

The Hospitalist Steward

Rick Greco DO, FACOI

Challenges in Hospital Medicine

March 24, 2017

Disclosures

- I'm from West Virginia
- Regional Medical Director with Sound Physicians
- Married off 2 daughters last year and still paying for it



Objectives

- Talking points for hospitalist value proposition
- Understand real dollar impact of LOS and CMI, and observation days
- Concepts of risk adjusted payment system
- Metrics driving direct revenues for our hospital partner
- Future compensation models
- Bundled care payment initiative

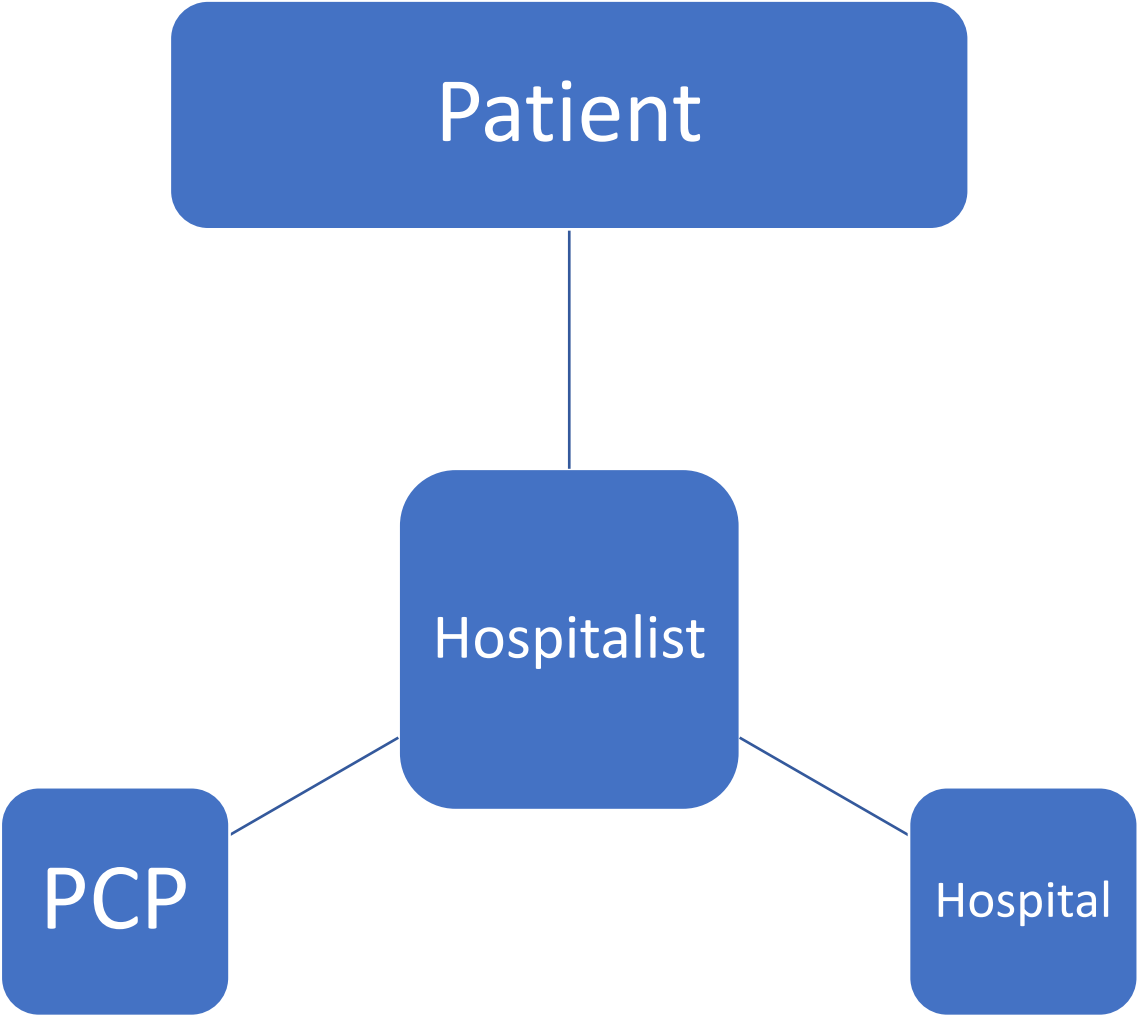
Doctor

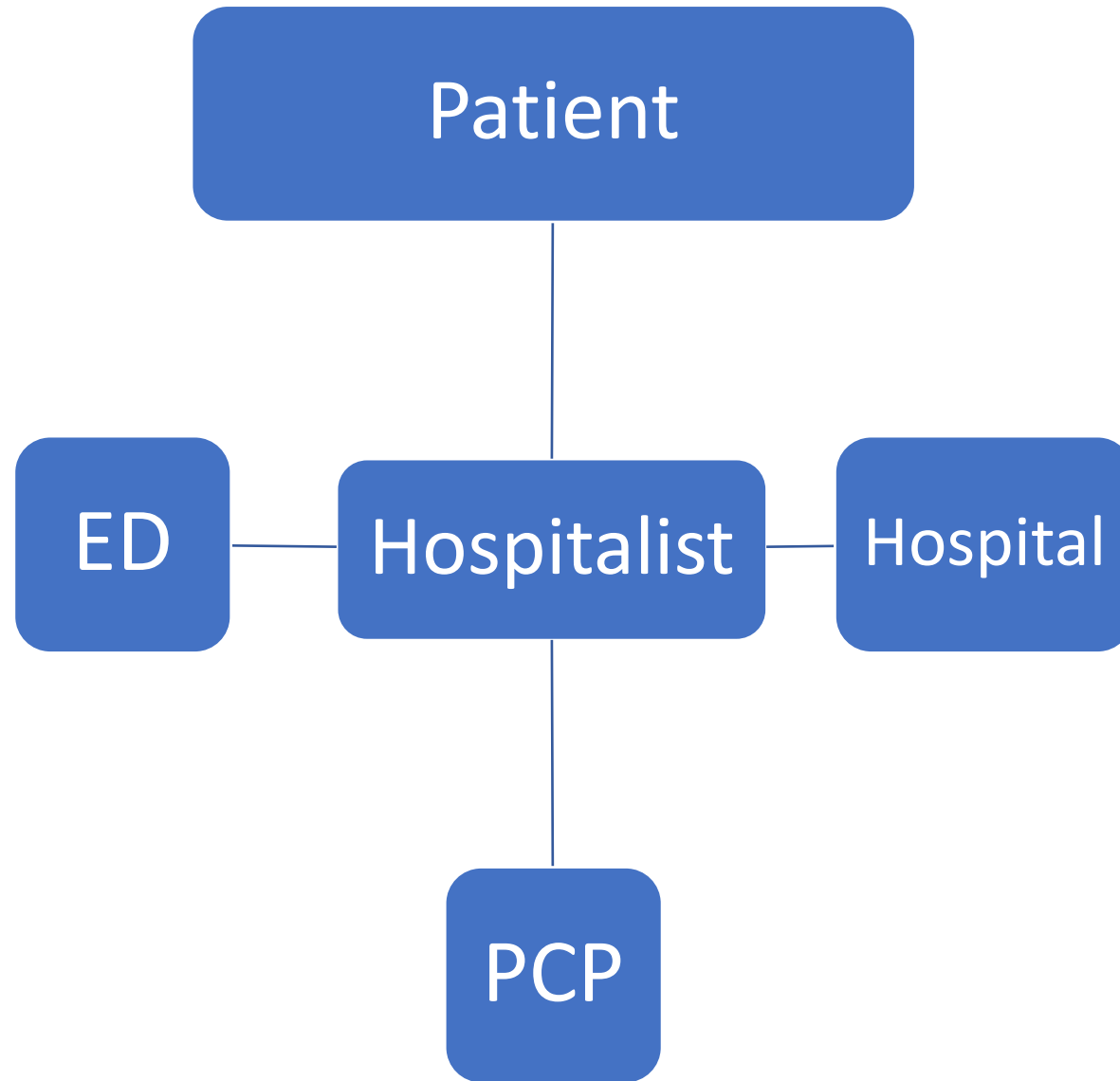
Patient

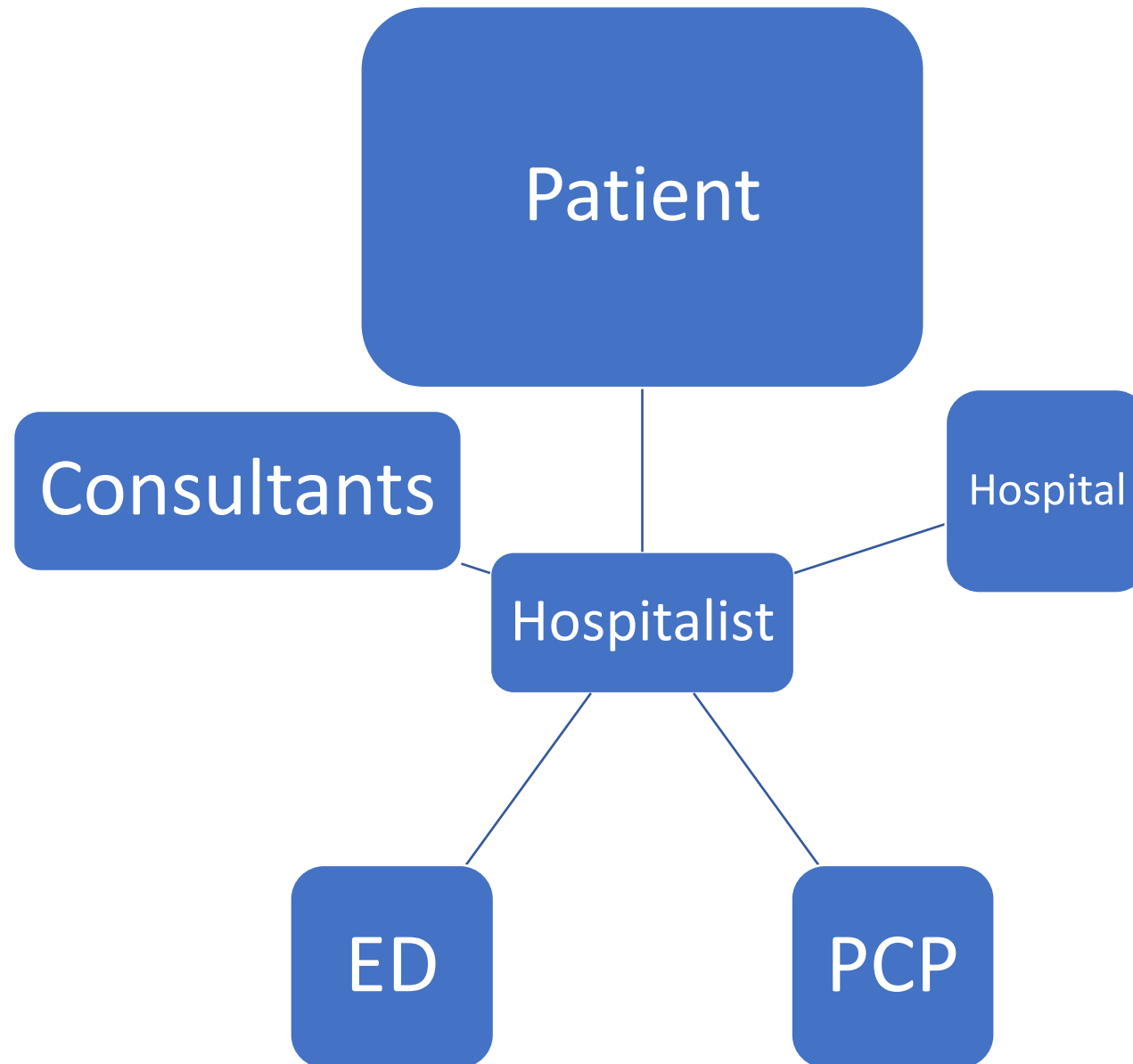
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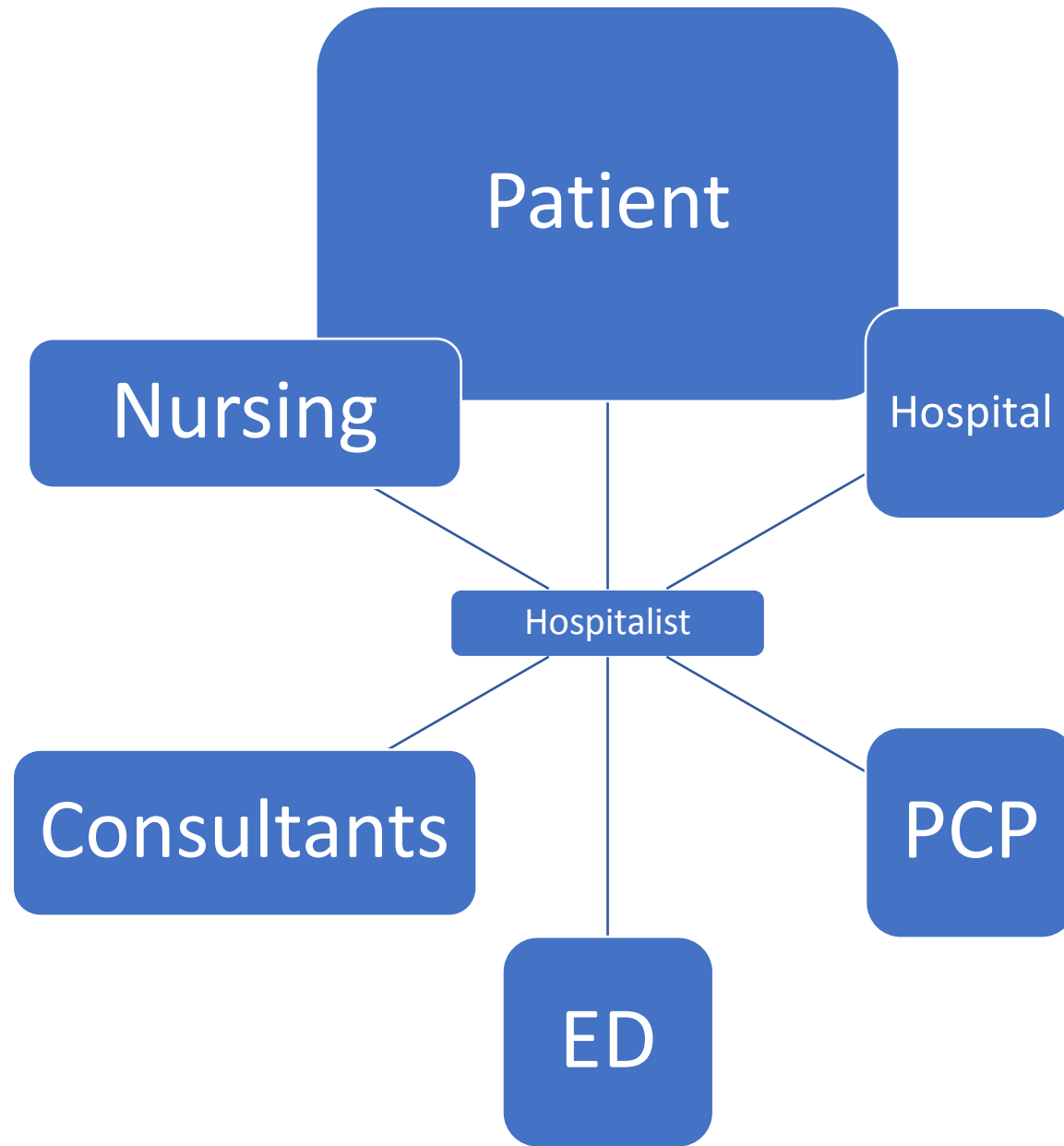
Hospitalist

