

# Certificate Training Program Session 8

## Welcome! Before We Begin:

Sign-in at the back

Pick up agenda

Sit with your CTP team at your assigned table



Institute for Healthcare Quality,  
Safety and Efficiency

SCHOOL OF MEDICINE

UNIVERSITY OF COLORADO ANSCHUTZ MEDICAL CAMPUS

# Curriculum Overview

KEY
Team Check-in
Inspiration
Background
Process Improvement
Leadership
Quality/Safety
Coaching
EMR

8/20	#1	Welcome	Beginning with the End in Mind	Objectives & Introductions	Overview	Leadership Defined	Team Norms	
8/27	#2	UCH Sleep	Thriving as a Leadership Imperative	Value Defined	Introduction to Quality Improvement	IHQSE Model of Change	Coaching	
9/3		Coaching						
9/10	#3	CHCO Secure Chat	Investigate the Problem	Problem Statement	Voice of the Customer	Process Mapping	Stakeholder Analysis	EMR Process & Data
9/17		Coaching						
9/24	#4	UCH Multidisciplinary Pain Clinic	Investigate the Problem	Understanding Root Causes	Baseline Data	Business Case	Coaching	
10/1		Coaching						
10/8	#5	UCH Neurosciences	QI vs. Research		Leading Change			
10/15		Coaching						
10/22	#6	DHA Antimicrobial Stewardship	Data Collection Plan			Myers Briggs		
10/28		Coaching						
11/12	#7	CU Medicine Dermatology	Leading Change: Vision		DEI in QI		Positive Deviance	
11/19	#8	UCH Infectious Disease	Leading Change: Sense of Urgency	Understanding Business Drivers	Negotiating for what You Need		This Place Called Academia	
11/26		Coaching						
12/3	#9	UCH Nursery	Hone the Intervention	Identifying Your Intervention		Design Thinking	Wellness	Leading Change Guiding Coalition
12/10	#10	DHA Clinical Informatics	Leadership Journey: Tom Gronow	Aim Statement		Optimizing EMR Requests	Storytelling	Team Logo
12/17		Coaching						
1/14	#11	CHCO ICU Delirium	Alumni Presentation	Leadership Journey: Jena Hausmann		Pre-mortem Analysis	Leading Change: Awareness Campaign	Mid-year Report Overview

KEY	Team Check-in	Inspiration	Background	Process Improvement	Leadership	Quality/Safety	Coaching
Session	Topic		Key Question(s)		Assignment	Due	
<b>Coaching</b> Data collection plan, problem statement							
#7 Nov. 12	Team Check-in: CU Medicine Dermatology		Who are my colleagues?		<input type="checkbox"/> Develop/utilize current vision tying to project Due Nov. 19 <input type="checkbox"/> DEI Scan, Complete Positive Deviance Exercise Due Jan. 28	<input checked="" type="checkbox"/> Develop Problem Statement <input checked="" type="checkbox"/> Affinity Diagram	
	Positive Deviance		How can I harness successful behaviors to drive improvement?				
	DEI in QI		How can we apply a DEI lens to QI?				
	Leading Change: Vision		How do I tie my project back to a larger vision?				
#8 Nov. 19	Team Check-in: UCH Infectious Diseases		Who are my colleagues?		<input type="checkbox"/> Finalize Sense of Urgency Due Dec. 3	<input checked="" type="checkbox"/> Draft Business Case <input checked="" type="checkbox"/> Develop/utilize current vision tying to project Complete literature review <input checked="" type="checkbox"/> Complete Program Evaluation/QI/Research Tool	
	Leading Change: Sense of Urgency		How do we create the desire for change?				
	Understanding Business Drivers		What is driving the decision making on our campus and how can we best influence those issues?				
	Negotiation		How do I negotiate for what I need?				
	This Place Called Academia		How do the finances flow and drive the priorities of an Academic Medical Center?				
<b>Coaching</b> Sense of urgency, DEI Scan, create communication plan							
#9 Dec. 3	Team Check-in: UCH Nursery		Who are my colleagues?		<input type="checkbox"/> Develop list of potential interventions, Finalize Guiding Coalition, Complete Design Thinking Exercise Due Jan. 28	<input checked="" type="checkbox"/> Sense of Urgency, Data Collection Plan	
	Hone the Intervention		How do I develop an intervention?				
	Design Thinking		How do I develop a process for redesigning care?				
	Identifying Your Intervention		How do I create an action plan for my intervention?				
	Wellness		How do we ensure that our work enhances, not worsens wellness?				
	Leading Change: Guiding Coalition		Who do I need to <u>involved</u> my project team?				

# Today's Learning Objectives

- 1 Understand funds flow on an Academic Medical Campus
- 2 Understand what is driving healthcare decisions
- 3 Be able to negotiate for what you need
- 4 Develop a plan to create a sense of urgency for change for your project.





# Team Check-in: UCH Infectious Disease

## Aim and Problem Statement

- Introductions
- Tell us about your program
- What is the problem you think you will focus on?
- Members:
  - Nipun Atri, MD
  - Karrine Brade, PharmD, BCIDP
  - Lakshmi Chauhan, MD
  - Brian Grundy, MBBS, MPH



# Creating a Sense of Urgency

Jeff Glasheen, MD



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# Objectives

- Understand the three components to building urgency
- Build urgency for your project



# The Change Process

- Establish a sense of urgency
  - People need to think there is a problem
- Creating a guiding coalition
  - Find the thought leaders and engage
- Develop a vision and strategy
  - “Where” going and “how” things will change
- Communicate the change vision
  - Must be dogged & constant: coalition on board
- Empower broad-based action
  - Remove obstacles
- Generate short-term wins
  - Plan and create these; reward the “changers”
- Consolidate gains, produce more change
  - Use credibility for more change
- Anchor new approaches in culture
  - Make this part of the culture going forward







# Establish a sense of urgency

- People need to think there is a problem
  - Is this an important problem?
  - What is the crisis?
  - What are the opportunities?
  - How can these be related to your colleagues?
- If you cannot create a sense of urgency...
  - Stop!
  - It'll fail. Guaranteed!
  - Don't go to step 2 unless you've got this



# Good is the enemy of great

Sense of Urgency

~~Good~~ + change being difficult = no change



# Burning Platform vs. Burning Aspiration

- <https://youtu.be/Tfn6vD4yyC4>

- Take-aways

1. To sustain change you must transition from burning platform to burning aspiration/ambition
2. Urgency must address both organizational and personal motivations
3. The fire, or 'big why', must be at the center of your work
  - "He who has a why to live can bear almost any how" -Nietzsche



# Process for Creating Urgency

- Step 1: Tell a story that encapsulates the problem
- Step 2: Use data to show the scope of the problem
- Step 3: Tie back to purpose and vision



# Sense of Urgency: Story





# Sense of Urgency: Data—Scope of Problem

2412 per year

201 per mo.

