

The Business Side of Inpatient Medicine

2022 Washington ACP Annual Meeting

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Disclosures & Acknowledgements

- **Nothing to disclose**
- **Many thanks to Dr. Andrew White (UW) for allowing us to adapt some slides for this presentation**

Learning Objectives

- 1. Appraise main sources of hospitalists' salary**
- 2. Demonstrate how reimbursement methods affect hospitalists day-to-day**
- 3. Learn differences in charges vs. costs**

Who is here today?

- Medical students
- Residents/fellows
- Hospitalists and APPs
 - Been in practice < 1 year
 - 1-5 years?
 - >5 years
- Any other disciplines in the audience?
- Anyone from out of state?

HISTORY of **HOSPITAL MEDICINE**



SHM IS FOUNDED

January 1997, SHM is founded by two hospitalists, John R. Nelson, MD, MHM and Winthrop F. Whitcomb, MD, MHM.



**19
96**

HOSPITALIST FIRST COINED

The term "hospitalist" is first coined in a 1996 New England Journal of Medicine article by Robert Wachter, MD, MHM.

**19
97**



**20
02**

PROGRAMS PROVEN EFFECTIVE

A January 2002 study on the hospitalist model showed improved quality of care and efficiency. Implementation of hospitalist programs decreased hospital costs by 13.4 percent and length of stay for patients by 16.6 percent while improving quality and patient satisfaction.

HISTORY *of* HOSPITAL MEDICINE

20 07

LENGTH OF STAY REDUCED

A September 2007 study from the Archives of Internal Medicine found that hospitalists reduced acute length of stay by approximately half a day.

20 09

INCREASE OF MEDICARE PATIENTS

A 2009 report in The New England Journal of Medicine revealed that the number of Medicare patients seen by hospitalists and general internists increased from 46.4 percent in 1995 to 61 percent in 2006. This increase was almost entirely attributable to the proliferation of hospitalists throughout America's hospitals.

20 09

LENGTH OF STAY REDUCED AGAIN

A 2009 Loyola University Health System Study showed that patients who were co-managed by a hospitalist had an average length of stay of 3.8 days, while patients who were not seen by hospitalists had an average stay of 5.5 days. This reduction in length of stay had no negative impact on quality.





20
09

REDUCTION IN READMISSIONS

A September 2009 study on teamwork during discharge showed a reduction in rehospitalizations. Teamwork across disciplines in the hospital, which is often coordinated by a hospitalist, improves the transition from hospital to home for older patients with fewer return visits to the hospital, a reduction in morbidity rates and healthcare costs while positively impacting the quality of life and discharge satisfaction.

TWENTIETH ANNIVERSARY

2016 Article from NEJM penned by Bob Wachter celebrating the 20th anniversary of the specialty <http://www.nejm.org/doi/full/10.1056/NEJMp1607958>