Hospital







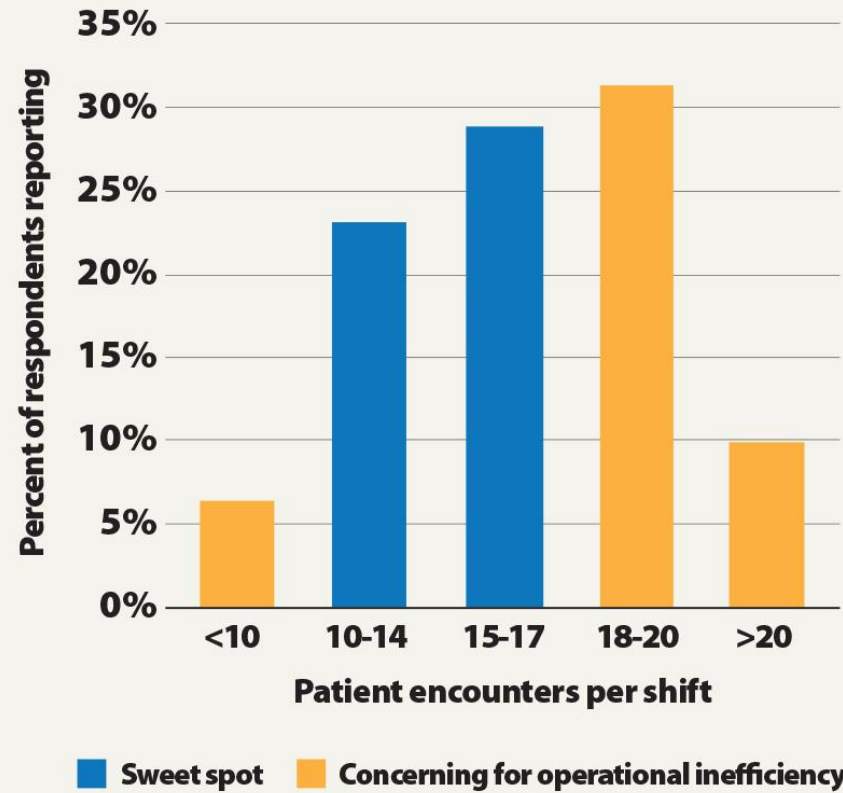


Hospitalists are not cheap dates

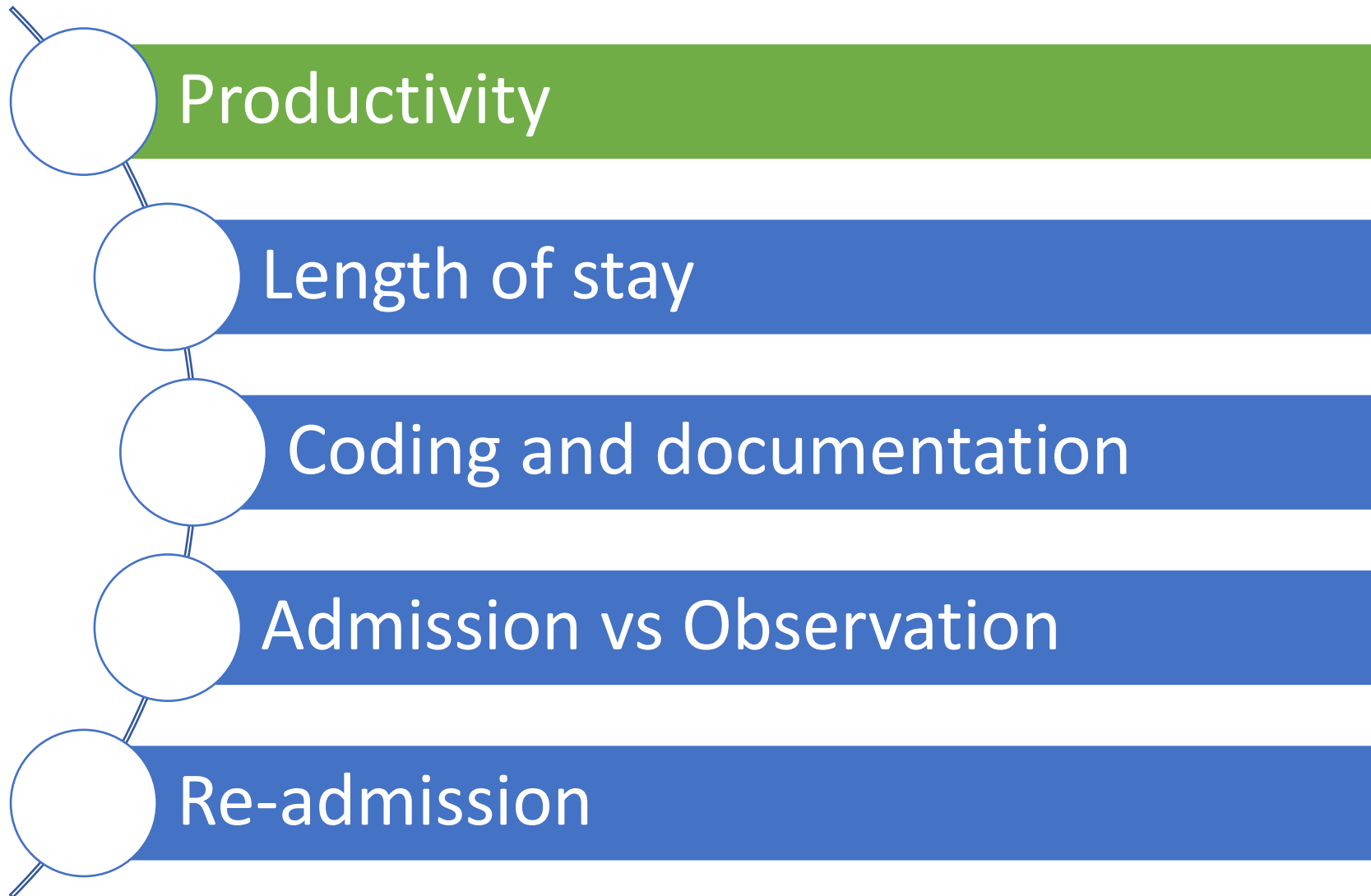


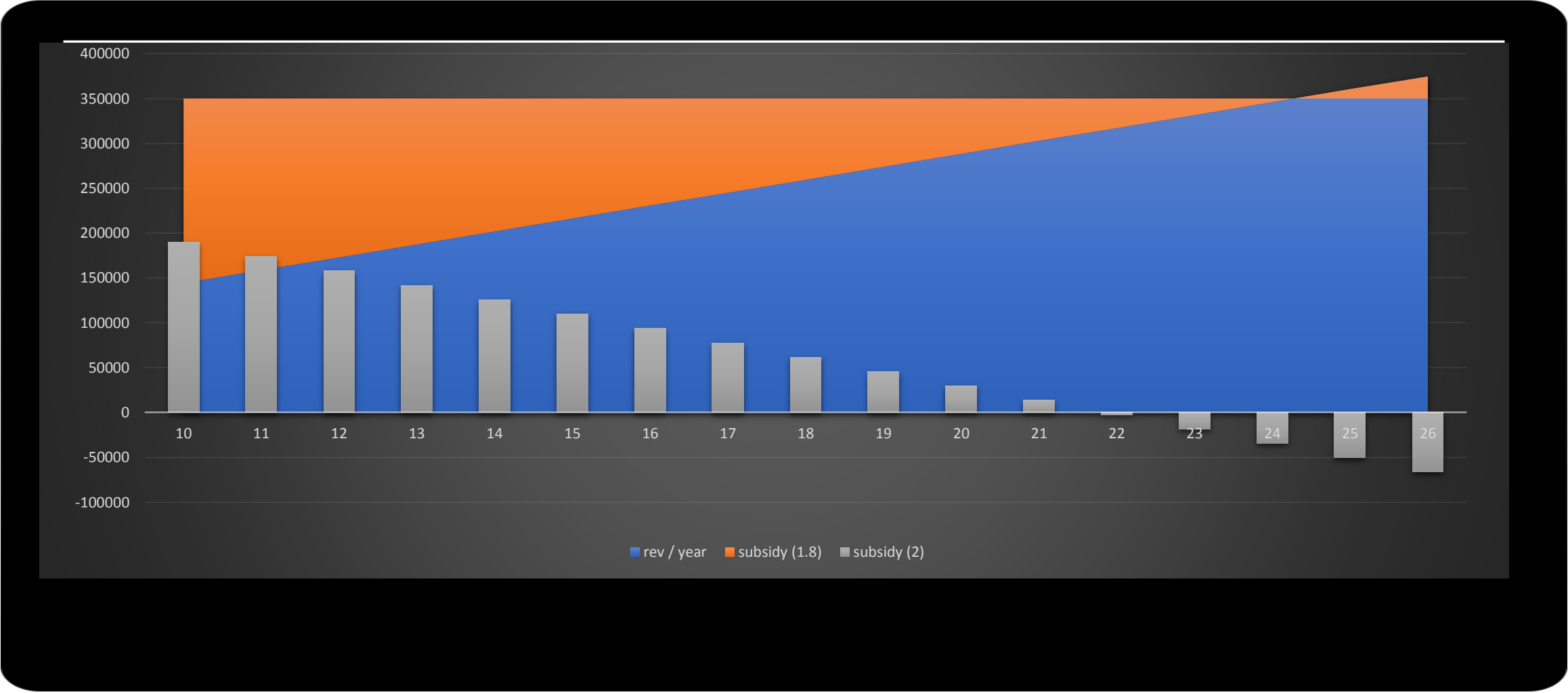
Number of patient encounters per shift

In the chart below, the blue columns include the sweet spot (10.2 to 15.4 encounters per day) for operational efficiency, assuming a median salary (per MGMA) of \$254,000 per year.



