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The rapidly disappearing community pediatric inpatient unit

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Greed kills babies. Children's lives matter. Children over profit.

These were the slogans proclaimed by signs carried by protesters outside of MedStar Franklin Square Medical Center in Baltimore in early May of 2018 to protest the closure of the dedicated pediatric emergency department and inpatient pediatric unit.

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But administrators at Franklin Square Medical Center had made their decision long before the glue had dried on the signs, and the protests of patients and community officials fell on deaf ears. Eight doctors and 30 other staff had already lost their jobs, including the chair of pediatrics, Scott Krugman, MD.[1]

And this was just another drop in a slow ooze of pediatric inpatient units based in community hospitals that have seen the ax fall on what was thought to be a vital medical resource for their communities – yet not vital enough to survive its lack of profitability. From Taunton, Mass., to Chicago, Ill., to rural Tennessee, pediatric inpatient units in community hospitals have failed to even flirt with breaking even, let alone show profitability. Many community pediatric inpatient units are saddled with rock-bottom reimbursements offered by state Medicaid programs, the overwhelmingly prevalent payer for pediatric hospitalizations, which is compounded by the seasonality and unpredictability of pediatric inpatient volumes, so many have seen a glowing red bottom line lead to their demise.

What does this mean for pediatric health in underserved and rural communities? The closure of the pediatric inpatient unit at MedStar Franklin Square Medical Center meant the loss of physicians and nurses staffing the child protection team helping to assist the local district attorney in child abuse

cases. Sometimes described as "secondary care," community pediatric hospitalists also serve as a link between primary care providers and tertiary care subspecialists; they can serve as pediatric generalists throughout a hospital and provide newborn nursery care, delivery room resuscitations, ED consultations, procedural sedations, psychiatric unit support, surgical comanagement, and informal or formal outpatient consultations.[2] Losing even a small inpatient pediatric unit can have a ripple effect on inpatient and outpatient pediatric services in a health system and community.

For patients and their caregivers, the loss of pediatric inpatient services in their community hospital can erect additional hurdles to appropriate health care. The need to travel longer distances to urban centers or even the other side of town can be challenging given the difficulties posed by long distances, traffic congestion, public transportation, or just parking.[3] For patients suffering from longer hospitalizations caused by medical complexity or chronic illnesses, traveling long distances can exacerbate the caregiver stress from attempting to care for a family at home while participating in the care of a hospitalized child. Longer travel times can also worsen family stress by increasing a caregiver's absence from home and increased nonmedical expenses, not to mention loss of wages.[4] Comfort levels with inpatient providers can also suffer because most pediatric units in community hospitals are staffed by either community general pediatricians or very small pediatric hospitalist groups, which breeds familiarity with frequently admitted patients and their caregivers. This familiarity can be lacking in large academic centers, with confusing and ever-rotating teams of academic hospitalists, residents, and medical students.[5]

What is driving the slow drumbeat of pediatric inpatient unit closures? On a macroeconomic scale, pediatric hospitalizations have been dropping yearly, driven down by immunizations (despite the best efforts of certain celebrities), antibiotic stewardship, and improved access to outpatient care. In 2006, there were 6.6 million hospitalizations for children aged 17 years and younger,[6] but by 2012 this had dropped to 5.9 million hospitalizations.[7] In the same age group, the rate of hospitalization from the ED dropped from 4.4% in 2006 to 3.2% in 2015.[8]

On a hospital level, the presence of multiple small pediatric units in a region may not make sense from a cost standpoint, and a larger, merged unit may provide higher quality because of its higher volumes. On a state and local level, alternative payment models have been implemented with the best of intentions but have led administrators at community general hospitals to look at pediatric units as the lowest hanging money-losing fruit in their efforts to survive a brave new world of hospital payment.

