

CARDIOLOGY PRACTICE OPTIONS™

A PRACTICAL RESOURCE TO SUCCEED IN HEALTH CARE

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Early CABG Discharge May Overstate Savings

Cost-reduction efforts are often aimed at reducing inpatient length of stay (LOS). Cardiac surgeons, for example, are frequently encouraged to pursue certain strategies—such as fast-track protocols, same-day admission, and early extubation—that reduce LOS for patients undergoing coronary artery bypass graft (CABG) surgery.

A new study using data on CABG patients at the Boston Medical Center shows that such strategies may not reduce total health care costs by as much as expected. The reason: CABG patients who are discharged early after meeting fast-track protocol criteria are often sent to rehabilitation facilities or other extended care centers, where stays may be longer than necessary.

Cost Shifting, Not Saving

Published in the *Journal of Thoracic and Cardiovascular Surgery*, in May, the study compared the LOS, discharge location, and readmission rates of CABG patients treated in 1990, before fast-track protocols were implemented, and those treated in 1998, after fast tracking had been widely adopted. The researchers found that while LOS fell significantly, almost half of the 1998 patients were discharged to extended care facilities, where lengths of stay were 10 days on average.

Managed care has prompted physi-

cians to send patients home earlier, says Harold Lazar, MD, a cardiovascular surgeon at Boston Medical Center and the lead author of the study. "There is no question that hospitals pressure physicians to reduce LOS," he adds. "To do so, physicians use various creative strategies to enable them to discharge patients earlier without shortchanging patient care. If patients cannot go home, we discharge them to other facilities to keep hospital LOS down. As a result, early discharge strategies result in some cost shifting from the hospital setting to a rehabilitation setting."

During the 1990s, Lazar and his colleagues at the center had noted that while LOS for CABG had decreased with the implementation of fast tracking, more patients were being discharged to rehabilitation facilities. "We were interested in determining whether LOS in an era of fast tracking was correlated with more discharges to extended care facilities," Lazar says. "If so, the cost savings touted as the result of early discharge would be reduced or perhaps even negated."

The study was based on a retrospective chart review of 786 CABG patients treated at the center in two different years. Among the patients studied, 407 underwent surgery in 1990, before fast-track protocols were implemented. This group was com-

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pared with 379 patients who underwent CABG surgery in 1998, after fast-track protocols were widely adopted.

"In 1990, patients were sent home when they were ready to go home," Lazar explains. "By 1998, fast tracking was in full swing. Physicians were encouraged to discharge patients by the fifth postoperative day, based on early extubation protocols and discharge criteria, such as a stable heart rate, independent ambulation, and adequate nutrition."

Relative Costs

The researchers found that from 1990 to 1998, LOS fell from 9.2 days to 5.4 days. In 1990, 97% of the discharged CABG patients went home, and 3% were sent to extended care facilities. In contrast, just over half of

using other health care services. They are not necessarily saving that much money by prompting hospital discharge. Savings through early discharge are offset by the increased use of extended care facilities and home health services and the need for hospital readmission."

The real question is whether extended care facilities use more or less resources than acute care facilities. "In many instances, the charge per day at a rehabilitation facility is lower, but the total charge of the stay is substantial," Lazar explains. "Rehabilitation facilities offer and bill for numerous services, such as medical and cardiology consultations, physical and nutrition therapies, social workers, psychiatrists, and rehabilitation specialists. In addition, some patients whose care is not

"Surgeons are encouraged to focus on decreasing LOS, and believe that they save the hospital thousands of dollars if they discharge a patient a day early," says Paul Taheri, MD, MBA, a general surgeon and co-author of the Michigan study. "But the belief that early discharge generates a high level of cost savings does not make sense intuitively. Diagnostics and interventions—the most costly aspects of care—occur in the early days of a hospital stay. If one day at the end of the stay is lopped off, how much can really be saved?"

Taheri's analysis revealed that the incremental resource costs incurred on the last day of stay were about \$420 on average, or about 2.4% of the \$17,734 mean total cost of care for the 12,365 patients. Mean LOS for the group was 10.5 days.

Furthermore, last-day costs were relatively low regardless of whether patients had minor or major surgery. For patients who had not undergone major operations (less than \$1,000 incurred in surgical costs), the last-day cost was about \$432, or 3.4% of the average total cost of care of \$12,631. Patients undergoing major surgery (meaning more than \$2,000 in surgical costs) incurred a mean cost of about \$396 on their last inpatient day, which was about 1.5% of the \$26,547 average total cost. "Early discharge to lower care modalities is often simply shifting costs from inside to outside the hospital, rather than reducing costs for the system as a whole," Taheri observes.

Improving Care

Given such costs, it is often more cost effective to keep a CABG patient in the hospital for an extra day or two than to transfer the patient to an extended care facility, Lazar says. "Patients undergoing CABG surgery typically feel better by day five or six," he explains. "If on day five a patient still can't get out of bed or walk very well, the surgeon

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"Savings from early discharge are offset by increased use of extended care facilities and home health services, and hospital readmission."

—Harold Lazar, MD, Boston Medical Center

the 1998 discharged CABG patients went home, and the rest—43%—were discharged to extended care facilities. The average LOS at these facilities was 10.6 days. What's more, 5% of the 1998 patients required readmission, compared with 0.5% of the patients in 1990.