7 per day

70% higher than national average



# Sense of Urgency: Tie Back to Vision

Best Pediatric Hospital Medicine Program in the Country



# Step 1: Create a Story

- Keep your story short
  - Your story should be jarring...it should command people's attention
  - Personalize it
    - Include a picture of a person
    - Include a first name, bit about their life
  - Skip parts of the story that are not absolutely necessary to the goal
- Memorize the key parts/all of the story
  - Don't type details on the slide or read it from a page
- Pause/slow for emphasis at the key points, let the impact set in
- Mold the story to fit your objective
- Assignment—Create your Story



# Step 1: Create a Story

- Assignment—Create your Story

# Step 2: Use Data for Scope

- Stories are great, but have a short half life
- Use data to convince people of the scope of the problem
- Does not have to be research-level data
  - Can be 10 chart reviews, survey data, interviews
  - Local data better than national or published
- Extrapolate and contextualize your data to show impact
  - If found in 6 of 20 charts = 30%
    - Extrapolate this 30% over 30,000 discharges
      - 9,000 per year in our hospital
    - Contextualize—that's 750/month, 173/week, 25/day, once during this presentation
- Assignment—What data will show the scope of your problem



# Step 2: Use Data for Scope

- Assignment—Use the data to create your scope of the problem



# Step 3: Tie Work to a Vision or Purpose

- Use a vision that people already believe in
  - The undeniably best academic hospital medicine program in the country.
- If you don't have one, create one for your program
- You can also tie back to sense of purpose
  - As physicians, we are at our core, diagnosticians.
- Then show that the work ties directly back to the vision or purpose
  - Show me how doing this will allow me/us to achieve our vision
    - We all want to be the undeniably best academic hospital medicine program
    - Wouldn't the best have the fewest diagnostic errors
    - Lead the nation in fixing this problem
    - That is the opportunity we have before us!
- Assignment—tie your work back to a vision or purpose



# Step 3: Tie Work to a Vision or Purpose

- Assignment—tie your work back to a vision or purpose. Use an existing vision or create one. This needs to be inspirational AND aspirational.
- We aspire to be the best xxxxx in the hospital/country/world/galaxy.



# Step 4: Share Urgency Frequently

- Every time you share information remind people about the urgency
  - This can be the entire spiel or just ‘remember Ariana,’ or ‘recall that every day 12 people suffer a serious diagnostic error.’
  - It should be short, like a 15-30 second reminder.
- Without urgency, you are just asking people to do something they don’t want to do.
  - The result is predictable



# Step 4: Share Urgency Frequently

- Assignment—use this slide deck at all/many/most future presentations. Be able to speak to the key points when you don't have ppt available.



# This Place Called Academia

Understanding the form & funding of academic medical centers to get what you need



# Objectives

- Understand School and Hospital funding
  - Identify sources & impact of GME, DRG & CMI
- Understand business drivers
  - Learn to leverage them for support
- Negotiate for resources
  - How to get resources to support your work





# How Well Do You Know You?

## School of Medicine

- What was the total SOM revenue last year?
- What are the three main sources of funding at the school of medicine?

## Hospital

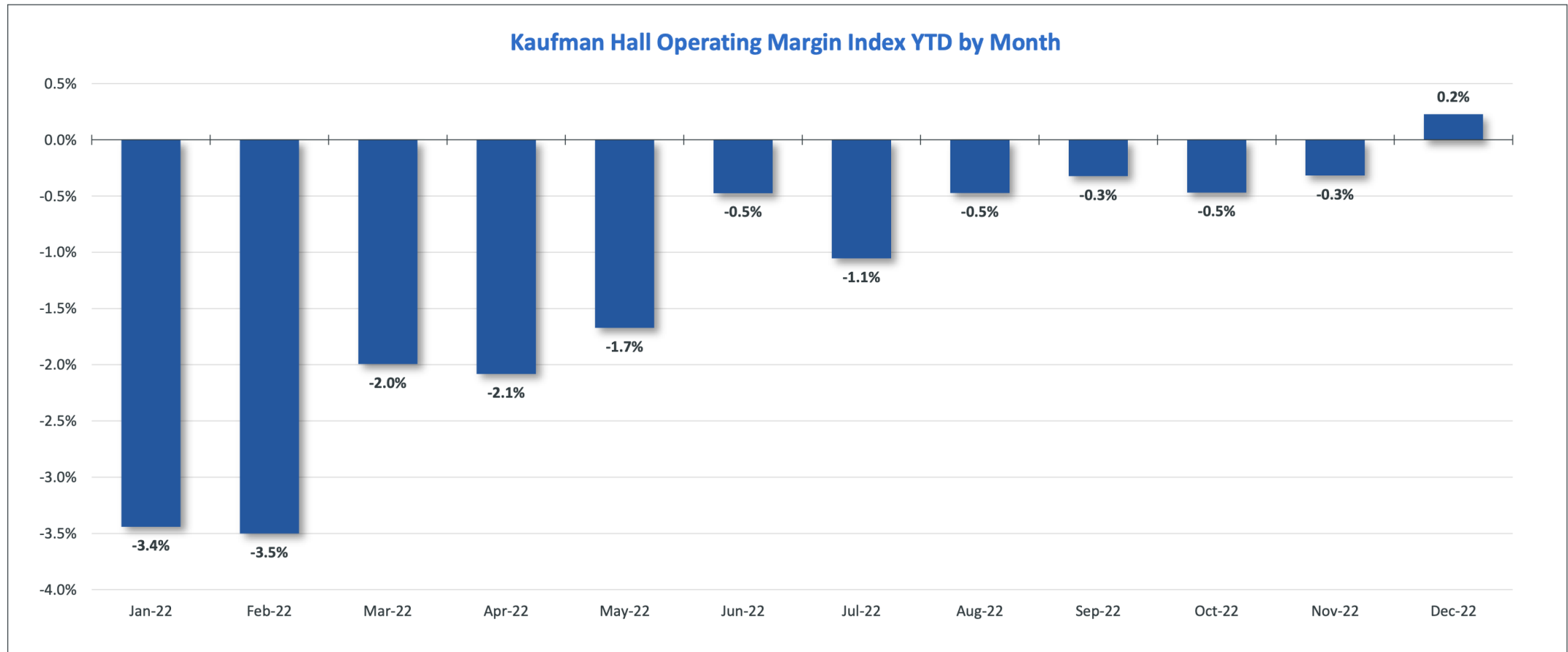
- What is the annual amount that your hospital receives in GME support for resident education?
- What does your hospital get paid to care for a pt. w/ PNA?



