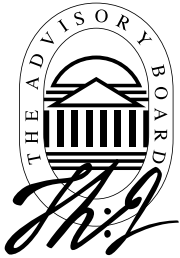


BEST PRACTICE IMPLEMENTATION KIT

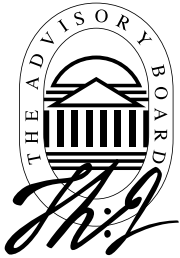


HOSPITALIST PROGRAM FINANCIAL FUNDAMENTALS

Ensuring Accurate ROI Projections

- ☞ Components of ROI Analysis
- ☞ Variables Impacting Program Returns
- ☞ Predicting Patient Volume
- ☞ Calculating Expected Revenue
- ☞ Gauging Appropriate Staffing
- ☞ Quantifying Supplemental Revenue Gains

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Ensuring Accurate ROI Projections

WITH SINCERE APPRECIATION

The Clinical Advisory Board would like to thank the following individuals to whom we are particularly indebted for their contributions to this work.

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Revenue Opportunity from Reducing ED Divert Hours Tool #7
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I



CLINICAL ADVISORY BOARD ESSAY

Factors Driving Hospitalist Program Returns

- ☞ Components of ROI Analysis
- ☞ Variables Impacting Program Returns

As hospitalist programs grow rapidly, hospitals question value of their investment

In recent years hospitals have turned to hospitalist programs to address multiple operational challenges including reduced resident hours, increased patient volume, and reluctance from specialists to assume emergency department call duties. Insufficient business planning, hasty implementation, rapid growth in volumes, and poor program design have caused many programs to falter.

Programs Facing Up-Hill Battle

NAIP The Hospitalist
 The Newsletter of The National Association of Inpatient Physicians Vol. 5 No. 5 September 2001

When Hospitalist Practices Fail...
 By Deborah Gesensway

“Two of three [hospitalists] were on their way out, citing burnout, low pay, and no respect.”

“The practice grew too fast. It took on way too much debt.”

“[Hospitalists] had no idea which patients had priority... couldn’t get x-ray results, and spent 50 percent of their time doing nonclinical things...”

“Their mind-set was not primarily, ‘I want to get up every day to do the work of a hospitalist.’ Their mind-set was primarily, ‘I’m a pulmonary doctor, and I am willing to do the hospitalist stuff too if it’s good for my practice.’”

“Hospitals are under a lot of pressure to justify every program, and some hospitalists don’t know how to do that, so they don’t have an argument for a hospital that goes into thinking that we will set this up, and year after year it will be self-sustaining.”

“...doctors failing to code and document their work properly and continuing to use a billing and collections staff that doesn’t do its job right.”

“...failing...because of their eagerness to get a new practice off the ground. The hospitalists...basically did anything they could to get a managed care contract, but they found out they couldn’t survive on the rates they had agreed to.”

Of the hundreds of hospitalist practices that have sprung up in the last five years, only a handful have failed or out-and-out folded. But many have floundered—enough, at least, to support a prosperous consulting business for those hired to help hospitals, clinics, and groups save their hospitalist investments.

Although the reasons hospitalist practices stumble may be as individual as the health care markets they are in, distressed practices share some common flaws.

Consider the case of Patrick Cawley’s now thriving but once-troubled hospitalist practice in Conway, South Carolina. The 40-doctor multispecialty group that he and seven other hospitalists were part of started having financial difficulties for many of the same reasons experienced by many multispecialty groups formed across the country throughout the 1990s: The practice grew too fast. It took on too much debt. And all this exacerbated an ongoing dispute in the group about how expenses should be allocated, with the hospitalists and the non-hospitalists wanting them to pay more.

In the end, four of the hospitalists, including Dr. Cawley, left the group and started their own single-specialty hospitalist group working at one of the two hospitals they had served before. The one and one-half years since the breakup have been tough, especially since recruiting two additional hospitalists to bring the group up to the size needed to cover the workload has taken time. But with a sixth hospitalist set to come on board this month, Dr. Cawley said he thinks the practice is back on track. And even when everybody had to work too many hours for too many days at a stretch, going it alone was still better than being part of the bigger group.

Dr. Cawley lists several lessons he learned from his experience, starting with the fact that he thinks hospitalists should be in single-specialty groups where all the doctors are working for the same goal and have generally the same work ethos and ethic.

In addition he said, “all hospitalist groups have to be careful about adding more business too fast,” given how long it takes to recruit top-quality hospitalists to a group. “I’ve seen a lot of groups take on new referral areas and specialties before they have been able to successfully recruit,” he explained. “That is fine for a couple months, but when they stretch into six, twelve months, you are

an eighteen-month-old hospitalist program where two of the three doctors were on their way out, citing burnout, low pay, and no respect. Getting up to five was key—including recruiting a “night-owl” specifically for one of the twelve-hour shifts, he said.

Just as important for saving the program, he said, was reorganizing it so that it was no longer under—and Mr. Ness emphasizes the word “under”—the internal medicine department. Part of the problem, he said, was that the hospitalists, who were all Board-certified internists, felt as if they had been hired simply to do the work the other primary care physicians didn’t want to do. In other words, he said, they felt they were treated like residents.