Sources: 2016 Today's Hospitalist Compensation & Career Survey
MGMA Physician Compensation and Production Survey: 2014 Report
Based on 2013 Data





RVU

• Admit codes	RVUs
• 99222	2.61
• 99223	3.86
• Follow ups	
• 99232	1.39
• 99233	2.00
• Discharges	
• 99238	1.39
• 99239	1.90

Provider revenue drivers

- RVU = 44\$
- Average RVU / Encounter 1.86
- Average RVU / Year 4106
- Average encounter/ year 2208 (13/day)
- Revenue of 180 K

Work load example

Hospitalist A

- 3 admits
 - 99222 (2.61) 7.83
- 12 follow ups
 - 99232 (1.39) 16.68
- 3 discharges
 - 99238 (1.28) 3.84
- Total RVUs 28.35 rvus
- Total revenue \$1,247

Improved E/M coding impact

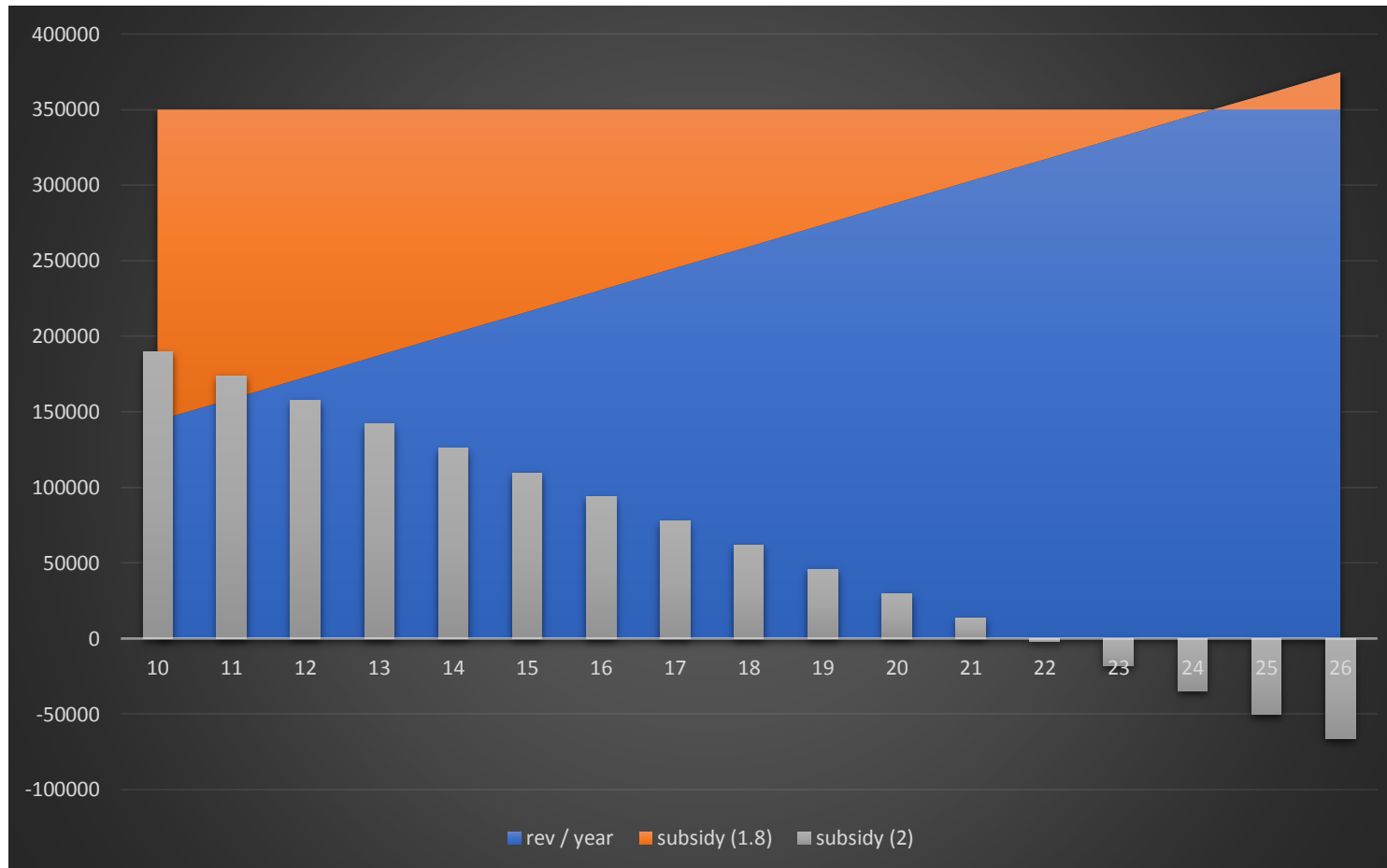
Hospitalist A

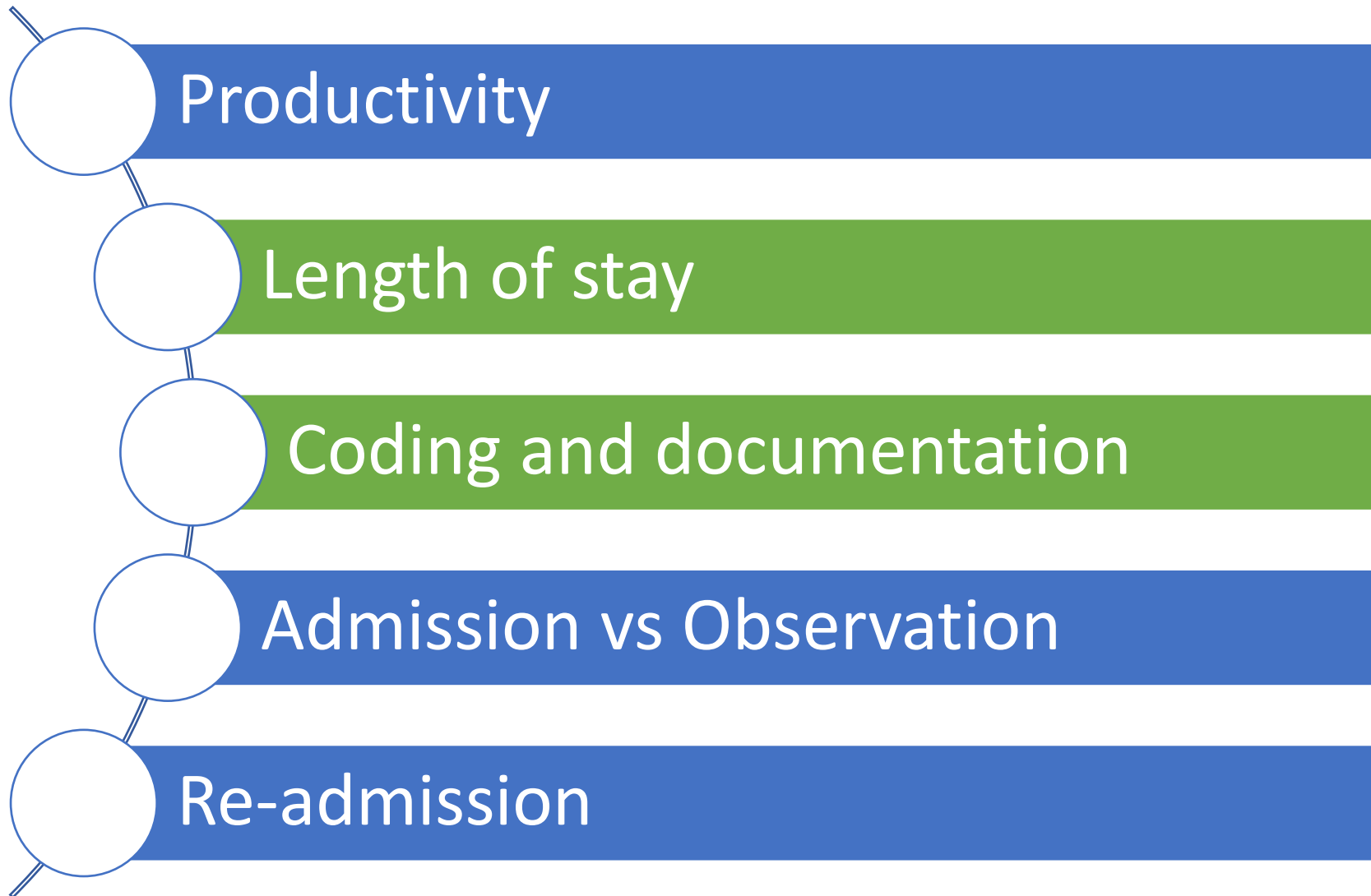
- 3 admits
 - 99222 (2.61) 7.83
- 12 follow ups
 - 99232 (1.39) 16.68
- 3 discharges
 - 99238 (1.28) 3.84
- Total RVUs 28.35 rvus
- Total revenue **\$1,247**

Hospitalist B

- 3 admits
 - 99223 (3.86) 11.58
- 12 follow ups
 - 6x 99232 (1.39) 8.34
 - 6x 99233 (2.00) 12.00
- 3 discharges
 - 99329 (1.90) 5.70
- Total RVUs 37.62
- Total Revenue **\$1,655**

