A Shared Bottom Line: Effective Geriatrics Services Improve Patient Care, Hospital Finances

Maximizing Revenue and Quality of Care for Older Patients

Hospitals need to structure their services so that the revenues provided by older patients, almost all of whom have insurance, contribute to their system's stability.

- **Hospital-Based Geriatric Clinics Can Be Magnets for Hospital Business**
  Hospitals with geriatric clinics provide good continuity of care for older patients, a potential competitive edge. They also create downstream revenue and referrals for higher-margin procedures.

- **Well-Handled Transitions Avoid DRG Bounce-Backs**
  Using an interdisciplinary professional team to manage care transitions can reduce errors and avoid re-hospitalizations, saving money and improving margins.

- **Treating Co-morbidities Off DRG Periods**
  Effective coordination between the inpatient and outpatient settings can allow hospital physicians to focus on the main presenting condition, while managing comorbidities in outpatient or subacute settings after discharge.

- **Geriatric Protocols, Units Can Efficiently Allocate Nurses and Auxiliary Staff to Patient Needs**
  Programs such as NICHE (Nurse Improving Health System Elders) and ACE (Acute Care for the Elderly) Units bring evidence-based practices to hospital care, leading to better patient outcomes and staff retention.

- **Geriatric Consult Services, NPs Ensure Appropriate Care**
  Geriatric co-attendings can shorten lengths of stay, get better clinical results, and reduce costs.

Increasingly, older adults are the central business of hospitals and health systems. Patients 65 and older already constitute the largest volume of care these facilities provide. Nevertheless, divisions and services too often opt out, by custom or inclination, from seeking higher-quality and more cost-effective care for older patients. For many CEOs and other leaders, first class geriatric care is viewed as a money loser.

This perspective cannot be sustained. In a turbulent business environment, forward-thinking CEOs are beginning to realize that better services for older patients, almost all of whom are insured, will be fundamental to their institutions' long-term vitality. Effective geriatric planning has vast implications for a hospital or health system. It can improve patient safety, bolster clinical outcomes, enhance patient satisfaction, provide a distinctive niche in the marketplace, reduce potential liability and litigation, and strengthen an academic health center's long-term financial standing. A systematic, tailored approach to the provision of medical services to older patients, therefore, should be an integral part of any academic health center's strategic plan.

The JAHF Contribution

Founded in 1929, the John A. Hartford Foundation is a committed champion of health care training, research and service system innovations to ensure the well being the well being and vitality of older adults. Our overall goal is to increase the nation's capacity to provide effective, affordable care for older Americans. Since 1982, the Foundation has provided $219 million to enhance and expand the training of doctors, nurses, social workers and other health professionals who care for elders. In addition, $68 million has been awarded to foster innovations in the integration and delivery of services for all older people and promote their widespread adoption.

Caring for Older Adults: The Next Big Thing in Academic Health Centers

Three major forces are creating more older patients for hospitals: demographic trends, advances in prevention, and the higher use of high technology interventions by older persons.

Shifting demographics and increasing life expectancy are having a growing and incontrovertible impact on hospitals. Currently, more than one-third of all people admitted to hospitals are over age 65, and people in this age group account for 46 percent of hospital days.[1] These numbers will grow as the Baby Boom generation begins to reach age 65 in 2011, just a few years away. Academic health centers (AHC) will need the tools to manage this changing patient population mix effectively and the vision to see the opportunities to improve both their care and margins.

Physicians, nurses, and social workers expert in managing complex elderly patients can prevent many of the hazards of hospitalization for the elderly, such as medication errors, delirium, falls, depression, functional decline, infection, pressure ulcers, and others. Early recognition and treatment of these conditions translate to shorter lengths of stay, decreased need for long-term care, improved physical functioning, and fewer readmissions. By addressing the particular health conditions of older patients, aging-savvy health professionals improve clinical outcomes and lower costs to the entire system. A case study at one AHC looked at outcomes of patients over age 65 discharged with a medical diagnosis from two different hospitals in 2002 and compared patients treated by geriatricians to patients treated by non-geriatricians. Despite the fact that the patients of the geriatricians were older (84 vs. 76 years old) and had equivalent or greater comorbidity, their lengths of stay and mortality were lower than for the patients of the non-geriatricians. In addition, the net revenue per case was better for the geriatricians' patients: a $586 surplus vs. a $443 loss.[2] While not a guarantee of savings in other locations, these findings are highly suggestive of financial advantages.

When considering financial issues relevant to treatment of older adult patients, it is important to note that hospitals with postgraduate medical training programs receive greater Medicare reimbursement than hospitals without those programs. And while academic health centers (AHCs) have higher expenses than community hospitals, the margins are greater, as well.[3]

Models for Maximizing Revenues from Older Adult Patients

There are many models AHCs can adopt to improve services, grow revenues and reap cost savings from the care of older patients. Variations in local reimbursement systems and factors such as bed availability and local and university traditions may influence how an AHC adopts one of these innovations. However, efficient care systems that utilize geriatric expertise will serve hospitals and patients well no matter what the reimbursement structure and local environment require.

Hospital-Based Geriatric Outpatient Clinics as Magnets for Hospital Business

Geriatrics expertise, when coupled with high-margin procedures such as hip replacement, CABG, or neurosurgery, can lead to better patient outcomes and shorter stays in hospital. The result is better margins, downstream revenues, and a competitive edge in recruiting patients.

