subscribe to our show on iTunes or on your preferred podcasting platform and connect with us on social media. Again, this is Janis Powers, and welcome to The Powers Report Podcast.

This show is the second of a two-part series about a critical aspect of the health care system that seems to fly under the radar: hospitals. It's an aspect of the industry that needs significant change but is probably the most resistant to it. As I mentioned in the previous show, we have to talk about hospitals because they spend a lot of money. In 2017, the US spent $3.5 trillion on health care (1). A third of those dollars, over 1.1 trillion of them, was spent by hospitals. In comparison, only about 10% of the spend went towards drugs. We hear a lot more in the news about drugs because most Americans take at least one prescription medication a day. But big money is spent by hospitals and given the cost pressures in the industry, we need to focus on making sure the big spenders are operating as efficiently as possible.

In the previous podcast I talked about some of the reimbursement issues and operational challenges that hospitals are facing. Here's a brief summary. Medicare and Medicaid provide hospitals with 60% of their payments (2). As a result of the cost crunch in health care, the Centers for Medicare & Medicaid Services (CMS) has been coming up with programs and tactics to reduce payments to hospitals. Hospitals have been struggling to abide by the continuously shifting regulatory burden they've been experiencing and it's made it hard for them to think strategically about how to best structure their business.

Couple that with the fact that much more care provided by hospitals is in the outpatient arena. Over half of all payments hospitals receive is for outpatient care. Hospitals are facing serious competition from other organizations that don't have to provide the myriad services hospitals are required to offer – like emergency care, access to expensive equipment and the provision for certain levels of staffing. It makes it a lot more expensive for a hospital to do many of the things its competitors can…and payers are taking note. Hospitals are either losing volume or accepting major cuts in reimbursement that, in many cases, result in providing care at a loss.

In this podcast, I'll talk about how hospitals are reacting to these changes. And importantly, I will offer up some suggestions about what I think hospitals should be doing to best position themselves over the next decade.

One challenge hospitals have is that the majority of them are not for-profit entities. According to the American Hospital Association, there are 5,262 community hospitals in the U.S (3). About 75% of them are not-for-profit. That means their goal is to have a profit of zero. Not-for-profit hospitals – like most not-for-profit enterprises – think differently about running their businesses. Oftentimes they look for grants and donations to supplement revenue instead of looking at how to best position themselves in the market so they can optimize operations. These hospitals do engage in cost savings exercises, but somehow, they wind up spending all the money they take in. And on top of that, they don't pay taxes.

For-profit hospitals are incented to generate a profit. Many are publicly traded and have to report to shareholders. They have much more financial discipline because their financial statements are analyzed by a broad swath of individuals and organizations, including the Securities and Exchange Commission.

Of course, many people object to the for-profit structure of hospitals because the dollars that are diverted to shareholders in profits are potentially dollars that could be used by patients to supplement the cost of care or to increase quality. It is a trade-off, for sure, and finding that ethical balance is tricky.

But make no mistake about it. Not-for-profits could learn a lot about maximizing operations from for-profit entities. Let's take an example.

The largest not-for-profit system in the US is CommonSpirit Health. This is as of February 2019 and it is the result of the merger of Catholic Health Initiatives or CHI, and Dignity Health (4). Let's look at the financial performance of the two systems that comprise CommonSpirit from their 2017 financial data. CHI has 100 hospitals and Dignity Health has 39 (5, 6). For year ending June 2018, CHI showed an operating loss of over $275 million. For 2017, Dignity Health had about a $67 million operating loss (7). Together, the two organizations lost over $340 million from operations.

Both CHI and Dignity Health had other revenue, like investment income, that put both organizations in the black, overall, for net income. Their combined net income was $715 million. That's for two organizations that run, among other things, about 140 hospitals. $715 million in net income.

Now compare that to the largest for-profit health system, which is HCA, the Hospital Corporation of America. HCA has 185 hospitals in the US and the UK (8). In 2017, HCA's provision for income taxes, or what they expected to pay in taxes, was over $1.6 billion (9). That was on income of almost $4.4 billion.

In other words, HCA had over $2.7 billion in net income – and that's *after* paying $1.6 billion in taxes! CommonSpirit generated $715 in net income. HCA is bigger by about 40 hospitals, but it generated literally billions of dollars more than CHI and Dignity Health combined.

Of course, this isn't a completely fair comparison. Both hospitals systems run more than hospitals. They operate rehab sites, ambulatory surgery centers, etc. They operate in different states. Nonetheless, the magnitude of the difference is significant enough to cast doubt on the fact that not-for-profit hospitals are being run as efficiently as they could be.

As noted, CommonSpirit is the result of a recent hospital system merger. Over the past few years, hospitals have been using mergers as a means to lower costs. Hospitals expect to use their combined purchasing power as a merged entity to negotiate better rates on supplies and drugs. This is somewhat straightforward to pursue and hospitals have experience in making these negotiations, especially when it comes to negotiating for supplies.