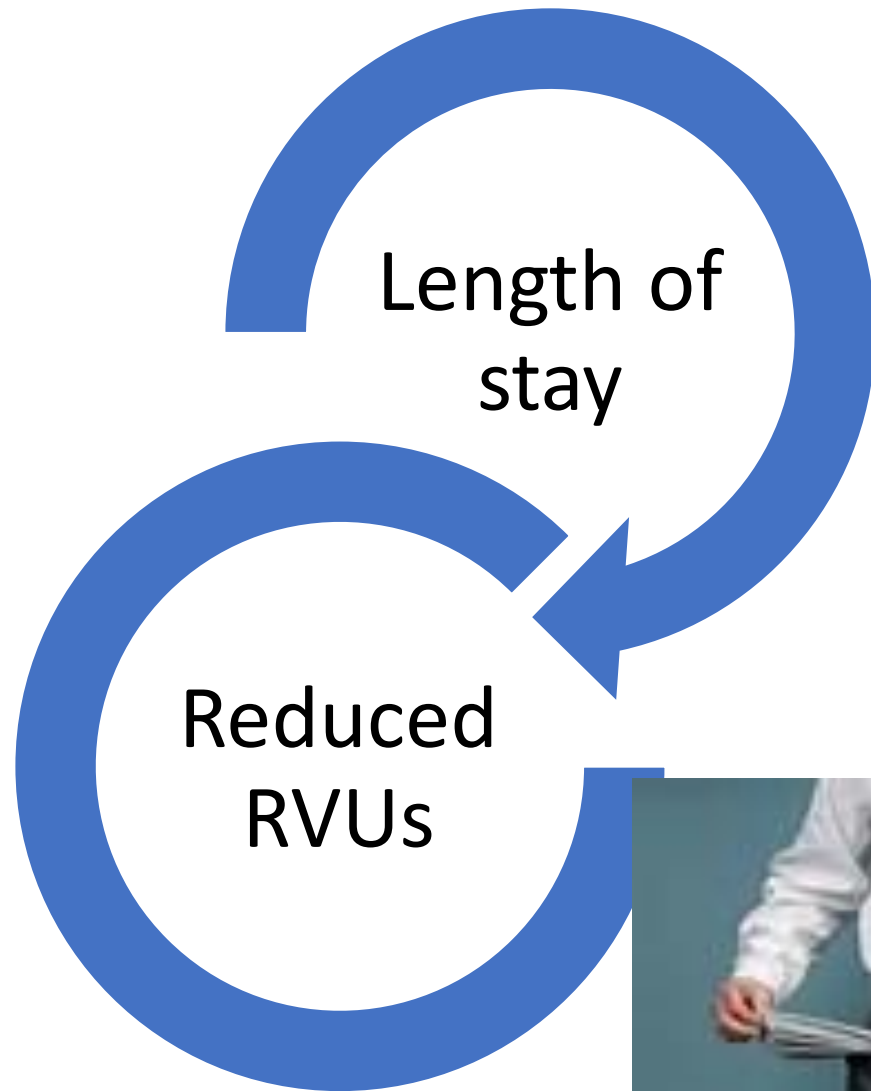
Subsidy vs revenue





LOS:CMI







Discharge before 11 AM

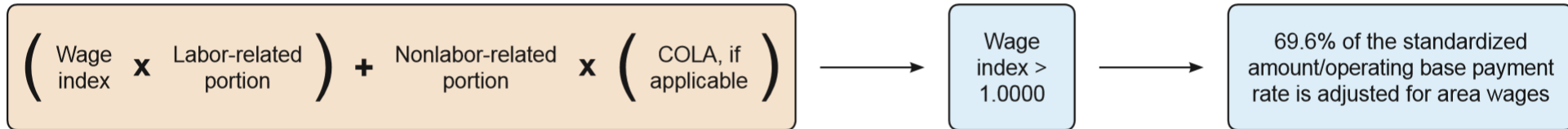


What are the numbers ?

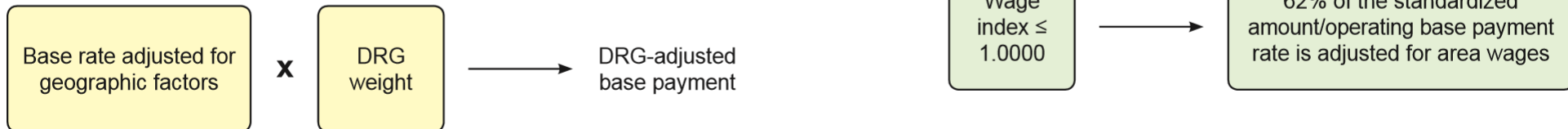
- What is your hospital's base rate ?
- Daily cost of care
- Average CMI
- Length of stay

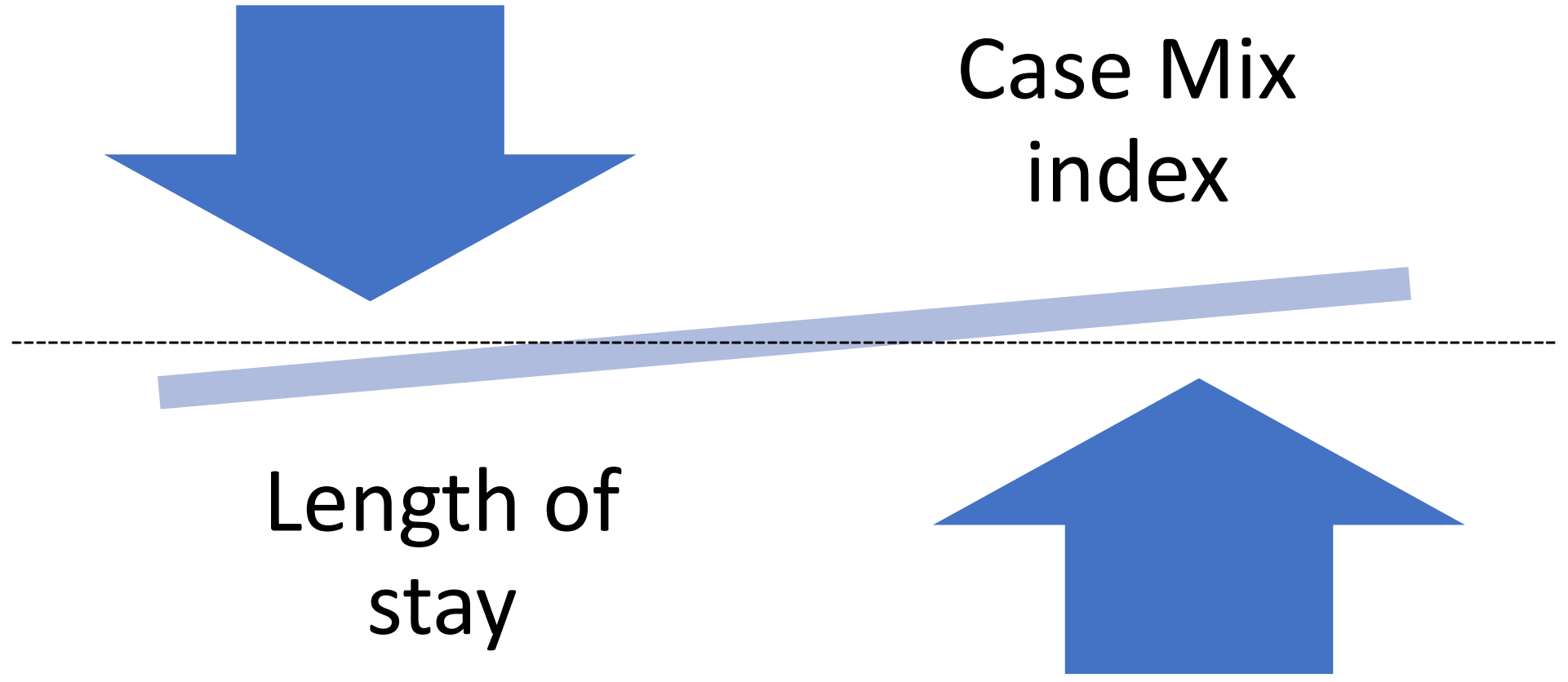
Acute Care Hospital Inpatient Prospective Payment System: Operating Base Payment Rate