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16



HISTORY of HOSPITAL MEDICINE



20
17

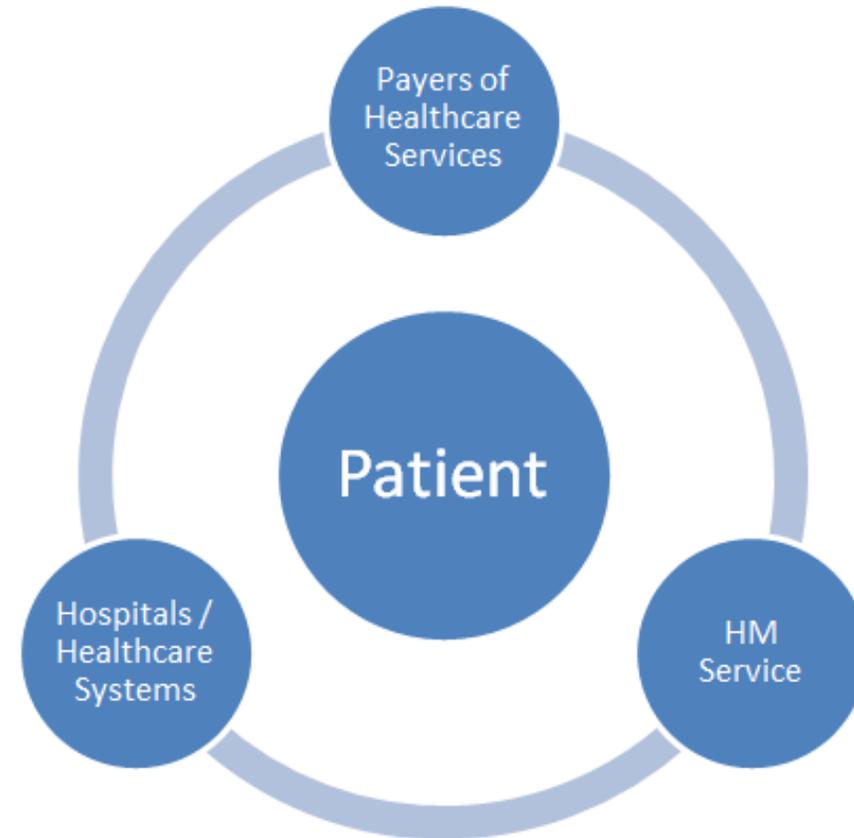
ENTER C6 BILLING CODE

2017 Hospitalist billing code C6 implemented by CMS to better benchmark hospitalists against other specialties.

Hospitalists have become the fastest growing medical specialty...

What is the business relationship between hospitalists, payers and hospitals?

Inpatient Care Continuum



<https://keystonehealthcare.com/the-hospitalist-imperative-alignment/>

What are the main sources of the hospitalist's salary?

- **Professional fee billing**
- **DRG based facilities fee**
 - Hospital funding support makes up the rest**
- **Why would hospitals pay hospitalists to make up the rest of their compensation?**
 - Service and Value**

National Averages (SHM 2020)

Private hospitalists

- Median salary **\$307,633**
- Average **4,360 RVU/FTE**
- Hospital support/FTE
\$198,750

Academic hospitalists

- Median salary: **\$237,289**
- (Western US **\$225k**)
- Average **3659 RVU/FTE**
- Hospital support/FTE
\$166,806

Day in the life of hospitalist

(3 cases)

Dr. Washington

- **1st patient: handoff from nocturnist, admitted overnight**
- **37 yo man presents to ED with chest pain**
 - Resolves with nitroglycerin**
 - EKG without ischemic changes**
 - has family hx of CAD and NEG 1st serum markers**
 - Pending nuclear stress test**

Dr. Washington

- **Nuclear stress test: Normal**
- **Preparing to discharge the patient with PCP f/u, you receive a call from utilization management**
- **Observation vs. admission? ****
 - 48 hrs vs. Two-midnight rule**
 - Medicare Part A vs. B hospital reimbursements**

1st patient case takeaways:

- **37 yo man w/atypical chest pain, negative stress test**
- **In the hospital for about 24 hours**
- **Observation status: considered outpatient billing**
- **Medicare part B reimbursements**

Day continues...

- **2nd call from the ED**
- **55 yo man with hx of COPD, presents with SOB, cough and fever**
- **Vital signs: T 39.4, HR 122, RR 28, BP 85/45, O2 sat 91% on 6L (patient is not on oxygen at baseline).**
- **Labs show Na 128, K 3.8, HCO3 28, BUN 44, Cr 2.4, Gluc 180.**

Day continues...

- **Admit the patient and indicate admission diagnosis: severe sepsis**
- **“Septicemia or severe sepsis without mechanical ventilation > 96 hours with major complication or comorbidity”**
- **Medicare Severity Diagnosis Related Groups (MS-DRGs)**
DRG weight & length-of-stay: 1.8722 & 4.8 days

Overview of MS-DRGs **

- **Major diagnostic categories (MDC)**
 - Each corresponding to an organ system (~25)**
 - Medical vs. surgical**
- **Hospital case mix variables**
 - Principal & secondary diagnoses**
 - Complications & co-morbidities**
 - Discharge status**
- **Version 39.1: 72,750 diagnoses and 78,227 procedures**

