

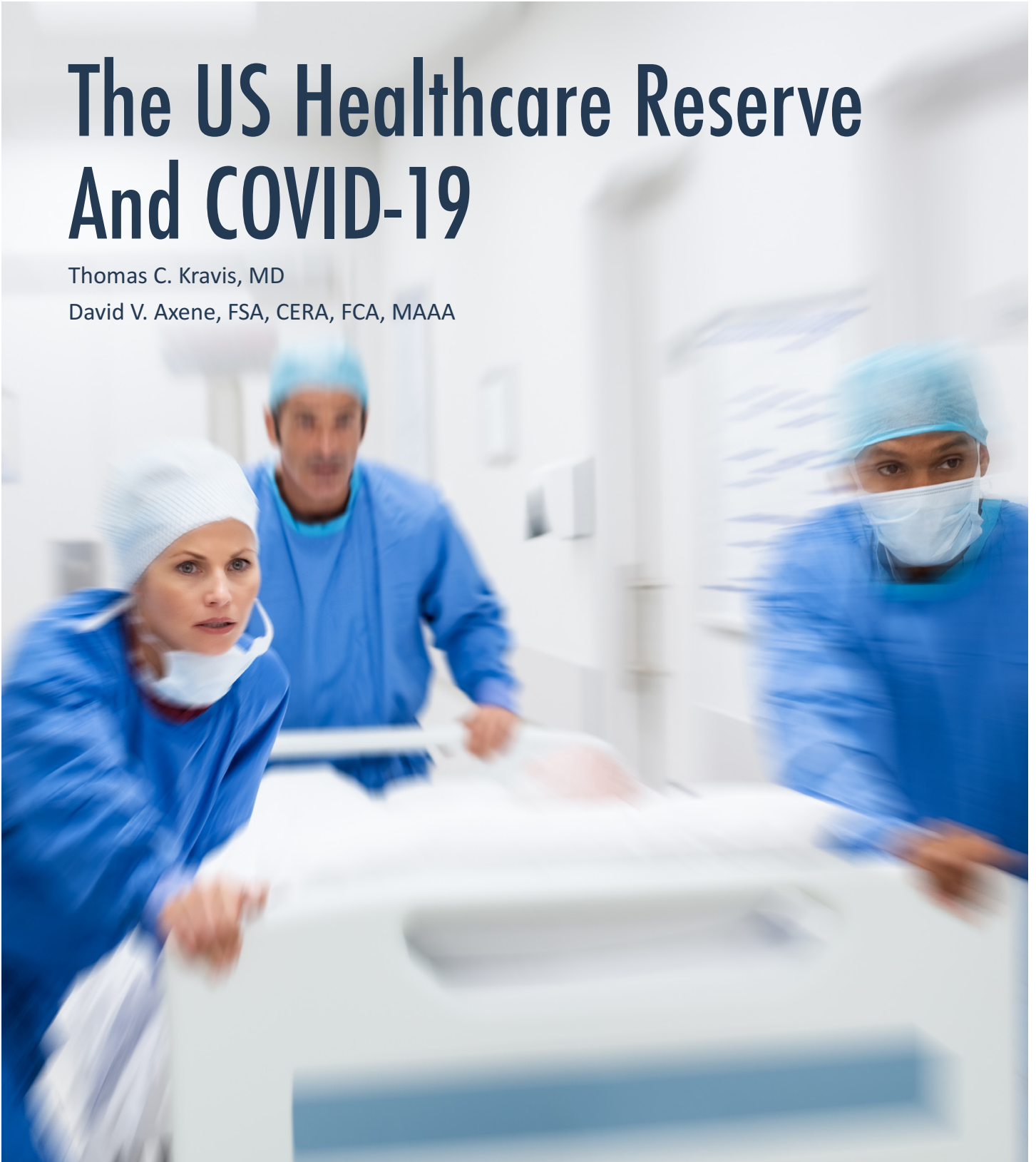


Inspire

The US Healthcare Reserve And COVID-19

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Much is being said in the news this week about the impact of COVID-19 and the potential surge in healthcare demand and the damaging impact this could have on our great US health care system. The government frequently references the value of strategic reserves that are “well managed” to maintain and protect our economy (i.e., petroleum, FEMA funds, medical supplies, etc.). However, there is barely a whisper about managing equally as well the resources available to meet the requirements of delivering necessary and safe quality medical care during this pandemic or those that may follow.

The critical 15-day period announced by the administration March 16th focuses on “flattening the curve” and protecting the impact on our health care system, particularly the surging demand for care. This would include hospital access, and in particular, would apply to elderly patients with underlying medical conditions that place them at high risk for inpatient care often requiring sophisticated care and perhaps intensive care beds with many of these patients needing respirators which may now be in short supply. Not to mention the additional need for specialists, nursing and support staff, and the fact that intensive care units (ICUs) are not uncommonly a venue where patients may experience more complications such as new infections associated with catheters; or that ICU survivors are 2-3 times more likely to die compared to age and sex matched controls.