At Lewis-Gale Clinic, hospital medicine is now its own department with its own chair, Harsukh Patolia, who says that no longer does the cardiology service page a hospitalist in the middle of the night simply because one of its patients is coming in. “We needed some sort of a mediator” to work through issues like that to keep the practice alive, he explained.

“If it wasn’t for the restructuring, we wouldn’t have the hospitalist practice now,” Dr. Patolia said. “People were leaving, and even I would have looked at an outpatient practice, but I didn’t want to do that.”

Hiring the right people for the right jobs was also key. Sometimes practices fail because square pegs are being pounded into round holes. John R. Nelson, NAIP’s past president, is temporarily working to shore up a hospitalist practice in the Seattle area that had imploded in part for this reason.

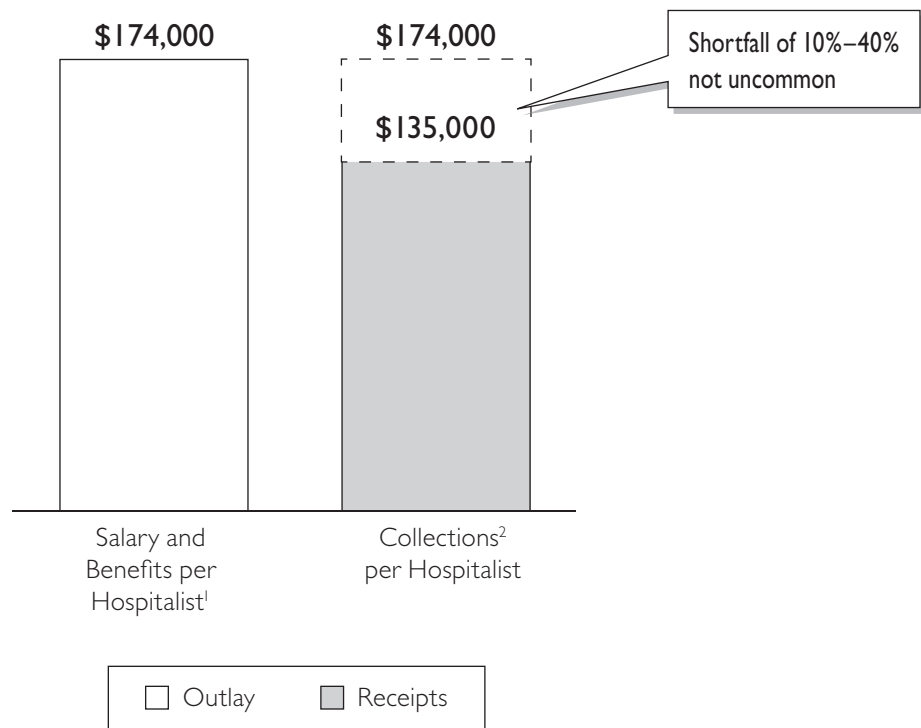
At that hospital, he explained, four enterprising pulmonologists created a hospitalist practice, doing much of the hospital’s general medicine admitting, seeing unassigned ER patients, and taking all the referrals. But, Dr. Nelson explained, “their mindset was not primarily, ‘I want to get up every day to do the work of a hospitalist.’ Their mindset was primarily, ‘I’m a pulmonary doctor, and I am willing to do this hospitalist stuff too if it’s good for my practice.’” Several years later, when they got just too busy, the group exercised their contracts out and told the hospital that in 90 days they were going back to being pulmonary subspecialists only.

No one at the hospital wanted to see the program disappear, so Dr. Nelson was hired as a stop-gap temporary replacement, and he

Inquiry born of financial shortfall of professional billings compared to program outlays

It comes as a surprise to many that professional billings of a single hospitalist often do not cover the outlay for salaries and benefits. It is not uncommon for programs to have a revenue shortfall of 10 to 40 percent. Worse, the shortfall often endures years after implementation. Consequently, the first course of action is to gather sufficient quantitative evidence to support the continuation of the program.

Professional Fees Not Always Covering Costs



IN OVER THEIR HEADS

“Hospitals are under a lot of pressure to justify every program, and some hospitalists don’t know how to do that. They don’t have an argument for a hospital that goes in it thinking that we will set this up, and then after a year, it will be self-sustaining.”

Roger Heroux
 Hospitalist Management Resources
 Colorado Springs, Colorado

¹ Median 2002 data.

² 25th percentile to median, 2002 data.