Revenue - Expenses = Margin

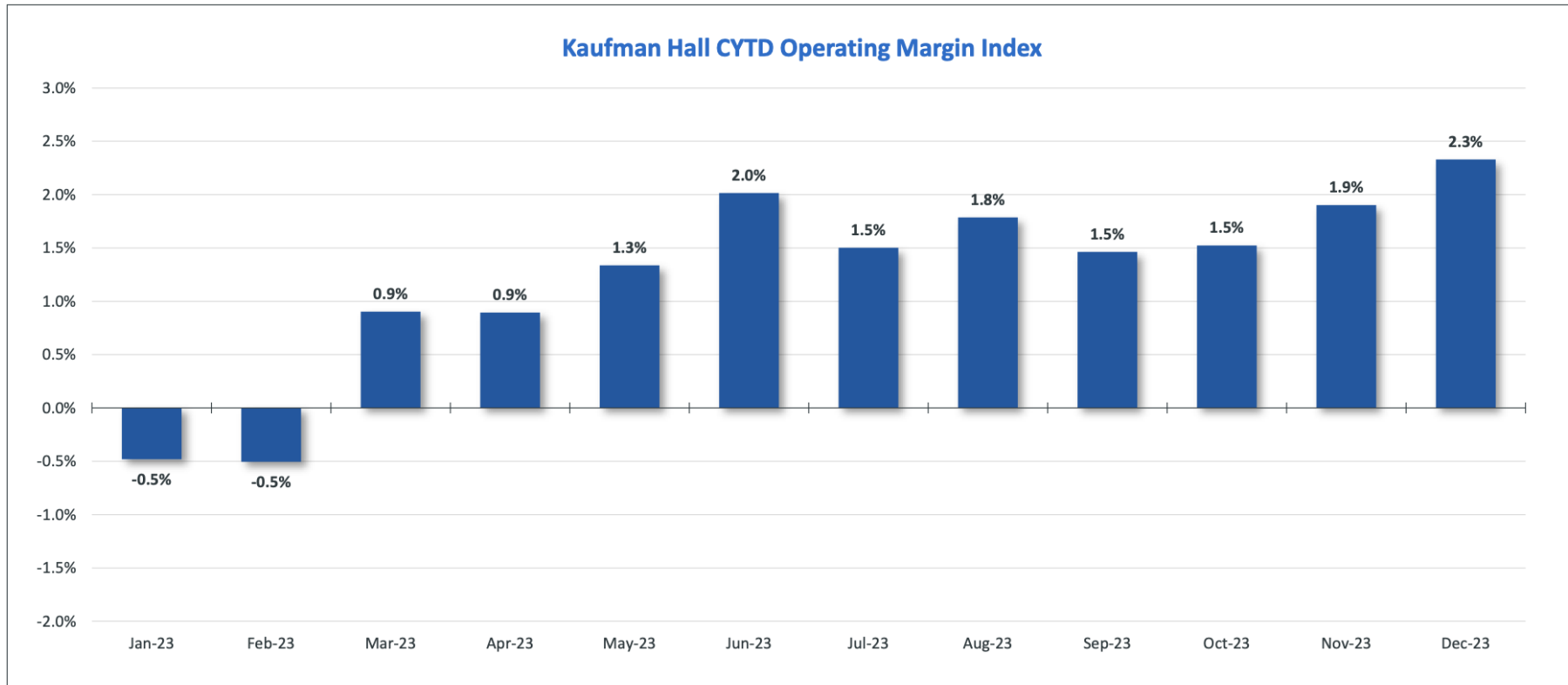


# Average Hospital Operating Margins



# Average Hospital Operating Margin

## Operating Margin



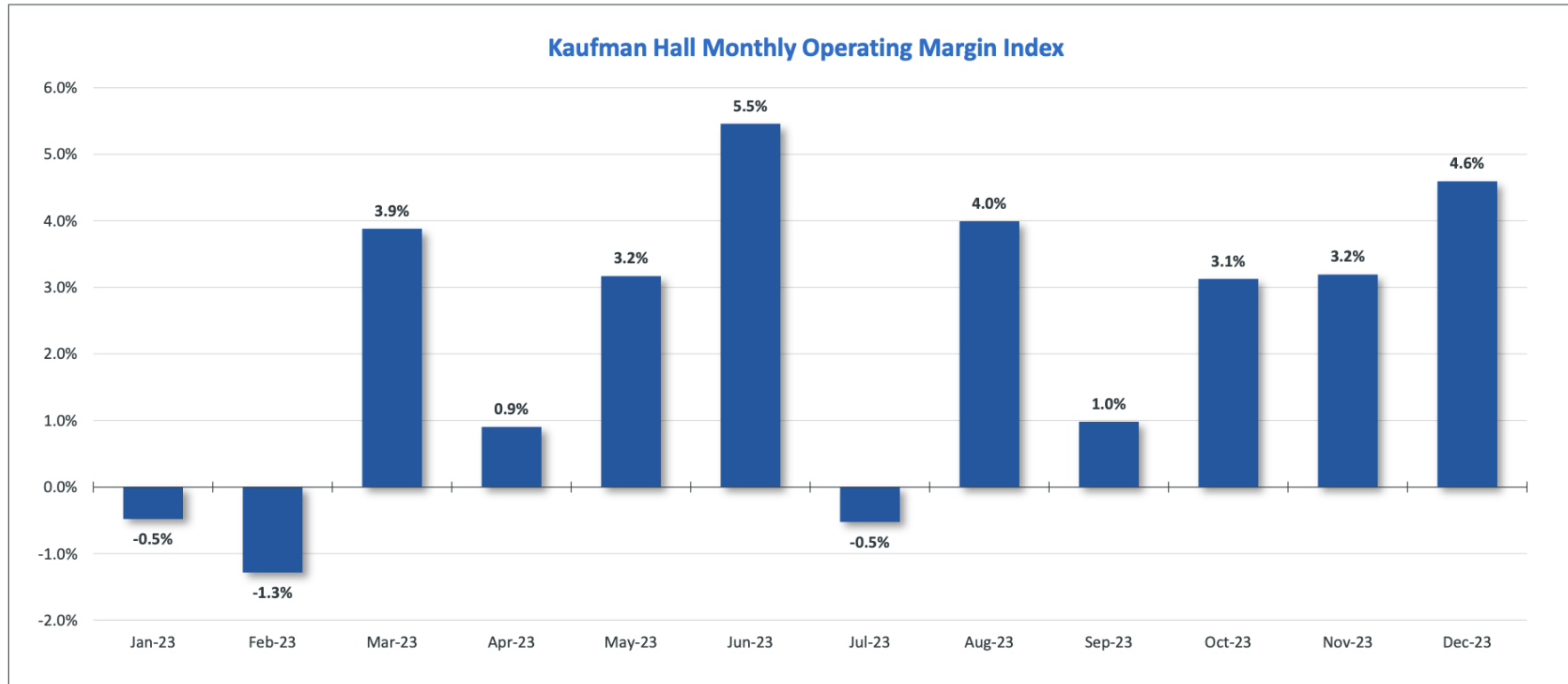
Kaufman Hall, National Hospital Flash Report (December 2023)

\* Note: The Kaufman Hall Hospital Operating Margin and Operating EBITDA Margin Indices are comprised of the national median of our dataset adjusted for allocations to hospitals from corporate, physician, and other entities.



# Average Hospital Operating Margin

## Operating Margin *(continued)*



Kaufman Hall, National Hospital Flash Report (December 2023)

\* Note: The Kaufman Hall Hospital Operating Margin and Operating EBITDA Margin Indices are comprised of the national median of our dataset adjusted for allocations to hospitals from corporate, physician, and other entities.

