2022 Clinical Challenges in Hospital Medicine
May 11-14

Team Strategies for Inpatient Care Efficiencies

Robert G Good, DO, MACOI
Carle Foundation Hospital
Professor of Internal Medicine-CICOM

Carle Illinois
COLLEGE OF MEDICINE

Disclosures

NONE

The Problem

- Entire health care system is under major financial stress
  - Hospitals
  - Clinics
  - Nursing homes
  - Independent providers
  - Insurance companies

ACOI

Payer changes

- Reduce fee for service
- Medicare reductions
- DRG payments
- Capitated care
- Payer mix shift
  - Increased Medicaid-MCO
  - Increased Medicare Advantage
    - Decreased Medicare
- Decreased insurance
- Increased SELF pay

ACOi

Health care system solutions

- Improved efficiency
- Create systems – combine physicians/hospital
- Increased risk sharing arrangements
- EMR updates
- Hospital at Home
- Hospitalists

ACOI

“The strength of the team is each individual member. The strength of each member is the team” – Phil Jackson

ACOi

Everybody is on the TEAM

While we are all thinking of nursing, therapy
Services, advanced practice providers,
Case management
– let's think of others that may not be traditionally
Considered.

Social Work

- Critical to evaluate social determents
- Offers a softer side of medicine

Specialty Physician Services

- Avoid unnecessary consultations
  - Add to delays in discharge
  - Often complicates hospitalizations
- Increases expenses
  - Increases testing – "one more test"
    - Then why did I order it
- Confuses patients

You are not a referral machine but an internal medicine attending physician

Diagnostic testing – MRI/CT/PET/colonoscopy/etc.

- Obtain as outpatient when result will not change hospital care
- Increases cost to system – DRG payment does not pay
  - Probably reimbursed as outpatient
- Increases length of stay
- Non-clinically significant incidental finding

Post Acute Care

- Nursing homes
  - Skilled
  - Custodial
- Long Term Acute Care hospitals (LTAC)
- Rehabilitation Centers
- Transition Care Clinics
- PCMH

- Medicare A-hospital/Skilled care; pay by DRG or per diem; paid by Medicare Taxes in employment
- Medicare B-physician services; Fee for service; paid by premium by patient
- Medicare C – Medicare Advantage; premiums
- Medicare D - Pharmacy