But a merger also means that the administration from both systems should also be consolidated. Ad this is an area where hospitals could use some serious help. One study identified that a quarter of hospitals' costs were attributed to administrative expenses (10). The US spends much more on administrative costs that other countries. It's a sign of the health care system's inefficiency. It would be great if CMS could put some metrics in place that penalize hospitals for too much administrative overhead. I'd like to see that.

A downside, at least for insurers and employers and patients, is that some hospital mergers create monopolistic systems in selected communities. A merged system can oftentimes control the majority of facilities in a community. When that happens, the merged entity can command higher reimbursement because they control the market. That's great for the hospital system because it increases their reimbursement, but it's bad for the community because it drives up the cost of care.

In fact, some hospitals have become almost predatory in their billing practices. You've experienced this if you've received a hospital bill that includes ridiculous charges for things you didn't know you needed at prices that make no sense at all. I'm taking about the legendary $50 aspirin or the $20 hospital gloves.

Then there are the charges that come out of the emergency room. You might get billed for a doctor's service at a super high rate because the doctor isn't on your insurance plan, despite the fact that the hospital is. Or you may have received a test in the emergency room, like a CT Scan, that could have been done later, like at an outpatient imaging center, at a much cheaper price. The stories abound. Hospitals may feel justified in finding other ways to drive up revenue because they have to make up for the losses they're receiving from CMS. But in the end, it's the patients that lose. So much for compassionate care.

In fact, I think hospitals are having a bit of an identity crisis.

People come to the hospital when they're sick. Hospitals generate revenue by treating people when they're sick. Yet a recent wave of hospital PR positions hospitals as the purveyor of community wellness. This role leverages their central role in many communities as a source of charity care and compassion (despite the aforementioned aggressive billing tactics). Hospitals want their patients to be healthier because that's best for the patients. Yet hospitals make their money when patients are sick.

To this point, one of the strangest ad campaigns I've ever seen was run a few years back by renowned New York academic medical center, Mount Sinai. It declared, If our beds are filled, it means we've failed (11). Think about that. Hospitals, like hotels, strive for high occupancy levels. That means that they're getting paid more because more patients have been admitted. So this ad campaign is basically saying that the hospital will be successful if it doesn't make any money because they don't want any patients in their beds. Only a not-for-profit organization could get away with saying something so ludicrous.

The problem with hospitals pursuing this community wellness idea is that 80% of health outcomes are derived from non-clinical factors. In other words, most of the reasons that contribute to whether or not a person has a positive health outcome has nothing to do with the care he or she gets in the hospital. It's the external determinants of health – education, income, zip code, lifestyle, community, etc. that impact health outcomes.

That means that if hospitals want to take on a larger role in community wellness, then they have to start providing services that address these external determinants. That's why we've seen some hospitals provide grocery stores on site. They want their patients to have access to healthy food. Hospitals are

also engaging in relationships with ride-hailing apps and taxis to help patients get to and from care delivery sites – and it helps cut down on using ambulances to get to the hospital too. Medicare Advantage plans can use some of their resources for these types of population wellness activities.

As a component of a community's wellness delivery system, hospitals can apply for all kinds of public and private grants. These grants enhance a hospital's operating performance because they bring in revenue. When you put these two functions – that of providing wellness and that of treating the sick – under the auspices of one entity, a hospital, the dollars for wellness and for treating the sick become blended in one operating structure.

This can be a problem because treating the sick and promoting wellness function with two completely different business models. With wellness programs, the metrics for return on investment, or ROI, stretch over years. Wellness metrics can be measures of rates of diabetes in a community, access to grocery stores that provide healthy food, availability of primary care services. These things take time to change. You can't reverse a community's trends in obesity in a year. And many of these goals require partnerships across the public and private sectors. That, in my mind, is what the government should be for. They're in a position to use funds to help everyone in a community - not just the patients that may be affiliated with or reached by the hospital.

I'd rather see hospitals focus on doing their core business. Treating the sick. And if they want to provide wellness, they should do it through a discrete, separate operating entity that has its own profit and loss statement.

And this brings me to a final, but very pragmatic issue. The physical manifestation of what a hospital is needs to change. Hospitals need to become much smaller and much more specialized. They need to shrink their main campuses and do a better job of extending offerings through a portfolio of services that include sites in their communities and critically, in the homes of their patients.

Think about the main hospital in your community. Depending on where you live, your main community hospital has probably been there for over 50, if not 100 years. The whole campus isn't that old. But the core, central structure probably is. And that means that for decades, tens, even hundreds of thousands of people have walked through the halls, climbed the staircases, taken the elevators. All these patients and workers and visitors bring...germs. Zillions of them. Even a top notch housecleaning crew will never be able to neutralize the bacterial infestation that has built up not just on the floors and walls, but also inside the building's structure. This is one of the reasons why the worst place to be when you're sick is in the hospital.

