Maximizing Hospital Medicine ROI

Strategies to optimize your HM program.

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IDENTIFYING AND LEVERAGING HOSPITAL MEDICINE VALUE DRIVERS

As hospital budgets grow tighter, hospital administrators are forced to examine the costs of supporting each clinical service line, not just as they relate to patient care, but where the rubber meets the road: the hospital's bottom line. As a member of the Hospital Medicine team, you can directly impact the value of the care delivered in your HM program. When well-managed, an HM program can deliver improved patient outcomes and a significant return on investment, influencing many economic and behavioral value drivers, including: length of stay, case mix index, value-based purchasing bonuses, readmission penalties, patient satisfaction, and resource utilization.

In this white paper, we outline the primary drivers of hospitalist-generated value and identify strategies to optimize the value of your HM program:

- **Improved clinical quality**
- **Care efficiency**
- **Patient experience**

VALUE DRIVER:
OPTIMAL EM-HM TRANSITIONS OF CARE

Emergency and Hospital Medicine programs function best when they work together. When the two programs are at odds with each other, their conflict has a ripple effect that increases cost, affects patient experience, patient safety and physician satisfaction, and compromises care consistency. When the programs are aligned, care quality, efficiency, performance, and satisfaction improve.

Aligning EM and HM programs depends on open lines of communication, agreed upon EM-HM process standards, mutual goals, accountability, and objective data measures. When the two programs work closely together to manage patients admitted by the ED, your hospital will see improvements in metrics that improve patient care, including:

• EM left without treatment (LWOT) rates
• EM door-to-provider times
• ED length of stay (LOS) for admissions
• Inpatient length of stay

If the EM and HM programs do not collaborate, it is the patients who suffer. Those admitted have to wait longer in the ED, which reduces both the ED and the inpatient patient experience scores. The ED then backs up, increasing the LWOT rate. When the EM and HM programs work collaboratively for the good of the patients, both programs succeed, and the hospital ultimately reaps the benefit of a well-functioning system.

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VALUE DRIVER:
ACCURATE CASE MIX INDEX

By making certain to capture the severity of a patient's illness—that is, documenting the complications/comorbidities that accompany a diagnosis—hospitalists ensure that the correct Diagnosis-Related Grouping (DRG) is assigned to a patient, ultimately prompting a more accurate (and improved) case mix index (CMI).

The CMI is a reflection of the value of bundled DRG payments and advises the expected length of stay (LOS). The CMI also impacts the quality scoring of patient outcomes by capturing the complexity of the case and ensuring more accurate reimbursement rates.

Hospitalists who are well-versed in appropriate documentation guidelines and collaborate with clinical documentation specialists can significantly improve the accuracy of the CMI for medical and surgical patients. High functioning teams will perform documentation on the day of service, include significant comorbidities in daily notes, and promptly respond to coding queries.

> Strong HM teams capturing the severity of each case also help align the actual LOS with CMS' expected LOS time and rate. For example, if acute respiratory failure is misrepresented as simple pneumonia, there is a significant financial impact to the CMS LOS. CMS reimburses simple pneumonia as a 2.9 day LOS and $4,931 payment; significantly less than the 4.9 day LOS and $10,144 payment for acute respiratory failure.

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VALUE DRIVER: EFFICIENT ROUNDING PRACTICES AND RESOURCE UTILIZATION

Reducing the cost per case happens by focusing lab tests and consultations only on scenarios that are clinically appropriate and, whenever possible, using medications listed on the hospital's formularies.

A strong HM team participates with case management to help deliver care essential to a patient's recovery while avoiding unnecessary testing or deferring tests and procedures to those that can be delivered in ambulatory settings. Daily multidisciplinary team rounds will help facilitate appropriate utilization of clinical resources and expedite patient progression to lower acuity settings as clinically appropriate.

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VALUE DRIVER:
VALUE-BASED PERFORMANCE IMPROVEMENT

Medicare payment for services provided is dependent on improved clinical quality through attention to CMS's value-based programs. A key role of a well-run HM program is to maximize performance on measures that reflect quality metrics. The goal is to document improved efficiency, outcomes, and patient experience, while minimizing hospital acquired conditions, mortality, and readmissions.

