PRACTICE MODELS FOR INPATIENT GI CONSULTATION

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“An expert is somebody who is more than 50 miles from home, has no responsibility for implementing the advice he gives, and shows slides”

Edwin Meese III
The Evolution of a New Species – The Hospitalist

- 1996: “Hospitalist” (Wachter, Goldman) (“>25% of time spent on inpatient care”)
- 1997: National Assoc. of Inpatient Physicians
- 1999: 65% of internists had Hospitalists in their community
- 2003: 8000 practicing Hospitalists in the US
- 2010: 20,000 practicing Hospitalists in the US
- 2016: 50,000 Hospitalists projected
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Subspecialty Hospitalists starting to appear

Optimizing the Efficiency of Hospital Coverage - Why Bother?

- Cost Pressures
  - On Physician Groups
  - On Hospitals
Maintaining Profitability in Times of Increasing Cost Pressures

- Rank order by expected collections per hour worked in each location (per Tom Deas):
  - Clinic $300
  - Hospital $500
  - ASC $1300
  - In your car $0

Optimizing the Efficiency of Hospital Coverage - Why Bother?

- Cost Pressures
  - On Physician Groups
  - On Hospitals

- Change in patterns of inpatient medicine
  - Shorter LOS
  - Increased acuity/complexity
  - IM hospitalists
    - Need to match immediate availability
Changes have made the traditional clinical structure of a physician providing both inpatient and outpatient services more difficult to sustain.

- Inpatient volume and the acuity of illness means that it may no longer possible for providers to see outpatients or perform endoscopic procedures in an ambulatory endoscopy center (AEC) while reserving inpatient care to early in the morning, at lunch-time, or late in the evening.

- This traditional practice structure is increasingly leading to suboptimal care in both settings as well as to lost revenue and patient inconvenience when cancelling outpatient appointments due to inpatient emergencies and leading to decreased physician satisfaction and increased burnout.

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- Designation of a dedicated inpatient Gastroenterology provider allows immediate on-site care for patients presenting with urgent or emergent needs.

- Allows the inpatient Gastroenterology provider to become more proficient in complex endoscopic procedures that are more often employed in severely ill patients.
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- Practicing exclusively in the inpatient setting also allows the provider to become more proficient in the particular intangibles associated with specific hospitals – i.e., which staff to contact to arrange logistics regarding endoscopy scheduling; becoming familiar with the hospital pathologists, radiologists, and surgeons whose collaboration is vital for the modern inpatient Gastroenterology practice.

- Improved proficiency in how to order Gastroenterology-specific diagnostics and treatments within the electronic medical record system – all of which lead to better efficiency and improved patient care.

Potential benefits of a Hospitalist system

- Reduction in LOS and cost per patient
- Improved on site availability
- “Practice makes perfect”
  - Reduction of variability of care
  - Expert care of acutely ill patients
  - Advanced procedure skills
Potential concerns about a Hospitalist system

- Poor acceptance by patients?
- Poor acceptance by GI provider?
- Trading quality for efficacy?
- Loss of information in the hand-off?
- Diminishing skill level of office physicians?

The #1 Obstacle - Tipping the Scale

Efficiency
Shareholders’ Preferences
Hospitalist System
To Improve Efficiency

Different Models of Hospital Coverage

- Physician follows own patients
- Physicians in group do block rotations
- Dedicated GI hospitalists
  - All patients must be “handed off” to GI hospitalist
Factors affecting choice of model

- Size of group
- Hospital volume
- Physician skillset requirements and availability

Internal Challenges and Efficiency Drains

- Provider skill set
  - Need to provide all services offered at his/her hospital
  - Invest in NPP training
  - Ability to communicate

- Provider mindset
  - Establish productivity expectations
  - Pick team players

- Process streamlining
  - Uniform schedules
  - Minimize shared coverage/mixing teams
Capacity Management

- "Flexible flow" environment
- Strategies to deal with variable demand
  - On-call person picks up overflow
  - Become good at triaging
  - Other hospitalist team helps out
  - Adjust outpatient procedure schedule
  - Allow hospitalists to perform interpretation of non-urgent services (e.g. capsules)
- Cannot staff for peak capacity
  - Use down-time for "marketing"/PR

Challenges at the Interface

- Access to outpatient records
  - EMR - Practice server accessible via internet
  - Care coordinator as facilitator
- Complete and accurate reporting of services
  - Charge capture software, wireless transmission
  - Track performance
  - Hassle factor
- Diminishing skill set of office MDs with dedicated GI hospitalist model
GI Hospitalist System - Definite Challenges

- Group culture
  - Two classes of physicians
    - Voting blocks
  - What is fair and equitable?
  - Salary structure
    - Base guarantee of mean income plus incentive
- Burn out – Try to avoid by:
  - Diligent capacity planning
  - No calls/holidays
  - Turn beeper off at 5pm
  - “Safety valve” for busy days
    - On-call MD
    - NPP
    - Fellow hospitalists