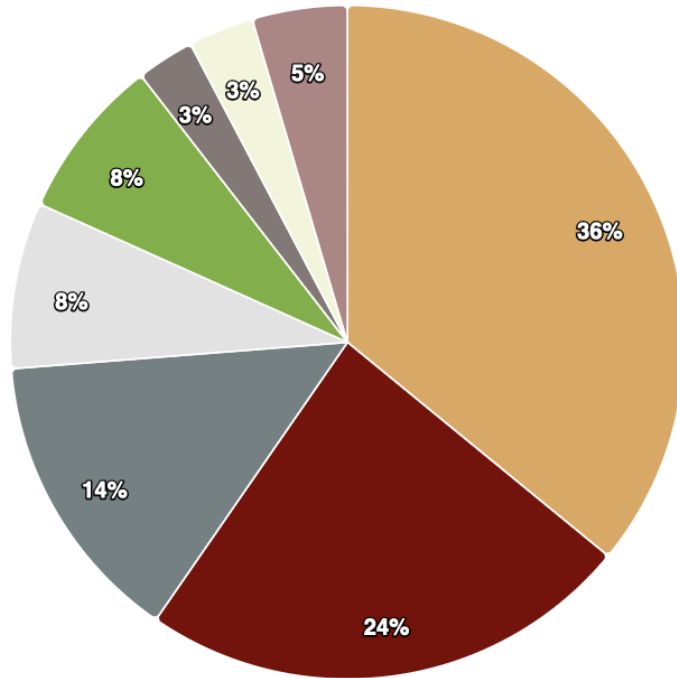
Revenue - Expenses = Margin





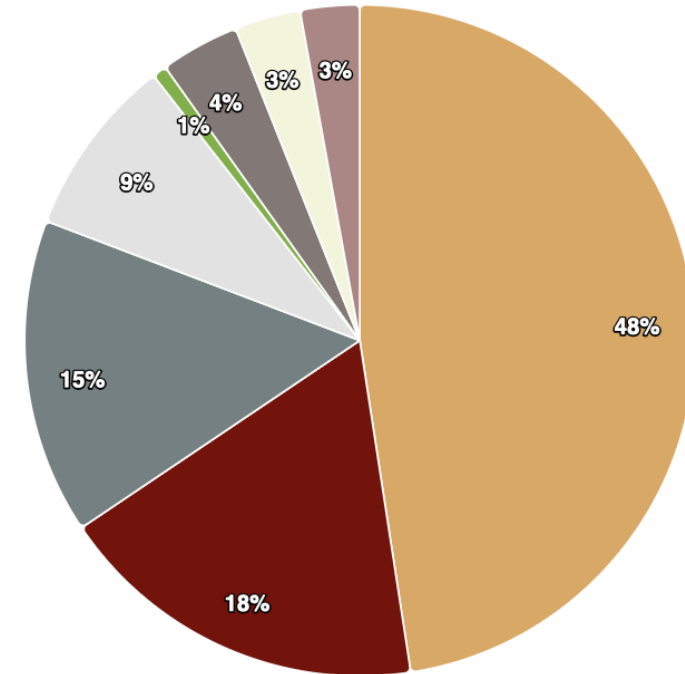
# Medical School Revenue by Source

Public Medical Schools



Median = \$663M

Private School Revenues



Median = \$914M

- Practice Plan
  Hospital
  Federal Grants and Contracts
- Other Grants and Contracts
  Government and Parent Support
- Gifts and Endowment
  Tuition and Fees
  Miscellaneous Sources

# Funding Hospitals

- Charge to insurer/patient for clinical care
  - Prospective payment—Diagnosis Related Group (DRG)



# The DRG:

## Or, Why Hospitals Care About Length of Stay

- LOS ↓ 0.5 d/pt
  - Costs/case ↓ \$1,000
  - 34,084 admissions
- Benefit #1: Cost Savings
  - 34,084 admissions x \$1,000 saved = \$34.1 million saved
- Benefit #2: New Revenue
  - 34,084 admissions x 0.5 d↓ LOS = 17,042 bed days saved
  - 17,042 bed days x \$500 = \$8.5 million generated

**Total Benefit = \$42.6 million/yr**



# Funding Teaching Hospitals

- Charge to insurer/patient for clinical care
  - Prospective payment—Diagnosis Related Group (DRG)
- Training adds costs
  - Faculty, offices, classrooms, libraries, technology
  - Inefficiency of learner-provided care
- Medicare
  - DRG per admission plus GME payments

# Graduate Medical Education Payments

- Direct GME (DME)
  - Costs directly allocated to education
    - Resident salary/ben & faculty costs/overhead
  - Per Resident Amount (PRA)
    - Hospital's DME costs/# of residents in 1984
    - Trended forward by inflation increases
  - PRA multiplied by number of residents
  - Multiplied by ratio—Medicare/total hospital days

# DME Calculation

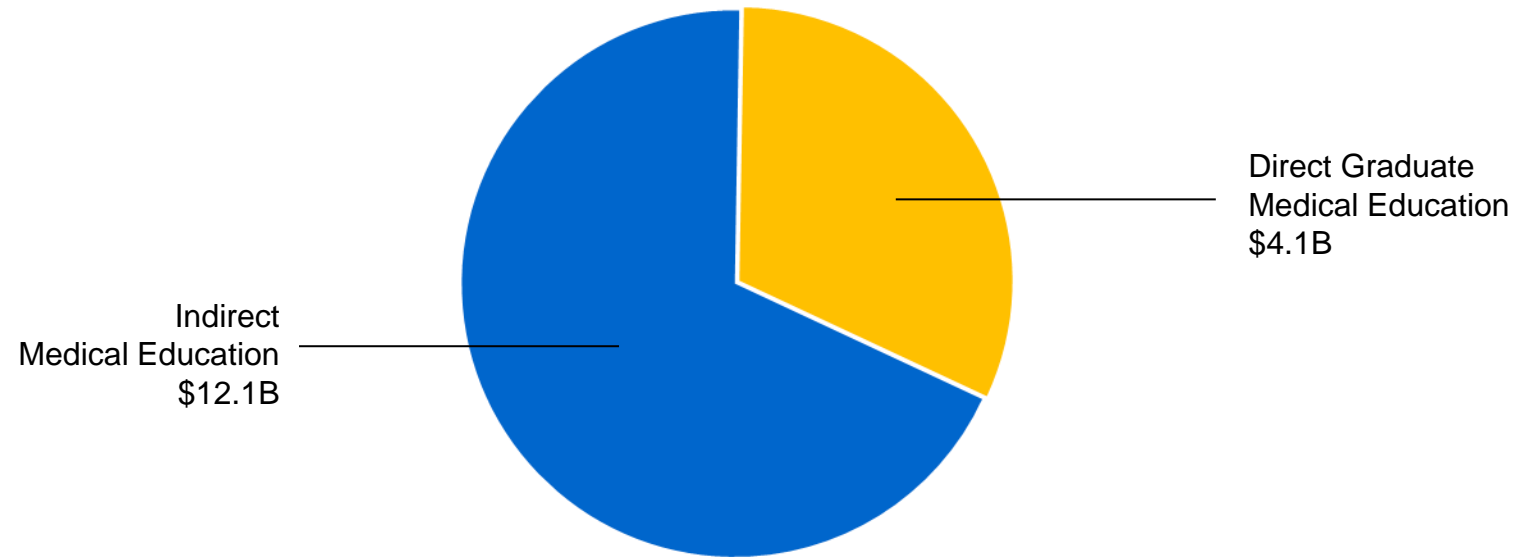
DME = (# residents x PRA ) x Medicare ratio