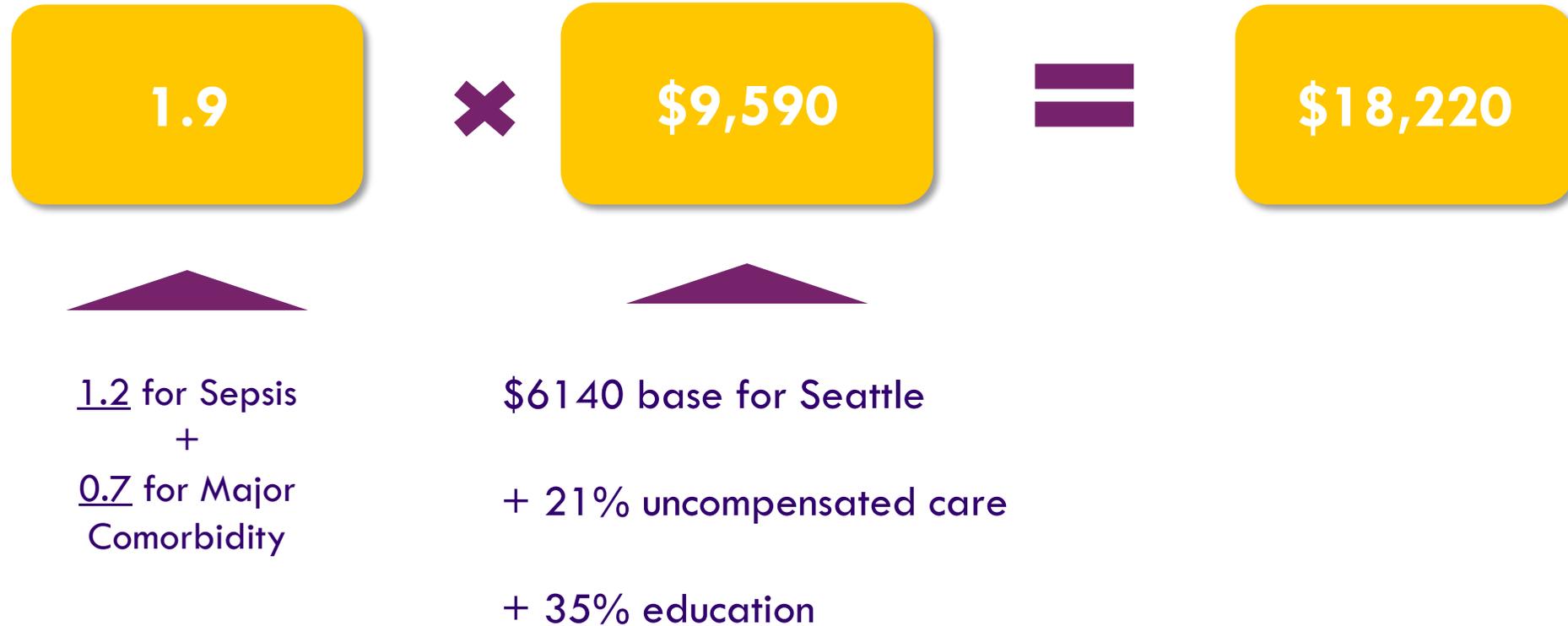
What determines the DRG payment?



Clinical complexity & expected cost

- Local wages and supply costs
- Uncompensated care
- Medical education

Example of DRG for sepsis



These numbers approximate reality but are for illustration purposes only

Day continues...

- **Based on the 2nd patient's principal diagnosis, the hospital would be reimbursed \$18220 for the entire hospital stay**
- **On hospital day 4, you get a call from the clinical nurse care coordinator, asking if the patient is ready for discharge**
- **Open your EMR message inbox and see a clinical documentation query**

What is a query?

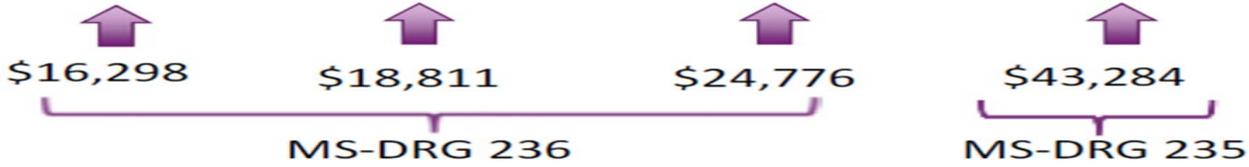
- A question posed to the provider asking for their clinical interpretation of a case, based on their professional judgment
- Query= Clarification
- Clinical Documentation Query: The process CDSs use to facilitate modification of provider documentation to ensure the integrity of the medical record, resulting in accurate, consistent, and reliable coded data