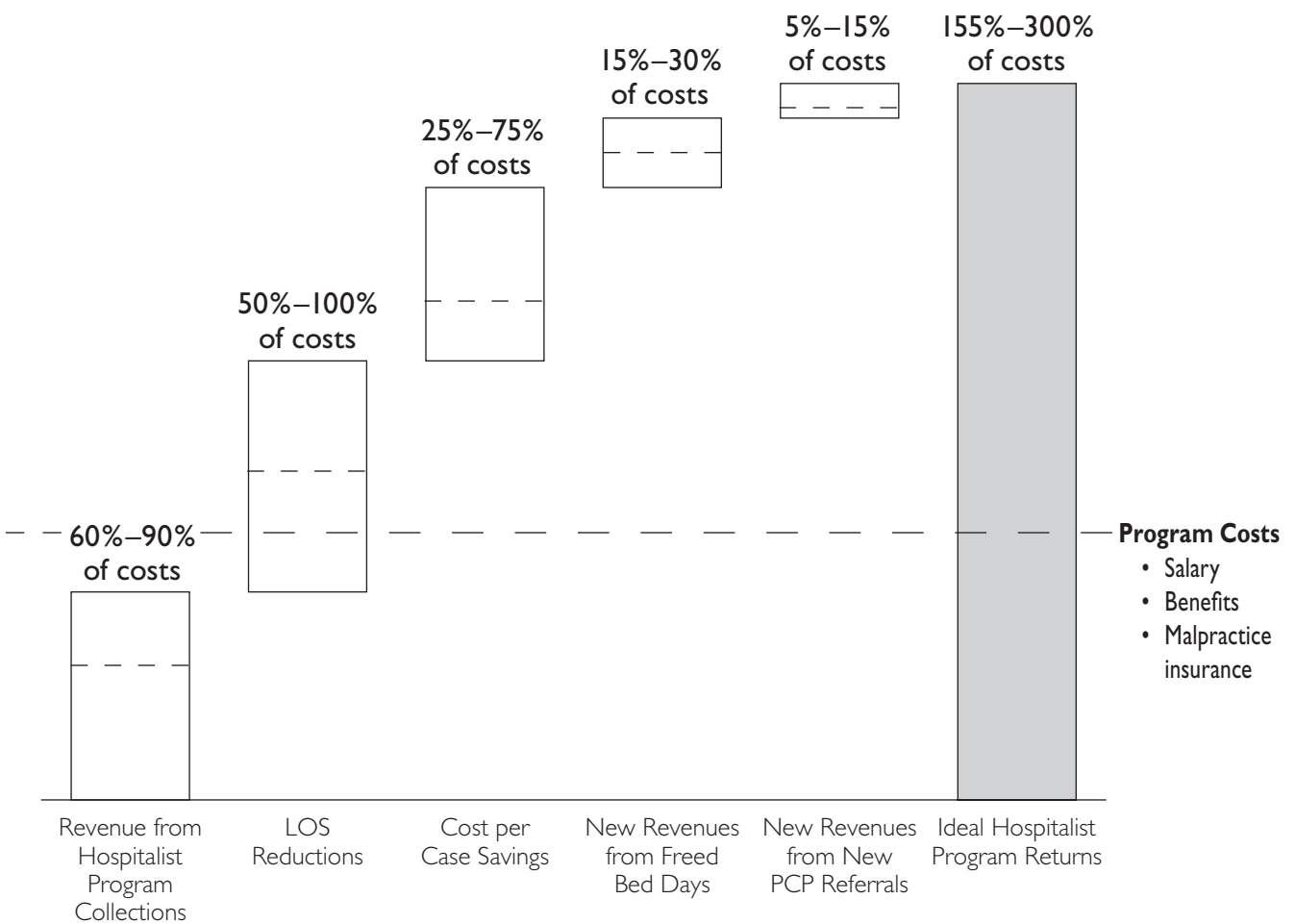
Source: Gesensway, 2001; 2002 Hospitalist Productivity & Compensation Survey, Society of Hospital Medicine (S.H.M.); Clinical Advisory Board interviews.

COMPONENTS OF ROI ANALYSIS

Returns better quantified through combined analysis of revenue and direct and indirect savings

Program returns derive not just from revenues gained through professional billings, but also from reductions in the direct cost of care provided to hospitalist service patients and larger efficiencies gained hospitalwide through care process improvements. At a minimum, hospitals are advised to consider revenue from collections, length of stay and cost per case savings, new revenues from freed bed days, and new revenues from added referrals originating from hospitalist program referring physicians.

Understanding the Sources of Program ROI



Hospitalist program revenue potential contingent on physician productivity

The revenue potential of any hospitalist program hinges on the clinical productivity of its physicians, which is directly correlated to program design. The majority of billable activity is typically comprised of inpatient visits (including H&P's and discharges). However, where inpatient caseload per hospitalist is modest, physicians can complement visit activity with consults and procedures.

Revenue Potential a Function of Productivity

Hypothetical Revenue Analysis









Service Provided	Medicare Allowable Charge ¹	Highly Productive Physician		Less Productive Physician	
		Volume	Revenue	Volume	Revenue
Inpatient Visits					
H&P's (range)	\$63–\$131	345	\$40,695	228	\$27,130
Critical Care Visit	\$175	25	\$4,300	16	\$2,752
Daily Visit (range)	\$33–\$67	800	\$73,700	1,188	\$48,642
Discharge	\$57	320	\$18,240	211	\$12,027
		Subtotal Inpatient Visits			\$136,935
Consults					
Inpat – Limited to Complex	\$69–\$168	70	\$8,260	46	\$5,428
Outpat – Limited to Complex	\$68–166	55	\$6,240	36	\$4,084
		Subtotal Consults			\$14,500
Outpatient					
Observation Visits (range)	\$57–\$131	200	\$18,800	120	\$11,280
ER Visit	\$81	30	\$3,240	13	\$1,053
SNF Initial, Subsequent Visits	\$36	60	\$2,160	40	\$1,440
		Subtotal Outpatient			\$24,200
Procedures (sample list)					
Central Line	\$45–\$196	92	\$7,781	65	\$5,309
Lumbar Puncture					
Arthrocentesis					
Thoracentesis					
Paracentesis					
Intubation					
CPR					
	Subtotal Procedures			\$7,781	\$5,309
Total Professional Fees			\$183,416		\$119,145

¹ Charges will vary significantly in each market and ranges will be impacted by payer mix.