Number of residents	125
	x
Per resident amount	\$110,000
	x
<u>Medicare/total days</u>	<u>35%</u>
DME	\$4,812,500

# Indirect Medical Education Payments

- Compensation for higher costs associated with care provided by learners
  - Inefficiency of learners
  - Increased resource utilization
  - Higher complexity of care
- Add on payment to each DRG payment
- Calculated based on resident-to-bed ratio

# GME payments



<https://www.graham-center.org/maps-data-tools/gme-data-tables.html>

Denver Health → DME \$2,416,060 + IME \$7,275,823 = \$9,691,883

Children's Hospital Colorado → \$10,422,603

University of Colorado → DME \$10,767,176 + IME \$42,869,828 = \$53,637,004



# Top Ten Hospitals

• NYU Langone Hospital	\$314,577,312
• New York Presbyterian Hospital	\$278,207,008
• Montefiore Medical Center	\$266,149,520
• Mount Sinai Hospital	\$221,718,240
• UPMC	\$150,687,424
• Mass General Hospital	\$150,813,136
• Yale New Haven Hospital	\$140,602,160
• Stanford Healthcare	\$139,390,240
• University of Pennsylvania	\$131,850,168
• Brigham and Women's	\$131,206,744



# How Much Does a Hospital Get Paid to Care For a Pt. with Pneumonia?

- Each DRG has a ‘Relative Weight’
  - $RW = \frac{\text{avg. of resources to care for the DRG}}{\text{avg. of resources for all DRGs}}$



# What's the DRG-RW for Pneumonia?

**TABLE 5.—LIST OF MEDICARE SEVERITY DIAGNOSIS-RELATED GROUPS (MS-DRGS), RELATIVE WEIGHTING FACTORS, AND GEOMETRIC AND ARITHMETIC MEAN LENGTH OF STAY—FY 2015 Final Rule**

MS-DRG	FINAL Post-Acute DRG	FY 2015 NPRM Special Pay DRG	MDC	TYPE	MS-DRG Title	Weights	Geometric Mean LOS	Arithmetic Mean LOS
184	No	No	04	MED	MAJOR CHEST TRAUMA W CC	0.9889	3.3	4.0
185	No	No	04	MED	MAJOR CHEST TRAUMA W/O CC/MCC	0.6628	2.4	2.8
186	Yes	No	04	MED	PLEURAL EFFUSION W MCC	1.5452	4.8	6.2
187	Yes	No	04	MED	PLEURAL EFFUSION W CC	1.0691	3.5	4.5
188	Yes	No	04	MED	PLEURAL EFFUSION W/O CC/MCC	0.7609	2.5	3.2
189	No	No	04	MED	PULMONARY EDEMA & RESPIRATORY FAILURE	1.2136	3.9	5.0
190	Yes	No	04	MED	CHRONIC OBSTRUCTIVE PULMONARY DISEASE W MCC	1.1743	4.2	5.1
191	Yes	No	04	MED	CHRONIC OBSTRUCTIVE PULMONARY DISEASE W CC	0.9370	3.4	4.2
192	Yes	No	04	MED	CHRONIC OBSTRUCTIVE PULMONARY DISEASE W/O CC/MCC	0.7190	2.7	3.3
193	Yes	No	04	MED	SIMPLE PNEUMONIA & PLEURISY W MCC	1.4491	4.9	6.0
194	Yes	No	04	MED	SIMPLE PNEUMONIA & PLEURISY W CC	0.9688	3.8	4.5
195	Yes	No	04	MED	SIMPLE PNEUMONIA & PLEURISY W/O CC/MCC	0.7044	2.9	3.4
196	Yes	No	04	MED	INTERSTITIAL LUNG DISEASE W MCC	1.6635	5.4	6.9
197	Yes	No	04	MED	INTERSTITIAL LUNG DISEASE W CC	1.0615	3.7	4.6
198	Yes	No	04	MED	INTERSTITIAL LUNG DISEASE W/O CC/MCC	0.8054	2.7	3.3
199	No	No	04	MED	PNEUMOTHORAX W MCC	1.8345	5.8	7.5
200	No	No	04	MED	PNEUMOTHORAX W CC	1.0084	3.4	4.3
201	No	No	04	MED	PNEUMOTHORAX W/O CC/MCC	0.7096	2.5	3.2
202	No	No	04	MED	BRONCHITIS & ASTHMA W CC/MCC	0.8775	3.2	3.9
203	No	No	04	MED	BRONCHITIS & ASTHMA W/O CC/MCC	0.6535	2.5	3.0
204	No	No	04	MED	RESPIRATORY SIGNS & SYMPTOMS	0.7041	2.1	2.7
205	Yes	No	04	MED	OTHER RESPIRATORY SYSTEM DIAGNOSES W MCC	1.3999	4.0	5.3
206	Yes	No	04	MED	OTHER RESPIRATORY SYSTEM DIAGNOSES W/O MCC	0.7942	2.4	3.1
207	Yes	No	04	MED	RESPIRATORY SYSTEM DIAGNOSIS W VENTILATOR SUPPORT 96+ HOURS	5.3425	12.4	14.4
208	No	No	04	MED	RESPIRATORY SYSTEM DIAGNOSIS W VENTILATOR SUPPORT <96 HOURS	2.2969	5.0	6.9
215	No	No	05	SURG	OTHER HEART ASSIST SYSTEM IMPLANT	15.4348	11.3	17.3
216	Yes	Yes	05	SURG	CARDIAC VALVE & OTH MAJ CARDIOTHORACIC PROC W CARD CATH W MCC	9.5238	13.0	15.8
217	Yes	Yes	05	SURG	CARDIAC VALVE & OTH MAJ CARDIOTHORACIC PROC W CARD CATH W CC	6.3291	8.7	9.9
218	Yes	Yes	05	SURG	CARDIAC VALVE & OTH MAJ CARDIOTHORACIC PROC W CARD CATH W/O CC/MCC	5.5693	6.4	7.3
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220	Yes	Yes	05	SURG	CARDIAC VALVE & OTH MAJ CARDIOTHORACIC PROC W/O CARD CATH W CC	5.2056	6.6	7.3
221	Yes	Yes	05	SURG	CARDIAC VALVE & OTH MAJ CARDIOTHORACIC PROC W/O CARD CATH W/O CC/MCC	4.6347	4.9	5.4
222	No	No	05	SURG	CARDIAC DEFIB IMPLANT W CARDIAC CATH W AMI/HF/SHOCK W MCC	8.6570	9.9	11.9
223	No	No	05	SURG	CARDIAC DEFIB IMPLANT W CARDIAC CATH W AMI/HF/SHOCK W/O MCC	6.2924	4.4	6.0
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# How Much Does a Hospital Get Paid to Care For a Pt. with Pneumonia?