CDI queries

- Coders can't infer or assume, so sometimes CDSs must ask for documentation that seems obvious (to providers) and/or ask you to “link” a symptom to a diagnosis.
- A response should be made to every query whether you agree or disagree.
 - Example: Add to discharge summary “Experienced acute respiratory failure; resolved with ...(tx)”
- Any attending providers/ APPs can answer queries even if it's not directly assigned to you

Query Example with Financial Impact

MS-DRG	235/236: Coronary Bypass W/O Cardiac Cath			
APR-DRG	166: Coronary Bypass W/O Cath			
Pdx	Coronary Artery Disease			
Ppx	CABG-single vessel			
	Hyperlipidemia	Hyperlipidemia	Hyperlipidemia	Hyperlipidemia
		DM I with hyperglycemia	DM I with hyperglycemia	DM I with hyperglycemia
			BMI 46	BMI 46
			Obesity Hypoventilation	Obesity Hypoventilation
				Post-op HF
				ARF with Hypoxia
SOI/ROM	1/1	2/1	3/1	4/4
RW	2.6441	3.0517	4.0194	7.0219



2nd patient case summary

- **Came through the ED**
- **Diagnosed with severe sepsis, treated per bundle protocol**
- **Spent 8 days in the hospital**

Medically ready for discharge on day 5, but miscommunication with patient about discharge wishes led to an extra 3 days

Charge vs. Cost (*poll)

- **Charges** are what clinicians and the hospital bill for services
 - CMS** requires publishing hospital chargemaster prices
 - Rarely reimbursed in full: flat rates based on **MS-DRGs**
- **Cost** is the amount that it takes to provide those services
 - Expense to the healthcare system

The tally:

Charges	\$45,444
DRG payment	\$18,220
Costs	\$19,598
	<hr/>
	\$ -1,378

From the view of a CEO

Minimize costs to avoid losses

Use fewer studies

Meds – generic, po when possible

Decrease length of stay

Quality and Satisfaction

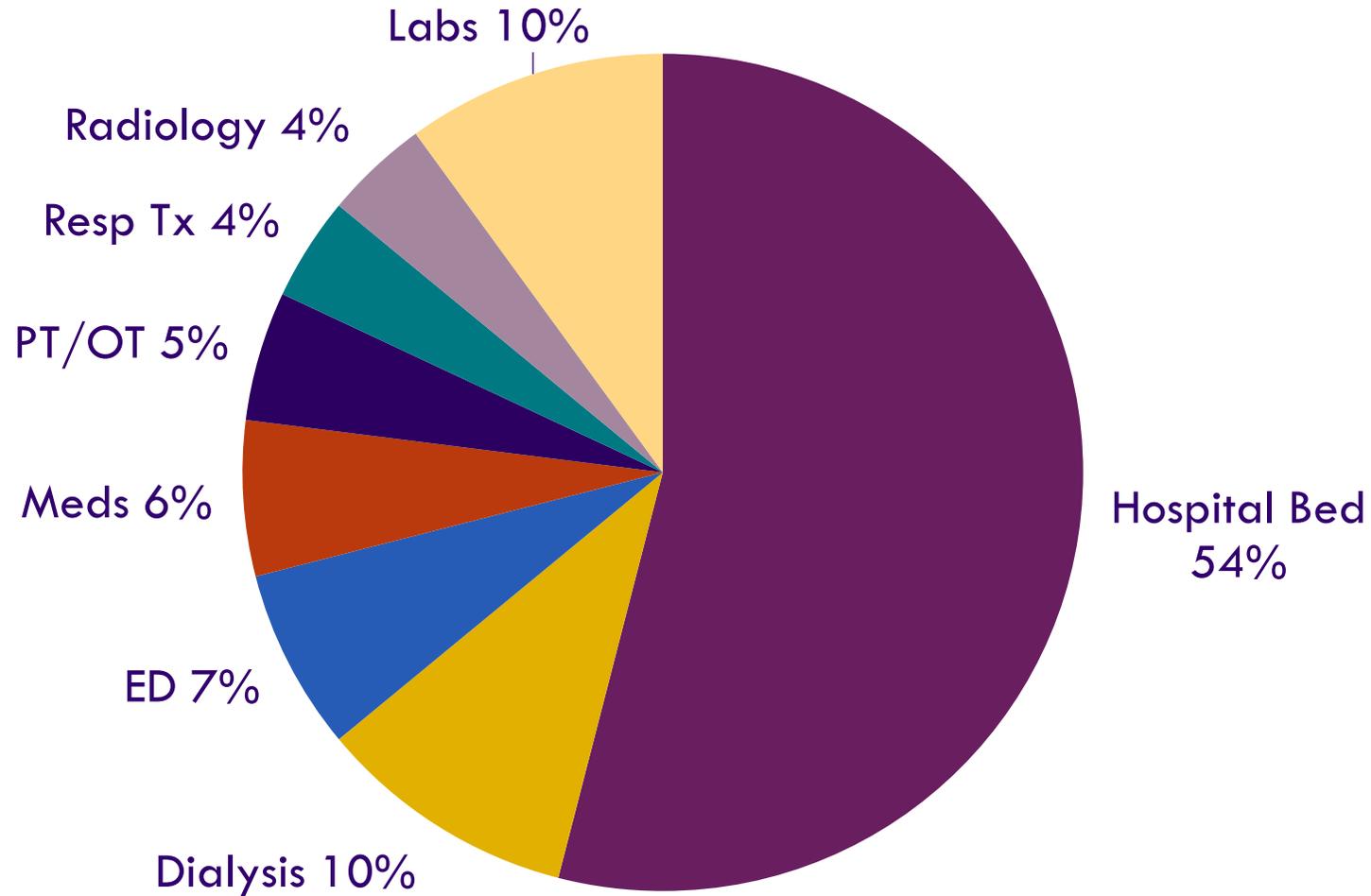
Who is best suited to do this?