Experience and availability of support staff have greatest potential to enhance clinical output

Various considerations have varying impact on hospitalist clinical productivity. Of greatest importance are the experience of individual hospitalists, use of incentive compensation, and the availability of staff to support hospitalist day-to-day activities. Each can raise the complexity and volume of services provided. Duties beyond patient admission, rounding, and discharge on the medicine/surgery units may be essential to freeing bed capacity but may affect productivity negatively overall.

Weighing the Impact on Productivity

<i>Consideration</i>	<i>Issue</i>	<i>Impact on Productivity</i>
Hospitalist Training and Experience	Affects mix and volume of services provided	
Availability of Support Staff	Affects mix of services, patient load per hospitalist	
Hospitalist Compensation	Affects patient load, volume of services	
Lifecycle of Program	Affects consult procedure volume, revenue	
Range of Duties		
ICU	Affects acuity of services, negatively impacts load	
ED	Affects acuity of services negatively impacts load	
Observation Unit	Affects mix of services, negatively impacts load	
Nonclinical— e.g., Committee Work	Negatively affects load and volumes	

Revenue also heavily impacted by uncontrollable factors of payer and case mix

Not to be dismissed, hospital payer and patient case mix will have a significant effect on hospitalist program revenue capture. Whereas both factors are largely uncontrollable, the impact of case mix can be mitigated through proper billing. As the graphic illustrates, failures to document and subsequently code for the appropriate intensity of services rendered will bleed potential revenue.

Professional Collection Matrix

Controllable Factors

- Coding to ensure accurate charge capture for patient population
- Ability to expedite patient throughput to maximize hospitalist service volumes

Professional Fees					
CPT Code	Medicare	Medicaid	Commercial	Blue Cross	Self-Pay
99221 Initial Hospital Care – Low	\$86	\$49	\$119	\$136	\$8
99222 Initial Hospital Care – Medium	\$97	\$66	\$130	\$147	\$10
99223 Initial Hospital Care – High	\$135	\$92	\$177	\$189	\$13
99231 Subsequent Hospital Care – Low	\$29	\$20	\$49	\$47	\$4
99232 Subsequent Hospital Care – Medium	\$48	\$33	\$63	\$70	\$5
99233 Subsequent Hospital Care – High	\$69	\$47	\$102	\$97	\$8
99238 Hospital Discharge ≤ 30 min.	\$59	\$41	\$61	\$82	\$5
Hospital Admissions					
Distribution of Payers	58%	7%	10%	20%	5%

Uncontrollable Factors

- Distribution of payers a given of marketplace
- Case mix a function of trauma status, services provided in market

Direct savings next component of comprehensive return-on-investment calculation

Multiple metrics track the direct savings afforded hospitals through the implementation of hospitalist programs. Length-of-stay (LOS) reductions typically provide the fastest and greatest gains. Beyond LOS, programs are well served to calculate gains from reducing variable costs per case and inappropriate admissions if duties include ED admission evaluation. Finally, the cost impact of reduced clinical complications should be factored into direct savings.

Quantifying Direct Savings

Savings Metric	Rationale	Opportunity
Average length of stay		<ul style="list-style-type: none"> • Two-year average 15%–20% LOS savings • 0.5–1.0 days saved • Savings plateau over time
Cost per case		<ul style="list-style-type: none"> • Average decline of 13.4% per case • Care pathway improvements will accelerate decline
Reduced clinical complications		<ul style="list-style-type: none"> • Decreased or no change in mortality with hospitalist care • Reduced variability of patient outcomes
Avoidable admits		<ul style="list-style-type: none"> • Hospitalists can care for patients on an outpatient basis in the ED or in an observation unit • Case studies suggest hospitalists can reduce unnecessary admissions upwards of 50%

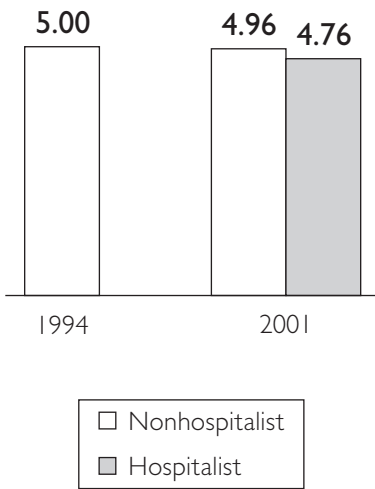
Source: Averbreh A, et al., "Implementation of a Voluntary Hospitalist Service at a Community Teaching Hospital; Improved Clinical Efficiency and Outcome," *Annals of Internal Medicine*, Vol. 137, Number 11, December 2002; HealthPartners Medical Group, Minneapolis, Minn; University of California, San Francisco Medical Center; Clinical Advisory Board interviews and analysis.