Skilled Nursing Predictor

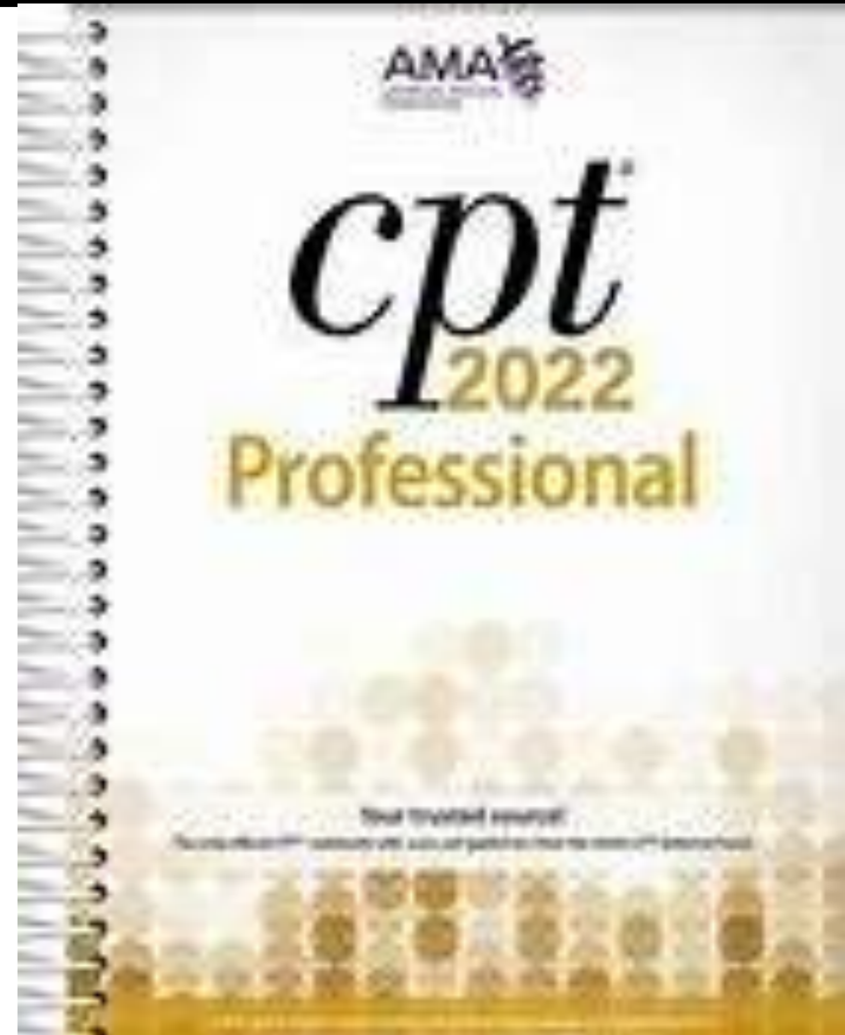
Skilled Nursing Care Calculator

Criteria	Score	definition
Can tolerate daily skilled therapy		1-cannot tolerate therapy; 3-tolerates 2-3 days/wk; 5- 4 days; 9-10-full 5-7 days
Have cognitive ability		10 normal to 1 or advanced dementia
Motivation		10 highly motivated to 1 no interest
Significant change in level of function		10 major change to 1 or no change
Unable to ambulate 40 feet		0-unrestricted ambulation; 5 - 30-50 ft; 10 no ambulation
Needs greater assist than contact guard		0- unrestricted ambulation 100% to 5- contact guard 50% of time to 9 -90% CG
Complex Wound care intensity		0-no dressings; 10-multiple daily dressings require RN
Wound vac		0- no wound vac; 10 + wound vac
Multiple IV therapy		0- no IV; 10- 2 or greater IV infusions requiring RN care
CADD pump		0-no CADD; 10-Cadd pump
New Ostomy, g-tube, trach		0-no tubes; 10-new tubes
Can care giver take care of ostomy,gtube		0-caregiver capable; 10-caregiver not capable
Hospice or palliative care		1-hospice ; 2-5-various levels of Palliative care with limited rehab potential; 7-10 high potential for improvement
PT needed daily		10- PT needed >4 days/wk; 1-PT <5 days
CMS TOTAL	0.0	
Readmission potential	0.0	0.0
TOTAL Score	0.0	**A score of > 45 generally meets criteria**
Hb < 12 gms at discharge		1=Yes; 0 = No
Oncology Service		1=Yes; 0 = No
Sodium < 135 at discharge		1=Yes; 0 = No
Procedure performed during hospital		1=Yes; 0 = No
Admission type		1= Urgent/Emergent; 0 = elective
Number of hospitalization previous year		1= 0-1; 2=2-5; 3= >5
Length of stay > 5 days		1=Yes; 0 = No
		% of readmission

ACOi

Get the right CPT code

- For office and outpatient services, selecting CPT codes will depend solely on:
- **Medical decision making (MDM) as defined for each service.** The AMA provides extensive clarifications in their guidelines to help define the elements of MDM OR
- **Total time spent on the date of the encounter.** This includes non-face-to-face services. Make sure you know the time ranges for each code.



Medical Decision Making

Problem Complexity

- Number of issues
- Acute vs chronic
- Risk of Mortality / Morbidity

Data reviewed

- Diagnostics
- Consultations
- Chart review
- Imaging

Shared Decision Making

- Alternatives of care
- Social & cultural components

MEDICAL DECISION MAKING	Description
Problem Complexity	
• Issues or Diagnosis	@PROBDIAG@
• Mortality/Morbidity	***
DATA	
• Laboratory	***
• Consultations	***
• Chart Review	***
• Images/Radiology	***
Shared Decision Making (SDM)	
• Alternatives of Care	***
• Social / Cultural Components	***

SUMMARY	***

Pharmacists

ACOi

- Discharge reviews to reduce error rate
  - 25% of hospital readmissions related to medications
  - Duplications
  - Beers list
  - Reduce polypharmacy
  - Patient education
- Clinical follow up
  - Hypertension, diabetes, anti-coagulation, COPD, CHF

Patient Centered Medical Home

- Ambulatory team that services a center for primary care
- Involves social work, nursing care management, monitoring
- Likely has a registry of chronic disease patients to monitor and follow up.