The most extreme (or advanced, depending on your viewpoint) model is in Maryland: Since 2014, acute care hospitals have been only able to receive a fixed amount of revenue from all payers, including Medicare, Medicaid, and commercial insurers.[9] Known as an all-payer global budget, it incentivizes lowering unnecessary costs of care, such as readmissions, but also encourages cauterization of cost centers hemorrhaging money – such as inpatient pediatrics. Even the venerable Johns Hopkins

Children's Center has seen its profitability pale in comparison to the expansion team Johns Hopkins All Children's Hospital in St. Petersburg, Fla., which is the second-most profitable hospital in the Hopkins system, only edged out by Sibley Memorial Hospital – which also sports an out-of-state location in the District of Columbia.[10]

But all hope is not lost for your comfy local pediatric inpatient unit. In other states and regions where a more favorable (to hospitals) payer mix exists, large pediatric hospitals are still engaged in turf battles with other local competitors to grab market share. In these regions, community pediatric units have survived by partnering with large pediatric institutions, either through affiliations or wholesale transplantation of the larger pediatric institution's providers, nurses, and EHRs into essentially what is a leased floor. In addition, large pediatric institutions that participate in capitated models such as accountable care organizations have paradoxically found it financially favorable to direct "bread-and-butter" pediatric hospitalizations to community pediatric units, which often provide the same care at a lower cost.

Utilizing community inpatient pediatric units was "initially ... a means of expanding their market share and 'downstream' revenue from transfers, but more commonly now [is] a way of alleviating the costs associated with admitting low to moderate acuity patients to the main tertiary sites," said Francisco Alvarez, MD, associate chief of Regional Pediatric Hospital Medicine Programs at Lucile Packard Children's Hospital in Palo Alto, Calif. "The cost of care provided by pediatric hospitals has always been higher than the average cost for nonpediatric hospitals in regard to caring for pediatric patients due to their highly skilled specialties and services. These have become more scrutinized by private and government insurance plans and, in some cases, have led to lower reimbursements and therefore a lower or deficient net revenue for certain patient populations."

For community pediatric hospitalists, the shifting sands of reimbursement on which pediatric inpatient care is built can be a motion illness–inducing experience. In addition to concerns over community health care, job security, and population health, care provided in community hospitals can often be subtly undercut by tertiary and quaternary care pediatric hospitals.

"The focus of pediatric residency programs in freestanding children's hospitals has created a situation where new pediatricians have less opportunity to develop respect for community pediatric hospital medicine," said Beth Natt, MD, director of pediatric hospital medicine in the Regional Programs at Connecticut Children's Medical Center, Hartford. "We are the nameless 'OSH,' the place that gets 'Monday-morning quarterbacked' in resident morning reports without having a voice at the table. Add this to residents learning 'only' protocolized care as opposed to a spectrum of appropriate care, and we create a culture of 'wrong and right' with the backward nonprotocol driven community docs looking like they are practicing medicine in the Wild West."

What's a community pediatric hospitalist to do, faced with an uncertain future and diminishing respect? Continuing to partner with local pediatric providers, community leaders, and local health care advocacy groups will help to enmesh inpatient providers in the fabric of a community's health care. But making the value case to hospital administrators is critical for community pediatric hospitalists, as adult hospitalists realized soon after the inception of the hospitalist field.

Goals valued by hospital administrators are pursued on a daily basis by community pediatric hospitalists, and these successes need to be brought to light. Achieving value and quality metrics, pursuing high-value care, reducing readmission rates, championing EHRs, and improving documentation are goals that community pediatric hospitalists and hospital administrators can work toward together.[11] By pursuing and sharing success in meeting these shared goals, perhaps the local community pediatric inpatient unit can survive – and thrive.

As for Dr. Krugman, he has moved on and is soon to be gainfully employed again. But he continues to be focused, as always, on the health of his patients.

"What are we going to do to take care of kids in their own communities?" Dr. Krugman asked. "It's going to be an increasing challenge over the next decade due to the consolidation of children's hospitals and low payments, especially for hospitals that are adult-focused. Unless we find a way to pay for pediatric care as a country."

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