Case in Point: Program wins continued hospital support via direct savings analysis

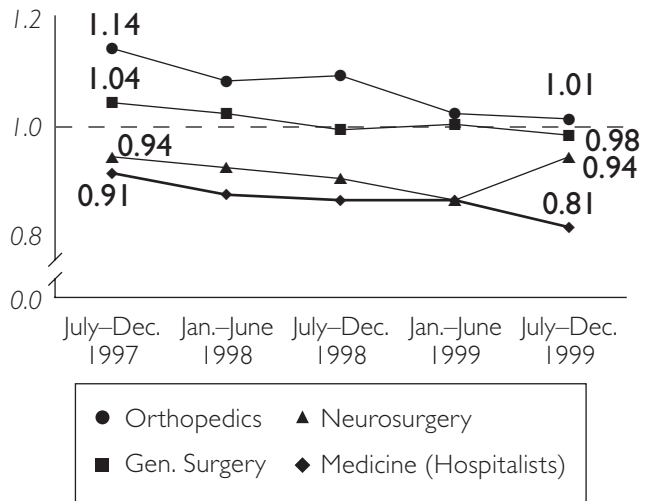
Following senior level scrutiny of ROI gains, Busia Medical Center¹ conducted a comprehensive direct savings analysis to portray financial returns provided by their service. Using University Health System Consortium (UHC) benchmarks for comparison, the program demonstrated exceptional LOS performance. Savings were quantified by calculating the number of bed days saved and then illustrating the revenue opportunity if freed beds were backfilled with high-margin procedural cases.

Making the Program's Case at Busia Medical Center

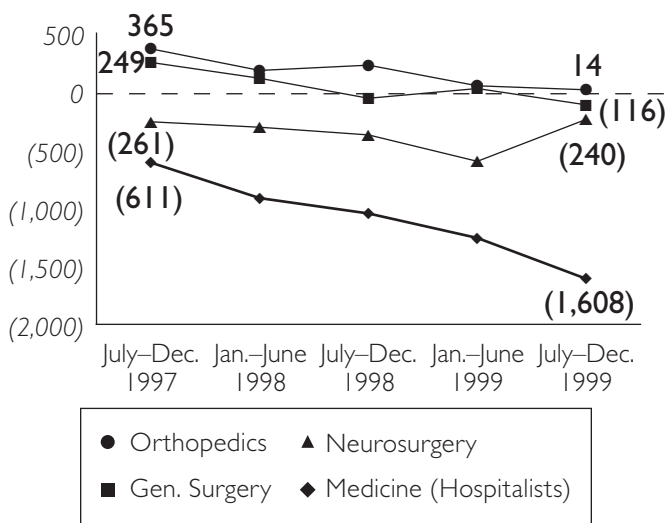
Comparative ALOS, Days



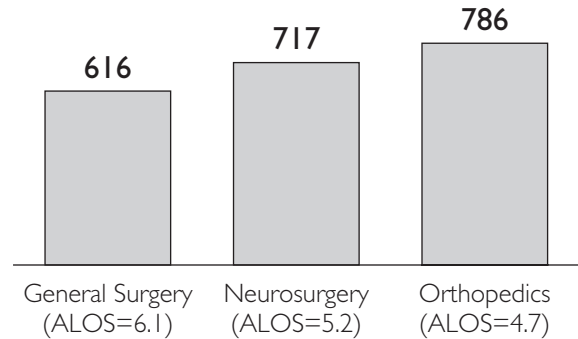
LOS, Indexed to UHC² Benchmark



Bed Days Saved, Indexed to UHC² Benchmark



Potential Additional Cases per Year in Unit



¹ Pseudonymed institution.

Source: Clinical Advisory Board interviews.

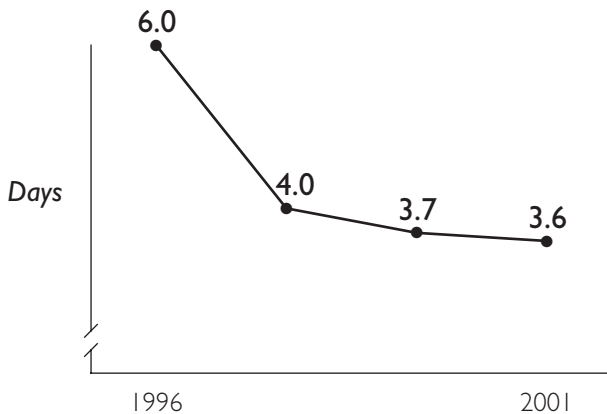
² University HealthSystem Consortium.

Over time, essential to shift direct savings focus from LOS to variable costs per case

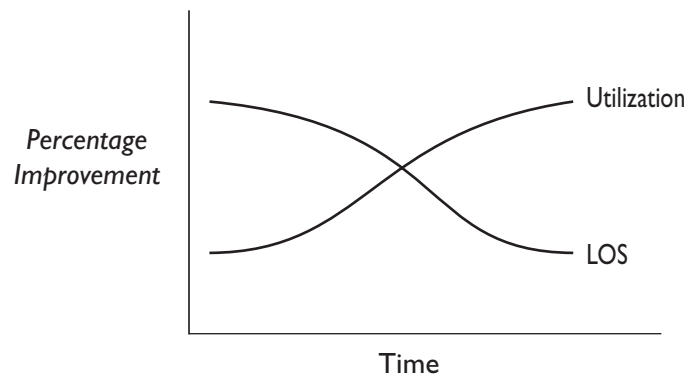
While hospitalists’ dedicated presence produces handsome LOS gains in the first years of program implementation, improvements slow over time as the opportunity narrows and the peer group dwindles. Mature programs should shift the direct savings focus to reducing variable costs per case achieved by standardizing the care of high-volume patient populations cared for by hospitalists and, over time, nonhospitalists alike.