IT – EPIC – Cerner - Meditech

ACOi

- Improved efficiency of EMR systems
- Plan sessions with educators to improve your function and understanding of the benefits of EMR

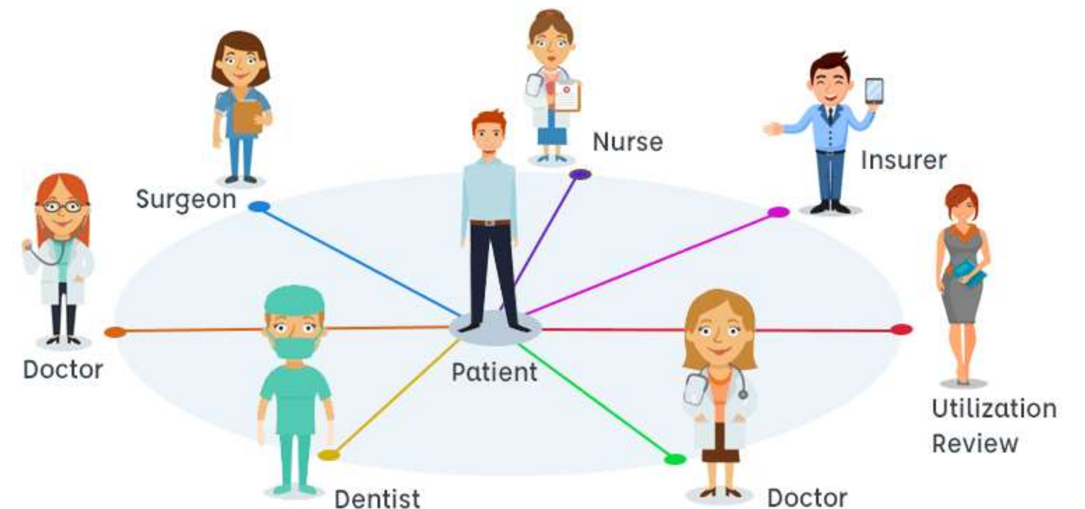
Insurance – including MCO (Medicaid) Medicare Advantage

- Great resource that the patient is already paying for
- Often forgot
- Case management
- Difficult placement
- Follow up support – approvals for specialty services, CHF/Diabetes monitoring, etc.

- They are part of the team to support your patient

THE PATIENT

- Patient-Centered Care
- Shared Decision Making
  - Many options and alternatives to care
  - Each patient situation is unique



THE HUDDLE – White Board Rounds

- Experience with Team
- Time to share information, focused on discharge
  - 90% of health care occurs in the ambulatory world

ACOi

CASE STUDY – DAVID 78 y/o male

- Progressive chest pain – radiation to neck
- History of moderate-severe aortic stenosis
- Change in mental status & gait – abnormal outpatient MRI showing microvascular disease
- Diabetes, Coronary disease (prior stent 7 years ago) & Hypertension
- ASA 81 mg; Carvediolol 3.125 mg BID; linagliptin 5 mg QD; Metformin 1000 mg BID; Tamulosin 0.4 mg HS; Atorvastatin 20 mg HS; HCTZ 25 mg QD

David's Team in prep for discharge

- Pharmacists to review medications and see patient in clinic in 2 days since Amlopidine was stopped during hospitalization
- PCMH – primary physician will see 7 days – Care manager already had conversation with inpatient case manager about chronic care management.
- Medicare Advantage Case Manager involved with diabetes care and getting time with dietician
- Therapy services will be working on gait and balance

ACOi

"Teamwork is the secret that makes common people achieve uncommon results" – Ifeanyi Enoch Onuoha

ACOi

2022 Clinical Challenges in
Hospital Medicine