- Each DRG has a ‘Relative Weight’

- $RW = \frac{\text{avg. of resources to care for the DRG}}{\text{avg. of resources for all DRGs}}$

- $\text{Payment} = \text{DRG-RW} \times \text{Blended Rate}$

- $\text{Blended Rate} = \text{Base Rate } (\$7,926) + \text{Modifiers } (\$2,722)^* = \$10,648$

- Pneumonia Payment =

- $\$10,648 \times 0.70 = \$7,454$

Or,

- $\$10,648 \times 0.96 = \$10,222$

Or,

- $\$10,648 \times 1.44 = \$15,333$

\*Base rate modified for:

- 1) IME Costs
- 2) Wage Index
- 3) Cost Outliers
- 4) Disproportionate Share



# Case Mix Index:

Or, Why Hospitals Care about Procedures & Documentation

- CMI = Represents avg. DRG-RW for all cases
  - $CMI = \frac{\text{All DRG-RW}}{\text{Total no. of discharges}}$
- Small CMI Change = Large Revenue Change
  - UCH CMI
    - AY 2020 1.90
    - AY 2021 1.98
  - Each change in 0.01 = \$106.48/pt. (Blended rate/100)
  - UCH had 34,084 patients in 2021
    - Each 0.01 change =  $\$106.48 \times 34,084 \rightarrow \$3,629,264$
    - Net Revenue Increase =  $\$3.6m \times 8 = \$29,034,115^*$
- Procedures & appropriate documentation dictate CMI



# How Well Do You Know You?

## School of Medicine

- What was your total SOM revenue last year?
- What are the three main sources of funding at your school of medicine?

## Hospital

- What is the annual amount that your hospital receives in GME support for resident education?
- What does your hospital get paid to care for a pt. w/ PNA?



# Objectives

- Understand hospital revenue and expenses
  - Identify sources & impact of DRG, GME & CMI
- Understand business drivers
  - Learn to leverage them for support
- Negotiate for resources
  - How to get resources to support your work





# Goal

Learn how to build the case for getting what you need

# 3 Steps To Get What You Need

- What do they want?
- What do you want?
- Find the shared interest.



**c-SUITE**





# Business Drivers

- External forces that dictate internal objectives, tactics and decisions
- Most often:
  - Driver is invisible to the front-line staff
  - But the reaction to the driver is visible



# Hospital CEO Objectives

Objectives
Make money
Build cancer, cardiovascular, transplant
Reduce LOS
Build new buildings
Nurse satisfaction/Magnet Status
Recruit/Retain specialists
Patient Satisfaction
Need to enhance quality
JC Core Measure performance
Reduce never events/Improve safety
Reduce resource utilization
Reduce 30-day readmits
Consolidation into health systems



# What are the Business Drivers?

Business Drivers	Objectives
	Make money
	Build cancer, cardiovascular, transplant
	Reduce LOS
	Build new buildings
	Nurse satisfaction/Magnet Status
	Recruit/Retain specialists
	Patient Satisfaction
	Need to enhance quality
	JC Core Measure performance
	Reduce never events/Improve safety
	Reduce resource utilization
	Reduce 30-day readmits
	Consolidation into health systems

# Back To Reality

- At your tables, revisit the objectives
- For each objective note how you can positively influence them
- Record the findings in the 3<sup>rd</sup> column





# How Can You Impact the Objectives

Objectives	How You Can Impact
Make money	
Build cancer, cardiovascular, transplant	
Reduce LOS	
Build new buildings	
Nurse satisfaction/Magnet Status	
Recruit/Retain specialists	
Patient Satisfaction	
Need to enhance quality	
JC Core Measure performance	
Reduce never events/Improve safety	
Reduce resource utilization	
Reduce 30-day readmits	
Consolidation into health systems	



# Key Steps

- What do they want?
  
  
  
  
  
  
  
  
  
  
- What do you want?

# What do you want?

- Time for academic mission
- Exposure to learners/resources for scholarship
- Sustainable positions



# Key Steps

- What do they want?
- What do you want?
- Find the shared interest.



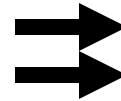
# Types of Negotiations

Competition



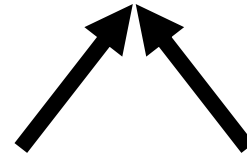
Win-Lose

Compromise



Lose-Lose

Collaboration



Win-Win

# Interests, Not Positions

- Positional bargaining leads to competition...  
...you are likely to lose the competition
- Rather, bargain over shared interests
  - Understand their interests
    - Not what they need (position), but why they need that (interests)
    - 5 Whys?
  - Freely share your interests (builds trust)
    - Not what you need (position), but why you need that (interests)
- Brainstorm for solutions that allow both parties to ‘win’



# Example: QI Project

- The Problem:
  - LOS Ortho Hip Fracture had risen to 6.6 days
  - Unclear primary service—ortho vs. medicine
  - Delays in getting to OR
  - Poor transition of care
- Results in:
  - Higher cost/case
  - More readmissions
  - Higher mortality



# Example: QI Project

- The Positions:
  - HMG—Need QI resources
  - Hospital—Not adding QI resources
- The Interests:
  - HMG—improved outcomes; resources/research time
  - Hospital—improved outcomes; didn't want to spend more money
- Not Interested in:
  - HMG—Doing work for free; chart abstraction, etc.
  - Hospital—funding research





# The Concept: Lost In Translation

- Hospital's quality, safety and efficiency



- Hospitalist's research; promotable activity



# The Shared Interest: Improve Value/Save Money

- Hospital's desire to not invest in 'research' is an attempt to save money
- Hospitalist's ability to successfully improve outcomes (b/c has support) will enable the hospital to save money

