

January 7, 2010

# Hospitals: Radical Cost Surgery

**A hospital that slashes costs—and delivers high-quality care as it innovates? Yes, it exists**

By [Catherine Arnst](#)

Walk into most hospitals, and you'll see patients scattered about the halls on gurneys or wheelchairs. They're waiting to be moved from intensive care to a standard ward, or to an X-ray room, or to physical therapy. Each journey adds to the patient's discomfort and increases the risk of infections and other complications. Tally up a single patient's migrations over 24 hours, and they may consume as much as half a day of staff time.

Walk into Providence Regional Medical Center, in Everett, Wash., and you will see a hospital trying something different: It brings the equipment to the patient. In 2003, Providence opened one of the few "single stay" wards in the nation. After heart surgery, cardiac patients remain in one room throughout their recovery; only the gear and staff are in motion. As the patient's condition stabilizes, the beeping machines of intensive care are removed and physical therapy equipment is added. Testing gear is wheeled to the patient, not the other way around. Patient satisfaction with the "single stay" ward has soared, and the average length of a hospital stay has dropped by a day or more.

This is just one of many changes—some radical, many quite small—that have enabled Providence Regional to join a special subset of American hospitals: those that do not lose money on Medicare patients.

Almost 60% of U.S. hospitals report losing 20 cents on the dollar for every elderly patient that comes through their doors. They make up the difference by charging the under-65s a far higher fee. But Providence breaks even on the elderly, even though Medicare pays about \$1,000 less per enrollee in the hospital's region than the national average. The hospital accomplishes this feat while winning a doctor's satchel full of national awards for top-notch care, placing it among the elite 5% of all U.S. hospitals.

High quality at a low price. Every other industry strives for that combination, but a hospital that does both is all too rare. Providence and its cost-efficient brethren demonstrate that quality care can be delivered at an affordable price, provided hospitals can be persuaded to rethink decades-old practices.

The crazy world of hospital economics does not offer a lot of incentives to change. Both Medicare and private insurers reimburse on a piecework basis—known as fee-for-service—that encourages hospitals to treat more, prescribe more, and test more. Economists refer to this arrangement as a "value-blind" payment system since no premium is paid for quality.

Consequently, hospitals have no financial motivation to invest in productivity-enhancing computer technology, management experts, or efficiency research—and by and large, they don't.

Columbia University economist Frank Lichtenberg calculates that productivity growth for the hospital industry has increased at less than half the rate of the general economy.

There are no proposals in either the House or Senate reform bill to scrap the fee-for-service system. As a result, the Congressional Budget Office expects the legislation to do little to halt the medical inflation that has pushed health-care spending to 16.2% of the gross domestic product. Because hospitals are among the largest employers in many congressional districts, their political clout protects them from reforms that would cause any real financial pain.

But even under a value-blind system, there are ways to "bend the cost curve," an oft-stated goal of President Barack Obama. The nonprofit Institute for Healthcare Improvement last year identified 70 regions around the country, out of a total of 306, where high-quality care is delivered at a reasonable cost. One of those regions is Everett, home of Providence Regional.

Providence is the only hospital in this coastal city of 98,000 people located 20 miles north of Seattle. It is the third-largest hospital in Washington, with two campuses serving 25,000 overnight patients a year, and operates the second-busiest emergency room in the state. It's building a \$500 million, 368-bed tower, due to open next year, that will double its capacity.

What sets Providence apart from its peers is not size or location but its ability to operate within a Medicare-designated budget. The majority of U.S. hospitals have the market power to demand higher reimbursements from private insurers to make up for what they see as insufficient payments by Medicare. Because of a wave of consolidation in the 1990s, when more than 900 hospitals merged (including the two medical centers that created Providence Regional), some 90% of the U.S. population that lives in metropolitan areas is now served by just one or two hospital networks. "Hospitals simply don't need to be efficient," says Dr. Robert A. Berenson, a leading health-care economist and member of MedPAC, an independent agency that advises Congress on Medicare. "They are able to get payment differentials from the private sector of 30% to 35% over what Medicare pays." In some markets, it's 50% to 100%, he says.