Adjusted for geographic factors

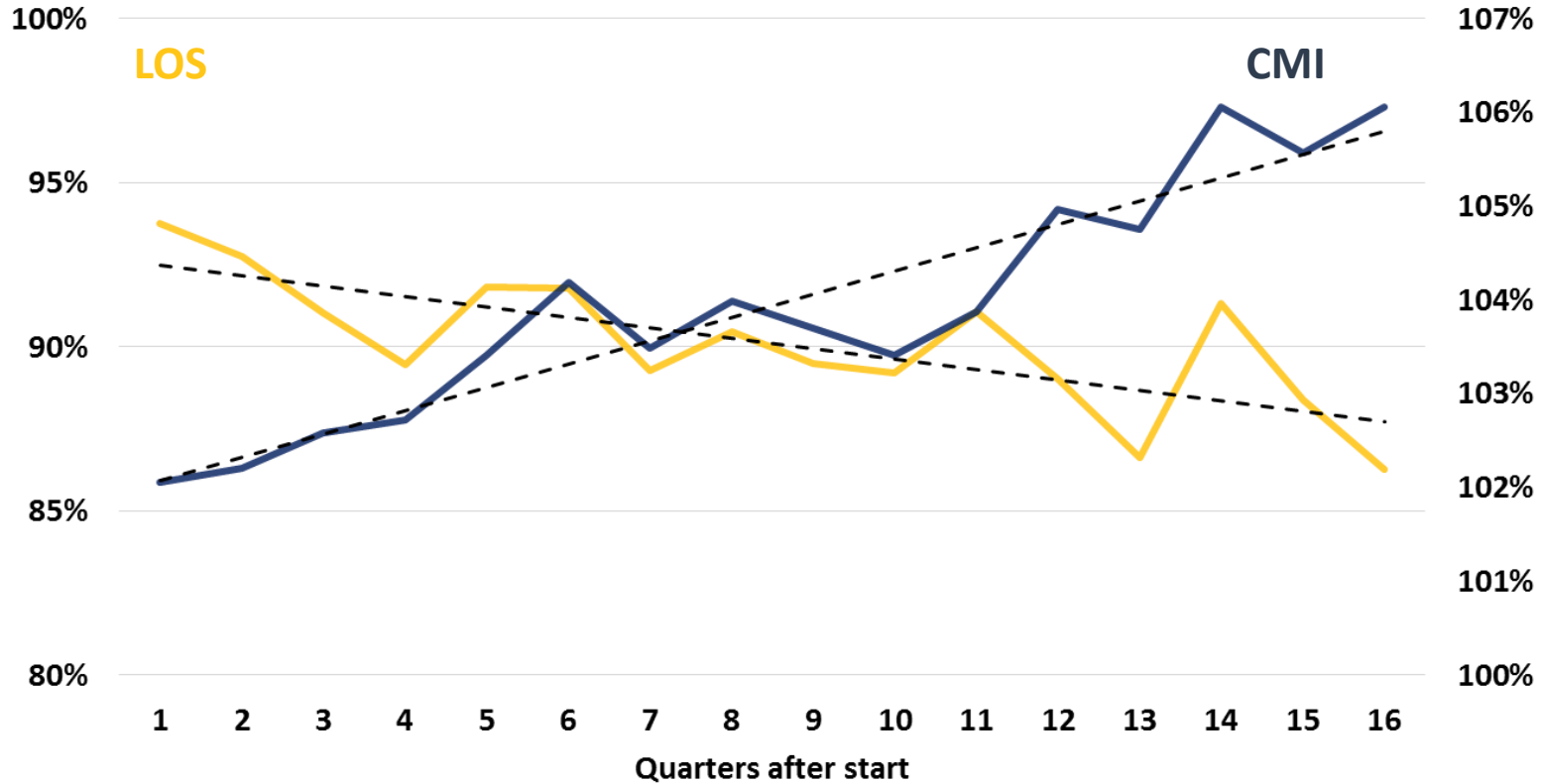


I. Adjusted for case mix





CMI/LOS Trend Post-Implementation (% of HCUP) All Sites After Jan 2011



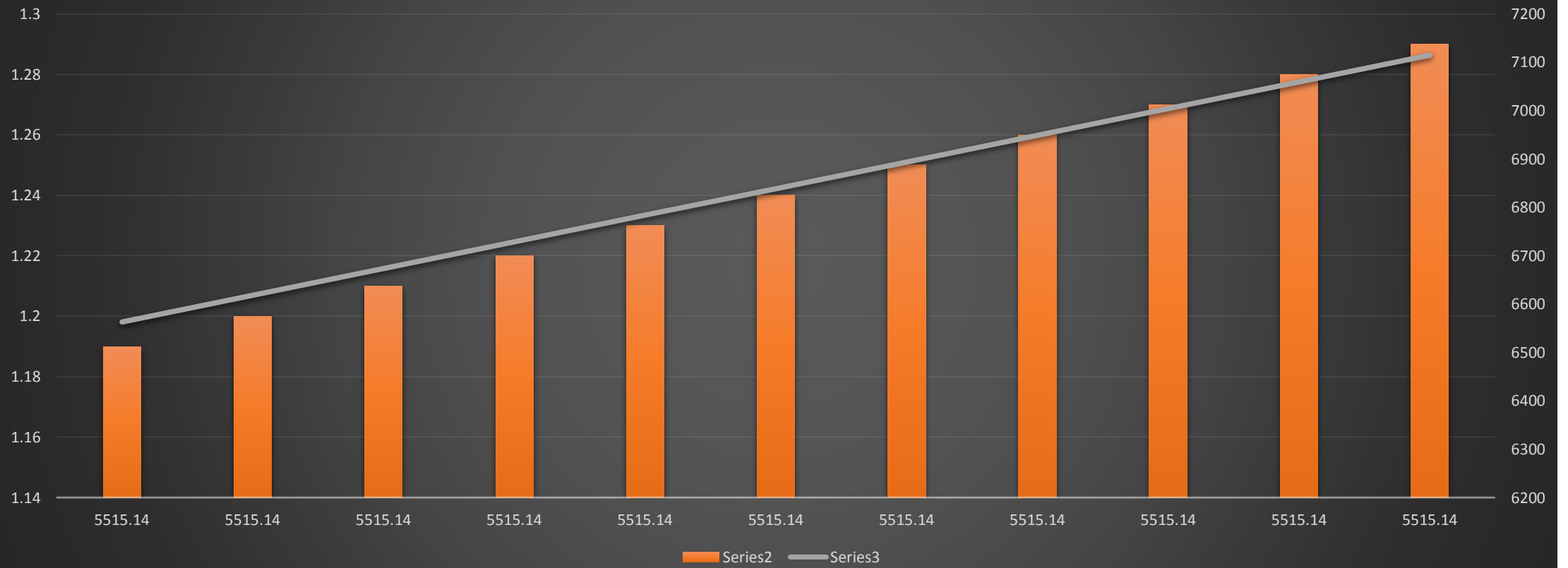
CMI

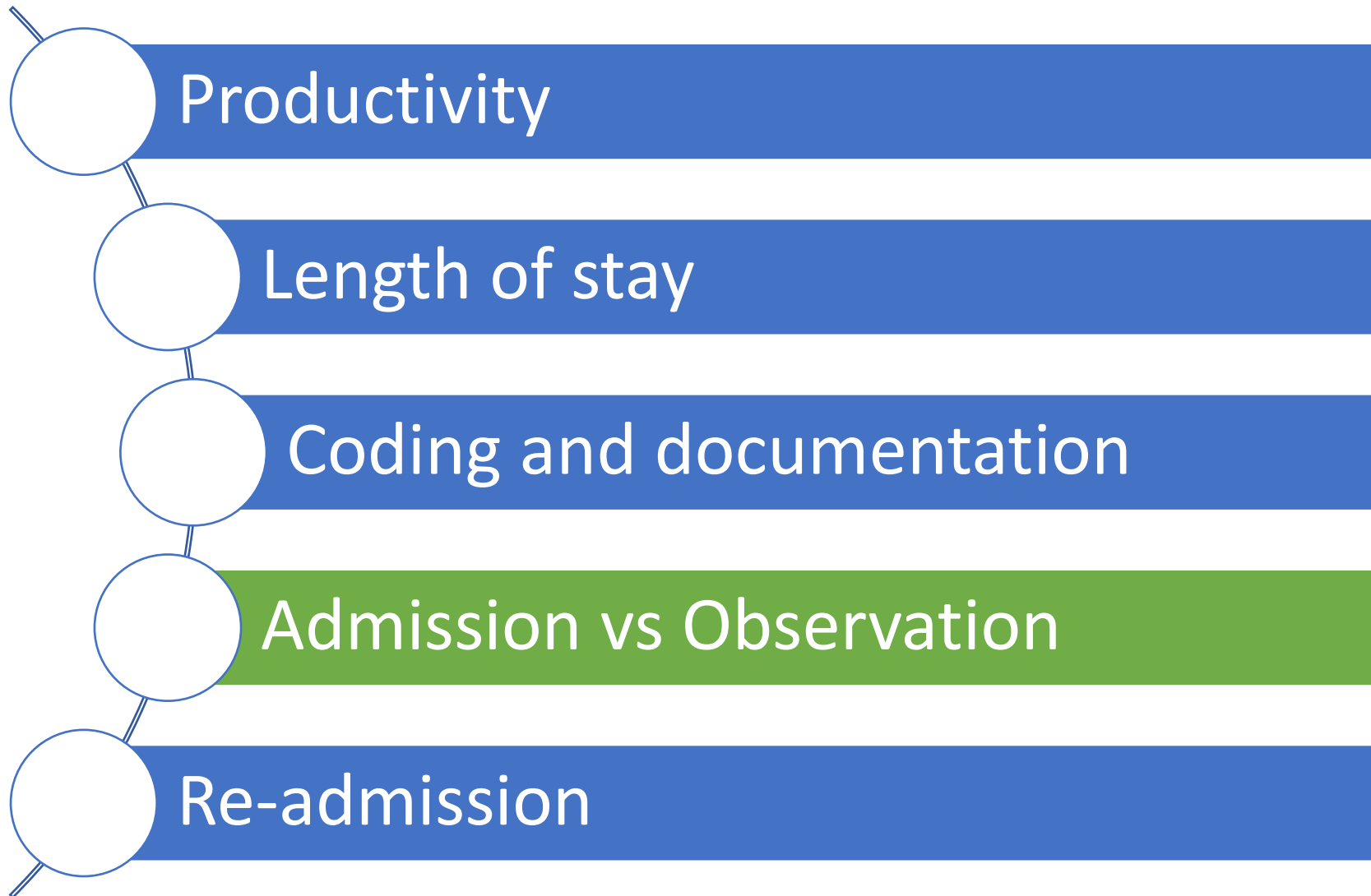
- Small changes = Big difference for hospital partner
- DRG
- MS-DRG
- MC
- MCC
- Know how to calculate your impact
 - Base rate x CMI

Partner education ...