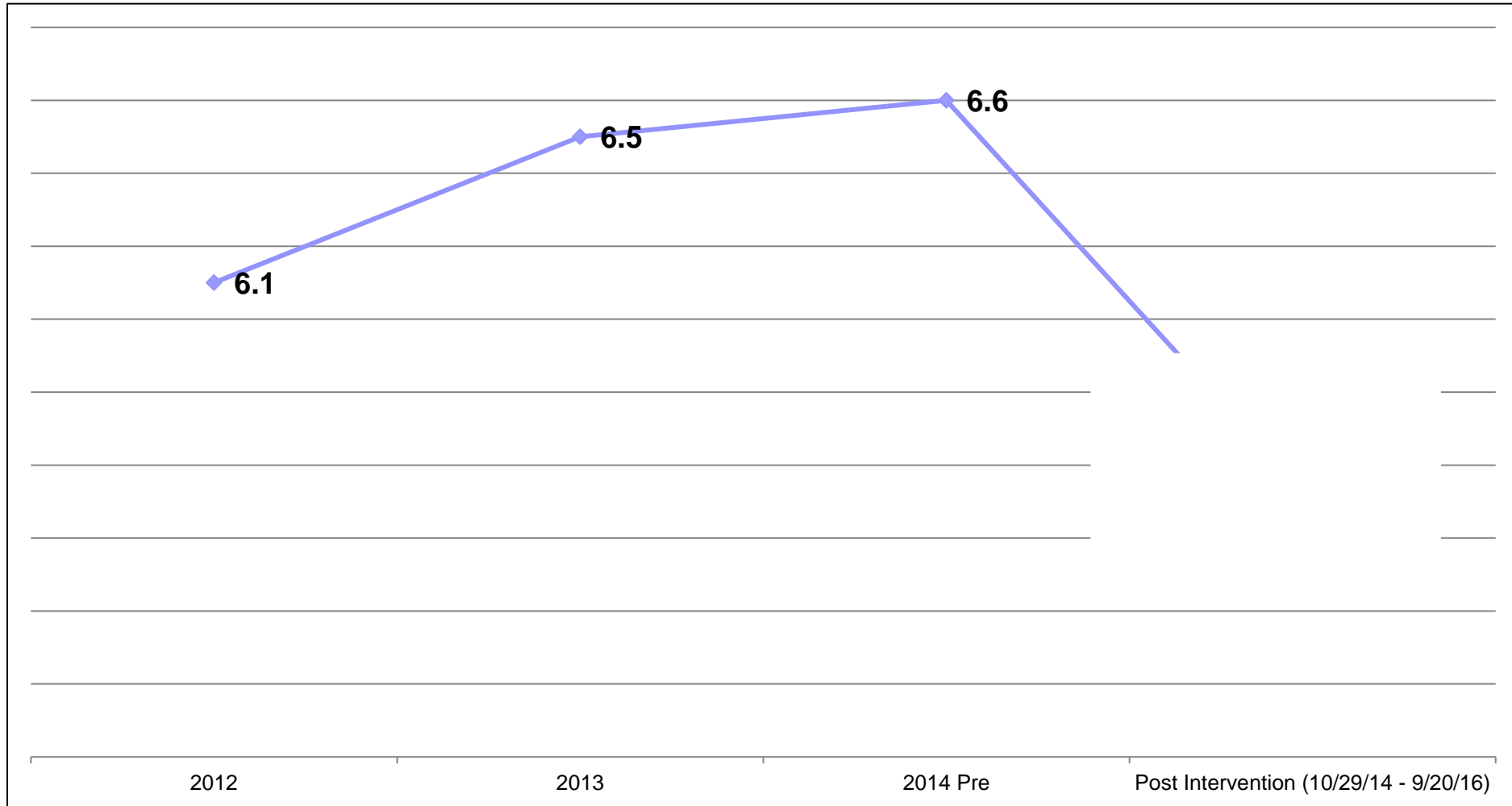


# The Collaborative Solution

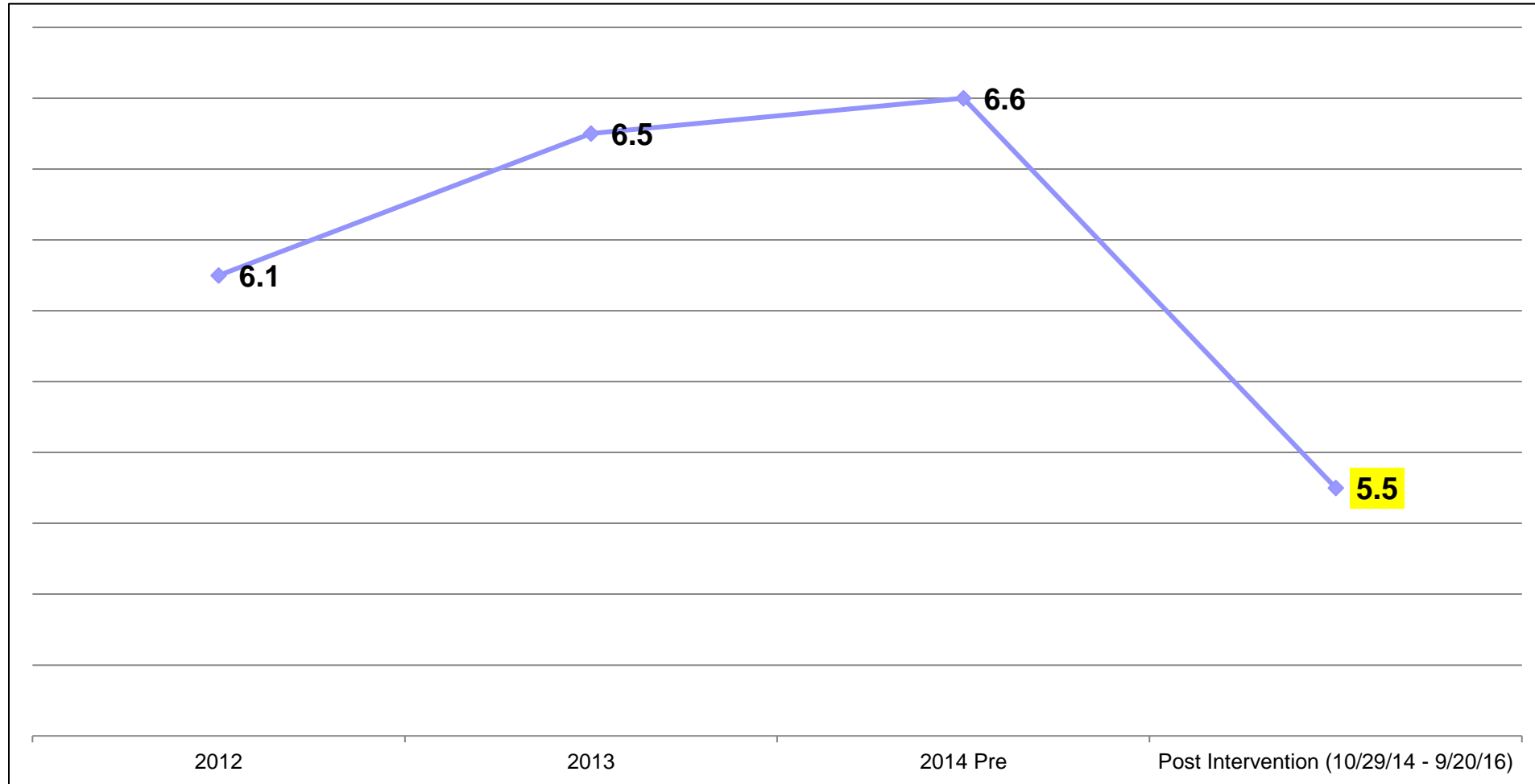
- Fund:
  - 10% Hospitalist FTE time = \$20k
  - 10% Data Analyst time = \$10k
  - 10% Process improvement time = \$10k
- The 'Promise':
  - Lower LOS = Save money
  - Better Outcomes



# The Outcomes



# The Outcomes



# Pre to Post implementation outcomes

Metric	Baseline	Post	Relative change
Average LOS	6.6 days	5.5 days	1.1 day reduction
Percent on unit/on service	62%	83%	34% increase
Calcium prescribed at discharge	30%	88%	193% increase
Vit D prescribed at discharge	40%	89%	123% increase
Bisphosphonate prescribed at discharge	3%	83%	26 fold increase
CBC performed	100%	99%	1% decrease
BMP performed	93%	96%	3% increase
HFP/CMP performed	43%	89%	107% increase
Vit D lab performed	43%	94%	119% increase
PCP (internal) follow up scheduled	3%	69%	22 fold increase
PCP (internal) follow up completed	3%	43%	13 fold increase
MBC follow up scheduled	3%	48%	15 fold increase
MBC follow up completed	3%	25%	7 fold increase
Ortho follow up scheduled	82%	94%	15% increase
Ortho follow up completed	77%	82%	7% increase

Readmissions 3.2% → 2.7%

Mortality at 1 year 25.6% → 13.2%



# The ROI

- Cost
  - \$40k
- LOS reduction 1.1 day
  - Savings = 100 patients/year x \$1,500/pt. = \$150k
  - Revenue = 110 pt days saved
    - 1.1 pt. days saved x 100/year
    - 110 x \$500/day = \$55k
- Return on Investment = 5:1
- And...slightly lower readmissions
- And...significantly lower mortality
- And...publication!