We are now starting to hear conversations that suggest we should emulate China’s 10-day hospital construction projects as if new hospital construction would meet the expected surge while interspersed are questions as to what the US will do to protect access to hospital care.

Some of our immediate health care responses have been:

- Encouraging common sense behavior: hand washing, social distancing, and protecting high-risk individuals
- Implementing virtual and telehealth care: minimize face-to-face visits where possible
- National triage: if you are not sick with serious signs and symptoms, first call your doctor, but do not feel it is necessary to seek care in a health care facility or emergency department.
- Postpone elective medical procedures: wait if you can and if your doctor concurs but if there is a surge your elective procedure may not take priority and could be triaged for care at a later time.
- Increase supply where possible: order more ventilators and respirators, recruit former or retired health care workers—but little is said about the appropriate use of evidence-based guidelines to determine when to initiate assisted ventilator care and to transition patients to a less intensive setting hence making the length of stay shorter and making that ICU or other bed available for another patient.

Many of these efforts are focused on reducing health care system demand to free up supply and be able to meet the anticipated needs of the demand surge from COVID-19. However, these well-intended responses have ignored perhaps the most obvious tool at our disposal:

Increased access and capacity by eliminating or at least minimizing the potentially avoidable care already in our health care system by relying on the “experts”- i.e., using evidence-based decision support tools that have already been reducing unnecessary medical services over the past few decades.

This is our **“Unintended Strategic” Healthcare Reserve** that awaits discovery and immediate deployment before the surge hits us.

Most of our professional careers have been focused on improving the quality and efficiency of the health care system. During our combined 80 plus years of experience, we have had the privilege of serving clients both domestically and internationally. All of our clients were interested in how they could efficiently deliver high quality, cost-effective, patient-centered care. We have worked with some of the finest clinical minds and have helped develop some of the most significant evidence-based tools to accomplish this in today’s health care marketplace.

Recent national hospital utilization statistics show that on average 86 out of every 1,000 Americans are admitted to an acute care hospital and stay in the hospital an average of 4.6 days¹. Consulting assignments focused on the identification of potentially avoidable care based upon clinically sound evidence-based practice guidelines have demonstrated these utilization levels are higher than what could consistently be achieved in an optimally managed delivery system. Such delivery systems are expected to reduce the admission rate from 86 to 58 per 1,000, a 33% reduction in the admission rate. In addition, the length of stay would be reduced by 0.9 days, a 20% reduction. In total this would result in a 46% reduction in hospital use, freeing up substantial beds for use by other patients. Major health care organizations such as Kaiser Foundation Health Plan have achieved comparable results with their enrolled population. What does this mean? First of all, it suggests that one out of every three individuals in the hospital today shouldn’t be there. Also, they are staying almost an additional day longer than they need to be staying and other credible data suggests those additional days “in a bed” places the patient at increased risk for certain hospital-based complications. In total, these patients are often consuming nearly twice the level of resources clinically needed to provide appropriate care of their conditions.

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The reductions in inpatient care are achieved through the effective implementation of evidence-based clinical decision-making and are often related to safe, efficient, alternative venues of care including home, home health care, skilled nursing care and other ambulatory venues where quality outcomes and patient satisfaction have been observed. In fact, inefficiencies have also been identified across this continuum of care and patients, for example, may occupy a skilled nursing facility (SNF) for an admission and or a length of stay that does not meet evidence-based guidelines as discussed above. Improving similar efficiencies for care provided in SNFs also increases the capacity of the inpatient hospitals since patients can be transitioned from inpatient care to this and other less intensive levels of care hence increasing the inpatient bed capacity of the system.

Nationally we have over 900,000 staffed beds. The previous analysis suggests only about 54% of the patients in these beds are medically necessary (i.e., needed or appropriate), freeing up about 400,000 additional hospital beds to help meet the needs of the anticipated COVID-19 surge. From a resource planning perspective, we have almost twice the number of beds than occupied today. Instead of focusing immediate action to increase the supply of beds through bricks and mortar, action should be focused on eliminating the potentially avoidable and often unnecessary or not medically necessary care that exists in the system today.

Systemic inefficiencies permeate through all of today's health care system. The combination of implementing evidence-based care management initiatives and additional resources where possible should help resolve much of our supply needs without costly new construction. Perhaps we should focus on this harmful condition in our current system as we attempt to resolve our immediate COVID-19 concerns.

Endnotes

- 1 <https://www.cdc.gov/nchs/fastats/hospital.htm>

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