- Be an internist
- More specific with dx the better
- Educate the team on basic MCC and CC especially common in your patient population
- Coders are your friends not the enemy
- Low hanging fruit
 - Chf
 - Respiratory failure
 - Obesity vs Morbid Obesity
 - AKI vs acute renal failure
 - Uncontrolled DM
 - Pathologic fracture ?
 - HCAP

Chart Title





Observation challenge

Hospital a 2,555 admits with 40 % obs rate

Admit to IN patient

- 1533
- \$ 7,000 average revenue
- \$ 10,731, 000

Admit to OBS

- 1022
- \$ 2,500
- \$ 2,555,000

Observation impact

Hospital a 2,555 admits with 40 % obs rate after shift of 20% reduction
40 % reduced to 32 % generated 1.2 M

Admit to IN patient

- 1737
- \$ 7,000 / case
- \$ 12,159,000

Admit to OBS

- 817
- \$ 2,500 / case
- \$ 2,042,500

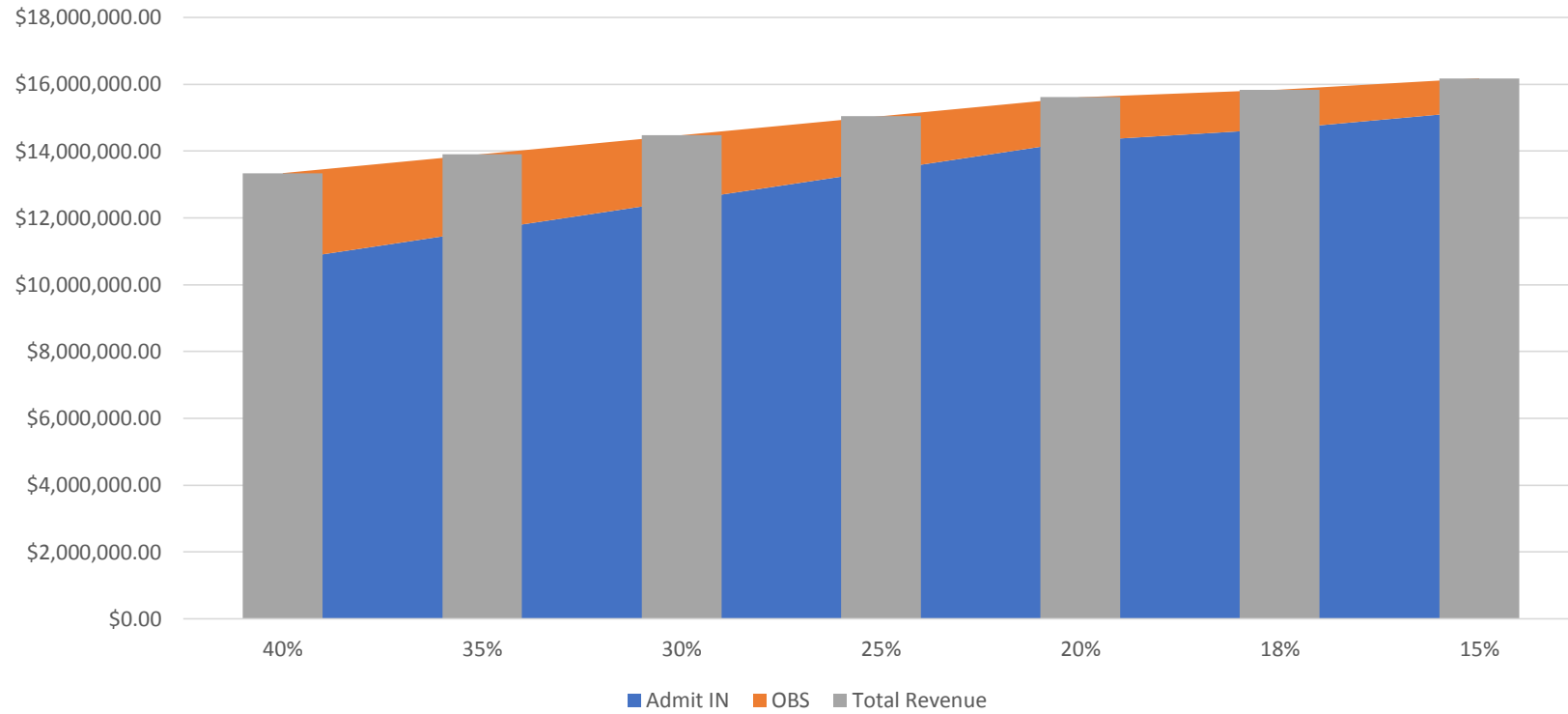
Partner education

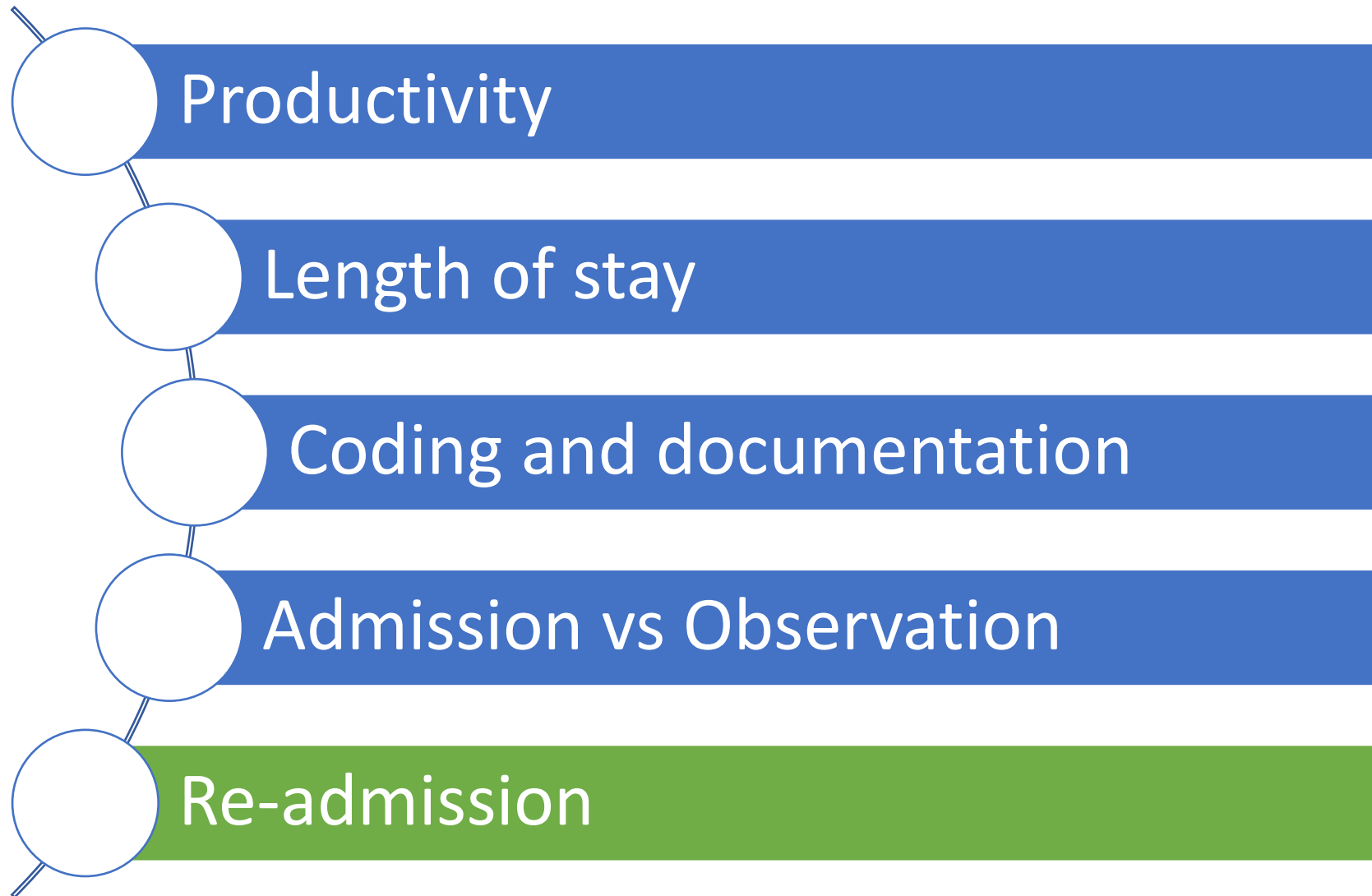
- Understand the value
- Work is the same
- Educate partner and ED staff
- Night team advantage ... make a decision before midnight
- Symptoms vs diagnosis
- Suspected, probably, likely (not “possible”)
- If you use a mediator, Talk to them