Providence doesn't have enough private payers to engage in such fee-shifting. Forty percent of its annual revenues come from Medicare, and an additional 13% from Medicaid. Commercial insurers account for only 39%. Dependence on Medicare has forced it to focus on taking costs out of its operation rather than maximizing revenues.

To get those savings, the hospital tries to standardize best practices whenever possible. "There is a tremendous variation in medical delivery that is not quality driven," complains Dr. James Brevig, director of cardiac surgery at Providence. Doctors and nurses are often reluctant to analyze and change their methods because it would mean revamping long-accepted treatments or routines. As a result, says Brevig, "there are no standards in hospitals. Why is that? It's crazy. No other industry is like this."

Providence took a different path after picketing by workers nine years ago reflected a shattered morale. A new administration decided to attack the internal staff divisions and foster collaboration among doctors, nurses, and administrators. Everyone is encouraged to contribute ideas on driving down costs and improving patient outcomes. "I'm eligible for retirement, and under the prior leadership I would have left," says pediatric nurse Kathy Elder, a 34-year veteran of Providence. "They were very hierarchical, very closed. There was a lack of trust all around."

The current CEO, 48-year-old David T. Brooks, a fast-talking Detroit native, took over two years ago. He says the administration is open to suggestions from any and all staffers. "We have scorecards for everything around here, which measure both quality and efficiency. If all we had were great clinical outcomes but costs kept rising, that just wouldn't be good enough."

The staff embraced the challenge to innovate. The nursing team came up with the idea of checking on patients every two hours without waiting for a call button, to see if they need help walking to the bathroom or moving about their rooms. Ten percent of fatal falls by the elderly in the U.S. occur in hospitals. This one change at Providence reduced falls by 25%, according to chief nursing officer Kim Williams. "We believe we'll see more improvement over the next six months."

## **CONTROVERSIAL PRACTITIONERS**

One of the bigger changes at Providence, implemented in 2003, is to place the day-to-day care of almost all its inpatients in the hands of hospitalists, a new type of doctor that has emerged in the last decade. Unlike primary care physicians, who usually visit their patients only early in the morning or late at night, hospitalists are available around the clock, checking that medications are administered properly, chart orders followed, and infection risks minimized. About 37% of Medicare inpatients are attended by hospitalists nationwide, and several studies have associated their use with better outcomes. Providence has also published data showing that infections, lengths of stay, and surgical complications have dropped since starting its own program.

But hospitalists are still controversial in many communities, because primary care physicians are wary of giving up control of their patients, along with their share of inpatient fees. Dr. Joanne C. Roberts, one of the first hospitalists at Providence, has not seen this conflict in Everett, possibly because most of the hospitalists and primary care doctors are associates at one large medical practice, Everett Clinic. That's not true everywhere, she says. "In another community where I worked, independent doctors were pretty hostile. Everyone was trying to grab part of the money. That just doesn't happen here."

The lack of hostility could be because Washington attracts people who appreciate the region's quality of life. The ocean on one side of Everett and the Cascade Mountains on the other are their own kind of bonus. "It helps that most doctors don't move to the Seattle area just to get rich," says Dr. William M. Wisbeck, a radiation oncologist at Providence.

It also helps that Providence has no competition nearby. "We don't have to engage in a medical arms race," says Dr. Lawrence M. Schechter, chief medical officer. Instead, a 20-member Value Analysis Committee consisting of doctors, nurses, and administrators scrutinizes every proposal for a major equipment purchase to determine if it is warranted in terms of patient need, rather than to keep up with the competition or to increase billings.

Providence's savings efforts don't stop at the hospital doors. It offers financial training courses to the 800 independent doctors affiliated with the hospital in an effort to get them thinking about cost efficiencies. That's no easy task, however, since savings don't necessarily flow into their pockets. Cutting back on unnecessary services may be better for the bill payer, but it lowers the income of doctors and hospitals.