One way that hospitals can increase revenues from older adult patients is with a hospital-based geriatric clinic. The presence of such a clinic on the campus of an academic health center serves as a magnet, attracting patients who have geriatric syndromes and complex medical illnesses. These patients use the affiliated hospital for ancillary services, such as lab and diagnostic tests and outpatient procedures, and, when necessary, are admitted to that hospital, generating significant downstream revenue. Hospital-based geriatrics clinics have a multiplier effect, with one study finding that for every $1 billed in professional charges in the clinic, $17 was billed elsewhere in the hospital system.[4] In managed care systems, the clinics can also be an important part of strategies to avoid preventable hospitalizations and reduce emergency department visits.

Systems Planning For Treating Comorbidities in Frail Patients

Because Medicare pays for just one discharge DRG (Diagnosis Related Group)—even if there are comorbidities—hospitals can experience diminishing returns when they treat frail older adults with multiple health needs. Physicians are likely to order tests to ensure that multiple co-morbidities are fully stable before discharging a patient, thus increasing costs charged against that DRG. A more efficient approach builds in mechanisms for coordination between inpatient and outpatient settings so those patients are treated in the hospital for the acute precipitating illness. Subsequently, other conditions can be treated in another setting within the AHC system. There, chronic conditions can be more appropriately managed by a geriatric physician or nurse practitioner, and in capitated systems this care can often be provided in comparatively less costly venues. This may be a geriatric outpatient clinic, a skilled nursing facility, or some other subacute care setting. By addressing co-morbidities quickly after discharge, geriatricians can also reduce the rate of readmissions.[5]

Ensure Appropriate Care with Geriatric Protocols, Units, Consult Services

The allocation of patients to specialized units such as Acute Care for the Elderly (ACE) Units and programs to increase nurses' competence with older patients while creating systematic change—see NICHE (Nurses Improving Health System Elders) at www.nicheprogram.org—can bring evidence-based practices to hospital care and lead to better patient outcomes and staff retention. After training, Geriatric Resource Nurses are a relatively low-cost option for putting aging knowledge across units and clinics. AHCs have also reported impressive results using a geriatric co-attending model to ensure that patients receive appropriate care. For example, a multidisciplinary hip fracture service in which geriatricians co-attended with orthopedists resulted in fewer medical complications, shorter hospital stays, and a shorter time until surgery.[6]

Care Transitions: A Key Target for Service Efficiencies

Effective systems approaches to caring for older patients can run the gamut from tailored retraining of staff to new information systems. Many improvements can be launched with a relatively small up-front cost.

Efficient management of transitions between health care settings represents another opportunity where health systems can improve their bottom lines. Transfers between the hospital, rehabilitation center, nursing home, and other settings can be highly stressful for patients. Additionally, in a vertically integrated system, an AHC can lose money through duplication of services, faulty transfer of information, and other inefficiencies. Because geriatric physicians, nurses and social workers are more aware of particular vulnerabilities older patients face in transfers, and because they are comfortable working across settings, these clinicians can ensure patient safety and satisfaction and save money for the institution. For example, geriatricians can facilitate quicker transfers, making sure the patient is seen in the lowest cost setting appropriate for the care required. Geriatricians also are aware of the need for efficient transfer of comprehensive information to accompany the patient—especially important for older adults who may have complicated health problems and treatment regimens involving multiple providers. Importantly for customer satisfaction, patients often identify geriatricians as best able to discuss medical issues and care planning with them. The different sites of care can incorporate teaching and training in support of AHCs' teaching mission, while providing further opportunities to fulfill Joint Commission on Accreditation of Healthcare Organizations (JCAHO) requirements for monitoring quality of care and addressing patient safety issues, as well.

[1] United States. Dept. of Health and Human Services. Administration on Aging. *A Profile of Older Americans: 2000.* 17 May 2005 https://assets.aarp.org/rgcenter/general/profile_2000.pdf.

[2] Resnick, Neil. Personal interview. February 2005.

[3] Goodwin JS. Developing a Geriatric Business Plan for an Academic Medical Center. Journal of the American Geriatrics Society. April 2002;50(4):755-60.

[4] Dang S, Baker G, Lipschitz DA. Financial Effect of a Hospital Outpatient Senior Clinic on an Academic Medical Center. Journal of the American Geriatrics Society. October 2002;50(10):1621-8.

[5] Naylor MD, Brooten DA, Campbell RL, Maislin GM, McCauley KM, Schwartz JS. Transitional Care of Older Adults Hospitalized with Heart Failure: A Randomized, Controlled Trial. Journal of the American Geriatrics Society. May 2004;52(5):675-84.

[6] Khasraghi FA, Christmas C, Lee EJ, Mears SC, Wenz JF Sr. Effectiveness of a Multidisciplinary Team Approach to Hip Fracture Management. Journal of Surgical Orthopaedic Advances. Spring 2005;14(1):27-31.

For More Information

Information about the Foundation's programs is available at our Web site www.jhartfound.org.

See also:
Association of Directors of Geriatric Academic Programs: www.americangeriatrics.org/adgap/
Hartford Geriatric Nursing Initiative: www.hgni.org
Geriatric Social Work Initiative: www.gswi.org

THE JOHN A. HARTFORD FOUNDATION 55 EAST 59TH STREET, NEW YORK, NY 10022 212 832-7788