An HM team that embraces evidence-based practice, improves standardization of practices, and delivers high-quality customer service can significantly boost reimbursement under value-based systems of care.

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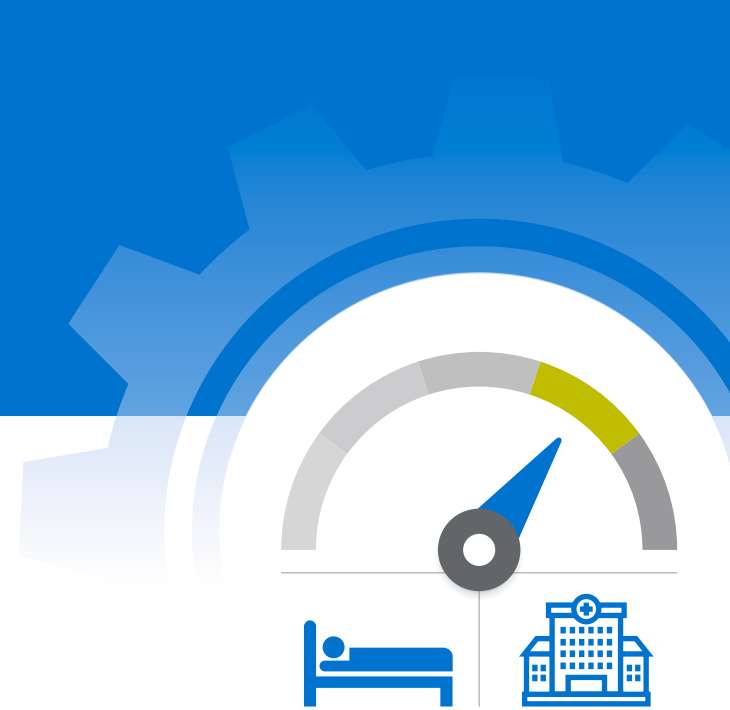
VALUE DRIVER:
REDUCTION IN AVOIDABLE HOSPITAL DAYS (LOS)

The most important resource hospitals have to improve their bottom line is available beds to admit additional patients. Therefore, it is essential to manage patients well and efficiently discharge them as soon as there is no longer a clinical need for that hospital bed. Additionally, patients who spend avoidable days in the hospital awaiting discharge require staffing and pharmaceutical resources, while being exposed to preventable harm. Cost estimates of a hospital stay vary from $500–1500 per day (med/surg vs. telemetry vs. ICU bed) and are comprised of nursing labor, pharmacy, lab and imaging expenses. More concerning, a hospital is a high-risk environment where the risk of medical complications such as DVT, decubitus ulcers, hospital-acquired infections, or functional decline increases over time.

A good HM program will work closely with case management to anticipate discharge needs from the day of admission, so that when the patient is ready for discharge the necessary resources are available. Three additional strategies to improve HM LOS are to balance staffing with patient volume, anticipate the schedule for continuity of care, and provide data and feedback to your providers.

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VALUE DRIVER: DISCHARGE PLANNING AND POST-DISCHARGE MANAGEMENT

Discharge planning should begin at the time of admission. By assessing the patient's probable discharge needs and working with case management, physical and occupational therapy, and nutrition, the hospitalist can begin preparations to send the patient safely home with appropriate services or discharge to a post-acute care setting. Likewise, the hospitalist's responsibility does not end at the time of discharge from the hospital.

> It is essential to a well-run HM program that there is complete and timely transfer of all medical information that the post-discharge provider, whether in the community or in the post-acute care facility, requires. By assuring complete transfer of information, medical care and patient safety are improved, and ED and hospital readmissions are minimized.

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CONCLUSION

A well-functioning HM program focused on quality and outcomes provides a clear ROI for hospitals, while also creating loyalty and satisfaction for both patients and physicians. The ED will perform better and have an improved community reputation due to lower LWOT rates and improved throughput metrics. When a patient is admitted, solid HM programs can assure that documentation supports the appropriate severity of illness for patients, thereby improving case mix index and reimbursement. When the patient is ready for discharge, the HM program assures that avoidable days in the hospital are minimized, and discharge planning and post-discharge coordination of care are optimized.

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