Peer to Peer ... Just tell me what to say



Admit Vs Obs progress from 40 to 15 %





What happens at discharge

- Patients discharged:
 - Without understanding their illnesses
 - Without understanding their medication
 - Without clear follow-up plan
 - Without medications
 - With pending tests
 - Without a follow up appointment
 - Without warm handoff

**CONGRATULATIONS
DR. RICK GRECO**

In honor of the
Honorable Board of
Trustees, administrative
and employees on staff
for celebrating the
appointment of
Dr. Rick Greco
as the new appointee to
the office of President of
the American College of
Surgeons.

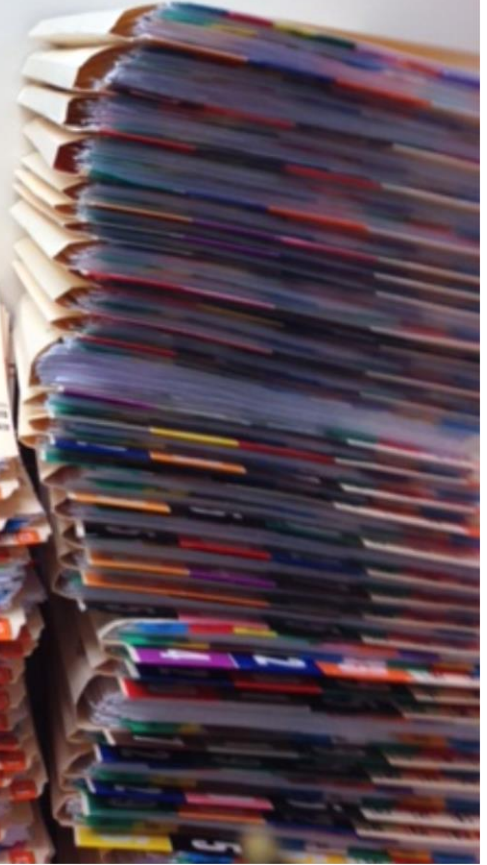


Rick Greco, DC, FACD



Dr. Greco

Dr. Craik

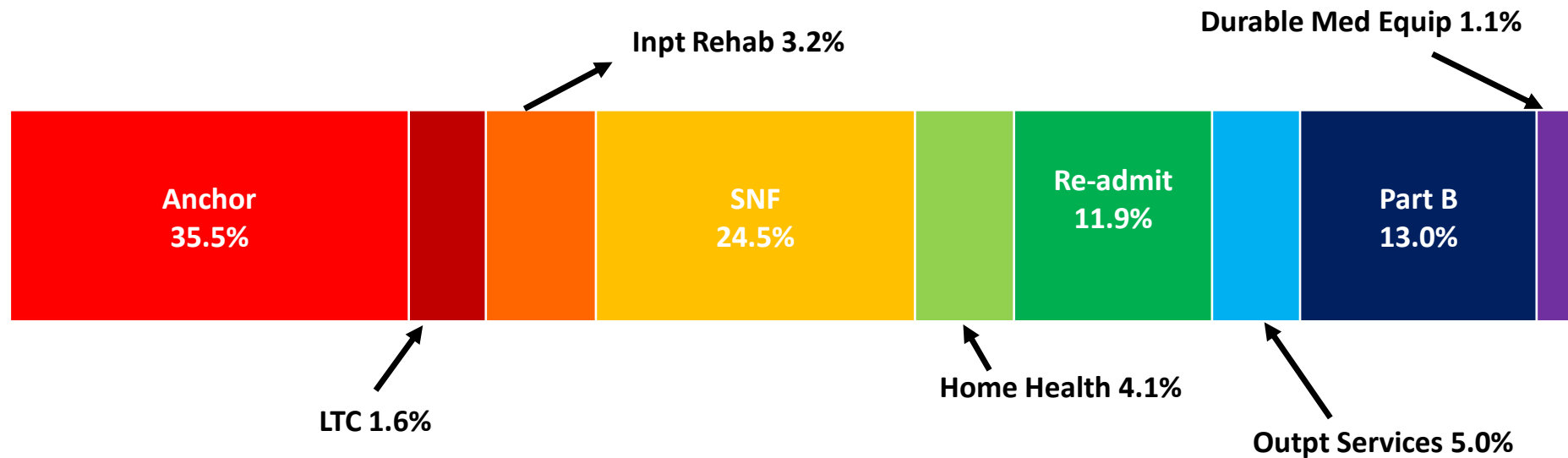


Bundled Care Payment Initiative

- Model 1
 - Hospital stay only (done)
- Model 2
 - Includes anchor stay and post acute period
 - Initiated by Hospital or physician group involved with anchor stay
- Model 3
 - Post acute only
 - Maybe initiated by SNF, Home Health, Physician Group
- Model 4
 - Admitting hospital gets the \$ and distributes to providers
 - Starts with anchor stay and includes post acute time period

Care Across The Healthcare Continuum

- **The Care you provide in the hospital is only part of a patient's road to recovery**

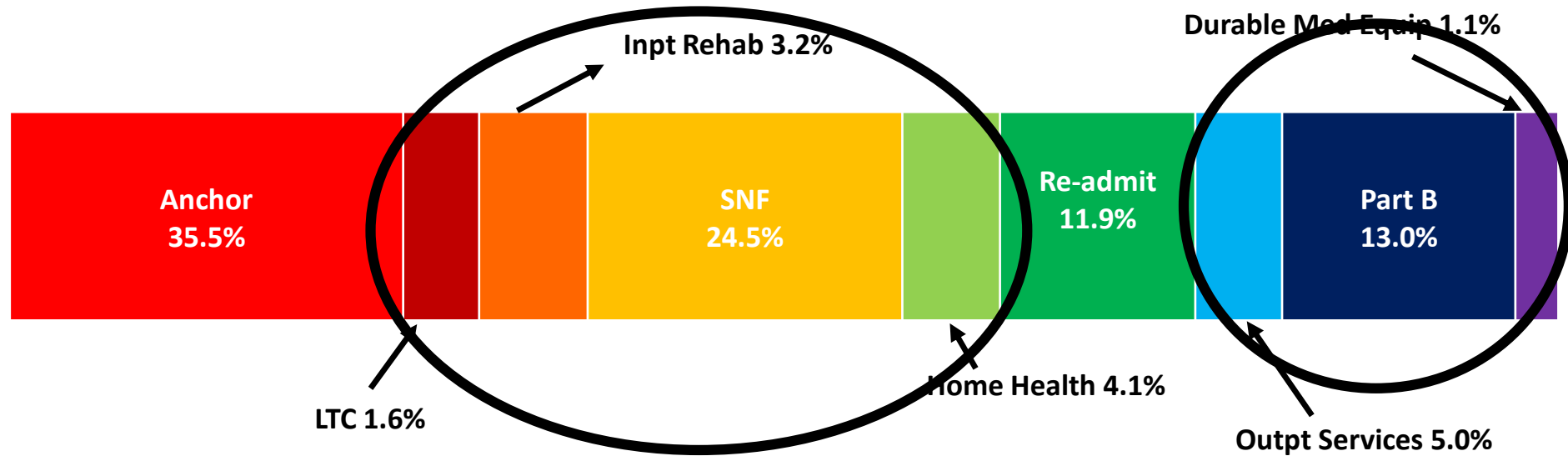


Managing post acute care

- Appropriate next site of care
 - Home
 - Home with home health
 - SNF
- Control SNF length of stay
 - Role for investing in SNF-ist ?
 - Preferred SNF
 - Shared risk
- Avoid re-admits
 - Warm handoffs with SNF and PCP
 - Quick post dc follow up with PCP or DC clinic
 - Educate the ED

Care Across The Healthcare Continuum

2/3 of a patient's recovery happens outside of the hospital



Questions

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