Program Gains Change Over Time

LOS Savings Across Five Years



Savings Opportunity as Program Matures



SETTING AN APPROPRIATE BENCHMARK

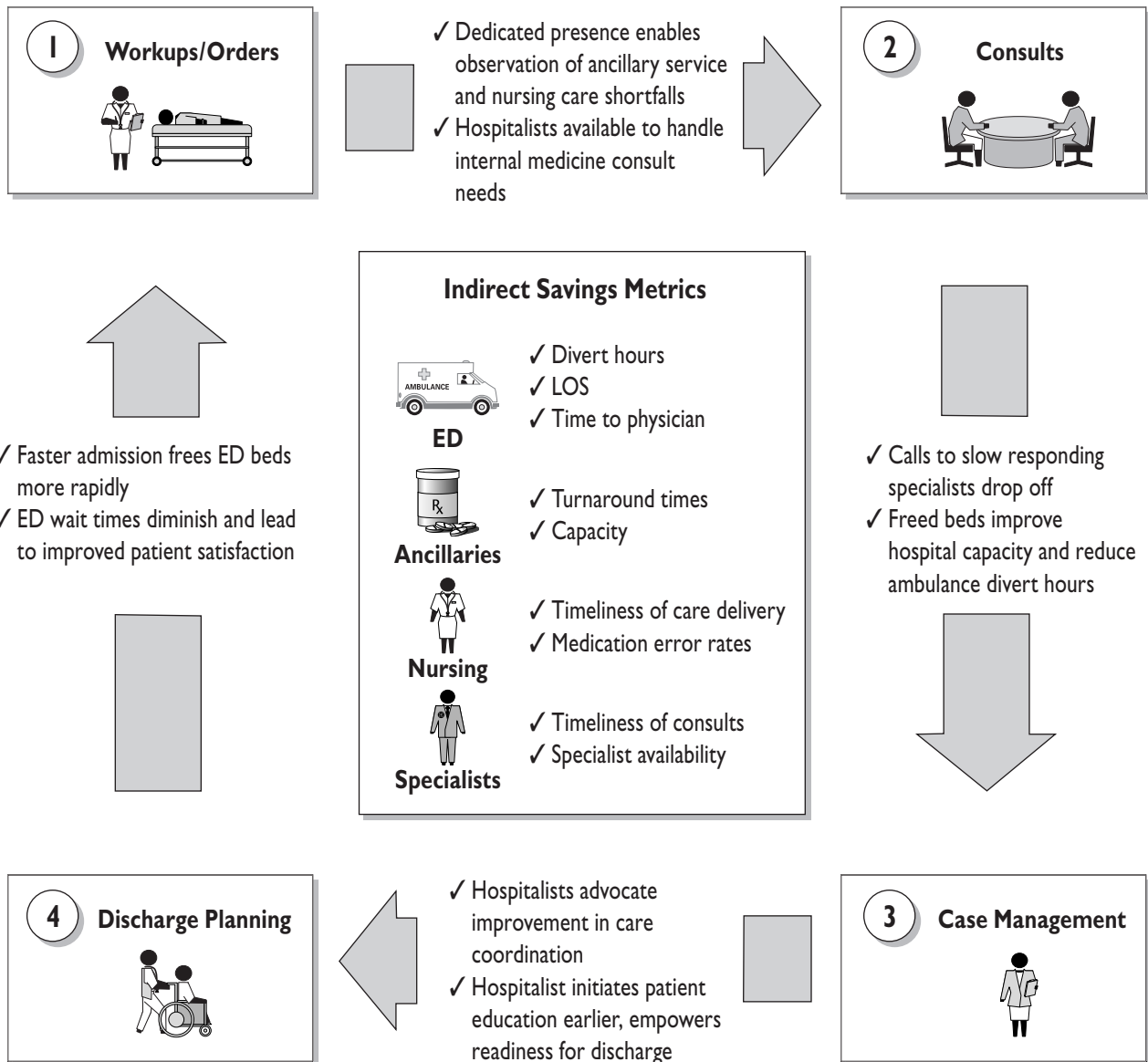
“As the [hospitalist] program matures, PCPs not referring patients to the hospitalist service are increasingly at the ‘top of their game.’ They are the physicians who want to practice and take pride in the treatment of hospitalized patients, and are going to get better over time, just like the hospitalists. So across the tenure of the program, the so-called reference group of nonhospitalists, are reducing their ALOS, eschewing the differential results, and may actually be undercutting the hospitalists’ benefits.”