Thus there is no national rush to imitate Providence's strategies. The Centers for Medicaid & Medicare Services, which administers Medicare, tries to encourage fiscal restraint through its reimbursement rates, but hospitals consistently argue that these rates are too low. MedPAC estimates seem to support this position—it calculates that hospital Medicare margins were -7.2% in 2009. But overall operating margins are far more robust. Thanks to income from private insurers, the nation's 5,000 nonprofit hospitals had a median operating margin of 8.4% in the second quarter of 2009, according to a Thomson Reuters ([TRI](#)) analysis. Health insurers, by comparison, had a median margin of less than 4%.

Brooks says Providence's 2009 operating margins were 6%, despite its heavy dependence on Medicare. Reaching that level is a challenge. As the only major hospital in a fast-growing county, Providence must provide every kind of medical service. Thus its lucrative cardiology unit and high-tech cancer centers are offset by an obstetrics ward that delivers 4,000 babies a year. The hospital loses money on almost every one of those births. Providence also has to absorb some \$16 million in unpaid bills each year, more than any other Washington hospital except a public facility in Seattle.

Charity care fulfills a moral mission at Providence that sometimes trumps economics. The hospital is owned by the Sisters of Providence, a Canadian order of Catholic nuns founded in 1843 to minister to the poor. "Everything we do has to uphold our core values," says Brooks. "Our mission doesn't end with our business goals."

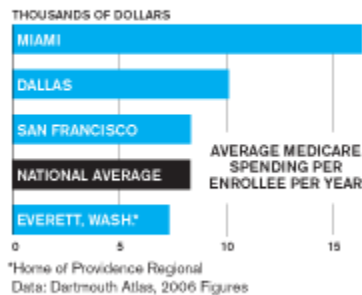
## DOING PENANCE

But business goals and social mandates do sometimes align. To make life easier for dying patients, Providence opened a hospice in 2003 that offers palliative treatments. Patients tend to express relief when offered the option of hospice over hospital care, says Dr. Roberts, the hospitalist who helped start the program. She recalls one day last fall when the palliative care staff was asked to consult on two patients who, between them, had been admitted 35 times to the hospital within 12 months. "As a result of calm discussions with patients and families regarding their goals for their own care and future, both were referred to hospice," she says. Roberts estimates that Medicare saves an average of \$3,120 on patients who choose hospice over drastic interventions.

Providence also seeks to soften contentious encounters among doctors and patients by doing penance for errors. The hospital set up an independent panel to investigate medical mistakes, disclose its findings to the patient, and voluntarily offer a financial award if warranted. As a result, Providence has only two malpractice suits pending, compared with an average of 12 to 14 at other hospitals of similar size.

When Providence can't find standard medical practices, it innovates. That was the case with blood transfusions. Cardiac and orthopedic surgeons realized a few years ago that there was no widely accepted data on the optimal amount of blood to give patients during surgery, despite the \$240 cost per bag. Dr. Brevig started looking around and found several studies that correlated greater transfusion volumes with longer patient stays and higher infection rates.

## KEEPING A LID ON HOSPITAL COSTS



He was particularly surprised that transfusion rates varied greatly from hospital to hospital, regardless of the patient's status. "The variations were related to the culture of the hospital, not the decisions of the doctor," he says. Brevig set out to create a low-transfusion culture at Providence. He got surgeons to slow down because speedy operations cause more blood loss. Settings were changed on heart bypass machines to save blood, and the hospital hired a blood conservation coordinator. In a study of 2,531 operations at Providence, Brevig reported that the incidence of transfusions was reduced to just 18% in 2007, from 43% in 2003, while the average patient stay was reduced by half a day. The changes have saved Providence an estimated \$4.5 million.

Brevig has been proselytizing for his plasma practices at medical meetings, but to little avail. Only some 200 U.S. hospitals have a blood conservation program. Since patients are billed the cost of the plasma, doctors aren't motivated to change their habits.

There is also the fear that cutbacks on services will lead to accusations of rationing. Dr. Donald Berwick, president of the Institute for Healthcare Improvement and a longtime campaigner for better, safer hospitals, says this attitude must be revamped. In a recent speech he called on hospitals to reduce costs by 10% over the next three years without harming care. In almost every case, he noted, fewer interventions and adherence to standards lead to better medical outcomes. "Doctors and patients alike need to realize that the best health care is the very least health care that we need," he said. "The best hospital bed is empty, not full."

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