## ■ ORIGINAL RESEARCH & CONTRIBUTIONS

# Geriatric Hip Fracture Care: Fixing a Fragmented System

Mary E Anderson, MD; Kelly McDevitt, RN, MS, ONC; Ethan Cumbler, MD; Heather Bennett, MS, MBA;  
Zachary Robison, MBA; Bryan Gomez; Jason W Stoneback, MD

Perm J 2017;21:16-104

E-pub: 00/00/2017

<https://doi.org/10.7812/TPP/16-104>

### ABSTRACT

**Context:** Fragmentation in geriatric hip fracture care is a growing concern because of the aging population. Patients with hip fractures at our institution historically were admitted to multiple different services and units, leading to unnecessary variation in inpatient care. Such inconsistency contributed to delays in surgery, discharge, and functional recovery; hospital-acquired complications; failure to adhere to best practices in osteoporosis management; and poor coordination with outpatient practitioners.

**Objective:** To describe a stepwise approach to systems redesign for this patient population.

**Design:** We designed and implemented a comprehensive geriatric hip fracture program for patients aged 65 years and older at our academic Medical Center in October 2014. Key interventions included admission of all ward-status patients to the Orthopedics Service with hospitalist comanagement; geographic placement on the Orthopedics Unit; and standardized, evidence-based electronic order sets bundling geriatric best practices and a streamlined workflow for discharge planning.

hospitalists, primary care physicians, geriatricians, and other subspecialists.<sup>11</sup>

Recognition of the fragmentation in geriatric hip fracture care has prompted a call to action by major professional societies, hospital regulatory agencies, insurers, and national and international health organizations.<sup>3,12-20</sup> Despite the strong evidence in favor of a population health management-based approach to geriatric hip fracture care, it can be challenging to introduce any change initiative at the local level. A step-by-step framework for successful systems redesign for this patient population is difficult to find. Our aim is





# Shared Interest Breakout

- Step 1: What does your hospital/clinic want?
- Step 2: What are the business drivers?
- Step 3: How can your project impact those?
- Step 4: What do you need?
- Step 5: Develop your shared interests.



# Summary

- Business drivers are external forces that dictate internal tactics and decisions
- Key to success in negotiation is...
- Never bargain position, rather bargain interests
- 3 key steps
  - Understand what they want
  - Understand what you want
  - Develop shared interests



# Appreciative Debrief

Share with the group one thing you found most intriguing from this session



# Evaluation



# Next Steps

## Due – Session 8, Nov. 19, 2024

- Draft Business Case
- Complete literature review
- Complete program evaluation/QI/Research Tool
- Develop/utilize current vision tying to project

## Due – Session 9, Dec. 3, 2024

- Finalize sense of urgency
- Complete affinity diagram

Happy  
Thanksgiving!

Date Assigned	Assignment	Due Date
#1 – Aug. 20, 2024	<ul style="list-style-type: none"> <li>• Develop group ground rules</li> <li>• Complete Leadership Defined Self-assessment</li> </ul>	Review in coaching
#2 – Aug. 27, 2024	<ul style="list-style-type: none"> <li>• No new assignments</li> </ul>	
#3 – Sept. 10, 2024	<ul style="list-style-type: none"> <li>• Complete voice of customer</li> <li>• Build stakeholder analysis</li> <li>• Develop a problem statement</li> <li>• Meet with Dr. Moksha Patel</li> </ul>	#6 – Oct. 22, 2024
	<ul style="list-style-type: none"> <li>• Complete a process map</li> </ul>	#7 – Nov. 12, 2024
#4 – Sept. 24, 2024	<ul style="list-style-type: none"> <li>• Reading: Kotter, John. <i>Leading Change: Why Transformation Efforts Fail</i></li> </ul>	#5 – Oct. 8, 2024
	<ul style="list-style-type: none"> <li>• Draft business case</li> </ul>	#8 – Nov. 19, 2024
	<ul style="list-style-type: none"> <li>• Complete affinity diagram</li> </ul>	#9 – Dec. 3, 2024
#5 – Oct. 8, 2024	<ul style="list-style-type: none"> <li>• Complete Myers-Briggs Assessment</li> </ul>	Friday, Oct. 18, 2024
	<ul style="list-style-type: none"> <li>• Complete literature review</li> <li>• Complete Program Evaluation/QI/Research Tool</li> </ul>	#8 – Nov. 19
	<ul style="list-style-type: none"> <li>• Complete data collection plan</li> </ul>	#9 – Dec. 3, 2024
#7 – Nov. 12, 2024	<ul style="list-style-type: none"> <li>• Develop/utilize current vision tying to project</li> </ul>	#8 – Nov. 19, 2024
	<ul style="list-style-type: none"> <li>• DEI Scan</li> </ul>	#12 – Jan. 28, 2025
	<ul style="list-style-type: none"> <li>• Complete Positive Deviance Exercise</li> </ul>	
#8 – Nov. 19, 2024	<ul style="list-style-type: none"> <li>• Finalize sense of urgency</li> </ul>	#9 – Dec. 3, 2024
#9 – Dec. 3, 2024	<ul style="list-style-type: none"> <li>• Complete Design Thinking Exercise</li> </ul>	
	<ul style="list-style-type: none"> <li>• Develop list of potential interventions</li> <li>• Finalize guiding coalition</li> </ul>	#12 – Jan. 28, 2025
	<ul style="list-style-type: none"> <li>• Complete aim statement</li> </ul>	#11 – Jan. 14, 2025
#10 – Dec. 10, 2024	<ul style="list-style-type: none"> <li>• Finalize logo</li> </ul>	#13 – Feb. 11, 2025
	<ul style="list-style-type: none"> <li>• Draft mid-year report out</li> </ul>	#12 – Jan. 28, 2025
#11 – Jan. 14, 2025	<ul style="list-style-type: none"> <li>• Complete pre-mortem assessment</li> <li>• Create and implement a communication plan</li> </ul>	#13 – Feb. 11, 2025
	<ul style="list-style-type: none"> <li>• Finalize mid-year report out</li> </ul>	#13 / #14 – Feb. 11 or 25, 2025