Robert Wachter, M.D.
University of California, San Francisco

In addition, indirect savings may substantially contribute to hospitalist program returns

Indirect savings secured through care process enhancements are the final source of gains provided by hospitalist programs. Key metrics worth tracking include ED divert hours, ED LOS, ED visit volumes, readmission rates, patient satisfaction rates, ancillary services turnaround times, timeliness of administration of therapies, timeliness of internal medicine and specialty consults, and medication error and adverse event rates. The goal is to quantify the indirect impact of the hospitalist program on patient throughput and clinical use of services.

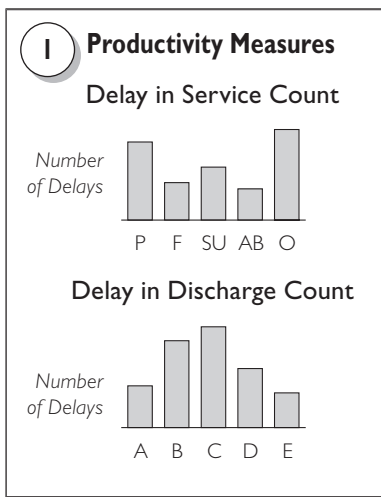
Indirect Savings from Care Process Enhancements



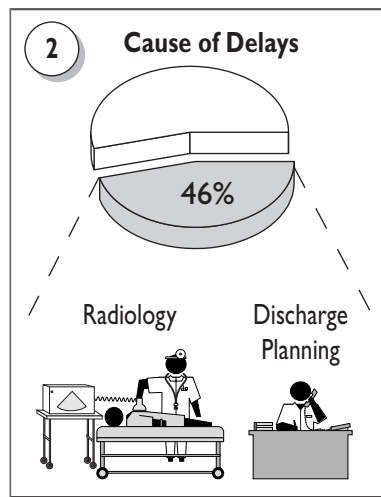
Case in Point: Hospitalist-directed effort enhances care process for all patients

At Estrada Hospital,¹ the information system used by the hospitalist group tracked delays in care and found that the radiology and discharge planning departments were responsible for almost 50 percent of all the delays. Further analysis revealed that 80 percent of the delays occurred during the weekend, with peak periods in demand for echo service occurring between 11 a.m. and 7 p.m. each day. By providing echo services on the weekend, all radiology delays were eliminated and patient LOS was reduced by one to two days.

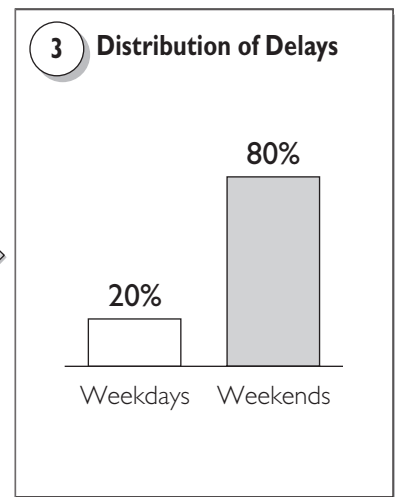
Making Hospitalwide Improvements at Estrada Hospital



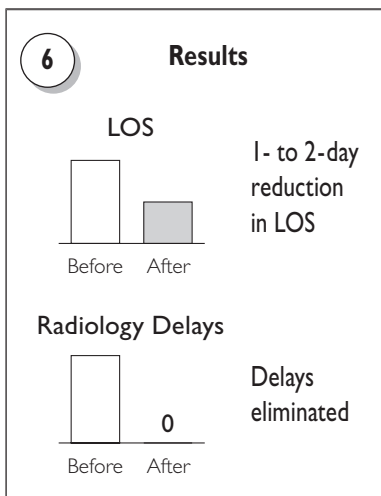
Monthly productivity measures highlight delays in service, discharge



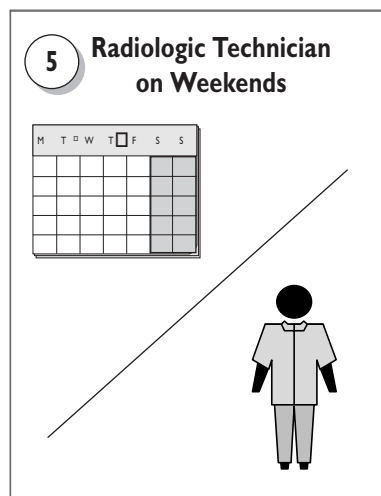
Nearly 50 percent of delays attributed to radiology, discharge planning departments



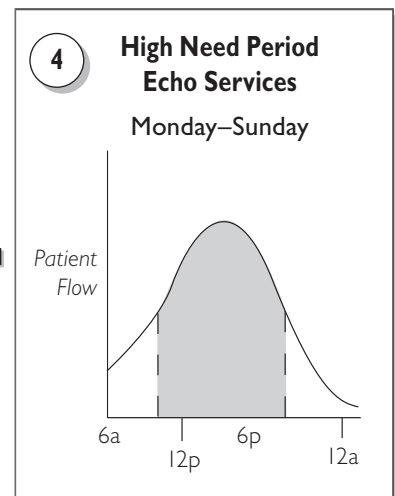
80 percent of delays found to occur on weekend



Changes result in shorter length of stay for patients and elimination of radiology delays



Radiologic technicians paid double their hourly rate to work overtime on weekends



Analysis reveals peak patient flow hours occur between 11 a.m. and 7 p.m.