One GH GI Hospitalist Model

- Inception in 2005
  - 15 MD practice; 1MD/1PA team covering 2 hospitals
- In 2009
  - 2 hospitalist teams of 1MD/1PA
  - 2 clinical coordinators
  - 3 hospitals (plus outpt scopes)
- Per MD/PA team
  - 3-8 procedures
  - 5-15 new patients
  - Average inpt census 20 per team (<10% primary)
GI Hospitalist System – Pleasant Surprises

- Retaining senior colleagues
- Significant gains in efficiency translate into considerable revenue increase for office physicians
- Close relationship with other hospital based physicians and nurses
- Patients love MD/PA accessibility
- Busy hospital-based practice for advanced endoscopic procedures

FULL TIME HOSPITALIST MODEL

DIGESTIVE HEALTH SPECIALISTS
TACOMA
The DHS GI Hospitalist Model

- Inception in 1997
  - 5 MD practice; 1MD/1PA team covering 2 hospitals
- In 2009
  - 4 hospitalist teams of 1MD/1PA
  - 2 nurse schedulers
  - 7 hospitals (plus outpt scopes)
- Per MD/PA team
  - 8-10 procedures
  - 5-15 new patients
  - Average inpt census 20 (<10% primary)

GI Hospitalist Schedule

- Mon-Thurs 7am-5pm, Fri 7am-12noon
  - 7am: accept beeper and sign-out from on-call MD
  - 5pm: sign out remaining work and problematic patients to oncoming on-call MD
- No call (weekday, weekend, holiday)
  - Except ERCP background ~1/month
- Call provided by office MDs
- Weekend PAs (Friday 7am-Monday noon)
- [Weekend MDs - if we can find them]
Non-Physician Providers - Responsibilities

- Rounding on all established patients
- New consultations
- Communication
  - Family conferences
  - Referring providers
  - ER/ICU staff
  - Social work
- Teaching/PR activities
- Be accessible

NPP - MD Interface

- Morning - Review inpatient census
- Afternoon - Review inpatient census
- Phone calls, voicemails, text messaging
- MD rounds on
  - New patients
  - ICU patients
  - Patients on primary GI service
  - Other patients as identified by NPP
- Spends >50% time doing procedures
NP/PA Incident-to laws

Incident-to billing is a way of billing for services provided by a non-physician practitioner (NPP) such as a nurse practitioner (NP), physician assistant (PA), or other non-physician provider.

1) NPP may treat a patient for a new problem and will need to bill under their own NPI.
2) Incident-to guidelines are for services provided by NPP under the direction of a Physician that has established a problem and a treatment plan. Incident-to guidelines were developed by Medicare, and other insurance carriers do not necessarily follow Medicare’s lead. Ask your insurance payer for clarification.
3) If NPP treats patients for a new condition that is not part of the incident-to treatment plan, NPP needs to bill under their own NPI.
4) Physician must perform subsequent services that reflect his/her continued active participation in and management of the patient’s care, in order to NPP to continue billing under incident-to. A specific time frame of physician involvement and management is not stipulated.
5) New patient visits cannot be split or shared between the NPP and physician in order to bill incident-to follow-up visits. The physician must independently see the patient and establish a plan of care for the condition.
6) When in doubt bill using the NPP’s NPI number.

GI Hospitalist: Physician Productivity

Track: Expect*:
- E&M encounters ~1000
- Procedures ~1500
- wRVUs ~6800-7500wRVU
- Charges ~$1.0-1.2Mio
- Receipts ~$400-450k

*4.5 days/wk, no call/weekends, covering 2 hospitals, working with PA
Problems and their potential solutions

- **Burn-out** → No calls, no holidays, sufficient vacation
- **Beeper** → Turn off at set time
- **Lack of information** → Phone, PDA, Fax, EMR
- **Unfavorable payer mix** → Innovative compensation models

Problems and their potential solutions

- **Fluctuating work load** → Physician Extenders, open access endoscopy, “deal with it!”
- **Need to follow-up complex patients** → Creation of a follow-up clinic
- **Multiple hospitals** → Good music in the car...
The GI Hospitalist Team – Keys to Success

- Communication
- Know everyone’s value – and their limits...
- Stay cool and smile...
- Go home when it’s time to go

Build structure and incentives to create “ownership” mentality for hospitalists

- Avoid “shift” mentality
- Implement compensation system that rewards performance including productivity and clinical quality.
- Participation in group and management strategy and governance.
- Provide adequate support at office (billing, coding, communication, EMR access, follow up)
- Develop and track performance goals and metrics with hospitalist.
- Share with hospitalists and other stakeholders.
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Summary

- Dedicated GI hospitalist model probably allows for the most efficient hospital coverage
  - ...if you can pull it off!
- Rotating hospitalist model may be the best compromise for most settings, allowing immediate presence while maintaining every provider’s skill set, avoiding two-tier system and minimizing risk for burnout
- Non-physician providers are critical to increase efficiency (and quality) of care
GI Hospitalist System – Definite Pros

- Significant gains in efficiency
  - Revenue increase for office physicians
- Predictable schedule
  - Retaining senior colleagues
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