Hospital associated infections are things like MRSA that are contracted by patients that are incidental to their reason for being at the facility. Like, they're recovering from pneumonia, and then they contract this hospital-acquired infection that wreaks havoc on their bowels. Worse yet, they can't take drugs to get rid of it because many of these infections are so powerful, they resist antibiotics. On a typical day, one in 31 hospital patients has a health care-associated infection (12).

Now consider that over the years, wings and departments and offices and parking garages have been added on to the main hospital. Wayfinding is insane. There are arrows on the walls, on the floors. Maybe there's color coding to help you find your way around. Or there's a numbering scheme which is about as useful as the Dewey Decimal system. Hospital layouts are confusing and inefficient.

And on top of that, these serpentine sites are expensive to maintain. All those hallways? It costs money to clean them, to provide utilities for them and to insure them. (I mention insurance because it's oftentimes calculated as a function of hospital square footage. So the bigger the facility, the higher the insurance cost.)

But the biggest problem with today's hospitals from a facilities perspective is that they're anachronistic. Many of today's facilities were designed to treat a range of patients with different levels of acuity in an inpatient setting. Yet over half the revenue and well over half the patients at hospitals are associated with outpatient services. Hospitals complain that their outpatient care should be reimbursed at a higher rate than what freestanding facilities get because of all the overhead they have to provide from a regulatory perspective.

From an operational perspective, many hospitals are prolonging the financial bleed-out because they are not appropriately adjusting service models when care is moved off site to another outpatient setting. Outpatient surgery is a great example. Let's say some of the outpatient cases move out of the hospital into an ambulatory surgery center, which is a totally separate facility. But the hospital is still doing other outpatient surgery cases on site. That OR department still has to operate to serve not only the other outpatients, but inpatient and emergency cases too.

Here's what typically happens. When there's excess capacity, efficiency at the hospital starts to drop. This happens in every department, and I know this because I've spent years analyzing utilization figures in surgery, radiology, inpatient floors, etc. Say the hospital had five ORs dedicated to performing outpatient surgery. Cases for two ORs were shifted to the ambulatory surgery center. At the very least, two ORs at the hospital should be taken off line and not used. Instead, all five wind up getting staffed and used. More doctors get to book surgeries in the morning, which they like, because there's more space available. Surgeries take longer than they need to because there's no need to operate with efficiency. Turn-around time, meaning how long it takes to clean up the room and prep it for the next procedures, is slower. There you have it. Costs go up.

Well, in response to this outpatient transition, maybe hospitals need to make it official and shift out a portion of their outpatient care to freestanding facilities, separate from the hospital, out in the community closer and more convenient to patients. If they do, that means that hospitals need to shutter, re-purpose or, heaven forbid, demolish part of their current facilities footprint. That takes a real shift in operating philosophy. It also requires a major infusion of capital to invest in the facilities portfolio reconstruction. Nonetheless, hospitals should be much more aggressive in their facilities reorganization plans and look to shutter, shift and demolish when the opportunity arises.

Finally, there's the final frontier of health care delivery – the home. There have been wonderful advancements in internet of things – IOT – gadgets and devices that can help coach, monitor and even talk to patients while they're in their homes. CMS hasn't taken major steps with regard to setting up reimbursement structures for at-home care beyond allowing for hospice and home health – and those services are a very human resources intensive way to provide care.

Here's what hospitals are doing: protecting the hospital fortress. Hospitals are waiting for guidance from CMS about what will be reimbursed, where and for how much. When these policy changes negatively impact their top line, they protest or lobby for change.

Here's what they should be doing: redefining how they'll perform their core mission: treating the sick. They need to get a much better handle on their operations so they can take some calculated risks. They should be proactively designing the hospital of the future - be it on their existing campus, out in the community or in patient homes - and then lobbying the government and private insurers to develop payment models that work for them.

We've come a long way since the first hospital opened in America. That was back in 1751, when the Pennsylvania Hospital founded by Benjamin Franklin and Dr. Thomas Bond began welcoming patients. Hospitals in the United States can perform amazing surgeries, therapies and treatments. The older we get, the more likely we'll wind up being treated in one of them. My hope is that today's sprawling campuses and heavily administered organizations can streamline themselves, evolve their operational functionality and operate more efficiently. Let local governments focus on wellness so we can limit our time in hospitals as we work towards being as healthy as we can be.

This is The Powers Report Podcast. Please subscribe to our show and please follow me, Janis Powers, on social media. We will be featuring listener questions, comments and suggestions on future podcasts. Please see our website at powersreportpodcast.com to submit questions and ideas on the Contact page. I look forward to hearing from you. Thanks so much for listening!

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