Specialist or surgeon in OR or in clinic?

Hospitalist aligned with medical center goals

- Lower costs for the hospital and the hospital supports our salary

How could doctors spend less?



What if LOS were changed?

Our patient 3d beyond “medical clearance”

Service	Daily Cost
Bed	\$1155
Medications	\$115
Labs	\$107

$$\$1377 \times 3d =$$

\$4131

2nd patient case takeaways:

- **55 yo man with comorbidities admitted for severe sepsis**
- **MS-DRG weight & length-of-stay: 1.8722 & 4.8 days**
- **Received CDI query to accurately capture reimbursement**
- **Prolonged LOS led to increased costs**

Last patient...

- **3rd call from the ED**
- **76 yo woman with hx of type 2 DM, HTN, hypothyroidism, and osteoporosis presents after mechanical fall landing on her L side. XR shows a displaced hip fracture requiring surgery**
- **Orthopedic surgery requests a medicine consult for preop evaluation and co-management**

Last patient...

- **Co-managed between hospital medicine and orthopedic surgery**
- **Hospital Medicine Surgical Co-Management Programs**
 - Orthopedics, NGSY, ENT, etc**
 - Quality, engagement, financial**

Why Co-management?

ORIGINAL ARTICLES

Surgical Comanagement by Hospitalists Improves Patient Outcomes A Propensity Score Analysis

Rohatgi, Nidhi MD, MS; Loftus, Pooja MS; Grujic, Olgica; Cullen, Mark MD; Hopkins, Joseph MD, MMM;
Ahuja, Neera MD

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Why Co-management?

- **Patient did well with surgery and was discharged to home with clear communication from hospitalist to her PCP**

Med rec confirmed by hospitalist with PCP

- **Had follow-up appt in 1 week**

Concern addressed in clinic and avoided a readmission to the hospital

- **The HCAHPS survey for the orthopedic surgery service has been consistently in the 95th percentile**

Many comments acknowledge the care coordination of hospitalists

3rd patient case takeaways:

- **78 woman admitted after mechanical fall for ORIF**
- **Hospitalization co-managed between hospital medicine and orthopedics**
- **Co-management optimal for care coordination and communication**
- **Avoided patient's re-admission & reimbursement penalty**

Overall takeaways:

- 1. Hospitalists are compensated through professional fee billing, DRG-based facility fees and hospital support.**
- 2. MS-DRGs affect day-to-day practices of hospitalists.**
- 3. Hospitalists' work entails accurately capturing charges and decreasing unnecessary costs.**

Thank you!

Questions?

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