"LOS was significantly lower in 1998, despite the fact that the patient base had become older and sicker," Lazar says. "Unquestionably, this lower LOS was achieved through the use of other health care services."

The analysis revealed that the surgeons who had the shortest LOS exhibited the largest number of discharges to extended care facilities. "Many hospitals track individual surgeons' LOS, implying that lower lengths of stay are better," Lazar notes. "But these surgeons are simply

actively managed may languish in rehabilitation facilities longer than necessary. LOS in extended care facilities may be double that for acute care facilities. If we are truly going to achieve cost savings, the same fast-tracking concept adopted by hospitals should be adopted by rehabilitation facilities." Furthermore, the cost of an acute care inpatient day becomes much lower over the course of the patient's stay.

Other studies have shown that efforts to reduce LOS through early discharge may have only a limited financial payoff. In the *Journal of the American College of Surgeons*, in August 2000, researchers at the University of Michigan Health System reported that reducing a patient's LOS by one full day reduced the total cost of care by less than 3%.

“Early discharge can work optimally only if extended care facilities are integrated with the acute care facility.”

—James Schibanoff, MD, Milliman USA

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may choose to send that patient to a rehabilitation facility. However, if the patient is stable, a higher quality and lower cost option may be to keep the patient in the hospital for an additional 24 to 48 hours, at which point he or she can return home. Extending the hospital stay briefly will avoid rehabilitation that the patient may not really need, and may avert the need for readmission later. And two extra days in the hospital may cost much less than a week in an extended care facility.”

Other studies have shown that early discharge guidelines do yield cost savings, says James Schibanoff, MD, editor-in-chief of *M&R Care Guidelines*, published by Milliman USA, consultants in Seattle. “The concept of earlier discharge includes not only eliminating unnecessary days at the beginning and end of hospitalization, but also improving the processes of care so that fewer complications occur,” he explains. “For example, early extubation and tactics to prevent atrial fibrillation can decrease the complication rate for CABG patients. Several studies have shown that it is possible to decrease acute care LOS safely without substituting a prolonged stay in an extended care facility. The length of stay in an extended care facility should substitute for the number of days the patient would have remained in the acute care facility.”

To accomplish this result, patients in extended care facilities need to be monitored closely so that they are managed for discharge as aggressively as they would be in acute care facilities. “Furthermore, the proper infrastructure must be in place so that patients receive high-quality care at

each care level,” Schibanoff adds. “Early discharge can work optimally only if extended care facilities are also working optimally and are integrated with the acute care facility.”

Implications for Cardiologists

The Boston study highlights the fallacy that CABG patients must be recovering faster since they are discharged sooner, Lazar says. “Shorter lengths of inpatient stay mask the important quality implication that these patients still require a certain period of postoperative care and monitoring,” he adds. “Even if they don’t have to stay in the hospital, they need to be in a monitored environment where they can get additional care if needed.”

As the population ages, the total costs of CABG must include postoperative monitoring, Lazar continues. “We can’t blame physicians for this need, nor should we penalize them for choosing to keep postoperative patients in the acute care setting,” he says. “Some facilities lean heavily on physicians to discharge CABG patients as soon as possible, while third-party payers may refuse to contract with physician groups that do not discharge their patients by a certain day. Hospitals and third-party payers should recognize that older CABG patients require more time to recuperate, either two extra days in the hospital or seven to 10 days in a rehabilitation facility.”

Furthermore, at some point, reducing LOS has a negative effect on quality. This fact is underscored by the significantly greater readmission rate among the 1998 patients. “Patients in 1998 were 10 times more likely to be readmitted after discharge than those

treated in 1990,” Lazar says.

A CABG patient could develop an arrhythmia or a wound problem a few days after surgery that might be fatal if the patient is not in the hospital to receive immediate treatment. “For many patients, it’s hard to argue that care is better outside the hospital,” Taheri observes. “If a patient needs an extra day or two for wound evaluation, for example, he or she is better off in the hospital, because that’s where the doctors are.”

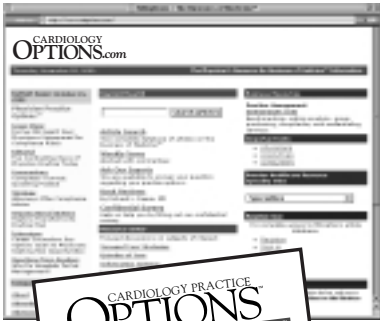
Fast-Track Safety

Physicians have long been skeptical about quality of care under early discharge guidelines, Lazar says. However, he is quick to point out that a number of patients studied were discharged home and not readmitted. Therefore, early discharge guidelines clearly have some value. “Low-risk patients do not have to spend a full week in the hospital,” he says. “The danger comes when we try to apply fast-track protocols to high-risk patients. In general, physicians must use clinical judgment when making discharge decisions, even when guided by protocols for discharge. Still, early discharge guidelines have to be fairly conservative and stringent in order to maintain care quality.”

Schibanoff believes physicians are in the best position to lead improvements in care processes that can decrease complication rates. “In many cases, complications are not an act of God, but are the result of a system of care that can potentially be improved,” he says.

—Reported and written by Deborah J. Neveleff, in North Potomac, Md. More information on cardiology strategies is available on our Web site (see page 16).

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