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INSIGHTS AND INNOVATION FOR RURAL HOSPITALS AND PROVIDERS

Seeds For A Successful Hospital Medicine (HM) Service

CORRECTING MISUNDERSTANDINGS AND QUESTIONS TO CONSIDER WHEN DEVELOPING YOUR HM SERVICE

by Jim Burnette, President/CEO, HospitalMD

Whitepaper

THE NEED FOR HM SERVICE

There are two fundamental purposes for a HM service: (a) "coverage, and (b) revenue growth. To ask if the purpose of your HM service is coverage **or** revenue growth is not a trick question. Coverage is a passive idea. With it there is no implicit or explicit performance expectation. Coverage may actually result in volume and revenue decline. Generating revenue is active, requires coverage, and is packed with performance expectations. The difference is how you present the idea, the message that people hear, the emphasis, and expectations. The message is subtle, but what people hear is what they expect.

Coverage sounds like you are simply providing a service for someone's convenience. The message is show up, work the shifts you are scheduled, and treat patients. The qualifications are minimal. If you do these three things, your performance will probably be 100%. You may have meant that you expect a number of other outcomes, but no one heard that. To communicate this message in a hospital that is financially fragile is dangerous.

Revenue growth is a very different purpose. Coverage is implicit in this purpose, but long term success (generating revenue growth) requires much more than coverage. The basis of a HM service that is designed to grow revenue is physicians that "hear" your message and are motivated to make a difference, are above average, understand customer service, have an attitude of cooperation and team work, and understand the financial implications of their medical decisions. There is no shortage of sick patients going through your ED that can't make your income statement and balance sheet change.

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VOL1.4

Admission rates have not changed materially in 25 years.

What is (or was) the purpose(s) or needs for a HM service? Grow revenue.

The following are simply conditions that create the opportunity to grow revenue:

To respond to your attending Medical Staff's mandate because the attendings do not want to attend inpatients any more.

The "old school" physician did not question attending all of his patients in the local hospital. As these physicians have grown older, they have become tired of the pace, workload, and long day, and they prefer a better quality of life in the latter part of their career.

Physicians are less dependent (or do not need) income from attending inpatients.

A realization that with the (generally continuing) decline in reimbursement, "attending" is financially inefficient.

To provide supplemental coverage for the convenience of the attending medical staff in the form of relieving or eliminating after-hours admission phone calls and coverage for the weekend.

To entice and recruit young physicians that want to practice in a small (rural) community for the quality of life and eliminate the requirement to work long hours and weekends, and participate in unattached call.

What is the current need for a HM service (if different than "original need")?

SCOPE OF SERVICES

What is the level of current utilization of each service, and what incremental enhancements to existing services are possible? What additional services are possible? Limitations on the scope of current medical, surgical, and clinical/ancillary (diagnostic and treatment) services and patient acuity are deterrents. After you establish an inventory of services offered, you need to inventory the medical services available. Any imbalance is sub-optimal.

CREDENTIALS/ PRIVILEGES

The credentials your physicians need must match your scope of services.

Recruit physicians that actually meet the required credentials.

A CV is not proficiency. You must determine if the physician is actually proficient.

Credentials of the Emergency Medicine (EM) staff must be aligned with HM physicians and visa-versa. Otherwise, the result will be EM physician will identify admission prospects that can't be kept local and will be transferred because the HM physician is not capable; or the EM may not identify all admission prospects.

ORGANIZATION AND MANAGEMENT

ORGANIZATION

HM services are typically organized as a separate service to coincide with the hospital's nursing organization. For the HM service, this structure should be purely a place where HM providers work "geographically". The HM and EM services in a small hospital should be operated as one service line and under a single Medical Director.

The Medical Director must:

Have organizational and financial responsibility, and corresponding authority.

Have medical authority and responsibility.

The HM manager must have leadership skills, direct access to the hospital's executive staff, and direct access to the Medical Staff leadership.

What expectations or guidance are set forth in the Medical Staff By-Laws and Rules and Regulations related to acute inpatient medical care?

Is there an active Utilization Management function/committee/role of the Medical Staff; and how does it manage difference of experience, skills, and motive between EM and HM physicians?

HM SERVICE STAFFING

Days per week and hours per day (especially shift start and end times) should be established to meet times needed, not for convenience of the providers.

Coverage of less than 24 hours per day almost always involves a trade off since shift hours need to accommodate patients that can and should be discharged early in the day to make beds available, and the need to be accessible in the late afternoons and evenings to facilitate admissions that come through the ED.

Standalone HM services in some small hospitals is far more expensive that the benefit. If the ED patient volume and HM patient volume permit, a "hybrid" structure may be most useful. It is certainly more cost-effective.

Mid-level providers should be considered.

As daily census varies widely, allowing HM physician to leave their shift and "clock out" . Remember, the schedule is to grow revenue, not be convenient.

Are HM physicians on call after on-site work hours to assist with questionable potential admissions that come the ED?

Avoid opting for reducing cost at the expense of generating additional revenue. No one saves themselves into prosperity.

PROVIDER PAY

Higher pay doesn't guarantee better medicine and better results. But is does provide more options to chose from, and permits you to command higher performance. A highly attractive compensation package makes it difficult to leave and go somewhere else. The compensation of all providers, and in particular HM and EM physicians, in a small hospital must lean toward a rate that is higher than the small hospital market rate.

PERFORMANCE EXPECTATIONS

First, expect high performance; and hold the HM service accountable.

What are the performance expectations? Do you hold providers accountable for quality, customer service/satisfaction, as well as financial results?

Is performance reviewed with providers and are they held accountable for meeting standards? Do cases of questionable medical necessity, or claims declined because of being medically unnecessary go to the Medical Staff UR function for review and resolution?

Do HM providers assist the hospital billing staff in defending claims denied for medical necessity?

How are HM physicians evaluated in relation to one another? Are individual EM and HM physicians evaluated in terms of the other's capabilities and performance? All physicians are not equal.

Is the acute admission performance of individual EM physicians judged compared to performance of the overall HM service, and/or with respect to EM/HM pairs working concurrent shifts?

How is the performance of the HM service measured in terms of potential market share or numerical goals?

Are providers aware of cases that could have been documented at a higher ICD-10 or CPT with improved documentation? How are they coached to improve?

What are the consequences of expectations met or not met?

What method exists for retrospective individual case review of high risk patients, transfers, etc.?

ACTUAL SERVICE DELIVERY

Know your numbers and know acceptable benchmarks.

What is your acute admission rate through the ED? What is the OBS rate?

At what point in the admission decision does the Hospitalist become involved?
Office-based PCP/specialist?
Emergency Medicine?

What is the basis of admission

decisions (understanding of regulatory authority for medical necessity, third-party standards [e.g. InterQual, Milliman, etc.], limitations of HM physicians' medical training, experiences, nursing and hospital staff limitations, and physician comfort level and risk threshold)?

Do your EM and HM providers have final authority for making the admission decisions based on medial necessity or are they directed by the UR/UM staff?

What are the expectations of the PCPs regarding treatment of their patients, for keeping local versus transferring to another hospital, and for hand-off upon discharge?

Do PCPs expect a call from HM physician to participate in admission decision?

For more on this topic, read Insight Newsletter V1.4 "Seeds and Silos" (July 2016) available online at: www.hospitalmd.com/resources.

–Jim Burnette