¹ Pseudonymed institution.

Source: Clinical Advisory Board interviews.

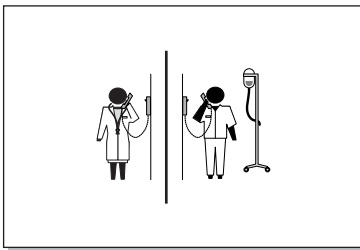
VARIABLES IMPACTING PROGRAM RETURNS

Accounting aside, suboptimal financial returns derive primarily from program design failures

When ROI accounting reveals subpar performance, poor financial returns are often the consequence of insufficient planning, investment, and expectation management. Root cause failures include: no focused objective for service, insufficient allocation of support staff (in particular, nursing or case management), little (or no) use of incentive compensation, poor availability or turnaround of ancillary services, and antiquated revenue capture methods.

Poor Returns Derive from Poor Program Design

No Stated Objective for Hospitalist Service



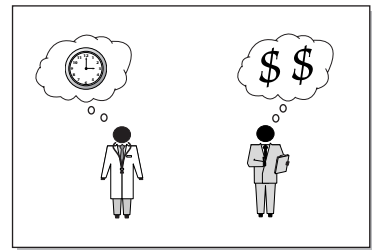
- Hospitalists attempt to tackle too many goals at outset
- Multiple masters of program leaves hospitalists attempting to expedite throughput, standardize care delivery, and improve outcomes at same time

Insufficient Assignment of Clinical Support Staff



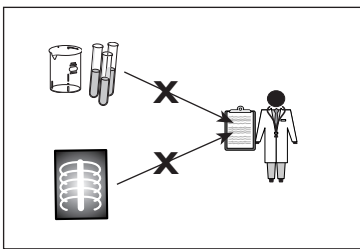
- Hospitalist encumbered by administrative tasks
- Hospitalist clinical productivity, caseload inconsistent with industry standard

Poor Use of Incentive Compensation



- Hospitalists looking to work fewest hours, for greatest salary
- Hospital may not negotiate incentives to appropriately reward best physician behaviors

Inefficient Hospital Care Processes



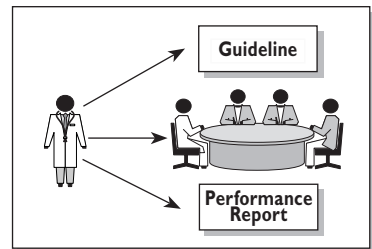
- Hospitalists' efficiency hampered by slow lab or radiology service
- Hospitalists' care process slowed, LOS not reduced

Poor Revenue Capture Process



- Professional fees often denied due to poor coding and/or documentation
- Hospital fails to recognize cases as hospitalist service patients

No Means to Measure Hospitalist Program Value



- Value analysis incomplete or not performed with regard to nonpatient care activities
- Savings opportunities not measured or qualified

Red flags identify design shortfalls and opportunities for program overhaul

The twenty-four questions below were designed to help members identify opportunities for reengineering hospitalist program operations based on the critical design failures witnessed in our research. A “no” answer to any question would highlight where your institution varies from best practice. Information on how best to reengineer hospitalist program operations can be found in a companion work titled *Second-Generation Hospitalist Programs: Strategies for Securing Program Returns*.

Top Line Member Red Flag Assessment¹

Defining Roles and Expectations

- Does the program have a hospitalist leader?
- Do PCPs and patients have a brochure that describes the hospitalist program in detail?
- Does your hospitalist staff spend more than a third of the shift off the med/surg unit?
- Are hospitalists consulting on patients who might require house staff care?

Dedicating Support Staff

- Are hospitalists spending less than 30 percent of their time on administrative tasks?
- Is someone besides the hospitalist responsible for coordinating the discharge process?
- Are nonclinical staff dedicated to provide documentation support?
- Are dedicated case managers provided to the hospitalist service?

Ensuring Adequate Ancillary Services Support

- Do you have night and weekend coverage for key ancillary services?
- Are treadmills, CT scanners, ultrasound machines, MRIs, and respiratory diagnostics always staffed?
- Are lab, physical therapy, and rehab centers always available?
- Are services efficient and do they rarely suffer patient backups?

Maximizing Program Revenue Capture

- Is there a formal hospitalist coding and billing training program?
- Does the billing department trend hospitalist habits to ensure proper coding?
- Are patients tracked through departments to ensure hospitalist revenue capture realized?
- Is there a chart review mechanism in place to review hospitalist billing?

Tracking Program and Hospitalist Performance

- Are you tracking hospitalist program performance and individual practice pattern metrics?
- Do you regularly present hospitalist program successes and future plans to executive board?
- Have group and individual benchmarks been set?
- Have you dedicated staff (hospitalist or case manager) to the task of program data collection?

Aligning Hospitalists' Incentives

- Do hospitalist contracts include pay based on productivity and quality measures?
- Are hospitalists profiled on individual performance?
- Are performance standards that are not financially rewarded discussed during reviews?
- Are hospitalists aware of disciplinary measures for consistent underperformance?

¹ A “no” answer to any question highlights an opportunity to improve program performance.